Let My Doctors Decide

A Call to Action for Patients and Providers

> **"Achieving Patient-Centered Health Care Coverage to Improve Health, Lower Costs, and Support Patient-Physician Relationship: Embrace LMDD Principles."**
>
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As CMS recently noted, the clinician-patient relationship is **"the most powerful force in our healthcare system for improving health outcomes."** Unfortunately, too often health plan and PBM policies interfere to undermine that relationship and the positive health and economic benefits that could follow. For example, 90 percent of physicians report that prior authorization requirements imposed by health plans have had negative clinical impacts on their patients. The coverage goals of public and private payors, including employers, Medicare, and Medicaid, also may not align which leads to higher costs for those payors. For example, a health plan may restrict access to higher cost treatments and favor lower cost ones associated with side effects. Looking at overall costs, however, a payor may prefer the higher cost treatments if the side effects cause a patient or caregiver to miss work or school, increase their risk of injury at work, or file for disability benefits. Moreover, many public and private payors manage medications and medical care coverage and costs separately in silos, which creates disincentives for considering overall medical costs when designing and implementing drug benefits.

Days missed from work or school and productivity lost due to preventable disability, sick days, workers compensation injuries, and caregiving needs cost employers significantly, but may not affect health plan costs. Misaligned incentives hinder promoting and protecting overall health and wellness and limit the economic benefits of improved health for both the individual and the payor.

Adopting the principles set forth by Let My Doctors Decide will help align health care coverage more closely with the overall goals of affordably promoting individual and population health while managing overall costs. To that end, we urge CMS, employers, insurers, and other decision-makers to adopt patient-centered principles for benefit designs and related contracting that are transparent and build upon the clinician-patient relationship by focusing coverage policies on: Empowering Provider Decision-making; Promoting Access and Adherence; and Addressing Affordability.

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Empowering Provider Decision-Making

- Require policies regarding step therapy be clinically based on current evidence and applied for clinical reasons only. The treating physician, not the insurer, should have the final say as to whether a patient has "failed" on a therapy.
- Prohibit non-medical switching of medications without notification and consent of the patient, including treatment options involving biosimilar medications. Decisions about which therapy to use should remain between patients and their doctors.
- Avoid creating additional barriers or patient risks such as requiring patients to transport intravenous medications to their provider for administration.

Promoting Access & Adherence

- Require clear and transparent appeals processes for coverage denials, including responses within 72 hours in urgent circumstances with patient access continuing uninterrupted during the appeals process.
- Prohibit requirements that limit patient access to specific pharmacies that may or may not be convenient for the patient or provide access to medications in a timely manner.
- Prohibit use of step therapy and prior authorization policies for individuals stable on a treatment regimen. People stable on therapy who experience a change of employer or health plans should not be required to restart the step therapy process. Simple certification of clinical benefit from the treating clinician(s) should meet any documentation requirements without any interruption in treatment for the patient.
- Prohibit contracts that use rebates and other volume discounts to ban inclusion of other treatment options from formularies. Contracts that use rebate walls or rebate traps stifle competition, increase costs, and restrict patient access to a wider, and in some cases more effective, range of treatment options.

Addressing Affordability

- Pass rebates on prescription medicines directly to the individual patient at the pharmacy counter. Documentation on the share and distribution of rebates should be provided to the plan sponsor at least annually.
- Address high patient cost-sharing by:
  - Requiring that patients get the benefit of discounted prices for a medications at the plan's negotiated rate throughout plan year, including in meeting deductibles and in calculating coinsurance.
  - Prohibiting limitations on patient use of copay assistance programs, including assuring that such assistance counts towards meeting cost-sharing requirements such as deductibles and out-of-pocket maximum limits.
  - Eliminating excessive cost sharing for medicines by including monthly out-of-pocket caps, spreading deductibles over the course of a plan year, and/or providing coverage options with first-dollar coverage for medications.
- Avoid contracts that link reimbursement for drug coverage administration services to the price of a medication. This can incentivize use of medications based on the higher price instead of the greater clinical benefit as determined by the treating physician.