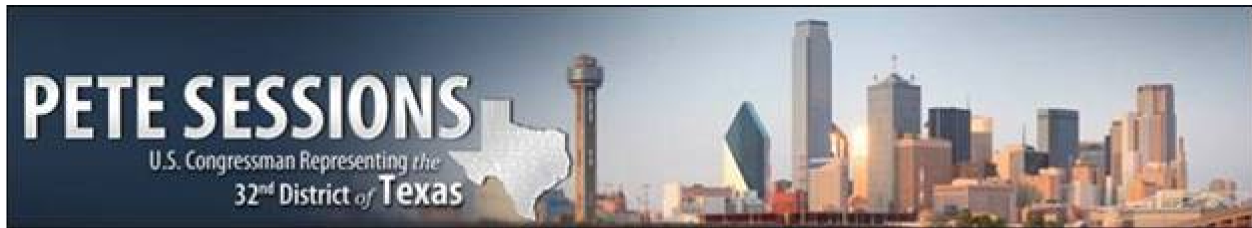

For Immediate Release: March 2, 2017
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Thank you, Mr. Speaker, for the opportunity to submit this statement for the record. In my hometown of Dallas, Texas we are proud of our pharmacists that fight for patients and their healthcare needs, as well as the pharmacy students at Texas Tech University Health Science Center-School of Pharmacy and UT Southwestern Medical Center Pharmacy Practice Residency Program who are following in their footsteps. I've had the opportunity over the past months to visit with specialty and compounding pharmacists, pharmacy students, independent and community pharmacists, and those working at larger pharmacies such as CVS and Walgreens. I've also heard firsthand from my constituents, especially senior citizens and parents of disabled children that rely on these pharmacists' expertise and accessibility to ensure their continued quality of care.

In these conversations, it has become clear that while innovation and technology has truly made the impossible possible, the very existence of those who dispense the miracles of the lab into the marketplace is being threatened. I've heard from independent and specialty pharmacies that have been forced to permanently close their doors due to unsustainable profit margins as a result of backdoor tactics employed by those who are more interested in lining their pockets then ensuring a vibrant pharmacy marketplace where businesses of all sizes and models can compete.

The stories I heard from my constituents in Dallas were recently supported by reports published by the Community Oncology Alliance and the Centers for Medicare and Medicaid (CMS) regarding direct and indirect remuneration (DIR) fees. These fees were first implemented by CMS as a method to track the annual amount of drug manufacturer rebates or other related price adjustments that resulted in a cost difference between what CMS paid Pharmacy Benefit Managers (PBMs) for Medicare Part D drugs. The idea was that if PBMs received rebates or other savings on the cost of prescription drugs, then those savings should be sent back to those who foot the original bill. In the case of Medicare Part D, that is CMS. Transparency, accountability, and good stewardship of taxpayer dollars were the driving forces behind the creation of DIR fees; however, these intentions have since been discarded.

Fast forward to today. The meaning, purpose, and intent of DIR fees have been applied in broad, sweeping ways and impacted independent, community, and specialty pharmacies in ways I cannot image Congress ever envisioned. Many PBMs have co-opted the notion of DIR fees and

used it as a mechanism to require pharmacies to pay fees directly to the PBM when they apply to enter their preferred network or fill a prescription. Yet the exact prices of the fees, when they are charged, why they are charged, or what quality standards will be employed are, in many cases, virtually unknown.

Imagine for a moment that several years ago you moved out of an apartment. You were never told if you had to pay a cleaning fee upon move out, what you would be charged if they filled a nail hole, or even what condition the apartment should be in upon move out. Then, years later, suddenly the apartment complex with no explanation demanded an outrageous sum of money that, if you had known would be expected of you, you would have never moved into the apartment in the first place.

This example may seem outrageous and like complete fraud. In any other context besides the pharmacy-PBM relationship, I believe there would be no dispute that it is fraud. Yet today this very situation is occurring. This lack of price transparency is especially concerning for community oncology practices given the high cost of specialty cancer drugs. Unless Congress acts or current practices by many PBMs change, I'm very concerned that the patients in Dallas who depend on community oncology practices won't have access to the affordable and reliable care they rely on. In fact, just last month CMS warned that the rise in pharmacy DIR fees has increased Medicare costs to the government and forced more beneficiaries into the coverage gap. This is the exact opposite of CMS' intent in creating DIR fees. Clearly the system is broken and needs swift and reasonable reform.

Specifically Congress should act to prohibit retroactive DIR fees on pharmacies, which is exactly what legislation introduced by Congressman Morgan Griffith from Virginia does. The "Improving Transparency and Accuracy in Medicare Part D Drug Spending Act" prohibits Medicare Part D plan sponsors and PBMs from retroactively reducing payment on clean claims submitted by pharmacies under Medicare Part D. Based on the facts of the case, this commonsense, pro-patient reform will lead to lower Medicare costs for taxpayers, increase transparency in drug pricing, help seniors more effectively budget for drug costs and preserve access to locally owned pharmacies. I strongly urge my colleagues on both sides of the aisle to join me in cosponsoring H.R. 1038.

I thank the pharmacists in Dallas, Texas and across the nation who work tirelessly on behalf of families who rely of consistent access to affordable care. The vibrancy of our healthcare ecosystem depends on a level and certain playing field for pharmacies and I will continue to work toward that goal.