July 11, 2024

Hemi Tewarson, JD, MPH
Executive Director
The National Academy of State Health Policy (NASHP)
1233 20th St., N.W., Suite 303
Washington, DC 20036

Re: Prescription Drug Affordability Boards and Upper Payment Limit Plans

Dear Executive Director Hemi Tewarson,

We, the undersigned, greatly appreciate the NASHP's work to track and inform state policymakers on important matters that affect Americans and their access to healthcare such as lowering prescription drug costs. The National Association of Chain Drug Stores (NACDS), the American Pharmacists Association, and the National Community Pharmacists Association are committed to providing and promoting high-quality patient care, improving patient access, and lowering healthcare costs across the care continuum for patients while supporting pharmacy providers in the process. We are writing to comment on the Upper Payment Limit (UPL) policies along with NASHP's model language referencing the UPL [1] being considered by some Prescription Drug Affordability Boards (PDABs) across the country. To date, PDAB legislation has been enacted in 11 states with the expectation that more states will soon follow.[2] Of the eleven currently enacted PDABs, four contain UPL price limit threshold provisions.[3]

We understand and support the purpose of the PDABs; however, we fear there may be a significant impact on the availability and accessibility of certain prescription drugs at a patient's neighborhood pharmacy in states where the UPL provision is being considered and effectuated. We believe this would have unintended consequences of restricting patient access, exacerbating pharmacy closures, and further decreasing pharmacy reimbursement to unsustainable levels (which are already often below cost) by market-dominant Pharmacy Benefit Managers (PBMs). To that end, our pharmacists and pharmacies are encouraged by the spirit of these policies to help lower prescription drug costs for patients and want to be part of the solution while ensuring appropriate guardrails are put in place to protect the pharmacy providers that provide frontline healthcare to all Americans.

Pharmacy Reimbursement Overview

Pharmacy reimbursement should be comprised of two parts: 1) the product cost; and 2) a professional dispensing fee across payer markets (e.g., Medicaid, Medicare, commercial) to help ensure reasonable reimbursement and sustainable pharmacy services for beneficiaries. The dispensing fee is typically

[1] https://eadn-wc03-8290287.nxedge.io/wp-content/uploads/2022/12/2022-PDAB-Model-Act_Form_080222-2.pdf
[2] Colorado, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Ohio, Oregon, and Washington.
[3] Colorado, Maryland, Minnesota, and Washington.

calculated to incorporate the costs of a pharmacist's time reviewing the patient's medication history/coverage, filling the container, performing a drug utilization review, overhead expenses (rent, heat, etc.), labor expenses, patient counseling, and more to provide quality patient care.[4] For example, in Medicaid, the Centers for Medicare and Medicaid Services (CMS) requires all states to adopt a more transparent reimbursement model under the 2016 Covered Outpatient Drug Final rule[5]. CMS' final rule uses actual acquisition costs and a professional dispensing fee as a benchmark to balance the need for affordable solutions and adequate reimbursement for actual costs. To illustrate further, Maryland Medicaid performed a cost of dispensing (COD) study in 2020 that found on average, Maryland pharmacies, including specialty, spent $13.72 to dispense most medications. Additionally, for non-specialty pharmacies only, the average cost of dispensing was $12.03 per prescription.

Without necessary guardrails to ensure reasonable reimbursement for community pharmacies, UPLs could inadvertently result in inadequate or below-cost reimbursement to pharmacy providers and pharmacies by failing to make up the difference between the UPL and the pharmacy's cost to acquire and dispense the prescribed drug. This outcome could force pharmacies to either operate at a loss, choose not to stock certain medications that a UPL applies to, or worse, potentially close their doors permanently—ultimately worsening patient outcomes, reducing medication adherence, and increasing prescription abandonment. Careful consideration of the impact on pharmacies and the communities they serve is important to help avoid preventable adverse downstream consequences on patient access to essential medications and overall health outcomes.

Proposed Solutions to Ensure Patient Access to Affordable Medications

We are concerned that UPLs will exacerbate inadequate and unreasonable pharmacy reimbursement if they do not incorporate reasonable reimbursement methodologies and practices to help preserve patient access. NASHP should revise its model UPL language to ensure that the PDAB-established UPL is never lower than a pharmacy's actual acquisition cost. This will ensure that UPLs do not further strain the finances of pharmacies. Additionally, the UPL must include a requirement for applicable payers to provide professional dispensing fees or administration fees aligned with the state's Medicaid's professional dispensing fee rates (discussed above) on any prescription claim subject to a UPL. The Colorado PDAB has already set a precedent of incorporating a pharmacy dispensing fee in its UPL methodology.

Furthermore, PDABs should also consider adjusting the UPL in a timely manner, similar to CMS, for selected drugs that fall below the acquisition and dispensing costs so that pharmacies are not subject to underwater reimbursement from any payer. Lastly, we respectfully ask NASHP to share the pharmacy communities' proposed solutions regarding PDAB's UPLs with relevant members engaged in these efforts.

[4]CMS defines the professional dispensing fee at 42 CFR § 447.502 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447/subpart-I/section-447.502

[5]Medicaid Program; Covered Outpatient Drugs, 81 FR 5169https://www.federalregister.gov/documents/2016/02/01/2016-01274/medicaid-program-covered-outpatient-drugs

NACDS, APhA, and NCPA appreciate NASHP's efforts to advise state lawmakers on ways to reduce prescription drug costs and enhance affordability for patients and welcome the opportunity to collaborate to address these serious concerns. We strongly encourage the incorporation of adequate reimbursement safeguards, as mentioned above, for pharmacies in future NASHP PDAB model language updates and UPL action plans and toolkits. This will help ensure lawmakers understand the full scope and impact of PDABs with UPL authority on constituents, taxpayers, patients, and community pharmacies while continuing their vital work to alleviate patient costs and access hurdles to care. The undersigned organizations will continue to urge state lawmakers and PDABs to ensure fair reimbursement for pharmacists and pharmacies and the patients they serve.

For questions or further discussion, please contact NACDS at cboutte@nacds.org (Christie Boutte, Senior Vice President, Reimbursement, Innovation and Advocacy), NCPA at Joel.Kurzman@ncpa.org (Joel Kurzman, Director, State Government Affairs), and APhA at mmurphy@aphanet.org (Michael Murphy, Advisor State Government Affairs).

Sincerely,

National Association of Chain Drug Stores (NACDS)
National Community Pharmacists Association (NCPA)
American Pharmacists Association (APhA)

The National Association of Chain Drug Stores, Inc. (NACDS) is comprised of chains of diverse sizes that operate standalone pharmacies and pharmacies in grocery and mass retail settings. NACDS members include regional chains, with as few as four stores, and national chains. Please visit NACDS.org.

APhA is the largest association of pharmacists in the United States advancing the entire pharmacy profession. APhA represents pharmacists in all practice settings, including community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health. As the voice of pharmacy, APhA leads the profession and equips members for their role as the medication expert in team-based, patient-centered care. APhA inspires, innovates, and creates opportunities for members and pharmacists worldwide to optimize medication use and health for all.

NCPA represents America's community pharmacists, including 19,400 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 (LTC) settings. Together, our members represent a $94 billion healthcare marketplace, employ 230,00 individuals, and provide an expanding set of healthcare 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 concerns we have received from independent and LTC pharmacies.