Testimony on

Lowering Prescription Drug Prices: Deconstructing the Drug Supply Chain

By

Estay Greene, Pharm.D., M.B.A.

Vice President, Pharmacy Services

Blue Cross and Blue Shield North Carolina

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Introduction

My name is Estay Greene and I am the Vice President of Pharmacy Services with Blue Cross and Blue Shield of North Carolina (Blue Cross NC).

Since 1933, Blue Cross NC has offered its customers high quality health insurance at a competitive price and has led the charge toward better health and more consumer-focused health care in our state. We are a not-for-profit company, and we employ more than 4,700 North Carolinians and serve more than 3.89 million customers. We are active in the group, individual, state, Federal Employee, and Medicare marketplaces. We will soon be entering the Medicaid marketplace.

Blue Cross of NC is a member of the Blue Cross Blue Shield Association (BCBSA), a national federation of 36 independent, community-based, and locally operated Blue Cross and Blue Shield companies that collectively provide healthcare coverage for one in three Americans. Blue Cross and Blue Shield companies offer quality healthcare coverage in all markets across America and participate in all federal insurance programs, including the Federal Employee Health Benefits Program (FEHBP), Medicare Advantage, Part D, CHIP and Medicaid managed care programs. BCBS companies also serve individuals and employers in the small and large group markets. We are committed to high quality, affordable coverage for all regardless of pre-existing conditions. Blue Cross of NC has offered coverage in the Affordable Care Act Exchanges in every county in North Carolina since 2014.

For nearly a century, BCBS companies have provided secure and stable healthcare coverage to people in communities across the country, allowing them to live free of worry, free of fear. Serving one-in-three Americans nationwide (over 106 million), BCBS companies, their foundations, and their employees stand committed to their local communities – where they live and work. They do this by creating and supporting programs that drive positive health outcomes addressing some of the most pressing issues affecting the country today: community health disparities, the opioid epidemic and social determinants of health.

I would like to thank Chairwoman Eshoo (D-CA) and Ranking Member Burgess (R-TX) for their leadership in holding today's hearing and providing the opportunity to discuss key ways to improve patient access to affordable prescription drugs. In my remarks today, I will address:

I. How Blue Cross NC engages with drug supply chain entities
II. Blue Cross NC activities to help patients afford prescription medicines
III. Policy solutions to address rising drug prices

Blue Cross NC Engagement with Drug Supply Chain Entities

PBMs Provide Services for Blue Cross NC and its Members

Blue Cross NC holds ownership of a PBM, Prime Therapeutics, along with 17 Blue Cross Blue Shield owner clients. Prime Therapeutics, a not-for-profit, assists with the administration of the pharmacy benefit including a variety of services to Blue Cross NC members such as handling

pharmacy claims, contracting and developing preferred and non-preferred retail pharmacy networks, providing customer assistance and developing formularies and utilization management programs. The most significant PBM role is to leverage its volume of covered lives when negotiating with manufacturers for discounts on prescription drugs.

The primary form of drug discounts by PBMs has evolved into manufacturer rebates on some brand and specialty drug products. Today, PBMs negotiate with manufacturers for the rebates to secure the lowest net prices for their health plan and employer clients. In the commercial market, PBMs pass along the vast majority of rebate dollars to their health plan clients, who, in turn, use those savings to decrease premiums or reduce out-of-pocket costs for prescription drugs for all of their insured customers. All Prime Therapeutics owner clients receive a pass through of 100 percent of manufacturer rebates (see the *Blue Cross NC activities to help patients afford prescription medicines* section below for how Blue Cross NC shares rebates with members).

In the Part D and MA-PD markets, PBMs are required to pass on rebates to plan sponsors, and plan sponsors, with few exceptions, then use those rebate dollars to keep premiums low for all of their Medicare beneficiaries. Low Part D premiums ensure access to Part D coverage. CMS noted that higher rebates and other price concessions lead "to lower bids and, therefore, puts downward pressure on beneficiary premiums."[1] In the Medicaid markets, either states or a contracted entity (e.g., Medicaid MCO or its PBM) negotiate with manufacturers to secure supplemental rebates for state Medicaid programs.

[1] Centers for Medicare & Medicaid Services. Fact Sheet. "Medicare Part D – Direct and Indirect Remuneration (DIR)." 19 January 2017.

Health plans and their PBM partners have had some success in holding drug manufacturers' monopoly pricing power in check. In PBM drug trend reports for 2017, several PBMs cited negative or low, single-digit spending growth for commercial, Medicare and Medicaid clients even when the specialty drug spending trend was in the double digits.[2] This demonstrates the value of PBMs negotiating manufacturer rebates on behalf of health plans and their enrollees, while highlighting the growing concern of specialty drug pricing and utilization.

The Role of Pharmaceutical & Therapeutic (P&T) Committees: Informing Decisions with Supply Chain Entities and on Pharmacy Benefits

A PBM will leverage its purchasing power when negotiating with drug manufacturers for the lowest possible net price, but there are other conditions and programs in use to drive prices lower for enrollees. PBMs and/or their health plan clients determine:

- Whether a drug will be a covered drug on a formulary
- A drug's formulary tier placement and the corresponding cost-sharing amount
- Whether a drug is subject to safety protocols or utilization management programs that encourage consumers to select drugs based on safety, clinical effectiveness and cost effectiveness

PBMs use drug formulary and coverage status (e.g., tier and extent of utilization management requirements such as step therapy) for a given drug relative to competitive products to negotiate

[2] For examples, see CVSHealth Drug Trend Report 2017, https://payorsolutions.cvshealth.com/sites/default/files/cvs-health-payor-solutions-2017-drug-trend-report-feature-april-2017.pdf; Prime Therapeutics trend reports 2017, https://www.primetherapeutics.com/en/news/pressreleases/2018/drugtrend-2017-release.html; Express Scripts trend report, http://lab.express-scripts.com/lab/insights/industry-updates/record-low-increase-in-rx-spending-in-2017.

discounts in the form of rebates from manufacturers. The PBM and its plan client in turn agree to cover drugs and offer enrollees incentives to use particular medications (such as lower cost-sharing through tier placement).

These decisions are made with input from a pharmacy and therapeutics (P&T) committee, a multidisciplinary expert group that is usually comprised of *external* doctors, pharmacists and other health care professionals, along with some plan medical professionals. This committee reviews medications and related products throughout the year based on current evidence-based medicine and makes recommendations on which drugs to include on the plan formulary. In making the decision to add a drug to the formulary, the evidence would have to show clinical benefit to have the drug available for use by a plan's members. When recommending to not add a drug, the clinical evidence generally must be insufficient to meet the standard of adequate scientific rigor to prove efficacy or safety.

P&T committees may determine that some drugs are simply as good as what is currently available. In those cases, the drugs in question will not be given as high a priority for inclusion in the formulary unless their side effect profile represents an improvement from the alternative. It also may replace the current drug if it provides an equal or superior alternative but is more cost effective. If a drug is excluded from a formulary, plans will cover at least one alternative treatment that is both as effective and safe in treating a disease or condition.

Cost considerations do not enter into the P&T decision-making process as to whether a given drug meets the scientific evidence hurdle to support that it is both safe and effective for the

conditions that it is designed to treat**.** However, once a P&T committee determines that a drug falls into the "may add" category[3], a plan takes into consideration the cost of similar drugs. That generally is operationalized by favoring the most cost-effective drug(s) in a category for inclusion in the formulary, or by choosing to differentiate competing products through benefit design, e.g., through tiered formularies where a similar drug of higher cost sits in a tier that requires a higher member contribution. This is an example of the importance of distinguishing pharmacy policy from pharmacy benefits. P&T committees rarely are involved in creating pharmacy benefits, unless they are asked to render an opinion about the potential advantages or harm to a patient of a benefit design.

Blue Cross NC Activities to Help Patients Afford Prescription Medicines

Blue Cross NC shares the Committee's goals to ensure patients have access to safe, effective and affordable prescription medicines. Here are three specific policies or tools we are using:

First, we made the decision starting January 1, 2019, to pass back drug rebates directly to customers when they buy rebated drugs. In the first quarter of 2019, we passed back $3.13M to members in rebates, decreasing our members' cost share by 19 percent. This change applies to all of our fully insured customers and is an option for large employers whose claims we manage but are paid by their employer.

[3] Here we use drugs in the "may add" category to mean a drug that may or may not be added as a covered drug under the pharmacy benefit for reason that therapeutically equivalent drugs, with similar efficacy and risk profiles, are available.

Blue Cross NC negotiates prescription rebates with drug manufacturers to help offset the high costs of their products. We have always passed back these rebates to our customers, and we will continue to do so. In the past, we have spread the rebates across our entire customer base to offset premium increases. Now, as costs at the pharmacy counter continue to soar, we are going to target this benefit specifically to our members taking high cost, rebated prescription drugs.

This is especially important for members with high deductible health plans who could potentially bare a much larger out-of-pocket cost for high-priced rebated drugs. High deductible plans were introduced as a way to hold down premiums in response to continually rising health care and pharmaceutical costs. They have grown in enrollment: among our fully insured population, members with high deductible health plans increased by 600 percent since the end of 2006 – or from 16,000 members in 2006 to more than 110,000 at the end of 2018.[4]

Here is how passing back rebates will work for a member who hasn't yet met their deductible: if you are taking a prescription drug that costs $300, and there is a $100 rebate on the drug, you will now pay $200.

While our policy change will help, much more must be done. In just the last three years, drug manufacturers have increased costs for our customers by $360 million, but only increased rebates by $130 million – pocketing $230 million of their cost increases[5].

[4] Blue Cross NC internal data, accessed May 7, 2019
[5] Blue Cross NC internal data, accessed Dec. 8, 2018

A study released this week from Johns Hopkins found that drug prices were 3.2 to 4.1 times higher in the U.S. on average than in comparison countries, even with rebates taken into account.[6]

And even with passing back more than $3 million in the first quarter, Blue Cross NC and those same members still paid more than $33 million for rebated drugs in that same timespan.[7]

To significantly address high costs, we have to address the main driver: expensive prescription drugs. We believe that proposals that increase competition in the pharmaceutical industry are necessary to bring lower-cost, equally effective medicines to patients.

Second, BCBS companies are committed to providing access to prescription medicines and educating members about formulary changes in a clear and effective matter. Consumers need actionable information about their pharmacy benefits and cost-sharing amounts. Blue Cross NC educates our members on how their pharmacy benefits work to access prescription drugs and provide a variety of interactive tools to help members choose the most effective, most affordable medicine.

Specifically, we recently launched a transparency tool around Rx pricing where we send information to members about the lower cost options available to them. The tool uses claims data to track members' prescriptions. When a less expensive, equally effective alternative is identified, the member is notified by email or text message. The tool, called Rx Savings

[6] Johns Hopkins University Bloomberg School of Public Health, May 6, 2019
[7] Blue Cross NC internal data, accessed May 7, 2019

Solutions, has generated $10 million in member drug savings, and has an average savings of $153 per fill.[8]

Third, to help members with high-deductible health plans save on drug costs, we waive the deductible on the purchase of preventive care medications. Currently, we waive the deductible on medications that prevent drug use, cancer, cardiovascular events, osteoporosis, and asthma.

Policy Solutions to Address Rising Drug Prices

Blue Cross NC applauds the committee for holding this hearing and seeking this opportunity to address the high cost of prescription drugs. We support policies to ensure that people have timely access to safe, effective and affordable cutting-edge prescription medicines when they need them. BCBS companies across the United States have been working to move to value-based and outcomes-based arrangements for prescription medicines to achieve improved quality at lower cost.

Based on these experiences as well as BCBS companies' generations of healthcare experience and commitment to ensuring their customers' health needs are met, BCBSA has identified four key strategies to address escalating prescription drug costs and ensure that people have timely access to safe, effective, cutting-edge prescription medicines and their generic equivalents at the most affordable price, and in the right setting. These include:

[8] RxSS 2018 Book of Business results over the last 2–3 years.

1) *Reducing barriers that limit competition and consumer choice*. Currently, significant barriers hinder patients' timely access to affordable and safe generic drugs and biosimilars. Promoting competition and consumer choice will make prescription medicines more affordable. To that end, we support passage of the CREATES Act, bills that prohibit anticompetitive pay-for-delay arrangements, and bills banning patent abuses that unduly delay generic and biosimilar entry.

2) *Promoting greater transparency and sharing of information regarding the pricing of prescription medicines*. Understanding how drug prices are currently established is a necessary step in discussing any policy options that are meant to address the unsustainable rate of rising prices. There should be transparency regarding the pricing of prescription medicines, a drug's effectiveness relative to other treatments and an assessment of the therapeutic value of the product. It is also important that health insurers know which new drugs are coming into the pipeline. This allows health insurers to work with doctors and pharmacists in planning and working to ensure there are ways to get prescription medicines to patients at the most affordable cost.

3) *Providing medical and healthcare professionals with the tools they need to support patient education and adherence*. BCBS companies support policies that give medical professionals the tools they need to educate and support patients in taking their prescription medications as directed. Unfortunately, nearly three out of four people report that they do not always take their prescription medicine as directed. Addressing this

problem would improve patients' health and safety, prevent adverse side effects and unnecessary hospitalizations, and, as a result, help to rein in costs.

4) *Promoting additional regulatory changes that help patients get the right medicines for them, at the most affordable prices*. BCBS companies believe that a number of regulatory adjustments can be made to increase competition and improve patient access to affordable prescription medicines. These include: (a) removing the "protected class" status in Part D for certain medications to allow for better drug price negotiations and increased use of tools to help patients get the right medicines at the most affordable prices; (b) ensuring FDA regulation of prescription drugs off-label use ; and (c) modifying drug marketing guidelines to include transparency on pricing and improved information on clinical effectiveness.

More information on these recommendations can be found in BCBSA's white paper, "Ensuring Patient Access to Safe, Effective and Affordable Prescription Medicines."[9]

Again, we commend the committee for taking on these important issues as it is critical that all stakeholders work together to ensure the affordability of prescription drugs for all Americans. Achieving this important goal will require the public and private sectors to collaborate to develop solutions that benefit patients and the entire health system.

[9] "Ensuring Patient Access to Safe, Effective and Affordable Prescription Medicines," https://www.bcbs.com/sites/default/files/file-attachments/page/DrugPricing_WhitePaper_110317.pdf

Thank you for the opportunity to testify today and your leadership in seeking opportunities to improve healthcare.