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HOW STATES CAN REFORM HEALTH CARE TODAY

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CHAPTER 7

Empower Patients

Let Them Own and Control Their Prescriptions

Jeffrey A. Singer, MD

KEY TAKEAWAYS

- The move to e-prescribing took power away from health care consumers, who previously possessed written prescriptions and shopped around for better prices and service.
- Technology exists to allow patients to possess their e-prescriptions and make shopping even easier.
- Starting in 2022, new federal rules will allow consumers to use this new technology, but state regulations stand in the way.

PROBLEM

Until recently, most patients received their prescriptions in writing, on paper. They carried their prescriptions with them and were able to shop at various pharmacies and decide, based on price and service, where to get them filled. In essence, with that prescription in hand, they were in control. It stayed with them until they gave it to the pharmacy. When health records went digital and e-prescribing became the most common means of prescribing, patients lost control over their prescriptions. Ironically, an unintended consequence of electronic prescribing was to reduce patient autonomy along with the ability to comparison shop.

In March 2020, the U.S. Department of Health and Human Services issued new rules, scheduled to take effect in 2022, that will allow patients to

access their electronic health records using a smartphone app and to share their medical records.[1] This rule change will allow patients to utilize their personal prescription information to shop for prescription drugs. In the same way that consumers can shop for almost every other product, patients will be able to use new tools, such as smartphone apps, to find the best price, convenient delivery time and location, and overall customer service experience for filling their prescriptions.[2]

These new rules reinforce the idea that patients own their medical records. The ability of patients to access their medical records from a secure electronic database for their own purposes will soon be a reality. For example, an "advocate app" (an app that works for the patient and not a third party such as an insurer) can shop for the prescription and transmit it to the pharmacy offering the best combination of price and convenience. Unfortunately, to make this a reality, states must remove pharmacy and health information transfer regulations that were created decades ago, before the rise and widespread adoption of web-based shopping platforms and information systems.

As health insurance premiums, deductibles, and copays continue to rise, consumers are increasingly seeking ways to diminish the sting of prescription drug prices. Technology entrepreneurs have responded to the problem with online websites and smartphone apps, such as GoodRx and SingleCare, that allow consumers to take advantage of various discounts negotiated with pharmacies by "middlemen" called pharmaceutical benefits managers (PBMs). These websites and apps compare the actual price that consumers will face, accounting for negotiated discounts, for the same drug across pharmacies and then let patients select a pharmacy to dispense their prescription.[3] Patients pay out-of-pocket for these prescriptions but often pay less than if they used their health plan.

Pharmaceutical benefits managers contract with health insurance companies to provide prescription drug benefits to health plans, but the discounts that PBMs provide can be misleading. Pharmacies, like other health care providers, artificially inflate the prices they charge third-party payers to start the bargaining process with the PBMs. The negotiated "discount" prices are off the inflated charges and may include hidden PBM fees. These fees are then paid to the PBMs by the pharmacies as a portion of the money patients pay them for prescriptions. Some refer to the payment to the PBMs as a "claw back." That is why people who do not have insurance often pay less for a drug than people who use their insurance.[4] They can deal directly with the pharmacies without paying any hidden fees.

Numerous web-based pharmacies, by eschewing third-party payers, already offer patients deeper discounts than can be obtained by PBMs.[5] They can soon be competing alongside PBMs with price-tracking apps, making shopping easy for consumers. Consumers who forgo their insurance by using these pharmacies are not subject to 30-day or 90-day supply restrictions imposed by health insurance plans and can purchase larger supplies of non-controlled medications, but state-level information regulations and pharmacy regulations need updating for these kinds of innovations to propagate.

Most state pharmacy regulations only permit electronic transfers of original prescription orders between pharmacies owned by the same company that use a common or shared database. For example, in most states, pharmacy law currently permits a patient to have a prescription moved from a Walgreens in one city to a Walgreens in another city by a pharmacy technician or another assistant. While it is not required that the pharmacist perform the e-transfer, this type of prescription updating appears relatively easy for patients.

When two pharmacies are not within the same chain and therefore do not have a shared database, a patient must formally request that a pharmacy transfer the prescription to another pharmacy. In that case, most states only allow a pharmacist or pharmacist intern to transfer the prescription to the new pharmacy, where only a pharmacist or pharmacist intern may receive it.[6] But under ordinary circumstances, patients using prescription apps who discover they can get a better price for their prescription at a competing pharmacy must make a request to the pharmacist to transfer the prescription to the less-expensive pharmacy.

In most states, pharmacists are not required to oblige such requests and certainly might not prioritize requests to transfer their business to a competitor. Patients can also contact their prescriber to request that a new prescription be issued to the cheaper pharmacy. In some cases, a prescriber will require them to make another office visit just to get the same prescription sent electronically to a different pharmacy. Both options can be inconvenient, time-consuming, and not worth the effort. This presents substantial difficulty for many patients, such as those traveling and needing to transfer a prescription. Furthermore, such inconveniences disincentivize comparison shopping.

State pharmacy regulations have no provisions to address the transfer of prescription orders and prescription history to intermediaries that act on behalf of the patient, including nondispensing pharmacy networks. Nondispensing

pharmacists are often important team members in integrated health care systems.[7] These are licensed pharmacists who do not dispense drugs. However, they provide advice to patients and prescribers on drug interactions and coordinate and manage dosing and timing of prescribed medications. Nondispensing pharmacy networks are entities that employ pharmacists to provide clinical services aimed at optimizing patients' drug therapy programs to health plans, health care facilities such as nursing homes, and individual patients, but they do not dispense medications.[8] Such networks are qualified and well positioned to be among the intermediary navigators envisioned here.

State pharmacy and information transfer regulations are insufficient for today's technological advances that can empower patients in the health care marketplace. The federal government updated regulations to comport with technological advances. Now it is time for states to do the same.

PROPOSAL

Putting patients first should be the goal of any health care reform. In many states, regulations do not allow patients to control their prescriptions, and they block patients from the benefits of the revised federal rules expanding patient information access and control. Removing these obstacles would allow a new market in which prescription drug pricing is more transparent to fully blossom.

To improve patients' health and financial well-being and allow them to benefit from technological advances, states should remove regulatory obstacles to the electronic transfer of prescriptions between pharmacies not owned by the same company and not sharing a common database. They must also remove the requirement that such transfers may only be conducted between pharmacists or pharmacy interns.

Furthermore, states should pass legislation that explicitly requires health care providers, including pharmacies not within the same company, to electronically transfer a patient's current medication history to a provider designated by the patient. This would take place upon a patient's request and would be consistent with federal regulations allowing patients access to their medical records. The legislation should stipulate that transferred prescriptions or prescription refill orders would serve as the equivalent of the original electronically transmitted prescription order. It should also require that, upon a patient's request, their current medication history be transferred to a designated third party via a smartphone app. The third party, in turn, will

make prescriptions available for dispensing pharmacies to retrieve and fill as instructed by the patient.

In essence, these reforms would allow patients to own their prescription history and control where to receive their medications. Removing current rules that make it inconvenient for patients to take advantage of price information already available from online and app-based services will stimulate price competition among pharmacies. This competition should lower prices and improve convenience, potentially increasing medication adherence.

Moreover, with these barriers gone, new types of services can emerge, including those that avoid third-party payers and that offer direct-to-consumer pricing. Insurance plans usually limit the dispensed amount of a prescribed noncontrolled medication to either a 30-day or a 90-day supply. Third-party payer restrictions do not apply when patients buy from direct-to-consumer pharmacies without involving their health plans. This allows them to buy a full year's supply of a noncontrolled drug at once, adding cost savings and convenience.[9] Price-tracking smartphone apps may allow direct-to-consumer pharmacies greater market access.

Customers will be empowered by the easy access to information about drug price differences among a wide array of competing pharmacies. As nondispensing pharmacies and other intermediaries compete in this new market, expect innovations such as free same-day prescription delivery services, patient education services, and provider rating features. Patients who already seek services from direct primary care and concierge medicine providers should immediately appreciate the advantages this reform offers.

The Goldwater Institute developed model legislation to guide lawmakers who seek to implement such reforms.[10] The model legislation requires that medical practitioners transfer medication history and prescriptions "to a patient's preferred non-dispensing pharmacy network via smartphone app whereby prescription[s] can be made available for dispensing pharmacies to retrieve and fill prescription[s] as directed by [the] patient." It requires nondispensing pharmacy networks to keep records of all inbound and outbound prescription medication activity for seven years. The model bill does not discuss other types of app-based intermediary networks that a patient may wish to contract—it only refers to nondispensing pharmacy networks via smartphone apps. This might be for strategic reasons. The model legislation also provides instructions for circumstances in which connectivity between providers and smartphone app intermediaries is lacking.

OVERCOMING OBSTACLES

Many special-interest groups benefit from the status quo and may oppose these reforms because of their financial interest. For example, existing state regulations making it more difficult to transfer a prescription from a pharmacy to its competitor benefit some pharmacies at the expense of consumers. These pharmacies will likely argue that the regulatory status quo is in the best interest of patient safety.

Pharmacy boards are likely to claim that price-tracking apps managed by nonpharmacists, who may be unaware of drug interactions and contraindications, are a safety risk to patients. However, such apps merely compare prices for prescriptions ordered by licensed health care professionals. The prescriptions ultimately are still dispensed by licensed pharmacists, who can exercise their professional expertise and judgment.

The Goldwater Institute's model legislation only refers to smartphone apps of nondispensing pharmacy networks. It becomes difficult for pharmacies and pharmacy boards to use safety concerns as an argument against this reform if transmissions are occurring between licensed dispensing and nondispensing pharmacists and other health care professionals.

Electronic health record (EHR) vendors initially balked when the Department of Health and Human Services announced the new rules that allow patients to access their electronic health records using a smartphone app and to share their medical records. They claimed they would incur enormous costs adapting their systems to comply with the interoperability requirement. They also voiced concern about privacy risks.[11] By April 2020, the nation's largest EHR vendor, Epic, had announced that it supported the new rules. The American Hospital Association remained opposed, citing compliance costs and privacy concerns.[12] Its president, Rick Pollack, remained concerned that the rules did not adequately "protect consumers from actors such as third-party apps that are not required to meet the same stringent privacy and security requirements as hospitals."

Expect hospital groups and EHR vendors to raise similar concerns at the state level. However, privacy and security requirements for interoperability that satisfy requirements of the Health Insurance Portability and Accountability Act (HIPAA) must be satisfied under the new HHS rule, and under the HHS "Blue Button" project, EHR vendors provide patients a secure way to download their information from a provider's database. The Blue Button

symbol signifies the provider's site has functionality for patients to securely download their records.[13]

Pharmacies may argue it is dangerous for people to use price-tracking apps to distribute prescription orders because prescriptions could be divided among multiple pharmacies, and pharmacists may be unaware of other medications patients are receiving from competitors that might interact with the prescription they are dispensing, but the same is true now. Presently, pharmacists only see the medication history of their patients within the shared company database. It is not unusual for patients to ask their provider to electronically transmit different prescriptions to different pharmacies to save money. The model legislation requires the smartphone app network to maintain records for seven years, from which patients can access a more complete medication history if needed. This feature aligns with federally established Blue Button requirements.

Opponents might raise concerns over how reform would handle prescriptions of controlled substances. The model legislation provides that for the e-transfer of prescriptions covered under the federal Controlled Substances Act, "the medical practitioner and pharmacy shall ensure that the transmission complies with any security or other requirements of federal law."

Unlike GoodRx and SingleCare, which only display PBM-negotiated discounts, emerging apps might display prices offered by direct-to-consumer pharmacies alongside PBM-negotiated prices with different pharmacies. The PBMs might argue that letting patients see the difference between PBM-negotiated prices and direct-to-consumer prices will undermine their efforts to negotiate better prices for the insurance plans they serve, but letting consumers see the difference between the price negotiated by the PBM and the amount of money that is being paid to the pharmacy does not hinder PBM negotiations. Instead, it puts pressure on PBMs to lower their claw-back amounts because of enhanced competition with web-based direct-to-consumer pharmacies.

Health insurance plans may oppose this reform as patients discover they can more effectively cut out-of-pocket drug expenses by using price-tracking and nondispensing pharmacy apps in lieu of their health plans. This helps open the way for disrupters like Amazon and Walmart to offer alternative health plan models to patients and employers, including employers with self-insured health plans.

While some interest groups will oppose this policy reform, permitting patients to fully own their prescriptions should attract support across ideological lines. Reform advocates should cultivate alliances with consumer groups,

faith-based health-sharing ministries, the American Association of Retired Persons, the Association of Mature American Citizens, and other consumer empowerment organizations. This reform is simple. It does not require any revenue expenditure. It imposes no costs on taxpayers or health care providers. It simply updates state regulations that did not anticipate advances in communication technology so patients can make use of an exciting new market that was heretofore suppressed.

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