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For:
United States House Committee on Energy and Commerce
Subcommittee on Health

On:
"Health Care Spending in the United States: Unsustainable for Patients, Employers, and Taxpayers"

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Introduction

The National Association of Chain Drug Stores (NACDS) thanks Chairman Guthrie, Vice Chair Bucshon and Ranking Member Eshoo for the opportunity to submit a statement for the record for the House Committee on Energy and Commerce Subcommittee on Health on "Health Care Spending in the United States: Unsustainable for Patients, Employers, and Taxpayers."

NACDS represents traditional drug stores, supermarkets and mass merchants with pharmacies. Chains operate 40,000 pharmacies and NACDS' member companies include regional chains, with a minimum of four stores, and national companies. Chains employ nearly 3 million individuals, including 155,000 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 health care affordability. NACDS members also include more than 900 partners and over 70 international members representing 21 countries.

NACDS applauds the Subcommittee's efforts to advance policies that improve healthcare access and lower costs for millions of Americans. Specifically, NACDS appreciates the successful efforts to advance Pharmacy Benefit Manager (PBM) reforms that align with the NACDS Principles for PBM Reform; reforms that will help ensure patent access to pharmacy services by providing reasonable pharmacy reimbursement, require the establishment of standardized pharmacy quality measures, and increase PBM transparency for patients and pharmacies. Most notably, we were pleased to see the passage of H.R. 5378, the *Lower Costs, More Transparency Act* on December 11, 2023. The reforms provided by H.R. 5378, along with those that have advanced through the Senate Finance Committee, will make substantial progress in providing sustainability and predictability to the pharmacists and pharmacies providing quality patient care in communities throughout the nation.

While the nation's largest PBMs are working to run out the clock on real legislative reform, NACDS urges Congress to finish the job and swiftly enact bipartisan Medicare Part D and Medicaid PBM reforms. The reforms that have been the subject of extensive Congressional examination and bipartisan agreement will significantly mitigate the effects of rapidly deteriorating Medicare Part D pharmacy reimbursements that, as of January 2024, are taking many pharmacies even further below cost for the prescriptions that they fill every day. This untenable situation of decreasing reimbursement combined with lingering pharmacy DIR fees is putting patient access and pharmacies in jeopardy and leading to higher healthcare costs for patients. Immediate enactment of real PBM reforms in Medicare and Medicaid will maintain patient access to pharmacy and bring much needed fairness, transparency, accountability and sustainability to the healthcare system while reducing patient and federal spending.

In 2023, four committees in the House of Representatives and four committees in the Senate held hearings, advanced legislation, or launched investigations into PBM practices. Today, even as Congress continues efforts to enact PBM reforms, a bipartisan group of 14 Senators joined to urge the Federal Trade Commission (FTC) to complete its own extensive study into PBM business

practices and their consequences for Medicare access and affordability. In the commercial prescription insurance market, employers are increasingly choosing PBM alternatives to reduce costs. One major employer in the Fortune 100 just announced it will drop its PBM for its 175,000 employees to reduce costs. These actions serve to underscore the responsibility that Congress and the current Administration have to protect Medicare and Medicaid beneficiaries as well as taxpayers from the costs associated with PBM practices.

In spite of the threats to pharmacy viability posed by PBM practices, 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 underutilized when it comes to providing healthcare services at lower costs. Today, about **90% of Americans live within 5 miles of a community pharmacy**[1] and **85%** of adults report that **pharmacists are easy to access –** making them the highest rated healthcare destinations in this category.[2] 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, **73%** of those surveyed also support pharmacists helping patients prevent chronic diseases, a top driver of healthcare costs. Yet one must ask today what would be lost if PBM tactics fray further the fabric of trusted, convenient, and reliable pharmacy teams who have served as the face of neighborhood healthcare.

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 hospitalizations, and **saved $450 billion in healthcare costs**.[3] 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.[4] **This would be a cost savings of $10,162 per patient.**

A Congress interested in reducing healthcare costs can do so by taking the following steps to reduce patients' prescription drug costs, protect pharmacy viability, and enhance patients' access to pharmacy services:

1. Enact PBM reforms in Medicare and Medicaid like those included in H.R. 5378 and measures advanced through the Senate Finance Committee.
2. Enact H.R. 1770/S. 2477, the *Equitable Community Access to Pharmacist Services Act* (ECAPS), which would establish Medicare Part B reimbursement for essential pharmacist services. ECAPS seeks to foster Medicare beneficiary choice to access pharmacist services for common health threats, like influenza and COVID-19, building on the effectiveness

[1] https://www.japha.org/article/S1544-3191(22)00233-3/fulltext
[2] https://accessagenda.nacds.org/dashboard/
[3] https://pubmed.ncbi.nlm.nih.gov/36202712/
[4] 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).

and broad reach of pharmacy-based care during the pandemic, including in rural and underserved areas, which saved hundreds of billions of dollars in healthcare costs.[5]

3. Include community pharmacies in innovative healthcare models across public and private payers to lower healthcare costs, especially in the design and implementation of value-based care models that seek to explore opportunities to expand healthcare access, advance healthcare outcomes, and promote healthcare savings.

PBM Reform

PBMs' opaque and self-serving business practices lead to higher 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. Today, just six PBMs account for 96 percent of the U.S. market share, while the top three PBMs made up a staggering 79 percent, threating competition, innovation, and costs.

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.[6] 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.[7] Five of the top six PBMs are owned by large national health insurers. This vertical integration and lack of competition in the marketplace makes it increasingly difficult for pharmacies to negotiate fair business practices and transparency because the PBMs and health insurers have undue commercial market power and leverage in the relationship. This creates negative consequences for patients, pharmacies, employers, taxpayers, and communities – seemingly for all but the PBMs and payers.

As illustrated by MedPAC, Medicare Part D's 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. 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. 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.

As a result of these factors, retail pharmacies are in a crisis, facing unsustainable financial pressures as they are increasingly reimbursed by payers below the cost of buying and dispensing

[5] https://pubmed.ncbi.nlm.nih.gov/36202712/

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

prescription drugs. Dire financial pressures have forced pharmacies to take drastic steps, such as closing outright or reducing hours of operation and delaying innovative care services that otherwise could improve health outcomes and reduce costs. Every pharmacy closure means fewer healthcare access points (e.g., vaccinations, MTM, diabetes management) for Americans.

The epidemic of pharmacy closures is reducing access to vital healthcare services, especially in rural areas where options are already limited. 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 pharmacy services – health screenings, disease state management, vaccinations (e.g., flu, COVID-19), patient counseling, medication adherence, and testing for example – all in addition to essential access to prescriptions, can help improve health outcomes and generate overall healthcare savings for Americans.

Patient 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 like ECAPS 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.[8] 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 ECAPS 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 – as of July 2023 – more than 307 million COVID-19 vaccines, in addition to more than 42 million tests, and dispensing more than 8 million

[8] https://pubmed.ncbi.nlm.nih.gov/36202712/

antiviral courses.[9] Those figures only have increased since that time – with COVID-19 vaccinations in pharmacies now exceeding 320 million. Compared to medical centers, pharmacies provided more than 90% of COVID-19 vaccinations, excluding temporary and government public health sites.[10] During 2022-2023, more than two-thirds of adult COVID-19 vaccinations were administered at pharmacies.[11] With respect to testing, pharmacies provided 87% of the free tests administered through the Improving Community Access to Testing (ICATT) program.[12] Similarly, in considering pharmacies' impact on antiviral access, HHS reported that 87.5% (35,000 of the 40,000) antiviral dispensing sites are pharmacies.[13] Pharmacies convincingly 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.[14]

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 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.[15] 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.

NACDS urges 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 enactment of H.R. 1770/S. 2477, the *Equitable Community Access to Pharmacist Services Act*. More information on this important legislation is available from the Future of Pharmacy Care Coalition.

Include Pharmacies in Innovative Healthcare Models

Healthcare payment model reform to reward value-based care, better quality, and improved

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[9] https://www.liebertpub.com/doi/10.1089/hs.2023.0085
[10] https://www.iqvia.com/insights/the-iqvia-institute/reports/trends-in-global-adult-vaccination
[11] https://www.liebertpub.com/doi/10.1089/hs.2023.0085
[12] 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.
[13] 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
[14] https://accessagenda.nacds.org/dashboard/
[15] https://www.gao.gov/assets/720/718907.pdf

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 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.[16]

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.[17] 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.[18] Healthcare spending on non-optimal medication therapy is estimated at **$528.4 billion per year**[19] and medication non-adherence is estimated to cost the system **$290 billion** per year.[20]

[16] 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
[17] 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
[18] 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
[19] 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
[20] Rosenbaum L, Shrank WH; "Taking Our Medicine - Improving Adherence in the Accountability Era;" New England Journal of Medicine;

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**.[21] 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 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.[22]

Conclusion

NACDS thanks the Subcommittee for the opportunity to communicate pharmacy priorities that will deliver lower cost prescription drugs, protect pharmacy viability, and enhance access to pharmacist services for those that we mutually serve. Further, NACDS appreciates the action of the House Energy & Commerce Committee and the House of Representatives to pass meaningful PBM reform in the form of H.R. 5378, the Lower Costs, More Transparency Act, and urges leaders in the House to pair those reforms with measures advanced through the Senate Finance Committee – including those that would protect patients in Medicare as well as in Medicaid. As members of the Subcommittee look to collaborate with the pharmacy community, provide questions, or engage in further discussion, please contact NACDS' Christie Boutte, Senior Vice President, Reimbursement, Innovation and Advocacy at CBoutte@nacds.org or 703-837-4211.

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.

[21] 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.

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