NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Statement

Of

The National Association of Chain Drug Stores

For

United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

On

Making Prescription Drugs More Affordable: Legislation to Negotiate a Better Deal for Americans

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1) Introduction

The National Association of Chain Drug Stores (NACDS) thanks Chairwoman Eshoo, Ranking Member Burgess, and the Members of the Subcommittee on Health for the opportunity to submit a statement for the hearing on "Making Prescription Drugs More Affordable: Legislation to Negotiate a Better Deal for Americans."

NACDS and the chain pharmacy industry are committed to partnering with Congress, HHS, patients, and other healthcare providers to find solutions to lower the cost of prescription drugs and improve access to quality, affordable healthcare services. NACDS represents traditional drug stores, supermarkets and mass merchants with pharmacies. Chains operate over 40,000 pharmacies, and NACDS' over 80 chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ nearly 3 million individuals, including 157,000 pharmacists. They fill over 3 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 900 supplier partners and over 70 international members representing 21 countries. Please visit nacds.org.

As a key stakeholder in the drug supply chain, community pharmacists have for generations been trusted, highly accessible healthcare providers deeply committed to providing accurate prescriptions and helping patients take medications as prescribed. Community pharmacists provide a critical role in the continuum of care for patients. Importantly, not only do pharmacist interventions improve patient health and outcomes, but also pharmacy care has been shown to save downstream health care dollars. As the Subcommittee explores policies to lower the cost of prescription drugs, we offer the following recommendations we believe will help achieve that goal while improving patient health.

2) Lowering Costs and Improving Health Through Pharmacy DIR Reform

NACDS strongly urges the Committee to include pharmacy direct and indirect remuneration (DIR) reform as part of any legislative package it advances. Pharmacy DIR fee reform is designed to close a Part D loophole that allows plans and their pharmacy benefit managers (PBMs) to levy DIR fees on pharmacies resulting in artificially inflated drug prices for Medicare beneficiaries, and for the retroactive claw back of reimbursement from pharmacies months or even years after the pharmacy claim was initially paid. Thus, DIR fees adversely affect beneficiaries, pharmacies, and Medicare.

DIR fees artificially inflate out-of-pocket costs for seniors, making it harder for them to afford their medication, which ultimately puts them at risk for deteriorating health. Beneficiary access to prescription drugs is further jeopardized as community pharmacies are being forced out of business because of excessive and unjust use of DIR fees against pharmacies.

The U.S. Department of Health and Human Services (HHS) has thoroughly documented how these DIR fees unfairly increase beneficiary drug costs and increase taxpayer costs for catastrophic coverage and low-income cost-sharing subsidies.[1] HHS recognizes that pharmacy DIR fees harm beneficiaries by reducing competition and transparency, thus hindering beneficiaries' abilities to make informed decisions about how to best meet healthcare needs. CMS stated:

> consumers cannot efficiently minimize both their costs and costs to the taxpayers by seeking and finding the lowest-cost drug or a plan that offers them the lowest-cost drug and pharmacy combinations.[2]

CMS further stated that:

> the quality of information available to consumers is even less conducive to producing efficient choices when pharmacy price concessions are treated differently by different Part D sponsors; that is, when they are applied to the point-of-sale price to differing degrees and/or estimated and factored into plan bids with varying degrees of accuracy.[3]

Importantly, HHS concluded that reforming pharmacy price concessions would lead to overall beneficiary savings of $7.1 to $9.2 billion over 10 years by substantially reducing prescription drug cost sharing. [4]

Pharmacy DIR reform will also lead to savings for taxpayers from improved medication adherence and behavioral changes by Part D plans and PBMs to keep premiums low.[5] Pharmacy DIR reform will improve medication adherence by making prescription drugs more affordable for beneficiaries through lower cost-sharing, which in turn will help reduce the costs associated with non-adherence—that is, patients not taking their medications as prescribed by their healthcare provider. Medication non-adherence contributes to $100-290 billion in unnecessary healthcare expenditures every year as a result of increased hospitalizations and other avoidable, expensive medical services.[6,7,8]

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[1] 83 Fed. Reg. 62152, 62190-92 (Nov. 30, 2018).
[2] *Id.* at 62176.
[3] *Id.*
[4] *Id.* at 62192-3.
[5] In 2018, the consulting firm Milliman reviewed a CMS proposal to include all pharmacy price concessions and half of manufacturer rebates in negotiated prices at the point-of-sale and found that not only would they likely have a positive effect on medication adherence, which would result in lower healthcare costs through overall improved health, but that they would produce additional savings through changes in plan behavior. Milliman found that "the net impact of potential behavioral changes could be to reduce spending for all stakeholders, with overall government savings of $8 to $73 billion over ten years." The conclusion was that Part D plans compete for beneficiaries based on premiums and will work to reduce or eliminate potential increases in premiums, such as through better utilization of generic medications, when appropriate. (Milliman, "Reducing Part D Beneficiary Costs Through Point-of-Sale Rebates" (January 16, 2018).)
[6] Rosenbaum L, Shrank WH; "Taking Our Medicine - Improving Adherence in the Accountability Era;" *New England Journal of Medicine*; Aug. 22, 2013
[7] Network for Excellence in Health Innovation; "Bend the Curve: A Health Care Leader's Guide to High Value Health care;" 2011.
[8] The NCPIE Coalition; "Enhancing Prescription Medicine Adherence: A National Action Plan;" 2007.

Numerous studies have shown a direct correlation between higher medication costs and lower medication adherence.[9] A recent study found that medication nonadherence for diabetes, heart failure, hyperlipidemia, and hypertension resulted in billions of dollars in Medicare fee-for-service expenditures, millions of hospital days, and thousands of emergency department visits that could have been avoided.[10] Specifically, the study estimated that avoidable costs from medication nonadherence of four chronic conditions is $28.9 billion, representing 31 percent of the total Part D expenditures. The study further found that if the 25% of beneficiaries with hypertension who were nonadherent became adherent, Medicare could save $13.7 billion annually, and could avoid 100,000 emergency department visits and 7 million inpatient hospital days.[11] A number of other studies have found similar results[12] that improving medication adherence lowers overall medical costs, which will save taxpayers money through lower overall Medicare costs.

Ensuring access to prescription drugs at local, community pharmacies is especially vital. A 2019 study found that older adults filling prescriptions for statins, beta blockers, or oral anticoagulants at pharmacies that closed experienced an immediate statistically and clinically significant decline in adherence during the first 3 months after closure compared with their counterparts. That difference persisted over 12 months and was greater among older adults living in neighborhoods with fewer pharmacies.[13] Medicare Part D DIR is forcing pharmacies out of business, and beneficiaries are paying the price through higher out-of-pockets costs and worsening health. Since 2011, there has been a net loss of over 4,000 pharmacies nationwide due to pharmacies being forced to close, many of these in rural areas with only a single pharmacy store for miles.[11] These closures have left many without access to a nearby pharmacy and are jeopardizing their health.

Without DIR reform, we can expect the situation for beneficiaries and taxpayers to continue to worsen. The use of pharmacy DIR fees has increased exponentially over the past decade and is expected to continue growing in the coming years. HHS recently found that DIR fees have grown 45,000 percent since 2010 and the use of performance-

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[9] A literature review of 160 studies revealed that an increase in patient share of medication costs is directly associated with a significant decrease in medication adherence. (Eaddy MT, et al; "How Patient Cost-Sharing Trends Affect Adherence and Outcomes;" *Pharmacy & Therapeutics*; January 2012. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3278192/).

[10] 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.

[11] *Id.*

[12] A 2017 white paper found that the direct medical costs and consequences related to not taking medication as prescribed is estimated to be 7 to 13 percent of national health spending annually—approximately $250 billion to $460 billion in 2017, translated to a potential cost to taxpayers of $6 trillion over 10 years. ("A Treatable Problem: Addressing Medication Nonadherence by Reforming Government Barriers to Care Coordination;" *Prescriptions for a Healthy America*; October 2017.) And a 2016 cost-benefit analysis concluded that between one and two thirds of medicine related hospitalizations are caused by poor adherence. Improving adherence could result in annual per-person savings ranging from $1,000 to $7,000, depending on the disease state. (Patterson JA, et al; "Cost-Benefit of Appointment-based Medication Synchronization in Community Pharmacies;" *American Journal of Managed Care*; 2016.)

[13] Qato DM, Alexander GC, Chakraborty A, Guadamuz JS, Jackson JW; "Association Between Pharmacy Closures and Adherence to Cardiovascular Medications Among Older US Adults."; *JAMA;* April 19, 2019.

[11] NCPDP Pharmacy Provider File and NACDS Economics Department. July 1, 2019.

based pharmacy price concessions increased, on average, nearly 225 percent per year between 2012 and 2017 and now comprise the second largest category of DIR received by sponsors.[12] Relief is needed for both beneficiaries and struggling pharmacies.

Closing this loophole that allows Medicare Part D plans and PBMs to continue to unjustly harm beneficiaries, taxpayers, and pharmacies through the use of DIR fees is way overdue; a fact that has recognized by members of this Subcommittee. In June of this year, 105 members of the House of Representatives sent a letter to President Donald Trump noting the "missed opportunity" to reduce seniors' out-of-pocket costs for prescription drugs when pharmacy DIR fee reform was excluded from a recent Medicare rule. The legislators, including one-third of the House Energy and Commerce Committee's majority members, urged the administration to finalize pharmacy DIR reform this year. Similarly, the Senate Finance Committee, led by Chairman Chuck Grassley (R-IA) and Ranking Member Ron Wyden (D-OR) sent a letter to the Administration urging HHS to use its regulatory authority to reform pharmacy DIR for plan year 2021.

NACDS strongly urges members of this Subcommittee to build upon this momentum and take action to address pharmacy DIR fees by supporting the *Phair Pricing Act of 2019* (H.R. 1034), sponsored by Representative Doug Collins R-GA), and co-sponsored by Energy and Commerce Committee members Lisa Blunt Rochester (D-DE), Dave Loebsack (D-IA), Peter Welch (D-VT), Buddy Carter (R-GA), Morgan Griffith (R-VA), David McKinley (R-WV), and Cathy McMorris Rodgers (R-WA).

The *Phair Pricing Act of 2019* will make much needed reforms in the use of pharmacy DIR fees by prohibiting PBMs from imposing retroactive pharmacy DIR fees, establishing a standardized quality metrics system in Medicare Part D, and establishing an audit system for pharmacies to report when they are reimbursed below cost. These reforms will lower out-of-pocket costs for Medicare beneficiaries, provide taxpayer relief, and serve as a lifeline for pharmacies struggling to stay open.

3) A Focus on Standardized Pharmacy Quality Reduces Healthcare Costs

Along with pharmacy DIR fee reform, the development of standardized pharmacy quality metrics and a corresponding pharmacy focused incentive program will save taxpayers billions of dollars by aligning incentives for the entire Medicare program. A pharmacy quality incentive program will encourage a more systematic investment in pharmacy quality designed to facilitate care coordination, reduce medical errors, advance population health, and empower and motivate beneficiaries to achieve better health outcomes through improved medication adherence, which as noted above, dramatically affects total cost of care.

A standardized pharmacy quality incentive program will also achieve savings and better health outcomes through better access to medication optimization services. These services are focused on the patient and encompass activities that improve health outcomes by addressing medication appropriateness, effectiveness, safety, adherence,

[12] 83 Fed. Reg at 62190-1.

and access. Medication optimization services delivered by community pharmacies are central to the care of beneficiaries. With nearly all Americans (91.7 percent) living within 5 miles of a community retail pharmacy, improving access to such face-to-face interactions are critical to achieving national-scale improvements in health outcomes and lowered costs.[14]

We urge members of the Subcommittee to support policies and legislation that promote better medication adherence and health outcomes through the development of pharmacy-specific quality metrics and a pharmacy quality incentive program.

4) Conclusion

NACDS thanks the Subcommittee for your consideration of our comments. We urge members of the Subcommittee address pharmacy DIR fee reform by supporting the *Phair Pricing Act of 2019* and by introducing legislation creating standardized pharmacy quality metrics and a pharmacy quality incentive program.

[14] Patients who participated in brief face-to-face counseling sessions with a community pharmacist at the beginning of statin therapy demonstrated greater medication adherence and persistency than a comparison group who did not receive face-to-face counseling. The intervention group had statistically greater Medication Possession Ratio (MPR) than the control group every month measured. (Taitel M, Jiang J, Rudkin K, Ewing S, Duncan I; "The impact of pharmacist face-to-face counseling to improve medication adherence among patients initiating statin therapy;" *Patient Prefer Adherence;* 2012;6:323-9. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3340117/.) Likewise, a systematic review was conducted using 51 studies determining the optimal modes of delivery for interventions to improve adherence to cardiovascular medications. Among person-dependent interventions (nonautomated phone calls, in-person interventions), phone calls showed low success rates (38%). In-person pharmacist interventions were effective when held in a pharmacy (83% successful) but were less effective in clinics (38%). (Cutrona SL, Choudhry NK, et al; "Modes of Delivery for Interventions to Improve Cardiovascular Medication Adherence;" *AJMC*; December 2010. https://www.ajmc.com/journals/issue/2010/2010-12-vol16-n12/ajmc_10dec_cutrona929to942?p=1)