

Testimony of

Bruce T. Roberts, R.Ph.

Executive Vice President & CEO

National Community Pharmacists Association (NCPA)

House Energy and Commerce Committee

Subcommittee on Health

Thursday, June 25th, 2009

Chairman Pallone, Congressman Deal, and Members of the Health Subcommittee, I am Bruce T. Roberts, Executive Vice President and CEO of the National Community Pharmacists Association (NCPA). I am a licensed pharmacist in the state of Virginia and former owner of a community pharmacy in Leesburg, Virginia.

NCPA represents the owners and operators of more than 23,000 independent community pharmacies in the United States. We very much appreciate the opportunity to testify before you today about the role of pharmacy in health care reform and, in particular, our views on the draft House legislation that was released last week.

In many communities throughout the United States, especially in urban and rural areas, independent community pharmacies are often the primary source of a broad range of health care products and services. These include prescription drugs and over-the-counter medications, as well as health care-related products such as diabetes testing supplies, canes, crutches, ostomy supplies and specialty compounded prescription products. Many of our pharmacies also offer free home delivery to their patients.

Incorporate Pharmacists' Services into a Reformed Health Care System

To date, the traditional role of pharmacists in the health care delivery system has been focused on safely dispensing prescription medicines. However, over the last 30 years, the role of the pharmacist has expanded from being solely a reliable dispenser of prescription products to that of provider of patient care services.

All across the country, community-based pharmacists are involved in providing a wide range of patient care programs that help to enhance the use of prescription medications and other health care products. These include medication therapy management services; immunization programs for seniors under Medicare Parts B and D; diabetes self education and training under Medicare Part B; smoking cessation and weight management programs; and other patient-centered programs. We believe that any reformed health care system should expand the availability of these programs because they can help improve quality of care and reduce health care costs.

For every dollar that the health care system spends on paying for prescription medications, we spend at least another dollar on additional health care services to treat the adverse effects of medications that are taken incorrectly or not taken at all. These include hospitalizations, physician office visits, and emergency room visits. That is an unacceptable situation which needs to be addressed.

For example, a primary cause of costly hospital readmissions is the lack of patient adherence to medications used to treat chronic medical conditions, such as hypertension and high cholesterol. Pharmacists can play an important role in post acute care settings in helping patients manage their medications through education, training, and monitoring.

We also know that pharmacists' face-to-face interventions are the most cost-effective interventions in improving health outcomes. Mirixa, a health care company that focuses on providing MTM services, recently did a study of over 10 million Medicare Part D prescription claims and found that face-to-face interventions with pharmacists about their medications help to reduce drug spending by \$34 per patient per month, or over \$400 per year. Telephone interventions and letters sent to patients were far less effective in improving medication use and reducing costs.

The draft House language appears to allow the involvement of non-physician practitioners – such as pharmacists - in the medical home pilot project. We recommend that this language be clarified and strengthened to make it clear that pharmacists should be included. Pharmacist involvement in a patient's medical home can help improve the use of prescription medications, especially in those individuals that have multiple chronic diseases.

We also believe that health insurance plans offered under the exchange should provide a comprehensive pharmacy benefit, rather than just a prescription drug benefit. This pharmacy benefit would include prescription drugs plus pharmacist-delivered medication therapy management (MTM) services. These MTM services would be provided for select individuals who take a certain number of medications for chronic illnesses, have multiple chronic medical conditions, and incur a certain level of high prescription drug spending each year.

Fix Medicaid Pharmacy Reimbursement System

NCPA very much appreciates the fact that the draft House language includes reforms to the Average Manufacturer Price (AMP)-based reimbursement system for Medicaid generic drugs. We appreciate the Committee's recognition that inadequate Medicaid pharmacy reimbursement could significantly reduce Medicaid recipients' access to prescription services from community retail pharmacies.

The bill would reset the Federal Upper Limit (FUL) for generics at 130% of the weighted average AMP, rather than 250% of the lowest AMP for a particular generic. The current language also attempts to redefine the "retail pharmacy class of trade" to assure that manufacturers only include sales prices to retail pharmacies when calculating AMP. It is important for the AMP definition to reflect only manufacturers' sales to traditional "retail community pharmacies". That is because AMP could become a benchmark for pharmacy reimbursement in Medicaid and Medicare, as well as private commercial prescription drug plans. An AMP definition that includes PBM rebates, or sales to mail order pharmacies, among others, would artificially lower the AMP and underpay retail pharmacies for prescription medications.

For most independent community pharmacies, 90 percent or more of their revenues are derived from prescription sales. Independents serve twice as many Medicaid recipients as larger pharmacies. Many independents operate pharmacies in rural and urban locations where most Medicaid recipients live. Revenues derived from Medicaid prescriptions are a critical source of revenues for independent pharmacies.

For that reason, we are concerned that Medicaid generic drug reimbursement at 130% of the weighted average AMP as proposed in the draft House bill, combined with the low dispensing fees paid by states, will, in total, still significantly underpay pharmacies for dispensing low-cost generic drugs in the Medicaid program. This could raise Medicaid costs in the long term if more higher-cost brand name drugs are dispensed. Last year, we supported H.R. 3700, the Fair Medicaid Drug Payment Act, which would have set FULs at 300% of the weighted average AMP. We believed that setting the FUL at 300% of the weighted average AMP would provide sufficient reimbursement to assure that pharmacies would be able to continue to dispense generics.

Data from the Congressional Budget Office show that FULs set at 130% of the average AMP would be significantly problematic for independent community pharmacies. The CBO found that the average AMP is equal to 68% of the acquisition cost of prescription drugs for independent community pharmacies. (*Congressional Budget Office, Prescription Drug Pricing in the Private Sector, Publication No.2703, January 2007, Table 5, p.19.*) That is, a pharmacy would only be paid 68 cents on the dollar if pharmacies were being paid at the average AMP. Therefore, just to get independent pharmacies back to their acquisition costs of purchasing prescription drugs from wholesalers, the FUL would have to be set at least at 150% of the average AMP.

Reimbursement at anything less than 150% of the weighted AMP will mean that independent community pharmacies are selling their products at a loss under Medicaid. Moreover, while Congress may only want to pay pharmacies their acquisition costs for generic medications, the reality is that state dispensing fees do not cover the costs of dispensing. Currently, the dispensing fee in every state under Medicaid is not high enough to cover the cost of dispensing, which on average is about \$10.89 per prescription. In fact, many states pay only a third or less of the actual cost of dispensing. Thus, the higher payments for the generic product help to offset low dispensing fees.

Thus, we implore Congress not to address only one side of the Medicaid pharmacy reimbursement equation. Total payment for generic medications and dispensing fees must be adequate to cover pharmacies' costs to purchase and dispense the product. For that reason, NCPA asks that the Committee consider a higher FUL reimbursement rate for generic medications, especially for critical access pharmacies that serve a higher percentage of Medicaid recipients, or rural pharmacies. We also ask that the language include a requirement that states set dispensing fees based on recent cost of dispensing surveys to assure that pharmacies can continue to dispense Medicaid generic prescriptions and keep their doors open.

Modify Pharmacy DMEPOS Accreditation Requirements

Health care reform efforts should start by reducing unnecessary and costly government regulations on health care providers, especially small providers.

For example, we believe that requiring state-licensed, state-supervised community retail pharmacies to obtain both accreditation and surety bonds to sell simple DMEPOS items such as diabetes testing supplies to Medicare beneficiaries is basically overkill.

While we understand the need to assure Medicare program integrity, thousands of pharmacies across the country – mostly small pharmacies – will not be accredited at all or not have finished the DMEPOS accreditation process by October 1st – which will mean they will not be able to provide diabetes testing supplies to Medicare beneficiaries. This is totally contrary to all the efforts being targeted at coordinating care. Medicare beneficiaries tend to obtain their prescription medications and supplies from a single source – their local community pharmacy. Disrupting their source of supply of diabetes testing supplies could result in less frequent blood glucose monitoring and higher costs for hospitalizations and physician visits to treat complications of diabetes.

We applaud the 90 bipartisan Members of the House and the 13 Members of the Energy and Commerce Committee that support H.R. 616, the bill introduced by Congressmen Berry and Moran that would exempt pharmacies from these redundant and unnecessary accreditation requirements. We also appreciate the work of Congressman Space in introducing H.R. 1970, which would exempt pharmacies from additional costly and unnecessary surety bond requirements. If there is a willingness to exempt pharmacies from these requirements, we ask that Congress consider acting before October 1st, which is the deadline for providers to attain accreditation and surety bonds.

Assure Efficient Operation of Public Health Insurance Plan Option

Under the House proposal, payment rates for prescription drugs under the public plan proposal would be negotiated by the Secretary. We have some concerns with the language as drafted. That is because, over the years, community pharmacies have had significant issues with CMS in setting adequate payment rates under Medicaid for generic drugs.

In addition, CMS has also failed to approve reasonable increases in state Medicaid pharmacy dispensing fees when reliable data showed that such increases were warranted. CMS has also been unresponsive to pharmacy concerns in situations where payment rates for generics have been too low.

For these reasons, we would be very concerned with giving authority to set payment rates for prescription drugs to the Secretary without some basic guidance as to how these rates should be established and updated.

We also ask that the language be clarified such that administration of any drug benefit under a public plan would be accomplished by a pharmacy benefits administrator (PBA) rather than a pharmacy benefits manager (PBM). We would prefer a model used by the state Medicaid programs, or the Department of Defense (DOD) TRICARE program, where an “administrator” is used, which we believe will save money for the public program. That is because under a PBA, most if not all negotiated drug manufacturer rebates would be passed through to the public program.

The public plan would also benefit because “spread pricing” would be eliminated. Under “spread pricing”, PBMs commonly charge the plan sponsor one price for a prescription, and then pay the pharmacy a lower amount for the prescription, pocketing the difference. Medicare Part D has recently prohibited this practice, known as “spread pricing”. The public plan option should fully benefit from any rebates or discounts paid by manufacturers or pharmacies, and not have part of these retained by a PBM intermediary.

With respect to any public plan option established, we also ask that standards be established for payment rates to pharmacies, including the establishment of dispensing fees, and that “any willing pharmacy” be allowed to participate in a public plan option if it is developed.

Conclusion

In conclusion, NCPA believes that the House draft is a good place to start with respect to discussions about how to reform the nation's health care system. In particular, we think there are many opportunities for pharmacists to help improve the use of prescription medications in a reformed health care system through an expansion of pharmacist-delivered medication therapy management services.

We also believe that Congress should strengthen the community pharmacy infrastructure by assuring appropriate reimbursement for Medicaid prescriptions, given that independent community pharmacies serve a much higher share of Medicaid recipients than other pharmacies.

We also ask that you allow us to continue to serve our Medicare beneficiaries with diabetes by removing the unnecessary burdens of DMEPOS accreditation and surety bonds on small businesses.

Finally, we urge Congress to build transparency and accountability into any public plan option that might be developed, and that, to maximize savings, a pharmacy benefits administrator be used rather than a pharmacy benefits manager. We look forward to working with the Congress and the Administration on reforming our nation's health care system and thank you for the opportunity to testify.