NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Statement

Of

The National Association of Chain Drug Stores

For

United States House of Representatives
Committee on Ways and Means

On

The Cost of Rising Prescription Drug Prices

February 12, 2019
10:00 a.m.

1100 Longworth House Office Building

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Introduction

The National Association of Chain Drug Stores (NACDS) thanks Chairman Neal, Ranking Member Brady, and the Members of the Committee on Ways and Means for the opportunity to submit a statement for the hearing on "The Cost of Rising Prescription Drug Prices."

NACDS and the chain pharmacy industry are committed to partnering with Congress, HHS, patients, and other healthcare providers to improve the quality and affordability of 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 the face of neighborhood health care, chain pharmacies and pharmacists work on a daily basis to provide the best possible care and the greatest value to their patients with respect to access to critical medications and pharmacy services. Based on their first-hand experiences with pharmacies and pharmacists, Americans also trust the recommendations of pharmacies and pharmacists on related public policy issues. A national poll of registered voters conducted January 4-6, 2019, by Morning Consult and commissioned by NACDS bears this out. In the poll, 69 percent of registered voters say pharmacists are credible information sources on prescription drug savings, making pharmacists the highest-ranked healthcare professionals in this regard. Further, 86 percent of registered voters support pharmacists using their expertise to identify policies that will lower patients' drug costs and that build on the *Know the Lowest Price Act*. Enacted in 2018, the *Know the Lowest Price Act* banned "gag clauses" that prevented pharmacists from informing patients when they can save money by paying cash for a prescription rather than using insurance.

As this Committee examines the cost of rising prescription drug prices, we offer the following for your consideration, based on pharmacy's first-hand experiences on the front lines of healthcare delivery.

Lowering Cost Through Pharmacy DIR Reform

In November 2018, CMS issued a proposed rule, "Modernizing Part D and Medicare Advantage to Lower Prices and Reduce Out-of-Pocket Expenses" that would lower beneficiary out-of-pocket costs by reforming the Part D program to require that pharmacy direct and indirect remuneration (DIR) fees, also known as "pharmacy price concessions," are passed on to patients. These reforms include:

- **Redefining the "negotiated price" to include all pharmacy price concessions**. Because beneficiary cost sharing is based on negotiated price, a lower negotiated price would lead to lower beneficiary cost sharing;

- **Developing a broad definition of "price concession" to include all forms of discounts, direct or indirect subsidies, or rebates that serve to reduce costs incurred by Part D sponsors**. Again, this would help ensure the lowest negotiated price and thus, lower beneficiary cost-sharing; and

- **Developing standardized pharmacy performance metrics for 2020 as the first step toward the development of Medicare Part D pharmacy quality incentive program**. Without a pharmacy quality incentive program, Part D plans lack incentives to offer the best pharmacy care to beneficiaries. Pharmacy incentive payments would support higher quality and health outcomes. Examples are medication optimization and improved medication adherence, which would improve patient outcomes and reduce downstream healthcare costs.

Per CMS, Part D plans' use of DIR grew an extraordinary 45,000 percent between 2010 and 2017. This has led to Medicare beneficiaries paying more out-of-pocket, the federal government not fully understanding what it is paying for prescription drugs, and retail pharmacies conducting business in an environment where they are unsure whether a payment will be clawed back as "DIR." This all ultimately can endanger beneficiary health through reduced access to prescription drugs and reduced medication adherence, which raises other healthcare costs.

Pharmacy DIR Fees Increase Drugs Costs and Reduce Patient Health

Pharmacy DIR fees increase beneficiary costs and shift costs to the federal government. As CMS recognizes in the proposed rule, "when pharmacy price concessions are not reflected in the price of a drug at the point of sale, beneficiaries do not benefit through a reduction in the amount they must pay in cost-sharing, and thus, end up paying a larger share of the actual cost of a drug."[1] Pharmacy DIR fees obfuscate true drug prices, thus undermining the transparency needed to allow all stakeholders, notably patients and providers, to make informed decisions about how to best meet healthcare needs. As CMS also points out, "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]

NACDS further agrees with CMS that the quality of information available to consumers is even less conducive to producing efficient choices as pharmacy price concessions are treated differently by different Part D sponsors; that is, they are

[1] 83 Fed. Reg. at 62174
[2] Id. at 62176

applied to the point-of-sale price to differing degrees and/or estimated and factored into plan bids with varying degrees of accuracy.

Beneficiaries are likely unaware that the increasing use of DIR fees has led to inflated drug costs. The impact of higher cost-sharing for beneficiaries not only increases out-of-pocket costs for prescription drugs, but it also negatively impacts medication adherence, leading to increased total cost of care and poorer health outcomes.

Better Medication Adherence and Medication Optimization Reduce Healthcare Costs
Not only will instituting DIR reform reduce beneficiary cost sharing, but coupled with a pharmacy quality incentive program, it will save taxpayers billions of dollars by aligning incentives for the entire Medicare program, which will encourage a more systematic investment in pharmacy quality programs designed to facilitate care coordination, reduce medical errors, advance population health, and empower and motivate beneficiaries to achieve better health outcomes through medication optimization services and improved medication adherence.

Medication optimization services encompass patient-centered activities that improve health outcomes by addressing medication appropriateness, effectiveness, safety, adherence, and access. Medication optimization services delivered by community pharmacies are central to the care of beneficiaries. Nearly all Americans (91.7 percent) live within 5 miles of a community retail pharmacy and in 2017 nearly 73 percent of prescriptions dispensed in the U.S. were filled at retail pharmacies. Face-to-face interactions with beneficiaries at the point-of-dispensing allows the pharmacist to counsel and educate the patient and is critical to achieving national-scale improvements in health outcomes and lowered costs.[3]

The better use of medicines will also reduce medication 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

[3] 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

other avoidable, expensive medical services.[4,5,6] 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.[7] 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.[8] Multiple, credible sources have drawn the same conclusion: medication non-adherence is a costly, preventable problem that dramatically affects total cost of care.

Studies also demonstrate that the total cost of healthcare decreases significantly when patients take their medications as prescribed. For example, patients who are adherent to their medications have more favorable health outcomes such as reduced mortality and use fewer healthcare services, especially hospital readmissions and ER visits, leading to reduced healthcare costs.[9] Similarly, a 2014 study funded by the National Institutes for Health examined data from a large, diverse sample of Medicare beneficiaries, and concluded that obtaining prescription drug insurance through Part D was associated with an 8 percent decrease in the number of hospital admissions, a 7 percent decrease in Medicare expenditures, and a 12 percent decrease in total resource use. Additional studies of patients being treated for specific disease states such as diabetes,[10] high cholesterol,[11] and Parkinson's Disease offer additional support for the connection between improved adherence and lower healthcare costs.

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[4] Rosenbaum L, Shrank WH; "Taking Our Medicine - Improving Adherence in the Accountability Era;" *New England Journal of Medicine*; Aug. 22, 2013

[5] Network for Excellence in Health Innovation; "Bend the Curve: A Health Care Leader's Guide to High Value Health care;" 2011.

[6] The NCPIE Coalition; "Enhancing Prescription Medicine Adherence: A National Action Plan;" 2007.

[7] "A Treatable Problem: Addressing Medication Nonadherence by Reforming Government Barriers to Care Coordination;" *Prescriptions for a Healthy America*; October 2017.

[8] Patterson JA, et al; "Cost-Benefit of Appointment-based Medication Synchronization in Community Pharmacies;" *American Journal of Managed Care*; 2016.

[9] Braithwaite S, et al; "The Role of Medication Adherence in the U.S. Healthcare System;" *Avalere Health*; June 2013.

[10] The Pennsylvania Project evaluated a pharmacy-based medication adherence initiative across 283 pharmacies. The intervention, which included pharmacist-led screening for medication non-adherence and counseling for those at an increased risk, led to statistically significant improvement in medication adherence for all medication classes that were studied, and an annual per patient cost savings of $241 for improved adherence to oral diabetes medications and $341 related to improved adherence to statin medications, Pringle JL, et al.; "The Pennsylvania Project: Pharmacist Intervention Improved Medication Adherence and Reduced Health Care Costs;" *Health Affairs*; August 2014.

[11] One study found significant savings due to improved adherence to diabetes medications — or per beneficiary savings of approximately $5,000 in medical spending. The potential for population-wide savings from improved medication adherence for patients with diabetes is illustrated by the fact that only approximately half of Part D patients reported good medication adherence. Stuart, BC, Dai, M, Xu, J, Loh, FH, Dougherty, SJ; "Does Good Medication Adherence Really Save Payers Money"; *Medical Care*.

DIR reform and the implementation of a pharmacy quality incentive program will improve medication adherence by making prescription drugs more affordable for Medicare beneficiaries, which in turn will help reduce the unnecessary costs associated with non-adherence. These savings will contribute to overall Medicare savings that would result from the Part D rule.

Conclusion

NACDS thanks the Committee for your consideration of our comments. CMS should use their authority to include pharmacy DIR fee reform and the movement towards a pharmacy quality incentive program in the final rule. These changes will lower out-of-pockets costs for beneficiaries, make medicines more accessible, and improve medication optimization, thus leading to greater adherence and better health outcomes and lower overall healthcare costs. We urge members of the Committee to voice their concerns to Secretary of Health and Human Services and urge the inclusion of these policies in the Final Part D Rule.