CVS Health

September 13, 2018

Mr. Tony Coelho, Chairman
Partnership to Improve Patient Care
100 M Street SE - Suite 750
Washington, DC 20003

Dear Tony:

Thank you for your letter to CVS Health's CEO Larry Merlo. He asked me to reply on his behalf as the Chief Medical Officer of CVS Health.

I would like to address your concerns about CVS Health's new policy that allows self-funded plan sponsors (overwhelmingly employers) to avoid coverage of medications that have a launch price of greater than $100,000 per quality adjusted life year (QALY). Currently, this option is available only to self-funded plans.

As I am sure you are aware, launch prices for new prescription drugs have been steadily increasing for years, continuing to go up into the hundreds of thousands of dollars each year, pushing costs per QALY into the $300,000-$500,000 range — costs the U.S. health care system simply cannot absorb. Unfortunately, pharmaceutical firms want to retain their ability to name the initial ("launch") price for their patented products at whatever level they deem fit, and subsequently increase the prices of those products with no limits imposed by health care payors. Unchecked, this practice has led us to a point where many in health care and health policy believe the prices of pharmaceuticals are unsustainably high.

Rising drug prices are having an impact on patients every day, especially those in high deductible health plans who are paying an increasing share of the cost of their prescription drugs. These patients cannot benefit from medicines they cannot afford.

That's why, at CVS Health, we are committed to using every tool possible and continuing to drive innovation to bring down the cost of drugs. We remain focused on providing the right drug to the right patient at the right time at the lowest possible cost. PBM cost containment strategies have a proven track record of helping improve medication adherence and promoting better patient health while keeping drug cost inflation under control in spite of continued manufacturer driven drug price increases.

The cost per QALY ratio is determined based on publicly available analyses from the Institute for Clinical and Economic Review (ICER), an organization skilled in the development of comparative effectiveness analyses. Quantitative methods, such as the concept of the QALY, can help enable a comparison between the cost and effectiveness of medications. The QALY is recognized by US and international authorities as the gold standard for capturing how much a treatment improves patients' lives. It is especially helpful because it measures health gains in a way that can be transparent and fair across all kinds of health conditions. Importantly, medications deemed "breakthrough" therapies by the U.S. Food and Drug Administration will be excluded from this program, which will instead focus on

expensive, "me-too" medications that are not cost effective, helping put pressure on manufacturers to reduce launch prices to a reasonable level.

Since the QALY measures absolute improvements in quality or length of life, the greatest potential for large gains is accorded to treatments of patients with serious illnesses or disabilities. As a result, many treatments of life-threatening or fatal illnesses are found to generate substantial QALY gains and to be ultimately "cost-effective" even if very expensive. Good recent examples of this are the CAR-T therapy for children with leukemia, several precision treatments for patients with lung cancer, and a new drug for patients with severe congestive heart failure. All these treatments are very expensive, but in ICER reports all were found to provide significant improvements for patients with very serious, chronic illness, and were therefore determined to meet a reasonable cost-effectiveness standard. Because the QALY standard applies uniformly across all health conditions and plan members, our benefit design will not be discriminatory and, in fact, will improve the chances that patients with disabilities and serious illness will be able to get the treatments they need at a price they and the health system can afford.

As it relates to your concern on the method of cost-effective analysis, the fact is that the cost per QALY is a matter of equal parts the intrinsic value of the medication and the arbitrary price the company sets for it. That is a key point of the program – to get the pharmaceutical industry to price things at a reasonable value at the time the treatment is launched. Using the ICER value assessment, the pharmaceutical company will know exactly what the price needs to be set at for a drug to be included as a covered benefit. To be clear, with this new program in the market, it is the pharmaceutical manufacturer that is determining access to the medication by its choice of a launch price.

We believe as more payors adopt such programs, manufacturers will begin to moderate launch prices. Until now, PBMs such as CVS Health have had no ability to impact the initial launch price of a drug, which is set solely by the manufacturer seemingly without regard to the inherent value of the medication or what the payor or patient can afford. This new approach, harnessing the power of the market, could change manufacturer behavior. CVS Caremark continues to use other PBM techniques to help lower costs for payors and their members, but lower launch prices could help bring about real deflation in drug prices.

Our intent with this program is to bring the pharmaceutical industry to some sense of rationality around drug pricing, using comparative effectiveness research and cost effectiveness analysis. We believe market forces can then encourage manufacturers to initially price their drugs at what is widely seen as a reasonable value in health care.

We would be happy to meet with you to discuss our program in more detail. We will reach out to find a mutually agreeable time.

Sincerely,

Troyen A. Brennan, M.D.
Chief Medical Officer
CVS Health