Balancing the Tradeoffs Between Cost, Innovation, Accessibility and Affordability

January 10, 2017

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Common Ground

Living longer and better

- A shared priority

Cost containment

- Part of a healthy healthcare system

Solutions

- Better off developing them together

Prescription Drug Prices: *What Do Payers Pay?*

Private Payer

- **Price – Discounts + Rebates**
- Patient OOP = copay or coinsurance

Commercial | Medicare Part D Insurers

- **Price – Discounts + Rebates**
- Patient OOP = zero, copay, or coinsurance

Medicaid

- **Best Price – 23% rebate + CPI guarantees [+ supplemental rebates]**
- Patient OOP = zero or copay

Outpatient Pharmacy Ecosystem

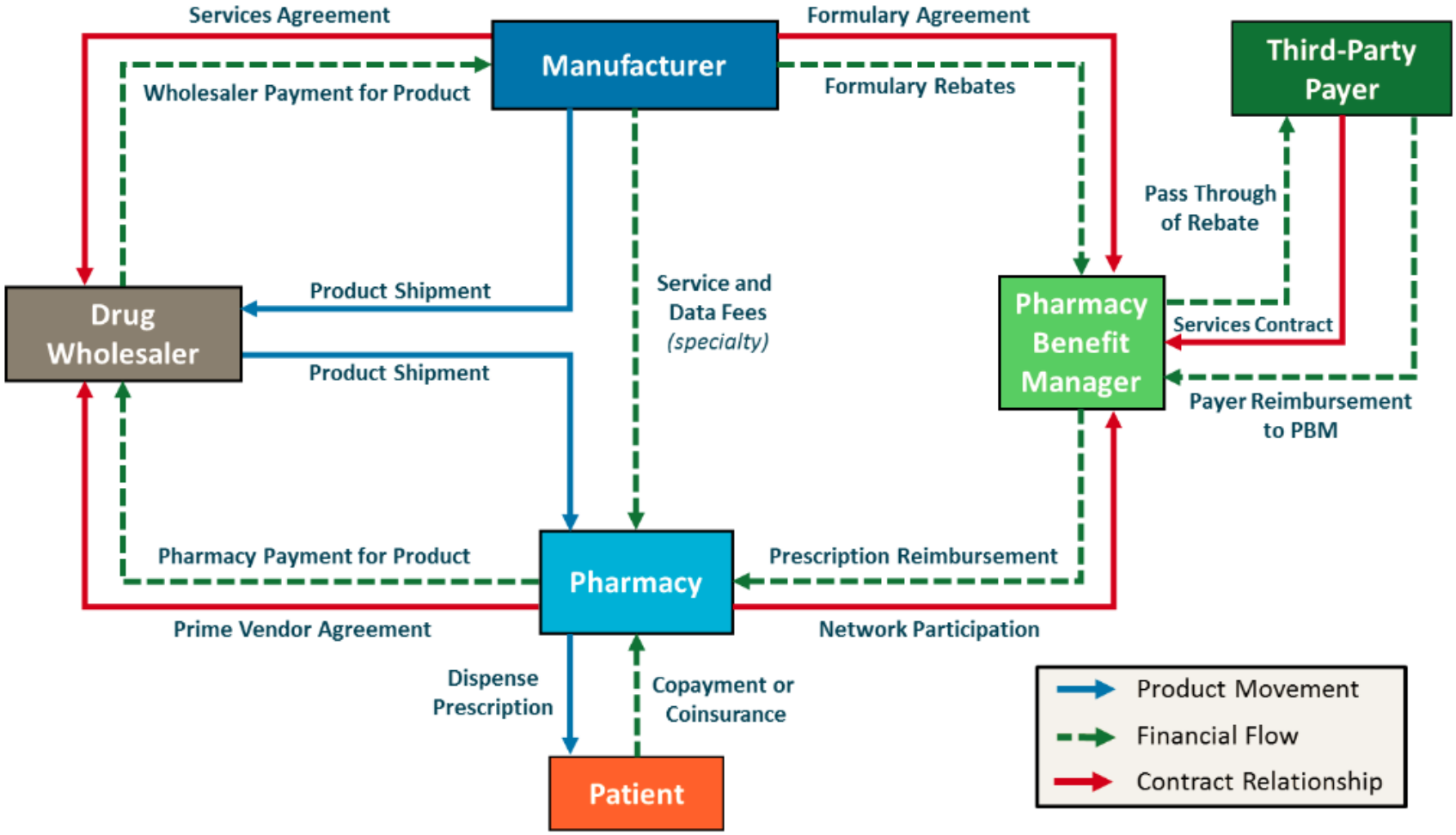
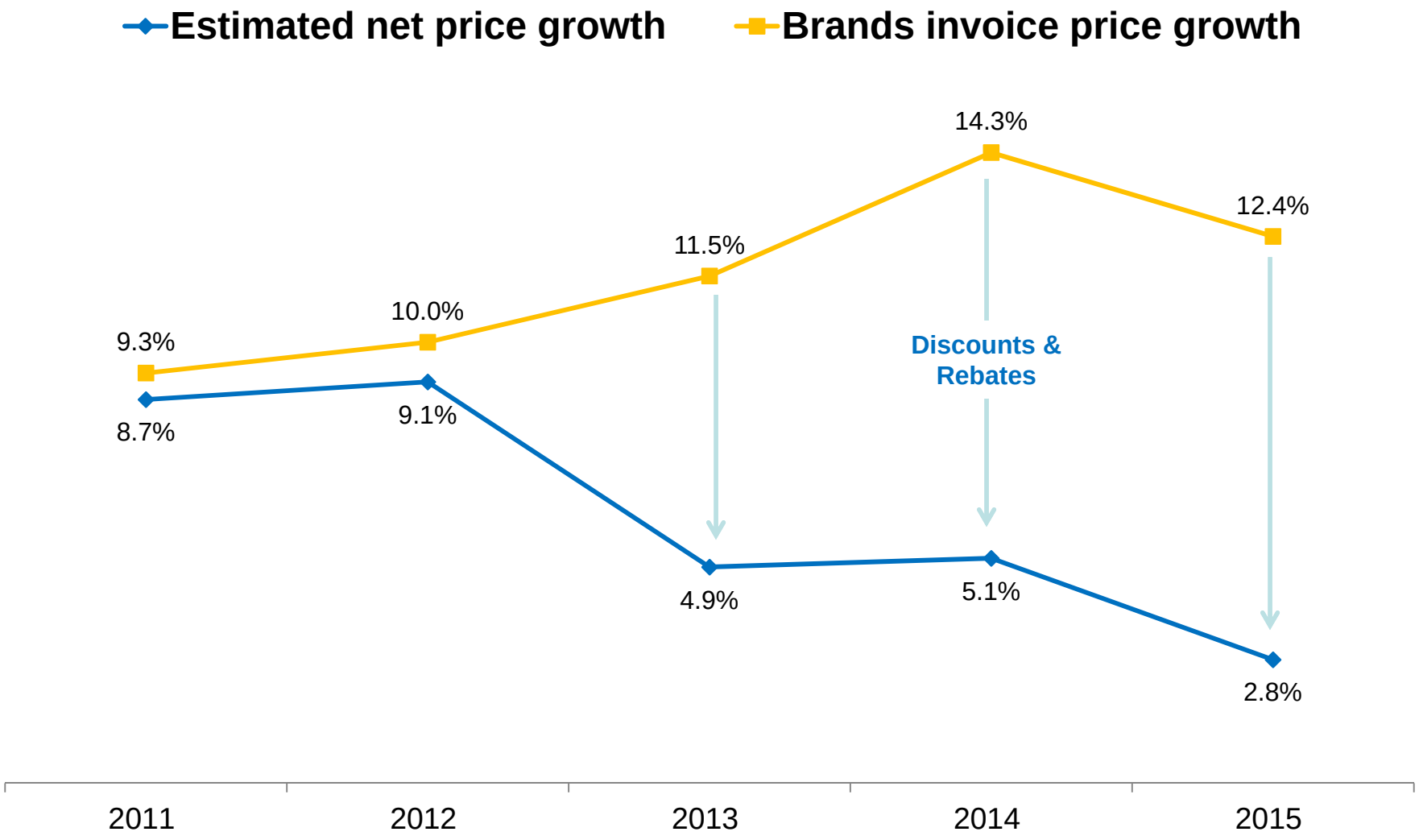


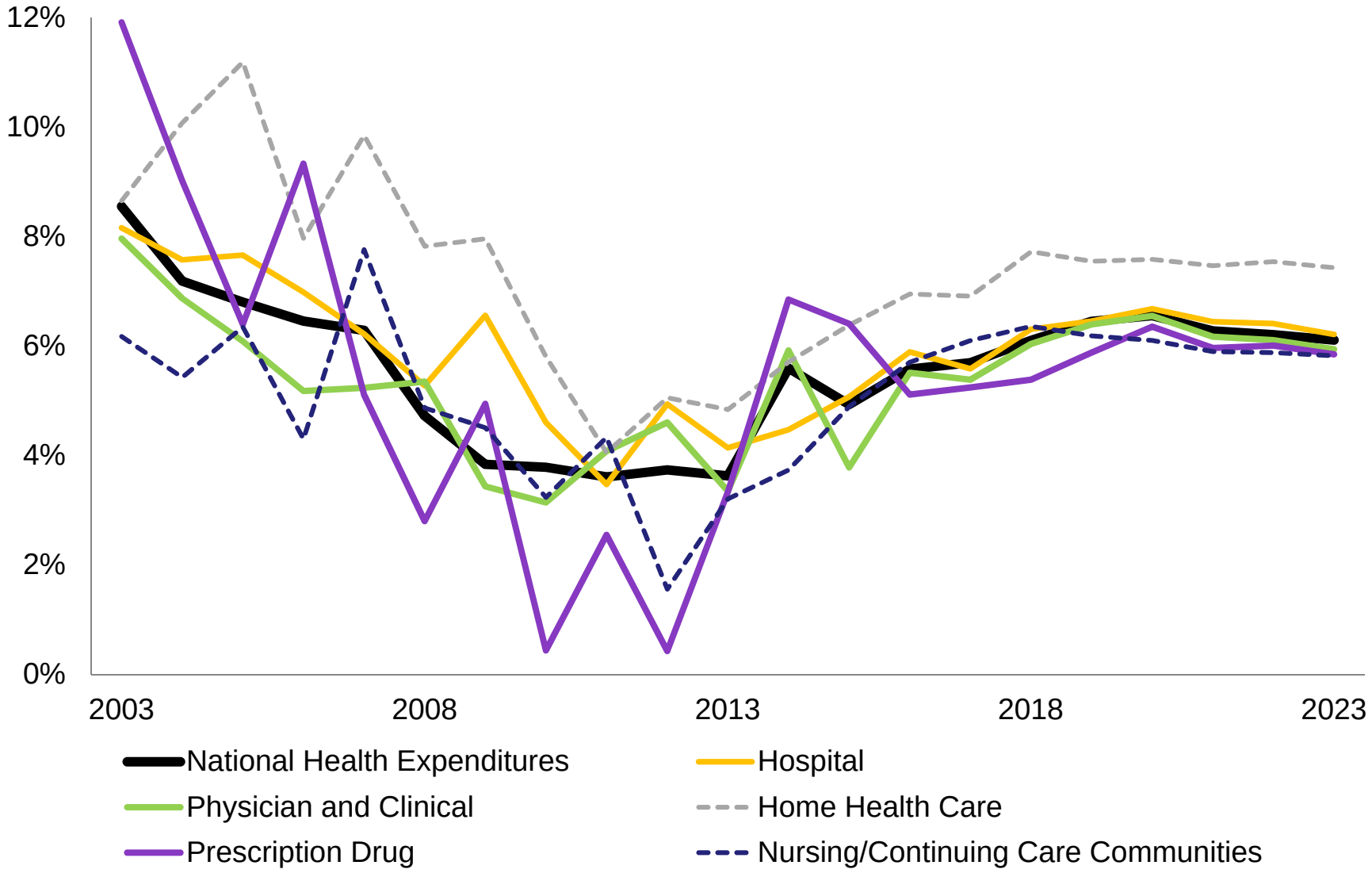
Chart illustrates flows for patient-administered, outpatient drugs. Please note that this chart is illustrative. It is not intended to be a complete representation of every type of financial, product flow, or contractual relationship in the marketplace.
Source: Fein, Adam. J., *The 2016 Economic Report on Retail, Mail and Specialty Pharmacies*, Drug Channels Institute, January 2016.
(Available at http://drugchannelsinstitute.com/products/industry_report/pharmacy/)

Gross vs. Net Price Growth



SOURCE: IMS Health, National Sales Perspectives, IMS Institute for Healthcare Informatics, March 2016

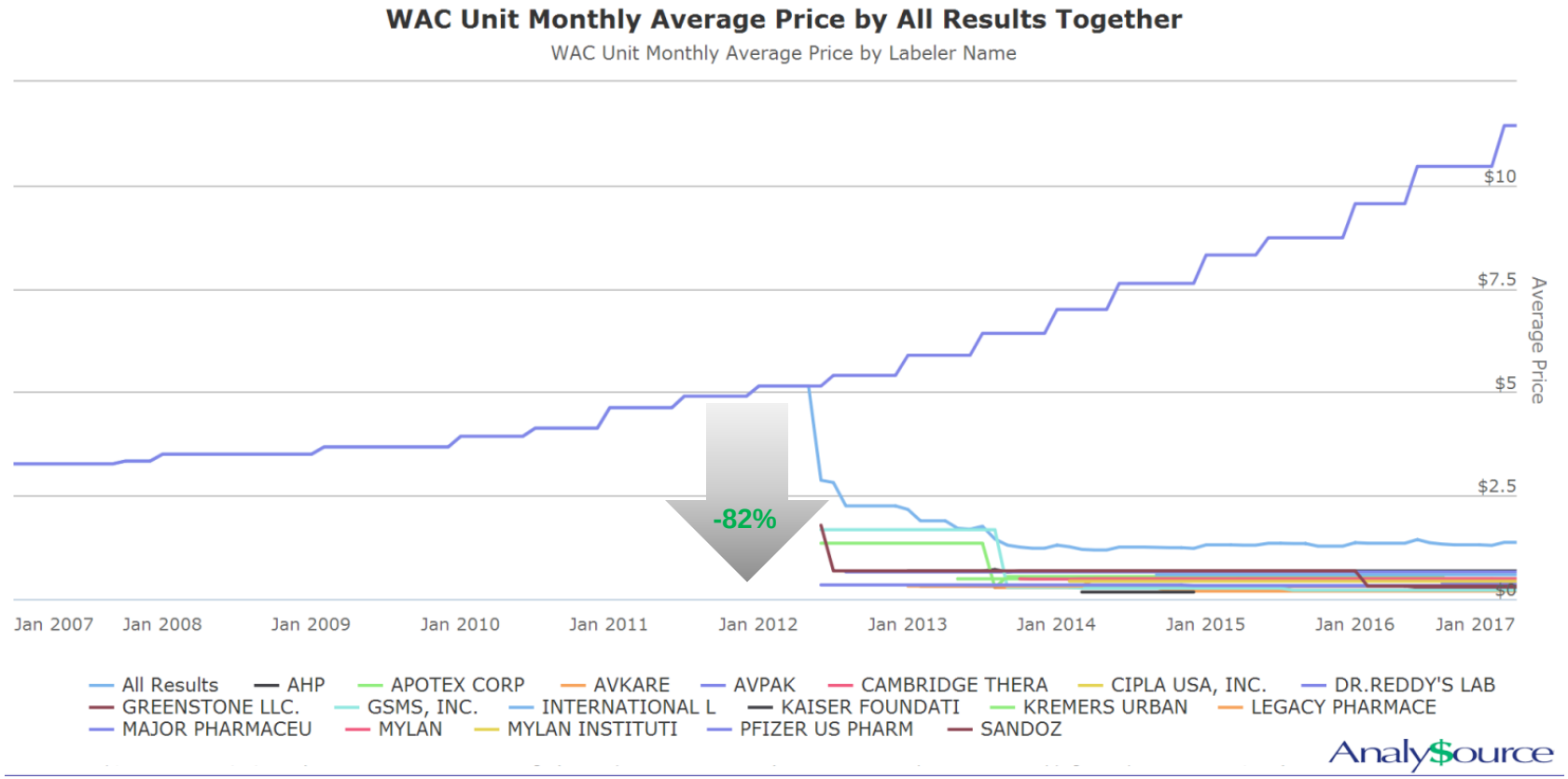
U.S. Healthcare Spending: *Growth*



SOURCE: CMS: National Health Expenditure (NHE)

Built-In Cost Containment Mechanism

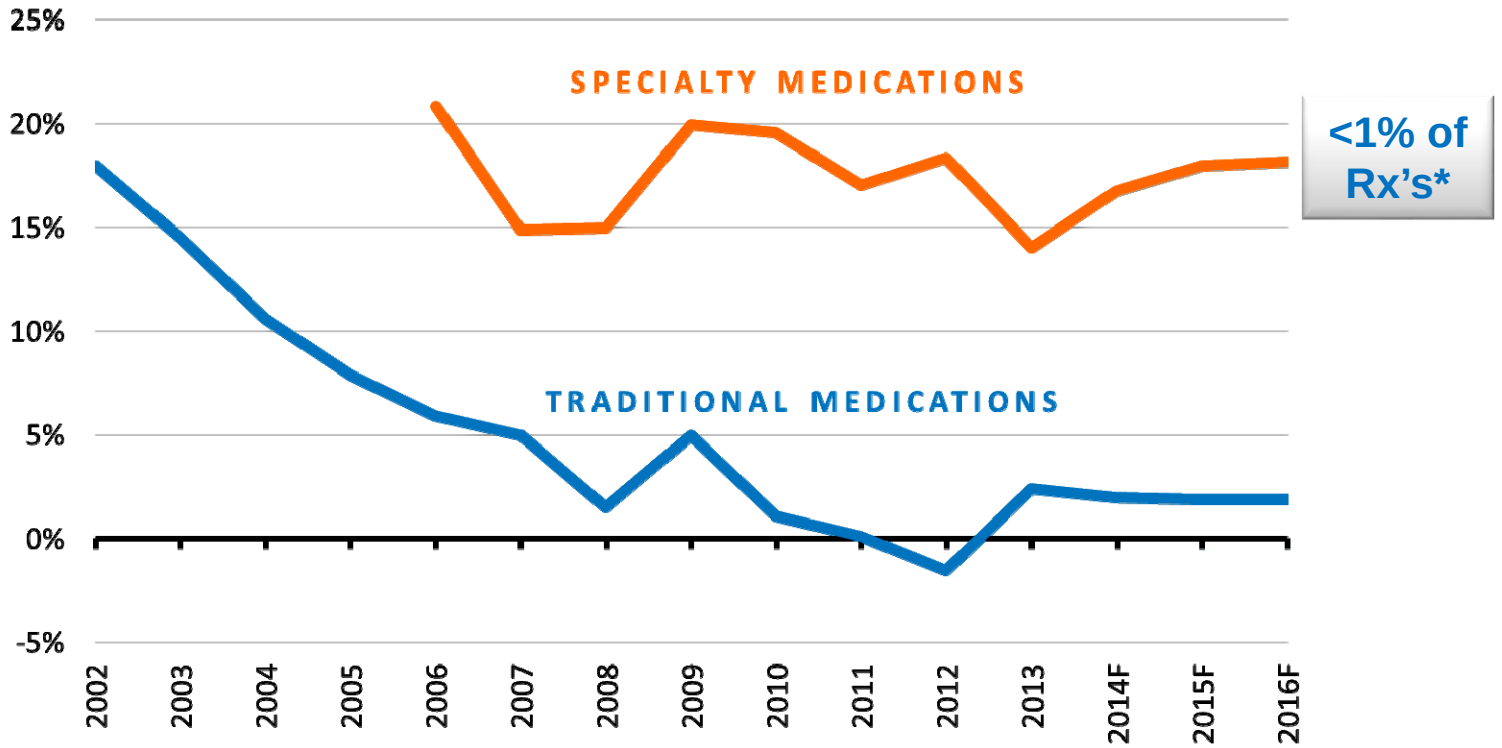
Brand-Generic Product Cycle



SOURCEs: Analy$ource Online 1/5/2017 (Selected from FDB MedKnowledge (formerly known as NDDF Plus) data included with permission and copyrighted by First Databank, Inc.)

What About Specialty Medicines?

Pharmacy Benefit Drug Trend, Traditional vs. Specialty Drugs, 2002-2016



<1% of Rx's*

Source: Pembroke Consulting analysis of Express Scripts Drug Trend reports, various years
Published on Drug Channels (www.DrugChannels.net) on April 10, 2014.

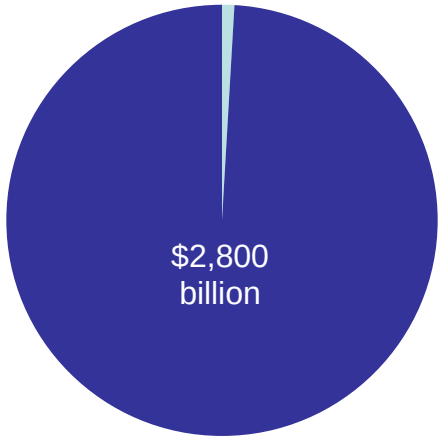
DRUG CHANNELS INSTITUTE

SOURCE: Pew Trusts. http://www.pewtrusts.org/~/media/assets/2015/11/specialty-drugs-and-health-care-costs_artfinal.pdf

What About Oncology Medicines?

Spending on Cancer Medicines Represents <1% of Overall Health Care Spending

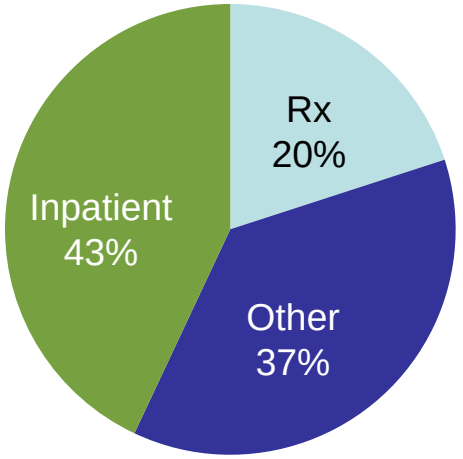
Cancer Medicines as a Portion of Total U.S. Health Care Spending, Billions, 2012



IMS Institute for Healthcare Informatics, Declining medicine use and costs: for better of worse? A review of the use of medicines in the United States in 2012. May 2013. And Martin AB, et al. National health spending in 2012: rate of health spending growth remained low for the fourth consecutive year. Health Affairs, January 2014 (33):1, 67-77.

Cancer Medicines Represents 1/5 of Total Spending on Cancer Treatment

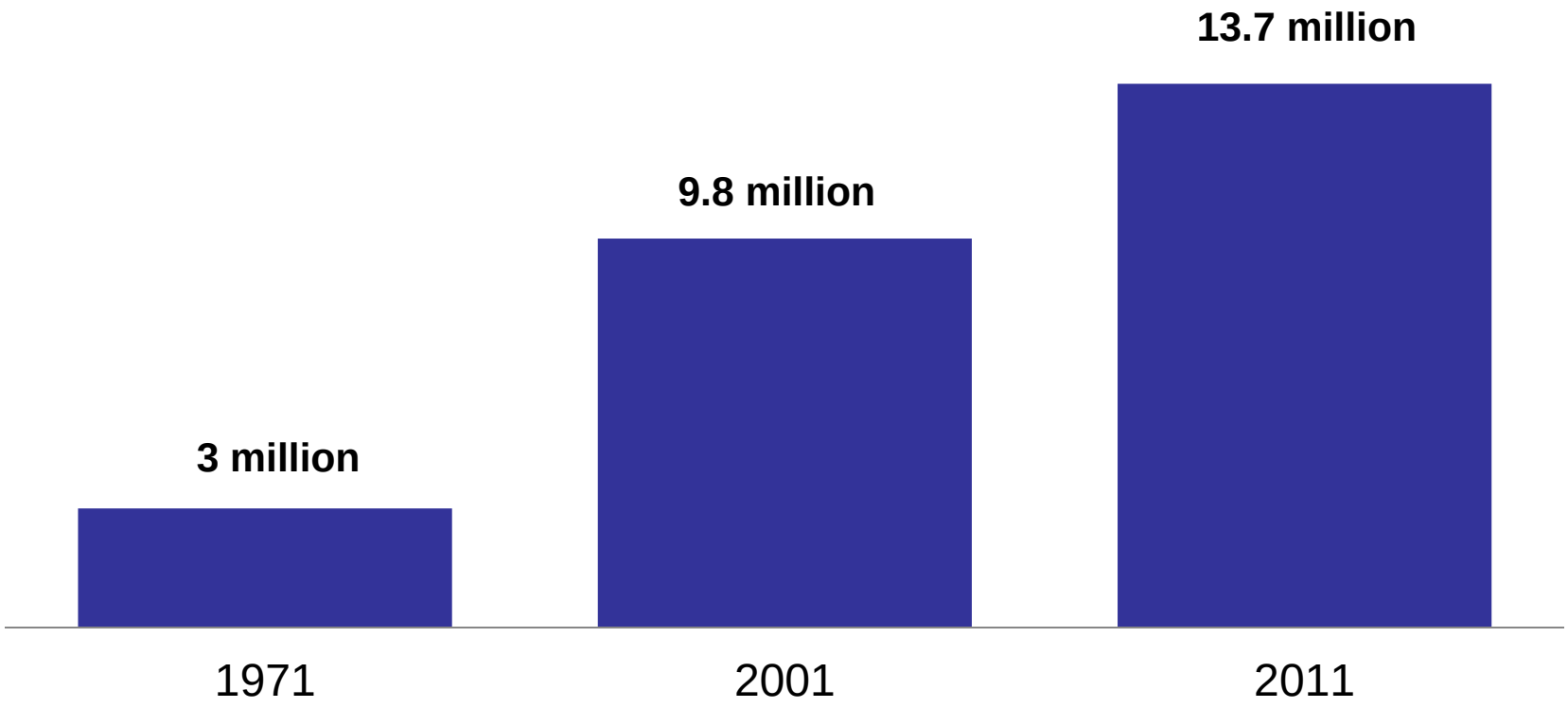
Total U.S. Cancer Care Spending, 2011



K. Fitch et al. "Benefit Designs for High Cost Medical Conditions." *Milliman Research Report*. April 22, 2011. p. 11.

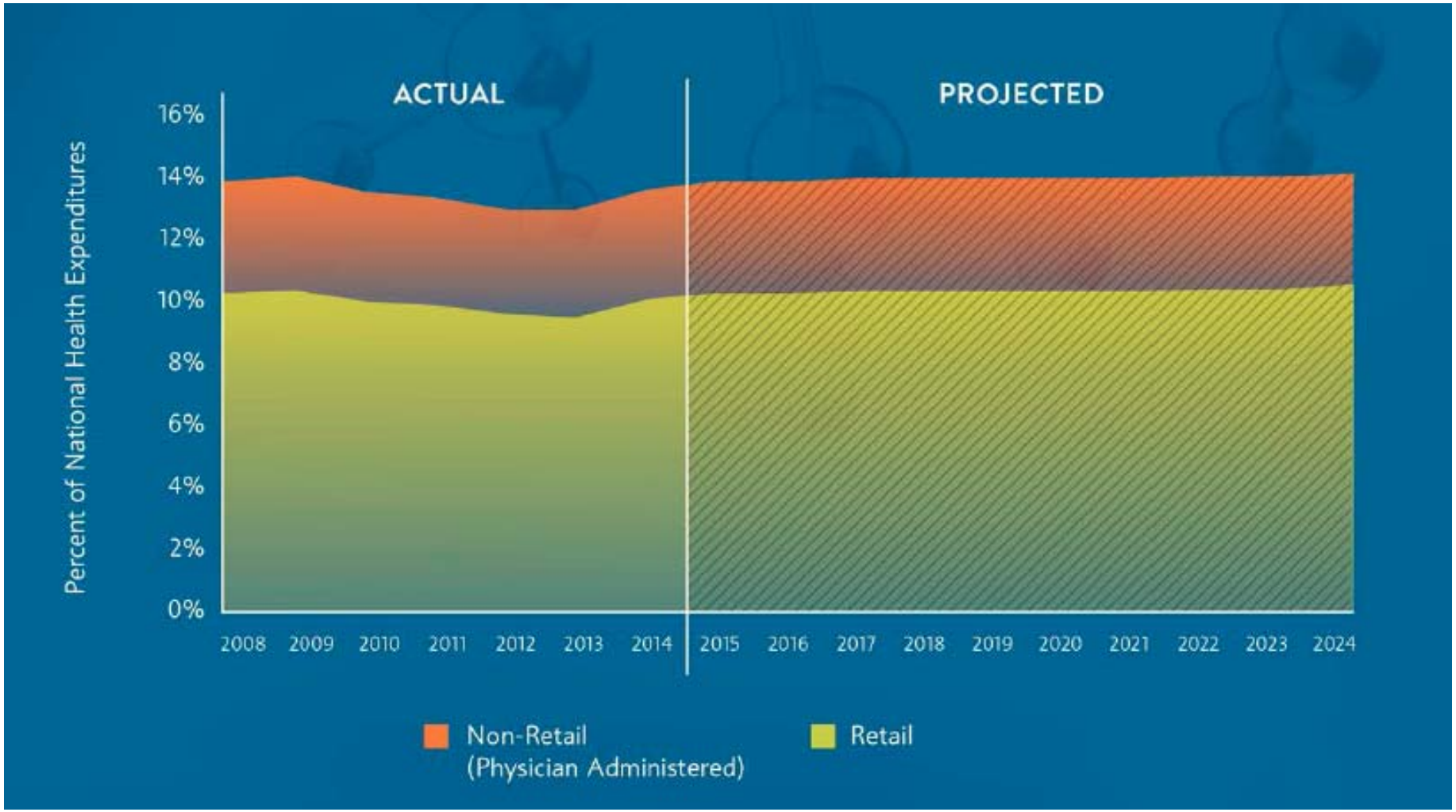
Value of Cancer Innovation

More People Surviving Cancer



SOURCES: U.S. Cancer Survivors Centers for Disease Control and Prevention, “Cancer Survivors-United States, 2007,” 10 March 2011, Siegel, R., DeSantis, C., Virgo, K., et al. (2012), Cancer Treatment and Survivorship Statistics, 2012. CA: A Cancer Journal for Clinicians. doi: 10.3322/caac.21149. American Association for Cancer Research. AACR Cancer Progress Report 2013. Clin Cancer Res 2013;19(Supplement 1):S1-S88, http://cancerprogressreport.org/2013/Documents/2013_AACR_CPR_FINAL.pdf

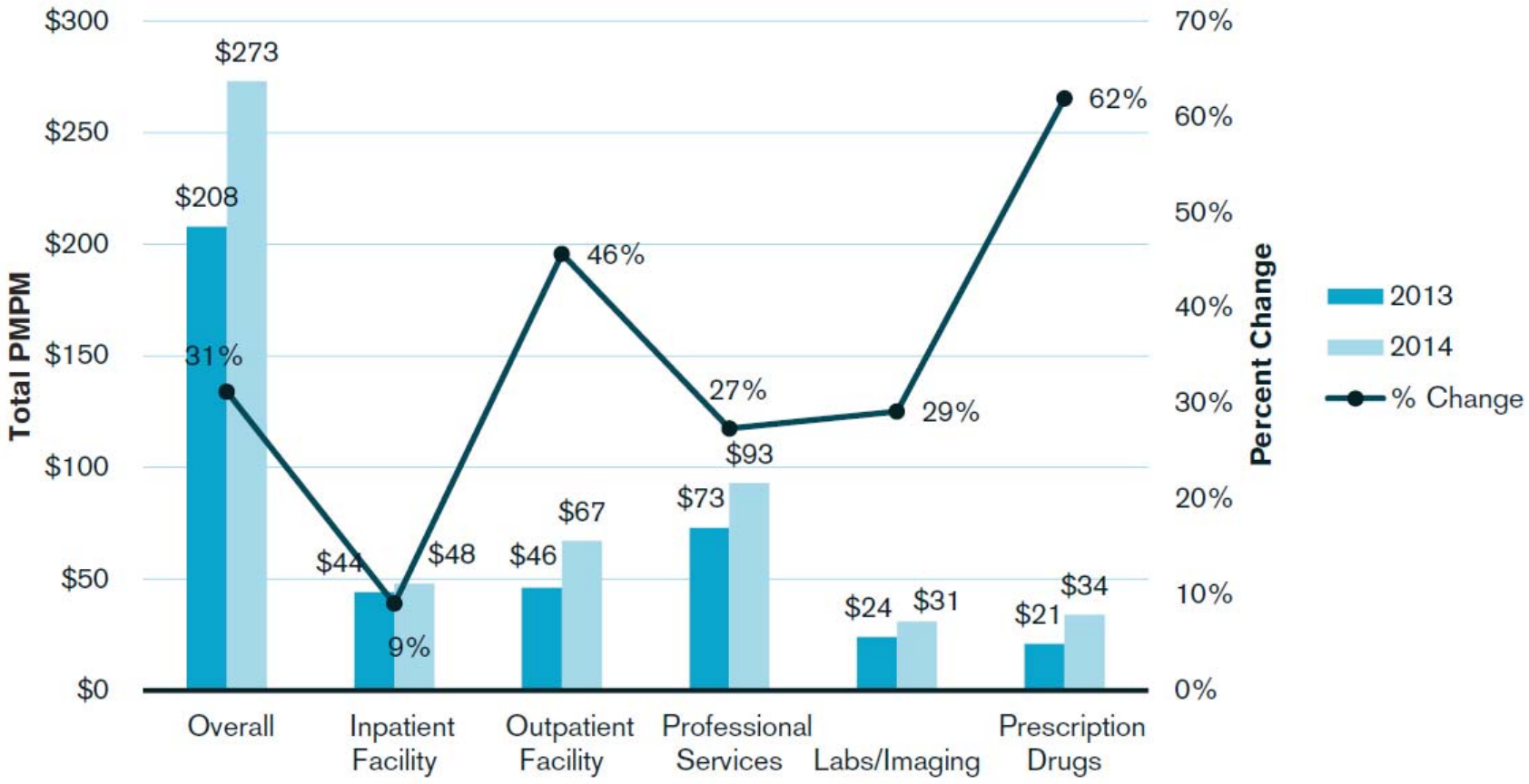
U.S. Health Care Spending: *Total Spending*



SOURCE; Altarum Institute, "A Ten Year Projection of Prescription Drug Share of National Health Expenditures Including Non-Retail," August 2015.

Maryland Case Study

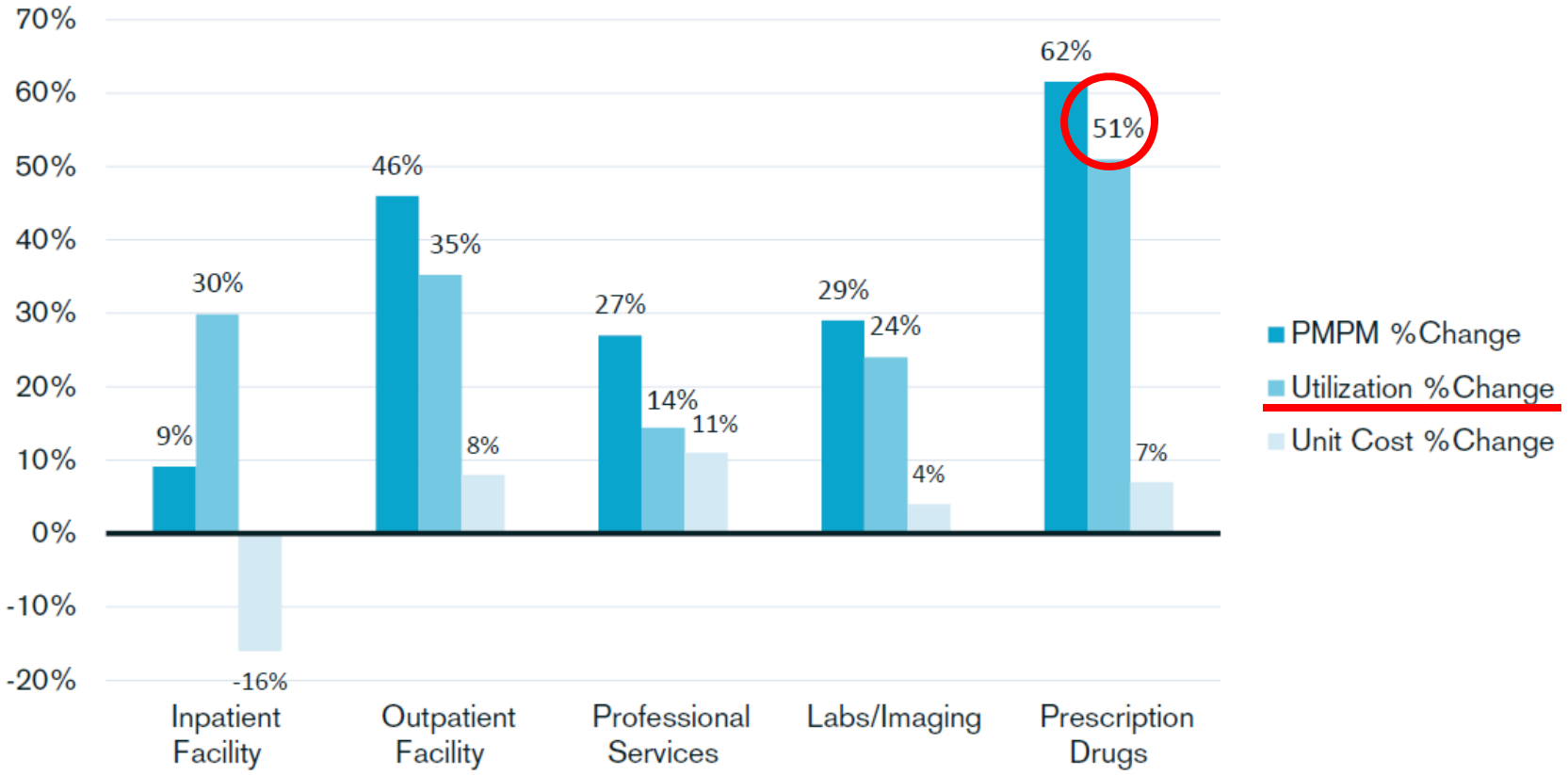
Total PMPM Changes, Individual Market



SOURCE: Maryland Health Care Commission, "Spending and Use Among Maryland's Private Fully Insured.

Maryland Case Study

Changes in PMPM Spending, 2013 - 2014: Utilization per 100,000 Members | Cost per Unit



SOURCE: Maryland Health Care Commission, "Spending and Use Among Maryland's Private Fully Insured.

Maryland Case Study

EXHIBIT 8a. Spending Among Maryland's Younger-Than-65 Population, 2014

	Total	Market		
		Large Employers	Small Employers	Individual
SPENDING				
PMPM spending, all services combined	$308	$313	$329	$274
PMPM OOP, all services combined	$66	$52	$71	$81
PMPM SPENDING BY SERVICE CATEGORY				
Inpatient facility	$51	$51	$52	$48
Outpatient facility	$62	$58	$62	$67
Professional services	$98	$97	$102	$93
Labs/imaging	$30	$30	$30	$31
Prescription drugs	$68	$77	$83	$34

EXHIBIT 8b. Spending Among Maryland's Younger-Than-65 Population, 2013

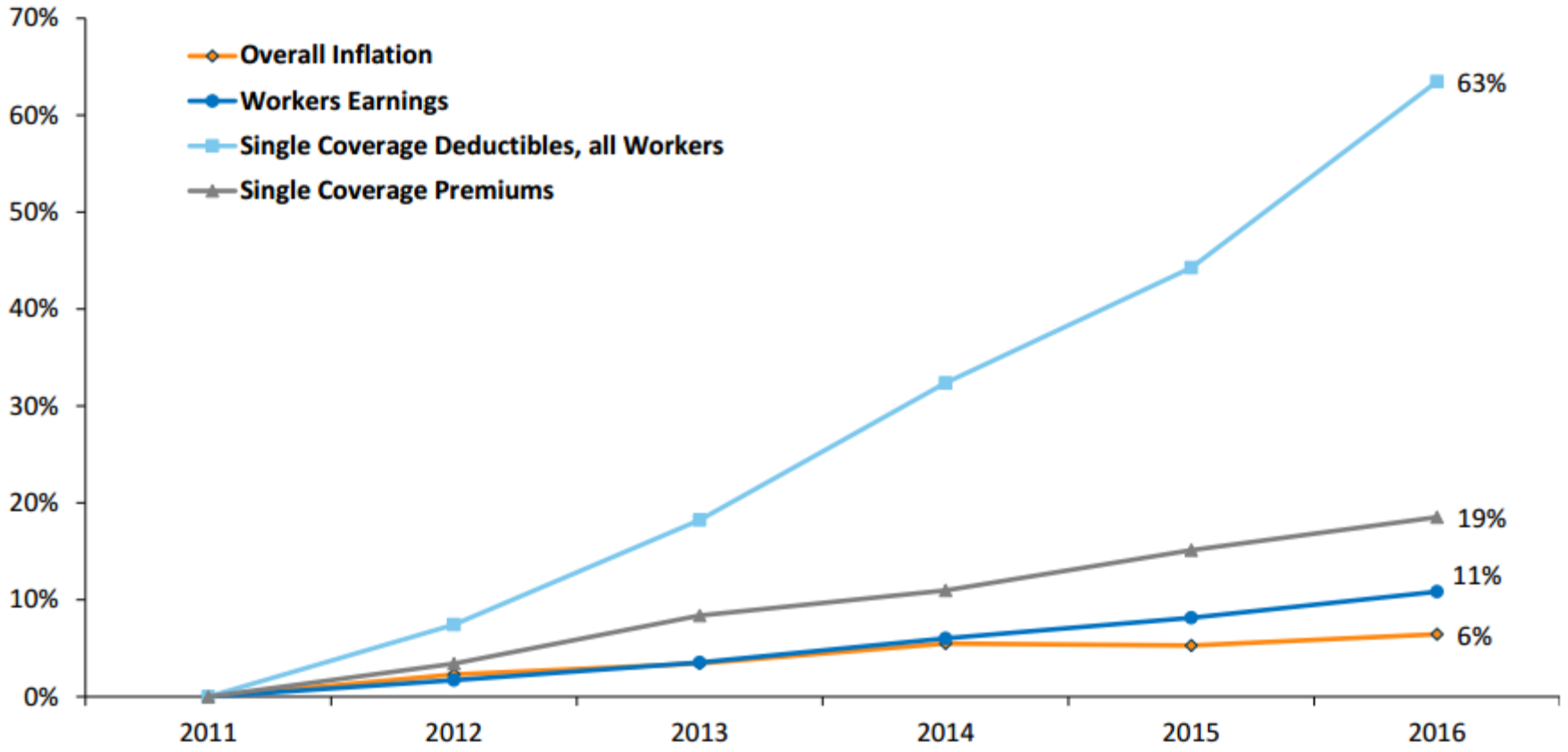
	Total	Market		
		Large Employers	Small Employers	Individual
SPENDING				
PMPM spending, all services combined	$298	$313	$336	$207
PMPM OOP, all services combined	$62	$52	$72	$68
PMPM SPENDING BY SERVICE CATEGORY				
Inpatient facility	$57	$59	$62	$44
Outpatient facility	$56	$58	$61	$46
Professional services	$91	$95	$98	$73
Labs/imaging	$28	$29	$29	$24
Prescription drugs	$66	$72	$86	$21

SOURCE: Maryland Health Care Commission, "Spending and Use Among Maryland's Private Fully Insured.

Better Use of Data for Innovation and Affordability

Image from: http://healthpopuli.com/wp-content/uploads/2014/03/image.jpg

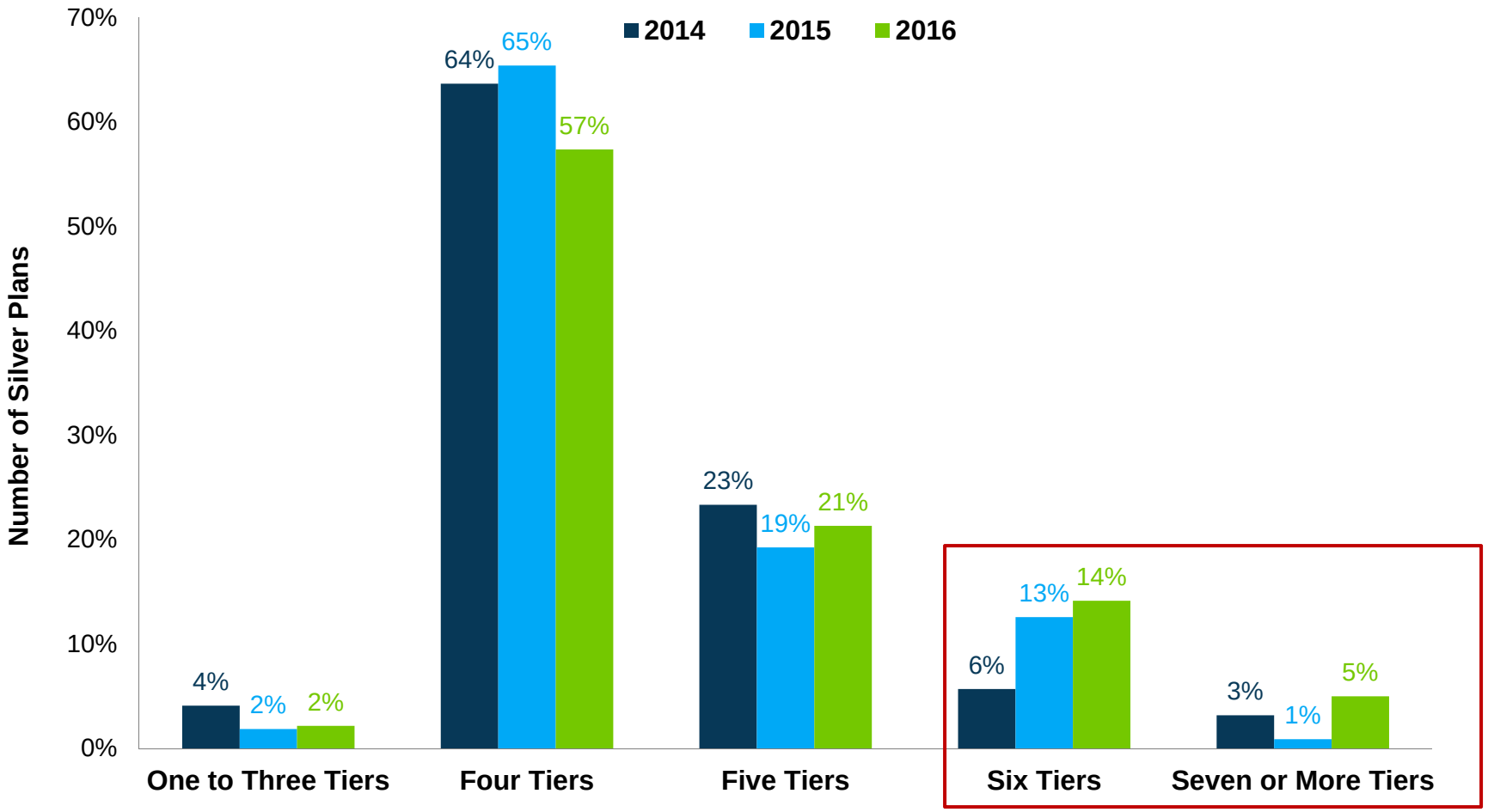
Benefit Design Trends: *Deductibles*



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2016. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2016; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2016 (April to April).

Benefit Design Trends: *Drug Tiers*

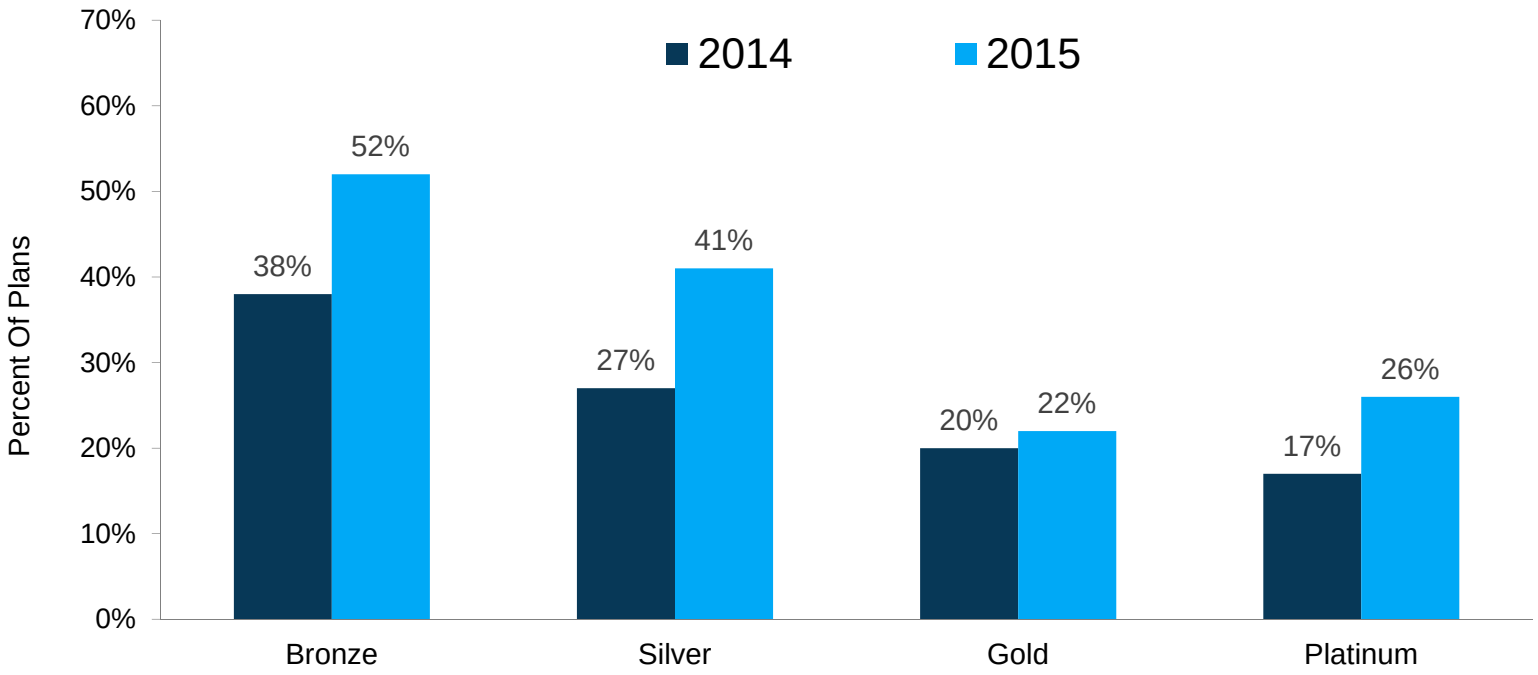
NUMBER OF FORMULARY TIERS IN SILVER PLANS, 2014, 2015 AND 2016



Note: The case study analysis only includes silver plans. Plans that noted only pre-deductible cost-sharing amounts were excluded from the analysis; this which explains why the total number of plans shift across the analysis. Avalere did not include heath plans in which there was no cost sharing across service categories or that had deductibles that were equal to the out-of-pocket maximum. 1. Avalere PlanScape®, a proprietary analysis of exchange plan features, December 2015. Avalere analyzed data from the FFM Individual Landscape File released October 2015.

Benefit Design Trends: *Co-insurance*

PERCENT OF PLANS SPECIALTY TIERS WITH COINSURANCE ABOVE 30 PERCENT



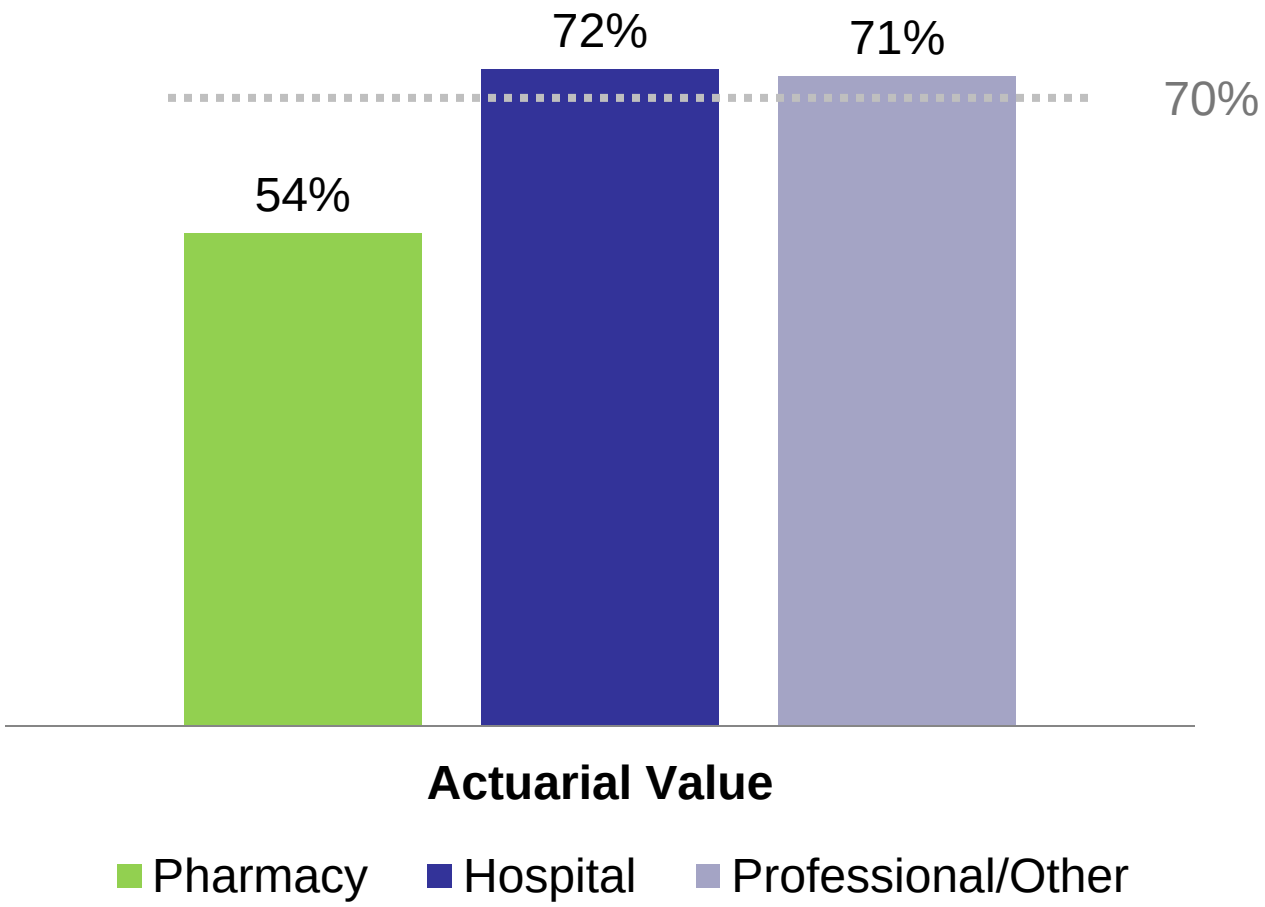
For specialty tier drugs, 2015 plans are requiring higher coinsurance rates compared to 2014. There was a 14 percentage point increase in the proportion of bronze and silver plans utilizing specialty tier coinsurance greater than 30 percent from 2014 to 2015.

Note: This data includes the FFM landscape file as well as data from Covered California and New York State of Health. Notably, the FFM landscape file forces plans into four tiers of data which excludes some cost-sharing detail. When plans indicated "no charge" in the HHS Landscape file, Avalere assigned the plan to $0 copayment or 0percent coinsurance depending on which cost-sharing type was most prevalent for the specified benefit. Avalere did not include heath plans in which there was no cost sharing across service categories or that had deductibles that were equal to the out-of-pocket maximum. For Tiers 1 – 3 Avalere used $0 copayment, and for Tier 4 Avalere used 0percent coinsurance. Plans that noted only pre-deductible cost-sharing amounts were excluded from the analysis; this which explains why the total number of plans shift across the analysis.

1. Avalere PlanScape®, a proprietary analysis of exchange plan features, December 2014. Avalere analyzed data from the FFM Individual Landscape File released November 2014 and the California and New York state exchange websites.

Benefit Design Trends: *Cost-Sharing*

Percent Paid by Patients in "Silver" Plans



SOURCE: Impact of Health Insurance Marketplace on Participant Cost Sharing for Pharmacy Benefits, Milliman May 2014 .

Rx Out-of-Pocket Cost: *State Approaches*

Legislation

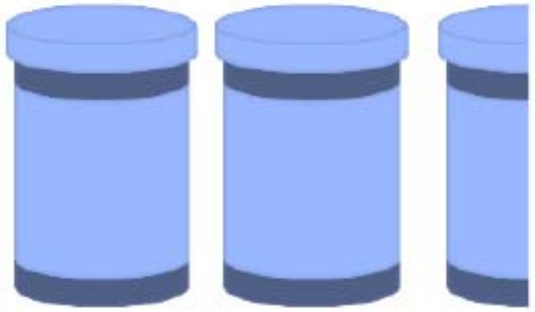
- **Prohibition on "Specialty Tiers"**
  - New York – Only 3 Rx tiers allowed
- **Lower Annual Rx Maximum Out of Pocket (MOOP)**
  - Maine - $3,500 Rx annual MOOP for drugs with co-insurance
  - Vermont – Annual Rx MOOP equals the minimum deductible amount for HDHP ($1,300)
- **Post-Deductible Copay Caps**
  - CA - $250/$500 per 30 day Rx
  - DE - $150 per 30 day Rx
  - LA - $150 per 30 day Rx
  - MD - $150 per 30 day Rx

Regulation

- **CA – Copay Caps**
  - Tier 4 drugs in Exchange plans capped at $250 or $500 (Bronze plans) per 30 day supply, after deductible is met
- **MA, VT – Limit Rx Tiers**
  - Exchange plans are limited to three (3) Rx tiers
- **Connecticut, CA, DC – Separate Rx Deductible**
  - Standard plans in Exchanges have a separate, relatively low drug deductible
  - CA limits separate Rx deductible to $500 or $1000 for Bronze plans
- **CO, MT – Fixed Copays / No Rx Deductible**
  - A subset of plans must offer flat copays
  - Some of the subset must have no Rx deductible

Adherence: *Medication Synchronization*

- Medication non-adherence costs the U.S. $290 billion annually
- Medication synchronization coordinates chronic prescriptions to be filled on the same date each month
- Enabling legislation in Connecticut (Conn. Gen. Stat. § 38a-510)



Med sync patients are over **2.5 times** more likely to be adherent to medications.

SOURCES: Network for Excellence in Health Innovation (NEHI), “Improving Medication Adherence: A $290 Billion Opportunity.” http://www.nehi.net/bendthecurve/sup/documents/Medication_Adherence_Brief.pdf. National Community Pharmacists Association (www.ncpanet.org/medsynch.

Innovative Contracting