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Testimony re: HB 2176
House Insurance Committee
Presented by Derek R. Hein
on behalf of
Kansas Association of Chain Drug Stores
February 18, 2015

Mister Chairman, Members of the Committee:

My name is Derek Hein, and I am governmental affairs consultant for the Kansas Association of Chain Drug Stores which represents NACDS member's including 11 companies operating just over 280 stores, employing over 27,000 full and part-time employees and paying over $331 million in state taxes.

On behalf of the members of the KACDS operating in Kansas, I am writing in support of HB 2176 – Medication Synchronization.

Medication synchronization allows pharmacists to work with prescribers and patients to get patients with multiple medications on a regimen where they receive their prescriptions all at the same time, meet with a pharmacist, and are contacted during the period between refills to ensure there have been no changes to their regimen. The outcome of such a program increases adherence to sometimes complex medication regimens and ensures a pharmacist is reviewing that regimen.

Poor medication adherence leads to more frequent hospitalizations, poorer health, higher healthcare costs, and increased risk of death. The improper use of medications results in $215 billion in avoidable US healthcare costs including $105 billion due to non-adherence alone.[1]

Medication synchronization can improve adherence by 22-24% across a range of chronic conditions.[2] In addition, Medication synchronization is a tool that Medicare uses today.

In support of the final 2012 rules which went into effect in 2014, the Centers for Medicare and Medicaid stated the following … *We believe that we have sufficiently accounted for the tradeoffs and implications of the potential impact of our requirement, both in the proposed rule and in this final rule with comment period. In the preamble and the Regulatory Impact Analysis section of the proposed rule and this final rule with comment period, we specifically accounted for the additional*

[1] IMS Institute for Healthcare Informatics, Report: *Avoidable Costs in US Healthcare, June 2013*
[2] *Patient Centric Model: Pilot Data Analysis Report,* David Holford, PhD et al, Virginia Commonwealth University School of Pharmacy, March 8, 2011

dispensing fees, as well as the administrative and programming costs that we believe Part D sponsors will incur in implementing this requirement. Despite these costs, we continue to estimate savings in the hundreds of millions each year to the Part D program.[1]

The estimated cost to Part D sponsors is $0.5 million and the savings to Part D sponsors and beneficiaries is $1.8 billion.[2]

KACDS strongly supports this legislation and respectfully asks the Honorable Members of the Committee to pass this bill out of Committee.

Thank you for your consideration and I would be happy to take any questions.

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[3] Centers for Medicare and Medicaid, Final Rule with Comment Period, Federal Register/Vol. 77, No. 71/Thursday, April 12, 2012/rules and Regulations, related section, 423.100, 423.104 and 423.153.
[4] http://www.gpo.gov/fdsys/pkg/FR-2012-04-12/pdf/2012-8071.pdf