PRIVATE SECTOR SOLUTIONS TO AMERICA'S HEALTH CARE CHALLENGES
REMARKS AS PREPARED FOR TOM MORIARTY
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Thank you for that introduction. I also want to thank the entire team at Bloomberg Intelligence for convening this Summit, and my fellow panelists from earlier today for that engaging discussion.

This Summit couldn't have come at a better time – this is truly an exciting and eventful time to be in the health care arena.

As we mark the seventh anniversary of the Affordable Care Act being signed into law, and the House may be on the verge of voting on a repeal and replace bill, this conversation is truly timely and necessary.

But as earlier discussions illuminated, there are still many more challenges all of us must grapple with as we move forward – regardless of how events in Washington play out.

And I'm delighted to have this opportunity to share our perspective on these issues. Through our work, we know pharmacy management is one of the most effective tools to improve health outcomes and lower costs – two goals we all share.

THE PROBLEM: RISING HEALTH CARE COSTS

Everyone – families, small and large employers, the health care industry, and government – is acutely aware that health care spending continues to grow too rapidly.

Right now, health care spending accounts for about 18 percent of our nation's GDP. If current trends continue, this spending will account for 20 percent within the next several years.

Rising health care costs will further squeeze family budgets, further constrain economic growth and job creation, and further impede important investments in other areas like research, education, and infrastructure.

The good news is that the current trajectory of health care spending is not inevitable. But we need to understand how we got here in order to fix it.

The cost of chronic and complex diseases is undeniable. Today, 1 in 2 Americans have a chronic illness like obesity and heart disease – and almost 1 in 6 Americans have three or more chronic conditions. We spend nearly 85 percent of our health care dollars caring for these Americans. And nearly half of all Medicare dollars are spent on the 14 percent of Medicare patients with six or more conditions.

High launch prices for branded products and price increases for older drugs are undeniable.

Over the past few years we've seen more "me-too" drugs come to market and fewer breakthrough therapies. Many of these "me-too" drugs are supported with heavy direct to consumer advertising and other marketing support.

These pricing dynamics are exacerbated by the slow drug approval timeline which effects competition. At the start of 2017, there were more than 4,000 pending generic drug applications waiting for approval at the FDA.

The drug approval process in the United States is significantly slower than in the European markets – on average 50 percent slower. And we're woefully behind Europe in the number of biosimilar approved for the American market – just four compared to 20 in Europe.

They're also exacerbated by more consumers enrolling in health plans with higher deductibles and co-pays. Consumers in these plans can sometimes face high out-of-pocket costs for prescriptions – making it more likely those prescriptions are never filled.

Finally, these pricing dynamics are exacerbated by a broader, systemic issue that stems from misaligned objectives. As I'll discuss later, one of the ways we're working to realign incentives is by creating innovative care delivery models that improve quality and deliver care at the lowest-cost setting.

CVS HEALTH LEADING THE WAY

As a company that touches consumers and patients at multiple points along the health care continuum, we have learned valuable lessons on how to drive better patient outcomes and lower health care costs.

Let's look at addressing chronic and complex conditions.

All too often we tend to discuss the issue in the context of people needing more medications. But Americans taking their medications as prescribed is one of the most effective ways to fight chronic diseases like high blood pressure, diabetes and high cholesterol that are significant cost-drivers.

In fact, prescription drugs are the "first, logical choice for medical intervention" for nearly 90 percent of people with chronic and complex diseases. Unfortunately, up to 50 percent don't take their medications. Up to one-third don't even have their prescriptions filled. Often cost is a barrier.

What does this mean? Studies have shown improved medication adherence could save nearly $300 billion in unnecessary medical costs each year.

Better pharmacy management has a major role to play in driving medication adherence.

Through personalized counseling and clinically-effective interventions, pharmacists are an influential voice in helping patients take their medications as directed.

Better pharmacy management also reduces costs for consumers. Pharmacists are uniquely qualified to recommend cost-effective alternatives to more expensive drugs – increasing medication adherence, improving health outcomes, and saving consumers and our clients' money in the process.

The data bear this out. Let's take hospital readmission as an example:

- 1 in 7 patients are readmitted within 30 days.

- Two-thirds of these patients are readmitted because of a problem with their medication – either an adverse drug reaction or failure to take their medications as prescribed.

- Research shows that up to 75 percent of these hospital readmissions are preventable.

By reducing readmissions, pharmacist interventions save lives and generate system savings of up to 65 percent – that's more than $3,300 per patient.

Now let's talk about the impact of better pharmacy management in government programs. The Ohio Medicaid program is a good case in point:

By 2011, the Ohio Medicaid program had carved nearly all its pharmacy benefits into Medicaid managed care.

Working with these plans, including Molina and CareSource, we've used PBM tools such as care coordination for complex populations to drive higher quality care and reduce costs.

As a result, Ohio spent 13.3 percent less – on average – than states without prescription drugs in their managed care system.

We've also seen similar results in Medicare Part D. Using PBM tools, Part D costs have been 45 percent lower than original projections – and average premiums have remained stable over time. That's what we mean when we say PBMs add significant value to the health care system.

We're also introducing innovative lower-cost care settings. Most of you are familiar with our MinuteClinics, where we provide preventive services like vaccinations and flu shots, as well as clinical support to help those with chronic conditions better manage their health.

Our Coram infusion service provides IV treatments to patients in their homes, and we're seeing good results. It's more convenient for patients, so they are more likely to adhere to their medications and it's dramatically reducing costs for payors by offering care in a lower-cost setting. This translates into better patient outcomes – including a 48 percent reduction in hospital admissions during transitions of care.

Finally, we're walking the walk in our role as a purchaser of health care.

Our employee health care plan covers about 185,000 lives, including dependents. It's a high deductible plan that's designed to promote preventive care and increased medication adherence.

That's why it includes a preventive drug list, where our plan pays for the full cost of preventive generics and brand insulins – that means no co-pay or co-insurance for members. The plan also pays 80% of the cost of preventive brand medications, with no deductible applied.

Our preventive drug list accounts for less than 1 percent of total plan costs – saving our employees and their families money at the pharmacy counter.

Based on our experience, we believe this is a model more employers and health care plans should adopt to save their members money and improve health outcomes.
These are some of the ways we're working hard every single day to get patients the medication they need at the lowest possible cost. Because we know that patients lose access when they can't afford their medications. And this leads to poorer health outcomes and increased costs.

PUBLIC SECTOR REFORMS: REDUCING PRICES THROUGH INCREASING COMPETITION

The rising cost of drugs is a legitimate concern and the calls for action are loud – and needed. But, as we look at policies and solutions, we must closely examine each one to ensure they achieve our end goals. And we should be wary of any "easy" fixes.

As prescription drugs are becoming more and more central to health care management, solutions should ensure the system works for consumers and payers. That is why PBMs are critical. And government has a role to play by fostering competition and transparency.

Government can create more competition and lower costs by increasing the flow of generics and biosimilar to market. At CVS Health, 85 percent of the drugs we dispense each year are generics. In 2015, generic drugs saved Americans $227 billion – and more than $1 trillion in the last decade.

Clearing out the backlog of generic drug applications at the FDA and approving more biosimilars will only increase the savings. This must be a top priority.

We also need new policies that recognize a changing health care delivery system.

Simply put, pharmacists must be empowered to provide patient care – because, as I discussed earlier, pharmacists are uniquely positioned to boost medical adherence and reduce wasteful or unnecessary spending.

And we need better regulatory and payment structures that provide an incentive for care in more cost-effective settings.
And, as policymakers consider drug pricing solutions for government programs, we want to make sure they recognize that PBMs negotiate extremely well in Part D where competition exists. In the absence of competition, other changes will fail to deliver the desired impact.

PRIVATE SECTOR SOLUTIONS: THE ROLE OF PBMS

This brings me to my final point: PBMs add significant value to the supply chain.

Our job is to ensure the right care for consumers and lower costs. Many of our clients are sophisticated, Fortune 100 companies you hear about every day. They push us to innovate and work hard on their behalf.

If we didn't drive cost containment for them, they would fire us. In other words – our job is to extract costs from the system, not add to them.

To that end, our latest data show that our tools are working, and we are successfully bending the cost curve.

Earlier this month, we announced that our PBM clients achieved the lowest drug cost trend in the past four years, even with rising drug prices. We reduced trend, the rate of drug spending growth, from an unmanaged 11 percent rate – largely driven by brand list price increases – to 3.2 percent actual cost growth by using our PBM management solutions that include price protection and the negotiation of rebates – greater than 90 percent of which are passed back to clients.

In fact, 38 percent of our commercial clients actually spent less on their prescription benefit in 2016 than they did in 2015.

Importantly, out-of-pocket costs for members also dropped 3 percent compared with the previous year. That's why every one dollar invested in PBM services returns six dollars in savings for payors and the patients they serve.

And we're going even further.

Last month, the Health Transformation Alliance announced a partnership with our PBM and OptumRx that breaks new ground in the effort to lower health care spending for some of America's largest corporations.

HTA estimates that this new group purchasing approach will save participating companies each about $10 million dollars annually, a combined $600 million over three years.

Another example of how we help consumers save money at the pharmacy counter is EpiPen. While EpiPen's price has increased 150% over three years, we've been able to keep our clients' cost growth to less than 10% per year through negotiated discounts and price protection.

This has kept out-of-pocket costs lower for consumers and decreased their overall average costs – including both copays and coinsurance – from 26% of the list price in 2009 to 11% in 2016.

Also in January, we also began offering Adrenaclick, a less-expensive epinephrine auto-injector at all our pharmacies. This authorized generic is a FDA-approved device with the same active ingredient as other epinephrine auto-injector devices.

Consumers can now purchase this device at a cash price of $109.99 for a two-pack – the lowest cash price in the market and less than the $649 EpiPen.

And just last week, we launched a prescription savings program that offers point-of-sale discounts directly to patients on certain medications. Our Reduced Rx program will help patients with high out-of-pocket costs pay for essential medications.

Under the program, we're partnering with Novo Nordisk to offer vital insulin drugs at a cost of $25 per 10 ml vial – significantly lower than the market rate. And we plan to expand the program to other medications and to address other conditions.

Here's what these examples show: When we align our interests with our clients and consumers – everyone does better.

I want to share one other way we're accelerating this alignment. With more consumers in health plans with high deductibles, many are seeing the true cost of medications for the first time.

For consumers used to paying a $15 copay, having to spend $5,000 or more out of their own pocket to reach a deductible causes great concern. One way we know we can help relieve this concern is by helping control costs at the point of prescribing as well as at the point of dispensing.

That's why we're leading the charge to design a system that use electronic health records to share information the PBM has, such as formularies, available low-cost generics, and pre-authorization requirements with physicians before they prescribe a medication.

With this data, physicians can see what their patient's out-of-pocket costs are and compare costs for different brands while they are discussing medication options with their patient.

This visibility can reduce costs across the system, including administrative costs for physicians. Perhaps most importantly, it will reduce the time consumers spend getting their prescriptions filled and the unpredictability they may face at the pharmacy counter today.

Simply put, it can help consumer use their drug benefit in a more meaningful, cost-effective way.

Let me conclude by just acknowledging that we don't have all the answers.

No single solution will solve all these problems. And every player in the health care system has a role to play.

That's why this Summit is so important. What we bring to the table are these proven successes that we can and should continue to build on to improve health outcomes and lower costs. And we welcome polices that do just that.

Thank you.