Testimony of

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Chairman Grassley, Ranking Member Baucus, and Members of the Senate Finance Committee, I am David W. Bernauer, Chairman and Chief Executive Officer of Walgreen Company, which is based in Deerfield, Illinois. I am pleased and honored to be here today to participate in this important hearing of the Senate Finance Committee on implementation of the Medicare Part D prescription drug benefit program.

Walgreens is the nation's largest pharmacy chain with sales of more than $42 billion last year. We have provided pharmacy service to patients for 105 years and have more experience meeting the prescription needs of patients than any other pharmacy in the country. Today, we operate more than 5,100 pharmacies in 45 states and Puerto Rico, employ nearly 20,000 pharmacists and will dispense more than 500 million prescriptions this year.

Preparing Walgreens for Medicare Part D

Walgreens and the chain drug industry in general recognize that Medicare Part D is the most significant expansion of Medicare since its inception. We are pleased that millions of additional seniors now have access to prescription drug coverage as a result of the new Part D benefit. However, there have been several important challenges for beneficiaries and pharmacists in transitioning to the new Part D benefit.

We appreciate all the steps that have been taken by CMS, states, and plans to work with us to ease this transition for beneficiaries and pharmacists. For example, we appreciate all the time and effort expended by CMS in working with our industry and the health plans in developing the "TrOOP facilitator". This tool allows pharmacies to electronically query a special database that is supposed to instantaneously return information to the pharmacist about the Part D plan in which a Medicare beneficiary has been enrolled, including the beneficiary's billing information. It will also facilitate coordination of benefits with other payers. The development of the TrOOP facilitator was a very important public-private partnership that should serve as the model for how current and future Medicare Part D implementation issues are addressed.

We appreciate the fact that many senior HHS and CMS officials have visited dozens of retail pharmacies across the nation over the past few weeks – including Walgreens' pharmacies – to see first hand the challenges that pharmacists and beneficiaries are having with Part D. We know from talking with them that these visits have been an eye-opening educational experience. We hope these visits have helped them better understand the environment in which we provide pharmacy services and result in practical ideas and solutions for addressing the issues that were brought to their attention.

At Walgreens, our pharmacies are committed to helping seniors understand the new Part D drug benefit. Like many other chain pharmacies, we developed an extensive education and outreach program to train our pharmacists, district pharmacy supervisors, and other senior personnel about Part D. We've had more than 1,400 pharmacy staff employees volunteer to speak in their communities to senior groups about Part D and educate them on the benefits and enrollment process. In fact, our pharmacists will continue these senior outreach efforts throughout the enrollment period. Twice last fall, we held week-long Medicare Part D information days at our pharmacies nationwide. We also developed our own Medicare prescription insurance plan report - called the Walgreens Rx Savings Advisor - which provides seniors with a free, personalized list of Part D plan options based on their current prescription drug needs. We have provided 500,000 individually, personalized reports to date, including 282,000 in January alone. Our patients have found this to be an important part of their decision process in selecting a Medicare Part D drug plan.

In addition, many of our pharmacists have taken extra time and effort to learn the "ins and outs" of Part D so they can help beneficiaries understand how to make the most of the new drug benefit. Pharmacists are also doing all they can to be sure that Medicare beneficiaries' prescriptions are filled in a timely manner. I know that many of our pharmacists have worked long hours to obtain correct billing information for beneficiaries as well as correct copay information. I cannot say enough about the dedication of the pharmacists that work for Walgreens – and pharmacists all across the country – in trying to make this benefit work.

Walgreens knew that implementing Part D would be a monumental task, and that the proverbial "rubber would meet the road" at the 52,000 community retail pharmacy counters across the country. Consequently, we did everything possible to prepare our pharmacists and pharmacy staffs understanding they would have an essential role in making the program work. That's because pharmacists know their patients' medication needs, and are ultimately responsible for providing them with their prescriptions. Pharmacists know the importance of medications in managing the chronic medical conditions of the elderly.

Current Implementation Issues with Part D

We want to provide you with an honest assessment of how the Part D program is going from the pharmacy perspective, now that we are well into the second month of the program's operation. In general, implementation of the program is going better as compared to the early weeks of the program. This is due primarily to tens of thousands of individual efforts by CMS staff, the insurance plans, and pharmacists across the country who found ways to navigate through the roadblocks of determining coverage for their Medicare patients.

As more and more beneficiaries receive their actual identification cards from Part D plans, and CMS and the plans enter data into the TrOOP facilitator more quickly, the situation is improving. Today, the chances are greater that the beneficiaries' plan and billing information will be active when the beneficiary comes into the pharmacy as compared to a few weeks ago. In fact, the lack of accurate data in the system was the primary reason why so many low income individuals may have been charged higher copays than they should have been charged.

Walgreens would like to make some recommendations on how CMS, states and Part D plans might address some of the implementation issues we are having with Part D:

Modify Enrollment Effective Dates: Because individuals are becoming eligible for Medicare everyday, and the dual eligibles have the option of changing plans every month, one systemic issue that needs addressing is what's commonly referred to as the "enrollment lag".

Right now, a beneficiary can join a Part D plan anytime during a month and expect the enrollment to be effective the first day of the next month. But if they apply in the last few days of the month, it is not possible for CMS and the plans to process the beneficiary's application, confirm eligibility with CMS, and provide the critical "4Rx" billing information to TrOOP facilitator – so that it is in the pharmacy system - in such a short timeframe.

In fact, the lack of data in the system as a result of late-month enrollments or plan switches has been, and may continue to be, the single most challenging issue that pharmacists face with Part D. If we don't have the data, we cannot fill the prescription, and that triggers a whole series of potential calls to CMS and the plans to obtain this billing information. For this reason, we suggest that policymakers address the "enrollment lag" issue.

Multiple options are available to address this issue, and we want to work with CMS and plans to find a solution. Some see the solution as educating beneficiaries that, by enrolling late in a month, there will be delays in the activation of their prescription drug coverage. Others have suggested that an enrollment deadline be established each month so that there is sufficient time to process applications and enter the billing information in the system. Whatever the options, it is important to address this systemic issue soon.

Promote Standardization among Plans' Policies and Procedures: Virtually 100% of all prescription claims are processed electronically today, making pharmacy claims processing far more efficient than any other segment of health care. Yet, third-party prescription administrative issues still consume almost one-quarter of the average pharmacist's work time. These administrative tasks have further multiplied as Part D has come on line due to the dozens of new Part D plans each having their own policies, processes and procedures for pharmacists to follow in order to fill prescriptions.

Like most chain pharmacy companies, Walgreens has developed standard workflow processes in our pharmacies that allow for the most efficient filling of prescriptions. But, these varied and onerous third party prescription processing issues disrupt the pharmacy workflow and dramatically reduce the efficiency in filling prescriptions for Medicare beneficiaries.

We would all agree that the pharmacist's time is better spent interacting with Medicare beneficiaries and other patients, helping them to understand how to take their medications, rather than sorting through paperwork. In addition, the tens of thousands of hours spent each year by pharmacy personnel in resolving these third party administrative issues needlessly drive up the costs of these programs for plans and the Federal government. Thus, it would seem to be to everyone's benefit to reduce the administrative costs of processing prescriptions.

To that end, we urge CMS to use its leverage, as the largest payer for prescription drugs in the nation, to bring plans and pharmacies together to create and require more standardization in third party prescription claims processing, pharmacy messaging, and procedures that would benefit Medicare Part D, Medicaid, and other Federal health care programs. For example:

- Some Part D plans require that we fax forms to physicians to obtain prior authorization to dispense some medications, while other plans require us to call the plans' "help desk." We need plans to develop consistent and standard messages and procedures for pharmacists. For example, all plans should have the same method for overriding messages on non-formulary drugs and for dispensing transitional supplies of medications. We also suggest that CMS standardize the plans' transition policies to reduce confusion among pharmacies and beneficiaries, and do a much better job of explaining the policies on the front end.

- Part D plans should also develop consistent messages to pharmacies that differentiate when a drug is "non formulary" in contrast to when a drug is "not a Part D covered drug", such as a benzodiazepine. A message that simply tells the pharmacist that a drug is "non formulary" is not descriptive enough for the pharmacist to make this distinction.

Because of the lack of clarity in the message, some pharmacists may spend time seeking approval from Part D plans for a drug that would never be covered under Part D. This is a poor use of time for the pharmacist, the plan, and the beneficiary.

If a plan is not going to cover a drug because it is not on the formulary, the pharmacist needs to know that information at the point of sale, so they can take necessary steps to bill any other wrap-around coverage that the beneficiary might have.

- Part D plans also need to return information to the pharmacist about formulary medication options if the medication prescribed by the physician is a non-formulary drug. The infrastructure is in place to allow for this, but no one has required plans to do this. This has become, and will continue to be, a big issue with dozens of Part D plans, each with a different formulary and different tiers within their formulary, not to mention that each plan can change the drugs on the formulary with a simple 60 days notice. It is literally impossible for pharmacists to keep track of all these formularies. Part D plans have posted formularies on their websites, and such information is also available through *Epocrates,* but it remains much more efficient for the pharmacist if the plan returns the information in a message to the pharmacist at point of sale. This reduces the wait time for the beneficiary and can reduce the number of inquiries to the plan; hence, the need for when a plan rejects coverage, it should include a message to the pharmacist indicating formulary options for the prescribed drug.

- It is important that we work through issues relating to when a drug is covered under Medicare Part B versus Part D. There is potential overlap for coverage under both programs depending on how a medication is being used and how it is being administered. We believe it's important to minimize the extent to which plans are using "prior authorization" on drugs that could be covered under either Part B or Part D. We need to work toward a solution that provides Part D plans with important clinical information from the Part B DMERCs so that the plan can determine whether the pharmacist should bill the drug to Part D or Part B without costly and burdensome prior authorizations.

Ensure that States Work Directly with Part D plans and CMS on Reimbursement: Many states felt compelled to step up to the plate during the early days of Part D implementation and cover the prescription drug costs and copays of some of their dual eligibles who couldn't obtain their drugs under Part D. We have been working with the states that have implemented these programs to ensure that we understand their interim policies. Some states have defined and implemented their programs better than others, and the wide variety of these programs has been another challenge to processing claims for dual eligibles.

Almost every state has indicated that they intend to seek recovery of the funds that they are spending for these temporary programs from Part D plans. Pharmacies have worked diligently to only bill these temporary state Medicaid programs as a payer of last resort. Pharmacists are making every reasonable effort to bill a Part D plan or the Wellpoint/Anthem Point of Service (POS) system, if the dual eligible individual comes to the pharmacy without their identification card, and/or the information cannot be found in the TrOOP facilitator. However, pharmacists cannot be expected to spend countless hours on the phone trying to get these two options to work before they bill a state.

States should work directly with Part D plans to recover any monies that they spent for Part D drugs without involving pharmacies as billing intermediaries. CMS has pledged to pay states for the costs of covered Part D drugs – without involving pharmacists - through a temporary demonstration program. To be eligible for this demonstration program, the state must cease operating their emergency coverage programs by February 15th. That may be an unrealistic deadline if additional problems occur in February with the dual eligibles, so we urge CMS to approach that deadline with flexibility.

However, we think that CMS and the states should recognize that retail pharmacy does not want to be caught in the middle of recovery and collection efforts if states and plans have disputes regarding whether prescriptions should have been dispensed. We encourage states to

carefully consider using this demonstration program to recoup their monies. We also ask CMS to use their influence to dissuade any state from using a pharmacy recoupment initiative to recover monies from Part D plans through retail pharmacies. Moreover, we urge CMS to require that states ensure that pharmacies are made whole for the tens of thousands of emergency prescriptions that they dispensed to Medicaid recipients when the pharmacist was unable to file a claim with a Part D plan.

Similarly, as in the case with states that are seeking recoupment of monies from Part D plans, we believe that pharmacies must not be caught in the middle of any payment reconciliation that might have to be made between Part D plans if, for example, the beneficiary has switched from one plan to another. Any adjustments that need to be made between plans in these situations should be done through a plan-to-plan reconciliation process, rather than involving retail pharmacies as billing intermediaries. We encourage CMS to do all they can to encourage plans to complete work on the plan-to-plan reconciliation process that was started several months ago to avoid these potential situations.

Addressing Part D Issues Moving Forward

Right now, we are all working together to address implementation issues in the very early stages of the new Part D benefit. We are making progress, but we obviously have more work to do and we are willing to do our part. The fact of the matter is that we may be fine-tuning this benefit for many years to come. Beyond the issues that we have already described, we see several other critical first-year implementation issues for the Part D program.

For example, we should consider that there will be significant challenges in moving millions of beneficiaries from the non-formulary drugs they currently take to a plan's formulary drugs. This will have to occur before exhausting their transition supplies of non-formulary drugs. This challenge will be especially pronounced for the dual eligibles. These individuals generally take more medications than other Medicare beneficiaries, so transitioning them to formulary medications should occur as soon as possible, but as safely as possible because of the time that it may take. We believe that CMS' recent decision to require

plans to provide a 90-day supply of transition medications – rather than just a 30-day supply -- will ease the transition to formulary drugs.

However, plans, beneficiaries, and physicians must use this extended time frame to aggressively start the transition now. To that end, CMS must monitor whether plans are taking the necessary steps over the next few weeks to help beneficiaries understand what they need to do and how they need to do it in order to transition to formulary drugs, so that confusion and delay at the pharmacy are minimized. The burden of helping beneficiaries to transition their medications is a shared responsibility, not just the responsibility of pharmacists.

We also think that there could be a significant last-minute enrollment surge among beneficiaries before the May 15th open enrollment deadline. This could create a sudden surge of individuals that want to use their benefit on June 1. The entire system needs to be prepared to process these applications quickly, get the information in the TrOOP facilitator, and be ready to fill prescriptions for these beneficiaries.

Finally, we are concerned about managing the expectations of individuals that will fall into the "donut hole" or coverage gap during the middle of the year. While many seniors were probably aware of the "donut hole" when they signed up for a plan, we are concerned that some did not or will not fully understand the issues relating to the "donut hole". CMS and the plans should consider ways to help educate beneficiaries about the implications of the "donut hole" as the middle of the year approaches so that pharmacists do not bear all the burden of helping seniors understand this component of the benefit design.

Other Challenges Facing the Industry

While this hearing has been called to examine Medicare Part D implementation issues, we want to provide the Committee with our views on another important issue facing the industry. The Budget Reconciliation bill includes significant cuts to Medicaid. In particular, the bill would reduce payments to pharmacies for generic medications by about $6.3 billion over the next 5 years. Walgreens is very concerned about these cuts for several reasons.

- We are concerned that these reductions in payment will take away much of the incentive for pharmacies to dispense generic medications. We are perplexed why policymakers and the Congressional Budget Office (CBO) believe that decreasing generic payments will increase generic drug dispensing. The total reimbursement to Walgreens for a Medicaid single-source brand-name drug averages $128, while the average generic reimbursement is $20. Clearly, increasing generic utilization is the most effective way to reduce Medicaid costs. In fact, with these payment reductions, just the opposite will happen, leading to higher – not lower – drug costs to the government. We believe that many states will need to take action this year to increase their generic dispensing fee, or they may see a reduction in generic drug dispensing in their states.

- There is an aggressive implementation timeline for the new Medicaid pharmacy payment provisions included in the legislation. In fact, the first implementation milestone occurs this July when CMS is supposed to make Average Manufacturers Price (AMP) data available to the states and the public. We are concerned that, under the current definition of AMP, these data will not reflect the actual prices paid by retail pharmacies for brand and generic medications. As a result, they could provide a misleading picture to states, private plans and consumers about the true acquisition costs of retail pharmacies.

  Unfortunately, these data will become public a whole year before CMS provides more specific direction to manufacturers on how to calculate AMP. That regulation is expected in July 2007. That means for at least a 12 months, data will be available in the public realm that may not accurately reflect retail pharmacies' acquisition costs for prescription drugs. We believe that these data should not be made public or shared with the states until the AMP can be more accurately, appropriately, and consistently defined.

- Reductions of this magnitude in Medicaid, coupled with the economic impact that Part D is having on pharmacy, will undoubtedly affect access to pharmacies. We do not believe that policymakers have considered the cumulative economic effect of these programs on the ability of retail pharmacies to continue to stay in business. Many pharmacies in the

United States – including those operated by Walgreens -- serve a high number of Medicaid recipients as a percentage of their business. If prescription revenues sharply decrease in these pharmacies as a result of Medicare Part D and generic payment reductions, these locations may have no option but to reduce hours or even close. This would seriously harm the ability to meet the health care needs of communities in which these pharmacies are located.

- The new Federal generic upper limits are supposed to be implemented in just 11 months – January 1, 2007. Given all the problems and issues that pharmacies have experienced with the January 1, 2006 implementation of Medicare Part D, we caution policymakers about implementing another major change in pharmacy payment streams in such a short period of time after Part D, and especially on January 1st – which is already a date of great changes for pharmacies every year.

We urge that policymakers consider the delay or revision of these Medicaid pharmacy payment changes as the industry adjusts to the operational and economic challenges of Medicare Part D.

Conclusion

Walgreens appreciates the opportunity to go on the record regarding these implementation issues in the early stages of the new Medicare Part D benefit. We are committed to working with Congress, CMS, states, plans and beneficiaries to ensure that the benefit is delivered in the most efficient manner. We know that many of these issues will eventually be resolved, but other issues will develop down the road that will also have to be addressed. We ask that you call on us if we can provide any further information about these issues. Thank you.