NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Statement of:
Steven C. Anderson, FASAE, CAE, IOM
President and Chief Executive Officer
National Association of Chain Drug Stores (NACDS)

For:

United States House Committee on Education & the Workforce
Subcommittee on Health, Employment, Labor, and Pensions

On:

"Lowering Costs and Increasing Access to Health Care with Employer-Driven Innovation"

January 11, 2024

National Association of Chain Drug Stores
(NACDS)
1776 Wilson Blvd., Suite 200 Arlington, VA
22209
703-549-3001
www.nacds.org

Introduction

The National Association of Chain Drug Stores (NACDS) thanks Chairman Good and Ranking Member DeSaulnier for the opportunity to submit a statement for the record for the House Committee on Education & the Workforce Subcommittee on Health, Employment, Labor, and Pensions hearing on "Lowering Costs and Increasing Access to Health Care with Employer-Driven Innovation."

NACDS greatly appreciates the Subcommittee's work to advance healthcare access, innovation, and lower costs for millions of Americans. The U.S. healthcare system incurs the highest spending and conversely yields the worst health outcomes, compared to other high-income countries.[1] This data indicates that the U.S. spends about twice as much as our peers on healthcare, with the lowest life expectancy and the highest rate of people with multiple chronic health conditions. In other words, not only are Americans living shorter lives, but they are doing so with more disease and disability.[2] To achieve superior results, the nation desperately needs new solutions and should look towards the pharmacy community.

Meaningfully modernizing our healthcare system, including overdue Pharmacy Benefit Manager (PBM) reform, will help promote transparency, prioritize health outcomes, prevent diet-related diseases, and reduce spending. Congress should leverage the unique expertise of all sectors such as pharmacy and put a stop to egregious PBM practices that have proven counterproductive to the nation's goals of lowering healthcare costs. Major PBM players have also been a key driver to the looming pharmacy crisis in America. For example, community pharmacies continue to offer undeniable scale and clinical services to profoundly improve patients' health outcomes and save downstream healthcare dollars, yet this capacity remains vastly untapped and pharmacy reimbursements from PBMs are often below-cost.

About **90% of Americans live within 5 miles of a community pharmacy**[3] and **86%** of adults report that **pharmacies are easy to access**.[4] Many pharmacies are open extended hours – including nights and weekends – when other healthcare providers are unavailable. Across populations, people visit pharmacies more often than any other healthcare setting. Moreover, **80%** of those surveyed also support pharmacists helping patients prevent chronic diseases, a top driver of healthcare costs.

When pharmacies were more fully leveraged during the recent public health emergency, pharmacy interventions averted more than 1 million deaths, prevented more than 8 million

[1] The Commonwealth Fund. U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes. January 2023, available at: https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022
[2] The Commonwealth Fund. U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes. January 2023, available at: https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022
[3] https://www.japha.org/article/S1544-3191(22)00233-3/fulltext
[4] https://accessagenda.nacds.org/dashboard/

hospitalizations, and **saved $450 billion in healthcare costs**.[5] Additionally, a recent study found that a 50% uptake of a pharmacist-prescribing intervention to improve blood pressure control was associated with **$1.137 trillion in cost savings** and could save an estimated 30.2 million life years over 30 years.[6] **This would be a cost savings of $10,162 per patient.**

The accessibility and clinical expertise of pharmacists and pharmacies lends very well to driving solutions that improve healthcare access, promote innovations, and mitigate preventable spending that results from suboptimal health outcomes. The unique footprint and infrastructure of community pharmacies should be leveraged and appropriately reimbursed to help advance healthcare solutions that prioritize outcomes, prevention, cost-savings, access, and equity. To better empower pharmacies in transforming healthcare to help meet the needs of the American people, NACDS strongly recommends the Subcommittee members consider the following:

1. **Support "Real PBM Reform" with the passage of measures like S. 2052, the Protect Patient Access to Pharmacies Act, H.R. 5400/S. 2436, the NO PBMs Act, and H.R. 1613/S. 1038, the Drug Price Transparency in Medicaid Act** as well as support broader reforms to halt the manipulative practices of Pharmacy Benefit Managers (PBMs) that continue to increase healthcare costs for patients and threaten the viability of community pharmacies to continue serving their communities, including in rural areas. PBM profits are soaring across all payer types while they make people pay more for their medicines and make it difficult for pharmacies of any size to stay open. People and communities across this country rely on their pharmacies. Many of the policies included in these measures are reflected in H.R. 5378, the *Lower Costs, More Transparency Act*, which was recently passed by the House of Representatives, and the Senate Finance Committee-approved *Better Mental Health Care, Lower-Cost Drugs, and Extenders Act*. NACDS urges swift enactment of these reforms in 2024.

2. **Support access to pharmacist services** through the successful passage of the *Equitable Community Access to Pharmacist Services Act* (H.R. 1770/S. 2477) in Medicare Part B – and consider similar opportunities to improve beneficiary access to pharmacist services within commercial health plans. HR 1770 seeks to foster Medicare beneficiary choice to access pharmacist services for common health threats, like influenza and COVID-19, building on the effectiveness and broad reach of pharmacy-based care during the pandemic, including in rural and underserved areas, that saved hundreds of billions of dollars in healthcare costs.[7]

3. **Encourage the inclusion of community pharmacies in innovative healthcare models across public and private payers,** especially in the design and implementation of value-

[5] https://pubmed.ncbi.nlm.nih.gov/36202712/
[6] Dixon DL, Johnston K, Patterson J, Marra CA, Tsuyuki RT. Cost-Effectiveness of Pharmacist Prescribing for Managing Hypertension in the United States. JAMA Netw Open. 2023;6(11).
[7] https://pubmed.ncbi.nlm.nih.gov/36202712/

based care models that seek to explore opportunities to expand healthcare access, advance healthcare outcomes, and promote healthcare savings.

1. PBM Reform

PBMs' opaque and self-serving business practices, including their abuse of pharmacy performance measures in the Medicare Part D program, lead to inflationary effects on drug prices, restrictions on patient access, and unfair and below-cost pharmacy reimbursement. The ability of pharmacies to provide prescription medications and related care to patients is often controlled and manipulated by the three largest vertically integrated PBM insurers, which threatens America's frontline of care at pharmacies and the patients who rely on them for care and access.

America's pharmacies have been struggling with reimbursement challenges for decades, due to or exacerbated by the absence of oversight and understanding of the competition-eroding practices of PBMs that impact timely patient access, pharmacy sustainability, and pharmacy's innovative vision to empower patients' total health and wellness. As illustrated by MedPAC, Medicare Part D's direct and indirect remuneration (DIR) fees, or fees that PBMs claw back from pharmacies weeks or months after they pay pharmacy claims, skyrocketed from $8.7 billion (11%) in 2010 to $62.7 billion (29%) in 2021, which is in part due to the expanded market leverage of PBM-insurers and a non-transparent pharmaceutical supply chain. As we've seen historically, these challenges could lead to beneficiary non-adherence, financial harm to beneficiaries, downstream hospitalizations resulting in increased healthcare costs, and more pharmacy closures.

NACDS applauds Chairman Good and Ranking Member DeSaulnier for prioritizing this bipartisan issue of PBM reform this Congress and for your continued commitment to fight for transparency and competition to lower costs for Americans. Comprehensive PBM reform is needed to help our healthcare system innovate, lower costs, and instill increased transparency and accountability for PBMs. This will help ensure there is a future for pharmacies nationwide and foster heightened access to care and improved health outcomes for the patients they serve.

The Pharmacy Benefit Manager Marketplace and Impact on Pharmacies

Prescriptions filled by patients who are paying cash without any form of insurance or discount card account for only about 3% of the total volume of prescriptions.[8] While approximately 91% of prescriptions filled have a payment component coming from Medicare Part D, Medicaid, or a commercial insurance plan, these plans are ordinarily administered by PBMs. The top three PBMs manage about 80% of prescription drug volume.[9] Five of the top six PBMs are owned by large national health insurers. This business environment makes it very difficult for pharmacies to negotiate fair business practices and transparency because the PBMs and health insurers have more commercial market power and leverage in the relationship due to their size and scale. This creates a one-way street with negative consequences for patients, pharmacies,

[8]Source: IQVIA, National Prescription Audit & RxInsight, June 2022; Approximately 5.4% of patients use a discount card to assist with payment.
[9]https://www.xcenda.com/insights/skyrocketing-growth-pbm-formulary-exclusions-concerns-patient-access

employers, taxpayers, and communities – seemingly for all but the PBMs and payers.

Retail pharmacies are in a crisis, facing unsustainable financial pressures as they are increasingly reimbursed by payers below the cost of buying and dispensing prescription drugs. Dire financial pressures have forced an alarming number of pharmacies to take drastic steps, such as possibly paring back hours of operation and delaying innovative care services that otherwise could improve health outcomes and reduce costs. PBMs' retroactive fees and claw backs often occur weeks or months after a transaction closes, when the PBM arbitrarily decides to recoup a portion of the pharmacy's reimbursement. These fees and claw backs have made the economic viability of community pharmacies increasingly difficult, due to the unpredictability of reimbursement and the increased damage to bottom lines.

It is important to examine pre-COVID pharmacy closures. According to IQVIA, between December 2017 and December 2020, almost 2,200 pharmacies closed nationwide.[10] There has also been approximately an additional 1,500 retail pharmacy closures between December 2020 and September 2023, per IQVIA, which means fewer healthcare access points (e.g., vaccinations, MTM, diabetes management) for Americans. Some of the PBMs' manipulation of pharmacies was partially abated during the pandemic; however, the ominous situation for pharmacies now is worse than ever before.

The epidemic of pharmacy closures is reducing access to vital healthcare services, especially in rural areas where options are already limited. Communities across the nation depend on neighborhood pharmacies among all healthcare destinations. A recent study published in the Journal of the American Medical Association also found that pharmacy closures led to a significant drop in medication adherence for older adults taking cardiovascular medications, which has obvious implications for patient health and healthcare costs. Preserving patient access to robust pharmacy provider services and networks like health screenings, disease state management, vaccinations (e.g., flu, COVID-19), patient counseling, medication adherence, and testing— all in addition to essential medication access — can help improve health outcomes and generate overall healthcare savings for Americans.

We look forward to continuing to work with the Subcommittee and other Members of Congress to stop the manipulation by PBMs both domestically and internationally once and for all because the clock is ticking. Without PBM reform, we can expect there to be continued increases in patients' medication costs, limits on patients' choice of pharmacies, restrictions on access to medicines that are right for patients and jeopardy of the sustainability of the pharmacies and pharmacy teams on whom patients rely.

To that end, please see below **NACDS' Principles of PBM Reform** to increase transparency and ensure comprehensive reform of harmful PBM tactics and practices:

I. Help to Preserve Patient Access to Pharmacies by Addressing PBM's Retroactive Pharmacy Fees

[10] IQVIA Data, 2020. Closures disproportionately impacted rural areas.

Retroactive DIR Fees/Claw Backs – Pharmacy access can be undermined when health plans and their middlemen, PBMs, arbitrarily "claw back" fees retroactively from pharmacies weeks or months after a claim has been adjudicated/processed. This manipulation of pharmacy reimbursements may diminish access to care *(e.g., pharmacies being forced to close their doors or pare back hours and healthcare services)* when PBMs are unpredictable, not transparent, and payment falls below a pharmacy's costs to acquire and dispense prescription drugs. Policymakers should consider enacting laws that prohibit payers or PBMs from retroactively reducing and/or denying a processed pharmacy drug claim payment and obligating them to offer predictable and transparent pharmacy reimbursement to better protect pharmacies as viable and reliable access points of care for patient services.

II. Provide Fair and Adequate Payment for Pharmacy Patient Care Services

Reasonable Reimbursement & Rate Floor – Pharmacy access remains at risk when PBMs reimburse pharmacies below the cost to acquire and dispense prescription drugs. Pharmacy reimbursement that falls below the costs to acquire and dispense prescription drugs threatens future sustainability for pharmacies to continue providing valuable medication and pharmacy care services to communities. Policymakers should enact laws to adopt a reimbursement rate floor that requires PBMs to use comprehensive reimbursement models that are no less than the true cost to purchase and dispense prescription drugs to help maintain robust public access to pharmacies.

Standardized Performance Measures – A crucial part of comprehensive DIR fee reform is advancing pharmacy quality that improves outcomes for beneficiaries and drives value in care which are essential to controlling costs in the healthcare system. Arbitrary performance measures developed by PBMs assess the performance of the pharmacy without pharmacies' input and create a moving target for pharmacies to show value and improve health outcomes. Measures vary across the various plans and dictate DIR fees (or claw backs at the State level) imposed on pharmacies, as well as help create substantial system dysfunction and unnecessary spending in the Part D program. Policymakers should enact laws to standardize PBM's performance measures for pharmacies to help set achievable goals for pharmacies before signing a contract to promote harmonization in the healthcare system and improvements in health outcomes.

III. Protect Patient Choice of Pharmacies

Specialty – Some PBMs require patients with rare and/or complex diseases to obtain medications deemed "specialty drugs" from designated "specialty pharmacies" or mail-order pharmacies which impedes patient access to their convenient local neighborhood pharmacies where specialty drugs are filled as well. Prescription drugs should not be classified as "specialty drugs" based solely on the cost of the drug or other criteria used to limit patient access and choice—instead, should focus on clinical aspects such as requiring intensive clinical monitoring. Policymakers should enact laws to establish appropriate standards for defining and categorizing specialty drugs to ensure comprehensive and pragmatic patient care and access and prohibit PBMs from steering patients to only specialty pharmacies, including those owned by the PBMs, for their

prescription needs.

Mail Order – Medication access and care can be weakened when PBMs manipulate the system by requiring patients to use mail-order pharmacies only. Some plans impose penalties such as higher copays or other financial disincentives for choosing a retail pharmacy instead of a mail-order pharmacy which is often owned by the PBM. Policymakers should support patient choice and access by enacting laws to prohibit PBMs from requiring or steering patients to use mail-order pharmacies.

Any Willing Pharmacy - Due to PBMs' network and contract barriers, pharmacies willing and ready to serve patients may be ineligible to provide important pharmacy services and patients may experience unnecessary delays and interruptions in patient care. Patients should have the choice and flexibility to utilize the pharmacy that best meets their healthcare needs. Policymakers should enact laws that require PBMs and plans to include any pharmacies in their networks if the pharmacy is willing to accept the terms and conditions established by the PBM to help maximize patient outcomes, and cost savings and ensure patient access to any willing pharmacy of their choice.

IV. Enforce Laws to Stop PBM Manipulation and Protect Pharmacies and Patients

Audits – PBMs routinely conduct audits to monitor a pharmacy's performance and reverse or claw back pharmacy payments when there are alleged issues with a particular pharmacy claim. PBM audits interrupt the pharmacy workflow, can extend wait times, and detract attention from the quality of care patients receive. Policymakers should enact laws that support fair pharmacy audit practices to ensure timely patient care delivery at community pharmacies and bring efficiency, transparency, and standardization to the PBM audit process.

Oversight Authority – There are growing concerns that pro-pharmacy and pro-patient legislative successes might be undercut if PBMs fail to comply with such laws and/or states fail to fully enforce these laws. Such failure could significantly impact pharmacy reimbursement and overall patient access. Policymakers should establish and enforce laws already on the books to regulate harmful PBM reimbursement practices that may harm patients and the healthcare system as we know it, especially at the pharmacy counter, and empower state regulators to do the same to enforce PBM transparency and fair and adequate pharmacy reimbursements.

2. Support Access to Pharmacist Services

Despite their proven ability to improve health outcomes and save downstream healthcare dollars, today, pharmacists are among the only healthcare professionals omitted from Medicare statute as Part B providers – and this issue also permeates the commercial health plan space as well. Consequently, pharmacists' accessibility and clinical expertise have been largely untapped in promoting better care quality, value, and access, including in rural and underserved communities. Bipartisan legislation (H.R. 1770/S. 2477) would help address this omission in Medicare by

providing payment for essential pharmacist services under Medicare Part B and ensure pharmacists can continue to protect vulnerable senior communities. As mentioned above, pharmacy interventions during the COVID-19 pandemic averted more than 1 million deaths, prevented more than 8 million hospitalizations, and saved $450 billion in healthcare costs.[11] This legislation builds on that proven success and would help support Medicare beneficiaries with the option to seek low-acuity care for common illnesses from their local pharmacies helps enhance access and quality, in a manner that meaningfully supplements existing care capacity in a tangible and cost-effective way. Consider, for example, individuals who may benefit from having additional access options and the choice to seek low-acuity care services at their local pharmacies, instead of foregoing care until their condition worsens and ultimately leads to a costly hospital visit that could have been avoided. Congress can help the nation achieve a healthier and more sustainable healthcare system, prioritizing access, outcomes, and value by supporting the successful passage of H.R. 1770 and the Subcommittee should consider opportunities to support access to pharmacist services across commercial health plans as well.

Throughout the COVID-19 public health emergency, pharmacies were a trusted, equitable provider of vaccinations, tests, and antivirals, providing more than 307 million COVID-19 vaccines, in addition to more than 42 million tests, and dispensing more than 8 million antiviral courses.[12] Compared to medical centers, pharmacies provided more than 90% of COVID-19 vaccinations, excluding temporary and government public health sites.[13] During 2022-2023, more than two-thirds of adult COVID-19 vaccinations were administered at pharmacies.[14] With respect to testing, pharmacies provided 87% of the free tests administered through the Improving Community Access to Testing (ICATT) program.[15] Similarly, in considering pharmacies' impact on antiviral access, HHS reported that 87.5% (35,000 of the 40,000) antiviral dispensing sites are pharmacies.[16] Pharmacies unequivocally demonstrated their ability to meaningfully expand critical access to care across vulnerable communities during the COVID-19 pandemic, and the American people have taken notice. According to a poll conducted by Morning Consult and commissioned by NACDS in December of 2022, 64% of adults agree that learning the lessons of the pandemic means keeping in place policies that make it easier for patients to access services from pharmacists and other pharmacy team members.[17]

Not only did pharmacies provide unparalleled access to COVID-19 vaccines, tests, and antivirals, pharmacies surpassed expectations when it came to serving vulnerable and underserved communities. For example, 43% of people vaccinated through the Federal Retail Pharmacy

[11] https://pubmed.ncbi.nlm.nih.gov/36202712/
[12] https://www.liebertpub.com/doi/10.1089/hs.2023.0085
[13] https://www.iqvia.com/insights/the-iqvia-institute/reports/trends-in-global-adult-vaccination
[14] https://www.liebertpub.com/doi/10.1089/hs.2023.0085
[15] Miller MF, Shi M, Motsinger-Reif A, Weinberg CR, Miller JD, Nichols E. Community-based testing sites for SARSCoV-2 — United States, March 2020–November 2021.MMWR Morb Mortal Wkly. 2021;70(49):1706-1711.
[16] US Department of Health and Human Services. https://www.hhs.gov/about/news/2023/04/14/factsheet-hhs-announces-amend-declaration-prep-act-medical-countermeasuresagainst-covid19.html
[17] https://accessagenda.nacds.org/dashboard/

Program were from racial and ethnic minority groups, exceeding CDC's goal of 40% — the approximate percent of the U.S. population comprised of racial and ethnic groups other than non-Hispanic White.[18] Pharmacies also supported concerted efforts to foster testing and antiviral access in vulnerable and rural communities, helping to ensure access points across diverse populations, especially in those communities without other healthcare providers within reach.

We urge the Subcommittee to leverage community pharmacies moving forward to help achieve your goals to improve health and lower downstream spending, including in rural and underserved areas. It is clear that the American people deserve more accessible options to improve their health, including access to the clinical care and expertise of their local pharmacist that proved irreplaceable over the last three years. The Subcommittee can help make better health and lower downstream costs a reality by supporting the successful passage of the *Equitable Community Access to Pharmacist Services Act* (H.R. 1770/S. 2477). More information on this important legislation is available from the Future of Pharmacy Care Coalition here.

3. Encourage the Inclusion of Community Pharmacies in Innovative Healthcare Models

Healthcare payment model reform to reward value-based care, better quality, and improved clinical outcomes can help align incentives toward what really matters - better health, while lowering unnecessary and preventable costs for our healthcare system. However, despite a multitude of research examples and published literature on the value of pharmacies and pharmacists to improve health outcomes through clinical services and save downstream healthcare dollars, pharmacists and pharmacies have yet to be directly engaged as care providers in the existing CMS Innovation Center's value-based care models and further opportunities exist to engage pharmacies in value-based care across commercial payers, as well. NACDS urges the Subcommittee to consider opportunities for commercial plans to include pharmacists and pharmacies in innovative healthcare models, including value-based care. More detail on the tremendous value of including pharmacies in the CMS Innovation Center's work, for example, to advance value-based care can be found in a 2021 report available here.

The 2021 report highlights a myriad of evidence supporting the clinical effectiveness of pharmacists to move the needle on healthcare quality, outcomes, and value, including in rural and underserved populations. For example, a CMS Innovation Center-funded, pharmacy-led chronic care management initiative was designed to serve an underserved population. This initiative aimed to optimize patient health and reduce avoidable hospitalizations and emergency visits for high-risk patients by integrating pharmacists into safety net clinics. This collaborative program resulted in reduced rates of uncontrolled blood sugar by nearly a quarter (23%), improvements in LDL with 14% more patients controlled, and improvements in blood pressure with 9% more patients controlled at 6 months in the intervention group (collaborative care model with

[18] https://www.gao.gov/assets/720/718907.pdf

pharmacists as leads) versus the control group (primary care physicians only). Through this project, pharmacists identified 67,169 medication-related problems in 5,775 patients, which resulted in a 33% reduction in readmissions per patient per year.[19]

Additionally, pharmacists as medication experts are positioned to help reverse increased spending attributable to suboptimal medication use and promote better health outcomes. For example, it was estimated that up to $21.9 billion could be saved within the U.S. healthcare system by optimizing medication use.[20] Also, it has been estimated that lack of medication adherence causes 125,000 deaths, at least 10% of hospitalizations, and hundreds of billions of preventable healthcare spending.[21] Healthcare spending on non-optimal medication therapy is estimated at **$528.4 billion per year**[22] and medication non-adherence is estimated to cost the system **$290 billion** per year.[23] Importantly for Medicare beneficiaries, it was recently estimated that medication nonadherence for diabetes, heart failure, hyperlipidemia, and hypertension resulted in billions of Medicare fee-for-service expenditures, millions in hospital days, and thousands of emergency department visits that could have been avoided. If the 25% of beneficiaries with hypertension who were nonadherent became adherent, Medicare could **save $13.7 billion annually**, **with over 100,000 emergency department visits prevented and 7 million inpatient hospital days that could be averted**.[24] Pharmacists can help curb these wasteful spending trends and improve health more broadly.

Also, looking across quality measures used in existing CMS programs, pharmacists are well positioned to help address a wide variety of quality measures by optimizing medication use, improving uptake of preventive care, like screenings and vaccinations, and supporting improvements in chronic disease control. Research continues to support pharmacists' ability to meaningfully impact these priority clinical areas, yet pharmacies and pharmacists have not had the opportunity to directly engage in the CMS Innovation Center's models, and opportunities exist to further leverage pharmacies in innovative healthcare models across private payers, as well.

The subcommittee should act on opportunities to improve outcomes, advance access, and reduce

[19] Chen SW. Comprehensive Medication Management (CMM) for Hypertension Patients: Driving Value and Sustainability. University of Southern California. http://betheresandiego.org/storage/files/cmm-for-htn-usc-steven-chen-condensed-slide-deck.pdf ; Chen SW. Integration of Pharmacy Teams into Primary Care. The Center for Excellence in Primary Care and the Center for Care Innovations. May 2015. https://www.careinnovations.org/wp-content/uploads/2017/10/USC.CEPC_.pharm_webinar_FinalV.pdf

[20] Shrank WH, Rogstad TL, Parekh N. Waste in the US Health Care System: Estimated Costs and Potential for Savings. JAMA. Published online October 07, 2019322(15):1501–1509. doi:10.1001/jama.2019.13978

[21] Viswanathan M, Golin CE, et al. Interventions to Improve Adherence to Self-Administered Medications for Chronic Diseases in the United States: A Systematic Review. Ann Intern Med. 2012. https://annals.org/aim/fullarticle/1357338/interventions-improve-adherence-self-administered-medications-chronic-diseases-united-states

[22] Watanabe JH, McInnis T, Hirsch JD; "Cost of Prescription- Drug Related Morbidity and Mortality;" Annals of Pharmacotherapy; March 26, 2018. http://journals.sagepub.com/doi/10.1177/1060028018765159

[23] Rosenbaum L, Shrank WH; "Taking Our Medicine - Improving Adherence in the Accountability Era;" New England Journal of Medicine; August 22, 2013. Shrank WH, Polinski JM; "The Present and the Future of Cost-Related Non-Adherence in Medicare Part D;" J Gen Intern Med 30(8):1045–6.

[24] Lloyd, Jennifer T., Maresh, Sha, Powers, Christopher, Shrank, WH, Alley, Dawn E; "How Much Does Medication Nonadherence Cost the Medicare Fee-for-Service Program?"; Medical Care; January 2019.

preventable healthcare spending by leveraging community pharmacies in innovative healthcare models across public and private payers. Doing so would not only strengthen development of innovative care models, but would also support needed advancements in healthcare access, including in rural areas, in addition to healthcare technology and data interoperability.[25]

Conclusion

NACDS thanks the Subcommittee for the opportunity to share ideas on how Congress can help meaningfully advance healthcare access, innovation, and lower costs. As PBMs attempt to run out the clock on real PBM reform, we urge the Subcommittee to continue to keep this bipartisan healthcare matter top of mind this Congress to help protect Americans and their pharmacies. For collaboration, questions, or further discussion, please contact NACDS' Christie Boutte, Senior Vice President, Reimbursement, Innovation and Advocacy at CBoutte@nacds.org or 703-837-4211.

[25] https://leavittpartners.com/wp-content/uploads/2023/04/Pharmacy-Data-Interoperability-04.03.23.pdf