"The Future Challenges, and Opportunities, for U.S. Health Care"
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Today I'd like to address a critically important topic, to our country and everyone in this room: that's the future of health care.

We're hearing a lot of rhetoric about it on the campaign trail and in the media.

I'm sure we'll hear even more leading up to Election Day, and into next year when a new administration and Congress take office.

My hope is that we'll begin to focus less on the rhetoric and more on the reality … because the future of health care is far too important as an economic issue, along with the impact it's having on our workforce.

At CVS Health, we believe that "Health is everything."

We're all patients at some point in our lives. We all want care that is more affordable, accessible, and effective.

I believe we're making progress toward that goal. At the moment, however, it's as if we have two health care systems operating side-by-side …

The health care system of yesterday, in which insufficient competition leads those who produce goods and services to produce more and charge more with no accountability for outcomes.

And the health care system of tomorrow, in which consumers are empowered with more choices and more information to improve quality and outcomes, while driving down costs.

I'm going to offer you my perspective on both the challenges and the opportunities that exist in our health care system.

My perspective is informed by CVS Health's role in health care delivery – both as a health care provider and as an employer that, like many of you, wrestles with how to provide high-quality, affordable health benefits to our more than 240,000 colleagues.

As business leaders and employers, we have a critical stake in the discussion and the realities surrounding the future of health care.

So I'm going to lay out three basic facts.

Fact #1: Health care spending is growing too rapidly, and it's affecting the entire economy.

I don't think that comes as a surprise and I don't believe there's much disagreement about this, but let me point out just a few statistics …

In 1960, health care spending was 5 percent of GDP.[i] Today it is 18 percent.[ii]

If the trend continues, health care will reach 20 percent of GDP within the next 10 years.

Said another way, 1 out of every 5 dollars in this country will go toward health care.

Those extra two percentage points equate to more than $250 billion per year … money that would not be spent on other national priorities, such as education or infrastructure.[iii]

Clearly, this trajectory demonstrates that there are things that just aren't working in the delivery system.

One obvious example is the cost, and cost inflation, of brand-name prescription drugs. Although they make up just 15 percent of all prescriptions that are dispensed, branded drugs make up 75 percent of the pharmaceutical spend. And their costs are rising faster than health care inflation overall.[iv]

There are broader issues as well. The prices of many products and services in health care do not necessarily reflect better outcomes for patients.

And the health care system does not prioritize cost as a variable in delivering quality care, in the appropriate clinical setting.

I'll expand on each of these issues in a moment, as all of them contribute to making health care more expensive than it needs to be.

The good news is, the current trajectory of health care spending is not inevitable. But it's going to require action.

That leads me to Fact #2: We talk about health care spending as if it's a fixed cost – that's one of the paradigms that we must break, because it's not.

There are three major variables that contribute to health care spending: quality,

access, and cost.

Let me briefly highlight these three and the challenges associated with each.

I'll start with quality.

Management of chronic disease accounts for 86 percent of health care spending, and today nearly half of all Americans suffer from one or more chronic diseases, such as diabetes, hypertension, and cardiovascular disease.[v]

More effective care coordination for these patients – including the management of their medications – could reduce spending by about $300 billion per year.[vi]

Contributing to the growth of chronic disease, obesity and tobacco use alone amount to half a trillion dollars each year in unnecessary health care costs and lost economic activity.[vii] That's "trillion," with a "T."

However, fewer than 3 percent of Americans follow recommended guidelines for a healthy lifestyle, including diet and exercise.[viii] So, another big opportunity.

If we look at access…

One in five Americans lacks regular access to primary care.[ix] As a result, many choose the least cost-effective site of care: the Emergency Room.

Recently I read an article about a father whose young daughter cut her finger, so he rushed her to the ER, fearing she might need stitches. It turned out all she needed was a Band-Aid. He was relieved, until he received the bill from the hospital … $629. For a Band-Aid.[x]

That's not an isolated case. On average, the cost of an ER visit is nearly $600 more expensive than the cost of alternative sites of care.[xi]

And there are many other examples beyond the ER of how lower-cost, high-quality sites of care can make a meaningful cost difference.

So increasing access to these care settings is another very big area of opportunity.

Third, cost.

In too many cases, the cost of products and services in health care bear little relation to patient outcomes.

For example, how much an MRI costs depends entirely on where you have it

performed.

According to Medicare data, the average cost is about $2,600.

But in reality, it could cost you as little as $470, or as much as $13,000.[xii] For exactly the same scan.

A more timely example is EpiPen. The manufacturer, Mylan, has raised the price nearly 600 percent over the last seven years, without any increase in clinical benefit.

I could go on.

However, all of these examples of what's not working in health care actually reflect the health care system of yesterday.

Fortunately, there are examples of a very different health care system that addresses the pain points I just referenced.

That brings me to Fact #3: There are solutions to the challenges of quality, access and cost.

Virtually everywhere you look in health care today, you see innovative approaches resulting from market competition.

If we look at quality…

As I said a moment ago, chronic disease accounts for 86 cents of every dollar spent on health care.

We all have a stake in reducing this as consumers, employers, insurers, providers, and government.

A healthy competition has emerged to see which approaches to improving quality will prove most effective. These include experiments with medical centers of excellence, bundled payments, and accountable care organizations, to name just a few.

CVS Health is one of many employers experimenting with the ACO model, in selected markets.

And we are also among the 73 percent of all employers who are making employee well-being a high priority.[xiii]

As you may know, helping Americans quit tobacco is a special concern at CVS

Health, because smoking-related illness is the leading preventable cause of disease and death in the U.S.

That's why we decided two years ago to stop selling tobacco products in every CVS Pharmacy.

I'm happy to report that the evidence shows that this action has made a difference in helping to reduce the rate of tobacco use in markets across the country.

Our focus now is on preventing young people from smoking in the first place, with a goal of creating the first tobacco-free generation.

Second, let's look at solutions related to access.

One of the most important changes I see taking place in health care today is the proliferation of convenient, low-cost sites of care to empower consumers with more choices. I call this the "retailization" of health care.

Urgent care centers and retail health clinics are growing rapidly. They're up to 80 percent less expensive than the ER for the services they provide, with the same or better outcomes.[xiv] This makes them an ideal complement to primary care and an alternative to the ER for a growing list of services.

There's also greater use of other cost-effective settings, like in-home care and telemedicine.

Think back to the ER visit resulting in the $600 Band-Aid. Imagine if that father had used an app on his phone to teleconference with a health care professional, instead of driving to the ER. That's where health care is headed.

And thanks to technology, care in retail settings can be coordinated with primary care physicians and other health care professionals through the patient's Electronic Health Record. In fact, our CVS Health in-store retail clinics, branded as MinuteClinic, have now formed alliances with more than 70 major health systems across the country to do just that – including here at the University of Chicago Medical Center and Rush University Medical Center.

Because medications are involved in the vast majority of health care treatments – especially in those managing chronic disease – most patients interact far more frequently with their pharmacist than they do with their physician. Our pharmacists play a critical role in making the health care system more accessible, and also more effective, through the delivery of patient care programs.

Medication non-adherence. I describe it as a national epidemic. Research indicates

that one in three patients who start a maintenance prescription for a chronic disease will decide to discontinue treatment before the first refill is even due. Less than one-half take their doses as prescribed, and three in four people will stop taking their medication within the first year of starting their therapy. As medication adherence declines, Emergency Room visits and hospital stays increase among patients with chronic illnesses.[xv]

So pharmacists are playing an increasingly important role in tackling the complicated issues associated with chronic disease and medication adherence.

Third, there are solutions to reducing costs by helping people be better health care consumers.

I'll share a quick story with you about a conversation I had with a CVS colleague enrolled in one of our consumer-directed health plans.

She was alarmed about the cost of an MRI, which as I mentioned earlier can be highly variable. The doctor suggested a site that was going to cost $1,300. She said, “You know, under our traditional plan I had a co-pay, and the cost for this would have been a couple hundred dollars.”

Of course, that might have been her cost, but we all know the actual cost would still have been $1,300.

So I asked, “Did you use our cost-comparison tool?”

She hadn’t, so we looked, and found that there were far less expensive options available. She selected one of the alternatives, and said the quality and experience were both great.

This type of consumer behavior is still a very new experience for many, but it’s becoming more common, and it’s going to cause more and more providers to compete on both quality and cost.

And I want to come back to prescription drugs, because there are market solutions to make pharmaceutical companies compete to lower prices.

Let’s look at one recent high-profile example.

In 2014, the drug Sovaldi was introduced as a revolutionary cure for Hepatitis C. But there was massive public outrage over the cost: $84,000 for a 12-week treatment cycle.

As a result of a competing drug being introduced in the market several months

later with comparable therapeutic effectiveness, and tough private-sector negotiations by pharmacy benefit managers, the price was lopped in half. As a result, the cost of treating Hep C patients in the U.S. last year was lower than many government- controlled health care systems pay.[xvi]

Now, it is a fact that pharmaceutical companies are raising prices for new and existing branded drugs at rates exceeding health care inflation overall.

Pharmacy benefit managers, also referred to as PBMs, are responding to these tactics with aggressive cost-reduction strategies, in part by combining the purchasing power of millions of Americans on behalf of their employer and health plan clients.

This slide tells that story in a powerful way. The red line shows the average year-over-year inflation percentage-point change for the list price of branded drugs.

The grey line on the bottom shows the net year-over-year inflation change for those same drugs, resulting from negotiations with PBMs.

These strategies are most effective when there is product competition within a class of drugs – particularly from generics or biosimilar products.

Now, pharmaceutical manufacturers talk a lot about innovation, but when they don't face competition, they've demonstrated very little innovation in pricing their products in ways their customers can afford.

It's also important to note that PBMs deploy a variety of tools and capabilities to ensure that clients and members receive the right pharmaceutical care at the lowest possible cost.

In 2015, the drug trend for clients of CVS Caremark was less than 5 percent. And year-to-date in 2016, it's running at about 3.5 percent. In both cases, well below the published inflation rates shown by that red line.

I'd like to conclude by returning to where I began: that health care spending is increasing too rapidly, and reducing it must be a national priority.

But that does not mean it should only be a priority inside the Beltway in Washington, D.C., or in our state capitals.

As I said in my opening remarks, while health care is about people, fundamentally we face an economic challenge. Through competition, employers, providers, insurers, and others are discovering market solutions to the challenges of quality, access and cost.

So I want to leave you with one final fact: common-sense, market-oriented reforms have helped to address quality, access, and cost. And there is more that can be done:

- First, there's the opportunity to continue to improve the Affordable Care Act. Whether you originally supported the ACA or not, I think everyone would agree that it has increased access to care for about 20 million people. But much more must be done to make sure that access is affordable.

- Second, the federal government can improve quality by funding objective comparative-effectiveness research. This would help Americans distinguish between procedures, services, and drugs that actually provide greater value from those that are overpriced. And the government could add more drugs to the preventive drug list, to help prevent, treat and manage chronic illnesses.

- Third, let's create more competition to lower the cost of prescription drugs by increasing the flow of generics and biosimilars to the market. This is critically important. There is currently a backlog of more than 3,000 potential drug approvals in the FDA, many of which are generics. Clearing out this backlog, and increasing the speed to market of new biosimilars, needs to be a top priority.

That said, I do remain optimistic.

I believe we can get past the rhetoric, focus on the facts, and bring all stakeholders together around a common-sense agenda to create a system that is more affordable, accessible, and effective. All of you have a huge stake in the debate, so I hope you will stay actively engaged.

Let's complete the transformation of American health care. Let's create a system that works for everyone, and is sustainable for generations to come.

Again, thank you for the opportunity to be with you, and I look forward to your questions.

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Endnotes

[i] Centers for Medicare and Medicaid Services, National Health Expenditure Data > Projected

[ii] Altarum Institute, Moderate 2016 health spending growth continues a slow downward trend

[iii] CMS, NHE Projections 2015-2025 – Table 02

[iv] Percentage of all prescriptions in the US market for 2015 taken from IMS; Average cost range from "The 2016 Economic Report on Retail, Mail, and Specialty Pharmacies," Drug Channels Institute, Jan 2016 (page 4).

[v] U.S. Centers for Disease Control and Prevention.

[vi] Medication Adherence: A $300 Billion Problem. Prescriptions for a Healthy America.

[vii] "Obesity, Smoking Damage U.S. Economy," Gallup

[viii] "Healthy Lifestyle Characteristics and Their Joint Association With Cardiovascular Disease Biomarkers in US Adults," Loprinzi, Paul D. et al. *Mayo Clinic Proceedings* , Volume 91 , Issue 4 , 432 – 442 (see article in *The Atlantic*)

[ix] Health Resources and Services Administration [HRSA]. Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations.

[x] "The case of the $629 Band-Aid — and what it reveals about American health care," Vox.com

[xi] Medical Expenditure Panel Survey. Statistical Brief 111: Expenses for a Hospital Emergency Room Visit, 2003. Rockville, MD: Agency for Healthcare Research and Quality. (Quoted in National Quality Forum, Reducing Emergency Department Overuse: A $38 Billion Opportunity.)

[xii] "Why Does an MRI Cost So Darn Much?" MONEY magazine

[xiii] 2015 Willis Towers Watson/NBGH Best Practices in Health Care Employer Survey

[xiv] Mehrotra A, Liu H, Adams JL, Wang MC, Lave JR, Thygeson NM, et al. Comparing Costs and Quality of Care at Retail Clinics With That of Other Medical Settings for 3 Common Illnesses. Ann Intern Med. 2009;151:321-328.

[xv] Goldman D, "Pharmacy Benefits and the Use of Drugs by the Chronically Ill.", J. of the Amer. Med. Ass'n, 19 May 2004.

[xvi] "Comparison of Hepatitis C Treatment Costs," IMS Institute for Healthcare Informatics, July 2016