July 15, 2022

Commissioner Mike Kreidler
Washington State Officer of the Insurance Commissioner
302 Sid Snyder Ave., SW
Olympia, WA 98504
EMAIL: rulescoordinator@oic.wa.gov

SUBMITTED VIA EMAIL AND WEB FORM

Re: Proposed Rule on Cost-Sharing for Prescription Drugs (R 2022-05)

Dear Commissioner Kreidler:

The Pharmaceutical Care Management Association ("PCMA") appreciates the opportunity to comment on the Washington State Office of the Insurance Commissioner's ("OIC") proposed rule ("Proposed Rule") for cost-sharing on prescription drugs (R 2022-05). Specially, PCMA has concerns on the prepublication draft of the Proposed Rule released on June 30, 2022. This prepublication draft would make amendments to WAC 284-43-5080 "Prescription drug benefit design" based on SSB 5610 passed during the 2022 Legislative Session, which permits third-party cost-sharing for prescription drugs within specific parameters.

PCMA is the national trade association representing pharmacy benefit managers ("PBMs"). PCMA's member companies administer drug benefits for more than 266 million Americans who have health insurance through employer-sponsored health plans, commercial health plans, union plans, Medicare Part D plans, managed Medicaid plans, and others.

Cost-sharing is an important tool used by PBMs to drive down prescription drug costs for the residents of Washington. On behalf of PCMA's member companies, below are comments, concerns, and recommendations, regarding some of the changes being pursued the OIC within the Proposed Rule.

WAC § 284-43-5080 (1) – Prescription drug benefit design
This subsection currently states, "A carrier may design its prescription drug benefit to include cost control measures, including requiring preferred drug substitution in a given therapeutic class, if the restriction is for a less expensive, equally therapeutic alternative product available to treat the condition."

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We are concerned about the possibility that "given therapeutic class" could restrict the use of preferred therapeutic equivalent products that may not be in the same therapeutic class. We request consideration of the following edit to this section:

- "A carrier may design its prescription drug benefit to include cost control measures, including requiring preferred drug substitution ~~in a given therapeutic class,~~ if the restriction is for a less expensive, equally therapeutic alternative product available to treat the condition."

WAC § 284-43-5080 (4)

This subsection currently states, "A carrier may require an enrollee to try an AB-rated generic equivalent or a biological product that is an interchangeable biological product prior to providing coverage for the equivalent branded prescription drug."

SSB 5610 includes provisions for preferred therapeutic equivalent use. We request consideration of the following edit to this subsection:

- "A carrier may require an enrollee to try an AB-rated generic equivalent**, preferred therapeutic equivalent,** or a biological product that is an interchangeable biological product prior to providing coverage for the equivalent branded prescription drug."

WAC § 284-43-5080 (5)(a)

This subsection contains a multitude of new language drafted by the DOI. Cost-sharing assistance programs include: (1) need-based patient assistance programs, and (2) third-party cost-sharing assistance programs limited to insured Washingtonians. Cost-sharing assistance programs for insured Washingtonians exist in many forms including those that are presented at the point-of-sale in the pharmacy as well as those that are applied *after* the point of sale. Carriers and PBMs have zero visibility into any cost-sharing contributions that occur outside of the claim submission process that occurs at pharmacies when prescriptions are filled. For this reason, we request the following edit:

- (5)(a) For the purposes of this subsection cost sharing or out-of-pocket amounts include payments **to a pharmacy** from all sources as though it was paid by the enrollee directly and must be applied in full toward the enrollee's applicable cost sharing…."

WAC § 284-43-5080 (5)(b)

This subsection requires that: "if an enrollee requests and exception…or appeals a denial of an exception request, and the request or appeal is still pending, any amount paid by or on behalf of an enrollee for a covered prescription drug must be applied towards the enrollee's contribution to any application deductible, copayment, coinsurance, or out-of-pocket maximum until the review is resolved and the status of the request is communicated to the carrier."

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PCMA respectfully requests that additional clarifying language be added to this subsection to make clear that in the event an enrollee's request to an exception or an appeal of a denial of an exception request are unsuccessful that neither the PBM nor health carrier be responsible to apply any cost contribution made by the enrollee be applied toward the enrollee's cost-sharing for prescription drug benefits.

Currently, subsection (5)(b) of the Proposed Rule leaves open the possible interpretation of no resolution nor finality should an enrollee be unsuccessful in seeking cost-sharing coverage under the terms of the enrollee's prescription drugs benefits.

WAC § 284-43-5080 (5)(d)
Subsection (5)(d) requires that for non-grandfathered health plans with a prescription drug benefit, the health carrier must disclose to the enrollee specific information in the enrollee's certificate of coverage

These specifics include, that cost contributions or amounts paid, "including payments made through application of a manufacturer drug coupon or other manufacturer discount, must be counted towards an enrollee's contribution to any application deductible, copayment, coinsurance, or out-of-pocket maximum" under certain scenarios.

First, the entirety of this subsection, including (i) – (iv), set forth scenarios in which there again may be no resolution nor finality. Because of this, PCMA respectfully requests that additional clarifying language be added to this subsection to make clear that in the event an enrollee's request to an exception or an appeal of a denial of an exception request are unsuccessful that neither the PBM nor health carrier be responsible to apply any cost contribution made by the enrollee be applied toward the enrollee's cost-sharing for prescription drug benefits.

Second, subsection (5)(d) of the Proposed Rule would establish a process that under specific scenarios, an enrollee using a pharmaceutical manufacturer's "drug coupon…or other manufacturer discount," have payment made under those programs count toward the enrollee's cost-sharing.

Pharmaceutical manufacturers rely on financial subsidy programs to increase product uptake among insured patients, i.e., "enrollees." Unlike means-tested patient assistance programs, which assist uninsured or indigent populations, copay assistance and free drug programs target patients who are already covered by insurance plans. By targeting drugs with sub-optimal formulary placement, these programs aim to rapidly increase product utilization outside the confines of traditional insurance processes.

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Employer costs rise dramatically when enrollees choose expensive drugs over more affordable options. Drug coupons and copay assistance programs undermine employers' ability to use utilization management tools, such as varying copay amounts for different-priced drugs, to reduce drug costs. Since the use of copay coupons reduces the utilization of more affordable medication options, overall prescription drug costs will continue to increase dramatically.

Considered illegal in federal health programs, copay coupons are banned in Medicare and Medicaid, but are still allowed in the commercial market (except in Massachusetts). Payers such as PBMs and health carriers are generally supportive of programs that facilitate patient access to specialty and high-cost drugs. However, they do not support programs that undermine formulary design since additional expenditures do not provide patients with additional health benefits.

Generally, patient assistance programs are offered by manufacturers to uninsured low-income individuals who cannot afford their prescription drugs because the price of the prescribed drug is not subject to a PBM and/or health carrier's cost-sharing tools to drive down the cost. The current language of subsection (5)(d) would disincentive pharmaceutical manufacturers from negotiating the prices of their drugs down because it would allow enrollees (i.e., insured individuals) the ability to double-dip not only by utilizing a manufacturer's patient assistance program by having any cost contributions count toward the cost-sharing under the terms of the enrollee's prescription drug benefits.

The Value Provided by PBMs

PBMs are essential to negotiations with pharmaceutical manufacturers to drive down the costs of prescription drugs for enrollees. PBMs enhance competition in the drug supply marketplace by acting as group purchasers of prescription drugs – similarly to what Costco and Sam's Club do for their members. Manufacturer rebates negotiated by PBMs increase utilization of brand drugs beyond what it would have otherwise been because the drugs are more affordable, which leads to greater access and drug adherence.

The work PBMs do to promote generics results in an estimated additional 15 percent (%) of drugs dispensed are generic, bumping generic dispensing to 90 percent of prescriptions, because of PBM services.[i] Generic drugs offer significant cost savings to plans, so PBMs give patients incentives to use generic drugs instead of competing brand drug.

Again, we appreciate the opportunity to provide comments on the OIC's proposed rule on cost-sharing for prescription drugs.

Please feel free to contact myself of Tonia Sorrell-Neal, PCMA's Senior Director of State Affairs (Tsorrell-Neal@pcmanet.org) with any questions or for further discussion.

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Sincerely,

Peter Fjelstad

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Director, State Regulatory & Legal Affairs

CC: Barb Jones, Senior Health Policy Analyst and Rules Coordinator, WA OIC

[i] Mulligan, Casey B., Ph.D, *The National Bureau of Economic Research: The Value of Pharmacy Benefit Management* (July 2022), *available at*: (http://www.nber.org/papers/w30231).

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