Pfizer Inc.
235 East 42nd Street
New York, NY 10017

November 15, 2016

Office of the Lieutenant Governor
State Capitol Building
210 Capitol Avenue, Room 304
Hartford, CT 06106

Re: *Potential Strategies to Better Control Rising Pharmaceutical Costs*

Dear Lt. Governor Wyman, Director Schaefer, and the Members of the Connecticut Health Care Cabinet:

Pfizer Inc. (Pfizer) appreciates the opportunity to offer comments on the Health Care Cabinet's (Cabinet) preliminary recommendations for controlling pharmaceutical spending in the State of Connecticut. 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.

Connecticut is home to the largest site in Pfizer's R&D network and our Groton site serves as a Center of Excellence for drug discovery and development. Pfizer also operates a state-of-the-art clinical research unit in New Haven, where colleagues perform clinical research studies. Nearly every Pfizer medicine is developed in part by more than 3,000 Connecticut colleagues who work to translate advanced science and technologies into the therapies that matter for patients in need. Pfizer Connecticut colleagues are leading the way in drug development, providing vital information, tools, technologies, data, drug targets, and compounds to scientists around the globe, at every level of drug discovery and development, and across all of Pfizer's therapeutic areas.

Pfizer is committed to meeting the needs of patients and improving the health care system and, as such, we applaud Lieutenant Governor Wyman and the Cabinet for undertaking this important work of identifying ways to improve the efficiency and quality of health care delivered to the citizens of Connecticut. Furthermore, given the interconnected nature of health care, we appreciate that the Cabinet is examining payment and delivery reforms across all medical services.

With respect to the proposed strategies for reducing prescription drug costs, Pfizer agrees that there may be systemic and patient-level benefits from exploring value-based contracting models (i.e., performance based contracts or indication specific pricing (Sections 2.B.1. and 2.D.1.I.)) and enhancing medication adherence (Section 3), respectively. We recognize that value-based contracts have the potential to align incentives between manufacturers, payers, and patients, thereby reducing inefficiencies that exist under the current system. With appropriate investments in IT system development, improving integration between claims, clinical data, and regulatory reforms,

value-based payment models will likely see significant expansion. We see an important opportunity to partner with the State of Connecticut to control cost and enhance patient care by improving medication non-adherence, which contributes to an estimated $290 billion annual in wasteful spending.[1]

Pfizer is looking forward to productive discussions on the above mentioned strategies as well as exploring additional collaborations in lowering overall healthcare spending. However, we have concerns regarding those strategies put forward to control prescription drug costs that require the disclosure of business information that offers no benefit to payers, providers, or patients and could compromise market competition. We understand that the recommendations are preliminary and will continue to evolve in 2017. Therefore, our comments below are primarily procedural and are intended to ensure that any emerging strategies offer real solutions that are not only feasible to implement, but have the potential to lower overall health care spending and ultimately benefit patient health outcomes.

Specifically, Pfizer believes that the Cabinet should consider the following recommendations:

i. Include a broader set of stakeholders in the Connecticut Health Care Cabinet, including those from the prescription drug delivery and reimbursement system and additional patient advocates;
ii. Integrate the Cabinet's efforts with the Task Force to Study Value-Based Pricing of Prescription Drugs to be formed pursuant to Special Act 16-18[2];
iii. Examine insurance benefit design trends that impact patient out-of-pocket costs;
iv. Examine prescription drug spending within overall health care spending and in the context of the broader health care system; and
v. Review findings and reports from the Washington State Task Force on Patient Out-of-Pocket Task Force.[3]

Recommendation #1: We respectfully request that the Cabinet include stakeholders involved in the prescription drug delivery and reimbursement system as well as patient advocates in the development of pharmaceutical cost containment proposals.

Prescription drug delivery and reimbursement is extremely complex and involves multiple entities, including manufacturers, wholesalers, pharmacies, pharmacy benefit managers (PBMs), insurers, and employers (See Appendix A). The system is also evolving such that the system now often includes specialty pharmacies, specialty distributors, outpatient infusion centers, and group purchasing organizations (GPOs). As the complexity of the system has increased, the complexity of reimbursement has also increased. Despite their highly specialized knowledge of the ecosystem, few of the above noted entities have been involved in the development of the Cabinet's preliminary

[1] NEHI, *Improving Patient Medication Adherence: A $290 Billion Opportunity.* http://www.nehi.net/bendthecurve/sup/documents/Medication_Adherence_Brief.pdf
[2] Connecticut Special Act 16-18. https://www.cga.ct.gov/2016/act/sa/pdf/2016SA-00018-R00SB-00309-SA.pdf
[3] Washington State Task Force website: http://www.doh.wa.gov/AboutUs/PatientOutofPocketCostsTaskforce.

recommendations. Pfizer believes that that these entities should be included in any policy development processes that seek to inform or shape prescription drug spending in Connecticut.

In addition, we believe that the Cabinet should include patients representing a range of conditions. Efforts to contain health care costs must also account for intended and unintended health and financial impacts on patients. Patients and patient advocate perspectives are vital to a robust policy development process and should be included in the Cabinet's work.

Recommendation #2: Integrate the Value Based Prescription Task Force into the Cabinet's work on prescription drugs.

This year, the legislature passed Senate Bill No. 309 (Special Act 16-18), *An Act Establishing a Task Force to Study Value Based Pricing of Prescription Drugs*.[4] The Task Force is charged with examining value based pricing and submitting its findings by January 1, 2017. Given that there appears to be overlapping goals between the Cabinet and the Task Force, we recommend that the Cabinet consider integrating the work streams together to improve efficiency and as another mechanism to potentially expand the breadth of stakeholder involvement.

Recommendation #3: Given the significant role that insurance benefit design plays in how patients utilize – or do not utilize – the health care system, the Cabinet should examine strategies to ensure that cost-sharing does not impede access to medically necessary care and thereby increase poor health outcomes and health care costs.

Insured patients are facing ever-increasing out-of-pocket cost burdens in the form of higher medical deductibles, more frequent use of pharmacy and combined medical/pharmacy deductibles, higher copayments, and more frequent use of co-insurance. Since 2006, the percentage of covered workers in employer-sponsored health plans with a general annual deductible has increased from 55 percent to 80 percent, with an average general annual deductible of $1,217 in 2014.[5] Between 2011 and 2016, deductibles in employer-sponsored health plans increased 7 times faster than wages.[6] The proportion of commercial health plans with pharmacy deductibles grew by 100 percent between 2012 and 2015.[7]

When a deductible applies to a service or to a prescription drug, the patient typically must pay the full cost of the service or drug before any cost sharing (such as a co-pay or coinsurance) applies. Deductibles shift costs away from insurers and often represent high up-front costs for patients.

[4] Connecticut Special Act 16-18. https://www.cga.ct.gov/2016/act/sa/pdf/2016SA-00018-R00SB-00309-SA.pdf.
[5] Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006–2014. Available online at: http://kff.org/report-section/ehbs-2014-summaryof-findings/.
[6] Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2016. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999 -2016; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2016 (April to April).
[7] IMS Institute for Healthcare Informatics, "Emergence and Impact of Pharmacy Deductibles," September 2015.

After meeting their deductible, patients are also facing more tiers and higher cost-sharing for their prescription drugs. The number of tiers health plans use has been steadily increasing. In 2016, 14 percent of Exchange plans used 6-tier formularies and 5 percent used 7-tier formularies.[8] Similar trends are occurring with the use of high coinsurance. In 2015, 52 percent of bronze plans had specialty tier coinsurance of greater than 30 percent.[9]

Connecticut has established protections against high deductibles and excessive cost-sharing for prescription drugs in their exchange plans; however, such protections have not been extended to plans offered off of the Exchange.[10] Therefore, high out-of-pocket cost presents a significant barrier to care for many of the sickest patients. Reduced access to necessary medicines contributes to use of higher cost health care services such as emergency rooms and inpatient hospital services.

Recommendation #4: Examine prescription drug spending within overall health care spending and in the context of the broader health care system

Medicines are among the most effective and efficient use of private and public health care dollars, and are powerful "levers" for stemming the tide of illness and disability. We see this, for example, in cancer, where medicines have helped increase survival rates and allow people to return to their daily lives. In the last decade (1998-2010), life expectancy for cancer patients increased by four years. Not only does this represent added time with loved ones, but generated an enormous economic value of approximately $1.9 trillion—where only between 5-19 percent went to pharmaceutical companies and doctors.[1] The U.S. government even acknowledges that medicines save money in other parts of healthcare, such that when the Medicare Program spends more on medicines, the Congressional Budget Office actually books savings in hospitalizations and other services.[11]

Despite claims that prescription drugs account for a disproportionate share of health care spending and are among the fast growing components of health care cost, drugs represent around 9 percent of total healthcare costs in 2014 and contributed 13 percent to Exchange plan premium growth.[12-13] This is because as new medicines come into the market, the price of older medicines drops significantly once the patent expires.

Pfizer believes that the Cabinet should ensure that strategies to lower prescription drug costs should take into account that prescription drug spending is a relatively small proportion compared with other health care services and investment in medicines can lower health care spending.

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[8] Avalere PlanScape®, a proprietary analysis of exchange plan features, December 2015.
[9] Avalere PlanScape®, a proprietary analysis of exchange plan features, December 2014. Avalere analyzed data from the FFM Individual Landscape File released November 2014 and the California and New York state exchange websites.
[10] PhRMA, Connecticut's 2016 Health Exchange Plans. http://phrma.org/files/dmfile/CT-Exchanges4.pdf.
[11] Congressional Budget Office (2012). Offsetting effects of prescription drug use on medicare's spending for medical services. Congressional Budget Office Report, Retrieved at http://www.cbo.gov/ sites/default/files/cbofiles/attachments/43741-MedicalOffsets-11-29-12.pdf.
[12] CMS, National Health Expenditures Data. 2014.
[13] Avalere Health, *Health Insurance Premium Increases Largely Mirror Spending*. November 16, 2015.

Recommendation #5: Review findings and reports from the Washington State Patient Out-of-Pocket Task Force.[14]

Pursuant to Senate Bill 6569, Washington State recently convened the Patient Out-of-Pocket Cost Task Force to examine policy approaches for reducing patients prescription drug out-of-pocket cost burden.[15] The Task Force included representatives from the health insurance industry, patient advocates, manufacturers, academics, and consumers. They have conducted a thorough review of short, mid, and long-term policy options to address patient out-of-pocket issues that may serve as a useful model for Connecticut.

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Pfizer appreciates the opportunity to comment on the preliminary recommendations to control prescription drug costs, and we welcome further discussion. Please do not hesitate to contact me if I can be of further assistance. We look forward to working with the Office of the Lieutenant Governor, the Cabinet, and other stakeholders to enhance health care for the residents of Connecticut.

Sincerely,

Tom Brownlie
Director, Global Policy
Pfizer Inc.

[14] Washington State Task Force website: http://www.doh.wa.gov/AboutUs/PatientOutofPocketCostsTaskforce.
[15] Washington State Senate Bill 6569. http://lawfilesext.leg.wa.gov/biennium/2015-16/Pdf/Bills/Senate%20Passed%20Legislature/6569-S.PL.pdf.

Appendix A – Current U.S. Outpatient Pharmacy Distribution and Reimbursement

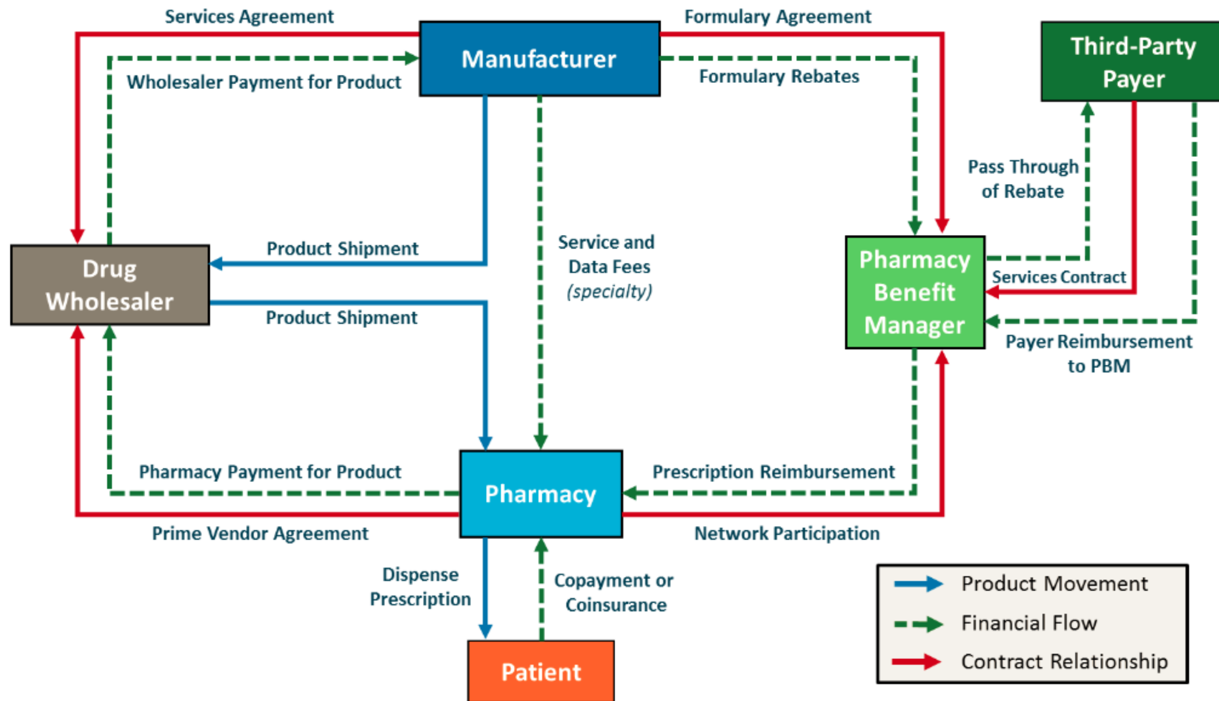

Chart illustrates flows for patient-administered, outpatient drugs. Please note that this chart is illustrative. It is not intended to be a complete representation of every type of financial, product flow, or contractual relationship in the marketplace.
Source: Fein, Adam. J., *The 2016 Economic Report on Retail, Mail and Specialty Pharmacies*, Drug Channels Institute, January 2016.
(Available at http://drugchannelsinstitute.com/products/industry_report/pharmacy/)