Attachments—Additional Questions for the Record

Subcommittee on Health
Hearing on
"Lowering Prescription Drug Prices: Deconstructing the Drug Supply Chain"
May 9, 2019

Estay Greene

The Honorable Michael C. Burgess, M.D.

1. Something I find particularly concerning about our drug supply chain is the possibility of drug shortages. These can occur because of natural disasters, manufacturing issues, or business decisions. What are each of your respective companies doing to prevent drug shortages?

   As a payer, Blue Cross Blue Shield of North Carolina (Blue Cross NC) is not part of the drug supply chain and does not have an effect on drug shortages. However, Blue Cross NC closely monitors when these drug shortages occur to keep our members informed of potential impacts to their care and treatment.

2. With the success of 21st Century Cures we are beginning to see a remarkable number of treatments and potential cures moving through drug development pipelines. What is Blue Cross Blue Shield doing to prepare for the approval of these drugs to ensure that patients will be able to access and afford them?

   Blue Cross NC closely monitors the drug pipeline, including receiving information from manufacturers, to be ready and prepared when medication is approved. Blue Cross NC works with our network of pharmacies and providers to ensure contracts are in place as quickly as possible so members have cost-effective access to these new medications.

3. Yesterday, the Administration released a rule requiring manufacturers to include drug prices in direct-to-consumer (DTC) advertisements. This would shine a light on manufacturer drug pricing strategies and provide consumers more information about their prescription drug options. What would the effect of this type of price transparency have on Blue Cross Blue Shield and the overall market?

   Along with the Blue Cross Blue Shield Association (BCBSA), Blue Cross NC believes that disclosure of the list price will provide a catalyst for patients to discuss medications with their treating physician to determine if an equally effective, lower cost drug is available. In some cases, a conversation about affordability will lead to discussions about more affordable, alternative treatments for a patient, which will

lead to greater patient adoption of a therapy and improved adherence. We believe this new rule will have a positive effect on the overall market.

The Honorable John Shimkus

1. Given that most of the witnesses on the panel have referenced the role of creating value in the health care supply chain, please comment on: Existing areas where Congress or the Administration may have needlessly added to the cost that patients or the government pays for a particular product, service, or intervention. For example, do you have recommendations on how reforms to existing laws like Stark and the Anti-Kickback Statute could accelerate value-based contracting within Medicare and Medicare Advantage?

   One existing area where cost has been added is in Medicaid "best price" policy. Removing limits put on Medicaid "best price" to allow commercial payers to negotiate these contracts allows each entity, whether private or public, the ability to negotiate an agreement that meets the needs of the population they serve. Lifting this policy does not prevent Medicaid plans from attaining the same agreements.

2. How do we ensure that these value-based reforms benefit patients and protect taxpayers?

   A benefit of value-based reforms to patients is continued access to breakthrough medications at the lowest possible premium and out of pocket cost. For taxpayers, value-based agreements guarantee that dollars are spent on a cure or for a desired outcome. If a positive outcome is not achieved, dollars are refunded and taxpayers are not held responsible.

   Protections on initial pricing of medication should consider the value therapies will bring to patients that achieve outcomes. Prices should not be artificially inflated to cover costs for patients that do not have positive outcomes using the drug. If the pharmaceutical industry can increase prices to cover the risk of failure, the "value" of a value-based relationship disintegrates.

The Honorable Brett Guthrie

1. During the hearing, Blue Cross Blue Shield of North Carolina testified that some insulin products are excluded from the plan's formulary. How much will a plan beneficiary pay for an insulin product that is excluded from your plan's formulary?

   If a medication is approved through the formulary exclusion exception process, the member will pay a non-preferred brand copay or coinsurance in accordance with their benefit plan design. A member will pay the list price if the product is not approved through the exception process.

a. Will the amount the patient pays out-of-pocket for the insulin product count toward their deductible if they have one? Why or why not?

Yes

b. How many beneficiaries went through Blue Cross Blue Shield of North Carolina's step therapy protocol to try and get access to an insulin product that was excluded from the formulary for each of the past five years? For each year:

i. On average, how many different insulin products did an individual have to try before their request was approved to gain access to their preferred product?

1 product on average, consistent through all years.

ii. How many of these requests were approved?

YEAR	APPROVALS	DENIALS
2015	1118	712
2016	416	229
2017	727	420
2018	303	268
2019	Incomplete Data	Incomplete Data

iii. How much did an individual pay for the insulin product if the request was approved?

YEAR	PRICE PER DAY
2015	$1.64
2016	$1.69
2017	$2.15
2018	$2.37
2019*	$2.96**

* No rebate is available to pass through to members on these products at point of sale.

** Represents data YTD as of 8/7/2019 - average member cost share will

decrease through the year as deductibles are met.

iv. How long did it take for the request to be approved?

8.95 hours on average from submission of the provider's office to notification of approval. Authorizations are loaded within 1 hour of approval for pharmacies to process the claim.

v. Was the insulin product covered while the approval decision was pending?

No, but coverage can be retrospective if approved.

2. During the hearing, Blue Cross Blue Shield of North Carolina said that the company just removed an insulin product from its formulary mid-year, on April 1, 2019. The witness said that Blue Cross Blue Shield of North Carolina removed Basaglar because the company decided to pass-through rebates on insulin to its beneficiaries, and as a result, the company's preferred product, Lantus, was less expensive than Basaglar for beneficiaries. Previously, however, Blue Cross Blue Shield of North Carolina allowed beneficiaries the option of whether they wanted to use the Basaglar product—which had a lower list price—or Lantus. Why did Blue Cross Blue Shield of North Carolina remove Basaglar from its formulary entirely rather than continuing to give patients the option of choosing the lower or higher priced product?

   a. Why did Blue Cross Blue Shield of North Carolina previously think it was appropriate to give beneficiaries a choice between products, but now that rebates are passed through to the patient, decide that patients should not have that choice?

   Rebate pass through was not the only reason Basaglar was removed from the formulary. Blue Cross NC's decision to remove Basaglar from the formulary was made based on the clinical equality of Basaglar to Lantus, the number of long acting insulin products on Blue Cross NC's formulary, and the financial review of those products which is done at least annually.

   Pass through rebates allowed decision makers to worry less about the "sticker price" of products because members would now be subject to the sticker price, less the rebate in the deductible or their cost share portion of coverage. Since the clinical appropriateness of the medications is the same, Blue Cross NC's decision gave members access to the product with the lowest overall cost.

   b. How much of the rebate that Blue Cross Blue Shield of North Carolina receives for Lantus is passed through to the beneficiary at the point-of-sale?

This is proprietary information and cannot be shared.

c. Have the rebates, discounts, and/or fees that Blue Cross Blue Shield of North Carolina receives for Lantus changed at all since Blue Cross Blue Shield of North Carolina decided to pass-through rebates on insulin to the patient and remove Basaglar from the plan's formulary?

No.

d. Did all the patients that were taking Basaglar switch to Lantus or has Blue Cross Blue Shield of North Carolina received requests from beneficiaries to continue using Basaglar? If Blue Cross Blue Shield of North Carolina has received requests from beneficiaries to continue to use Basaglar, how many requests has it received and has the company granted these requests?

- Not all patients taking Basaglar switched to Lantus; patients also switched to other long acting insulins that are preferred products under the Blue Cross NC formulary such as Toujeo, Tresiba, and Levemir.
- Of the 129 patients that were on Basaglar prior to 4/1/19, 92 did not seek a formulary exception to continue using Basaglar.
- Of the 37 that requested a formulary exception to continue using Basaglar, 16 were granted approval and 21 were denied.

e. How much, on average, would a beneficiary pay for Basaglar before April 1, 2019, and how much, on average, would a beneficiary pay for Basaglar after April 1, 2019?

On average members paid $2.99/day for Basaglar Q1 of 2019. On average members paid $2.73/day for Basaglar Q2 of 2019. This number will decrease through the year as members meet their deductible.