August 30, 2016

Sent via email to: rulescoordinator@oic.wa.gov
Mike Kreisler
Washington State Insurance Commissioner
P.O. Box 40255
Olympia, WA 98504-0255

Re: Registration and regulation of pharmacy benefit managers (R 2016-07)

Dear Commissioner Kreisler:

These comments are submitted on behalf of the Alliance for Patient Access (AfPA). AfPA is a national network of physicians and health care professionals, including prescribers, dedicated to ensuring patient access to approved therapies and appropriate clinical care. AfPA appreciates the opportunity to comment as the Office of the Insurance Commissioner (OIC) implements the provisions of RCW Title 19.340 as it pertains to the processes and procedures for registration and regulation of pharmacy benefit managers (PBMs) by the OIC, and OIC's proper oversight of the activities of PBMs.

AfPA urges the OIC to exhibit their authority to discourage PBMs registered in the state from the practice of non-medical switching - dropping coverage of certain medications or pricing patients out of their drugs - and additionally to hold PBMs accountable through OIC's registration and renewals process, based on their willingness to provide a clear, transparent, and up-to-date list to patients of drugs covered under the plan. Additionally, AfPA believes that a change in a patient's medications should only be allowed with the consent of the treating physician and their patient, and therefore submit that proper notification be required of registered PBMs.

As you are aware, non-medical switching arises when health plan or PBM policies cause a stable patient to "switch" medications for reasons other than a medical condition and without the medical judgment of the patient's treating physician. In fact, physicians are not notified typically if their patient's plan suddenly excludes coverage of a medication that the stable patient was prescribed. Switches may take a variety of forms - some insurers price patients out of their chosen medication by placing the therapy on a specialty tier that requires burdensome cost-sharing, while other plans may eliminate coverage altogether for certain medications. As AfPA providers and others conclude, these actions are undertaken as a cost-saving measure by the insurer or PBM, not based on therapeutic value or safety.

AfPA wants to emphasize that restriction to access by PBMs and "switching" of medications has dire consequences to the patient population, and at a minimum, physicians should be given an opportunity to consent to a treatment other than the prescribed medication, as opposed to the PBM taking on the role of the physician by limiting or excluding coverage for a preferred medication. A patient's access to medications should be regarded on an individual basis, as determined by the medical expertise of their own physician, and not a third party. Stabilizing a patient takes trial and error by physicians to find therapies that, first of all, work for the patient, and second, provide minimal side effects in the patient. When a medically stable patient is "switched" by their coverage plan, their symptoms have a strong possibility of reemergence, and the change can further lead to medical complications that require an increase in doctor's visits or even hospitalization. In effect, repeated doctor's visits and treatment associated with the complications of switching one off their medication become more costly - lab testing, appointments, and emergency room visits may be unavoidable - which defeats the purpose of the plan's action of providing access strictly to a less-costly medication in the first place.

Even if a patient is able to regain access to their original medication may find that it has reduced efficacy. In some cases, the very act of switching can render the original medication less effective. Undoubtedly, medications improve quality of life, provide management of or completely remove symptoms associated with the patient's condition, and can also preclude a relapse or further need for treatment.

The practice of switching prescribed medications by PBMs has become a persistent problem nationwide, and AfPA wishes to bring this issue to the attention of policymakers so that PBMs are being held accountable for these decisions. As a recent example, CVS Health revealed this month that it will exclude 35 prescription medication from its 2017 formulary. Two of those are biological treatments for cancer and diabetes – which CVS will now replace, it says, with lower-priced biosimilars. This comes on the heels of the same PBM's announcement back in 2015 that it would drop coverage of 95 medications. CVS's chief medical officer acknowledged to news outlets earlier this month that it: "makes sense to do this in order to reduce cost." Reductions in coverage which leads to switching patients off their medication is not exclusive to CVS Health. The practice has become more and more common - all in the name of cost control. Similarly, Express Scripts list of excluded medications, as of this month, is now up to a total of 85 excluded medications.

Non-medical switching by health plans and PBMs is harmful not only to the patient, but undermines the patient-physician relationship. Essentially, when a PBM drops coverage of a medication or penalizes the patient for use of a certain medication by making one pay a higher rate out-of-pocket, the plan is saying that they know better what about the patient's needs than the treating physician. This action ignores the process physicians and patients underwent to find a successful medical therapy over the course of their relationship. Patients should have access to the treatments that their doctor prescribes - whether a brand-new drug on the market, or a tried and

true, safe and effective course of treatment. Physicians and prescribers are trusted resources for the patient community, and PBMs should not be allowed to displace medical advice of the patient's own provider in the name of controlling cost.

Last, as the OIC considers registration and annual renewals of pharmacy benefit managers (PBMs), it would be a great benefit to patients in Washington state that PBMs be held accountable to provide clear and transparent, and updated formulary drug lists. AfPA would respectfully request that OIC require PBMs to provide to their enrollees updates of the complete list of all covered drugs on its formulary drug list, including any restrictions on particular tiers of drugs under the plan. This allows patients to make informed decisions before selecting a plan for health coverage. Since time is of the essence for the treatment of some conditions, this information is critical for providers and their patients. Time, particularly for those patients with chronic and complex conditions, is not a luxury they enjoy when managing their symptoms, and a published and updated drug formulary list could alleviate confusion about drug coverage.

Restricting non-medical switching, and holding PBMs accountable to reduce this practice, protects patient health and gives due regard to the physician-patient relationship and the provider's role in guiding patient care. Please let me know if AfPA can provide additional information to your office.

On behalf of AfPA, thank you for your time and attention to this matter.

Sincerely,

Brian Kennedy
Executive Director

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