NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

NCPA NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

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Stephanie A. Barna, JD, LLM
Acting Assistant Secretary of Defense for Manpower and Reserve Affairs
United States Department of Defense
6000 Defense Pentagon
Room 3E1030
Washington, DC 20301-6000

Dear Ms. Barna:

Thank you for holding the recent stakeholder meeting to discuss improving the prescription drug benefit for military families. Finding a viable path forward to restore beneficiaries' prescription access at their local community pharmacies while sustaining a cost-effective drug benefit is a worthwhile and achievable objective. Under your leadership, we stand ready to work with you and other stakeholders to find a compromise solution that will improve point-of-service access to pharmacist care, improve choice, and address correctable cost disparities within the TRICARE prescription program.

As noted during the meeting, beneficiaries that rely on brand name maintenance medications are required to access their needed prescriptions through the mail, or at a Military Treatment Facility (MTF). We believe that point-of-service prescription access can be restored to local community pharmacies, and that changes to improve access may be implemented in such a way to generate savings for the Department of Defense (DoD).

Cost Parity

Background

Under current policy, DoD pays disparate prices for acquiring brand name, maintenance medications depending on whether that medication is dispensed at an in-network community pharmacy, or through mail order/MTF. This is due to how the voluntary rebate acquisition vehicle is structured. Today's acquisition process and incentives are extended to manufacturers to yield additional voluntary rebates for prescriptions filled in a MTF or through mail order. The DoD is currently not getting those same rebates for drugs dispensed at in-network retail community pharmacies. As a result, the DoD is incurring higher costs for acquiring drugs than necessary. This disparity has forced DHA to require the use of mail order and MTFs for brand name maintenance medications instead of finding affordable solutions to ensure beneficiary access to retail community pharmacy.

Solution

This disparity can be corrected by adopting a singular contracting vehicle per class of drug regardless of the dispensing location. Testing this strategic change at this time will give DoD the opportunity to design lasting infrastructure and better prepare the agency to manage drug costs long into the future. Especially as brand name, specialty drugs become more prevalent within the population, one contracting vehicle will serve as a more effective tool to keep costs down. Recalibrating the acquisition vehicle this way also puts the patient at its center, not the point of

access. This is key to infrastructure design and will optimize the Department's ability to tailor their negotiations with manufacturers and contractors to respond to population needs within the armed forces, in line with readiness objectives, rather than directing beneficiaries to an access point that may not suit their healthcare needs.

Result

Adopting one contracting vehicle per class of drug would ensure that the DHA can effectively reach beneficiaries with chronic health conditions from day-one of their diagnosis. Adopting this vehicle will not only better prepare DHA to respond to cost pressures stemming from specific disease states but also lead to administrative efficiencies through streamlined rebate collection management processes, and less expensive dispensing fees already agreed to through in-network retail community pharmacy contracts. (See Appendix II, A). It is believed that the current administrative fees for prescriptions filled through mail order may be as much as three times higher than at the retail setting, today.

Equal acquisition costs and pricing parity begins with an acquisition vehicle that is inclusive of all points of service. Taking that important first step opens the door for a budget-neutral or potentially net cost-saving solution for DoD to restore access to retail community pharmacies for beneficiaries who rely on brand name maintenance medications via community pharmacies. Transitioning to a singular contracting vehicle essentially will arm DHA with the negotiating tools it needs to take the next step and begin to close the gap between the 32 percent average cost difference for brand-name maintenance medication prescriptions filled in mail and MTFs versus the cost of the same medications when dispensed in the retail setting. (See Appendix II, B). The agency accepts and pays these disparate prices today for the first [up to second] fill dispensed at retail pharmacies, yet more can be done to both control costs within that gap, and restore access to retail community pharmacy, if rebates are negotiated by class of drug, rather than a point-of-access basis.

Additionally, increasing access to pharmacist counseling and care can drive better value through the pharmacy benefit in several ways. Related to costs, access to pharmacist care has been proven to lead to better medication adherence. Pharmacists are also valuable assets to the health care team through their ability to correct potentially adverse drug interactions through face-to-face care. (See Appendix II, C). Health care consumers across the country are concerned with rising drug prices, and if beneficiaries can be seen at the pharmacy counter, it could improve abandonment rates and ensure high-risk patients begin to take their medications as soon as they are prescribed. (See Appendix II, D). Community pharmacists can help TRICARE beneficiaries optimize their medications, furthering DoD in its mission to excel in terms of combat readiness as well as to curb long-term health care costs while taking care of military families.

Existing Defense Health Agency Authority

The DoD and DHA have the authority to take the steps necessary to achieve acquisition cost parity through a singular contracting vehicle. (See Appendix I). However, DHA has expressed concerns that changes to the TRICARE program to achieve acquisition cost parity for brand name maintenance prescription drugs could place existing voluntary discounts at MTFs and mail order at risk through lack of manufacturer participation. In fact, the DHA has several tools available at its disposal to mitigate such risks and encourage manufacturer participation, especially if they are applied to a singular contracting vehicle that is designed to be inclusive of all points-of-service.

DHA has acknowledged how effective these tools are, and in a November 2016 presentation, the then Chief, Pharmacy Ops, DHA, Dr. George Jones stated that "[f]ormulary management plays a key role in negotiating with manufacturers" and that it led to $120M cost avoidance in FY16. (See Appendix II, E).

Specifically, the tools available to DHA within their existing wheelhouse and scope of authority include:

- preferred or basic core formulary placement;
- prior authorization; and,
- medical necessity requirements and quantity limits.

As it has done in the past, DHA can and should use these important tools in the most effective manner possible to mitigate the concern about lack of manufacturer participation and ensure continued manufacturer enthusiasm to provide discounts through any new system designed to achieve cost-acquisition parity across points-of-service.

Additional Services Furnished by Pharmacies

In addition to dispensing medications, local community pharmacists provide many valued and cost-saving services. Examples include:

- medication adherence services such as medication therapy management (MTM),
- access to health tests,
- helping to manage chronic conditions such as diabetes and heart disease,
- expanded immunization services,
- prescribing of birth control, and
- services to help combat the opioid crisis through greater access to community-based intervention services and essential screenings and immunizations related to Hepatitis B, Hepatitis C, HIV, and Tuberculosis (TB). (See: Appendix III, A).

In fact, the TRICARE program is already successfully utilizing and realizing the value of pharmacies through the provision of vaccinations to TRICARE beneficiaries. Recognizing the cost effectiveness of pharmacist-provided vaccinations, the DoD authorized TRICARE beneficiaries to obtain vaccinations at a retail network pharmacy for a $0 co-payment. In its final rule expanding the authority of retail pharmacies to provide vaccinations, DoD estimated that in the first six months of the immunization program, it had saved over $1.8 million by having vaccinations provided through the pharmacy rather than the medical benefit (*Federal Register*, Vol. 76, No. 134, p. 41064). This cost savings did not take into consideration the savings from medical costs that would have been incurred to treat influenza and other illnesses if TRICARE beneficiaries had not been vaccinated. In addition, DoD noted in its final rule that:

> *"adding immunizations to the pharmacy benefits program is an important public health initiative for TRICARE, making immunizations more readily available to beneficiaries. It is especially important as part of the nation's public health preparations for a potential pandemic, such as was threatened in the recent past by a novel H1N1 virus strain. Ensuring that TRICARE beneficiaries have ready access to vaccine supplies allocated to private sector pharmacies will facilitate making vaccines appropriately*

available to high risk groups of TRICARE beneficiaries." (Federal Register, Vol. 76, No. 134, p. 41063). (See: Appendix III, B).

As it did with immunizations, DoD should explore opportunities to utilize retail community pharmacists to their fullest extent, especially for the provision of care to TRICARE beneficiaries managing chronic conditions who rely on brand name maintenance medications.

Access to Pharmacist Care

One of the greatest value proponents of the retail community pharmacy industry to the TRICARE program is its reach. Community pharmacies provide convenient point-of-service and provide access where others simply do not. Requiring use of mail or an MTF pharmacy may not always best meet the health care needs of a TRICARE beneficiary. A MTF pharmacy may be too far to travel for a person needing face-to-face consultation with a pharmacist. Many beneficiaries have trouble identifying whether their medications are brand name or generic and don't know which pharmacy is allowed for which drugs. For others who require medication that needs special handing or refrigeration, the mail is not the best option. As a member of the health care team, pharmacists are well positioned to improve access to a wide array of services, supplementing MTFs and other overburdened providers.

In sum, eliminating the current purchasing cost disparity through a singular contracting vehicle would eliminate the need for DoD to steer beneficiaries to either a MTF or mail order to control drug costs. Testing these changes now, putting the beneficiary at the center of how DHA manages its acquisition process and negotiations with manufacturers along with other stakeholders and vendors, would give DHA the tools it needs for long term success to effectively align insurance design incentives with core population needs. Creating this linkage to the person, as opposed to the point-of-service, will not only help foster readiness but also simplify and expand the options available to military families dealing with chronic health conditions and how they access the medications and care they need to lead healthy lives.

Thank you again for your leadership and we look forward to continuing to work with you and other stakeholders to implement the acquisition cost parity solution that this document lays out and benefits TRICARE beneficiaries through increased access and better health, and the DoD through reduced costs and improved administration.

Sincerely,

National Association of Chain Drug Stores
National Community Pharmacists Association