Patient Affordability in the United States

Overview

At Pfizer, our purpose is to create breakthroughs that change patients' lives. We are proud to have played a role in developing and manufacturing some of the most important medical innovations of the past 175 years. By uniting transformational technology and innovative science, Pfizer is pioneering biopharmaceutical innovations that not only treat difficult diseases but have the potential to cure or prevent them.

But all of these breakthroughs will not do anyone any good if patients cannot afford them.

Ensuring patients have access to affordable, high-quality health care, including prescription medicines, is essential for the health of the U.S. population. Prescription medicines are cost-effective treatments, which can save the health care system money by avoiding more costly medical services such as emergency room visits and hospitalizations. At Pfizer, we are investing in programs and services that help lower the cost of medicines and support policies that improve patient access and affordability. The challenge we face today is that scientific innovation is outpacing the capabilities of our existing health systems to provide broad, affordable access to our breakthroughs, with the result that individuals and societies around the world may not have access to innovative medicines. Fundamental to Pfizer's approach in supporting patients, public health and value-based healthcare is creating solutions that make medicines more affordable.

We are committed to creating sustainable business models to broaden access. Many of our approaches focus on patients with the greatest coverage gaps and patient out-of-pocket exposure. We seek to apply affordability programs across the patient journey and to the entire product portfolio, encompassing all therapeutic areas and both launch phase and in-line assets. We are pursuing disruptive solutions in terms of differential pricing, cash flow solutions, business model transformation and transaction cost reduction.

We partner and advocate with payers, governments, and others in the health care system to promote policies that relieve patients' financial hurdles and provide access to our medicines at a cost they can afford. We also offer patient assistance and donation programs in certain situations when insurance or reimbursement systems fail to provide affordable access to our medicines. And, building on our 30-year legacy of experience manufacturing biologics, our portfolio of biosimilars offers additional treatment options at potentially lower costs, which can create savings and efficiencies for the health care system.

Insurance Benefit Designs and Patient Costs for Medicines

Health insurance plans require patients to pay for a portion of their medicines, through copays, coinsurance, and/or deductibles. This means that patients pay an agreed upon amount per prescription at the pharmacy counter. For example, "copays" require a patient to pay a fixed amount per prescription, while health plans with "coinsurance" require patients to pay a percentage of the medication cost, which is common for specialty drugs. Health plans with a deductible require patients to pay the full deductible amount before the insurer will start paying for prescription medicines. Patients enrolled in a high deductible health insurance plan, as defined by the Internal Revenue Service, can be coupled with a Health Savings Account (HSA), which allow for pre-deductible coverage for a limited number of medical services and medications that

are deemed preventive care.[1-2] HSA funds can be used to help patients pay for prescription drugs and medical services.

In recent years, health insurers have moved away from benefit designs that offer fixed copays per prescription to solely utilizing coinsurance and/or high deductibles, shifting more of the cost sharing burden to patients.[3] This trend has not gone unnoticed by Americans. According to a recently released patient experience survey, affording out-of-pocket health care costs, such as copays, deductibles, and coinsurance, is the most important health care issue to patients.[4] While the utilization of coinsurance and high deductible plan designs allow insurers to discourage the use of medical services and potentially redirect patients to lower cost alternatives, these strategies can also impact patient adherence to treatment, health outcomes, and overall system costs.[5]

Policy Reforms to Improve Patient Affordability

Pfizer supports policies that improve transparency, predictability, and patient affordability for prescription drugs. To achieve this goal, Pfizer supports state and federal policies that lower a patient's out-of-pocket costs. Examples include:

- Limiting or capping patients' out-of-pocket costs for medicines,
- Ensuring that the discounts and rebates manufacturers give to pharmacy benefit managers (PBMs) and insurance companies directly benefit patients at the pharmacy counter, and
- Protecting the safety net manufacturers provide through patient assistance.

Limiting or capping patients' copays

Patients are increasingly being required to take on a bigger share of medication costs, and that is particularly true when it comes to innovative treatments. Pfizer supports policies that require health insurers to offer plans with fixed and predictable copays, as well as policies that require annual patient out-of-pocket dollar limits or caps. Beginning in 2025, Medicare Part D beneficiaries annual out-of-pocket spending will be capped at $2,000, adjusted for inflation in subsequent year, and plans must offer enrollees the option to pay out-of-pocket prescription drug costs in the form of capped monthly payments instead of all at once at the pharmacy.[6] Pfizer has long advocated for these important patient affordability protections.

Manufacturer discounts and rebates at the point-of-sale

Pfizer supports policies that require manufacturer discounts and rebates negotiated with health insurance plans to be passed through to patients at the point-of-sale. On average, more than half

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[1] Internal Revenue Service, High Deductible Health Plans. Available at: https://apps.irs.gov/app/vita/content/17s/37_03_005.jsp?level=advanced. Last accessed May 14, 2024.

[2] IRS Notice 2019-45. Additional Preventive Care Benefits Permitted to be Provided by a High Deductible Health Plan Under § 223. https://www.irs.gov/pub/irs-drop/n-19-45.pdf

[3] American Medical Association (2020). Mitigating the Negative Effects of High Deductible Health Plans. https://www.ama-assn.org/system/files/2020-11/nov20-cms-report-2.pdf

[4] PhRMA (2023). Patient Experience Survey. https://phrma.org/resource-center/Topics/Access-to-Medicines/Patient-Experience-Survey---Protecting-Lifelines-to-Access-and-Innovation

[5] National Pharmaceutical Council (2024). Patient Centered Formulary and Benefit Design. https://www.npcnow.org/topics/patient-centered-formulary-benefit-design

[6] Centers for Medicare & Medicaid Services. Available at: https://www.cms.gov/inflation-reduction-act-and-medicare/part-d-improvements/medicare-prescription-payment-plan. Last accessed May 31, 2024.

of the spending on brand medicines is retained by third parties in the form of rebates or discounts provided by the manufacturer.[7] In 2022, these rebates, discounts and other price concessions totaled $250 billion.[8] Allowing patients to have access to these negotiated rebates could save patients, especially those with high deductibles and coinsurance, hundreds of dollars annually.[9]

Protecting the Patient Assistance Safety Net

Pfizer supports policies that prevent third parties from diluting manufacturer copay assistance programs, such as those that carve out specialty medications from their drug insurance benefit plan or do not count the financial assistance patients receive from drug manufacturers towards their deductible or out-of-pocket maximums. According to research, manufacturer copay assistance has helped to reduce patient costs by nearly $19 billion in 2022 and almost $80 billion over the last five years.[10] However, in recent years third parties have implemented various programs and schemes (accumulator adjustment programs, copay maximizer programs, and alternative funding programs) that increase the out-of-pocket burden for patients and expose people with chronic or life-threatening conditions to large, unexpected costs.[11]

[7] PhRMA. (2023) Policies to Help Patients Pay Less for Their Medicines: Share the Savings. https://phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMA-Refresh/Fact-Sheets/P-R/POLICIES-TO-HELP-PATIENTS-PAY-LESS--FOR-THEIR-MEDICINES_Feb-2024.pdf

[8] PhRMA. (2023) Policies to Help Patients Pay Less for Their Medicines: Share the Savings. https://phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMA-Refresh/Fact-Sheets/P-R/phrma-ppl-onepager-sharesavings-v12.pdf

[9] PhRMA. (2017). Sharing Negotiated Discounts Could Save Patients More than $800 Annually and Would Increase Premiums About 1 Percent. https://phrma.org/resource-center/Cost-and-Value/Sharing-Negotiated-Discounts-Could-Save-Patients-More-than-800-Annually

[10] IQVIA Institute. (2023). The Use of Medicine in the U.S. 2023. https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/the-use-of-medicines-in-the-us-2023

[11] All Copays Count (2024). Copay Accumulators Harm Patients. https://allcopayscount.org/patient-impact/