MASSACHUSETTS
HEALTH POLICY COMMISSION

2025 Pre-Filed Testimony

As part of the
Annual Health Care Cost Trends Hearing

Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

INSTRUCTIONS FOR WRITTEN TESTIMONY

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2025 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Friday, October 31, 2025**, please electronically submit testimony as a Word document to: HPC-Testimony@mass.gov. Please complete relevant responses to the questions posed in the provided template. If necessary, you may include additional supporting testimony or documentation in an appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

Your submission must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission. All submissions are public record and will be posted to the HPC's website.

If you have any difficulty with the template or have any other questions regarding the pre-filed testimony process or the questions, please contact HPC General Counsel Lois Johnson at HPC-Testimony@mass.gov or Lois.Johnson@mass.gov.

THE 2025 HEALTH CARE COST TRENDS HEARING: PRE-FILED TESTIMONY

The Massachusetts Health Policy Commission (HPC), along with the Office of the Attorney General (AGO), holds the Health Care Cost Trends Hearing each year to examine the drivers of health care costs and consider the challenges and opportunities for improving the Massachusetts health care system.

The 2025 Health Care Cost Trends Hearing offers a critical opportunity to discuss the pressing issues challenging the stability and sustainability of the Commonwealth's health care system. These include mounting affordability issues, workforce constraints, financial volatility, increasing prescription drug costs, and threats to health care access and coverage – and the ongoing efforts to address them.

Recent federal action has created uncertainties about the health care landscape in Massachusetts. It will require a renewed commitment among stakeholders and policymakers to work together towards a health care system that is more affordable, accessible, and equitable for all residents. The 2025 Health Care Cost Trends Hearing will convene industry leaders, clinicians, and community members to reflect on recent policy actions and invite further collaborative action in Massachusetts, advancing the Commonwealth's health care goals and values.

Amid the federal activity, Massachusetts is still contending with existing affordability hardships facing the Commonwealth's residents. Massachusetts now has the highest family health insurance premiums in the country. In 2024, the average annual cost of health care for a family exceeded $31,000 (including out-of-pocket spending). As health care spending grows as a portion of household income, more and more families incur medical debt and avoid using needed care. These rates become particularly dire when health care premiums and out-of-pocket spending reach 25% of total income – a reality that 41% of Hispanic families and 26% of black families in Massachusetts faced in 2023 compared to 9% of white families. Furthermore, the average annual cost sharing per person grew from $849 in 2019 to $1,049 in 2023 (a 29% increase), and residents paying $5,000 or more annually in cost sharing doubled from 2019 (1.5%) to 2023 (3.1%).

This is the first hearing since the enactment of two significant health care laws earlier this year (Chapters 342 and 343 of the Acts of 2024), which strengthen the health care market, address rising prescription drug costs, and enhance the public transparency and accountability of the Commonwealth's health care system – including requiring additional health care market participants to provide public testimony. As the HPC, the AGO, and other state agency partners continue implementation of these new laws, the 2025 Health Care Cost Trends Hearing will focus on working together to safeguard the Commonwealth's commitment to health care affordability, access, and equity.

The pre-filed written testimony affords the HPC and the AGO, on behalf of the public, an opportunity to engage with a broad range of Massachusetts health care market participants. In addition to pre-filed written testimony, the public hearing features in-person testimony from leading health care industry executives, stakeholders, and consumers, with questions posed by the HPC's Board of Commissioners about the state's performance under the [Health Care Cost Growth Benchmark] and the status of public and industry-led health care policy reform efforts.

QUESTIONS FROM THE HEALTH POLICY COMMISSION

1. In recent years, prescription drugs have been a key driver of spending growth in the Commonwealth, consistently growing at a faster rate than the state's health care cost growth benchmark, and contributing to challenges related to health care affordability, medication access, and health disparities among Massachusetts residents.

    a. What policies or strategies should policymakers and/or other market participants consider to (1) provide greater transparency and (2) address the growing cost of prescription drugs in Massachusetts, balancing patient access to needed medications and therapies with the imperative to offer affordable coverage for employers and residents?

As the Commonwealth evaluates its prescription drug spending and impact on Massachusetts patients, Pfizer urges the state to consider stakeholders operating in the prescription drug supply chain that may drive increased out-of-pocket costs for patients and overall spending. The state may seek to prioritize reforms that address misaligned incentives that drive cost.

The share of brand medicine spending retained by manufacturers has consistently and steadily decreased. Specifically, a report by Berkeley Research Group found that half of every dollar spent on brand medicines goes to entities that play no role in the research, development, or manufacturing of medicines.[1] Other actors in the pharmaceutical supply chain, including pharmacy benefit managers (PBMs), insurers, 340B covered entities, and the government through statutory rebates take 50 percent of every dollar.[2]

Given these persistent challenges in prescription drug spending and the systemic issues within the pharmaceutical supply chain, thoughtful state reforms to address PBM practices and the 340B Drug Pricing Program could serve as key strategies to enhance transparency, promote cost accountability, and address misaligned incentives. Such reforms could help

[1] PhRMA (2025). *New study: Entities that don't make medicines get half of what is spent on those medicines*. https://phrma.org/blog/new-study-entities-that-don-t-make-medicines-get-half-of-what-is-spent-on-those-medicines

[2] *Ibid., 1.*

ensure that savings are passed on to patients and payers, supporting both improved access to essential therapies and greater affordability for employers and Massachusetts residents.

PBMs administer prescription drug benefits for health plans and employers, negotiating discounts and rebates with manufacturers and paying pharmacies for medications.[3,4] PBMs, with their health plan clients, design formularies, set utilization management requirements such as prior authorization, and control drug tiering and cost-sharing requirements for patients. In short, PBMs and their health plan clients control enrollee access and affordability of medicines.

Three PBMs control nearly 80 percent of U.S. prescriptions and medication access for about 270 million Americans.[5] PBMs argue that they leverage their scale to lower drug costs and premiums for patients and payers. In practice, however, certain PBM business practices are contributing to higher overall costs and patient affordability challenges.

PBMs often receive substantial manufacturer rebates and fees based on a drug's list price. However, there is limited transparency regarding how much of these rebates they pass back to health plans or patients.[6] A recent analysis found manufacturer rebates paid to PBMs for branded drugs reached $356 billion nationally in 2024.[7] While PBMs reportedly pass most rebates to insurers, they often retain a portion and rarely share rebates directly with patients at the pharmacy counter.[8,9] Spread pricing, where a PBM charges a health plan more for a drug than it reimburses the pharmacy and keeps the difference, has been documented as another revenue source. Over five years, the three largest PBMs generated an estimated $1.4 billion in income from spread pricing on just 51 generic drugs.[10] These opaque practices raise payer costs and, ultimately, premiums.

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[3] Massachusetts Health Policy Commission. (2025). *Testimony on pharmacy benefit manager drug pricing in Massachusetts*. https://www.mass.gov/doc/hpc-testimony-on-pharmacy-benefit-manager-drug-pricing-in-massachusetts/download
[4] Commonwealth Fund. (2025). *What pharmacy benefit managers do — and how they contribute to drug spending*. https://www.commonwealthfund.org/publications/explainer/2025/mar/what-pharmacy-benefit-managers-do-how-they-contribute-drug-spending
[5] U.S. Federal Trade Commission (2024). *Interim Staff Report, Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies.* https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf
[6] *Ibid., 5.*
[7] Fein, A. J. (2025, July 15). *Gross-to-net bubble hits $356B in 2024—But growth slows to 10-year low*. Drug Channels Institute. https://www.drugchannels.net/2025/07/gross-to-net-bubble-hits-356b-in.html
[8] Commonwealth Fund. (2025). *What pharmacy benefit managers do — and how they contribute to drug spending*. https://www.commonwealthfund.org/publications/explainer/2025/mar/what-pharmacy-benefit-managers-do-how-they-contribute-drug-spending
[9] *Ibid., 5.*
[10] U.S. Federal Trade Commission. (2025). *Specialty generic drugs: A growing profit center for vertically integrated pharmacy benefit managers* (Second Interim Staff Report). https://www.ftc.gov/system/files/ftc_gov/pdf/PBM-6b-Second-Interim-Staff-Report.pdf#page=26

Because PBM rebate revenue is tied to list price, PBMs have a perverse incentive to favor drugs with higher list prices and bigger rebates.[11] The Federal Trade Commission recently alleged that the "Big Three" PBMs used their market power to demand ever-higher rebates, prompting manufacturers to raise list prices in a vicious cycle.[12] For example, even when lower-priced versions of insulin came to market, PBMs excluded them from formularies in favor of higher-priced, higher-rebate products. This "rebate trap" contributed to an increase in insulin list prices of over 1,200 percent (e.g., a leading insulin went from ~$21 in 1999 to $274 by 2017).[13] The skewed formulary incentives can similarly hinder access to lower-cost drugs, including generics or biosimilars, in other therapy areas, shifting costs to patients, especially those with high deductibles or coinsurance who pay based on list price.[14] In short, PBMs' profit models can conflict with the goal of affordable patient access.

Reforms that address PBM rebate retention, spread pricing, and the perverse incentives to favor drugs with higher list prices for larger rebates could help ensure savings flow through to patients while maintaining patient access.

Key policy strategies Massachusetts could consider include:

Transparency Reporting: Require PBMs to disclose rebate amounts, administrative fees, and spread pricing on drugs to the state and/or to health plan sponsors.[15] Increased transparency can provide insights into what factors are contributing to cost increases and help direct future policy decisions. Since 2017, over twenty-five states including Maine, New York, and Washington have enacted laws requiring PBMs to disclose rebate information.[16] Such rebate reporting requirements were also codified earlier this year via the Massachusetts PACT Act,[17] which mandates annual data submissions to the Center for Health Information and Analysis (CHIA) by PBMs—including rebate amounts, administrative fees, and spread pricing. We urge CHIA to conduct the necessary rulemaking to implement these provisions.

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[11] Petersen-KFF Health System Tracker, Price transparency and variation in U.S. health services. January 13 ,2021. https://www.healthsystemtracker.org/brief/price-transparency-and-variation-in-u-s-health-services/.
[12] *Ibid., 5.*
[13] U.S. Federal Trade Commission. (2024). *FTC sues prescription drug middlemen for artificially inflating insulin drug prices*. Federal Trade Commission. https://www.ftc.gov/news-events/news/press-releases/2024/09/ftc-sues-prescription-drug-middlemen-artificially-inflating-insulin-drug-prices
[14] Association for Accessible Medicines. (2024). *U.S. Generic & Biosimilar Medicines Savings Report*. https://accessiblemeds.org/wp-content/uploads/2025/01/AAM-2024-Generic-Biosimilar-Medicines-Savings-Report.pdf
[15] Commonwealth Fund. (2025) *What pharmacy benefit managers do — and how they contribute to drug spending*. https://www.commonwealthfund.org/publications/explainer/2025/mar/what-pharmacy-benefit-managers-do-how-they-contribute-drug-spending
[16] National Academy for State Health Policy. (n.d.). *State pharmacy benefit manager legislation tracker*. NASHP. https://nashp.org/state-tracker/state-pharmacy-benefit-manager-legislation/
[17] Massachusetts General Court. (2024). *Mass. Gen. Laws Ch. 12C, § 10A: Reporting requirements for pharmacy benefit managers* (as amended by 2024 Mass. Acts Ch. 342, § 22, effective April 8, 2025). Retrieved from https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter12C/Section10A

Rebate Pass-Through to Patients: Patients should benefit from medicine discounts negotiated on their behalf. PBMs and insurers determine whether patients receive the discounts and rebates they negotiate with pharmaceutical manufacturers. Unlike other medical services where the patient pays *less* when their insurer negotiates a better price, very few, if any, patients pay less at the pharmacy counter despite billions of dollars in discounts and rebates paid to PBMs and insurers by manufacturers.[18] Instead, most manufacturer discounts and rebates are retained by PBMs as profit or are passed to an insurer, rather than the patient obtaining the medicine.[19] Several states, including Arkansas,[20] Indiana,[21] New Mexico,[22] North Carolina,[23] and West Virginia[24] require that PBMs set individual enrollee cost-sharing amounts for prescription drugs based on post-rebate prices (i.e., patients benefit from negotiated discounts).

Delinking PBM Compensation from Drug Prices: "Delinking" policies would prohibit PBMs and their affiliates from receiving fees or other compensation based on the price of a medicine. As previously noted, rebates and fees paid to PBMs are predominantly tied to a medicine's list price. Breaking the link between PBM compensation and the price of medicines could help address incentives that drive up costs for patients and employers.[25] Colorado recently became the first state to enact this comprehensive reform. Starting in 2027, PBMs in Colorado will charge only flat service fees, with no rebate- or spread-based earnings.[26] Delinking may have an impact on commercially insured patients that are exposed to list prices through deductibles and coinsurance.

By enacting these PBM reforms, Massachusetts could increase accountability for the "middlemen" and reduce hidden costs. Transparent, pass-through PBM reforms would help ensure that manufacturer rebates and discounts are directly reflected in reduced insurance premiums or out-of-pocket costs for Massachusetts patients.

Another potential policy area to provide greater transparency and address the growing cost of prescription drugs in Massachusetts, is through a state examination of the 340B Drug Pricing

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[18] *Ibid., 5*

[19] *Ibid., 5*.

[20] Arkansas General Assembly. (2023). *Act 333 of 2023: Healthcare Insurer Share the Savings Act and Arkansas Pharmacy Benefits Manager Share the Savings Act*. Retrieved from https://arkleg.state.ar.us/Home/FTPDocument?path=%2FACTS%2F2023R%2FPublic%2FACT333.pdf

[21] Indiana General Assembly. (2023). *Senate Bill 8: Prescription drug rebates and pricing*. Retrieved from https://iga.in.gov/legislative/2023/bills/senate/8/details

[22] New Mexico Legislature. (2023). *Senate Bill 51: Cost-sharing contributions for prescriptions*. Retrieved from https://www.nmlegis.gov/Sessions/23%20Regular/final/SB0051.pdf

[23] North Carolina General Assembly. (2025). *Senate Bill 479: SCRIPT Act*. Retrieved from https://www.ncleg.gov/Sessions/2025/Bills/Senate/PDF/S479v8.pdf

[24] West Virginia Legislature. (2021). *House Bill 2263: Committee Substitute for House Bill 2263*. Retrieved from https://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=HB2263%20SUB.htm&yr=2021&sesstype=RS&i=2263

[25] Multistate. (2025) *Pharmacy benefit manager reform: How states are changing PBM operations*. https://www.multistate.us/insider/2025/8/7/pharmacy-benefit-manager-reform-how-states-are-changing-pbm-operations

[26] *Ibid., 25.*

Program (340B program). The 340B program is a federal program created in 1992 with a worthy goal, to enable certain safety-net hospitals and clinics to purchase outpatient drugs at deep discounts to better serve uninsured and low-income patients. Under the 340B program, pharmaceutical manufacturers are required to sell drugs to "covered entities" (e.g., disproportionate share hospitals, federally qualified health centers, etc.) at significantly reduced prices. Covered entities are expected to use the savings to improve care for vulnerable populations through free or reduced-price medications or expanded services.[27]

In recent years, however, the 340B program has expanded exponentially with little transparency or accountability, raising concerns that its benefits are not always reaching the intended patients and may be contributing to higher costs elsewhere. In Massachusetts, 32 hospitals, including major academic medical centers and hospital systems, currently participate in the 340B program.[28] In 2023, 340B sales reached $66 billion nationally, increasing 23 percent from just 2022.[29] The 340B program is now the second-largest drug-purchasing program after Medicare Part D.[30] Several key expansions of the 340B program have largely fueled this growth including the Affordable Care Act's broadened eligibility for hospitals, the consolidation of clinics under hospital systems, and the rapid growth of contract pharmacy arrangements.[31] While these developments have enabled more health care providers to access 340B discounts, they also have contributed to the complexity and scale of the program within the Commonwealth and across the country, with little evidence of enhanced patient care.[32]

Contract pharmacy arrangements have evolved into sophisticated enterprises that allow covered entities to maximize 340B revenue.[33] Due to 2010 HRSA guidance, covered entities can partner with unlimited external pharmacies, which are often large for-profit pharmacy chains, to dispense 340B drugs to patients.[34] In fact, an estimated 69 percent of contract pharmacies are owned or affiliated with for-profit PBMs.[35] Prior to 2010, covered entities were permitted one contract pharmacy if they did not have an onsite pharmacy. This change

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[27] American Society of Health-System Pharmacists (ASHP). (2025). *FAQ: 340B Frequently Asked Questions*. https://www.ashp.org/-/media/assets/ambulatory-care-practitioner/docs/340-B-FAQ.pdf

[28] PhRMA (2024). *What's the 340B program like in your state?* PhRMA. https://phrma.org/blog/whats-the-340b-program-like-in-your-state

[29] Health Resources & Services Administration. (2024). 2023 340B Covered Entity Purchases. https://www.hrsa.gov/opa/updates/2023-340b-covered-entity-purchases.

[30] Blalock E. (May 2024). Measuring the Relative Size of the 340B Program: 2022 Update. Berkeley Research Group, LLC. https://www.thinkbrg.com/insights/publications/measuring-relative-size-of-340b-program-2022-update/

[31] Crippen, D. (2024). *340B Impact on the Federal Budget*. 340B Reform. https://340breform.org/wp-content/uploads/2024/10/AIR340B-CBO-Memo.pdf

[32] Congressional Budget Office. (2025). *Growth in the 340B Drug Pricing Program*. https://www.cbo.gov/publication/60661

[33] Long, R., Mulligan, K., Frasco, M. A., Trish, E., & Chernew, M. (2025). *Cui Bono? Misaligned Incentives in the 340B Program*. Schaeffer Center White Paper Series. Leonard D. Schaeffer Center for Health Policy & Economics, University of Southern California. https://doi.org/10.25549/ZZRC-6E12

[34] Health Resources and Services Administration (HRSA). (2010). *Notice regarding 340B Drug Pricing Program—Contract Pharmacy Services*. Federal Register, 75(43), 10272–10277. https://www.federalregister.gov/documents/2010/03/05/2010-4755/notice-regarding-340b-drug-pricing-program-contract-pharmacy-services

[35] Avalere Health. (2024, July 31). *PBM, mail-order, and specialty pharmacy involvement in 340B*. Avalere Health Advisory. Retrieved from https://advisory.avalerehealth.com/insights/pbm-mail-order-and-specialty-pharmacy-involvement-in-340b

following sub-regulatory guidance from HRSA led to a dramatic expansion in the number of contract pharmacies participating in the 340B program, growing from several hundred in the early 2000s to more than 30,000 nationwide today.[36]

Massachusetts 340B covered entities have actively contributed to the expansion of contract pharmacy arrangements, currently maintaining over 5,000 agreements with for-profit contract pharmacies.[37] Notably, approximately 1,500 of these contracted pharmacies are located outside the Commonwealth, underscoring the program's broad geographic reach and commercial integration.[38] Additionally, a majority of these contract pharmacies are owned by PBMs or large pharmacy chains, further complicating the distinction between 340B discount programs and the conventional pharmacy distribution system.[39]

340B hospitals purchase prescription drugs at steep discounts, then charge patients, payers, and insurers significantly higher prices for them. This profit, or "spread," on a 340B prescription can be substantial. Hospitals often bill insurers and patients full price for drugs acquired at steep discounts, using the margin to fund operations. According to one analysis, tax-exempt 340B hospitals sometimes markup medicines three to seven times the discounted price.[40] These markups become built into premiums and increase overall costs for employers, taxpayers, and patients.[41, 42]

A January 2025 report by the Berkeley Research Group found that growth in 340B hospital pharmacy revenues was the second-largest driver of U.S. brand drug spending growth from 2022 to 2023, behind only PBM, insurers, and other supply chain entities.[43] In other words, 340B has become a major financial force in the drug market.

As noted above, entities that do not manufacture drugs now capture over half of every dollar spent on brand-name medicines.[44] 340B covered entities and their partner pharmacies account for a growing share of this, now taking 18 times more of the "drug dollar" than a decade ago.[45] Moreover, a recent report from the Congressional Budget Office concluded that there is no indication patients are seeing benefits from the 340B program.[46]

Key policy strategies could include:

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[36] Drug Channels (2025). *The 340B contract pharmacy market in 2025: Big chains and PBMs tighten their grip*. Drug Channels. https://www.drugchannels.net/2025/06/340b-contract-pharmacy-market-in-2025.htm
[37] *Ibid., 28*.
[38] *Ibid., 28.*
[39] PBM Accountability Project. (2024). *340B and PBMs: How middlemen exploit a safety-net program*. https://www.pbmaccountability.org/340b.
[40] AIR340B (n.d.). *Overview of the 340B Drug Pricing Program*. Retrieved October 30, 2025, from https://340breform.org/overview/
[41] PhRMA (2024) 340B spending is exploding, forcing prices up for patients, employers and government programs. https://phrma.org/blog/340b-spending-is-exploding-forcing-prices-up-for-patients-employers-and-government-programs.
[42] IQVIA. (2024). *The cost of the 340B program part 1: Self-insured employers*. https://www.iqvia.com/locations/united-states/library/white-papers/the-cost-of-the-340b-program-part-1-self-insured-employer
[43] *Ibid., 1.*
[44] *Ibid., 1.*
[45] *Ibid., 1.*
[46] *Ibid., 32.*

Mandate 340B Transparency Reporting: Indiana recently enacted a 340B transparency law which requires 340B hospitals to submit annual reports detailing their 340B program finances.[47] Reports must include the total value of 340B discounts received, revenue generated from 340B drug sales, and a comprehensive account of how the resulting revenues were utilized to enhance patient care.[48] The legislation was driven by a bipartisan concern that 340B has veered from its original purpose. By collecting data on charity care levels, patient mix, and use of funds, Indiana aims to "focus a light" on whether hospitals are doing the right thing for indigent patients.[49] Massachusetts could enact a similar 340B hospital reporting requirement, empowering the HPC or Department of Public Health to gather information from any hospital system participating in 340B program.

Ensure 340B Revenue Directly Assist Patients: Massachusetts may also encourage or require non-profit hospitals to maintain a minimum level of charity care to maintain their tax-exempt status. Specifically, the state could require that any non-profit hospital participating in the 340B program to provide discounted or sliding-scale pharmacy services for uninsured and underinsured patients using those discounted drugs. If a low-income uninsured patient is treated at a 340B hospital, they could receive the medicine at or near the 340B acquisition price.

2. Direct-to-consumer ("DTC") sales of prescription drugs is a growing trend in the United States, enabling pharmaceutical companies to sell their drug products to patients directly or through a third party or government platform, often at discounted prices. If your company currently offers or has publicly announced plans to offer any DTC programs, either directly or through a third-party, for the sale and distribution of any of your prescription drug products, please respond to the following questions:
    a. How do you select the drug products offered in your DTC programs? Which drug products do you offer through your DTC programs and which do you plan to offer?

Pfizer does not currently offer direct sales of prescription drug products. However, on September 30, 2025, Pfizer announced that it will participate in a direct purchasing platform, TrumpRx, that, once established, will allow American patients to purchase medicines from Pfizer at a significant discount. The majority of Pfizer's primary care treatments and some select specialty brands will be offered at savings that will range as

[47] Indiana General Assembly. (2025). *Senate Bill 118: 2025 session actions and documents*. https://iga.in.gov/legislative/2025/bills/senate/118/actions
[48] *Ibid., 40.*
[49] WISH-TV. (2025, March 5). *Indiana lawmakers push for transparency in 340B drug discount program*. https://www.wishtv.com/news/politics/indiana-340b-program-transparency/

high as 85percent and on average 50percent. The specific terms of our agreement remain confidential.[50]

b. For each drug product that you currently sell through your DTC programs, indicate the DTC price for a one-month supply, and the DTC price's percentage discount off list price (if prices differ by dosage, please respond separately for each).

Pfizer does not currently offer direct sales of prescription drug products.

c. Please describe any eligibility requirements that consumers must meet to purchase drug products through your DTC programs, and which payment methods your programs accept or will accept, including cash pay, insurance, FSA/HSA accounts, and other payment methods.

Pfizer currently does not offer direct sales of prescription drug products.

d. Please describe any prescriber consultations that you facilitate, either directly or through a partnership with a provider organization, for consumers seeking to purchase a drug product through your DTC programs.

Pfizer currently does not offer direct sales of prescription drug products.

3. Massachusetts now has the highest family health insurance premiums in the United States. In 2024, the average annual cost of health care for a family exceeded $31,000 (including out of pocket spending). This reflects the growth in underlying health care costs. As health care spending grows as a portion of household income, more and more families incur medical debt and avoid using needed care. Collaborative, urgent action across market participants is needed to reverse these trends. How can your organization contribute to this effort?

Medical debt has become a pervasive burden on American families, deterring many from seeking care and straining household finances. Nearly one-third of U.S. adults of working age

[50] Pfizer. (2025). *Pfizer reaches landmark agreement with U.S. government to lower drug costs.* https://www.pfizer.com/news/press-release/press-release-detail/pfizer-reaches-landmark-agreement-us-government-lower-drug

are in debt due to medical or dental bills, making medical debt a leading cause of personal bankruptcy.[51] This debt often forces difficult trade-offs: about 40 percent of indebted adults report cutting back on food, heating, or rent to pay medical bills.[52]

Pfizer recognizes the need to address the rising cost of health care nationally and in Massachusetts, particularly as it relates to the growing burden of medical debt on families. Pfizer offers copay assistance programs for many of its products to reduce the financial burdens associated with deductibles, coinsurance, and copays among commercially insured patients. Our copay assistance programs can significantly reduce out-of-pocket costs to qualifying patients, who may pay as low as $0 for their medicines.[53] We also offer free medicines to qualifying patients insured by Medicare or Medicaid, and to patients who are uninsured.[54] Our free medicine program provided 44,000 patients with over 351,000 Pfizer prescriptions for free in 2024.[55]

In addition to offering these assistance programs to help patients access treatments and avoid debt, Pfizer is committed to being part of the solution by actively working with stakeholders to address medical debt through legislative solutions. States across the country are recognizing the medical debt crisis and stepping up with policy solutions that broadly fall into a few strategic categories:

- Expanding Financial Assistance and Coverage
- Capping or Eliminating Interest on Medical Bills
- Regulating Debt Collection Practices (Billing, Lawsuits, Garnishments, Liens)
- Removing Medical Debts from Credit Reports
- Innovative Debt Relief Programs (Debt Forgiveness, Purchasing)

Massachusetts currently addresses medical debt on several fronts: maintaining near-universal insurance coverage, funding a statewide charity care program for the needy,[56] mandating interest-free, low-payment hospital payment plans,[57] and curbing aggressive collection practices (limits on wage garnishment and property liens).[58] However, there remain important policy tools not yet in place that the Commonwealth could adopt. The following measures – drawn from effective state interventions elsewhere – could be considered:

- **Ban Medical Debt from Credit Reports:** Massachusetts could prohibit credit reporting of medical debt, ensuring that medical bills do not damage consumers' credit scores. Over a dozen states (including Colorado, New York, Illinois, California, Maryland, and

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[51] Kona, M., & Raimugia, V. (2025). *State protections against medical debt: A look at policies across the U.S. in 2025*. Commonwealth Fund. https://www.commonwealthfund.org/publications/fund-reports/2025/jul/state-protections-against-medical-debt-look-policies-across-us
[52] Commonwealth Fund. (2023). *Health Care Affordability Survey: The Price of Health*. https://libertyandwealth.com/americas-medical-debt-crisis/
[53] PfizerForAll. https://www.pfizerforall.com/
[54] *Ibid., 53.*
[55] Pfizer. (n.d). *PfizerRx Pathways*. https://www.pfizerrxpathways.com
[56] *Ibid., 51.*
[57] Massachusetts Law Reform Institute & Health Law Advocates. (2024, May). *Medical bills and debt*. Massachusetts Legal Help. https://www.masslegalhelp.org/health-disability-rights/medical-debt/medical-bills-and-debt
[58] *Ibid., 51.*

North Carolina) have enacted such bans or are in the process.[59] Adopting a similar ban in Massachusetts would mean no resident's credit score suffers due to medical bills, improving access to loans, housing, and employment for those with past medical expenses. This policy is low-cost to implement and addresses the reality that medical debt is an unreliable indicator of credit risk.[60]

- **Cap or Eliminate Interest on Medical Debt:** Unlike some states, Massachusetts currently has no statutory limit on interest rates that can be charged on medical debt judgments or payment plans.[61] Arizona's Proposition 209 (approved by 72 percent of voters in 2022) is a model – capping interest on medical debt at 3 percent per year, or the federal one-year Treasury rate, if lower.[62] Similarly, North Carolina and New Jersey have new laws limiting medical debt interest to 3 percent annually.[63] Connecticut and Delaware went even further – prohibiting charging any interest on medical bills or debt collection.[64] By enacting a 3percent cap or zero-interest rule, Massachusetts would join at least 13 other states that have curbed interest charges on medical debt.[65]
- **Prohibit Extreme Collection Actions (Liens, Garnishments, Arrest):** Massachusetts already limits wage garnishment and protects a portion of home equity, but it does not entirely ban these aggressive collection tools for medical debt. States like New York (2022) and North Carolina (2023) have outlawed placing liens on patients' primary homes and garnishing wages to collect medical debt.[66] Massachusetts could similarly amend its laws to ensure no one's home or essential wages can be seized over medical bills. Thirteen states now forbid or strictly limit medical debt–related property liens.[67] Furthermore, Massachusetts could extend protections to wages by effectively banning wage garnishment for medical debts, as New York and North Carolina have done.[68]
- **Expand Eligibility for Hospital Financial Assistance:** One preventive strategy is to ensure more middle-income families qualify for free or discounted care before debt accrues. Massachusetts' Health Safety Net currently guarantees free hospital care for uninsured patients up to 150 percent of the federal poverty level (FPL), and a partial subsidy on a sliding scale up to 300 percent FPL.[69] However, many families with moderate incomes just above these cutoffs still struggle with large medical bills, particularly if they have high-deductible insurance. Massachusetts could consider

[59] *Ibid., 51.*
[60] Consumer Financial Protection Bureau. (2025). *CFPB finalizes rule to remove medical bills from credit reports*. https://www.consumerfinance.gov/about-us/newsroom/cfpb-finalizes-rule-to-remove-medical-bills-from-credit-reports
[61] *Ibid., 51.*
[62] Ballotpedia. (2022). *Arizona Proposition 209, Healthcare Debt Interest Rate Limit and Debt Collection Exemptions Initiative (2022).* https://ballotpedia.org/Arizona_Proposition_209,*Healthcare_Debt_Interest_Rate_Limit_and_Debt_Collection_Exemptions_Initiative*%282022%29
[63] *Ibid., 51.*
[64] *Ibid., 51.*
[65] *Ibid., 51.*
[66] *Ibid., 51.*
[67] *Ibid., 51.*
[68] *Ibid., 51.*
[69] Massachusetts Law Reform Institute. (2025). Health services for all [PDF]. Mass Legal Services. https://www.masslegalservices.org/system/files/library/health%20services%20for%20all-ENG%202025%20%281%29.pdf

raising its income thresholds for hospital charity care. In 2022, Washington State implemented the nation's strongest charity care law, ensuring free hospital care for patients up to 300 percent FPL, and substantial discounts up to 400 percent FPL.[70] Oregon's experience, as Washington noted, showed that broadening charity care did not cause financial harm to hospitals[71]– a key consideration for sustainability. Additionally, Massachusetts could require that physician groups affiliated with hospitals also honor these charity care policies.

- **Tighten Regulation of Medical Debt Sales and Collection Practices:** Another opportunity is to regulate how medical debt is transferred or collected to prevent predatory behavior. Massachusetts could prohibit the sale of medical debt to third-party debt buyers, at least for certain cases (e.g., debts of lower-income patients or those eligible for financial assistance). California, New Mexico, and North Carolina already forbid hospitals from selling debt for patients who qualify for charity care or are below certain income levels.[72] Massachusetts might also stipulate that if a patient is on a payment plan or actively communicating about a bill, the provider cannot sell the debt – similar to protections in New Jersey and Florida.[73,74] Furthermore, Massachusetts could join the states that bar debt buyers from adding extra fees or interest on purchased medical debt (as California does), and forbid debt collectors from pursuing foreclosure on medical debts (as Colorado now does).[75] The state can complement these restrictions with enhanced transparency and enforcement: requiring hospitals to report their debt collection actions and outcomes, by demographics, to a state agency. Maryland's recent law, for example, mandates detailed reporting on hospital debt lawsuits and financial assistance provided, which helps track whether hospitals are complying with the spirit of the law.[76]
- **Implement a State-Supported Debt Relief Program:** Finally, Massachusetts could directly alleviate the existing burden of medical debt that residents carry. Following the lead of Illinois and Connecticut, Massachusetts could partner with nonprofit organizations to buy medical debt and forgive it. For example, Illinois' new Medical Debt Relief Program is using $10 million in state funds to erase an estimated $1 billion in medical debt for over 340,000 residents.[77]

Additionally, and as mentioned above, Pfizer is concerned about abuse within the 340B Drug Pricing Program and the lack of charity care provided by Massachusetts' 340B hospitals which may be contributing to the medical debt problem. As mentioned earlier, under the federal

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[70] Washington State Office of the Attorney General. (n.d.). *Washington State Charity Care Law*. https://www.atg.wa.gov/charitycare

[71] Washington State Department of Health. (2025, January). *2023 Charity Care in Washington Hospitals: Report to the Legislature*. https://doh.wa.gov/sites/default/files/2025-01/2023CharityCareinWashingtonHospitals.pdf

[72] *Ibid., 51*

[73] Stevens & Lee. (2025, August 7). New Jersey's Medical Debt Relief Act now fully in effect. JD Supra. https://www.jdsupra.com/legalnews/new-jersey-s-medical-debt-relief-act-5417988

[74] Florida Legislature. (2024). *House Bill 7089: Medical debt reform*. https://www.americollect.com/2024/04/florida-legislature-passes-medical-debt-reform-with-hb-7089/

[75] *Ibid., 51.*

[76] Maryland General Assembly. (2025). *Senate Bill 981: Hospitals – Financial Assistance and Collection of Debts – Policies (Chapter 694)*. https://mgaleg.maryland.gov/2025RS/Chapters_noln/CH_694_sb0981t.pdf

[77] The New School Budget Equity Project. (2024, December 17). *The state of government-led medical debt cancellation efforts*. https://budgetequity.racepowerpolicy.org/reports/medical-debt-relief

340B program, manufacturers reduce prices of outpatient medicines by tens of billions of dollars each year for safety-net clinics and qualifying non-profit hospitals ("covered entities"). The expectation is that those entities will use the profit they generate from the program to help vulnerable patients access more affordable medicines, but a lack of transparency and oversight has led to abuse of the 340B program.[78]

Many hospitals participating in the 340B Drug Pricing Program, including hospitals in Massachusetts, generate significant profits from discounted drug purchases but frequently fail to reinvest these profits into charity care.[79] In fact, charity care provided by 340B hospitals has been declining, even as 340B revenues climbed.[80] Charity care levels at Massachusetts 340B hospitals have generally declined over the past decade, even as hospital revenue from 340B drug discounts soared.[81,82] Charity care makes up, on average, just 1 percent of total operating costs at Massachusetts hospitals, with 94 percent of these hospitals falling below the national average for all hospitals.[83] Expanded insurance coverage under the Affordable Care Act, the Massachusetts Health Care Reform Law, and low uninsured rates may have reduced the demand for charity care.[84] In other words, hospitals faced fewer uninsured patients needing free care, which may partly explain the contraction in charity care levels. However, data from the American Cancer Society Cancer Action Network Survivor Views survey reveals that 98 percent of cancer patients report having health insurance at the time they incurred medical debt—most of them enrolled in high-deductible health plans without access to Health Savings Accounts (HSAs).[85] This suggests that while insurance coverage has expanded, many patients still face significant financial barriers to care. The prevalence of underinsurance may mean that charity care needs persist, even if they are not reflected in traditional metrics focused solely on the uninsured population.

At the same time, 340B program revenues did not shrink in parallel. In fact, the 340B program grew substantially during this period. Nationwide 340B drug purchases quadrupled from $9

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[78] PhRMA. (2025). *340B State Profiles: Massachusetts* [Fact sheet]. https://cdn.aglty.io/phrma/fact-sheets/340b/2025/Fact%20Sheet%20-%20340B%20State%20Profiles%20Massachusetts.pdf

[79] U.S. Government Accountability Office. (2023). *340B Drug Discount Program: Information about Hospitals That Received an Eligibility Exception as a Result of COVID-19* (GAO-23-106095). Retrieved from https://www.gao.gov/products/gao-23-106095

[80] DistilInfo Hospital IT. (2022, March 24). Mass hospitals offered low charity care despite high 340B revenue. https://distilinfo.com/hospitalit/2022/03/24/mass-hospitals-offered-low-charity-care-despite-high-340b-revenue/

[81] Pioneer Institute. (2022). *Study: Massachusetts hospitals pull back on charity care as revenue from federal 340B drug discount program explodes*. PRWeb.https://www.prweb.com/releases/study-massachusetts-hospitals-pull-back-on-charity-care-as-revenue-from-federal-340b-drug-discount-program-explodes-802236091.html

[82]https://distilinfo.com/hospitalit/2022/03/24/mass-hospitals-offered-low-charity-care-despite-high-340b-revenue/ *Ibid., 80.*

[83] *Ibid., 78.*

[84] *Ibid., 80.*

[85] American Cancer Society Cancer Action Network. (2024). *Survivor Views: Majority of cancer patients & survivors have or expect to have medical debt*. https://www.fightcancer.org/policy-resources/survivor-views-majority-cancer-patients-survivors-have-or-expect-have-medical-debt

billion in 2014 to $147.8 billion by 2024.[86,87] Massachusetts hospitals likewise expanded their participation (e.g., by adding contract pharmacies) and benefited from increasing 340B savings.[88] Reduced need for charity care should have led to a smaller 340B footprint, yet the opposite occurred: hospitals continued to reap growing 340B savings even as charity care provision declined.[89]

Pfizer is advocating for federal reforms that ensure vulnerable patients benefit from the program and improve transparency and oversight of the 340B Drug Pricing Program. While the state cannot alter the federal 340B program's core requirements, it can enforce greater transparency and set expectations to ensure hospitals reinvest in their communities, such as:

- **Transparency and Reporting Requirements**: Massachusetts currently has no mandate for hospitals to report 340B revenue or the use of those funds.[90] North Carolina and other states now compel hospitals to detail 340B proceeds and community benefit expenditures).[91]
- **Standardized Definition of Charity Care:** Currently, what counts as "charity care" can vary by hospital. Massachusetts follows the federal framework where charity care generally means free or discounted care provided to those who cannot pay, but there is no uniform statewide standard quantifying required charity care levels.[92] Massachusetts could establish a clear, standardized definition of charity care that focuses on the cost of care provided to uninsured or low-income individuals.[93] This would exclude some nebulous "community benefit" categories that hospitals sometimes count (like unpaid medical bills that get written off as bad debt, or indirect activities).
- **Minimum Charity Care Expectations and Accountability:** Unlike some states, Massachusetts does not mandate that a non-profit hospital provide a minimum level of charity care or community benefit to maintain its tax-exempt status.[94] One potential

[86] Smith, B., & Archambault, J. (2022). *Study: Massachusetts hospitals pull back on charity care as revenue from federal 340B drug discount program explodes*. Pioneer Institute. PRWeb. https://www.prweb.com/releases/study-massachusetts-hospitals-pull-back-on-charity-care-as-revenue-from-federal-340b-drug-discount-program-explodes-802236091.html
[87] IQVIA. (2025). *The size and growth of the 340B program in 2024*. IQVIA. https://www.iqvia.com/locations/united-states/library/white-papers/the-size-and-growth-of-the-340b-program-in-2024
[88] *Ibid., 78.*
[89] Hopkins, M. J., Macsata, B. M., & Laws, J. (2025). *The 340B Drug Rebate Program and its Potential Impacts on Annual Revenues, Executive Compensation, and Charity Care Provision in Eligible Covered Entities: Supplemental Report*. ADAP Advocacy & Community Access National Network. https://www.adapadvocacy.org/pdf-docs/2025_ADAP_Project_RW_340B_Asset_14_ExecComp_Supplemental_Report_02-21-25.pdf
[90] Mulvey, M. (2024, July 23). *An evaluation of 340B in Massachusetts*. Pioneer Institute. https://pioneerinstitute.org/blog/blog-better-government/blog-transparency/an-evaluation-of-340b-in-massachusetts/
[91] 340B Report. (n.d.). *Covered entity reporting requirement bills*. 340B Report. Retrieved October 27, 2025, from https://340breport.com/legislative-map/covered-entity-reporting-requirement-bills/
[92] Health Equity Collaborative. (2024, October). *The state of U.S. charity care: Solutions to improve the patient experience and achieve more equitable health outcomes*.https://healthequitycollaborative.org/wp-content/uploads/2024/10/Final-HEC-White-Paper-340B-and-Charity-Care-October-2024.pdf
[93] *Ibid., 80.*
[94] *Ibid., 92.*

policy solution is to tie hospital tax exemptions to a charity care standard. For example, Massachusetts could require that a 340B hospital's charity care spending (or overall community benefit) be at least a certain percentage of its patient revenue or equivalent to its 340B savings.

STATEMENT FROM SIGNATORY

I, Tom Brownlie, represent that I am legally authorized and empowered to represent the named organization, Pfizer Inc., for the purposes of this testimony. This testimony is signed under the pains and penalties of perjury.

Tom Brownlie
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