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BlueCross BlueShield of Tennessee defends new specialty drug policy as some legislators cry foul

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Providers and state legislators continue to clash with BlueCross BlueShield of Tennessee over the insurer's plan to lower costs for some self-funded employer groups by targeting provider-administered specialty drugs - the most expensive of all pharmaceuticals.

Traditionally, providers buy these infusion or injection drugs directly from a wholesaler, then bill the insurer and the patient for the cost of the medication plus a small mark-up to cover their overhead. But BlueCross' new plan stops reimbursing providers for those drugs for some of its members and instead requires them to be obtained through a specialty pharmacy in the insurer's preferred network.

The move has caused an uproar among some powerful physician groups who believe it will cause major workflow changes, lead to more medication waste and place an excessive burden on seriously ill patients. But BlueCross officials contend those fears are alarmist, and that the move to control skyrocketing drug costs is a response to pleas from employer groups - BlueCross' customers - that foot the bulk of the bills for these high-cost treatments.

"It's not savings for us, it's for the groups. We've had employer groups say to us that they don't even want to cover these drugs. We strongly advise against that," said Natalie Tate, vice president of pharmacy for BlueCross BlueShield of Tennessee.

Bruno Delagneau, a pharmaceutical company consultant, said specialty drug prices are going to be higher, not just because the cost of getting these products to market is high, but also because the benefit for the patient and society is high.

"There's an argument that products should be priced based on their benefit, not necessarily other factors such as the cost of manufacturing or the cost of research and development, or competitors' price, so that's going to drive the price of specialty pharmaceuticals, as well," Delagneau said.

Specialty drugs play an increasingly important role in treating chronic conditions such as cancer, rheumatoid arthritis, psoriasis, inflammatory bowel disease and multiple sclerosis, as well as rare diseases. In total, there are about 400 drugs that BlueCross considers specialty, with a 60/40 split between self-administered and provider-administered drugs, Tate said. The new policy doesn't affect drugs patients inject or take on their own, which are typically already obtained through specialty pharmacies.

"Every day it seems like there's more [specialty drugs] coming to market," Tate said. "As we look at the pipeline, the vast majority of research and development is focused on provider-administered drugs."

One of those drugs, Zolgensma, became available in May 2019 and carries a \$2.1 million price tag. The one-time injected gene therapy is a breakthrough for young pediatric patients with the rare disease spinal muscular atrophy, a leading cause of infant death. Tate said a couple of BlueCross members have already been treated with the drug.

BlueCross is not alone in its attempts to rein in these costs. A 2019 survey from the National Business Group on Health found 85% of employer respondents rated the high cost of drugs as the No. 1 or No. 2 most concerning pharmacy issue. Other payers are working to move people to different sites of care, tightening prior authorization requirements or requiring a similar, cheaper drug be used first.

"Employers are very concerned about how to finance the high cost of new million-dollar drug therapies. Some of these therapies will cost more than what an employee will earn in a lifetime," Brian Marcotte, president and CEO of the National Business Group on Health, said in a news release.

For now, the new policy applies only to BlueCross BlueShield of Tennessee members in 100 self-funded employer groups, including the state health plan. Within these groups, there are about 5,500 employees and dependents who require specialty pharmaceuticals, according to BlueCross officials.

The state health plan covers the state's government employees, including teachers and local government employees, and their beneficiaries. About 3,500 participants in that plan use provider-administered specialty drugs, according to documents obtained through an open records request. Joan Williams, public information officer for the state benefits administration that oversees the plan, said the state spent more than \$1.63 billion on plan expenses in 2018, and more than 26% of that was on drugs - higher than any other category of health care.

"Pharmaceutical spend is rising at the highest rate [increasing 35% between 2015 and 2018], with specialty drugs driving this increase [48% increase during the same time period]. Specialty drugs now account for 44% [\$259.3 million] of the \$586.6 million total plan gross pharmacy spend," she said.

BlueCross told the state it could cover the same drugs while saving Tennessee between \$9 million and \$12 million in taxpayer dollars through the new program. That's because there's a mark-up when providers buy the drug themselves and then bill for them. BlueCross officials said this old system wasn't problematic when drugs were cheaper, but this new method will help

rein in costs by eliminating a middleman, and because the specialty pharmacies are giving BlueCross discounts on the drugs.

Dr. Jack Erter, a medical oncologist with Tennessee Oncology and the president of the Tennessee Oncology Practice Society, said that seemingly minor change will have a major impact on his group and patients. That's because when a provider obtains a drug it's billed as a medical benefit - which is "a more open system" - but when it comes through a pharmacy, it becomes a pharmacy benefit - which comes with strict rules. Although that's not problematic for basic retail drugs, it's a concern for specialty drugs that are more complex and given to sicker patients, Erter said.

One of those rules is that drugs are dispensed to specific patients and can't be returned or used for anyone else. Erter said that causes a workflow and inventory nightmare for medical groups. Each patient needs lab work done to make sure they're well enough to receive the infusion drug. Often, they're too sick at the time and will need to return for follow-up appointments, he said. Meanwhile, the drugs will have to be stored under the patient's name in the office, and some have a short shelf life.

"That's a major source of waste and economic cost in itself; some of these drugs are given weekly," he said.

Drugs also must be paid for in advance rather than billed for after the fact as part of the office visit. Erter said that shifts more of the cost burden to patients and means those who can't afford to pay for their medicine up-front may miss their treatment. It also limits access to discount programs available to doctors under the medical benefit, he said.

"With the pharmacy benefit, all of the pharmacy benefits are going to be tightly managed by BlueCross, and there's no way to access these point-of-care discounts," Erter said.

BlueCross officials said specialty pharmacies also can obtain patient assistance, and that freedom providers have under the medical benefit is the reason why the new program is necessary. As it is now, providers buy the drugs at a discount and mark up the price for reimbursement. Although the markup is needed to cover their overhead, BlueCross officials said some providers take advantage of the situation.

"We still believe many providers objecting to this new process are motivated by their potential loss of revenue," BlueCross officials said in an emailed statement, adding that fears over increased waste are overblown.

"Waste can happen in the system today. We're not suggesting this process will completely eliminate waste. We don't believe it will substantially increase waste, and financially, we still believe in the value of this program," officials said.

The new policy was also set to apply to some TennCare beneficiaries within BlueCross' managed care organization starting Jan. 1. However, that process was delayed once legislators got wind of the provider concerns.

State Rep. Robin Smith, R-Hixson, a former nurse and chairwoman of the House Insurance Committee, called the new policy "a classic example of where insurance can have an impact on an outcome, and they're looking at efficiencies and savings - not at patients.

"It's very important to make sure that we're spending money carefully and wisely, but we're not going to save the taxpayers money on the backs of the most medically fragile," Smith said. "The state legislature is very concerned that, A, this is going to cause a material change to the benefits of some of the more medically fragile, and B, the power of insurance companies is showing that they do things with memorandum and not through developing some type of collaboration to make sure things are going to work."

BlueCross officials said they "strongly disagree" with those concerns.

"We're still covering the same list of drugs. We're still covering the services of providers to administer the drugs, at the same rates we do today. And we're not asking members to receive their treatments at different facilities," officials said.

Pharmaceutical consultant Delagneau said the drug supply chain and market in the United States makes any attempt to control costs a challenge.

"The issue with pharmaceutical prices is you never know the real story, because there's no transparency. It's very opaque," he said. "The pharmaceutical drug market in the U.S. is very complex, because we have many layers, and all of these layers of people, all these businesses, are trying to make money, and we made the market free. If you can launch a product that's \$100,000 per year for a quality treatment, and people are ready to pay for it, why wouldn't you do it?"

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