July 16, 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

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

Dear Chairman Rangel and Chairman Waxman:

The National Community Pharmacists Association (NCPA) has reviewed the draft of *America's Affordable Health Choices Act*, which was released on July 14th, 2009. We appreciate all the hard work that has gone into drafting this document 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 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fact that the bill includes important reforms to the AMP-based reimbursement system for Medicaid generic drugs that was originally enacted in the Deficit Reduction Act (DRA) of 2005.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 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.

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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.

Operation of Public Health Insurance Plan Option: 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 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.

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.

Pharmacists' Involvement in Medical Home Pilot Project: We believe that involvement of pharmacists **i**n 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. We urge the Committee to include language similar to that included in Section 935 of the Senate HELP health reform bill that would establish a grant program to implement medication therapy management in the treatment of chronic disease.

Requirements to Provide Health Insurance: Community pharmacies on average employee 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 do have concerns regarding the $250,000 maximum payroll amount at which employers will begin to pay a penalty if they do not provide health insurance. 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,

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