THE ASPEN INSTITUTE

SPOTLIGHT HEALTH

DEEP DIVE: DRUG PRICES AND ACCESS TO MEDICINE

Doerr-Hosier Center, McNulty Room
Aspen, Colorado

Friday, June 24, 2016

LIST OF PARTICIPANTS

KIRSTEN AXELSEN
Vice President Global Policy, Pfizer

GEOFFREY CHAIKEN
Co-Founder and CEO, Blink Health

KEN DAVIS
President and CEO,
Mount Sinai Health System

EZEKIEL EMANUEL
Vice Provost for Global Initiatives,
Diane V.S. Levy and Robert M. Levy University
Professor, Chair of the Department of Medical Ethics
and Health Policy,
University of Pennsylvania

LISA GILL
Deputy Content Editor, Best Buy Drugs,
Consumer Reports

KIAH WILLIAMS
Co-founder and Director at SIRUM

ALAN WEIL
Editor in Chief, Health Affairs

* * * * *

DEEP DIVE: DRUG PRICES AND ACCESS TO MEDICINE

(1:15 p.m.)

MR. WEIL: Good afternoon. My name is Alan Weil. I am editor in chief of *Health Affairs,* we are the leading health policy journal in the United States. And I'm really honored to be able to moderate this afternoon's panel. We're taking a deep dive on drug prices and access to medicine. In Aspen deep means 90 minutes instead of 60 minutes.

This is a topic that has many facets. And obviously, even with our 90 minutes we can't cover them all. But I thought I would just set the stage for a moment and then bring our panelists in, as we start to tell the story and analyze these issues.

Prescription drugs that count for about 1 out of 10 of the $3 trillion we spend on healthcare every year in the United States, they are a big part of the healthcare sector. And we go through various cycles, where we pay a lot of attention to prescription drugs and then we kind of forget about them.

The last time we were seeing big spikes in prescription drug spending, it had to do with blockbuster drugs coming online but as they went off patent, the share of spending going to prescriptions tapered off and people sort of let the issue go away.

The issue is very much back on the horizon partly just because people now have health insurance products often that have significant patient cost sharing. And so they are seeing the price of drugs. But there are at least two fairly different phenomena that are leading us to the conversation today. And we're going to try to make sure that we cover both of them although doing either one of them full justice would take more time than we have.

One is at the very high end and people talk about the Sovaldi or Havoni to address hepatitis C, sorry. And we also talk about very high end cancer drugs, specialty drugs; drugs that can cost $100,000 a year. Even those two examples are very different. When you compare them, they are high cost, but in terms of the expected lifesaving value and potential and potential savings for the healthcare system, they're quite different. And so even just talking about high cost specialty drugs is a very heterogeneous category.

At the other hand we have the highly -- the high volume, high prescription often generic drugs, where again you would imagine that prices would be falling with competition but we're seeing costs out of reach for many people in that area as well.

And so as we unfold the conversation today, we're going to try to keep our eyes on both ends of this market because they affect us all. And you may have had an experience with one market or the other but we're going to try to bring them all together.

So if that's sort of the global picture and why it is we need to have this conversation, a scholarly journal like ours, we tend to talk about big numbers, hundreds of billions of dollars and how much we spend.

But I'm going to start by asking Lisa Gill from *Consumer Reports* who has just completed some work on this issue, not from the perspective of the overall healthcare system but from the perspective of patients and families. Tell us what you've learnt.

MS. GILL: Thank you, Allen. Before I begin, I have two disclosures I just have to tell you. The first one is you will see all my comments come from the place of how this problem affects consumers. And yes, we are concerned about the system but we are looking at this problem acutely, how it affects every day Americans, that's the first thing.

And my second disclosure is that I wanted to work at *Consumer Reports* ever since I was a kid. Yeah, even when I had a paper out. And that's why I was particularly honored to be able to work on a recent special investigation on high drug prices. We can see from this that our work that this problem, the impact is real and the scope is huge. We spoke with hundreds of consumers about this problem. We looked at hundreds of their stories and we were astounded.

One of them that I wanted to just share with you because it's actually unremarkable but sad in how common it was, was a story of Marlene Condon.

She actually appears in the magazine story. She is about 50 years old. She is from Virginia. She has rheumatoid arthritis and a drug works for her, a really old school generic hydroxychloroquine. She has been taking this drug for a long time and it's been really inexpensive for about two decades. But -- and she spends about $30 for a three months supply. But a few months ago back in the fall, she went to go fill a prescription and the pharmacist told her, "Marlene, hang on to your head because this --

SPEAKER: Right.

MS. GILL: -- drug price went up. And it wasn't by just a little bit, it went up to more than $500. So Marlene has insurance, which is great but her insurance, the deductible is $12,900, so she was never going to meet that in a year's time, so she had always had been paying out of pocket.

She did what thousands of Americans did and have told us that they do, when a price hike is this profound, they just walk away from the prescription. She did not fill the prescription, so as many physicians in the audience, you know that by not taking your rheumatoid arthritis treatment, not only do your symptoms get worse but the actual disease worsens.

Marlene told us in an interview that her doctors were furious at her because that she had become debilitated from not taking her drugs. She couldn't even do normal household chores. She finally went online and through using some coupon, discount coupon services, actually similar to Blink Health, which we'll hear about later, also GoodRx some others that we'd looked at, she was able to get the price down something closer to $300. Now that is still a profound amount for her. She said she struggles with this.

Marlene and her situation, we estimate she was one of 33 million Americans just in the last 12 months who told us that their drug prices had hiked unexpectedly at the pharmacy counter for drugs they take all the time. So it's not just high-end very expensive drugs, it was old school generics. It was branded drugs, it was everything.

The average price people paid extra was about $62. Now, that may not sound all that big of a deal. I don't think for our panelists here $62 will be all that much more and maybe for you guys not either. But for the -- the average household income in this country is about $52,000. So a $60 hike in price for something that you take all the time, you don't get any extra benefit or value to, turns out to be a really huge deal.

The problem with -- and the most amazing thing from Marlene's situation is that there are no protections. There are no laws from Congress. There are no rules or regulations from the FDA, the CMS, from the FTC that stopped that situation, there are no emergency brakes from Marlene and millions of people like her.

And the problem with that is that we could also see from our research that high drug prices just like what Marlene experienced negatively impacted people's household incomes and actually how they organized their household finances. And the most disturbing thing that we found is besides people cutting out things like dining out or going, you know, going to Disneyland or taking their

families out to other places is that they stopped buying groceries, which was just unbelievable to us.

They also had to reorganize finances in terms of using their credit cards more often just to pay for everyday household expenses. They also postponed paying bills. Some people told us they wound up getting a second job or they postponed retirement in order to pay for their medications. It was astonishing.

Other people didn't go to the doctor when they should. They didn't fill prescriptions like they were supposed to. And when they did fill them, they didn't take them correctly. So my challenge to this panel and actually to all of you, you know, this conversation takes place in the ethics track and my question is how many more people have to suffer with this problem before we come up with a real world solution. How many more families will need to choose between very important medications that they need and groceries, and that's my challenge. Thank you.

MR. WEIL: Thank you.

(Applause)

MR. WEIL: Well, Kirsten Axelsen, you're from Pfizer and I'm sure you hear these kinds of criticisms all the time, do we need more rules? Do we need more breaks? Is that the way that we address the concerns that we just heard about?

MS. AXELSEN: Well, first of all, thank you. Thanks for having us here today and for convening the panel. Like Lisa I came here, wanted to have a conversation that would lead to solutions; because as there has been a huge amount of medical innovation over the last 10 years and we've seen -- or 20 years really, we've seen 5-year survival rates for a number of cancers reach and exceed 90 percent.

The kinds of drugs we're developing are completely different. They are targeted, they tend to be more for conditions where there are no alternative therapies. They generally achieve larger incremental improvements in health.

The way we do delivery of reimbursement has not changed in this country in decades. We're still doing reimbursement delivery negotiating with health plans the same way we always have. We also had 40 new medicines get approved by the FDA in 2014 and 2015 at exactly the same time health insurance plans lost a lot of the tools they had to manage risk.

So if you get that person who needs hepatitis C drug or a drug for cancer, you don't have the same tools that you used to have to spread their risk over a longer period of time and you're operating in a very competitive pool.

We don't have incentives that allow health plans or really anyone in the healthcare system to consider value over a long period. You know, this last time we saw drugs spending growth in the double digits, which it was 12 percent in 2014. The last time we saw that kind of drugs spending growth was in -- around the 2000's.

If you look over the 10 year period, total drug spending over 10 years grew less than hospitals and physicians. That's the way drugs are, there is a spike when there's a lot of new innovation then the drugs go off patent. There is 90 million people taking a generic medicine from Pfizer. The prices have gone down 90 percent for those drugs. But what is a failure and some of it has to be addressed is exactly the situation that Lisa had just raised.

When there are older generic medicines or medicines that are for very small conditions, there is not enough competition. When you are the sole source supplier of a generic, there is a lot of pricing power. We need to work on addressing these failures and addressing ways so

that plans, patients and providers all have the ability to take the preventive care they need and reap the benefit of it. And you ought to be able to make money as a health insurance company by bringing a sick person into your plan and making them better.

MR. WEIL: So help me understand one of the comments you made.

MS. AXELSEN: Yeah.

MR. WEIL: Health insurance companies lost one of their tools for managing risk.

MS. AXELSEN: Yeah.

MR. WEIL: I'm not -- first of all I'm not sure I understand it. Second of all it sounds to me like that's a tool they would use against you, so I'm not sure why that's a place you focus.

MS. AXELSEN: It's a good thing in that you have take all covers. It's a bad thing if you haven't planned for the person who needs that very high cost medicine. And we happen to have the very high cost medicine, the hepatitis C medicines come on the market, at exactly the same time the plans were operating in this very new environment. It's a good thing that it was brand new, you know, 2014 was an incredibly challenging year for everybody to operate in this new environment.

You know, the hepatitis C drugs were found cost effective by NICE, right, in the UK. These drugs are found cost effective over a long period of time but they're very difficult to manage in an annual budget cycle. They are so incredibly difficult to manage, if you're trying to put a premium out there that says, low as possible so you can attract as many beneficiaries as possible.

MR. WEIL: Okay. Zeke, you've given us some thought from a number of perspectives. Your title

affiliates you with the University of Pennsylvania but give us your perspective on this --

MR. EMANUEL: So I just want to make four quick points. The first one is Alan, I don't like to correct moderators but I think it's really important to not say that drugs represent only 10 percent of healthcare spend. That is true if you go look in the books, the National Health Expenditure it says 10 percent but they don't include all drugs in that number.

The true number is somewhere between $1 in $7 of healthcare spend, so about 17 percent. And for most insurance companies it's now over 20 percent of their spend expenditure is related to drugs and for particular kinds of patients like multiple sclerosis patients it will be 40 percent or 50 percent of their total healthcare bill is related to drugs.

That makes it a much bigger problem, not a small minor problem and for many years the drug companies said, "Listen, we are only 10 percent, don't worry about it, it's a small amount of money. Look at them, the hospitals; look at them, the doctors. It's a big, big chunk of the bill."

The second thing I would say is that drug pricing is totally irrational. There is no rhyme or reason to it. And I just want to give you a three or four examples. We're willing to spend as a society about $5,000 for a lifesaving antibiotic. The latest ones against MRSA approved a couple of years ago; $5,000. For an antiviral that also cures hepatitis C $50,000. We're willing to spend 10 times more. For a drug that treats cancer and maybe gives you a 2 or 3 months it can be a $150,000. And then for a drug that will maybe slow down multiple sclerosis but certainly won't cure it and won't get you dancing in the streets, another 150 or so thousand dollars.

Does this make sense? We cure people on one hand and it's a low price. We give them a few months, we don't cure anyone. It's a super high price.

So one of the solutions is -- this is a panel about solutions -- so my third point is we should have a more rationale system for pricing drugs. Now, we have proposed that they be what's called value-based pricing. The price of a drug order ought to reflect the value in terms of health improvement it gives you.

It's hard to determine health improvement when you first approve a drug, right? Because you don't have a lot of data on small numbers of people in clinical trials. But you'd make an estimate there. You come back three years later with more data, make a revised estimate. So that would be the first part of our proposal.

The second part of our proposal is drugs on the market. We should not be seeing 10 percent 20 percent price increases year by year. They're not getting that much more valuable and most of these the value or the health improvement hasn't really increased dramatically. Those price increases should be no greater than the price increase in the general economy.

And the last point I would make in this proposal, this three part proposal is that in response to this moderation of drug prices relating it to the value that they bring in terms of health improvement, insurance companies ought to say, "Well, if its priced by value, we will actually put it in a preferred tier so that patients don't get super high copayment levels, so that they can actually take these drugs."

I will say we've had discussions with a lot of drug companies, not Pfizer, about this. They have not been willing to come out publicly and endorse it and even in private conversations they hem and haw about lots of other things; passing the blame, as you heard, to insurance company design or to this design and not to their own pricing.

So I think that's a reasonable plan that we suggested. I think it's actually a solution. And my last point is, the fourth point here is, when will we get solutions to your patient, 2021, after the next election. Because it will become so intolerable that the American public is going to demand action.

Now there is a conditionality I would say on that my last, final, final point really Alan is --

SPEAKER: We can't wait that long.

MR. EMANUEL: Right now, Medicare-- I know, I know it's a long time to wait but it's just -- that's politics. Right now, Medicare is debating a new way to pay for things like cancer drugs. And the drug companies have pulled out all stops to try to kill it. They've gotten -- released the oncologist doctors; my colleagues, I'm an oncologist; they've released the patient advocacy groups, they heavily support with their money. If that goes down, if the drug companies are able to succeed in killing the CMS reform proposal then we might not see actually any drug reform proposal. That -- being able to pass that is going to be critical to getting our arms around the drug cost problem.

MS. AXELSEN: Could I respond to that --

MR. WEIL: So, yeah. Before I --

MS. AXELSEN: Yeah.

MR. WEIL: I was just going to say to the audience that we're going to sort of tee up a few topics and some of them we'll circle back to but I want to get everyone into the conversation. Why don't you give a quick --

MS. AXELSEN: Yeah.

MR. WEIL: Just on -- if you could just focus on value --

MS. AXELSEN: Absolutely.

MR. WEIL: -- purchasing side because there's a lot there.

MS. AXELSEN: And, you know, it's not passing the blame to drug companies -- to health insurance companies. I'm saying that the health insurance companies need the right tools to be able to negotiate price better. I mean we've seen prices come down over the last year. The average branded price grew by 2.8 percent in the last year. So while you're seeing these big list price increases, a lot of that is being given back in discounts because pharmaceutical companies and health plans are negotiating.

As far as making access available to patients, I agree. The drugs once they're approved and when they are found value-based, they need to be on the formulary and available to the patients without the same kind of caution and hurdle. You know, there are -- so, of course drugs should be value based. Pricing should be value based. Well, let's just say that health plans aren't doing that with their pharmacy and therapeutics committees.

We're going in, we're negotiating, we're using evidence, the evidence that is available on a drug is first approved is the most limited it's ever going to be. You know, the two or three months of life for a cancer medicine, that is based on the clinical trial that's typically done on the person who has the most severe disease.

As the drug is used in people of less disease severity, you do see longer and longer increases in life. And there's a downside to sort of having a single entity do value based pricing. There were no medicines approved by NICE for cancer in 2013 and 2015. So there does need to be a balance. We're all trying to work towards value-

based pricing. Let's do things that really test the value of our medicines. Let's open up the evidence that's in real world data sources so that we can see what medicines are actually doing in practice. Let's make it easier for --

MR. EMANUEL: I'm going to find it really hard, really hard to sit back. Is Pfizer willing to publicly say it value base -- it prices its drugs today based upon their health value.

MS. AXELSEN: Pfizer? Yes.

MR. EMANUEL: All of your drugs, all of your $100,000 drugs are value-based.

MS. AXELSEN: And when you --

MR. EMANUEL: Excuse me, you have cancer drugs where the price per life say -- per year of life say is over $250,000. That's not a value based price.

MS. AXELSEN: Why would a health plan pay for a medicine if they didn't believe there was value in the medicine. We've got health plans that have as many lives in them as many countries do. They're negotiating the --

MR. EMANUEL: I don't want to hijack it Alan but --

MR. WEIL: Yes, you do, but I won't -- so --

MR. EMANUEL: I know -- I've controlled myself. It's difficult as it is.

MR. WEIL: So let's -- as I say we have time for a deep dive but I want to take a comment, Zeke that you made at the beginning, which is that drug pricing is irrational. Geoff Chaiken, you have built a business around the -- trying to address that irrationality, it was alluded to in Lisa's comments, why don't you tell us where -- what you are up to and how it fits into this ecosystem?

MR. CHAIKEN: Yeah, thanks Alan for having me and thanks everyone for joining. I think what I actually want to start off with you is sort of describing how dysfunctional -- a different element of how dysfunctional this market is and why it's dysfunctional. Because once you sort of understand what's going on underneath the hood, you are in a position to solve it, and I don't want to wait till 2021. Till then -- or wait till politicians solve the problem, I think that the private sector and entrepreneurs in technology and in collaboration amongst all the people on this floor can actually solve the problem a lot faster than that.

So the first thing I want to say is that the pharmacy is like one of the most bizarre places out there. It's the only place in retail where people don't know what the price of the product is till they get to the pharmacy register. And I want to sort of put a hypothetical situation out there. Imagine Ken, CEO; me -- or actually Zeke, the VP and me the guy that they just laid off, went into a Publix groceries store. And we each had -- we were in three separate lines, we each had the same white loaf of bread, cost a dollar to manufacture.

Ken went in, he paid $4 for that white loaf of bread. Zeke went in, he paid $20 for that white loaf of bread. I go in, I'm just laid off, I pay $150 for that white loaf of bread that was manufactured for a dollar at the bakery next door.

If that happened in the grocery store there would literally be a riot. That's actually what happens every day in the pharmacy. There is no transparency and people pay radically different prices for exactly the same product at the same store. And so what that means is that with that lack of transparency you have no traditional market forces that are operating. And the outcome is that you have this irrational pricing that everyone is sort of talking about at the table here or on the panel here.

And what that ends up leading to is what Lisa was actually referring to, which is actually that 35 percent of medications are just left at the pharmacy counter, which is like it's a completely shocking statistic. And 50 percent of medications are actually just not taken as prescribed. People are pill splitting, they're missing their doses and that's obviously a huge tragedy for them. It's also a huge tragedy for the overall system because a lifetime of medications in many cases is cheaper than a few weeks in the hospital.

So there is a major problem that patients are facing. And actually providers are facing a similar problem, which is that just as patients are blind to the price of medications before they get to the pharmacy counter, physicians are blind to the price of medications before they get to the pharmacy counter.

So a doctor has plenty of tools to determine what the -- whether a drug is therapeutically appropriate. There is a whole bunch of things that are integrated into their EMR to determine what the safety and efficacy of a medication is. But they have no idea what the price of the medication is. And the reality is that if a price -- if medication isn't economically appropriate for a patient it's not therapeutically appropriate for a patient because they don't take it.

So this is a major problem and it's a problem for patients. It's actually a problem for providers. It's a problem for pharmaceutical manufacturers. It's a problem for pharmacies and it's an overall problem for the system. The reality is that pharma companies aren't winning in this battle. Pharmacies aren't winning in this -- everyone's losing. There is just literally everyone losing.

So the good news though is that these are -- this type of problem, where you have this type of market inefficiency, is a problem that we know how to solve as a society. We've done it over and over again. And the basic thing that you need to do in order -- so, the first

thing it has to happen is we have to move these transactions online.

So what happens, basic what happens today in this industry, it's the last major industry where there is no digital transaction. There is no ability to purchase those medications online. And so that prevents the Amazon effect from effectively happening. And we've seen the Amazon effect in books. We've seen it in travel. We've seen it in transportation. We've all experienced that across almost everything that we consume every day, as goods go online you dramatically lower prices and you improve experiences. And the reason that you lower prices is, there are two reasons that are -- two things that happen with the Amazon effect.

The first is that you're able to provide transparency, so even if you only have 10 percent online penetration the local book store, the local grocery store has to compete against that transparent price that causes prices to go down. You're also able to aggregate demand. And the third thing that you are able to do is you're able to improve experiences by doing mass customization. We've all experienced that as we've gotten recommendations or we've been able to use points or loyalty points or other things to improve our experiences.

So that's basically what we're doing at Blink Health, which is we're not waiting till 2021, until politicians change the laws. We're moving this category of commerce online today that allows us to dramatically lower prices.

And we're doing it actually in partnership with everyone. The beauty of it is that Blink today is available at every single pharmacy in the country. So even though we're providing lower prices on medications, those pharmacies are actually partnered with us for generic medications, which are 80 percent of fills. We're now working our partnerships with every major pharmaceutical manufacturer.

So while they may not want new legislation they're very eager to work with technology companies that are figuring out ways of making sure that the right patients are getting the right medication at the right time for the lowest cost. So -- go on.

MR. WEIL: So before I bring our last two -- and I just want to return, Lisa, you set the stage for us. Are you now confident we aren't going to have to wait till 2021?

MS. GILL: Well, no, so, you know, Blink Health and other sort of discount online coupon offerings are excellent, I would say, stop-gap measures and they are a symptom of like a larger problem. And there are services that we recommend people use but, you know, there's some important things.

One is that what they pay doesn't actually go toward their deductible, so it doesn't -- this is all happening kind of like outside the insurance system. We have often said that's the best way to get a good deal, which is just like mind blowing to me. I mean insurance companies and pharmacy benefit managers exist for the very sort of public trust in order to protect people from high prices. And yet, it's bizarre to me that you can -- I mean the service is great but we also have to acknowledge it's a symptom of like this larger problem.

So it's a good service but it's like not -- I worry tremendously that it is just these stop-gap measures to help people afford the day-to-day drug.

MR. CHAIKEN: What I'm referring to, there's two different things. So what Lisa is referring to are what are called discount card providers, which is a product that's been around for a very long time. And so, actually what you're seeing with Blink -- and the reason I haven't spent enough time about what we're actually doing in detail but is really just the tip of the iceberg.

It's -- Blink doesn't all these problems today. What we basically did is we took the top 100 medications, which represent about 80 percent of fills and we made those dramatically expensive. The last 20 percent of fills, which are branded medications and also more rarely taken generics, we haven't focused on. But it's the fact that we move the transaction online, not the fact that we're giving a coupon because a coupon is an existing product. That then allows you to begin negotiating with all the parties who are sitting at this table right now and create transparency that -- it's just the beginning of being able to lower prices.

And so that's a fundamental difference that hasn't happened before. There is today 0 percent ecommerce penetration in the pharmaceutical industry.

MR. WEIL: So I want to bring our two last panelists in so that we can have even more exciting exchanges than we've had thus far. Ken Davis from the Mount Sinai perspective. When, Zeke, when you said you don't like to disagree with the moderator and you -- which is fine and but then talked about the role that pharmacy plays. And I certainly agree with you on accounting.

From a health system perspective it's even larger because prescription drugs are integral to the whole continuum of care that you provide. And so as you take this issue on, from a health system perspective, where does it lead you in terms of access and the ethical issue that Lisa started us off with?

MR. DAVIS: I've given a lot of thought to these questions and what can we do to fix it. And what are the macroeconomic circumstances that get us to this place. So one of the things that our colleagues so far from the pharmaceutical industry haven't talked about is the cost of developing a drug. And the question is, what's a fair return on investment for that cost. And what troubles me a lot about the Sovaldi and Havoni situation is that the cost of developing that drug is relatively modest. The

cost of buying the company that originally developed that drug was a lot of money.

And yet they produced for us to ingest as consumers a very new model of how to price drugs. Because instead of saying we want a fair return on investment they said, "Let's think about how much money we're going to save everybody in the healthcare system because they won't have the complications downstream of hepatitis C."

And I looked at that and I said, "My God, I can't remember other companies saying that with some extraordinary drugs." And I thought back on, imagine if we had modelled penicillin that way. Imagine if we had modelled a polio vaccine that way. In fact, when I was in second grade I got the polio vaccine free. Imagine what would have happened if somebody had said let's figure out the downstream costs, we're going to save the healthcare system with the polio vaccine. I'm sure my parents couldn't have afforded it.

So how have we allowed that to happen? I think in part we've allowed that to happen because -- and we forget this -- that the cost of drugs in the rest of the Western world and the rest of the developed world is a fraction of what it is in the US. Because we have not allowed trade policy to turn to those countries and say the US citizen isn't the only one who is going to support R&D in the world.

And I think we've got to make this a trade policy as well in order that American citizens don't have to pay the whole cost of R&D. I would also want to address the issue of generic drugs.

I mean this is awful, we see this in our formulary all the time. We see drugs that previously were very low cost, suddenly have a single supplier and be either unavailable or at a ridiculous price. And the question is, how did we let that happen as a country? And my partial answer to that is we have lost sight of the fact that when a generic drug is approved by other

regulatory authorities in the Western world, from other drug companies that are quite capable, and would be, I'm sure, more than willing to have their plants inspected by FDA, that we haven't then facilitated a rapid importation and a rapid approval of drugs that are generic that we've already had that are being sold in Europe, right here in the US.

And we should identify when they are a source of sole providers and move very quickly to facilitate importation on those generic drugs. So I'd like to see some of those solutions really come to fore.

MR. WEIL: So before I bring Kiah in, I just want to -- I'm going to turn to Zeke. The notion of pricing on value, we are doing that in healthcare all over the place. It does seem like drugs are a ripe opportunity. I just heard a pretty good critique, if you look at this historically, I just wondered how you respond to that.

MR. EMANUEL: Yeah, I think Ken is certainly right. One way of pricing drugs is a return on investment or capital investment. My feeling is we are not going to get to that place. And that's not how we price drugs today. And I don't think we could get agreement on that. So I think pricing on value as you point out, it's something we're building into the health system in every other place and it's something that I think drug companies should be forced to agree to.

Let me just add one other element about this drug importation issue that Ken mentioned. I talked to the FDA, senior FDA officials. I noticed that the commissioners over there, they were very happy that it takes them 23 months to approve a new production line on generic process, it's down, and they think they're going to down to 10 months. 10 months? I think that's -- you know, it's better than 23.

But the fact is, just imagine if we said to Google or anyone else who is doing some, "All right, you

got a new product, you got the new thing you want to run, 10 months we're going to have to look at it before you can release it." I mean, it just doesn't seem like that is the speed of our commercial markets today. And I think we -- you know, there is a lot of reasons for it. Not enough funding of the FDA, et cetera. But I do think we need to be able to have much faster introduction into the marketplace so a market can work effectively and when prices are irrationally low or are irrationally raised, you can actually get some competition quickly.

And Ken's got one idea. I think that's quite reasonable but not the only thing --

MR. DAVIS: I want to make a comment though about the problem with value and qualities. As a ex-neuroscientist who developed -- you've developed drugs and worked with drug companies and have some expertise in psychotropics; I look at some of the things that NICE writes and I think, "God, those guys don't have any nuance." I mean, where is database for some of those conclusions? They just are not the experts that are really necessary to tell you what the quality really is.

You talked about the conclusion of a Pfizer study may only give you a 2 to 3-month extension but they are the sickest patients. That's exactly right. The databases are so narrow and that when non-experts begin to look at those databases and they are driven by the economics of, you know, taxpayer-paid healthcare systems, what happens is you wind up with silly solutions.

And I'm just not sure that we're going to have the qualifications to make the right decisions if we're simply based on qualities; which takes me back to maybe an idealized world.

But I think there used to be a social contract here. And that social contract between the pharmaceutical companies and the taxpayers and consumers was, "We're never going to have an exorbitant price. We're going to fairly price so that everybody can afford drugs." And

somehow that's been lost. Now maybe it's because they're different generation of CEOs, who instead of being ex-MDs and scientists are now lawyers or marketers. But it's just they've broken what was the social contract.

MR. WEIL: So I need to bring Kiah in because she's been sitting patiently. Kiah Williams, you're at SIRUM and you're looking at another angle on gaining -- providing people with access to drugs. Why don't you describe a little of what you all do?

MS. WILLIAMS: Yeah. I want to tackle this from a larger med area of -- healthcare spends, what, $3 trillion a year, right? Some estimates suggest that the amount of money that is wasted in our system is as much a third. So we have a huge healthcare system that is just wasting resources kind of left and right.

One of the things that we are looking at, for example, is drug waste. So there's an estimated above $5 billion of unused medicine that's going to waste every year in the United States.

This is not necessarily the medicine in your medicine cabinet. People always ask, "Well, can I just give you my drugs and you'll get them to someone who needs them?" I mean, where -- we do see a vision at some point where we could safely take back medications if someone is no longer needing them and potentially put those back into the supply chain. But it's actually a waste -- kind of small amounts of surplus everywhere in our supply chain from manufacturers and wholesalers who -- you know, every time there is drug shortage, the first place everyone looks, the manufacturer or wholesaler, how did you let this happen.

So everyone has these built-in supply chain surpluses of 5 to 15 percent when you're a multi-billion dollar company this ends up being a lot of drugs. And so straight through the supply chain from manufacturers to wholesalers down to hospitals, nursing homes, assisted

living facilities, all these places have small amounts of surplus.

And guess what's great about the surplus. It exactly mirrors the medications that are being prescribed because they were prescribed and paid for, et cetera. So we have this really interesting dataset of all these medications, including some of the very, very expensive branded medications that we see kind of just right now going into, the best case, the medical waste incinerator. Worse case, they're being flushed down our toilets. And we see that happening across the US where our water supply is just getting, you know, hammered.

So our whole vision is how do we take this. We know there is billions of dollars of surplus. We know that about 1 in 4 working-age people in the United States right now can't afford the prescription drugs they need to stay healthy. I think you spend a lot of great time talking about how people who are insured can't afford their medications because they have very high deductibles. They have also very high co-pays. What happens when your co-pay for a generic medication is $25 and you have diabetes and heart disease and now you are spending $100 or more a month on co-pays alone? The answer is people don't take their drugs. People split their pills, people skip groceries.

We've heard patients who've literally told us that, you know, for them it's a difference between paying their rent and buying the prescriptions they need to stay healthy. While at the same time we have $5 billion of medicine right now that's going in medical waste incinerators and in our toilets.

So, essentially what we are trying to do is how do we match this waste, which is $5 billion at -- that's at net add value, so that's not the retail value in which a consumer walking into a pharmacy is going to see, how do we match that waste with this 50 million people who can't afford the prescription drugs.

And, you know, I think this is one solution of how do we just do better in healthcare of taking better care of the resources that we have, how do we utilize those better so that, for example, physicians and providers don't actually have to make the -- a very tough decision between what they deem to be therapeutically appropriate for economic reasons, because we also see that where providers are saying, "Oh, I know you can't afford this medicine. I'm going to go off of this big box retailers, $4, $5 formulary even though I know this isn't the best treatment plan for you."

So I think that there is just -- this is just one avenue in our $3 trillion healthcare system where we ought to do better because the people who are suffering are not the people on the stage. The people who are suffering are the people who are uninsured or are under-insured with plans that are very expensive and are basically what we call bus insurance. If you get hit by a bus, you might not go bankrupt. But for anything else, good luck.

So I think this is where in the healthcare system this is just one area where we just need to do better with the resources that are already out there. We need to all collectively think about what are ways that we can reduce some of these costs. This is not from our perspective, they are all these ethical issues of how much should someone pay for $120,000 hep C drug right now. Like, that's a serious ethical quandary of who is paying for this, how are they paying for it.

But I think what -- you know, our kind of common sense perspective is there is a lot of issues in healthcare that are very complicated. And maybe it's going to require legislation or new administration, we are not sure. But there's a lot of things in healthcare right now that just really suck and we can do something about them today. So why don't we start working on that now? And I'll leave it up to other folks to figure out the tougher policy to --

MR. WEIL: So now that everyone's been able to join in the conversation, I want to keep us on this ethical lens because we're in the ethical track. And appreciate it, at least you mentioning of it at the outset. And I'm going to try to go down two paths and we'll see how long they take, maybe we'll only make our way down one.

Ken, I'm very drawn to your final -- your most recent comment about the limitations of sort of clunky valuation metrics, the notion that once you disaggregate a population you may find a subset of the population, where the effects are quite large, the majority it's quite small if you do some sort of averaging. It looks like something is of low value. And certainly, if you want to promote discovery and advancement, we need to invest the capital. But from -- the ethical question, I wonder is, is sort of the -- again, a little bit of where we started, which is somewhere someone is paying for that advance.

It's either built into their insurance premium and it's built into their taxes. We've heard stories of people who are struggling to afford the basics. And so I guess the ethical question is, even if those valuation formulas or calculations are somewhat rough, it's -- seems to me it's pretty hard to deny that we are imposing upon people, either through taxes or premiums, the requirement that they contribute to the development of these products, where the yield is probably less than paying -- than what they would get if they were covering their rent.

So I just wonder if we could talk a little bit about the tradeoff and the ethics of advancing medicine, which is something we all want to do, but also taking into account the pinch that it places on people. Chaik, go ahead?

MR. CHAIKEN: Yeah. So I think -- I actually think what you're sort of asking is the pricing versus access debate. And I think you actually have to tie those two things together. And I think that most people don't

really understand what's going on and why price and access are actually the same issue.

And actually I think that the US system has an opportunity to leapfrog what's going -- I don't think this is the most perfect in Europe either or in other parts of the world, where the way pricing happens is actually restricting access.

So effectively you've just, sort of -- you know, with the way that it works in the US, it's also the way that it works in Europe. The payers, whether they are countries or whether they're insurance companies, is essentially pit Pfizer versus Merck against each other. And they say, "We're going to give you access, we're going to give you a lower tier on the formulary to our population of patients, whoever gives us a lower price on those medications." And there is a war that goes on. And in some insurance plans, it's Lipitor that gets on the formulary and in other insurance plans it's Zocor that gets on the formulary.

And they do this -- they are able to do this more effectively actually in Europe than they are in the US because there is only a single payer, and so they're able to negotiate even lower discounts. But at the end of the day, that's actually a terrible system for patients because we have overwhelming evidence today that different patients respond differently to different medications. There are some patients who should be on Zocor, there are other patients who should be on Lipitor. And so if you've negotiated a 50 percent decrease in the price of that medication, Lipitor versus Zocor, the amount of expense that you're going to cause the system by having a patient on the wrong medication actually doesn't work.

So a lot of the debate today is about basically whether it's a return on investment model, or whether it's a value-based medicine model. We're basically talking about regulating pricing. Every time you regulate pricing, you know, you basically destroy innovation in some way, shape, or form and there's a winner and a loser.

And the reality here is that right now the people who are losing the most are patients because they're either overpaying for their medications, or the medications that they want are not on their formulary, they are just not available to them.

And so I think what actually has to happen is we have to create a system, where the pie can grow for everyone because the only way that we're going to get changed is that the pharma companies actually have to get bigger, they have to -- they have to be -- they're only give up things and work collaboratively if they can actually generate more sells. And at the same time, we have to figure out ways of taking that -- those benefits and giving them to patients and to health systems in ways that the whole pie gets bigger as opposed to Zeke arguing that, you know, we need to lower prices and basically make sure prices are lower so that pharma companies make less money or so that providers make --

MR. EMANUEL: I didn't -- wait, wait don't trigger a view I didn't say. First of all, I said that there are some drugs are underpriced. And I've said this publicly. I've written about it. They are underpriced. Their value is much more than we are willing to pay. Almost every vaccine fits that bill. They are -- they cure or they prevent us from getting an illness and we are unwilling to pay a lot of money for them. They are almost all underpriced.

I'm saying what we should pay for is the commonsense notion, "I pay more for something that really improves my health and I pay less for something that doesn't really improve my health." That seems to me pretty commonsensical.

MR. CHAIKEN: Who is going to make that -- but who is going to make that judgment?

MR. EMANUEL: Wait. I'll -- I'll tell you -- we have --

MR. CHAIKEN: I'm curious.

MR. EMANUEL: We have -- first of all, we have a system and unlike what Ken and Kirsten said, I said, and I acknowledged, right at the start, when a drug hits the market we have the least data we have. But we have to make an assessment as to what the price is. Guess what, Pfizer makes that assessment of what price it wants to charge, J&J does, Merck does. We make an assessment.

And then I said we come back 3 years later when we have better data, sometimes that data does show. It's really effective in some small population and overall it's worthless, right? We get -- have those kind of datas. Avastin is a case, the drug for -- that was used for metastatic breast cancer, right? And then you changed what you're going to price it at because it has either shown to be more valuable or just the same value, or less valuable. You make that assessment over and over again.

I don't see any other way of making a objective coherent assessment of what the benefit is to the price. If you want to tell me we have no way of assessing the benefit of our interventions, then we are all sunk. Then there is no grounded way of deciding whether we should pay $100,000 for a drug or $5 for a drug.

MS. WILLIAMS: Well, but that --

MR. WEIL: Kiah, go ahead.

MR. WILLIAMS: So you'd asked earlier, are drugs priced based on their value. They're priced based on their value and also affordability. And vaccines is a perfect case. When you go -- when we determine the price of a drug, you go and you talk to providers, you talk to health plans, you talk to patients and you talk about the attributes of the drug that you know at that point. And you ask what a reasonable price would be. You also look at other things on the market that are treating that same condition, whether it's surgery or something else.

If it's something like a vaccine that has a very broad population, you also think about the impact on the insurance premium and the impact on the budget for the state. So you don't price that drug to reflect its value. So there is an affordability constraint. You also think about things like your patient assistance programs. Pfizer recently expanded their patient assistance to 400 percent of the federal poverty loan, that's about $100,000 for a family of 4, to address exactly the problems that Lisa has been raising. So all those things go into it.

If you want one central assessor of value, that's one central entity that has other pressures on them -- political pressures, budget pressures, and then you end up in a different game. There is lower prices in Europe and other countries with single-payers for everything, doctor's fees, hospitals, drugs, you get lower prices by excluding certain providers. That's it.

MR. EMANUEL: Let's just be clear for a second. In the American healthcare system hospital prices are actually regulated, right Ken?

MR. DAVIS: Yes.

MR. EMANUEL: Who determines your Medicare price?

MR. DAVIS: 62 percent of what we do is determined by the feds.

MR. EMANUEL: Okay. Doctors. Who determines how much an office visit? The feds do. Let's take drugs. They have a monopoly guaranteed to them by the federal government right through patents and FDA exclusivity. And who helps determine their prices?

MS. WILLIAMS: Nobody.

MR. EMANUEL: Nobody. Okay? It's not the way the system works.

MS. WILLIAMS: But that's -- that's absolutely not correct. The health plans do exactly the same kind of value assessment that the NHS does, or anybody else, and they have millions of lives in them. So it's not a system where you're just putting a price out there. If it were, the prices will be higher. It's a system where you're negotiating and you have other people on the other side of the table looking at the information.

MR. EMANUEL: Sovaldi did not look at the affordability to Medicaid, it didn't look at the affordability to (inaudible).

MS. WILLIAMS: The price came down 50 percent.

MR. WEIL: So, but I think -- I mean, we are having two different conversations here. I mean, one is, what does the public payer do. And the other is, what does the private market look like. And you're emphasizing appropriately the dynamics of the private market. Zeke, you're emphasizing the limitations of what the government's role is in setting prices in pharmacy relative to other services. So I'm not sure -- I just think you're looking at different parts of the puzzle there.

MS. GILL: You know, I have to jump in and say, you know, Ken said something earlier that was fantastic. And he talked about the social contract and how we've just completely lost sight of it. And these discussions, I think, are an effort, I think, everyone is trying to sort of redefine what that social contract is. And part of it that I've wanted to say a while ago is that, you know, taxpayers get hit two times. So if somebody like Marlene gets hit with a high price, no protections, but her tax dollars have actually gone about, you know, some -- a healthy percentage goes toward the basic science research that drug companies and other companies use. So you are -- you get hit in both ways.

MR. EMANUEL: Now, wait a second. Also a third time. She pays for Medicare --

MS. GILL: For Medicare. That's exactly right.

MR. EMANUEL: -- and Medicaid --

MS. GILL: Right.

MR. EMANUEL: -- and they have to pay the drug bill.

MS. GILL: Exactly.

MR. WEIL: So I want to bring in another social contract element. There is this program called 340B which is designed to provide access to lower-cost drugs for safety net institutions. Kiah, your -- a lot of your clients or your provider systems are part of that. Why doesn't that as part of the social contract solve the problem?

MS. WILLIAMS: So as you've heard across the board, the healthcare system is very fragmented. To suggest that one program, be it, you know, corporate patient assistance programs or federal 340B drug pricing, which is a program that's meant to lower the costs of purchasing prescription drugs at federally qualified health centers and non-profit clinics, to suggest that just one program that we are anywhere in the realm of a place where one program will meet all of these different fragmented needs in areas, I think, is just not realistic.

So that's a great program for some federally qualified health centers. You have, you know, on-site pharmacies or contract pharmacies, to help reduce the price of drugs for them to receive. However, you do end up with these supremacy issues of, it doesn't always include every drug, or when you have an exorbitant price hike in generics, that's also reflected in that area.

So I think one of the advantages of our model in trying to redistribute what's already out there is our costs of procuring medicine have nothing to do with what

the costs were assessed or the value assessed by the pharmaceutical company or the hospital that purchased it or the nursing home, et cetera.

So it's this really interesting model where us getting the drugs is not impacted by their market value. And thus, what we are able to do is then take those drugs and say, "Great, we need to make sure that we get all of these drugs to the right patient at a price point that that they can afford and we need to create the system that is more transparent in drug pricing so that people know what they're going to get."

You would never buy a car and then 6 months later get a bill for it. So why are we expecting people to do the same with their healthcare?

And I think 340B is a great example of one way that the federal government has tried to step in and stabilize some drug pricing for community health centers that are doing good work. But it doesn't include every drug. They still see the same issues of pricing hikes for very old generics or for branded, and in some cases it doesn't actually include all the drugs.

MS. GILL: It's also abuse, too. I mean, this 340B is notoriously abused by hospital systems.

MR. WEIL: Why don't you expand on that?

MS. GILL: Well, I mean, you know this is not an area we've looked deeply into. But you can see that in some cases those medications, while the hospital maybe able to obtain them at a tremendous discount, those discounts are -- they are not often passed on to people with commercial insurance. They are actually sold at the regular price.

And so you have a person who is, like a taxpayer who has already paid for this discounting to happen and is paying full price back on top of it. It's just a --

MS. WILLIAMS: Yeah. So to add on to that, to explain a little bit, so there is this whole issue of part of the way that that program was set up was, "Hey, we'll give you discounted pricing, and if you have commercial payer clients in, charge them that price." And then the idea is some sort of like trickle down. So you're going to make money from commercially insured and then you should pass on that savings to low-income people.

MS. GILL: Right. And it's the same concept.

MS. WILLIAMS: And it isn't -- it also isn't a regulated space where it says --

MS. GILL: Right.

MS. WILLIAMS: "Okay, if you made a profit, x hospital, --

MS. GILL: Right.

MS. WILLIAMS: -- you must give this medication for free to a patient."

MS. GILL: Right.

MS. WILLIAMS: You're right.

MS. GILL: And it's the -- you know it's the same concept too is, you know, Kirsten mentioned earlier about discounts that are sort of -- that happen in the industry side of things. But these discounts never make their way toward a consumer. The discount may go to an insurance company or an employer, but a consumer doesn't -- I don't feel the rebate necessarily, you know, from so many pills being sold.

MS. WILLIAMS: And part of what's going on there is what I described early on is -- I mean, the plans are under a medical loss ratio. They have to pass on the rebates. But they pass them onto the premium. They pass them onto what you pay each month rather than passing them

onto to the co-pay for the medicine. And so they are getting the consumers, but they are not getting the consumers for the medicines.

So if you are the person who has a rare disease or has rheumatoid arthritis, you go and you experience that very high cost-sharing for your condition. So it's the people who are the sickest who are getting the least benefit from those discounts. And that's where I -- the point that I raised earlier. I think we have to figure out how to get the tools in the hands of the plans and all of the healthcare system so the incentives are in the right place.

So if you failed on a cheaper medicine, if you've taken a generic and you failed under a generic, you should be allowed to get the branded medicine at a lower co-pay, or whatever it is that you need. I don't think those -- I don't think the systems are in place for pharmacy benefit managers. That's the other -- I mean, I think there is for certain kinds --

MR. WEIL: Okay.

MS. WILLIAMS: I mean, I don't want to take us too far away, but that is the gist of the point.

MR. WEIL: Just going to that. And I want to get back a little bit to the value. But --

MR. CHAIKEN: Yeah, so I think -- I mean, the issue is that we have this blunt instrument today where it's a one-size-fits-all formulary, it's a one-size-fits-all system. Either your whole population gets access to a medication or it doesn't. And the reality is, as you just said, there should be smart step therapy. But if your insurance company today mails you your claim 2 or 3 weeks later, they have no way of communicating with you. Your pharmaceutical company has no idea who you are. You actually maybe willing to give a patient a discount, but if you don't know who they are, haven't an ability to

communicate with them, or deliver them money, how can you do it?

And so that is the role of technology. And I think we are going to see that. I mean, that's what we are working on. We are going to see it very quickly where you can facilitate these transfers of value between people who want to do it and we can start the patient on a generic medication first. Once we realize that that's not the appropriate medication for them, we can move them to a branded medication. We can allow Pfizer actually to deliver money to that patient and give that patient -- that drug for the patient for free if that's something that they wished.

And by the way, so everyone should download the Blink app and -- (laughter) -- if you enter the code "Aspen," everyone in here got $20 off for the next medication. But that's the type of the thing that --

MR. EMANUEL: How much did you pay for that advertisement?

MR. CHAIKEN: Nothing. But the -- but whatever the -- whoever uses it. But the basic point is that we are able to do that with technology today, that it's more of the show to demonstrate something. And I could create that coupon or offer and give it to a patient to get them to do a specific behavior, but so could Pfizer, so could Mount Sinai, so could the government, if they wanted to. And that's the type of smart directing, and smart pricing that you are now able to do with technology.

MR. WEIL: So I want to have a little bit more conversation about value, tee up a hopefully a quick -- it's not a quick topic, but hopefully you'll handle it quickly because I want to make sure the folks in the room get into the conversation.

So, you know, we'd had this nice conversation about value, and Kirsten you said we do price on value. Now in -- from a public policy perspective, we have

proposals to change how the federal government procures in Part B. And it didn't -- you know, it didn't exactly meet with great enthusiasm and it was called value -- you know, it was designed to promote payment on the basis of value. So I wonder if -- and Ken, I know you've given some thought to this too. I wondered if the two of you could reflect on sort of what the difference is between what's being proposed and the concept that you said that the industry actually supports.

MR. DAVIS: You know, what's ironic about the question that you ask is when I choose what drugs will be on the Mount Sinai formulary for the 37,000 employees we have, I can bargain. I mean, I can say I don't want that drug because it's essentially a branded drug and we have an equivalent generic. So we are just not going to have it. Two cases in point. I mean, people should just, I think, really understand these issues.

When NEXIUM came out, the Purple Pill, so the Purple Pill is just the L-form of Prilosec. So this racemic mixtures, this may be complicated chemistry, but suffice it to say that this is just a way of getting around a patent with some simple chemistry that made the Purple Pill sound like it was something special.

Now, if I'm running the formulary, what I say is we're not going to have NEXIUM on the formulary, end of story, because Prilosec is generic now, we're just going to buy that. Medicare can't say that. Medicare has got to take it on.

And then doctors are detailed by the pharmacy -- the pharmaceutical companies and they are somehow made to believe that the Purple Pill is better. The same thing happened with Celexa and Lexapro. And they were detailed like crazy. And being a psychiatrist I know all the misstatements that were made about the L-form about Lexapro versus Celexa. But we won't allow our Medicare formulary to have the same kind of flexibility that we have when we manage our formulary.

MS. WILLIAMS: So I guess I can address the Medicare drugs that are used in the hospital or physician's office or the Medicare formulary point that you just raised. I mean the Medicare formularies for the drugs that are in pharmacies, retail drugs, are determined by health plans. And they do exclude drugs. And that's how they get discounts.

Unlike a system outside of the US, where there is only one formulary, if your drug is not available on your health plan, then you can switch health plans the next year. And you try to -- and there's actually a very good tool -- I was talking about transparency -- there is a very good drug finder tool that you can look and -- you can go on and look and you can see not just what the drug costs but what your co-pay is, when you are making your decision about what plan to go into.

And that's part of why the Medicare Part D program has gotten good satisfaction ratings from seniors for a number of years.

Now, the drugs that are dispensed to the doctors' office and in the hospital -- and you raised the pilot, I mean I can respond to that a little bit, I know Zeke spoke to it as well. The issue there is that the government has proposed reducing the amount of money that goes to the doctor for that drug. It used to be that you'd get -- doctors would get the sales price of the drug plus what's effectively now 4 percent, and they are proposing reducing that to 2 percent.

The concern -- and it's a big pilot and you get concern that, well physicians and the pharmaceutical companies have raised is what would that mean for access to oncologists who were using that money to sustain their practice, basically that's how part of the way they do medication management and see those patients. It's a fee for distributing the medicine.

Should their fee be tied to the price of the medicine? No. That's not a great system. But the

concern with this very big pilot is to go very quickly to that would cause a disruption in access. And what many have asked for is that there is appropriate safeguards put in place and appropriate studies be put in place and this pilot be scaled up on a smaller basis so you can see what this kind of change would mean for patients and their access to physicians.

MR. EMANUEL: You did describe the change accurately, okay? The way Medicare pays for things like oncology drugs, multiple sclerosis drugs is, they take the average sales price of the last quarter and they then say to the doctor, "You get that average sales price plus 6 percent for administering it." So if you're prescribing a drug that's $10,000 in the month, you get $10,000 and $600 for prescribing it.

By giving a percentage, you're incentivizing the doctor to prescribe more expensive drugs when there are two drugs of clinical -- that are clinically equivalent. It's just like paying a commission to a car salesman who then has an incentive to sell you a more expensive car. So doctors have a financial incentive to prescribe more expensive drugs.

There is very good data out there that doctors surprisingly respond to financial incentives and switch their prescription to more expensive drugs, we have the data in oncology, my area, around lung cancer in particular.

The proposal by Medicare is the following, because the average sales price across the country is not the same number, there is some fluctuation in it, we are going to give you the average sales price plus 2.5 percent and then we're going to give a flat fee $16, $17 dollars.

Now it turns out -- it's not less money for every drug, it's more money for all drugs up to $450 or so dollars, but it's turns out to be a flat fee above that so the difference between prescribing $100 drug and $10,000 drug goes away. And you then decide whether the $100 drug

or the $10,000 drug for the same condition when they're clinically equivalent, which one to prescribe, that was part one.

Part two is, then we should actually change what the patient sees, the patient if they're getting a value based drug want to see no copay and let's see how that works. There is no reason to say suddenly doctors won't be able to prescribe drugs. All the drugs are still on the formulary what doctors won't be able to do is get more reimbursement for prescribing more expensive drugs.

Doctor shouldn't be getting that reimbursement, they should decide what to prescribe on the basis of whether it works for the patient or it doesn't work for the patient, not what they are going to get because they prescribe a more expensive drug that's the basis of this. Now what has happened, oncologists who make more money when they prescribe more expensive drugs screamed, patient adequacy groups, paid for by -- many of them having significant contributions from the drug companies screamed, "We're going to be denied drugs." This proposal doesn't deny any one, any drug, it's just takes away the financial incentives to prescribe more expensive drugs.

Why is CMS doing it? It doesn't have any other tools, no other tools to try to effect the drug pricing issue. And the American public wants the drug pricing issue addressed. That's the bottom line. And I think it's a -- is it the most ideal solution? I don't think so, I don't there is anybody in the country including Medicare who thinks it's the ideal solution, but it's what they have the tools they have available.

MS. GILL: Actually, you are right about one thing you – you know about –

MR. EMANUEL: Only one thing?

SPEAKER: Oh, my God.

MS. GILL: About 75 percent of Americans that we spoke to in our nationally represented poll, said they want government action of some kind to solve -- shore up this problem and that is --

MS. WILLIAMS: So just quickly what is interesting is -- you know we work mostly in the outpatient setting, what's interesting is there is actually a lot of regulation on the outpatient setting to kind of combat this very thing, so for example (inaudible) says you can't be a doctor and own a pharmacy. Why? Because then you end up in this super -- of course, people are going to start prescribing things that then their pharmacy will make more money on. So I do think there is -- it's super interesting that we have some of these in place in some parts of the government and in some parts of healthcare where we're saying there is this clear, you know, conflictive of interest like we need to address this. We need to not pay prescribers to give some certain medications.

There is also a recent whole -- article looking at copay foundations, which are, you know, these organizations that are largely funded by pharmaceuticals that help basically distribute money out to individuals who can't afford their copay for certain drugs. There are these clear kind of conflicts of interest here, where when you're paying someone to take a drug or paying someone to prescribe a drug you end up with this very messy system that we are currently in.

And so it's just interesting because on the outpatient setting I do see that we have some of these factors in place that alleviate this concern.

MR. CHAIKEN: So I just want point out -- I want to point out one thing about sort of the regulatory complexity and sort of the regulatory solution to the problem and just point out how some of the regulation -- so I think regulation is definitely a part of the solution, but it's also created a lot of the problems. And so those are the things that we have to recognize.

And I will just give one example, so, if we thought about what is going on actually with generic medications, the generic suppliers are all the same, so they've merged globally and there is one -- basically, there are a few big producers of the generic medications. And everywhere outside the United States we've had actually generic deflation, which make sense, it's a commodity, the prices should decline. In the US for consumers you've had generic inflation and it's been substantial.

And so the question is like how is that happening when the same companies are purchasing this and they are selling it outside the United States for less money? So it's not actually so much an issue that the FDA hasn't approved these things, like they have access to it. What's actually happening is that there are these crazy things called PBMs, which most people don't understand called pharmacy benefit managers.

And the pharmacy benefit managers, there was a conflict about 15 years ago, where Merck sort of founded the first pharmacy benefit manager called Medco. And what they're supposed to do is they work on behalf of insurance companies to negotiate prices about on drugs for the clients of those insurance companies.

Well it's a little bit of conflict if Merck owns the company that is supposed to negotiate those prices. So the government basically mandated that Merck divest Medco and said this has to be independent company. But then a few years later -- and so for branded medications, they actually sort of work in more functional way, they don't have a conflict.

A few years later the government actually said pharmacy benefit manager, you can merge with a pharmacy and so now you have the two largest -- the company that supposed to manage your drugs spend, one of the their two largest ones, one is Express Scripts, the other one is Caremark. Caremark owns CVS. So if you want to know why

your drug prices are increasing, the people who are suppose to be causing the prices to decline actually own the pharmacy. And so you can actually look, these are public companies, we can look at what has happened to their profitability per script and they go up and up every year. There is conflict of interest.

The same thing Express Scripts is the second -- is the first largest PBM, they actually make two-thirds of their profitability from their pharmacy -- their mail order pharmacy but these were things that government actually mandated, basically they allowed this to happen. So and it was a --

MR. EMANUEL: Let's be careful --

MR. CHAIKEN: They didn't mandate.

MR. EMANUEL: They didn't prohibit it.

MR. CHAIKEN: They did -- but they actually, they pointed to a study that showed mail order was a very effective way of keeping people adherent to their medications. And because of that we created a system where you now have massive generic inflation in the US. So you know none of these solutions -- there is no easy solution to these problems and it's -- I don't think it's government, it's not only technology, it's going to be some collaboration of all these forces working together figuring out ways that everyone can win, but it is crazy actually what's going on.

MR. WEIL: So, I'm -- I need to get the room and I'm going to a ask question, simple, simple question.

(Laughter)

MR. WEIL: Geoff your scenario, three of you walk in by the same loaf of bread that cost a dollar to produce, you've just been laid off, you have the highest price. Globally, from an ethical prescriptive we're actually -- and we had a very -- this very US pricing

focus but, there was -- we are very comfortable with the notion that as the first world, as the richest country we need to subsidize drug creation and pay higher prices so that people can live just have truly life saving drugs in the rest of the world.

My question is when you came up with that scenario, you gave the highest price to the person who just been laid off, but if we had this scenario where the lowest price was to the person that Lisa described at the beginning who is trading off between rent and drugs, would we feel more ethically comfortable and is that sort of what we should aspire to, or should we aspire to a market level where you walk into the grocery store and a loaf of bread is the same price for everybody.

MS. GILL: I have to say I think we have to ascribe to transparency and to -- so Geoffrey's point earlier that -- everybody knows that what the price is. And that is not just consumers, that goes to employers, that goes to the government all payers because the part of the problem there is no explanation of benefits, when you fill out a prescription.

There is no way of knowing really how much everybody is getting paid. And part of it is the pharmacy benefit managers like Express Scripts and CVS Caremark, there is nothing that forces them to show how -- where are all this money goes. And that is, to me, one of the greatest problems.

The other part, you know, you mentioned a minute ago is there is also no requirement that they act as a fiduciary, they do not have to act on behalf of their clients, they can act on their own behalf.

MR. WEIL: I would think your ethical thing is -- I think we do want actually a fair price that is the same price for everyone, and what we want to do is subsidize people who have lower income in other ways like subsidize their purchase of insurance, or subsidize reducing their copays and things like that.

I don't think you want to have -- one of the problems of the pharmacy price system is, I think was -- Weil pointed out is it's a total black box and prices are all over, you've list price, you've the discounted price.

None of us know really what that is, we infer it from lots of information in the market place, but it's a total black box. I think we would like to have a transparent price and subsidize people who are lower income in other ways to get their health insurance. I think that would be much fairer system.

MS. GILL: That's exactly what the Affordable Care was intended to do, subsidize people who have lower income and whether it's their copays or their premiums. The transparency point is one that we need to better, we need to make it very easy when you're buying an insurance plan that you can see what your drugs costs, what your hospitalization is going to cost you, what your primary care will cost you, what cancer centers are available to you. So people really can shop around and get the right product that's right for them.

MR. EMANUEL: What about seeing what our drug prices really are?

MS. AXELSEN: The list prices for drugs are published. They are publicly available for any --

MR. EMANUEL: List prices are not real.

MR. WEIL: All right.

MS. WILLIAMS: So this whole issue of like the list price, the retail prices, it is I think unconscionable that if you're a low income person you walk into a pharmacy and you get what's called the usual customary price, which is like a retail price, no one paid -- but if you have insurance you would never pay that amount, no one would pay that.

And it's even interesting like coupon programs are organizations like Blink that are basically just adding on exiting coupons to that retail price just to bring it lower, it's like going into, you know, I go to a car wash but there is a coupon bin right next to the cash register, that's gives you $5 off.

(Laughter)

So literally the fact that we have to have services that are like reaching a coupon, taking it out and giving it to the cashier -- like this silly, you are the only one who has to pay that price. You know, I even heard stories of people who know their insurance is canceled, they give their insurance card number at the hospital or at the doctor's office. And then the person comes back and say "Oh! wait, sorry your insurance is covered -- it was canceled but we're still going to give you that lower prices, because we're not going to give you the regular pricing." I mean that's -- the was really unconscionable of this system, is that if you're low income you're paying the price that no one else is paying.

MR. CHAIKEN: Right. I just want to point out, so just one thing to clarify. So just people know, Blink is not a coupon service. So what we are -- basically, Blink is doing -- so the way that Blink works.

MS. GILL: It's voucher system.

MS. WILLIAMS: It's a voucher system.

MR. WEIL: All right, lets --

MS. WILLIAMS: There is not much difference.

MR. CHAIKEN: It just relates to -- because we are actually a fiduciary of users, so what we are doing is -- these prices do exist already, which is the whole point and we're giving everyone access to the those insured company prices.

MS. WILLIAMS: So you're negotiating the best discount.

MR. CHAIKEN: Right. And we actually do sign, when you join you do sign a fiduciary, we become a fiduciary of our members so that we can't make money unless basically there is a --

MS. GILL: How come everybody can do that, that's my question?

MS. WILLIAMS: The two most important parts are transparency and then insurance stability for low income people.

MR. WEIL: All right can we focus there? Ken?

MR. DAVIS: I think Zeke put it very well. I mean we would like to have a fixed price, but then we have to make it affordable, we have to do that with subsidies or other mechanisms. But Alan, when you started, one of the points that the made is, we're all comfortable with the notion that the US will pay for drug discovery and drug development and we're going to be beneficiaries to the rest of the world.

And the point that I want to make is I think that's not true for the Western world, I think the Western world has to now start to contribute to the costs and they can't just keep their prices 50 percent or 25 percent or what it is in the US so that American consumers wind up over paying for drugs to support the R&D effort that we need that is so essential.

MR. WEIL: All right. I didn't leave you much time, but I know there are some questions out there. I see Peter in the back, if we can get a microphone, please identify yourself, and we will get through what we can.

MR. ORSZAG: Peter Orszag, I had a quick question, probably the hardest part here is who would determine the value based nature of the pricing? So I

want to come back to Ken's point that you can determine for your own employees this drug versus that drug. In some of the accountable care organizations, but not all of them, drugs are included in others they're excluded.

So is a path forward here to move more of that decision making to people like Ken -- by moving towards effectively capitative payment, but with the drugs incorporated in for the providers.

MR. WEIL: Well, obviously I agree but that's because Peter is a trustee of our board.

(Laughter)

SPEAKER: Tough question for the CBM.

MR. DAVIS: No, no but you know when the decision making is that local and the expertise is there, I trust it a lot more than I trust a lot of things to go on at NICE. I mean I've read too many things from NICE and I go, "Who is the expert there? Who is thinking that through?" So I'm frightened of what's going to happen and who is going to be the authorities to establish what the quality and what the value is.

In a perfect world I'd certainly support it, in a perfect world Zeke is absolutely right, I just don't trust the perfect world.

MS. WILLIAMS: Or make something else

MR. WEIL: Make something else

MR. EMANUEL: Let me amend or clarify something. I did not actually say that there would be one organization making the value based pricing, I think you're going to have a lot of different independent assessments, the drug companies make their own assessment before hand and that should be made public often they do not publish them. I think we should have several

independent groups like (inaudible), we would have nice data, we could have other groups, there are lots of academic groups that can do this.

I actually think we should have a number of analysis because all of them have a lot of judgment costs, all of them have access to different ways of analyzing the data, we've done a number of studies where different, very, very expert groups come to slightly different conclusions on this. So I don't there should actually be one organization. One of my objections about NICE is, it's one organization it's directly tied to coverage, I actually don't like that, I'd like to have very different possibilities but all made public. And the drug companies often do not publish their assessments of cost effectiveness.

MS. WILLIAMS: So that's the kind of solution that we need to be considering. If doctors are on the hook for the hospitalizations and the outcomes they need to also be able to establish a formulary and Senator Wyden put forward a bill that would have allowed that to happen to allowed that to happen to allow an ACO to determine a formulary or help a beneficiary to pick one health plan that is right for them, that's the kind of solution we need to be moving toward.

As far as publishing, comparative effectiveness data a lot of that is published in journals but also remember pharmaceutical companies have limitations on what they can go out and proactively communicate. You can communicate what's on your label. And so, that's something else too.

MR. EMANUEL: That's got nothing to do with publishing --

MR. ORSZAG: But there is a still problem with that because let's say an independent ACO decides, we've got to have a hepatitis C drug, so they put it on the formulary, what are they going to do. And they are still paying $100,000 for it, and they can't afford it. I mean

I have the problem in New York state, where the Medicaid system can't afford to give Sovaldi or Harvoni to the patients or who need it.

So they're essentially rationing it, they are de facto rationing it. That doesn't stop the epidemic and that isn't the way healthcare should be delivered. And you can't justify it based on return on investment. That gets me to the question of what happened to the social contract? What happened to the people with core values that say, "We develop these drugs in order to have a fair return, a fair profit and to make sure that we're really helping everyone who needs the drug."

And I tell you no matter how many coupons there are and no matter how many discounts there are, in New York state we're not helping everybody who needs that hepatitis C drug.

MS. WILLIAMS: You know I was just going to say one thing to our person asked the question, we could actually empower government agencies now that study these issues -- like and I know PCORI or ARC (phonetic) to actually include cost as part of their analysis that could happen like today. But we don't.

MR. WEIL: We told them, they're not allowed to. Please, right here, let's get a microphone up at the front.

It's going to be all right

(Laughter)

SPEAKER: Thank you. My name is Tamana, I'm a family physician. And I want to say first of all thank you all for coming. No offense to Mohammad Ali but the Rumble in the Jungle has nothing on this.

(Laughter)

Very cool talk. My question is honestly at this point should price transparency become a part of informed consent? And the reason I say that -- and I might also add not informed consent that the physician is responsible before it because I don't want to destroy the practice of medicine. But the reality, should price transparency point of care, price transparency become a portion of informed consent.

A violent biopsy is not a harmless procedure especially in the current economic milieu of the United States. That is not the case, medical bankruptcy we all know these stats I won't go into it. But the long and the short is this, is the patient being counseled on the treatment, on the pros, on the cons, both pros and cons. Should price transparency be included in that conversation in a point of care manner so that a patient can make an effective decision as a consumer, because we call them consumers but they need the transparency to be an educated consumer about what to do or not to do.

MS. GILL: Oh my God, I love this idea. Thank you so much for raising that, that is an absolutely excellent point. We can see from our doctor polls that although a lot of physicians tell us like 8 out of 10 tell us that they're very concerned about prices and affordability, only 2 out of 10 actually talk to their patients about it. And that is exactly to your point I think that's fantastic.

MR. WEIL: I just I -- we had a paper in *Health Affairs* just a couple of months ago about the -- it was great study, where they actually listened in on conversations in doctors' offices. And all these lost opportunities to talk about cost and the effects it would have -- the potential of an alternative treatment. It didn't get at this issue specifically that you've raised of informed consent. But there are some nice literature on this.

MS. AXELSEN: In an altruistic world, in a perfect world you wouldn't actually ask physicians to make

these decisions or to have them basically serve -- a lot of family physicians are basically half time social workers. Like at this point, that is half of your job is a social worker, 30 percent is paper work, and 20 percent is patient care, right. I mean this is ideally we would not have these discussion. But I do think, you know, to a point that Geoff made in the past -- right now it's a ethical grey area where to some extent if you're going to give a prescription to a patient and they're not going to fill it, is that helpful?

So, I think like the ideal world would be no, a physician would not have to have this informed consent of saying, just so you know this is how much it's going to cost. I think the world that we're in today if we want to actually start seeing people at levels of medical adherence go up it probably wouldn't hurt if 1 in 4 people aren't affording the drugs that they need to stay healthy.

MR. DAVIS: Yeah. But look it's not a panacea, Lisa's patient isn't helped by price transparency.

MR. WEIL: So let's -- right back here.

MS. BALDELOMAR: Hi, my name is Raquel Baldelomar. I'm a writer with Forbes. When you hear about drug prices in the media, a common name that comes up is Martin Shkreli who raised the price of Retrophin by 5000 percent. Yeah, there are also all these other pharmaceutical companies like Valeant who do the same yet they just don't do it to the same extent.

My question to you is, is Martin Shkreli because he is the youngest, the loudest, the brashest, is he being unfairly penalized and made a scapegoat for the pharma industry? And if so, what do you do about all of these other pharma companies who sold business models by taking a drug, raising its price and not putting any money to R&D.

MS. AXELSEN: This is exactly what our investigative report talked about. Unfortunately what

Martin did was 100 percent legal. And that is part of the lack of consumer protections that just don't exist to protect us from really just exploitation and profiteering.

MR. EMANUEL: I think the answer is we facilitate the approval of generics from Western Europe and other developed countries we put it on a fast track.

MS. AXELSEN: But the thing that people don't understand is this happens -- this was one example of extreme example but drug pricing changes it is a stock market, big health systems have whole purchasing departments that that's all they work on, is how do you reduce the price, oh if we buy it this month and from this manufacture it's going to be 30 percent cheaper than this other manufacturer next month. I think this is not a new phenomenon.

MR. WEIL: So, let's get -- I'm going to try to get two more if we're lucky, so right up here.

MS. LINTZ: Hi, I'm Janice Schacter Lintz, CEO of Hearing Access & Innovations. Slight deviation, I don't understand how come doctors can't own pharmacies but audiologists can prescribe and sell hearing aids. I mean I know it's slightly the off topic but not really.

MR. EMANUEL: No, no, no. Doctors are not allowed to own pharmacies.

MS. LINTZ: Right I understand but why can an audiologists prescribe and sell a hearing aid, which is really kind of the same thing, it's the same inherent conflict of interest.

MS. AXELSEN: It's a medical device.

MR. WEIL: It's a device, right.

MS. AXELSEN: It's a difference.

MS. LINTZ: And so it is the distinction a device versus a pill.

MR. WEIL: I don't know the ins and outs.

MS. LINTZ: I mean you just need the conflict of interest

MR. WEIL: I don't know the ins and outs. I think that that market place, sorry.

MS. LINTZ: I was hoping you would knows, just because

MR. WEIL: We'll find someone who knows, it's the Ideas Festival, someone here knows.

(Laughter)

MS. LINTZ: Okay.

MR. WEIL: In the back, in the purple.

DR. NICHOLS: So, Dr. Karen Nichols, I'm an osteopathic physician, I've been in private practice for 15 years and I've been dean of our school in Chicago for the last 14.

I have never been a fan of direct to consumer advertising. And I understood it but I hadn't heard you speak anything about it, what is further confusing me is why are we having direct to consumer advertising for drugs that the patients have no input into deciding to take, it just doesn't make any sense to me. And I'd like to know what you say that has to do with this whole issue of pricing?

MR. WEIL: So we could I'm sure spend a lot of time on this.

(Laughter)

MR. EMANUEL: I think most of us would probably be -- maybe except the drug companies against it, it is a bad idea. There is only one other country, a developed country that does it, New Zealand. Now, if you would like to take it away right, probably the people who would yell the loudest are the networks. They make a lot of money from it probably they'd yell even louder than the drug companies. And so I think we've created this kind of interest group that is -- that protects this kind of thing. But most of us see no rational reason that we should actually do it.

MR. WEIL: Anyone want to take a different approach?

MR. CHAIKEN: Well I think I mean direct to consumer advertising does have a role in I think in the pharmaceutical industry in terms of the educating people. The problem, I think it gets back to -- and people you guys -- some people here might disagree -- but I think that there are certain conditions -- there is certain to direct to consumer communication -- or there is communications to both physicians and to patients that pharmaceutical manufacturers do that's productive. And I think that - we know there is plenty of cases it just works with sales force. Where we could all say the sales force has too much influence over physicians but if there isn't a sales force it takes about 10 years for standard of care to be practiced across an area. And so we've have to decide who is going to fund that education. If there is way to do it more productively than a single silly television ad that is one size fits all solution for everyone that's definitely not an ideal outcome.

MS. GILL: No, I mean -- I will say direct to consumer advertising creates the purpose of it is to create demand but it also can expand the definition of diseases. And it is -- at the same time it also increases prices. And we can see in repeated national surveys that we've done about one out of every five people tell us that they've asked their physician to prescribe medication they've seen advertised on TV. And the most amazing thing

is that about two-thirds of doctors year-after-after will go right ahead and write it.

That may not sound like such a huge deal but it's often for the most expensive medications. And then the consumers come back and say, "Well, I can't afford it." And the -- by the mean time this drug maybe is working for them or they are just accustomed to it.

MR. WEIL: All right. I think this notion of joining the issue of direct to consumer to the issue of physician education. And the detailing and all of the other ways that if the primary rationale is about education then we should think about how do you get clinical information to the hands of clinicians as well as patients think about those holistically as opposed to an ad here or a lunch there.

Well, we have successfully taken a deep dive, please join me in thanking this terrific panel.

(Applause)

* * * * *