

**October 13, 2016**

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**Intelligence Squared U.S.**

**Blame big pharma for out-of-control health care costs**

For the Motion: Ezekiel Emanuel, Neera Tanden

Against the Motion: Lori Reilly, Paul Howard

Moderator: John Donovan

**AUDIENCE RESULTS**

**Before the debate:**

**33% FOR**

**28% AGAINST**

**39% UNDECIDED**

**After the debate:**

**42% FOR**

**48% AGAINST**

**10% UNDECIDED**

Start Time: (00:00:00)

John Donovan:

Now, I want to welcome to the stage two gentlemen who have helped bring this event to the Skirball Center tonight. First I want to welcome -- I have a card. Well, I've lost it, so I'm going to just vamp. His name is Arnav Kacker. He is with the Adam Smith Society, and also Robert Rosenkranz who is chairman of Intelligence Squared U.S. Let's welcome them to the stage.

[applause]

Hi, Bob.

00:05:00

Hi, Arnav. Arnav, you are our partner tonight, the Adam Smith Society.

Arnav Kacker:

I am.

John Donovan:

For those -- for those who don't know what the society is, fill us in.

Arnav Kacker:

Well first of all, thank you all for being here, and thank you to Intelligence Squared for bringing this event to fruition. I'm Arnav Kacker and the co-president of the Adam Smith Society chapter at NYU's Student School of Business. And for those of you unfamiliar with us, the society seeks to promote a forum for the discussion of ideas with economic implications, whether they revolve around policy making and governance or even the more esoteric aspect of political philosophy. So, to that end, we have 27 chapters around the nation, including chapters at each of the top 20 MBA programs, and we have six chapters that look beyond students and engage local business leaders and alumni who want to remain invested in our mission.

John Donovan:

And does doing a debate then fit into what you're about?

Arnav Kacker:

Well, we think that MBAs should graduate with more than just skills in finance and management and keep an eye on the larger picture and understand the knock-on effects that business decisions can have on societies at large.

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And we've seen the rhetoric get ever more divisive, so we seek to instill some sort of objectivity to it so -- and offer a fair and balanced voice, and discuss the merits and demerits of capitalism in a more modern-day context. So this event, together with Intelligence Squared, was a very natural extension of our mutual interests.

John Donovan:

Okay, thank you. Thanks very much.

[applause]

And Bob Rosenkranz, we always come out and we chat a little bit about why we're doing the topic. And tonight, you know, the word "capitalism" has come up. The pharmaceutical industry would seem to be a paragon of capitalism.

Robert Rosenkranz:

Well, it is actually, in a sense, not a paragon of capitalism because unlike normal businesses, there are a great many distinctive features of the pharmaceutical industry that make it extremely atypical. So let me start right at the beginning.

00:07:00

Much of the technology or the science behind drugs is government funded. The pharmaceutical companies incur huge expense, in part to develop useful drugs, but a big part of the expense is getting through a government process of approval. They then are awarded with a government-granted monopoly for a period of time, that is a patent. And finally, they sell their products not so much to consumers who are making a decision whether or not to spend money on this drug or another, but the ultimate person who's paying is either an insurance company or the government itself. So, it is a model that is very, very far removed from normal business activity and normal capitalist activity. And as a result, I think tonight's debate will require the audience to be really alert to some of these nuances and some of these interactions between government and business and how they play out.

00:08:12

John Donovan:

So listen hard, you're saying.

Robert Rosenkranz:

Listen hard.

John Donovan:

But there won't be a quiz. There will be a vote. All right. I want to thank these two gentlemen, and let's welcome our debaters to the stage.

[applause]

So, I mentioned that we turn this debate into various kinds of programming, and for that reason, you'll see a little bit, the sausage getting made. There will be times in the evening when I'll say things like -- first of all, I'll be saying my name over and over again. That's not because I forget, it's because we take artificial breaks.

00:09:01

You know, I'll say, "We'll be right back," and you'll see that I haven't gone anywhere. So -- so I hope that you'll role with that and maybe actually enjoy it. But the other part of it is that there are going to be times in the evening when we come back from those breaks, when it would be great if you were clapping. And so --

[laughter]

So every now and then, I'm going to ask you to please applaud spontaneously. And one of those times is right now as we begin.

[applause]

So, let me be blunt about something, and that is that a lot of people, and quite probably a lot of people in this hall, would otherwise be dead right now or at least a lot less healthy, but for the work that pharmaceutical companies do. If you think of how many times you've taken antibiotics, casually saving yourself from death by infection. If you think about vaccines and the way they have shielded you against deadly and disabling disease, if you think about the fact that HIV infection is no longer a death sentence, there is a lot that we have to be grateful for when it comes to the products that drug companies invent and then sell to us.

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So, why do people hate the drug companies so much? In a word, it's prices. We have to pay for the drugs and sometimes we have to pay a lot. On the other hand, drug companies need to make a profit, because otherwise, perhaps, they just wouldn't bother. But where's the point when the drug makers charge too much and to what extent are drug prices themselves driving health care costs overall? Well, those questions sound like the makings for a debate so let's have it. Yes, or no to this statement: Blame Big Pharma for Out of Control Health Care Costs. A debate from Intelligence Squared U.S. We are here at New York University Skirball Center in partnership with the Adam Smith Society with four superbly qualified debaters who will argue for and against the motion Blame Big Pharma for Out of Control Health Care Costs.

00:11:00

As always, our debate goes in three rounds and then our live audience here in New York votes to choose the winner, and only one side wins. Let's have you vote right now as you come in off the street to see your position on this motion. Once again, the motion is: Blame Big Pharma for Out of Control Health Care Costs. If you agree with the motion, use that keypad at your seat. Push number one. If you disagree, push number two. And if you're undecided, push number three. You can ignore the rest of the keys on the keypad they are not live, and if you push the wrong button by mistake you can correct yourself. You have about 10 more seconds to do that and the system will lock in your last vote. I'll wait for eye contact to return to me.

[laughter]

For heads to swivel. I'm not going to point to the two people who are still working on it.

[laughter]

Okay. It looks good. We're locked out, correct? Yes. Okay.

00:12:00

Here's what I want to remind you of. In an Intelligence Squared debate, we have you vote twice. You've just voted for the first time. And then we have you vote again at the end of the evening after you've heard all of the arguments. And what we do is we give victory to the team whose numbers have moved the most upwards. Percentage points is what we use. So it's the difference between the two votes that will decide our winner. I just want to make that clear and I'll remind you of that a few more times. So you'll vote at the end and then we have about a 90-second turnaround to get the results and the tabulations and then we declare our winner. Okay. Our motion is this: Blame Big Pharma for Out of Control Health Care Costs. We have two debaters arguing for this motion. Please let's first welcome Ezekiel Emanuel.

[applause]

And Ezekiel, who will be called Zeke a lot this evening, you are chair of department of medical ethics in health policy at the University of Pennsylvania.

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You were a White House special advisor on health policy. You helped to shape the Affordable Care Act. You are also an oncologist. You treat cancer patients. And in that role we're wondering when you're treating and making decisions for your patients, how much do the cost of drugs actually come into consideration?

Ezekiel Emanuel:

Zero. Not at all. Doctors don't know the cost of any drugs by and large, and so it's not actually a factor that enters their mind when they write a prescription.

John Donovan:

All right. Interesting answer, and can you tell us please who your partner is?

Ezekiel Emanuel:

Neera Tanden. Long-time friend and co-conspirator on the Affordable Care Act.

John Donovan:

Ladies and gentlemen, please welcome --

Neera Tanden:

He's only joking, just to be clear.

[laughter]

John Donovan:

Please welcome Neera Tanden.

[applause]

Neera, you are the president and CEO of the Center for American Progress. You also served as an advisor on health reform in the Obama administration. Also, you were a policy director for Hillary Clinton's first presidential campaign and you're still advising her.

00:14:02

A recent political profile said this about you, that you are quote "Hillary Clinton's anger translator."

[laughter]

What the heck does that mean?

Neera Tanden:

I think that means that I am full of sweetness and light.

[laughter]

John Donovan:

Much of which will be on display tonight I'm sure.

Neera Tanden:

Absolutely.

John Donovan:

Ladies and gentlemen, the team arguing for the motion.

[applause]

And we have two debaters arguing against the motion. Please welcome Paul Howard.

[applause]

Paul Howard, you are director of health policy and senior fellow at the Manhattan Institute where you are also a member of Project FDA, which aims to reform the FDA. So, what's wrong with the FDA in 40 words or less?

Paul Howard:

Well, like all big institutions it tends to be pretty risk averse and more worried about bad things happening than making good things happen faster.

John Donovan:

Okay. Interesting answer as well.

00:15:00

And who is your partner?

Paul Howard:

Lori Reilly.

John Donovan:

Ladies and gentlemen, Lori Reilly.

[applause]

And Lori, you're executive vice president for policy research and membership at the Pharmaceutical Research and Manufacturers of America, which abbreviates to PHARMA, representing some of the world's leading pharmaceutical companies. Now, in the campaign that we've been seeing, through 2016, prescription drug costs have been something of an issue. And you've said that it's fair to have a conversation about costs. That should be on the table. How would you rate the level of discourse between the candidates on this topic?

Lori Reilly:

On this topic, I would say that the conversation has been minimal, at best. And I think it could be improved with a more informed debate.

John Donovan:

That's what we're going to have tonight. Ladies and gentlemen, the team arguing against the motion.

[applause]

Now, as I said, we go in three rounds. And then, the first round is about to begin.

00:16:00

The motion is this: Blame Big Pharma for Out-of-Control Health Care Costs. Round One - opening statements from each debater in turn. They will be six minutes each. And first to speak -- and you can make your way to the lectern -- first speaking for the motion, "Blame Big Pharma for Out-of-Control Health Care Costs," Neera Tanden, president and

CEO of the Center for American Progress and the Center for American Progress Action Fund. Ladies and gentlemen, Neera Tanden.

[applause]

Neera Tanden:

Good evening, everyone. It's a great honor to be here to talk about one of the most important issues, I think, we face in the healthcare system. And it -- there are many issues that aren't getting proper discussion in our presidential debate, but this is one that has actually united those candidates. Candidates who rarely agree on anything have actually both talked about this challenge. And as we think about this debate tonight, and this conversation, I wanted to start off with where I think this debate really should start off.

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Which is with consumers, and people affected by high drug prices. I just want us all to keep in mind throughout this evening, moms who are working hard every day, moms like Lauren Bauman [spelled phonetically], who has had cancer for 10 years and relies on a daily dose of Gleevec, a cancer drug whose price has more than tripled since 2001. Even with insurance, her co-pay is as high as \$2,200 a month. \$2,200 a month. That has driven her family into bankruptcy and forced her and her 9-year-old daughter to move out of their house. And she says she has no choice, because without this pill, she will die.

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That's -- that is a terrible, terrible story. But there are stories like that throughout our country. Stories of 70-year-old diabetes patients who rely on insulin and whose price has tripled in a decade; the mom and her son who both need -- who have severe allergies and both need an Epi-Pen, and have to split it between the two of them. Now, we're going to hear a lot tonight about who is responsible for these situations. I have to remind everyone that pharmaceutical costs in the United States are higher than in any developed country. What does that mean? Consumers around the world are paying much less than consumers in the United States. Why is that? That's because pharmaceutical companies charge us for higher costs.

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They charge us more than they charge anyone else. Now, their response is usually that we need innovation, and that's what's driving costs. But when you really look at it, the truth is that pharmaceutical companies -- the vast majority of pharmaceutical companies are spending more on marketing than they are on research. They're spending, in fact, much more, usually, on marketing than on research. And let me

remind everyone that the American consumer: Lauren, that the grandparent, the child who needs these drugs -- all of us as consumers are paying twice. We pay high drug prices, but we also, as taxpayers, pay for the National Institutes of Health, the research to fund pharmaceutical companies. So, the American consumer is really bearing this price on both ends. We are paying high prices, higher than anyone else in the world.

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And we are paying for the research. More research is done in the United States, federal investment, than elsewhere. And that's why, I think, this has become such a critical issue in this election and at a time when there is so much disagreement on so many issues. We are seeing Republicans and Democrats support strong action to reign in the price of pharmaceuticals. And the reason why is that pharmaceuticals aren't like any other issue. They're not like -- it's not a normal market. Pharmaceuticals are -- pharmaceutical companies are able to price -- to basically charge a monopoly price and rely on numerous insurance companies who don't have that pricing power to just pay what they can charge. And that is why you're seeing this outrage around the country. You're seeing this outrage because there is only one Epi-pen.

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There is only one drug. And essentially, the pharmaceutical company is saying, I'm not going to charge you the value of this drug. I'm going to charge you whatever I can. And in a healthcare system, that's not right. In a system where people need these drugs to live, that's not right. So, we'll get into more solutions as we go this evening. But I'd just like to say -- leave you with the words of one healthcare observer who recently said, "Imagine if Jonas Salk would have priced the polio vaccine like today's drug companies. We'd still have polio." So, with that, I will turn it over to the other side.

John Donovan:

Thank you, Neera Tanden.

[applause]

John Donovan:

And our motion is: Blame big pharma for out-of-control healthcare costs. And here to make his opening statement against the motion, Paul Howard, director of health policy and senior fellow at the Manhattan Institute.

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Ladies and gentlemen, Paul Howard.

[applause]

Paul Howard:

Thank you, John, and good evening. My role here tonight probably seems like a steep uphill climb. I think that for most people in the audience you probably feel the same way about the pharmaceutical company as you do about a pat down at the TSA. And not all of that skepticism is unwarranted. Some patients, particularly those with serious chronic illnesses, are paying too much out of pocket for their medicines, and we need to find a solution for that. So I'm not here to defend the industry or any part of the industry. What I am here to do is to defend the policies that keep Americans healthy and provide hope in the face of a devastating diagnosis. Lori is going to talk about how we can do that in a few minutes -- about how we can balance innovation and access.

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But the important thing is to continue innovation and expand access, because if we go down the road that other nations have gone down and use price controls to control investment in innovation in the industry, make no mistake, we will have fewer medicines, people will suffer and die unnecessarily. And if we step back and take a look at the big picture, not the headlines of the moment, not last year's data, but decades of data and evidence, we'll see that medicines properly used are the things that keep us out of the most expensive parts of the healthcare system; that's hospital beds and nursing homes.

After you hear Lori and I speak, you're going to join us in voting against the motion that we should blame big pharma for runaway healthcare costs because they are not the biggest costs we face. It's not the suffering from Alzheimer's or diabetes. It's not the prolonged disability and premature death that's being driven by medicines.

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That is what they are meant to cure. Zeke and Neera are going to be arguing that drug costs, not hospital costs, not nursing homes, not physician visits, are going to sink the economy unless we empower a committee of government regulators to step in and set prices and profits for medicines. If you think that the core problem with American healthcare today is that we don't have enough bureaucrats and committees, then I'd encourage you to accept their plan. If, on the other hand, you want innovation that moves at the pace of 21st century technology, I have an alternative for you that focuses on competition, innovation, and, of course, containing total healthcare costs. The problem with our debates around drugs is that the prices of drugs are very easy to see. They come with sticker prices. The benefits can be harder to see because they accrue over years and decades.

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Let me give you just three examples. From 1969 to 2013, mortality from cardiovascular disease declined by nearly 70 percent thanks to medicines that were highly effective for high cholesterol and high blood pressure. For HIV/AIDS, mortality has declined by 85 percent. And today, some patients can keep their disease in check with a single pill. Even a disease as complex as cancer, we've seen gains; 20 percent over the past 20 years, a reduction in mortality and with better treatments coming online every day. Remember, none of these developments were inevitable. If we had handled the prescription drug challenge the way many other countries do and the way our opponents tonight suggest, we would see fewer innovations, and we'd wait longer for them. Now, apply that analysis to the future and think about what it means. There are new technologies on the way that promise to do even more to lower medical costs and improve health.

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Gene therapies that can restore sight to blind children, stem cell therapies that can restore a working pancreas to a diabetic woman who no longer has to rely on insulin. Shouldn't we be doing everything possible to bring those technologies to patients as quickly and safely as possible?

Let me close with a few basic facts about why you should vote against the motion tonight. First, government actuaries and independent analysts agree the total level of spending we're going to be devoting to medicines is going to stay level for the next decade, at about 16 percent of total spending. About 85 percent of that spending is coming from somewhere else. To put it another way, we're going to spend more on physicians and hospitals -- a trillion dollars more, over the next decade. Second, it's essential to remember that effective prescription drugs can actually reduce other healthcare costs. So, the Alzheimer's association projects that if we had a treatment by 2025 that just delayed, not cured --

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-- just delayed Alzheimer's by five years, over the next decade, Medicare would save close to \$350 billion, and patients would be saving more than \$220 billion in out-of-pocket costs. So when we look at the total cost of care, how much is devoted to medicines, how much of the increase is somewhere else, we see a very different picture, because sometimes a drug that looks expensive is going to wind up being the cheapest option for treating that condition we have. And those expensive medicines don't stay expensive forever. Patents expire, prices plummet. Doctors, MRIs and hospital beds start expensive, and they stay expensive. If we're serious about slowing runaway healthcare costs, what we need to do is not focus on the sticker price of the drug but of the total price of delivering better health. We need business models that reward doctors and hospitals for delivering better care and reducing costs. The overarching

principle is simply this: More experiments, more competition, and fewer attempts to micromanage innovation because we don't know --

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-- because a venture capitalist who has billions of dollars at stake doesn't know what the technology is that's going to be best positioned to improve our health a decade from now. So please join me in voting against the motion: Blame big pharma for runaway healthcare costs. Thank you.

John Donovan:

Thank you, Paul Howard.

[applause]

And that is the motion: Blame Big Pharma for Out of Healthcare -- Blame Big Pharma for Out-of-Control Healthcare Costs. And a reminder of what's going on, we are halfway through the opening round of this Intelligence Squared U.S. debate. I am John Donovan. We have four debaters, two teams of two, arguing it out over this motion: Blame Big Pharma for Out-of-Control Healthcare Costs. You have heard from the first two debaters and now on to the third, debating for the motion, here is Zeke Emanuel. He is an oncologist and chair of the Department of Medical Ethics and Health Policy at the University of Pennsylvania. Ladies and gentlemen, Zeke Emanuel.

[applause]

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Ezekiel Emanuel:

Thank you very much. I do want to remind you that the topic here is: are drugs driving healthcare costs? It's not, do we want more research on drugs? Do we want cures of diseases that we can't control, like Alzheimer's? It's about drug pricing and driving healthcare costs. We agree with John Donovan. We agree with Paul, right? We all want drugs that are actually beneficial for us, have minimal side effects. But we don't want those drug prices of \$150,000 per year to take those drugs. And how much you save on Alzheimer's all depends on how much they're going to charge for that drug, which, by the way, was not mentioned.

So let me review a few points with you as to why in fact it is drug prices that are driving high healthcare costs. First, I want to remind you what Neera said about that drug Gleevec, which is a cancer drug, to treat chronic myelogenous leukemia, or CML. It's a great drug. It took a disease that was a chronic disease --

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-- but blasted off and killed people in six months and basically made people live a very long time with the disease. The drug was introduced in 2001, as Neera had said, at about \$3,300 per month. It has gone up about 300 percent. No added research to the drug. No new innovation in the drug. The price just went up because the drug company had a captive audience and there was no cap in the United States. And let me point out, that drug is 71 percent cheaper in the next most expensive country, Switzerland, where that drug company sits at home and it's substantially cheaper in Germany, England, Canada than even that. There are multiple drugs out there on the market that are about \$150,000 per year, don't cure anyone, ameliorate the disease, but are hugely expensive. For multiple sclerosis, the FDA recently approved Lemtrada, \$150,000.

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It reduces multiple sclerosis flares from two and a half in every two-year period to one point 75 in every two-year period, does not cure one patient, \$150,000 for that drug. There are plenty of drugs in cancer that are similar. No one in this room, well I'm not sure, this is New York. Many in this room may be able to afford that, but most Americans --

[laughter]

-- where the median income is \$56,000 a year, cannot afford those drugs. Do you know who pays for that extra money? You do, through your higher premiums and your taxes. Let me make a second point. Drug costs are going up faster than any other segment of the health care marketplace. Since 2008, six years -- eight years, brand named drugs, those drugs that have the big sales name, right, have gone up in price 164 percent.

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Regular inflation in American society? 12 percent. In 2014, drug costs went up 13 percent, 2015, 8 percent. Compare that to the rest of the health care marketplace. Hospitals went up about 4, 4.5 percent. Doctor visits went up about 4.8 percent. Drug costs are going up much faster than the rest of the health care marketplace. And that's going to carry on into the future, because the most expensive part of drug costs are those specialty drugs and those specialty drugs are going up at 20 percent, and they're the ones drug companies are bringing to marketplace. Here's one quote, "The cost of chemotherapy drugs for cancer is increasing at a rate significantly higher than other cost components of actively treated cancer patients driven largely by those specialty drugs, but chemotherapy drug increases have been offset by slower growth in other areas like cancer surgery."

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So, it's drug prices that are driving high costs in cancer. Third point. Drug companies claim that they need these high prices to pay for research. Remember, most of them spend less than 20 percent of their dollars on research. They spend more on marketing than they do on research at all. And drug companies are hugely profitable. The average profit in the drug industry is 15 percent, but Diliad, which had that new hepatitis drug, profit margin 55 percent. Biogen 33 percent. Even Behemoths like Pfizer are at 15 percent. And compare that to other industries. Cars. What's the profit margin of car makers? Six percent. Big oil. Big dangerous oil, 8 percent. The pharmaceutical industry is the most profitable industry in the United States. They could use with a little less profits, and still have plenty of incentive to do all that research. And we should compare drug profits -- drug company profits, with the people who they're going to say are the bad guys.

00:34:02

Insurance companies. None of us like insurance companies and I'm not here to defend a single one of them.

[laughter]

But their profit margin is nowhere near drug company profit margins. Drug company profit margins, I mean, Aetna, 4 percent profit margin. Cigna, 5.5 percent profit margin. Humana 2.4 percent profit margin. Substantially less than 15 percent and substantially less than 55 percent.

Let's conclude by noting that the United States government gives drug companies a monopoly through patents and FDA marketing exclusivity, and then we don't regulate their prices. We know what happens when you give a patent or marketing exclusivity and a monopoly to a company. It exploits the monopoly by just jacking up the prices, and that's what drug companies have done. Every other country in the world regulates the prices. We in the United States, we grant the monopoly and then we say, why are prices so high when we don't regulate them.

00:35:00

So we have to actually control drug prices. Either the drug companies do it, or we do need the government to step in and actually control drug prices.

John Donovan:

Thank you, Zeke Emanuel.

[applause]

And the motion again is "Blame Big Pharma for Out-of-Control Health Care Costs." And here to make her opening statement against the motion, Lori Reilly. She's executive vice president for policy research and membership at the Pharmaceutical Research and Manufacturers of America. Ladies and gentlemen, Lori Reilly.

[applause]

Lori Reilly:

Thank you. In the 1990s, HIV-AIDS was feared not just because of the human toll it was taking on society. It was also feared because of the strong financial impact it was having on our healthcare system. But in the mid-1990s, combination therapy treatments came to market. And since that time, HIV-AIDS death rates have fallen by 86 percent in this country.

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Today, it's chronic disease and treating patients with chronic disease that are responsible for 90 percent of all healthcare costs. Just one of these -- diabetes -- is responsible for \$245 billion in costs. We have medicines to treat patients with diabetes. We know how to treat them and we have guidelines that tell us how to treat them, but yet only one in three patients today is adequately treated for their diabetes. If we did more to get those patients treated and have them adherent to their medicines, we would save \$19 billion in this country. But the real tsunami, in terms of healthcare costs, is coming in the not-too-distant future, when we can anticipate spending a trillion dollars to care for patients with Alzheimer's disease. If we do nothing to address those costs, they're coming. I don't know of any other way to address those costs, other than innovation. And the good news is that we're making strong progress in our science.

Today, immunotherapy medicines that are hitting the market are using the body's own immune system to fight back against hard-to-treat cancers.

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And we're seeing that progress already, with cancer death rates falling 23 percent just since 1991. When we talk about health care costs, though -- and Zeke mentioned it -- Hepatitis C is one that comes to mind. But what people don't often talk about is that before these new, innovative treatments hit the market, we were spending \$30 billion a year in this country to treat patients with Hepatitis C, and those costs were projected to climb to \$80 billion in 20 years. But again, innovation happened. New medicines hit the market that took a disease that killed five times as many people as HIV-AIDS does in this country and cured it in eight to 12 weeks of time. And something else happened. In under a year, we had two additional Hepatitis C medicines that came to market, and the price of those medicines fell by 40 to 60 percent, in terms of what they cost before.

From a clinical perspective, we've cured a million patients from Hepatitis C in two-and-a-half years.

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That's more than the previous 20 years combined. While it's clear that the launch of those medicines in 2014 caused prescription drug spending to grow, and we hit a high-water mark of 12.5 percent in 2014, the government actuaries, though, predict over the next decade, spending for medicines will be in line with all other forms of healthcare spending costs. Why should we believe the actuaries? Well, let me explain. The system in our country works like this. When a brand name medicine gets approved, it can expect to get competition from another brand name medicine in under two years of time. And the example I just used, with Hepatitis C, that competition happened in less than a year. When that competition happened, prices fall. In addition, we have generic entry. And when generic entry happens, typically, 10 to 12 years after a product hits the market, 80 percent of costs drop for that product.

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Market share shifts overnight. Today, 90 percent of all medicines used in this country are generic. And we have something also very different. Neera mentioned in her opening that we have all of these different payers, and they don't have enough pull to get -- to actually negotiate with our companies. Well, that's untrue. There are three large pharmacy benefit managers in this country that buy on behalf of 75 percent of all prescription drugs. And they use that leverage extensively to drive big discounts and big rebates from companies, to the tune of \$115 billion last year.

So, to say that there's not competition in our marketplace is factually incorrect. And the difference between medicines and all other forms of healthcare is that our costs do fall over time. We don't have generic hospitals or generic doctors. The cost of procedures, like an angioplasty, have gone up 66 percent, and there is no signs that it will ever fall.

00:40:00

But the price of medicines does fall over time. I'm not going to sit here and argue, though, that solving the healthcare challenges that we face are somebody else's problem. We all share in trying to get to a better system, and we do believe that there are solutions that can be out there that will address some of the cost challenges we face. Paul mentioned the need to reform the FDA.

Today, there are 4,000 drugs sitting at the Food and Drug Administration, generic drugs, waiting to get approval. The average time to get a generic drug approved at the FDA today is four years. That's too long. Getting generic medicines to the market sooner increases competition. We also need to ensure that the FDA can keep pace with the

regulatory science and the new advances we're making so that they can review brand name drugs quicker and get those to market so that they compete with other brand name drugs. And we also need to address the challenges to moving towards a value-based healthcare system. We embrace the movement towards moving towards a value-based healthcare system, but we also need to recognize that today there are challenges that make it difficult to do so.

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The need for future innovation is clear. Drug costs, though, are not unsustainable. Disease and the costs associated with disease in this country is what is unsustainable. While the solutions that you're going to hear espoused by my opponents tonight attempt to glorify some of the systems that we see abroad, they typically fail to acknowledge the real consequences when governments seek to set prices, intervene in markets, and determine the value a given medicine has. Those decisions are best left to patients and providers. I urge you to vote against the motion tonight. Thank you.

John Donovan:

Thank you, Lori Reilly.

[applause]

And that concludes round one of this Intelligence Squared U.S. debate where our motion is "Blame Big Pharma for Out-of-control Health care Costs."

Now, we move onto round two. And in round two, the debaters address one another directly, and they also take questions from me and from you, our live audience here in New York.

00:42:03

Our motion is this: Blame Big Pharma for Out-of-Control Health care Costs. We have a team arguing for the motion made up of Neera Tanden and Ezekiel Emanuel. They have portrayed a pharmaceutical industry that is -- they say is a major culprit in driving up the cost of health care overall, a -- an industry that just because it can, sets exorbitant prices before our captive audience, prices that are out of all proportion to their real value. They say that this overlooks the contribution that taxpayers make to the development of these drugs, that these companies get to operate as temporary monopolies. And they suggest also that perhaps the need is for them to be regulated. As it was said, drug companies could still make less profit and still stay in business.

The team arguing against the motion, Paul Howard and Lori Reilly, argue that drug prices cannot be the driving force behind rising health care costs because their

percentage of the overall price over time has been relatively steady and is predicted to remain that way.

00:43:03

They said that even high-priced drugs deliver a value by keeping people out of hospitals and out of nursing homes which is -- which would result in much more expense to the population at large. Innovation, they say, needs to be rewarded. Investment needs to be paid for. And that's what profits are for. So, those are really the dividing lines between the two camps here on stage. I think also, to some degree, there is a sort of stealth debate taking place here about whether or not pharmaceutical pricing should be regulated or not. Strictly speaking, that's not what we are debating. But if the conversation wanders into a little bit of that, I'll allow it to go in that direction.

[laughter]

But what we really -- what we really want to get to is what's in the motion: Is big pharma the main reason -- a significant reason that health care costs are going higher and higher? And I found an interesting disparity immediately between the two sides. The side arguing against the motion has claimed that as a percentage of overall health care costs, the drug prices account for about 16 percent --

00:44:06

-- roughly have for a long time, have for decades, are predicted to do so. The team arguing against the motion, to quote them almost verbatim, say drug costs are going up faster than any other sector in the health care marketplace. Let me take the argument first of the team arguing for the motion. If your opponents are right, they blow quite a big hole in your argument. Zeke Emanuel.

Ezekiel Emanuel:

No, I mean, the fact of the matter is that specialty drugs, which are those drugs used for cancer and multiple sclerosis and rheumatoid arthritis are -- drug companies are investigating those. They are in fact going up at much higher rates, 20 and 25 percent price increases. And those are the drugs that are increasingly going to the FDA and being approved. And the fact that the actuary has predicted one thing or another, it has no bearing on that future, because the actuary has been wrong over and over again about his predictions of health care costs.

00:45:02

He actually said that Obamacare would cost about \$1 trillion, it is actually coming in substantially lower than his prediction. On the drug costs, I think he hasn't factored in the fact that we're going to have more of these specialty drugs used more frequently,

and the fact that there's no limitation on the prices. He has to guess what drug companies are going to charge. What we've seen is they'll charge the limit.

John Donovan:  
Okay.

Ezekiel Emanuel:  
And by the way, let's point out, Mylan charged \$600, got all this attention --

John Donovan:  
Zeke, Zeke.

Ezekiel Emanuel:  
-- and never rolled back their price.

John Donovan:  
Zeke. Zeke. Zeke.

[laughter].

Ezekiel Emanuel:  
Yes, John?

John Donovan:  
I am the moderator. Paul Howard.

Ezekiel Emanuel:  
I'm the speaker.

John Donovan:  
Yeah. All right. I'm going to say it now. I need you -- I need you to participate according to the rules, and the rules are that when I interrupt and ask you, you'll yield unless you have a --

Ezekiel Emanuel:  
I'll try to behave.

John Donovan:  
-- a very good reason. That's the -- how we'll keep it going. Paul Howard.

Paul Howard:  
I want some more of whatever Zeke's drinking.

00:46:00

Look, I mean, the dissonance here is this: They're pointing to individual drug prices and saying they're going up, up, up, up. And we're pointing out that, look, there are powerful negotiators, these large insurers that are standing between consumers and getting enormous rebates that last year cut drug price increases from around 12 percent down to a net 2.8 percent. Zeke had pointed to specialty drugs and saying, that's where the cost is going, funnily --

John Donovan:

So what's wrong with that argument?

Paul Howard:

Well, funnily enough, it doesn't keep going up, up, up forever, because what happens is biosimilars, the generic versions of these expensive injectable drugs, enter the market and compete. Now, look, there's not an infinite amount of complexity here. We saw, during the 1990s, people really -- and Lori spoke to this -- saying, oh, my God, how are we going to afford all these statins or HIV drugs? The market adapted, and we did, and drug prices fell. Commercial spending fell as early as 2000 -- as late as 2012.

John Donovan:

Neera Tanden.

Neera Tanden:

So there is just two facts here that I would like spell out, just to remind everyone. We don't -- we can all have estimates of the future.

00:47:01

The reality is, in 2014 alone, just to reiterate, prescription drug prices -- all prescription drug prices, not just specialty drugs -- that all prescription drug prices increased by 12.2 percent. It was 8 percent last year, but that, of course, in both years is the fastest rate of growth for any part of the health care system. When you look at Medicare -- the Medicare actuary, Medicare officials see prescription drug prices as the fastest growing part of the health care system. We can have projections into the future, but this is our lived experience. And one of the reasons why you see Republicans and Democrats naming prescription drug prices as their top concern on health care issues, finding a rare area of bipartisan support is because we are living this experience of paying exorbitant prices for drugs.

00:48:00

Exorbitant prices that people in other countries don't pay and still have access to quality drugs.

John Donovan:

Okay, let's let your opponent -- Lori Reilly.

Lori Reilly:

Thank you. What Neera quoted was actually not price growth. That was spending growth. And spending growth is the combination of price times volume. So she's right that in 2014 we did see spending growth increase. And a large part of the reason that we had that, again, was new treatments for hepatitis C that are curing a disease that kills five times as many people as HIV/AIDS, that was going to cost our health care system \$80 billion over the next 20 years' time. If you look back at the entire last decade in terms of spending growth for prescription medicines, we were less; less in terms of spending growth compared to hospitals, compared to doctors, compared to home health care. If you look going forward over the next decade, we're expected to spend \$2.4 trillion more on health care in this country.

00:49:00

85 percent of that additional 2.4 trillion is attributable to hospitals, doctors, home health, nursing homes, everyone but prescription drugs. We're about 15 percent of that increase going forward.

John Donovan:

Okay, let's let Zeke --

Ezekiel Emanuel:

It's always everyone else. Let's get clear on two important points. One of the reasons patients are noncompliant with their medications, a very large reason they're noncompliant with their medications, is prices, because prices are very high. Just take the diabetic example that was given before. Insulin in the United States, non-discounted price, \$372 for a month of treatment in the United States compared to \$46 in France. Genuvia, another drug for diabetes, \$330 in the United States compared to \$35 in France. That's a major reason for noncompliance. The second point I want to address is, they're saying, look, all we need is competition. But the fact is you get a lot of competition in the drug market, and it doesn't necessarily drive down prices, because as I mentioned before, doctors don't know prices.

00:50:03

Here's an article from JAMA just this August. Competition between two or more brand name manufacturers selling drugs in the same class does not usually result in lower prices.

For example, consider the statins for cholesterol. We have six that were off patent and generic and two that were on patent and the price for one of them on patent increased

91 percent from \$112 to \$214 per prescription and still sold the last for Astra Zeneca. Prices doesn't matter on competition in the health care marketplace.

John Donovan:  
Lori Reilly.

Ezekiel Emanuel:  
Because there's -- patients are not buying them.

John Donovan:  
Lori Reilly.

Lori Reilly:  
Thank you. Part of the issue that Zeke is pointing out has to do with how insurance companies treat cost sharing for medicines relative to any other part of the health care system. Today patients are asked to pay on average 20 percent out of pocket for their prescription medicines. Compare that to hospital costs out of pocket, 4 percent. Physicians under 10 percent.

00:51:00

So it's no surprise that when patients go to the pharmacy counter, they're asked to pay more for their medicine out of their own pocket and that's how our insurance system works today. Zeke mentioned list price growth, and that's an important thing to remember here. List price growth is not the price that a PBM, one of those three large PBMs pays for a product. He specifically mentioned insulin prices. The net prices for insulin are cheaper today than they were three years ago. Cheaper today than they were three years ago, but part of the problem in our health care system is that we have a rise in high deductible health plans where today patients are being asked to pay out of pocket that list price. The payers, the health plans, are not providing those discounts back to the individual patient. Something's wrong with that system when a patient is asked to pay full price for something when the payer or plan gets it for 50 percent off. That's what's wrong with our health care system and that's what we need to focus on, and I would just say one more thing, which is in regards to Zeke mentioned statins.

00:52:03

I want to talk about hepatitis C since it was recent. As soon as the introduction of Hep C --

John Donovan:  
Actually, Lori, --

Lori Reilly:  
[unintelligible] 40 to 60 percent --

John Donovan:

Hang on that -- hang on that thought, because I want to let Neera Tanden respond to what you've said already and we can come back.

Lori Reilly:

Okay.

John Donovan:

To that thought. Neera Tanden.

Neera Tanden:

Yeah. I think we should really take on -- I want to take on both of these points. I -- you know, I'm no great fan of the insurance companies for sure, but we should recognize here that one of the reasons why people don't really have access to good data around list prices is because pharmaceutical companies aren't transparent about prices. A great way for us to instill some competition into the pharmaceutical market is for us to all as consumers have an assessment of these prices, what's going into them, how much research dollars are driving into the cost, how much marketing dollars are driving into the cost, but they won't share that information with us because they think that's information only they should have.

00:53:00

If you believe in markets you should believe in transparency and if you believe in transparency you should believe that consumers should be able to evaluate that. But one of the reasons why I don't think they want to drive to a value-based system is because there are so many costs unrelated to the value of the drug that are driving this, marketing and sadly, high profitability. Again, pharmaceutical companies are the highest profit margin companies in the --

John Donovan:

All right.

Neera Tanden:

-- much more than insurance companies to which I agree we could have a lot more competition there as well.

John Donovan:

Paul Howard, I mean, the point that Neera Tanden just made about -- and this was made earlier in the debate about the high profit margins of some pharmaceutical companies, one going as high as 55 percent, the argument was made those profit margins are so high that pharmaceutical companies could just make less money and still be okay. What about that? The hint being they should make less money.

Paul Howard:

Well, the thing I find kind of amusing of Neera and Zeke's point, especially Neera, is, you know, what's the right profit?

00:54:02

I guess you know. I mean, maybe it's the automotive industry's 6 percent. How about fast food, 2 percent? What other industry do you want to be more profitable than the one that's attempting to get a cure for HIV? I mean, the challenge that we're talking about here is that we actually want two things. We want R&D to be as inexpensive as possible so many more people can bring medicines to market and compete and then primary care indications we do see prices fall after these rebates that the insurers get. We want to make sure those are passed along to patients. So, the challenge here is look, if you want to see someone else -- if you want to see investors send their money somewhere else into a less risky industry, maybe software, the next Snapchat, by all means, cut the profits for the pharmaceutical industry. Those investors in those companies can send their money elsewhere.

John Donovan:

So the notion --

[talking simultaneously]

Wait, wait. One second. One second. One second.

Neera Tanden:

I need to respond.

John Donovan:

One -- wait. One second. So the notion that there is a number that's too much to you just makes no sense.

00:55:00

Paul Howard:

No. The number is what is it that you need to get? What is the profit margin you need to get to reward your investors? And that's --

Neera Tanden:

[laughs] Okay.

Paul Howard:

-- for the risk that they bear.

Neera Tanden:

I'm so loving this. So --

[laughter]

-- I think I'm so pleased that you mentioned venture capital, right? Because I think -- the kind of prototypical example people have today is not the traditional pharmaceutical company that's plowing so much money. But we know it's -- this does not really happen, but there's the theory that they're plowing so much money into research, and they're basically doing that in order to find that miracle drug, which we all hope they do. But what's actually -- the biggest change in the pharmaceutical market is the rise of the Martin Shkreli of the world, which is an essential -- you could call it "venture capital," you could call it "vulture capital," but the idea of it --

[laughter]

-- is essentially to use the monopoly power of particular drugs to drive the highest prices to -- for individuals, and basically live off the system to extract profits.

00:56:06

That is the newest innovation. And truly, like, existing pharmaceutical companies recognize that as a challenge. And that is -- in a system where you do not have true competition -- is a challenge. And I appreciate -- I do not want to set the profit margin for a company. But when there is a drug that people literally have to choose between bankruptcy and paying -- even when they have health insurance -- I'm sorry to say, I think 55 percent might be something you might bat an eye at. I'm not saying I'm going to set that price. But we live in a world where at least you could admit -- at least you could admit that should trouble you.

John Donovan:

Lori Reilly?

Lori Reilly:

Well, it does trouble me, because I view that as a failure of the health care system, Neera. You know, the purpose of insurance is to spread risk across large populations.

00:57:01

So, to the extent that you have a patient who is sick and needs expensive care -- whether it's a medicine or whether it's a surgical procedure -- that insurance -- that's the purpose of insurance, to be there to help pay for those instances. With regards to profitability, I want to come back, because I think we always cite profitability be --

profitability of the companies that we've all heard of, right? You'll trounced out Gilead's profitability or Pfizer's profitability. But the reality is, 90 percent of the 1,200 biopharmaceutical companies that exist today make zero profit. You've cherry-picked the 10 percent of them that do. But the hope is –

[laughter]

-- it's true, Zeke. The hope is that -- all of them. And you know, bringing up Martin Shkreli, I'll be the first to say what he did was shameful. But what he did was take advantage of a system where that --

Neera Tanden:  
Absolutely.

Lori Reilly:  
-- product was off-patent --

Neera Tanden:  
Absolutely. Took advantage of the system --

Lori Reilly:  
-- off-patent --

Neera Tanden:  
-- [inaudible] --

Lori Reilly:  
-- had no generic available. We do need to find opportunities to make sure –

00:58:00

-- if we've got 90 percent of drugs on the market today are the generic, let's make sure that we have a competitive market for generics, too, when drugs go off-patent.

Ezekiel Emanuel:  
So, let's --

John Donovan:  
Zeke Emanuel.

Ezekiel Emanuel:  
Let's just make two points here. The first is, the 15 percent I quoted, on average of profitability in the biotech pharmaceutical industry was across the whole industry. Of course there are going to be some winners and some losers, but the fact is, it's the most

profitable industry in the United States. And I would ask, does it have to be that high? The second thing I'd like to do is just -- let's take apart the Hepatitis C drug, since they think it's such a big drug. So, a lot of the research was funded by the NIH, the initial research. Then, a small biotech company started, and they put in about a billion dollars of research. Gilead came along and bought them for \$11 billion. And then, way above what the amount of research they had put in -- a super-premium price.

00:59:00

And then Gilead priced Sovaldi at \$84,000 per patient, made back its \$11 billion before a year. They were selling almost \$700, 800 million per month of the drug. That's their best example. They have made a huge amount of money. They are 55 percent profit margin. Did they need the 55 percent profit margin? Did they need to get all their investment back in one year? This was a company where a lot of the research was done by the public, and only a billion dollars of it was research --

John Donovan:  
Okay.

Ezekiel Emanuel:  
-- 10 percent.

John Donovan:  
I'm assuming those are rhetorical questions.

[laughter]

Lori Reilly, I said I would get back to you on Hepatitis C.

Lori Reilly:  
Yeah.

John Donovan:  
Let's use this opportunity.

Lori Reilly:  
Absolutely. So, \$50 billion dollar is what was spent on biopharmaceutical research to bring a Hepatitis C medicine to market. And that \$50 billion -- 99 percent of what was done failed, never got to market.

01:00:02

Gilead was successful in bringing the first product to market to treat Hepatitis C. It was launched at a price that was neutral to existing treatment. And just to give you an idea

of what the existing treatment was, it was a drug -- three drugs, actually, that had to be taken for almost an entire year, that worked in less than half of the patients, that made patients so sick they typically stopped taking the medicine. And then a new medicine came along, cured the disease for 95 percent of patients in eight to 12 weeks of time. And in less than one year, we had competition from two additional products, and the price of those products have dropped 40 to 60 percent. So we can talk about hepatitis C, but to me, it is a good example of how competition in our marketplace works, and it works very, very quickly.

Neera Tanden:

Just under that example, I will remind the audience, Gilead made back its huge profit margin in a year, right?

01:01:00

And the competition -- the competition that came in under your fact scenario, two competing drugs came in a year in, right? So the issue there is, why does Gilead have to charge that high a price --

John Donovan:

Paul Howard.

Neera Tanden:

-- to begin with?

John Donovan:

Paul Howard.

Ezekiel Emanuel:

And also, they had a lower price in England.

John Donovan:

Go ahead, Paul Howard.

Zeke, you're not Paul Howard.

[laughter]

Ezekiel Emanuel:

I can impersonate him.

Paul Howard:

You think you can. Look, Zeke has written about this. Zeke, you've written that you think actually the Hepatitis C Sovaldi is a good deal, right? Look, you're cherry-picking in a different sense. There was another drug, Incivek from Vertex, that was launched I

think in 2011 that had a 75 percent cure rate that then got withdrawn from the market because Sovaldi was so much better. So there are all these examples. And we can talk about the NIH.

Look, 88 percent of drugs that go into clinical trials fail, right? The entire biotech industry until just a few years ago was in the red. So we can look around and see, oh, my gosh, there's some remarkably profitable products here. But actually a lot of what they do is fail.

01:02:01

And Gilead is under, you know, stock pressure right now because they're looking around at their competitors, they're taking huge decreases in their profitability because they're facing competition. You can't look at a snapshot in time.

[talking simultaneously]

Ezekiel Emanuel:

You can't look at a snapshot --

John Donovan:

All right, and --

Ezekiel Emanuel:

You can look -- you cannot look at one drug and one drug and say, 90 percent fail. You have to look at a portfolio because like good investors that are investing across a portfolio, and across that portfolio, their profit margin is 15 percent, the highest profit margin of any industry in the United States. So they're doing quite well even with all those failures. They know how to make a huge profit.

John Donovan:

All right, all right. Hold it, hold it. I want to go to audience questions in a minute. Again, I want to remind you how it works. If you raise your hand, I'll call on you. Please wait for the microphone. Stand up, tell us your name, ask a question that's on topic. Before we go to that, I just want to take one question to this side. I'll put it to Neera Tanden.

Something that your side hasn't chewed on yet was your opponent's argument that some of these specialty drugs actually in the long run save a lot of money.

01:03:01

That they pay themselves back over and over again in terms of overall health care costs, for example, by keeping people out of hospitals and out of nursing homes. It's a logical argument. I haven't heard you respond to it.

Neera Tanden:

I'm happy to respond to it. You know, I think we all want every part of the health care system and there -- to reduce costs, and it's absolutely the case that prescription drugs, when it replaces a -- you know, a surgery or a longer form of cure, that's important, absolutely. But I think the thing we have to remember is the question here is, can we do it at higher value for you the consumer? That is the question.

You know, if you argue that over the long run, value will go up, then there's no argument against any higher price for any drug. And the question is, that's not how any other industry works. You know, when we're thinking about the iPhone or a new car, it's not like, oh, the thing is -- it's replacing something in the future.

01:04:04

They are facing competition right now. And the one thing I just would like to say before we get to questions is to remind everyone here that we're also in a world in which this is not a traditional market because everyone here is subsidizing this industry with the research we pay for. It is a massive subsidy in a sense to the pharmaceutical industry which then turns around and charges all of us who are subsidizing them through our taxpayer dollars, the highest price they can charge.

John Donovan:

Response from the other side? Response from the other side.

Paul Howard:

Sure. I mean, look, I think one of the problems that Neera's pointing toward, which I actually think there's a version of truth in that is, when align all the costs and say, for this person, what's the best way to keep them healthy for as long as possible? The technology that does that the best is going to be, in many cases, an effective prescription medicine, sometimes a generic, sometimes a branded drug.

01:05:02

But then if you say to the doctor, "Here you go, here's your bundle, you use the thing that's most important to keeping this person healthy and keeping costs down," that is the right alignment here. But you guys are singling out drugs like they're widgets. So let's just push down the price here on this thing, and it could turn out that then someone is in worse health later because you're not using the technology that's most efficient to get to where you say you want to --

Ezekiel Emanuel:

But, Paul, these --

Neera Tanden:

We want them to --

Ezekiel Emanuel:

-- \$150,000 drugs for cancer, for multiple sclerosis, they do not cure anyone. They extend life in cancer at most, two, three, four months. They do not cure anyone. They're \$150,000. Multiple sclerosis drugs, they reduce the number of flares. They don't cure anyone. It is false to say all the drugs are like Sovaldi for Hepatitis C. Most of these super high expensive drugs are not curative, and they do not actually make people walk around and dance who otherwise didn't. And they don't substitute for hospitalizations and surgeries.

01:06:01

John Donovan:

Let's go to some audience questions. Right down -- I'm -- ma'am, yes. You just -- you do -- you're -- you're reading me, yeah. If you could stand up. Here comes the mic on your left-hand side.

Female Speaker:

Hi. My name is Bonnie Wiper. I have a question for the pharmaceutical -- the pro pharmaceutical side. I hear -- I read and hear all the time that the pharmas kind of -- if we keep -- try to regulate drug prices, that they threaten to stop innovating and therefore we won't -- the consumer won't get the drugs that we need. By the same token, you talk about a robust and competitive market among pharmas. Don't you think that the competition -- that if the drugs were -- if the prices were regulated, and the pharmas followed through with their threat to stop innovating, don't you think competition would make that a self-defeating strategy?

01:07:10

John Donovan:

Do you think the competition -- you don't want to have a leading question.

Female Speaker:

Do you.

[laughter]

John Donovan:

Lori Reilly.

Lori Reilly:

Well, first of all, I would say just because the government isn't in the business of setting prices -- although I would say for a lot of our market they do because we pay a very -- 60 percent rebate in Medicaid. We pay a 50 percent coverage discount in Medicare part B. We pay 30 -- 340B discounts at half of the hospitals in this country. So there are a number of our prices that are regulated by the government. But I would say just because in the commercial private sector side that the government hasn't stepped in to control the prices, don't confuse that with there isn't cost containment in our sector. To the contrary. We have essentially three purchasers that are buying our drugs. They have huge leverage. One of them buys on behalf of more people that are the entire country of France.

01:08:00

What does that mean? They have a "take it or leave it" policy. Just this past week, one of our companies who makes insulin announced that they're cutting 1,000 employees as a result of the fact that the competition in the insulin marketplace is driving further and further in deeper discounts. And it's because of that leverage that they have, it does keep costs in check. Yes, 2014 was a big year. I am not going to sit here and deny that. But what I ask you to look at is, look at the last past 10 years. The spending growth for drugs was below virtually every other type of health care, meaning every other form of health care spending was growing higher. Go forward the next decade. We're in line with where spending is expected to be for virtually every other segment of the health care system. So, we do have costs containment in the health care sector, in the prescription drug sector. Just because it isn't the government deciding how much to pay for something doesn't mean that there aren't --

John Donovan:

Okay.

Lori Reilly:

-- other powerful purchase --

John Donovan:

Okay. I want -- Zeke -- and I'm not asking this sarcastically.

01:09:00

Will you -- will your response say something that we haven't said before?

Ezekiel Emanuel:

Yes.

John Donovan:

Okay, go for it.

Ezekiel Emanuel:

Pfizer, if we had a more regulated price, is not going to suddenly start producing cars and not suddenly going to go into the media business, right? It's in the pharmaceutical business. And if its price margin went from 14 percent to 10 percent, it wouldn't get out and dissolve itself. So that's a false argument that innovation would go away.

Lori Reilly:

Could I just come back to that, because I --

John Donovan:

Yes.

Lori Reilly:

-- didn't touch the piece on returns. When it comes -- when an individual makes an investment in a biopharmaceutical company, they're making that investment knowing that almost 90 percent of what we put into an FDA lab is going to fail. So, they're betting on the chance that maybe that money that they're putting in is going to be one of the successful ones. So, as a result, they expect to get a return for that investment. So it's not to say that companies would entirely go out of business, but I think it does deter companies, and it deters investors when you're told, "Oh, that expectation of a return, it isn't going to be that anymore."

01:10:03

Neera Tanden:

Actually, I think they make that investment because you have a 55 percent profit margin, which is why they can't get anywhere else in any other industry.

Lori Reilly:

But Neera, Neera, we don't have a 55 percent profit margin and you know better.

Neera Tanden:

It's 15 percent across the --

Lori Reilly:

No, it's not.

Ezekiel Emanuel:

[unintelligible] 15.

Neera Tanden:

Zeke said --

Lori Reilly:

No.

John Donovan:  
Fifteen.

Neera Tanden:  
Fifty-five in one industry, 15 across. One company, 55 percent -- 15 across, 55 percent in one company.

[laughter]

Paul Howard:  
To be fair, the congressional budget office, which is the scorekeeper for Congress looked at this I think back in 2005 and said look, compared to other high tech industries -- compared to other high tech industries, the pharmaceutical industry gets above average returns, but it's probably normal when you look at the risks that they face. When you think to that investor am I going to wait 10 years, have an 88 percent failure rate, or am I going to go somewhere else, commercial real estate --

Ezekiel Emanuel:  
Paul, that argument doesn't work because risk is not tied to any individual drug.

01:11:01

It's tied to a portfolio and we know that that risk isn't high. How do I know the risk isn't high? Because the profit margin is 15 percent.

[unintelligible]  
[talking simultaneously]

Paul Howard:  
The profit margin is what you need to reward someone for taking risk.

John Donovan:  
All right. I want to move on to another question, but I do want to say that last question was a great question.

[laughter]

[applause]

So, use that as the model. It really was very short and really opened up a nice avenue for the debate to continue. I just want to look on the side. Sir, on the aisle.

Neera Tanden:

A lot of pressure on the next one.

John Donovan:

Yeah. Well, coming down your right-hand side. Right behind you. Wait, wait, wait, whoa.

Male Speaker:

Thank you. I think that you are both wrong. I'm sorry.

[laughter]

I --

John Donovan:

I need you to --

Male Speaker:

I know I sound like Trump, sorry.

John Donovan:

Yes. Just ask a question.

01:12:00

Male Speaker:

You are both partially right, okay, but my question is why basing the whole discussion about profit you talk about fair profit. I'm an architect. You know --

John Donovan:

No, no, no. I need you -- I can't hear your life story, sir, I need you to ask a question. I don't mean that rudely.

Male Speaker:

Okay.

John Donovan:

But just --

Male Speaker:

Why basing the discussion about profit and not how make the system better to find a way to make it more affordable?

Neera Tanden:

Yes, the question -- I'll take that first initially. The question is is our pharmaceutical companies responsible for high drug prices and do -- should we find that to be

something that's problematic? And so that's why we are looking at the profitability of pharmaceutical companies and when you try to avert the role of pharmaceutical companies by pointing the finger at insurance companies or pointing the finger at hospitals, I think it is relevant that those systems have much less profitability in them.

01:13:04

And that is the reason why we are raising the issue of profitability. If you -- if there was very low profitability we would all recognize that that would probably be an indication of price.

John Donovan:  
Let's --

Neera Tanden:  
But that variability is why I think there is a lot of anger at high drug prices.

John Donovan:  
Response from the other side. Paul Howard.

Paul Howard:  
Well, I mean, we should return, of course, to the question of the debate, which is should we be blaming pharma for runaway drug -- runaway health care costs.

John Donovan:  
Out of control.

Paul Howard:  
Right. Right. Out of control. Out of control, running away. So, look, it's 16 percent. It's going to stay at around 15, 16 percent. Look, 500,000 people were hired in the health care sector last quarter. It's not the profitability, it's the base spending that you're talking about and we're spending much more on hospitals and physician services so even if the lower rate of increase on a bigger base turns out to be more money, that's why it stays level over time.

01:14:02

John Donovan:  
Again, great question. That really moved things. Thank you. Zeke, you've been really cooperative lately.

[laughter]

Do you want to respond to -- am I --?

Neera Tanden:

This is him well behaved, just for the record.

Ezekiel Emanuel:

This is as well behaved as I get. So, look, I think if we want to talk about solutions to the problem, we're happy to talk about solutions. You know, we do agree with Paul that you need to streamline the FDA and they do need to get more resources to approve generic drugs and other drugs more rapidly. As Neera has said, we need more transparency about what goes into that price. How much is government research? How much really is that company's research? How much is the marketing? How much is the profit? And we believe that you should tie the pricing of drugs to how much benefit they produce for patients, including whether they forestall a surgical procedure, forestall a hospitalization. Drug companies don't price according to that, how much health benefit drugs get, because if that were true, you would not get \$150,000 cancer drug or Multiple Sclerosis drugs that don't cure anyone and prolong life two or three months.

01:15:06

We want innovation. All of us want innovation. That doesn't mean we want sky-high, \$150,000 drug prices--

John Donovan:

Lori Reilly to respond.

Ezekiel Emanuel:

-- two separable issues.

John Donovan:

Lori Reilly.

Lori Reilly:

Yeah. Well, I would challenge the notion that companies aren't willing to pay and have -- be paid based on value. Just yesterday, there was a major deal announced between AETNA and Merck for their diabetes drug, where those drugs will be tied towards value-based outcomes. Amgen and Pilgrim entered into a contract just a few months ago on their new PCSK9.

Ezekiel Emanuel:

As a representative of PHARMA, would you agree -- would you endorse the idea that we should have all drug prices be value-based pricing? If you agree, we are on the same side, and I'll move over there.

[laughter]

Lori Reilly:

I --

Neera Tanden:

And add in there, price transparency.

Lori Reilly:

I would argue -- well, let's get transparency narrowed that patients want --

Ezekiel Emanuel:

No, no, no. Don't go off the value-based pricing. Just answer that question.

Lori Reilly:

I would agree that most --

John Donovan:

Do you want to come up here --?

Lori Reilly:

-- that drugs today --

[laughter]

-- Zeke -- drugs today, more than any other part of the health care system, are, in part, based on value.

01:16:04

We have to do lengthy clinical trials where the safety and efficacy products of our medicines are put to the test.

Ezekiel Emanuel:

True.

Lori Reilly:

Two-thirds of all drugs submitted to the FDA have comparator data submitted with them today. We then have to go in front of the payers and demonstrate to them the value that our medicines will provide to them. They don't have to cover our medicines if they don't want to. But I will say --

Ezekiel Emanuel:

But you have a monopoly --

Lori Reilly:  
-- our system -- Zeke --

John Donovan:  
Wait, whoa --

Ezekiel Emanuel:  
-- and they set the prices.

Lori Reilly:  
Zeke --

John Donovan:  
Whoa, let her finish.

Lori Reilly:  
We are moving towards a system of value. And a number of our companies have stepped forward and said, "We're willing to engage in contracts that are focused on outcomes." Is it easy to do? I'll be honest, it's not. And part of the reason it's not is government regulation. Government regulation is stuck in a fee-for-service world, and we're moving towards a value-based system. So, I would hope -- and ask you if you would agree with us that changing some of the current government regulations about how we communicate about our products, what we can do to support patients and insure their adherence are addressed so that we can move more rapidly to that system.

01:17:00

Ezekiel Emanuel:  
Well, let me first say, I'm not sure whether you answered my question or not about value-based pricing. If you're agreed -- it's very hard to see how you could have any drug priced at \$300,000 or even \$150,000 for a year, because that's way over any value-based pricing. And we have a lot of drugs --

Lori Reilly:  
Well --

Ezekiel Emanuel:  
-- that are like that. So --

Lori Reilly:  
Zeke --

John Donovan:

All right. Let me call --

Lori Reilly:

-- you're talking about cost-effectiveness, and that's a whole other --

Ezekiel Emanuel:

That's value-based pricing.

Lori Reilly:

-- can of worms. That's not value-based pricing.

John Donovan:

I want to remind you that we're in the question and answer section of this Intelligence Squared U.S. debate.

[laughter]

I do have to get this said. So, let me do this. I want to remind you that we are in the question and answer section of this Intelligence Squared U.S. debate. I'm John Donovan, your moderator.

[applause]

We -- that's not what I was indicating.

[laughter]

We have four debaters, two teams of two debating this motion: "Blame Big Pharma for Out-of-Control Health Care Costs." Another question.

01:18:00

Sir, right down the middle. You're wearing an orange sweater or top. And mic is coming down the right. Are there people in the far upstairs? I can't -- higher up, that I can't see who are waving?

Male Speaker:

Hi. I guess my question is about -- it's two parts -- is about how other countries, developed countries, are keeping costs down. So, I would like both to explain how those systems are different, how they're making it work. And then also, what are the potential barriers -- D.C. Gridlock aside -- to implementing those things in the U.S. and the scalability and stuff --

John Donovan:

Wait. That's a policy issue that I don't think is going directly to our question -- do we blame big pharma for out-of-control health care costs.

Neera Tanden:  
I will get it there.

John Donovan:  
We're not -- we're not debating solutions.

Neera Tanden:  
I'm happy to get it to that, though --

John Donovan:  
You've got to get it there --

Neera Tanden:  
-- [inaudible] --

John Donovan:  
-- in 25 seconds.

Neera Tanden:  
So, the reason that -- it might be a minute.

01:19:00

The reason --

John Donovan:  
No, no. Really, you don't have a minute. Do it in half -- 30 seconds or give up.

[laughter]

Neera Tanden:  
That seems kind of mean.

John Donovan:  
No. No. I want to keep things --

Neera Tanden:  
[laughs]

John Donovan:  
Keeping it shaped, on topic.

Paul Howard:

Do we have equal time?

Neera Tanden:

So the issue here is -- this, I think, is really relevant to how much pharmaceuticals are driving it in the United States, because when you look at other countries, they are paying dramatically less for -- lower prices. The reason why they are drive -- having lower prices is because you have someone -- not necessarily the government. In many countries, it's a private actor that has market power for many, many consumers -- not just insurance companies -- multi-consumers. It has that market power to negotiate a lower drug price. And I think that is an indication as to why monopoly power in the United States is really on one end.

01:20:00

We are paying higher than any other country because you can say there's three PBNs, there is a Medicare system, there is multiple insurers that are paying. There -- we have a much more fragmented system, and that is why this is an indication as said precisely why, in the United States, pharmaceutical companies are driving that price up, because they never charge this much anywhere else in the world.

John Donovan:

Okay. Nicely done. Nicely connected. Let's let the other side respond, please.

Paul Howard:

I think that was more than 30 seconds, though.

John Donovan:

Yeah, you're going to get equal time. It was a minute and 12 seconds.

Paul Howard:

So, look, the U.S. is the world's medicine chest. So we produce far more drugs, far more drug research, Silicon Valley, all of that stuff. And once you produce the drug, the company -- it's like a plane that takes off. The people who are paying first class and people who are sitting in coach, but everybody gets to the same place. But once the U.S. companies produce those products, they have every financial incentive to sell them even though they're taking a massive haircut on the price.

01:21:01

Now, economists are unanimous that R & D -- global R & D, depends on global revenues. So those countries are free riding on our investments in research and development, and there'd be more medicines available to everyone if they were paying U.S. prices.

[applause]

Neera Tanden:

Yes. And perhaps if we -- what that means is we are very much subsidizing on both ends. We're paying for high research dollars, and we're paying high consumer dollars, right? So maybe we could have a system where we pay less, other countries pay more. I'm definitely for that.

[applause]

Lori Reilly:

Can I address the NIH point, because it's come up many times.

John Donovan:

Yes, Lori. And then I have a question for you from Facebook.

Lori Reilly:

Quickly? Okay.

Neera Tanden:

And we can do that by Medicare and negotiating drug prices.

Lori Reilly:

The National Institutes of Health does spend money on research and development, but their entire budget last year was \$30 billion. The entire budget for biopharmaceutical research and development was over 75 billion.

01:22:00

Not all of the NIH budget goes to research. And in fact, a few years ago, Congress asked NIH to do a study, and it said, "Do us a favor. Look at the top 50 drugs that are sold in this country and tell us how many of them had a connection back to NIH funding." They ended up looking at 47 drugs and found that four of them had a connection back to the NIH, not insignificant at all. And we know that the role that the NIH plays is extremely important. It helps fund a lot of the basic research. But to say that NIH funding is a substitute for the risk that happens by biopharmaceutical companies to bring a new medicine to market significantly undervalues the role that biopharmaceuticals play.

Neera Tanden:

No one is saying it's a substitute. I just want to be clear about that.

[applause]

John Donovan:

Zeke Emanuel, we -- Zeke, we have -- we have a question, Zeke, from Facebook, someone named Poncho Loayra [spelled phonetically] is asking, "Should we set up the system so that we can import drugs from other countries?"

Neera Tanden:

It's for you, Zeke.

Ezekiel Emanuel:

Look, if we had fair prices here, we wouldn't be looking to import drugs.

01:23:02

The fact that we're looking to import drugs from Canada is just because we want to make an arbitrage on the pricing, not because they make better drugs in Canada that we can't get in the United States. So it's really a pseudo argument. The importation would only be a way to pressure the drug companies. We have more effective ways, actually, of getting reasonable prices, it seems to me. If we can't get to those agreements because of political gridlock, as noted, then maybe we need importation which we -- which, by the way, the FDA does have that power to do when prices are up or there are shortages. And so we can actually do that. But it's an indirect way. It's a substitute for actually directly addressing the pricing problem.

John Donovan:

Sir, over in the -- yeah. You can sit that -- if you can stand up, a mic's going to come down from your right-hand side, I hope.

01:24:00

Male Speaker:

Hello. My name is [unintelligible] Mina. Given that there are many points in the health care system where [unintelligible] have to pay for services, pay for getting better, and as was said before, the amount of the prices passed on to consumers to pay out of pocket is higher for prescription drugs. Why is prescription drug costs not the place to put more pressure on driving those costs down for individuals paying out of pocket?

John Donovan:

I'm taking this question to this side. Let me let them go first, then you respond.

Lori Reilly:

I do think there --

John Donovan:

Lori Reilly.

Lori Reilly:

I do think there does need to be more done to address some of the challenges that patients are paying when they go to the pharmacy counter. I don't think it's right that insurance companies treat patients that have diseases like HIV/AIDS or rheumatoid arthritis or MS differently than they treat someone who has to go into the hospital and have a surgical procedure. But they do today. Patients today are punished based on their biology. If you need a medicine, you can expect to pay more out of pocket for it relative to a procedure that might cost exactly the same if you need it in the hospital setting.

01:25:04

And that's wrong. I think in our system that's wrong. We've also seen a growing shift in terms of really high deductible plans. You know, it used to be the case, when you went to the pharmacy counter January 1, you had insurance coverage from day one. Well, now what's happening is that they're saying, no, drugs are part of this really big deductible, maybe 3, 4, \$5,000 deductible. And those discounts and rebates that I talked about earlier, the payers and the PBMs, they're not passing those discounts on to patients at point of sale, and that's wrong. No patient should ever be paying more for a medicine than their insurance company paid for that medicine.

John Donovan:

Neera Tanden?

[applause]

Neera Tanden:

I just -- no disagreement there. I'd say one quick thing about this, which is, if you have insurance companies insulate the price of drugs, which is what you're calling for, if you say, you know, helping for surgeries, you only pay 4 percent.

01:26:02

For drugs you only pay 4 percent. What that's saying is just, your premium will rise with high drug prices, and you will just not see it in the drug price.

Lori Reilly:

Neera, I --

Neera Tanden:

So that is -- but no, no.

Lori Reilly:

Neera --

Neera Tanden:

I just want to be clear -- just want to be clear about this. If the system works as it does, and -- and you -- and you have that -- I mean, I hear what you're saying about the rebates in particular. I get that. What's really happening is that they are driving that price down and that is also being -- that rebate is being reflected in your premium. I guess you don't -- you don't want to say that, but that is true.

Lori Reilly:

Can we talk about the premiums?

John Donovan:

Well, actually -- actually, I happen to know that one of the debaters needs to make a train so --

[laughter]

So I'm going to move on to the last part of this round, and it's what we are calling "the 15/30 volley." And in this, each side gets the formal opportunity to put a challenge or a question to the other side, showing why they're wrong and why their opponents are very wrong.

01:27:00

They get 15 seconds to make their point. Their opponents get 30 seconds to respond, and then there's a 15 second rebuttal, and then we'll switch and then do the whole thing to the other side. At the end of each of these time periods, 15 and 30 seconds, I'm going to ring a bell. That means you have to stop talking. So I'm going to start with this team. The team arguing for the motion, either of you can go. In 15 seconds, what do you have to say right now to the other side? Your 15 seconds starts now.

Ezekiel Emanuel:

How are we going to actually reduce drug costs given the fact that they are high, they have gone up substantially in the last few years, and we have more specialty drugs coming out. This -- where the price -- prices are 20, 30 percent higher.

Lori Reilly:

I --

John Donovan:

Go ahead.

Paul Howard:

Look, get the government out of the way. There is something called Medicaid best price that limits the ability of insurers and companies to come together and say, hey, pay for performance. We're going to save you money, we're going to improve that patient's health, and that puts the onus on the drug manufacturer to perform, and lowers the barriers facing patients.

01:28:00

John Donovan:

Oh, you didn't use all your time. 15 seconds to respond to what you just heard from them. Are you convinced?

Ezekiel Emanuel:

Well, look -- no, I'm not convinced because there is no indication that drug companies are actually lowering the opening price, and they keep -- when they have a drug out there, they keep raising the price over and over again. It's not clear at all that they're going to be willing to give in to prices. As a matter of fact, only when they're forced to lower prices.

John Donovan:

All right, your side now gets to put -- what do you want to say to the other side?

Lori Reilly:

I would say, there seems to be an assumption from the other side that anytime spending on medicines goes up, it's automatically a bad thing. But if spending goes up because we're curing disease and we're bringing new breakthrough treatments, that doesn't seem like a bad thing to me, particularly if these medicines can prevent the need to use other more costly health care services. But it seems like, from your side, that seems like a bad thing.

Neera Tanden:

No --

John Donovan:

Take it, Neera.

Ezekiel Emanuel:

We are agreed that if the drug is curative, if the drug decreases side effects or saves money in the system, that's a good thing.

01:29:00

The problem is we have these super high drug prices, 150,000, \$300,000 drugs that don't cure anyone, and they're still exorbitantly expensive. And that makes it difficult for people to actually take the drugs and be healthy. And –

Neera Tanden:

And I -- I think we'd all agree -- and maybe we could all agree as a group, we definitely want more high value in the system. We definitely want drugs that work for --

John Donovan:

15 seconds to respond.

Paul Howard:

Look, you want the iPhone. You don't want the first cell phone. There's going to be incremental improvements. There are going to be things that are not perfect cures, and you want to pay for them too, right? You want people to have advantages and get better. You're not going to say to them, "Wait until there's a cure, and until then, we're not going to treat you."

John Donovan:

Time is up. That concludes this round, and it concludes round two of this Intelligence Squared U.S. debate -- where our motion is: Blame Big Pharma for Out-of-Control Health care Costs.

[applause]

John Donovan:

Now we move on to round three. Round three will be brief closing statements from each debater in turn.

01:30:00

They will be two minutes each. Here making her closing statement in support of the motion, which is once again Blame Big Pharma for Out of Control Health Care Costs, Neera Tanden, president and CEO of the Center for American Progress.

Neera Tanden:

I want to thank everyone for this fantastic debate and thank the folks who we are arguing vigorously with. I think we come back -- come to a place where we all want higher value in the system, but we have essential questions like how do we have a system in which a drug, the drug price, goes up over time, not goes down. We've looked at these very famous cases recently, and I think that tells you that when a drug has existed for a while, it's been on the market, it gets a new company entering in, buying it, and then driving up the price, not driving down the price.

01:31:00

And I appreciate that is not -- that is an exception, that's not the rule, but that exception tells you this market is not working properly. And from a market perspective, we do need to figure out a strategy to ensure that pharmaceutical companies who are responsible for these high prices that we are seeing in drugs have more competition, have more incentive, have more of the structure to not basically drive the highest price they can get away with, which is fueling the bipartisan concern we see on this issue. There is almost no issue I agree with Donald Trump on, but even he has called for Medicare negotiating drug prices because of the anger and the issue that people are seeing with this.

01:32:00

Every other country has that level of negotiation. We are the only country that doesn't, and that is why I hope you will vote for the motion that shows that Pharma is responsible for drug prices being so high.

John Donovan:

Thank you, Neera Tanden.

[applause]

The motion: Blame Big Pharma for Out of Control Health Care Costs, and here making his closing statement against this motion, Paul Howard, director of health policy and senior fellow at the Manhattan Institute.

Paul Howard:

Thank you. I'm going to ask you for a moment to pretend that you're a billionaire. Your name is Mark Cuban. You're on "Shark Tank." And someone comes to you and they're pitching a new idea. It's a parking app. It'll cost them \$100,000. They'll hire some coders and they'll be on the iTunes store in a year, maybe two years tops. There's no barrier to enter. You can get right out there and start earning money. The next person to pitch you is somebody who has a new idea for a drug, and it's going to cost them let's say \$50 to \$100,000,000 just to get through human clinical trials for the FDA and then there is an 88 percent chance that in 10 years it'll be a flop.

01:33:10

Which investment are you going to make? That is the challenge that we're facing. Look, the FDA is the biggest barrier here. It's the barrier in generic drugs. It's a barrier to more innovative medicines. We need to find ways to bring more effective medicines to market less expensively so we can have both incremental and breakthrough innovations and more of all of the above and then tie them to the performance in the

market. Because our biggest problem, as I spoke at the beginning, is not the drug price, it is the illness and the death and the disability that we all grapple with. And so the fact that we have very low Alzheimer's drug spending right now because we have no effective treatments is not a cause for celebration. It should be a cause for alarm. So, I agree with Zeke that we need to tie more to value, but so many of our federal regulations prohibit pricing to value.

01:34:00

Micromanage who gets what price and who can do what, and that is one of the biggest things standing in front of us, especially the FDA's drug regulations that make it so difficult to innovate and so expensive to innovate. And if we change pricing without changing how we innovate, all we're going to wind up is with fewer drugs and a drug that you don't have for a serious disease is infinitely expensive because you can't buy it.

John Donovan:

Thank you, Paul Howard.

[applause]

The motion again, Blame Big Pharma for Out of Control Health Care Costs, and here making his closing statement in support of the motion, Zeke Emanuel, vice provost and chair of the department of medical ethics and health policy at the University of Pennsylvania.

Ezekiel Emanuel:

Let me remind you and Paul. We're not debating the FDA and its regulatory policy. We're not debating government regulation. We're not debating whether we want innovation or not. We all want innovation and we want cures for diseases like Alzheimer's. We're not here to debate all those things. We're here to debate drug pricing and drugs outrageously high prices.

01:35:02

Remember what I said at the start -- since 2008, drug prices -- brand name drug prices have gone up 164 percent. Regular inflation in the entire marketplace, 12 percent. In the last few years, drug prices have gone up two or three times more than every other segment of the health care market. And what's driving that are higher prices by -- higher profits by the insurance company than any other segment of the marketplace and any other segment of health care. They make more profits -- three times as much as the insurance company, sometimes seven times as much as other insurance companies. The other side wants you to say, "Look, we should change the deductibles and the co-pay so it's more affordable for people." It may be more affordable for people, but as Neera pointed out, it's hidden in your premiums unless we bring drug prices down.

01:36:00

Yes, your deductible when you go buy your medicine will be lower, but your premium will go up unless we take control of drug prices. So, we have suggested that it is drug prices driving health care costs, and what we need to do is to bring drug prices in line with their health benefit. If they're curative, we don't have a problem paying a real good price for it. But we don't want outrageously high prices for minimal health benefits. We want value-based pricing that ties the health benefit to the price, and that's not what we have today, and that's not where the pharmaceutical industry has been going. It's been going -- using its monopoly power to get as high prices as it can get, and that's why it's driving high health care costs. Vote for the proposition.

John Donovan:

Thank you, Zeke Emanuel.

[applause]

And that proposition, one more time, "Blame Big Pharma for Out-of-Control Health Care Costs." And here making his closing statement against that motion -- I'm sorry -- here making her closing against that motion, Lori Reilly, executive vice president of the Pharmaceutical Research and Manufacturers of America.

01:37:03

Lori Reilly:

Thank you, and thank you for having me tonight. I want to reiterate; drug spending is not the reason why we're seeing large increases in health care spending. Over the next decade, we're expected to spend an additional \$2.4 trillion on health care. That's a lot of money. 15 percent of that is expected to be as a result of drugs. But in that next decade, it's possible that we're going to see new medicines come to market that, for the first time, actually treat Alzheimer's disease. We're going to see medicines that add to our war chest of medicines in oncology. The progress that we can make over the next decade is significant, and I would argue, it's worth that 15 extra percent in health spending costs. Why is it worth it? Because today, there are millions of patients today that are clinging on hope. They're clinging that -- hoping that our industry is able to bring something to market for a disease that ails them.

01:38:02

Two years ago, I lost my mother to ALS, it's a devastating disease, where there is no treatment, there is no cure -- and quite honestly, today, there is no hope. And for patients, whether they have ALS, or Parkinson's, or Alzheimer's, or cancer -- I don't know another solution than innovation progressing in the future. We have done that in

HIV-AIDS. We've done it in Hepatitis C. And we're now at a point -- and we're on the cusp of doing it in many other areas. But we have to have the ability to move on. I think 15 percent of our health care dollar devoted to some of the biggest and boldest advancements we see in health care is well-worth it. We talked today a lot about prescription drug spending growth. We didn't talk at all about the 85 percent of health spending growth in every other area of our health care sector. We didn't question why the cost of a procedure goes up year after year after year.

01:39:00

That's a worthwhile debate to have. I'm not afraid to talk about drug costs, but let's talk about all health care costs, and how do we get to real solutions.

John Donovan:

Thank you, Lori Reilly. Your time is up.

[applause]

And that concludes round 3 of this Intelligence Squared U.S. debate, where the motion is "Blame Big Pharma for Out-of-Control Health Care Costs." And now, it's time to learn which side you feel has argued the best. We want to ask you, again, to go to the keypads at your seat and vote as you did at the beginning. Take a look at the motion. If you agree with it, push number one -- that's this team. If you disagree, push number two. That's this team. If you became or remain undecided, push number 3. And again, I'll wait for you to get done with that, and then I have a couple things to say while we're waiting for the results, which will be about a minute-and-a-half. You'll be okay on that train. Everybody's good on the voting? Yeah. All right. Let me say this.

01:40:00

We really -- we really, really aspire, in this series -- since Bob Rosenkranz started it -- to present a level of discourse that we can all be proud of -- to participate in. Interesting that it's set in relief of the last several weeks of a political discourse nationally that has been disappointing and discouraging. It's wonderful that we did what we did here tonight. And for that, I congratulate the spirit, the civility, the intelligence, and the gamesmanship of these four debaters. They were terrific.

[applause]

I also want to say this. I loved all of the questions tonight. That's not always the case. They all really moved the debate forward -- and including the question that I was going to pass on, and Neera jumped on it. And then I scolded her, and then she said I was mean -- and I want to say --

[laughter]

-- I want to apologize, because you proved --

Neera Tanden:

Oh, no.

John Donovan:

-- me wrong. You did a --

Neera Tanden:

No.

John Donovan:

-- very hard thing, bringing that question in. So, well-done.

01:41:04

[applause]

We really thank the Adam Smith Society, great partners in putting this on. Thank you to the Adam Smith Society.

[applause]

And also, we're doing a series over the next -- over the past year and in the year to come on health care issues. And we're doing that with the very generous support of a supporter named Thomas Campbell Jackson. I'm not sure if he's a stand-up-and-take-a-bow kind of guy, but I'd like to stand up and take a bow. Okay. Just the hands.

[applause]

He's refreshingly modest and we really -- so, you saw a hand go up. We appreciate that so much. And that -- the reason I bring that up, also, is because Intelligence Squared U.S. is a non-profit organization. We create these programs and put them out into the world through all of the channels that I've been talking about. They also are reaching a lot of classrooms.

01:42:00

I was on a CNN program over the weekend, and another one of the guests, who teaches debate out in -- what town -- oh, darn. I forget what school he was with -- what university. But he said to me, "I can't tell you how many students have come to join our

debating program because they've been listening to your podcasts and they're so excited about it."

[applause]

And we were really, really delighted about that. Our last debate pre-election is going to be at the Kauffman Center uptown. It's on October 26th -- that's on the Upper West Side. And this is another one of our topics that we're interweaving with the political discourse taking place nationally. The motion is going to be "Give Undocumented Immigrants a Path to Citizenship." And for the motion, we have Angela Kelly of the Center for American Progress. She advised the Obama White House on immigration, and Marielena Hincapie. She's the executive director of the National Immigration Law Center. Arguing against, we have Steven Camarota, who is director of research for the Center for Immigration Studies, and Rich Lowry, who is editor of the National Review.

01:43:06

After the election, we're going to be looking -- doing a couple of debates that sort of look at what we've just been through. And on November 14th, in Washington, we're going to be debating the effects of gerrymandering. And then, on November 29th, we're going to be debating the foreign policy legacy of President Obama. So, I think those are going to be great debates also, and you can get tickets on our website, and also visit the rest of our -- take a look at what the rest of our season will be, coming up next year. And you can also comment. And our website now allows you to actually debate with each other in a civil way.

[laughter]

There's a robot moderator there, much like myself. Okay.

[laughter]

So, the results are all in. Again, the motion is "Blame Big Pharma for Out-of-Control Health Care Costs."

01:44:01

Again, I want to remind you, it's the difference between the two votes that determines our winners. In the first vote, 33 percent agreed with the motion, 28 percent were against, and 39 percent were undecided. In the second vote, the team arguing for the motion, their second vote was 42 percent. That means they went up 9 percentage points, which is now the number to beat. The team arguing against the motion, their first vote was 28 percent. Their second vote was 48 percent. They picked up 20 percentage points.

[applause]

The team arguing against the motion has won this debate -- Blame Big Pharma for Out-of-Control Health Care Costs. The team against has won.

[applause]

Congratulations to them. Thank you from me, John Donovan, and Intelligence Squared U.S. We'll see you next time.

[applause]

Okay.

01:45:00