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DAN'S PLAN
TO LOWER RX COSTS

Dan McCready's 10-Point Plan to Lower Prescription Drug Costs

North Carolinians deserve a healthcare system that doesn't force families to risk bankruptcy to pay for skyrocketing prescription drug costs just so big pharmaceutical companies ("Big Pharma") can line their pockets. Yet nearly six in 10 Americans who spend more than $100 a month on their prescriptions say it is difficult to afford the cost of their prescription medicine, while nearly three in 10 say that they have skipped taking medication as prescribed during the last year because of cost.

Year after year, Big Pharma keeps raising prices on American families. Per capita spending on retail prescription drugs has increased by more than 10x since 1960 and by more than 5x since 1985 after adjusting for inflation (see Figure 1). Total spending on retail prescription drugs has increased to well over $300 billion annually (see Table 1). Insulin prices are soaring. The price of a vial of Eli Lilly's drug Humalog rose from $35 to $234 in 15 years. Reimbursements for brand-name drugs in Medicare Part D increased more than 60% from 2011 to 2015 even after accounting for rebates.

Central to the problem of high U.S. drug prices is foreign freeloading. Americans pay far more for prescription drugs than consumers pay in other developed countries because Americans are effectively subsidizing pharmaceutical research and development for the world.

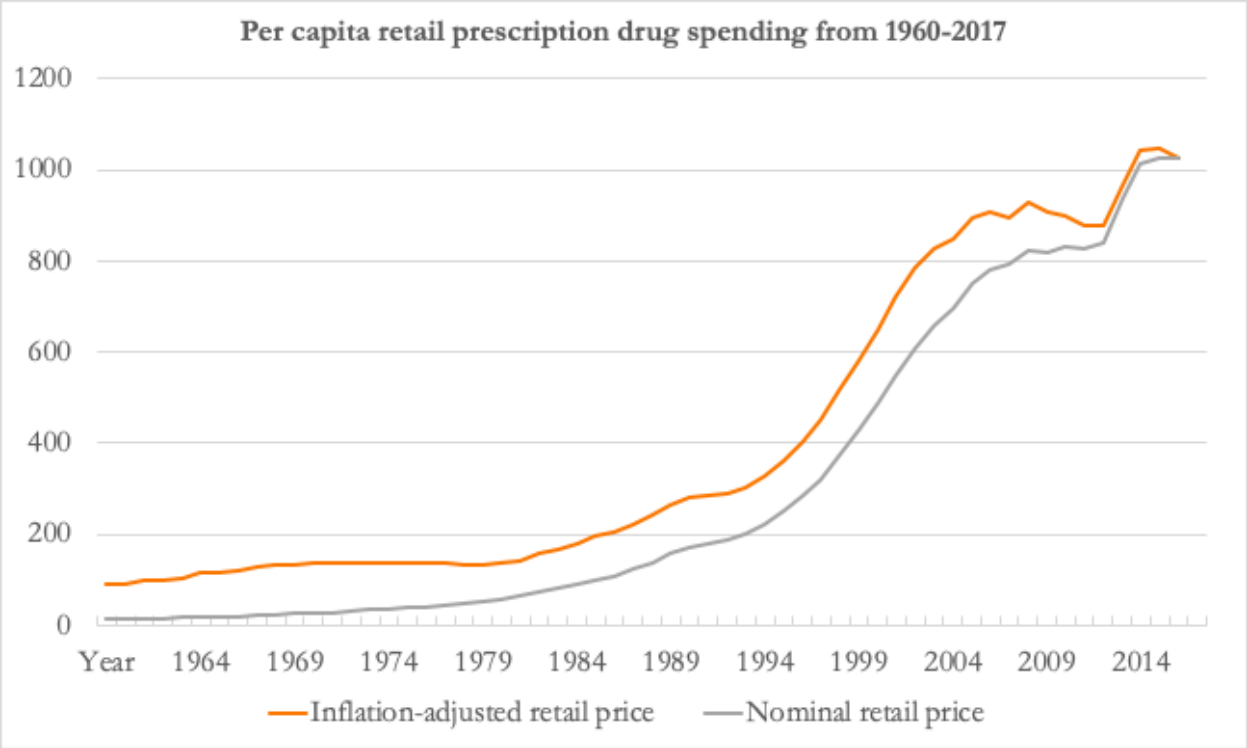
A large driver of costs are branded drugs, as opposed to lower-cost generic drugs. In North Carolina, according to BlueCross BlueShield of North Carolina claims data, customers spent $1.5 billion on branded drugs in 2017 compared to only $361 million on generics, even though 87 percent of prescriptions were generic.

The cost of prescription drugs in America is unacceptable, and it's time for action.

My 10-point plan includes common-sense and bipartisan reforms to take on the high prices of U.S. prescription drugs by reforming domestic drug pricing and sales, addressing foreign freeloading, and encouraging generic drug alternatives. Lowering prescription drug prices shouldn't be a partisan issue; a number of these reforms build on the work being done currently by the Trump administration. None of these ten reforms are silver bullets, and they are by no means exhaustive. But together they will make a big difference in lowering drug prices for North Carolina families.

Big Pharma Keeps Raising Prices on American Families

Figure 1



Source: Kaiser Family Foundation Analysis of National Health Expenditures Account, data accessed June 19, 2019, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html

Solutions to Domestic Pricing Issues

Big Pharma, along with costly middlemen known as pharmacy benefit managers ("PBM"), are taking advantage of American consumers. Big Pharma is bending the rules in their favor by spending tens of millions of dollars on lobbying to keep Congress from fighting back. That's allowed them to post record profits while everyday Americans struggle to pay for prescription drugs. It's time for Congress to stand up to these special interests.

1. Crack Down on PBMs

"Gag clauses" by Medicare Part D plan sponsors prevent pharmacists from telling customers about lower-cost drugs. Pharmacists must stay silent while a customer pays more under her insurance plan than she could pay with cash for a similar drug. Such gag clauses benefit PBMs, the middlemen who negotiate drug prices for insurers and large employers. Thankfully, last year Congress passed legislation, which was signed by President Trump, to eliminate standard gag clauses. Now it's time to enforce the law robustly and prevent PBMs from finding new ways to hike patient costs.

In North Carolina, House Bill 466 from the 2017 session of the North Carolina legislature took a step in the right direction by permitting pharmacists to discuss lower-cost alternative drugs with consumers. The bill passed unanimously except for a single vote: State Senator Dan Bishop's. This alarming vote followed his vote, along with only nine other representatives, against a bipartisan bill to stop price hikes on certain life-saving cancer drugs. Bishop has refused to explain these perplexing votes, which raise concerns about his relationship with pharmaceutical companies.

2. Stop the drastic price hikes

Almost a century ago, the creators of insulin transferred their creation to the Governors of the University of Toronto for $1 because they believed the drug should be affordable and available widely. That's a mindset that's hard to imagine today, when insulin's cost has skyrocketed to $450 a month and has more than tripled in the last decade. Price hikes like these are fundamentally wrong. We should make it illegal for pharmaceutical companies to impose severe price hikes on lifesaving prescription drugs without a market-based justification.

3. Use Medicare's purchasing power

The VA negotiates drug prices with pharmaceutical companies to keep down costs. So does every other developed nation. But Big Pharma lobbyists ensured that the 2003 law creating Medicare Part D outpatient drug coverage made it illegal for Medicare to negotiate drug prices. Medicare should be permitted to negotiate directly with pharmaceutical companies so Medicare's 55 million beneficiaries can use their bargaining power to achieve savings like the VA and other countries have long done. Everyone from The National Academy of Sciences to President Trump have supported this reform. While savings estimates vary widely, if this reform saved just 5% on Medicare's prescription drug spending (which was $129 billion in 2016), that would be substantial: $6 billion a year.

4. Move toward value-based purchasing

States have begun experimenting to enable drug makers and purchasers to negotiate drug prices based on health outcomes rather than volume. The Trump administration included value-based purchasing in its prescription drug plan. These are steps in the right direction. Federal programs should take bigger steps toward value-based purchasing. Using the power of federal spending, value-based purchasing could bring orphaned drugs back to market and reduce the costs of drugs whose prices have been raised without justification.

5. Tighten restrictions on marketing to doctors

Big Pharma is spending considerable marketing dollars to influence the prescriptions that doctors write, a practice that evidence suggests leads to higher drug prices. Dr. Ian Larkin, a professor at the UCLA Anderson School of Management, says: "Pharmaceutical companies are spending something like double the amount that they spend on research and development [of new drugs] on marketing to doctors." Larkin and his team found that restricting pharmaceutical detailing, a form of direct marketing to physicians, was associated with fewer prescriptions of detailed drugs in six of eight major drug classes. Even modest substitutions of generic for brand-name prescriptions result in big savings. While regulations have increased transparency in recent decades, the federal government should further limit the types and amounts of marketing dollars pharmaceutical companies should be allowed to spend to influence doctors.

Solutions to Foreign Freeloading

Unlike other developed countries, the U.S. does not regulate drug prices directly. Foreign governments cap drug prices charged by U.S. drug makers well below the prices that the drug makers charge in the U.S., which means American consumers are effectively subsidizing pharmaceutical research and development for the world. Accordingly, Americans spend more on prescription drugs than anyone in the world.

6. Lower Medicare Part B drug prices

In light of such freeloading, the Trump administration has proposed an initiative to reduce prices for Medicare Plan B prescription drugs that are administered by doctors and hospitals. Rather than set Medicare payments at the average sales price for the U.S. market, as is current policy, the payment price would be linked to an international basket of prices. According to HHS: "A senior who receives an eye medicine that currently costs Medicare $1,800 a month but other countries just $300, would see their co-insurance drop from $4,400 a year to $900 a year after full implementation of the proposal." HHS projects $17 billion of savings over five years. The Trump administration's initiative should be fully implemented.

7. Import safe prescription drugs from Canada

Another initiative we should implement to address foreign freeloading is the importation of safe, lower-cost prescription drugs from Canada. President Trump has also expressed support for this idea. Safeguards should be enhanced to protect consumers from counterfeits, learning from the Food and Drug Administration's experience importing drugs to address drug shortages.

Solutions involving Generic Drugs

Substituting lower-cost generic drugs for brand-name drugs has been proven to be highly effective at lowering costs. Unfortunately, the generic drug market is being manipulated and consumers are paying the price. We need more generic drug drugs and better regulation of bad activity.

8. Streamline approvals for generic drugs

The Trump administration launched a successful initiative to streamline generic drug approvals, and the initiative should be expanded. Since January 2017, the FDA helped more than 1,600 generic drugs get approval — a substantial increase over its approvals during the Obama administration. The administration estimated $26 billion in savings in lower prices from new generic drug products from January 2017 through July 2018.

9. Increase competition in the generic market

A recent lawsuit by the Connecticut Attorney General's office, joined by 43 other states and Puerto Rico, suggests that the largest players in the generic drug industry were colluding to raise prices. If true, this is simply wrong. Bad actors should be held accountable to the fullest extent of the law. At the same time, the federal government should create more competition by making low-interest loans available to companies willing to invest in generic drug markets.

10. Close evergreening loopholes

The federal government gives drug makers 20-year patents to market their drugs exclusively before having to compete with generics. This allows drug makers to recoup their research and development expenses. But Big Pharma works to keep generics off the market by "evergreening" their patents — for example, by repurposing and reformulating medications to add years to patent periods. Robin Feldman, a professor at UC Hastings College of the Law, found that 78% of the drugs associated with new patents were existing drugs. The loopholes that allow evergreening should be closed. Greater scrutiny should be applied in the patent review process so that safe and effective generic drugs are not being kept off the market just so Big Pharma can increase their profits.

Table 1

Expenditures on Personal Health Care Services and Prescription Drugs, 2009 to 2018, in Billions of Nominal Dollars

	Personal Health Care (PHC)	Retail Prescription Drugs	Percent of all PHC	Non-Retail Prescription Drugs[1]	Percent of all PHC	Total Prescription Drugs	Percent of all PHC
			%		%		%
2009	2,118	255	12.0	99	4.7	354	16.7
2010	2,196	256	11.7	100	4.5	356	16.2
2011	2,282	263	11.5	103	4.5	366	16.0
2012	2,379	264	11.1	103	4.3	367	15.4
2013	2,469	271	11.0	106	4.3	377	15.3
2014*	2,596	305	11.8	119	4.6	424	16.3
2015*	2,729	328	12.0	128	4.7	457	16.7
2016*	2,862	343	12.0	134	4.7	477	16.7
2017*	3,016	364	12.1	142	4.7	506	16.8
2018*	3,184	385	12.1	150	4.7	535	16.8
Projected Growth 2013-2018	5.2%					7.3%	

* Projected.

Source: CMS, National Health Expenditure (NHE) Amounts by Type of Expenditure and Source of Funds: Calendar Years 1960-2024. The projections are based on the 2013 version of the NHE released in December 2014.

[1] Estimated based on the assumption that non-retail drugs are 28 percent of all drug expenditures.

Table taken from ASPE Issue Brief, Observations on Trends in Prescription Drug Spending, March 28, 2016, https://aspe.hhs.gov/system/files/pdf/187586/Drugspending.pdf, accessed June 19, 2019.