January 4, 2013

National Healthcare Operations, Healthcare and Insurance
U.S. Office of Personnel Management
1900 E. Street, NW, Room 2347
Washington, D.C. 20415

Re: Patient Protection and Affordable Care Act; Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges; Proposed Rule; RIN 3206-AM47

To Whom It May Concern:

On behalf of the National Community Pharmacists Association (NCPA), I am writing to highlight several issues that OPM may wish to consider as it moves forward with the implementation of the Multi-State Plan Program as required under the Affordable Care Act (ACA). NCPA represents America’s community pharmacists, including the owners of more than 23,000 community pharmacies, pharmacy franchises and chains. Together these employ over 300,000 full-time employees and dispense nearly half of the nation’s retail prescription medicines.

In addition to restating the PBM reporting requirements required of all Exchange plans under the ACA, OPM should also implement the PBM transparency provisions that the Agency recently put into place for the Federal Employees Health Benefit plan (FEHBP) for the Multi-State Plans (MSPs) in any final rule.

On March 12, 2012, HHS published the final rule on Health Insurance Exchanges and NCPA was pleased to note the inclusion of the PBM transparency requirements required of PBMs that serve qualified health plans (QHPs) in exchanges and Part D that were included in Section 6005 of the ACA. Section 156.295 of the final exchange rule is entitled *Prescription drug distribution and cost reporting* and requires all QHP issuers (in a form and manner specified by HHS) to provide to HHS all of the following information:

- The percent of all prescriptions provided through retail pharmacies to mail order and the generic dispensing rate and substitution rates of each
- The aggregate amount and types of rebates attributable to patient utilization under the QHP and the aggregate amount of rebates passed through to the QHP issuer and number of prescriptions dispensed
- The aggregate amount of the difference between the amount the issuer pays its PBM and the amount the PBM pays retail and mail order pharmacies
The Multi-State Plans (MSPs) as a subset of Qualified Health Plans (QHPs) also have to comply with the PBM transparency provisions stated in Section 6005 of the ACA. In the interest of consistency, NCPA recommends that OPM include a provision similar to Section 156.295 of the HHS final exchange rule in any final MSPP final rule. In addition, in light of the fact that the Director of OPM will set the standards for the MSPP and has the explicit statutory authority to negotiate with each MSP a medical loss ratio, a profit margin, and other terms and conditions of coverage that are in the interests of the enrollees in such plans, NCPA also recommends that OPM require MSP issuers also provide the Director of OPM with a copy of the PBM disclosures that will be submitted to HHS.

These requirements are critical to ensure that the MSPs are receiving this necessary information from their PBM in order to better manage the drug benefit portion of the plan. This required reporting will provide a baseline transparency into the relationship between the PBM and health plans. Thus, enabling them to accurately apportion PBM fees into medical/quality expenses versus administrative expenses for the purpose of compliance with the required medical loss ratio (MLR) calculation.

NCPA also recommends that OPM implement the PBM transparency provisions that the Agency put into place for the Federal Employees Health Benefit Plan (FEHBP) for the MSPs.

In advance of the 2011 plan year, OPM implemented a number of PBM transparency provisions for the FEHBP in recognition of the fact that the PBM contracting process needed a greater level of transparency and that OPM needed certain information in order to be able to better manage the drug benefit portion of the FEHBP. A recent estimate indicated that the current cost of the FEHBP drug benefit is responsible for a third of the total cost of the program. In recognizing the gravity of this statistic and attempting to better manage prescription drug costs, OPM responded by requiring PBMs that serve the FEHBP to make certain necessary disclosures that go above and beyond those required under the ACA. NCPA strongly encourages OPM to continue its new found scrutiny of the PBMs and apply these “lessons learned” to the MSPP.

**Minimum Pharmacy Access Standards Should be Required of Multi-State Plans Operating in the Exchanges**

One of the questions (#16) that OPM identified in its 2011 Request for Information on the Multi-State Exchanges was concerning ensuring access in “states or regions of the country that are difficult to serve.” Following the passage of the ACA and in response to regulations issued thus far on the topic of the Exchanges in general, NCPA has been consistent in our belief that federal standards or guidelines are essential for certain aspects of the prescription drug benefit. Community pharmacies represent the most accessible point in patient-centered healthcare. Typically, consumers do not need an appointment to talk with a pharmacist in a community pharmacy about prescription or over the counter medications or any other health-related concern. By ensuring that beneficiaries have ready access to a trusted pharmacy care provider or “safety net” of local community pharmacies, MSPs could enhance quality patient care and access.
NCPA believes, that similar to Medicare Part D and other government-funded programs, that minimum pharmacy access standards should be required of all plans (MSPs and QHPs) operating in the exchanges, such as those used in Medicare Part D and TRICARE. These standards stipulate that 90% of plan enrollees in urban areas shall have access to a retail pharmacy within 2 miles of their residence; 90% of plan enrollees in suburban areas shall have access to a retail pharmacy within 5 miles of their residence; and 70% of plan enrollees in rural areas shall have access to a retail pharmacy within 15 miles of their residence.

In Terms of Pharmacy Network Adequacy, NCPA Cautions OPM Not to Equate Access to Mail Order Pharmacy with Access to Face-to-Face Interaction with a Pharmacist

Another issue that OPM raised in its initial RFI on Multi-State Plans (#17), was the issue of how health plan issuers would handle “limited network capacity in hard-to-serve regions.” NCPA is concerned that some plan issuers may try to assert that mail order pharmacy is a cost saving technique that can provide adequate access to pharmacy services. While NCPA does not oppose the offering of mail order pharmacy as one option that should be available to plan beneficiaries, there are a number of critical factors that distinguish access to retail pharmacy from access to mail order pharmacy. The intrinsic value of face to face contact with a pharmacist and related counseling typically results in more effective medication use and optimized health care outcomes which may ultimately save money on averted downstream medical care. Finally, mail order pharmacy may not be suitable for certain patient populations, like the elderly or those with multiple chronic conditions, that typically benefit the most from personalized attention from their pharmacist.

OPM Should Reinforce in Any Final Rule that Multi-State Plans Operating in an Exchange Must Comply With “Any Willing Provider” Laws, PBM Audit Laws or Prohibition on Mandatory Mail Order Pharmacy Laws.

In response to concerns about sufficient pharmacy access, many states have passed “any willing pharmacy” laws to ensure that health plans operating in their state that provide prescription drug benefits through a pharmacy network must allow the inclusion of any pharmacy willing to meet the terms and conditions for participation in the plan’s network. Many times, health insurers do not fully comply with these requirements leading to the necessity of State Insurance Departments frequently issuing “reminders” to the health insurers. Furthermore, many states have passed legislation that establish common sense rules for PBM audits of pharmacies as well as legislation that prohibits the imposition of mandatory mail order pharmacy provisions on health plan beneficiaries. NCPA feels strongly that OPM should issue in any final rule or alternately, in sub-regulatory guidance, a provision that reinforces that multi-state plans operating in an Exchange must comply with any state “any willing provider” or “any willing pharmacy” law, PBM audit law or prohibition on mandatory mail order pharmacy law that is currently in force and effect.
Commercial health insurance offerings, as well as government-sponsored health insurance programs, have seen the advent and rise of “limited” or “preferred” pharmacy networks. In order to ensure sufficient beneficiary access to pharmacy services and to avoid any one pharmacy provider being allowed to dominate the multi-state plan marketplace, independent community pharmacies should be allowed the opportunity to participate in preferred pharmacy networks. Any pharmacy that wishes to join any “preferred” network may have to agree to the same terms and conditions as those imposed on all network participants. Just as there are standards for networks, any preferred networks that are created must have determined access standards so that beneficiaries are not discriminated against.

Many Consumers of Multi-State Plans in the Exchanges are Likely to Share Common Characteristics with Medicaid and/or Medicare Beneficiaries and Therefore, Additional Guidelines and Protections are Needed

Many of the protections and guidelines related to network adequacy that are currently in place for Part D beneficiaries and in some cases Medicaid beneficiaries recognize the vulnerable nature of these populations either in terms of age, medical condition or poverty level. Exchanges are going to be utilized mainly by a demographic that has had little or no access to health insurance, and in turn, access to health care services or prescription drug therapies. Therefore, this is a population that in the early years of Exchange operation are likely to need added protections or oversight to ensure they will be receiving high quality products and services that are appropriate to meet their needs. In the absence of any specific federal guidelines for network adequacy, it is therefore essential that at a minimum, any state laws or regulations that have been passed that address this issue are upheld and actively enforced with regard to plans offered in the Exchanges.

NCPA Recommends that OPM require MSPs in State Exchanges to include an Annual Pharmacist-Provided Comprehensive Medication Review As a Quality Improvement Strategy

The Affordable Care Act stipulates that “qualified health plans” in an Exchange must implement a quality improvement strategy that provides increased reimbursement or other incentives for a number of activities including: (1) improvement of health outcomes through medication and care compliance initiatives; (2) activities to prevent hospital readmissions; and (3) implementation of wellness and health promotion activities.

To this end, NCPA recommends that MSPs in state exchanges include, as a covered service, an annual Comprehensive Medication Review administered by a pharmacist in their area. The pharmacist shall review the patient’s complete medication profile to detect any potential conflicts or duplications and work with the patient’s doctor(s) to optimize each patient’s medication regimen. This type of medication therapy management (MTM) has been recognized by both the Medicaid and Medicare programs as an effective tool, particularly with respect to those patients with multiple chronic conditions. In addition, there are pharmacy quality metrics that are currently being utilized by CMS for purposes of the Medicare Part D program that could be utilized by qualified health plans to measure pharmacy performance. NCPA urges OPM consider the value of pharmacist provided MTM services as well as the utilization of pharmacy quality metrics when providing MSPs with more information surrounding their quality improvement strategy.
Conclusion

OPM has a proven track record in administering the Federal Employees Health Benefits Plan and under the ACA, the OPM Director has wide latitude and discretion in negotiating contractual terms with each Multi-State Plan issuer for the express benefit of the enrollees in such plans. Given the somewhat vulnerable nature of Exchange consumers at least in the short term, NCPA is hopeful that OPM will consider the implementation of additional federal standards or guidelines in the area of prescription drug benefits and emphasize the importance of the retention of existing state requirements in this area. NCPA greatly appreciates the opportunity to provide these comments and suggestions.

Sincerely,

John M. Coster, PhD., RPh.
Senior Vice President, Government Affairs