Statement of the National Community Pharmacists Association (NCPA)

United States Senate Committee on Finance

Hearing on Healthcare Entitlements: The Road Forward

June 23, 2011

The National Community Pharmacists Association ("NCPA") welcomes and appreciates this opportunity to provide input and suggestions regarding efforts to eliminate waste and generate savings within healthcare entitlement programs, particularly as they relate to pharmacy care providers. NCPA represents the pharmacist owners, managers and employees of more than 23,000 independent community pharmacies across the United States. The nation's independent pharmacies, independent pharmacy franchises and independent chains dispense nearly half of the nation's retail prescription medicines.

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, FEHBP, TRICARE and other programs. NCPA strongly believes in the mission to cut waste and retain savings in federal health care programs in order to maximize the benefits that those programs provide to beneficiaries. NCPA and our members stand willing and able to assist Congress in realizing these savings and offer our services to streamline the delivery of pharmaceutical products and to promote cost-effective health care. Accordingly, NCPA urges Congress to recognize the role that independent community pharmacies can play in reducing spending on prescription drugs and avoiding preventable yet costly encounters with the health care system including emergency room visits and hospitalizations.

NCPA believes that significant waste exists in the delivery of these 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.

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Recommendations

NCPA and independent community pharmacists are committed to eliminating waste and capturing savings within federal healthcare programs. We offer a number of proposals for achieving those goals.

- Promote policies that encourage the use of generic drugs in the Medicaid, Medicare Part D and TRICARE programs – where generic drug use is lacking as compared to the private sector plans, which have a generic drug utilization rate of about 72 percent; [1]
- Ensure that PBMs return to the federal government billions of dollars in manufacturer rebates that the PBMs retain from federal healthcare programs. This is especially important in the Medicare Part D programs and Medicaid managed care programs. The HHS Office of Inspector General ("OIG") has stated that a lack of transparency by PBMs raises concerns that Part D plan sponsors may not have enough information to ensure that beneficiaries and taxpayers are receiving the benefit of rebates from drug manufacturers;
- Require PBMs to place a priority on effective fraud reduction and mitigation efforts. To that end, PBMs under contract to federal health care programs should be required to place an emphasis on attacking this problem of fraud rather than targeting legitimate pharmacies and recouping large sums of money for technical and administrative errors. Moreover, PBMs should also be required to transfer recovered amounts to the appropriate plan sponsors to reduce costs to beneficiaries and taxpayers rather than retaining these funds as revenue for the PBMs;
- Promote greater use of lower cost generic drugs by requiring PBMs to disclose publicly the generic substitution rates by PBM-owned mail order pharmacies and the amount of manufacturer rebates received to increase the utilization of brand-name drugs. This is especially important in the TRICARE pharmacy program where the generic use rate in mail is 51 percent, well below the retail pharmacy generic dispensing rate of 72 percent. [2]
- Pass *S. 1058, the Pharmacy Competition and Consumer Choice Act of 2011,* sponsored by Senators Pryor and Moran, which promotes PBM transparency and will highlight savings to be attained from PBM reforms;
- Pass *S. 274, The Medication Therapy Management Empowerment Act of 2011*, sponsored by Senators Hagan and Franken, which would expand the delivery of MTM services to Medicare Part D beneficiaries to reduce health care costs resulting from unnecessary emergency department utilization and preventable hospitalizations caused by medication therapy problems Pass *H.R. 1936, the Medicare Diabetes Access to Care Act*, sponsored by Congressmen Schock and Welch, which preserves effective management of diabetes by ensuring continued Medicare beneficiary access to diabetic testing supplies and counseling supplied by community pharmacies.

Increase Use of Lower-Cost Generic Medications

Generic drugs are one-fifth of the cost *of brand name drugs. Nothing can save the health sys*tem more money than if, where medically appropriate, every possible prescription is dispensed with a generic drug rather than a brand, even after accounting for the lucrative rebates that PBMs earn on brand name drugs. Yet, many Federal programs generic dispensing rates are lower than the national average.

[1] Based on statistics contained within the 2010 10K SEC filings for the big 3 PBMs.
[2] Based on statistics provided to NCPA by the TRICARE Pharmacy Program.

The Congressional Budget Office ("CBO") recently reported that the generic dispensing rate in Medicare Part D is 64%[3] and the generic dispensing rate in Medicaid is 68%[4] according to a study by the Generic Pharmaceutical Association This should be compared to a generic utilization by private plans of approximately 72%.[5] Mail order generic dispensing rates are much lower. The increased use of mail order drives up drug spending and results in fewer opportunities for face to face interventions by pharmacists. These interventions improve drug therapy and reduce health care spending on expensive health care encounters in the hospital emergency room. Greater reliance on the delivery of prescription drugs through retail pharmacy will improve generic dispensing rates in federal healthcare programs, thereby achieving billions of savings over the existing system. Here is a comparison of generic dispensing rates of mail order pharmacies to retail pharmacies:

Mail Order Generic Dispensing Rates[6]

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

Community Pharmacies Generic Dispensing Rate[7]

72%

Collect Billions of Dollars in Manufacturer Rebates Being Retained by PBMs

Most federal programs use pharmacy benefit managers (PBMs) to administer drug benefits. These include Medicare Part D, Medicaid, FEHBP, and TRICARE. Yet, the federal government is unable to determine accurately whether 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. In addition, federal programs are not currently tracking whether PBMs retain a percentage of total manufacturer rebates as well as funds that are intended for pharmacy professional services and cost of dispensing.

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]

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[3] Congress of the United States, Congressional Budget Office, *Effects of Using Generic Drugs on Medicare's Prescription Drug Spending*, September, 2010.
[4] Generic Pharmaceutical Association, *Economic Analysis of Generic Pharmaceuticals 1999-2008. $734 Billion in Health Care Savings*. May 2009
[5] Based on statistics contained within the 2010 10K SEC filings for the big 3 PBMs.
[6] *Id.*
[7] *Preliminary data from 2011 NCPA Digest, National Community Pharmacists Association.*
[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.*

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. Congress should take action to bring transparency to what happens to these rebates and force PBMs to pass through these rebates to the federal government.

Refocus Government Fraud Efforts on Truly Fraudulent Activities

The Federal government is legitimately focused on assuring program integrity. We work closely with Federal and state agencies to assure that there is nothing but the highest program integrity in the government programs in which we participate. However, government policymakers should be concerned about the potential for fraud in PBM-administered programs. There are numerous settled and active cases of fraud against PBMs which should raise policymakers' concerns. Here are just a few:

- In *State Attorneys General v. Express Scripts, Inc*. (filed May 27, 2008), State Attorneys General in 29 states and the District of Columbia settled consumer protections claims against Express Scripts for $9.3 million plus up to $200,000 reimbursement to affected patients. The claims resulting in settlement alleged that Express Scripts engaged in deceptive business practices by illegally encouraging doctors to switch their patients to different brand name drugs for the purpose of saving the patients and their health plans money despite the fact that these switches did not necessarily result in any savings for the patients or the plans, but actually resulted in higher margins and bigger rebates for Express Scripts. The settlement also prohibited Express Scripts from soliciting drug switches under specified circumstances.

- In *States Attorneys General v. Caremark, Inc., et al*. (filed Feb. 14, 2008), 28 states and the District of Columbia issued complaints and consent orders against Caremark and two of its subsidiaries: Caremark, L.L.C. and CaremarkPCS, L.L.C. (formerly AdvancePCS) for their alleged illegal drug switching practices, which violated each of the States' Consumer Protection Acts. In conjunction with the complaints, the States each also issued a consent decree/final judgment with Caremark agreeing to a collective settlement of $41 million ($38.5 million to the states and $2.5 million in reimbursement to patients who incurred expenses related to certain switches between cholesterol-controlling drugs). The States alleged that Caremark engaged in deceptive trade practices by deceptively encouraging doctors to switch patients from originally prescribed brand drugs to different brand name prescription drugs.

- In *In re Pharmacy Benefits Managers Cases*, No. JCCP4307 (Cal. Super. Ct. May 30, 2003), the Prescription Access Litigation Project (PAL) and the American Federation of State, County, and Municipal Employees (AFSCME), AFL-CIO, filed suit against the nation's four largest PBMs for inflating prescription drug prices. The lawsuit alleged that through a pattern of illegal, secret dealings with drug companies the PBMs forced health plans

[10] *Id.*

and health care consumers to pay inflated prescription drug prices and reaped billions of dollars in illegal profits by steering health insurers and health care consumers into reliance on more costly drugs. This case is currently pending in the California Superior Court of Los Angeles County as of December 6, 2010.

Moreover, last year, community pharmacies had difficulty collecting tens of millions of dollars for legitimately-dispensed prescriptions from a Part D plan that was terminated by CMS from the Medicare Part D program midyear. Based on our interactions with CMS to try and get claims paid for these legitimately-dispensed prescriptions for beneficiaries, it appears that CMS had no statutory recourse to require the plan to pay pharmacies for these prescriptions. CMS stated that it lacked authority to intervene, even though CMS prepays Part D plans each month for each Part D beneficiary enrolled in the plan. This meant that in this case, CMS had already paid the terminated plan its per member per month payment for the period of the unpaid claims. The result was that taxpayers' funds were already in the hands of the plan, the plan did not initially pay the claims, and the only tool CMS was able to use was writing threatening letters to the already-terminated plan.

CMS was actively involved in the case, yet felt they had no leverage over the plan since it had already been terminated from Part D. As a result, CMS advised us to work directly with the plan. This was an unfortunate situation, given that the government had already prepaid the plan for these claims with taxpayers' funds, which the terminated plan was holding. While we appreciate that the claims were finally paid, we believe that this type of situation needs to be addressed in any expansion of fraud, waste and abuse legislation to protect the taxpayers and the Federal government from similar situations.

With respect to pharmacy fraud, we obviously believe that fraudulent pharmacies should be kicked out of Federal programs. At the same time, we are also concerned that law-abiding pharmacies are being targeted by PBMs for auditing that has little or nothing to do with fraud but everything to do with padding profits. As the OIG exclusions lists will tell you, only 0.2%[11] of all excluded providers are pharmacies, which is an indicator of the extremely low risk of fraud in our sector. Unfortunately, instead of focusing on detecting and deterring fraud, PBMs have been focusing their resources harassing law-abiding pharmacies to find non-substantive technical issues on which to base denials of claims and to recoup funds for claims already paid.

To be clear, NCPA supports appropriate auditing of pharmacies. Every provider in a government health care program expects to be subject to appropriate audits and pharmacies are no different. NCPA does not advocate for any provider having the ability to retain reimbursement for claims for which payment is not permitted under the relevant law, regulation or contract. Many PBM audits, however, are not legitimate audits. These PBM audits are nothing more than fishing expeditions by PBMs to find hyper-technical issues on which to deny payment even when the claim is otherwise allowable, legitimate and appropriate. For example, we hear multiple examples of PBMs recouping tens of thousands of dollars in prescription claims for legally-valid and appropriate prescriptions for mere technical issues such as a case in which a pharmacist placed a sticker on the back of the prescription rather than the front. Here are some typical examples from a local community pharmacy:

[11] Compiled using data from the United States Department of Health & Human Services, Office of Inspector General, List of Excluded Individuals/Entities.

- *Recently, a doctor changed the amount of refills on a written prescription without initialing it. The auditor requested $1,700 back from us – the full cost of the drug plus our dispensing costs. In protest, the physician wrote a letter affirming that it was her handwriting and that she did indeed want those refills for the patient. The auditor would not accept this and we appealed again. The physician wrote another letter but it was also refused. It's too expensive for a small pharmacy like ours to fight with a lawyer, so we're forced to pay the $1,700, not to mention the lost hours contesting this.*

- *Another doctor prescribed a specific strength of Seroquel. The doctor had to retrace the prescription because his handwriting is a little shaky. The auditor accused us of altering the prescription and attempted to invalidate it. Again, the doctor and pharmacist have to take time away from patients to affirm the prescription's legitimacy.*

- *One minor, clerical mistake was met with a $6,000 penalty. We adjudicated the claim mistakenly with the wrong doctor's name. The doctor was in the same practice as the prescribing physician, and had also seen this patient the month before, but did not write the prescription on this occasion. The audit company refused all explanations, including letters from both doctors. Finally, we appealed to the insurance company. Within 24 hours they called us back and had manually changed the doctors in their system to reflect the correction*

These practices are inappropriate and do nothing to serve beneficiaries or reduce actual fraudulent activities in the program. Instead, these are bald-faced out of control efforts by PBMs designed to recoup funds for legitimate prescriptions. Again, NCPA agrees that audits are necessary to protect the integrity of the program and to recoup any reimbursement amount that is erroneous or improper. But, the current state of PBM audits far exceeds those boundaries and is resulting in the recoupment of legitimate reimbursement amounts. For that reason, we believe that there should be more standardization on how PBMs audit under Federal programs, what issues may be legitimately subject to audit, and how pharmacies may appeal decisions and receive appropriate and prompt adjudication of these claims. This will help assure that these audit activities will be properly focused on truly going after the "bad actors", not technical administrative issues that have nothing to do with fraud. The days of big PBMs harassing small community pharmacies should stop.

Recognize Wastefulness of Mail Order

It is a popular myth that mail order saves money. PBMs want payers to think that mail-order saves because the PBMs earn (and in many cases 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. Finally, no amount of manufacturer rebates paid on a brand name drug can make a prescription less costly than if a generic is dispensed.

Community pharmacies do a much better job at dispensing generics because we don't have the perverse incentives that PBMs have to push brand name drugs through mail order outlets in order to collect lucrative rebates. The higher generic dispensing rate at retail pharmacies compared to mail-order demonstrate that retail pharmacy is much more effective at promoting generic drugs than mail order pharmacies, which results in significant savings. NCPA believes that Congress should enact legislation which stems the tidal wave in existing prescription drug payment policies that push drugs through

the mail order channel to the exclusion of retail pharmacies and perversely promotes expensive brand name drugs over generic drugs.

The TRICARE program is attempting to encourage more mail order use, even though TRICARE mail order contractor only dispenses generic drugs just over 50 percent of the time. [12] This is at least 10 percentage points lower than even other mail order programs, where the generic dispensing rate is already low. Compare this to the fact that retail pharmacies in the TRICARE network dispense generic drugs over 70% of the time.[13] TRICARE should undertake a beneficiary-focused education initiative to increase the utilization of generic drugs through retail pharmacies rather than sending them to the mail order pharmacy.

Better Management of Patients' Drug Therapy

As much as $290 billion[14] is spent on health care each year due to 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 because we can monitor 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, NCPA urges Congress to pass S. 274, The Medication Therapy Management Empowerment Act of 2011. This proposed legislation will provide more coverage for and greater access to MTM services provided by community pharmacies, encourages preventive care among Medicare Part D beneficiaries and improves medication adherence by Medicare Part D beneficiaries. The end result is that more investment in MTM services reaps long term savings by avoiding costly health care interventions and hospitalizations.

Reduce 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 company continues 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 lose-lose situation for Medicare and for beneficiaries with diabetes. Medicare pays for test strips

[12] Based on statistics provided to NCPA by the TRICARE Pharmacy Program.
[13] *Id.*
[14] New England Healthcare Institute, *Thinking Outside the Pillbox: A System-wide Approach to Improving Patient Medication Adherence for Chronic Disease*, 2009.

that aren't 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.

Given the costs and waste associated with mail order diabetic testing supplies, NCPA believes that Congress should pass H.R. 1936, the Medicare Diabetes Access to Care Act. This bill will preserve and ensure Medicare beneficiaries' access to community pharmacy diabetic testing supplies and the all-important face-to-face counseling that they receive from their community pharmacies. Such counseling and monitoring will improve diabetes testing adherence avoiding long run costly diabetes complications.

Conclusion

NCPA and its members remain committed to combating waste, fraud and abuse within federal healthcare programs, and stands at the ready to assist with these efforts. NCPA seeks to partner with the federal government in generating health care savings, while providing high quality health care to our patients. However, NCPA has concerns about misperceptions regarding the false savings associated with PBMs and mail order pharmacy. To summarize, NCPA maintains that passage of the proposed legislation referenced above and focusing on the issues outlined will generate more savings and eliminate more waste from federal healthcare programs than any efforts by PBMs or mail order pharmacy.