January 6, 2017

The Honorable Kevin McCarthy
Majority Leader
House of Representatives
Washington, D.C. 20515

The Honorable Kevin Brady
Ways and Means Committee
House of Representatives
Washington, D.C. 20515

The Honorable Virginia Foxx
Education and the Workforce Committee
House of Representatives
Washington, D.C. 20515

The Honorable Greg Walden
Energy and Commerce Committee
House of Representatives
Washington, D.C. 20515

Dear Majority Leader McCarthy, Chairman Brady, Chairman Foxx, and Chairman Walden:

As you solicit input from the nation's governors and insurance commissioners on how to proceed with replacement of the Affordable Care Act (ACA), the National Community Pharmacists Association (NCPA) would like to take this opportunity to provide you with the community pharmacist perspective on several bipartisan implementing regulations and provisions of the ACA, such as Sections 2503, 3109, 6005 and 10328 that should be retained in a replacement package.

The National Community Pharmacists Association (NCPA) represents America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $81.5 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis. Independent community pharmacies are often located in underserved inner-city and rural areas. Community pharmacists are the most accessible and among the most trusted health care providers and work with patients to manage chronic health conditions and counsel them on proper use of medication.

In fact, medications are the primary method of treating chronic disease, and are involved in 80% of all treatment regimens. Unfortunately, medication-related problems, including poor adherence, cost the nation approximately $290 billion annually—13% of total healthcare expenditures—and results in health complications, worsening of disease progression, emergency room visits, and hospital stays, all of which are avoidable and costly.

Any ACA Replacement Package Should Ensure that Health Plans Provide Meaningful Prescription Drug Coverage Including Ample Pharmacy Networks and Patient Access to an In-Person Pharmacist

Through the health exchanges and expansion of Medicaid, the ACA provided access to these necessary medications to over 22 million people, providing the previously uninsured the treatments necessary to manage chronic conditions such as heart disease and diabetes rather than seeking costly emergency room treatment when complications arose. Any ACA replacement must preserve prescription drug coverage as an essential benefit to help reduce overall health care costs.

However, prescription drug coverage alone is ineffective if beneficiaries cannot utilize the benefit. As former Surgeon General C. Everett Koop noted, prescription drugs don't work in patients who don't take them.

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Therefore patients ought to continue to have access to a robust pharmacy network that includes meaningful access to retail pharmacies, including independent pharmacies, to fill their prescriptions and promote proper adherence. A 2013 report found the leading indicator of adherence was the patient's personal relationship with the pharmacist or pharmacy staff[1]. In recognition of the importance of face-to-face interaction between patients and pharmacists, ACA implementing regulations provide that health plans may not mandate that patients receive their prescriptions via a mail order pharmacy—but rather that patients must have the ability to choose. NCPA would recommend that any ACA replacement retain this valuable component.

Any ACA Replacement Package Should Retain Changes to Calculation of Medicaid Pharmacy Reimbursement and Ensure that Reimbursement Include Cost of Medication and Cost of Dispensing

Section 2503 of the ACA amended the calculation of Average Manufacturer Price (AMP) and how it is used to determine Medicaid pharmacy reimbursement. Implementing regulations clarified that such reimbursement should include the cost of the medication as well as the cost of dispensing. ACA replacement legislation should retain these critical provisions. As previously mentioned, independent pharmacies are often located in underserved rural and urban communities and serve a large number of Medicaid patients. In fact, for the average independent community pharmacy, 17% of all prescription revenues are from Medicaid and prescription revenues account for 92% of total revenues. It is imperative that pharmacies be fairly compensated for the medications they dispense under Medicaid and that such reimbursements consider both the actual ingredient cost as well as the cost to dispense the prescription when determining pharmacy payments. Otherwise, some pharmacies may cease to participate in the Medicaid program, creating medication access issues to those who rely on the program.

In addition to maintaining the aforementioned bipartisan provisions that promote access to pharmacies, ACA replacement should also consider measures that expand the pharmacist's role in the health care system. The National Governors Association (NGA) released a white paper in 2015[2] encouraging states to better integrate pharmacists into the healthcare delivery system based on the significant role pharmacists can play in helping patients manage chronic disease. Section 10328 also recognized the importance of the pharmacists role in this area by improving Medicare Part D medication therapy management (MTM) programs, including an annual face-to-face comprehensive medications review (CRM). We recommend retaining this section of the ACA and build upon it to further integrate pharmacists into the health care delivery team.

Any ACA Replacement Package should Retain Provisions to create greater oversight of Pharmacy Benefit Managers (PBMs) and the role they play in escalating drug prices and increasing costs to taxpayers

In an effort to gain greater insight into secretive PBM business practices, Section 6005 of the ACA requires PBMs serving exchange plans and part D to disclose to HHS the generic dispense rate for retail and mail order pharmacies, the amount of rebates collected and the amount passed onto the health plan, and the total difference the PBM charged the plan and what it paid out to pharmacies. Such transparency provisions are common sense and allow government entities to better determine whether PBMs are providing appropriate value, and we recommend retaining this section in ACA replacement legislation.

Finally, we believe Section 3109 of the ACA should also be included in replacement legislation. This provided an exemption from accreditation standards for pharmacies who derive less than 5% of their revenues from DMEPOS billings.

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[1] *Medication Adherence in America: A National Report Card*. Langer Research Associates; June 2013

[2] *The Expanding Role of Pharmacists in a Transformed Health Care System*. The National Governors Association; January 2015

Replacing a program as large and as impactful as the ACA is not an easy task. As Congress explores its options, we hope you will consider retaining these provisions that have proven bipartisan support as a foundation for a replacement package.

Thank you for taking our views into consideration.

Sincerely,

B. Douglas Hoey R.Ph, MBA

CEO, National Community Pharmacists Association

CC: National Governors Association