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LEGISLATIVE MEMO

Proposed Bill Would Allow State Program Managers to Change Doctors' Prescriptions

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Introduction

The legislature is considering a bill, SB 5892, that would allow state program managers to alter a doctor's prescription for patients covered by state-subsidized health programs when a cheaper substitute is available. The bill would also prolong patient suffering by requiring them to fail to respond to a state-prescribed drug before being allowed access to the medicine prescribed by their doctor.

If passed, the bill would repeal the "dispense as written" provision, an important safeguard protecting sensitive doctor/patient relationships which was included in major health care legislation signed by Governor Locke.

Background

On June 26, 2003, Governor Locke signed a major health care bill (SB 6088) intended to reduce the cost of prescription drugs for state-funded health care programs. The law requires pharmacists to substitute a less expensive drug taken from a state-approved Preferred Drug List for the medicine prescribed by a physician, if state program managers think the cheaper drug might have equal medical efficacy.

Initially, the Washington State Medical Association, representing doctors across the state, strongly opposed the state's interference in the private relationship between doctors and their patients, and in the doctor's ability to treat his patients in the way he thinks is best.

In response to this concern, legislative sponsors added a clause that forbids the substitution of one drug treatment for another if the doctor specifically directs the pharmacists to dispense the medication that was originally prescribed. The "dispense as written" provision was key to gaining the support of many legislators and of the Washington State Medical Association for passage of the bill. Without inclusion of the "dispense as written" provision, it is likely SB 6088 would not have passed.

Proposed Repeal of the "Dispense as Written" Provision

SB 5892 would overturn the legislative agreement that was forged during passage of the Preferred Drug List program, repeal an important legal safeguard for doctors, and break the

assurances that lawmakers gave doctors when the program was enacted.

Section 1 of the bill states[1] "A state purchased health care program may impose limited restrictions on an endorsing practitioner's authority to dispense as written..." This provision would give state program managers the authority to overturn a doctor's instructions and require a pharmacist to give a patient a medicine different than the one prescribed by the doctor.

The substitution can be made when "...the endorsing practitioner's frequency of prescribing dispensed as written for nonpreferred drugs is in significant noncompliance when compared to the prescribing patterns of his or her peers..." This provision says state program managers can overturn a doctor's instructions if the managers think a doctor is using his "dispense as written" medical authority too much when treating sick patients.

In addition, the bill would:

- Allow state program managers to immediately substitute cheaper generic drugs for doctor-prescribed medicines without first submitting the cheaper drug to review by the state's pharmacy and therapeutics committee.

- Allow state program managers to restrict a doctor's medical authority in prescribing drugs for the patient's first course of treatment of a specific illness. If the patient's condition fails to improve under the treatment required by state program managers, then the patient will be allowed to try the medicine that was first prescribed by the doctor. This "fail-first" policy prolongs the suffering of patients while state managers try to save money within their program.

- Allow state program managers to substitute a cheaper over-the-counter drug for the prescription drug ordered by the patient's doctor.

- Allow state program managers to bar a doctor from prescribing medicines for off-label use. Under this provision doctors would be forbidden from giving a medicine to a patient if the medicine's label says it was originally developed to treat a different health condition, and program manager thought the off-label use was not justified by statistical or other data.

In the practice of medicine, doctors often find that drugs, such as aspirin or other pain killers, can be used successfully to treat a variety of health conditions, far beyond their original use. This provision of the bill would prevent sick people covered by state-subsidized health programs from benefiting from this common practice.

The Medical Risks of the Mandatory Preferred Drug List Program

A Washington Policy Center study, "Treatment Denied: State Formularies and Cost Controls Restrict Access to Prescription Drugs," underscores the risks of a rigid formulary program that does not allow doctors to have the final say over medical treatments. Among the study's major findings are the following.

- **Adverse impact on vulnerable patients**. The study found that state formulary drug programs have an adverse impact on the most vulnerable patient populations, particularly the poor, the mentally ill and people living with diabetes and HIV/AIDS.

- **Reduced health care quality**. The research found that centralized control of prescription drugs

[1] Senate Bill 5892, "An act relating to authorizing state purchased health care programs...," 61st Legislature, 2009 Regular Session.

affects the quality of health treatment by shifting medical decision-making from patients and their doctors to state agency managers.

- **A "fail first" treatment policy**. Formulary regulations in many states require mental patients to "fail" on older, cheaper drugs before they are allowed access to newer and more expensive treatments.

- **Lack of performance measures**. Formulary programs were often instituted without proper trials, evaluation or safeguards. They generally avoid traditional benchmarks that identify and measure performance shortcomings.

- **Cost-driven health care**. State officials tend to over-react to costs, downgrading patient outcomes and delaying access to new treatments in an effort to control budgets.

- **"Off-label" ban**. Formulary programs often forbid "off-label" uses of new drugs, barring doctors from using new treatments in the most effective way.

- **Expected savings seldom materialize**. In Tennessee lawmakers estimated savings of 10% from formulary controls and cut public mental health funding accordingly. Expected savings never appeared, although quality of care declined for mentally ill patients.

- **Delayed access**. The study found state formulary programs can cause treatment delays, suffering and death. Local newspapers reported a death associated with the Florida program, because a patient skipped doses while waiting for approval required by state formulary regulations.

Conclusion

The result of the overly-complicated preferred drug regulation and the "fail-first" treatment policy is that sick patients who would benefit from new and promising drugs are denied access to these treatments.

The bill's ban on off-label drug use has two harmful effects. First, it denies effective treatments to patients in the name of saving money for the state. Second, it increases the inequality of treatment within health care system, because patients outside state-subsidized programs are allowed access to the full range of medical treatments recommended by their doctor, while sick people covered by state programs are not.

Without the "dispense as written" safeguard, the state's Preferred Drug List program poses a serious obstacle to the doctor/patient relationship, and places patients at risk of not receiving the medications they need to treat their unique health conditions.

Paul Guppy is Vice President for Research at Washington Policy Center, a non-partisan independent policy research organization in Seattle and Olympia. Nothing here should be construed as an attempt to aid or hinder the passage of any legislation before any legislative body.