TOWNCREST Pharmacy
2306 MUSCATINE AVENUE, IOWA CITY, IA 52240
PHONE (319) 337-3526, FAX (319) 337-5271

1. In your testimony, you described the current drug pricing scheme as a "broken system." What actions by Congress are most urgent to fix the broken system, including but not limited to PBM reforms?

   Congress, much like other payers we work with, should expect certain outcomes with their purchases. Medications, regardless of their price, can cause negative outcomes if not monitored appropriately. I am fortunate that I have worked collaboratively with colleagues who are focused on practice-based research in which we have a replete of studies to demonstrate the "value" of community pharmacists, who through their knowledge and expertise ensure that their patients are achieving a positive therapeutic response with safe and effective medications. Community pharmacists across this country have story after story on how they have impacted patients through their clinical work with patients and collaborative working relationship with other health care providers. This work of community pharmacists is saving the health care system a lot of money through reductions in health care utilization including hospitalizations, emergency room visits, and appropriate medication use. Yet our system is broken because this work cannot be sustained with the current reimbursement system. So, actions by Congress can include the following:

   a. *Fundamentally, PBM and health plan reimbursement to pharmacies must be fixed first. Pharmacists cannot continue to be reimbursed less than their acquisition prices to acquire a product. PBM reform that not only demands transparency for all parties involved but enforces fair and reasonable reimbursement for product. It's not just about a transparent cost of the drug, but a fair professional fee paid to pharmacists to provide their services performed when dispensing the medication (covers the cost of filling the prescription and overhead). Without these changes, pharmacies will continue to close. No small business could continue to function this way, and often, pharmacists are the only health care provider for miles.*

   b. *Congress needs to require that both Medicaid and Medicare reimburse pharmacists, at a minimum, for their acquisition costs plus a professional dispensing fee.*

   c. *Federal laws should be passed to ensure fair reimbursement mandates and anti-affiliate self-dealing protections. Delaware is a good example where PBMs "may not reimburse a pharmacist or pharmacy for pharmacy goods or services in an amount less than the amount the pharmacy benefits manager reimburses itself or an affiliate for the same pharmacy goods or services."*

   d. *Require PBMs to have fiduciary responsibilities to patients and be audited for full disclosure of their activities.*

   e. *Banning harmful PBM business practices, including but not limited to PBMs' use of price discrimination, utilization of harmful PBM fees, and other "claw back" mechanisms on pharmacies, use of "spread pricing," and "patient steering," for brand, generic and specialty drugs and to PBM-affiliated pharmacies.*

   f. *Eliminate vertical integration.*

   g. *Eliminate arbitration clauses in pharmacy contracts and make all disputes public.*

2. How does a small business like yours contribute to the broader health of your community, including through job creation?

   Thank you for this question. I am all about the data as I frequently state, "let the data speak". First, non-optimized drug therapy is costing this country $528.4 billion each year due therapy not being optimized (to achieve a therapeutic outcome), non-adherence, under prescribing, adverse events, and other medication therapy problems).[1] *Compare that to what we spent in prescription medications, $340 billion.*[2] *So, in essence, for every dollar we spend in drug therapy, we spend another $1.55 to correct the problems associated with non-optimized drug therapy.*

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1. *Watanabe JH, McInnis T, Hirsch JD. Cost of Prescription Drug-Related Morbidity and Mortality. Ann Pharmacother. 2018 Sep;52(9):829-837. doi: 10.1177/1060028018765159. Epub 2018 Mar 26. PMID: 29577766.*
2. *https://actuary.org/prescription-drug-spending-in-the-u-s-health-care-system/#:~:text=Health%20care%20spending%20in%20the,was%20spent%20on%20prescription%20drugs.*

I operate eight pharmacies and have over 70 employees in eastern Iowa. My pharmacies continue to innovate by offering patient and preventive care services, such as Medication Therapy Management (MTM) wellness screenings, immunizations, and adherence services. Many of our rural communities don't have access to any other health care provider for miles. If we're serious about improving preventive care and treating chronic disease, Congress needs to act now to keep community pharmacies like mine open. I am proud to provide jobs to neighbors in my communities and continue to offer innovative services to expand access to care and create job opportunities in my state. My pharmacy is a lifeline for my fellow Iowans who could lose access to their only trusted health care provider if I can't keep these pharmacies open. Congress should immediately pass federal legislation, such as H.R. 3164, the Ensuring Community Access to Pharmacist Services Act (ECAPS), and Senator Grassley's Pharmacy and Medically Underserved Areas Act to allow Medicare beneficiaries to use their insurance to receive services provided by pharmacists practicing within their state scope of practice. This will create new opportunities to create jobs in rural communities and provide life-saving health care services to our nation's seniors.
As I mentioned in my earlier question, we have demonstrated that we can identify medication therapy problems (MTPs), work with the patient and prescriber to resolve the MTPs and monitor the patient to ensure they are achieving a positive therapeutic outcome. So, through appropriate medication management, we are contributing to the health of the community. Add on the primary care services that we provide in the community, the community pharmacists impact can and does affect the health of the community. Here are other reasons why we contribute to the health of a community.

a. *We are fully embedded in our community. We are best able to spot health related trends quicker than organizations outside our pharmacy and community. We have cultivated strong relationships with our patients, providers, and community partners such as public health agencies, food banks, emergency management agencies, law enforcement agencies, and churches.*

b. *When we can provide our full level of services, the community is stronger as we are a hub for healthcare in the community. Pharmacy staff are the most accessible healthcare providers. We can provide patient physical and mental health assessments, test and treat medical conditions, administer immunizations, and make recommendations on many healthcare issues.*

c. *We assist local medical staff with drug information, patient compliance information, and other important drug therapy services.*

d. *We help patients with referrals to local and regional agencies for help with everything from provider appointments, obtaining food, shelter, insurance assistance, transportation assistance, and home repair services through our imbedded community health workers (CHWs) and other pharmacy staff. Our staff perform Social Determinates of Health surveys and can provide immediate action based on patient needs.*

e. *Communities and neighborhoods that have a pharmacy are more likely to attract other retail businesses, medical facilities, and factories. Pharmacies create daily traffic for the community and stop retail leakage. Pharmacies make communities more efficient by reducing the amount of time needed to obtain healthcare which leads to less time away from work and school.*

f. *Pharmacy staff participate in community boards, volunteer in community projects, mentor youth and promote small business formation by example and mentorship.*

3. What unique strengths in patient service and care do you feel independent pharmacies can bring to their communities that big corporate pharmacies cannot?

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We are embedded in the community and have firsthand information about local health issues and local patient needs. We can tailor our services to the specific needs of our patients and communities. When adequately paid for our services, we can start pilot programs to bridge the gap between the services being provided and those needed by the community. We have relationships with patients that other providers do not have. We see the patients in our pharmacy and in the community and know them by name. We look out for them and in many cases see changes in a patient's health before their physician does. Our relationships with patients and providers speed up access to care which improves patient health outcomes. Our transition of care services prevents drug therapy errors caused by multiple factors. We protect patients from negative medication therapy outcomes when the patients are the most vulnerable. Patients see us as a trusted source of information and care. We are the people that translate medical information into a form that patients can understand. In many cases the pharmacy owners and staff all live in the same community that the pharmacy provides services.

Community pharmacies know their patients, and their patients trust them. I can offer a level of patient care services that big corporations and PBMs simply cannot. For example, my patients have access to a live person, pharmacists who are clinically trained, whom they trust and who advocate for their best interests. As I stated in my testimony, current PBM reimbursements constantly put me in an ethical dilemma where I often take a loss on medication to ensure my patients receive the lifesaving medications they need. We need to remember the adage, "It's all about the Patient," as we look for ways to improve the system. Right now, due to consolidation in the healthcare marketplace and the big PBMs ' take-or-leave-it contracts that provide zero or underwater payments to community pharmacists, it seems to be anything but about the patient!

4. The largest PBMs use spread pricing for pharmacy reimbursement. These PBMs retain a portion of rebates, which do not flow to the end consumers. Why do benefits brokers and consultants continue to advise plan sponsor payer clients to use PBMs which utilize this strategy?

   The spread pricing models allow for the most profit for the PBMs and allow the benefit brokers and consultants to siphon money from the plan for uses that do not reduce the cost of healthcare. These plans tend to pay pharmacies below the cost of dispensing. It is a form of corporate theft from the pharmacy as the pharmacy is not being reimbursed for the cost of the medications that they dispense or for the services that they provide to the patient and the health plan. This is one of the biggest causes of increased healthcare costs.
   Brokers and consultants may not owe a fiduciary duty to plan sponsors and may have misaligned incentives to recommend higher total drug spend plans due to kickbacks they receive from PBMs. PBMs are focused on profits and not patients. APhA has urged the FTC to address the issue of health care insurance brokers and the kickbacks they receive from PBMs for securing business. The legality and appropriateness of these financial arrangements have not been fully investigated or illuminated, adding significantly to the cost of health care, and may be used as a tactic to further restrict trade in the employer-purchased insurance market, including PBM selection by not presenting employers with the broadest range of options for benefit management, such as with smaller transparent PBMs. Congress needs to implement reforms banning PBMs' abusive use of spread pricing and put patients over PBM profits.

5. What alternatives exist to the spread pricing model that would better benefit consumers?

   Insurance models where all rebates are passed through to lower the cost of the plan to the patient and to pay the pharmacy provider appropriately for their products and services.

   I would recommend looking to the states. For example, Ohio's Single Pharmacy Benefit Manager (SPBM) model, where a recent two-year report found:
   - *$333 million in administrative savings.*
   - *Nearly $140 million in net savings.*
   - *Over $700 million in dispensing fees paid directly to Ohio pharmacies.*
   - *A 99% pharmacy network participation rate, reversing years of closures, particularly among independents.*

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- *Elimination of spread pricing, claw backs, and network steering.*

This model delivers transparency and stability while achieving cost savings, making it a clear candidate for national consideration

6. Benefits brokers and consultants receive compensation from the Big 3 PBMs when they recommend their products to clients. Does this practice increase the friction in the transaction and if so, would prohibiting PBMs from compensating benefits brokers who work for plan sponsor payers affect the competitive landscape between PBMs?

   This practice increases the friction in the transaction and increases costs as the brokers do not create positive healthcare outcomes and tend to do only what benefits the brokers/consultants. These relationships have also led to the exclusion of local pharmacy providers for ancillary services that are contracted through other sources and likely benefit the broker/consultants and not the patients.

   Would refer to my answer above. APhA supports Congress and the FTC ending the anti-competitive business practices.

7. How has recent vertical integration between PBMs and insurers affected competition, pricing, and access to generics and biosimilars?

   Pharmacies are forced to purchase more expensive generic and biosimilar brands than the pharmacy can purchase from their wholesaler. Vertical integration also creates unwarranted classes of "specialty drugs" that do not deserve this classification. These "specialty drugs' are only available through PBM owned specialty pharmacies where the prices charged to the patient's insurance plans are greatly inflated. Service from these pharmacies tends to be unreceptive to patient needs and can delay access to medications and/or deliver medications that have not been handled safely due to temperature and handling.

   Overall, it has increased prices and restricted access. Would refer the Committee to:
   a. *The FTC's second interim report found that the large PBMs charge significant markups for cancer, HIV, and other critical specialty generic drugs.*
   b. *The House Committee on Oversight and Government Reform's PBM report, which found the vertically integrated PBM marketplace has "monopolized the pharmaceutical marketplace by deploying deliberate, anticompetitive pricing tactics that are raising prescription drug prices, undermining community pharmacies, and harming patients across the United States."*