



SUBMITTED VIA E-MAIL TO: ehb@dora.state.co.us

Office of the Governor, State of Colorado
Colorado Division of Insurance
Colorado Health Benefit Exchange

September 10, 2012

Re: Comments on Draft Essential Benefits Benchmark Plan Recommendation

Pfizer, Inc. (Pfizer) appreciates the opportunity to comment on the draft essential benefits benchmark plan recommendation developed by the Office of the Governor, the Division of Insurance, and the Colorado Health Benefit Exchange. Pfizer is a research-based global pharmaceutical company dedicated to the discovery and development of innovative medicines and treatments that improve the quality of life for people around the world.

We strongly believe that essential health benefits should include a wide range of health care products and services that meet diverse patient needs, and provide the scope of benefits under a typical employer plan, as mandated by the Affordable Care Act (ACA). Patients and their healthcare providers should have access to a broad array of treatment options, and patients' out-of-pocket exposure should be affordable and transparent, so the most appropriate treatment choices can be made. Given our commitment to biomedical research and development, we also believe essential health benefits should take into account the role of innovation and the advancement of medical and scientific knowledge in providing access to treatment options.

In accordance with these principles, we offer the following recommendations for your consideration:

- 1) To allow stakeholders to fully evaluate whether the draft recommendation provides meaningful coverage of innovative treatments for all consumers, detailed formulary information should be publicly released before final adoption of the plan as the state's benchmark.***

Innovative medicines enable people to live longer, healthier, and more productive lives. A recent study found that medicines specifically account for 50 to 60 percent of increases in survival rates since 1975.¹ Another study revealed that life

¹ Pharmaceutical Research and Manufacturers of America, Pharmaceutical Industry Profile 2010 (Washington, DC: PhRMA, March 2010).

expectancy for cancer patients has increased about 3 years since 1980, and 85 percent of those gains are attributable to new treatments, including medicines.²

In addition to strengthening health outcomes, prescription drugs lead to long-term cost savings across the health care system by reducing unnecessary hospitalizations and preventable medical care. For example, a study of Medicare Part D revealed that comprehensive drug coverage is associated with reductions in non-drug spending, resulting in overall savings to Medicare of \$13.4 billion in a single year.³

Thus, it is essential that Colorado select a benchmark plan that provides comprehensive prescription drug coverage and access to innovative therapies. To allow Coloradans to fully assess whether the proposed benchmark plan, Kaiser Ded/CO HMO1200D, provides comprehensive prescription drug coverage, detailed formulary information should be publicly released. This should include, at a minimum, the plan's formulary, criteria for adding and removing prescription drugs from the formulary, and specific details on the plan's non-preferred drug authorization process. This information is not included in the plan summary, policy form, or comparison charts that have been posted on the Division of Insurance website. While Pfizer supports the objectives that Colorado used in developing its draft recommendation,⁴ we believe that a complete evaluation of drug coverage under these objectives cannot be made without reviewing formulary information.

In addition, releasing formulary information for the Kaiser Ded/CO HMO1200D plan will allow consumers, providers, and other stakeholders to evaluate the implications of the "one drug per class" standard set forth in federal guidance. Under this standard, if a benchmark plan offers a drug in a certain category or class, all individual and small group plans must offer at least one drug in that same category or class. Although Pfizer believes this standard falls far below the level of benefits currently available under most employer plans and is wholly inadequate to address the needs of many patients, we recognize that it is applicable until additional federal guidance states otherwise. As such, it is essential that Colorado's benchmark plan cover a broad distribution of therapeutic classes for all disease categories. Measuring whether the Kaiser Ded/CO HMO1200D plan provides such coverage is nearly impossible without formulary information.

2) Colorado should evaluate the cost-sharing requirements of its recommended benchmark plan to protect consumers from unexpected financial obligations and ensure plan compliance with the ACA's prohibition on discriminatory benefit design.

² Ibid.

³ Pharmaceutical Research and Manufacturers of America, Pharmaceutical Industry Profile 2012 (Washington, DC: PhRMA, April 2012).

⁴ Office of the Governor, the Division of Insurance, and the Colorado Health Benefit Exchange, Draft Recommendation for Stakeholder Input, August 31, 2012, p. 1 (stating that inclusion of state-mandated benefits, covering each of the ten required statutory categories, limiting market disruptions, promoting carrier and consumer participation in the market, and balancing comprehensiveness and affordability were objectives considered in developing the draft recommendation).

In its announcement on August 31, 2012, Colorado states that its draft benchmark recommendation “does not extend to cost-sharing.”⁵ For the reasons outlined below, Pfizer recommends that Colorado evaluate the relevance of cost-sharing before finalizing its benchmark recommendation.

Cost-sharing is an integral element of plan benefit design and heavily impacts consumer access to health care. A Milliman report found that the degree to which beneficiaries have access to prescription drugs or other services depends in large part on *how* these services are covered, which includes not only what items and services are covered benefits, but also the amount of cost-sharing that is imposed on those benefits.⁶ According to Milliman, the impact of cost-sharing requirements is so great that “covered services with much higher patient cost-sharing or much more limited access than most other services could be thought of as outside the core benefits.”⁷

In fact, research shows that burdensome patient out-of-pocket costs and high copayments can cause people to delay or forgo needed treatment. According to a 2007 study in the *Journal of the American Medical Association (JAMA)*, for each 10 percent rise in cost sharing, medicine use fell between 2 percent and 6 percent.⁸ Studies have shown that, even for severe life-threatening diseases such as cancer, significantly more patients abandon treatment at higher co-pays. When patients do not adhere to their treatment regimens as established by their health care providers, their conditions may worsen, creating higher health system costs in the future.

The impact of excessive cost-sharing requirements on patients is one of the reasons why the ACA explicitly prohibits benefit designs from discriminating against individuals because of their age, disability, or expected life.⁹ To ensure plan compliance with this ACA provision, Colorado should evaluate the cost-sharing requirements and affordability of the Kaiser Ded/CO HMO1200D plan and ensure that the plan provides accessible and affordable coverage of necessary and appropriate medical therapies. Also, the plan’s out-of-pocket obligations, whether coinsurance or copayments, should be designed such that they fall within a limited and narrow range across the full array of disease categories.

3) Colorado should establish clear and meaningful standards for comparing health plans to the benchmark plan, including consideration of formulary breadth and cost-sharing.

The draft recommendation correctly notes that plans in the individual and small group markets will be required to offer benefits that are “substantially equal”

⁵ Ibid.

⁶ B. Pyenson et al., “Essential Health Benefits - What is Typical?,” Milliman, May 2011, available at <http://insight.milliman.com/article.php?cntid=7637>.

⁷ Ibid.

⁸ D. Goldman, et. al., “Prescription Drug Cost Sharing, Associations with Medical Utilization and Spending and Health,” *Journal of the American Medical Association*, July 4, 2011, available at <http://jama.ama-assn.org/content/298/1/61.abstract>.

⁹ Patient Protection and Affordable Care Act, Public Law 111-148 (March 23, 2010), as modified by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (March 30, 2010), Title I, Subtitle D, Section 1302.

to the state's benchmark plan.¹⁰ However, the draft recommendation does not address how Colorado will define "substantially equal" beyond actuarial equivalence.

To make a reasoned judgment about the comparability of coverage, Colorado should develop a set of criteria that address multiple aspects of coverage, including the following:

- For prescription drug coverage, formulary breadth must be evaluated. This includes ensuring that plans cover a broad distribution of therapeutic categories and classes that reflects, at a minimum, the range of drugs covered by the benchmark plan.
- To further protect consumers, excessive cost-sharing requirements and utilization management should be a consideration. For instance, if the benchmark plan does not utilize discriminatory specialty tiers or restrictive step therapy, individual and small group plans should not be considered substantially equal to the benchmark coverage if they do.
- A plan's exceptions and appeals process should be at least as robust as the benchmark plan. For prescription drug coverage, this includes ensuring that the plan provides enrollees with the opportunity to obtain an exception when a needed drug is excluded from a plan's formulary or placed on a higher cost-sharing tier.

Pfizer encourages Colorado to publicly outline criteria that the state will use to evaluate whether plan coverage is actually comparable to the state's benchmark plan. Such criteria should include, at a minimum, the factors listed above and draw on current best practices in the commercial and employer-sponsored market.

4) Colorado must ensure that plans do not utilize benefit design flexibility to discriminate against vulnerable, high-cost consumers.

The draft recommendation also notes that federal guidance issued to date allows plans to make actuarially equivalent substitutions to the benchmark plan.¹¹ Pfizer supports multiple choices of benefit designs, which the flexibility to substitute benefits is intended to foster. However, it is critical that Colorado establish consumer protections that prevent plans from using this flexibility to risk select in a manner that leaves vulnerable, high-cost consumers with extreme financial obligations.

¹⁰ Office of the Governor, the Division of Insurance, and the Colorado Health Benefit Exchange, Draft Recommendation for Stakeholder Input, August 31, 2012, p.2.

¹¹Ibid.

A recent issue brief from the *Robert Wood Johnson Foundation* and *Urban Institute* provides an illustrative example.¹² In a selected state, mandated coverage of oral chemotherapy was shown to save individual patients up to \$7,000 per year, but because the patients who needed oral chemotherapy only made up 0.4 percent of enrollees, the cost of the mandate only increased employer premiums by 0.014 percent.¹³ This relatively low premium impact means that if a plan in this state was allowed to vary benefits from the benchmark plan to exclude oral cancer drugs, there may not be a detectable impact on actuarial equivalence; particularly, if the plan offset the exclusion with benefit changes for less costly enrollees.¹⁴ However, the substantial impact on individual cancer patients could dissuade some from enrolling in the plan, while allowing the plan to avoid the total cost of care for those patients.¹⁵

To ensure that plans do not adjust services in a manner that discriminates against vulnerable, high-cost consumers, Colorado should consider reviewing substitutions to ensure that they are actuarially equivalent and non-discriminatory. The state should also consider consumer protections such as a formulary review process, limitations on specialty tiers and excessive cost-sharing, and a robust appeals process.

Conclusion

We appreciate the opportunity to review the draft recommendation for Colorado's essential benefits benchmark plan. We look forward to more detailed analyses, additional information, and ongoing opportunities to provide input.

Thank you for your consideration. Should you have any questions related to these comments, please feel free to contact me at 480-948-4948.

With kind regards,



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Pfizer, Inc.

¹² L. Clemans-Cope, et. al., "Protecting High-Risk, High-Cost Patients: Essential Health Benefits, Actuarial Value, and Other Tools in the Affordable Care Act," Robert Wood Johnson Foundation, Urban Institute, June 2012, available at <http://www.rwjf.org/files/research/74504.quickstrike.essentialbenefits.pdf>.

¹³ Ibid.

¹⁴ Ibid.

¹⁵ Ibid.