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PATIENT COST SHARING FOR PRESCRIPTION DRUGS:  
POLICY ISSUES

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**Welcome and Overview:**

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**Panel 1: Revamping the Medicare Part D Benefit Design:**

PAUL B. GINSBURG, Moderator  
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DOUGLAS HOLTZ-EAKIN  
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ELIZABETH JURINKA  
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U.S. Senate Committee on Finance

NICHOLAS UEHLECKE  
Professional Staff Member (R)  
Committee on Ways and Means, Subcommittee on Health  
U.S. House of Representatives

**Panel 2: Mechanisms to Reduce Cost Sharing for Commercially Insured Patients:**

MARGOT SANGER-KATZ, Moderator  
Health Care Correspondent  
The New York Times

GEOFF JOYCE  
Director of Health Policy, Leonard D. Schaeffer  
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## P R O C E E D I N G S

MR. GINSBURG: Hi. Good morning. I'm Paul Ginsburg, Director of the USC Brookings Schaffer Initiative on Health Policy. Pleased to welcome you to this conference on patient cost sharing in prescription drugs. We're going to talk about three issues during this conference. One is the issue of the Medicare Part D benefit design; then we're going to talk about some issues that, I think, more commercial coverage, the issues of coupons provided by manufacturers to support use of their drugs by individuals; and finally the issue of whether, in either Medicare Part C or commercial programs, whether rebates on some drugs should go roughly to the patients who use the drugs or as they are today to lower the premium of the prescription drug plans. We have two panels. The first one is on Medicare Part D and the second one is on the other two issues. And we're really pleased that since we planned this conference and announced it the issue has become more timely with the proposals in the president's budget for an out-of-pocket cap on Part D, and a different way of handling the rebates in Medicare Part D as Well,. So, I'm going to start off the first panel by introducing our first speaker who was Erin Trish from the University of Southern California, the Shafer Center for Health Policy and Economics.

MS. TRISH: All right. Well, thank you very much, Paul, for the introduction, and thank you for being here. I'm going to focus today on talking about a proposal to cap out-of-pocket spending and Medicare Part D. But before we get into that proposal I thought it was important to just kind of put this in the broader context and recognize that Medicare Part D has been an incredibly successful program overall. We've seen a considerable increase for access to affordable prescription drug coverage for seniors with robust market participation from market participants as well as the program coming in below expected costs. So, one of the

concerns here, though, has been about continued high out-of-pocket spending particularly for seniors with relatively high prescription drug spending. So, what's driving that concern? Well, if you look at the initial standard benefit design in 2006 or the first year of Part D coverage, what you can see is that beneficiary started in kind of a traditional metrics of an insurance policy with a deductible after which they faced 25 percent coinsurance through something called the "Initial Coverage Period." But beneficiaries who spent more than about \$2200 in prescription drug spending, then entered into something called the "Coverage Gap" or the "Donut Hole" where they faced the full cost of prescription drugs. This led to a lot of concerns about affordability for seniors, about utilization and other types of concerns about health outcomes. And as a result there's been -- the Affordable Care Act included policy provisions that really worked toward reducing out-of-pocket spending or filling in this donut hole. So, what we've seen is that progressively and initially by 2020 and now by 2019 beneficiaries will just face 25 percent coinsurance through both the initial coverage period and, also, through the former donut hole. But none of these policies have really focused on this kind of final portion of the benefit phase called the "Catastrophic Coverage Region." So, beneficiaries with very high prescription drug spending. So, in 2018 about \$8500 in total prescription drug spending move out of this donut hole phase and into something called the "Catastrophic Coverage Period after which they face five percent coinsurance on all prescription drug spending for the remainder of the year. So, this is an uncapped benefit with unlimited potential out-of-pocket spending for these beneficiaries.

So, when thinking about what that means for beneficiaries and what capping that out-of-pocket spending at that level might mean, it's important to recognize that there are two kind of fundamentally different groups of beneficiaries in the Part D program. Lower income beneficiaries qualify for something called the "Low Income Subsidy Program"

where the federal government pays not only for the premiums for these beneficiaries but also either all or the vast majority of their cost-sharing. So, in the initial years of the Part D program these LIS beneficiaries represented about 40 percent of total beneficiaries, but they're much more likely to reach catastrophic coverage. And so, the vast majority are essentially over 80 percent of beneficiaries that reached catastrophic coverage qualified for these low income subsidies and, therefore, they were insulated from this cost-sharing, and this kind of uncapped or unlimited benefit wasn't really applicable to them because the federal government was financing these cost-sharing provisions for them.

What's important to recognize is that fundamentally the Part D market has changed since the initial years of the program and we've seen a considerable growth in the number of non-LIS beneficiaries who reach catastrophic coverage. So, what that means is that there are now many more beneficiaries that truly do face this kind of risk of uncapped prescription drug spending and are susceptible to high and unlimited out-of-pocket spending in the absence of a cap in Part D. Now, not only have they increased in terms of the number of these beneficiaries but their spending has also considerably increased over time and projected to continue to do so, suggesting that not only are there more of them but they are potentially susceptible to much higher levels of out-of-pocket spending as well. Now, it's certainly the case that the provisions to fill in the donut hole have helped these beneficiaries in terms of reducing their out-of-pocket spending. So, this is an analysis that we've done looking at a specific sample of non-LIS beneficiaries who take specialty drugs and looking at their out-of-pocket spending in Part D, but breaking that up in terms of below the catastrophic coverage threshold and above the catastrophic coverage threshold. What you can see is that with the introduction of the ACA's provisions to fill in the donut hole, there was a significant reduction in out-of-pocket

spending among these beneficiaries below the catastrophic coverage threshold. But at the same time we continue to see increased out-of-pocket spending resulting from the spending that they incur while in the catastrophic coverage threshold. So, this is the spending based on that five percent coinsurance liability off the list price of drugs, and you can see that this continues to grow over time and that the ACA's provisions did not, in fact, reduce that portion of the out-of-pocket spending; we wouldn't have expected it to. So, on net what you can see here or kind of the main takeaway is that, yes, the provisions to fill in the donut hole did result in a kind of one-time downward shift in out-of-pocket spending for these beneficiaries, but that their out-of-pocket spending continues to grow and that they continue to be susceptible to the lack of a true out-of-pocket cap or a true insurance protection in this program.

So, that leads me to make a recommendation that it's time for Part D to consider implementing and -- for policymakers to consider implementing a cap in the Part D program, a true out-of-pocket cap; to provide true insurance protection for beneficiaries from high and currently unlimited out-of-pocket spending. Now, others have also, kind of shared this vision or shared these recommendations, in particular, as a standalone policy in the case of Wyden's Senate bill -- or senate proposal and in conjunction with other reforms in the case of the MedPAC recommendations and most recently, as Paul mentioned, in the president's budget on Monday. Implementing this type of out-of-pocket cap would be consistent with other reforms that we've seen recently in other insurance markets. So, particularly in the commercial insurance market. The Affordable Care Act requires that all commercial insurance policies, so both employer sponsored policies as well as exchange policies, that they include a true out-of-pocket cap on spending for all covered essential health benefits including prescription drugs for these commercial plans.

So, beneficiaries do indeed have the protection of this true out-of-pocket cap in the commercial market.

Now, the Medicare program itself does not include a true cap on out-of-pocket spending in the Part D program, but also in the Parts A and B programs that cover medical services. But beneficiaries have the ability to cap their out-of-pocket spending for these medical services covered under the Parts A and B benefits by either enrolling in a Medicare Advantage plan, which are required to have a cap on out-of-pocket spending, or by choosing to enroll in certain Medigap or other supplemental policies that may offer this benefit. But no such protections exist in Part D and beneficiaries have no possible way to cap their out-of-pocket spending in Part D. And it's important to note that even in the case where a beneficiary is enrolled in a Medicare Advantage plan that covers that also offers Part D coverage, they face a cap on out-of-pocket spending for the medical services covered under the A and B benefits, but not on the Part D side of the prescription drug spending of those benefits.

So, what might be the impact of implementing such a policy? So, certainly we would reduce out-of-pocket costs for this growing number of non-LIS beneficiaries that reach catastrophic coverage. So, over a million beneficiaries in 2015. But, additionally, this would provide financial protection, or kind of true insurance protection, against the uncertain potential cost of how -- or the potential for very high out-of-pocket spending among not all the non-LIS beneficiaries in the Part D program, which are also growing both in number as well as a share of overall Part D beneficiaries. So, if you took this out-of-pocket spending and capped it, that's, you know, that spending has to essentially go somewhere. And so, if we shifted that to become plan liability, what you would expect plans to, in turn, increase premiums which would result in a premium increase spread across all beneficiaries. And also resulting federal spending increase, although, divvied

up in different ways across the different ways that the federal government finances the Part D program.

So, what do I mean, by that? I'm going to break through that now, here, with an example of we've done some analysis of the 2013 Part D claims, and what we find is that in 2013 there was about \$27 billion in total spending in the catastrophic coverage region across all beneficiaries. This is based on the kind of list price or the actual pharmacy paid price. Now, of that about 5 percent of that is the beneficiary liability or about \$1.4 billion in total spending. So, if we implemented a cap at the catastrophic coverage threshold, this is the additional spending that would be transferred and will become plan liability rather than beneficiary liability. In turn, plans would increase premiums for all beneficiaries, and because the federal government subsidizes the premiums for all beneficiaries, this premium increase would be split partly among beneficiaries who would see an increase of about 85 cents per member per month and also partly, or in large part, as a federal spending increase of about a billion in increased spending on the direct subsidy program. But, as I mentioned, the federal government also pays the premiums for the LIS beneficiaries. So, we would see an increase in federal spending on the LIS premium subsidy component of federal spending. So, it's important to note that among this 5 percent beneficiary liability, as I mentioned, for the low income subsidy beneficiaries, the federal government is already paying that, what would be kind of the 5 percent beneficiary liability in the form of the low income cost-sharing subsidy. And so, if you took if you capped this liability and shifted the liability to the plans for both the LIS and non-LIS beneficiaries, that would be a significant reduction in federal spending on the program that subsidizes cost-sharing for low-income beneficiaries.

So, what does that mean taken altogether? We'd expect a relatively modest impact in terms of both a modest increase in beneficiary premiums as well as modest overall

federal spending on this this policy proposal. But it's important to note that the cost of implementing such a proposal would increase over time because we see increasing and continued trends toward increasing spending in the catastrophic coverage phase of the Part D benefit. Now, it's also possible that capping out-of-pocket spending you could think that this would induce some behavioral responses either on the part of beneficiaries or perhaps on, you know, manufacturers in terms of their pricing decisions, which could result potentially in kind of an unintended consequence of higher spending or higher prices. Though, it's not necessarily clear that moving from a policy of 5 percent coinsurance and catastrophic to 0 percent would've a significant impact in this regard. But it's important to note that while capping out-of-pocket spending would provide true insurance protection for beneficiaries against potentially high and unlimited out-of-pocket costs, it would not address other concerns about the Part D program, namely, the continued and persistent increases in federal spending and the reinsurance or kind of the federal subsidy of catastrophic spending, other kind of Part D incentives that are motivating or potentially driving this spending or the underlying growth in net drug prices. And so, it's possible that particularly in conjunction with implementing out-of-pocket cap in Part D that some of these other complementary policy proposals may become more attractive as a means to think about, you know, if we're concerned about the increasing cost of implementing an out-of-pocket cap over time there are other complementary policy reforms that could help to potentially rein in or address this growth in Part D spending and the reinsurance or in the catastrophic coverage region. So, things like revamping the federal reinsurance program and, essentially, shifting more liability from the federal government to the plans, potentially things like excluding what currently counts. So, currently in the donut hole the manufacturer finance discounts for beneficiaries count toward their, essentially, true out-of-pocket or what kind of what

accumulates as their spending that moves them through the benefit phases. So, a proposal to, essentially, remove that from the calculation of your out-of-pocket spending over time, and also a policy proposal, which we'll hear more about in kind of general in the next proposal -- or, excuse me, in the next panel, focused on requiring plans to pass a portion of rebates directly through to beneficiaries at the point of sale.

So, each of these proposals would, essentially, be expected to reduce the number of beneficiaries that reach catastrophic coverage in some way and, potentially, reduce spending that occurs in the catastrophic coverage region. Though, it's important to note that they would've different impacts in terms of their actual effect on beneficiaries out-of-pocket spending, but nonetheless could be implemented in conjunction with an out-of-pocket cap that may reduce some of the concerns about the increasing cost of implementing this type of policy over time.

So, with that I think I'll wrap it up just by noting that my policy recommendation is that it's time to consider implementing or it's time to implement a cap on out-of-pocket spending in Part D in order to protect beneficiaries from high and unlimited out-of-pocket spending or, essentially, to turn this into true insurance protection for these beneficiaries, and that complimentary reforms could be considered in conjunction with this proposal as a means to address kind of broader concerns about federal spending on the Part D program and, in particular, in the catastrophic coverage region.

MR. GINSBURG: Well, thank you very much, Erin.

(Applause)

MR. GINSBURG: Next we'll hear from Doug Holtz-Eakin, President the American Action Forum.

MR. HOLTZ-EAKIN: Well, thank you, Paul, and thank you for the chance to be here today. When Paul invited me he told me my job was to be

disagreeable, and I'm well suited to the task, but I do want to thank Erin for just a fantastic presentation and a very clear, sort of, discussion of the issues.

So, when I first saw the title for this I thought it was just wrong, right? Because the question isn't do we want a cap in Part D, because we could put the cap at \$10 million a year and we'd have exactly the same program we have right now. So, the real question is, do we want to lower the cap to the current catastrophic maximum and are we willing to accommodate the trade-offs that come with that? And I think Erin is laid out very clearly the kind of issues that arise. You're going to have higher premiums and beneficiaries are going to see that and have higher federal government spending. You may see changes in the formularies that are offered in Part D and you just have to decide whether those are trade-offs you are willing to accept in order to put this insurance backstop in place. I want to, at least, say a few words in defense of the U.S. taxpayer and the idea that putting them on the hook for this might not be a good idea.

It is currently fashionable to blame the US budget outlook on the tax bill that was passed in December, but I want to remind everybody that the CBO baseline in January of 2017, prior to any such legislative action, contained \$10 trillion of deficits over the next 10 years and that was driven by large growth in federal entitlement programs, in particular, federal health programs like the ones we're discussing right now. And so, I don't think one should casually add to that bill because it's already one that we can't pay, and we ought to think hard about the design of these programs. I want to want to say a few words about that. And the mirror image of the large growth in beneficiaries' costs in the reinsurance area is federal spending in that reinsurance area. They're picking up 80 percent of this right now and it's growing well over 15 percent a year. So, this is already a problem, I'm not sure we want to add too much to it. So, but that's an issue. And the question is if we did that who are we doing it for? Well, as it turns out we're doing it for a

very small part of the Medicare population, about two and a half percent, who are, by definition, the most affluent of the Medicare population, and it seems like an odd place to spend your scarce taxpayer dollars if you really don't have a lot of choices.

So, you know, that's really the issue and people are going to come down in different places on it, that's perfectly, understandable, but I'm at least worried about the outlook for the for the program. I have to admit this I was a CBO director when the Part D program was birthed and implemented, and I've always admitted that I like it more than like my children, so I want to take care of it over the next foreseeable future. And there are some developments here that I think are a little bit troubling.

So, as Erin mentioned there are these proposals to accompany the catastrophic cap with changes in the reinsurance, and I want to talk a little bit about the president's proposal which is mirror image of the MedPAC proposal as well. Basically what this would do is it would put in the catastrophic cap and then in that area the insurance plans would've to pick up 80 percent of the cost and the federal government would pick up 20 percent.

Right now the federal government picking up 80 percent. So, the idea is to put the plans on the hook for more liability and give them better incentives. That all made sense.

Accompanying that is this notion that when you're counting the dollars to get to the cap you no longer get to count dollars that are, essentially, paid by the manufacturers in the donut hole which was this 50 percent discount. And so, yes, you're on the hook for more liability once you get to the catastrophic region, but it takes longer to get there. People are spending more genuinely out of pocket and that raises the possibility that you're going to have beneficiaries paying more not less. In fact, some will there's no question about it. And so, that's something to think about. The troubling development happened in between the president's budget and these original proposals, which was they passed the Bipartisan Budget Act of 2018, and in it they changed the rules on what's going to

happen in the donut hole, and now the manufacturers, instead of being on the hook for 50 percent, are going to be on the hook for 70 percent, and we were on track to have this be a split which was 50, 25 for the plans and 25 for the beneficiary, and they didn't take that that additional 20 off the beneficiary, they took it off the plans, which I'm just going to describe as mystifying. And, I mean, I don't understand it. We do not ask auto parts manufacturers to kick into auto insurance. We don't ask the builders to kick into homeowners insurance. This is a bizarre thing. But the upshot is if you now go with something like the president's proposal in the presence of this 70 percent share for the manufacturers, the plans themselves are only on the hook for 5 percent in the donut hole and there are relatively few people who are going to get to the catastrophic region and so, they're not on the hook for much in the way of liability in the donut hole or in a catastrophic region. And it's not my idea of an insurance plan when you pay premiums and they don't cover any liability. That seems odd. And so, I want to thank Erin for, you know, floating this proposal. I think the design issue is an important issue that ought to be addressed, but it's going to take looking at all these pieces simultaneously because right now we're on track in this piecemeal fashion to end up in, what I think, is a very bad design.

MR. GINSBURG: Oh, thank you, Doug. Next we have two reactors from Congress. There's Liz Jurinka who is the Chief Health Staff on the Democratic side for the Senate Finance Committee and Nick Uehlecke who is a professional staff member on the Committee on Ways and Means, Subcommittee on Health on the Republican side. Liz, would you like to speak first?

MS. JURINKA: Sure. It's a hard act to follow Doug. The congressional reaction to Doug's reaction of what we did in Congress last week, I like it. I think it's a good way to start. No, But first I want to say thank you, Paul, thank you, Doug for having

us, for having Nick and I to be able to give this congressional reaction. I see a lot of friendly faces in the audience. So, hopefully for QA we can keep them friendly. I see Liz here and Dr. Rivlin, and it's really a pleasure to be here this morning.

I think Paul's comments were exactly right in the very beginning, that this panel is particularly timely given the president's budget and what happened in Congress last week. Selfishly, for me, Senator Wyden has a lot of pride of authorship, and so to see many of his policies, at least, alluded to in the president's budget and then have such, I would say, great reform of, at least, closing the donut hole last week in addition to extending CHIP for four years and, of course, passing a chronic care bill. This is a great time for us here at the Finance Committee, so I will just say that.

I do think that, however, having said all of that, that Erin's comments are also timely. The notion that we are making improvements to the program and for beneficiaries I think that's -- the idea that we don't have an out-of-pocket cap for beneficiaries is something that we should be concerned about. Having said that, I do think the financing, and I agree with Doug, that the taxpayer or the question of how to pay for it is always going to be something that we have to deal with. And I actually do agree with Doug, that the notion that plans are not responsible, particularly, in reinsurance or what their role in reinsurance is, is something that we should be looking at in Congress. I think that, you know, the notion of restructuring Part D, however, if you say that it's like a lightning comes and strikes you in Congress because Part D is so popular and it is such a successful program. Having said that, the cost of Part D is increasing and I know that that is blasphemous to many because it is such a prized program, but it is true, nonetheless, and I think part of that really has to do not only with the underlying structure of the program but also the question of what is the role of the manufacturer and what role they have in setting the launch price to begin with. There are a lot of proposals in the

president's budget that just came out to address, I think, what we would call, maybe the web, if you will, of how drugs are both paid for, how the beneficiary pays for them, what have you whether it's point-of-sale rebates that was included in Senator Wyden's see-through bill or whether we are going to have an out-of-pocket cap, but there is nothing in that proposal that really directly addresses the issue of launch price. And so, we have to figure out both in Congress, but also within the administration, what are options there. My boss has said many, many times he really enjoys having the private sector have a role to play in health care, but we also want to make sure that health care is affordable. And so, if people can't access drugs that they need then we're kind of missing the mark. I think, you know, reinsurance in particular, however, should be, I think, one of the next things that Congress deals with when it talks about Part D and changes to Part D. I mean, just a few facts. Spending on Part D grew by nearly 60 percent between 2007 and 2014. Reinsurance payments have doubled over the last decade and are becoming the number one or the single largest component of Part D spending. And reinsurance is this kind of hidden component, if you will, not necessarily to people in this room, but to folks at home, they don't understand how reinsurance works, but the government is on the hook for an enormous amount of that spending. So, we really do need to take a look at that if we're going to keep this program as successful and accessible as it is. And with that, I think I'll pass it to Nick. And I'm really looking forward to your questions.

MR. UEHLECKE: Hi, everyone. Nick Uehlecke with the Ways and Means Health Subcommittee. Apologies first for being a little tardy. My cab driver's cab just died about four blocks away and I, sort of, sprinted the rest of the way. And I have to do this at the beginning just to save my job, but these are my thoughts, my opinions, not that of my chair, my conference, pretty much everyone in the pecking order above me, which is a lot of people you'd be surprised. The fortunate part about being last is that I

get to keep my comments short and leave it mostly up to your questions. But I think the words that I wanted to speak with you today are very different than the statement that I came up with two weeks ago that I just kind of tossed out on the way here, because the world is dynamically changed, I think, since what we did last week, and I use the royal we, and what happened with the president's budget.

I think that when you look at what we did in the budget deal last week, it's and likely not what we would've come up with in the House in our conference, to be completely Frank with you. I think that Doug had made a couple of good points there on -- and I think that we're kind of still a little bit of soul-searching ourselves on have we left the soul of the Part D program intact and kind of the intent of what we were trying to do after what we did. And, you know, some of the details aside, now I think we're looking at, you know, what's next what, what are the possibilities, what are the things that we need to do to ensure that we are working as a group to provide, kind of, the essential -- what's essential to be access for beneficiaries who need the drugs and truly cannot access them whether it's due to cost or whether it's due to the plan formularies.

And so, that brings me a little bit to this concept, and I think that both Erin and Doug touched on it a little bit, which is responsibility, you know, personal responsibility. And I don't mean that just on the beneficiary aspect, I mean, it on the entire continuum of when a drug is manufactured all the way through to all the folks that touch how it is priced and how it's handled, and how it gets to the beneficiary along the way. Because I don't think that the answer, honestly, to the issue of drug pricing and how are we going to lower prices, how we're going to make sure that people have access is an issue that we alone in the federal government are going to be able to sit down in a room and answer. It's an issue, I think, that, you know, physicians need to be a part of. I think when we're talking about prescribing and prescribing habits, and how the Medicare program itself works,

where I think we are largely a drugs first program. I think that we need to look at the beneficiary level as well and talk about personal responsibility there, and I think that the raging debate between the manufacturers and the benefit managers as well, needs to come down to, kind of, a more rational side of, you know, instead of throwing barbs out there we need to, kind of, come together and say, what can we do all together to make this problem work along the continuum?

So, speaking from my angle of it, I do think that there is a general agreement that, you know, 15 years ago the debate over drugs was accessibility. Doug's right, I mean, when he was over at CBO what we were debating was, do seniors have access to these drugs? I mean, the world has dynamically changed on the side of innovation over the course of the last 20 years, and I think that in that administration it was, kind of, this point of, wow, we need to figure out a way to give seniors complete accessibility to this series of drugs as the baby boomers start coming in so quickly. And so, as accessibility started getting solved along that time, I think we have now reached this issue of accessibility because of affordability.

And so, speaking on, kind of, both sides of it, we're kind of hitting a point where the debate that we are having, and amongst our staff and amongst the staff of our committee members and our RLAs and everybody, as we sit down and talk about this issue is, is that how are we going to take head-on this concept of innovation? We're now seeing curative drugs, right? We saw what happened with Hep C a couple of years ago and what that did to the system. And I think that one of these issues of how are we going to pay for these drugs, how are people going to pay for drugs that cost, say, a million dollars, but it cures you of something for the rest of your life? You know, and so I think that the current way that we're doing things is working, but we need to make sure that the kind of tsunami that's coming it's something that we're prepared for. I mean, I think that

we're all, kind of, on the edge of our seats when we talk about things like dementia and Alzheimer's every time a company gets really close. And I think we're all, kind of, I mean, the company is probably pretty sad, but we're all saddened when it doesn't work out or, you know, we don't get to the endpoint that we want to get to. But are we truly ready for a drug that will slow down or reverse the effects of dementia as a health care system? To be honest with you, we're not. We don't have the alternative payment models in place for this population. Honestly, I think we dropped the ball highly for this population and it's something that we are working on to be prepared for, but if we thought that the Hep C issue was -- that is a drop in the bucket to what happens to the entire healthcare system when we're seeing folks with early onset Alzheimer's in various parts of the world passing away at the age of 30. Everybody, everybody who's ever forgot their keys is going to be wanting to take this drug. And so, you know, it's something that I think we all need to work together to be prepared for. I know that we, you know, we are willing to sit down at the table and have this discussion.

Now, again, if we had started this discussion do I think that we would've agreed to some of the changes that were made last week if it wasn't a large part of a larger budget deal? Probably not. And so, we are having discussions with the administration on their policies as well, and we're still, kind of, in the digesting track of all the policies, and I look forward to working with, I think, a lot of the smart minds in this room, in the audience, and up here this table on what the future really holds on this. Thank you.

MR. GINSBURG: Thank you, Nick. Let's throw out a question to any of the panelists that would like to answer it. To what degree will the president's proposal with this treatment of catastrophic coverage, in a sense, be a catalyst for discussion of many of these other issues in Part D that all of you have brought up?

MR. HOLTZ-EAKIN: I think it's going to be an important catalyst. I mean, one of the things that has happened between, you know, 2003 and now is that many people who were around at the birth of Part D have now left Congress and a lot of people who are associated the program are not around to explain the original intent and the integrity of the policy design. It's now viewed as just another government spending program. That was far from the case. It was consciously crafted to be a competitive system with private insurers bearing the financial liability, giving them strong incentives to negotiate effectively with the manufacturers, and let's provide the access to these drugs for seniors and, you know, give them insurance against the out-of-pocket costs, and that insurance did not exist in nature. I mean, there was no private product against the financial cost of outpatient prescription drugs.

So, that whole policy design, I think, people have lost track of why it was designed the way it was, and it has worked incredibly well. I always remind people that the Part D program had in it government fallback plans in every region because no one believed -- that's not true -- many people did not believe that it would work and that private people would step up and provide this product. They've never been used. It has it has really worked much better than anyone has ever dreamed. And so, my concern with things like the donut hole, not that I care about pharma versus the insurers, I actually don't care about either of them a bit. But if you think about what they're doing in the donut hole, this 70 percent is really just a tax-and-spend program that does not take advantage of the incentives of insurers. They're just going to take it from the pharma guys and you could have it taxed to death, and distribute it out to the beneficiaries, that was not the program design, and so we're slowly undermining it. And I think it'd be great if we have a discussion about what do we want out of this program, not from a just a total spending point of view but from the incentives that the program embodies.

MR. GINSBURG: You know, what's interesting, Doug, is that when the program was passed there was an expectation, which proved to be generally true, there was a particular benefit design of the law, but the plans had the flexibility, so all through it, and they did it except when it came to the donut hole and the catastrophic because, at least, either would've driven the premium up too high and it would've provided a selection spiral, which one prominent company, Humana, found when it tried to offer brand name drugs without a donut hole.

MR. HOLTZ-EAKIN: I mean, just as a matter of perspective, that's right, but you know, most people aren't in the donut hole or in the catastrophic version. Two-thirds of the beneficiaries are in the initial coverage part. And so, for the vast majority of seniors this discussion really doesn't apply, and it's the smaller subsets that are in those areas that we have to worry about.

MS. JURINKA: I guess I would just -- I would agree and disagree to the extent that Nick is right, and I think he is, that we are looking at curative treatment, we are looking at new and innovative therapies that are more and more expensive. It's not so much that the two-thirds are not in the coverage gap, it's in the event that more folks are getting the drugs, that there --

MR. GINSBURG: Sure. Or the two-thirds.

MS. JURINKA: Right. It is. That's right. But like to the extent that drugs are becoming more and more expensive for a variety of different treatments and diagnoses, more people are going to potentially be in that coverage gap. But I think the other point though or going back to Paul's original question of what is the -- I take of what is the, you know, impact of these policies being in the president's budget. The president has the bully pulpit. I mean, he has the largest stage. The fact that this policy is in the budget means it is a shift in terms of potentially where this administration is in thinking

about drugs, which I think is important. I would also argue, you know, the president's budget also includes Graham-Cassidy which we are, you know, we will throw ourselves in front of a train to let that happen. So, I mean, there's a balancing act of how much weight we want to put on any one particular policy and that'll be the royal we. Right, Nick? We're going to throw ourselves in front of that train.

(Laughter)

MS. JURINKA: So, I would say, you know, Senator Wyden has had his RX cap bill out there for quite some time. So, now to have the administration echo this idea of this additional protection for some of the most vulnerable is important. It's important to our office, I think it's important to Democrats. I think the question, I guess, I go back to is, is this a signal of the administration that they want to take on the issue of pharmaceutical pricing and spending or are these going to be policies that end up in a document that is kind of paraded across Congress for a week, which don't get me wrong we had the secretary up before the Finance Committee yesterday, as I mentioned before, and it is important, but what happens next? What does the administration do? Does the secretary say these are things that he is going to call on Congress to do? And if that is the case then we need bipartisan support because, I've already mentioned, Senator Wyden is already there. Maybe it's some of the other aspects of how we finance or restructure, fine, but it's going to require bipartisanship at all levels of government in order to actually move any of these policies forward.

MR. GINSBURG: Other thoughts on anything on the panel before we go to questions?

MR. HOLTZ-EAKIN: I'll say one more thing and then I'll shut up. So, I think it's just important to note that this, sort of, the innovation and these expensive drugs are not -- that's not independent of the incentives that are in Part D and elsewhere in the

payment system. I mean, the fact that insurers don't have any donut hole liability and have only 15 percent of the catastrophic region says that they don't have a real big incentive to stop purchasing the very expensive drug. And if they were on the hook for more they might be saying to the manufacturer, "You know, that's great, but this other one is cheaper and does nearly as well as what we're actually going to put in the formulary." And so, I think we need to think about the whole thing pretty carefully.

MS. JURINKA: And just on that -- Doug, is it just the two of us? I'm just kidding. It's like we're going to have like a little (inaudible).

MR. HOLTZ-EAKIN: No, no, I said it was too (inaudible)  
(Laughter)

MS. JURINKA: Don't promise something they can't deliver on, Doug. No, I think the other thing is that policy did not -- there are a few times in Congress when you pass something without the input of CBO or other folks. CBO, one of the reasons that it actually ended up in the budget, besides there being a four-way agreement, was that there was savings associated because plan bids were not going to be as high, premiums would lower. So, I agree with the idea that the plan does need to have a role in this to, you know, help negotiate, for all intents and purposes, with manufacturers to lower prices. But what CBO also found, or at least what they said, was in shifting this to the 70 percent or 75, or 60 whatever it is, that the plan bids would actually go down and, therefore, would help, you know, premium and save the government money. The savings was from, you know, the federal spend, not necessarily on premiums. So, to the extent that the plan now is going to have a, I don't know, less expensive option I think that that's something else to think about. But I understand what you're saying and I agree that we need to continue to think about what that role is of the insurer.

MS. TRISH: I think also just picking up on some of your earlier comments, Doug. So, now we're in a situation where, you know, in the initial kind of introduction there was an intention to engage plans in a particular way, now we've kind of piecemeal, as you pointed out, filled in these different provisions. Plans face very different incentives at different portions of the benefit phase and, essentially, keeping in mind that the plan that this is all based on the list price of spending, so we also have these rebates and now a plan's on the hook for 5 percent of spending plus the rebates that they're bringing in. I mean, you just kind of recognize that if you were to design this now and recognize and say this is the benefit design we want to get to or we have today, you may think about a very different way of engaging this plan behavior and incentives to kind of get at the outcomes that you're achieving. And so, perhaps it's time to rethink more broadly now that we've come to a different place and what this benefit looks like. Is it time to think about how can we best use the market forces that plans have to offer and kind of getting the outcomes we want and, you know, perhaps protecting beneficiaries from high out-of-pocket costs in conjunction with that?

MR. GINSBURG: Just one more closing thought. I think the point Doug brought up about engaging the insurers and having them have something at stake is very important when we're dealing with very expensive prescription drugs. Because, you know, as things have evolved with hundred thousand dollar-a-year treatments or more we can't make much use of patient cost-sharing as a device to control utilization. That's really just a matter of how much the patient kicks in. So, in a sense the authorizations, the managements that the insurers bring have become much more important in the drug area than they used to be, and if we disable the insurers then we're really -- it's uncontrolled.

MR. GINSBURG: This would be a good time to go the audience. We've got four really good panelists, and I just want to ask you to direct your question to a particular panelist who would speak first. Fiona.

MS. SCOTT MORTON: So, I had a comment for Doug, but my questions for Erin. So, I think one of the true purposes of insurance is the smooth financial risk, so I think it is odd to say if we don't want to spend another federal dollar, the place we don't want to spend it is for the person with uncontrollable uncapped costs, and instead we want to spread it evenly to the tune of 30 cents a person across the population. So, we could just take a dollar from everybody in tax revenue and give 30 cents of it to each old person and that would be what we're doing now in Part D or we could take a dollar from each person and actually insure somebody who we don't know the identity of that person today, but they're exposed to some really large costs, and we would all prefer as people who don't know whether we're going to be the sick ones to have that insurance. So, my question for Erin is you didn't show a distribution of those costs. I'm surprised about that. If the point of this is to ensure the really extreme cases, which none of us want to be, how many of those are there and what do they look like? if all the people in the catastrophic region were paying \$500 in the catastrophic region that's very differ than if most of them are paying \$2 and once somebody's got a bill of a million.

MS. TRISH: Yeah. No, so I think that's a very important point. And there is a distribution and there are some who's been, you know, who essentially just modestly cover across the catastrophic coverage phase and have very little out-of-pocket spending. There are some who have very high out-of-pocket spending and catastrophic coverage. There are also some for whom this is a persistent year-over-year type of condition and they'll be taking these drugs for the rest of their life. And there are some

for whom this is kind of a one-off, you know, this is something that we cure in this year. And so, I think it's a really important point that this will impact beneficiaries in very different ways in terms of the actual out-of-pocket spending.

MR. FOURNIER: Charles Fournier with the Type 1 Diabetes Defense Foundation. This morning we heard another different definition of cost for the sale price cost of drug, but the one word we never heard is (negative) price. Can you explain what was the original (off mic) intent in having insurance company negotiate price and convey that (negative) price to the beneficiary as a plan, and (off mic) intent has been filled today?

MR. HOLTZ-EAKIN: So, the original design and the intent was to have multiple prescription drug plans competing to get beneficiaries, and that the power of that competition would force them to negotiate strong with manufacturers for as low a drug price as possible so that they could keep their premiums down and attract the beneficiaries into the program, and that has, by and large, been pretty successful. There are these issues now about the nature of how you get to the final negotiated price and how much rebate gets delivered and at what point it gets delivered, and that's the next panel and it's a good discussion to have. But I think the big picture, the intent was very simple, it was to have powerful competition for beneficiaries, induce powerful competition for lower drug prices from manufacturers and that, has by and large, worked well.

MR. KLEIN: Okay. I'm Dan Klein with the PAN Foundation. We're the largest independent charitable foundation helping cover out-of-pocket costs for patients on Medicare, so we deal with these patients every day. And I want to first start by reminding the panel that the people we're talking about that Doug referred to as the most affluent in Medicare are people who are 150 percent of federal poverty level and above. Typically, we're helping people between 150 and 400 percent of federal poverty level.

These are folks who are already spending in excess of 20 percent of their income on health care related out-of-pocket costs. So, we're talking about people with Parkinson's, people with MS, people with cancer. And if they're lucky enough to make it to the catastrophic threshold and still be able to fill their prescriptions then at least their out-of-pocket costs come down. But the reality is that many of them can't even get to that point without getting outside assistance. So, when you talk to people with cancer and you talk to people with MS, and you talk to people with Parkinson's well over 50 percent are unable to afford their out-of-pocket costs before they get to the catastrophic threshold. So, I think there needs to be a little reality check about what we're talking about. We're not talking about the need for consumerism. Nick talked about increased consumerism, but I'd remind the panel that, again, people on cancer or with cancer, people with Parkinson's, people with MS, people with serious illnesses often don't have a lot of choices about what medication they're going to take. And in some instances, in fact, in many instances there isn't a cheaper alternative. So, again, I think it's easy to make the policy question so complex that we forget about the near-term needs of patients. So, we had a call the other day. I had a call from a woman who was trying to renew her grant. She has MS. She takes a drug that keeps her from falling down.

MR. GINSBURG: Yeah, could you --

MR. KLEIN: Okay.

MR. GINSBURG: -- wrap it up.

MR. KLEIN: I will. So, she needs help covering \$50 a month in copay or she can't take this drug, and that's who we're talking about. So, I just want to remind folks that there's a very practical side to this discussion.

MR. GINSBURG: Okay, thank you. Yeah, Mike Miller.

DR. MILLER: Hi, Mike Miller. I'm a longtime policy physician here in D.C. about 30 years. Doug brought up the concept of incentives for the plans. I wanted to go back to broaden that to incentives for the drug companies and ask this question to Elizabeth, because my analysis was in the budget bill. It actually increases the incentives for manufacturers to raise their launch prices because if they're going to be told they've got to give a minimum of a 70 percent discount for these drugs in the donut hole, which could be more than 70 percent if there's rebates on top of that, and that could be exacerbated if TrOOP doesn't count towards getting to catastrophic. Is that any part of the discussion? Was that thought about when this this proposal was developed? And since you've said that Senator Wyden is very concerned about launch prices it seems to go in the opposite direction. Thank you.

MS. JURINKA: Sure. And so, we're talking about with the budget last week as opposed to the budget on Monday, which is --

MR. MILLER: Budget bill versus (inaudible)

MS. JURINKA: The budget bill versus the budget proposal, got it.

MR. MILLER: One is real, one is theoretical.

(Laughter)

MS. JURINKA: There's a joke there somewhere, I know. But no, I think -- no, I appreciate that. No, I don't think -- I think the issue that drove that particular debate last week was, number one, closing the donut hole sooner, right? Accelerating the closing of the donut hole by a year. That was really the genesis of this. And then I think for those that were in that discussion, I think the other question was, how do you do that and what savings to CBO give you for all the various options? I think when you're talking about a \$280 billion budget cap increase some of that, you know, the idea of the dollars and cents of what policies get you drives a lot of that debate. The issue of launch

price, though, I think goes well beyond that one particular policy, right? The notion of, I mean, in a crass way, right now, companies are going to launch at whatever the market will bear, whether it's a 70 percent within that donut hole or not. And that's how it's been and, you know, it is what it is. I think that that's okay in a lot of sense, in a lot of ways. But, you know, is that concern what drove that? No, not at all. I don't think that, and I don't know that that policy -- no one has told us at this point that that is going to be a real reason that launch prices either go up or go down. In fact, I think some folks, at least, that what we have heard a little bit in coming out of this is what the impact on the plan is actually going to be. Are plans going to change what they cover? Are you going to have plans that now want to tailor a plan? Is an insurer going to tailor a plan to target people that are not going to get in the donut hole or those that are going to only get to catastrophic? I think the bigger issue -- and I don't know, we haven't looked at any kind of data or analysis that shows that one way or another. I'm just saying that this is kind of in the ether now in the last week, some side comments that we've heard. I think the bigger question is also going to be reinsurance. I go back to that. That is the sleeper issue here. The notion of 70 percent for the manufacturer I think is, in some ways, a sideshow to the amount of money that we are spending on reinsurance, and to the extent that there is a role for the plan to negotiate a better deal for catastrophic or for, you know, the highest cost drugs. That's really where we need to go.

MS. O'CONNELL: Thank you very much. I guess my question are for the congressional people.

MR. GINSBURG: Identify yourself.

MS. O'CONNELL: My name is June O'Connell, I'm an attorney. I'd like to ask about generics and assert the fact that with Part D enrollees can switch plans each year without penalty unlike a gap plan, for instance. As long as you're within your

window you can go from plan Medicare, Plan D, Acme to Plan D box with no penalty if you're in the time frames. So, there has been an emphasis on generic, going with generic in a lot of these programs, but generic isn't cheap anymore depending on the number of suppliers. So, I wonder if you can kind of discuss the role of how you see monitoring generics within these Plan D options.

MS. JURINKA: So, I think that, I mean, the generic utilization in this country is, you know, some of the highest that it's ever been. I think that's a good thing. We're looking at close to 90 percent which is great. I think that your point that you're making, I think that some of what I'm hearing is to the extent that there is not generic competition even if there's only one generic drug that doesn't necessarily mean that it's any cheaper.

MS. O'CONNELL: Right.

MS. JURINKA: Right.

MS. O'CONNELL: Or are cheap.

MS. JURINKA: Or are cheap, right. Exactly. I think that, you know, yes it is something that we should be monitoring. You know, the budget also included biosimilars participating in the budget that passed last week, not the theoretical budget from Monday. Including similars counting in the donut hole which was, I think that someone that, actually, everyone across the board agreed was something that should happen, we should not incentivize only the biologic, there should also be that 50 percent discount or now change to apply in the donut hole as well.

I take your point that generics are also expensive. It's something that folks don't often talk about. I think there's this assumption that generic drugs are, you know, \$1 or \$2 pills or a couple pennies or what have you, that's not necessarily the case. But I think also to your point it is not necessarily in the spotlight of the issues that people are necessarily

focused on when they're talking about total spend. I think encouraging the use of generics. And this is completely out of my space, it's more the help committee, I know that the FDA is working quite hard and diligently to approve applications for generic drugs to bring that competition to the market.

I know other folks and other committees have talked about various ways of encouraging not only generic utilization but bringing generic competition more to the forefront. I think that's fine. But, you know, I think in terms of our conversation today we really are talking about dollars and cents and protection for those beneficiaries, that this gentleman was talking about before, whether it's generic or brand, and what that, kind of, financial component is for the patient. So, I take your point and I think it's something that should be part of whatever discussion.

MR. GINSBURG: Is anyone in the back? Yes. Okay.

DR. POPLIN: I'm Dr. Caroline Poplin. I'm a primary care physician. I'm also an attorney. We represent whistleblowers who bring off-label marketing cases. We just settled one against Celgene last year for \$280 million. Celgene's original product in 1998 was thalidomide. It was approved for skin disease associated with leprosy, and it was sold for cancer. Now you know how much it cost to manufacture thalidomide, but it was priced according to the diseases for which it was being marketed illegally. Now they made a new one based on thalidomide called Revlimid and it was priced even higher, and doctors started using thalidomide because it was cheaper. So, they raised the price of thalidomide. How can you have competition if there's no competition on price? The competition is always on quality and these drugs are marketed to be, quote unquote, "different" They're marketed as brands, and if you only have two or three what kind of leverage does an insurance plan have to get the price down to, say, the European level? That would be for Mr. Holtz-Eakin.

MR. HOLTZ-EAKIN: I said I wasn't going to talk anymore. No. I think in the competitive space we've seen a lot of examples where the key number is two. Like if you have one, you know, we saw that when we launched the Hep C drugs, but when we go from one to two to three you do see dramatic increases in competitive pressure. Is that competition, you know, textbook perfect? Probably not. But, you know, what you really want to do is try to get as much entry as you can that in the end is the only way to solve for lower prices. I don't think you want to necessarily aspire to European levels which are not market driven prices, right? And one of the things that happens is that we end up footing the research bill for the global pharmaceutical market in a great way. And so, that's a different issue and a tough one.

MR. GINSBURG: Okay. Well, we're out of time for this panel. And I'd like to thank the panel.

(Applause)

MR. GINSBURG: And I'm going to hand off my moderator job to Margot Sanger-Katz from the *New York Times*.

MS. SANGER-KATZ: Good morning, everyone I'm Margot Sanger-Katz. We are going to talk a little bit more about thinking about how consumer incentives will influence drug pricing and the performance of various actors in the drug space. I have a wonderful panel. I just want to introduce everyone. I think the format is pretty similar to what you guys saw before, but we're going to have a couple of presentations and then we'll have a discussion among ourselves, and then we will call upon you to ask questions. So, please be storing them up and thinking of really sharp and concise questions so we can get to a lot of them. So, my panel includes Geoffrey Joyce who is the director of the Schaeffer Policy Center at a USC. Fiona Scott Morton who is a health economist and professor of economics at the Yale School of Management. Adam Fein who's the president of

Pembroke Consulting and the CEO of the Drug Channels Institute. Elizabeth Fowler who is the vice president of Global Health Policy at Johnson & Johnson. And Steve Miller who's the chief medical officer at Express Scripts. So, Professor Joyce, you want to kick us off?

MR. JOYCE: Sure. Thanks Margot. I'm going to go out on a limb and say this panel should be a little more contentious than the catastrophic copay.

MS. SANGER-KATZ: You know, in a friendly way.

MR. JOYCE: Yeah. And this is collaborative work with Karen Van Nuys and others at Schaeffer, and it's been supported by the Schaeffer Center and a grant from NIA. Growing public concern over rising prescription drug costs are fueled by these types of international comparisons. Here's the price of Humira. Just an example, a typical RA drug. It's price in the U.S. is two or three times higher than it is in European countries. And not surprisingly given this, a vast majority of Americans think the government should do something to control rising drug costs, that ranges from requiring pharmaceutical manufacturers to justify their prices to government negotiation or capping drug prices, to even importation of drugs from foreign countries.

And if you look at the data actual out-of-pocket expenditures on average in prescription drugs have not increased that significantly over the past decade, but the fraction of folks who are exposed to the full cost of a drug has. So, the yellow bars show, these are for large employers in the U.S., in 2014 about a quarter of large health plans had a separate deductible for prescription drugs compared to, let's say, 4 percent a decade prior, and we're seeing the same trend in an increase in coinsurance instead of a fixed dollar copayment.

So, in essence some fraction of beneficiaries are exposed to the higher cost of the drug. Increasingly common, but obviously controversial, response among manufacturers is to

offer rebates that either reduce or eliminate the copayment on a drug. These types of coupons are banned from federal programs, let's say, Medicare and Medicaid, for example, under the Anti-Kickback Statutes. They were initially banned in Massachusetts. That ban was repealed in 2012, and then Massachusetts adopted -- will prohibit coupons on drugs that have a generic equivalent.

So, a multisource brand that has a generic equivalent in states like California and many others are either proposing or have enacted legislation to follow the Massachusetts ban, i.e., on multisource drugs. The response on the commercial sectors been different. It's typically been let's exclude drugs from the formulary that are highly couponed or else let's not count the coupon amount towards fulfilling your deductible. So, the question today is, should federal or state governments enact legislation to ban copay coupons? Advocates of coupons say it improves access, particularly, for high cost drugs with unique therapeutic benefit. Critics of the programs or coupons in general say it circumvents the plans benefit design, which is trying to push people towards what they feel are lower cost drugs for the plan, so patients fill more expensive therapies and, therefore, total drug expenditures rise as a result of coupons.

So, we looked in 2014, we scraped the web for the existence and the prevalence of coupons in 2014. We focused on the 200 highest expenditure drugs in 2014 to try and get a sense of what fraction, what prevalence of coupons exist in the market, what type of drugs are being couponed, and what are the characteristics of those coupons. And among the 200, 68 of them were generics, and they did none of them had coupons. So, it's largely a brand phenomenon, which is not surprising. And among the 132 brands we looked at, the highest-expenditure ones, about 42 did not have coupons, 90 did. So, roughly two-thirds of branded drugs had a coupon in 2014.

Here's what a typical coupon might look like. This might be an online ad or print ad.

Here's one for another RA drug, ORENCIA where the member's required to pay just \$5 out-of-pocket as a copay. And if we looked in our data on these 200, what we see is the modal coupon most plans try and get the copay to \$25 or less. And, typically, they put a limit on how much you can benefit in a year, a calendar year. It ranged quite a bit from maybe below \$500 to as high as \$24,000 annual cap on a beneficiary is how much they could save. But I'd say the majority of them promise savings of in excess of \$1,000 in a year. And almost all of the coupons had some time expiration, So, about half had some it's it valid for X number of uses after the initial use or for one year from the start, things of that -- the most common was to put a limit, in this case, 12 scripts, for example, could be couponed.

So, most of the criticism of copay coupons have focused on the role they play in discouraging patients from substituting towards a generic. In the sample of our 90 drugs only 19 of them had a generics equivalent. The vast majority, 71 of them, did not have a generic substitute in the market, but they may have had some other therapeutic substitute. And so, what we did is we asked clinical pharmacists at USC to evaluate these 71 single-source drugs that didn't have a generic equivalent, but may have had some level of substitutability. They said 25 percent of them had a closed generic substitute in the class that was a generic, 35 had a reasonably close therapeutics substitute, but that was also a single-source brand, and 11 of the 71 did not have a therapeutic substitute. They were single-source drugs that had unique therapeutic value. So, then we looked at, well, what are the prices of these alternatives? And, again, 11 of the 71 had no therapeutic substitute at all, 25 of them had generic substance. So, some other drug in the class that was a reasonable therapeutic exchange, but that was generic and they were markedly lower in price, not surprisingly, and then 35 of these had a

substitute, but that was also a single-source brand and it was very similar in price to the coupon drug, and the majority of those also had coupons. So, in some ways it's couponing other drugs that are similar price --

MS. SANGER-KATZ: Can I interject for one question?

MR. JOYCE: Sure.

MS. SANGER-KATZ: Are those prices the list prices or the negotiated prices?

MR. JOYCE: These are the prices from Medicare data. So, it's actually what's paid by the beneficiary in the plan. Good question. Okay? But the point being -- and I think it maybe I can synthesize this better. We tried to illustrate the impact of copay coupons on two dimensions. On the vertical axis its impact on total drug expenditures, and on the horizontal axis its impact on therapeutic options. And, again, moving away from the origin is, we think, better and clearly the 19 coupons for drugs that had a generic equivalent increased costs with little therapeutic benefit. They don't expand options for patients at all. But I think the positive note of that is these are 2014 data. Today, plans have largely eliminated this. Through prior auth and through formulary exclusions we're not seeing coupons on multisource drugs today as we did in 2014. On the other extreme, about 11 drugs, the clinical pharma said, had no therapeutic substitute. They were unique therapeutic value and this clearly expands options for patients, and they may or may not increase costs.

In between these two extremes are drugs that have imperfect therapeutic substitutes, 25 of which had a generic. So, I think we could say it maybe expands options for beneficiaries, but it clearly raises cost to the system, and the other 35 improved options, I think, its therapeutic choices for patients and had very minimal impact on cost because

the drugs that they induce substitution from were similarly priced and the majority of those also had coupons.

In general, I think the coupon should be seen as a strategic response by manufacturers to higher patient cost-sharing and increasing PBM control over formulary decisions.

Coupons can weaken formulary compliance. In 2014 one in five coupons were steering patients away from a generic equivalent. One in eight were designed for single-source drugs that had no therapeutic substitute, and the remaining fell in between, some that had a close generic substitute that was generic and much cheaper, 60 percent that did not have, sort of, a cheaper alternative.

So, is a total ban warranted? We don't think so. Given the current pricing system a ban on coupons would reduce access to some therapeutic products for some patients, and coupons should be seen more as a symptom of, sort of, a dysfunctional and an opaque pricing system and not the disease in and of itself. And if you think about who should benefit who or should profit from the pharmaceutical supply chain, I think there's been increasing evidence over time that the pharmaceutical supply chain eats up more of the economic rent and profit than it should, and that the rewards and the risks are largely being borne by the manufacturers, and the innovations largely coming from manufacturers. So, if we're going to, sort of, tilt the field in one direction it should be away from the supply chain and more towards rewarding manufacturers for innovative products. But I think the take-home message here is a total ban is unwarranted. I think a ban on drugs that have generic equivalents is reasonable, but I think that is largely been taken care of by the market. But I think excluding the coupons altogether would adversely affect some patients and tilt the field away from manufacturers.

MS. SANGER-KATZ: Terrific. So, Professor Scott Morton, I know you have a more skeptical view of these coupons.

MS. SCOTT MORTON: Let me just say one word about the previous panel. There was a little departure from accurate economics there that I just want to fix before everybody goes home with their notes. Okay? There was some discussion of launching at a price that the market will bear and that we have market driven prices. Let's remember that the market in the United States is very largely Part D. If what you're launching at is a price the market will bear that means what Part D will pay. So, we shouldn't be thinking, oh, there's some correct abstract market price out there that somehow the government is paying through its government program. No, prices are being set in response to the government program. So, if we make it very lucrative for plans to get people into the catastrophic region, which we have, because then the government pays a big share of the bill, then they have a reason, along with manufacturers, to raise list price because that gets people into the catastrophic region fast and give them rebates to lower the pain, but that helps the plan by getting the patient into the catastrophic region which is very profitable. So, that's what the panel was talking about, changing those rules, but you just have to remember that the prices are being set knowing that these government programs are out there. So, that's just important. And that's the problem with this whole world is that there isn't any benchmark of a real price because we don't have uninsured consumers.

So, what I thought I'd do to, sort of, explain how the -- Okay? it's on my laptop, but it's not showing up here. Have I done something wrong? Okay? good. What I thought I'd do is just remind us why we have insurance, Okay?? Because I think that's really key to understanding whether we want these coupons. Okay? People want insurance because they want to smooth their health care costs over time or across people. We don't know if we're going to be the one to get cancer, we don't know if a year from now we're going to have a massive medical bill, and that's what insurance is all about, creating this really

smooth flow so that I pay a premium every month and then don't have to worry about it.

Okay? That's what we want.

So, the ideal thing there would be to just have premiums and no out-of-pocket payments at all, but there are some imperfections. People might overconsume. If they just had a premium and absolutely no out-of-pocket payment, they might consume stuff just because it was free. Okay? And not really think about the cost of it. So, we need some small copays for that. And then the insurer is responsible for negotiating prices, not the patient. And how does the insurer extract discounts by walking away, by saying there's drug A and drug B and I'm going to move my million people to drug B, and that's going to get me a lower price on drug A or B? How do you move people?

I belong to an HMO, the (inaudible) HMO just takes one drug off the formulary and out of the pharmacy, and puts the other one in and that's what I get. Okay? But if you're seeing a doctor in the community, a kind of a fee-for-service arrangement, then that doctor is not under the control of the insurer. The insurer can only shift chair through you, the patient, by giving you a copay. So, drug A is \$5 copay and drug B is \$70 copay. And that is the tool being used to shift you from drug A to drug B, that's the tool that enables the insurer to pay less, to say to drug A, "Your price is too high, I'm going to move everybody to drug B, and I can because I will give them copays that make them move, and then you won't have any business." So, we need copays to reduce moral hazard, this overconsumption, and allow the insurer to shift chair, that's why we need them. However, ideally we want as much full insurance as possible. These copays, we want to set them to do those two things, but that's it. We don't need them to be higher, they don't serve any other purpose.

So, our current problem is driven by high health care costs where employers want to get out of paying those costs, and so they make a high deductible. They say, "All right, that

reduces the cost of my pharma benefit because the first \$2,000 are being paid by the employee." Or a specialty tier. "I'm going to have the first 30 percent -- or "I'm going to have 30 percent of \$100,000 biologic paid by the patients and that just reduces the cost of the benefit." Those kinds of out-of-pocket payments are not achieving either of these things. They're not reducing moral hazard because \$30,000 for your biologic is not going to, you know, you're consuming because you need it, and the very high copay is once you get to a level where you can shift people from drug A to drug B, because they prefer to pay \$5 than \$70 having them pay \$700 or \$600 for their EpiPen, in the deductible is not helping with that either. Okay?

So, these high out-of-pocket payments aren't doing anything useful, but they give the manufacturer strategy. So, I'm going to give the -- if I'm the manufacturer now I give the money to the patient to help them with their copay because they want that, okay, because it's so high in return for them consuming the drug. What's the problem with that? The patient is insured, so there's an externality. The patient consumes the drug and everybody else in their plan is paying for it. Okay? The payment to the patient then stops, a full stop in the insurer from being able to switch them around. They don't pay any- -- They pay \$5 if they the generic, \$5 for brand A, \$5 for brand B because they get a coupon, and the insurer can't move them. Once the insurer can't move them they say to drug A, "Well, your price is kind of high and we're going to shift people away" and drug A says, "No, you're not. I've got everybody on a coupon. So, I'm not going to reduce my prices and equilibrium prices stay higher." Okay?

So, the problem here is that the coupon defangs the only tool we have in the branded context for lowering prices, which is getting drugs A and B to compete for the business of the insurer because the insurer can move patients back and forth. Okay? That is a really critical tool to lowering prices. So, that's the problem. The intuition here is suppose we

said, "Okay, we're going to let the head of the city transportation department who chooses which roads were going to build, to let --" and by the way we the taxpayers pay for the roads, "we're going to allow the head of the transportation to take money from the construction company to help pay for the road. The construction company is going to give the head of the department of transportation some money because they want to be chosen." Okay? Do we allow that? No. That's a kickback, right? You're taking a person who is spreading the cost on to everybody else, letting them take a kickback from the provider, and then choose that provider's product. Okay? That's not a good way to design public policy. Patient coupons and financial aid to insured patients are kickbacks designed to reduce the elasticity of demand. Okay? And what they do is they raise prices. There's a clear conflict of interest here, I take the coupon, my costs are lowered, and the cost of my very expensive drug is passed on to all of you. Okay? So, that that's why we don't think they're good public policy.

So, the ultimate harm is higher prices. The PBM, as I said, can't shift share away from a brand with a high copay if the brands going to undo the high copay with a coupon. So, I just gave you a numerical example. You could have a \$15 copay and the expensive brand has a \$70 copay, normally everybody would pick the low one. Okay? But now suppose the brand gives a coupon that lowers the 70 down to 15, now A and B are the same. Why would the consumer move? Why would the consumer listen to their insurer and say, "Oh, actually drug B is cheaper?" They won't. So, the threat, "Give me a lower price or I will move my business" becomes an empty threat, and the patient is shifting costs. Okay?

So, what is the right policy? If you just take away patient coupons and financial aid you expose patients to very high cost. So, if you're going to do this you have to have a policy pair. Okay? It's very important that these two things go together. I would say you

absolutely have to have some copays in order to allow competition between brands to exist in this market through the PBM and the insurer. So, you have to forbid manufacturer coupons or any kickback. In general, we can't have the manufacturer be the one helping the patient with her drug costs, that's not good public policy. But in that world employers or insurers could design a plan that had very high out-of-pocket payments and there would be nothing that consumers could do about that.

So, we have to pair this ban with limits on out-of-pocket payments. So, you could pick a number, California picked 250, you could pick 150. When I was on a panel here last year a representative from CVS Express Scripts said that about \$100 difference in copays enough to move people around. So, if I face drug A at a zero cost and drug B at \$100 out-of-pocket cost, I would be inclined to consume drug A. That kind of difference is the difference we need. So, we could allow for copayments up to say \$150 per month or course of treatment, and that would be enough to allow the PBM to do its work and be enough to prevent moral hazard. I wouldn't be consuming things because they were free, but at the same time we -- and we would be protecting patients because that would limit their out-of-pocket costs, but at the same time we would be taking the manufacturer out of the picture. Okay?

Allowing the manufacturer to pay patients to take their drugs, okay, is perverse, right? You create a real conflict of interest because the drug costs \$5,000. I'm going to pay the patient \$100 to take a \$5,000 drug. Okay? That's not going to result in a good outcome. Right? We're going to see that prices are going to be higher and there's going to be no limit on the ability of the manufacturer to set a high price because the PBM is not well-armed. Okay? So, that was all that I wanted to say. Thank you.

(Applause)

MS. SANGER-KATZ: So, I'm curious a little bit about why you think we have this system with these coupons?

MR. FEIN: Hi. Thanks to Geoff and Fiona for two very interesting and different perspectives on a pretty complex issue. And I have just a couple minutes to give some thoughts on this. You know, and I think it's important to -- it reminds me of something I learned in graduate school many years ago in theory, theory and practice are the same. In practice they're different. And if we think about the world of the pharmaceutical industry today, we really have not -- people's mental model is this image of drug reps knocking on doctors' doors, this sort of primary care blockbuster, but that world is basically over. The world of the pharmaceutical entry is bifurcated. We have, as some people have mentioned, about a 90 percent generic dispensing rate today. Roughly 85 percent of people pay less than \$20 a month out-of-pocket before the effect of any coupons. Ninety-five percent of people pay less than \$40. I put the data on Drug Channels yesterday. And then we have this other side of the story, this very small percent of people who are paying very high out-of-pocket costs, very small patient populations, relatively expensive drugs, relatively rare conditions. A lot of the mainstream conditions we can treat with generic drugs.

So, the industry is bifurcated and that's why we're having this kind of conversation. We don't really need to go help the same people with those generic drugs in the same way. And generic drugs is in a massive deflationary phase right now in the last couple of years. But on the other side, we have an enormous amount of cost-shifting going on where we've seen from 2- to 3- to 4- to 5-tier plans now we're those highest tiers are often coinsurance tiers and the patient's obligation can be hundreds or thousands of dollars. And so, we have this kind of interesting diversity here, and part of what is driving this now, if you think about where the money is flowing and what's affecting the patient.

You know, we talk about rebates as money going from the manufacturer to the payer and they're using that to, who knows what they're using it for. Right now rebates are more than a hundred billion dollars and they're being balanced in an increasingly small number of prescriptions.

So, we have a, you know, and I've termed this the gross to net bubble, this very wide gap between the list price and the net price. For some patients they're exposed to that list price because they're in a deductible phase where they're paying a coinsurance which is a percent of the list price, and for many of those drugs their payer maybe collecting a rebate that they never see. So, we have some really interesting challenges when you think about patient cost-sharing. We have some principal-agent problems. We're Brookings, I think I can say principal-agent, right? Yeah, I think I can.

MS. SANGER-KATZ: Moral hazard.

MR. FEIN: Yeah. Did I mention moral hazard? Yeah.

(Laughter)

MR. FEIN: (I got to work in adverse selection.) I'll come back to that.

MS. SANGER-KATZ: I'm gonna be much nicer than usual, guys.

MR. FEIN: So, thanks. But, you know, think about it, your employer, if you think about commercial insurance which pays for about 40 to 45 percent of all outpatient drug costs right now, they may or may not have your our best interests at heart. They may want to set up a tiering structure that prevents certain people from working at their companies. Just last week Publix, it was revealed, didn't pay for HIV drugs. Why? I don't know. We can guess. They were sort of forced, embarrassed into doing it. We have the payer, the employers collecting large amounts of these rebates which may or may not be shared with you and me. You know, one survey found that 70 percent of employers didn't share the value of the rebates with the patient. So, you may

be paying 20 percent of that drug and then your employer may be collecting a rebate for that. In some cases we have totally broken categories where competition is so intense that the net price after rebates has been flat or negative. Short-acting insulins is the classic example here where the net price has been flat, but the list price has gone up at like a 45-degree angle, and that gap is a whole bunch of money being poured into the system to the point where the employer doesn't actually pay for anything, they're just collecting these rebates and spreading it around.

So, when we think about policy solutions we have to be very cautious about what's happening here. When the manufacturer steps in to provide that copayment support for a product which, as Geoff pointed out, doesn't have a generic alternative, is maybe a single-source drug, is maybe a specialty drug treating a small patient population, in some sense it's another form of discount. It's another discount they're providing that either the plan would pay or the consumer would pay, but somebody besides the employer is paying when the manufacturer steps in. So, we have to be really cautious about sort of trying to over-engineer the world we're in now where we have a lot of different actors acting in a lot of different ways, and I think using, to be honest, Fiona, I think using very loaded words like "kickback" to describe a very complex system of funds that are flowing around with entities that have very widely disparate incentive structures is, in my opinion, not the way we want to think about providing access to needed therapies for people of rare and unusual conditions.

And I'll make one final point because I think I have ten more seconds. I want to be really cautious when we're talking about single-source products for people with conditions like cancer, MS. I don't think you need to be bribed to take that product. This is not a situation of deciding should I get an iPhone X or should I stick with my iPhone 8. We're talking about medicines that are crucial to health, and so I don't think the word "kickback"

is applicable here because I think the word "choice" is not really relevant when it comes to these medicines. And the whole nature of insurance is, I think as Fiona eloquently stated, to help us get over these kind of tough situations which, frankly, any of us could find ourselves in. So, with that I will let the panel move on.

MS. SANGER-KATZ: Yeah. I'm curious is the --

MR. FEIN: Oh.

MS. SANGER-KATZ: Oh, sorry.

MR. FEIN: Go ahead. I'll move off. Okay. Sorry.

MS. SANGER-KATZ: Oh, no. I would like to move on, but, you know, obviously, you're viewing things from the pharma side. How do you guys think about these coupons? I mean, I assume kickback is probably not the preferred term, but --  
(Laughter)

SPEAKER: Yeah. Probably not.

(Laughter)

MS. FOWLER: So, I think it's one strategy to make sure that the patients can afford their drugs. Is it ideal? No. I don't think it was something that's dreamed up as like this would be an ideal way to move the market in a, I mean, you know we saw some of that in Geoff's comments. It's not ideal, but it's one of many strategies to try to make sure that people can afford their drugs. So, I guess could I just step back and make a few other remarks?

And when we did this call, the prep call, we were told that we could start with sort of anything we wanted to say. I don't know that it was that broad, but I do want to --

(Laughter)

MR. FEIN: It is now.

MS. FOWLER: It is now, right. I do want to respond to the previous panel because I thought it was really interesting and they raised a lot of good points, and one of them was I was really glad that both of the congressional panelists said that they were open to relooking at the budget deal from last week because I think increasing the share of discounts that pharma pays and then shifting that mostly to the plan instead of patience is not probably the best policy. I would love to see sort of rethinking about moving more of that benefit to the beneficiaries. So, I was really glad to hear that there was some openness to thinking about that. I don't know if it would happen before March 23<sup>rd</sup>, but certainly open to that discussion.

And then, also, just on Part D as somebody who was there and worked on Part D legislation in in the Congress in Liz's job, actually, the world has shifted a lot since 2003. We've moved from where a world where the focus is on chronic conditions, diabetes, chronic heart failure, hypertension to a world where there's so many more innovative products and specialty products. And so, I think the world hasn't caught up in terms of the way that the benefit is structured, in the way that the costs are distributed in the program. So, I'm really glad to think that there's a way to rethink that now that we have a different world for pharmaceuticals and would love to see something that protects beneficiaries in their out-of-pocket costs.

And so, that sort of brings us to our current discussion. If you look at where cost-sharing has moved since 2006, that's the year that the Part D program was implemented, deductibles have increased by 300 percent and coinsurance has increased by almost 90 percent. That's across the board, not just for pharmaceuticals, for all healthcare and, unfortunately, in health care in this country everything moves up, nothing moves down, and that's across the board, and just, sort of, our reality. But cost-sharing has had a real impact on adherence. And if you look at abandonment rates, which I think we haven't

really talked about, the more you pay in cost-sharing the less likely you are to take the drugs. That has a really negative impact on patients. So, patients are more than twice as likely to abandon brand medicines filled in the deductible than those filled when the benefit kicks in.

And I think some more data, going back to your point about cancer drugs and MS patients, that it's really when you're thinking about those important health choices it's not really a choice. An abandonment of oral oncolytics, if you look at the patients with the highest cost-sharing, they're more likely to abandon or not fill their prescriptions at all. So, if claims with cost-sharing over \$500 had four times more likelihood of being abandoned compared to drugs with cost-sharing of less than \$100, and this is for patients with cancer. For patients with MS, a 2009 study found that abandoned was 5.7 percent when the out-of-pocket was \$100 or less. But the odds of abandonment when the out-of-pocket expense was greater than \$500 was 7 times more likely. And this has an overall effect on not just healthcare outcomes for those particular patients, but also on health care spending overall. You're more likely to maybe land back in the hospital, experience an ER visit, etc.

So, and getting back to your question, Margot, there are a lot of strategies to try to make drugs more affordable, copay assistance, patient assistance programs, the foundations that we've talked about, and coupons is one of those. Coupons are not ideal, but it's better than patients not getting their drugs. And as the research, that Geoff explained, shows in many cases, coupons are used when there's really no alternative. So, in that instance it does look like it's more of a strategy to try to make the drugs affordable than to shift market share.

So, we keep talking about these issues in terms of economics in terms of programs, but these are real beneficiaries with real health issues. So, a better way, there's probably a

better way to think about this, and I hope we get to the point where we're talking about policies. Looking at an out-of-pocket cap, I think, in Medicare is really important. And President Trump and Senator Wyden on the same page, who would have thought? But good to see that that discussion is potentially now bipartisan.

Lots of focus on the spread -- the growing spread between list and net prices for drugs, and cost-sharing is sometimes, and often, based on the list price and not the net price, and that's a growing concern for the industry, something looking at policy options, looking at this growing spread and the price that the consumer pays or the patient pays at the point of service is an important part of the discussion. And imagine if this was hospital stays or physicians stays and your cost-sharing was based not on the negotiated rate that your insurer had made or the discounts that were made with the negotiated rates with the hospital but based on the actual billed price. I think that would not be tolerable. So, looking at passing rebates on, directly or indirectly, should be part of the discussion. I saw this week that researchers at Johns Hopkins suggested that maybe instead of passing rebates on to the patient they could be has passed on to the payer. Let's have that discussion and see what that looks like. But, really, I think from the industry perspective what we would really like to see is a movement towards value. And I know this is now an overused phrase, the whole notion of value in healthcare, but looking at innovative payment arrangements based on value, that if you bring value into the equation and payments are based on value, that we can look for a way to make those drugs more affordable. If we really believe that they're the right drug for the right patient at the right time, then let's make sure that it's affordable for the patients. So, look forward to the discussion, but those are my reactions.

MS. SANGER-KATZ: So, Mark will you -- I'm sorry, Steve, will you tell us what it looks like from the PBM and, I mean, how distorting do these coupons feel to

you in terms of, you know, managing the plans the way you want to? And I also would hope you could talk about, you know, what several panelists have mentioned, which are these very high and rising cost-sharing that beneficiaries are facing.

MR. MILLER: Yeah. So, thanks for having me. And this is, obviously, a complicated problem. A couple of facts you should know, and that is despite what we hear in the marketplace the system is actually, for most patients, working better. If you look at our data, the most recent data on comparing 17 price increases to 16 price increases, the drug trend for the United States for our commercial plans went up 1.5 percent, lower than inflation. And when you look at cost shares, we have worked really hard to keep cost shares down and our plan sponsors have kept it down. The average prescription increased cost-share went up 12 cents that is 12 pennies, per prescription in the last year. Now, do not get me wrong, there are many, many patients that are really hurting. Those patients that are unfortunate to have a serious illness and they're facing the full cost of the drug, they are hurting, and so we have to have policies that make a difference.

So, let's talk about coupons. Remember that coupons are put out there to protect market share. Pharmaceutical companies are rational. Remember they are not even asking for your ability to pay, they don't look at your finances for a coupon, they're indiscriminately given to everyone, and they're there to protect the market share. And if you interpret Geoff's data just a little different, that is, if you look at the 90 drugs that have coupons, 84 percent of them had an alternative choice that was probably cheaper, either a generic choice 20 percent of the time or a therapeutic switch the rest of the time. Only 11 drugs didn't face competition, and those 11 drugs probably didn't need to be given. Those were for things like Botox or other lifestyle drugs that don't actually need to have coupons, but they get coupons because they want to buy market share.

Patient assistance programs are much different. Patient assistance programs are designed for patients who have financial need, and financial evaluation of the patient is done prior to giving them the copay assistance. And so, copay cards have been outlawed by the federal government. Massachusetts outlawed them for a while until pharmaceutical manufacturers were able to pressure them to pull back on that. But studies by Aaron Kesselheim, Leemore Dafny at Harvard, and others have shown that coupons raised the price. And not only did they raise the price because they prevent switching, but they raised the price because they let the pharmaceutical manufacturer bring the price in at a higher entry price. Because if you can take the bull's eye off the manufacturer it allows them to have more price elasticity.

Now, let's talk about these patients that are paying excessive amounts. We strongly support having to do something about this. This is, as Fiona talked about, we've actually done price elasticity across all classes of drugs. I'm a transplant kidney doctor. I know that if my patient's copay goes above \$150 they start abandoning their drugs. Now, think about the crime of that. You've gotten the gift of life, you've gotten an organ, and adherence rates for transplants patients are around 80 percent. And so, that's unacceptable. It adds to rejection, hospital visits, loss of organs, and often loss of life. And so, we need to make so that there are sensible caps for people in all insurance forms, not just in Medicare Part D, but even in the commercial insurance we need to have sensible caps to achieve what Fiona's talking about. We need to have the tools to help move the patient to the right drug, but we also have to protect the patient at the high end because we can't subject them to these incredibly high prices and believe they're going to be able to take their cancer drug, their transplant drug, their MS drug, or other types of drugs.

So, I'll end my remarks there, but I think that, as you can see, it is a really complicated issue. I believe that coupons actually don't buy access, they're really just buying market share for the pharmaceutical companies. If you really want to talk about relieving patient suffering, you need to look at patient assistance programs which are also funded by the pharmaceutical manufacturers, and which really helped to make sure that those who have financial need are getting the help and not just indiscriminately to the marketplace.

MS. SANGER-KATZ: So, I'm going to just take my prerogative and ask a question or two of our panel, but everyone else get ready. I'm curious what feels like the right spread. You know, it seems that everyone on this panel is concerned that certain patients are being asked to pay extremely high cost-sharing on drugs, you know, whether it's a percentage of the list price or whether it's, you know, just these very high deductibles on pharmaceuticals. And, I guess, I just wonder like is the \$100 that -- or \$150 dollars that Fiona talked about, does that feel like the right spread to all of you? What, in an ideal world, would be the right limit or the right spread between the kind of drug that, you know, the lower-cost drug that you want to steer people towards, but the, you know, other option that some people might still choose to take?

MR. MILLER: Well, you know we've looked at this in -- you know, when you look at tiered programs we actually know that for when you go from generics to a branded product a copay difference as little as \$40 will help move those patients, a large percentage those patients. Now there are some patients that are not economically rational and they actually will pay the excess to have the branded product when there's a, you know, even a generic equivalent. And remember when a drug goes generic the pharmaceutical company actually raises the price on the brand which doesn't seem logical, but because those patients that are really loyal to that brand, if you're really loyal to Lipitor you'll buy Lipitor no matter what price it goes to. And so, we know that \$40 is

usually important between the tiers, first tier, second tier, third tier. When it comes to abandonment, and this is the specialty patients. These are these patients with the incredibly high copays, this is the one that's getting into catastrophic. We've done price elasticity, we know abandonment goes up above \$150. And so, I think that somewhere between 150, and you can index it for inflation or whatever, but I think somewhere above 150 should be the cap that you're looking at.

MR. FEIN: That's really interesting data, Steve. You know there's kind of an underlying assumption here that I just want to call out. We're all kind of talking as if the price is a thing. The price, you know, although it sounds like it should be a thing, there's a lot of different prices, and it's not necessarily one thing to say there's a list price, there's a net price, there's a net price the employer is paying, there's the price the consumer is paying, there's other prices in the whole drug channel system, but I don't think we should just automatically assume that the plan is always making the best decision. We don't know, we don't know when someone tells us, "Well, this is the lowest cost, you should switch." Maybe it's therapeutically close, maybe it isn't, you know, there's certainly some categories where different plans cover different drugs or drugs get moved from a formulary off of formulary, and your physician may or may not agree with that. Now I'm not a medical doctor like you, Steve, so I can't really comment on medical switching or non-medical switching, if you will. But I think we have to be careful about saying, you know, what exactly is the incentive? What is really the price that's causing them to raise my copayment? I would like them to be aligned with me. But they have other incentives, they're thinking about both the PBMs and the plan, and my employer that may or may not be aligned with my personal health care choice. So, you know, we have to be careful of just assuming that everyone who's always looking out for you or me, my best interest.

MR. JOYCE: And to follow up on that, I think it's a very good point, Adam, is that we overlook -- there's been consolidation in the PBM industry. So, the three largest PBMs, Express Scripts, CVS Caremark, and Optum have about 80 percent of the market.

SPEAKER: Your study said 66.

(Laughter)

MR. FEIN: It's actually 73 percent of adjusted claims in 2017.

MR. JOYCE: We shouldn't quibble over that. The point being is if you look at the national formularies of the large PBMs you'll see drugs even within a PBM, within CVS Caremark an MS drug is preferred one year, it's excluded the next and vice versa. If you look across the PBMs you see a drug that's preferred on Optum's formulary and it's excluded from CVS Caremark or Express Scripts. And that may not be a problem if the drugs are homogeneous and they're equally effective, but when you have heterogeneous responses and the drugs don't always work for the same, you want to have those options available, and you say, "What happens when I lose access to a formulary of Express Scripts or CVS Caremark, and I lose access to 15 million people?" Well, those 50 million folks have an excluded drug that they have to pay out-of-pocket for. And so, I think part of the coupons, you know, in a perfectly competitive environment, you're right, coupons are not ideal, but we're not in a perfectly competitive environment.

MS. SANGER-KATZ: But do the coupons apply in that situation where the drug is off formulary?

MR. JOYCE: If it's off formulary, no. And that's been the response of the PBMs.

MR. MILLER: You know, that's actually not how the system works, though. That is, there's grandfathering. So, when a patient's on a drug and having a

good clinical response, even when it changes off the formulary they often still have not only access to it but they get the reduced price of the copay. So, this blanket statement that people switching formularies actually lose access to the drugs is not how the market actually works.

MR. FEIN: But I'd interpret Geoff's comment as meaning we're assuming there's some, you know, totally rational completely sensible agent who's saying, "Well, this is obviously the best drug," and then if you happen to change jobs and you get a different formulary, someone is saying, "No, actually this is the best drug, your other guy was wrong." And so, that's, I think -- there's a diversity.

MS. SCOTT MORTON: Yeah. It's not really the best drug, it's which one is going to offer the best terms today. We might think that a Honda and a Ford are both fine cars. If one of them is, you know, going to offer me a \$20,000 discount I'm going to drive that one. It's not that I think the other car isn't fine. So, the agent who's creating price competition here is the PBM. It's only by being able to shift people from one drug to the other that a low price can be extracted. So, if the PBM goes out and says, "Well, I really want to have all drugs, A, B, C, and D on my formulary," then what kind of bargaining can they do? "I'm going to exclude you if you don't give me a lower price." "Well, no, I've already promised not to exclude anybody. I've already promised not to favor one drug over another by giving them more market share." So, this is a very important tool, and if we don't have this tool we don't have price competition between drugs, and that's just a very expensive thing to give up. If we want to give everybody access to every drug, every minute then I think we have to have some kind of price regulation because then there's no way to stimulate competition. If we have a formulary we don't have to have price regulation. We can say, "Look, there's two of you and you

provide a similar benefit and I'd like you to compete for my business," and that's how we do a lot of markets in the United States. It works pretty well.

MS. SANGER-KATZ: -- but I do want to make sure we have time for some audience questions. So, up here in the front. And will you please, everyone who speaks, please tell us your name, and also just be mindful of how long you are speaking so that other people will get a chance.

MS. KEMPS: (Kathryn Kemps) with (Alta) Resources. And I know there's about 10,000 medications available, prescription medications available on the market today, and this may go from more the catastrophic area that you've been discussing this morning to more of a what are the PBMs doing and what are the manufacturers doing when we look at a kind of the movement toward curative therapies that also require diagnostic testing. I'm interested in what the PBMs, if we're talking about switching formularies and we're talking about moving there, what's the accountability for appropriateness? We've talked about access and we've talked about affordability, but appropriateness becomes one of those three areas in three buckets. So, I'm interested in understanding from a manufacturer standpoint and then the PBM standpoint, what's occurring there when we have curative therapies that also combine with diagnostic testing for more precise medication use?

MS. SCOTT MORTON: Well, I'm hoping that they're matched up, where there's a patient that potentially could benefit from the right therapeutic that there's the right diagnostic tool that suggests that that's the right therapy for the patient, and that they're both covered in a way that's affordable. So, is that happening in the market today? I don't know, and I guess as medicine becomes more and more sophisticated I'm not sure that our current tools are equipped to deal with some of that. And, yes, maybe for 90 percent of the market it is, but for that 10 percent with very high cost cases and

very expensive diagnostics as well as therapeutics, I'm not sure our current system, whether it's Part D or commercial, is equipped to deal with that, and covering the right things at the right time.

MR. MILLER: Yeah. So, it's great question. So, we actually believe that diagnostics and therapeutics are being more linked together, especially, for expensive diseases. As you're probably aware, there's 70,000 genetic tests out there today of which only a couple of them actually been proven to be beneficial. And even amongst those genetic tests, let's take BRCA1, the Angelina Jolie, you know, there are 61 approved CLIA labs which means their quality is identical, yet the price difference for the test actually ranges from \$250 to \$5,000.

So, one of the tools we've put in place is, actually, we're working with our physicians to not only recommend which tests to order, we're also helping them steer it to the right location so that it's at the highest quality at the lowest cost. We're then helping those doctors interpret those tests, and then getting those patient on a care pathway for treatment. But this is going to take a lot of change in the benefit, what's going to be paid for in the pharmacy benefit versus the medical benefit. This is why we actually purchased a company called eviCore. It allows us to do this across both benefits. And so, and when you think about -- someone mentioned this -- we have to move towards value. I think Liz mentioned this. And so, when you look at it we're doing really unique innovative things on the payment side including amortization, value-based contracting, adherence guarantees, and other things because we're going to have to get from this unit cost to something different, especially, in the era of the ultra-expensive curative medications.

MS. SANGER-KATZ: Let Paul ask a question. It's his show.

MR. GINSBURG: Thanks, Margot. Paul Ginsburg, Brookings and USC. I heard a lot of economic terms in the discussion this morning, but one term I haven't heard is "price discrimination." And when we talk about a single-source drug without of therapeutic equivalents that has coupons, in the sense the question is if it's patient assistance really steer to low income, you know, then that's probably a type of price discrimination that we think is maybe okay. Is that really being steered -- are patient assistance plans really just focusing on low income patients or are they really masquerading as coupons which then means, you know, this is going to affect the price the drug is introduced at. So, any comments about issues like that.

MS. SCOTT MORTON: Well, Steve covered it, I think. I mean, in the sense that the coupons are freely available, as Geoff's research shows. So, they're not price discrimination. But patient assistance where I have a 30 percent copay on a \$100,000 drug, that's when I send my financial information to the manufacturer and get patient assistance. So, that is price discrimination.

MR. GINSBURG: That's right. And, actually, one thing I thought of is that if it is going to be price discrimination, truly channeling the discounts to low-income people, who should be doing the judgments in a sense is this something that governments or a foundation should be doing as opposed to the manufacturer?

MS. SCOTT MORTON: Right. So, I think we have outsourced a lot of this problem to the manufacturers. And I agree with you, my instinct is that if we're going to help people pay for drugs we really, as a society, need to do that, the government or some neutral party, and not the manufacturers themselves or patient assistance foundations funded by manufacturers which are not going to be entirely neutral.

MR. FEIN: Can I just challenge this notion of financial assistance, too? I mean, again, I'm going to go back to my employment example. The average household

income in the United States is about \$56,000, something like that, and some of these specialty drugs which affect 1 to 2 percent of prescriptions at most have an average prescription price of maybe \$4,000 to \$5,000 with maybe a 25 percent coinsurance. So, the average American is not going to be able to say, "Oh, I've got to pay \$1500 out of my pocket for a couple of months until I hit my out-of-pocket deductible." That's an untenable situation. Now, the plan could cover that. The employer could cover that, but instead they've said, "Okay, manufacturer, we dare you. We're going to put this incredible burden on the patient and if you don't step up and lower your price and give more discounts into the market, you'll sell zero."

So, you know, again, we're thinking of this as, you know, these loaded words like "kickback," but, you know, financial assistance for the average American would be, okay, you know, your plan has decided they don't really want to give you a very generous benefit, so we, the manufacturer, are going to essentially give you another discount off our list price, but instead of giving it to the PBM, to the plan where it may or may not reach the patient, we're going to give it directly to the patient. So, again, I think, you know, when you think about these circumstances they're not so cut and dried, and that's why I think you really have to be cautious when we can we talk about policy changes.

MS. FOWLER: Well, and from the manufacturer perspective those patient assistance programs are sort of income targeted. And so, you have to fill out an application, there's an evaluation about affordability. The coupons, I think, and going to the question, when you're looking at a sole-source drug and looking at potentially on a specialty tier, you already know, you have your own market research. I mean, we have our market research, you know who can afford it and who can't, and it becomes largely unaffordable. And so, I think the coupons, it's not just a matter of, well, I want to bring everybody in and it's a market share issue. It's an affordability issue and making sure

that patients can afford them because you've already done the research. You know where it's going to land on the formularies and you know that it's going to be a problem for a lot of patients. So, maybe it's indiscriminant, but --

MR. JOYCE: One last point. I think we forget, and Fiona mentioned, what is the primary aim of insurance? It's to protect from catastrophic risk and financial loss. But a second implicit part of insurance is a redistribution from healthy to the sick. And the way the current system works right now with very high list prices and these rebates that go through the PBMs and maybe to the plan and maybe, maybe go to lower premiums. That implicitly doesn't affect the person who's incurring the cost of the drug for which the rebate is generated on. So, in essence the current system is a redistribution from the sick to the healthy. It lowers the premiums of everybody in the plan whether they use a drug or not, on the back of the person who's using that high-cost drug.

MR. FEIN: Yeah, I mean, I've used the term reverse insurance to describe the situation, and I think the other thing to remember is there's a range of payers out there. We have a very diverse system and just take the employer market, 40 to 45 percent of the market. Some employers say, "My employees are really valuable, they get gold-plated coverage." Others say, "My employees are generic factors of production, I don't really care. Here's a 25 percent coinsurance, have a nice day." So, the pharmaceutical manufacturer is selling into this market which has very different price sense, price elasticities, and some may say, "Hey, \$100 copayment for you because we love our employees," and other people say, "25 percent coinsurance. Okay, manufacturer, you want that extra sale? You've got to discount." So, in other words to say the market is not working, you're really seeing this kind of, you know, price discrimination occurring. And I don't like the word "discrimination" because it has other

kinds of connotations that I don't think are appropriate, but you're really seeing different prices in the market based, in some sense, on what that plan is willing to pay for the agent they're negotiating on -- or the principal they're negotiating on behalf of. That's, again, these differentiated incentives. You know, we have a lot of different crazy incentives in the system.

MS. CANTOR-WEINBERG: Hi. I'm Julie Cantor-Weinberg with Prime Therapeutics which is a PBM owned by (18) Blue Cross/Blue Shield plans. Doesn't some of this discussion, though, ignore the larger market? For example, I take Restasis. I pay very, very high cost-sharing for it. It treats dry eyes, but it's the drug that was sold to an Indian tribe to delay generic competition. So, you know, my cost-sharing, you know, sure a coupon might help me, but it would be more helpful if, to quote the FDA Commissioner, "We could stop the shenanigans and get more generic competition on the market faster." So, I don't know if that's a question or a comment.

MR. MILLER: I'll just say that, you know, we actually, and we put out a policy statement a couple weeks ago, pay for delay and all these other shenanigans things are driving up the cost of health care. As you know, for instance, Amgen and Abdi entered into a deal that was not publicly disclosed in which the generic version of Humera will be available in Europe this year, but it won't be available in the United States until 2023. And so, when you have these things going on and you can't get biosimilars into the marketplace which could actually reduce the cost by tens of billions of dollars for Americans. And so, we need to do everything we can. And Scott Gottlieb has been a breath of fresh air at the FDA. He is aggressively trying to get through the generic backlog, but he's also using the power of the agency to prioritize generics that are in short supply, to get those applications moved to the top. And so, I think you're going to see it will take time. It's like turning a, you know, a battleship or an oil tanker. It will take

time, but I think you have a real advocate at the FDA who's going to try to drive down generic prices.

And to Adam's point, generic prices, overall, continue to come down. Over the last eight years generics have deflated by 80 percent. So, generics continue to get cheaper and cheaper, and that doesn't mean there aren't some really high-priced generics, as you've heard before other people say, but overall the generic marketplace is working.

MR. FEIN: And, actually, Steve, I'll bring up something you brought up earlier. I know we're talking about all these problems, but I think you said commercial spending increased by one and a half percent, half of that increase was utilization, more people taking more drugs and half of it was price. So, 0.7 percent, if I remember correctly. So, I know we're talking about this, you know, oh, this terrible problem, but, you know, I'm sorry, one and a half percent spending growth doesn't sound like, you know, the sky is falling. I mean the rhetoric around drugs and drug spending is totally disconnected from some of the data and facts. I mean, the people who read my blog know my favorite saying in the world, everyone's entitled to their own opinion, but they're not entitled to their own facts.

MS. ROBINSON: Christy Robinson with Matrix Global Advisors. My question's particularly for Fiona, although anyone's welcome to it. For drugs like the 11 in Geoff's study that our single-source with no therapeutic equivalent, I assume that you still see a problem with coupons with those. I wonder if you'll explain why.

MS. SCOTT MORTON: Sure. I mean, my feeling is that if we're going to ban coupons we have to restrict the consumer exposure to price. So, as Steve said, something like \$150 for a prescription is about right in terms of creating incentives and not creating too much hardship. So, you need those two together. Right? If you banned all coupons and financial aid and you didn't limit consumer exposure that would be very

dangerous for consumers. What we've got now is increasing price -- sets up incentives to increase prices.

Why do I think it's important to ban coupons for everything? Because you never know when a therapeutic substitute will be invented, and we don't really know whether there's a therapeutic substitute for, perhaps, some segments of the population or there could be a step therapy. If this is a cholesterol drug, perhaps, we can try you on drug A for a few months. If it doesn't work we move you to drug B that's more expensive. So, you might call that drug B not having a therapeutic substitute because it's better, but maybe there's a way to, you know, create some elasticity of demand nonetheless.

So, I think it's easier, also, to just have one public policy if you're going to have it. And because the process of invention is always creating. You know, we have a hepatitis C innovator, and then a year later we have a second hepatitis C. So, often something without a good therapeutic substitute today we'll have one tomorrow. And so, I think if you took away the coupons and the patient assistance and you added a cap on expenditure then you'd have a lot of competition, and that would be really great.

MS. FOWLER: Can I just say that if there's a public policy that says that coupons are allowed for single- source drugs, but if there's a therapeutic equivalent then they're not allowed, presumably, when the therapeutic equivalent comes on the market the coupons aren't allowed and the manufacturers are going to comply with that. It's sort of suggesting that there's games going on that sort of skirt --

MS. SCOTT MORTON: Well, one of the things that's tricky about these coupons is it's really hard to know who's using them. I mean, there are rules against them in various places, but actually if you go to the drugstore and you swipe, it's really not clear how anybody in your insurance company or anywhere else is going to figure out how you paid for that product. It's not easy to track these. It's very hard. The reason we

don't have studies of the -- more studies on the effect of coupons is because we can't measure their use. So, if we can't -- and if patient assistance from the manufacturer arrives in the form of a check, and then they pay their, you know, out-of-pocket cost, we can't track that either.

So, part of the problem here is we really don't know very much about how much of this patient assistance is happening.

DR. FEIN: You know, I actually think that is a little bit of a simplification of what's happening in the marketplace. You know, most -- and I'll let Steve talk about his company specifically, but most PBM mail pharmacies will not accept copay coupons of any kind. The specialty pharmacies often will accept coupons simply because those are often single-source drugs for exactly these coinsurance situations. Now, I, as a payer, let's say I'm an employer I could say to my employees, "You know what, you have to use the mail pharmacy because that's the way we're going to just lock down this coupon situation." The reality is some employers say, "Well, that's kind of a mean solution and people get all grumbly about it, and I want to keep my employees happy." Remember these are, 'I'm over here, I'm Goldman Sachs.' I'm like, oh, no, these are very high paid, you know, people. I want to be very nice to them. You can go any pharmacy you want. Well, then I might lose control.

So, there's this tension that payers have in terms of how much control are you going to give out of the hands of the patient, out of the hands of the physician to this central authority that you're putting your faith in? If I worked at, you know, Yale and they said, "Okay, you have to drive a Honda," and then I got hired by Harvard and they said, "Well, now you have to switch to a Ford," was Harvard right or was Yale right? I don't know. And that's part of the challenge we're talking about. The more control you put on this, the more you're taking away things, and I think that creates -- there's some trade-offs here.

MR. FOURNIER: Charles Fournier with the Type 1 Diabetes Defense Foundation. I have a question for Elizabeth about patient assistance program and insulin. The list price of analog insulin is about \$300. I simplify. The net price paid by payers on Humalog, for example, is about 75 percent discount, would be about \$65. The patient assistance program offer only 40 percent discount which means that the manufacturer derived 3 times the amount of profit out of people who can't afford insulin. Do you think it's fair and don't you think that the patient assistance program should be offering the net price that they are offering to the payers?

MS. FOWLER: We're now getting beyond my level of expertise and knowledge of patient assistance programs in terms of how they work and what the prices are. But, you know, I just will go back to saying that the ideal is to try to find the patients who are having trouble and try to provide that assistance. So, you know, we put out a transparency report last year, we're getting ready to put out another transparency report that talks about how we run our patient assistance programs, and I would refer you to that, and I'm happy to connect you with somebody who can help answer your questions, but that goes beyond my knowledge of patient assistance programs.

MR. MILLER: Yeah, I'll just add a little bit, and that is the pharmaceutical companies, many of the pharmaceutical companies actually don't like the couponing either for the very purpose that Geoff said, and that is it's not accomplishing their goal. That is, their competitor is putting out a coupon also and it's not successfully moving market share, especially because formularies over lie it, and the formulary can actually dictate which the patient has to do. Recognizing the problem that you're talking about, that there are patients either in the donut hole or patients that actually can't afford their medications, or people who don't have insurance. We started a company called Inside Rx in which we are actually giving the rebate to the patient. So, you can actually go

electronically, its branded products unlike the usual coupon programs that are -- or these usual programs that are for generic only. And so, this is in cooperation with Lilly, Johnson & Johnson and many other manufacturers wherefore patients who want to pay cash, you can actually get the rebated price and pay cash. And so, for insulin, for instance, is one of the biggest uptakes we've had in the program because insulins have been so popular. Actually, the other one that's really big is erectile dysfunction drugs, not surprisingly, but it is a great way for diabetics who don't have insurance to actually get their medications at the lowest price possible.

MS. SANGER-KATZ: Have we exhausted our questions?

MR. CLASS: Hi. This is James Class from Gilead Sciences. And I just wanted to see if we could maybe think of a positive way forward. We did touch on value a little bit. And I was just wondering, is there any potential to address some of the root cause problems here through more creative thinking and value-based insurance design?

MS. FOWLER: Well, that would certainly be something that we would be willing to look at going back to the point about getting the right drug to the right patient at the right time and being rewarded for it, and if you are able to do that it's actually affordable for the patient. So, would welcome that debate and that discussion, and I think that's, you know, at this point where the industry is and part of the solutions on the table.

MR. MILLER: So, value-based contracting is already in the marketplace. Actually, we even do with you all. And so, and there's different values you can give. So, I'll give an example. In hepatitis C one of the things we're doing in a value-based program is we're guaranteeing adherence. If the patient is inherent for all 84 days we refund to the manufacturer the price anything they paid -- I mean refund to the payer anything they've paid towards it. That requires us to innovate. Right? We had to actually come up with predictive models to predict which patients would take the

medications, and which one wouldn't. We had to come up with cell phone apps, we had to come up with letter campaigns, call campaigns. But to be very honest I got the drugs so cheap I was able to even send nurses out to people's homes and shove the pills down their throats if we had to. The reality is, is because of that we were able to get adherence rates of over 93 percent which is actually greater than what was in the clinical trials. And we were able to save plans and the patient's over a billion dollars in the first year and successfully treat over 50,000 patients. And so, that's an example of a value-based program, but it's different than what you think.

On a flip side what we're doing is we have in place for rheumatoid arthritis or the inflammatory disease categories a discontinuation guarantee. That is 25 percent -- the docs don't know which drug to start you on when you have rheumatoid arthritis. They don't know if it's Humera, Enbrel, Cimzia, what it is. And so, they pick one off the shelf. If you stop that drug, for whatever reason, in the first 90 days, it doesn't matter if it's non-adherence or if it's not clinically working, or if you're having side effects, the manufacturer will refund two-thirds of the money back to you. And an average of \$3,000 a month that could be up to \$6,000 for the first three months. So, it's an adherence guarantee because, essentially, for that patient it's has been a defective product. It didn't work for them. And that's a value-based program. So, it allows it to have the broadest formulary because we've been able to do it with all the payers. It allows us to give a value above and beyond just lowest net price. And so, that's been wildly popular amongst our plans adopting that.

And so, the trouble for value-based programs, though, is we're going to need the government to help us out. We have to develop safe harbors so you and I can discuss things that may not be in the label, and we have to do something about Medicaid best price if we're ever going to expand it to the federal program. So, it only works right now,

for the most part, in commercial programs. Seema Verma has shown great interest in expanding this to the government programs. You may have heard her discussion about (car tease). We're doing it on the commercial side. She'd like to do it, also, on the government side.

So, I think there's a tremendous runway for value-based programs, but we're going to need some help from the government and the regulatory agencies to give us the safe harbors to do it.

MS. FOWLER: And just to reiterate, that's exactly the direction we should be going and applaud Express Scripts for everything they're doing in this space in addition to the government. I think reconsidering some issues that make it difficult, there's also operational challenges as well, and some of the data challenges. So, there's a whole discussion to be had around what tools and policies might make it easier to go down this road, but that's the direction that we'd like to see.

MS. SCOTT MORTON: What's effective in what Steve said is in action by the PBM, that something like a call or a reminder or innovation on that side. Let's remember we're here talking about the patient cost-sharing. If you want to say value-based insurance design is, I'm going to have you pay \$5 for a generic and \$100 for a brand, and the brand has a coupon, the value-based insurance design doesn't do anything. Okay? So, that's why the success here, I think, is partially in stuff that's not about cost-sharing by the patient. It's value-based between -- it's the contracts between the manufacturer and the employer and Express Scripts, and it's things like, let's have the nurse visit your house. That makes sense because you're not undoing it with a coupon.

MR. JOYCE: Quick follow-up. There was colleagues at Rand did a study on waste in the healthcare system. This is going to be easy, we'll find tons of waste. Well, it's very hard to find a drug, a device, a procedure that doesn't work for

some patients. I think the incentives, particularly, in pharma world is when you've invested a lot of money, the marginal costs are close to zero, and it's all profit thereafter. So, you push and you try and get the drugs into as many people's mouths as possible, whether they're effective or not. And I think when you talk about sort of risk-based or value-based it's to have risk being shared, have it be outcomes-based. If this drug does lower cholesterol in your patients then we'll pay. And so, the financial incentives for both the manufacturer and the plan are to get the drugs to the appropriate people, not to put them in as many mouths as possible.

MR. FEIN: And maybe I'll just add one final comment here. As we're thinking about all this there's also this very kind of delicate trade-off of, you know, we want competition, we want lower prices, which we're getting, the market is getting that, but we also don't want to sort of kill the incentives for innovation, and that is kind of a delicate beast. There's lots of things to invest in, the next version of Candy Crush, an electric car, a space rocket, I mean, a new web app. There's so many things you could invest in, but if we want companies and investors to pour money into these very speculative treatments, and if you follow what happens with biotech funding, billions of dollars have been lost chasing things. You know, we have to make sure we don't lose sight of that. We're not going to get a cure for Alzheimer's if someone does actually create one and we say, "Well, forget it we're taking it. Goodbye. Sorry. Thanks for your work." We've already invested tens of billions of dollars and gotten nowhere. So, I think we need to just, as we're thinking about this, let's not lose sight of this. We've created this very interesting, good innovation engine and we need to make sure we don't just try to kill it for some short-term benefit because in 10 or 20 years our children are going to be very unhappy with us.

MS. SANGER-KATZ: So, I hope we can all come back to do another panel on optimal incentives for innovation in this sector and others because I think there's lots of interesting questions there. But I think I'm going to let you guys all go. Thank you so much for being a great audience and asking great questions. And thanks to our panelists.

(Applause)

MR. GINSBERG: I just want to close the conference. First, I want to thank Margot for being a splendid moderator, and I want to thank Loren Adler and Abby Durak from staff at Brookings for all the work they've done behind the scenes on the conference. And also I thank Leonard Schaeffer for the funding to the USA Schaeffer initiative for health policy that made this possible. Thank you.

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