I'm Thomas Temple, Executive Vice President and CEO of the Iowa Pharmacy Association. Our Association represents the more than 2,200 pharmacists in our state and nearly 900 pharmacies. Our members practice pharmacy in community, hospital, long term care, clinic and academic settings.

We appreciate the opportunity to share our comments and insight with you today on the general topic of drug product selection in the State's Medicaid Program.

First, however a little background on Iowa's drug product selection law … In 1976, the Iowa General Assembly agreed to enact, at the request of the pharmacy profession in Iowa, legislation providing pharmacists with the authority to utilize their professional judgment in the selection of generically equivalent drug products. That legislation, which was initially opposed by the pharmaceutical industry and certain elements of organized medicine, eventually passed by wide margins based largely on arguments related to science and the potential cost savings to individual consumers.

Over the next 20 years, as coverage for prescription drug benefits in private and public sector benefit programs increased dramatically, the scope of generic drug dispensing grew exponentially. And while the difference in the cost of brand name pharmaceuticals and generics in the late 70's were only a few dollars, the cost difference today is quite considerable. An example to illustrate this difference is with the brand name drug from the PDL, Accutane, written for a prescription of 30 capsules. This drug is available generically to a pharmacy at a cost of $145.00/30 caps (available in 30 or 100 count size); however the brand cost to pharmacy is $590.10/30 caps (available only in 100 count size). Pharmacies already stock the generic version of Accutane. In this example, the pharmacy has to order the brand medication which would not be stocked otherwise and spend $1967.00 to purchase the 100 count size. After filling a prescription for #30, the pharmacy is left with #70 capsules of inventory. The prescription may or may not have refills, so the pharmacy can only hope that the physician keeps the patient on the medication for at least two more months so that the cost of obtaining the medication is recouped. In this example the cost difference for filling this prescription with the brand name product is $1822.00 to the pharmacy.

8515 Douglas, Suite 16 • Des Moines, IA 50322 • 515/270-0713 • FAX 515/270-2979
Website: www.iarx.org • E-mail: IPA@iarx.org

Over the past 32 years Iowa's drug product selection law has remained fundamentally unchanged. Pharmacists have full authority to utilize their clinical judgment and their knowledge about the relative prices of pharmaceutical therapy to make decisions regarding the most cost effective therapy available to patients. Physicians also retain the authority to require a specific brand of a pharmaceutical product by simply indicating DAW (Dispense as Written) or Do Not Substitute on the face of their prescription. And patients are always advised if product selection decisions are to be made. In all cases each decision must be made to the economic advantage of the patient.

In the case of Medicaid, pharmacists are required to select less costly generic and therapeutically equivalent products so that the State realizes the best economic value for its investment in pharmaceuticals. And there exists within Medicaid policy a patient safeguard to ensure that patient care is not compromised at the expense of saving money.

To the greatest extent, Iowa's drug product selection law has worked effectively for virtually all segments of the health care system – patients, payors, physicians and pharmacists. And it's a law which is supported by both science and sound medical and pharmacy practice, possessing appropriate patient safeguards and protection against economic harm to patients and payors alike.

For these reasons, the pharmacists of Iowa would strongly discourage legislators from pursuing changes to the law on the basis of emotion and anecdotal, non-science based rationale. To do so would cause an unnecessary increase in expenditures for pharmaceuticals and impair patient access to pharmaceutical therapy.

PDL Concerns

Consistent with the logic expressed above pharmacy does have concerns with respect to the State PDL. While we do not oppose the basic premise behind the PDL concept and in fact, support much of the PDL list, we do have concerns when it comes to including brand name drugs on the PDL when there exists a generically equivalent product, which is less expensive in the marketplace. Forcing pharmacies to stock a brand name PDL product to serve the Medicaid population only causes the pharmacy to incur a significant increase in inventory cost – cost which, in many instances, cannot be recovered because there is no other market in the private sector which will cover the drug.

While we understand the desire and responsibility on the part to IME to contain costs, we do not believe that brand name products should be placed on the PDL when such products have a less expensive generically equivalent product in the marketplace. To mitigate any loss in potential savings, reasonably set MAC pricing levels could be established. Alternatively, if brand name drugs must be included on the PDL, pharmacies should be given advance warning of PDL changes, and a transition period should be implemented each time a PDL change is made wherein both the previous and new PDL products are covered and payable to the pharmacy. In this situation, pharmacies have the opportunity to dispense the remaining inventory for a specific branded PDL drug to Medicaid beneficiaries.

In addition to our concerns with the PDL list itself, we also have two other concerns as it relates to the process with which the list is created. The first concern relates to the lack of transparency involved in the process. Although we recognize that there exists some transparency limits imposed upon the process by the federal government, we nevertheless believe that the State should seek maximum transparency in pricing discounts offered by pharmaceutical pricing. The lack of transparency fosters an environment of mistrust and a potential for financial relationships between a limited number of people which are less than healthy. Accordingly, pharmacy would encourage the legislature and AG's office to explore the potential for increasing greater transparency in the PDL process.

Lastly, we remain concerned over action taken by the IFMC and IME this past July to consolidate responsibilities for the PDL process and the DUR process with one vendor – Gould Health System. For more than 24 years the Iowa Pharmacy Association, in collaboration with organized medicine, provided a peer review process of quality assurance through administrative and clinical support of Iowa's Drug Utilization Review Commission. The separation of administrators for the PDL and DUR process provided a healthy system of checks and balances. Such a system no longer exists since July when the two processes were consolidated within DHS.

IPA believes that the legislature should direct IME to reestablish the DUR peer review process within organized pharmacy and medicine in the State of Iowa. Such an action would serve to reestablish a check and balance system within the Medicaid pharmacy program and reconnect provider physicians and pharmacists with their peer colleagues.

Assuring Quality

The final commentary we would make to this Interim Committee is that far too often policymakers fall into the mistaken trap of considering drugs and medications as mere commodities to be acquired at the best price. Pharmaceuticals are complex chemical substances which, when used appropriately, represent the most cost effective form of therapy available and which provide great relief from disease and suffering. However, when used inappropriately, medications can cause great harm to patients and force an unnecessary expenditure of health care resources. In fact, studies have shown that for every $1 spent on medications we spend another $1 treating the adverse effects of inappropriate medication use.

Here in Iowa the professions of pharmacy and medicine are collaborating with IME on a program of Medication Therapy Management (MTM) where greater focus is devoted to the care of patients with chronic disease and who are at the highest risk for developing drug related adverse events. IPA encourages the Medicaid program to expand the extent of MTM programming in the state of Iowa.