

Dear Representative:

As a community pharmacist I am grateful for all the hard work that has gone into drafting **H.R. 3200, America's Affordable Health Choices Act of 2009**, and I appreciate the many opportunities that a reformed health care system presents for pharmacists to help improve the use of prescription medications, reduce health care costs, and enhance patient care. There are approximately 23,000 independent community pharmacies throughout the United States and these pharmacies and these pharmacies have face to face contact with thousands of patients every single day-in many areas where there is little access to other healthcare providers appreciate your support for community retail pharmacy.

This bill includes many provisions that allow us to better serve our patients by strengthening the pharmacy infrastructure. However, I do have concerns about certain provisions which I believe could impede my ability to serve my patients.

Medicaid Pharmacy Reimbursement (Section 1741, Payment to Pharmacists): As you know pharmacies have been extremely concerned about the dramatic reduction of Medicaid reimbursements for generic drugs enacted in the Deficit Reduction Act (DRA) of 2005. I appreciate the reforms to this system included in H.R. 3200. These reforms, which have important bipartisan support, are critical to ensuring the continued dispensing of lower cost generic medications, and the viability of small independent community pharmacies.

The bill excludes from the definition of Average Manufacturers' Price (AMP) those prices paid for pharmaceuticals which retail pharmacies do not have access to, such as mail order pharmacies, and PBM rebates. The AMP definition should as closely as possible reflect the prices paid only by retail pharmacies. The bill also changes the basis of reimbursement from the "lowest AMP" of a multiple source drug to the "weighted average" AMP of that drug. This will help ensure more accurate reimbursement for pharmacies than under DRA levels.

I am concerned that 130% of the weighted average AMP will not cover my costs to purchase and dispense generics drugs. Although 130% of the weighted AMP will most likely be higher than under the DRA's method (estimated at 36% below my acquisition cost) it concerns me that legislation introduced last Congress set the reimbursement rate at 300% of the weight AMP. The reimbursement rate included in this bill is less than half of the 300% multiplier. I am aware that with the current economic environment 300% may not be realistic, but I implore you to keep in mind that reimbursement for generics at no more than 130% of the weighted average AMP, combined with the low dispensing fees paid by states, could limit my ability to serve my Medicaid patients. Additionally, this reimbursement rate could impact generic dispensing which makes no sense because generic drugs are substantially less expensive than the brand name alternative.

Please keep in mind that independents serve a higher percentage of Medicaid recipients than other pharmacies. Many independents operate pharmacies in rural and urban locations where most Medicaid recipients live so those patients and pharmacies would be disproportionately impacted by inadequate reimbursements.

Exemptions from Medicare DME Accreditation and Surety Bond Requirements: I am extremely appreciative of the provisions in the bill that would modify the DMEPOS accreditation and surety bond

requirement as they apply to pharmacies. As a state-licensed health professional, I see these costly accreditation and surety bond requirements as just another unnecessary regulation that will only serve to reduce my patients' access to these important health care products.

Unless these modifications are enacted by October 1, 2009, Medicare beneficiaries' access to diabetes testing supplies – such as blood glucose test strips and lancets – as well as other non complex DMEPOS items, such as crutches and canes, would be significantly reduced.

I am also supportive of extension of the October 1, 2009, deadline which was included in the bill. It would give providers more time to complete the accreditation process if they have submitted an application before August 1, 2009.

Again, I thank you for including these DMEPOS provisions but I urge Congress to consider moving these DMEPOS provisions separate from a broader health reform bill due to the October 1, 2009 deadline.

Operation of Public Health Insurance Plan Option and PBM Transparency: I strongly support the language included by Congressman Weiner that would begin the process of creating transparency requirements for pharmacy benefit managers (PBMs) if they are used by health insurance plans that operate in the exchange, including the public plan option. These transparency requirements will provide important information to plan sponsors to make sure that PBMs are serving the best interests of the plan sponsor and its enrollees, rather than the self-serving financial interests of the PBMs.

These provisions would require that plans disclose their generic dispensing rates in retail pharmacies compared to mail order; indicate how much of the rebates and discounts they obtain from drug manufacturers are passed through to the plan sponsors; and indicate whether they keep part of the payment that the plan makes to the PBM to pay the pharmacy for prescriptions. Many of these transparency requirements have already been adopted by Medicare Part D plans to protect the taxpayer in this program. Similar requirements should be incorporated into other taxpayer funded programs.

The opponents of transparency will argue that the provisions in the House bill will disclose sensitive financial information that will compromise their ability to negotiate with pharmaceutical manufacturers. Nothing is further from the truth. The language does not even require PBMs to pass through rebates or disclose sensitive pricing information; it simply requires disclosure of aggregate information on some of the most basic key elements of how PBMs work so that payers can help assess if they are getting a good deal.

I am concerned that the bill lacks specificity on how reimbursement rates for prescription drugs under the public plan will be determined by the Secretary. It gives no direction to the Secretary in negotiating the contract terms-it gives the Secretary complete discretion. The bill should specify that the payments to pharmacies should include reimbursement for the pharmacy's cost of product as well as a dispensing fee, based on annual cost of dispensing surveys. Also, it would be to the government's benefit to include language that clarifies that the drug benefit will be by a pharmacy benefits administrator (PBA) rather than a pharmacy benefits manager (PBM). In models like the state Medicaid programs or the DOD TRICARE program, an "administrator" is used, and all manufacturer rebates are passed through to these programs.

Finally, we would appreciate inclusion of an ‘any willing provider’ provision in the bill – similar to Medicare Part D and Medicaid - so that any pharmacy that is willing to accept the payment rates can participate.

Pharmacist MTM Services: I support an amendment offered by Congressman Butterfield and accepted by the Energy and Commerce Committee that would establish a grant program to test new and innovative methods to deliver medication therapy management services by pharmacists, especially in the treatment of chronic medical conditions. Time after time pharmacists’ involvement in the treatment of patients with chronic medical conditions, such as diabetes and heart disease, have proven to substantially decrease medical costs and improve the health of those patients.

Thank you for your consideration. Should you need additional information or have questions please do not hesitate to contact me. I look forward to working with you as healthcare reform legislation comes before you on the House floor.