6 November 2020

Standing Committee on Health
Sixth Floor, 131 Queen Street
House of Commons
Ottawa ON K1A 0A6
Canada

Eli Lilly Canada Inc.

P.O. Box 73, Exchange Tower
130 King Street West, Suite 900
Toronto, Ontario M5X 1B1
1.416.694.3221 | 1.800.268.4446
www.lilly.ca

RE: GUIDELINES OF THE PATENTED MEDICINE PRICES REVIEW BOARD (PMPRB)

Thank you for the opportunity to provide comment on the Guidelines of the Patented Medicines Prices Review Board (PMPRB), which were issued October 23, 2020.In providing this input, it is important to underscore that the serious flaws that mar the new PMPRB Guidelines stem directly from poor policy in the amended Patented Medicines Regulations.

Lilly Canada was established in 1938, the result of a research collaboration with scientists at the University of Toronto, which eventually produced the world's first commercially available insulin. The company built its first facility in 1946, and today our Canadian headquarters is still located in Toronto, Ontario. Our work focuses on oncology, diabetes, autoimmunity, neurodegeneration, and pain. We employ more than 300 people across the country.

The changes to the PMPRB pricing framework mark a radical redefinition of the simpler rules that defined "excessive pricing" previously, to include a complex, rigid and arbitrary set of economic factors and revenue caps. There is no other country that applies these factors in the way being proposed by the PMPRB. This has added high uncertainty and unpredictability to the life sciences sector and to Canadian patients who stand at the mercy of an untested pricing regime. Both the amended Regulations and the Guidelines come into force on January 01, 2021.

Consultation Process

With respect to the PMPRB pricing framework, Lilly has significant concern relating to the consultation process for the Regulations. The near-unchanging text of the regulations over the full span of the consultation processes and the concerns expressed in the voluminous stakeholder input suggests a lack of real intent by Health Canada to sincerely consider the feedback received. While the government material on PMPRB denotes a number of rounds of consultation across the discussion paper, regulations, and subsequent guidelines opportunities, stakeholders such as Lilly continue to have grave reservations about the final product. The sizeable number of stakeholders unhappy with the government's final product – including the 17,401 signatories of a Parliamentary e-petition[1] - , coupled with the relatively unchanging nature of the regime suggests that the government has not been serious about incorporating feedback to develop an effective regulatory suite that is acceptable to stakeholders.

The Intent

In the words of then Minister of Health, Jane Philpott, the intent of the regulatory modernization of the PMPRB, announced in 2017, was to "make drugs more affordable for Canadians" by "lowering drug prices." In fact, in the form that the Regulations and Guidelines will take on, the affordability of medicines for Canadians most in need will be undermined. Canada's most vulnerable populations – and the public drug plans that they rely on – will lose out. Some of the revenue currently funneled to public plans will be redistributed to private insurers that operate in a highly competitive, profit-driven marketplace.

[1] https://petitions.ourcommons.ca/en/Petition/Details?Petition=e-2546&fbclid=IwAR2HUb7rAib7N5If6NUuXIuDV04lEuh9iE6Mjs_i3oRaTjj8vsZmXh_Z9mw

Currently, through the pan-Canadian Pharmaceutical Alliance (pCPA), Canada's public drug plans negotiate lower drug prices preferentially for those Canadians most in need. The ability to secure discounts on behalf of these plans is especially important in Canada because of the public/private market split and the very different roles that each market serves. Public drug plans take on the needs of economically and otherwise vulnerable citizens and do so within fixed annual healthcare budgets. Any savings they obtain from discounts through the pCPA are directed back into public coffers – often to offset broader health budget deficits.

The pCPA has reported savings of more than $2.3 billion annually, negotiated by the public drug plans and directed to vulnerable Canadians[2]. Of note: Canada's public health budgets absorb **70%** of **all** health care costs for **all** Canadians, including those with private drug plan coverage. The public share of this burden has not declined in more than 40 years. In contrast, profit to private payers has increased year-over-year for the last twenty years.

Regulations

On June 29, 2020, the Federal Court of Canada declared that subsection 3(4) of the amended Regulations on the net price calculation is invalid, void, and of no force and effect for being ultra vires the *Patent Act*. Lilly continues to have grave concerns about the practicality and legality of the remaining amended Regulations.

Guidelines

While the PMPRB made changes to the Guidelines following consultation the draft versions we remain deeply concerned by the magnitude of the impact, and the many operational and technical issues that remain. These concerns are not lessened by assurances from the PMPRB that some issues can be dealt with, case-by-case, as they arise – and by changing the Guidelines as problems become apparent. This undermines the very purpose of Guidelines and inserts a high degree of uncertainty and unpredictability into what is already a complex process in the extreme. Further, and importantly, the Guidelines give Board staff a vast amount of discretion in how they are applied. This adds another layer of uncertainty for manufacturers.

In closing, despite a number of rounds of consultation on the PMPRB project, Lilly continues to have grave concerns about the impact of the Regulations and Guidelines on the pharmaceutical sector. As a result of the uncertainty and commercial impacts described above, manufacturers may have no option but to delay – or cancel – launches in Canada, most notably for Category I drugs – the very ones that fill the greatest unmet needs for patients.

Enclosed is Lilly's response to the draft guidelines consultation, which provides a detailed, technical response to the deficiencies of the proposed guidelines.

Sincerely,

Lauren Fisher
Vice President, Corporate Affairs
Eli Lilly Canada

Attached: Eli Lilly Canada PMPRB consultation submission

[2] https://www.pcpacanada.ca/about

Eli Lilly Canada's Submission to the
Patented Medicine Prices Review Board on the Draft Guidelines 2020

Statement of Alignment with Innovative Medicines Canada Submission

Lilly is aligned with all elements of the Innovative Medicines Canada (IMC) written submission to the draft PMPRB Guidelines consultation. Lilly's submission serves to provide additional perspective and detail, to complement and reinforce key elements of the IMC submission.

Disclaimer

Eli Lilly Canada Inc. (Lilly) understands that the PMPRB intends to update its Guidelines within the framework of the amendments to the *Patented Medicines Regulations*, which are not yet in force. While Lilly is committed to constructive engagement with the PMPRB on the draft Guidelines, Lilly's response to this consultation is not intended and should not be interpreted as supporting the amendments to the Regulations or current Guidelines proposals. On June 29, 2020, the Federal Court of Canada declared that subsection 3(4) of the amended Regulations on the net price calculation is invalid, void, and of no force and effect for being *ultra vires* the *Patent Act*. Lilly continues to have grave concerns about the practicality and legality of the remaining amended Regulations. Lilly reserves the right to oppose any aspect of the amended Regulations or Guidelines that exceed the jurisdiction of the Board.

Introduction

This document represents Eli Lilly Canada's (Lilly's) submission to the Patented Medicine Prices Review Board (PMPRB) on the proposed PMPRB Draft Guidelines 2020 (Draft II). While Lilly acknowledges that the PMPRB made changes to the proposed Guidelines between "Draft I" and "Draft II", we remain deeply concerned that many operational and technical issues remain. These concerns are not lessened by assurances from the PMPRB that some issues can be dealt with, case-by-case, as they arise. This undermines the very purpose of Guidelines and inserts a high degree of uncertainty and unpredictability into what is already a complex process in the extreme. Manufacturers have no option but to delay – or cancel – launches in Canada, most notably for Category I drugs. The irony in this lies in the fundamental role of the PMPRB in the *Patent Act* as the "consumer protection pillar", to ensure patients have access to important medicines.

In addition to Lilly's technical concerns, what was absent in Draft I, and remains so in Draft II, is transparency around the de facto policy interpretations, made by the PMPRB staff and Board, which underpin the Guidelines. One step removed, these interpretations impose profound impacts on stakeholders, but it is not always possible to ascertain the underlying policy intent from the actual Guidelines. This makes it difficult for stakeholders to predict the full extent of their impact. The question here is not so much whether the underlying policy intentions fit within the very broad statutory intent of the *Patent Act*, but rather, whether the policy intentions are the *right ones* in the current context. The author of this document has been contacted by two government officials in the last week asking for help understanding "how will these changes affect" the provincial jurisdictions.

Lilly suggests that this confusion indicates that there is value in greater simplicity than the current draft Guidelines provide. Lilly supports the IMC position that the PMPRB should anchor to the bright-line principle that Canada not exceed the international median price.

As a summary point, Lilly believes that issue fatigue should not truncate the consultation process. Sufficient time must be taken upfront to get the guideline package right. A new regulatory framework governing price ceilings for patented medicines should not be implemented until it is complete and coherent.

Federal Court Decision Means the Guidelines Process must be Reset

On June 29, 2020, the Federal Court ruled that sections of the August 21, 2019 amendments to the *Patented Medicines Regulations* regarding confidential third-party payments are outside the scope of the *Patent Act*. In a public statement on July 8, 2020, the PMPRB indicated the following:

> *The PMPRB is reviewing the decision to evaluate its impact but, at this time, does not believe any substantive changes to the June 2020 Draft Guidelines are required as a result. However, we invite stakeholders to share any views they may have regarding the import of Justice Manson's decision as part of their written submission to the PMPRB in the context of the current consultation on the June 2020 Draft Guidelines*.

Lilly disagrees with the PMPRB's assessment. Without access to third-party payments, PMPRB can only regulate net prices to ex-factory customers. The PMPRB cannot implement its Maximum Rebated Price

(MRP) concept, which regulates net price to third-parties. Moreover, the 2019 amendments to the *Patented Medicines Regulations* are clear that PMPRB access to third-party payments is necessary for patentee compliance with the new economic factors (pharmacoeconomic value, market size, and GDP/GDP-per-capita). Accordingly, the new economic factors are inextricably connected to the MRP concept in the draft Guidelines. The PMPRB must, therefore, suspend the current Guidelines consultation, and release a new Guidelines package that is consistent with regulatory tools that are within its mandate. The PMPRB should not consult on the use of information that is deemed by the Federal Court to be beyond the PMPRB's jurisdiction.

Excessive Pricing and Policy Intent

The PMPRB was created as the "consumer protection pillar" of the *Patent Act* and mandated to ensure that the prices of patented medicines sold in Canada would not be "*excessive".* The focus, then, and now, has been on high-innovation medicines where, in the absence of competition, there is a risk of "excessive" pricing – or what has been termed abuse of monopoly power[1]. However, there is no clear definition of "excessive" in either the Act or the Regulations and while the PMPRB suggests there is an upside to this: "it allows for a flexible and contextually-driven interpretation of "excessive" pricing"[2], the downside is that stakeholders are left to infer the underlying policy intent of a new regulatory framework. What must be the guidepost in all of this for the PMPRB, of course, is the consumer protection mandate and the prevention of excessive pricing. At the same time, it is likely that the creators of the *Act* would have seen the futility in any underpinning of "excessive" that made patients' access to the highest value medicines untenable because of barriers sewn into the Guideline framework.

Economic Factors as Illusory Bright Lines: the QALY/ICER

The Economic Factors, adopted by the PMPRB as a core element in setting a ceiling price for Category I medicines, serve as a case-in-point for these barriers. The PMPRB promised objective, unambiguous standards, or "bright lines", which leave little or no room for varying interpretation. However, that the bright line defining the QALY thresholds changed drastically between Draft I and II of the Guidelines, shifting from $60,000 in Draft I to $150,000-200,000 in Draft II, makes it clear that the determination of excessive is more anchored in arbitrary decisions built on "philosophical sand"[3] than sound rationale. However, surely the critical role of the PMPRB is to exercise the highest level of reasoned judgment to ensure that the definition of ceiling price is fair and situated within the Canadian context.

An essential part of this context is Canada's social contract with its vulnerable populations: an explicit policy of this Liberal government that "We are committed to provide more direct help to those who need it by giving less to those who do not." With respect to drug pricing, the World Health Organization (WHO) suggests that what differential pricing – what the PMPRB has called "discriminatory" pricing – should be seen as "equity" pricing to be used as an explicit government strategy to remedy differential abilities to pay and so, differential access to medicines. This occurs now through differential pricing

[1] PMPRB. PMPRB Guidelines Modernization. Ottawa: Patented Medicine Prices review Board. May 2016
[2] Interview: Douglas Clark – Executive Director, Patented Medicines Price Review Board (PMPRB), Canada. Pharma Board Room. Interview: Douglas Clark – Executive Director, Patented Medicines Price Review Board (PMPRB), Canada. 26.09.17.
[3] The "philosophical sand" question asks at what point an accumulation of tiny grains of sand becomes a "heap". The determination is wholly arbitrary as is the designation of the QALY threshold.

that occurs between public and private payers. The point was dealt with in depth in Lilly's submission on the Draft Guidelines 2019.

Notwithstanding the issue of whether the ICER/QALY and other Economic Factors should be used at all in determining excessive pricing, there will be significant, if not unworkable complexity in calculating a usable QALY for PMPRB's purpose, given the very different intentions of CADTH and INESSS for using the same numbers. The HTA bodies are making reimbursement recommendations to public payers for the purposes of their price negotiations. In fact, that is the intended use of the ICER across the globe – as a very important input into a deliberative process which includes other factors.[4] If payers believe the QALY is too low, or that some other factor outweighs its importance, they can circumvent it. As case-in-point, the last few years have seen the UK expand factors for decision making, especially for rare diseases. **Of critical note:** if the QALY is used by the PMPRB to set a ceiling price, payers must not exceed it. Provincial government payers will have lost their rightful jurisdictional authority.

In setting a ceiling price, the PMPRB requires, from CADTH, a single-point estimate for each medicine. In contrast, CADTH and INESSS calculate ranges that allow for different reimbursement scenarios that are important to payers – and they are not a homogenous group. The following table includes ICERs for actual CADTH (pCODR) analyses for oncology medicines submitted from 2017 on.

Product ICERs pCODR	Manufacturer Estimate	pCODR Low Estimate	pCODR High Estimate
Alectinib	$67,903	$36,935	$224,325
Abemaciclib	$331,023	$189,609	$2,125,957
Ixazomib indication I	$793,478	$238,718	$918,518
Indication II	$378,299	$464,746	$1,751,236
Carfilzomid	$192,970	$157,554	$261,646
Brentuximab Vedotin	$32,470	$72,991	$79,319
Atezolizumab	$266,947	Not provided	$566,858 (only est)

Market Size

Setting aside the absence of an explanation by the PMPRB for the determination of the threshold for the Market Size factor, what is of greater concern is its use at all. Although the PMPRB makes mention of its purpose to assess budget impact and, so, affordability, these are not the purview of the PMPRB: they rest with provincial and territorial jurisdictions as budget holders.

Further, the market size factor, which applies tiered price ceilings based on a product's revenue, poses a special problem. For all intents and purposes, it is a profit/revenue cap (delicately termed by the draft Guidelines a "market size adjustment"). There are few enough instances of profit caps internationally for any industry – even fewer in Canada. In fact, it is worth determining whether beyond the National Energy Program (1980-1985) this would set a new precedent here. In addition, because the PMPRB

[4] Pearson, Steven D. The ICER Value Framework: Integrating Cost Effectiveness and Affordability in the Assessment of Health Care Value. Value in Health 21 (2018) 258-65.

ceilings apply to both public and private insurers, there would be a transfer of profit from the pharmaceutical industry to *another private industry* – private health insurance, with no way to ensure the savings would be passed on to consumers. For 2017, the Canadian Health and Life Insurance Association (CHLIA) reported a surplus of $9.0 B in health premiums over health benefit payouts for private insurers. Their profit margin has steadily increased between 2007 and2017, the last year that numbers were available. This transfer of profit to private insurance companies is perverse, given that 70% of all health care costs for all Canadians are paid publicly. Public plans, which cover vulnerable Canadians, are the losers. Further as a summary point, in applying a revenue/profit cap, the PMPRB is applying a special penalty to the most innovative medicines. It seems that is contrary to the intent of the *Patent Act*.

Technical Content

Notwithstanding Lilly's ongoing concerns with, and opposition to, the proposed Guidelines package, we remain open to further discussions with the PMPRB and the federal government on a reasonable and appropriate path forward. As the central regulatory approach laid out in the new draft Guidelines has not changed from the original, Lilly's core positions are consistent with those articulated in our submission to the 2019 draft Guidelines consultation. Below is a non-exhaustive list of key concerns, which is intended to provide the PMPRB and other stakeholders with insights to help inform the development of a new Guidelines package.

Existing Patented Medicines are not Grandfathered

Regarding the establishment of a Maximum List Price (MLP) for existing medicines, the draft Guidelines state (p. 17):

> *The MLP for Grandfathered and Line Extension medicines is set at the lower of*
> *(i) the highest international price ("HIP") for the PMPRB11 countries for which the patentee has provided information; or*
> *(ii) the patented medicine's ceiling (e.g. the "NEAP") under the Guidelines applicable prior to the issuance of these Guidelines. (s.72)*

Patented medicines that received a Drug Information Number (DIN) prior to the publication of the amended *Patented Medicines Regulations* on August 21, 2019, should be fully grandfathered. Investments associated with regulatory approval, reimbursement, distribution and customer support for these medicines were made prior to the initiation of discussions regarding changes to the PMPRB regulatory framework.

Lilly's portfolio includes a medicine that would undergo a list price reduction in excess of 25% under the provisions of the 2020 draft Guidelines. At a minimum, existing medicines should be offered a fair and appropriate transition, with the annual reduction in list price capped at five percent or less.

Excessive Price Standard is not Respected

Regarding new Category I High Cost medicines, the draft Guidelines state the MRP will be calculated as follows (p.15):

> *(1) The Incremental Cost-Utility Ratio ("ICUR") measured in cost per quality-adjusted life years ("QALYs") for each indication of the patented medicine will be identified from the cost-utility analyses filed by the patentee.*
> *(2) The price at which the patented medicine's ICUR would be equivalent to the Pharmacoeconomic Value Threshold ("PVT") will be identified (the "Pharmacoeconomic Price" or "PEP").*
> *(3) The ICUR will be compared against the applicable PVT and reduction floor, based on its Therapeutic Criteria Level (s. 62)*

The proposed calculation of the MRP does not respect the standard of excessive price regulation. A new medicine in Lilly's oncology pipeline would be subject to the above MRP calculation. It is anticipated that this medicine would be issued a conditional Notice of Compliance (NOC/c) by Health Canada, as it would be submitted on the basis of Phase 2 data. Based on the proposed definitions for the assignment of Therapeutic Criteria Levels, Lilly is faced with the risk of punitive levels of price reduction, of 40% or more below the Maximum List Price. Adding to the uncertainty, it is unclear whether the cost-utility analysis for the medicine would be deemed by PMPRB staff to be sufficient for the calculation of a PEP, and "… if the analysis submitted does not allow for the determination of the MRP as described above, the MRP is set at 50% of the MLP." (s. 64) This has prompted Lilly to undertake an assessment of whether commercial launch of this medicines is feasible in Canada.

MRP Concept Compromises the Confidentiality of Net Prices

The MRP of any patented medicine could be estimated on the basis of information readily available in the public domain – namely, the cost-utility analysis, the proposed Therapeutic Criterial Level (TCL) definitions and the MRP price adjustment charts on page 35 of the draft Guidelines. The provision to keep TCL levels confidential does not meaningfully address confidentiality concerns. In fact, the assignment of specific reduction floors off MLP has exacerbated confidentiality risk relative to the 2019 draft Guidelines. The draft Guidelines result in unacceptable risk of exposure of the MRP, which is sensitive commercial financial information. We are unaware of any regulator worldwide that exposes net price information in this manner.

MRP Concept is not Operationally Feasible

Provincial/federal/territorial government-funded drug plans will only consider reimbursement of a medicine following a positive recommendation by a Health Technology Assessment (HTA) agency, and a price negotiation through the pan Canadian Pharmaceutical Alliance (pCPA - a buying coalition of government-funded drug plans). In Lilly's recent experience, it takes upwards of two years to achieve reimbursement on government-funded drug plans following the issuance of a DIN by Health Canada. Moreover, reimbursement may never be achieved, if the HTA agency does not recommend funding or if a pCPA negotiation closes unsuccessfully. Months or years may elapse before rebates to government-funded plans are paid, and where formulary listings are not achieved, rebates are never paid.

Among private drug plans, not all negotiate Product Listing Agreements, as they have other mechanisms available to control drug plan costs for their clients that are less burdensome and costly from an administrative perspective.

Allowable Price Ceilings cannot be Predicted

Under the current PMPRB regime, allowable ceiling prices can be predicted by patentees, within a reasonable margin of error. The price tests used to establish non-excessive price ceilings are based on objectively verifiable information - namely, the prices of the patentee's own medicine in other markets and the price of comparable medicines in Canada. This predictability has underpinned a system of voluntary compliance by patentees, which has been functioning well for three decades. Excessive pricing investigations and hearings are exceptional.

Predictability has also meant that revenue forecasts associated with new medicines can be prepared within a reasonable margin of error. This has allowed Lilly to secure budget and make the substantial investments required for new medicine launch in Canada (regulatory approval, reimbursement, distribution and market support).

The regulatory framework in the draft Guidelines challenges predictability and voluntary compliance in several ways, notably:

- *Pharmacoeconomic Price (PEP) concept:* Pharmacoeconomic studies are, by definition, built on multiple assumptions. The uncertainty associated with the results is typically expressed as a range of values, which in Lilly's experience, can be very broad. For Category I medicines subject to the PEP, patentees would not be in a position to predict, within a reasonable margin of error, an allowable ceiling price at launch.
- *Reassessment Triggers:* The draft Guidelines contain multiple triggers for the reassessment of an allowable ceiling price, most notably the approval of a new indication (use) for a medicine, or sales exceeding the Market Size Threshold (p. 18).
- *Staff Discretion:* The draft Guidelines allow for significant latitude on the part of PMPRB staff, notably in the assignment of Therapeutic Criteria Levels, the selection of Relevant Indications and the conduct of the dTCC and International Therapeutic Class Comparison (iTCC) tests.

Disincentive to First Launch in PMPRB 11 based on use of Median dTCC Test

Regarding the calculation of the interim Maximum List Price (iMLP), the draft Guidelines state (p. 12):

> *If the patentee has not filed international price information for the PMPRB11 countries, the iMLP is set by the top of the domestic Therapeutic Class Comparison ("dTCC"). (s. 41)*

Following the interim period (minimum of five countries or three years, whichever comes first), the MLP is set as the lower of the list price or the Median International Price. A new medicine in Lilly's pipeline would be subject to the dTCC test for the establishment of its iMLP and MLP, as it has been scheduled to launch first in the PMPRB 11. The proposed use of the dTCC in the draft Guidelines would have significant impact on price, which has prompted Lilly to revisit launch plans for this investigational new medicine. Any use of a median therapeutic class comparison is inconsistent with an excessive price standard and is, therefore, inappropriate.

2020 Draft Guidelines Package is Incomplete

Patentees have again been asked to comment on an incomplete Guidelines package. The draft Guidelines suffer from omissions and contradictions, and they contain concepts the application of which could be interpreted in materially different ways. Moreover, the draft Guidelines were not accompanied by the online filing tool, which is intended to replace the current *Guide to Reporting*. As a result, patentees do not have a full understanding of how PMPRB intends to apply the draft Guidelines.

CADTH and PMPRB have both confirmed that CADTH has not finalized an approach to support the implementation of the PMPRB's proposed MRP calculation methodology. The Guidelines package is not ready for consultation in the absence of this information.

Technical Working Groups with Patentees are Required

The draft 2020 Guidelines, like the 2019 draft Guidelines, were conceived in the absence of meaningful engagement in Technical Working Groups with the regulated stakeholder, namely patentees. As a result, the proposed price regulation framework is fundamentally flawed, and presents significant operational barriers, as noted above.

The case studies appended to the IMC Guidelines submission highlight some perverse – and presumably unintended – consequences.

Sufficient time must be taken to get the regulatory package right for Canadians. Patented medicines are an integral component of our healthcare system. A new regulatory framework governing price ceilings for patented medicines should not be implemented until it is complete and coherent, and stakeholders can be assured that it respects a reasonable set of core principles: predictability and fairness; operational feasibility and efficiency; full grandfathering or appropriate transition for in-market medicines; and access to new medicines in a timeframe comparable to what Canadians currently enjoy. Lilly would welcome an opportunity to engage with PMPRB through technical working groups to generate a Guidelines package that is aligned with these core principles.