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The Cost of Independent Pharmacy Antitrust Exemptions, 2013-2017

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Date: March 28, 2012

CRA Project No. D17631

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1. Executive Summary

In 2011, the latest in a series of pharmacy antitrust exemption bills, H.R. 1946, was introduced. The bill would create a five-year antitrust exemption to allow independent pharmacies to negotiate collectively with health plans and pharmacy benefit managers (“PBMs”) over payment rates and other contract terms. Under current antitrust law, regulators would consider such collective negotiations to be collusion.

Regulators generally reject the need for antitrust exemptions and the Federal Trade Commission (“FTC”) has testified against a similar pharmacy antitrust exemption bill. According to the FTC, a pharmacy antitrust exemption “threatens to raise prices to consumers” and “threatens to increase costs to private employers who provide health care insurance to employees, potentially reducing those benefits” all “without any assurance of higher quality care.”¹ Likewise, in scoring previous pharmacy antitrust exemption legislation, the Congressional Budget Office (“CBO”) noted that pharmacy antitrust exemptions would “increase premiums for group health insurance” and lead employers to respond with “reductions in the scope or generosity of health insurance benefits.”²

Charles River Associates (“CRA”) has been commissioned to estimate the potential impact of pharmacy antitrust exemptions proposed in H.R. 1946. We find that:

- H.R. 1946 could increase direct costs to commercial payers by \$7.6-\$15.6 billion over five years, an average increase of approximately 4-8 percent of total prescription sales across all independent pharmacies;
- Increased costs from antitrust exemptions to independent pharmacies would likely be passed on to health insurers, employers, and consumers and could result in employers reducing health insurance benefits;
- While antitrust exemptions under H.R. 1946 do not apply to most federal programs, they would allow pharmacies to collectively bargain with plans in the new state-based health insurance exchanges, which could increase federal costs;
- There is no compelling economic reason to confer antitrust exemptions to independent pharmacies, since these institutions are profitable and protected by existing competition laws; and
- Existing market mechanisms give independent pharmacies leverage to bargain with health plans and PBMs. Both government and private payers require health plans and PBMs to meet pharmacy access standards for their plan members, which gives

¹ Prepared Statement of the FTC before the Antitrust Task Force of the H. Comm. on the Judiciary, Concerning H.R. 971, “The Community Pharmacy Fairness Act of 2007,” 110th Cong., Oct. 18, 2007, (<http://www.ftc.gov/os/testimony/P859910pharm.pdf>).

² CBO, “H.R. 971: Community Pharmacy Fairness Act of 2007,” Congressional Budget Office Cost Estimate, January 11, 2008 and September 26, 2008.

pharmacies in unique locations added bargaining leverage. Likewise, nearly 80 percent of independent pharmacies rely on intermediaries known as Pharmacy Services Administration Organizations (“PSAOs”) that pool the bargaining power of many independents to collectively negotiate reimbursement and contract terms with health plans and PBMs.

2. Introduction

Following several years of significant reform and structural change, health care continues to command significant political, regulatory, and judicial attention. Recent attention culminated in the 2010 signing of the Patient Protection and Affordable Care Act (“PPACA”), the health care reform law that will introduce significant structural changes to health care access over a staggered implementation from 2010 through 2018. Under PPACA, sophisticated payers, including employers, unions, government programs, commercial health insurers, and pharmacy benefit managers (“PBMs”) will continue to provide pharmacy benefits using networks of independent and retail pharmacies. Through insurance plans available on state health insurance exchanges and individual and employer coverage mandates, PPACA is anticipated to ensure insurance coverage for 90 percent of non-elderly U.S. residents.³

In providing health care coverage, payers (health insurers and PBMs) often build networks of health care providers from which their covered patients are encouraged or required to seek treatment or therapy. Competition among potential members of a network is one way in which payers reduce costs: payers accept those pharmacies that provide the most efficient services. In return, those pharmacies that are part of payer networks gain access to the number of potential patients whose benefits are managed by that payer.

2.1. Current legislation proposing independent pharmacy antitrust waivers: H.R. 1946

Independent pharmacy representatives contend that the current economic circumstances have placed independent pharmacies at a competitive disadvantage to payers and PBMs. The suggested remedy, antitrust exemptions, would allow independent pharmacies to bargain collectively with health plans and PBMs. In particular, antitrust exemptions would allow independent pharmacies to collude to determine the reimbursement required to dispense prescriptions to patients. In May 2011, Representative Thomas Marino (R-PA) introduced H.R. 1946, the “Preserving Our Hometown Pharmacy Act.”⁴ Notably, among other provisions H.R. 1946 would:

3 Congressional Budget Office (“CBO”), “Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act,” March 13, 2012, Table 3. Judicial challenges to PPACA are pending, with oral arguments before the Supreme Court scheduled for March 27-29, 2012. As noted below, changes to PPACA or the expected sources and mix of insurance types will affect the potential cost of independent pharmacy antitrust waivers.

4 U.S. House of Representatives, 112th Congress, “H.R. 1946,” May 23, 2011 (“H.R. 1946”).

- Define “independent pharmacy” by “market share” rather than ownership status or chain affiliation;⁵
- Convey an antitrust exemption to independent pharmacies for a period of five years (with an additional year for contracts entered into during the five-year period);
- Limit such antitrust waiver to exclude boycotts, market allocation, unlawful tying, and monopolization or attempts to monopolize;⁶ and
- Prevent application of the antitrust exemption to certain government programs, including Medicaid and Medicare Parts C and D.⁷

This study evaluates the direct commercial cost increases that would likely result from granting antitrust exemptions to independent pharmacies under H.R. 1946. The cost estimates are based on price increases resulting from collective negotiation by independent pharmacies on reimbursement terms. This report does not include all aspects of direct commercial costs (e.g., reduced tax revenues, increased health insurance exchange subsidies), nor does it quantify indirect expenses (e.g., cost increases to payers passed through to patients). As described in the following sections, this analysis concludes that:

- There is no compelling economic reason to confer antitrust exemptions to independent pharmacies, as these institutions are profitable, are protected by enforcement of existing competition laws, and have at their disposal existing means through which legitimate competitive concerns can be addressed;
- Despite the exemptions introduced in H.R. 1946, direct costs to payers could increase by \$7.6 to \$15.6 billion over 5 years, an increase of 3.8 to 7.9 percent of total prescription sales across all independent pharmacies; and
- There are reasons to believe that direct and indirect costs would also be borne by the government, despite exclusion of governmental programs in the scope of permissible collective activity under H.R. 1946.

⁵ Under H.R. 1946, an independent pharmacy is defined as a pharmacy that has a “market share” of less than 10 percent in any PDP region and less than 1 percent in the United States. In earlier legislation (H.R. 971, introduced in 2007), independent pharmacy was defined as a pharmacy not owned or operated by a publicly traded company.

⁶ This provision would seem to be potentially contradictory, as collective negotiation will not lead to change if the colluding independent pharmacies lack the market power necessary to extract higher reimbursements. As any change under the legislation is predicated on this strengthened market position, the analysis and cost estimate that follow assume that independent pharmacies operating with an antitrust exemption would be able to affect reimbursements despite the exclusion of monopoly or attempted monopolization.

⁷ Other provisions include a full list of the specified government programs for which the waivers are to have no application, definitions, and a requirement for a General Accountability Office study of the impact of the legislation to during the fifth year of enactment. For full details, see H.R. 1946.

2.2. Previous legislation proposing independent pharmacy antitrust waivers: H.R. 971

The call for independent pharmacy antitrust waivers is not new. In October 2007, the U.S. House of Representatives Judiciary Committee's Antitrust Task Force held a hearing at which the Federal Trade Commission ("FTC"), a government regulatory agency that protects competition, provided testimony in which it concluded that:

"Simply put, although the Commission is sympathetic to the difficulties independent and family pharmacies face, the exemption threatens to raise prices to consumers, especially seniors, for much-needed medicine. It also threatens to increase costs to private employers who provide health care insurance to employees, potentially reducing those benefits, and to the federal government, which was projected to have paid over 30 percent of the costs of prescription drugs in 2006, all without any assurance of higher quality care. For these reasons, the Commission opposes the legislation."⁸

The support for the cost estimates of H.R. 1946 is provided below. Section 3 considers whether the conditions faced by independent pharmacies support the grant of antitrust waivers. Section 4 summarizes the literature and opinions regarding price increases expected to result from antitrust waivers. Section 5 estimates the costs of providing antitrust exemptions under H.R. 1946 and provides details of the calculation.

3. Antitrust exemptions are unnecessary for independent pharmacies

3.1. There is no economic justification for antitrust waivers for independent pharmacies

Analysis of previous legislation that would grant antitrust waivers noted that the economic circumstances of independent pharmacies did not support the notion of a competitive imbalance with payers and PBMs. Using data collected and disseminated by the National Community Pharmacy Association ("NCPA"), a trade association for independent pharmacies, review of the financial circumstances of independent pharmacies showed that the average gross profit margin for independent pharmacies was near 20 percent and increasing in 2005 and that the volume of prescriptions was increasing concurrent with increases in gross profit margin.⁹

⁸ Prepared Statement of the Federal Trade Commission before the Antitrust Task Force of the H. Comm. the Judiciary, Concerning H.R. 971, "The Community Pharmacy Fairness Act of 2007," 110th Cong., Oct. 18, 2007, (<http://www.ftc.gov/os/testimony/P859910pharm.pdf>).

⁹ A 2007 CRA report on the same topic relied on data provided in the NCPA Digest, which was then publicly available. (Peter J. Rankin, Monica G. Noether, and Emily Telleen-Lawton, "The Cost of Independent Pharmacy Antitrust Exemptions," May 2007 ("CRA 2007").) Since 2007, distribution of the NCPA Digest has been restricted to NCPA membership. Where possible, this updated cost study uses data from NCPA to maintain consistency.

Recent data indicate that independent pharmacies remain profitable. Figures from the NCPA suggest that pharmacy profit margins are not declining and that gross profits have nearly doubled over the past ten years. NCPA figures also suggest that independent pharmacy profit margins are at their highest levels since 2003, while the NCPA Digest points out that the total gross margin has “remained in the 22 to 24 percent range seen over the past 10 years.” Average revenues per pharmacy location, which were \$1.967 million on average in 1999, were at \$4.026 million in 2009. Correspondingly, gross profits, which were at \$472,000 per pharmacy location in 1999, reached \$958,000 in 2009. Owner’s compensation, defined as the sum of compensation paid to a working pharmacy owner and a pharmacy’s net operating income, averaged \$274,000 per pharmacy location.¹⁰

3.2. Current regulations safeguard competition and allow legitimate coordinated activity

The FTC, along with the Antitrust Division of the U.S. Department of Justice (“DOJ”) and State Attorneys General, monitors competition and enforces laws and regulations intended to protect consumers from inappropriate corporate behavior. Central to that responsibility is the monitoring of “market power,” which describes the ability to affect prices, relative to competitive levels, for a significant period of time. The regulatory agencies and State Attorneys General 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).

The FTC and DOJ have established a series of general and health care-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.¹¹ The agencies have also articulated the conditions under which collective agreements are ancillary

¹⁰ Adam Fein, Ph.D., “Owning a Pharmacy: Still Pretty Profitable,” January 25, 2011, available at <http://www.drugchannels.net/2011/01/owning-pharmacy-still-pretty-profitable.html>.

¹¹ DOJ and FTC, “Horizontal Merger Guidelines,” August 19, 2010, available at <http://www.justice.gov/atr/public/guidelines/hmg-2010.html>.

and subordinate to achieving some significant procompetitive end, such as quality improvement or cost reduction.¹²

In addition, mechanisms exist to allow independent pharmacies to reduce administrative costs and increase volumes without antitrust exemptions. Pharmacy Service Administrative Organizations (“PSAOs”) provide a range of services to pharmacies, including PBM contract management and negotiation.¹³ Nearly 80 percent of independent pharmacies rely on PSAOs that pool the bargaining power of many independents to collectively negotiate reimbursement and contract terms with health plans and PBMs.¹⁴ The typical PSAO represents thousands of pharmacies. It gives a group of independent pharmacies access to benefits normally associated with large, multi-location chain pharmacy corporations such as pooled contractual negotiating power, centralized claims payment, and reconciliation of prescription payment activity.¹⁵

3.3. Antitrust exemptions are a flawed response to perceived competitive imbalance

The grant of antitrust exemptions tends to be a particularly problematic response to perceived competitive imbalances. The search for antitrust exemptions can be a rent-seeking activity that provides no economic efficiency and may be unjustified. It can increase the problems of market power and substantially increase prices without providing any gain to consumers.

Former FTC chairman 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

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- 12 This is a topical consideration, as the FTC and DOJ recently released a joint policy statement on Accountable Care Organizations (“ACOs”), another facet of health care reform. Under this reform model, groups of providers and suppliers “may work together to manage and coordinate care for Medicare fee-for-service beneficiaries...” (FTC and DOJ, Antitrust Division, “Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program,” Federal Register, Vol. 76, No. 209, October 28, 2011 (“FTC and DOJ ACO Statement 2011,” pp. 67026-67032.)) Despite the program specifically calling for coordinated activities, the FTC and DOJ note “The Agencies [FTC and DOJ] recognize that not all such ACOs are likely to benefit consumers, and under certain conditions ACOs could reduce competition and harm consumers through higher prices or lower quality of care.” (FTC and DOJ ACO Statement, p. 67026.) In their discussion, the FTC and DOJ reiterate a position previously articulated in “various policy statements, speeches, business reviews, and advisory opinions” that “Joint price agreements among competing health care providers are evaluated under the rule of reason, however, if the providers are financially or clinically integrated and the agreement is reasonably necessary to accomplish the procompetitive benefits of the integration.” For the full discussion, see FTC and DOJ ACO Statement, p. 67027.
- 13 Medicare: Sponsors’ Management of the Prescription Drug Discount Card and Transitional Assistance Benefit, United States Government Accountability Office, January 13, 2006, fn. 24. For an example of such a PSAO, see: http://progressivepharmacy.com/PBM_contract_management.php.
- 14 NCPA, 2006 NCPA-Pfizer Digest, 2006 p. 53, Table 14. Department of Health and Human Services, Office of the Inspector General, “Review of Medicare Part D Contracting for Contract Year 2006,” A-06-07-00082, July 2008, pp. 5-6.
- 15 Statement of Adam J. Fein before the U.S. House of Representatives Committee on the Judiciary, Subcommittee on Intellectual Property, Competition, and the Internet Hearing on “The Proposed Merger between Express Scripts and Medco,” Tuesday, September 20, 2011.

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.”¹⁶ A similar sentiment was expressed in the FTC and DOJ’s “Dose of Competition” Report.¹⁷ The FTC contends that the argument for antitrust waivers “presupposes that providers are at the mercy of monopsony health plans,” which has not been demonstrated to be true.¹⁸ Additionally, the FTC states that even if the premise of the argument were true, the establishment of an opposing “provider cartel” could doubly harm consumers, who could be forced to pay elevated fees to the provider cartel in addition to any inflated fee imposed by the monopsony health plan.¹⁹ The Antitrust Modernization Commission, a body created by Congress “to evaluate the application” of antitrust laws, states that an antitrust exemption creates “economic benefits that flow to small, concentrated interest groups, while the cost of the exemption are widely dispersed, usually passed on to a large group of consumers through higher prices, reduced output, lower quality, and reduced innovation.”²⁰

Since 2007, the FTC has issued several complaints against organizations suspected of such conduct; it has also released a number staff comments from its Bureaus of Economics and Competition detailing the potential anticompetitive effects of exemptions from collective bargaining regulations.²¹ It has recently advised against antitrust waiver legislation for health care providers in Puerto Rico and Ohio.²² It has pursued enforcement actions against

16 FTC Chairman Robert Pitofsky, *Thoughts on “Leveling the Playing Field” in Health Care Markets*, speech delivered to the National Health Lawyers Association, February 13, 1997.

17 “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.’ (“Improving Health Care: A Dose of Competition, A Report by the FTC and the DOJ,” July 2004, Chapter 2, p. 21. Parenthetical material included in source material.).

18 FTC Staff Comment to the Puerto Rico House of Representatives Regarding Senate Bill 2190 Concerning Health Care Collective Bargaining, January 30, 2008 (“FTC Comment on SB 2190”), <http://www.ftc.gov/os/2008/02/v080003puerto.pdf>, p. 6.

19 Ibid.

20 Antitrust Modernization Commission, Report and Recommendations, Apr. 2007 (“AMC Report”), p. 335. http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf; seen in FTC Comment on SB 2190, p. 6 and FTC Staff Comment to the Honorable William J. Seitz, Senator, State of Ohio Senate, Regarding Ohio Executive Order 2007-23S, Establishing Collective Bargaining for Home Health Care Workers, February 14, 2008 (“FTC Comment on Ohio Executive Order 2007-23S”), p.5.

21 See, for example: FTC Comment on SB 2190; FTC Comment on Ohio Executive Order 2007-23S; FTC Press Release, “U.S. Court of Appeals Affirms FTC Decision That Texas Doctors’ Group Engaged in Illegal, Anticompetitive Price-Fixing,” May 16, 2008. <http://www.ftc.gov/opa/2008/05/ntsp.shtm>; FTC Press Release, “FTC Settles Price Fixing Charges Against San Francisco bay Area Doctors’ Group,” June 4, 2009, <http://www.ftc.gov/opa/2009/06/altabates.shtm>.

22 FTC Comment on SB 2190; FTC Comment on Ohio Executive Order 2007-23S.

North Texas Specialty Physicians Group,²³ Alta Bates Medical Group,²⁴ and Minnesota Rural Health Cooperative.²⁵ While enforcement actions have generally pertained to physician groups, the FTC states, “the competition analysis is consistent across different types of health care providers.”²⁶

4. Antitrust waivers are expected to increase costs

4.1. Geographic access requirements tend to convey market power

Health plan sponsors, both public and private, typically require that their network of pharmacies be sufficiently broad to provide in-network pharmacies close to members' homes.²⁷ For example, the Centers for Medicare & Medicaid Services ("CMS") require that health plans seeking to participate in Medicare Part D create pharmacy 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 sponsor 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 sponsor 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 sponsor live within 15 miles of a network pharmacy that is a retail pharmacy.²⁸

Facing specific geographic requirements for pharmacy networks, PBMs and health insurers must choose among a limited set of pharmacies in local geographic areas. As a result,

23 FTC Press Release, "U.S. Court of Appeals Affirms FTC Decision That Texas Doctors' Group Engaged in Illegal, Anticompetitive Price-Fixing," May 16, 2008. <http://www.ftc.gov/opa/2008/05/ntsp.shtm>.

24 FTC Press Release, "FTC Settles price Fixing Charges Against San Francisco bay Area Doctors' Group," June 4, 2009. <http://www.ftc.gov/opa/2009/06/altabates.shtm>.

25 FTC Press Release, "Minnesota Health Care Provider Group Settles FTC Price Fixing Charges," June 18, 2010. <http://www.ftc.gov/opa/2010/06/ruralhealth.shtm>.

26 FTC Comment on SB 2190, p. 6.

27 CRA 2007, p. 16.

28 42 CFR 423.120.

pharmacies need mainly compete on quality and price within the set of local alternatives.²⁹ To the extent the limited choice of alternatives permits pharmacies to increase prices or reduce quality above the competitive level, there is what the antitrust literature refers to as market power.³⁰ By virtue of their being a limited set of alternatives in a geographic area, PBMs and payers could not turn to other pharmacies should the pharmacies in an area collectively reduce their quality or increase their prices. For example, if there is only one pharmacy in a rural area near a mass of plan members, the pharmacy would have market power as it would have to be included in pharmacy networks and would face little competitive constraint relative to a multi-pharmacy situation.³¹ However, when there is a limited set of pharmacies that currently competes on quality, price, and other metrics, through collective negotiation that antitrust waivers would allow, independent pharmacies would be allowed to coordinate activities and reduce such competition. Having a limited set of local competitors, pharmacies acting in concert can have market power where individually they do not.

4.2. Collective bargaining leads to increased reimbursements

When collectively bargaining, independent pharmacies act as one and are thus able to demand network inclusion at higher reimbursement rates (on a quality-adjusted basis) or ensure that none of them contracts with the PBM or insurer. When independent pharmacies effectively coordinate,³² areas containing multiple and mainly independent pharmacies will become like those containing only one pharmacy. In its enforcement actions against health care providers that have collectively bargained, the FTC has found that “groups have often sought fee increases of 20 percent or more.”³³ Additionally, for other types of health care

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- 29 Note that the requirement that only 70 percent of members in rural areas and 90 percent otherwise be within the specified geographic proximity creates incentives for a limited second-order of competition among pharmacies across geographies not to fall outside of the 70th or 90th percentiles, respectively. The degree of competition is substantially reduced, however, relative to one in which local pharmacies compete directly to be the preferred in-network provider.
- 30 Market power is defined in the economics literature as pricing above marginal cost (Jean Tirole, *The Theory of Industrial Organization*, 4th Ed., 1990, Cambridge: MIT Press, p. 284). Economists tend to use it on a quality-adjusted basis, where lower quality without appropriate reductions in cost would also be viewed as having market power.
- 31 It is well documented that this situation arises in rural areas. 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 (Ronald A. Wirtz, “Special Delivery? Innovations are Changing How, Where and When People Receive Pharmacy Services – Not Everyone Is Thrilled,” *FedGazette*, Federal Reserve Bank of Minneapolis, January 2006).
- 32 Note that the economics literature on coordination strategies among firms that cannot explicitly collude often finds instability among cartels due to their inability to impede defections (for an overview, see Jean Tirole, *The Theory of Industrial Organization*, 4th Ed., p. 241, 1990, Cambridge: MIT Press). If activities under the waivers can be enforced, however, pharmacies may be able to impede defections through the force of justiciable agreements and act as more perfect monopolists than a typical cartel.
- 33 FTC, Prepared Statement Before the Antitrust Task Force of the H. Comm. the Judiciary, Concerning H.R. 971, “The Community Pharmacy Fairness Act of 2007,” 110th Cong., footnote 18, Oct. 18, 2007, (<http://www.ftc.gov/os/testimony/P859910pharm.pdf>). The cited groups sought increases in fees of 20 percent to 90 percent.

providers, the health economics literature has shown both theoretically and empirically that as providers with multiple locations merge or otherwise collectively negotiate rates with payers they are able to obtain higher prices.³⁴ One antitrust remedy used for mergers raising concerns regarding market power is to require separate negotiation.³⁵

4.3. Increased reimbursements will increase costs to plans and increase national health expenditures

The impact of increased reimbursement rates will pass through into higher plan premiums and increases in national health expenditures. As noted above, the FTC has stated that the PBM industry is highly competitive. Additionally, state insurance regulators ensure that health insurers set prices sufficiently to break even, and profit margins among health plans are lower than the median industry.³⁶ The competitiveness of PBMs and payers has a critical economic consequence for who bears cost increases: any cost absorption by PBMs or insurers would likely be only transitory.³⁷ Increased costs from antitrust exemptions to independent pharmacies would likely be passed on to health insurers, employers, and consumers and could result in employers reducing health insurance benefits. The net result is that cost increases would pass into higher costs borne by beneficiaries and plan sponsors, which would in turn raise U.S. health expenditures and the rate of medical inflation.³⁸ This increase in costs will also increase government spending through:

34 See theoretical models and their application in Katherine Ho, "Insurer-Provider Networks in the Medical Care Market," *The American Economic Review*, Volume 99, Number 1, March 2009 , pp. 393-430(38); Cory Capps, David Dranove, and Mark Satterthwaite, "Competition and Market Power in Option Demand Markets," *The RAND Journal of Economics*, Vol. 34, No. 4 (Winter, 2003), pp. 737-763; Robert Town and Gregory Vistnes, "Hospital competition in HMO networks," *Journal of Health Economics*, 2001, vol. 20(5), pages 733-753, September. See empirical estimates of the effects of hospital consolidation in Cory Capps and David Dranove, "Hospital Consolidation And Negotiated PPO Prices," *Health Affairs*, 23, no. 2, 2004, pp. 175-181; Leemore Dafny, "Estimation and Identification of Merger Effects: An Application to Hospital Mergers," *Journal of Law and Economics*, Vol. 52, No. 3, August 2009, pp. 523-550; W. B. Vogt, and Robert J. Town, "How has hospital consolidation affected the price and quality of hospital care?" *Research Synthesis Report* 9, 2006, Robert Wood Johnson Foundation, Princeton, NJ.

35 For example, see FTC Press Release, "FTC Issues Final Opinion and Order to Restore the Competition Lost in Evanston Northwestern Healthcare Corporation's Acquisition of Highland Park Hospital," April 28, 2008, <http://www.ftc.gov/opa/2008/04/evanston.shtm>.

36 Yahoo! Finance Industry Summary, http://biz.yahoo.com/p/sum_qpmd.html, comparing Net profit margin for health plans relative to other industries, as viewed on March 22, 2012.

37 Regulators have described the PBM industry as highly competitive, and economics argues that in competitive industries cost increases pass through directly to customers (i.e. health insurers and employers in the case of PBMs). (CRA 2007, p. 19.) Additionally, there is evidence that in health insurance, little in the way of premium increases comes from recent insurer concentration whereas the vast majority appears to be related to cost increases (Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan, "Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry," NBER Working Paper No. 15434, October 2009.)

38 Current National Health Expenditures are estimated at nearly 18 percent of GDP (CMS, "NHE Fact Sheet" https://www.cms.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp). The CBO projects that National Health Expenditures will reach 49 percent of GDP by 2082 (CBO, "The Long-Term Outlook for Health Care Spending," November 2007, p. 13).

- 1) Increases in the health insurance tax subsidy. Through increasing the amount of employees' earnings paying for untaxed items such as employer sponsored health care or flexible spending accounts for health insurance, the amount of employees' earnings subject to taxation will decline. The net effect is an increase in the tax subsidy provided to health insurance and a decline in tax revenues.
- 2) Increased costs for health insurance exchange subsidies under PPACA. Due to the subsidies being indexed to the cost of the second lowest cost silver plan on a state-based health insurance exchange, an increase in plan costs will translate directly into increased subsidies.³⁹
- 3) Spillover onto Medicare and other Federal Programs. As noted by the CBO, the effects of antitrust waivers that do not apply to federal programs can nonetheless raise costs to federal programs.⁴⁰ Though H.R. 1946 prevents application of the antitrust exemptions to government programs like Medicaid and Medicare Parts C and D, the same pharmacies will negotiate with the same payers or PBMs to determine participation in those government programs. While they will not be permitted to actively coordinate for negotiations with government programs, they will have learned information from other independent pharmacies (e.g. cost structures, valuations) and the negotiating positions of payers and PBMs that could inform their negotiations and willingness to participate in these government programs.

4.4. CBO score of similar legislation

In 2008, the CBO scored similar provisions in H.R. 971.⁴¹ The CBO estimated that independent pharmacy payments would increase one percent upon renegotiation, and that it would increase the costs to group health insurance by less than 0.1 percent, before accounting for responses to the cost increase. Responses to the cost increase, including "reductions in the scope or generosity of health insurance benefits," were expected to offset 60 percent of the cost of the bill.

The CBO's approach to H.R. 971 may not be appropriate generally or in the current context. First, it is not clear how the CBO reached the conclusion of a one perfect increase in drug costs for independent pharmacies. Other health care providers that have colluded or merged have obtained reimbursement increases of 20 percent or higher.⁴² Areas served mainly by independent pharmacies, such as rural areas, would see a marked reduction in competition. Second, it is not clear that reductions in coverage should be ignored as costs of the legislation, as economists have found that the cost of health insurance plans comes directly

³⁹ See Patient Protection and Affordable Care Act, Part A, Title I, Subtitle E, Sec. 1401.

⁴⁰ CBO, "H.R. 971: Community Pharmacy Fairness Act of 2007," January 11, 2008 and September 26, 2008.

⁴¹ Ibid.

⁴² See supra note 333. The cited groups sought increases in fees of 20 percent to 90 percent.

out of employees' earnings.⁴³ To the extent health care becomes more expensive, either employees get less in earnings or they lose a benefit.

5. Estimated cost increases from H.R. 1946

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

- Result in reimbursement increases of 20 percent on commercially insured prescriptions, consistent with FTC determinations of increases due to collective action, representing a 66.7 percent increase in the commercial gross profit rate,⁴⁴ or
- Equal those 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 32.4 percent increase in the commercial gross profit rate.⁴⁵

The result is that in the first scenario, costs would increase by an estimated \$15.6 billion or 7.9 percent of current total prescription sales across all independent pharmacies. In the second scenario, costs would increase by \$7.6 billion or 3.8 percent of current total prescription sales across all independent pharmacies.

A complete description of the cost model methodology and sources are provided in the notes to Exhibits A and B. Significant aspects of the cost estimate model include:

- *Price elasticity of demand for prescriptions:* The impact that these two scenarios have on total pharmacy costs to payers, 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. 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

43 For a review of the literature, see Ezekiel Emmanuel and Victor Fuchs, "Who Really Pays for Health Care? The Myth of 'Shared Responsibility,'" Journal of the American Medical Association, March 5, 2008, Vol. 299, No. 9, pp. 1057- 1059.

44 See supra note 33. Note that the commercially insured group excludes the Federal Employee Health Benefit Program as well as government programs including Medicare Part D, consistent with H.R. 1971.

45 For details, see CRA 2007, p. 20. While there have been other health care examples of cost increases following collective behavior since 2007, as noted above, this scenario is consistent with those more recent developments and specific to independent pharmacies. This cost report includes a third scenario in which independent pharmacy gross margins for commercially-insured prescriptions approaches the gross margins for cash transactions. In this scenario, costs could increase up to \$39.7 billion or 20.1 percent of total prescriptions across all independent pharmacies.

numbers of uninsured. The cost model adopts price elasticity of demand for pharmaceutical prescriptions of -0.27 based on a summary of economic research.⁴⁶

- *Assumed percent of lives covered with inflexible geographic access requirements:* 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 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. As a result, the cost model includes a parameter to account for the possibility that some commercial accounts could avoid the cost increases associated with antitrust exemptions.⁴⁷
- *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 to participate than independent pharmacies located in more competitive areas, where chain, supermarket, and mass merchandiser pharmacies are more prevalent. The model calculates costs separately for rural independent pharmacies to account for this possibility.
- *Effects of health insurance exchanges on the mix of prescriptions per payer type filled at independent pharmacies:* The cost model incorporates evidence-based assumptions regarding the Part D share of prescriptions, but H.R. 1946 notes that antitrust waivers are not to apply to Medicare Parts C or D. More prospective assumptions must be made regarding payer mix following the creation of health insurance exchanges and changes in Medicaid eligibility under the Patient Protection and Affordable Care Act.

As described in the technical notes of Exhibits A-1 and A-2, the cost model adopts CBO estimates of change in payer mix among the non-elderly population over the next five years, starting in 2013.⁴⁸ Revisions to the CBO analysis, particularly if they reflect any structural changes resulting from Congressional amendments or judicial

46 Dana Goldman, Geoffrey Joyce, and Jesse Malkin, "The Cost of a Medicare Prescription Drug Benefit: A Comparison of Alternative," 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).

47 The cost model assumes that the percentage of covered lives with inflexible geographic access requirements decreases from 100 percent starting in Year 1 by the same amount, 10 percent, each year.

48 CBO, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," March 13, 2012, Table 3.

review of PPACA, will require updates to this aspect of the cost model, if relevant. The cost model also adopts CMS statistics on payer mix for the elderly population and holds those constant over the next five years, starting in 2013.

The cost model assumes that each payer type will retain its relative drug utilization per beneficiary even as the number of beneficiaries in each segment changes. As there is no established drug utilization estimate for the health insurance exchanges, they are assigned an average utilization. The cost model demonstrates that health insurance exchanges will cover an increasing share of prescriptions, consistent with CBO projections, starting in 2014. Medicare utilization is expected to decline slightly, while Medicaid utilization is expected to increase. Decreases in share are also expected to occur for the third-party payer and cash segment shares.

Exhibit A: Cost Projections for Antitrust Waivers to Independent Pharmacies

	Year 1 (2013)		Year 2 (2014)		Year 3 (2015)		Year 4 (2016)		Year 5 (2017)		
	[a]	[b]	[a]	[b]	[a]	[b]	[a]	[b]	[a]	[b]	
	All	Rural pharmacies	All	Rural pharmacies	All	Rural pharmacies	All	Rural pharmacies	All	Rural pharmacies	
Base Cost Projections for Independent Pharmacies											
[1]	Geographic distribution of independent pharmacies, 2010	100%	52%	100%	52%	100%	52%	100%	52%	100%	52%
[2]	Number of independent pharmacies, 2010	23,064	11,993	23,064	11,993	23,064	11,993	23,064	11,993	23,064	11,993
[3]	Prescription sales per independent pharmacy location (\$000)	4,754	4,754	5,060	5,060	5,386	5,386	5,733	5,733	6,102	6,102
[4]	Total independent pharmacy prescription sales (\$M)	109,647	57,016	116,707	60,688	124,222	64,595	132,220	68,754	140,734	73,181
[5]	Gross margin (GM) percentage for prescriptions at independent pharmacies, 2010	23.3%	23.3%	23.3%	23.3%	23.3%	23.3%	23.3%	23.3%	23.3%	23.3%
[6]	Total prescription GM per independent pharmacy location (\$000)	1,108	1,108	1,179	1,179	1,255	1,255	1,336	1,336	1,422	1,422
Payer Mix for Independent Pharmacies											
[7]	Third-party payer (TPP)	46.7%	20.0%	44.4%	20.0%	44.0%	20.0%	43.2%	20.0%	43.1%	20.0%
[8]	Cash	11.9%	54.0%	8.1%	54.0%	6.7%	54.0%	5.4%	54.0%	5.4%	54.0%
[9]	Medicaid	13.4%	19.1%	17.8%	19.1%	17.9%	19.1%	17.7%	19.1%	17.3%	19.1%
[10]	Medicare Part D	28.0%	18.6%	27.1%	18.6%	27.4%	18.6%	27.4%	18.6%	27.3%	18.6%
[11]	Health insurance exchanges	0.0%	0.0%	2.6%	20.0%	3.8%	20.0%	6.3%	20.0%	6.9%	20.0%
[12]	Share of Prescriptions Covered by TPPs, Excluding Federal Employees	45%		42%		42%		41%		41%	
[13]	Percent of Covered Lives with Inflexible Geographic Access Requirements	100%		90%		80%		70%		60%	
Base Revenues for Cost Simulation											
[14]	Independent pharmacy TPP prescription sales (\$M)	48,873	25,414	49,365	25,670	52,090	27,087	54,394	28,285	57,732	30,021
Cost Simulation Scenarios											
	Percent GM increase	Change in Gross Margin	Percent GM increase	Change in Gross Margin	Percent GM increase	Change in Gross Margin	Percent GM increase	Change in Gross Margin	Percent GM increase	Change in Gross Margin	
[15]	Increase prices such that gross margins on TPP equal those on cash transactions	170.0%	34.0%	170.0%	34.0%	170.0%	34.0%	170.0%	34.0%	170.0%	34.0%
[16]	Increase prices on TPP transactions by 20%	66.7%	13.3%	66.7%	13.3%	66.7%	13.3%	66.7%	13.3%	66.7%	13.3%
[17]	Increase prices such that gross margins on TPP increase to North Dakota requested rate	32.4%	6.5%	32.4%	6.5%	32.4%	6.5%	32.4%	6.5%	32.4%	6.5%
Effect of -0.27 Price Elasticity of Demand for TPP Prescriptions											
	Percent GM increase	Change in Gross Margin	Percent GM increase	Change in Gross Margin	Percent GM increase	Change in Gross Margin	Percent GM increase	Change in Gross Margin	Percent GM increase	Change in Gross Margin	
[18]	Increase prices such that gross margins on TPP equal those on cash transactions	124.1%	24.8%	124.1%	24.8%	124.1%	24.8%	124.1%	24.8%	124.1%	24.8%
[19]	Increase prices on TPP transactions by 20%	48.7%	9.7%	48.7%	9.7%	48.7%	9.7%	48.7%	9.7%	48.7%	9.7%
[20]	Increase prices such that gross margins on TPP increase to North Dakota requested rate	23.7%	4.7%	23.7%	4.7%	23.7%	4.7%	23.7%	4.7%	23.7%	4.7%
Increases to Gross Margins for TPP Prescriptions											
	All	Rural pharmacies	All	Rural pharmacies	All	Rural pharmacies	All	Rural pharmacies	All	Rural pharmacies	
[21]	Increase prices such that gross margins on TPP equal those on cash transactions (\$M)	12,130	6,308	11,027	5,734	10,343	5,378	9,450	4,914	8,598	4,471
[22]	Increase prices on TPP transactions by 20% (\$M)	4,757	2,474	4,324	2,249	4,056	2,109	3,706	1,927	3,372	1,753
[23]	Increase prices such that gross margins on TPP increase to North Dakota requested rate (\$M)	2,312	1,202	2,102	1,093	1,971	1,025	1,801	937	1,639	852
Resulting Total Prescription Sales											
	All	Rural pharmacies	All	Rural pharmacies	All	Rural pharmacies	All	Rural pharmacies	All	Rural pharmacies	
[24]	Increase prices such that gross margins on TPP equal those on cash transactions (\$M)	61,003	31,722	60,392	31,404	62,433	32,465	63,844	33,199	66,330	34,492
[25]	Increase prices on TPP transactions by 20% (\$M)	53,630	27,888	53,689	27,918	56,146	29,196	58,100	30,212	61,104	31,774
[26]	Increase prices such that gross margins on TPP increase to North Dakota requested rate (\$M)	51,185	26,616	51,467	26,763	54,061	28,112	56,195	29,221	59,371	30,873
[27]	Increase prices such that gross margins on TPP equal those on cash transactions	24.8%	24.8%	22.3%	22.3%	19.9%	19.9%	17.4%	17.4%	14.9%	14.9%
[28]	Increase prices on TPP transactions by 20%	9.7%	9.7%	8.8%	8.8%	7.8%	7.8%	6.8%	6.8%	5.8%	5.8%
[29]	Increase prices such that gross margins on TPP increase to North Dakota requested rate	4.7%	4.7%	4.3%	4.3%	3.8%	3.8%	3.3%	3.3%	2.8%	2.8%

Exhibit A: Cost Projections for Antitrust Waivers to Independent Pharmacies

Sources:

- [1] 52% is the estimated share of independent pharmacies serving 20,000 people or less in 2010. "NCPA Digest Finds Independent Community Pharmacies Reducing Health Costs Through Generic Use, Patient Counseling," NCPAnet.org, October 10, 2011, <http://www.ncpanet.org/index.php/news-releases/1166-ncpa-digest-finds-independent-community-pharmacies-reducing-health-costs-through-generic-drug-use-patient-counseling-.> The NCPA notes that this percentage has remained constant recently.
- [2][a] "NCPA Digest Finds Independent Community Pharmacies Reducing Health Costs Through Generic Use, Patient Counseling," NCPAnet.org, October 10, 2011, <http://www.ncpanet.org/index.php/news-releases/1166-ncpa-digest-finds-independent-community-pharmacies-reducing-health-costs-through-generic-drug-use-patient-counseling-.> The number of independent pharmacies has remained fairly constant in recent years. Adam J. Fein, "2010: A Good Year for Independent Pharmacies," DrugChannels.net, September 6, 2011, <http://www.drugchannels.net/2011/09/2010-good-year-for-independent.html>.
- [2][b] = [1][b] * [2][a].
- [3] "2010 NCPA Digest Executive Summary," <http://www.ncpanet.org/pdf/digest/2010/2010digestexecsum.pdf>, Figure 1. Sales are projected from 2009 according to the 2000-2009 CAGR, 6.44%, such that Year 1 represents 2013. Additionally, 92% of total independent pharmacy revenue is assumed to derive from sales of prescription drugs. "NCPA Digest Finds Independent Community Pharmacies Reducing Health Costs Through Generic Use, Patient Counseling," NCPAnet.org, October 10, 2011, <http://www.ncpanet.org/index.php/news-releases/1166-ncpa-digest-finds-independent-community-pharmacies-reducing-health-costs-through-generic-drug-use-patient-counseling-.>
- [4] = [2] * [3] / 1,000.
- [5] Adam J. Fein, "The True Economics of Pharmacy Ownership," DrugChannels.net, October 18, 2011, <http://www.drugchannels.net/2011/10/true-economics-of-pharmacy-ownership.html>. This number remained fairly constant, mainly increasing, over the 5 years from 2006 to 2010.
- [6] = [3] * [5].
- [7-11][a] See Exhibit A-1.
- [7-10][b] Adam J. Fein, "The True Economics of Pharmacy Ownership," DrugChannels.net, October 18, 2011, <http://www.drugchannels.net/2011/10/true-economics-of-pharmacy-ownership.html>.
- [11][b] Health insurance exchanges GM is assumed to equal TPP GM.
- [12] = [7][a] - 8 * 2.0 / 746. In 2008, 8 million people were federal employees, retirees, and dependents. USGAO, "Prescription Drugs: Overview of Approaches to Control Prescription Drug Spending in Federal Programs," June 24, 2009, <http://www.gao.gov/products/GAO-09-819T, p. 2>. According to Exhibit A-1, the average number of prescriptions per TPP enrollee is 2.0, and that is divided by 746 million total prescriptions.
- [13] To maintain comparability with CRA 2007 analysis, this cost model also assumes a decrease of 10% in each year modeled.
- [14] = [4] * [12].
- [15][a] = [8][b] / [7][b] - 1.
- [15][b] = [8][b] - [7][b].
- [16][a] = 33.3% / [7][b] - 1. Assuming constant COGS, revenue as reported in [4], and TPP shares as reported in [7], a 20% increase in TPP price would increase TPP GM to 33.3%.
- [16][b] = 33.3% - [7][b].
- [17][a] The 32.4% North Dakota pharmacist requested rate was used as a benchmark in CRA 2007 analysis.
- [17][b] = [7][b] * [17][a].
- [18][a] = [15][a] - [15][a] * 0.27. To maintain comparability with CRA 2007 analysis, this cost model also assumes a price elasticity of demand for prescriptions of -0.27.
- [18][b] = [7][b] * [18][a].
- [19][a] = [16][a] - [16][a] * 0.27.
- [19][b] = [7][b] * [19][a].
- [20][a] = [17][a] - [17][a] * 0.27.
- [20][b] = [7][b] * [20][a].
- [21] = [4] * [12] * [13] * [18][b].
- [22] = [4] * [12] * [13] * [19][b].
- [23] = [4] * [12] * [13] * [20][b].
- [24] = [14] + [21].
- [25] = [14] + [22].
- [26] = [14] + [23].
- [27] = [21] / [14].
- [28] = [22] / [14].
- [29] = [23] / [14].

Exhibit A-1: Payer Mix for Independent Pharmacies

	Year 0 (2012) [a]	Year 1 (2013) [b]	Year 2 (2014) [c]	Year 3 (2015) [d]	Year 4 (2016) [e]	Year 5 (2017) [f]
Estimated Effects of the Patient Protection and Affordable Care Act (PPACA)						
<i>Coverage under current law (millions of non-elderly people by calendar year)</i>						
[1] Third-party payer (TPP)	167	169	170	171	173	174
[2] Cash	55	56	56	56	56	57
[3] Medicaid	34	34	35	34	32	32
[4] Medicare Part D	13	13	13	14	14	14
[5] Health insurance exchanges	-	-	-	-	-	-
[6] Total	268	271	273	274	275	277
<i>Expected change due to implementation of PPACA</i>						
[7] TPP	2	1	(3)	(3)	(6)	(7)
[8] Cash	(2)	(2)	(18)	(24)	(30)	(31)
[9] Medicaid	-	1	13	15	17	16
[10] Medicare Part D	-	-	-	-	-	-
[11] Health insurance exchanges	-	-	8	12	20	22
[12] Total	-	-	-	-	1	-
<i>Coverage under PPACA (millions of non-elderly people)</i>						
[13] TPP	169	170	167	168	167	167
[14] Cash	53	54	38	32	26	26
[15] Medicaid	34	35	48	49	49	48
[16] Medicare Part D	13	13	13	14	14	14
[17] Health insurance exchanges	-	-	8	12	20	22
[18] Total	268	271	273	274	276	277
Total Population by Payer Type						
<i>Elderly Medicare-eligible population with drug coverage</i>						
[19] TPP	9					
[20] Cash	0					
[21] Medicaid	0					
[22] Medicare Part D	23					
[23] Total	32					
<i>Total population by payer type under PPACA</i>						
[24] TPP	177	178	175	176	176	176
[25] Cash	53	54	38	32	26	26
[26] Medicaid	34	35	48	49	49	48
[27] Medicare Part D	36	36	36	37	37	37
[28] Health Insurance Exchanges	-	-	8	12	20	22
[29] Total	300	303	305	306	308	309

Exhibit A-1: Payer Mix for Independent Pharmacies

Independent Pharmacy Prescriptions by Payer Type

Average number of prescriptions filled at independent pharmacies per beneficiary

[30]	TPP	2.0
[31]	Cash	1.7
[32]	Medicaid	2.9
[33]	Medicare Part D	5.9
[34]	Health Insurance Exchanges	2.5
[35]	Average	2.5

Number of prescriptions by payer type (millions)

	349	351	345	347	346	346
[36]	TPP					
[37]	Cash	88	90	63	53	43
[38]	Medicaid	98	101	138	141	141
[39]	Medicare Part D	210	210	210	216	219
[40]	Health Insurance Exchanges	-	-	20	30	50
[41]	Total	746	752	777	788	800
						803

Percentage distribution of prescriptions by payer type

[42]	TPP	47%	47%	44%	44%	43%	43%
[43]	Cash	12%	12%	8%	7%	5%	5%
[44]	Medicaid	13%	13%	18%	18%	18%	17%
[45]	Medicare Part D	28%	28%	27%	27%	27%	27%
[46]	Health Insurance Exchanges	0%	0%	3%	4%	6%	7%
[47]	Total	100%	100%	100%	100%	100%	100%

Sources:

[1-5, 7-11] CBO, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," March 2012, <http://.cbo.gov/publication/43076>. "Medicaid & CHIP" is assigned to Medicaid. "Employer" is assigned to TPP. "Nongroup & Other" is divided based on note. Half is assigned to TPP, and all "Nongroup & Other" change is assigned to TPP. The remainder of "Nongroup & Other" is assigned to Medicare. "Uninsured" is assigned to Cash

[6] = sum of [1-5].

[12] = sum of [7-11].

[13-17] = corresponding [1-6] + [7-12].

[18] = sum of [13-17].

[19-22] See Exhibit A-2.

[23] = sum of [19-22].

[24-28] = corresponding [13-17] + [19-22][a].

[29] = sum of [24-28].

[30-35] See Exhibit A-2. "Health Insurance Exchanges" is assumed to have an average number of prescriptions per enrollee.

[36-40] = corresponding [24-28] x [30-34][a].

[41] = sum of [36-40].

[42-47] = corresponding [36-41] / [41].

Exhibit A-2: Independent Pharmacy Prescriptions by Payer Type

Independent Pharmacy Mix of Prescriptions by Payer Type, 2009

[1]	Third-party payer (TPP)	45.0%
[2]	Cash	11.0%
[3]	Medicaid	15.3%
[4]	Medicare Part D	28.7%
[5]	Independent Pharmacy Prescriptions (millions), 2009	754

Number of Non-Elderly Individuals by Payer Type (millions), 2010

[6]	TPP	164
[7]	Cash	50
[8]	Medicaid	40
[9]	Medicare Part D	14
[10]	Total	267

Number of Elderly Individuals by Payer Type (millions), 2010

[11]	TPP	9
[12]	Cash	-
[13]	Medicaid	-
[14]	Medicare Part D	23
[15]	Total	32

Total Number of Individuals by Payer Type (millions), 2010

[16]	TPP	172
[17]	Cash	50
[18]	Medicaid	40
[19]	Medicare Part D	37
[20]	Total	299

Average Number of Independent Pharmacy Prescriptions Filled per Beneficiary

[21]	TPP	1.97
[22]	Cash	1.66
[23]	Medicaid	2.88
[24]	Medicare Part D	5.93

Exhibit A-2: Independent Pharmacy Prescriptions by Payer Type

[25]	Average	2.52
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Sources:

- [1-2] "2010 NCPA Digest Executive Summary,"
<http://www.ncpanet.org/pdf/digest/2010/2010digestexecsum.pdf>, Table 1. Cash is assumed to be the remainder after government programs and other third-party programs are accounted for.
- [3-4] NCPA's 2010 Digest notes that 44% of independent pharmacy prescriptions are covered by government programs. NCPA, "2010 NCPA Digest Executive Summary,"
<http://www.ncpanet.org/pdf/digest/2010/2010digestexecsum.pdf>, Table 1. NCPA's 2011 Digest summary notes that the 2010 ratio of Medicaid to Medicare prescriptions at independent pharmacies is 16 to 30, respectively, and that ratio has been used to split the 44% between the programs. "NCPA Digest Finds Independent Community Pharmacies Reducing Health Costs Through Generic Use, Patient Counseling," NCPANet.org, October 10, 2011, <http://www.ncpanet.org/index.php/news-releases/1166-ncpa-digest-finds-independent-community-pharmacies-reducing-health-costs-through-generic-drug-use-patient-counseling->.
- [5] Adam J. Fein, "Chains Win Big in 2009," DrugChannels.net, April 15, 2010,
<http://www.drugchannels.net/2010/04/chains-win-big-in-2009.html>.
- [6-10] Letter from the CBO to Majority Leader Harry Reid, November 18, 2009,
http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10731/reid_letter_11_18_09.pdf, Table 3. "Medicaid & CHIP" is assigned to Medicaid. "Employer" is assigned to TPP. "Nongroup & Other" is divided based on note c. Half is assigned to TPP, and all "Nongroup & Other" change is assigned to TPP. The remainder of "Nongroup & Other" is assigned to Medicare. "Uninsured" is assigned to Cash.
- [11-14] Centers for Medicare and Medicaid Services, "Total Medicare Beneficiaries with Prescription Drug Coverage," as of February 16, 2010, <http://www.cms.gov/prescriptiondrugcovgenIn>. "Medicare Part D" is assigned to Medicare Part D. "Retiree Drug Subsidy," "FEHBP Retiree Coverage," "Active Workers with Medicare Secondary Coverage," "Other Group Coverage," and "Medigap and other sources" are assigned to TPP. Figures are multiplied by the share of Medicare enrollees that have met the age criteria for Medicare enrollment in 2010. CMS, "Medicare Enrollment: National Trends: 1966-2010,"
<http://www.cms.gov/MedicareEnrpts>.
- [15] = sum of [11-14].
- [16-20] = corresponding [6-10] + [11-15].
- [21-24] = corresponding [1-4] * [5] / [16-19].
- [25] = corresponding [5] / [20].

Exhibit B: Present Value of Cost Projections for Antitrust Waivers to Independent Pharmacies

		Nominal [a]	Net Present Value Given 10% Discount Rate [b]		
		All	Rural pharmacies	All	Rural pharmacies
	Base Revenues for Cost Simulation				
[1]	Independent pharmacy third-party payer (TPP) prescription sales (\$M)	262,454	136,476	197,362	102,628
	Expected Cost Increases as a Result of H.R. 1946				
[2]	Increase prices such that gross margins on TPP equal those on cash transactions (\$M)	51,548	26,805	39,705	20,646
[3]	Increase prices on TPP transactions by 20% (\$M)	20,215	10,512	15,571	8,097
[4]	Increase prices such that gross margins on TPP increase to North Dakota requested rate (\$M)	9,824	5,109	7,567	3,935
[5]	Increase prices such that gross margins on TPP equal those on cash transactions	19.6%	19.6%	20.1%	20.1%
[6]	Increase prices on TPP transactions by 20%	7.7%	7.7%	7.9%	7.9%
[7]	Increase prices such that gross margins on TPP increase to North Dakota requested rate	3.7%	3.7%	3.8%	3.8%
	Resulting Total Independent Pharmacy Prescription Sales				
[8]	Increase prices such that gross margins on TPP equal those on cash transactions (\$M)	314,002	163,281	237,067	123,275
[9]	Increase prices on TPP transactions by 20% (\$M)	282,669	146,988	212,933	110,725
[10]	Increase prices such that gross margins on TPP increase to North Dakota requested rate (\$M)	272,278	141,585	204,930	106,563

Sources:

[1-4, 8-10][a] Exhibit A. Nominal amounts are sums of Years 1-5.

[1-4, 8-10][b] Exhibit A. Present values are found by summing $\frac{(\text{nominal})}{(110\%)^{(1/n)}} \text{ for Years 1-5, where } n = \text{Year.}$

$$[5] = [2] / [1].$$

$$[6] = [3] / [1].$$

$$[7] = [4] / [1].$$