Dechert LLP

Independent Pharmacies:

Myths Versus Reality

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CVSHealth

Introduction

The independent pharmacy lobby has been warning about the dire financial situation of independent pharmacies for decades. Its alarmist claims over time are part of a well-worn playbook ignoring inconvenient real-world facts, including those in the lobby's own reports. Funded by thousands more independent pharmacies than there are Starbucks or McDonald's stores in the United States, the lobby claims that low reimbursement rates caused by PBM self-dealing have driven independent pharmacies into extinction. Accepting this story at face value, Federal Trade Commission ("FTC") Chair Lina Khan has regularly repeated the lobby's claims that independent pharmacies have "shuttered" because of PBM practices.[1]

The evidence, however, persistently proves the independent pharmacy lobby wrong. Despite claims of despair, the penetration rate of independent pharmacies has remained relatively stable over the past twenty years. Independents' share of U.S. retail pharmacies has remained steady at about 35% for more than a decade despite fierce competition among more than 60,000 retail pharmacies. Store counts have corresponded with retail sector trends. Likewise, profit margins reported by independent pharmacies have proven remarkably stable and healthy.

Moreover, independent pharmacies charge much higher prices than peers. Ordinary-course documents and data show year after year that independent pharmacies, compared to national chains and other pharmacies, charge Caremark much higher prices. The price difference is significant. The impact on Caremark's commercial clients alone exceeds $300 million annually. Even while charging these high prices, the data show independent pharmacies maintain a high share.

Independent pharmacies understandably dislike PBMs, who work to protect plan sponsors, including American employers and unions, from efforts by independent pharmacies to charge even higher prices to consumers. That is why the lobby devotes substantial resources to telling lawmakers that independent pharmacy and consumer financial incentives align and that independent pharmacies need regulatory protection from PBMs. Independent pharmacy interests are not, however, consumer interests. Instead, the independent pharmacy lobby pushes for measures that would artificially inflate healthcare costs above competitive levels while lining its members' own pockets. But the funds to cover these higher prices would come from the pockets of consumers, including both employers and individuals.

In pushing for higher reimbursements and more advantageous business terms, independent pharmacies are not alone. Beyond banding together through lobbying groups, independent pharmacies also benefit from close relationships with the nation's largest drug wholesalers, which help them join their purchasing power and collusively bargain for higher prices. Given the number of independent pharmacies, PBMs are all but required to include independent pharmacies in even the narrowest of pharmacy networks. Independent pharmacy negotiations are not a story of David versus Goliath. If not for PBMs keeping drug prices in check, independent pharmacies would rip off consumers with even higher prices.

Independent pharmacies, like all businesses, would understandably like higher prices for the services that they offer. Yet claims that current reimbursement rates to independent pharmacies are unacceptably low—or lower than rates paid to other market participants, including PBM-owned pharmacies—are false. Giving in to independent pharmacy demands would have real costs and consequences for consumers. Policymakers must

understand that the independent pharmacy lobby does not have a reliable track record and is not an unbiased observer. Objective data have consistently disproven its claims. And objective data show that patients and plan sponsors will be the ones faced with rising costs if the persistent demands of the independent pharmacy lobby for higher reimbursement rates are met.

This paper proceeds in two parts. First, this paper shows that past warnings about the demise of independent pharmacies have not materialized. For years, independent pharmacies have maintained about a 35% share of U.S. retail pharmacies. Second, this paper demonstrates that independent pharmacies charge higher prices and explains why, highlighting the array of sophisticated groups that collectively negotiate for and coordinate independent pharmacies in rate negotiations. The price gap between independent pharmacies and peers is substantial, leading to greater costs borne by consumers. Independent pharmacies are not the victims of unfair or discriminatory pricing, as they have alleged to the FTC and others. Instead, independent pharmacies are a driver of higher consumer drug spend to the tune of at least hundreds of millions of dollars annually.

I. Dire Warnings from Independent Pharmacies Have Been Repeatedly Proven False

A. Independent Pharmacies Have Sounded the Same False Alarm for Decades

The independent pharmacy lobby has been offering alarmist predictions of doom for independent pharmacies for at least 15 years. As early as August 2006, the Coalition for Community Pharmacy Action proclaimed: "Make no mistake about it. Community pharmacies are in peril[.]"[2] Later that year, the Community Pharmacists Congressional Network similarly complained: "With many independents struggling to survive, there is a high probability that patients may soon see their neighborhood pharmacy disappear."[3]

Five years later, similar claims were made when independent pharmacy groups objected to the merger of Express Scripts and Medco. As a National Community Pharmacist Association ("NCPA") representative declared in testimony before Congress in late 2011: "This entity could single-handedly put pharmacies out of business, reducing competition and choice for consumers…This proposed merger threatens the very existence of community pharmacies and the individualized care that we provide."[4]

Independent pharmacy lobby allegations that PBMs would "put pharmacies out of business" did not end in 2011. In March 2014, the President of the Oklahoma Pharmacist Association warned that "[n]early 600 Oklahoma pharmacies are at risk of shutting down" because "[t]he pharmacy benefit managers are not willing to negotiate fairly."[5] A year later, the NCPA again warned that "[s]ubstantial problems undermine the viability of these small business health care providers, threatening patient access to their most trusted and often most convenient pharmacies."[6] Later in 2014, the NCPA President testified before Congress that "the overly concentrated and largely unregulated PBM industry is wreaking havoc on small business pharmacy owners like myself."[7]

Independent pharmacist groups have even bragged about the extent to which their warnings sounded like a broken record. By early 2017, for example, the NCPA boasted that it had already "been laser-focused for years on abuse by PBMs that threatens the viability of many community pharmacies."[8] And yet, without ever acknowledging its past, demonstrably wrong dire predictions, the NCPA just continued to warn that the business environment "makes it difficult for independent pharmacies to stay in business."[9]

The NCPA made the same point yet again in 2019 when it released a survey showing that "58% of respondents say based on current prescription reimbursement, they are somewhat likely or very likely to close their doors in the next two years.[10] And the NCPA was still singing the same song in 2020, when it warned that PBM practices "are killing Main Street, family-owned pharmacies that have been serving their communities for years, and sometimes decades."[11]

While these warnings about PBMs driving independent pharmacies out of business continued for well over a decade, the messaging from the independent pharmacy lobby has not always been entirely consistent. When complaining about the threat posed by PBMs in 2011, for example, the NCPA was adamant in sworn Congressional testimony that "we are not crying wolf."[12]

By contrast, more than a decade later, the NCPA features a cartoon pamphlet on its website called "The PBM Story" that depicts the following terrifying PBM wolf:

Source: NCPA, THE PBM STORY (2021), http://www.ncpa.co/pdf/PBM-Storybook-12pg.pdf

In this case, a picture certainly is worth a thousand words. Independent pharmacy groups have been crying wolf for the better part of two decades under the guise that supracompetitive prices paid to independents would somehow save plan sponsors and consumers money.

And here they go again. In December 2021, the NCPA CEO wrote to FTC Chair Khan "I think you will find that using the FTC's 6(b) authority to conduct an industry study of PBMs discriminatory reimbursement practices will be eye-opening in terms of how reimbursement pressures are shuttering small business independent pharmacies."[13] Then, in June 2022, the NCPA claimed a "PBM Shakedown" was "driving local pharmacies out of business."[14] And by October 2022, the NCPA had progressed to crudely depicting PBMs as "bloodsuckers" and handing out "F*** PBM" pins at an event headlined by Chair Khan to help NCPA raise money to fund its lobbying efforts against PBMs:[15]

The doom-and-gloom message pushed by the independent pharmacy lobby has not changed in many years. Yet as dataset after dataset shows, at no point have these warnings proven credible.

B. The Number of Independent Pharmacies Has Remained Stable

Despite dire warnings from the independent pharmacy lobby over the last two decades, multiple objective data sources—including two sources relied upon by the NCPA's own publications—show that independent pharmacies have remained strong over the same period. This resilience should not be surprising. Indeed, while consistently predicting its own downfall to support government regulation of PBMs from one side of its mouth, the independent pharmacy lobby has openly bragged about its success from the other. Two decades ago, for example, then-NCPA President Jim Martin declared: "I think that independent pharmacy can say like Mark Twain, 'The report of my death was an exaggeration.' We're far from dead. We're very much alive."[16] The same applies today, as the following datasets from NCPDP, IQVIA, and even the NCPA itself continue to show that reports of the independent pharmacy industry's death remain greatly exaggerated.

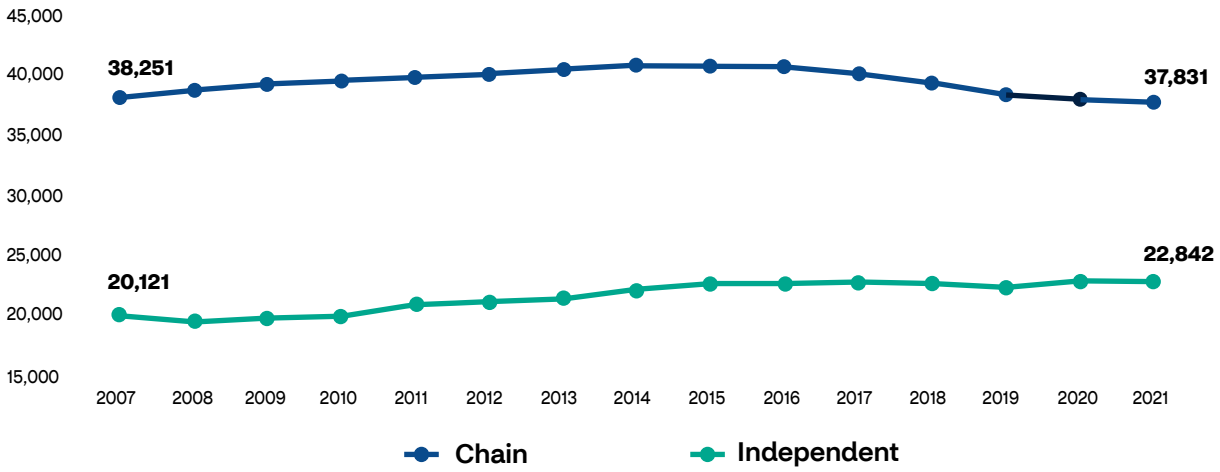
1. National Council for Prescription Drug Programs Data

The National Council for Prescription Drug Programs ("NCPDP") is a not-for-profit, standards development organization with over 1,500 members across the pharmacy services industry. NCPDP maintains a robust dataset tracking real-world pharmaceutical data that is relied upon for claims processing within the healthcare system and for other purposes.[17] In particular, the NCPDP makes considerable efforts to identify all pharmacy locations, advertising "incomparable verification processes" that allow users to access current information on new pharmacies, identify gaps in pharmacy networks, and maintain accurate pharmacy directories.[18]

As a measure of their reliability, NCPDP standards are regularly relied upon by government agencies and third-party payers. The Health Insurance Portability & Accountability Act of 1996, for example, required that the U.S. Department of Health & Human Services ("HHS") establish national standards for electronic transactions to improve the efficiency and effectiveness of the nation's health care system and, for all retail pharmacy transactions, HHS adopted standards set by the NCPDP.[19] This reliance on NCPDP standards adds to the reliability of the NCPDP data, with even the 6(b) PBM study order requesting data based on these NCPDP standards. As one academic source explains: "Retail pharmacies have an incentive to maintain their correct information with NCPDP because NCPDP supplies information such as addresses and unique pharmacy identification numbers to government agencies and third-party payers."[20] Because of its reliability and accessibility, NCPDP data also is regularly relied upon by government reports and academic papers.[21] Even the NCPA until recently relied on NCPDP data for its own pharmacy counts, although it subjected that data to unspecified adjustments.[22]

Instead of showing a decline in independent pharmacy counts over the years, the NCPDP data points in the opposite direction with a 13.5% increase in independent pharmacy locations between 2007-2021, as shown below.[23]

Chain and independent Pharmacy Counts (2007-2021)



Source: University of Iowa Summary of NCPDP Data

As this chart shows, the number of chain pharmacy locations fell by more than 1% over the same period, with a more significant drop over the last five years.[24] Academic papers have also observed independent pharmacy growth based on the same underlying NCPDP data.[25]

2. IQVIA Data

IQVIA, formed in October 2016 through the combination of IMS Health and Quintiles, maintains a set of national prescription sales data that has been described as the "industry standard source for national pharmaceutical prescription activity," which "measures demand in terms of dispensed prescriptions to consumers across three unique pharmacy channels: retail, mail service, and long-term care."[26] To assemble

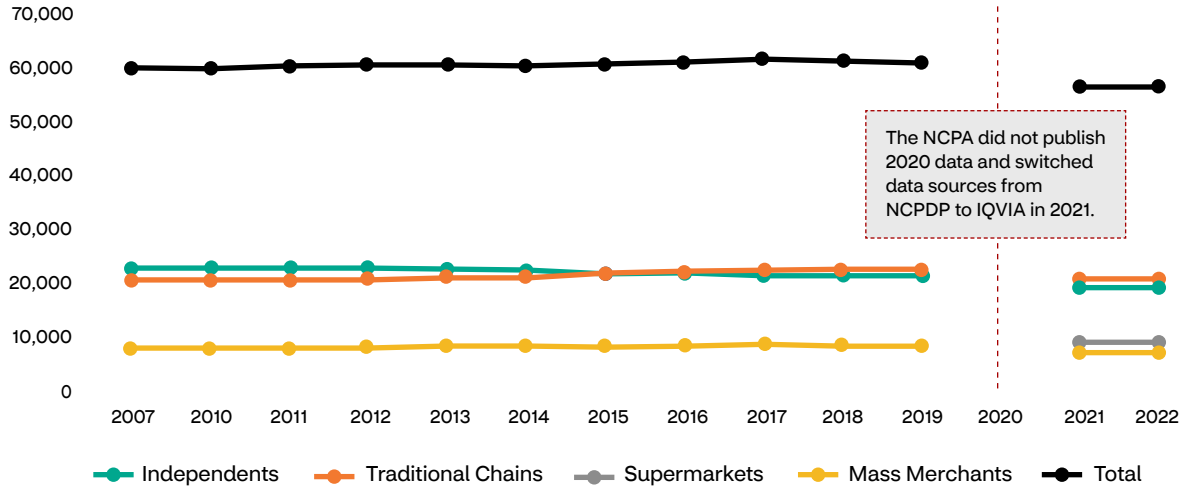
this data, IQVIA "collects new and refilled prescription data daily from sample pharmacies covering 93% of outpatient prescription activity, and projects this information to create a national estimate for all products, therapeutic classes and manufacturers."[27] IQVIA also tracks prescriptions by different groups of retail pharmacies, including "chains, mass merchandisers, independents, and food stores."[28]

The NCPA—which had long relied on its own analysis of NCPDP data—recently turned instead to IQVIA to track the number of independent pharmacies.[29] Like the NCPDP data, however, IQVIA data also refute the independent pharmacy lobby's drastic claims. As reported by Adam Fein's Drug Channels, "IQVIA data show that the total number of independent pharmacy locations has held relatively stable over the past 20 years."[30]

3. NCPA Data

The NCPA also regularly publishes reports tracking counts of independent pharmacies. Far from showing any dramatic decline, the trajectory of independent pharmacies in the NCPA data corresponds with other retail pharmacy formats, as shown below.

NCPA Pharmacy Count Data by Store Type (2009-2022)



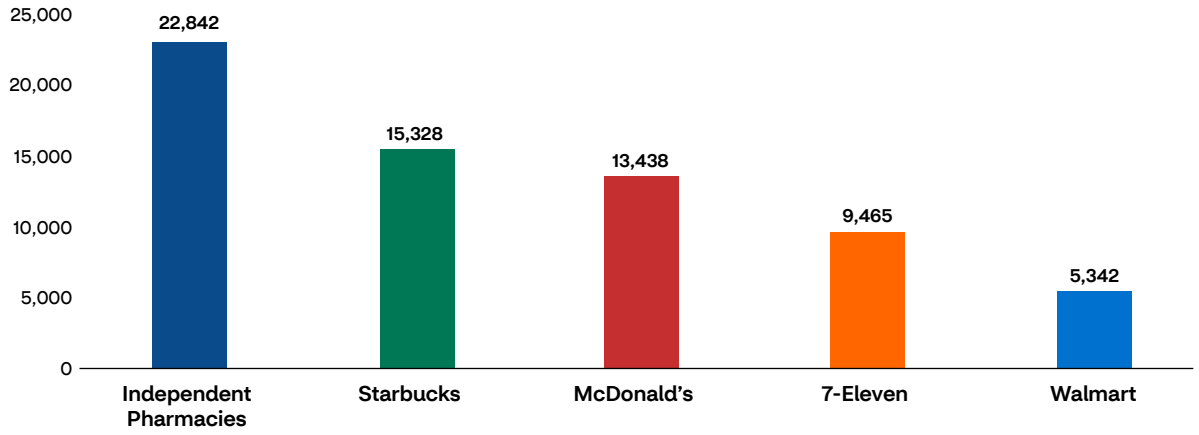
Source: NCPA Digests (2014-2022); no data published for 2020; data for 2022 is as of June 2022.

As this demonstrates, NCPA's own data show that independent pharmacies have maintained their position relative to other formats, such as chains and supermarkets, for more than a decade. These facts have not been missed by observers, who have noted that any recent trend of independent pharmacies downward in the NCPA data has matched a downward trend with "the total number of U.S. retail pharmacy locations."[31] The only notable "drop" in the NCPA count—for all pharmacies—occurs between 2019 and 2021, when NCPA switched its underlying data source from NCPDP to IQVIA, which both show consistent trends despite slightly different methodologies.[32] This reflects differences between the NCPDP and IQVIA datasets rather than any change in real-world facts.

C. Independent Pharmacy Margins and Shares Have Been Stable and Healthy

While the independent pharmacy lobby often couches its concerns in terms of patients' interests, each independent pharmacy is ultimately a business. As one past NCPA President explained: "While we all want the best outcomes for our patients, we are also in business. It is not a crime to make a profit. It is only fair that whatever payment system is in place provides pharmacists with a reasonable return on investment."[33] Indeed, the evidence indicates that "[o]wning a pharmacy, with all of its hassles and obligations, remains more lucrative than being [a pharmacy] employee."[34] Far from going extinct, there are more independent pharmacy locations today—even accepting the most conservative estimates from the NCPA—than locations for many of the most common retail chains, as shown below.[35]

Number of U.S. Locations

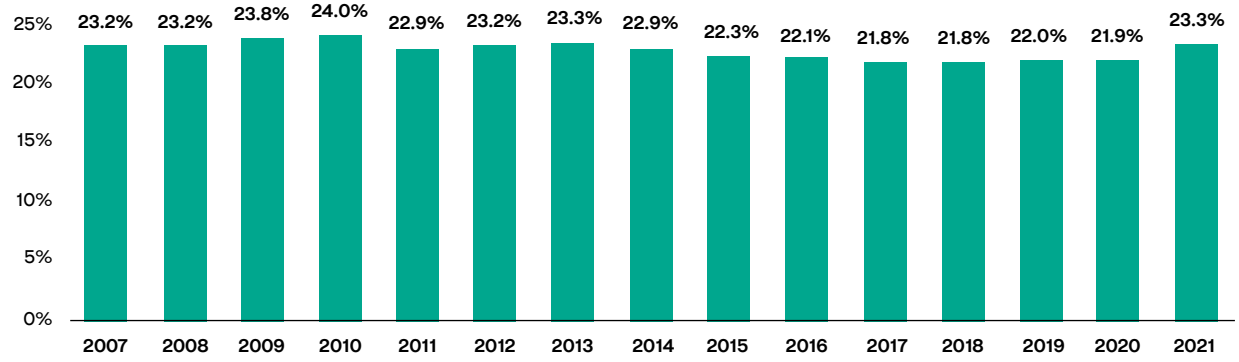


A deeper dive into the NCPA, NCPDP, and Caremark data help put this further into perspective.

1. NCPDP Data Confirm Stable Shares for Independents

As shown directly by NCPA's own data, independent pharmacies have had remarkably consistent gross margins for more than a decade.

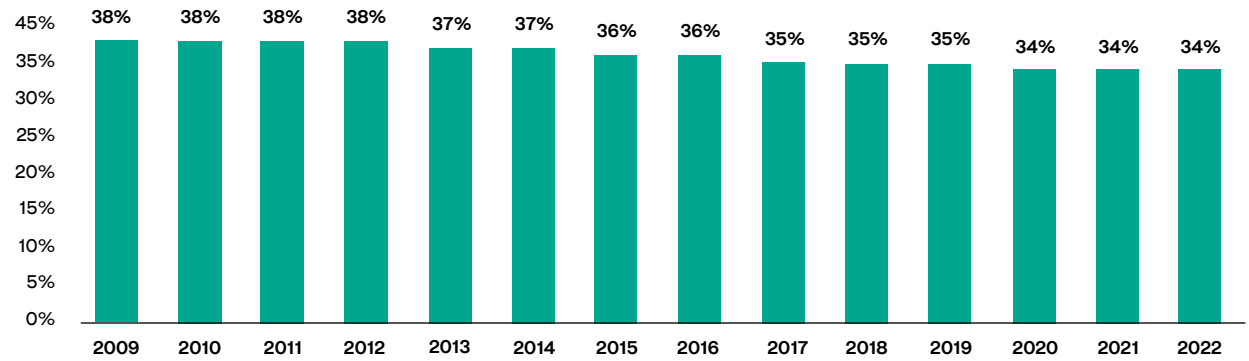
Independent Pharmacies Average Gross Margins (2007-2021)



Source: NCPA Digests (2008-2022).

NCPA data on the independent pharmacy share of U.S. retail pharmacies also shows a remarkable degree of stability over the same period.

Independent Pharmacies Share (NCPA Data 2009-2022)



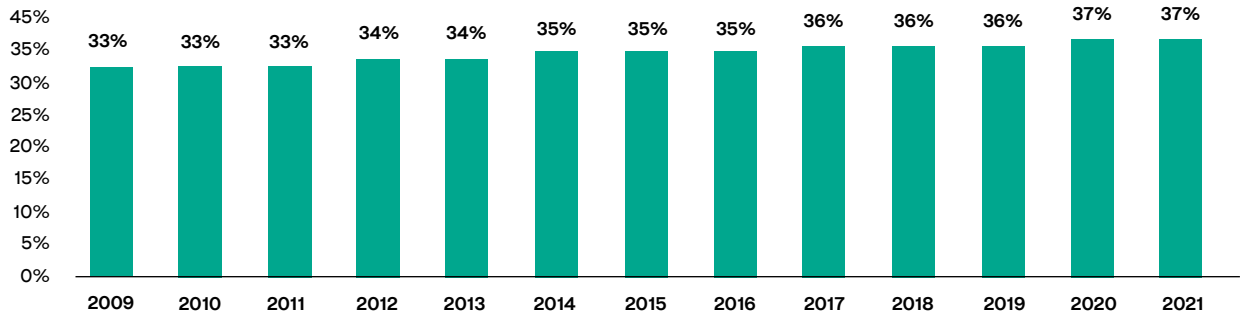
Source: NCPA Digests (2014-2021).

These stable margins and shares are at the very least inconsistent with NCPA messaging suggesting the end is near for independent pharmacies.

2. NCPDP Data Confirm Stable Shares for Independents

NCPDP data present a similar picture of stability but even shows slight *growth* in the share of independent pharmacies over the last decade.

Independent Pharmacies Share (NCPDP Data 2009-2021)



Source: University of Iowa Summary of NCPDP Data (2022)

This data sharply contrasts with the false claim that independent pharmacies are all closing their doors.

3. Caremark Data Also Confirm Stable Shares for Independents

Consistent with the NCPA and NCPDP data above, data on the composition of Caremark networks confirm that independent pharmacies comprise a large portion of in-network pharmacies. Caremark, of course, is not alone there. Express Scripts, for example, recently presented data showing that independent pharmacies account for 35% of its retail pharmacy networks.[36] Independent pharmacies account for even higher portions of Caremark's networks.

Caremark's most popular pharmacy network by far is its national network, which is a network of more than 60,000 pharmacies that covers more a majority of members enrolled in commercial plans. Independent pharmacies account for about 41% of pharmacies in Caremark's national network. Beyond that, Caremark's most popular "narrow" or "tightly-managed" network is referred to as Advanced Choice. As that network excludes Walgreens, independent pharmacies account for even a larger share.

In terms of drug spend, which can vary based on pharmacy hours of operation, staffing levels, mix of drugs dispensed, population density (e.g., rural vs. urban), and numerous other factors impacting a pharmacy's overall volume of business, independent pharmacies have a significant share of Caremark's book of business. Ordinary-course documents show that independent pharmacies have accounted for about one-third of Caremark's retail pharmacy spend. Independent pharmacies thus account for a very significant portion of Caremark's networks based on both pharmacy counts and spend that is broadly in line with, if not above, NCPA and NCPDP estimates.

D. "Pharmacy Desert" Allegations Are Based on Outdated and Misleading Data

Though remarkably stable, independent pharmacies are not immune to the macroeconomic challenges at times faced by all businesses, especially during economic downturns. This is particularly the case in rural areas, where independent pharmacy exits have garnered attention. In September 2022, for example, FTC Commissioner Bedoya lamented that "[t]oday, rural independent pharmacies are closing one after another after another."[37] "Right here in Minnesota," he declared based solely on a 2018 update from the University of Iowa, "thirty rural zip codes, from 2003 to 2018, lost their only pharmacy."[38] Commissioner Bedoya—based on the same 2018 report—similarly raised the following concerns in June 2022:

> *From 2003 to 2018, over 1,230 independent, rural pharmacies reportedly closed their doors. In that same time, 630 rural ZIP codes lost their only pharmacy. That included 28 ZIP codes in Oklahoma, 32 ZIP codes in Minnesota, and 46 ZIP codes in Texas, that did not have a single pharmacy as of 2018.*[39]

Respectfully, for these statements Commissioner Bedoya relies on a single source based on 10-to-20-year-old data that coincided with the Great Recession and does not reflect the trend shown in more recent data from the same source at the University of Iowa.

Consider the 30 zip codes in Minnesota that lost their only pharmacy from 2003 to 2018. 26 of those 30 exits—all but four—took place between 2003 and 2013, a period during which the United States faced a substantial economic recession affecting many different businesses.[40] The fact that 26 zip codes lost their only pharmacy sometime between one and two decades ago does not suggest that "today" stores are "closing one after another after another." The same principle applies across the board. A full 61 percent of those exits in Oklahoma and 70 percent in Texas occurred before 2013.[41] Of all the rural zip codes that lost their only pharmacy between 2003 and 2018, 490 (or 78 percent) of those exits occurred before 2013.[42]

Importantly, these counts of rural pharmacy exits are not limited to independent pharmacies; instead, they include all pharmacies, including chain pharmacy exits,[43] which include CVS pharmacies and supermarket or mass merchant stores that generate most revenue from non-pharmacy sources. When zooming in on rural independent pharmacies in particular, "the sharpest decline occurred between 2007 and 2009, with a 7.2 percent decline in the number of these pharmacies (from 7,383 in January 2007 to 6,853 in January 2009)."[44] This time frame from over ten years ago is significant because it closely coincides with the Great Recession that wreaked havoc on all retail businesses, especially in rural areas. Ignoring the impact of the Great Recession when considering those figures ignores basic economic realities completely unrelated to PBMs or the pharmacy industry more specifically.

"The Great Recession (December 2007 to June 2009) was the worst economic downturn in the United States since the Great Depression."[45] As one measure of its impact, Business Dynamic Statistics maintained by the U.S. Census Bureau indicate that the number of all companies operating in the United States declined by more than 5% between 2007 and 2010.[46] Moreover, over the same period, "very small establishments exited at a rate nearly twice as high as the economy average."[47] In part, this greater impact on smaller business may have been influenced by a profound disruption in small business lending, which "was significantly affected by the Great Recession" and associated bank failures.[48] Amid this enormous disruption, it is unreasonable to expect that independent pharmacies would have escaped unscathed. In this context, a 7.2% decline in rural independent pharmacies from 2007 to 2009 would be consistent with national trends, falling right between the average closure rate for all businesses and small businesses across all areas over the same period. Again, these closures during this severe economic downturn more than a decade ago do not reflect an on-going pattern today nor is there evidence attributing the closures to PBMs.

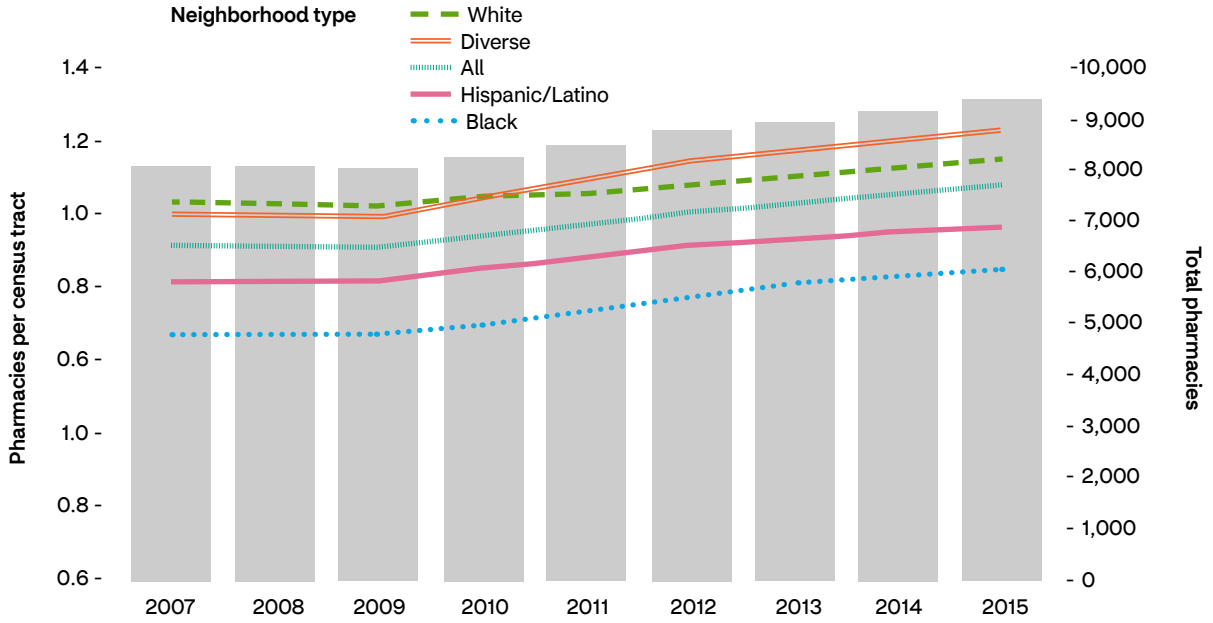
None of that is to diminish the very real problems that exist in some rural and urban areas that may limit access to affordable healthcare. Concerns have been raised, for example, about "pharmacy deserts," or neighborhoods with an average distance to the nearest pharmacy of 1.0 mile or more (or 0.5 miles or more in low-income neighborhoods where vehicles ownership is less widespread).[49] Commissioner Bedoya, for example, has raised concerns that independent pharmacy "closures are also happening in cities, creating pharmacy deserts where low-income people, who rely on walking and public transportation, have nowhere to go to get their medicine."[50] Commissioner Bedoya alleges that "[a] recent study of the 30 biggest cities in the country found that Black and Latino neighborhoods were consistently less likely to have a pharmacy – and that study tied those closures to the rise of PBMs."[51] Here again, however, Commissioner Bedoya relies on a single source with stale data. Even so, the study concludes that the number of pharmacies increased in Black and Latino neighborhoods.

Although published recently, the Health Affairs study cited by Commissioner Bedoya rests entirely on data covering the period between 2007 and 2015.[52] In other words, the "recent study" uses data that is more than eight years old. Moreover, the study explains that "the total number of pharmacies increased overall in all types of

neighborhoods" during that period.[53] Far from showing a dire picture of pharmacy closures, the first exhibit to the study – which pairs pharmacy count data maintained by the NCPDP with demographic data from the American Community Survey – presents the following unambiguous portrait of across-the-board pharmacy growth across all neighborhood categories tracked in the 30 biggest cities in the country.[54]

Exhibit 1

Pharmacy availability in the 30 most populous US cities, by neighborhood type, 2007-15

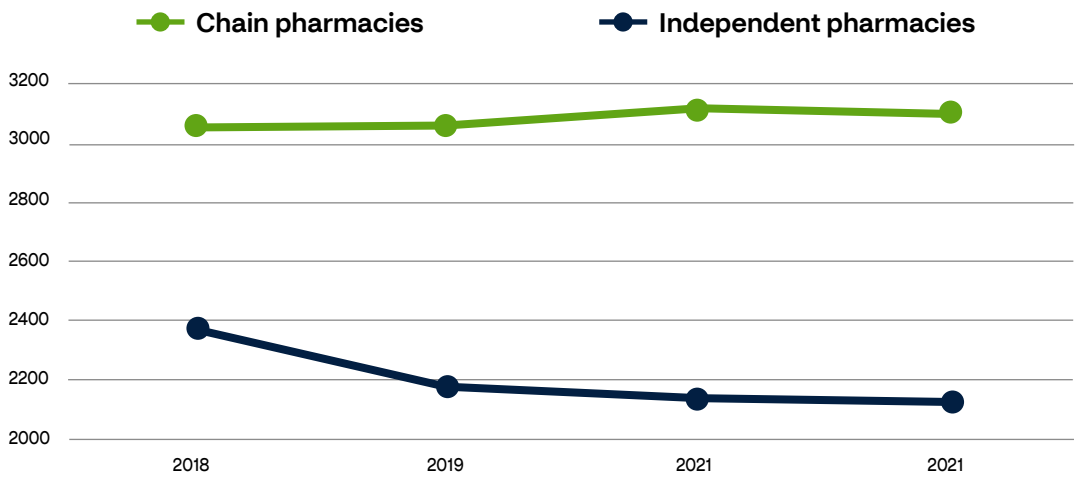


In addition, contrary to Commissioner Bedoya's statement, nothing in the study "tied" pharmacy closures to the rise of PBMs. Instead, the authors at most speculate that PBMs contribute to lower pharmacy prices, which could possibly in turn be "expected" to lead to pharmacies closing: "Closures and the resulting pharmacy deserts are expected to increase because of the growth of pharmacy benefit managers, which contribute to lower reimbursement rates to pharmacies."[55] The study does not present any specific data or evidence tying pharmacy pricing levels following PBM negotiations to pharmacy closings. In fact, the study did not even show a decrease in pharmacy counts over the study period or an increase in the number of pharmacy deserts. And as NCPA's own data shows, independent pharmacy margins have been practically unchanged during the period of the Health Affairs study and beyond.[56]

Moreover, this evidence-free attempt to somehow blame pharmacy deserts on PBMs ignores the fact that concerns about retail deserts are not unique to retail pharmacy services. Similar concerns have long been raised, for example, about other retail industries such as "food deserts" (or "areas where people have limited access to a variety of healthy and affordable food")[57] and "banking deserts" (or "areas without sufficient access to bank branches").[58] The existence of retail "deserts" is alleged in many sectors and may be part of broader economic patterns in affected areas completely unrelated to PBMs. This is a particular concern in minority communities; as McKinsey has found: "Black consumers continue to be underserved in areas such as food, housing, healthcare, broadband, and banking."[59] Where these broader problems exist across the board, there is no evidence tying them to PBMs. PBMs are not responsible for food, banking, housing, or broadband deserts, and they are not responsible for alleged pharmacy deserts, either.

Commissioner Bedoya's concerns about independent pharmacy closures—almost entirely based on a 2018 update from the University of Iowa—are also inconsistent with the University of Iowa's most recent update to this study in August 2022.[60] As shown below, far from showing a continued decline in rural independent pharmacies since 2018, the number of independent pharmacies in the most rural "non-core" areas edged up between 2018 and 2021, even as the number of chain pharmacies slumped in those areas over the same period:[61]

Number of Pharmacies in Non-Core Area



At the same time, even the decline of chain pharmacies in these non-core rural areas can be deceptive, as described by Professor Fred Ullrich of the University of Iowa:

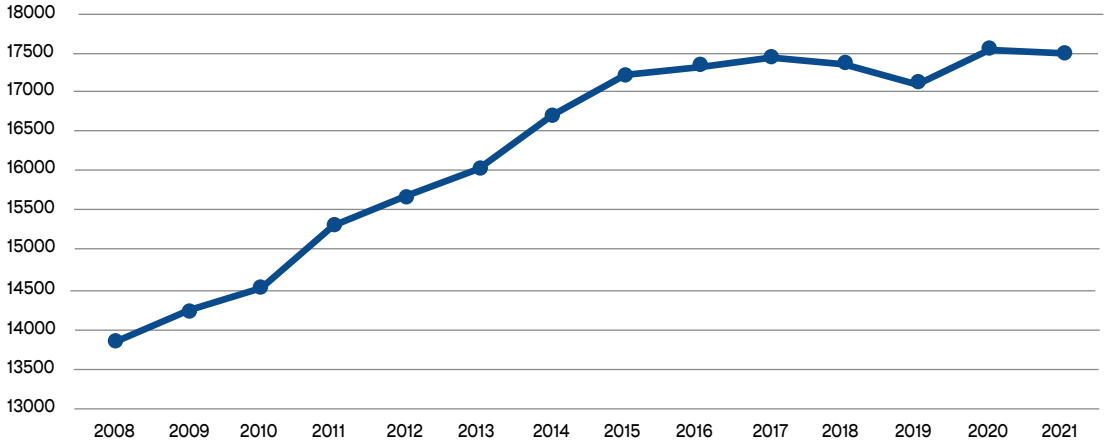
> The issue in many rural locations...was that several large retailers closed their operations entirely. For example, there was a regional retail chain named Shop[k]o, kind of like a smaller regional Walmart, that in 2019 announced it was closing department stores in 360 locations. These were largely rural locations. Shop[k]o had a metropolitan presence, but it was largely known in the Midwest for serving rural, smaller communities. Many of those stores that they closed also contained a pharmacy. Thus, the pharmacy closure had little or nothing to do with the pharmacy's performance itself.[62]

This one-time event—the bankruptcy liquidation of a former Big Box store that also operated pharmacies—should not be viewed as a barometer of pharmacy health in rural areas.

Quite to the contrary, these "chain closures actually created some opportunities in some rural areas."[63] In the Wisconsin towns of Stevens Point and Plover, for example, independent pharmacies quickly moved in to fill the gaps left by Shopko closures.[64] Around the same time, approximately 1,300 miles away in Bridger Valley, Wyoming, a former Shopko pharmacist worked with the South Lincoln Medical Center to open a new pharmacy in place of the former Shopko that was previously the only pharmacy in the town of 6,000 people.[65] And in between Plover and Bridger Valley, pharmacist Bill Mather opened yet another a new pharmacy to replace the Shopko in Greenfield, Iowa, that had previously been the only pharmacy in town.[66] These are just several examples of how independent pharmacies were quick to enter areas affected by the Shopko bankruptcy. This raises an important point: while it is easy to count pharmacy closures, policymakers should take note of all the new pharmacies opening as well, in addition to increased online mail order options, including from Amazon.

Along the same lines, the 2022 University of Iowa update shows another important trend: the tremendous growth of independent pharmacies in metropolitan areas since 2008. Indeed, while the University of Iowa's analysis of NCPDP data shows that the count of chain pharmacy locations in metropolitan areas declined by nearly 2% over that period, the number of independent pharmacies grew by 26.5%, as shown below. [67]

Number of Independent Pharmacies in Metropolitan Areas



Source: University of Iowa Analysis of NCPDP Data (Aug. 2022)

The data demonstrate how, far from extinction, independent pharmacies have thrived and enjoyed above average growth in metropolitan areas in recent years.

II. Independent Pharmacies for Years Have Successfully Negotiated High Prices

At their core, the independent pharmacy lobby's complaints relate to their purportedly inability to negotiate high enough pricing. Like their repeated predictions of doom, however, the independent pharmacy lobby's claims of unfairly low pricing have repeatedly been proven false.

A. Joint Selling Groups Run by Fortune 50 Companies Help Independent Pharmacies Negotiate High Prices

Contrary to the narrative pushed by the independent pharmacy lobby, the relationship between independent pharmacies and PBMs is not a story of David versus Goliath. Far from it. About 80 percent of independent pharmacies belong to group selling organizations referred to as pharmacy services administrative organizations ("PSAOs").[68] Today, the three largest PSAOs provide services to over 17,000 independent pharmacies.[69] Each of these PSAOs are run by some of the world's largest companies, and together they allow independent pharmacies multiple competing avenues to jointly negotiate prices.

Price Negotiator	Fortune 500 Rank	PSAO	No. of Pharmacies
AmerisourceBergen	10	Elevate Provider Network[70]	>5,200
Cardinal Health	15	LeaderNet[71]	>5,400
McKesson	16	Health Mart Atlas[72]	>7,000[73]

The scale of these PSAOs alone is noteworthy. The number of independent PSAO members of McKesson's PSAO alone, for example, vastly exceeds the network of pharmacies operated by Walmart or Rite Aid.[74] The AmerisourceBergen and Cardinal Health PSAOs each also have more than double the number of pharmacy members as Rite Aid. Moreover, the more than 17,000 pharmacy members of the AmerisourceBergen, Cardinal Health, and McKesson PSAOs together have about as many retail locations as CVS Pharmacy and Walgreens combined.[75] And beyond the top three PSAOs, additional PSAOs operating under the banners AlignRx, Pharmacy First (f/k/a Third Party Station), and EPIC Pharmacy Network, Inc., also collectively represent approximately 8,200 independent pharmacies.[76]

B. Independent Pharmacies Consistently Achieve High Prices

Caremark data and documents demonstrate that independent pharmacies have successfully negotiated high prices for themselves for years. Caremark ordinary course documents emphasize that "independents have historically been paid as well or better than chains."

To compare pricing by pharmacies, Caremark internally uses a metric referred to as the overall effective discount ("OED"). The brand drug discount, generic effective rate, dispensing fee, and the transmission fee all are factored into the OED used for price benchmarking. Over and over again, the OEDs show independent contracts lag chains – meaning independent pharmacies offer smaller discounts, which leads to higher prices for consumers. Indeed, ordinary course documents show that, as compared with specific pharmacy chains, PSAOs representing independent pharmacies consistently negotiated for and received the highest prices among all pharmacies in Caremark's national network between 2018 and 2022, holding each of the top seven spots for "most expensive pharmacy" each year:[77]

Caremark Commercial National Network Highest Prices by Provider (2021-2022)

	Rank	2021	2022
Highest prices	1	PSAO 1	PSAO 1
	2	PSAO 2	PSAO 2
	3	PSAO 3	PSAO 3
	4	PSAO 4	PSAO 4
	5	PSAO 5	PSAO 5
	6	PSAO 6	PSAO 6
	7	Chain 1	Chain 1
	8	Chain 2	Chain 2
	9	Chain 3	Chain 3
	10	Chain 4	CVS
Lower prices	11	CVS	Chain 5

Ordinary course documents show the same pattern for all pharmacies in Caremark's most popular narrow or tightly-managed network, referred to as advanced choice:[78]

Caremark Advanced Choice Network Highest Prices by Provider (2021-2022)

	Rank	2021	2022
Highest prices	1	PSAO 1	PSAO 1
	2	PSAO 2	PSAO 2
	3	PSAO 3	PSAO 3
	4	PSAO 4	PSAO 4
	5	PSAO 5	PSAO 5
	6	Chain 1	Chain 1
	7	Chain 2	Chain 2
	8	Chain 6	Chain 6
	9	CVS	CVS
Lower prices	10	Chain 4	Chain 4

Because reimbursement terms with independents are not as aggressive as the chains, plan sponsors end up paying higher prices due to independents. In the ordinary course of business, Caremark measured an annual increase of more than $300 million in commercial drug costs at independent pharmacies when compared to the chains as of November 2021. Yet even this sum understates the costs borne by consumers because of independent pharmacies negotiating much higher prices compared to peers because it is limited to Caremark's commercial national network. The harm to consumers well exceeds $300 million annually when accounting for Caremark's Advanced Choice and hundreds of other pharmacy networks offered to clients. The magnitude of consumer impact due to high independent pharmacy prices is likely even larger when accounting for prices independents charged to PBMs other than Caremark.

Many other ordinary-course documents similarly confirm that independent pharmacies charge high prices that are ultimately borne by plan sponsors and consumers. For example, one ordinary-course analysis performed by Caremark looked at all claims filled for one state plan for the period between November 2017 and October 2019 and found that the plan paid nearly $35 million more each year for drugs dispensed by independent pharmacies than it would have paid if the prescriptions had been dispensed at the lower rates accepted by chain pharmacies:

Category	Average Independent Pharmacy Cost Per Prescription as Compared to Chains	Annual Increased Cost from Independent Pharmacy Prescriptions
Brand	+ 17.8 %	$18.7 million
Generic	+ 55.0 %	$16.1 million

This example helps to illustrate the extent to which independent pharmacies demand higher reimbursement, with direct impacts on the plan sponsors like government health plans, employers, and unions that ultimately are responsible for those payments.

Likewise, independent pharmacies have persistently demanded higher reimbursement for participation in Medicare Part D pharmacy networks. Medicare Part D plans with preferred pharmacy networks significantly reduce drug spending and out-of-pocket expenses for seniors.[79] The PSAOs led by Fortune 50 companies have acted to limit independent pharmacy participation in these networks that make coverage more affordable. In 2020, AmerisourceBergen (Elevate)—an early adopter of this approach—described its recommended strategy as follows:

> *More often than not, patients pick their pharmacy and then pick their plan—not the other way around. In growing numbers, independent pharmacies are confirming that they can participate in standard cost-share networks, retain access to patients and be more profitable in the process.*[80]

This situation has proven not to be short-lived. By 2023, AmerisourceBergen (Elevate) was again encouraging members of its PSAO to forgo participation in preferred networks—for its sixth year in a row—and it was joined by McKesson (Health Mart Atlas) and AlignRx among others in advising their PSAO members to avoid most Medicare Part D preferred networks.[81]

In some ways, the decision by PSAOs and other independent pharmacies to eschew participation in Medicare Part D preferred networks was predictable as part of a concerted strategy by independents to snub preferred status to charge higher prices as non-preferred pharmacies in the same networks by taking advantage of CMS's any willing pharmacy rule, among other factors.[82] As FTC Staff observed in a 2014 letter to CMS, Medicare's any willing pharmacy provisions may "hinder the ability of plans to steer beneficiaries to lower-cost, preferred pharmacies" and "threaten to harm competition and Medicare beneficiaries" by "depriving" beneficiaries of the option to select narrow networks of preferred pharmacies in exchange for lower costs.[83] In line with the FTC Staff's concerns, independents have taken advantage of these provisions to charge higher prices rather than compete to lower costs for Medicare beneficiaries. These refusals to participate in preferred networks demonstrate the extent to which PSAOs and their members feel comfortable acting as price-setters and not price-takers in PBM negotiations.

C. State Audits Confirm Higher Independent Pharmacy Pricing

The independent pharmacy lobby has a long history of making claims that independent pharmacies receive discriminatory, low prices. In response to these claims, the states of Ohio, Arkansas, and Florida have each conducted audits comparing reimbursement rates for independent and PBM-owned pharmacies. These audits have consistently found that independent pharmacies receive higher or similar prices compared to PBM-owned pharmacies.

1. Ohio Government Audit

In 2018, in the wake of "growing concerns about declining reimbursements to independent community pharmacies," the Ohio General Assembly asked the Auditor of the State of Ohio to examine several issues concerning pharmacy benefits under its Medicaid program.[84] In response, the State's auditor conducted an analysis of retail pharmacy pricing and PBM performance for Ohio's managed Medicaid plans.[85] In connection with that effort, the Ohio Department of Medicaid retained HealthPlan Data Solutions, LLC to conduct a review that included analysis of pharmacy pricing.

When it completed its report in 2018, HealthPlan Data Solutions could not substantiate independent pharmacy lobby claims that PBMs compensated their own pharmacies with higher reimbursement rates. Instead, HealthPlan Data Solutions determined that independent pharmacies charged 3-4% more than CVS pharmacies for both brands and generics.[86] Yet far from accept these findings, the NCPA brazenly asserts in FTC comments—without any citation—that the Auditor of the State of Ohio "found discriminatory reimbursement because PBMs compensated their affiliated pharmacies at a higher rate than independent pharmacies."[87] The NCPA presumably believes that the FTC will not bother to read the auditor's actual report, which shows independent pharmacies charged higher prices.

2. Arkansas Government Audit

Also in 2018, in connection with efforts to push for new state laws regulating PBM price negotiations with pharmacies, the Arkansas Pharmacists Association CEO Scott Pace stood on the floor of the Arkansas state capitol building with what he claimed was evidence of "more than 270 popular drugs in the state" for which "CVS pays itself at least $60 per prescription more than it pays pharmacies."[88] Holding this supposed "evidence" in hand, Pace told the crowd: "This is an example of blatant self-dealing."[89] In response to these concerns, the State of Arkansas passed an act that authorized the Arkansas Insurance Commissioner "to license and regulate the activity of PBMs."[90]

In line with its authority under this new law, the Arkansas Insurance Commissioner promptly engaged an audit team in 2019 to investigate the allegation of pricing differentials between independent and PBM-owned pharmacies.[91] The audit evaluated differences in reimbursement rates paid to different categories of pharmacies for three health plans that had selected Caremark for PBM services.[92]

Far from corroborating the Arkansas Pharmacists Association's allegation, the audit found the exact opposite: "For the Empower [health plan] dataset the Independent Pharmacies were paid significantly more than the CVS Pharmacies."[93] Indeed, for generic prescriptions covered by this plan, the data showed independent pharmacies charged a whopping 33.34% more than their CVS-owned counterparts.[94] For the remaining two health plans in Arkansas, the audit found no statistical difference between reimbursements for CVS pharmacies and independent pharmacies.[95]

The audit findings in Arkansas were so damning for the independent pharmacy lobby that the NCPA disingenuously chose to ignore their existence entirely in the public comments it submitted to the FTC in 2022. The NCPA comments do conveniently regurgitate the claims made by the Arkansas Pharmacists Association in February 2018 about "over 200 examples of discriminatory reimbursement," falsely stating that "Arkansas" (rather than the Arkansas Pharmacists Association lobby) "found that the PBMs were paying themselves, on average, over $60 more per prescription than they were paying independent pharmacies."[96] The NCPA comments fail to mention, however, that an actual audit released by the Arkansas Insurance Commissioner refuted those claims. The NCPA was certainly aware of the audit (which is available on its website),[97] and its decision to put forward the claims of the Arkansas Pharmacists Association instead of the subsequent state audit results speaks volumes as to NCPA's lack of credibility. The NCPA's lobbying playbook is not deterred by real-world facts.

3. Florida Government Audit

Several months after Arkansas released the results of its audit, the Florida Agency for Health Care Administration also released a study that it had commissioned to analyze pharmacy pricing for its Statewide Medicaid Managed Care program.[98] The Florida study involved the analysis of 22.7 million claims for fifteen managed care plans over a 12-month period.[99] The study showed that independent pharmacies charged prices that are 9.8% higher than PBM-owned pharmacies. Broken down by prescription type, independents charged an average of 2.6% more for non-specialty branded pharmaceuticals and 36.4% more for non-specialty generics.[100]

The Florida study also provides compelling evidence that the lower pricing offered by PBM-owned pharmacies are associated with lower costs for plan sponsors. Overall, plans paid 12.5% less for prescriptions dispensed by PBM-owned pharmacies than prescriptions dispensed by independent pharmacies, including 2.5% less for non-specialty branded pharmaceuticals and 33.3% less for non-specialty generics from PBM-owned pharmacies.[101] Here too, however, the NCPA attempts to re-write history. Rather than engage with those results, the NCPA in its FTC Comments asserts that the study supports its claims of unfair pricing, but—in what has become a familiar pattern—fails to provide any direct citation to the audit report to substantiate its claim.[102] This conspicuous omission is explained by the fact that the actual data demonstrate independent pharmacies charged higher prices than PBM-owned pharmacies.

D. Independent Pharmacies Have a Long History of Illegal Collusion to Gain Higher Prices

While most independent pharmacies jointly price through the Fortune 50 PSAOs, others have engaged in joint selling activities challenged as illegal coordination. The FTC has repeatedly filed complaints against independent pharmacy groups over the last several decades for attempts to raise and fix prices for pharmacy services through threats of group boycotts and other collusive actions that harm consumers.

In 2012, for example, the FTC filed a complaint against a cooperative of approximately 350 pharmacy-owners in Puerto Rico that facilitated agreements to fix prices with payers and engaged in a concerted refusal to deal with payers that refused to pay higher prices.[103] This conduct was particularly egregious given that the FTC had previously filed a similar complaint against another association of 125 pharmacies in Puerto Rico for remarkably similar conduct that was alleged to have increased fees by 22%.[104]

FTC actions against similar coordinated coercive activity by independent pharmacies also have been filed against groups of pharmacies in Colorado,[105] Maryland,[106] Minnesota,[107] New York,[108] Oregon,[109] and Tennessee.[110] In the case of New York, an administrative law judge found that the collective fee demands of the pharmacists—coordinated through slews of local pharmaceutical associations and societies—cost the State of New York alone several million dollars.[111] These FTC actions should serve as a poignant reminder that pharmacy association campaigns for higher reimbursement, if successful, burden consumers with higher drug costs.

III. Conclusion

Independent pharmacies serve an important role in the delivery of healthcare. Despite overblown warnings, that role has remained largely unchanged for more than a decade. The overall number of independent pharmacies has remained relatively constant, thanks to stable profit margins and high prices. The evidence demonstrates that independent pharmacies, whether alone or in partnership with Fortune 50 PSAOs, have considerable staying power and high prices. Contrary to much of the independent pharmacy lobby's rhetoric, there is no crisis facing independent pharmacies.

What the independent pharmacy lobby has long coveted, however, is a world without managed pricing or the competitive pressure from PBM negotiations on behalf of payer clients and consumers. Yet what the lobby fails to mention is that lessened competitive pressure will result in even higher independent pharmacy prices and higher costs for consumers.

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