



NATIONAL ASSOCIATION OF
CHAIN DRUG STORES

**Testimony in Support of
HB 7324 An Act Concerning Medicaid
Reimbursement Rates to Pharmacists**

**Impact of the Federal Deficit Reduction Act of 2005 on
Pharmacy Reimbursement, Use of Low-Cost Generics, and
Continued Pharmacy Access in Connecticut Medicaid**

Testimony of the
National Association of Chain Drug Stores
to the
Committee on Human Services

Presented by:

Brian K. Bruen
Director, Policy Studies & Research
National Association of Chain Drug Stores
413 North Lee Street
Alexandria, VA 22314
(703) 549-3001

The National Association of Chain Drug Stores appreciates the opportunity to submit testimony to the Committee on Human Services concerning the financial threat looming on the horizon for Connecticut's community retail pharmacies. Connecticut's pharmacies will later this year face a federally mandated \$11.9 million annual reduction in state and federal payments for generic drugs dispensed under the Medicaid program. We are here to ask the support of the Committee on Human Services for House Bill 7324, which provides for an adjustment to the dispensing fees paid to pharmacies by Medicaid, using the \$5.96 million windfall to Connecticut resulting from the mandated federal reductions and the available federal match to offset these devastating cuts.

We would also ask the Committee to consider a technical change to the legislation which we believe would more accurately represent the legislation's intent. As the federal cuts are likely to be implemented in state fiscal year 2008, we believe the study referenced in Section 1 of House Bill 7324 should focus on the impact of new upper limits in that fiscal year.

Connecticut's approximately 630 community retail pharmacies employ more than 36,700 people – including over 1,500 pharmacists – and pay an estimated \$326 million in taxes to the state annually. These pharmacies meet the prescription drug needs of every Medicaid beneficiary in the state, even when those beneficiaries are unable to pay state co-payments. These pharmacies also helped to successfully transition thousands of seniors and persons with disabilities to the Medicare Part D prescription drug program early last year, with pharmacists and other pharmacy staff working long hours to ensure that the prescription drug needs of the state's elderly and disabled were met.

The Deficit Reduction Act and its Threat to Connecticut's Pharmacies

Under the Deficit Reduction Act of 2005 (the DRA), the Centers for Medicare and Medicaid Services (CMS) will later this year revise the formula for setting the federal upper limits (FULs) on how much states can pay pharmacies for generic prescription drugs dispensed under Medicaid. Those changes will drastically reduce those FULs and expand the number of drugs to which FULs are applied.

Under the new federal rules, FULs will now be based on the lowest "average manufacturer price (AMP)," which is supposed to reflect prices paid to pharmaceutical manufacturers for drugs distributed to the "retail pharmacy class of trade." However, the definition of AMP proposed by CMS would include sales to mail order pharmacies, pharmacy benefit managers (PBMs), outpatient clinics and outpatient hospital pharmacies. All of these types of pharmacies receive prices, discounts and rebates that are not available to community retail pharmacies. This definition also would not reflect additional costs that retail pharmacies normally pay to wholesalers for their services. As a result, AMP will not approximate retail pharmacy's acquisition costs.

This proposed definition is a significant change from current practice, under which FULs are based on the lowest published list price (typically average wholesale price (AWP) or wholesale acquisition cost (WAC)). In addition, the AMP-based FULs will be established as soon as there is one generic on the market, rather than after there are two, as under current law.

Impact on Pharmacy

In late January of this year, the Government Accountability Office (GAO) reported to Texas Congressman and former U.S. House Energy and Commerce Committee Chairman Joe Barton that the new AMP-based FULs will average 36 percent below what it costs pharmacies to purchase generic drugs. For more expensive generics, AMP-based FULs will average 65 percent below pharmacies' acquisition costs. In January 2006, the Congressional Budget Office (CBO) estimated that the DRA's FUL provisions would reduce retail pharmacies' total Medicaid product reimbursement (state and federal) by around \$6.3 billion between 2007 and 2010, with federal spending reduced by \$3.6 billion and state spending by \$2.7 billion. It should be noted that CBO assumed "that states would raise dispensing fees to mitigate the effects of the revised payment limit on pharmacies and preserve the widespread participation of pharmacies in Medicaid" [emphasis added].

The National Association of Chain Drugs Stores has estimated that the change in the FUL formula could reduce Medicaid's upper limits for generics with existing FULs by as much as 70 percent. Across all generic drugs, reimbursement could fall by an average of about 25 percent nationwide even when the dispensing fees paid to pharmacies are included. For Connecticut Medicaid, NACDS estimated a total cut of about \$8.90 for each generic prescription dispensed, or a total reduction in pharmacy reimbursement (state and federal) of \$11.9 million once AMP-based FULs are implemented and fully annualized. Connecticut Medicaid will realize a windfall of nearly \$6.0 million from this reduction.

Connecticut Medicaid pays pharmacies a dispensing fee of \$3.15 per prescription. This fee falls well below the actual costs required to maintain the pharmacy and to dispense prescriptions. The current fee is about 30 percent of what the accounting firm Grant Thornton LLC recently estimated to be the average cost of dispensing a prescription nationally (\$10.50 per prescription). It is 32 percent of the average for retail pharmacies in Connecticut (\$9.72 per prescription) in that same study.

The current fee is even 40 cents lower than the \$3.55 Medicaid dispensing fee in effect 20 years ago, in 1986, despite constantly escalating pharmacy costs.

The average net profit for chain pharmacies is just 2 to 3 percent. Profit margins have been shrinking for several years due to reimbursement cuts and increasing product and administrative costs. Once AMP-based reimbursement for generics is implemented, Connecticut's community pharmacies – particularly those in urban centers and remote rural areas where Medicaid populations are most concentrated – could find their profit margins dramatically smaller if not entirely eliminated. It could become financially difficult for some pharmacies to maintain their current operating hours and staffing levels, or to continue to provide a number of services such as free delivery. Stores could even be forced to close. These unintended consequences would, in turn, have a detrimental impact on pharmacy access for Connecticut's Medicaid beneficiaries and other community residents.

Generic Incentives are Crucial to Connecticut Medicaid's Fiscal Health

Ensuring that pharmacies are adequately reimbursed for generic drugs is not only important to maintaining pharmacy access for Medicaid beneficiaries and other citizens, but also crucial to ensuring that Medicaid program costs are kept in check. The average cost of a generic paid for by Connecticut Medicaid program in the first six months of 2006 was about \$26 – less than 16 percent of the \$165 average cost for brand-name drugs and a \$139 difference.

If pharmacies are reimbursed below their costs for generic drugs, there will be a significant financial disincentive for them to continue to ensure that low-cost generics are dispensed before their more expensive brand name equivalents. Connecticut Medicaid law requires prescribers to substitute lower cost generics for off-patent brands unless they can document the clinical failure of the generic equivalent and they write on the prescription must be dispensed as written. However, pharmacists can make Medicaid beneficiaries aware of generic alternatives for other brand-name medications they may be taking or recommend generic medications for other, untreated health conditions that the beneficiary can discuss with his or her physician. Where financial disincentives to dispense generics exist, it is less likely that the dispensing pharmacist will make that extra effort.

Conclusion

Given AMP-based pricing that threatens to cut reimbursement to pharmacies for generic drugs at or below their costs to acquire those drugs, Medicaid dispensing fees will have to be adequate to cover dispensing costs. Otherwise, Connecticut's community retail pharmacies will suffer a crippling financial hit and the state's residents – particularly Medicaid beneficiaries but also other residents – could find access to pharmacy services curtailed. In addition, the state's attempt to save costs by shifting use to low-cost generics could suffer a serious setback.

We respectfully ask the Committee to support House Bill 7324, the technical change noted above, and subsequent adjustments in pharmacy dispensing fees. These changes can be supported by \$6 million state windfall under the DRA and the available federal match. Connecticut Medicaid should use this fee increase to encourage state pharmacies to continue to provide the state's low-income residents with access to the same high level of prescription drug care and services they have provided for years. Such an increase also would encourage pharmacies to continue to partner in promoting the use of cost-effective generics in the Medicaid program.