United States Senate

Committee on Commerce, Science, and Transportation

Hearing on

“Short-supply Prescription Drugs: Shining a Light on the Gray Market

Jul y 25, 2012

Oral Statement for the Record
Prepared by:

Patricia Earl, Industry Analyst, NCPD

Submitted by the

National Coalition of Pharmaceutical Distributors

20101 NE 16th Place
Miami, FL 33179
Phone: (305) 690-4233, ext.234
Fax: (786) 437-1851
Website: www.ncpdusa.org

Good afternoon, first I would like to thank Chairman Rockefeller, Ranking Member Hutchison and distinguished Members of the Committee for the Committee's strong leadership in addressing the critical problem of short-supply prescription drugs in the supply chain. I have submitted a more complete statement, but in this portion of my testimony, I would like to discuss the issues you have brought to "light". I have more than a quarter century experience with the pharmaceutical supply chain and understand all sides of the distribution model. In addition to my experience in the distribution industry, I have served as an industry expert in federal court proceedings involving supply chain practices.

I am here today to represent the views of the National Coalition of Pharmaceutical Distributors (NCPD) and its members, which are predominantly small and independent pharmaceutical distributors.

I cannot emphasize enough the value that small – or secondary – pharmaceutical distributors bring to the health care system. These organizations are there when no one else is – in the middle of the night, on the weekends and in remote parts of the country where no one else wants to deliver because it's not considered profitable. As a result, small distributors help save lives every single day. They save lives by making it their business to ensure that quality medicines reach a patient in the safest, fastest and most cost-effective way possible – no matter the time or location.

Few others can say the same thing.

Their value is so profound that we have email after email from customers – including the NIH – thanking them for the help they have provided to find medicine or deliver it at the last minute to save a life (and at a reasonable price) – a function primary wholesalers are simply not geared to perform.

Despite their value, small, secondary distributors have come under fire recently because few people really understand them or have taken the time to see where they fit in the supply chain. The arguments have ranged from accusations of price gouging to shifting product between multiple companies as a means to increase profits to working with fake pharmacies.

These allegations are little more than character assassinations and are not grounded in reality.
What's more, these characterizations fail to reflect one basic fact of this market: There are thousands of small distributors that work with hospitals across the nation. To remain competitive, they must comply with all laws, follow pedigree and handling requirements to the letter and still offer an economical price point that allows for only a modest profit margin. If they do anything else, they run the risk of permanently losing a customer.

See, hospitals comparison shop. If they don't like a price offered by one company, they will call another. When it comes to working with secondaries, health care providers don't face the same restrictions they do with the Big 3 wholesalers. They are free to move their account elsewhere.

This is a reality that every small distributor out there is well aware of. And they know that if they were to engage in the types of activities you accuse them of, they would not be in business very long.

As you learn more about this industry – which represents less than 1 percent of all drugs bought and sold across the nation – you will see that the activities you are trying to paint as nefarious actually have legitimate and reasonable explanations:

On the subject of "price gouging" or mark-ups: Secondary distributors pay the highest prices for drugs in the entire U.S. supply chain – sometimes as much as 91 percent more than one of the Big 3 wholesalers would ultimately pay for the same product. What's more, many people will look at a pedigree and compare the cost a distributor paid for a drug to the price he sold it for and assume the entire amount was pocketed as profit. That's the furthest thing from the truth. Pedigrees do not show how much was spent on things like shipping, which can be much more expensive than the drug itself if the hospital needs it delivered overnight.

On the subject of several companies being involved in the handling of a product: We are all aware, Mr. Chairman, that you are in possession of a handful of pedigrees that show multiple distributors handled a

product before it got to the patient. I do not know the circumstances that led to these situations, so I can't defend these pedigrees specifically, but I can say is that these incidents are anomalies. Our members work tirelessly to make sure that the route from distributor to customer is as straight as possible because they want to get the product to those who need it as fast as possible, and because they know that they face stiff competition. Even when a drug is in short supply, more than one distributor can still get it, and as I said, hospitals comparison shop. So, for every one pedigree you find that shows multiple touch points, we have literally thousands of pedigrees that show only one or two distributors were involved and with a nominal profit realized. In fact, one NCPD distributor handles 1.2 million pedigrees every year. The handful of pedigrees in your possession do not even equal one-tenth of 1 percent of the number of products he handles in one year.

Finally, on the subject of fake pharmacies: By law, pharmacies are allowed to sell a small portion – 5 percent or less – of their inventory to distributors, as long as they comply with state regulatory requirements. In most cases, pharmacies take advantage of this law to sell drugs that will expire within 90 days that they do not believe they can dispense in that timeframe. Instead of letting them go to waste, many pharmacies will sell the products to an authorized distributor – both small, independent companies, as well as large wholesalers. The authorized distributor, in turn, will sell it to a medical provider that can use it immediately.

Ultimately, this practice is a win-win – drugs don't go to waste, pharmacies don't lose large quantities of money on products that are expiring and providers are able to get pharmaceuticals at a discounted rate. This is a legitimate and necessary practice, and is not a fake pharmacy. Our members will not work with fake pharmacies – or pharmacies that do not dispense drugs to patients – and report them to the proper authorities when they encounter them.

That ends my oral presentation and I urge you to read the more comprehensive testimony that I have submitted.

Thank you Mr. Chairman, Ms. Ranking Member and members of this committee.