Health Care Reform: Changing the Current U.S. Market Place

Maine Worksite Wellness Initiative

June 9, 2011

Why is Pfizer involved in talking about health reform?

- Pfizer's interest in improving patient health aligns with the goals of reform and quality improvement efforts
- Medications play an essential role in the care process
- Health reform enhances access to medicines for enrollees in Medicare Part D plans, in part because pharmaceutical companies are funding half of the cost of closing the "donut hole"
- Health reform supports increased patient engagement and the ability of providers to improve medication management and adherence levels, which can help patients get the most value from the medicines they take

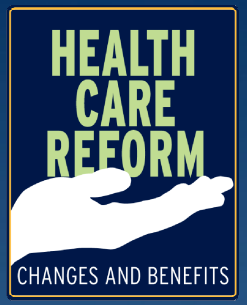
Kaiser Family Foundation. http://www.kff.org/healthreform/upload/8061.pdf. Accessed October 12, 2010. Accessed October 12, 2010; The Patient Protection and Affordable Care Act. HR 3590, 111th Cong, 2nd Sess (2010).

By 2014, access will be improved through multiple initiatives

2010	Plans that provide dependent coverage must cover unmarried dependents until they reach 26 years of age
2014	Requires US citizens and legal residents to have health coverage or pay a penalty
2014	Raises the threshold for Medicaid eligibility to 133% of the Federal Poverty Level (from 100%)
2014	Incentivizes employers with 50 or more employees to provide health insurance

Kaiser Family Foundation. http://www.kff.org/healthreform/upload/8061.pdf. Accessed October 12, 2010.

HEALTH CARE REFORM
CHANGES AND BENEFITS



Health Care Reform Major Expansion: 2014 and Beyond

	Health Care Reform Element	Timing
Insurance Reforms	• Prohibition on all pre-existing condition exclusions • Limits premium variation • Guaranteed issue • All private coverage must meet minimum standards • Limits on total out of pocket spending • No lifetime maximums	2014
Individual Mandate	• Penalty for individuals not purchasing insurance • Subsidies for low income to enroll in coverage	Phase in 2014
Employer Responsibility	• Penalty for large employers who don't offer coverage	2014
Insurance Exchange	• State based competitive marketplace • Government oversight and benefit standards	2014
Medicaid Expansion	• To 133% of federal poverty level	2014
Cadillac Tax	• 40% tax on the premium for employer benefits valued at over $27,500 for family	2018

Key Health Reform Provisions for the Pharmaceutical Industry

	Health Care Reform Element	Timing
Medicaid Rebate	• Minimum rebate of 23.1% including FFS and MCO	Initiated 2010
340B Hospital	• Outpatient discounts to an expanded set of hospitals	Initiated 2010
Comparative Effectiveness	• Private/public entity; no direct ability to apply to formulary	Initiated 2010
Fee on Drug Companies	• $28B over 10 years; paid relative to market share	Initiated 2011
Medicare "Donut Hole"	• 50% discount from pharma, government pays 25%, patient pays 25%	Initiated 2011, govt. phases to 25% by 2020
Follow-on Biologics	• 12 years data exclusivity protection + 6 months pediatric extension available	In market 2014-2015
Independent Payment Advisory Board	• **Commission with cost growth saving targets**	**2015**

Manufacturer contributions and government subsidies will phase down patient coinsurance in the gap — from 100% to 25%

2010

- Beneficiaries who reach the donut hole in 2010 will receive a rebate check for $250

2011

- Starting January 2011, pharmaceutical companies will contribute 50% of a brand-name drug's price; government will begin to add subsidies for generic agents

2012

- Medicare Part D cost sharing for dual-eligible individuals treated in the community will be equal to those who receive institutional care

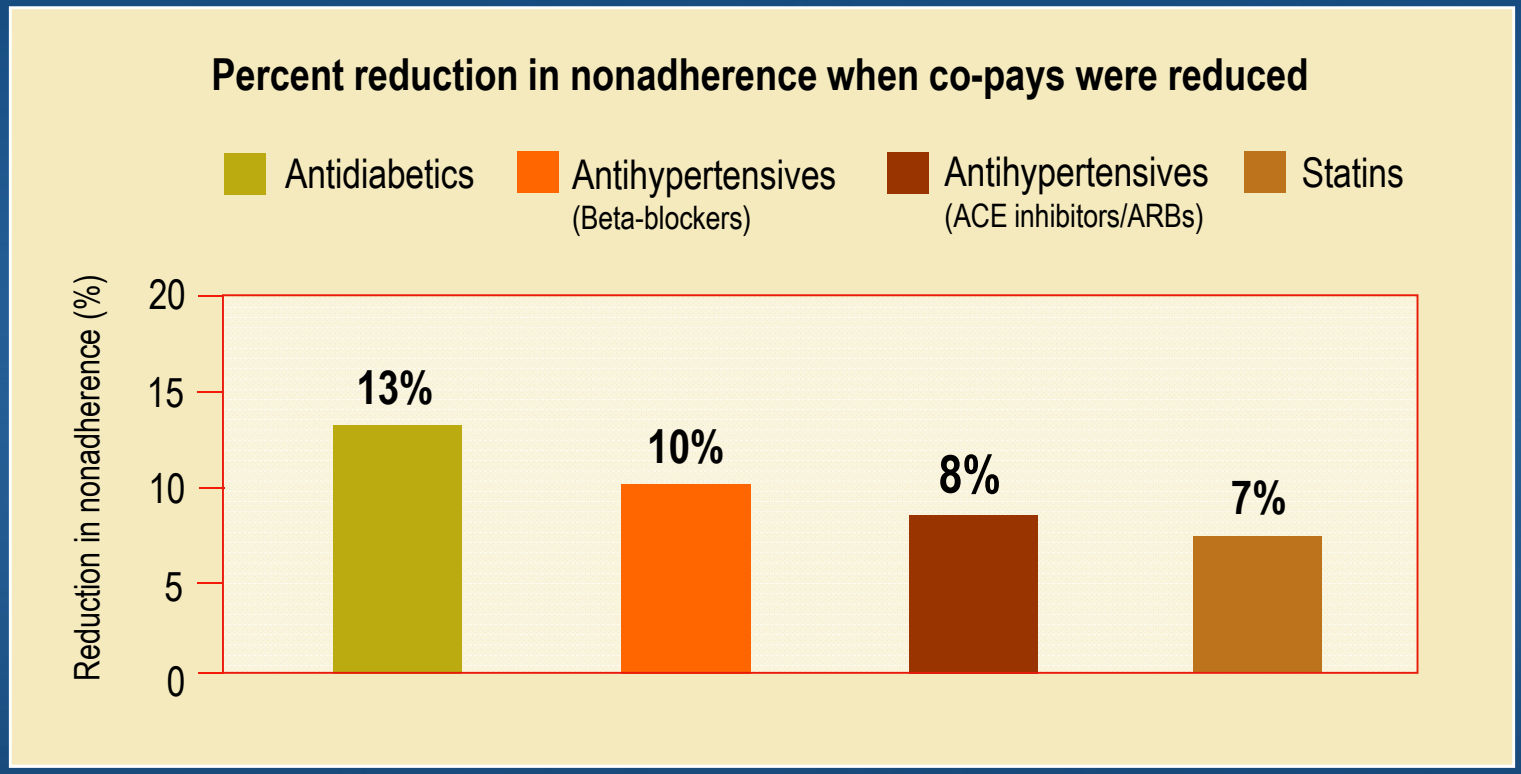
2013

- Government will provide additional subsidies for brand-name drugs that will increase until 2020, when the coverage gap will be closed

Kaiser Family Foundation. http://www.kff.org/healthreform/upload/8061.pdf. Accessed October 12, 2010.

HEALTH CARE REFORM
CHANGES AND BENEFITS

Closing the donut hole has the potential to improve adherence



The effects of a value-based intervention (reduction in co-pays for 5 classes of medication) added to a disease management (DM) program at one large company were compared with the effects of the same DM program without the value-based component at another large company.

There was a nonsignificant difference in nonadherence to inhaled steroids.

- Analysis compared co-pay reduction + disease management with disease management alone

ACE = angiotensin converting enzyme; ARB = angiotensin receptor blocker.

Adapted from Chernew et al. *Health Aff (Millwood)*. 2008;27(1):103-112.

HEALTH CARE REFORM
CHANGES AND BENEFITS

Medicare Part D plans must identify enrollees eligible for medication therapy management (MTM)

Currently

- Seniors with 3 or more chronic conditions take an average of 6 prescription drugs, which may be prescribed by different physicians and may not be coordinated

2013

- Law requires assessment of medication usage by plans on a quarterly basis
- Auto-enrolls those eligible in MTM to optimize use of prescription medications
- Plans must provide an annual comprehensive medication review to be provided person-to-person or using telehealth technologies

Neuman P et al. *Health Aff* (*Millwood*). 2007;26(5): w630–w643. Epub 2007 August 21; The Patient Protection and Affordable Care Act. HR 3590, 111th Cong, 2nd Sess (2010).

HEALTH CARE REFORM
CHANGES AND BENEFITS

For patients covered on private insurance plans: new plans must provide these services without co-payments*

In 2010

- Preventive services recommended (rated A or B) by US Preventive Services Task Force (USPSTF), including:
  - Screening for breast cancer,† cervical cancer,‡ and colorectal cancer§
  - Cholesterol screening (men ≥35 and women ≥45 years of age)
  - Tobacco-use counseling and evidence-based tobacco cessation interventions
  - Obesity screening and counseling for adults and children
  - Screening for human immunodeficiency virus (HIV) for persons at high risk
  - Depression screening
- Vaccinations recommended by the CDC, such as tetanus, diptheria, pertussis; pneumococcal; measles, mumps, rubella; varicella; and influenza‖
- Preventive care for infants, children, and adolescents and women that is recommended by Health Resources and Services Administration

*Grandfathered plans are exempt from this requirement.

† Mammography every 1-2 years for women aged 40 and older.

‡ Screening in women who have been sexually active and have a cervix.

§Beginning at age 50 years and continuing until age 75 years.

‖As appropriate according to age and risk factors.

About the law. Background: the Affordable Care Act's new rules on preventive care. http://www.healthcare.gov/law/about/provisions/services/background.html. Accessed November 6, 2010.; Kaiser Family Foundation. http://www.kff.org/healthreform/upload/8061.pdf. Accessed October 12 , 2010.; MMWR. www.cdc.gov/mmwr/pdf/wk/mm5540-Immunization.pdf. Accessed November 24, 2010. USPSTF A and B Recommendations. August 2010. http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. Accessed November 9, 2010.

HEALTH CARE REFORM
CHANGES AND BENEFITS

Americans receive only about half of the preventive services that are recommended

- Analysis of data on treatment and prevention of a broad spectrum of conditions in 6712 US adults showed that only 55% of patients received recommended preventive care
- Goldman et al estimated that if obesity in seniors were reduced to 1980s levels, Medicare could save $1 trillion over a 25-year period

Goldman DP et al. The value of elderly disease prevention. *Forum for Health Economics & Policy*. 2006;9(2):Article 1. http://www.bepress.com/fhep/biomedical_research/1;
McGlynn EA et al. *N Engl J Med*. 2003; 348:2635-2645.

HEALTH CARE REFORM
CHANGES AND BENEFITS

Supports comparative effectiveness research to help eliminate waste and variability of care in Medicare reimbursement

Initiated 2010

- Established an independent Patient-Centered Outcomes Research Institute (PCORI) to compare the clinical effectiveness of medical treatments
- The goal is to assist "in making informed health decisions by advancing the quality and relevance of evidence" about the way health problems can be prevented, diagnosed, treated, monitored, and managed
- Research will focus on different patient subpopulations, health outcomes, and appropriateness of the medical services and items
- PCORI will not assess value or cost-effectiveness. However, Medicare may take findings into account in its reimbursement decisions

Schulz D. *AHIP HI-WIRE*. June 24, 2010. http://www.ahiphiwire.org/FocusVBBD/News/default.aspx?doc_id=605129. Accessed October 14, 2010; The Patient Protection and Affordable Care Act. HR 3590, 111th Cong, 2nd Sess (2010).

HEALTH CARE REFORM
CHANGES AND BENEFITS

Creates a Center for Medicare and Medicaid Innovation (CMI) within the Centers for Medicare & Medicaid Services (CMS)

2011

- Its purpose: to test a broad range of innovative payment and delivery models that reduce costs while preserving or enhancing quality
- These models could be expanded throughout the Medicare and Medicaid programs and the Children's Health Insurance Program (CHIP)

2011

- Models being tested focus on primary care, care of chronic disease, adoption of HIT, and payment and delivery models, including:
  - Patient-centered medical home (PCMH) models for high-need Medicare and Medicaid beneficiaries
  - Medical homes that address women's unique health care needs
  - Models that transition primary care practices away from fee-for-service toward other reimbursement models

Kaiser Family Foundation. http://www.kff.org/healthreform/upload/8061.pdf. Accessed October 12, 2010; The Patient Protection and Affordable Care Act. HR 3590, 111th Cong, 2nd Sess (2010).

HEALTH CARE REFORM
CHANGES AND BENEFITS

The CMS Shared Savings Program builds on earlier Medicare pilot programs

2012

- Starting in January 1, 2012, CMS will recognize Shared Savings entities – eg, accountable care organizations (ACOs) – that coordinate services and are accountable for a defined patient population
- ACOs may be physician-led or hospital-led
- Shared savings will be linked to cost-savings and achievement of quality metrics
- These types of payment and delivery reforms may begin to shift clinical and financial risk downstream from plans to providers with the opportunity to share in the rewards for improved outcomes

The Patient Protection and Affordable Care Act. HR 3590, 111th Cong, 2nd Sess (2010).

Other Medicare initiatives to promote accountability, preserve or enhance quality, and reduce costs

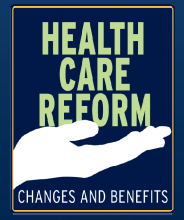
2012

- Establishes a hospital value-based purchasing program based on performance on quality measures
  - Provides incentive payments to hospitals that meet quality benchmarks, while the readmission program reduces payments to hospitals for preventable readmissions

2013

- Evaluates and tests bundled payments
  - Establishes pilot to evaluate bundled payment for an episode of care that begins 3 days prior to hospitalization and spans 30 days following discharge

Kaiser Family Foundation. http://www.kff.org/healthreform/upload/8061.pdf. October 12, 2010.



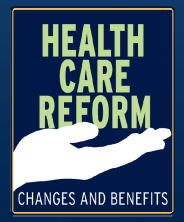
Supports the role of the patient-centered medical home (PCMH) in promoting high-quality care

- Provides grants to implement multidisciplinary "health teams" of nutritionists, pharmacists, social workers, and physician assistants to support implementation of the PCMH model

  Requirements include:

  - Electronic health records (EHRs)
  - Focus on coordinated disease prevention and chronic disease management
  - Implementation of care plans that integrate clinical and community prevention and health promotion services
  - 24-hour care management and support during transitions in care settings
- Explicitly directs the newly created CMI to test the medical home model

Keckley PH, et al. http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/US_CHS_MedicalHome2_091610.pdf. Accessed October 14, 2010 ; The Patient Protection and Affordable Care Act. HR 3590, 111th Cong, 2nd Sess (2010).



Other ways that ACA supports PCMH

- Medical homes are included as a measure of performance for health plans
- For Medicaid enrollees with chronic conditions, the federal government will provide matching funds to those states that provide options for Medicaid enrollees to receive their care under a medical home model (2011)
- Creates the Primary Care Extension Program, which provides primary care training and implementation of medical home quality improvement and processes

Keckley PH, et al. http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/US_CHS_MedicalHome2_091610.pdf. Accessed October 14, 2010 ;
The Patient Protection and Affordable Care Act. HR 3590, 111th Cong, 2nd Sess (2010).

HEALTH CARE REFORM
CHANGES AND BENEFITS

The Health Information Technology for Economic and Clinical Health (HITECH) Act supports the implementation of health information technology by individual practices

2011

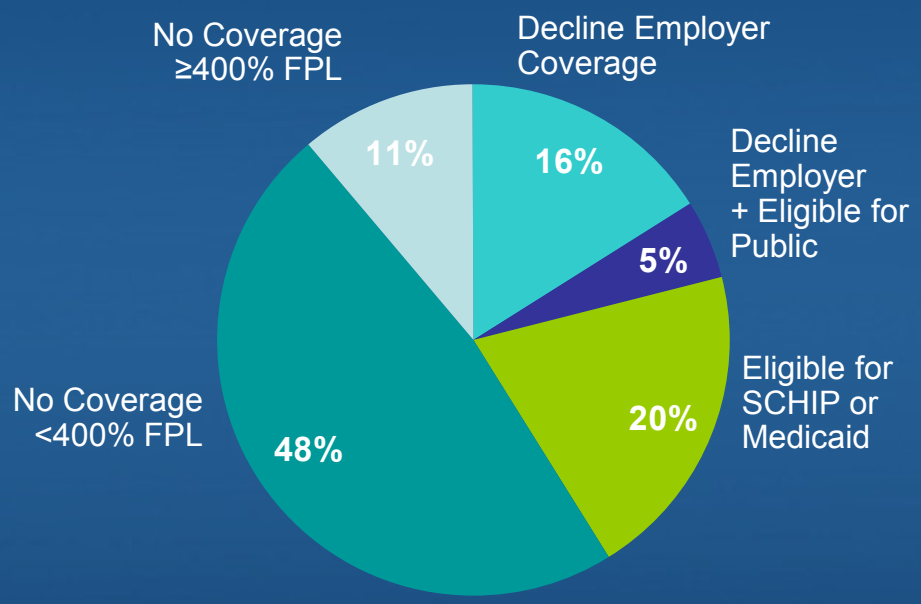
- Providers will be able to earn substantial bonus payments if they adopt electronic records; incentive payments depend upon “meaningful use”
- Meaningful use standards require use of EHR to improve the quality of care – to collect essential health data, support better clinical decisions, and give patients electronic access to their own medical records
- The maximum annual incentive payment for qualifying doctors for 2011 or 2012 is $18,000. The maximum amount of total payments under the Medicare program is $44,000
- Registration begins in 2011
- Website: http://www.cms.gov/EHRIncentivePrograms/

Blumenthal D, Tavenner M. *N Engl J Med*. 2010;363(6):501-504; EHR incentive programs: Medicare eligible professionals. Centers for Medicare & Medicaid Web site. http://www.cms.gov/EHRIncentivePrograms/60_Medicare_Eligibile_Professionals.asp#TopOfPage. Accessed November 9, 2010; Garrett D. *Breakthroughs: HIT That Enables Quality, Efficiency, and Value*. 2010;June:6- 8. http://www.healthleadersmedia.com/breakthroughs/getPDF.cfm?PDF=253045.pdf. Accessed October 14, 2010; Sebelius K. *Kaiser Health News*. August 26, 2010. http://www.kaiserhealthnews.org/Columns/2010/August/082610Sebelius.aspx. Accessed October 14, 2010.

Covering the Uninsured: Not a Windfall for the Pharmaceutical Industry

Use of medicine will increase to a relatively modest degree
Many of the currently uninsured are young and healthy; some have turned down coverage
The newly insured will obtain medicines at a discount, many are now paying the full cash price
Most new prescriptions will be generic
The major coverage expansion starts in 2014, nearly half will be covered in Medicaid
Not all uninsured will be covered – CBO projects 22 million uninsured in 2019
There will be some erosion of coverage in the employer market

Current Profile of U.S. Uninsured



- 59% are younger than 35
- 90% are in excellent or very good health
- 22% are undocumented immigrants; not eligible for coverage

CHANGES AND BENEFITS

Pros and Cons of Health Care Reform for Key Players

	Key Implications
Patients	• Increased Access to more predictable and affordable coverage (+) • Penalty for not participating (-) • New taxes (-)
Health Plans	• New beneficiaries; many are young and healthy (+) • Individual Mandate not particularly strong & guarantee issue (-) • New regulation and oversight (-) • Increased focus on premium increases (-) • Medical loss ratio must not exceed 85% (+/-)
Doctors	• No "fix" to Medicare payment (sustainable growth rate) (-) • New patients (+) but potential exists for overcrowding (-) • Health Information Technology; uncertainty & cost (-) • Quality incentives (+/-)
Hospitals	• Less uncompensated care (+) • Payment updates and adjustments (-)

Source: Current Population Survey 2009 projected to 2014 Price Waterhouse Coopers internal proprietary model, Congressional Budget Office Nov 2009 analysis of Senate Finance Committee Bill passed Nov 2009 http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf#nameddest=Table1, RAND Compare website * Cadillac tax is regardless of employer size

HEALTH CARE REFORM
CHANGES AND BENEFITS

ACA expands access, focuses on prevention, and promotes innovations in health care quality and delivery

Expanded access

- An estimated 28 million people will be newly insured by 2016
- Medicare Part D beneficiaries who reach the donut hole will receive some relief in 2010; by 2020, the donut hole will be closed

Focus on prevention

- Recommended screenings and preventive care will be provided at no charge to Medicare enrollees and to those insured through private plans*
  - Medicare enrollees entitled to an annual wellness visit at no charge; targeted beneficiaries eligible for MTM

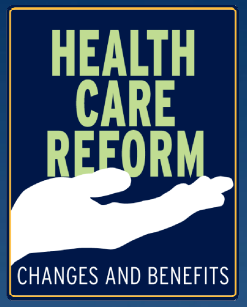
Innovation

- Initiatives support use of EHR, alternative care delivery models and payment models, and cost-effectiveness research
- Pfizer's interest in improving patient health aligns with the goals of reform and quality improvement efforts

*Exemptions provided for grandfathered plans.

Fact sheet. http://www.healthcare.gov/news/factsheets/pdf/07-14-10_prevention_seniors_fact_sheet.pdf. Accessed October 14, 2010.; Kaiser Family Foundation. http://www.kff.org/healthreform/upload/8061.pdf. Accessed October 12, 2010; McGlynn EA et al. *Health Aff (Millwood)*. 2010; 29 (6): 1142-1446;
The Patient Protection and Affordable Care Act. HR 3590, 111th Cong, 2nd Sess (2010).

HEALTH CARE REFORM
CHANGES AND BENEFITS



Thank you

NPC05208 © 2010 Pfizer Inc. All rights reserved. October 2010