NATIONAL PRESS CLUB LUNCHEON WITH PFIZER CEO IAN READ

SUBJECT: HEALTHCARE AND THE PHARMACEUTICAL INDUSTRY

MODERATOR: JEFF BALLOU OF THE NATIONAL PRESS CLUB

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JEFF BALLOU: [sounds gavel] Good afternoon, ladies and gentlemen. And for those of you who are just now tuning in, our television audience and our public radio audience, and on the Internet, welcome to the National Press Club, where since 1908, we have been the embodiment of the Constitution.

Before we get started, I want to remind our guests here in the audience of some housekeeping rules, for those of you may have come in a little late. Please put your phones at least on vibrate, because we know you want to tweet, and we want you to follow the action. And so, on Twitter, you can follow us on @PressClubDC and using the hashtag #NPCLive.

And I want to introduce the head table. As I introduce each of you, please stand briefly as your name is announced, from my left and your right. Ferdous Al-Faruque, Senior Reporter at MedTech Insight, and the Treasurer of the National Press Club; Michele Salcedo, Desk Editor at the Associated Press, and the Membership Secretary of the National Press Club; Sally Susman, Executive Vice President of Corporate Affairs at Pfizer; Donna Leinwand Leger, Breaking News Editor at *USA Today*, and a past-President of the National Press Club; Kenneth Cole, Senior Vice President of Government Relations at Pfizer.

Skipping over myself for a moment, Kasia Klimasinska, Economy Reporter for Bloomberg News and Deputy Team Leader for the National Press Club Headliners Team which organizes all of our speakers here in the Club. Skipping over our speaker for a moment, Danny Selnick, Senior Vice President for Business Wire's Public Policy Wire, and the National Press Club Member who organized today's luncheon; Andrew Topen, Vice President of Global Media Relations and Digital Communications at Pfizer; Kathleen Parker, Syndicated Columnist for the *Washington Post*; Virgil Dixon, Washington Bureau Chief at

Modern Healthcare; Susan Jaffe, Washington Correspondent for *The Lancet*, and a contributing writer for Kaiser Health News; Alan Schleifer, Chairman of Fourth Annual Wharton DC Innovation Summit. [applause]

And I am Jeff Ballou, News Editor for the Americas for Al Jazeera. And now it's time to bring in our speaker.

As we gather, the healthcare bill intended to replace President Obama's signature legislative achievement is subject to small, maybe, internal conflicts within factions of the Republican Party – actually, massive – who, along with President Donald Trump, is driving the measure. As the salvos continue to be shot back and forth on Capitol Hill, some of the issues wrapped up in the debate for healthcare are accessibility and affordability and innovation. Some of the latter are tied up in obtaining lifesaving pharmaceuticals with prices that seem to keep rising and not falling.

One of the stewards of the drug industry is Ian Read, CEO, Pfizer Pharmaceuticals. If you've heard of tetracycline, the key ingredient to combat acne; Ibrance, which combats breast cancer; Lipitor, created to combat cholesterol; or that little blue pill, Viagra, well you know what that's for, all of that falls under Mr. Read's care.

But Mr. Read doesn't come from research and development labs, like penicillin, which helped put Pfizer on the map, but the financial house as an auditor. Which may be good training because Mr. Read and his counterparts are under tremendous fire to make, for example, $100,000 cancer drugs more affordable without having patients needing to apply for special assistance programs. Or, in Pfizer's direct case, under fire by being fined a record 84 million pounds – or $105 million for you and me – for overcharging Britain's national healthcare system.

It's also taken heat from both sides of the aisle, from the President of the United States and from Democrats in past years like former Senator Carl Levin for uprooting their headquarters from their humble beginnings in Brooklyn and going to Ireland for better tax deals. Which they contend is for better job growth.

The Trump administration, for its part, believes the price of prescription drugs can be lowered by simply cutting corporate taxes to keep the companies from moving overseas. However, Mr. Read feels that there is no need to alter its drug-pricing practices in a story in Reuters in late January, and that the President doesn't understand his industry.

We will talk about these and other issues, along with a robust question-and-answer period, but after opening remarks. Please give a warm National Press Club welcome to Ian Read, the CEO of Pfizer. [applause]

IAN READ: Good afternoon. Thank you to the National Press Club and Jeff Ballou for this opportunity and wonderful welcome. I'm delighted to be here with you today.

At Pfizer, our culture values straight talk. I actually have a coin – I won't bring it out today – that expresses that philosophy. So today I want to have a candid conversation with you about the risks and drug discovery and development; the economic contributions of our industry; the barriers to patient access to affordable healthcare, including medicines; and some observations regarding how we can create a healthcare system that supports innovation and provides patient access.

Drug discovery and development: If you think back to what treatments were available in the 1940s – I know most of us can't do that – they were available for infections, depression, ulcers, blood pressure, Parkinson's. Those are almost nothing. You could look at a TV ad and see a patient in front of a doctor in black-and-white and the medicine cabinet behind that physician, and he'd turn and it was bare.

Today that is not the situation. Today we have incredible medicines that have turned fatal illnesses, like HIV and AIDS, into chronic conditions. Slowed progression for rheumatoid arthritis; cured a disease such as Hep-C; helped to prevent childhood illnesses with vaccines; provided treatment for painful ulcers and GERD. And if you have GERD, which is reflux, it makes your life a misery. It's not a trivial thing to be able to take a pill once a day and not have that issue. And of course, GERD leads to cancer and other conditions. And in cancer, we're developing new immunotherapies that harness the natural ability of the body's immune system to recognize and fight cancer, along with the other amazing discoveries we've made with small molecules in chemotherapy in the previous 20 years.

In fact, in 2014 and '15, more than 40 new medicines were approved by the FDA. Many of these medicines were for rare diseases, cancers and other conditions where there were no good treatments available. The pipeline across the biopharmaceutical industry for new medicines has never been more promising with more than 7000 medicines under development around the world. And an average 70% of drugs across the pipeline are potentially first-in-class medicines; that is, that drug has not been discovered before, that mechanism has not been discovered before.

So to what do we attribute this progress? I believe it's the result of focused investment in the highly risky undertaking of drug discovery and development, combined with advances in basic research from our universities and the NIH and other types of institutions.

From discovery through FDA approval, developing a new medicine, on average, takes 10 to 15 years and costs $2.6 billion. Now, that's the number from Boston University. And less than 12% of the potential medicines that make it to Phase 1 clinical trials are approved by the FDA. Now, you can look at this study, and it's complex, and you can quibble about how it was done. I can give you a very easy way of knowing what it costs to develop a drug. Pfizer spends $8 billion a year. On research and development. We were lucky if we produce three drugs a year. I don't need the study to know what it costs to bring new drugs to society in today's environment.

For example, between 1988 and 2014, there were 96 unsuccessful attempts and only seven new drugs developed to treat melanoma. Ninety-six unsuccessful attempts. In brain cancer, there were 75 unsuccessful attempts, and only three new drugs. And in lung cancer, there was 167 unsuccessful attempts, and ten new drugs, one of which was Pfizer's Xalkori.

To discover and develop a new drug, the biopharmaceutical industry spends on average six times more on R&D as a percentage of sales compared to other major industries in the US. In 2015, the industry invested a combined $58.8 billion in research and development. That's 28 billion more than the entire NIH health budget. Of which only a fraction is dedicated to drug discovery.

The drug discovery process is complex and not well understood. After 38 years in the industry, I'll tell you it's probably one of the most complex undertakings that humanity has – to take an idea and shepherd it through the drug discovery process over 15 years, ensuring excellence at every stage and data at every stage, to finally get a drug that can be taken by humans with a positive risk/benefit equation. So let's briefly review what it takes to discover, develop and bring a new medicine to patients in somewhat layman's terms.

The process begins with basic research, undoubtedly done by researchers who are at academic institutions and government institutions like the National Institutes of Health. These researchers find, postulate – postulate, sometimes find – biologic pathways that give insights into a disease or possible approaches for treating that disease. This is a critical step, but it is light years away from having a medicine that can treat your condition.

The pharmaceutical industry draws from these basic research findings once they've been validated. Normally in academia you publish, it gets validated by somebody else, then validated. You understand. The understanding improves. At that point, the industry may begin a drug discovery process from those original scientific findings. Our scientists take this understand and translate it into a research hypothesis, often through animal models, that begin a 10- to 15-year journey to get a medicine to patients.

We discover a molecule, create a molecule, synthesize a molecule, large or small, that we believe will interact in the right way with a target pathway. We run studies to ensure the molecules, large or small, have what we believe is the desired biological effect. We verify the compound's pharmacokinetics and pharmacodynamics profile in how to fix the body. And we run multiple toxicology studies to determine safety prior to beginning initial trials in humans.

At that point, we then conduct early studies, referred to as Phase 1 and Phase 2, to understand the right dosing and assess the safety, efficacy and quality of the compound, and identify the right patient population. One Phase 2 has been passed for safety and efficacy, we conduct large Phase 3 trials, thousands of patients – the largest one Pfizer ever conducted was 85,000 patients – to prove the risk/benefit of the drug. And then we submit this data to a regulatory body like the FDA for approval.

This process has many interactions and false starts. Very often you start with a basic drug substance. You believe it's going to be efficacious, but it's toxic. Or you remove the

toxicity and you find it's no longer efficacious. There's multiple attempts to try and get the right medicine with the right distribution that its risk/benefit profile is favorable.

To best illustrate this process, I'll share with you a Pfizer example using Ibrance, our first-in-class drug for the treatment of advanced breast cancer, one of the deadliest, most poorly understood cancers. The Ibrance journey started in 1990 with original research done by independent researchers that identified and characterized cyclin-dependent kinases, which are key regulators of cell growth division. Through collaboration with researchers at UCLA, we were able to identify the right patient population for our compound. And by 2008, we had an acceptable molecule that we believed appropriately interfered with the cyclin kinase to disrupt the growth of tumors.

This result was that after 25 years of initial basic research, we had a CDK inhibitor. And seven years after the first patient was dosed in clinical trials, Ibrance was approved by the FDA. More than 55,000 patients in the US alone now have been treated by Ibrance since its approval in 2015.

And before the drug was even approved and launched, we began conversations with the healthcare community. We spoke to more than 80 payers, more than 20 breast cancer experts, and more than 100 oncologists to build an understanding of the value of this medicine – what it does, what it does against competition, what advances it gives, how it changes people's qualities of life, how it extends their life. And based on that input, we negotiated with the plans and the payers a price and access for Ibrance.

We continue to make significant investments in Ibrance. It has been studied in patients with early breast cancer, and there are 34 ongoing investigated and initiated research programs across various non-breast cancer tumors.

And after two years on the market, two years, there are two competitors – one approved and one in development. And that's how the market evolves. You get a patent on your molecule, you don't get a patent on treating the disease. Your molecule has to have superior efficacy or superior characteristics to be successful. And more and more, we're followed in very quickly by competitors with similar-looking molecules.

Today, there are other therapy stories like Ibrance – Pfizer's Xalkori for patients with advanced non-small cell cancer whose tumors are alk-positive and ros-positive; Merck's Keytruda, for melanoma and non-small cell lung cancer; and Gilead's Harvoni for hepatitis-C. These new therapies are the result of improvements in our understanding of biology, enhanced collaboration and translational research with academics and research institutions, and huge investment and risk-taking by the industry.

Let's talk about economic contributions to the industry. A continued stream of new treatments won't flow if society is not willing to fund and support a modern biopharmaceutical industry that gets cures to patients. I'd like to note that in 2014, the biopharmaceutical industry in the United States represented 3.8% of total US output, which amounts to an impact of more than $1.2 trillion.

When you take into account the value of goods and services produced by the industry and their total impact on the economy, $1.2 trillion. This includes the economic activity of its workforce and more than 4.4 million jobs across the US economy, including direct and indirect vendor and supply jobs.

That being said, I want to be clear: We understand our responsibility. Every scientist understands their responsibility. And we at Pfizer understand our responsibility – to produce medicines that bring significant value and that are competitively priced. We're working towards an understanding by society of the investment we make, the risks we take – and by we, I mean our shareholders, the people who fundamentally fund Pfizer – and appropriate return on the totality of our investment. A successful drug will normally be profitable. Unfortunately, there's a lot of dry holes on the way to a successful drug. And you need to have a cash flow to support the entirety of the biopharmaceutical ecosystem.

Let's talk about access and transparency. We understand the access issues of patients and what they face with co-pays and high deductibles, and the need for value chain transparency in this process. We gave away for free to 250,000 patients in the US 1.7 million prescriptions in 2016, because the process is broken. Those patients need to come to us at last resort because the insurance system is failing them.

Transparency should allow patients and physicians to make the right choice for the intervention that delivers the most value. That's transparency. How does the physician know what the best product is? How does the patient know that they're getting value from that product? However, we know that patients are paying higher out-of-pocket costs and a greater percentage of the cost associated with life saving or medicines to improve their condition as compared to expensive interventions like hospital admissions, emergency rooms, physicians' diagnosis.

On an average, patients in our insurance system paid 3% of the cost of hospital care out of your own pocket. However, you're asked to pay 15% out of your pocket for drug costs. This is not transparency. Most consumers do not know this.

Rather, medicine reimbursement costs are often used by the system, insurers and providers, to avoid adverse selection. Adverse selection is when you have a higher proportion of sick people in your plan than your competitors.

When considering transparency and patient access, the value of the entire healthcare system needs to be taken into account, not just pharmaceuticals, which represent 12% of the total healthcare system's costs. We need to consider two factors, I believe: visibility and understanding what you're getting for your insurance, make it clear to the patient; and a patient-focused benefit design that meets the patient's needs.

I'd like you to use the analogy that patients need solid insurance, good insurance, similar to the type of insurance you have for your homes. If a person's home is destroyed by

fire, their insurance company covers the majority of the costs to rebuild the house. People know what they're getting. They're able to rebuild their house.

When it comes to your health, you should be able to have insurance that covers diseases like cancer or rheumatoid arthritis without having to bear the burden of the majority of the expense. Individuals cannot afford modern pharmaceuticals. It has to be done through an insurance system or a risk-sharing system. The costs to produce and bring safe, effective drugs to market are out of the reach of individual pockets.

However, the way insurance plans are currently designed, prescription costs are shifting to patients in order to contain costs in the short term. A lot of the plans now have large co-pays, $6000 deductibles before you get to any repayment. No first-dollar payment for pharmaceuticals. This is not good insurance.

There are little incentives for the prevention or cure over the long term. In many cases, benefit designs are constructed to avoid sick patients. For instance, previous to the Affordable Care Act, we have a product called Chantix, which helps you stop smoking. Insurance companies wouldn't cover it. Why not? They don't want smokers on their insurance rolls; they're a bad risk. So we had great difficulty getting access for Chantix in the insurance system.

Hepatitis-C, let's look at that example. One example is the pricing discussion that occurred when hepatitis-C treatment was introduced. The crux of the debate was not about the value of the drug. The evidence demonstrated it's cost effective, and I'll discuss that in a moment. The debate was really about the short-term impact on Medicare and managed care budgets of an uninspected, expensive, high value medicine which they hadn't budgeted for. They have no risk adjustments for it.

So before hep-C was available, the average annual cost of the healthcare system for treating a patient with hep-C, depending on which stage they were in, was $60,000 per year for patients with end-stage liver disease, $112,000 for patients with liver cancer, and $500,000 per patient for those receiving a liver transplant. And average expected lifetime patient cost to treat all stages of hep-C was $205,000, approximately.

Compare these costs to the fact that more than 90% of patients with the most common form of hep-C can expect to be cured with the new hep-C drug in as little as eight weeks. This is a lifetime cost now of slightly more than $40,000. And because of intense competition, the cost is now 50% less than the initial cost it was launched at.

Let's look at returns of the industry. I think there are many ways that the pharmaceutical industry, we can point out, benefits society. There are various ways of looking at it. The transparency bills you're seeing in most of the states are not an appropriate way of measuring the benefit of the pharmaceutical industry. The drugs developed by the industry have built-in incentives for innovation and cost containment through patent expirations. To Jeff's point, assuming that the drug, once it's approved, only has half of its

patent life left – patent is not 20 years; effective maximum patent life you can get is 14 – once the patent expires, the drug is broadly available in the form of generics.

Today, more than 90% of new prescriptions are for generics in our healthcare system. They are available forever to society at the price of generics. They would not have been available if they weren't discovered, if there was no innovation money for their discovery.

Another indicator, broadly, of equitable return is shown by the industry's financial performance. Of course, a successful drug is highly profitable. That's a real insight. If you look at the average return of the pharmaceutical industry over the last five years compared to 25 other major industrial sectors, including consumer, software, services, telecom, energy and insurance and healthcare, managed healthcare, the pharmaceutical industry ranks 19th in terms of price-to-earnings ratio, out of 25 – a key indicator of the growth prospects of a company, the price-to-earnings index. Eleventh in terms of return on equity; ninth in terms of return on capital; and ninth in terms of return on assets. I see no evidence of extraordinary return in the pharmaceutical industry compared to the other industries that are in the Bloomberg index.

It's also noteworthy that since March 2010, the return of the pharmaceutical industry has been lower than the largest health insurance companies, including United Health, Aetna, Cigna, Humana and Centene. As a whole, these companies outperformed the S&P 500 stock index, which returned 135% over this time period. Collectively, these insurance companies gained nearly 300%, including dividends, while the pharmaceutical industry returned 91%, including dividends – less than the S&P and far less than the insurance companies.

Overall, I think it's fair to say that we're being responsible when it comes to the pricing of our medicines. We're producing great value for society and simultaneously taking large financial risks due to the uncertainty of the drug. We don't set prices; we negotiate prices. We negotiate on the value of the drug, the value to society. And the arbiters of that are the insurance companies and the payers.

There are two examples to demonstrate if you want more specifically the value of what we do. In ten years, statin use has generated nearly – and this is from accredited health economic magazines – nearly 1.3 trillion in economic value to the US, of which around 950 billion was retained by society with around 20% of the value accruing to the industry through the revenue from selling the drugs. So we retained 25% of the total value of statins. At the same time, the cost of statins have now gone down 90%. Society now has that benefit of that invention forever at generic pricing.

From 1988 to 2000, improvements in cancer survival created an estimated 23 million additional life years, creating 1.9 trillion of additional societal value. Eighty-one percent of that value accrued to society; 19% accrued to the pharmaceutical industry. However, we understand that while drugs are highly cost effective, our health ecosystem is making it difficult for patients to get the healthcare they need at a cost they can afford, especially in lifesaving medicines.

I believe we have a collective opportunity to start mending our broken system by working with all stakeholders and making sure the voice of the patient is heard. We believe there are four tenets required to create a healthcare system that meets patients' needs:

We need to provide all patients with access to quality healthcare coverage, coverage that includes preventative care, access to cost-effective interventions like medicine, and comprehensive care for diseases like cancer. We stand willing to play our part in helping patients have access to those medicines. We do already with our patient assistance programs.

We need to have incentives for prevention-based healthcare that reward people for good health and provide financial incentives that enable providers to manage risk and encourage prevention. We need to get the right incentives in the system, incentives to pay for health, not for the treatment of illness.

If health plans and providers were compensated for improving health over the long term, and patients were rewarded for investing in their health, all parties would benefit, but especially patients who would have good insurance and patient-centered benefit designs that cover high value treatments at affordable co-pays.

We need to base decisions regarding healthcare on long-term value and not one year's budget. And I've always looked at both sides of the ledger. Let's not just look at this year's pharmacy bill. Let's look at all the costs of the healthcare system and all the healthcare costs saved while using this medicine. Long-term outcomes versus short-term financial budgetary considerations.

And we need to base our solution on competitive market principles. Get the right incentives for the whole healthcare sector in the right place. Specifically for the pharmaceutical industry, I'd say we need policies that spur public and private funding. Most laboratories, most companies like Pfizer have a huge number of projects we don't progress; we just can't simply afford it. We just cannot simply cover the cost of capital.

We need increased investment in manufacturing. We need regulatory reform that accelerates the potential of today's scientific advancements and accelerates the development and approval of life-changing medicines while also eliminating the backlog of generics. And we need favorable tax and trade policies that create a level playing field, protect American intellectual property and remove barriers to access.

We believe committing to each of these ideas can lead to an efficient market-based system for all segments of the healthcare ecosystem – providers, payers, biopharmaceutical companies, and more importantly, and most importantly, patients.

With that, I'd be very pleased to take your questions. Thank you very much. [applause]

MR. BALLOU: Just a housekeeping note on questions. If you have a question, you're here in the house, you have these cards on your table. You may write down your

questions and pass them up to either end of the head table. We'll sort through them and we'll try to get to as many as time allows.

You like the gavel? It's a replica of George Washington's gavel given to me at my inaugural.

First of all, as you can imagine we have quite a few through the Internet and so forth. We have a bunch of different questions. I have not seen all of these questions in depth and, just for the record, neither has Mr. Read, so he has not been prepped for these things, as it should be.

This question actually comes from one of our board members who actually covers healthcare for National Public Radio: What do you think of the negotiates on the healthcare bill on Capitol Hill? And specifically, lawmakers today are debating whether insurance policies should be required to have a minimum level of benefits to qualify for tax subsidies. These include prescription drug coverage. And do you think these so-called essential health benefits should remain in law?

MR. READ: I can't give you any prediction. I'm not a politician, I'm a businessman who's trying to get important cures for patients. What I would say is that we would support, or we do support any system that ensures patients get access, that their incentives are in the right place, that there's choice in the system, and that people get the ability to choose the insurance they need for the particular time they are in their life. And we do believe old people should choose to have insurance.

As regard having essential benefits, I think it's a situation of, my preference is less regulation and more market-based incentives is the right way to answer that issue. But you do need a safety net. So I believe the law should have an appropriate safety net for people who cannot afford insurance and who have preexisting conditions.

MR. BALLOU: Just a quick follow-up, because this is sort of breaking. The House Freedom Caucus chair says there's no deal on the House Republican bill to replace the Affordable Care Act. What's the impact on the industry from your vantage point? That President Trump has been saying, "I want this bill. I think I can make a deal." And he's told you directly something you criticized about that he doesn't understand your industry.

MR. READ: I don't believe there's any short-term impact for the industry. I think there's a tremendous impact for patients, short term.

MR. BALLOU: What would that be?

MR. READ: Short term, I think you'd see a system of the Affordable Care Act that is collapsing. It's pushed into existence no first-time coverage for pharmaceuticals. It's pushed into existence 6000 deductible before you get to any, any, reimbursement. For instance, when *King v. Burwell* was being discussed, we looked at what would happen if they had struck down the federal exchanges. And we decided that we would provide our

medicines for free to everybody who were on the exchanges. Cost to Pfizer? $40 million a year. In a $52 billion corporation, that's nothing. Because no one's using our medicines in the exchanges, because the exchanges don't provide them access. So I think we do need to reform the healthcare the way it's delivered, and the consequences will be with patients.

MR. BALLOU: But a lot of people had the perception that the pharmaceutical industry's a very powerful industry. Couldn't you prevail upon– is it just the layman's thinking that you couldn't prevail upon the insurance industry to cut a decent deal for patients?

MR. READ: The insurance business is in the business of taking more revenues than they pay out in premiums. [laughter]

MR. BALLOU: True. So therefore, has no incentive to–

MR. READ: That's their business.

MR. BALLOU: Well, moving on. [laughter] A question from the audience: The American Medical Association, the American Hospital Association and the American Association of Clinical Physicians, as well as many other healthcare groups have expressed their opposition to the current Republican Affordable Health Care Act bill. Does Pfizer also oppose this bill? And if so, why? If not, why not?

MR. READ: We're in a democracy. Everybody can express their own opinion. Pfizer has not expressed a formal opinion on the present bill in front of Congress. We support principles that we'd like to see enacted, like ability to access medicines, reasonable co-pays, fairness in the system, choice in the system. We support those elements of any plan.

MR. BALLOU: What specific regulatory reforms would you like to see at the Food and Drug Administration?

MR. READ: I'd like to see a message from society to the Food and Drug Administration that they want the Food and Drug Administration to move more towards a better balance between risk and benefit. I think the FDA has been set up and has been conditioned by society and conditioned by Congress to be extremely conservative and not willing to take the appropriate risk-to-benefit view on the development of new drugs.

MR. BALLOU: Speaking of which, what do you think of President Trump's pick to head the FDA? Like him? Don't like him?

MR. READ: Do you know, Dr. Scott, the doctor, I've met him in business situations. I think he's a respected physician. He's certainly been a regulator. He knows the FDA. I think he was there as a deputy at one point. So we look forward to working with him and the Administration to ensure that our drugs get to patients as quickly as possible.

MR. BALLOU: What's Pfizer doing to control the misuse and excessive prescription of its highly profitable opioids?

MR. READ: I'm not sure I necessarily accept the premise, but we produce opioids because they're an extremely important part of the healthcare system for people who need to deal with chronic pain. We promote these products strictly on label to physicians. And we also have a product, as you know, naloxone, which can rescue you from an overdose. That we're making available at $11 for one treatment, which I believe seems a very reasonable price if it saves somebody's life. It's one injection. We've also given a million dollars to the states and a million doses of naloxone to the states who are ravaged by this condition. I mean, opioid addiction is destroying families and destroying parts of our society. So we will support anything that allows the appropriate use of opioids.

MR. BALLOU: If you can make that drug available for $11, why not lower the cost of Ibrance?

MR. READ: Because we have to look at what the value of Ibrance delivers to the healthcare system and the cash flows that we need to continue doing research in cancer. So it's a matter of what value does the drug deliver, and we need to recover that value. Because if we don't, we can't continue to invest. This is why I use the macroeconomics for you. If we had a return on capital of 25%, then I think society could say, "Wow, that's a pretty rich return on capital." Our return on capital as an industry is around 11%. It's not that healthy. The starting return on capital is 8 or 9% that your shareholders require.

So you have to understand that our focus is, what's the value of the product? Can we recover a portion of that value? I noted to you that in statins and in cancer, we recover 20% of the value. So we're conscious of affordability. We negotiate with the health plans to ensure that they see the value in what we've provided. That's how we price.

MR. BALLOU: Different question. You harped on transparency a lot, and accessibility. Yet, in the state of Massachusetts your company had to be subpoenaed to have information on your donations to patient assisted groups, because essentially the Massachusetts prosecutors felt that you were contributing to the inflation of costs [simultaneous conversation]

MR. READ: That's their point of view. I would argue that what we do is totally within the rules of the OIG. We feel we're completely within the present regulations and laws. And so, we act accordingly. But we are cooperating with his investigation.

MR. BALLOU: You mentioned that the insurance system is broken. Healthcare obviously is front and center. What's the one thing you want Congress to know?

MR. READ: Get the incentives right. You get a system to work if incentives are right. You don't get a system to work by regulations. You fine-tune a system with regulations, you ensure some equity through regulations. But if I was to wake up tomorrow and redesign the healthcare system as one person's view, most people stay in the same

geographic area. They don't switch hospitals the way we switch insurance companies or providers or doctors. I think the risk and the reward should be placed on the providers in our system. They should be compensated for taking that risk. And if they're taking that risk, they're totally incentivized to look to the health of their population and not the number of treatments they give that population. That would focus them truly on healthcare. And they would hold the patient for most of their life, so the incentive and risk should be held there. Insurance companies could provide a service of adjudicating the level of sickness of the population so there are appropriate transfers to those providers. That would align incentives.

MR. BALLOU: There's a lot of questions, as you can imagine, about Congress and about drug prices. What concerns do you have about Congress getting into the drug-pricing market as they debate this latest version of healthcare?

MR. READ: I think I don't believe that price controls in any part of our economic activity produce choice or opportunity or innovation. And so, I would advocate against any type of price control. It's a very blunt instrument. It won't allow innovation. It won't allow the huge cures we see. And it won't allow the diversity in choice. So I think it's a bad policy.

MR. BALLOU: According to one of the trust journalism transparency sites, *OpenSecrets.org*, your company spent 2.7 million on political donations, and another 9.7 on lobbying. What did it get you?

MR. READ: What we spend on, and I can't really confirm or deny those numbers because I don't really know if–

MR. BALLOU: It's right here.

MR. READ: You can stand there; I don't know where they come from. But my point of view is that we have to, as part of society, be part of a legitimate discourse with our regulators and the people who regulate us, and the political class. We have to be involved. We have to advocate for choice and access and low co-pays. We have to be part of society. This expenditure is part of the political discourse, which we think we're entitled to as a company.

MR. BALLOU: And what does that mean for the little guy and gal who's not walking around with that kind of money in their pocket, in terms of the voices to Congress.

MR. READ: Well, I think every part of society has different ways of expressing their views. And they join associations, they can express their views individually, they can write to their Congressmen. They don't spend that sort of money because they're not trying to interact with the 50 states and all of the Congressmen and all the Senators and all of the regulators and inform and educate. So they don't need to spend that type of money.

MR. BALLOU: The US Veterans Administration pays some of the lowest prices for drugs, doing bulk purchasing. Should that be expanded?

MR. READ: It's not due to bulk purchasing. There's an agreement, there's a deal. That a deal that was–

MR. BALLOU: So you disagree with the premise of the question.

MR. READ: Yes, it's not due to bulk purchasing. There's a deal that was struck a long time ago, and the United States is a prime example of nobody pays the same price for their medicines. It's a marketplace. And there was a deal struck that basically says that we, as an industry, accept that the veterans are a population in need of additional care, and we provide our product close to non-commercial prices to the veterans. And we do that on the basis of those prices don't affect the prices that we sell to Medicaid. And the prices we sell to Medicaid, which are highly discounted, don't affect the prices we sell to the private sector. This allows us to create access for the most unfortunate members of our society, while preserving a business model that allows us to continue to fund innovation.

MR. BALLOU: So there's no way to extrapolate that model and keep your industry solvent?

MR. READ: No, no. You could extrapolate that model. And this is what the Europeans do; they're monopoly purchasers. By the way, it's an oxymoron saying you negotiate with governments; you don't negotiate with governments. [laughter] You take what they offer you if you've already got all your investments sunk. So the result of extending those preferential prices would mean a substantial reduction in the total volume spent on research and the opportunities for new products. Without the US market, there would not be the tremendous expansion in the innovative therapies that are available today and will be available in the future. Basically, you're seeing Europe freeriding on American innovation.

MR. BALLOU: And so, how do you balance the scales, then?

MR. READ: You need good trade agreements where intellectual property is protected.

MR. BALLOU: Speaking of trade agreements– [laughter]

MR. READ: That's one solution.

MR. BALLOU: The President, of course, bailed on TPP. What's the impact?

MR. READ: We didn't support TPP because it was really bad for our intellectual property. It didn't give us 12 years on biologics, which we have in the US. Most of these countries, if you look at Canada, if you look at Australia, if you look at New Zealand, all highly developed countries, all freeriding on inventions in the United States. If you look at access for their population– I don't have exact numbers here, but I think if you say there were 100 new products authorized in the United States, Australia and New Zealand, their population only has access to 30% of them. The UK, they have access to 47% of them,

normally, two to three years later than the US. Their citizens are not getting quality healthcare.

MR. BALLOU: So you're saying that's why Canada is cheaper?

MR. READ: Canada is cheaper because of rations. And Canada is cheaper because it can, because it freerides off American innovation. In our industry, let me be very clear here, we have sunk all the money up front. You're not paying for the pill. The pill is an artifact. What you're paying for is all of that clinical trial, all of that knowledge, all of that experimentation, which tells you that pill will do what it will do. The pill is irrelevant. It's just a way of getting that into your body.

And so, once you've done all that work, you're very subject to commercial blackmail. Because you need to try and recover as much money as you can from the sale of that intellectual property. And therefore you're forced by monopoly-purchasing governments to say, "Well, I know you get $100 in the US, and that's a market raise price, but we're not going to give you access to our market at all." And you have a choice. You can either say, no, in which case you get no funds to support your research, which means prices go up more in the US. Or you say, "Okay, what can I negotiate?"

Oh, and by the way, if you say no– I'll give you the example of Ibrance, to make it very clear to all of you. Ibrance is a huge advance. It allows women with metastatic breast cancer – estrogen-positive/HER2-negative, I've got to say that or the FDA will kill me – it gives them 24 months against the standard of nine of survival. It is an incredible revolution in the treatment of this cancer.

You go to the UK and the UK government has assessed this and is offering us pennies on the dollar. Pennies. And the problem is, I can say no, which I have, and we'll walk away. But Novartis is there. Lilly's there. The next company's there. And all of them have invested the money up front, and all are incentivized to try and recuperate something from that marketplace.

You cannot negotiate with governments.

MR. BALLOU: But on a slightly related scale, you remember when former President Bush teamed up with former President Clinton on PEPFAR and other things, going to third world countries to try to lower drug prices there. Can't that sort of same thinking be brought back here?

MR. READ: We do. That's why we give away 1.7 million prescriptions.

MR. BALLOU: But more than giving away the prescriptions. I'm talking about the pricing.

MR. READ: The price has to reflect the value of what you produce. If not, you don't have an economic system that makes sense. The price has to dictate where do you put your

resources? Do you put it into rheumatoid arthritis? Do you put it into cancer? Do you put it into mental disease? Pricing reflects economic value. And you need that to give choice. So if you distort those market signals, you distort everything we do. And so, our responsibility is to produce the best and greatest medicines we can that make the biggest impact on human life. And then to price it at a value that allows us to continue to do that work with a reasonable return to our shareholders. That's what we do. I've just shown you the indices, the return we get in the stock market. It's in the middle of the road. It's not at the higher end of what some industries earn.

So in the end, ignore the insurers in this, it's not that. It's society's decision of how much do they want to pay for innovation. And if you don't want innovation and you don't want the next cures, then price control. If you don't want innovation, then say you have to sell all of your drug prices at the same as you give to the veterans. These are not economic prices. These are prices for different segments of our population that have great need.

This industry needs to have a return that allows it to continue to do its research.

MR. BALLOU: But you get the perception. Because of the revenues of yours and other related companies, that was very popular during the presidential campaign in its populist speech–

MR. READ: It's always populist.

MR. BALLOU: But you get the whole notion that they're saying, "Hey, you're earning umpteen billion dollars in revenues. You can't cut us a break? What do you do with that perception?

MR. READ: Well, that perception needs to be addressed by really good insurance. It needs to be addressed by saying that we as a society want to take care of women who have metastatic breast cancer and we value, through our market mechanisms, this product at this price. If you didn't, I wouldn't be selling it at that price.

MR. BALLOU: So you're basically saying it's not your problem?

MR. READ: No! If we could advance, if we could speed up the FDA, if we could get drugs to market in less than 15 years, if we had a regulatory system that encouraged innovation, we could bring lots more drugs to market, which would lower prices. What I'm saying is, we advocate for ways of making our industry more productive. The more productive we are, the lower prices will be. Because there'll be more competition. There'll be more products in the market. And that's what drives pricing.

MR. BALLOU: We'll cut down on the follow-ups because we're running short on time. You said effective patent life is closer to 14 years. But what are your thoughts on evergreening? Alex Matter, a discoverer of Glivec has even said the practice is unethical.

MR. READ: Well, I'm not quite sure. Do you want to define what that term means, evergreening? Let's assume I'll take the common expression of it. It's where you take a molecule that is once a day and you change it so that it's now once a week. It has some value. If society wants to pay for it, they'll you for it. If they won't, they won't. In a market-based system I don't condemn it, I don't applaud it. It's up to society to decide, do they want a once-a-week treatment against the once-a-day treatment. Sometimes that's really important. If you're injecting yourself every day, that's an advance. If you're taking a pill once a week compared to once a day, it's pretty irrelevant and nobody should be paid a premium for that. And society does that.

In the US, in fact, you can't make money by evergreening. We don't. We have Lyrica, which is a product that's– we're bringing out a once-a-day formulation. But we started the research 12 years ago, and there were delays and delays and delays, and it's come to the market too late. And it won't protect our patent or protect our sales. I think in today's society, evergreening is a pretty failed strategy.

MR. BALLOU: Earlier this year, Bill Gates offered seed money to help develop vaccines for emerging diseases that could lead to global epidemics. Such vaccine development is generally unprofitable for pharmaceutical companies. What should be done to encourage drug companies to embark on such research?

MR. READ: Very simple: get the incentives right. You want an antibiotic that is– there is a dearth of new antibiotics. It's a product that you want people to invent and discover, but you don't want them to sell. Because you want to keep the antibiotics in reserve. So you need to find a way of creating an incentive to develop the antibiotic that's not related to the economic return of the antibiotic – for pandemics, Ebola, all of the diseases we could be subject that come out of the tropical forest or come from outside of the United States.

You need cures, but you can't make money from those cures. So the way to do it, I believe, is a transferable exclusivity voucher. If the FDA said to the community, "If you bring up a new antibiotic with these characteristics and we approve it, we'll allow you to extend the patent on one of your existing products." Now, that's an incentive. That would fuel not only some big companies, everybody will be looking at antibiotic development because they'd be able to sell, the small companies, they'd be able to sell their development to larger companies. The whole ecosystem would be invested in finding new antibiotics because there's an incentive that's fair to society and fair to the capital that goes into funding these research projects.

MR. BALLOU: We had Sylvia Mathews Burwell here before she left her post. She feels healthcare is a right, not a luxury. Your view?

MR. READ: Well, it's a right to the extent that society is willing to fund it and pay for it. And clean water is a right, to the extent that we've got sanitation and we pay for it, but we value it. I don't want to get too political or philosophical here, but there are very few rights in our Constitution. Intellectual property is one of them.

MR. BALLOU: Before I get to the last couple of questions, a couple of calendar announcements. Upcoming luncheons include AFL-CIO Chair Richard Trompke on April 4th; IRS Commissioner John Koskinen, just in time for Tax Day on April 5th; Joint Chiefs of Staff Chair General John Dunford will be here on April 21st; and ballerina Misty Copeland will be here on April 17th talking about her new book, *Ballerina Body*, on April 17th.

Before I give you the last question, we have a tradition here. Everybody, from Nelson Mandela, to Benjamin Netanyahu has received this mug. [laughter]

MR. READ: The same mug? [laughter]

MR. BALLOU: Not the same mug! It's yours.

MR. READ: Thank you very much. [applause]

MR. BALLOU: So the final question: If you became the czar of healthcare in the US, and had a guarantee that all stakeholders would live up to what you would be doing behind you, what would your recommendations look like? Or one recommendation?

MR. READ: Well, I think what I just described. I think I believe in choice and market-based solutions. I think our healthcare has been hugely distorted by a lack of incentives being in the right place. I feel that we need to go back to the physician/hospital/provider relationship with the patient. We need to provide incentives for the providers to look after their population and maintain health, and not be paid for how many MRIs they can do and how many X-rays they can do on a transactional basis.

So get the incentives right. Pay the physicians to keep people healthy. And everything else will align very easily.

MR. BALLOU: Thank you, Mr. Read. This concludes this National Press Club Luncheon. For more information, please go to our website at *www.Press.org*.

We are adjourned. [sounds gavel]

[applause]

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