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December 23, 2021

Andrea D. Willis, MD
Senior Vice President and Chief Medical Officer
BlueCross BlueShield of Tennessee
6021 Brentwood Chase Drive
Brentwood, TN 37027

Dear Dr. Willis:

On behalf of the more than 7,700 U.S. rheumatologists and rheumatology health professionals represented by the American College of Rheumatology (ACR), I am writing you regarding the proposed expansion of BlueCross BlueShield of Tennessee Advanced Specialty Benefit Management (ASBM) program. We are greatly concerned about the impact of this expansion on rheumatology practices and patients, and we urge you to reconsider this change. We also request the opportunity to speak with you further regarding our concerns.

As ACR has previously asserted in our communications about the ASBM program, these requirements threaten patients' access to critical treatments. Requiring practices to assume the additional –and unpaid-- administrative burden of ordering and storing specialty pharmacy drugs for each individual patient raises concerns for practice solvency and will likely result in practices be unable to continue providing these treatments. Practices currently engaging in the buy-and-bill model operate under thin margins. If forced to obtain drugs from a specialty pharmacy, even these small margins will be erased. Drug administration fees alone will not cover practices' overhead costs associated with in-office administration such as rent, utilities, drug storage, insurance, and staff salaries. The result of this policy will be a shift in site of care for BCBST patients' infusions to a more expensive hospital outpatient setting. Not only will treatment costs be higher in the hospital setting, but there will be a predictable minority of patients who, due to the inconvenience, the higher out of pocket cost, or simply fear of the unknown, will drop their treatments when transferred to this setting, causing their overall healthcare costs to rise as their rheumatic disease flares. We are also aware that a number of hospital facilities will not accept white bagging policies, and in these communities, the patients risk losing access to treatment all together.

In addition to our concerns about the impact of this program on practices' financial ability to continue providing these critical treatments, we also take issue with the amount of drug wastage it would cause. When purchasing drugs for buy-and-bill administration, there is no direct patient assignment. If a patient has drugs ordered through specialty pharmacy and that patient is unable to use the medication for any reason (i.e. infection, change in medical history, or intolerance/ineffectiveness of medication) then the medication must be wasted as it is unethical and illegal to administer the medication to a different patient. Furthermore, any necessary change in dosing

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will force a delay of treatment. Even if it appears that a health plan is able to pay less for drugs through a specialty pharmacy, wasting medication for one infusion for one patient will certainly undermine any potential savings.

The ASBM program also raises the important medico-legal issue of drug provenance. How did the drug arrive at the specialty pharmacy, how can the infusing provider verify its supply chain, and what are the legal ramifications of infusing a drug with a compromised supply chain? Biologic medications carry significant potential toxicity and have specific handling requirements. Physician purchasing gives practices full control over the purchasing, handling, storage, and administration of these complex therapies.

Finally, we have concerns about the impact of this program on patients' ability to afford treatment. Many patients depend on copay assistance funds to afford their medications. Under the current model of care, rheumatology practices can help patients by processing copay assistance cards at the point of care. However, under the ASBM program, patients will be responsible for paying the specialty pharmacy directly prior to the medication being shipped and it is unclear whether they will be able to use copay assistance funds. This would make specialty medications unaffordable for many and may force patients to discontinue treatment altogether.

The ACR appreciates and shares your concerns regarding the price of biologics. However, these are critical and life-changing treatments for patients with rheumatic diseases and we believe that providers' ability to buy-and-bill for these medications is the best option to ensure patient safety and continued access. We would greatly appreciate the opportunity to speak to you further about this issue and our concerns. For questions or to arrange a conference call, please contact Meredith Strozier, ACR Director of Practice Advocacy, at mstrozier@rheumatology.org or (404) 633-3777.

Sincerely,

Rebecca Shepherd, MD
Chair, ACR Insurance Subcommittee