MASSACHUSETTS

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Vice President
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May 11, 2018

Dr. David Cutler, Committee Chair
Health Policy Commission
50 Milk Street
Boston, MA 02109

Martin Cohen, Committee Chair
Health Policy Commission
50 Milk Street
Boston, MA 02109

Sara Sadownick, Deputy Director
Health Policy Commission
50 Milk Street
Boston, MA 02109

Dear Chairs Cutler, Cohen and Deputy Director Sadownick:

On behalf of Blue Cross Blue Shield of Massachusetts (BCBSMA), I am writing to follow up on our testimony at the May 9, 2018 listening session at the Health Policy Commission (HPC) regarding shifting drug distribution channels.

It is important to reiterate at the outset that BCBSMA does not have any policy that requires the brownbagging, whitebagging or home infusion of prescription drugs.

As you know, specialty drugs continue to show disproportionately high cost increases compared to the rest of the health care industry. As a not-for-profit health plan, we believe it is essential that we manage those costs while ensuring access to necessary treatments for our members.

In 2015, we found that a billing practice used by some providers of specialty infusion drugs was unnecessarily increasing costs without improving patient access or quality of care. Expensive infusion drugs were being purchased by providers directly, administered in a clinical setting, and billed outside our specialty pharmacy network at a greatly inflated rate. For example, a monthly treatment of the infusion drug Remicade cost approximately $5,000 through our specialty pharmacy network. We found that we were regularly being billed between $20,000 and $28,000 per treatment on the medical benefit. It is important to note that this is the cost of the drug alone, and that an additional clinical fee is billed for actually administering the infusion. The aggregate

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increased cost of this practice to Blue Cross members and accounts was approximately $20 million per year.

In response, we informed providers in 2015 that three infusion drugs—Remicade, IVIG, and Botox—would be required to be billed on the pharmacy benefit. This was not only the responsible thing to do for our accounts, but it also limits the cost-sharing exposure for our members. The pharmacy benefit is not subject to deductibles or coinsurance for most of our policies. That means that the most a member would pay when the service is billed through the pharmacy benefit is a $50 copay for a tier 3 drug. But when the service is billed through the medical benefit, a member could be responsible for thousands of dollars in coinsurance and deductibles. This would negatively impact the vast majority of patients, as 78 percent of our members have a plan design that includes a deductible, and 37 percent have coinsurance (with an average coinsurance rate of 20 percent).

We built time into our process to get detailed feedback on this policy change. Several providers informed us that their IT systems would not be able to operationalize the new requirement. We worked with those providers to find ways to implement the new policy without impacting the patient experience or the ability for providers be reimbursed.

The revised policy that went into effect in October 2015 allows Massachusetts providers to continue to buy and bill infusion drugs just as they had before. We would prefer that they do so on the pharmacy benefit, but it is not required. The only requirement is that they do so at the contracted specialty pharmacy rate.

We do not mandate how the provider obtains the drug. We do not mandate how the drug is administered. Those decisions are left to the discretion of the provider and the patient. A provider may decide to have a patient brownbag a drug to be administered in the office. In fact, providers do this fairly frequently with certain vaccines that have special storage requirements, like the HPV and rabies vaccines, as well as with injectable contraceptives. But it's important to stress that our policy is agnostic to those decisions. This is a billing change only. We will pay for the drug, regardless of how it is obtained or administered, as long as it is billed at the contracted rate.

All Massachusetts providers have successfully implemented this new policy, and now bill at the contracted network rate. In all, about 85 percent of providers continue to buy and bill just as they had before; and about 15 percent have chosen to process it through a network specialty pharmacy—either in-house or through a third party. Spending for these drugs has reduced by approximately 20 percent since the policy was enacted.

This billing policy change was the right thing to do for our members and accounts. We believe, in fact, that is a model on how to work collaboratively with stakeholders to find a solution that removed $20 million in unnecessary cost from the system without impacting quality, access or the

administration of important treatments.

Thank you for your consideration. If you have any questions, please do not hesitate to contact me.

Sincerely,

Michael T. Caljouw

cc: Chairman Stuart Altman, Health Policy Commission
Director David Seltz, Health Policy Commission