

August 4, 2009

The Honorable Charles Rangel, Chairman  
Committee on Ways and Means  
United States House of Representatives  
Washington, D.C. 20515

The Honorable Henry A. Waxman, Chairman  
Committee on Energy and Commerce  
United States House of Representatives  
Washington, D.C. 20515

The Honorable George Miller, Chairman  
Committee on Education and Labor  
United States House of Representatives  
Washington, D.C. 20515

**Subject: America's Affordable Health Choices Act of 2009 (H.R. 3200)**

Dear Chairman Rangel, Chairman Waxman and Chairman Miller:

The National Community Pharmacists Association (NCPA) is providing our views on the provisions that we would like to see in the health care reform bill that is considered by the full House of Representatives after the recess.

We appreciate all the hard work that has gone into drafting these documents and 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. We also appreciate your support for community retail pharmacy. NCPA represents the approximately 23,000 owners and operators of independent community pharmacies in the United States.

This bill includes many provisions that we can support because they allow us to better serve our patients by strengthening the pharmacy infrastructure. However, we also have some suggestions and concerns which we also outline in this letter. We look forward to working with you to address these concerns as the bill moves forward.

**Medicaid Pharmacy Reimbursement (Section 1741, Payment to Pharmacists):** NCPA very much appreciates the fact that the bill includes important reforms to the AMP-based reimbursement system for Medicaid generic drugs that was originally enacted in the Deficit Reduction Act (DRA) of 2005. 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.

For example, the bill would exclude from the definition of Average Manufacturers' Price (AMP) those prices paid for pharmaceuticals by non retail pharmacy purchasers, such as mail order pharmacies, and PBM

rebates. Because AMP will be used as a benchmark for pharmacy reimbursement in Medicaid and possibly other plans, these exclusions are critical. The AMP definition should as closely as possible reflect the prices paid only by retail pharmacies.

We would ask that consideration be given to the provision that permits the Secretary to use prices only paid by hospitals, physician offices and clinics in the calculation of inhalation, infusion and injection drugs. These prices should not be used to calculate an AMP for the retail class of trade, and should not be used to calculate FULs for community pharmacies.

We also appreciate the fact that the bill 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 assure higher and more accurate reimbursement for pharmacies than under DRA levels. We ask that the language include a requirement that manufacturers “smooth” over a 12-month period any discounts that they might give to retail pharmacies, and that only those products that are sold nationally be used to calculate a FUL.

Reimbursement at 130% of the weighted AMP will likely reimburse pharmacists more for generic medications than would have been the case under the DRA’s method. However, in the last Congress, we supported H.R. 3700, The Fair Medicaid Drug Payment Act of 2007, which would have set the reimbursement rate for generics at 300% of a multiple source product’s weighted average AMP. We believe reimbursement at 300% of the weighted average AMP is necessary to compensate for the fact that most states’ pharmacy dispensing fees are well below our costs of dispensing. While this percentage may be unrealistic in today’s economic environment, we remain concerned that reimbursement for generics at no more than 130% of the weighted average AMP, combined with the low dispensing fees paid by states, could negatively impact generic dispensing and reduce Medicaid patients’ access to many community pharmacies.

For most independent community pharmacies, 90 percent or more of their revenues are derived from prescription sales, and 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. Revenues derived from Medicaid prescriptions are critical to an independent pharmacy’s sustainability.

Therefore, we support many of the changes proposed in the bill to the AMP system, but we strongly urge that Congress consider a higher FUL reimbursement rate for generic medications as the legislative process moves forward. This is especially important for critical access pharmacies that serve a higher percentage of Medicaid recipients and rural pharmacies. We also ask that the language include a requirement that states set dispensing fees based on recent cost of dispensing surveys to assure that pharmacies can continue to dispense generic prescriptions for the Medicaid program and keep their doors open.

**Exemptions from Medicare DME Accreditation and Surety Bond Requirements:** We are extremely appreciative of the provisions in the bill that would modify the DMEPOS accreditation and surety bond requirement as they apply to pharmacies. As state-licensed health professionals, these costly accreditation

and surety bond requirements are redundant and will only serve to reduce beneficiary 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. We would ask the Committee to consider exempting from the accreditation requirements, other non complex DMEPOS items commonly provided by pharmacies. These include simple walkers, ostomy products, commodes, bedpans and urinals.

We also support the provision in the bill that would give providers more time to complete the accreditation process if they have submitted an application before August 1, 2009. The upcoming October 1, 2009 deadline makes Congressional action on these provisions particularly urgent. We are truly grateful for the bipartisan support we have received for the modification of these requirements, and urge Congress to consider moving these provisions separate from a broader health reform bill.

We also oppose the 0.5% payment reduction in DMEPOS that was included in the bill as a “pay for” for another Medicare item. Many pharmacies incur significant additional costs to participate as Medicare DMEPOS suppliers – including accreditation and surety bonds. This payment reduction, combined with these increased costs of participation, could result in other pharmacies dropping out of the program. A reduction in Medicare beneficiaries' access to critical DMEPOS items will result.

**Operation of Public Health Insurance Plan Option and PBM Transparency:** Under the bill, payment rates for prescription drugs under the public plan would be negotiated by the Secretary. We remain concerned about the lack of specificity in the bill regarding how these payment rates would be set. For example, we believe that 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.

We also ask that the bill be clarified such that the administration of the drug benefit would be accomplished by a pharmacy benefits administrator (PBA) rather than a pharmacy benefits manager (PBM). We would prefer a model like that used by the state Medicaid programs, or the DOD TRICARE program, where an “administrator” is used, and all manufacturer rebates are passed through to these programs.

We 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 – which we believe are scored as no cost by the CBO – 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. We note that 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.

Because of the lack of Federal oversight of PBMs, states have taken the lead to try and bring some controls to these unregulated entities that provide drug benefits to a quarter of a billion individuals. In fact, since 2003, over 36 states have attempted to enact laws to further regulate PBMs. While Maine has enacted the most comprehensive PBM transparency legislation, other states such as Maryland, Iowa, North Dakota, South Dakota and Vermont have also been successful in passing substantive measures to shed light on some of the questionable business practices of PBMs. In addition, there is PBM transparency legislation currently pending in Massachusetts, New Jersey, Ohio, Pennsylvania and South Carolina.

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.

**Expansion of Pharmacist MTM Services:** We support an amendment offered by Congressman Butterfield that would establish a grant program that would test new and innovative methods to deliver medication therapy management services by pharmacists, especially in the treatment of chronic medical conditions. We also believe that involvement of pharmacists in the medical home pilot project can help improve the use of prescription medications, especially in those individuals that have multiple chronic diseases. We appreciate the inclusion of non-physician practitioners – such as pharmacists – as part of the medical home concept in the delivery of medication therapy management services.

**Secretary Negotiations for Part D Drug Prices:** The intent of the provisions in the bill appear to provide the Secretary with the authority to negotiate lower prices directly with drug manufacturers for medications provided under Part D and the public plan. However, some of the language implies that negotiation could be directed at retail pharmacies. For example, the language indicates that the “...Secretary shall negotiate with pharmaceutical manufacturers the prices...that may be charged to PDP sponsors and MA organizations for covered part D drugs for part D eligible individuals who are enrolled under a prescription drug plan or under an MA-PD plan.”

Similarly, under the public plan option, "the Secretary shall negotiate with pharmaceutical manufacturers the payment rates...that may be charged for prescription drugs for individuals who are enrolled under the public health insurance option and shall establish a particular formulary for prescription drugs under such option." Drug manufacturers do not "charge" PDP sponsors, MA organizations, or individuals for prescription drugs. Pharmacies charge the plans for the drugs that they purchase. Plans negotiate with manufacturers for additional rebates, which are used to affect the benefit cost and to increase the Plans profitability.

If the goal is to negotiate with drug manufacturers to reduce drug prices, it is critical to make sure that these negotiations are not directed at retail pharmacies. We respectfully ask for clarification of the intent of this language to mitigate the potential adverse consequences that it could have on retail pharmacies and beneficiary access to prescription drugs and pharmacy services.

**Part D “Donut Hole” Discount Program:** We appreciate that the Committees have structured the PhRMA donut hole drug discount program such that the program operates through Part D plans. We ask that the final bill clarify that the new MIPPA “prompt pay” provisions included in 1860D-12 (b)(4) apply to payments from plans to pharmacies under this program. There is no reference to plans having to meet the prompt pay requirements for this donut hole coverage, and want to make sure that plans, which have to obtain refunds for these expensive brand name drugs from PhRMA companies, pay pharmacies under the same deadlines for covered Part D drugs that are outside the donut hole.

**Requirements to Provide Health Insurance:** Community pharmacies on average employ 13 people and the majority offer health insurance to their employees. As you might imagine, because community pharmacies generally operate on a net 2 percent profit margin, we are concerned about any new requirements that mandate that employers provide health insurance to their employees. For that reason, we appreciate provisions in the bill that would provide credits through the tax code that help small businesses defray the costs of providing health insurance coverage.

We appreciate that the House Energy and Commerce bill includes a \$500,000 maximum payroll amount at which employers will begin to pay a penalty if they do not provide health insurance. We would encourage that this amount be included in the final House bill that is considered on the floor. We ask the Committee to keep in mind that some small businesses, such as pharmacies and other health care providers with a small number of employees, still have higher average salaries than the typical small business. That is because they are required to hire highly-trained health professionals that command higher salaries in the marketplace. Therefore, we ask the Committee to consider this factor when determining the average annual salary phase out for tax credits to provide health insurance.

Mr. Chairman, we appreciate your hard work and that of all the Members of your Committee. We also appreciate the support you have shown for patients and community pharmacies which have more day to day

interaction with patients than any other healthcare provider. We look forward to working with you as this legislation moves through the Committee and to the floor of the House of Representatives.

Sincerely,

A handwritten signature in black ink, appearing to be 'B. Roberts', with a long horizontal flourish extending to the right.

Bruce T. Roberts  
Executive Vice President and CEO

cc: The Honorable Dave Camp  
The Honorable Joe Barton  
The Honorable Pete Stark  
The Honorable Wally Herger  
The Honorable Frank Pallone  
The Honorable Nathan Deal