Testimony of Dr. Albert Bourla, DVM, Ph.D.
Chief Executive Officer, Pfizer

Drug Pricing in America: A Prescription for Change, Part II

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Chairman Grassley, Ranking Member Wyden, and members of the Committee, thank you for the opportunity to speak with you today. My name is Albert Bourla. I have been with Pfizer for 26 years, and just last month had the honor of becoming its Chief Executive Officer.

Today, I am pleased to take part in such an important policy discussion within the United States Senate. Pfizer shares an important goal with this Committee: to ensure that America remains the leader when it comes to innovative medicines, and that our citizens have affordable access to these modern miracles when they need them.

In that frightening moment when you hear that you or a loved one has been diagnosed with a serious disease, one question comes to mind: "Is there a cure or treatment available?" The answer can change your life. And happily, the answer to that question increasingly is "yes."

Breakthrough medicines are coming quickly across a wide range of conditions. Most of them are discovered here, by the American Biopharmaceutical Industry, which is the crown jewel of innovation. Let me share a few examples. In 2015, Pfizer launched a life-changing new treatment for metastatic breast cancer that can delay the progression of the disease two times longer than previous treatments. Thanks to our meningitis B vaccine, parents can send their teens to college confident in the knowledge that being vaccinated helps protect them in the event of an outbreak on campus. In 2018, we brought 4 new cancer treatments to the market to treat varying forms of breast cancer, lung cancer and leukemia. And we are currently working on a non-opioid alternative with the potential to address the serious unmet needs of the more than 27 million Americans living with osteoarthritis and the more than 33 million suffering chronic low back pain.

But all of these breakthroughs won't do anyone any good if patients can't afford them.

That's why at Pfizer we are so committed to our purpose: *breakthroughs that change patients' lives*. Pfizer's more than 90,000 colleagues around the world come to work every day focused not only on creating breakthrough medicines, but also on making sure those medicines get into the hands of the patients who need them.

To create solutions that make medicines affordable for patients and our entire healthcare system, I believe that all players in the industry must come together and play a part. Whether it's hospitals or providers, pharmacy benefit managers or insurance companies, or

biopharmaceutical companies, we all have a role to play. The series of hearings being held by Congress can be a catalyst for this much needed collaboration.

There are two indisputable truths that make this the exact right moment for change:

1. Medicines alleviate human suffering and reduce overall system costs.
2. The horribly misaligned incentives within our healthcare system often prevent medicines from getting into the hands of patients.

Our healthcare system is broken, and we need to fix it. The system needs to be simpler and more transparent. It needs to incentivize innovation while simultaneously ensuring access. Simply put, it needs to put patients – and their health – first.

How will we know when the healthcare system is fixed? When patients feel real relief at the pharmacy counter – the kind of relief that means cost will no longer be a determining factor in whether someone picks up, and adheres to, their prescription. Too often, Americans are forced to choose between buying a medication that will improve, extend or save their lives or paying their bills. Too often, they fill their prescriptions, but take less than the prescribed dose in an effort to save money. Too often, lower-cost, FDA-approved generic and biosimilar alternatives are not made available to patients who desperately need them.

We must take bold actions to ensure these scenarios do not play out time and time again across America.

Pfizer intends to be a productive participant in this policy making and has come to the table with solutions. As such, we would like to propose four ideas to drive meaningful reductions in costs for patients:

1. Passing All Rebates to Patients

Today's current drug rebate system is good for two things: driving up both drug list prices and consumer out-of-pocket costs. In fact, in 2018, the average net price of Pfizer's medicines in the United States declined 1%. However, I am certain that patients using our medicines had a very different experience at the pharmacy counter since their costs in the current system are more closely related to the list price than the net price. This is impactful when patients pay a coinsurance or are in the deductible phase of their benefits coverage. In these instances, patients are being asked to pay an average of 10% to 20% or more out of their own pockets for many Pfizer products.

There are two reasons for this disconnect: changes in benefit designs are pushing more and more of the medicines' cost to the pockets of the patients, and none of the close to $12 billion of rebates that Pfizer paid in 2018 found their way to American patients. As long as rebates serve as profit drivers, we will continue to see a major disconnect between list prices and prices people pay at the counter.

Pfizer supports reforms that would create a system in which transparent, upfront discounts benefit patients at the pharmacy counter, rather than a system driven by rebates that are swallowed up by companies in the supply chain.

The way to alleviate sticker shock at the pharmacy counter is by changing the incentives in the supply chain so that more of the $150 billion in negotiated rebates and discounts actually reach patients. This can be accomplished by applying the discounts paid by the pharmaceutical manufacturer to the price actually paid by patients at the pharmacy. In 2019, Pfizer expects to pay billions in rebates to ensure patients with pharmacy benefits coverage in Medicare Part D and patients in commercial plans have access to our medicines. If the proposed rule to share rebates with consumers at the point of sale is finalized, we estimate that seniors taking Pfizer medicines could save $270 on average per year, and up to $574 per year for certain Pfizer medicines, through lower cost sharing – and that would outweigh any premium increases.

Research also shows that sharing discounts at the pharmacy counter could reduce total health care spending, and that reductions in overall out-of-pocket costs would outweigh any premium increases.

We realize that the transition away from rebates toward a point-of-sale discount model will result in a lowering of our net prices. Despite this potential negative financial impact, we support efforts to eliminate rebates because we believe the new model will be good for patients.

Importantly, we believe any reform should apply to all market segments as this will also lead to further reduction in list prices. A bifurcated market in which we eliminate rebates in government programs but maintain rebates for commercial plans will make it difficult for manufacturers to reduce list prices because it applies to all markets.

We will work with other leaders in the healthcare sector to advance these reforms, and we're committed to lowering list prices if the rebate rule applies to the commercial market.

2. Less Value, Less Pay

Pfizer supports the move to value-based healthcare and is prepared to stand behind the benefits that our medicines deliver to patients and to the United States healthcare system.

Medical science is advancing so rapidly that payment models simply haven't been able to keep up. That's why Pfizer is focusing not only on scientific innovation, but also on commercial innovations that will allow us to get breakthrough medicines into the hands of patients, while simultaneously holding all participants in the system – including Pfizer – accountable for the health outcomes they help produce.

This will require a fundamental shift in the way we think about the value that medicines deliver and how all participants in the system are reimbursed with regard to that value. It will also

require the evolution of insurance designs to advance value-based insurance plans that remove barriers to high-value treatments.

Imagine a system in which hospitals are rewarded for keeping patients from being readmitted; where physicians get paid more to prevent disease than they do to simply treat it; and where companies like Pfizer get paid based on the number of strokes we prevent or the number of cancer patients who go into full remission, rather than the number of pills we sell.

In such a system, if our medicines do not produce results, we would be paid less. And if they do produce results, we would be paid more. If done correctly, these arrangements – focused on the appropriate therapeutic areas – can align the interests of patients, health plans and biopharmaceutical companies around one shared goal: ensuring positive health outcomes for the patient.

To make this a reality, we need Congress's help to remove the roadblocks in the current system for the good of patients. I understand several members of this Committee are drafting a legislative effort to pave the way for broader adoption of outcomes-based arrangements, and we applaud these efforts.

3. Capping Seniors' Out-of-Pocket Medicine Costs

Patients are increasingly being required to take on a bigger share of their medicines' costs, and that is particularly true when it comes to innovative and expensive treatments. Today, patients are made to pay on average 14% of the cost of their medicines, but only 3% of the costs associated with hospital stays.

This is forcing patients to forgo taking needed medications, to cut their pills in half, or to limit their doses in ways that are not medically prescribed. In fact, there is evidence that at least a quarter of new Medicare Part D prescriptions are abandoned at the pharmacy counter if beneficiaries are asked to pay $50 or more, which unfortunately is often the case. This number can exceed 50% for new prescriptions.

This is bad not only for patients, but also for overall healthcare system cost. Patients who do not take their medications often end up in the hospital, costing the healthcare system much more. This needs to be fixed.

Excessive cost-sharing is one of the greatest barriers to patient adherence and leads to more frequent discontinuation of therapy. While spending on medicines has been growing at a slower rate than in prior years, the number of patients with high deductible plans and high co-insurance are growing rapidly. Since 2009, enrollment in high deductible plans has grown 250%, and since 2010 the number of patients exposed to high specialty tiers has grown 60%. In fact, I've heard from several Members of this Committee that their constituents – or they themselves – have recently gone to the pharmacy counter only to be shocked by an excessively high co-pay. That's why the time is now to review cost-sharing burdens in the Medicare

prescription drug program and to take steps to ensure seniors don't have to make the difficult decision of forgoing their needed prescription.

We commit to working with the Committee on meaningful policy solutions that remove the burdens seniors face in paying for their medicines, and we believe an important first step is capping the out-of-pocket costs seniors experience in the Medicare drug program.

4. Knocking Down Barriers to Lower-Cost Biosimilars

Medicines are the only segment of the healthcare system with a built-in cost containment mechanism. When a medicine's patent expires, lower-cost generics are made available, often at just 5% of the cost of the original branded product.

This system is working well for generic drugs. In fact, 9 out of 10 drugs sold in the U.S. today are lower-cost generics. However, the system is not yet working in the biologics space where the adoption of biosimilars is facing resistance.

Establishing a robust biosimilars market can help to lower the overall healthcare costs in the United States, and Pfizer is committed to bringing these more affordable treatment options to patients. That's why we must incentivize the use of biosimilars, which can be as much as 40% less expensive than the branded biologic for Medicare patients.

Unfortunately, adverse incentives that favor higher-cost originator biologics are keeping biosimilars from reaching patients. In many cases, payers decline to include lower-cost biosimilars or generics in their formularies because they would risk losing the rebates they can get by covering higher-cost medicines. I can't think of a more concerning example of a broken U.S. healthcare system that is directly impacting the pocketbooks of Americans.

We have also witnessed exclusionary contracting or misleading marketing practices that mischaracterize important elements of biosimilar criteria. This creates doubt and confusion among patients, and it must end. Interestingly, the rebate reform I referenced earlier would go a long way toward removing the perverse incentives that lead to such exclusionary contracts.

At Pfizer, we believe there are several solutions that could help patients and providers share savings associated with biosimilars and reduce costs to the Medicare program. Let me touch on two:

- A Shared Savings Biosimilars Model: Congress could direct the CMS Innovation Center (CMMI) to test a biosimilar "shared savings" approach in which Medicare savings associated with prescribing a biosimilar, as compared to a reference biological, would be shared with providers.
- Reduced Patient Cost Sharing for Biosimilars: CMS could provide reduced or zero-dollar cost sharing for biosimilars for patients for a certain period.

These ideas would have an immediate impact on patients and the affordability of their prescriptions.

Closing

In 2018, we estimate[i] that Pfizer vaccines protected more than 65 million babies and elderly patients; our medicines helped reduce the risk of heart attack or stroke for more than 48 million cardiovascular patients; and oncologists used our therapies to treat more than 1.2 million people battling cancer.

Overall more than 784 million people around the world used a Pfizer medicine or vaccine to improve their health and, in many cases, save their lives.

These are staggering and humbling numbers. More important, they represent real people; real people who rely on our innovations. They also serve as a reminder that we – like our industry peers – are among the biggest contributors of good to humanity.

This is why we come to work every day. It's why the researchers in our labs in California, Connecticut, Massachusetts and New York work day-in and day-out to perfect a formula. It's why our manufacturing colleagues in Georgia, Kansas, Michigan, Missouri, North Carolina, Ohio, Pennsylvania and Wisconsin – many of whom are represented by members of this Committee – work to ensure the reliable supply and highest standards of quality of our products.

And it's why we are here today to work with our peers, other participants in the healthcare system, and Congress to find ways to ensure the patients who need our medicines can access them so our industry's breakthroughs can continue to change patients' lives.

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[i] Patient counts are estimates derived from multiple data sources.