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September 7th, 2011

The Honorable Patty Murray
The Honorable Jeb Hensarling
Co-Chairs, Joint Select Committee on Deficit Reduction
United States Congress
Washington, D.C. 20510

Subject: Recommendations Regarding Medicare and Medicaid Savings

Dear Senator Murray and Representative Hensarling:

On behalf of the 23,000 small business independent community pharmacies, the National Community Pharmacists Association (NCPA) is writing to provide our views on cost savings as the Joint Committee considers options to further reduce the deficit by $1.2 trillion over the next 10 years as part of the Budget Control Act. We understand that entitlement program reforms may be considered as part of the discussions, and we are very concerned that certain reforms could mean drastic cuts to the Medicare and Medicaid drug reimbursement rates. This could reduce patients' access to community pharmacy services. However, we believe that significant savings can be found through simple reforms to the programs that will result in reduced drug costs for the Federal government and consumers.

Independent Community Pharmacies Serve Millions of Medicare and Medicaid Patients

Medicare and Medicaid prescriptions represent about 50 percent of the average small business pharmacy owner's revenues. As a result, any changes to the program, however small, could affect the ability of Medicare and Medicaid patients to obtain their health care services from a community pharmacy. Unlike large chain pharmacies, 92 percent of pharmacy small business owners' revenues are derived from sales of prescription medications. Many of the 23,000 small independently-owned community pharmacies throughout this country are found in rural and underserved locations where other pharmacies do not operate. We dispense 37 percent of all retail pharmacy prescriptions, and employ about 315,000 individuals. We appreciate your consideration of our views as the committee discussions continue.

NCPA's cost savings recommendations to the Joint Committee would streamline the delivery of pharmaceutical products through Federal programs and promote cost effective health care through:

- Increasing the Use of Lower Cost Generic Medications
- Reducing Wastefulness from Mandatory Mail Order Pharmacy
- Collecting Billions of Dollars in Manufacturer Rebates retained by Pharmacy Benefit Managers (PBMs)
- Better Management of Patients' Drug Therapy
- Reducing Waste in Medicare Part B Diabetes Testing Supplies

PBM Middlemen Create Bloat and Waste in Delivery of Federal Drug Programs

The Federal government pays for tens of billions of dollars in prescription drug programs for Medicare Part D, Medicaid fee-for-service and Medicaid managed care, Federal Employees Health Benefits Program (FEHBP), TRICARE and other programs. We believe that significant waste exists in the delivery of government-funded and government-subsidized prescription drug programs. Billions of dollars in savings remain "on the table" because of the lack of competition and oversight in the management of drug benefits in these programs by pharmacy benefit managers (PBMs).

In addition, improving the overall quality of medication use for patients in these programs through enhanced pharmacy care and medication therapy management (MTM) would also reduce spending by keeping patients out of the hospitals and emergency rooms. Common-sense, market-based reforms to these programs could reduce Federal government drug costs as well as reduce premiums and co-pays paid by both private and public sector consumers. We present our recommendations below.

Recommendation 1: Savings by Increasing the Use of Lower-Cost Generic Medications

Generic drugs are one-fifth of the cost of brand name drugs. Nothing can save the health system more money than using generic medications where appropriate. Yet, almost all Federal programs' generic dispensing rates are lower than the national average for private sector programs.

In a June 2010 study, the Medicare Payment Advisory Commission reported that the generic dispensing rate in Medicare Part D is 67%[1]. The Generic Pharmaceutical Association reported that in 2009 the generic dispensing rate for Medicaid was 69%.[2] Generic dispensing rates at PBM-owned mail order facilities are even lower. This should be compared to a generic dispensing rate by retail pharmacies of approximately 72%.[3] Accordingly, claims that increasing mail order in Medicare Part D and Medicaid will save the programs money are overstated, as illustrated below:

Mail Order Generic Dispensing Rates[4]

CVS/Caremark 61.3%
Medco 61.5%
Express Scripts 60.2%

Community Pharmacies Generic Dispensing Rate[5]

72%

Community pharmacies do a much better job at dispensing generics because they do not have the perverse incentives that PBMs have to push brand name drugs through mail order outlets in order to collect lucrative manufacturer rebates. For example, the TRICARE program is presently attempting to encourage more mail order use, even though the TRICARE mail order contractor only dispenses generic drugs just over 50 percent of the time.[6] This is at least 10 percentage points lower than even other mail order programs, where the generic dispensing rate is already low.

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[1] Medicare Payment Advisory Commission, MedPac June 2010, a Data Book, Health Care Spending and the Medicare Program. June 2010. Page 191.*i*.
[2] Generic Pharmaceutical Association, Medicaid Savings Through Generic Utilization, based on CMS Q3 2009-Q3 2010 data, 2011
[3] Based on statistics contained within the 2010 10K SEC filings for the big 3 PBMs.
[4] *Id.*
[5] *Preliminary data from 2011 NCPA Digest, National Community Pharmacists Association.*
[6] Based on statistics provided to NCPA by the TRICARE Pharmacy Program.

Compare this to the fact that retail pharmacies in the TRICARE retail pharmacy network dispense generic drugs over 70 percent of the time.[7] The higher generic dispensing rate at retail pharmacies compared to mail order demonstrates that retail pharmacy is much more effective at promoting generic drugs than mail order pharmacies, which results in significant savings.

Not only does mail order fail to capitalize on the use of low cost generic drugs, but the increased use of mail order can drive negative quality of care because of fewer face-to-face interventions by pharmacists. In-person, pharmacist-patient interventions improve drug therapy and reduce health care spending on expensive health care encounters in the hospital emergency room. Maximizing the use of generics in Federal programs is critical, given that a significant number of widely-used brand name medications will be coming off patent in the next few years. The Committee should include plans to promote higher generic drug utilization rates as part of any debt reduction plan given the potential for savings.

The bottom line is that we believe that a 5 percentage point increase in generic dispensing in Medicare Part D and Medicaid would result in about $9 billion in annual savings. For every percentage point increase above that, the programs would save about $1.8 billion annually.

Recommendation 2: Savings by Reducing Waste From Mandatory Mail Order Pharmacy

Patients should be able to choose whether they want to use their community pharmacy or mail order, not be forced into mail order by the PBM's self-serving plan designs whose goals are to enrich their bottom line at the expense of patient choice. Such policies also perversely promote expensive brand name drugs over generic drugs.

It is a popular myth that PBM-owned mail order pharmacy saves money. PBMs want payers to think that mail order saves because it is in the PBMs' self interest to dispense medications through their own mail order pharmacies. That is because the PBMs keep significant manufacturer rebates from the large quantities of expensive brand name medications that they push through mail order. At the end of the day, however, these rebates may or may not be passed through to payers. Moreover, PBMs repackage medications under their own label, assign them a higher cost basis, and then make it appear that they are still giving a higher discount on mail order prescriptions.

There is also a significant amount of mail order prescription waste. Recent pictures collected by NCPA in just a few weeks from dozens of our member pharmacists show that tens of thousands of dollars in expensive mail order prescriptions were not fully used because mail order simply cannot effectively manage patients' drug therapy from afar. For all these reasons, the Committee should consider policies that favor use of community pharmacies over mail order outlets.

Recommendation 3: Savings by Collecting Billions of Dollars in Manufacturer Rebates Being Retained by PBMs

As stated already, most Federal programs use pharmacy benefit managers (PBMs) to administer drug benefits. These include Medicare Part D, Medicaid, FEHBP, and TRICARE.

[7] *Id.*

Yet, the Federal government is unable to determine accurately to what extent PBMs are passing through to taxpayers or beneficiaries the billions of dollars in rebates they receive from manufacturers for drugs covered for enrollees in these Federal programs. The Federal government is leaving money on the table by not insisting on full, 100 percent pass-through of rebates PBMs receive from brand-name manufacturers.

There is cause for concern. A recent OIG report found that, for the year 2008, Part D sponsors received $6.5 billion in rebates, yet some sponsors may be inappropriately allocating rebates across their plans in order to maximize reconciliation payments inappropriately.[8] Notably, according to the OIG, most PBMs did not pass the full amount of rebates onto beneficiaries, and only 4 out of 258 sponsors provided rebates to beneficiaries at the point of sale.[9]

The OIG also found that sponsors underestimated rebates in 69% of their bids and 78% of Part D beneficiaries were enrolled in plans that underestimated rebates.[10] These underestimations lead to higher premiums for Part D beneficiaries and overpayments by CMS. This high percentage of underestimates may indicate that some PBMs deliberately underestimate their rebates in order to increase their profits. There is no consistency, uniformity or transparency in determining whether or how these rebates are going to lower drug costs in these programs. To truly realize government savings, particularly within the Part D program, there must be transparency as to what happens to these rebates and PBMs must be required to pass through these rebates to the Federal government and beneficiaries. Significant savings can be achieved through greater PBM transparency in Medicare Part D through enactment of the bipartisan H.R. 1971/ S. 1058, *the Pharmacy Competition and Consumer Choice Act of 2011*, and we urge its inclusion in the legislation drafted by the Committee.

Recommendation 4: Savings by Better Management of Patients' Drug Therapy

As much as $290 billion[11] is spent on health care each year as a consequence of medications that are either not used appropriately or patients not taking their medications as prescribed. Lack of adherence with medications for chronic conditions, such as high blood pressure or high cholesterol, is a major cause of readmissions to hospitals. Pharmacists, working with prescribers, can help improve the use of medications through counseling, adherence and medication therapy management programs. Community based pharmacists can have the most significant impact because of the personal, face-to-face education that we can provide and proper monitoring of our patients when we see them in the pharmacy.

Given the costs associated with poor medication adherence and the potential savings to be generated through medication therapy management, the Committee should incorporate *H.R. 891, The Medication Therapy Management Benefits Act of 2011.* This bipartisan proposed legislation will provide more coverage for and greater access to MTM services provided by community pharmacies, encourage preventive care among Medicare Part D beneficiaries, and improve medication adherence. The end result is that more investment in MTM services reaps long term savings by avoiding costly health care interventions and hospitalizations.

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[8] Department of Health and Human Services, Office of the Inspector General, *Concerns with Rebates in the Medicare Part D Program*, Daniel R. Levinson, March, 2011, OEI-02-08-00050.
[9] *Id.*
[10] *Id.*
[11] New England Healthcare Institute, *Thinking Outside the Pillbox: A System-wide Approach to Improving Patient Medication Adherence for Chronic Disease*, 2009.

Recommendation 5: Savings by Reducing Waste in Medicare Part B Diabetes Testing Supplies

Medicare Part B pays for billions of dollars each year in diabetes test strips, the majority of which are dispensed through mail order. These strips help beneficiaries maintain proper glucose levels. Yet, community pharmacists continually hear stories from patients about how the mail order companies continue to send test strips to the beneficiary, even if they don't need them.

Some patients indicate they have closets full of these strips. This means that either the mail order company is disregarding "stop orders" and has placed the person on automatic renewal even if they don't need the test strips or the person is not testing correctly, which could lead to further diabetes complications. This is a "no win" situation for Medicare and for beneficiaries with diabetes. Medicare pays for test strips that are not needed, while patients are not being managed well because they are getting their test strips from a mail order firm rather than being managed by their community pharmacist. Policymakers should rethink proposals that would shift more diabetes testing supplies to mail order outlets as this will only compound this waste issue.

Given the costs and waste associated with mail order diabetic testing supplies, we urge that the Committee's debt reduction legislation include *H.R. 1936, the Medicare Diabetes Access to Care Act.* This bipartisan bill will preserve and ensure Medicare beneficiaries' access to diabetic testing supplies through independent community pharmacy and the all-important face-to-face counseling that they receive. Independent community pharmacies cannot buy diabetes testing supplies at the same price as large chain pharmacies and mail order outlets, so applying lower reimbursement to our pharmacies would mean that many may simply stop providing these valuable items and services. Yet, the personal counseling and monitoring that we offer improves diabetes testing adherence, avoid costly diabetes complications in the long run, and reduce costly mail order waste.

Conclusion

We look forward to working with Congress to assure that pharmacy does all it can to reduce costs in the Medicare and Medicaid programs, while maintaining access to community pharmacies. Please call on us as a resource for any of these potential policy options, as we have collected significant data to support the positions that are outlined here. Thank you again and good luck with this important initiative.

Sincerely,

B. Douglas Hoey, R.Ph., M.B.A
Executive Vice President and CEO

cc: Members of the Senate Finance Committee
Members of the House Energy and Commerce Committee
Members of the House Ways and Means Committee