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American Retirees Education Foundation

NRLN
NATIONAL RETIREE LEGISLATIVE NETWORK

Prescription Drug Price Gouging

Congress Must Take Action to Mitigate Harm to Americans

EXECUTIVE SUMMARY

Total spending on prescription drugs in the U.S. reached $424.8 billion in 2015, an increase of 12.2 percent from 2014, according to a report from the IMS Institute for Healthcare Informatics. Spending adjusted for net prices reached $309.5 billion, an increase of 8.5 percent over 2014. Overall, federal health spending (latest data available) increased 11.7 percent to nearly $844 billion in 2014, compared with an increase of 3.5 percent in 2013. **Federal health care costs are expected to jump to $936 billion in 2016, outpacing the $882 billion projected spending on Social Security,** according to a report released in Jan. 2016 by the Congressional Budget Office (CBO). **Repeating, health care costs will exceed Social Security costs!**

Americans—with 10,000 more people turning age 65 every day in the U.S—are outraged that they are losing access to lifesaving and life-enhancing treatments because they have become less and less affordable. **More than 75% of Americans now say their top health concern is the rising price of prescription drugs, according to the Kaiser Family Foundation, a nonprofit, nonpartisan organization focused on health care.**

According to latest available figures, **prescription drugs accounted for $97 billion in Medicare spending in 2014**, an increase of 16.9 percent primarily because of the use of expensive new specialty drugs. In its June 2016 report to Congress, the Medicare Payment Advisory Commission (MedPAC), a Congressional agency charged with making regular recommendations on Medicare, warned that rising drug costs and other factors have helped drive Medicare Part D spending **up nearly 60 percent from 2007 to 2014**.

A Consumer Reports national telephone poll found that three-quarters of all Americans and 90 percent of seniors on Medicare—during any month currently take a prescription drug and on average take six prescription drugs. It should be no surprise that almost three-quarters of the public thinks that drug costs are too high. Politicians, health care payers, doctors and patients have all criticized drug pricing, saying medicines are out of reach for many patients and straining health care budgets.

Will Congress take action to lower prescription drug costs, the fastest growing part of the nation's health care budget? As a whole, members of Congress have to prove they are not bound by obligations to insurance companies and Pharma more than their own constituents. There's nowhere to hide now, it's time to fix it.

A July 13, 2016 Forbes article stated, we don't have a free market for prescription drugs in the U.S.; federal policy has profoundly distorted the marketplace.

It is a myth that Pharma deserves to benefit from its heavy R&D load. All tech-type companies manage relatively high R&D burdens but not many S&P 500 companies carry a higher ratio of profit to net income than do the average Pharma companies. Equally troubling is that a PhRMA survey of member companies found that its companies invested $58.8 billion on research and development in 2015, up 10.3 percent from the prior year. But, **American taxpayers shouldered a substantial burden of those costs**. About 38 percent of all

basic science research is paid for with tax money through federal and state governments, according to a 2015 study published in the Journal of the American Medical Association.

In a Consumer Reports Best Buy Drugs national telephone poll of more than 2,000 adults who take a medication, nearly one-third experienced a price hike in the last year on at least one of their meds. The study found that people were more likely to stop taking their medication; or skip filling prescriptions; or didn't take the prescribed dosage; split pills without contacting their doctor or pharmacist first; took expired meds, or shared prescription drugs with others to save money. Cutbacks weren't limited to refills or dosages. They skimped on groceries. They also reported relying more heavily on credit cards and putting off paying other bills. And where people were dealing with high drug costs, other financial setbacks weren't far behind. More than one out of four people whose drug costs spiked also reported experiencing a costly medical event. **They were also more likely than those not facing higher costs to report that they couldn't afford medical bills, missed major bill payments, or even lost their health coverage.**

PRESCRIPTION DRUG and OVERALL HEALTH CARE PRICING ARE IRRATIONAL AND MUST BE STOPPED BEFORE THEY BECOME THE MOST CRITICAL BURDEN ON OUR U.S. ECONOMY AND ITS ABILITY TO GROW. CONGRESS MUST COMPREHEND THE DIFFERENCES BETWEEN DRUG PRICE AND COST AT ALL LEVELS AND UNDERSTAND THAT COSTS ARE NOT DRIVING PRICING, GREED IS.

The NRLN Supports Policy Changes and Passage of Bills that Solve this Economic Threat:

The NRLN supports passage of legislation allowing Importation of Safe and Less Expensive Drugs from Canada and for Medicare to be directed to take competitive bids for prescription drugs.

NRLN's Position on Prescription Drug Competitive Bidding

Members of Congress have quoted CBO studies to wrongly justify a claim that the CBO and others have said that there would be very little savings if Health and Human Services (HHS) required competitive bidding for Medicare's drug business. These are old irrelevant claims. Other than two letters written in the 2006-2007 period by two incumbent CBO Directors to Oregon Senator Ron Wyden and others, there are no published relevant studies made available to support this claim. It has been said that the HHS Secretary would have to be authorized to set (not competitively bid) prices. In some cases, such as in chronic and fatal disease treatment drugs, this may be even more problematic today.

Since 2007, generic drug availability has mushroomed from less than 20 percent of drugs dispensed in the U.S. to where today they represent around 75 percent of the pills, capsule and injected drug units sold. A growing number of these drugs treat the same ailments! And, a growing number will treat even more as drug patents expire. This data is not speculation or political rhetoric. It's time to start Medicare competitive bidding.

For example, the patent on Crestor expired and competition is salivating to take market share away from the price gouging manufacturer who is now suing the Federal Drug Administration (FDA) to obtain extended patent protection because 800 Americans use Crestor to treat another illness. That is stooping very low to avoid what's good for America.

There is only one solution to this problem:

Congress should remove the prohibition on Medicare competitive bidding and replace it with a competitive bidding mandate to be applied wherever two or more FDA approved generic drugs, or two or more brand drugs, or a generic and brand drugs (upon patent expiration) treat the same medical condition.

S. 31 and companion bill H.R. 3061, the Medicare Prescription Drug Price Negotiation Act of 2015, has been in the Senate Finance Committee since Jan. 2015 and in the House Committees on Energy and Commerce and Ways and Means since July 2015. When government CBO staff last analyzed the proposal in 2006-2007 they estimated savings would be "negligible." That's in part due to uncertainty about what specific powers Congress would provide Medicare to have in negotiations, more importantly this study used market data that is over ten years old. NRLN original 2007 saving estimate was $15 billion per year which would be at approximately $54 billion per year in 2016. **We strongly urge passage!**

NRLN's Position on Prescription Drug Importation

Countries that practice socialized medicine exact low prices for people served in their countries by demanding below market pricing from American pharmaceutical manufacturers.

There are two counter measures to our manufactures being forced to take losses:

A. Pharma companies should exit these markets, thus protecting Americans and our economy from subsidizing socialized medicine.

B. To the extent pharma and Congress don't eliminate this unethical practice of absorption and passing of losses on to Americans and the U.S. economy, Congress must pass laws allowing importation of safe, and lower priced prescription drugs from Canada and elsewhere so that Americans and our economy benefit. Start with Canada NOW.

Companion bills S. 122 and H.R. 2228, the Safe and Affordable Drugs from Canada Act of 2015, have languished in the Senate's Health, Education, Labor, and Pensions Committee since Jan. 2015 and in the House's Energy and Commerce Committee since May 2015. **We strongly urge passage!**

The Secretary of HHS has the authority under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to issue an order to begin legal importation from Canada but refuses to act. Members of Congress should write letters to the Secretary (as the NRLN has) urging her to authorize the importation of safe, lower priced drugs from our northern neighbor. The Secretary should be ordered to do so by the President. Has the Executive Branch defaulted to a no position? Congress has failed repeatedly to enact legislation! The Executive and Legislative Branches appear to be accountable only to those who have huge sums of money. Both feign concern so as to sound like they care, then they take a snooze.

Lately, both Congress and HHS have run to hide behind a new excuse. They have told the NRLN that insurance companies won't approve importation. To this we say, tell them if they fail to do so they can no longer sell to Medicare. It is time to choose, to side with affected constituents.

The NRLN supports providing adequate funding to clear the FDA product approval backlog of over 4,000 generics. This would make more affordable alternatives more readily available to patients.

The NRLN urges Congress to pass legislation that bans pay-for-delay. The Supreme Court ruled on a single case that this practice restrained trade but that each case must be dragged through the courts for years while Americans—especially retirees—are denied access to cheaper generic drugs.

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Table of Contents

This whitepaper was researched and written for the American Retirees Education Foundation (AREF). The AREF expands the research and education reach of the National Retiree Legislative Network (NRLN).

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The Terrible Perfect Storm of Rx Prices

Fifty-seven million Americans age 65 and older and people with disabilities are caught in the terrible perfect story of prescription drug price gouging. They are taking more expensive medications while living on fixed incomes. Even with their Medicare prescription drug plan they are paying substantial out-of-pocket costs. This means that they especially feel the pain of pharmaceutical companies' relentless price increases while bills that would provide lower prices are bottled up in Senate and House committees.

Americans—with 10,000 more people turning age 65 every day in the U.S—are outraged that they are losing access to lifesaving and life-enhancing treatments because they have become less and less affordable. More than 75% of Americans now say their top health concern is the rising price of prescription drugs, according to the Kaiser Family Foundation, a nonprofit, nonpartisan organization focused on health care Voters are demanding a meaningful response from both Republicans and Democrats.

A July 13, 2016 Forbes article stated, we don't have a free market for prescription drugs in the U.S., federal policy has profoundly distorted the marketplace.

Why hasn't Congress taken action on prescription drug costs, the fastest growing part of the nation's health care budget? In 2016, prescription drug costs are expected to rise over 11%. In contrast, medical cost growth for high-deductible health plans is expected to be 8%, hospital services 8.2%, and physician services 5.5%, according to the 2016 Segal Health Plan Cost Trend Survey. Segal calculates that prescription drug price inflation is over 10x the rate of the Consumer Price Index.

PhRMA's Lobbying of Congress

Could it be that numerous members of Congress are being overly influenced by the Pharmaceutical Research and Manufacturers of America's (PhRMA) spending $2.3 billion lobbying in Washington, DC during the past decade, according a September 1, 2016 Reuters article. In the 2014 election cycle alone, the industry made $147.8 million in contributions to Representatives and Senators, according to OpenSecrets.Org, the Center for Responsive Politics, the nation's premier research group tracking money in U.S. politics.

"Clearly legislation is required, but you and I know that lightning could strike the Capitol dome in the same place not twice but 10 times, and this Congress would not be willing to stand up to the pharmaceutical lobby," said Representative Lloyd Doggett (TX-35) as reported by The Hill newspaper on Feb. 26, 2016.

Daraprim Price Increase Grabbed Spotlight

Prescription drugs price gouging took center stage in September 2015 with the news media, the public and some members of Congress when Martin Shkreli, then-CEO of Turing Pharmaceuticals, raised the price of **Daraprim**, a specialty drug, from $13.50 to $750 per pill. **Daraprim** is used mainly to treat toxoplasmosis, a

parasite infection that can cause serious or even life-threatening problems for babies born to women who become infected during pregnancy, and also for people with compromised immune systems, like AIDS patients and certain cancer patients.

Martin Shkreli has subsequently been arrested on unrelated charges but his actions highlighted the callous and unnecessary price gouging prevalent in the pharmaceutical industry that places Americans – especially retirees – in grave danger due to unaffordability of prescription drugs.

The Shkreli brand of greed and arrogance was on display at a Congressional hearing but so was the propensity for Congress to be shallow and insincere in relating to its constituencies. Elected members of Congress hope that introducing bills and holding a grand stand hearing or two will be enough to placate retirees and the rest of America as Congress does little to actually take action to support controlled drug importation from Canada or to take action to direct Medicare to start up an effective competitive bidding process. It's as though many members of Congress defy Americans to challenge them, maybe they truly believe that taking campaign money and protecting industry contributor's interests over those of constituents and the negative impact on the U.S. economy is OK.

Bills Held Up in Committees

In the aftermath of the media, public and Congressional firestorm over the huge increase in the price of **Daraprim**, some Senate and House committees have conducted hearings on aggressive drug price increases. Yet, no existing bills to lower the cost of prescription drugs have even had a vote in committees. S. 31 and H.R. 3061, the Medicare Prescription Drug Price Negotiation Act of 2015, has been in the Senate Finance Committee since Jan. 2015 and in the House Committees on Energy and Commerce and Ways and Means since July 2015.

A poll of 1,800 Americans in July 2015 by the Kaiser Family Foundation has shown that allowing Medicare to negotiate lower drug prices is supported by 87 percent of Americans. Polls have also shown that a majority of the public supports the importation of safe and less expensive drugs from Canada.

S. 122 and H.R. 2228, the Safe and Affordable Drugs from Canada Act of 2015, has languished in the Senate's Health, Education, Labor, and Pensions Committee since Jan. 2015 and in the House's Energy and Commerce Committee since May 2015.

NRLN Supports Passage of Rx Bills

The National Retirees Legislative Network (NRLN) supports the passage of legislation to allow Medicare to negotiate for lower drug prices and the importation of safe and less expensive drugs from our neighbors to the north. In 2016 alone, NRLN members have sent over 5,000 letters to members of Congress urging their support for the passage of these two bills. They can't understand why two bills that are obviously in the best interests of Americans can't get passed.

The NRLN acknowledges that drug companies sometimes have to raise prices in reaction to cost and overhead inflation caused by supplier price increases and employee wage and benefit changes. The pharmaceutical industry consistently points to research and development costs as the reason for exorbitant prices. While in some cases this may be the case, it seems obvious that R&D and marketing expense do not increase cost for a product once it has been long established in the market. This serves to put American consumers at risk who will either not buy the drug due to cost concerns or will resort to lower doses than prescribed by their doctors in order to make the medicine last longer.

Spending on Prescription Drugs Reaches $424 Billion

Overall, total spending on prescription drugs in the U.S. reached $424.8 billion in 2015, an increase of 12 percent from 2014, according to a report from the IMS Institute of Healthcare Informatics. Spending adjusted

for net prices reached $309.5 billion, an increase of 8.5 percent over 2014.

Spending on prescription drugs – especially the newer, breakthrough biometric drugs for the treatment of cancer, autoimmune diseases and Hepatitis-C – increased by double digits for a second year in a row and showed no sign of abating through 2020. That means consumers, insurers and federal health care services such as Medicare, Medicaid and the Department of Veterans Affairs were financially squeezed as more and more seniors and veterans had coverage and services.

Specialty drug spending on a net price basis reached $121 billion, up more than 15 percent from 2014. The cost of breakthrough specialty drugs doubled over the past five years; they make up a huge share of the overall annual cost of drugs. For example, $39.1 billion was spent in 2015 on cancer drugs alone, followed by $30.2 billion for autoimmune disorders and $18.8 billion for the treatment of hepatitis.

Major drug firms raked in an additional $25.6 billion (gross) in 2015 simply by raising prices on their brand-name drugs, according to a recent report by the IMS. The firm estimates that figure to grow to $155 billion over the next five years.

According to a report issued in July 2016, federal health officials in Washington projected by 2025, one-fifth of the U.S. economy will be devoted to the health care sector.

The more the U.S. spends on health care, the less the nation has for everything else, like education, safety, roads, bridges, etc. This is all happening at a time when prescription drugs are becoming a bigger and bigger share of where health care dollars go.

Harvoni was Gilead Sciences' top-selling drug in the U.S. 2015 for hepatitis C, raking in an estimated $14.3 billion in sales before discounts, according to The Wall Street Journal. The average 12-week treatment of **Harvoni** is $95,000 and **Sovaldi** is $84,000, before any discounts. **Epclusa**, which is expected to replace **Harvoni** and **Sovaldi**, will retail for $74,000 for a full treatment, or about $900 per pill Bloomberg News reported.

Since 2005, spending on prescription drugs has steadily risen with just one exception, in 2013, when it actually dipped by 3.2 percent. The IMS Health report provides only faint hope of a moderation in pricing over the next several years, projecting a mid-single digit growth rate.

According to Express Scripts Holding Co., the largest U.S. prescription benefit manager, there was a 16.2 percent increase in the average price of brand-name drugs already on the market in 2015, with an increase of 98.2 percent since 2011. Price-increases exceeding 20 percent were reported for one-third of brand-name prescription drugs in 2015.

Spending on retail-drugs does not include drugs administered at hospitals and doctors' offices, where patients receive many high-cost specialty drugs. This spending is embedded in other categories of health care spending and is not separately reported.

Specialty drugs account for less than 1 percent of prescriptions in the U.S. but represent about one-third of total drug spending. More than half of the 56 medications approved by the FDA in 2015 were specialty drugs. And more than 900 biologic drugs are currently under development, according to PhRMA.

According to the Kaiser Family Foundation, there will be an estimated 49.5% growth of the U.S. senior population by 2030. The expected increase in Part D spending will mean hundreds of dollars more in higher annual premiums and deductibles for beneficiaries over the coming decade. KFF noted one in four Americans report having difficulty affording their medications. Moreover, many specialty drugs are priced higher in the U.S. than they are in other developed countries.

According to the KFF, Medicare per beneficiary spending is projected to grow more rapidly for the Part D prescription drug benefit than for other Medicare-covered services. There will be an estimated 49.5% growth of the U.S. senior population by 2030. The expected increase in Part D spending will mean hundreds of dollars more in higher annual premiums and deductibles for beneficiaries over the coming decade.

Seniors with Medicare coverage for medication have another worry: hitting the “doughnut hole,” the Medicare Part D accounting system that tallies how much money the person and the plan spend together.

In 2016 a senior will hit the doughnut hole if he/she and his/her Part D plan together spends $3,310. Once that happens, all of his/her drugs switch to a complex “cost sharing” formula, paying 45 percent of a discounted price for branded drugs, or 58 percent for generics. Costs won’t drop back down until he/she is out of the “doughnut hole,” when spending reaches $4,850. Under the Affordable Care Act the coverage gap is gradually narrowing but won’t be completely closed until 2020.

Medicare Spent $97 Billion on Drugs in 2014

According to latest available figures, prescription drugs accounted for $97 billion in Medicare spending in 2014, an increase of 16.9 percent primarily because of the use of expensive new specialty drugs. In its June 2016 report to Congress, the Medicare Payment Advisory Commission (MedPAC), a congressional agency charged with making regular recommendations on Medicare, warned that rising drug costs and other factors have helped drive Medicare Part D spending up nearly 60 percent from 2007 to 2014.

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Drug Companies Spend More on Marking than R&D

Drug companies spend up to twice as much or more on marketing and promoting their products—including advertising—as they do on research and development. That's according to an analysis published in the Annals of Internal Medicine in March 2016. Says Wayne Riley, M.D., immediate past president of the American College of Physicians (ACP), one of the largest physician groups in the U.S. and the organization that did the review: "Pharmaceutical companies may price drugs at will, and in truth, it's not clear what that price is based on."

In fact, it would seem that the spending drug companies need to recoup with higher prices is at least partly due to how much is spent on direct-to-consumer advertising. The review of the 2015 annual reports of 10 of the world's largest drug companies revealed that all spent more on marketing and administration costs than research and development. Ideally, a drug company will spend a substantial portion of its revenue in R&D seeking new discoveries—finding new medical treatments and cures. Drug company behemoths Johnson & Johnson and Pfizer spent about 13 percent and 16 percent on R&D, respectively. At the same time, both companies spent about 30 percent of revenue on selling, marketing, and administrative expenses.

A PhRMA survey of member companies found that companies invested $58.8 billion on research and development in 2015, up 10.3 percent from the prior year. But American taxpayers shoulder a substantial burden of those costs. About 38 percent of all basic science research is paid for with tax money through federal and state governments, according to a 2015 study published in the Journal of the American Medical Association.

Fifty-one U.S. Representatives signed a Jan. 11, 2016 letter to HHS Secretary Sylvia Mathews Burwell urging the National Institutes of Health (NIH) to utilize "existing statutory authority to respond to the soaring cost of pharmaceuticals." Secretary Burwell's response letter of March 2, 2016 declined the request that NIH use its statutory "march-in rights" to break a drug patent when the drug is not "available to the public on reasonable terms," a definition the Representatives argued could be used to fight high drug prices.

The administration is not completely ruling out exercising "march-in-rights" in the future, with Burwell stating in her letter that HHS is "prepared to use its authority when presented with a case where the statutory criteria are met". **The NRLN is watching to see whether this will ever happen or if it is a dodge to protect the interests of pharmaceutical companies and not consumers.**

The drug industry doesn't play by the same rules as any other market, where exorbitant prices dissuade customers, says Kevin Riggs, M.D., a researcher at the Johns Hopkins University, where he focuses on health care costs. "A drug company can increase the price of a product many times over, and people will still buy it because they need it," he says. "At the end of the day, they largely charge whatever the market will bear—and with lifesaving medication, that's a lot."

Many policy makers have expressed concerns about government involvement in this issue because it establishes a precedent in government-set price controls that are antithetical to America's free market system. **The NRLN strongly believes in our country's free market system. Nonetheless, there are many steps that Congress could consider in the area of pharmaceutical drugs that fall well short of government price setting that would be highly appropriate.** Keep in mind that we are talking about prescription drugs and not discretionary consumer products like televisions and smartphones.

90 Percent of Seniors Take Prescription Drugs

Around half of all Americans—and 90 percent of seniors—during any month take a prescription drug. A Consumer Reports national telephone poll found that three-quarters of Americans on Medicare currently take an average of six prescription drugs. Rising prices quickly become overwhelming when people take multiple drugs or take them for chronic conditions for the rest of their lives. In 2014, more than 500,000 Americans each took at least $50,000 worth of prescription drugs. Americans pay out-of-pocket for a much greater share

of prescription drug costs than hospital costs. These costs will also continue squeezing federal and state budgets as Medicare, Medicaid and various other health care programs pay of prescription drugs.

It should be no surprise that almost three-quarters of the public thinks that drug costs are too high. Politicians, health care payers, doctors and patients have criticized drug pricing, saying medicines are out of reach for many patients and straining health care budgets.

The Wall Street Journal Article Compared Rx Internationally

The Wall Street Journal in a December 1, 2015 article reported that drug prices in the U.S. are shrouded in mystery, obscured by confidential rebates, multiple middlemen and the strict guarding of trade secrets. But for certain drugs—those paid for by Medicare Part B—prices are public. By stacking these against pricing in three foreign health systems, as discovered in nonpublic and public data, The Wall Street Journal was able to pinpoint international drug-cost differences and what lies behind them.

What it found, in the case of Norway, was that U.S. prices were higher for 93% of 40 top branded drugs available in both countries in the third quarter of 2015. Similar patterns appeared when U.S. prices were compared with those in England and Canada's Ontario province. **(See attachment)** Throughout the developed world, branded prescription drugs are generally cheaper than in the U.S.

Medicare Not Allowed to Negotiate Rx Prices

Current law bars Medicare from negotiating drug prices. This is known as the "noninterference" clause in the Medicare Modernization Act of 2003 which stipulates that the HHS Secretary "may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors, and may not require a particular formulary or institute a price structure for the reimbursement of covered Part D drugs. In effect, this provision means that the government can have no role in negotiating or setting drug prices in Medicare Part D.

This is in stark contrast to how drug prices are determined in some other federal programs; for example, the statutory requirement for mandatory drug price rebates in Medicaid, and a requirement that drug manufacturers charge the Department of Veterans Affairs (VA) no more than the lowest price paid by any private-sector purchaser.

For years, the "noninterference" approach seemed effective: Medicare drug costs rose about 1.5 percent annually on average for most of the last decade. But specialty drugs have contributed to the current huge rise in prices.

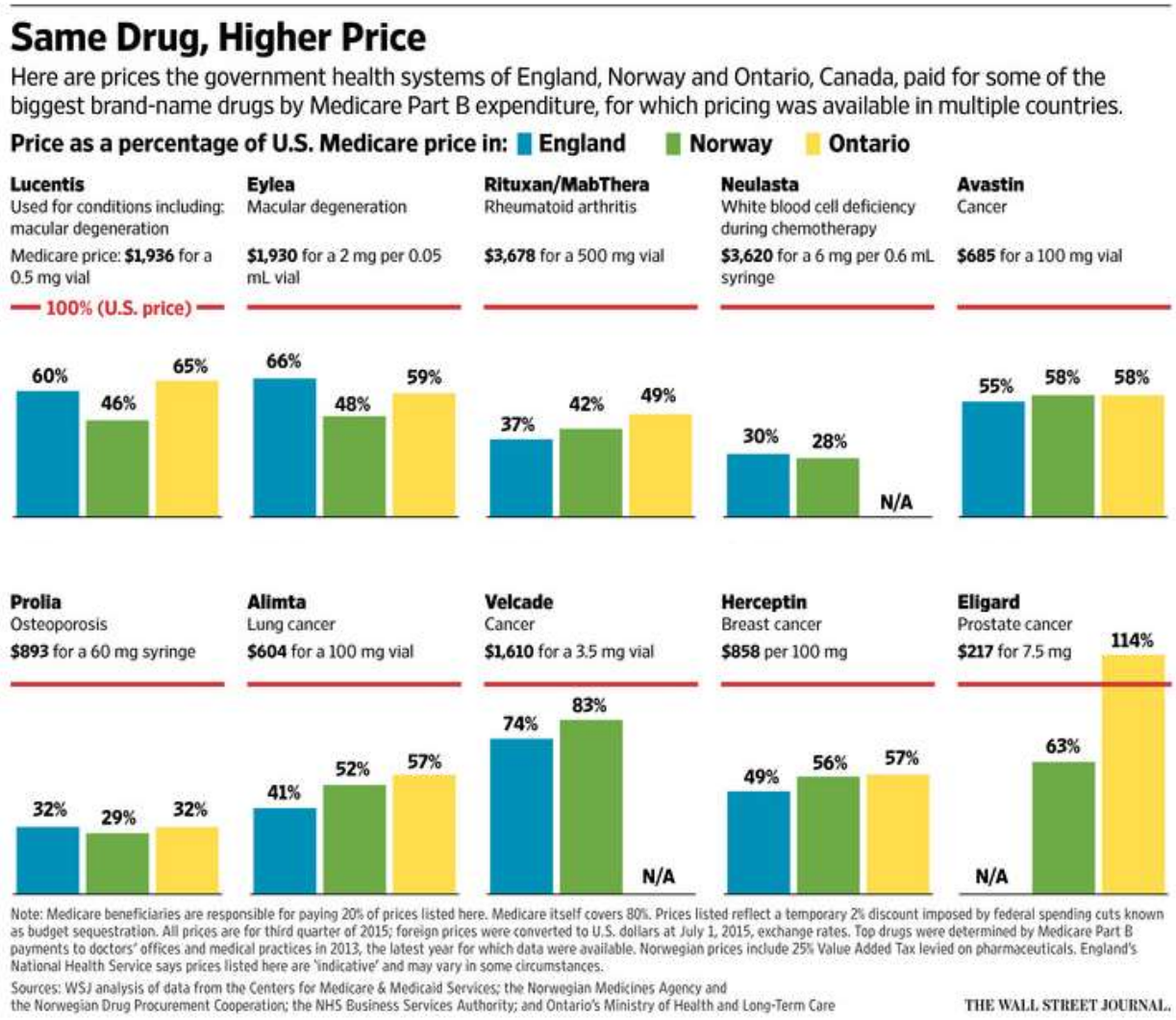
Experts disagree on how much money could be saved by allowing Medicare to negotiate for drug prices. When government actuaries last analyzed the proposal in 2007 they estimated savings would be "negligible." That's in part due to uncertainty about what specific powers Congress would provide Medicare to have in negotiations: Could Medicare refuse to pay for certain drugs? Could Medicare set up its own formulary, like those used in the private sector?
The NRLN believes that members of Congress who oppose Medicare negotiating drug prices should stop using the 9-year-old analysis as an excuse. Depending on which powers would be available, academics have estimated Medicare savings ranging from $15 billion per year to $54 billion per year.

Proof that government price negotiations can work to hold down the cost of drugs is demonstrated by the other two big government programs, Medicaid and the Veterans Health Administration (VHA), which do negotiate discounts. The differences in reimbursements for the same brand-name drugs are stunning: Medicare pays on average 73 percent more than Medicaid and 80 percent more than the VHA, according to a study by the School of Public Policy and Administration at Carleton University in Ottawa, Ontario.

As the country's main payer for prescription drugs, by not negotiating for a lower price Medicare is de facto setting the price of prescription drugs, the very thing that many members of Congress oppose. "Medicare is essentially forfeiting its buying power, leaving bargaining to doctors' offices that have little negotiating heft," said Sean Sullivan, dean of the School of Pharmacy at the University of Washington.

Asked to comment on the higher prices Medicare pays compared with foreign countries, the Centers for Medicare & Medicaid Services said: "The payment rate for Medicare Part B drugs is specified in statute."

Pharmaceutical and biotechnology companies in the S&P 1500 earn an average net profit margin of 16%, compared with an average of about 7% for all companies in the index, according to S&P Capital IQ.



Bloomberg News: U.S. Pays a Lot More for Top Drugs than Other Countries

Prices for brand-name drugs are typically higher in the U.S. than other developed countries. The drug industry has argued it's misleading to focus on U.S. list prices that exclude discounts

In an article published on December 18, 2015, Bloomberg News reported that its analysis found that even after discounts struck by drug makers behind closed doors with insurers, prices are higher in the U.S. than abroad.

The drugs analyzed were: **Advair** (Asthma Inhaler); **Crestor** (Cholesterol-Lowering Pill); **Gleevec** (Chronic Myeloid Leukemia Pill); **Herceptin** (Breast Cancer Infusion); **Humira** (Rrheumatoid Arthritis Self-Injection); **Januvia** (Diabetes Pill); **Lantus** (Long-Acting Insulin), and **Sovaldi** (Hepatitis C Pill). Of the eight drugs analyzed, seven cost more in the U.S. after estimated discounts than in most other high-income countries.

GlaxoSmithKline Plc's **Advair** asthma inhaler costs at least twice as much in the U.S. compared to other countries analyzed, even after an estimated 50 percent discount in the U.S. market.

After an estimated discount of 60 percent, AstraZeneca still charges more than twice as much in the U.S. for **Crestor**, a cholesterol pill, compared to Germany, and in other countries the price is even lower, according to the analysis of IHS data.

SSR Health was not able to estimate discounts for **Gleevec**, Novartis AG's drug for leukemia. Still, the analysis of IHS data found that the U.S. list price for that drug is more than triple the price that Novartis gets in other high-income nations. U.S. price increases for **Gleevec** over the last decade far outpaced "the modest discounts" Novartis has offered, David Whitrap, a spokesman for Express Scripts, said.

The analysis found that Roche Holding AG's **Herceptin**, a breast cancer drug, after rebates of roughly 15 percent, still cost about 85 percent more in the U.S. than in other high-income countries, and a third more than in Saudi Arabia, where the price is highest after the U.S.

Humira, AbbVie Inc.'s best-selling rheumatoid arthritis treatment, costs an estimated $2,500 a month in the U.S. after discounts, compared with about $1,750 in Germany, Bloomberg found. In other nations, the drug's price drops even lower.

The list price of Merck & Co.'s diabetes pill **Januvia** is cut in half on average by estimated discounts, according to the SSR Health data. Even so, Merck gets more than twice as much in the U.S. for a monthly supply of the same drug as in Canada, the next most costly place to buy it, Bloomberg found.

Sanofi gives U.S. discounts of about 50 percent on **Lantus**, a long-acting insulin, SSR Health found. It still costs 30 percent more in the U.S. than in China, the second-most expensive country.

The U.S. was not an outlier on prices for **Sovaldi**, Gilead Sciences Inc.'s hepatitis C pill. The blockbuster product was only slightly more expensive in the U.S. than most other high-income countries after rebates, and a little less costly than in Saudi Arabia.

In the U.S., drug companies set their own prices and raise them over time. One of the biggest U.S. buyers of medicine, Medicare, is prohibited from negotiating prices directly with drug companies. Private insurers and benefit managers strike their own rebate deals with drug companies, and details of these contracts are almost never disclosed.

In Europe, drug prices are often set by government health systems and decline over time as countries demand additional price cuts, said Floriane Reinaud, a principal analyst at IHS. "In the U.S., list prices are just a little bit crazy, and even with discounts that are tied to that it is still higher than Europe," Reinaud said.

"We can no longer sustain a system where 300 million Americans subsidize drug development for the entire world," said Steve Miller, chief medical officer for Express Scripts Holding Co., the largest U.S. manager of prescription-drug benefits.

NRLN's Position on Prescription Drug Importation

Countries that practice socialized medicine exact low prices for people served in their countries by demanding below market pricing from American pharmaceutical manufacturers.

There are two counter measures to our manufactures being forced to take losses:

A. Pharma companies should exit these markets, thus protecting Americans and our economy from subsidizing socialized medicine.

B. To the extent pharma and Congress don't eliminate this unethical practice of absorption and passing of losses on to Americans and the US economy, Congress must pass laws allowing importation of safe, and lower priced prescription drugs from Canada and elsewhere so that Americans and our economy benefit. Start with Canada NOW.

HHS Secretary Has Authority for Drugs from Canada

The Secretary of HHS has the authority under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to issue an order to begin legal importation from Canada but refuses to act. Members of Congress should write letters to the Secretary (as the NRLN has) urging her to authorize the importation of safe, lower priced drugs from our northern neighbor. The Secretary should be ordered to do so by the President. Has the Executive Branch defaulted to a no position? Congress has failed repeatedly to enact legislation! The Executive and Legislative Branches appear to be accountable only to those who have huge sums of money. Both feign concern so as to sound like they care, then they take a snooze.
Lately, both Congress and HHS have run to hide behind a new excuse. They have told the NRLN that insurance companies won't approve importation. To this we say, tell them if they fail to do so they can no longer sell to Medicare. It is time to choose, to side with affected constituents.

Harvard Medical School Study on Rx Cost in U.S.

Researchers from Harvard Medical School reviewed medical and health policy literature from January 2005 to July 2016 for articles addressing the sources of drug prices in the United States, the justifications and consequences of high prices, and possible solutions. In 2013, per capita spending on prescription drugs in the U.S. was $858 compared with an average of $400 for 19 other industrialized nations.

Their findings published on August 23, 2016 in the Journal of the American Medical Association (JAMA) revealed that FDA regulations and patents protect drug companies from competition, and federal law prevents Medicare from negotiating drug prices. All of this works together to allow drug companies to set their own prices.

The study's lead author Aaron Kesselheim, a professor at Harvard Medical School and the director of Harvard's Program on Regulation, Therapeutics, and Law, said high drug prices are an issue because when people can't afford a medication, they stop taking it.

Kesselheim and his colleagues propose a number of solutions. Those include giving Medicare the power to negotiate prices and removing some of the regulations that keep generics from speedily entering the market.

One source of high drug prices the authors discuss is that Medicare, which pays 29 percent of the money spent on prescription drugs in the U.S., can't negotiate with drug companies. When the Medicare Modernization Act of 2003 established prescription drug benefits in the U.S., the law also prohibited the Department of Health and Human Services from getting involved in price bargaining.

The paper in JAMA describes two forms of legal protection that give brand-name pharmaceuticals an effective monopoly. The first is exclusivity granted by the FDA that gives new small molecule drugs (like aspirin) and biologics (such as antibody or protein drugs) windows of five to seven years and 12 years, respectively, before generic versions can be sold. And patents can protect the active ingredient and chemical structure of a drug — as well as less fundamental aspects like its formulation and coating — for 20 years or more.

Generic manufacturers can sue to challenge these patents, but in a practice called pay for delay, big name pharma companies settle the suits and pay generics manufacturers to wait it out until the patent expires.

Pharma's argument for keeping the regulatory and patent protections in place is that it costs a lot of money to bring a drug to market. Kesselheim noted that there's evidence that lot of the innovation that goes into new drug development actually happens in academia and government laboratories. Although prices are often justified by the high cost of drug development, there is no evidence of an association between research and development costs and prices; rather, prescription drugs are priced in the U.S. primarily on the basis of what the market will bear.

NRLN's Position on Prescription Drug Competitive Bidding

Members of Congress have quoted Congressional Budget Office (CBO) studies to wrongly justify a claim that the CBO and others have said that there would be very little savings if Health and Human Services (HHS) required competitive bidding for Medicare's drug business. These are old irrelevant claims. Other that two letters written in the 2006-2007 period by two incumbent CBO Directors to Oregon Senator Ron Wyden and others, there are no published relevant studies made available to support this claim. It has been said that the HHS Secretary would have to be authorized to set (not competitively bid) prices. In some cases, such as in chronic and fatal disease treatment drugs, this may be even more problematic today.

Since 2007, generic drug availability has mushroomed from less than 20 percent of drugs dispensed in the U.S. to where today they represent around 75 percent of the pills, capsule and injected drug units sold. A growing number of these drugs treat the same ailments! And, a growing number will treat even more as drug patents expire. This data is not speculation or political rhetoric. It's time to start Medicare competitive bidding.

For example, the patent on Crestor expired and competition is salivating to take market share away from the price gouging manufacturer who is now suing the Federal Drug Administration (FDA) to obtain extended patent protection because 800 Americans use Crestor to treat another illness. That is stooping very low to avoid what's good for America.

There is only one solution to this problem:
Congress should remove the prohibition on Medicare competitive bidding and replace it with a competitive bidding mandate to be applied wherever two or more FDA approved generic drugs, or two or more brand drugs, or a generic and brand drugs (upon patent expiration) treat the same medical condition.

HHS should be authorized to award percentages of the business to up to three vendors so as to maintain continued supply and competition by competing products. This provision does not preclude single sourcing and sourcing decisions shall be the exclusive right of HHS.

Drugmakers Raise Prices for 2016 Despite Criticisms

According to a January 10, 2016 article in The Wall Street Journal, drugmakers didn't let up on price increases with the start of 2016, demonstrating the industry's pricing power in the face of mounting criticisms of prescription costs in the U.S.

Pfizer Inc., Amgen Inc., Allergan PLC, Horizon Pharma PLC and others have raised U.S. prices for dozens of branded drugs since late December, with many of the increases between 9 and 10 percent, according to equity analysts. The increases are on list prices, before any discounts or rebates that manufacturers sometimes provide insurers and other payers.

Some of the increases add thousands of dollars to the cost of already expensive drugs, and come on top of repeated price hikes in recent years.

Vanda Pharmaceuticals Inc. on Jan. 1, 2016 raised the price of its new drug **Hetlioz**, which treats a sleep disorder in blind people, by 10 percent, to $148,000 a year. The price of the once-daily capsule is now 76 percent higher than when it was introduced in 2014.

Amgen raised the price of the anti-inflammatory drug **Enbrel** by 8 percent in late December 2015. This followed an 8 percent increase in September 2015 and a 10 percent increase in May 2015. **Enbrel** costs about $704 a week for the typical dosing for treatment of rheumatoid arthritis, or more than $36,600 a year.

Acorda Therapeutics Inc. raised the price of its drug **Ampyra**, which is used to help multiple-sclerosis patients improve walking, by 11 percent on Jan. 1, 2016 to an annual cost of more than $23,650 a patient. **Ampyra** generated $315 million in sales for the first nine months of 2015, or 87 percent of total company revenue. Acorda offers rebates and discounts off the list price that are likely to cut about 40 percent from the latest price increase. The company has raised the price several times since the drug was approved in 2010.

In recent years, it has been common for drug companies to push through annual price increases in at least the high single digits around Jan. 1 for many brands—and in some cases additional increases throughout the year—as Amgen has done.

Allergan, which has agreed to be acquired by Pfizer for $160 billion, boosted prices by an average of 9.1 percent for more than 40 brands through June 2016. The increases included 9.9 percent hikes for the eye drug **Restasis**.

Horizon Pharma, whose brands include **ActImmune**, a treatment for hereditary diseases, boosted prices for five drugs by 9 to 9.9 percent through June 2016. The drug's new cost is about four times its cost at launch in the 1990s.

Uroxatral (10 mg tablets ER), used to treat symptoms of enlarged prostate, rose 197.5 percent**. Prandin** (2 mg tablets), a diabetes medicine, jumped 38 percent in 2013. Since 2006, **Prandin's** price tag has risen almost 300 percent.

The prices of 19 brand-name prescription drugs for skin conditions ranging from acne to cancer increased 500 percent on average between 2009 and 2015. The makers of **Edecrin**, a diuretic used to treat high blood pressure, raised the drug's price nine times between May 2014 and December 2015, from $470 a vial to $4,600. **Cuprimine**, a treatment for genetic liver disease, went from $888 in 2013 to $26,189 in 2015.

The World Health Organization considers insulin an essential medicine. In the United States, just three pharmaceutical giants hold patents that allow them to manufacture insulin. From 2010 to 2015, the price of

Lantus (made by Sanofi) went up by 168 percent; the price of **Levemir** (made by Novo Nordisk) rose by 169 percent; and the price of **Humulin R U-500** (made by Eli Lilly) soared by 325 percent. There are hundreds of similar stories.

Pharmacy Benefit Managers Most Likely Raise Prices

Even a generic version of insulin might not solve the price problems. According to a Feb. 20, 2016 New York Times article, something else is most likely also contributing to the rising price of insulin: a very powerful and largely invisible group of middlemen, known as pharmacy benefit managers, or P.B.M.s.

Benefit managers negotiate with drug companies on behalf of insurers, such as employer plans and government programs like Medicaid and Medicare Part D. In theory, their job is to bargain for lower drug prices.

The hitch is that the biggest P.B.M.s are out to make a buck. They get “rebates” from drug manufacturers — payments based on sales or other criteria, which look suspiciously similar to kickbacks. The rebates are not publicly disclosed, but they are sizable. Industry analysts estimate that those payments, and other back-room deals, amount to as much as 50 percent of the list price of insulin.

This, of course, creates a conflict of interest. Benefit managers are supposed to be driving down costs, but the system incentivizes them to choose the products with the largest rebates. It’s not clear whether most of these “savings” are passed along to consumers or simply pocketed. In Jan. 2016, a large insurer, Anthem, complained publicly that its P.B.M., Express Scripts, was not sharing enough of its savings.

Heather Bresch, Mylan CEO, who has raised the price of EpiPen 2-Pak from $57 a shot in 2007 to $600 for two auto-injectors became the pharmaceutical villain in August 2016. Mylan, receives less than half the list price for an EpiPen 2-Pak. On the $600 EpiPen, the PBM was likely receiving close to $300 on each prescription, according to an August 31, 2016 article in The Hill.

What is known is that business is booming for P.B.M.s. Together, the three biggest benefit managers — Express Scripts, CVS Health and OptumRx — bring in more than $200 billion a year in revenue. They also control over 80 percent of the P.B.M. market, involving 180 million insured people.

Top Ten Widely Used Drugs Have Hefty Price Increases

Major drug companies took hefty price increases in the U.S., in some cases more than doubling listed charges, for widely used medications over the past five years, a Reuters’ analysis of proprietary data found and reported in an April 5, 2016 article.

Prices for four of the nation's top 10 drugs increased more than 100 percent since 2011. Six others went up more than 50 percent. Together, the price increases on drugs for arthritis, high cholesterol, asthma and other common problems added billions in costs for consumers, employers and government health programs.

Sales for the top 10 drugs went up 44 percent to $54 billion in 2014, from 2011, even though prescriptions for the medications dropped 22 percent, according to IMS Health data.

At the top of the list was AbbVie Inc. (ABBV.N), which raised the price of arthritis drug **Humeral** more than 126 percent, Reuters found. Next were Amgen Inc. (AMGN.O) and Tea Pharmaceutical Industries Ltd (TEVA.TA), which raised prices for arthritis treatment **Enbrel** and multiple sclerosis drug **Copa one** by 118 percent.

The increases help explain federal data showing overall spending on drugs rose faster than doctor visits and hospitalization over the past five years.

Reuters based its analysis on the top 10 drugs, according to 2014 sales figures from IMS, and on proprietary pricing data provided by Traven Health Analytics.

Memorial Sloan Kettering Cancer Center oncologist Peter Bach said Pharmaceutical "companies have complete control over pricing in the U.S." By Bach's estimate, increases in 2015 on just one drug, Amgen's **Enbrel**, added up to $1 billion to care costs.

Commenting on the Reuters study on “CBS This Morning” Lisa Gill of Consumer Reports said for some consumers, the spike in prices leaves them with difficult decisions.

"They sometimes feel some pocketbook pain coming at the point of when they actually fill the prescription but that pain is very real. When these prices go up, we can see consumers don't fill prescriptions like they should. They don't take them like they should or they do other things. They don't buy groceries, they may not go out to dinner with their families. There are a lot of things they'll cut out in order to try to pay for the medications."

According to a July 15, 2016 New York Times article the two companies that produce **Humira** and **Enbrel** have found common ground in keeping those prices so high. They are deploying new patents to prevent patients from getting two essentially generic versions of the drugs for less money.

“It’s a lost opportunity to reduce health care costs,” said Fiona M. Scott Morton, a professor at the Yale School of Management. According to her study, biosimilars have been available in Europe for years and have reduced costs for some drugs as much as 80 percent.

Vermont Is First State Requiring Justification of Drug Prices

In June 2016, Vermont became the first state with a law requiring drug companies to justify steep price hikes. The Vermont law requires drug companies to explain price increases on medications identified by state officials for which significant health care dollars are spent and where list prices rose by 50% or more over the previous five year period or 15% or more over a 12 month period. For these identified medications, drug companies will be required to provide a report to the State Attorney General of “all factors that have contributed to a price increase” and “the role of each factor in contributing to the price increase.”

The law does not just target drug companies. It also requires health insurers to provide Vermont residents with information about how much they will pay out of pocket for their prescription drugs, and the law contains other price transparency provisions.

As Vermont’s governor was signing the legislation into law, Pfizer was in the process of raising the list prices of its drugs by an average of 8.8 percent, according to a Pfizer spokesperson. The price boost follows a similar one in Jan. 2016, which involved raising the list price of more than 100 drugs, some by as much as 20 percent.

Pfizer isn’t alone in this trend. Drug companies including AbbVie, Eli Lilly, Merck, and Bristol-Myers Squibb also continue to steadily raise prices across the board. Soaring price increases is an industry-wide phenomenon.

Jacking Up Prices Following an Acquisition

Some major price increases have occurred after a pharmaceutical company has acquired another drugmaker or purchased the rights to a prescription drug.

High prices aren’t necessarily the result of the costs of R&D. For example, Gilead didn’t discover its blockbuster hepatitis drug, **Sovaldi**. Instead, Gilead purchased Pharmasset the company that developed **Sovaldi** for $11 billion after key clinical trials had been completed. Gilead proceeded to charge $84,000 for a 12-weeks treatment of **Sovaldi** in order to recoup its acquisition costs.

When Rodelis Therapeutics acquired the rights to manufacture **Cycloserine**, which treats multidrug-resistant tuberculosis, the cost went from $500 a bottle to $10,800.

Cycloserine, a drug which treats multidrug-resistant tuberculosis, was acquired by Rodelis Therapeutics, which promptly raised the price to $10,800 for 30 capsules, from $500. But in August 2015 the company agreed to return the drug to its former owner the Chao Center, a nonprofit foundation affiliated with Purdue University.

The foundation now charges $1,050 for 30 capsules, twice what it charged before, but far less than Rodelis was charging.

A patient with multidrug-resistant tuberculosis might take two capsules a day of **Cycloserine**, along with other drugs, for 18 to 24 months, according to the Centers for Disease Control and Prevention. Under the price Rodelis planned to charge, a full course of treatment would have cost more than $500,000 for **Cycloserine** alone. With the new price from the Chao Center, it will be closer to $50,000.

The drug made by generic companies abroad costs only about $20 for 100 capsules.

Cycloserine, which went on sale in 1955 and is also known by the brand name **Seromycin**, was long produced by Eli Lilly and Company, which around 2000 decided to drop the drug, in part because the company was getting out of antibiotics.

Valeant Pharmaceuticals after that company acquired two heart drugs, **Isuprel** and **Nitropress**, from Marathon Pharmaceuticals it promptly raised their prices by 525 percent and 212 percent respectively. Marathon had acquired the drugs from another company in 2013 and had quintupled their prices.

In 2014, the drug company Retrophin—run at the time by Martin Shkreli—acquired **Thiola**, a 26-year-old drug that treats a rare condition in which patients constantly produce kidney stones. Retrophin raised the drug's price 1,900 percent.

In 2015, Valeant Pharmaceuticals International acquired Nitropress and Isuprel, injectable heart medications that are a staple at many hospitals, and raised the list prices more than 200 percent and 500 percent, respectively. In 2010, Valeant bought a pair of old drugs that treat Wilson Disease, an obscure disorder in which copper accumulates in the body. The company implemented a series of price increases that ultimately exceeded 2,600 percent.

Prices of Many Generic Drugs Climb Higher

Generic drugs represent about 80 percent of all prescription filled and have been one of the few bargains for Americans. However, the cost savings on generics are slowing. The AARP Public Policy Institute (PPI) found that the cost of 280 generic drugs widely used by older Americans fell by only 4 percent in 2013. This was the slowest rate of decline during any of the prior seven years.

Pharmaceutical experts have begun to notice something even more disturbing. The prices of many generic drugs that have been around for years have suddenly spiked. PPI found that 27 percent of the most widely used generics have gone up in price, in some cases into the stratosphere. For example: **Doxycycline hyclate** (100 milligrams), a widely used antibiotic, soared from $20 for 500 capsules in October 2013 to $1,849 in April 2014. **Glycopyrrolate** (20 milliliters), used during surgery to prevent slowing of the heart rate, climbed from $65 for 10 vials to $1,277 during the same period. **Pravastatin sodium** (10 mg), a cholesterol medication has surged from $27 to $196 for a one-year supply.

"Unfortunately, it's becoming clear that we can no longer rely on decreases in generic drug prices to offset unrelenting price increases for brand name and specialty drugs," Leigh Purvis, MPA, AARP PPI director of

health services research and coauthor of the new report, said in a statement. Purvis added, “This shift has serious implications for older adults and the entire health care system.”

Wayne Riley, M.D., immediate past president of the American College of Physicians (ACP), one of the largest physician groups in the U.S. said in a Consumer report article, “It’s those huge price hikes in everyday drugs that are having the greatest impact on consumers. Patients who have been taking generics for years are suddenly finding that their medication is unaffordable.”

Why are some generics, including pills that have been around for decades, suddenly so expensive? An important reason is that mergers and acquisitions in the generic drug industry have reduced the number of competitors. For example, between 2002 and 2013 the number of manufacturers making **Oral Digoxin**, a heart drug, fell from eight to three and the cost soared by 637 percent. Other competitors can enter the market but it can take a year or more to get Food and Drug Administration approval to make a generic and to ramp up manufacturing. Until then, prices can remain high. Pay-for-delay in bringing generic drugs to the market remains an issue.

One of the most egregious examples is **Plavix**, an anticlotting medication prescribed to prevent stroke. When the patent was challenged, the company that makes the drug agreed to pay a generic manufacturer tens of millions of dollars not to enter the market. The U.S. Supreme Court has ruled that brand-name drug makers can be sued for violating antitrust laws if they make a deal to pay a potential competitor to delay selling a generic version of a brand-name medicine. The high court’s opinion stated that “large and unjustified reverse payments” [pay-for-delay] from a brand-name to a generic drug company can trigger an antitrust lawsuit. The outcome of each lawsuit will depend on the facts in the case.

The National Retiree Legislative Network’s (NRLN) position is that it doesn’t want to see pay-for-delay cases dragged through the courts for years while Americans—especially retirees—are denied access to cheaper generic drugs. That is why the NRLN continues to lobby Congress to pass legislation that bans pay-for-delay.

Old Drugs Are Reformulated as Costly ‘New’ Drugs

According to Consumer Reports, reinventing old medications is a tactic called evergreening—where companies change or tweak the formula of a drug by, say, combining two older drugs to form a “new” pill. Or they create an extended-release version, or change the delivery method—for example, instead of a tablet or an injectable, the new version is inhaled. When that happens, the federal government may grant the drug company a new patent, which could be worth up to 20 years of protection for its drug, meaning it may not have any generic drug competitors. That can translate to greater revenue for a pharmaceutical company and higher costs for the consumer.

Thirty products that were reformulations of old drugs hit the market in 2015, according to recent report by the IMS. George Slover, senior policy counsel for Consumers Union, the advocacy arm of Consumer Reports, said, “Evergreening keeps drug prices high for consumers because it makes it harder for lower-cost generic alternatives to enter the market and give consumers a choice.”

Consider if Apple decided to charge $10,000 for a 20-year-old computer. What if Samsung priced a 20-year-old TV at $6,000 and cited the “high cost of innovation?” It would be ridiculous not because their costs of innovation aren’t high—but because it’s understood that consumers, in a free market, have no need to accept unaffordable prices.

Ten years ago, consumers were on the verge of getting a lower-priced, generic version of the brand name antibiotic **Doryx** (doxycycline). But the drug's manufacturer, Warner Chilcott, stopped making the drug in its original capsule form and instead began producing it as a tablet. This seemingly minor change meant that

generic manufacturer, Mylan, was blocked from being able to market the matching generic tablet it had been developing.

Warner Chilcott is now embroiled in a lawsuit that charges it used those and similar tactics—such as adding score lines to the tablets and ceasing production of the unscored tablets—to manipulate the patent and generic laws to stay one step ahead of generic manufacturers.

That tactic, called "product hopping," is a strategy drug makers have begun using in recent years to stall the development of generic versions of a medication so they can keep brand-name drug prices high. But it is coming under fire from the Federal Trade Commission and several consumer groups, which charge in a federal court case that it's a violation of antitrust law that bilks consumers of millions of dollars in high drug prices.

People are far more likely to fill an inexpensive generic prescription because skyrocketing drug prices and insurance fees have made brand-name medicines increasingly unaffordable. But, even generic drugs are seeing price increase.

Overall, prices of generics increased by almost 9 percent between November 2013 and November 2014, according to a 2015 report by Elsevier, a company that supplies information on drug pricing. Some prices remained stable or even dropped. But the cost of certain drugs went up—some as high as 75 times their previous prices—when they should have stayed the same or even gone down.

Christopher Kelly, a spokesperson for the Federal Drug Administration, told Consumer Reports the "FDA doesn't have a way to control what a company ultimately decides to charge under our present authorities." Kelly noted that the FDA pays particular attention to new generic drug applications from companies that would prevent shortages of medically necessary drugs. But "the pricing and decisions that companies make regarding pricing is an area currently outside FDA purview, and we have no enforcement capability in this area."

In the Consumer Reports poll, 77 percent of people taking a medication said the government should allow more generics onto the market sooner.

The NRLN supports providing adequate funding to clear the backlog exceeding 4,000 generics currently awaiting FDA approval. This would make more affordable alternatives more readily available to patients.

Many Americans Can't Afford the Price of Prescription Drugs

For Americans—especially seniors living on fixed incomes—prescription drug prices have become unfordable. Americans are rightfully concerned that they are losing access to lifesaving and life-enhancing treatments, simply because they're becoming less and less affordable. Even individuals who have health care insurance or are on Medicare are experiencing either the higher price of drugs or higher copay or both. When Medicare is hit with higher prices of drugs, taxpayers pay for the higher cost. Government programs now pay for half of all prescription drugs.

Some health care industry experts see a prescription drug crisis ahead given the skyrocketing prices of prescription drugs. A case in point, the per year price of Vertex's cystic fibrosis drug **Kalydeco** is $300,000. The prices of older drugs for multiple sclerosis have risen from about $10,000 per year in the late 1990s to more than $60,000 now, according to a study published in the Neurology journal. This has happened even as competition in the market has intensified with the introduction of new products.

Medical organizations, patient groups, health insurance firms and some members of Congress are deeply concerned. With the high cost, too many Americans are cutting dosage of their medicines or have stopped

filling prescription. It is estimated that one quarter of prescriptions aren't filled because Americans can't afford them. This places their health in jeopardy. Undoubtedly, this contributes to more hospitalizations resulting in more costs to individuals, health insurance firms, Medicare, Medicaid and even personal bankruptcies.

In an article published in July 2015 in the journal Mayo Clinic Proceedings, more than 100 prominent oncologists called for support of a grassroots movement to stem the rapid increases of prices of cancer drugs, including by letting Medicare negotiate prices with pharmaceutical companies and letting patients import less expensive medicines from Canada.

"There is no relief in sight because drug companies keep challenging the market with even higher prices," the doctors wrote. "This raises the question of whether current pricing of cancer drugs is based on reasonable expectation of return on investment or whether it is based on what prices the market can bear."

Cancer drug prices have increased more than tenfold between 2000 and mid-January 2016. The average price of cancer drugs is increasing by about $8,500 a year, far beyond the rate of inflation. Prices for cancer drugs routinely exceed $100,000 a year, and some new ones exceed $150,000. For example, a per year price for Celgen's cancer drug **Reylimid** is roughly $150,000.

Imbruvica, a drug used to treat mantle-cell lymphoma, has a wholesale list price of $116,600 a year for patients. For the higher dose needed by patients it is about $155,400 a year. Producers gave insurers discounts averaging 11 percent in 2014. Medicare pays most of the cost for more than half of the users of **Imbruvica** through Medicare Part D, but the patients still have an out-of-pocket cost of $7,0000 or more a year.

Keytruda and **Opdivo** help a patient's immune system more effectively seek out and destroy cancer cells. **Keytruda** will set the typical patient back $150,000 annually, while **Opdivo** comes in with an annual wholesale cost of $143,000.

Revlimid is the dominant treatment for front-line and second-line multiple myeloma, a type of cancer that affects a type of white blood cell known as plasma cells. Plasma cells are responsible for fighting the body's infections. **Revlimid** boasts a $100,000-plus annual wholesale cost because of its mammoth market share. Celgene, the manufacturer of **Revlimid**, struck a deal with generic drug manufacturers in December 2014 that protects **Revlimid** from facing a flood of generic entrants until late January 2026, and it gives the drug a very good shot at $10 billion-plus in annual sales by 2020 and beyond.

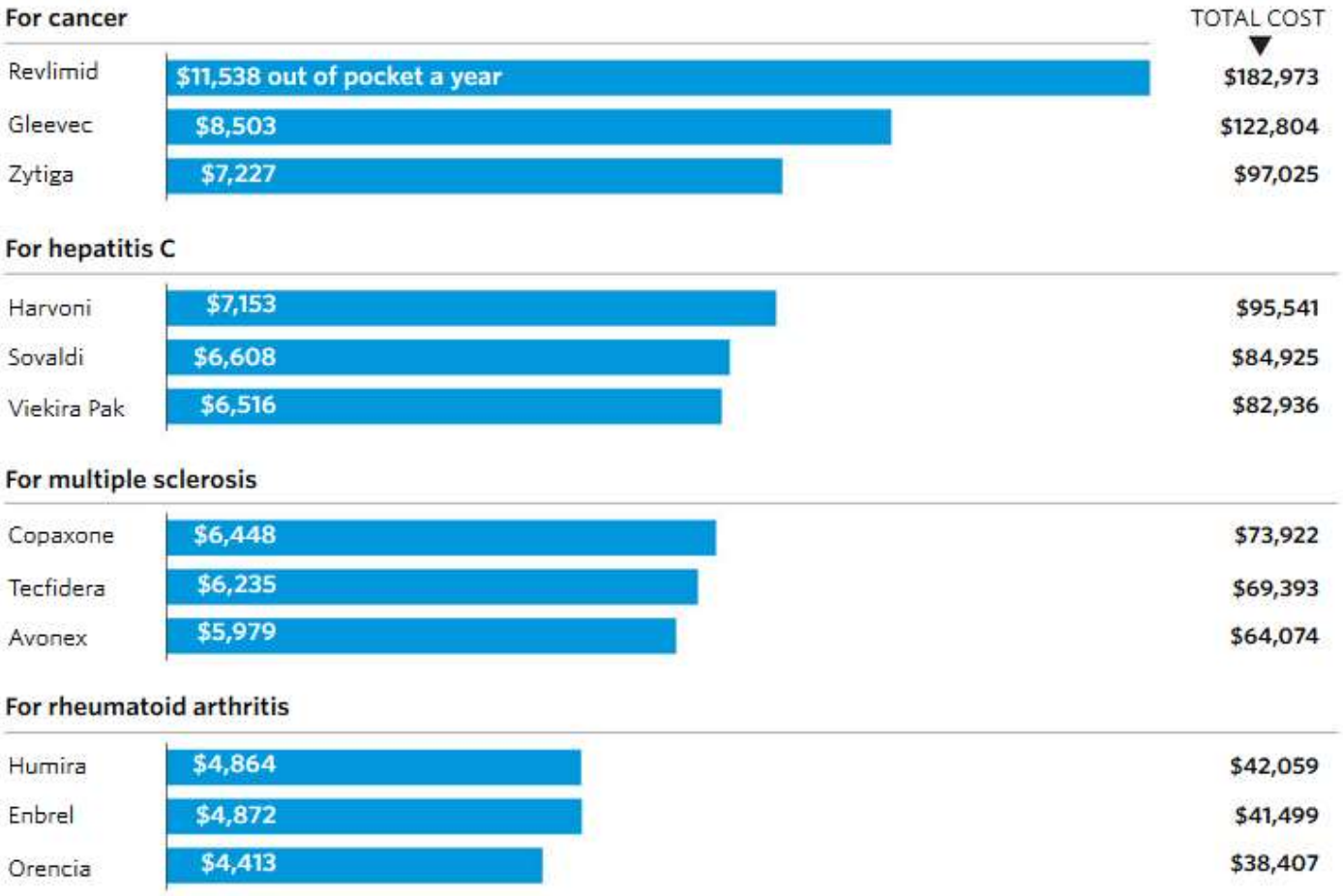
The average household income today for a family of four is $52,000, down 8 percent from a decade ago. Since each American has a 1 of 3 lifetime chance of developing cancer, millions of Americas are at risk of being unable to pay for the prescription medicines to control or hopefully cure their cancer. The high price of cancer drugs is causing harm by shortening the lives of patients who cannot afford the treatment. This is an injustice that creates differential treatment conditioned by financial status.

In a December 31, 2015 article in The Wall Street Journal, Peter Bach, a physician and health-policy researcher at Memorial Sloan Kettering Cancer Center in New York, said: "Drugs are so expensive that once they flow through our ragtag insurance system, we have patients who can't afford them, or they can barely afford them, so they're not getting therapies."

In an August 2015 survey conducted by the Kaiser Family Foundation, a quarter of U.S. prescription-drug users said it was difficult to afford them. In a survey, published in the journal Lancet Haematology in September 2015, 10 percent of insured U.S. patients with the blood cancer multiple myeloma said they had stopped taking a cancer drug because of its cost.

High Out-of-Pocket Cost for Medicare Patients

A Dec. 15, 2015 article in The Wall Street Journal published the following graph that showed the annual out-of-pocket financial impact on Medicare patients who take expensive prescription drugs. Below are the projected 2016 costs for a dozen commonly use specialty drugs.



Note: Total cost is based on drugs' retail pharmacy prices. Prices are based on default dose and quantity. Analysis includes 20 national and near-national prescription-drug plans. Source: Georgetown/Kaiser Family Foundation analysis of data from Centers for Medicare and Medicaid Services

As Drug Prices Increase, Quality of Life Goes Down

In a Consumer Reports Best Buy Drugs nationally representative telephone poll of more than 2,000 adults who take a medication, it found that nearly one-third of people experienced a price hike in the last year on at least one of their medications.

The problem with forking over the additional cash is that it hurt people in other ways—people were more likely to stop taking their medication; they also skipped filling prescriptions, or didn't take the prescribed dosage; split pills without contacting their doctor or pharmacist first, took expired meds or even shared prescription drugs with other people, compared to those whose drug costs remained steady.

Sometimes, the cutbacks weren't limited to refills and dosages. Desperate to afford their prescriptions, the survey found that people sacrificed in other potentially detrimental ways. They skimped on groceries. They also reported relying more heavily on credit cards and putting off paying other bills.

And where people were dealing with high drug costs, other financial setbacks weren't far behind. More than one out of four people whose drug costs spiked also reported experiencing a costly medical event. They were also more likely than those not facing higher costs to report that they couldn't afford medical bills, missed major bill payments, or even lost their health coverage.

It's a grim scenario some doctors say they are all too familiar with. "As physicians all too often we are seeing the situation where we prescribe a medication and a patient says 'doc, I just can't afford it.' We hear that all the time," says Wayne Riley, M.D., past president of the American College of Physicians.

"Patients and the general public are bewildered and extremely frustrated. More needs to be done to stem the rise in prescription drug prices and costs to patients," Riley added.

Pharmacists are worried too, seeing the everyday effects of not being able to afford medications. Says Beverly Schaefer, RPh, co-owner of Katterman's Sand Point Pharmacy in Seattle, "More and more I'm seeing that consumers are becoming acutely aware of rising drug prices. They are stretching doses, seeking alternatives, asking more questions of their doctor and pharmacist, and sometimes refusing prescriptions or asking for a less expensive treatment option.

Employer Health Benefits Declining for Retirees

Planning for retirement is tough enough - and it gets even tougher when promised retirement health care benefits from a former employer are changed or eliminated. According to an April 14, 2016 Reuters article, a growing number of U.S. employers are capping their risk of rising health insurance costs by sending retirees into private exchanges to buy coverage - often with little advance warning.

Two-thirds of employers provided retiree health coverage as recently as 1988, according to the Kaiser Family Foundation. This was usually supplemental coverage to pay for prescription drugs, cap out-of-pocket expenses or to cover Medicare's deductibles and co-pays. By 2016 that number had dwindled to just 23 percent.

Among the employers that still cover retirees, a growing number are shifting retirees into insurance exchanges. Similar to a shift from a defined benefit to a defined contribution, the expense risk is shifted from employer to retiree.

Aon Hewitt, a consulting firm that operates exchanges for employers, reports that 35 percent of public and private sector employers are using healthcare exchanges for all or some of their Medicare-eligible retirees. Of those that are not, 17 percent say they will do so in the future, and another 46 percent are considering it.

Aon data shows that 59 percent of companies sending retirees into exchanges do not index the subsidy; 28 percent index at their own discretion and only 13 percent automatically adjust the subsidy amount annually.

Doctors Who Take Pharma Money More Likely to Prescribe Brand-Name Drugs

An article co-published on March 17, 2016 by NPR, the Boston Globe and Tampa Bay Times reported that a ProPublica analysis has found for the first time that doctors who receive payments from the medical industry do indeed tend to prescribe drugs differently than their colleagues who don't. And the more money they receive, on average, the more brand-name medications they prescribe.

ProPublica matched records on payments from pharmaceutical and medical device makers in 2014 with corresponding data on doctors' medication choices in Medicare's prescription drug program.

Doctors who got money from drug and device makers—even just a meal– prescribed a higher percentage of brand-name drugs overall than doctors who didn't, ProPublica analysis showed. Doctors who received industry

payments were two to three times as likely to prescribe brand-name drugs at exceptionally high rates as others in their specialty.

Doctors who received more than $5,000 from companies in 2014 typically had the highest brand-name prescribing percentages. Among internists who received no payments, for example, the average brand-name prescribing rate was about 20 percent, compared to about 30 percent for those who received more than $5,000.

ProPublica's analysis doesn't prove industry payments sway doctors to prescribe particular drugs, or even a particular company's drugs. Rather, it shows that payments are associated with an approach to prescribing that benefits drug companies' bottom line.

"It again confirms the prevailing wisdom … that there is a relationship between payments and brand-name prescribing," said Dr. Aaron Kesselheim, an associate professor of medicine at Harvard Medical School who provided guidance on early versions of ProPublica's analysis. "This feeds into the ongoing conversation about the propriety of these sorts of relationships. Hopefully we're getting past the point where people will say, 'Oh, there's no evidence that these relationships change physicians' prescribing practices.'"

Overall, payments are widespread. Nationwide, nearly nine in 10 cardiologists who wrote at least 1,000 prescriptions for Medicare patients received payments from a drug or device company in 2014, while seven in 10 internists and family practitioners did.

Justifications for High Drug Prices Are Bogus

Drug companies claim that the high prices are due to research and development costs and the arduous Federal Drug Administration approval process to bring a drug to market. A December 9, 2015 article in The Wall Street Journal with the headline *Pharma companies' no. 1 justification for high drug prices is bogus* cited the newspaper's study showing the drug makers' claim is not the case. And much of the basic science research is conducted by government-funded researchers and agencies such as the National Institutes of Health. Experts agree that drug pricing is not research or manufacturing-cost driven, but rather profit-driven.

Marcia Angell, a senior lecturer in social medicine at Harvard Medical School and a former editor in chief of the New England Journal of Medicine, wrote in a Sept. 25, 2015 Washington Post article that there is very little innovation at the big drug firms. Very often, the original discovery occurs in a university lab with public funding from the National Institutes of Health (NIH), then licensed to a start-up company partly owned by the university and then to a large company.

She stated that drug companies' major creative output is trivial variations of top-selling medications that are already on the market (called "me-too drugs"), to cash in with treatments just different enough to justify new patents.

For example, she noted that the first of the statins, drugs that lower cholesterol, was Merck's **Mevacor**, which came on the market in 1987. There followed a whole family of "me-too" statins, including **Zocor** (also made by Merck), **Lipitor**, **Pravachol** and **Crestor**. There is little reason to believe that one is more effective than another at equivalent doses.

She claimed that the major drug companies are hardly strapped for money to cover their R&D: A look at their annual reports shows that they spend more on marketing and administration than on R&D. Pharmaceutical manufacturers are consistently among the most profitable companies.

Ms. Angell pointed out that drug makers are now getting some pushback from the public in response to their claims that they need the money, but they fall back on the rhetoric of the free market. They are investor-owned businesses, after all, they say, and they have a right to charge whatever the market will bear (which for

desperately sick patients or their insurers is quite a lot). But the pharmaceutical market is hardly an example of unfettered capitalism, because the companies are totally dependent on government support. In addition to receiving huge tax breaks and government-granted exclusive marketing rights, they are permitted to acquire drugs that resulted from NIH-funded university research.

Price gouging puts the health of Americans in jeopardy in order to make an unreasonable profit. Sadly, up until now, the voice of the pharmaceutical lobby is Washington has been louder than that of sick patients. The Pharmaceutical Research and Manufacturers of America (PhRMA), spent $18.32 million on lobbying in 2015, more than a ten-percent increase over the previous year, according to the Center for Responsive Politics. Without any competition or additional regulation of prices, the price of drugs are simply what the manufacturer sets for its monopoly product**.** Drug company profits continue to increase at a faster pace than any other sector of the health care industry.

Pharma Forces Waste and Extra Cost

If you thought the pharmaceutical industry couldn't get any more cynical than the now-infamous Turing Pharmaceuticals price gouging scandals of last year, you would be wrong.

Big pharma is raking in $3 billion in extra profits by forcing doctors and hospitals to waste drugs and to pay for that waste, according to a new study from Memorial Sloan Kettering Cancer Center in New York. While the practice isn't limited to cancer drugs, they were the basis of the study's assessment.

Here's how it works. A pharmaceutical company develops an expensive drug that is administered in a hospital or in a doctor's office. The appropriate dosage of that drug depends on body size. So a 130-pound woman needs far less than a 250-pound man. But the company sells the drug in a vial of only one size - the size that would be needed to treat the large man, for example. When the woman is treated, a nurse or doctor draws the smaller dosage from the vial, and the remaining medicine is discarded. Yes, an extremely valuable drug is trashed because safety protocols restrict how this kind of medication can be reused. Unconscionably, the patient is charged for the entire contents of the vial. That's where the $3 billion comes in - it is the marginal cost between the amount of drug that is needed and the drug that is sold.

It's not as though the company can't provide the drugs in a greater variety of vial sizes. It does so for the European market, where the regulators are far more diligent. The U.S. regulator, the FDA, does not have the authority to take price or efficiency into account when approving drugs for sale.

All this waste is paid for by the patient and through the tax dollars that support Medicare, Medicaid and the Veterans Health Administration, premiums paid to insurance companies, and of course co-pays of those who need these medications.

As for waste, the authors of the current study suggest that the FDA could, without taking cost into consideration, regulate vial size by issuing specific guidance. Or Congress could mandate that the pharmaceutical companies simply refund the cost of leftover drugs used in government programs. After years of hand-wringing over the skyrocketing cost of health care, one straightforward path to slowing it is available. It should be taken. Fighting waste and abuse by the companies that have their fingers in taxpayers' pockets should be as important as fighting waste and abuse in government.

Public, Medical Professionals Sour On the Drug Industry

A Nov. 14, 2015 article in HealthDay News reported on a STAT and the Harvard T.H. Chan School of Public Health poll that found most Americans now support aggressive regulation to keep health care costs in check, including price caps on drugs, medical devices and payments to doctors and hospitals. (The poll was

conducted online from Oct. 14-16, 2015 among 2,072 adults. Figures for age, gender, race/ethnicity, education, region and household income were weighted where necessary to bring them into line with their actual proportions in the population.)

- 73 percent support price controls on drug and device manufacturers.
- 70 percent would like price controls placed on hospitals.
- 66 percent want to authorize Medicare to negotiate drug prices.
- 63 percent support price controls on payments to doctors.
- 56 percent want to be able to import less expensive drugs from other countries.

The poll found that the pharmaceutical industry's reputation has suffered substantial damage. Barely half of all Americans now say drug companies are doing a good job for their customers, compared with the nearly 8 out of 10 who expressed that kind of confidence in a 1997 Harris Poll.

Humphrey Taylor, chairman emeritus of The Harris Poll, stated in the article: "Most people want to see a lot of different actions taken to contain health care costs, including government price controls of providers, drugs and devices, and two controversial actions which are currently prohibited -- allowing the importation of drugs from other countries and allowing Medicare to negotiate drug prices."

Taylor went on to say: "Every new headline about big drug prices increases the likelihood that Washington will revisit the issues of drug importation and Medicare negotiating drug prices -- policies fiercely opposed by the industry but strongly favored by the public."

The Modern Healthcare survey released on November 16, 2015 found almost all of the 80 leaders of hospital systems, insurance companies, large physician practices, industry trade groups and nonprofits want the government to set prices for breakthrough drugs.

Sixty-six percent of them want the government to "negotiate" prices for drugs sold through Medicare. More than half think the drug industry is lying when it says the $2.6 billion in R&D costs for each new drug that gets approved justify high prices, or when it says the prices reflect the value these breakthrough drugs bring to patients.

Congress Should Pass Bills to Reduce Cost of Prescription Drugs

For several years, the National Retiree Legislative Network (NRLN) has been advocating legislation to reduce the cost of prescription drugs. In 2015, there were 13 bills introduced in the U.S. Senate and U.S. House that the NRLN supports that, if passed, would result in prescription drug savings to Americans and in some cases also to Medicare. These bills are still in committees in 2016, the second session of the 114th Congress.

The hearings conducted by the Senate's Special Committee on Aging in December 2015 and March 2016, as well as the hearings by House Committee on Oversight and Government Reform in November 2015 and February 216 into soaring drug prices were positive actions. It is time for Senators and Representatives to get serious about reducing the cost of prescription drugs for Americans, especially seniors living on fixed income.

The following bills are pending in Senate committees. (Asterisk indicates companion bill in the House)
S. 31* - The Medicare Prescription Drug Price Negotiation Act of 2015
S. 122* - The Safe and Affordable Drugs from Canada Act of 2015
S. 131 - The Fair and Immediate Release of Generic Drugs Act of 2015
S. 648 - The Medicare Formulary Improvement Act of 2015 of 2015
S. 1790 - The Safe and Affordable Prescription Drugs Act of 2015
S. 1884* - The Medicare Prescription Drug Savings and Choice Act of 2015
S. 2023* - The Prescription Drug Affordability Act of 2015
S. 2019 - The Preserve Access to Affordable Generics Act of 2015

The following bills are pending in House committees. (Asterisk indicates companion bill in the Senate)
H.R. 2228* - The Safe and Affordable Drugs from Canada Act of 2015
H.R. 2623 - The Personal Drug Importation Fairness Act of 2015
H.R. 3061* - The Medicare Prescription Drug Price Negotiation Act of 2015
H.R. 3261* - The Medicare Prescription Drug Savings and Choice Act of 2015
H.R. 3513* - The Prescription Drug Affordability Act of 2015

Too many Americans are having to choose between paying for food, housing and other necessities, or try to stretch out their drug supply by cutting the prescribed dose or worse, simply going without their medicines.

Retirees, prospective retirees, all seniors (and all Americans) are being forced to accommodate prescription drug price gouging. This is at the expense of deferring or passing up altogether the purchase of goods and services that prop up the American economy and thus federal tax revenue that sustains our country. Members of Congress and the White House cite internal opinions and old studies that defy logic and reality, and Pharma has far too much influence over public policy on this matter It is time to change policy, to pass prescription drug importation and Medicare competitive bidding bills and to outlaw pay-for-delay once and for all!

Retirees know that interim steps already suggested by several in Congress would not go anywhere near the realm of government price setting. Retirees also know that the high prices they are paying for prescription drugs only serves to support market entry of those same drugs into countries around the world. It is time for Congress to pass these common sense bills and stand up for Americans' health and stop the price gouging. There is no time to waste.

Attachment: How Prescription Drug Prices Compare Internationally

http://graphics.wsj.com/table/GlobalDrug_1201?embed=1

How Prescription Drug Prices Compare Internationally

Source Article: Why the U.S. Pays More Than Other Countries for Drugs

By Jeanne Whalen; The Wall Street Journal ~ Dec. 1, 2015

	Drug	Package size	Medicare	Norway	England	Ontario	Used for conditions including:
1	Lucentis	0.5 mg syringe or vial	**$1,936**	$894	$1,159	$1,254	Macular degeneration
2	Eylea	2 mg/0.05 ml vial.	**$1,930**	$919	$1,274	$1,129	Macular degeneration
3	Rituxan/MabThera	500 mg vial	**$3,678**	$1,527	$1,364	$1,820	Rheumatoid arthritis
4	Neulasta	6 mg/0.6 ml syringe	**$3,620**	$1,018	$1,072	N/A	White blood cell deficiency
5	Avastin	100 mg vial	**$685**	$399	$379	$398	Cancer
6	Prolia	60 mg syringe	**$893**	$260	$286	$285	Osteoporosis
7	Alimta	100 mg vial	**$604**	$313	$250	$342	Lung cancer
8	Velcade	3.5 mg vial	**$1,610**	$1,332	$1,191	N/A	Cancer
9	Herceptin	Per 100 mg	**$858**	$483	$424	$493	Breast cancer
10	Eligard	7.5 mg	$217	$137	N/A	**$247**	Prostate cancer
11	Orencia	250 mg vial	**$881**	$437	$472	$390	Rheumatoid arthritis
12	Aranesp	500 mcg syringe	**$1,995**	$663	$1,146	$1,227	Anemia
13	Remodulin	20 mg vial	$1,205	**$3,684**	N/A	N/A	Pulmonary arterial hypertension
14	Sandostatin LAR Depot	10 mg kit	**$1,540**	$845	$734	$1,052	Acromegaly
15	Hizentra	1 gram vial	**$80**	$60	$72	N/A	Primary immunodeficiency
16	Synvisc	Three 16 mg/2ml syringes	**$601**	N/A	$320	N/A	Osteoarthritis knee pain
17	Botox	100 unit vial	**$563**	$178	$216	$284	Overactive bladder, chronic migraine
18	Erbitux	100 mg	**$527**	$270	$278	$302	Colorectal cancer
19	Abraxane	100 mg vial	**$968**	$412	N/A	$426	Cancer
20	Aloxi	250 mcg vial	**$205**	$89	$87	N/A	Nausea during chemotherapy
21	Lexiscan/Rapiscan	0.4 mg vial	**$207**	$76	$81	N/A	Coronary artery disease
22	Tysabri	300 mg vial	**$4,842**	$1,870	N/A	$2,573	Multiple sclerosis
23	Gammagard/Kiovig	1g/10 ml vial	$76	**$89**	N/A	N/A	Primary immunodeficiency
24	Faslodex	250 mg syringe	**$907**	$336	N/A	N/A	Breast cancer
25	Actemra/RoActemra	80 mg vial	**$305**	$168	$160	$144	Rheumatoid arthritis
26	Yervoy	50 mg vial	**$6,738**	$4,362	$5,856	$4,618	Skin cancer
27	Xolair	150 mg syringe or vial	**$852**	$463	$400	$487	Asthma

How Prescription Drug Prices Compare Internationally

	Drug	Package size	Medicare	Norway	England	Ontario	Used for conditions including:
28	Gamunex	1g/10 ml vial	**$78**	N/A	$66	N/A	Primary immunodeficiency
29	Nplate	250 mcg vial	**$1,399**	$836	$753	$754	Autoimmune disease
30	Orthovisc	30 mg/2 ml syringe	**$168**	N/A	$102	N/A	Osteoarthritis knee pain
31	Cimzia	Two 200 mg syringes	**$2,357**	$803	$1,117	$1,058	Crohn's Disease
32	Soliris	300 mg/30 ml vial	**$6,315**	$5,730	$4,919	$5,368	Rare diseases
33	Euflexxa	Three 20 mg syringes	**$451**	N/A	$305	N/A	Osteoarthritis knee pain
34	Octagam	5 g/100 ml vial	**$380**	$329	$319	N/A	Primary immunodeficiency
35	Benefix	1000 unit vial	**$1,451**	$936	$948	N/A	Hemophilia
36	Jevtana	60 mg/ 1.5 ml vial	**$8,659**	N/A	N/A	$4,618	Prostate cancer
37	Feiba NF/Feiba	500 unit/20 ml vial	**$899**	$652	N/A	N/A	Hemophilia
38	Emend/Ivemend	150 mg vial	**$255**	$84	$74	N/A	Nausea during chemotherapy
39	Halaven	2 ml vial	**$1,003**	$512	N/A	$389	Breast cancer
40	Neupogen	Ten 300 mcg vials	**$2,943**	N/A	N/A	$1,532	White blood cell deficiency
41	Vectibix	100 mg vial	**$987**	$472	$592	$498	Colorectal cancer
42	Benlysta	120 mg vial	**$479**	$189	N/A	N/A	Lupus
43	Cubicin	500 mg vial	**$372**	$172	$138	$143	Bacterial infection
44	Privigen	10 g/100 ml vial	**$753**	$499	$717	N/A	Primary immunodeficiency
45	Xiaflex/Xiapex	0.9 mg vial	**$3,370**	$1,094	$1,015	N/A	Peyronie's disease
46	Torisel	25 mg vial	**$1,521**	N/A	N/A	$995	Advanced renal cell carcinoma
47	Cerezyme	400 unit vial	$1,653	**$1,954**	$1,673	N/A	Gaucher disease
48	Pulmozyme	30 2.5 mg ampules	**$2,845**	$886	$775	N/A	Cystic fibrosis
49	Adcetris	50 mg vial	**$5,894**	$3,887	$3,904	$3,854	Hodgkin lymphoma
50	Arzerra	1,000 mg vial	**$4,819**	N/A	$2,842	N/A	Chronic lymphocytic leukemia

How Prescription Drug Prices Compare Internationally

	Drug	Package size	Medicare	Norway	England	Ontario	Used for conditions including:
51	Xyntha/ReFacto AF	250 unit vial kit	**$293**	$226	$196	N/A	Hemophilia
52	Ozurdex	0.7 mg	**$1,384**	$1,376	$1,359	N/A	Diabetic macular edema
53	Vpriv	400 unit vial	$1,375	**$2,367**	$2,202	$1,557	Gaucher disease
54	Firmagon	80 mg vial	**$282**	$181	$202	$203	Prostate cancer

Note: Medicare beneficiaries are responsible for paying 20% of prices listed here. Medicare itself covers 80%. Prices listed reflect a temporary 2% discount imposed by federal spending cuts known as budget sequestration. Foreign prices were converted to U.S. dollars at July 1, 2015, exchange rates. Rankings were determined by Medicare Part B payments to doctors' offices and medical practices in 2013, the latest year for which data were available. Norwegian prices include 25% Value Added Tax levied on pharmaceuticals. England's National Health Service says prices listed here are 'indicative' and may vary in some circumstances.

Source: WSJ analysis of data from the Centers for Medicare & Medicaid Services; the Norwegian Medicines Agency and the Norwegian Drug Procurement Cooperation; the NHS Business Services Authority; and Ontario's Ministry of Health and Long-Term Care