Statement for the Record
U.S. Senate Committee on Finance
Drug Pricing in America: A Prescription for Change, Part III
April 9, 2019

Chairman Grassley, Ranking Member Wyden, and Members of the Committee, the American Pharmacists Association (APhA) is pleased to submit the following Statement for the Record for the U.S. Senate Finance Committee Hearing "Drug Pricing in America: A Prescription for Change, Part III."

APhA, founded in 1852 as the American Pharmaceutical Association, represents nearly 60,000 pharmacists, pharmaceutical scientists, student pharmacists, pharmacy technicians, and others interested in improving medication use and advancing patient care. APhA members provide care in all practice settings, including community pharmacies, physicians' offices, hospitals, long-term care facilities, specialty pharmacy, community health centers, managed care organizations, hospice settings and the uniformed services.

Both Congress and the Administration have pointed out ongoing pharmaceutical benefit manager (PBM) practices in the Medicare program negatively impacting patient costs, care and access. Additional proposals from the Administration have emphasized PBMs operate in a consolidated, opaque space and pose a barrier to pharmaceutical companies lowering their prices[1] and spend a significant amount of effort trying to rectify the negative impact certain PBM practices have had on patients and pharmacies.

Build Off a Good Start

APhA appreciates the strong bipartisan support of the Committee for recent legislation signed into law that prohibits PBMs' use of so-called pharmacist "gag clauses" in Medicare and private health plans, to support the flow of information between pharmacists and their patients. These laws increase patients' access to more affordable and cost-effective medicines by empowering pharmacists to inform patients that a medication may be less expensive if purchased at the "cash price," rather than through their insurance plan. For years, pharmacists have been frustrated by their inability to help their patients who they knew were struggling with high co-payments. APhA also looks forward to working with the Committee to lower patients' out-of-pocket costs.

Similarly, APhA hopes the Committee will build off these bipartisan results to pass legislation prohibiting Medicare Part D plan sponsors/ PBMs from retroactively reducing payment on clean claims submitted by pharmacies which would, in turn, increase transparency in drug pricing, decrease beneficiaries' out-of-pocket costs and Medicare catastrophic coverage costs.

Address Retroactive DIR Fees

In 2018, APhA's House of Delegates passed a resolution stating "APhA opposes retroactive direct and indirect remuneration (DIR) fees and supports initiatives to prohibit such fees on pharmacies."[2] APhA has long had policy supporting the pharmaceutical industry's adoption of a

[1] HHS. American Patients First - The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs. May 2018, available at: https://www.hhs.gov/sites/default/files/AmericanPatientsFirst.pdf
[2] APhA. House of Delegates. Current Adopted Policy Statements 1963-2018. (JAPhA 58(4):356 July/August 2018). Pg. 115. Available at: https://media.pharmacist.com/hod/APhA_Policy_and_Procedures_2018.pdf

"transparent pricing" system which would eliminate hidden discounts, free goods, and other subtle economic devices,[3] like rebates between manufacturers and PBMs. As recognized by the Centers for Medicare and Medicaid Services (CMS), certain PBM practices, can result in higher prices at point-of-sale and consequently, higher beneficiary co-pays. DIR fees were originally designed to capture rebates and other mechanisms not included at the point-of-sale. However, DIR fees by PBMs are now being used beyond their original purpose to retroactively adjust pharmacies' payment months after the sale, sometimes below the price paid by the pharmacy. As stated by CMS in the November 2017 proposed Medicare Part D rule, "[b]etween 2010 and 2015, the amount of all forms of price concessions received by Part D sponsors and their PBMs increased nearly 24 percent per year, about twice as fast as total Part D gross drug costs, according to the cost and price concession data Part D sponsors submitted to CMS for payment purposes."[4]

Retroactive DIR Fees Increase Costs for Pharmacies and Patients

There is simply no connection between price concessions given by manufacturers to PBMs and the prices paid by pharmacies to their wholesalers. Thus, DIR fees "recovered" from pharmacies by PBMs are totally illogical (i.e., recovering money from pharmacies that pharmacies did not "receive" in the first place). Because current point-of-sale prices or copays paid by beneficiaries can be based on the contracted price before DIR is extracted, many beneficiaries actually pay higher out-of-pocket costs. CMS has cited numerous research that further suggest higher cost-sharing can impede beneficiary access to necessary medications, which leads to poorer health outcomes and higher medical care costs for beneficiaries and Medicare. Therefore, APhA strongly urges the Committee to prohibit PBMs' use of such fees as part of their payment methodology for pharmacies.

Retroactive DIR Fees Increase Medicare Catastrophic Coverage Costs

As you know, Medicare-enrolled seniors pay pharmacies a co-pay for medications, while the full price of the drug is credited against the patient's coverage limit. The PBM administering Medicare's prescription benefit decides to use retroactive DIR fees to take back a portion of the pharmacy's reimbursement for the actual costs of the patient's medication, often causing pharmacies to ultimately dispense a medication below cost, which jeopardizes maintenance of patient access. In addition, the original higher price – not the DIR adjusted price – is still counted against the patient, pushing them more quickly into Medicare's "doughnut hole" coverage gap in which they become responsible for a much greater portion of their prescription costs. Even after the coverage gap closes in 2020, the use of DIR fees significantly increases costs as these patients enter Medicare's catastrophic coverage phase, in which taxpayers are now on the hook for 80% of each patient's health care expenses.

Focus on Patient Care Services: Pharmacists Stand Ready to Help

APhA continues to remind HHS when developing mechanisms to lower drug costs to separately consider the reimbursement of the product cost, which is fixed for pharmacists, from the cost of dispensing and any related patient care service or performance incentive payment to provide adequate reimbursement under a business sustainable model that improves and does not

[3] APhA. House of Delegates. Current Adopted Policy Statements 1963-2018 (JAPhA NS8:362 July 1968) (JAPhA NS44(5):551 September/October 2004) (Reviewed 2006)(Reviewed 2011)(Reviewed 2016). Pg. 31. Available at: https://www.pharmacist.com/sites/default/files/files/16898%20CURRENT%20ADOPTED%20POLICY%20MANUAL%20-%20FINAL.pdf

[4] CMS. Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program. Proposed Rule. November 28, 2017. Available at: https://www.federalregister.gov/documents/2017/11/28/2017-25068/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare

disrupt our nation's pharmacy distribution system. Unfortunately, the current system still fails to provide a specific payment incentive for pharmacies to provide needed patient care services. A situation the Committee could remedy by passing legislation enabling beneficiaries to access pharmacist-provided patient care services under Medicare Part B. Last year, 56 Senators signed onto S. 109, the *Pharmacy and Medically Underserved Areas Enhancement*, a bill that enjoyed the support of many members of the Finance Committee. Such legislation would help improve health outcomes, increase quality, reduce costs and consequently, increase the viability and longevity of the Medicare program. In addition, this legislation aligns with team-based and cost-effective health care by facilitating opportunities for early intervention so as to minimize long-term health care costs, such as those associated with preventable higher-cost conditions. Providing coverage for patient care services by pharmacists, the medication expert on the health care team, would be a major step forward in making sure medications are appropriate and taken/ used correctly which would begin to address the $672 billion spent annually on medication-related problems and nonoptimized medication therapy, including nonadherence, [5] and maximize the federal government's significant investment in Medicare patients' medications.

APhA would like to thank the Committee for continuing to work with us and other pharmacy stakeholders to increase transparency of PBM practices for pharmacies and patients. We appreciate your ongoing leadership addressing the barriers to innovation which continue to increase America's rising health care costs. Please contact Alicia Kerry J. Mica, Senior Lobbyist, at AMica@aphanet.org or by phone to (202) 429-7507 to arrange a meeting with us to discuss the many services pharmacists provide to improve patient care, outcomes and reduce costs.

[5] Watanabe, Jonathan H. Et. al. Cost of Prescription Drug–Related Morbidity and Mortality. Annals of Pharmacology. First Published March 26, 2018. Available at: http://journals.sagepub.com/eprint/ic2iH2maTdI5zfN5iUay/full