NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

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For:

United States Senate Committee on Health, Education, Labor & Pensions: Subcommittee on Primary Health and Retirement Security

On:

"Feeding a Healthier America: Current Efforts and Potential Opportunities for Food is Medicine"

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Introduction

The National Association of Chain Drug Stores (NACDS) appreciates the opportunity to submit a statement for the record for the United States Senate Committee on Health, Education, Labor & Pensions Subcommittee on Primary Health and Retirement Security's hearing on "Feeding a Healthier America: Current Efforts and Potential Opportunities for Food is Medicine." NACDS lauds your continued partnership and leadership on Food is Medicine and dedication to PBM reform, which remains a top priority for NACDS and our members. There is a pharmacy crisis in America due to PBMs' extremely below-cost reimbursement and avaricious business practices which lead to inflationary effects on drug prices, restrictions on patient access, higher healthcare costs for patients, and an untenable future for community pharmacies in America. NACDS looks forward to continued opportunities to work collaboratively on Food is Medicine, comprehensive PBM reform, and other key issues to better serve the American people and promote health across communities nationwide.

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, especially those that target improved prevention, management, and treatment of chronic diseases and include the nation's most accessible healthcare providers – pharmacies and pharmacists.

Unfortunately, poor nutrition is annually linked to more than 500,000 deaths[3] and over 50 billion dollars in health costs[4] and nutrition-related chronic diseases remain on the rise with 6 in 10 Americans living with at least 1 chronic disease.[5] Chronic diseases, like heart disease, diabetes, and cancer, are the leading causes of death and the primary drivers of healthcare costs.[6] Healthy

[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] The US Burden of Disease Collaborators. The State of US Health, 1990-2016: Burden of Diseases, Injuries, and Risk Factors Among US States. JAMA. April 2018. https://jamanetwork.com/journals/jama/fullarticle/2678018
[4] Cardiometabolic disease costs associated with suboptimal diet in the United States: A cost analysis based on a microsimulation model. Jardim TV, Mozaffarian D, Abrahams-Gessel S, Sy S, Lee Y, et al. December 2019. https://doi.org/10.1371/journal.pmed.1002981
[5] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). May 18, 2023. https://www.cdc.gov/chronicdisease/index.htm
[6] https://www.cdc.gov/chronicdisease/index.htm

eating can help prevent and better manage these harmful and costly conditions.[7] In 2022, diagnosed diabetes in the US cost $412.9 billion,[8] and the annual U.S. healthcare spending and lost productivity from suboptimal diets is estimated to be more than $1 trillion.[9] When it comes to U.S. national security, poor diets have a major impact. In 2018, 71% of young people would not be able to join the military and overweight and obesity is a top reason for ineligibility.[10]

Addressing these complex problems requires collaborative solutions that focus on improving access and uptake of healthy foods across diverse communities. Food is Medicine interventions, such as produce prescriptions and medically tailored meals, have demonstrated important benefits in improving health outcomes and controlling health costs by supporting access to healthy food and better nutrition for people either with or at risk for diet-related conditions.[11,12] Importantly, the Community Preventive Services Task Force (CPSTF) recently issued a recommendation for fruit and vegetable incentive programs based on strong evidence of effectiveness in reducing household food insecurity and increasing household fruit and vegetable consumption. Their findings are based on evidence from a systematic review of 30 studies conducted in the United States.[13]

NACDS urges the Subcommittee to take action to improve access to Food is Medicine interventions, leveraging the entire healthcare continuum, including the unique expertise of pharmacies and pharmacists.

About **90% of Americans live within 5 miles of a community pharmacy**[14] and **86%** of adults report that **pharmacies are easy to access**.[15] Pharmacies are open extended hours – including nights and weekends – when other healthcare providers are unavailable. Across populations, people visit pharmacies more often than other healthcare settings. Moreover, **more than 70%** of Americans support pharmacists helping patients prevent chronic diseases, a top driver of healthcare costs.[16]

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[7] https://www.cdc.gov/chronicdisease/resources/publications/factsheets/nutrition.htm#:~:text=Consuming%20unhealthy%20food%20and%20beverages,in%20postmenopausal%20women%2C%20and%20colorectal

[8] https://diabetesjournals.org/care/article/47/1/26/153797/Economic-Costs-of-Diabetes-in-the-U-S-in-2022

[9] https://now.tufts.edu/2023/09/26/report-shows-food-medicine-interventions-would-save-lives-and-billions-dollars

[10] https://www.cdc.gov/physicalactivity/resources/unfit-to-serve/index.html

[11] Health and Economic Impacts of Implementing Produce Prescription Programs for Diabetes in the United States: A Microsimulation Study. Lu Wang, Brianna N. Lauren, Kurt Hager, Fang Fang Zhang, John B. Wong, David D. Kim and Dariush Mozaffarian. July 2023. https://www.ahajournals.org/doi/10.1161/JAHA.122.029215

[12] True Cost of Food: Food is Medicine Case Study. Tufts University Food is Medicine Institute. September 2023. https://now.tufts.edu/2023/09/26/report-shows-food-medicine-interventions-would-save-lives-and-billions-dollars

[13] https://www.thecommunityguide.org/findings/social-determinants-health-fruit-vegetable-incentive-programs.html?ACSTrackingID=USCDCCG_24-DM127084&ACSTrackingLabel=CPSTF%20Recommends%20Fruit%20and%20Vegetable%20Incentive%20Programs&deliveryName=USCDCCG_24-DM127084

[14] https://www.japha.org/article/S1544-3191(22)00233-3/fulltext

[15] https://accessagenda.nacds.org/dashboard/

[16] https://www.nacds.org/pdfs/Opinion-Research/NACDS-OpinionResearch-National.pdf

When the expertise of pharmacies was 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**.[17] 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.[18]

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 in advancing healthcare solutions for the American people that prioritize outcomes, prevention, cost-savings, access, and equity. **To better leverage pharmacies in transforming healthcare to help meet the needs of the American people, NACDS strongly recommends the Subcommittee members consider:**

1. **Supporting 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 foster beneficiary access to pharmacist services more broadly. Once enacted, S. 2477 would 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 recent public health emergency, including in rural and underserved areas. Following the passage of this critical legislation, NACDS urges the Subcommittee to consider additional opportunities for pharmacies to serve the American people in the future, including to help combat rising rates of diet-related chronic diseases.

2. **Supporting food is medicine access** through the successful passage of key legislation, including the Medical Nutrition Therapy Act (HR 6407/ S 3297), the Medically Tailored Home-Delivered Meals Demonstration Pilot Act (HR 6780 / S 2133), support for the Gus Schumacher Nutrition Incentive Program (GusNIP) expansions, and others. NACDS also looks forward to future opportunities for pharmacies and pharmacy teams to play a role in advancing access and uptake to key Food is Medicine interventions, including referrals for Medical Nutrition Therapy, medically tailored meals, and produce prescriptions.

[17] https://pubmed.ncbi.nlm.nih.gov/36202712/
[18] 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).

Discussion

Support access to pharmacist services to promote better health and control healthcare costs

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. 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 for common threats like flu and COVID-19. 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.[19] This legislation builds on that proven success and would help support Medicare beneficiaries with the option to seek routine 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 routine 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 S. 2477.

Also, it is important to consider the connection between diet-related diseases and poor outcomes from common conditions like flu and COVID-19. For example, data reported to CDC from January to May 2020 indicated that COVID-19 hospitalizations were 6 times higher and deaths 12 times higher for people with COVID-19 and an underlying medical condition such as diabetes, or heart disease.[20] There is also a strong connection between influenza and cardiovascular disease.[21]

Throughout the recent public health emergency, pharmacies were a trusted, equitable provider of vaccinations, tests, and antivirals, providing nearly 340 million COVID-19 vaccines to date, in addition to more than 42 million tests, and dispensing more than 8 million antiviral courses.[22] During 2022-2023, more than two-thirds of adult COVID-19 vaccinations were administered at pharmacies[23] and compared to medical offices during the 2023-2024 season, pharmacies provided

[19] https://pubmed.ncbi.nlm.nih.gov/36202712/
[20] https://archive.cdc.gov/www_cdc_gov/diabetes/library/reports/reportcard/diabetes-and-covid19_1702491562.html
[21] https://www.nfid.org/influenza-vaccination-is-critical-for-patients-with-heart-disease/
[22] https://www.liebertpub.com/doi/10.1089/hs.2023.0085
[23] https://www.liebertpub.com/doi/10.1089/hs.2023.0085

more than 90% of COVID-19 vaccines.[24] With respect to testing, pharmacies provided 87% of the free tests administered through the Improving Community Access to Testing (ICATT) program.[25] Similarly, in considering pharmacies' impact on antiviral access, HHS reported that 87.5% (35,000 of the 40,000) antiviral dispensing sites were pharmacies.[26]

Pharmacies unequivocally demonstrated their ability to meaningfully expand critical access to care across vulnerable communities during the recent pandemic, and the American people have taken notice. According to a poll conducted by Morning Consult and commissioned by NACDS in October of 2023, 81% of adults in the U.S. believe it's important to update policies to ensure that patients permanently have the same access to pharmacy vaccination, testing, and treatment services that were available during the COVID-19 pandemic.[27]

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.[28] Additionally, with respect to bivalent COVID-19 vaccinations, pharmacies administered 81.6% and 60.0% of bivalent vaccine doses in urban and rural areas, respectively.[29] 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.

The Subcommittee can help make better healthcare access, improved outcomes, 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.

Following the passage of this critical legislation, NACDS urges the Subcommittee to consider additional opportunities for pharmacies to serve the American people in the future, including to help combat rising rates of chronic diseases. Research strongly supports the ability for pharmacists to improve health outcomes and control healthcare costs through better prevention

[24] https://www.cdc.gov/vaccines/imz-managers/coverage/covidvaxview/interactive/adult-vaccinations-administered.html
[25] 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.
[26] 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
[27] https://accessagenda.nacds.org/dashboard/
[28] https://www.gao.gov/assets/720/718907.pdf
[29] https://www.cdc.gov/mmwr/volumes/73/wr/mm7313a2.htm?s_cid=mm7313a2_e&ACSTrackingID=USCDC_921-DM125690&ACSTrackingLabel=%20This%20Week%20in%20MMWR%3A%20Vol.%2073%2C%20April%204%2C%202024&deliveryName=USCDC_921-DM125690

and management of chronic diseases (See Appendix A).

In fact, leveraging the proven ability for pharmacies to make an important impact on chronic disease prevention and management, NACDS has undertaken two recent Food is Medicine projects as commitments to the White House Conference on Hunger, Nutrition, and Health. **First, NACDS' Nourish My Health campaign is a nationwide public education campaign aimed at highlighting the connection between eating nutritious foods and reducing the risk of diet-related heart disease, diabetes, and cancer.** Campaign messaging highlights the following calls to action: (1) Get a baseline health screening (blood pressure, cholesterol, blood sugar/blood glucose, and body mass index) and learn about your risk for nutrition-related diseases; (2) Improve your baseline numbers by adding healthy foods to your diet to live longer and healthier; and (3) Access important information about healthy foods, lifestyle modifications, and health screenings through the campaign website and related resources. In addition to leading health organizations engaging in the campaign, a dozen pharmacy organizations have also activated in the campaign, sharing key messages and resources with their audiences across communities, and providing important interventions, like baseline health screenings. To date, Nourish My Health has achieved **175 million impressions**, reaching Americans across the country, including rural and underserved populations. The campaign has also garnered **nearly 8,000 responses** to a nutrition security survey developed by the Food is Medicine Institute at the Friedman School of Nutrition Science and Policy at Tufts University. Please visit nourishmyhealth.org for more information.

Additionally, the Milken Institute Feeding Change and NACDS are working with multisectoral stakeholders and experts to determine the policy, infrastructure, operational, and programmatic steps necessary to leverage pharmacies in expanding access to Food Is Medicine interventions, especially for communities with high rates of diet-related disease and food insecurity. The learnings of this work, informed by 30 experts, will be available in early June, and will be leveraged to inform and promote scalable implementation of accessible and sustainable produce prescriptions across diverse communities. This work is part of a commitment by NACDS and the Milken Institute to the White House's Challenge to End Hunger and Build Healthy Communities. NACDS looks forward to continued opportunities for pharmacies to be leveraged more broadly in promoting access and uptake to Food is Medicine interventions that have demonstrated impact in mitigating harms from chronic diseases.

Support access to Food is Medicine interventions to improve prevention and management of rising chronic diseases

As described in the introduction, chronic diseases continue to pose a major threat to the health, wellbeing, and resiliency of the American people. Addressing these complex challenges will require collaborative solutions that help advance access and uptake to healthy food and patient

education supported by healthcare providers, including pharmacists, retail dieticians, and many others.

Several key pieces of bipartisan legislation introduced in this year's Congress offer important opportunities to advance access to Food is Medicine interventions and support the growing, robust research and evidence that demonstrates the critical value of Food is Medicine interventions. In particular, the **Medical Nutrition Therapy Act (HR 6407 /S 3297)** would expand eligibility for evidence-based Medical Nutrition Therapy (MNT) services in Medicare Part B from only people with diabetes and renal disease to encompass a more comprehensive array of chronic conditions, including prediabetes, obesity, cardiovascular disease, cancer, and others. The legislation would also allow more healthcare providers to refer Medicare beneficiaries into Medical Nutrition Therapy, including nurse practitioners, physician assistants, clinical nurse specialists, and psychologists, thereby improving needed access to MNT, which is generally provided by a registered dietician expertly trained in nutrition. Research indicates MNT is clinically effective and helps control healthcare costs, including for the conditions outlined in the bill.

Because the majority of Medicare beneficiaries have chronic conditions that can be impacted by nutrition, but may not meet current eligibility criteria for MNT today, this legislation would help fill a serious gap in Medicare Part B coverage to promote better management of chronic conditions. In the future, NACDS would appreciate the opportunity to collaborate on efforts that support pharmacists' ability to refer patients for Medical Nutrition Therapy, especially given that pharmacists see their patients far more often than other healthcare providers and can make a critical impact in expanding referrals for MNT to improve access. Consider, Medicare beneficiaries visit pharmacies significantly more often than primary care providers with 13 visits per year to pharmacies compared to 7 visits per year to primary care. That difference is even more pronounced in rural communities with 14 visits to pharmacies compared to 5 visits yearly to primary care.[30]

Additionally, the **Medically Tailored Home-Delivered Meals Demonstration Pilot Act (HR 6780 / S 2133)** would establish a four-year demonstration pilot under Medicare Part A to test clinical health outcomes and hospital readmissions for high-risk beneficiaries with diet-related chronic conditions who received home-delivered medically tailored meals. The legislation indicates that the pilot would include 20 hospitals providing 12 weeks of Medically Tailored Meals and 1 year of nutrition education for beneficiaries who participate in the demonstration. These meals are specifically designed by nutrition experts to support management of certain conditions, like diabetes, high blood pressure, and renal disease, to name a few.

Currently, medically tailored meals can be offered by Medicare Advantage plans through

[30] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7364370/

supplemental benefits, however, the majority of beneficiaries with traditional Medicare do not have access to medically tailored meals. This legislation offers an important opportunity to test potential impacts of Food is Medicine on a critical population of Medicare beneficiaries to help inform future, permanent changes to strengthen the Medicare program to best meet the current needs of beneficiaries, including changes that specifically addressing rising rates of harmful and costly chronic diseases. Given the accessibility and clinical expertise of pharmacies and pharmacists, NACDS appreciates any future opportunities to leverage pharmacies in advancing access and uptake of Food is Medicine interventions, including medically tailored meals, produce prescriptions, screenings and monitoring for chronic conditions, and other chronic disease prevention and management interventions broadly.

NACDS is also supportive of legislative efforts to fund meaningful programs that extend access to healthy foods for Americans, including the Gus Schumacher Nutrition Incentive Program (GusNIP) which offers incentives to encourage families participating in SNAP, for example, to purchase healthy foods like fruits and vegetables, among other initiatives. However, additional funding is needed to expand the impacts of this program. Legislation includes the GusNIP expansion Act (HR 4856), GusNIP Improvement Act (2. 2577), Opt for Health with SNAP (OH SNAP) Act (S 2015/HR 4149), and Local Farms and Food Act of 2023 (S 1205, HR 2323). These efforts would help support Americans in accessing healthier foods, address nutrition insecurity, advance food is medicine efforts to improve health, and help control downstream healthcare spending related to chronic diseases.

Conclusion

NACDS urges the Subcommittee to act on key opportunities to improve health outcomes, advance access, and reduce preventable healthcare spending, including through support for S. 2477, S. 3297, S. 2133, and others, in addition to comprehensive PBM reform. As rates of chronic disease continue to rise unsustainably, the nation needs collaborative solutions that leverage the collective expertise from across the healthcare ecosystem, including pharmacies and pharmacists. For questions or further discussion, please contact NACDS' Sara Roszak, Senior Vice President, Health and Wellness Strategy and Policy at sroszak@nacds.org or 703-837-4251.

Appendix A. Key Examples Demonstrating Pharmacists' Ability to Improve Chronic Disease Care		
Results of Pharmacist Care	**Intervention**	**Source**
Statistically significantly higher improvements in the individual areas of A1c, blood pressure, and statin goal attainment – 40% of patients in the pharmacist intervention group achieved all 3 clinical goals after intervention, compared with only 12% of patients in the usual care group.	Study of patients seen in clinics within a Primary Care Network (PCN) during defined period of time. Patients included in the intervention group if they were actively managed by a PCN pharmacist and had a diagnosis of diabetes. A control group included patients without access to a PCN pharmacist and was matched to the intervention group by baseline A1c results.	*Prudencio J, Cutler T, Roberts S, Marin S, Wilson M. (May 2018). The Effect of Clinical Pharmacist-Led Comprehensive Medication Management on Chronic Disease State Goal Attainment in a Patient-Centered Medical Home. JMCP. 2018;24(5):423-429. (Link)*
Results showed 637 drug therapy problems were resolved among 285 intervention patients. HEDIS measures improved in the intervention group compared with the comparison group for hypertension (71% versus 59%) and cholesterol management (52% versus 30%). Total health expenditures decreased from $11,965 to $8,197 per person. 12:1 return on investment.	MTM services provided by pharmacists to BlueCross BlueShield health plan beneficiaries in collaboration with primary care providers.	*Brian J. Isetts, Stephen W. Schondelmeyer, Margaret B. Artz, Lois A. Lenarz, Alan H. Heaton, Wallace B. Wadd, Lawrence M. Brown, Robert J. Cipolle, Clinical and economic outcomes of medication therapy management services: The Minnesota experience, Journal of the American Pharmacists Association, Volume 48, Issue 2, 2008. (Link)*
Mean reductions in systolic and diastolic blood pressure were 21.6 and 14.9 mmHg greater, respectively, in participants assigned to the pharmacist-led intervention than in those assigned to the active control.	Barbershops were assigned to a pharmacist-led intervention (in which barbers encouraged meetings in barbershops with specialty-trained pharmacists who prescribed drug therapy under a collaborative practice agreement with the participants' doctors) or to an active control approach (in which barbers encouraged lifestyle modification and doctor appointments).	*Victor RG, et al. A Cluster-Randomized Trial of Blood-Pressure Reduction in Black Barbershops. The New England Journal of Medicine. April 2018. (Link)*

Pilot study displayed improvement in diabetes and hypertension clinical markers associated with pharmacist provision of MTM. A1c goal achievement occurred in 52.84% of patients and hypertension control was reported in 65.21%. Pharmacists identified and resolved more than 1,400 medication-related problems and addressed multiple adverse drug event issues.	Three FQHC sites with distinct models of established pharmacist MTM services to care for patients with uncontrolled diabetes and/or hypertension.	*Rodis JL, et al. (2017). Improving Chronic Disease Outcomes Through Medication Therapy Management in Federally Qualified Health Centers. Journal of Primary Care & Community Health.* (Link)
In a simulated cost-effectiveness analysis of a 5-state Markov model, 50% uptake of a pharmacist-prescribing intervention to improve blood pressure control was associated with a $1.137 trillion in cost savings and could save an estimated 30.2 million life years over 30 years.	A pharmacist-prescribing intervention including a wallet card, education, and usual care to improve blood pressure control in the US.	*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).* (Link)