FDA hearing on Hatch-Waxman Act and drug pricing

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Transparency 1

Evidence is lacking in important areas, including evidence used to measure and evaluate the performance of the current policies that influence investments in R&D and drug pricing.

The studies by Joseph DiMasi and other industry consultants lack transparency about basic parameters, and are often used to confuse rather than inform policy debates. There is a need for more independent and granular data on R&D expenditures.

There are proposals to require greater transparency of R&D outlays, prices, revenues and other aspects of pharmaceutical markets.

The most important initiatives as regards R&D outlays are to require companies to report (1) the enrollment and costs of *each* clinical trial relating to the marketing approval of a drug, and (2) the third party funding, tax credits and other subsidies relevant to financing the development of the drug.

Investments in research and development involve risks and capital that are correlated to the timing and phase/stage of development. The more granular the reporting is of the trial costs, including as relates to specific trials, the year the expenditure was incurred, and the amount and nature of the third party subsidies, the more useful the information will be to policy makers and the public.

Transparency 2

Investors are entitled to transparency of certain economic facts that are material to the price of a security. The public, on the other hand, is typically barred from the most basic information relevant to drug development costs, pricing, etc.

There are currently many transparency initiatives, including, for example:

- UN High-Level Panel on Access to Medicines recommendations
- Provisions in S.771 and HR.1776.
- State legislative efforts

The FDA should insist on standardized disclosures of trial costs, R&D subsidies, and revenues from products, broken down at least by country.

Federal agencies that fund research, such the Army, BARDA, CDC and the NIH, should report on the enrollment and cost of each trial they fund, subsidize and/or co-sponsor. (The NCI used to publish per patient costs of trials it funded).

The licensing of federally-funded research should be far more transparent, as regards the entities requesting exclusive licenses, all of the terms of the licenses, the R&D costs, the revenues and prices of products sold and the distributions of royalties.

Non-voluntary licensing of patents

The US rules on compulsory licensing of patents should be amended to provide more robust authority and administrative discretion to determine remuneration.

Bayh-Dole march-in rights in 35 U.S.C. § 203 or the royalty free rights in 35 U.S.C. § 202 or 209 can and should be used in certain cases, but only apply to a relatively small number of products.

28 U.S.C. § 1498 can be used for any patent, to authorize use “by or for” the government, but the compensation standards present agencies with risks that deter its use. It should be clear that when a compulsory license is used to address an excessive price, the royalty can be reasonable and affordable, and enable the government to curb excessive prices and obtain affordable drugs.

The general rule should be that when there is an excessive price, a shortage, or a blocking patent, the monopoly rather than the patient should be at risk.

DoD mandate for non-voluntary licensing of federally owned medical inventions

The committee directs the Department of Defense (DOD) to exercise its rights under sections 209(d)(1) or 203 of title 35, United States Code, to authorize third parties to use inventions that benefited from DOD funding whenever the price of a drug, vaccine, or other medical technology is higher in the United States than the median price charged in the seven largest economies that have a per capita income at least half the per capita income of the United States.

National Defense Authorization Act for Fiscal Year 2018, Report to Accompany S. 1519, Committee on Armed Services. Senate Report 115-125. July 10, 2017. Page 173

Bundesgerichtshof Mitteilung der Pressestelle. Bundesgerichtshof gestattet weiteren Vertrieb eines HIV-Medikaments. X ZB 2/17 – Urteil vom 11. Juli 2017.

On July 11, 2017, the German Federal Supreme Court announced that it had affirmed the decision of the Federal Patent Court last year to issue a compulsory license allowing Merck to continue selling its HIV drug, raltegravir (marketed as Isentress). The compulsory license was requested by Merck amidst preliminary patent infringement proceedings in response to Shinogi's request for an injunction to bar Merck from selling the allegedly infringing drug. The request fell under both section 24(1) of the German Patent Law, which provides for compulsory licenses and section 85, which provides for compulsory licenses in scenarios of urgent need and public interest.

> *"The Federal Court also shares the assessment of the Federal Patent Court that a public interest in the granting of a compulsory license is credible. It is true that not every HIV or AIDS patient is required to be treated with raltegravir at any time. There are, however, patient groups that needed raltegravir to maintain the safety and quality of treatment. These include, in particular, infants, children under 12, pregnant women, people who need prophylactic treatment because of the risk of infection, and patients who are already treated with Isentress and who are threatened with significant side effects and interactions when switching to another drug." [Google translate]*

Exceptions are needed to all regulatory exclusivities

The test data (NDA and BLA), Orphan Drug, pediatric and regulatory delay exclusivities should be subject to limitations and exceptions.

Policies that require duplicative trials, which are necessary during period test data exclusivity, violate paragraph 16 of the 2013 Declaration Of Helsinki on Ethical Principles For Medical Research Involving Human Subjects. In Europe, regimes of (risk adjusted) cost sharing exist to avoid unethical duplicative experiments involving animals.

Government-funded drugs like Spinraza, which are ridiculously expensive, are also protected by regulatory barriers to entry, such as the Orphan Drug exclusivity, undermining the benefits of Bayh-Dole march-in rights as a remedy. In Europe, after an initial period in the market, the exclusivity can be challenged if it is not necessary or appropriate incentive, given the global sales.

When the United States faces shortages of drugs, such as the cases of Doxil and Fabrazyme, test data monopolies should not be a barrier to registering drugs that are needed.

FDA pediatric testing exception

The FDA pediatric testing exception can and should be reformed.

The FDA should only ask companies to finance trials when it first estimates the costs of the trials and compares that to the expected cost to the public of the extension of the market exclusivity.

At present, the public often pays more than $1 million in higher prices per child in an FDA-requested pediatric study.

Asthma Inhalers

Ventolin was first put on the market in 1967.

In 2013, the FDA took all CFC inhalers treatment of asthma and chronic obstructive pulmonary disease off the market, to be replaced with HFA versions.

The HFA version of Ventolin now has 15 patents in Orange Book, and typically cost from $50 to $80.

The costs of the CFC versions, outside the United States, are $1 to $2 in many markets.

The FDA should permit the CFC versions to be sold. The environmental benefits of the switch from CFC to HFA were trivial.

Parallel trade, personal importation

Governments can liberalize and regulate for safety commercial parallel trade in brand name products between the United States and countries with per capita incomes at least 50 percent of the US (if not across the board), at least when prices in the United States are excessive when compared to other high income countries, or when a shortage exists.

In Switzerland, private insurers have responded to excessive prices for Hepatitis C virus (HCV) drugs by reimbursing personal importation of generic HCV drugs. Italy also encourages liberalized personal importation.

The United States could liberalize personal importation of generic products when patented versions have excessive prices.

Delinkage

The federal government should undertake analysis of the costs and benefits of granting time limited monopolies on new drugs and vaccines, and compare to alternatives that do not link R&D funding, including incentives, to drug prices.

Delinkage has many advantages:

- By embracing marginal cost pricing for products, utilization and rewards can be optimal for drugs with different values in different uses (HCV drugs for patients with varying health problems, drugs that treat different diseases/indications, etc).
- Easier to manage than value-based or indication-based pricing, and can operate within budget constraints without rationing access.
- Delinkage allows incentives to more efficiently reward improvements in health care outcomes, while the current system over rewards drugs that match outcomes.
- Delinkage systems can be implemented progressively, with feasible transitions, with combinations of direct funding, R&D subsidies and robusts incentives to share access to knowledge, materials and data, and for success product development.

S.771 and HR.1776 both propose feasibility studies of delinkage by the National Academies, and the WHO is considering a feasibility study of delinkage as it relates to new drugs for cancer. The FDA should engage in discussion of the terms of reference (TOR) for such cost benefit and feasibility studies. More information on this topic is at http://delinkage.org

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