

Good Morning, Chairman Barton, Representative Deal, and members of the committee. Thank you for conducting this hearing and for providing me the opportunity to share the experiences with the new Medicare Part D program on behalf of the more than 24,000 community pharmacies and their patients.

My name is Dennis Song and my family pharmacy is Flower Mound Herbal Pharmacy in the Dallas-Ft. Worth Metroplex. I have worked in chain pharmacy for the first 20 years of my career and have owned my pharmacy for 8 years. I am a member of the Texas Pharmacy Association, the National Community Pharmacists Association, and a graduate of the University of Texas.

My pharmacy is like most family owned pharmacies...it employs 11 employees and have nearly 40,000 patients that come to the pharmacy for their medicine, dietary supplements, their flu shots, and for advice about their medicine. I also have many doctors, school nurses, and the county health department that utilize my pharmacy for drug and healthcare information. In a sense my pharmacy acts as the central medication information center for my community.

I make customized medications for patient's pets. For example, just last Tuesday I made a cat anxiety medicine and drained tuna cans to give it a tuna flavor. I deliver prescriptions to my patient's home if they want me to and I open after hours when patients need their medicine.

Like most every other pharmacist I know, I prepared for the Medicare Part D benefit by reading as much as I could and going to programs. I required my staff to attend educational programs and teleconferences to make sure they were prepared to help patients. I also gave Medicare Part D talks to the Rotary Club, senior and hospital groups. Despite my preparation, the first two months of the program have been very difficult for me as a small business owner and, most importantly, a struggle for my patients.

The problems have been well documented—there were problems with the transfer of patient information between CMS and plans, there were early problems with the eligibility inquiry system, and there was a lot of confusion among dual eligibles and other senior patients about which plan they were on and what they needed to do to navigate the system. At our pharmacy—and in thousands of others across the country—we did what we could to help patients. There are about 50 plans in my region but we tried to answer as many questions about plans as we could. Two of the pharmacists that work for me spent hours on the Medicare website trying to help their parents get enrolled. If it takes a pharmacist a couple of hours to enroll, there's no way an elderly patient should be

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expected to go through a website. Plus, I could count on one hand all of my senior patients who have a computer. Factor in the indigent, the dual eligibles, and its not surprising there was so much confusion.

We called plans and were on hold sometimes for close to an hour before we finally gave up. We did our best to make sure that patients were able to stay on their medication while we worked through the insurance hassles by giving them emergency supplies of their prescriptions. During the first couple of weeks, we gave an emergency supply to 20 percent of the elderly patients who came in the pharmacy—we want to make sure our patient’s don’t do without. Last, but not least, we opened up a line of credit at the bank so we could pay our bills but I’ll talk more about that a little later.

Things have improved in the last few weeks but there are still huge problems for the patients that will continue if needed changes to the program are not addressed. Prescription claims are going through much more often than they were but there are still quite a few that are rejected as unpaid—especially at the first of the month. The wait times on the phone have decreased but they are still running 5-10 minutes per call—but much better than an hour. When you are trying to fill two hundred prescriptions a day, it makes for an unacceptable situation for the pharmacy and for the patient.

My national association, NCPA has told me that there is an ongoing dialogue between CMS staff and the pharmacies and the CMS advisement increasing the time for transitional fills to 90 days has helped delay the problems that patients will have when the plan formularies are enforced. However, I do worry about patients when those formularies kick in. The pharmacists will have to try to explain to patients and their caregivers that the blue pill for their heart that they have been taking for years has been switched to a yellow pill that should do the same thing. That creates serious confusion and frustration for seniors. On top of that, I always ask myself if that is the best medicine for my patient. Plans change their formularies all the time depending on who is giving them the biggest rebate. It concerns me that patients might get confused or just fed up and stop taking their medicine.

As I mentioned, we try to make sure our patients don’t have to do without their medicine. As an example, I had a newly diagnosed diabetes patient who came in with the front page of the Dallas Morning News quoting Secretary Leavitt saying that “no patient should leave the pharmacy without their prescription.” He had actually circled the quote. He had enrolled in the plan but the plan had not entered him into his system. We tried to explain the situation to the patient but he kept referring to the newspaper quote. I wound up selling the medicine to him for what his co-pay *should* have been which was \$18 below my cost. What made it even worse was that there were two other patients—one who was

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another Medicare patient--who walked in and walked out because I was too busy trying to help the Medicare patient.

I mentioned the line of credit I opened so my pharmacy could pay its bills. One of the big problems with Medicare Part D is that the payments from the plans are slower and lower. By slower, I mean that for the dual eligibles, we used to receive payments from the state Medicaid program every 7 days. Under the new program, we are only supposed to get paid every 2 to 4 weeks but I have to pay my wholesaler bill weekly.

The plans make it difficult to tell what prescriptions have been submitted and what have been paid for. Some of the larger plans have also found reasons to delay payment. The point of the program is not for the plans to make money on the float but for me, it's made cash flow tight. I've been in business for 8 years and for the first time I've had to open a line of credit. I've almost maxed out the line and now I'm afraid my next move is to go into personal savings to try to cover the costs. It's scary. I know of a few pharmacies like mine that have already gone out of business over in the Valley in South Texas and I think there will be many others that will also have to close their doors if some changes to the program aren't made. Why are we being asked to both serve patients on the front lines and be the bank for the program? Unlike banks we collect zero interest for the money we are being forced to provide loans.

Some of the changes that I think should be made to the program are:

1) *There needs to be a prompt pay provision.*

Electronic Fund Transfers are done everyday with credit cards and banks. There is no reason why Plans couldn't pay the pharmacy on a daily basis or at least on a weekly basis. Pharmacies have no ability to negotiate with the plans—the contracts are take it or leave it—so we need CMS to step in and tell plans that they must pay the pharmacies with a daily EFT.

2) *The prescription cards that the plans issue should not be allowed to have a company specific logo on it.*

For example, one plan puts the Wal-Mart logo on their card. That seems outrageous to me and will make some patients think they have to switch pharmacies. Pharmacists are strictly prohibited from steering patients but the logo of a chain pharmacy is allowed on a card? Again, we need CMS to tell the plans—not just recommend--that they can't put a pharmacy logo on a patient's prescription card or there needs to be legislation to correct this situation. Pull out your social security card. Is there an advertisement on that card? There should not be any advertising that serves as proof of admission to Medicare Part D. This is a clear violation of the anti-steering provisions spelled out in the marketing guidelines issued by CMS.

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3) *Patients, doctors, and pharmacies need a standardized method of dealing with the plan formulary issues.*

Right now, if a prescription is not covered, a lot of plans send the pharmacy a message that says "drug not covered". That's it. No explanation as to why it was not covered. So, the pharmacy has to call the plan and find out why the drug is not paid for and what needs to happen to help the patient get their medication. The pharmacist then has to coordinate the paperwork between the patient, the doctor, and the pharmacy in order to help the patient get their medicine. This can take hours or even days. After all that time, the patient hopefully has not given up on the process and decided not to take their medicine.

There needs to be standardized messaging between all of the plans when they communicate with pharmacies and a standardized prior authorization procedure that reduces the administrative burden on patients, doctors, and pharmacies.

4) *Enrollment period needs to be realistic*

Patients were told that they could enroll as late as the end of the month and be in the system by the next day. That doesn't happen and is not a realistic expectation by anyone in the system. The result is that beneficiaries are frustrated and pharmacy staff have to chase down claims to try to help get the prescription paid. This unrealistic expectation creates a chain reaction that upsets the entire benefit. Dual eligible patients should have a deadline of at least 15 days and non-dual eligibles should have at least 30 days to be entered into the system.

5) *Standardized Contract Rate*

Pharmacies have dozens of plans offering take it or leave it contracts. Family owned pharmacies have no ability to engage in any form of legitimate negotiations. As a result we are forced to sign contracts that reimburse us below our cost. We believe CMS should use its authority to provide reimbursement guidelines to plans or there needs to be legislation to address the situation so that pharmacies are able to stay in business and continue to provide the services I have described here today for the American public.

In conclusion, I would add that I enjoy being a pharmacist and I believe I am making a difference in the thousands of patients who come in my pharmacies. However, I am very concerned that the slower and lower Medicare payments this year on top of the massive Medicaid cuts that Congress passed last month will force thousands of family pharmacies to go out of business and strand millions of patients without access to the medicine they need to help them stay healthy.

Thank you again for inviting me to share my experiences with the Medicare Part D program with you.