Senate Committee on Finance
The Medicare Prescription Drug Benefit: Monitoring Early Experiences
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Chairman Baucus, Senator Grassley, members of the Committee, I appreciate the privilege and opportunity to speak to you again about Medicare Part D and how it is affecting my patients and pharmacy.

I am the co-owner of an independent pharmacy in Kalispell, Montana. Our pharmacy employs three pharmacists and two technicians. There are five senior apartment buildings within three blocks of the pharmacy. In addition, we provide services to three assisted living facilities and the mental health center in our community.

Medicare Part D has now been in place for about sixteen months. During this time we have seen many changes. When I testified before you in February 2006, pharmacies and patients were facing many obstacles. The obstacles included patients not in the system, formulary changes, low and non-reimbursement to pharmacies, and pharmacies not having the ability to identify dual-eligibles. There were long wait times on the phones and too much confusion for seniors and mental health patients in choosing a plan.
I have seen many positive changes though. Dual-eligibles are more accurately identified. New identification cards have complete information and no co-branding. Patients are more readily identifiable in the E-1 system. The patients' medications have been changed to meet their formularies so fewer changes are required. Reimbursement is more timely.

Medicare Part D has been a salvation for many seniors. My pharmacy serves a very limited income community. These patients' budgets were so tight that even an antibiotic prescription forced a cut somewhere else. With Part D, these patients can afford their medication.

Even with all of the improvements, issues remain to be addressed. I continue to believe choosing a plan is too confusing. Last year, Montana had over 40 plans and this year we have over 50. I still believe there needs to be a less complicated way of choosing a plan.

Although we are not having as much difficulty meeting formularies established by the insurance companies, there are still problems. Insurance companies have changed their formularies, which forces the physician, pharmacist and patient to make a change in the patient medication. Many of these formulary changes appear to be made only for the benefit of the insurance company receiving a rebate from a drug manufacturer and not for the benefit of the patient. Also, the formularies were used as a criterion in choosing a plan for the beneficiaries. How can the insurance companies be allowed to change their formularies when a patient cannot make a change in plans? This is a great example of how patient care has not been addressed.

My pharmacy provides medication to our mental health facility. We are still having issues with changing their medication. As I testified last year, these patients should not have to change medication to meet a formulary because even a minor change can result in a hospitalization. We have seen several of our mental health patients require a hospitalization or at the very least go into a mental health safe house because of a change to meet a formulary.

I am still very concerned for patients who are forced to use mail order. Our senior population needs and deserves face-to-face interaction with their pharmacist. Our mental health patients deserve the same. There is more to practicing pharmacy than handing a patient a bottle of pills. I feel mail order compromises patient care.

I have encountered many patients for whom the donut hole was devastating. Prior to Medicare Part D, these patients were able to receive free or reduced cost medication supplied by the major drug companies. These medication programs ended for these patients when their Medicare Part D became active. The cost of the medications that were previously supplied by the drug manufacturer put these patients into the donut hole. These patients were able to pay for their generic medications and would not have been into their donut hole if the programs had continued.

I am very concerned when my patients reach the donut hole because they cannot afford drugs while they are in the coverage gap. Drug costs are extremely high, especially when generics are not available. Some of the formularies require a branded drug even when a generic is available, so we have to dispense the higher cost branded drug to the patient to meet the patient's formulary. The patient has to pay these high prices until they get through the donut hole. Being in the donut hole often means patients cannot afford their drugs and are forced to go without their medication. I saw patients hospitalized because of this. I even contacted physicians to see if we could get them on a cheaper drug.

We had patients who we knew from the implementation of Medicare Part D and their insurance formularies that they would definitely fall victim to the donut hole. We made requests with the physician to make changes in the patient's medication regimen early on. Again, this was not always optimum therapy, but it was better than leaving the patient without medication because they could not afford it.

I have had physicians vent their frustrations about the insurance formularies to me. They question who is practicing medicine, the physician or the insurance companies?

We had several of our mental health patients encounter severe financial burden after the Medicare Part D was initiated. These patients were rolled out of Medicaid services where their co-pays were $1.00 up to $5.00. The co-pays for their medication are now $30.00 to $60.00 because they are on tier 2 and 3 levels on their insurance formularies. I feel the same as I did at the start of Medicare Part D. These patients should not have been forced out of Medicaid and into a Medicare Part D insurance plan.

From my perspective, pharmacies are bearing the brunt of Medicare Part D. When Part D was initiated, pharmacists were confronted with an ethical dilemma. Do they care for the patient or do they worry about their finances? It was fortunate that the majority chose to care for the patient. The first payments my pharmacy received took 75 days, with the majority of insurance companies paying in 90 or more days. I had to pay my wholesaler every 15 days. I was forced to borrow money to meet my obligations. If it were not for the pharmacists taking care of patients last year, Medicare Part D would have failed. If the pharmacy had refused to provide medications for the patients because of non-confirmed payment, these patients would have been without medication. I am convinced that many patients would have been hospitalized because of their lack of ability to get medication.

Pharmacies are required to accept the reimbursements that are dictated by the insurance companies. When I look at our reimbursements, I cannot help but think that the insurance companies make more money on the prescriptions than the pharmacy. Reimbursement is not adequate, particularly when the shortages of pharmacists and pharmacy technicians are causing salaries to increase.

In the past year, we saw many pharmacies across the country close. In the same year, we saw an increase in the number of insurance companies offering Medicare Part D coverage.

My pharmacy – with 90 percent of patients on Part D – suffered a very large financial burden because of Medicare Part D. Sykes Pharmacy showed a profit of $81,000 in 2005 with gross sales of about $2.2 million. The profits for 2006 were $13,000 with gross sales of about $2.4 million. Our prescription volume actually increased from the previous year, which should have increased profits. What is very sad is that if we would have liquidated our inventory and invested the money, we would have been able to generate more profits than operating the pharmacy. Community pharmacies are the core of community practice. If this trend continues, there will not be community pharmacy practice.

I have discussed with my colleagues, the changes both positive and negative which have occurred in pharmacy since the implementation of Medicare Part D. The overall consensus is that the insurance companies have too much control and with no transparency. Patient care is not first and foremost. True patient pharmaceutical care needs to be face to face.

Medication Therapy Management is also at the full control of insurance companies. Insurers identify the eligible patients and then provide this service in-house. A full review of the patient's medications and discussions with the patient needs to be face-to-face. Due to fraud against the elderly, we educate our patients not to accept unsolicited phone calls or give information to people they don't know. It is confusing and scary for them to receive calls from the insurance companies. When a patient is counseled about their medication, it is important to read their body language to tell if they really understand what is being discussed. Patients do not like to discuss personal issues with

people they do not know or trust. In order to be effective and in the best interest of patient care, MTM needs to be done by the patient's local and trusted pharmacist.

I also question why the Medicare program does not recognize pharmacists as providers. Pharmacists spend a minimum of 6 years in school and obtain a specialized education. They should be paid for their professional services as part of the health care delivery system. Pharmacies should not have to sell potato chips and motor oil to make a profit.

In the sixteen months that have passed with Medicare Part D in place, many things have improved for patients, community pharmacies and pharmacists. For this I am pleased and hopeful. More improvements still need to be made. Hopefully we will see improvements choosing a plan, with patient care remaining first and foremost, and in reimbursement policies to pharmacies.

Thank you again, Chairman Baucus, Senator Grassley and members of the Committee, for inviting me here today. I will be happy to answer any questions.