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The Cost of Independent Pharmacy Antitrust Exemptions

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0. EXECUTIVE SUMMARY

During the past fifteen years, the number of consumers with prescription drug coverage has expanded dramatically. More widespread drug coverage has increased competition among retail pharmacies as many large and sophisticated payers, such as employers, unions, governmental programs, as well as health plans, hired pharmacy benefit managers (“PBMs”) to efficiently manage pharmacy benefits for their employees and enrollees. As a result of the competition induced by PBMs, pharmacy profit margins on prescriptions narrowed from the levels that pharmacies had historically earned when most of their customers were cash paying individuals. With the implementation of Medicare’s prescription drug benefit, even fewer consumers are paying in cash for their prescriptions. Independent pharmacy representatives claim that narrowing profit margins on prescriptions has caused their industry financial hardship and argue that they should receive antitrust exemptions that would allow them to bargain collectively with health plans and PBMs, even as their own industry data indicate increases in prescription volume, sales, and dollar profits.¹ This study finds that:

- Current antitrust laws provide legitimate mechanisms for pharmacies to collaborate to negotiate with payers and PBMs, when such collaboration enhances the quality or efficiency of care to patients;
- Under proposed pharmacy antitrust exemption legislation, direct costs to payers, including commercial payers and Medicare could increase by \$29.6 billion over 5 years, an increase of 11.8 percent of total prescription sales across all independent pharmacies;
- Costs to the Medicare Part D program and its beneficiaries could increase by \$6.4 billion over 5 years as a result of pharmacy collective bargaining; and
- The cost increases resulting from pharmacy collective bargaining would likely be passed on to health insurers, employers, and consumers. As costs increase, employers would likely face pressure to scale back, reduce, or even eliminate health care coverage for their employees. Including consideration of potential reduced or eliminated access to health care, the total costs of independent pharmacy antitrust exemptions exceeds the financial costs estimated by this report.

Antitrust regulators reject the need of antitrust exemptions in general and as applied to healthcare in particular. For example, the Federal Trade Commission, when commenting

¹ See *2006 NCPA-Pfizer Digest*, National Community Pharmacists Association, 2006 (“2006 NCPA Digest”), pp. 7, 10, and 20; and *The Chain Pharmacy Industry Profile*, National Association of Chain Drug Stores Foundation, 2005 (“2005 NACDS Profile”), p. 45.

upon legislation that would have extended antitrust exemptions to physicians, pharmacists, and other health providers, noted that:²

- “Doctors and other health care professionals could join together to demand substantially higher fees”;
- “Pharmacists could insist on higher payments for filling prescriptions...”;
- “Consumers and employers ... would face higher insurance premiums”; and
- “Consumers would pay more out-of-pocket and could see their benefits reduced.”

There is little doubt that the prospect of higher reimbursements motivates independent pharmacies’ petition for antitrust exemptions. Early support for proposed legislation noted that antitrust exemptions would combat the “[p]lummeting reimbursement that threatens to close independent pharmacies.”³ An antitrust exemption could help consumers only if it were the case—which it is not—that access to pharmacies was being compromised by a large number of business closures. Even under such circumstances, antitrust regulators would need to weigh the impact of reduced pharmacy access against higher prescription drug costs.

This study demonstrates that there is no need for antitrust exemptions for independent pharmacies, both because those pharmacies are profitable and because there exists no competitive imbalance affecting employers and insurers in the acquisition of pharmaceutical prescriptions from independent pharmacies. In fact, current requirements imposed by government programs and by health insurers (public and private) already convey a competitive advantage on pharmacies located in rural areas, and independent pharmacies already have organizations that can collectively represent their interests.

As a result, the provision of antitrust exemptions would be an expensive concession to independent pharmacies. The figure below presents the cost increases to health plans and patients expected to result from collective negotiation by independent pharmacies over pharmaceutical reimbursements, based on two scenarios:

² See *Prepared Statement of the FTC, Presented by Robert Pitofsky, Chairman, Federal Trade Commission, Before the Committee of the Judiciary, United States House of Representatives, Concerning H.R. 1304 the “Quality Health-Care Coalition Act of 1999,”* June 22, 1999. This statement included other consequences of H.R. 1304 not included above.

³ The American Pharmacy Cooperative, Inc. (“APCI”) “Call to Action.” This document also characterized H.R. 1671, the legislation introduced in 2005 to provide antitrust exemptions to independent pharmacies, as “similar to H.R. 1304.” The most recently introduced version of the community pharmacy collective negotiation legislation, H.R. 971, is similar to H.R. 1671, except that language specifying “no new right for collective cessation of service” is excluded from H.R. 971.

Potential Impact of Independent Pharmacy Antitrust Exemption	Total Cost Impact (\$ billions)	Cost Impact on Commercial Sector (\$ billion)	Cost Impact on Medicare Part D (\$ billions)	Increase in Prescription Costs at Independent Pharmacies (%)
Potential cost increases with proposed independent pharmacy antitrust exemptions	\$29.6	\$23.2	\$6.4	11.8%
Cost increases demanded in absence of independent pharmacy antitrust exemptions	\$9.2	\$7.2	\$2.0	3.6%

As the figure demonstrates, without considering the other types of behavior in which independent pharmacies might engage if allowed to cooperate (including rejection of cost control methods and group purchasing operations), antitrust exemptions for independent pharmacies would significantly increase pharmaceutical expenditures for health plans and patients. Over five years (e.g., 2008-2012, if legislation passed in 2007), independent pharmacy antitrust exemptions would increase costs by up to \$29.6 billion, an 11.8 percent increase over current spending at independent pharmacies.⁴ Of this total, roughly 22 percent of the increased spending results from the increased coverage by third party payers under Medicare Part D.

These costs are likely to be ultimately passed on to health insurers, employers, and consumers. As costs increase, patients fill fewer prescriptions and employers will likely scale back, reduce, or even eliminate health care coverage for their employees. Including consideration of reduced or eliminated access to health care, the total costs of independent pharmacy antitrust exemptions exceeds the financial costs estimated by this report.

⁴ Five year totals discounted to reflect time value of money; see Section 7.1 for additional detail.

1. INTRODUCTION

In 2005, Representatives Anthony Weiner (D–NY) and Jerry Moran (R–KS) co-sponsored H.R. 1671 as part of an effort to secure antitrust exemptions for independent pharmacies that would allow them to negotiate collectively with PBMs and health plans.⁵ While the legislation did not pass in 2006, the legislation was reintroduced in 2007 as H.R. 971. The proposed antitrust exemptions for independent pharmacies are not the first attempted in the health care industry; previous proposed legislation would have provided physicians and pharmacists with antitrust exemptions.⁶ The national provision of physician and pharmacist antitrust exemptions would have increased the costs of healthcare by 0.9 to 2.7 percent as a result of direct price increases and indirect costs associated with resulting changes in utilization of health care services ordered by physicians.⁷

This study evaluates one of the cost increases that would likely result from granting antitrust exemptions to independent pharmacies,⁸ namely the magnitude of price increases that would occur with collective negotiation by independent pharmacies on reimbursement terms. (It does not consider a number of other policy changes that might result from granting antitrust exemptions, which have been studied in other contexts).⁹ In particular, this study finds the following:

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- ⁵ As defined by H.R. 971, an independent pharmacy is defined as a pharmacy that is not owned or operated by a publicly traded company. As noted by the John Rector, the Senior Vice President for Government Affairs and General Counsel for the National Community Pharmacists Association (“NCPA”), the definition used by H.R. 1671 “will help us avoid the problems associated with the wrong-headed definition used by IMS, the National Association of Boards of Pharmacy, and others misrepresenting the marketplace by designating the owner of four or more pharmacies as a chain, not as an independent.” (See http://www.ncpanet.org/pdf/amrx_200506_notes.pdf, accessed April 18, 2006). The National Association of Chain Drug Stores (“NACDS”), alternatively, defines independent pharmacies as those with three or fewer locations. See 2005 NACDS Profile, p. 10. For the purposes of clarity, this study uses the definition provided by H.R. 971.
- ⁶ See, for example, the Quality Health Care Coalition Act, H.R. 1304, introduced in March 1999. At least one supporter of the independent pharmacy exemption legislation, the American Pharmacy Cooperative, Inc. (“APCI”), characterized H.R. 1671 as “similar to H.R. 1304” (See APCI “Call to Action”).
- ⁷ *The National Costs of Physician Antitrust Waivers*, prepared for Health Insurance Association of America (now America’s Health Insurance Plans, or AHIP), Charles River Associates Inc., March 2000, p. 6.
- ⁸ As written, H.R. 971 excludes from the exemption program negotiations with Federal programs (e.g., Medicaid, Federal employee health benefit program (“FEHBP”)). The cost estimates of this study assume costs would accrue only from commercial insurance accounts (i.e., Medicaid and cash prescription transactions are excluded from consideration).
- ⁹ Other reports have considered the cost implications of other types of behavior that might result from independent pharmacies antitrust exemptions. See, for example, PricewaterhouseCoopers, “Pharmacy Benefit Management Savings in Medicare and the Commercial Marketplace & the Cost Impact of Proposed PBM Legislation, 2008-2017,” pp. 2, 16, which found that requiring PBMs to publicly disclose details on negotiated discounts would increase drug costs to Medicare and private payers by \$219 billion over the 2008-2017 period.

- Current antitrust laws provide legitimate mechanisms for pharmacies to collaborate to negotiate with payers and PBMs, when such collaboration enhances the quality or efficiency of care to patients;
- Under proposed pharmacy antitrust exemption legislation, direct costs to payers could increase by up to \$29.6 billion over 5 years, an increase of 11.8 percent of total prescription sales across all independent pharmacies;¹⁰
- More than \$6.4 billion of the increased costs over 5 years would be attributable to implementation of Medicare Part D; and
- Cost increases from the proposed legislation would be passed through to health insurers and employers, providing pressure to increase costs and/or reduce health insurance coverage for employees and patients.

Each of these findings is discussed in greater detail below. Section 2 describes the distribution of and reimbursement for pharmaceutical prescriptions. Section 3 considers the economic support for antitrust exemptions and includes a discussion of the current mechanisms to protect competition. Section 4 summarizes literature and opinions regarding the distribution of cost increases that would result from granting antitrust exemptions. Section 5 provides estimates that antitrust exemptions to independent pharmacies would increase costs by up to \$29.6 billion over five years, or 11.8 percent of total prescription sales across independent pharmacies.

2. CURRENT PBM PRACTICES REDUCE COSTS WHILE LEAVING INDEPENDENT PHARMACIES PROFITABLE

The number of prescriptions dispensed has increased substantially over the past ten years.¹¹ Insurance coverage of pharmaceuticals began when most health insurance plans operated on an indemnity, or fee-for-service (“FFS”) basis. Under FFS insurance, patients typically had to make a coinsurance payment for prescriptions, often 20 percent of the negotiated price. The pharmacy at which a patient filled a prescription sometimes had arrangements with health insurers for discounts, but the patient often bore the responsibility of paying the full price of the prescription and seeking reimbursement from the health insurer. Consumers without insurance coverage typically paid undiscounted, full retail prices at the pharmacy counter.

¹⁰ The details of this analysis are addressed below.

¹¹ See, for example, *Prescription Drug Trends*, The Kaiser Family Foundation, November 2005, p. 1. The 2006 NCPA-Pfizer Digest reported a 2.8 percent increase in prescription volume between 2004 and 2005. See 2006 NCPA Digest, p. 6.

2.1. PAYERS RELY ON NETWORKS AND OTHER PBM COST CONTROL TECHNIQUES TO LIMIT PRESCRIPTION EXPENDITURES

More comprehensive managed benefit plans rapidly replaced the FFS private health insurance model in the 1990s, shifting the source of payment for prescriptions from patients to their insurers. In 1980, patient out-of-pocket spending accounted for 70 percent of prescription expenditures. By 2004, patients' out-of-pocket payments had fallen to 25 percent of spending on prescription drugs.¹² The increased numbers of consumers with prescription drug coverage had at least two significant effects on retail pharmacies. First, health plans sought to help employers and other plan sponsors to manage costs by establishing networks of health providers. Health plans (or their PBMs) also pooled the volume purchasing ability of the many consumers whose benefits they managed in order to negotiate favorable rates from health care providers (including pharmacies).¹³ Second, communications between health insurers (or their PBMs) and healthcare providers often resulted in contracts that defined the reimbursement terms and duration of the agreement.¹⁴ The reimbursement terms typically had two components: an "ingredient cost" and a "dispensing fee." In addition to this reimbursement, pharmacies also collected copayments, or flat per-prescription payments, from patients with health insurance that included prescription drug coverage.

The PBM business model has also evolved as management of the drug benefit has increased. From companies that initially handled only the administrative details of health insurance transactions, PBMs grew into sophisticated, integrated components of healthcare distribution and reimbursement. PBMs enter into contracts with "plan sponsors" – typically health insurers¹⁵ or self-insured employers – to provide management of pharmacy benefit

12 Centers for Medicare and Medicaid Services ("CMS"), *Historical National Health Expenditures (NHE) Amounts by Type of Expenditure and Source of Funds: Calendar Years 1965-2015*.

13 "By forming an exclusive network, a PBM is able to guide a covered entity's participants to certain pharmacies. The promise of increased customer volume creates an incentive for pharmacies to bid aggressively with lower drug prices in exchange for membership in a network. Pharmacies will be willing to compete more vigorously for inclusion in a network as the exclusivity of the network and the number of pharmacies in the relevant market increases." *March 8, 2005 Letter to Senator Richard L. Brown, North Dakota Senate*, Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics.

14 Some healthcare providers, including pharmacies, have claimed that there is no "negotiation" with the health insurer (or PBM). See, for example, John Rector, "Progress Steady on Community Rx Fairness Act," *America's Pharmacist*, August 2005, p. 56. Such a scenario does not by itself provide evidence of market power by an insurer or PBM (the criteria by which market power is defined are considered below). A scenario of little or no negotiation is at least as likely to demonstrate the competitiveness or oversupply of pharmacies. The terms of the contract would certainly change if a sufficient number of pharmacies opted not to accept the contracts.

15 In addition to commercial health insurers, government payers act as plan sponsors by contracting with PBMs to provide health care management for their own employees (e.g., FEHBP) and for the beneficiaries of government programs such as Medicare.

services. In general, PBMs handle claims processing, pharmacy network formation,¹⁶ formulary creation and maintenance, manufacturer rebate negotiations, disease management, and the creation and implementation of additional programs to control drug costs (such as generic substitution or mail-order dispensing).¹⁷ The degree to which a PBM accepts risk for cost overruns or trends depends on its contract with a plan sponsor, as do a number of other terms, such as whether and to what degree other PBM revenue (such as rebates) will be shared, the duration of the contract, and the penalties assessed for noncompliance with contract terms.¹⁸

2.2. PBMs PROVIDE SUBSTANTIAL COST SAVINGS

Empirical evidence suggests that consumers with prescription drug insurance administered by a PBM save substantially on their drug costs as compared to cash-paying customers.¹⁹ A study across 14 brand name drugs and 4 generics showed that health plan sponsors and their enrollees enjoyed prices that were 47 percent lower for generic drugs and 18 percent lower for brand name drugs.²⁰ Other commentators have noted that:

Since PBMs reflect aggregate purchases representing all individuals within a drug coverage program, their reimbursement formulas are established to extract volume purchase discounts from pharmacies. Levels of prices paid by PBMs generally are the lowest or some of the lowest accepted by pharmacies for any types of customers. Prices paid by cash paying customers and even Medicaid programs in many states are higher than what a PBM would pay. Thus the PBM pricing approach can be

16 In the current healthcare system, patients can obtain prescription drugs through a variety of different venues that include hospitals, physicians' offices, clinics, long-term care facilities, mail-service pharmacies, and several types of retail establishments, including chain drug stores, independent drug stores, mass merchants, and supermarkets.

17 *Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacies*, Federal Trade Commission, August 2005 ("FTC Mail Order Study 2005"), pp. 5-7, 10. The exact services provided by PBMs vary substantially depending on the needs and preferences of plan sponsors.

18 PBMs typically employ several methods that generate additional revenue. For example, formularies – lists of drugs that are reimbursed at certain levels – are common tools that reduce total costs by generating competition between branded pharmaceutical manufacturers to lower the effective net price of preferred drugs for patients and plan sponsors.

19 See *Improving Health Care: A Dose of Competition*, A Report by the Federal Trade Commission and the Department of Justice, Chapter 7, p. 16, July 2004.

20 See *Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies*, General Accounting Office, 2003, accessed at <http://www.gao.gov/cgi-bin/getrpt?GAO-03-196>, which is quoted in *Improving Health Care: A Dose of Competition*, A Report by the Federal Trade Commission and the Department of Justice, Chapter 7, p. 11, July 2004.

considered a negotiated price, volume discount strategy targeted at pharmacy providers.²¹

The Congressional Budget Office (“CBO”) has noted that the degree to which PBMs can effectively control drug costs depends on “their being allowed and encouraged to aggressively use the various tools at their disposal.”²² According to CBO, these tools include, among others, forming limited pharmacy networks.²³ In estimating the extent to which PBMs could manage costs in Medicare, CBO estimated that PBMs could save as much as 30 percent over unmanaged costs if allowed and encouraged to use the full range of tools at their disposal.²⁴

2.3. INDEPENDENT PHARMACIES REMAIN PROFITABLE

Despite independent pharmacies’ claims that their negotiations with PBMs do not occur on a “level playing field,”²⁵ independent pharmacies remain profitable. In 2005, the average gross profit margin that independent pharmacies earned on sales to commercial insurers (including Medicare managed care plans) was 19.3 percent, up 1.5 percentage points from the previous year. Their average gross profit margin on prescriptions filled for Medicaid beneficiaries in 2005 was 20.8 percent.²⁶ Their overall gross profit margin on prescriptions increased from 21.2 percent in 2004 to 22.7 percent in 2005, which coincided with an increase in volume.²⁷

²¹ See *Cost Control for Prescription Drug Programs: Pharmacy Benefit Manager PBM Efforts, Effects, and Implications*, Prepared for the Department of Health and Human Services’ Conference on Pharmaceutical Pricing Practices, Utilization and costs, By Kreling, David, August 8-9, 2000, pdf p. 2. Similarly, the Federal Trade Commission found that “Retail pharmacies may compete over the discounts from the reference price (AWP or MAC) they will offer a PBM depending on the type of plan sponsors and the number of members covered by the PBM. Retail pharmacies generally will offer higher discounts to be in a more exclusive network, because each retail pharmacy will fill a larger percentage of prescriptions if fewer retail pharmacies are in the PBM’s network. A PBM may have several networks, which differ in their exclusivity, that it offers its clients.” FTC Mail Order Study 2005, p. 5.

²² See Congressional Budget Office, “Issues in Designing a Prescription Drug Benefit for Medicare,” October, 2002, (“CBO 2002”), page xiii, accessed at <http://www.cbo.gov/showdoc.cfm?index=3960&sequence=0>.

²³ CBO 2002, p. xiii. Other tools include formularies, disease-management programs, and efforts to educate patients and physicians. “All of those tools, to one degree or another, work by influencing physicians’ or consumers’ choices about what drug to prescribe or where to fill a prescription.”

²⁴ CBO 2002, p. 40.

²⁵ “This legislation [H.R. 1671] would allow community pharmacies to negotiate on a more level playing field, helping to preserve these trusted elements of our communities.” John Rector, Senior Vice President for Government Affairs for NCPA, *America’s Pharmacist*, June 2005, p. 52. Accessed at http://www.ncpanet.org/pdf/amrx_200506_notes.pdf.

²⁶ 2006 NCPA Digest, p. 53.

²⁷ 2006 NCPA Digest, p. 11.

Additionally, in 2003 the number of independent pharmacies increased by over 400, which would have been unlikely to occur had the market for their services not been profitable.²⁸

As privately-held institutions, independent pharmacies must provide owners with compensation as well as the normal economic profits expected to derive from a viable business entity. That is, the total net profit of an independent pharmacy, known as the "owner's discretionary profit," has two components: the owner's compensation and the net profit to the pharmacy. In 2005, average payroll expense including owner compensation increased by 1.2 percent of sales.²⁹

According to a firm that facilitates the sales of independent community pharmacies, the owner's compensation component of profit is attractive: "Despite the intense pressure on prescription department profit margins, the more than 20,000 independent owners in this country continue to earn a substantial living, one which...places these owners in the top 4% of all United States wage earners."³⁰ Indeed, it appears that factors outside of financial performance, including buyouts from chain pharmacies as well as a nationwide shortage of new pharmacists, might be responsible when an independent pharmacy business elects to close.³¹

28 See *Gross Margins, Net Profits Up for Independents*, Drug Store News, No. 9, Vol. 26, July 19, 2004, p. 30.

29 2006 NCPA Digest, p. 10.

30 "Owning an Independent Pharmacy," Buy-Sell A Pharmacy.Com, 2005, accessed at, <http://www.buy-sellapharmacy.com/Article%20OWNING%20AN%20INDEPENDENT%20PHARMACY%20062404.pdf>. Buy-Sell A Pharmacy.Com has a partnership with NCPA. See *NCPA Seeks New Independent Pharmacy Owners*, Drug Topics, No. 22, Vol. 147, November 17, 2003, p. 33.

31 "Recently...access to pharmacy services in rural areas has begun to receive more attention, as a result of ... pharmacist shortages in some rural areas." Casey, M., Klingner, J., and Moscovice, I. *Access to Rural Pharmacy Services: Is the Problem Geographic Access or Financial Access?* Journal of Rural Health 18: 467-476, 2002. p. 1. (Note, however, that this study was not designed to address pharmacist supply issues). Similarly, "Finding relief pharmacists to fill in for those who are sick or on vacation is 'one of the biggest problems facing rural community practices - and small rural hospitals for that matter.'" *Special Delivery?* Innovations are Changing How, Where and When People Receive Pharmacy Services - Not Everyone Is Thrilled, Ronald A Wirtz, FedGazette, January 2006 ("Wirtz 2006a"), p. 7.

3. ANTITRUST EXEMPTIONS FOR HEALTH CARE PROVIDERS ARE UNNECESSARY

3.1. CURRENT ANTITRUST REGULATION AND ENFORCEMENT SAFEGUARDS COMPETITION

The Federal Trade Commission (“FTC”) was created in 1914 to “prevent unfair methods of competition in commerce.”³² The charge of the Antitrust Division of the U.S. Department of Justice (“DOJ”), similarly, has been to “promote and protect the competitive process – and the America economy – through the enforcement of the antitrust laws.”³³ Together, and supplemented by State Attorneys General, these agencies monitor competition and enforce laws and regulations intended to protect consumers from inappropriate corporate behavior. Of primary concern is the concept of “market power,” often described as the ability for sellers profitably to inflate prices charged or for buyers to suppress prices paid, relative to competitive levels, for a significant period of time. The regulatory agencies monitor both areas where sellers appear to be increasing prices above competitive levels (e.g., monopoly) as well as circumstances where purchasers appear to be decreasing prices below competitive levels (e.g., monopsony).

In order to enforce antitrust and protect competition, the regulatory agencies have established a series of general, and in some cases industry-specific, guidelines to distinguish appropriate and problematic corporate behavior. For example, the FTC and DOJ jointly issued and regularly update the Horizontal Merger Guidelines guidance, which identify the types of behaviors and market conditions likely to violate competition laws.³⁴

3.2. THERE IS NO RATIONALE FOR ANTITRUST EXEMPTIONS TO “LEVEL THE PLAYING FIELD”

Contentions that antitrust exemptions are needed presuppose some market imbalance that cannot be addressed by current competition laws and regulatory authorities. Antitrust exemptions, by definition, allow the legal formation of an economic entity that can create and maintain market power through coordinated behavior. Regulatory agencies and most economists have regularly dismissed the concept of combating perceived market power by creating “countervailing” market power. Such attempts are inefficient, requiring continued adjustment and interference in economic markets while running the risk of spreading competitive imbalance to related markets as the protected entities engage in various lines of business.

³² See <http://www.ftc.gov/bcp/conline/pubs/general/guidetofc.htm>.

³³ See <http://www.usdoj.gov/atr/overview.html>.

³⁴ *Horizontal Merger Guidelines*, U.S. Department of Justice and the Federal Trade Commission, Issued April 2, 1992; Revised April 8, 1997. Accessed at http://www.usdoj.gov/atr/public/guidelines/horiz_book/hmg1.html.

The FTC and DOJ have been particularly active in their enforcement of the antitrust laws in the health care industry through both prosecutorial activities and analysis and study. They have also provided substantial guidance to the health care industry through their Health Policy Statements,³⁵ and through various business review letters and advisory opinions on specific topics. In recent years, they have focused extensively on the health care industry in hearings and analysis. The agencies held an extensive set of hearings on health care competition, which resulted in the publication of a thorough evaluation of the state of competition in health care, entitled “Improving Health Care: A Dose of Competition” in July 2004. The FTC also undertook an analysis of mail order pharmacy services, which encompassed a review of the state of competition among PBMs in general.³⁶

In general, the federal antitrust agencies have supported the maintenance of competition by letting markets function when possible and intervening when they discern market power. In the particular context of antitrust exemptions, while chairman of the FTC, Robert Pitofsky noted: “From a policy and enforcement perspective, the most effective response to the emergence of excessive buyer power is not to permit the aggregation of some form of countervailing power. Rather, the appropriate response is to try to prevent the aggregation of excessive buying power in the first place.”³⁷ As noted in the FTC/DOJ “Dose of Competition” report, “The Agencies believe that antitrust enforcement to prevent the unlawful acquisition or exercise of monopsony power by insurers is a better solution than allowing providers to exercise countervailing power. Joel Klein, the Assistant Attorney General in 1999, noted that a ‘better approach [than allowing countervailing market power] is to empower consumers by encouraging price competition, opening the flow of accurate, meaningful information to consumers, and ensuring effective antitrust enforcement both with regard to buyers (health care insurance plans) and sellers (health care professionals) of provider services.”³⁸

As a result, the agencies have monitored consolidation among health insurers and PBMs and have taken action where they have felt it necessary. For example, in 2005 the DOJ investigated UnitedHealthcare’s acquisition of PacifiCare. Before allowing UnitedHealthcare to proceed with the transaction, the DOJ required it to divest pieces of the combined entity in Tucson, Arizona and Boulder, Colorado in order to prevent what it perceived as the potential for the exercise of market power in the purchase of physician services in these areas.³⁹

35 Revised Federal Trade Commission Justice Department Policy Statements on Health Care Antitrust Enforcement, issued 8/26/96, available at <http://www.ftc.gov/reports/hlth3s.htm>.

36 Dose of Competition. See also *Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacies*, Federal Trade Commission, August 2005.

37 *Level Playing Fields in Health Care Markets*, speech delivered by FTC Chairman Robert Pitofsky to the National Health Lawyers Association, February 13, 1997.

38 Dose of Competition, Chapter 2, p. 21. Parenthetical material included in source material.

39 Competitive Impact Statement, *United States of America v. UnitedHealth Group Inc., and PacifiCare Health Systems, Inc.*, United States District Court for the District of Columbia, Judge Ricardo M. Urbina, March 3, 2006, accessed at <http://www.usdoj.gov/atr/cases/f215000/215034.htm>.

Similarly, the FTC has reviewed several mergers in the PBM industry, and only allowed them to proceed after it was sure that competition would be maintained.⁴⁰ For example, it concluded its investigation of Caremark Rx, Inc.'s proposed acquisition of AdvancePCS with the following statement:

We also considered whether the proposed acquisition would confer monopsony (or oligopsony) power on PBMs when they negotiate dispensing fees with retail pharmacies....In the present case, there is no reason to expect a monopsony or oligopsony outcome – i.e. one in which the overall purchases from pharmacies are reduced – even if the acquisition enables the merged PBM (or PBMs as a group) to reduce the dispensing fees they pay to retail pharmacies. Characteristics of the relevant market make monopsony or oligopsony power unlikely. For example, contracts are individually negotiated between each PBM and each retail pharmacy company. In any event, the post-acquisition share of the merged firm for all purchases of prescription dispensing services would be below the level at which an exercise of monopsony power is likely to be profitable.⁴¹

As noted earlier, the FTC also undertook a thorough review of the PBM industry in its study of mail order pharmacies and concluded that “[d]ata in the report demonstrate that PBMs’ use of owned mail-order pharmacies generally is cost-effective for plan sponsors.”⁴² The FTC has also found that the PBM industry is competitive and that restrictions on its behavior, such as requiring “transparency” or restricting its ability to contract selectively, would hinder, rather than abet, the competitive process, resulting in higher costs.⁴³

40 For example, the FTC recently cleared the merger of CVS (retail pharmacy) and Caremark (PBM), and considered the competitive implications of a proposed merger between PBMs Caremark and Express Scripts. Rose, French, “Express Scripts Seeks More Time for FTC Review of Caremark Bid”, *Associated Press State & Local Wire*, January 31, 2007.

41 Statement of the Federal Trade Commission. *In the Matter of Caremark Rx, Inc./Advance PCS*. File No. 031 0239, February 11, 2004, accessed at <http://www.ftc.gov/os/caselist/0310239/0310239.htm>. (Footnotes omitted.)

42 FTC Chairman Deborah Platt Majoras, quoted in *FTC Issues Report on PBM Ownership of Mail-Order Pharmacies*, September 6, 2005.

43 For example, the FTC evaluated proposed legislation in California (A.B. 1960) that would have required increased disclosure of certain financial information by PBMs. The FTC noted that the proposed legislation was likely to increase prices and costs of pharmaceuticals, and concluded that “vigorous competition in the marketplace for PBMs is more likely to arrive at an economically efficient level of transparency than regulation of those terms.” (<http://www.ftc.gov/opa/2004/09/capbm.htm>, accessed October 5, 2004). Similarly, the FTC evaluated proposed legislation in North Dakota that would limit PBMs’ abilities to engage in selective contracting. The FTC noted that the proposed legislation (H.B. 1332) would “prevent covered entities from designing benefit plans to encourage participants to use network pharmacies that provide drugs to the plan at a lower cost than other network pharmacies.” *March 8, 2005 Letter to Senator Richard L. Brown, North Dakota Senate*, Federal Trade Commission’s Office of Policy Planning, Bureau of Competition, and Bureau of Economics.

In general, the FTC has found other practices used by MCOs that might be thought to restrict competition, such as contracting with a limited set of providers (“selective contracting”), to be pro-competitive in many situations, as it explained in its comments to Rhode Island officials regarding seven pieces of proposed legislations intended to preserve “freedom of choice” for patients requiring pharmacy services and to allow “any willing provider” to join pharmacy networks:

Competition among third party payers and health care providers can enhance the range of services available to consumers and reduce health care costs. The Commission has noted that the use of limited panels of health care providers has been an effective means of promoting competition and lowering the price of health care services. The Commission has accordingly taken law enforcement action against anticompetitive efforts to suppress or eliminate health care programs that use selective contracting to create a limited panel of health care providers. FTC staff has also submitted comments to government bodies about the competitive effects of various regulatory proposals to restrict selective contracting. Two of these comments addressed ‘any willing provider/freedom of choice’ requirements for pharmacies.⁴⁴

Limitations on choice are unlikely to be so severe that consumers’ access to pharmacy services is inadequate. Just as competitive forces encourage pharmacies to offer their best price and service combination to a payer to gain access to its subscribers, competition also encourages payers (and employers) to establish pharmacy service arrangements that offer the level of accessibility that subscribers prefer.⁴⁵

In addition to antitrust enforcement by the federal antitrust agencies, the Courts have also addressed issues of market power for the different participants in the health care system. For example, in 1984, healthcare providers sued Blue Shield of Massachusetts (now Blue Cross Blue Shield (“BCBS-MA”)), alleging that BCBS-MA exerted market power to secure noncompetitive prices from healthcare providers. The Court sided with BCBS-MA, as Judge

44 *April 8, 2004 Letter to Rhode Island Attorney General Patrick C. Lynch and Deputy Majority Leader, Senator Juan M. Pichardo, Federal Trade Commission’s Office of Policy Planning, Bureau of Competition, and Bureau of Economics (“FTC Letter to Rhode Island 2004”).* In addition, the FTC noted: “An abundance of empirical evidence now exists demonstrating that, other things equal, selective contracting increases the intensity of competition among providers, which is manifested in lower prices paid by insurers to providers. The competition’s intensity increases with the number of providers in the relevant market, and with the restrictiveness of the insurance contracts found in the market (i.e., HMOs, which have more limited panels than PPOs, induce more intense price competition among providers than would PPOs of equivalent size). These findings conform to economic theory. When insurers have a credible threat to exclude providers from their networks and channel patients elsewhere, providers have a powerful incentive to bid aggressively. Inclusion in a restricted panel offers the provider the prospect of substantially increased sales opportunities. Without such credible threats, however, providers have less incentive to bid aggressively, and even managed care organizations with large market shares may have less ability to obtain low prices.” (FTC Letter to Rhode Island 2004).

45 FTC Letter to Rhode Island 2004.

Breyer (now a Supreme Court Justice) noted that antitrust laws were written to protect consumers from high prices, not necessarily from low prices:

The Congress that enacted the Sherman Act saw it as a way of protecting consumers against prices that were too high, not too low. And, the relevant economic considerations may be very different when low prices, rather than high prices, are at issue. These facts suggest that courts should be cautious --reluctant to condemn too speedily -- an arrangement that, on its face, appears to bring low price benefits to the consumer.⁴⁶

While a few states (e.g., Washington, Texas, and Ohio) have passed antitrust exemptions for physicians, such legislation has wisely been rejected by several other states and at the federal level as expensive and unnecessary. The CBO estimated that proposed federal legislation to exempt physicians from antitrust scrutiny and allow collective bargaining would increase national expenditures on private health insurance by 2.6 percent when in full effect.⁴⁷ The CBO also predicted that such legislation would increase direct federal spending on healthcare programs such as Medicaid by \$11.3 billion and decrease tax revenue by \$10.9 billion over ten years.⁴⁸

4. ANTITRUST EXEMPTIONS FOR INDEPENDENT PHARMACIES WILL INCREASE PHARMACEUTICAL COSTS

4.1. GEOGRAPHIC ACCESS REQUIREMENTS ALREADY LIMIT PBM NEGOTIATION EFFORTS

As motivation for their pursuit of antitrust exemptions, independent pharmacies claim that they are at a competitive disadvantage relative to chain pharmacies in negotiating with health insurers (or their PBMs). However, health insurers' geographic access requirements already provide rural pharmacies with a bargaining advantage over PBMs. Health plan sponsors, both public (e.g., Medicare) and private, require that beneficiaries have convenient access to covered health care services. For example, the Medicare Prescription Drug Improvement and Modernization Act of 2003 (known as the Medicare Modernization Act, or "MMA")

⁴⁶ Kartell v. Blue Shield, 749 F.2d 922, 930-31 (1st Cir. 1984), cert. denied, 471 U.S. 1029 (1985), as cited in: *Level Playing Fields in Health Care Markets*, speech delivered by FTC Chairman Robert Pitofsky to the National Health Lawyers Association, February 13, 1997.

⁴⁷ Congressional Budget Office, "Cost Estimate: H.R. 1304, Quality Health Care Coalition Act of 1999, As Introduced on March 25, 1999," March 15, 2000 ("CBO Cost Study 2000"). Accessed at <http://www.cbo.gov/showdoc.cfm?index=1885&sequence=0>.

⁴⁸ CBO Cost Study 2000. The CBO also noted that: "[a]t present, CBO cannot estimate the likely increase in the cost of health insurance for employees of state, local, and tribal governments."

established an outpatient prescription drug program known as Medicare Part D. Health care plans seeking to participate as carriers are required to create pharmaceutical networks that meet the following geographic access requirements:

- At least 90 percent of Medicare beneficiaries, on average, in urban areas served by the Part D plan live within 2 miles of a network pharmacy that is a retail pharmacy;
- At least 90 percent of Medicare beneficiaries, on average, in suburban areas served by the Part D plan live within 5 miles of a network pharmacy that is a retail pharmacy; and
- At least 70 percent of Medicare beneficiaries, on average, in rural areas served by the Part D plan live within 15 miles of a network pharmacy that is a retail pharmacy.⁴⁹

Commercial health plans establish their own accessibility requirements for the members in their networks, typically including their desired or mandatory access requirements in their requests for proposals (“RFPs”) to PBMs. This particular element of the contract is not usually negotiated, but established as a necessary condition to be considered for contracting negotiations.⁵⁰ As a result, a PBM’s response to an RFP typically includes a report that estimates the distance between all of a plan sponsor’s insureds and the prospective PBM’s nearest pharmacy. Commercial geographic access requirements often follow the Medicare requirements, although a health care provider might occasionally offer lower rates to customers if they agree to slightly less restrictive accessibility requirements. While Medicaid programs generally do not specify precise access requirements, they typically offer broad networks.⁵¹ To entice pharmacies to participate in the Medicaid program, state governments sometimes offer Medicaid reimbursement rates that are higher than those offered by commercial health insurers.⁵² In fact, the National Community Pharmacists Association (“NCPA”) found that the gross profit margin for Medicaid (20.8 percent) exceeded the commercial insurer gross margin (19.3 percent) by nearly 8 percent.⁵³

As a result of the geographic distribution of retail pharmacy stores of all types, these geographic access requirements are typically most difficult for PBMs and health insurers to meet in rural locations,⁵⁴ where more than 50 percent of independent pharmacies are

49 This information is available through 42 CFR 423 Section 423.120; See also Appendix VII of the Medicare Prescription Drug Benefit Solicitation for Application from Prescription Drug Plans.

50 Based upon interviews with PBM industry personnel.

51 Medicaid reimbursements “must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.” (42 CFR 447.204).

52 “To serve a diffuse population, states have generally set reimbursement rates high—at least compared with other third-party payers—to ensure that an ample number of pharmacies agree to serve Medicaid clients.” Ronald A. Wirtz, “Cash, Check, or Third Party: Prescription Benefit Plans are Squeezing Retail Pharmacies,” *FedGazette*, January 2006 (“Wirtz 2006b”), p. 4.

53 2006 NCPA Digest, p. 53.

54 For example, there are only about 230 retail pharmacies in Montana, where 10 counties have no retail pharmacies and 17 counties have a single retail pharmacy. Wirtz 2006a.

located.⁵⁵ It is not uncommon for commercial insurers to provide higher reimbursement levels (either by increasing the ingredient cost reimbursement or the dispensing fee, or both) to rural pharmacies, and some state Medicaid programs also explicitly employ differential reimbursement formulas that provide more generous reimbursements to rural pharmacies.⁵⁶ These increased reimbursement rates may be a result of their higher costs or may result from the local market power these isolated rural pharmacies possess. Which explanation dominates likely depends on the characteristics of the local market and pharmacy.⁵⁷

4.2. THE STRUCTURE TO FACILITATE COLLECTIVE NEGOTIATIONS BY INDEPENDENT PHARMACIES ALREADY EXISTS

Independent pharmacies employ Pharmacy Service Administrative Organizations, or “PSAOs,”⁵⁸ which represent a number of independent pharmacies, in order to reduce administrative costs of contracting and to gain advantages that accrue from a larger volume of activities (economies of scale). PSAOs sometimes represent independent pharmacies in contractual negotiations with entities such as PBMs or managed care organizations.⁵⁹

Independent pharmacies often belong to more than one PSAO, although PBMs typically require that any given pharmacy interact with the PBM through a single PSAO.⁶⁰ In fact, rather than considering PSAOs a threat to reimbursement rates, PBMs typically prefer independent pharmacies to work through PSAOs, where feasible, because of the administrative efficiencies PSAOs provide to PBMs in building and maintaining pharmacy networks.

PBM support for PSAOs stems, in part, from the fact that, to date, PSAOs have not achieved significantly higher reimbursements for their independent and/or rural constituents because PBMs are not required to negotiate through them to build viable networks. While PSAO contracts occasionally achieve some small advantage in reimbursement relative to chain

55 “Rural” is defined as an area with local population less than 20,000; see 2006 NCPA Digest, p. 61.

56 For example, as of December 2005 the Medicaid dispensing fee in Utah was higher for rural pharmacies (\$4.40) than for urban pharmacies (\$3.90). Similarly, Louisiana and Michigan had Medicaid reimbursement terms that differ for independent and chain pharmacies. See Centers for Medicare and Medicaid Services, “Medicaid Prescription Reimbursement Information by State – Quarter Ending December 2005,” accessed at http://www.cms.hhs.gov/MedicaidDrugRebateProgram/08_MdPresReimInfo.asp.

57 While costs are often mentioned to be high for rural pharmacies, the 2006 NCPA Digest noted that rural pharmacies had the lowest average payroll expenses and the lowest operating expenses, and the highest profit of all independent pharmacies. See page 61.

58 PSAOs are sometimes known by other designations, such as “affiliations.” Some PSAOs, such as IPC, are privately held, while others (e.g., United Drug) are owned by pharmaceutical wholesalers (e.g. McKesson).

59 *Medicare: Sponsors’ Management of the Prescription Drug Discount Card and Transitional Assistance Benefit*, United States Government Accountability Office, January 13, 2006, fn. 24.

60 In such an arrangement, independent pharmacies might interact with different PBMs through different PSAOs.

pharmacies, these differentials have typically resulted from other considerations, including a sharing of administrative cost gains from collective representation of independent pharmacies. PBMs have not typically contracted with PSAOs that demand reimbursement terms for their member pharmacies that exceed competitive market levels. The historic willingness of individual pharmacies to defect from PSAOs or to join multiple PSAOs has limited any PSAO's efforts to achieve substantial reimbursement increases, as PBMs have maintained the ability to secure the participation of a sufficient number of pharmacies necessary to meet geographic access requirements.

4.3. ANTITRUST EXEMPTIONS TO INDEPENDENT PHARMACIES WILL INCREASE REIMBURSEMENTS TO INDEPENDENT PHARMACIES AND THESE COSTS WILL BE PASSED ON TO PAYERS, INCLUDING HEALTH PLANS AND THEIR CUSTOMERS

The geographic access requirements and existence of PSAOs combine to create an environment in which antitrust exemptions would likely enable independent pharmacies to extract significantly higher reimbursements from PBMs and health insurers. With antitrust exemptions that enable independent pharmacies to use PSAOs or similar entities to bargain on their collective behalf, independent pharmacies are likely to be able to use and enhance their market power.⁶¹

As discussed above, regulatory agencies, primarily the FTC, have repeatedly noted that the PBM industry is highly competitive. The competitiveness of the PBMs has a critical economic consequence for who will bear the costs that would result from antitrust exemptions: any cost absorption by PBMs would be transitory. That is, competition among PBMs will result in increased costs being passed through to plan sponsors (health insurers and employers). As a result, health insurers, employers, and their insured members would see higher healthcare costs and/or a reduction in healthcare benefits. As noted by the FTC in consideration of Rhode Island bills that would eliminate selective contracting for pharmacy services:

By eliminating an important form of competition in the market for pharmaceutical services, the Bills are likely to increase the cost of those services. These cost increases are likely to undermine the ability of some consumers to obtain the pharmaceutical services they need at a price they can afford. As a recent article in

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Rural pharmacies already possess substantial market power because they must often be included in networks in order for plans to meet geographic pharmacy access requirements for their enrollees. One might thus ask why an antitrust exemption confer additional benefits on rural pharmacies. There are a several responses: first, currently, even in rural areas, there is likely some competition with independent pharmacies in other areas. Second, the legislation would provide a unifying theme for PSAO negotiations, which currently reflect the fact that PBMs might resist negotiating with the pharmacies through the PSAOs if the terms are unfavorable. Similarly, in non-rural areas, where independent pharmacies face competition from chain stores, each individual pharmacy (independent or chain) exerts little market power. With an antitrust exemption, the independent pharmacies in urban areas could negotiate collectively, and given access requirements, it is unlikely that the PBMs could do without all independent pharmacies in these areas.

Health Affairs noted, ‘when costs are high, people who cannot afford something find substitutes or do without. The higher the cost of health insurance, the more people are uninsured. The higher the cost of pharmaceuticals, the more people skip doses or do not fill their prescriptions.’ Although the Bills appear intended to broaden access to pharmaceutical services, there is a significant probability they will have the opposite effect.⁶²

As noted in the FTC’s analysis, increasing the cost of PBM operations is expected to increase the costs to consumers and to lead potentially to decreased access to prescription services.

5. ANTITRUST EXEMPTIONS FOR INDEPENDENT PHARMACIES WILL INCREASE COSTS FOR PAYERS, INCLUDING HEALTH PLANS AS WELL AS PATIENTS BY UP TO \$29.6 BILLION OVER FIVE YEARS

This study has estimated the likely cost increases that would likely result from provision of antitrust exemptions under two scenarios, namely allowing independent pharmacies to increase their commercial reimbursements to levels that:

- Result in gross margins on commercially insured prescriptions equaling the gross profit realized from Cash prescriptions, representing an 88 percent increase in the commercial gross profit rate (the “Potential cost increase” scenario),⁶³ or
- Equal the amount that North Dakota pharmacists demanded, through apparent collective efforts but in the absence of collective negotiation legislation, to participate in Medicare Part D pharmacy networks, representing a 32 percent increase in the commercial gross profit rate (the “Cost increase demanded in the absence of legislation” scenario).⁶⁴

The impact that these scenarios have on total pharmacy costs to PBMs and their customers depends in part on how sensitive pharmacy customers are to price increases. The “price elasticity of demand” reflects how much patients reduce their consumption when the cost of prescription pharmaceuticals increases. If patients filled all their prescriptions regardless of cost, then there would be a direct, one-to-one relationship between the pharmacy’s increase

62 FTC Letter to Rhode Island 2004.

63 Based on median, rather than average, sales per pharmacy. See Section 7.

64 Pharmacies in North Dakota declined the reimbursement terms proposed by PBMs and noted instead that they might accept contracts with the following reimbursement terms: AWP – 10 percent plus \$4.50 for branded drugs; Maximum Allowable Cost (“MAC”) plus \$3.00 for generic drugs; and AWP – 15 percent plus \$3.00 for generic drugs that do not have MAC prices. According to *The Prescription Drug Benefit Cost and Plan Design Survey Report, 2005 Edition* (The Pharmacy Benefit Management Institute, Inc., sponsored by Takeda Pharmaceuticals North America, Inc., 2005), the average reimbursement terms for branded drugs in 2004 was AWP – 14.8 percent plus \$1.95. (See page 4). This study uses the difference in the current and demanded reimbursement rate for branded drugs to characterize this scenario.

in prices and an increase in its net sales and profits.⁶⁵ However, as suggested by the FTC statements on proposed legislation related to the PBM business model, it is more reasonable to expect that patients will fill fewer prescriptions (i.e., spend less) as the costs of those prescriptions increase. As a result of the proposed legislation, if patients are sensitive to the price of their pharmaceuticals, they may forego beneficial pharmaceutical care, just as increases in the cost of health insurance increase the numbers of uninsured.

A summary of economic research published between 1973 and 1999 indicates that for a 10 percent increase in the cost of a prescription, the volume of prescriptions consumed falls by 2 to 3.5 percent.⁶⁶ For the purposes of our study, we assume that prescription consumption would fall by the midpoint of this range, or 2.7 percent (i.e., the price elasticity of demand for pharmaceutical prescriptions is -0.27).⁶⁷ Under this assumption, the cost increases of the antitrust exemptions are:⁶⁸

Potential Impact of Independent Pharmacy Antitrust Exemption	Total Cost Impact (\$ billions)	Cost Impact on Commercial Sector (\$ billion)	Cost Impact on Medicare Part D (\$ billions)	Increase in Prescription Costs at Independent Pharmacies (%)
Potential cost increases with proposed independent pharmacy antitrust exemptions	\$29.6	\$23.2	\$6.4	11.8%
Cost increases demanded in absence of independent pharmacy antitrust exemptions	\$9.2	\$7.2	\$2.0	3.6%

As a result, independent pharmacy antitrust exemptions are expected to increase costs to health plans and patients from \$9.2 billion to \$29.6 billion over five years (e.g., 2008-2012, if

⁶⁵ For the purposes of this study, we do not consider the possibility of incremental effects to economies of scale or scope.

⁶⁶ *The Cost of a Medicare Prescription Drug Benefit: A Comparison of Alternative*, Dana Goldman, Geoffrey Joyce, and Jesse Malkin, RAND, January 2002, pp. 7-8. In addition to assessing other literature, this article estimated a price elasticity of demand of -0.27 (that is, a 10 percent increase in price is expected to decrease the volume of prescriptions purchased by 2.7 percent).

⁶⁷ This assumption means that patients would reduce spending on prescriptions by 2.7 percent if the cost of those prescriptions increased by 10 percent. The results based on alternative elasticity estimates are included below.

⁶⁸ See the technical notes for an explanation of the five-year cost aggregation and assumptions of the cost model.

legislation passed in 2007).⁶⁹ The costs increases from independent pharmacy participation in Medicare Part D programs generate roughly 22 percent of these costs.

5.1. COST INCREASES FROM ANTITRUST EXEMPTIONS DEPEND ON PHARMACY PARTICIPATION AND THE REQUIREMENTS FOR PHARMACY NETWORKS

In addition to the cost scenarios described above, the model of the costs of independent pharmacy antitrust exemptions also considers other factors that would affect the exemption costs. These factors derive from the particular form of the legislation or implementation of the antitrust exemption and the way in which pharmacies react to it, including:

- *The Effects of Medicare Part D on the payer mix of prescriptions filled at independent pharmacies:* The implementation of Medicare Part D increased the percentage of prescriptions reimbursed by third party payers by reducing the share of both Medicaid and Cash prescriptions.⁷⁰ Medicaid coverage of prescriptions fell as Part D shifted coverage for dual eligibles, or those beneficiaries who meet eligibility conditions for both Medicare and Medicaid, to Medicare. Before MMA, dual eligibles received outpatient prescription coverage from Medicaid, where they represented 14 percent of the Medicaid population and up to 40 percent of Medicaid spending.⁷¹ According to researchers from the Centers for Medicare and Medicaid Services (“CMS”), Part D is largely responsible for a 36 percent reduction in Medicaid drug spending between 2005 and 2006.⁷² Similarly, Medicare Part D also led to reductions in cash prescriptions. According to the Agency for Healthcare Research and Quality, Medicare beneficiaries accounted for slightly more than 50 percent of the out-of-pocket drug costs.⁷³ Based on recent CMS analysis, out-of-pocket prescription drug spending fell from 25 to 19 percent and private insurance prescription drug spending fell from 47 to 42 percent from 2005 to 2006.⁷⁴ Part D plans are administered by third party payers, either

⁶⁹ If patients were less sensitive to price increases, demonstrated by a price elasticity of demand of -0.20, the cost from full independent pharmacy participation would range from \$10.0 billion to \$32.4 billion over five years (increases of 4.0 to 12.9 percent of pharmaceutical spending at independent pharmacies). Alternatively, a larger price effect characterized by a price elasticity of demand of -0.35 would imply cost increases of \$8.2 billion to \$26.3 billion over five years (increases of 3.2 to 10.5 percent of pharmaceutical spending at independent pharmacies).

⁷⁰ John A. Poisal, Christopher Truffer, Sheila Smith, Andrea Sisko, Cathy Cowan, Sean Keehan, Bridget Dickensheets, and the National Health Expenditure Accounts Projections Team, “Health Spending Projections Through 2016: Modest Changes Obscure Part D’s Impact,” Health Affairs Web-Exclusive Collection, February 21, 2007 (“National Health Expenditures 2007”), p. w250.

⁷¹ See, for example, Kaiser Commission on Medicaid Facts, “Dual Eligibles: Medicaid’s Role for Low-Income Medicare Beneficiaries,” The Henry J. Kaiser Family Foundation, February 2006.

⁷² National Health Expenditures 2007, p. w247. This study assumes that all changes in payer mix between 2005 and 2006 result from implementation of MMA.

⁷³ *Chartbook #12: Outpatient Prescription Drug Expenses, 1999.* December 2003. Agency for Healthcare Research and Quality, Rockville, MD. http://www.meps.ahrq.gov/mepsweb/data_files/publications/cb12/cb12.shtml. While out-of-pocket expenses include more than cash expenditures (e.g., prescription copayments), the lack of Medicare outpatient prescription drug coverage before MMA indicates that Medicare’s share of cash payments would likely exceed 50 percent.

⁷⁴ National Health Expenditures 2007, p. w250.

unilaterally or through contracts with PBMs. But for the proposed PBM collective bargaining legislation, it is assumed that the Medicare program would enjoy the negotiated discounts that third party payers currently obtain.

After the close of the of the May 15, 2006 enrollment period, 38.7 million Medicare beneficiaries had enrolled in Medicare Part D, leaving between 4 and 5 million without prescription drug coverage.⁷⁵ Earlier in the year, Secretary Mike Leavitt of the Health and Human Services Department stated that prescription drug coverage for Medicare beneficiaries might reach 90 percent in the program's first year.⁷⁶ To account for the effect of Medicare Part D on prescription drug payer mix, the cost model adjusts the pre-Medicare Part D payer mix provided by the 2006 NCPA-Pfizer Digest in two ways:⁷⁷

1. Adjust the Medicaid and Cash prescription shares from the 2006 NCPA-Pfizer Digest to account for the 36 percent reduction in Medicaid drug spending and 24 percent reduction in out-of-pocket drug spending calculated by CMS personnel from 2005 to 2006;⁷⁸
2. Assume that the reductions noted in Step 1 account for 90 percent of the total affect of Medicare Part D and adjust the cost model for Years 2 through 5 to account for 100 percent.

In order to remain conservative, this study does not estimate the effect of the increased prescription volume that is likely to coincide with the provision of pharmaceutical coverage under the MMA.

- *The extent of coordinated behavior among independent pharmacies:* The extent of participation of independent pharmacies in collective negotiation is uncertain. If rural pharmacies enjoy greater competitive advantage in negotiations with health insurers or PBMs due to the small number of pharmacies in rural areas and the presence of geographic access requirements, they may have different incentives than the independent pharmacies located in more competitive areas, where chain, supermarket, and mass merchandiser pharmacies are prevalent. As a result, not all independent pharmacies may negotiate collectively.

For example, based on the scenario in which independent pharmacies increase prices on commercial prescriptions sufficiently to earn the same gross margin that they do on their cash-paying patients, the increased cost associated with full independent phar-

75 "Medicare Enrollment Figures Are Released by Government," Wall Street Journal, June 8, 2006.

76 "37 Million Medicare Beneficiaries Now Receiving Prescription Drug Coverage," News Release, United States Department of Health and Human Services, May 10, 2006.

77 According to the 2006 NCPA Digest, third-party payers accounted for 59 percent of prescriptions and Medicaid for 23 percent. See page 53.

78 National Health Expenditures 2007, p. w250. These reductions are applied to comparable payer categories from the 2006 NCPA Digest, which provides the "last glimpse of the independent community pharmacy marketplace before the implementation of Medicare Part D." (See page 3.)

macy participation would be \$29.6 billion over five years.⁷⁹ If only rural independent pharmacies participate, costs would increase by \$15.5 billion over five years.

- *The need for independent pharmacies in PBM networks:* As noted above, geographic access requirements force PBMs to include independent pharmacies in their provider networks. If costs of broad networks increase and PBMs negotiate new contracts with plan sponsors, a shrinking portion of the lives covered by PBMs may be subject to the access requirements, either because plan sponsors will relax the requirements in the face of increased costs or because PBMs will be less willing to actively manage lives covered by geographic requirements necessitating negotiations with independent pharmacies.⁸⁰

As a result, the cost model includes a parameter (“percent of covered lives with inflexible geographic access requirements”) to account for the possibility that some commercial accounts could avoid the cost increases associated with antitrust exemptions. The model adjusts this value over time to account for both implementation and mitigation efforts. Actively managed lives are assumed to account for 100 percent of insured lives in the first year of implementation as health insurers or PBMs bear immediate responsibility for compliance with geographic access requirements, regardless of the level of management offered by the PBM to a particular plan sponsor. The cost model assumes that PBMs would reduce their exposure to independent pharmacies over time, reaching this minimum level of 60 percent after five years.⁸¹

6. CONCLUSION: ANTITRUST EXEMPTIONS WILL INCREASE COSTS OF AND REDUCE ACCESS TO HEALTH CARE

Calls for antitrust exemptions to allow independent pharmacies to negotiate collectively are unwarranted. Even if antitrust exemptions were an appropriate tool to address competitive imbalances between pharmacies and PBMs or health insurance plans, which they typically are not, no such competitive imbalance exists. In fact, regulatory authorities have explicitly noted the competitive nature of the PBM industry. To the extent that prices paid to pharmacies have been reduced, these price reductions have benefited consumers, who maintain adequate access to retail pharmacies. The antitrust laws are not designed to protect individual competitors that may be harmed by competition, but rather to insure that

79 All estimates in this paragraph assume price elasticity of demand for prescriptions of -0.27.

80 Such behavior might change the geographic access requirement directly (e.g., by changing the percentage of patients that must live within a certain distance of a pharmacy) or by allowing alternative pharmacy options to service rural patients (e.g., mail order). Note, however, that while such behavior might avoid the cost increases associated with antitrust exemptions, the effect of the exemptions is still felt in resultant access reductions.

81 The model assumes that the percentage of covered lives with inflexible geographic access requirements decreases by the same amount (10 percent) in years 2, 3, and 4 to reach a level of 60 percent in year 5. In reality, another factor that might affect the speed of adjustment is the penalty or breach cost for noncompliance with geographic access requirements in the PBMs' contracts with plan sponsors.

consumer welfare is maintained through access to providers with reasonable prices and quality.

The financial health of independent pharmacies does not suggest that the segment is in danger of failing. While some individual stores may have closed, these closings appear more related to a shortage of qualified pharmacists than to the underlying financial condition of the stores. Independent pharmacies are profitable, and pharmaceutical sales to independent pharmacies have consistently increased.

The provision of antitrust exemptions, then, is effectively a wealth transfer program for independent pharmacies. The cost of such a transfer program to health payers and patients is expected to be up to \$29.6 billion over five years, representing an increase of up to 11.8 percent. Costs for the Medicare Part D program alone will increase by up to \$6.4 billion over five years. Including the reduction or elimination of access to health care for those affected by the cost increases would further increase the total cost of antitrust exemptions for independent pharmacies.

7. TECHNICAL NOTES

In general terms, this study relies on a model that estimates the costs of antitrust exemptions to independent pharmacies under several scenarios. In particular, the model is based on general financial information on independent pharmacies, including: median prescription sales per pharmacy,⁸² gross profit margins for prescription sales, the total number of independent pharmacies,⁸³ the payer mix (i.e., the percentage of prescriptions paid by private insurers, Medicaid, and by patients (cash)), and the gross margin for each type of payer.⁸⁴

7.1. NOTES ON FIVE YEAR ESTIMATES

This study calculates estimates the five-year costs of antitrust exemptions to independent pharmacies. The assumptions used to generate five year estimates:

- Changes in payer mix from implementation of Medicare Part D: As discussed above, this model assumes that changes to the payer mix observed by CMS (i.e., decreased

82 The 2006 NCPA Digest provides only median information for rural hospitals. This data limitation, combined with concerns that outliers may reflect data errors, motivated the use of medians in this analysis.

83 The 2006 NCPA Digest did not identify the number of independent pharmacies falling into the "rural" designation, instead stating that "More than 50 percent of community pharmacies are located in an area with a population of less than 20,000." (p. 61). According to the 2004 NCPA-Pfizer Digest, 32 percent of independent pharmacies contributing to the Digest were located in areas with a population exceeding 50,000. (*2004 NCPA-Pfizer Digest*, National Community Pharmacists Association, 2004, p. 61). When necessary, this study assumes that 60 percent of independent pharmacies are rural.

84 2006 NCPA Digest, pp. 6, 10-11, and 53.

Medicaid and out-of-pocket prescription drug spending) were captured between 2005 and 2006, but that the full affect of Medicare Part D will not be realized until the second year of the program. This study does not account for the expected increase in the number of prescriptions that will likely result from increased insurance coverage.

- Discounting future revenues and costs: The value of money changes over time – a \$100 prescription is more valuable today than it will be a year from now. Economists use a discount rate to account for the reduced value of money in the future. This model assumes a discount rate of 10 percent.

7.2. NOTES ON MAINTAINED ASSUMPTIONS OF THE INDEPENDENT PHARMACY ANTITRUST EXEMPTION COST MODEL

Finally, the cost model relies on several assumptions that describe the economic relationships underlying the cost estimates.

1. NCPA data are complete and accurate. The majority of data used for the cost model are provided by the 2006 NCPA Digest.⁸⁵
2. The cost model assumes that legislation will limit collective bargaining activity to commercial accounts (as in H.R. 971), including Part D plans since they are administered by third party payers.
3. The effect on annual total costs declines year-by-year during the five year time period analyzed. This is because the increased costs resulting from pharmacy collective bargaining would be expected to alter the way in which PBMs respond to geographic access requirements during the RFP process. (Plan sponsors also likely to alter geographic access expectations if cost increases are significant).
4. Independent pharmacies are equally able to affect all reimbursement terms through collective negotiation. In particular, the model does not differentiate between ingredient cost, dispensing fee, or Maximum Allowable Cost (“MAC”) reimbursement provisions.
5. The model offers no predictions on where cost increases will be absorbed. Rather, the analysis summarizes literature relevant to the competitiveness of PBMs, and uses economic theory to predict that the ultimate customers (employers and patients) will therefore bear the costs.
6. Independent pharmacies do not alter reimbursement demands due to loss of volume. As documented by NCPA, independent pharmacies enjoy a higher gross profit margin on non-pharmaceutical sales (34.2 percent) than on pharmaceuticals (22.7 percent).⁸⁶ This model assumes that independent pharmacies find it profit maximizing to maintain their reimbursement demands, despite any resulting loss in volume of pharmaceutical sales.

⁸⁵ Unlike most data used for consideration of healthcare cost or access issues, the 2006 NCPA Digest does not provide information necessary to assess the reliability of the reported data (e.g., survey response rate, treatment of outliers, quality assurance measures for financial estimates, etc.).

⁸⁶ 2006 NCPA Digest, p. 11.

7. The model considers only the costs that will result from collective negotiation by independent pharmacies on reimbursement terms. The model does not consider any restrictions on PBM business practices, nor does it consider any buy-side changes (e.g., from collective negotiation with wholesalers or manufacturers) resulting from collective negotiation by independent pharmacies. Such behavior would be additive to the costs estimated by this model.
8. Estimates of cost increases are less expensive than would be paying penalties. Depending on the contracts between PBMs and health plan sponsors, it might be the case that a PBM could operate, without breaching its contract with a plan sponsor, in violation of geographic access requirements. Such behavior would likely prompt a penalty payment to the plan sponsor. While it is unlikely that such behavior would persist for the five years of the study, the model assumes that the net cost of such behavior (including penalties, increased likelihood of breach, reduced probability of winning future accounts, etc.) exceeds the cost estimates generated by the model.
9. Per drug acquisition costs are constant for all payer types. In particular, the cost model assumes that independent pharmacies purchase drugs for the same price, regardless of the payer that will ultimately provide reimbursement for a prescription of that drug.

Individually, these assumptions have limited effect on the cost model, which is sufficiently flexible to provide sensitivity tests should the particular form of proposed legislation differ substantially from collective negotiation legislation like H.R. 971.

Appendix Table 1: Cost Projections for Antitrust Waivers to Independent Pharmacies
(Based on -0.27 Price Elasticity of Demand for Prescriptions)

	Year 1		Year 2 ³	
	All independent pharmacies	Rural pharmacies ²	All independent pharmacies	Rural pharmacies
Cost Projections for Independent Pharmacies¹ (assuming no other changes to status quo)				
Total prescription sales per pharmacy (2005)	3,210,239	2,801,365	3,542,349	3,091,175
Total prescription gross margin per pharmacy (2005)	728,490	617,406	803,855	681,279
Gross margin percentage for prescriptions	22.7%	22.0%	22.7%	22.0%
Total number of independent pharmacies ⁴	24,500		24,500	
Payer Mix for Independent Pharmacies, 2005⁵				
Third-party payer ⁶	71.6%	19.3%	73.0%	17.8%
Medicaid	14.7%	20.8%	13.8%	19.5%
Cash ⁷	13.7%	36.2%	13.2%	37.4%
Percent of Lives Covered by Third-Party Payers (Excluding Federal Employees)⁸		62%		64%
Percent of Covered Lives with Inflexible Geographic Access Requirements⁹		100%		90%
Base Revenues for Cost Simulation				
Percent of all independent pharmacies included in simulation	100%	60%	100%	60%
Independent pharmacy TPP prescription sales (\$ million)	49,029	25,670	55,316	28,962
Cost Simulation Scenarios				
Potential cost increases (independent pharmacy gross margin for TPP scripts increase to cash levels)	88%	16.9%	110%	19.6%
Cost increases attempted without legislation (gross margin for TPP scripts increase to ND requested rate ¹⁰)	32%	6.3%	32%	6.3%
Effect of (-0.27) Price Elasticity of Demand for Prescriptions				
Potential cost increases (independent pharmacy gross margin for TPP scripts increase to cash levels)	64%	12.4%	80%	15.5%
Cost increases attempted without legislation (gross margin for TPP scripts increase to ND requested rate ¹⁰)	24%	4.6%	24%	4.6%
Total Incremental Gross Margin Increases for TPP Prescriptions¹¹				
Potential cost increases (independent pharmacy gross margin for TPP scripts increase to cash levels)	6,060	3,173	7,732	4,048
Cost increases attempted without legislation (gross margin for TPP scripts increase to ND requested rate ¹⁰)	2,238	1,172	2,273	1,190
Resulting Total Prescription Sales				
Potential cost increases (independent pharmacy gross margin for TPP scripts increase to cash levels)	55,089	28,843	63,048	33,010
Cost increases attempted without legislation (gross margin for TPP scripts increase to ND requested rate ¹⁰)	51,267	26,842	57,588	30,152
Potential cost increases (independent pharmacy gross margin for TPP scripts increase to cash levels)	12.4%	12.4%	14.0%	14.0%
Cost increases attempted without legislation (gross margin for TPP scripts increase to ND requested rate ¹⁰)	4.6%	4.6%	4.1%	4.1%

Appendix Table 1: Cost Projections for Antitrust Waivers to Independent Pharmacies
 (Based on -0.27 Price Elasticity of Demand for Prescriptions)

	Year 3 ³		Year 4 ³	
	All independent pharmacies	Rural pharmacies	All independent pharmacies	Rural pharmacies
Cost Projections for Independent Pharmacies¹ (assuming no other changes to status quo)				
Total prescription sales per pharmacy (2005)	3,908,816	3,410,968	4,313,196	3,763,843
Total prescription gross margin per pharmacy (2005)	887,016	751,759	978,781	829,531
Gross margin percentage for prescriptions	22.7%	22.0%	22.7%	22.0%
Total number of independent pharmacies ⁴	24,500		24,500	
Payer Mix for Independent Pharmacies, 2005⁵				
Third-party payer ⁶	73.0%	17.8%	73.0%	17.8%
Medicaid	13.8%	19.5%	13.8%	19.5%
Cash ⁷	13.2%	37.4%	13.2%	37.4%
Percent of Lives Covered by Third-Party Payers (Excluding Federal Employees)⁸	64%		64%	
Percent of Covered Lives with Inflexible Geographic Access Requirements⁹	80%		70%	
Base Revenues for Cost Simulation				
Percent of all independent pharmacies included in simulation	100%	60%	100%	60%
Independent pharmacy TPP prescription sales (\$ million)	61,038	31,959	67,353	35,265
Cost Simulation Scenarios				
Potential cost increases (independent pharmacy gross margin for TPP scripts increase to cash levels)	110%	19.6%	110%	19.6%
Cost increases attempted without legislation (gross margin for TPP scripts increase to ND requested rate ¹⁰)	32%	6.3%	32%	6.3%
Effect of (-0.27) Price Elasticity of Demand for Prescriptions				
Potential cost increases (independent pharmacy gross margin for TPP scripts increase to cash levels)	80%	15.5%	80%	15.5%
Cost increases attempted without legislation (gross margin for TPP scripts increase to ND requested rate ¹⁰)	24%	4.6%	24%	4.6%
Total Incremental Gross Margin Increases for TPP Prescriptions¹¹				
Potential cost increases (independent pharmacy gross margin for TPP scripts increase to cash levels)	7,584	3,971	7,322	3,834
Cost increases attempted without legislation (gross margin for TPP scripts increase to ND requested rate ¹⁰)	2,229	1,167	2,152	1,127
Resulting Total Prescription Sales				
Potential cost increases (independent pharmacy gross margin for TPP scripts increase to cash levels)	68,622	35,929	74,675	39,098
Cost increases attempted without legislation (gross margin for TPP scripts increase to ND requested rate ¹⁰)	63,267	33,126	69,505	36,392
Potential cost increases (independent pharmacy gross margin for TPP scripts increase to cash levels)	12.4%	12.4%	10.9%	10.9%
Cost increases attempted without legislation (gross margin for TPP scripts increase to ND requested rate ¹⁰)	3.7%	3.7%	3.2%	3.2%

Appendix Table 1: Cost Projections for Antitrust Waivers to Independent Pharmacies
(Based on -0.27 Price Elasticity of Demand for Prescriptions)

Cost Projections for Independent Pharmacies¹ (assuming no other changes to status quo)

Total prescription sales per pharmacy (2005)
Total prescription gross margin per pharmacy (2005)
Gross margin percentage for prescriptions
Total number of independent pharmacies⁴

Payer Mix for Independent Pharmacies, 2005⁵

Third-party payer⁶
Medicaid
Cash⁷

Percent of Lives Covered by Third-Party Payers (Excluding Federal Employees)⁸

Percent of Covered Lives with Inflexible Geographic Access Requirements⁹

Base Revenues for Cost Simulation

Percent of all independent pharmacies included in simulation
Independent pharmacy TPP prescription sales (\$ million)

Cost Simulation Scenarios

Potential cost increases (independent pharmacy gross margin for TPP scripts increase to cash levels)
Cost increases attempted without legislation (gross margin for TPP scripts increase to ND requested rate¹⁰)

Effect of (-0.27) Price Elasticity of Demand for Prescriptions

Potential cost increases (independent pharmacy gross margin for TPP scripts increase to cash levels)
Cost increases attempted without legislation (gross margin for TPP scripts increase to ND requested rate¹⁰)

Total Incremental Gross Margin Increases for TPP Prescriptions¹¹

Potential cost increases (independent pharmacy gross margin for TPP scripts increase to cash levels)
Cost increases attempted without legislation (gross margin for TPP scripts increase to ND requested rate¹⁰)

Resulting Total Prescription Sales

Potential cost increases (independent pharmacy gross margin for TPP scripts increase to cash levels)
Cost increases attempted without legislation (gross margin for TPP scripts increase to ND requested rate¹⁰)

Potential cost increases (independent pharmacy gross margin for TPP scripts increase to cash levels)
Cost increases attempted without legislation (gross margin for TPP scripts increase to ND requested rate¹⁰)

Year 5 ³	
All independent pharmacies	Rural pharmacies
4,759,411	4,153,225
1,080,039	915,349
22.7%	22.0%
24,500	
Percentage	Gross margin
73.0%	17.8%
13.8%	19.5%
13.2%	37.4%
	64%
	60%
All independent pharmacies	Rural pharmacies
100%	60%
74,321	38,913
Percent gross margin increase	Incremental percentage gross margin
110%	19.6%
32%	6.3%
Elasticity effect	Incremental percentage gross margin
80%	15.5%
24%	4.6%
All independent pharmacies	Rural pharmacies
6,925	3,626
2,036	1,066
All independent pharmacies	Rural pharmacies
81,246	42,539
76,356	39,979
	9.3%
	2.7%
	9.3%
	2.7%

Appendix Table 1: Cost Projections for Antitrust Waivers to Independent Pharmacies
 (Based on -0.27 Price Elasticity of Demand for Prescriptions)

Cost Projections for Independent Pharmacies¹ (assuming no other changes to status quo)

Total prescription sales per pharmacy (2005)
 Total prescription gross margin per pharmacy (2005)
 Gross margin percentage for prescriptions
 Total number of independent pharmacies⁴

Payer Mix for Independent Pharmacies, 2005⁵

Third-party payer⁶
 Medicaid
 Cash⁷

Percent of Lives Covered by Third-Party Payers (Excluding Federal Employees)⁸

Percent of Covered Lives with Inflexible Geographic Access Requirements⁹

Base Revenues for Cost Simulation

Percent of all independent pharmacies included in simulation
 Independent pharmacy TPP prescription sales (\$ million)

Net Present Value
With discount rate of 10 percent
 251,126 131,485

Cost Simulation Scenarios

Potential cost increases (independent pharmacy gross margin for TPP scripts increase to cash levels)
 Cost increases attempted without legislation (gross margin for TPP scripts increase to ND requested rate¹⁰)

Effect of (-0.27) Price Elasticity of Demand for Prescriptions

Potential cost increases (independent pharmacy gross margin for TPP scripts increase to cash levels)
 Cost increases attempted without legislation (gross margin for TPP scripts increase to ND requested rate¹⁰)

Total Incremental Gross Margin Increases for TPP Prescriptions¹¹

Potential cost increases (independent pharmacy gross margin for TPP scripts increase to cash levels)
 Cost increases attempted without legislation (gross margin for TPP scripts increase to ND requested rate¹⁰)

Resulting Total Prescription Sales

Potential cost increases (independent pharmacy gross margin for TPP scripts increase to cash levels)
 Cost increases attempted without legislation (gross margin for TPP scripts increase to ND requested rate¹⁰)

Potential cost increases (independent pharmacy gross margin for TPP scripts increase to cash levels)
 Cost increases attempted without legislation (gross margin for TPP scripts increase to ND requested rate¹⁰)

Nominal		Net Present Value	
		With discount rate of 10 percent	
All independent pharmacies	Rural pharmacies	All independent pharmacies	Rural pharmacies
35,623	18,652	29,588	15,492
10,927	5,721	9,154	4,793
All independent pharmacies	Rural pharmacies	All independent pharmacies	Rural pharmacies
342,680	179,420	280,714	146,976
317,984	166,490	260,280	136,277
		11.8%	11.8%
		3.6%	3.6%

Notes

- ¹ Independent pharmacies are defined as those pharmacies that are not publicly owned or traded. Based on median sales, per 2006 NCPA-Pfizer Digest, pp. 10, 61.
- ² "Rural" pharmacies use the National Community Pharmacy Association ("NCPA") measurement of pharmacies located in areas with population less than 20,000. According to the 2006 NCPA-Pfizer Digest, more than 50 percent of community pharmacies fall into this category (see p. 61). According to the 2004 NCPA-Pfizer Digest, 32 percent of independent pharmacies contributing to the Digest were with a population exceeding 50,000. This estimate assumes that 60 percent of independent pharmacies are rural.
- ³ Total prescription sales per pharmacy and total prescription gross margin per pharmacy for all independent pharmacies and rural pharmacies for years 2 through 5 were calculated by projecting the simple average annual rate of prescription drug sales growth per pharmacy (10.3 percent) from the 2006 NCPA-Pfizer Digest over the last five years. (2006 NCPA-Pfizer Digest, p. 7.) In comparison, the government increased prescription drug spending a similar period by 12.5 percent. See *Trends and Indicators in the Changing Health Care Marketplace - National Health Expenditures and their share of Gross Domestic Product, 1960-2004*, Kaiser Family Foundation, accessed at www.kff.org. However, the results of this study are nearly insensitive to use of the Kaiser growth rate.
- ⁴ 2006 NCPA-Pfizer Digest, p. 6.
- ⁵ 2006 NCPA-Pfizer Digest, Table 14, p. 53. The cost model also assumes that 10 percent of third-party payer expenditures are for government employees and are thus excluded from cost estimates, as this was the case for H.R. 1671 and is expected to be a common feature of such legislation.
- ⁶ The implementation of Medicare Part D increased the percentage of prescriptions reimbursed by third party payers and reduced the share of both Medicaid and Cash prescriptions. As discussed in Section 5.1, the cost model uses prescription shares (for third-party payers, Medicaid, and Cash) provided by the 2006 NCPA-Pfizer digest (p. 52, see footnote 5 above). Year 1 of the cost model applies a 36 percent reduction to the Medicaid share of prescriptions and a 24 percent reduction to the Cash share of prescriptions, based on the Medicaid and Out-of-pocket reductions associated with the Medicare Part D program, as documented by John A. Poisal, Christopher Truffer, Sheila Smith, Andrea Sisko, Cathy Cowan, Sean Keehan, Bridget Dickensheets, and the National Health Expenditure Accounts Projections Team, "Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact," Health Affairs Web-Exclusive Collection, February 21, 2007 ("National Health Expenditures 2007"), p. w250. The cost model assumes that the National Health Expenditures information captured 90 percent of the effect of Medicare Part D in Year 1; Years 2 through 5 assume 100 percent of the full effect of Medicare Part D.
- ⁷ Gross profit for Cash payers calculated based on the the profit necessary to generate the total reported prescription gross profit rate (2006 NCPA-Pfizer Digest, p. 11) based on the established mix of payers and gross margins for third-party and Medicaid prescriptions (2006 NCPA-Pfizer Digest, p. 53).
- ⁸ In 1999, Federal employees accounted for 8.8 percent of national health expenditures, while private spending accounted for 55.9 percent of national health expenditures. As a result, this model assumes that the 15.7 percent of commercial insurance expenditures for Federal employees based on pre-MMA payer mix would be exempt from collective negotiations by independent pharmacies (as Federal programs were exempted from H.R. 1761). Applied to the 59 percent of prescriptions reimbursed by third party payers (NCPA-Pfizer Digest 2005, p. 6) before implementation of Medicare Part D, the cost model assumes that 9.26 percent of commercial prescriptions represent Federal employees and are thus exempted from collective bargaining by independent pharmacies under the proposed waivers. For details, see: Steffie Woolhandler and David U. Himmelstein, "Paying for National Health Insurance – And Not Getting It," *Health Affairs*, July/August 2002, pp. 88-98; and Centers for Medicare and Medicaid Services, Office of the Actuary, "National Health Expenditure Data," available at: http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage
- ⁹ Assumed to decrease to 60 percent over five years as PBMs reduce their exposure to independent pharmacies over time, using new contract cycles to address cost concerns with plan sponsors. See Section 5.1.
- ¹⁰ In early 2005 North Dakota pharmacies returned the same form letter to PBMs attempting to create networks for Medicare Part D. These form letters rejected the reimbursement terms proposed by PBMs and noted instead that pharmacies might accept contracts with the following reimbursement terms: AWP – 10 percent plus \$4.50 for branded drugs; Maximum Allowable Cost ("MAC") plus \$3.00 for generic drugs; and AWP – 15 percent plus \$3.00 for generic drugs that do not have MAC prices. (See Inside Washington Publishers, *Inside CMS*, Vol. 8, No. 11, June 2, 2005). According to *The Prescription Drug Benefit Cost and Plan Design Survey Report, 2005 Edition* (The Pharmacy Benefit Management Institute, Inc., sponsored by Takeda Pharmaceuticals North America, Inc., 2005), the average reimbursement terms for branded drugs in 2004 was AWP – 14.8 percent plus \$1.95. (See page 4). This study uses the difference in the current and demanded reimbursement rate for branded drugs to characterize this scenario
- ¹¹ Calculated as total prescription revenue for non-government third party payer prescriptions for percentage of lives with inflexible geographic access requirements, multiplied by the increase in the third-party payer gross margin.