

June 17, 2009

The Honorable Edward M. Kennedy  
Chairman, Committee on Health, Education, Labor, and Pensions  
United States Senate  
428 Senate Dirksen Office Building  
Washington, DC 20510

***Subject: Affordable Health Choices Act***

Dear Mr. Chairman:

The National Community Pharmacists Association (NCPA) welcomes the introduction of the “*Affordable Health Choices Act*”. NCPA is dedicated to health care reforms that improve the quality of health for patients, as well as reduce overall health care expenditures. Our members represent the owners and operators of more than 23,000 independent community pharmacies.

Throughout the health care reform debate, NCPA has proposed a number of policies (as indicated in the attached “Community Pharmacy Recommendations for Health Care Reform – April 2009” document) to improve medication use by expanding the responsibilities of the pharmacist in a reformed health care delivery system. We are pleased to see that certain sections of the Act would create a national framework for pharmacists to have a greater role in improving the quality of care patients receive. We respectfully provide our views on these sections, as well as other provisions in the Act.

**Section 212 – Grants to Establish Community Health Teams to Support a Medical Home Model**

We strongly support the language in this section that would require community health teams to provide patients with access to pharmacist-delivered medication therapy management services, including medication reconciliation. NCPA believes that pharmacists’ services should be an integral part of a patient’s medical home because prescription medications are the primary medical intervention used to improve health and quality of life. For example, the average individual takes 11.5 different prescription drugs a year<sup>1</sup>. A pharmacist can help patients manage and utilize their medications appropriately to achieve the best health outcomes.

As part of the patient’s interdisciplinary health care team, community-based pharmacists can help improve patients’ adherence with prescription medications, and reduce the incidence of hospital readmissions. Medication reconciliation is especially important as patients are often discharged from an institutional setting with new complex medication regimes that require education and training on appropriate self administration.

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<sup>1</sup> Kaiser State Health Facts, <http://www.statehealthfacts.org/comparemaptable.jsp?ind=267&cat=5>; Accessed June 15, 2009.

## **Section 213 – Grants to Implement Medication Management Services in the Treatment of Chronic Disease**

NCPA believes that more individuals could benefit from the medication therapy management (MTM) services provided by pharmacists, especially those with chronic medical conditions. Many of our members provide MTM services under the Medicare Part D program, and we have made several recommendations to the Senate Finance Committee to improve the operation of that program for Medicare beneficiaries.

We support the MTM grant program established in Section 213 because we believe that it will test new and innovative ways for pharmacists to deliver these MTM services to patients. That is, we believe that it will test how the delivery of and outcomes from such services are improved by providing pharmacists with more specific patient information, such as diagnosis and laboratory values, ideally delivered by connecting pharmacies to the interoperable health care network. Further, it allows pharmacists to play a larger role in reducing improper medication use, which has been estimated to cost \$177 billion in treatment costs annually.

### **Requirements on Pharmacies to Provide Health Insurance**

Most pharmacies are small employers that also try to offer health insurance to their employees. As you might imagine, as small businesses that generally operate on net 2 percent profit margin, we are concerned about new requirements that mandate employers provide health insurance to their employees. For that reason, we appreciate provisions in the bill that would provide incentives through the tax code that help small businesses defray the costs of health insurance coverage.

We ask the Committee to keep in mind that some small businesses with a small number of employees have higher average salaries than the typical small business. That is because pharmacies are required to hire highly-trained health professionals that command higher salaries in the marketplace. Therefore, we ask the Committee to consider this factor when determining the average annual salary phase out for tax incentives to provide health insurance.

### **Inclusion of Medicare DME Pharmacy Accreditation Exemption**

NCPA strongly supports the inclusion of language that is contained in S. 511, the “*Access to Durable Medical Equipment Act*”, which has been introduced by Senators Tester and Brownback. This bill would provide pharmacies with the same modified exemption from the CMS DME accreditation requirements that was granted to 17 other categories of health care professionals.

Pharmacies are among the only state-licensed, state-regulated health care providers now required by CMS to obtain costly and redundant “accreditation” to continue to sell diabetes testing supplies. These policies are unduly burdensome on small, independently owned pharmacies that have only a small percentage of their business in this area. In our view, these accreditation requirements were developed for those unregulated, unlicensed entities whose primary business is DME, not existing state-licensed health providers, whose Medicare DME sales only constitute a very small percentage of their overall sales. Accreditation will force many independent pharmacies to stop providing diabetes testing supplies, thereby dramatically limiting the access of Medicare beneficiaries to these products and services.

## **Features of Potential Public Plan Option**

NCPA recognizes that an intense discussion is occurring in relation to whether a publicly-administered health insurance plan should be established, and what form any such plan should take. We believe that the drug benefit component of any public plan that may be established should be administered by a Pharmacy Benefits Administrator (PBA), rather than a Pharmacy Benefits Manager (PBM). The PBA model (such as a fiscal intermediary) is how most Medicaid programs administer their drug benefit, as does the Department of Defense's TRICARE pharmacy benefits program.

Administrative costs are much lower in the Medicaid drug benefit program than in PBM-administered programs.<sup>2</sup> In addition, the Medicaid and TRICARE programs benefit more fully from manufacturer rebates and discounts, as the PBAs that administer these programs generally pass through all these price concessions to the government program sponsors. This is usually not the case with PBM-administered programs, where a significant portion of the rebates are retained by the PBM.

We believe that it makes most sense for the drug benefit component of a public plan option to be linked to the other health care components of the public plan. This will help demonstrate how effective use of medications can help reduce hospitalizations and other health care interventions. For that reason, we support the inclusion of pharmacist-delivered medication therapy management services in the public plan option. With a truly integrated approach, the value of pharmacist provided MTM and greater adherence to medications can be best realized.

Mr. Chairman, we appreciate your recognition of the potential role for pharmacists in an expanded health care system. We look forward to working with you as these proposals move forward in Congress, and ask you to call on us if we can be of further assistance.

Sincerely,



Bruce T. Roberts, R.Ph.  
Executive Vice President and CEO

cc: Senate HELP Ranking Member Michael B. Enzi

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<sup>2</sup> Adults in Medicaid pay on average administrative fees of \$1,752 annually, which is \$501 less than the average administrative fees paid by patients in low income privately insured plans. (Rowland D, Lyons B, and Rudowitz R. "Medicaid As A Platform For Broader Health Reform: Supporting High-Need and Low-Income Populations." Kaiser Family Foundation, May 2009. Average administrative fees for children enrolled in Medicaid are \$749, which is \$349 less than average administrative fees for children enrolled in low income privately insured plans. (ibid.)