July 20, 2017

The Honorable Michael Burgess
Chairman
Subcommittee on Health
Committee on Energy and Commerce
2123 Rayburn HOB
Washington, DC 20515

The Honorable Gene Green
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
2123 Rayburn HOB
Washington, DC 20515

Dear Chairman Burgess and Ranking Member Green:

Our organization writes to express support for the U.S. House Energy and Commerce Committee Subcommittee on Health's consideration of bipartisan legislation to strengthen and sustain the Medicare program. The National Community Pharmacists Association (NCPA) appreciates the opportunity to present bipartisan legislative recommendations that should be considered in order to improve and transform the Medicare Part D program. 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.

NCPA strongly supports the following legislation that aligns with the subcommittee goals of bipartisan solutions to improve the Medicare Program. Not only will these bills help increase Medicare beneficiaries' access to health care and help decrease Medicare costs, each bill has had strong bipartisan support in the House of Representatives.

Address the Growing Problem of Pharmacy "DIR fees" in the Medicare Part D program by Enacting H.R. 1038

H.R. 1038, the *Improving Transparency and Accuracy in Medicare Part D Spending Act*, would ban retroactive "DIR fees" on community pharmacies which increase both beneficiary out-of-pocket medication costs and CMS' Part D catastrophic costs. "DIR fees" jeopardize the viability of many independent community pharmacies.

This approach would require Medicare Part D Plan Sponsors or their pharmacy benefit managers (PBMs) to utilize point-of-sale discounts—rather than post-point-of-sale pharmacy price concessions. This would lower beneficiary cost-sharing and reduce Medicare program costs and liability. This approach would not prohibit the use of pay-for-performance arrangements but rather would encourage true quality incentive programs rather than the misaligned programs that blur the line between reimbursement for ingredient cost and pharmacy performance.

Pharmacy direct and indirect remuneration (DIR) fees are effectively clawback fees assessed on pharmacies retroactively months later, rather than deducted from claims on a real-time basis at the point-of-sale. This reimbursement uncertainty makes it extremely difficult for community pharmacists to forecast revenue and operate their small businesses.

100 Daingerfield Road
Alexandria, VA 22314-2888
(703) 683-8200 PHONE
(703) 683-3619 FAX

Earlier this year CMS identified several concerns resulting from the rapid growth in pharmacy DIR fees[1]. First, beneficiaries face higher cost-sharing for drugs and are accelerated into the coverage gap or "donut hole" phase of their benefit. Second, more beneficiaries reach the catastrophic phase of the benefit, for which CMS incurs approximately 80 percent of the cost. (HHS Office of Inspector General has noted[2] that these catastrophic costs have tripled in recent years - from $10 billion in 2010 to $33 billion in 2015 – driven by pharmacy DIR fees.) Third, liability for Part D costs is increasingly being shifted from Part D plan sponsors to CMS.

These findings were reinforced and bolstered by a report earlier this year by a leading actuarial firm commissioned by NCPA[3]. In addition, MedPAC recently warned[4] that, because of DIR, the gap between gross and net drug prices has grown 20 percent annually from 2010-2015 and that "plan incentives [are] not aligned with beneficiary and Medicare."

By utilizing tactics such as pharmacy DIR fees, the Part D plan sponsor or its PBM often receives additional compensation after the point-of-sale that serves to change the final cost of the drug for the payer (i.e., the price paid to the pharmacy for the drug).

The point-of-sale price/"negotiated price" recorded on Prescription Drug Event (PDE) records is extremely significant. It is used to calculate beneficiary cost-sharing and to adjudicate the Part D benefit. Any fees or payment that are made after the point-of-sale are not reflected in the negotiated price but rather are reported to CMS separately.

Many beneficiaries and caregivers rely on the online Medicare Plan Finder to evaluate and choose a Part D plan. However, the data displayed on Medicare Plan Finder are based on point-of-sale prices. The vast proliferation of DIR and post point-of-sale price concessions have rendered this drug price information grossly inaccurate.

Enact H.R. 1316 to increase transparency into how generic drugs are priced by PBMs and paid for in Medicare and other federal healthcare programs

H.R. 1316, the *Prescription Drug Price Transparency Act*, would extend the MAC disclosure requirements currently required in Medicare Part D to TRICARE and the Federal Employee Health Benefits (FEHB) Program. As of January 1, 2016 Medicare Part D plan sponsors/PBMs must update maximum allowable cost (MAC) lists every seven days "to accurately reflect the market price of acquiring the drug" and must also disclose prices in advance of their use for reimbursement and MAC prices must be disclosed to network pharmacies "in a manner and format that is usable by the pharmacies, so that pharmacies can validate the prices."

Generic prescription drugs account for the vast majority of medications dispensed by community pharmacies, yet there is no transparency into how they are priced in federal health programs by PBMs.

[1] CMS, "Medicare Part D – Direct and Indirect Remuneration," https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2017-fact-sheet-items/2017-01-19-2.html
[2] HHS Office of Inspector General, "High-Price Drugs Are Increasing Federal Payments for Medicare Part D Catastrophic Coverage," https://oig.hhs.gov/oei/reports/oei-02-16-00270.asp
[3] "The Impacts of Prescription Drug Direct and Indirect Remuneration under Medicare Part D", Feb. 2017
[4] "Payment and plan incentives in Part D", April 7, 2017

Through hidden MAC lists, PBMs can charge federal health programs at higher rates while paying much lower reimbursement rates to independent community pharmacies.

NCPA was very supportive of the finalization of the regulatory provision that put these requirements in place for Part D. However, even in part D there are still needed reforms.

Enact H.R. 1939 to give seniors more access to discounted copays for prescription drugs at their pharmacy of choice

The *Ensuring Seniors Access to Local Pharmacies Act*, H.R. 1939, would allow community pharmacies that are located in medically underserved areas (MUAs), medically underserved populations (MUPs), or health professional shortage areas (HPSAs) to participate in Medicare Part D preferred pharmacy networks so long as they are willing to accept the contract terms and conditions that other in-network providers operate under.

Medicare beneficiary access to prescription drugs is impeded by mandates from Part D plan sponsors and PBMs that effectively dictate which pharmacy to use based on exclusionary "preferred pharmacy" arrangements between PBMs and, often, Big Box pharmacies. Independent community pharmacies are not allowed to participate in some of these arrangements, even if they offer to accept the Part D plan's same contract terms and conditions.

This situation raises patient access concerns, particularly in underserved rural and inner city areas in which many independent pharmacies are located. Indeed, this problem was noted in a recent government-funded policy brief by the RUPRI Center for Rural Health Policy Analysis, which noted, "With looming closure without replacement of many of these pharmacies, an estimated 3 million rural residents are at risk of losing the only pharmacy in their community."[5] Moreover, CMS concluded that pharmacy choice policies such as H.R. 1939 are "the best way to encourage price competition and lower costs in the Part D program."[6]

Conclusion
NCPA greatly appreciates the opportunity to share our recommendations on ways to enhance the Medicare program and increase beneficiary access to prescription drugs and related essential health services.

B. Douglas Hoey, R.Ph., M.B.A
Chief Executive Officer

[5] "Issues Confronting Rural Pharmacies after a Decade of Medicare Part D," https://www.ruralhealthresearch.org/alerts/165
[6] "Announcement of Calendar Year (CY) 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter," https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/Announcement2014.pdf