Community Liver Alliance
100 W. Station Square Drive, Suite 1930
Pittsburgh, PA 15219
412.501.3CLA
www.communityliveralliance.org

STATEMENT OF
SUZANNA MASARTIS, EXECUTIVE DIRECTOR, COMMUNITY LIVER ALLIANCE
PENNSYLVANIA SENATE
BANKING & INSURANCE COMMITTEE
OCTOBER 24, 2017

Dear Chairman White, Minority Chair Street and Members of the Committee. My name is Suzanna Masartis, and I am the Executive Director of the Community Liver Alliance from Pittsburgh, PA. Thank you for the opportunity to submit this statement to your committee on this important issue.

The Community Liver Alliance represents patients suffering from liver disease and their caregivers. We provide resources to health care professionals at the local level and partner with government officials, departments of health and physicians on educational initiatives to ensure issues surrounding liver disease, including screenings and research funding, are recognized and supported.

As a patient advocacy group, we work to make sure that patients suffering from liver diseases have access to the treatments that can change their lives. There is no question that medical research and innovations -- and the new treatments and cures that follow as a result -- can be expensive. Industry statistics show it takes 10 years and $2.6 billion to bring one new drug from lab to market. And, certainly, we've all seen the headlines about the bad actors in the industry indiscriminately raising drug prices.

But the truth is, the prescription drug marketplace does actually work in making drugs accessible to patients. While drugmakers set a list price, a study this year by the Berkeley Research Group found that more than a third of the list price of a brand prescription medicine is rebated to pharmacy benefit managers, health plans and the government or retained by other stakeholders in the pharmaceutical supply chain. More often than not, as soon as one new drug is for sale, a competitor drug emerges and drives down prices. Soon enough, generics also appear at a fraction of the cost of the new drug. In fact, generic alternatives account for 90 percent of all medicines received by patients.

Take the Hepatitis C drug Sovaldi, for example. When Sovaldi hit the market in late 2013, the headlines railed against the $1,000 per pill/$84,000 cost for a new Hepatitis C product. You had to read the fine print to learn that Sovaldi is a curative treatment for a disease that affects over 4 million Americans. Due to market forces, there are currently seven competing products on the market for Hepatitis C and Sovaldi's list price has been cut in half from when it was launched. Without a curative treatment like Sovaldi, Hepatitis C patients had access only to maintenance drugs that did not have the same curative outcomes and often had devastating side effects, including loss of life. Before the Hepatitis C cures came to market, the virus was the number one cause of liver transplantation, costing more than $500,000.

Can this system withstand changes? Absolutely. And we appreciate your willingness to consider how to make the process better. However, Senate Bill 637 is not the way to do it.

On the surface, a Pharmaceutical Transparency Commission sounds like a good policy. In reality, it will make it harder for patients to access prescription medications.

First, the legislation ignores all of the players in the prescription drug supply chain -- insurers, pharmacy benefit managers, wholesalers and Medicare. It focuses only on the manufacturers, when all of these other entities impact a drug's pricing and availability. Anything less than a holistic approach is sure to skew the system, not improve it.

More disturbing are the bill's reporting requirements. It would require life sciences companies to report -- for each and every individual drug -- production and manufacturing costs, research and development costs, clinical and regulatory costs, and the total profit of the specific drug. It ignores the fact that federal antitrust laws prohibit disclosure of information that would impact pricing and competitiveness. So it's illegal for companies to meet these requirements in Senate Bill 637.

Keep in mind that pharmaceutical companies already report extensive information on costs, sales and R&D expenditures. This bill ignores the long and winding road a new drug must follow to make it into our medicine cabinets. And only 12 percent of drugs in clinical trials will result in an approved medicine anyway. Accounting for these discovery costs could be nearly impossible.

If the reporting requirements aren't bad enough, the bill allows an insurer or PBM to refuse to pay for a drug if a company does not produce this information -- which, remember, is information a company may not be allowed to provide under federal law in the first place.

The pharmacy benefit managers are obscure but influential middlemen. They process prescriptions for insurers and large employers that back their own plans, determine which drugs are covered and negotiate with manufacturers on one end and pharmacies on the other. There is also a little-known tactic that PBMs use to maximize profits called "clawbacks." Clawbacks work like this: A patient goes to a pharmacy and pays a co-pay amount -- perhaps $10 -- agreed to by the PBM and the insurers who contract with them. The pharmacist gets reimbursed for the price of the drug, say $2, and possibly a small profit. Then the PBM "claws back" the remainder. Most patients never realize there's a cheaper cash price.

It's very difficult to see how this legislation would help a patient with liver disease receive the necessary medication or lower prescription drug costs. It will do neither. It appears to be a mechanism for insurers and PBMs to hold on to as much money as possible at the expense of patients in need of treatments and cures. Oftentimes, pharmacists' hands are tied because many plans require pharmacies to collect payment when prescriptions are filled and prohibit them from waiving or reducing the amount. They are not allowed to inform their customers about the clawbacks, according to agreements they are required to sign.

If the committee *is* interested in exploring meaningful policies to rein in the out-of-pocket costs for patients, I would suggest members of the committee consider supporting the policies and principles as written in Senator Ward's bill, Senate Bill 913. The provisions in this legislation will actually help patients with out-of-pocket costs by requiring insurance companies to pass along the rebates paid by manufacturers to patients, allowing pharmacists to provide prescription drug information that would allow the patient to get the best price for medicines, and implementing an All Payer Claims Database to collect information and data on costs paid by health care payers.

The life sciences industry is a tremendous economic engine for Pennsylvania and an industry that offers not just products but hope and health. Senate Bill 637 would threaten cures and treatments,

threaten the jobs of those who discover and manufacture them, and threaten the lives of patients in need of those cures. Please excuse the pun, but we recommend you keep SB 637 bottled up in committee.

Sincerely,

Suzanna Masartis
Executive Director