May 9, 2016

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1670-P
P.O. Box 8016, Baltimore, MD 21244-8016

RE: Proposed Rule for Medicare Program; Part B Drug Payment Model; CMS-1670-P

Dear Administrator Slavitt:

The National Business Group on Health (the Business Group) appreciates the opportunity to comment on CMS’ proposed implementation of a new Medicare payment model under section 1115A of the Social Security Act (the Act). The Business group writes in strong support of Phase II of the proposal, and wishes to express concern about Phase I.

While we support the agency’s intent to remove the perverse incentive for providers to prescribe the highest priced therapies, particularly in cases where a better value drug has an equally or more effective treatment profile, we believe the proposed rule as currently written may have the unintended consequence of accelerating the consolidation of non-hospital affiliated independent clinical oncologists. Provider consolidation has resulted in substantial spikes in prices charged for health services across the board and hospital-affiliated facilities are often the most expensive sites for treatment involving specialty pharmaceutical products. We strongly urge CMS to carefully weigh any potential policy which may lead to additional vertical integration. Additionally, we feel strongly that manufacturer pricing of prescription drugs, as a chief driver in expenditure growth in health care, should be a more central focus of discussion and consideration of innovative approaches that help to create more sustainable, affordable pricing that also recognizes the clinical value of treatments, particularly those representing significant breakthroughs or advances in treatment. While the Business Group is supportive of consensus-driven solutions and open to dialog with all stakeholders, including manufacturers, our members are grappling with an unsustainable prescription drug pricing model, and struggling to continue to offer affordable drug coverage through employer-sponsored plans, particularly for specialty pharmacy products.

In the addendum, we provide more expansive suggestions which we believe respond to CMS’ requests for specific feedback, particularly as related to value based tools proposed in Phase II. Among our key comments are the following:

- We support the overarching approach of more closely aligning healthcare dollars with value delivered.
- We support eliminating financial incentives for prescribing a drug simply because its price is higher, but we have concerns with Phase I of the proposal as currently written. Specifically, we are concerned about the ability of non-hospital affiliated independent clinical oncologists...
to absorb the financial impact of the current proposal, which could lead to accelerated consolidation. For these providers, and other providers facing similar circumstances, we suggest that CMS not only consider abandoning the reduction in ASP add-on, but potentially increasing the add-on.

- We support the development of Clinical Decision Support (CDS) tools, which provide clinicians, staff, patients or other individuals with knowledge and person-specific information at appropriate times, to enhance the delivery of health care.
- We support reference pricing as a plan design tool, which nearly all large employers have implemented, to help ease the expenditure burden associated with prescription drug prices, but would echo our above comment that this does not address the primary issue of manufacturer pricing of pharmaceuticals.
- Additionally, we support reference pricing for certain services but would encourage CMS to continue pursuing broader provider payment reforms that move away from fee-for-service payments to encourage more efficient care delivery as the gold standard for payment and delivery reform.
- We support the exploration of indication-specific pricing through a targeted pilot program.
- We support the intent of risk-sharing agreements, as these types of interactions between insurers and manufacturers may have the effect of reducing the cost of prescription drugs for employers and employees, although more data are needed to demonstrate their impact.

The National Business Group on Health represents approximately 430, primarily large, employers (including 70 of the Fortune 100) who voluntarily provide generous health benefits and other health programs to over 55 million American employees, retirees, and their families.

Employers support plan design features that promote demonstrated evidence of clinical effectiveness, efficiency, and value-based benefit design. By prioritizing clinical effectiveness and value-based benefit designs, our members can assure that patients receive the highest-value, safest, and most medically appropriate health care services to meet their individual needs. Such a focus also helps group health plans maintain the balance between comprehensiveness and affordability of coverage while improving participants’ health and access to health benefits. Our members are at the forefront in adopting cost-effective, value-based plan designs such as reference pricing, for example.

Again, thank you for the opportunity to comment on this critical program. Please contact me or Steven Wojcik, the National Business Group on Health’s Vice President of Public Policy, at (202) 558-3012 if you would like to discuss our comments in further detail.

Sincerely,

Brian J. Marcotte
President and CEO
Addendum

Phase II

We applaud CMS’s efforts to test new alternative payment models within Medicare Part B. As the agency has accurately noted in its proposal, value-based arrangements have been implemented with increasing frequency by employers and in commercial health plans, pharmacy benefit managers, hospitals, and other entities that manage health benefits and drug utilization successfully. We support the overarching approach of more closely aligning healthcare dollars with value delivered.

However, we feel strongly that manufacturer pricing of prescription drugs, as a chief driver in expenditure growth in health care, should be a more central focus of discussion and exploration of innovative approaches. The pharmacy benefit is a major focus for employers given the high growth in spending trends, particularly for specialty pharmacy. Employers have implemented a number of efforts to manage spend through techniques including prior authorization, step therapy, utilization management, navigators and transparency tools to help employees and plan participants decide among providers and treatment options and to find the lowest price site for receipt of treatment with needed specialty pharmacy products.

In addition to the specific proposals put forth by CMS, which we address separately below, we would also suggest that CMS consider implementing transparency tools for beneficiaries. Publicly disclosing information about the price and quality of care at the provider and facility levels will enable beneficiaries to use this information to make more informed decisions about healthcare. Almost 72% of employers responding to the annual National Business Group on Health Plan Design survey, Large Employers’ Plan Design Changes, offer online transparency tools to their employees either through their health plans or a third party vendor. The tools provide plan members with meaningful information to choose health care based on quality, value and personal preference. We would encourage CMS to empower beneficiaries similarly, as transparency tools encourage smarter shopping and are consistent with the overall aim of “a better, smarter Medicare for healthier people.”

Risk-sharing agreements based on outcomes

We support the intent of risk-sharing agreements, as these types of interactions between insurers and manufacturers may have the effect of reducing the cost of prescription drugs for employers, although more data are needed on the impacts. Employers are encouraged that this type of innovative contracting may help slow rapidly escalating health care spending. With that in mind, we expect to see more employers seek opportunities to either directly engage in outcomes-based deals or encourage their plans to engage in these types of arrangements. The attractiveness of these arrangements are manifold, including creating a win-win situation for both manufacturers and payers—employers, insurers, and plan participants align incentives for appropriate, evidence-based use of expensive specialty pharmacy products.

A compilation of risk-sharing agreements\(^1\), compiled by the National Business Group on Health, uncovered numerous studies that report strong results in the U.S. from value-based insurance design programs. Excerpted examples from this research include:

1) Novartis employees realized cost savings in a value-based insurance design program for asthma, hypertension, and diabetes medication. After three years, hypertension medication compliance increased 9.4 percent (use rose five percent per program participant, on average).

2) Pitney Bowes employees realized cost savings (the program produced some savings for the company) in a diabetes and asthma value-based insurance design program where predictive modeling was used to determine which employees should be in a chronic disease management program providing the most favorable (tier 1) access to the right medication. As a result, diabetes medication compliance increased (by 13 percent among fixed-combination oral diabetes medication users) after three years, program participants relied less on asthma rescue therapy (declined 18 percent) after five years, and emergency room visits declined (decreased 26 percent for diabetes and 22 percent for asthma program participants) after five years.

3) In an analysis using data from Thomson Reuters’ Advantage Suite, a diabetes pharmacy program combining value-based insurance design and disease management produced increased compliance of 3.7 percentage points with prescription medications and adherence to diabetes guidelines in the program’s first year. Over three years, the program saw a return on investment of $1.33 for every dollar spent.

In addition to the value-based insurance design programs above, Appendix A catalogs what we were able to ascertain in the way of risk-sharing agreements entered into between manufacturers and insurers. Preliminarily results seem encouraging, but substantial data gaps exist.

**Indication-based pricing**

With multi-indication drugs on the rise, many of which are high-priced specialty drugs, employers are eager to consider options through which pricing can better reflect differential benefit by indication. In March 2016, the Institute for Economic and Clinical Review (ICER) released a white paper that detailed various models of indications-based pricing for pharmaceutical drugs, outlined the risks and benefits of these models for both payers and manufacturers, and made specific policy recommendations for how these types of agreements could be implemented. In particular, three major models of indication-specific pricing were described, which could be considered by CMS:

1. Distinct product differentiation, authorized and marketed under different brand names with different prices
2. No brand differentiation, distinct, separate discounts are applied for each indication
3. No brand differentiation, a single “weighted-average” price is developed using estimates of indication use across the population, with possible retrospective reconciliation through rebates based upon actual use

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The white paper specifically contemplates indication-specific pricing within Medicare Part B thusly (the calculation below, as modeled by ICER accounts for prompt pay discounts but not sequestration):

*If indication-specific pricing were applied to physician-administered drugs under the current buy and bill model, the reimbursement levels might not be sufficient to cover the acquisition cost of the drug for some indications. For example, consider a situation in which the average sales price of a drug with two indications is $750, and therefore the physician reimbursement for use of this drug for either indication would be ASP + 4.3%, or $782.25. However, if indication-specific pricing were being applied, the physician acquisition cost for the drug could be set at $500 for indication A and $1,000 for indication B. Under such a scenario the Medicare reimbursement of ASP + 4.3% ($782.25) easily covers the acquisition cost for the drug when used for indication A, but the physician would lose money when using the drug for indication B, even though use for indication B represents a higher clinical value (thus the higher price).*

Though our members recognize that there may be substantial implementation challenges to indication-specific pricing policies, we are also encouraged by CMS’s willingness to pilot this tool through the Medicare Part B program. We recommend that CMS additionally maintain an open dialog with employers and other payers, as well as manufacturers and providers to identify opportunities for additional legislative changes to federal reimbursement policies that obstruct indication-specific pricing agreements.

The Business Group supports the exploration of indication-specific pricing through a targeted pilot program.

**Reference Pricing**

Specific to prescription drugs, employers have long relied on reference pricing, particularly when generic alternatives to more expensive brand medications are available. As CMS contemplates reference pricing policies for pharmaceuticals, one potential academic resource is the Northwestern Journal of International Law and Business, which synthesized 16 studies describing 9 reference-pricing policies from 6 countries. The synthesis found that reference pricing “led to decreases in drug prices and increases in utilization of targeted medications, while also reducing payer and patient expenditures. The synthesis further suggested there was no increase in the use of medical services, such as physician office visits and hospitalization.

In addition to reference pricing for pharmaceuticals, evidence suggests that reference pricing may be a promising cost-control strategy when applied to frequently performed, non-emergency tests and procedures where the prices charged vary widely across providers but the quality of results remains largely similar. To that end, many employers have or are planning to differentiate cost sharing for the use of high-performance networks or centers of excellence. While fewer than 5% were doing so according to a recent survey, another one-quarter of employers have or are planning to adopt reference pricing or implement requirements that link reimbursement to second-opinion services by 2018.³

We expect employer interest in reference pricing to grow over time as wide variations in prices for same services become more known, particularly for relative standard services with little if any discernable difference in quality. A recent report from the Health Care Cost Institute (HCCI) underscores this issue, which has also been previously substantiated through research conducted by both the Institute of Medicine (IOM) and the Dartmouth Institute for Health Policy and Clinical Practice (TDI). Glaring regional and state price variations drive an enormous amount of waste in health care dollars. An example highlighted by the HCCI research pointed out that a pregnancy ultrasound in Ohio was priced at around $183 in Canton, but the same ultrasound was priced at around $522 in Cleveland.

The Business Group supports Medicare’s use of reference pricing as a plan design tool, which nearly all large employers have implemented, to help ease the expenditure burden associated with prescription drug prices, but would echo our above comment that this does not address the primary issue of manufacturer pricing of pharmaceuticals. We additionally support reference pricing for certain services but also encourage CMS to continue pursuing broader provider payment reforms that move away from fee-for-service payments to encourage more efficient care delivery as the gold standard for payment and delivery reform.

Below are both public and private examples from which CMS could obtain additional information to inform the rule-making process around reference pricing.

**CalPERS**
A 2013 study evaluated the impact of reference pricing on the use of and prices paid for knee and hip replacement surgery by members of the California Public Employees’ Retirement System (CalPERS), the country’s second largest purchaser of health benefits. The reference-pricing program saved CalPERS an estimated $5.5 million over two years, with most of the savings attributed to providers lowering their prices to meet the reference price.

**Kroger**
Cincinnati-based retailer Kroger Co. experienced a $4.3 million in company savings in 2012 after implementing reference pricing for prescription medication, and an additional more than $1.7 million in savings the following year. The program focuses on educating employees about the price variation in certain medical services and prescription medications. Kroger describes its model as being focused on two objectives: 1) to improve health and 2) reduce costs.

They implemented two specific target pricing programs: a radiology program and a prescription medication program. The radiology program is limited to outpatient services only; emergent and inpatient services are excluded. The program includes three components: Target Pricing on Select services; use of Anthem’s Advanced Imaging Management (AIM) educational Model with Pre-Certification call; and Imaging Cost and Quality Member Outreach. A target price is set for specific services, including abdomen CT, pelvic CT, chest CT, brain CT, and spine MRI. The target price is a “global” price, meaning it is inclusive of both the facility and professional charges. To determine the target price, an opportunity analysis was done by AIM for Kroger in March 2011. Two years of past experience were used. An actuarial analysis of unit cost by grouper code was conducted and an average, median, 25th, and 75th percentile was calculated for each grouper code, inclusive of high and low outliers, and a reference price was selected. Once the target price was established,
Kroger examined additional data to validate the target price and ensure access was maintained. Then, they pulled the facility information on global cost ranges from covered facilities in each state, allowing them to illustrate how many facilities would fall at or under the target price in order to validate whether the target prices selected would yield enough access for membership. Finally, they developed individual state maps showing the location of every Kroger member, overlaid with each imaging facility, and broke out, by procedure category, the proximity to membership to the target-priced providers.4

Prior to scheduling any high tech imaging procedure, a Kroger employee or their provider must contact AIM by phone or online. AIM then reviews high tech imaging for clinical appropriateness and provides information to providers and employees about safety, quality, and target pricing implications. Precertification is done in real-time. For cases that would exceed the target price, an Anthem outreach specialist will contact the affected enrollee to inform them that the selected service exceeds the reference price and offer assistance with alternative site selection, if the patient wishes to switch to an alternative site at or below the target price.

Employee Benefit Research Institute
A 2014 study of potential employer savings based on adopting a reference pricing design for the following health services: hip and knee replacement, colonoscopy, magnetic resonance imaging (MRI) of the spine, computerized tomography (CT) scan of the head or brain, nuclear stress test of the heart, and echocardiogram, yielded encouraging results. Based on the results of the overall study, potential aggregate savings were projected to reach $9.4 billion, if all employers adopted reference pricing for the health care services examined. The $9.4 billion represents 1.6 percent of all spending on health care services among the 156 million people with employment-based health benefits in 2010. Hip and knee replacements account for about 40 percent of the savings. While the incidence rate of hip and knee replacements in the population of people with employment-based coverage is relatively low, the costs are relatively high. In contrast, stress tests of the heart accounted for only 2 percent of the aggregate potential savings. While incidence rates ranged from 14 to 20 percent between 2008 and 2010, only $87 per case would be saved from RP (again assuming that providers below the reference price did not increase prices). Colonoscopies, CT scans of the head or brain, and echocardiograms each accounted for between 15–20 percent of aggregate potential savings, while MRIs of the spine accounted for about 10 percent of the potential savings.5

Phase I

With regard to Phase I, while we appreciate that the intent of the agency is to change prescribing incentives and to accelerate the uptake of quality and value payments for prescription drugs, we have concerns that changing the add-on payment to 2.5 percent plus a flat fee payment of $16.80 per drug per day may have the unintended consequence of also accelerating market consolidation and more vertical integration, particularly in oncology. This potential exists because, in reality, this reduction

in reimbursement is more substantial than it appears due to existing overlapping policies. For example, the current ASP methodology includes a customary distributor prompt pay discount, which is not passed on to purchasers, reducing the Part B add-on payment by about 1.5%.6

Layering onto the already reduced ASP reimbursement add-on, the Budget Control Act of 2011 additionally enacted a mandatory 2 percent sequester cut to Part B provider reimbursements, effectively establishing a rate of ASP plus 2.5 percent. And finally, the two-quarter delay in updating reimbursement rates means that when the market price of a drug rises, reimbursement rates lag. And, in today’s era of skyrocketing prescription drug prices, this is significant. Taking all of these factors into account, some stakeholders estimate that the current rate of ASP plus 6 percent is actually closer to a reimbursement rate of ASP plus 1.3 percent.

With these challenges in mind:

- Again, we feel strongly that manufacturer pricing of prescription drugs, as a chief driver in expenditure growth in health care, should be a more central focus of discussion.
- We support eliminating financial incentives for prescribing a drug simply because its price is higher, but we have concerns with Phase I of the proposal as currently written. Specifically, we are concerned about the ability of non-hospital affiliated independent clinical oncologists to absorb the financial impact of the current proposal, which could lead to accelerated consolidation. For these providers, and other providers with like circumstances, we suggest that CMS not only consider abandoning the reduction in ASP add-on, but potentially increasing the add-on.
- While it is not within the Business Group’s expertise to suggest specific carve outs, as mentioned above we are acutely concerned about the potential for negative or unintended consequences within the independent clinical oncologists community. But, there are likely other observations which should be made with regard to smaller, low-volume providers, which may not be limited to oncology, particularly in rural areas.

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### Appendix A

**Select Recent Examples of Publicly Disclosed U.S. Value-Based Pricing Agreements**

<table>
<thead>
<tr>
<th>Year</th>
<th>Disease or therapeutic area</th>
<th>Name of pharmaceutical(s)</th>
<th>Pharma Company</th>
<th>Payer</th>
<th>Contract Details</th>
<th>Rationale</th>
<th>Results</th>
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</thead>
</table>
| 2009 | Type 2 diabetes             | Januvia (sitagliptin) and Janumet (sitagliptin/ metformin) | Merck          | Cigna | Merck agreed to peg what insurer Cigna paid (bigger discounts in return for a better placement on Cigna’s formulary – assuring lower consumer out-of-pocket expenses [co-payment/co-insurance]) for Januvia and Janumet to how well individuals with Type 2 diabetes were able to control blood sugar. | - Improve consumer compliance to achieve health benefit.  
- Provide financial incentives to payers to treat individuals with Type 2 diabetes better and focus on results. | - Secured better placement on Cigna’s formulary because outcomes improved after a year.  
- Merck gave Cigna additional discounts (versus receiving reimbursement by Cigna) for achieving improved outcomes.  
- Drove volume.  
- Did not disadvantage competitors’ access.  
- Potential a free-rider problem.  
- Diabetes medications from competing companies also benefited from these compliance activities. |
| 2009 | Osteoporosis                | Actonel (Risedronate)       | Procter & Gamble (P&G), Sanofi-Aventis | Health Alliance | Established Fracture Protection Pilot Program (outcome-based reimbursement program). The Alliance for Better Bone Health (P&G and Sanofi-Aventis) agreed to reimburse Health Alliance for medical costs of treating covered non-spinal, osteoporosis-related fractures in post-menopausal, Health Alliance eligible female members correctly taking Actonel prior to the fracture (maximum number per 1,000 users over one year), by proportionally reducing Health Alliance’s cost of purchasing Actonel. | - Arrangement arose due to questions of Actonel’s efficacy in preventing non-spinal fractures.  
- Provide strong health benefit.  
- Payer would be reimbursed if Actonel did not achieve health benefit. | - Manufacturers were able to reach more patients by alleviating the payer’s efficacy concerns.  
- During first nine months of pilot,  
- P&G’s reimbursement to Health Alliance was 79 percent lower than the predefined limit established in the deal.  
- Incidence of non-spinal fractures was consistent with Actonel clinical trial data. |
### Appendix A

<table>
<thead>
<tr>
<th>Year</th>
<th>Disease or therapeutic area</th>
<th>Name of pharmaceutical(s)</th>
<th>Pharma Company</th>
<th>Payer</th>
<th>Contract Details</th>
<th>Rationale</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>Various, with a focus on chronic disease</td>
<td>Various</td>
<td>AstraZeneca</td>
<td>WellPoint’s data/analytic subsidiary HealthCore</td>
<td>Prospective and retrospective observational studies on disease states as well as comparative effectiveness research, will analyze how medicines and treatments already on the market are working in a number of disease areas, with a special emphasis on chronic illnesses. It also will provide insight into the types of new therapies most needed for treating and preventing disease.</td>
<td>AstraZeneca will use the HealthCore data, together with its own clinical-trial data, to guide decisions on where to invest its research and development dollars.</td>
<td>Partnership seems to have evolved: HealthCore and AstraZeneca have an alliance for building a database they call the Real-World Evidence Collaboration and the contract with Delaware Medicaid will provide additional records for that database.</td>
</tr>
<tr>
<td>2011</td>
<td>Various</td>
<td>Work will primarily focus on pharmaceuticals in Phase II and III, but no limitations on areas covered by the arrangement</td>
<td>Sanofi</td>
<td>United BioSource Corporation (Medco Health Solutions; now a part of Express Scripts)</td>
<td>Multi-year partnership for real-world evidence assessments during development and approval processes; ability to define relative value for pharmaceuticals early in development.</td>
<td>- More precisely identifies consumer populations with great unmet medical need. - Helps to determine consumer populations in which pharmaceuticals are most effective. - Generates real-world comparative effectiveness data. - Develops and implements novel care models to support practice of care, compliance, and consumer outcomes.</td>
<td>Not yet available.</td>
</tr>
<tr>
<td>2011</td>
<td>Exclusive to three chronic conditions affecting senior citizens: Alzheimer’s disease, pain, and cardiovascular disease</td>
<td>Various</td>
<td>Pfizer</td>
<td>Competitive Health Analytics (Humana)</td>
<td>Five-year partnership (evolved from previous collaborations between the two parties) to improve the quality, outcomes, and costs of health care for senior citizens.</td>
<td>- Brings leadership from Humana and Pfizer together to identify a research agenda that would be mutually beneficial.</td>
<td>Not yet available.</td>
</tr>
<tr>
<td>2011</td>
<td>Various</td>
<td>Various</td>
<td>Pfizer</td>
<td>United BioSource Corporation (Medco Solutions; now a part of Express Scripts)</td>
<td>Partnership is to identify and evaluate consumer subgroups in which investigational pharmaceuticals and marketed pharmaceuticals are shown to be most effective in improving care and health.</td>
<td>- Personalized medicine capabilities. - More effectively match individuals with pharmaceuticals that will benefit them the most, thereby improving consumer outcomes.</td>
<td>Not yet available.</td>
</tr>
<tr>
<td>2011</td>
<td>Multiple Sclerosis</td>
<td>Rebif</td>
<td>EMD Serono</td>
<td>Cigna</td>
<td>EMD paid Cigna rebates for adherent patients who suffered more relapses than expected</td>
<td>- Relapses can be financial hits for an insurance company, requiring seven days of hospitalization at a cost of up to $11,000.</td>
<td>Not yet available.</td>
</tr>
<tr>
<td>Year</td>
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<tr>
<td>2015</td>
<td>Hepatitis C</td>
<td>Harvoni</td>
<td>Gilead</td>
<td>Cigna</td>
<td>Cigna and Gilead Sciences, Inc. signed an agreement include Harvoni as the only preferred brand prescription drug treatment for customers with hepatitis C genotype 1, the most common form of the disease in the United States. Cigna clients and customers benefit from obtaining breakthrough clinical cure rates for hepatitis C while significantly lowering the cost of drug treatment.</td>
<td>&quot;Cigna is committed to offering customers and clients the most affordable solutions that deliver improved health while containing both drug and total medical costs. We have selected Gilead's Harvoni as the preferred drug treatment for hepatitis C genotype 1. Harvoni's clinical effectiveness, safety and convenience, coupled with our innovative customer counseling, will deliver material health and financial outcomes for our customers and clients,&quot; said Jon Maesner, chief pharmacy officer for Cigna Pharmacy Management.&quot;</td>
<td>Not yet available.</td>
</tr>
<tr>
<td>2015</td>
<td>cholesterol</td>
<td>Repatha (PCSK9)</td>
<td>Amgen</td>
<td>Harvard Pilgrim</td>
<td>Not available.</td>
<td>- According to media reports, in exchange for value-based reimbursement that is predicated upon both (i) patients meeting LDL-C reduction levels equivalent to the clinical trial outcomes, and (ii) patients taking no more than a set number of the medication in a prescribed period, Harvard Pilgrim agreed to provide Repatha unique formulary positioning.</td>
<td>Not yet available.</td>
</tr>
<tr>
<td>2015</td>
<td>Various</td>
<td>Various</td>
<td>Various</td>
<td>Express Scripts</td>
<td>Contracts with manufacturers that set different prices for different indications based on relative value. The drugs that will be covered by the program have not yet been disclosed but the indications will include prostate cancer, lung cancer and renal cell carcinoma. Manufacturers involved in the contracts are expected to announce them in the near future.</td>
<td>-</td>
<td>Not yet available.</td>
</tr>
<tr>
<td>2016</td>
<td>Treatment of heart failure with reduced ejection fraction</td>
<td>Entresto</td>
<td>Novartis</td>
<td>Anthem &amp; Cigna</td>
<td>The pay-for-performance agreement ties the financial terms to how well the drug improves the relative health of Cigna's customers. The primary metric is reduction in the proportion of customers with heart failure hospitalizations.</td>
<td>- The discounted amount Aetna and Cigna will pay for Entresto depends on whether the medication reduces hospitalizations for their commercially insured patients with congestive heart failure. In exchange, Novartis will gain volume, and Entresto will become a preferred drug, subject to prior authorization, on Aetna and Cigna's formularies.</td>
<td>Not yet available.</td>
</tr>
</tbody>
</table>
Original chart was adapted from “Value-based pricing for pharmaceuticals: Implications of the shift from volume to value.” 2012. Available at http://www.converge-health.com/sites/default/files/uploads/resources/white-papers/valuebasedpricingpharma_060412.pdf. Accessed March 10, 2016. Then, updates were added from the following sources:

http://www.modernhealthcare.com/article/20160220/MAGAZINE/302209963
https://aishealth.com/archive/nhpw071315-04