Balancing the Tradeoffs Between Cost, Innovation, Accessibility and Affordability

January 10, 2017

Tom Brownlie, Pfizer
Common Ground

Living longer and better
• A shared priority

Cost containment
• Part of a healthy healthcare system

Solutions
• Better off developing them together
Prescription Drug Prices: What Do Payers Pay?

**Private Payer**
- **Price – Discounts + Rebates**
- Patient OOP = copay or coinsurance

**Commercial | Medicare Part D Insurers**
- **Price – Discounts + Rebates**
- Patient OOP = zero, copay, or coinsurance

**Medicaid**
- **Best Price – 23% rebate + CPI guarantees [+ supplemental rebates]**
- Patient OOP = zero or copay
Outpatient Pharmacy Ecosystem

Chart illustrates flows for patient-administered, outpatient drugs. Please note that this chart is illustrative. It is not intended to be a complete representation of every type of financial, product flow, or contractual relationship in the marketplace.

Gross vs. Net Price Growth

Estimated net price growth: 9.3%, 9.1%, 9.3%
Brands invoice price growth: 8.7%, 10.0%, 11.5%, 14.3%, 12.4%

Discounts & Rebates

SOURCE: IMS Health, National Sales Perspectives, IMS Institute for Healthcare Informatics, March 2016
U.S. Healthcare Spending: Growth

SOURCE: CMS: National Health Expenditure (NHE)
Built-In Cost Containment Mechanism

Brand-Generic Product Cycle

WAC Unit Monthly Average Price by All Results Together
WAC Unit Monthly Average Price by Labeler Name

-82%

SOURCEs: Analy$ource Online 1/5/2017 (Selected from FDB MedKnowledge (formerly known as NDDF Plus) data included with permission and copyrighted by First Databank, Inc.)
What About Specialty Medicines?

Pharmacy Benefit Drug Trend, Traditional vs. Specialty Drugs, 2002-2016

Source: Pembroke Consulting analysis of Express Scripts Drug Trend reports, various years Published on Drug Channels (www.DrugChannels.net) on April 10, 2014.

What About Oncology Medicines?

Spending on Cancer Medicines Represents <1% of Overall Health Care Spending

Cancer Medicines as a Portion of Total U.S. Health Care Spending, Billions, 2012

- Inpatient: 43%
- Rx: 20%
- Other: 37%

Total U.S. Cancer Care Spending, 2011

$2,800 billion


Value of Cancer Innovation

More People Surviving Cancer

- 3 million (1971)
- 9.8 million (2001)
- 13.7 million (2011)

U.S. Health Care Spending: Total Spending

Maryland Case Study

Total PMPM Changes, Individual Market

Maryland Case Study

Changes in PMPM Spending, 2013 - 2014:
Utilization per 100,000 Members | Cost per Unit

SOURCE: Maryland Health Care Commission, “Spending and Use Among Maryland’s Private Fully Insured.”
## Maryland Case Study

### EXHIBIT 8a. Spending Among Maryland’s Younger-Than-65 Population, 2014

<table>
<thead>
<tr>
<th>SPENDING</th>
<th>Total</th>
<th>Large Employers</th>
<th>Small Employers</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMPM spending, all services combined</td>
<td>$308</td>
<td>$313</td>
<td>$329</td>
<td>$274</td>
</tr>
<tr>
<td>PMPM OOP, all services combined</td>
<td>$66</td>
<td>$52</td>
<td>$71</td>
<td>$81</td>
</tr>
</tbody>
</table>

### PMPM SPENDING BY SERVICE CATEGORY

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Total</th>
<th>Large Employers</th>
<th>Small Employers</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient facility</td>
<td>$51</td>
<td>$51</td>
<td>$52</td>
<td>$48</td>
</tr>
<tr>
<td>Outpatient facility</td>
<td>$62</td>
<td>$58</td>
<td>$62</td>
<td>$67</td>
</tr>
<tr>
<td>Professional services</td>
<td>$98</td>
<td>$97</td>
<td>$102</td>
<td>$93</td>
</tr>
<tr>
<td>Labs/imaging</td>
<td>$30</td>
<td>$30</td>
<td>$30</td>
<td>$31</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>$68</td>
<td>$77</td>
<td>$83</td>
<td>$34</td>
</tr>
</tbody>
</table>

### EXHIBIT 8b. Spending Among Maryland’s Younger-65 Population, 2013

<table>
<thead>
<tr>
<th>SPENDING</th>
<th>Total</th>
<th>Large Employers</th>
<th>Small Employers</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMPM spending, all services combined</td>
<td>$298</td>
<td>$313</td>
<td>$336</td>
<td>$207</td>
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<tr>
<td>PMPM OOP, all services combined</td>
<td>$62</td>
<td>$52</td>
<td>$72</td>
<td>$68</td>
</tr>
</tbody>
</table>

### PMPM SPENDING BY SERVICE CATEGORY

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<tr>
<th>Service Category</th>
<th>Total</th>
<th>Large Employers</th>
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<tbody>
<tr>
<td>Inpatient facility</td>
<td>$57</td>
<td>$59</td>
<td>$62</td>
<td>$44</td>
</tr>
<tr>
<td>Outpatient facility</td>
<td>$56</td>
<td>$58</td>
<td>$61</td>
<td>$46</td>
</tr>
<tr>
<td>Professional services</td>
<td>$91</td>
<td>$95</td>
<td>$98</td>
<td>$73</td>
</tr>
<tr>
<td>Labs/imaging</td>
<td>$28</td>
<td>$29</td>
<td>$29</td>
<td>$24</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>$66</td>
<td>$72</td>
<td>$86</td>
<td>$21</td>
</tr>
</tbody>
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Better Use of Data for Innovation and Affordability

Benefit Design Trends: *Deductibles*

![Graph showing benefit design trends for deductibles from 2011 to 2016. The graph includes lines for Overall Inflation, Workers Earnings, Single Coverage Deductibles, all Workers, and Single Coverage Premiums. The steep increase in the Single Coverage Deductibles, all Workers line is highlighted with a note of 63%.]

Note: The case study analysis only includes silver plans. Plans that noted only pre-deductible cost-sharing amounts were excluded from the analysis; this which explains why the total number of plans shift across the analysis. Avalere did not include health plans in which there was no cost sharing across service categories or that had deductibles that were equal to the out-of-pocket maximum. 1. Avalere PlanScape®, a proprietary analysis of exchange plan features, December 2015. Avalere analyzed data from the FFM Individual Landscape File released October 2015.
Benefit Design Trends: Co-insurance

PERCENT OF PLANS SPECIALTY TIERS WITH COINSURANCE ABOVE 30 PERCENT

For specialty tier drugs, 2015 plans are requiring higher coinsurance rates compared to 2014. There was a 14 percentage point increase in the proportion of bronze and silver plans utilizing specialty tier coinsurance greater than 30 percent from 2014 to 2015.

Note: This data includes the FFM landscape file as well as data from Covered California and New York State of Health. Notably, the FFM landscape file forces plans into four tiers of data which excludes some cost-sharing detail. When plans indicated “no charge” in the HHS Landscape file, Avalere assigned the plan to $0 copayment or 0 percent coinsurance depending on which cost-sharing type was most prevalent for the specified benefit. Avalere did not include health plans in which there was no cost sharing across service categories or that had deductibles that were equal to the out-of-pocket maximum. For Tiers 1 – 3 Avalere used $0 copayment, and for Tier 4 Avalere used 0 percent coinsurance. Plans that noted only pre-deductible cost-sharing amounts were excluded from the analysis; this which explains why the total number of plans shift across the analysis.

Benefit Design Trends: **Cost-Sharing**

**Percent Paid by Patients in “Silver” Plans**

<table>
<thead>
<tr>
<th>Actuarial Value</th>
<th>Pharmacy</th>
<th>Hospital</th>
<th>Professional/Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>54%</td>
<td></td>
<td>72%</td>
<td>71%</td>
</tr>
</tbody>
</table>

**Actuarial Value**

- Pharmacy
- Hospital
- Professional/Other

**SOURCE:** Impact of Health Insurance Marketplace on Participant Cost Sharing for Pharmacy Benefits, Milliman May 2014.
## Rx Out-of-Pocket Cost: State Approaches

<table>
<thead>
<tr>
<th>Legislation</th>
</tr>
</thead>
</table>
| ✤ **Prohibition on “Specialty Tiers”**  
  - New York – Only 3 Rx tiers allowed |
| ✤ **Lower Annual Rx Maximum Out of Pocket (MOOP)**  
  - Maine - $3,500 Rx annual MOOP for drugs with co-insurance  
  - Vermont – Annual Rx MOOP equals the minimum deductible amount for HDHP ($1,300) |
| ✤ **Post-Deductible Copay Caps**  
  - CA - $250/$500 per 30 day Rx  
  - DE - $150 per 30 day Rx  
  - LA - $150 per 30 day Rx  
  - MD - $150 per 30 day Rx |

<table>
<thead>
<tr>
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</table>
| ✤ **CA – Copay Caps**  
  - Tier 4 drugs in Exchange plans capped at $250 or $500 (Bronze plans) per 30 day supply, after deductible is met |
| ✤ **MA, VT – Limit Rx Tiers**  
  - Exchange plans are limited to three (3) Rx tiers |
| ✤ **Connecticut, CA, DC – Separate Rx Deductible**  
  - Standard plans in Exchanges have a separate, relatively low drug deductible  
  - CA limits separate Rx deductible to $500 or $1000 for Bronze plans |
| ✤ **CO, MT – Fixed Copays / No Rx Deductible**  
  - A subset of plans must offer flat copays  
  - Some of the subset must have no Rx deductible |
Adherence: Medication Synchronization

- Medication non-adherence costs the U.S. $290 billion annually
- Medication synchronization coordinates chronic prescriptions to be filled on the same date each month
- Enabling legislation in Connecticut (Conn. Gen. Stat. § 38a-510)

Med sync patients are over 2.5 times more likely to be adherent to medications.
