CVSHealth

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The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
Washington, D.C. 20201

Dear Secretary Azar,

I am following up on your recent comments before both the U.S. Senate Finance Committee and the Senate Health, Education, Labor and Pensions (HELP) Committee. I was surprised to hear you say that drug companies would like to lower prices but the pharmacy benefit managers have not been cooperating. I want to assure you that this is not the case for CVS Health.

As you know, manufacturers set drug prices. We do not instruct manufacturers on how they price their products. Consistent with that practice, we have not as part of the current dialogue or in any other circumstance, instructed manufacturers not to lower list prices. To be clear, we support the Administration's efforts to address high drug costs.

We have and will continue to work tirelessly on behalf of our clients and individual patients to lower overall drug costs. For our PBM clients, including employers, unions, health plans and government programs we serve, we have kept drug price growth at a minimal 0.2 percent, the lowest in five years, despite manufacturer brand list prices increases on drugs near 10 percent. Further, over 30 percent of our clients spent less in 2017, than they did in 2016 on prescription drug costs.

There is no question, however, that rising out-of-pocket costs for Americans at the pharmacy counter is a very real issue, especially to the millions of Americans now covered in a high deductible health plan (HDHP). In fact 45 percent of all covered beneficiaries are now in a HDHP. This means that more and more Americans are seeing higher out-of-pocket costs on the part of the benefit they use the most – their prescription drug coverage, because they often do not have full prescription coverage until they have met their deductible. There are actions that the Administration could take immediately which would help reduce out of pocket drug costs for consumers.

Under current Internal Revenue Service guidance, only certain preventive products and services may be covered by a high deductible health plan prior to satisfaction of the minimum deductible. However, this coverage should be expanded to include products for managing chronic conditions, or to allow a high deductible health plan to cover drugs prior to satisfaction

of the deductible. This option would help these plans provide more first dollar coverage at the pharmacy counter, improve medication adherence and health outcomes, and reduce sticker shock when consumers are filling their prescriptions. You can accomplish this goal immediately through the regulatory or guidance process.

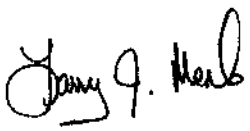
Another important tool we offer our clients, especially those with high deductible health plans, is the option to use rebates provided by pharmaceutical manufacturers into the patient's cost-sharing. We do this by applying rebates at the point-of-sale. When our clients adopt this option their members can see reductions in the price at the pharmacy counter reduced by 10 to 30 percent for many branded drugs. This reduction in price at the pharmacy counter will help increase medication adherence and ultimately beneficiary health. We believe that adopting point-of-sale rebates for employer and union health plans is something the Administration could encourage through further regulatory changes.

Ultimately, manufacturers set the price of the drug. In addition to our negotiation tools, we are using other innovations to help consumers deal with the high cost of prescription drugs. Another component of the company's comprehensive savings approach is bringing real-time benefits information to the point of prescribing. Through their electronic health records system, providers are able to see the member-specific cost for a selected drug, based on a member's coverage, along with up to five lowest-cost, clinically appropriate therapeutic alternatives based on the patient's formulary.

Early results show that prescribers accessing the real-time benefits changed their order for a patient's drug from a non-covered drug to a drug on formulary 85 percent of the time. If the initial medication was covered but non-preferred and there is a lower-cost alternative available, prescribers are changing the member's medication up to 40 percent of the time, resulting in a difference in out-of-pocket cost to the patient of approximately $75-$100 per prescription. I would urge you to use every regulatory tool at your disposal to encourage adoption of the use of point of prescribing real time benefit information.

I sincerely appreciate your attention to these matters and look forward to sitting down with you in the near future to discuss further.

Sincerely,



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