

June 6, 2019

The Honorable Richard Neal  
Chairman, Ways & Means Committee  
United States House of Representatives  
1102 Longworth House Office Building  
Washington, DC 20515

The Honorable Frank Pallone  
Chairman, Energy & Commerce Committee  
United States House of Representatives  
2125 Rayburn House Office Building  
Washington, DC 20515

The Honorable Kevin Brady  
Ranking Member, Ways & Means  
Committee  
United States House of Representatives  
1139 Longworth House Office Building  
Washington, DC 20515

The Honorable Greg Walden  
Ranking Member, Energy & Commerce Committee  
United States House of Representatives  
2322 Rayburn House Office Building  
Washington, DC 2051

*Re: House Committee on Ways and Means and House Committee on Energy and Commerce Discussion Draft; Request for Comments*

Dear Chairman Neal, Chairman Pallone, Ranking Member Brady & Ranking Member Walden:

As the Committees consider common sense steps to take in delivering better health care outcomes and experiences at lower costs, the National Community Pharmacists Association (NCPA) appreciates the opportunity to provide our perspective and present solutions that could improve the health of all Americans in a cost-effective manner.

NCPA represents American's community pharmacists, including 22,000 independent community pharmacies. Almost half of all community pharmacies provide long-term care services and play a critical role in ensuring patients have immediate access to medications in both community and long-term care settings. Together, our members represent a \$76 billion healthcare marketplace, employ 250,000 individuals, and provide pharmacy services to millions of patients every day. Our members are small business owners who are among America's most accessible healthcare providers. NCPA submits these comments on behalf of both community and long term care independent pharmacies.

NCPA supports the Discussion Draft that is the subject of this request for comments as reflected in our responses to the Committees' questions below. NCPA is concerned, however, that while the policies reflected in the Discussion Draft seek to deal with the misaligned incentives related to the catastrophic phase, plan sponsors and PBMs will transition their business practices to squeeze small business community pharmacies of plans' lost profits. Thus, NCPA would appreciate the Committees' thoughtful deliberation of the following policy considerations that seek to move toward a more transparent system in Part D that is not built off the backs of small business community pharmacies.

First, NCPA supports ending post point-of-sale price concessions (also known as pharmacy DIR) for the plan year beginning on January 1, 2020. NCPA supports this policy throughout all phases of the Part D Benefit. Part D plan sponsors and pharmacy benefit managers (PBMs) extract nearly all pharmacy DIR fees from pharmacies on a retroactive basis. The retroactive nature of these pharmacy DIR fees breeds uncertainty with reimbursement and makes it difficult for independent community pharmacists to operate their small businesses. The fees impact more than just small business pharmacies and have been linked to an increase in patients' coinsurance and drug spend at the pharmacy counter, pushing patients into the catastrophic phase at a faster rate.

Second, NCPA supports the creation of standard pharmacy quality measures for the plan year beginning on January 1, 2020. Currently, pharmacy DIR fees come in all sorts of shapes and sizes and often include onerous "quality" based retroactive fees that are unfairly and inconsistently applied to pharmacies that have little to no control of such measures.

Therefore, to address our members' first and second priorities, NCPA supports H.R. 1034, *The Phair Pricing Act*, sponsored by Representatives Doug Collins (R-Ga.) and Vicente Gonzales (D-Texas), which addresses the retroactive nature of these fees and ensures pharmacy quality is measured consistently and appropriately. This bipartisan bill would direct all pharmacy DIR fees, excluding positive incentive payments, between a pharmacy and a Part D plan sponsor or PBM to be included at the point of sale in order to decrease patients' medication costs and provide reimbursement clarity for small businesses. The bill also requires PBMs and plans to provide pharmacies with claims level data. Finally, the legislation would direct the Secretary of Health and Human Services (HHS) to establish or approve quality measures that apply to pharmacy operations and requires all Part D sponsors to utilize the HHS-established quality measures that are standardized and pharmacy specific. Currently, Part D plan sponsors and PBMs can arbitrarily impose quality measures on pharmacies, often to maximize their own financial gain and with no apparent benefit to patient care.

NCPA also supports H.R. 803, *Improving Transparency and Accuracy in Medicare Part D Drug Spending Act*, sponsored by Representatives Peter Welch (D-Vt.) and Morgan Griffith (R-Va.), which would prohibit Medicare Part D plan sponsors/PBMs from retroactively reducing payment on clean claims submitted by pharmacies.

Third, NCPA supports ensuring reasonable reimbursement and oversight of the negotiated price for the plan year starting on January 1, 2020. NCPA argues that Part D sponsors must offer product-specific reimbursement rates to network pharmacies that at a minimum cover the pharmacy's costs of purchasing and dispensing covered items and providing covered services as specified by the Secretary. In addition, NCPA requests that Congress require that contracts between the Part D plan sponsor and CMS must contain provisions wherein the Part D plan sponsors are held accountable for any violation of any requirements associated with negotiated prices or product-specific reimbursement rates.

Next, NCPA supports the reporting of claims level data to pharmacies for the plan year beginning on January 1, 2020. NCPA argues that Congress should require plans/PBMs to include suitable claim-level detail on the electronic remittance advices that accompany payments. The claim-level detail should include all fields needed to properly identify the claim, including the Claim Authorization Number, payment amounts including the Network ID used to price the claim, the specific dollar amounts and the

appropriate qualifier codes for each payment adjustment, including any fees or incentive payments. Each of these policies will bring increased transparency to the Medicare Part D program and patient savings.

Finally, in addition to the aforementioned priorities, NCPA appreciates the Committees' thoughtful deliberation of a movement towards drug pricing transparency in the Medicare Part D program by adopting the use of CMS' National Average Drug Acquisition Cost (NADAC) as the basis for product-specific reimbursement to pharmacies participating in Part D networks, plus a commensurate professional dispensing fee. NADAC, utilized in Medicaid, is based on voluntary national surveys of pharmacies and is intended to provide states with a reference acquisition price for brand and generic drugs. Drug acquisition cost data is collected through voluntary monthly surveys of retail pharmacies (random sample of both independent and chain). Then, NADAC is calculated using an average of invoice cost data. We have been supportive of state Medicaid programs utilizing the NADAC standard in their actual acquisition-cost based reimbursement formulas required for fee-for-service Medicaid programs, and contend that adopting NADAC in Medicare Part D will lead to increased transparency and savings.

NCPA offers additional comments on the questions the Committees have posed below:

**1. How the Part D program is addressing the problem of high cost drugs and how the program could better address the costs of these drugs? Specifically, whether or not Congress should consider changing or eliminating the distinction between the initial coverage phase and the coverage gap discount program?**

- There are currently many perverse incentives in the Part D program that encourage plan sponsors and PBMs to utilize certain business practices to the benefit of their plan and to the detriment of the government, patients, and small business community pharmacies. NCPA has been very vocal about the harms of pharmacy DIR (as described above) as one such practice. While Congress has tried to address some of these perverse incentives, plan sponsors have evaded Congressional efforts by implementing different business practices.
- For example, the 2018 BBA required manufacturers to give a 70 percent discount on brand name drugs dispensed to beneficiaries in the coverage gap, which alleviated beneficiary burden in the coverage gap. More so, the manufacturer discount is applied to the beneficiaries out-of-pocket spending used to calculate when a beneficiary enters into the catastrophic phase (the TrOOP). Policymakers should reconsider whether this discount should count towards a beneficiary's out-of-pocket spending, as this current policy provides plans with perverse incentives to encourage patients to take expensive brand name drugs. This allows plans to utilize the drug's higher costs to push the beneficiary into the catastrophic phase, alleviating the plan's liability.
- In the alternative to reconsidering the aforementioned, policymakers could consider eliminating the distinction between the initial and coverage gap phases, which would eliminate the current payment requirements and responsibilities under the coverage gap for various stakeholders. Policymakers could consider requiring plans to extend the initial coverage phase for a longer period of time, thus slowing patients' entrance into the catastrophic phase.
  - NCPA is concerned, however, that any change in phases could lead to plans implementing new ways to make up for losses, likely from our small business members.

- Thus, if Congress were to eliminate the coverage gap and extend a beneficiary's initial benefit phase, NCPA contends it will be more desirable for all DIR to be passed on to patients at the point of sale (POS).
- However, if Congress eliminates the coverage gap and extends a beneficiary's initial benefit phase, plans/PBMs could still increase the usage of DIR even while the DIR is assessed at the POS. That is, plans would still have incentive to aggressively increase DIR to push patients through the elongated initial phase and into the catastrophic phase. Thus, solutions to stave off that behavior would be required, such as increased plan liability in the catastrophic phase.

**2. What share of costs should be attributed to the beneficiary, Part D plans, and manufacturers under the current system and how this share should change if the liability were shifted for the manufacturer from the current coverage gap discount program to the catastrophic phase of the Part D benefit?**

- Part D plans should take on more liability in the catastrophic phase. This could incentivize plans to increase Utilization Management (UM) methods (PA, step, etc.) to stave off a patient's entrance into the catastrophic phase.
- NCPA could support this provision so long as patient savings is addressed via changes to DIR in Part D.

**Conclusion**

NCPA is committed to working with the staff and members of the Committees in its bipartisan efforts to reduce health care costs. We look forward to additional collaborative efforts between community pharmacies and other health care providers to improve the quality of care for all patients while reducing health care costs.

Sincerely,



Karry K. La Violette  
Senior Vice President of Government Affairs & Director of the Advocacy Center  
National Community Pharmacists Association