Are Independent Pharmacies in Need of Special Care? An Argument Against an Antitrust Exemption for Collective Negotiations of Pharmacists

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Are Independent Pharmacies in Need of Special Care? An Argument Against an Antitrust Exemption for Collective Negotiations of Pharmacists

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TABLE OF CONTENTS

INTRODUCTION ................................................................................................ 199
I. THE CONTOURS OF THE PHARMACEUTICAL SUPPLY CHAIN .................... 201
II. THE CURRENT LEGAL AND LEGISLATIVE FRAMEWORK ......................... 205
   A. THE CURRENT LEGAL LANDSCAPE ............................................................. 206
      1. ANTITRUST LAW .................................................................................. 206
      2. THE LABOR EXEMPTION ..................................................................... 209
   B. CONGRESSIONAL PROPOSALS FOR REFORM ....................................... 213
III. ECONOMIC ANALYSIS OF THE PROPOSED ANTITRUST EXEMPTION..... 216
   A. MARKET PRICE AND HEALTH CARE COSTS........................................... 216
      1. ANTITRUST DOCTRINE AND SELLERS’ CARTELS ............................. 217
      2. THE ARGUMENT OF COUNTERVAILING MARKET POWER IN RESPONSE TO MONOPSONY ........................................................................ 222
      3. QUESTIONING INDEPENDENTS’ ASSUMPTIONS: PBM MONOPSONY ..... 225
      4. EMPIRICAL EVIDENCE ......................................................................... 235
   B. QUALITY OF CARE .................................................................................... 237
      1. MARKET EFFICIENCY AND QUALITY OF CARE ................................. 238
      2. QUESTIONING INDEPENDENTS’ ASSUMPTIONS: QUALITY OF CARE ..... 244
CONCLUSION .................................................................................................... 250

* Yale Law School, J.D. expected 2013; Cornell University, School of Industrial and Labor Relations, B.S. 2009. I would like to thank the following individuals for all of their generosity as I conceptualized and wrote this Note: Carolyn Brokowski, Jamie Brooks, Christine Buzzard, Laura Keay, David Keenan, Elizabeth Kim, Robert Leider, Martin Rotemberg, and Anna Shabalov. Special thanks to the entire editorial team at the Yale Journal of Health Policy, Law, and Ethics and to George Priest, who supervised the project and provided insightful comments and guidance.
ARE INDEPENDENT PHARMACIES IN NEED OF SPECIAL CARE?

INTRODUCTION

The last half-century has witnessed a dramatic rise in both health care spending and associated efforts to rein in costs. As these factors and others coalesced, the "managed care revolution" was born. In the last several decades, health maintenance organizations (HMOs) — along with other managed care organizations (MCOs), such as preferred provider organizations (PPOs), point of service (POS) plans, and managed indemnity plans — have attempted to balance patients' quality of care against steadily rising health care costs. Although insurers greatly have improved access to care, they have faced sharp criticism from health care providers. Physicians and pharmacists, in particular, have accused insurers of using their unbridled market power to threaten providers' decision-making autonomy, endanger their livelihoods, and reduce the quality of patient care. As a result, a growing number of providers have begun to search for ways to bolster their bargaining power in order to negotiate more advantageous terms with MCOs.

As one solution for equalizing bargaining power, health care providers have proposed the relaxation of antitrust restrictions, thereby allowing these providers to join together with their competitors and collectively bargain with MCOs. Despite considerable support among the medical community for this approach, current antitrust and labor laws prevent providers from engaging in these activities. As a general matter, "[o]rganizations of independent [medical providers] who collectively mandate health-care prices fall directly within the scope of illegal price fixing. Likewise, a collective refusal by such groups to comply with the terms of managed care plans or a collective boycotting of managed care plans may constitute illegal trade restraints." Although the labor exemptions under the antitrust laws and the National Labor Relations Act

1 See generally Gail B. Agrawal & Howard R. Veit, Back to the Future: The Managed Care Revolution, 65 L. & CONTEMP. PROBS. 11 (2002) (discussing the factors that converged to produce the "managed care revolution").

2 See id. at 34 ("Health care costs continued to escalate. During the decades that followed the passage of the [Health Maintenance Organization (HMO)] Act, increasing numbers of employees had the opportunity to enroll in HMOs. The managed care revolution was underway.").


6 Id.
(NLRA) allow "employees" engaged in collective-bargaining activities to escape antitrust scrutiny, many health care providers are not likely to fall within this exemption.

As a result, these providers have turned to Congress to obtain their own antitrust exemption. Most recently, in May of 2011, New York Representative Anthony Weiner introduced the Community Pharmacy Fairness Act of 2011. If passed, this Act would grant independent pharmacies negotiating with a health plan over the provision of health care items or services the same preferable treatment as is afforded to employees engaged in collective bargaining with their employer under the NLRA. Weiner's bill followed on the heels of a similar proposal, introduced only one month earlier, to exempt, under certain conditions, all health care professionals engaged in contract negotiations with insurers from antitrust restrictions.

While numerous scholars have written about physicians' efforts to obtain an exemption to federal antitrust laws, the academic community has paid little attention to the unique circumstances of pharmacists. Pharmacists and physicians cannot be treated in the same fashion, as the two groups have distinct practices, insurance arrangements, and concerns. Independent pharmacists ("independents"), in particular, have fought hard for an antitrust exemption.

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7 National Labor Relations Act (NLRA), 29 U.S.C. § 157 (2006) (giving private-sector employees the "right to self-organization, to form, join, or assist labor organizations, to bargain collectively through representatives of their own choosing, and to engage in other concerted activities for the purpose of collective bargaining or other mutual aid or protection").

8 For a discussion of why this is the case, see infra Subsection II.A.2.


12 The definition of an "independent" pharmacist has differed somewhat depending on who has defined the term, when, and in what context. Essentially an independent is a pharmacy with a low market share and/or single (or small number) of store locations. See, e.g., Preserving Our Hometown Independent Pharmacies Act of 2011, H.R. 1946, 112th Cong. § 2(i)(3)-(4) (2011) (defining the term "independent pharmacy" to "mean[] a pharmacy that has a market share of—(A) less than 10 percent in any PDP region [as defined in section 168D-11(a)(2) of the Social Security Act (42 U.S.C. § 1395w-111(a)(2))]; and (B) less than 1 percent in the United States"); RUPRI CTR. FOR RURAL HEALTH POLICY ANALYSIS, UNIV. OF IOWA COLLEGE OF PUB. HEALTH, BRIEF No. 2011-5, INDEPENDENTLY OWNED PHARMACY
ARE INDEPENDENT PHARMACIES IN NEED OF SPECIAL CARE?

They argue that their weak bargaining power in relation to that of insurers has prevented them from effectively competing in the marketplace against chain and mail-order pharmacies to the detriment of their patients. In support of their position, independents have asserted that they are essentially powerless to oppose MCOs. Specifically, independents claim that MCOs have interfered with the patient-provider relationship, established draconian restrictions on pharmaceutical delivery, and reduced independents' reimbursements to unsustainable levels.13

This Note argues that the proposed antitrust exemption for independent pharmacies cannot be justified under the economic principles underlying antitrust law, on which independents have based their arguments. This Note begins by providing a novel analysis of the struggle of independent and community pharmacists in their efforts to obtain an antitrust exemption separate from that of physicians and other health care providers, including pharmacists working at supermarkets and chain pharmacies. In order to illustrate why independents feel such an exemption is needed, Part I lays out the landscape of the pharmaceutical supply chain. Next, Part II describes the current antitrust and labor laws to explain why independents currently are prohibited from collectively bargaining with MCOs. It then proceeds to outline the recent legislative initiatives to allow independents to bargain collectively with insurers.

Finally, Part III provides an analysis of the economic rationales put forth to justify the exemption initiatives identified in Part II. It explains — and ultimately rejects— independents' arguments that an antitrust exemption would improve patients' quality of care, while stabilizing or lowering health care costs. Specifically, it challenges independents' claim that there is sufficient evidence that MCOs reduce consumer welfare and undermine the efficiency of the health care market. This Note further argues that the proposed exemption would not be the appropriate method for remedying such a market failure, even if it could be said definitively to exist. In doing so, this Part concludes that in their quest for an antitrust exemption, independents have not compellingly demonstrated that an exception would achieve any societal goal that would trump the efficiencies created by free-market competition.

I. THE CONTOURS OF THE PHARMACEUTICAL SUPPLY CHAIN

To evaluate the proposed antitrust exemption, one must begin with an

13 Navarro & Cahill, supra note 3, at 24.
understanding of independents’ current position within the pharmaceutical industry. Numerous parties, intertwined through complex and often inconspicuous financial relationships, form the pharmaceutical supply chain. It is within this complicated framework that independents — located at the bottom of the pharmaceutical supply chain — claim that they are being squeezed in their negotiations with pharmacy benefit managers (PBMs).

The chain begins with the pharmaceutical manufacturers, who sell pharmaceuticals in bulk to wholesalers. These wholesalers, in turn, sell manufacturers’ drugs to pharmacies and hospitals, which finally distribute them to patients. When a consumer fills a prescription at a pharmacy, the pharmacy either accepts a cash payment directly from the patient or, alternatively, seeks reimbursement from the patient’s MCO or employer. Rather than directly reimbursing pharmacists who serve insurers’ customers, the vast majority of insurers have outsourced the administration of their prescription drug programs to PBMs, who typically are either stand-alone entities or subsidiaries of the MCOs. As PBMs “specialize[] in managing drug benefits,” the advent of PBMs has allowed insurers to manage drug costs more effectively. Acting as a middleman, the PBM reimburses the pharmacy for its expenditure and service, while simultaneously charging the patient’s MCO more for the expense.

One of the ways that the PBM earns profits is by maximizing the “spread”: the difference between the price that the PBM charges an MCO for a given drug and that which it reimburses the pharmacy. Thus, a PBM optimizes profits by seeking to charge an MCO the highest amount possible for a drug, while reimbursing a pharmacy as little as possible. PBMs’ primary mechanism for

14 For an excellent, detailed discussion of the pharmaceutical supply and the role of pharmacy benefit managers in the delivery of pharmaceuticals, see Fed. Trade Comm’n, Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacies (2005).
17 Peter R. Kongstvedt, Managed Care: What It Is and How It Works 90 (3d ed. 2009). By contracting on behalf of multiple MCOs, pharmacy benefit managers (PBMs) have more bargaining power than an individual MCO or sponsor would have on its own. See Howard Brody, Hooked: Ethics, the Medical Profession, and the Pharmaceutical Industry 63 (2007). This may be the case both with respect not only to negotiations with pharmacies, but also (and perhaps most importantly) with respect to negotiations with manufacturers. See infra notes 27–31.
19 Id.
20 PBMs compensate pharmacists for their services through a formula based on the drug’s average wholesale price (also known as the “AWP”) minus a percentage plus a dispensing fee. J.E. Pierce, 365 F. Supp. 2d at 127.
gaining bargaining leverage vis-à-vis the pharmacists with whom they contract is to create “pharmacy networks.” These consist of the retail pharmacies from which a given MCO’s customer can fill a prescription. A pharmacy can only join a network if it agrees to a low, yet guaranteed, reimbursement formula.

A given pharmacy will want to join as many networks as economically feasible in order to gain access to the PBMs’ client bases as well as to ensure stable and reliable sources of income. It can be devastating for a pharmacy to be excluded from a network because MCOs either force their patients to only purchase their drugs from network pharmacies or entice them to do so by offering significant financial incentives. Constraining their customers in this way allows MCOs to gain the bargaining leverage necessary to negotiate the low rates at which they reimburse pharmacies for supplying drugs and services to MCOs’ customers. At least according to independents, because the independent needs the PBM more than the PBM needs the independent, PBMs are able to force “take-it-or-leave-it” contracts—termed contracts of adhesion—on the independents with whom they contract.

A PBM is able to leverage bargaining power not only by controlling which pharmacies the MCO’s plan subscribers can frequent, but also by determining the pharmaceuticals that subscribers’ plans will cover. By engaging in these strategic negotiations, a PBM receives payments from manufacturers called “rebates,” which the PBM then passes on to the MCOs through below-market prices. While the PBM passes a portion of this rebate on to the MCO, it retains a fraction of the rebate for itself. It is through these additional transactions that independents, as discussed later, allege, in part, that the PBM is able to inflate its profits, reimbursing pharmacists at rates that do not reveal these additional

22 Id. at 4.
24 Health Strategies Consultancy, LLC, supra note 15, at 1–2.
27 S. Glied & K. Janus, Managed Care, in Health Systems Policy, Finance and Organization 332 (Guy Carrin et al. eds., 2009).
28 Id.; Regina Sharlow Johnson, PBMs: Ripe for Regulation, 57 Food & Drug L.J. 323, 328 (2002). The PBM must carefully balance its interest in charging MCOs the high prices necessary to earn profits, while still offering more competitive rates than its competitors; if a PBM sets its prices too high, an MCO will choose another PBM with more aggressive pricing to administer its plan. Fed. Trade Comm’n, supra note 14, at 8. See generally Terry Latanich, Pharmacy Benefit Manager “Spread”: A Reasonable, Rational, Realistic Business Practice, 44 J. Am. Pharmacists Ass’n 10 (2004) (discussing the business considerations surrounding the spread).
payments received from manufacturers.

A PBM obtains a rebate from a pharmaceutical manufacturer by developing a preferred list of medications called a “formulary.”29 Just as a pharmacy wants to be included in a PBM’s network, a manufacturer seeks to have its drug included on the PBM’s formulary. Having a formulary-listed drug drastically increases a manufacturer’s sales because an MCO either only reimburses patients for formulary-listed drugs or gives patients great financial incentive to purchase these drugs over others, such as by offering lower copayments.30 Thus, a manufacturer will offer a PBM a rebate if the PBM lists the manufacturer’s drug on the formulary over others31 and/or if the PBM is able independently to increase the manufacturer’s market share or sales volume.32

PBMs supplement the revenue received from both the spread and rebates by offering a variety of other services. Many of these services increase both efficiency within the pharmaceutical market and the provision of high-quality and safe health care services. First, PBMs charge MCOs directly for assisting pharmacies in checking whether a pharmaceutical poses a threat of drug interaction; whether a cheaper, generic drug substitute is available; and whether a consumer is currently eligible for a medication refill.33 Second, PBMs collect, package, and sell non-identifiable aggregations of data to manufacturers on their beneficiaries’ medication use.34 Finally, PBMs also administer their own mail-order pharmacies,35 allowing them to sell pharmaceuticals directly to consumers and cut out the middlemen retail pharmacies.36 Independents view this final practice as suspect, given the potential for conflicts of interest and what independents see as a serious challenge to health care quality — not to mention the vitality of the independent pharmacy industry.

In sum, one of the primary ways that a PBM maximizes the spread is by

29 Sandra J. Branda, Pharmaceutical Pricing Policies and Their Quality Implications, in ACHIEVING QUALITY IN MANAGED CARE: THE ROLE OF LAW 155, 157-59 (John D. Blum ed., 1997) (providing a general overview of the use of formularies); Sharlow Johnson, supra note 28, at 328–30. A committee, which is composed of physicians, pharmacists, the plan’s medical director, and external consultants, usually develops a formulary for a PBM based upon factors, including, but not limited to: cost, efficacy, safety, and patient-compliance rates. Id.

30 BRODY, supra note 17, at 63; David A. Balto, A Whole New World?: Pharmaceutical Responses to the Managed Care Revolution, 52 FOOD & DRUG L.J. 83, 85 (1997); Andrew S. Krulwich, The Response to Health Care Reform by the Pharmaceutical Industry, 50 FOOD & DRUG L.J. 1, 2–3 (1995); Sharlow Johnson, supra note 28, at 328.

31 Balto, supra note 30, at 85; Krulwich, supra note 30, at 2–3; Navarro, supra note 16, at 41; Sharlow Johnson, supra note 28, at 330.

32 Navarro, supra note 16, at 41.

33 FED. TRADE COMM’N, supra note 14, at 2.

34 Id. at 7.

35 See infra notes 218–220, 232–236.

36 Michael Johnsrud et al., Comparison of Mail-Order with Community Pharmacy in Plan Sponsor Cost and Member Cost in Two Large Pharmacy Benefit Plans, 13 J. MANAGED CARE PHARMACY 122, 123 (2007).
setting low reimbursement rates for pharmacies in exchange for admitting the pharmacy into the PBM’s network. In independents’ campaign for an antitrust exemption, the crux of their complaint is that they are being left out of this negotiation over reimbursement formulas. While the independent cannot bear to lose the insurer’s tens of thousands of plan subscribers as customers, the PBM conversely has little incentive to negotiate with the independent. As a result, PBMs allegedly force independents into contracts of adhesion, leaving them unable, or just barely able, to cover their costs.

Independents posit that they would be able to “level the playing field” vis-à-vis the PBMs if they were permitted to band together to negotiate collectively their reimbursement formulas. In other words, independents could obtain more favorable reimbursement rates, perhaps equal to or greater than those obtained by chain pharmacies, if they could together leverage their power to convince the PBM to raise prices to competitive levels. As the next Part will explain, however, current antitrust and labor laws prohibit independents from engaging in such collusion, thus leading them to turn to Congress to circumvent the confines of antitrust law.

II. THE CURRENT LEGAL AND LEGISLATIVE FRAMEWORK

This Part describes the current legal landscape, which prohibits independents from banding together to negotiate collectively with PBMs over reimbursement rates. First, Subsection II.A.1 outlines the antitrust legal framework, highlighting the goals from which this jurisprudence — at least in its current form — has sprung. This discussion forms the foundation necessary to understand the later discussion, in Part III, about both why it makes economical sense for such collective action to be prohibited and why a legislative exemption would be antithetical to the values that antitrust law is crafted to protect.

Next, Subsection II.A.2 briefly examines the relevant labor law. It proceeds to illustrate why independents currently do not fall under the NLRA antitrust exemption for “employees,” the applicability of which would obviate independents’ need for further immunity. Moreover, it explains why an antitrust exemption does not fit comfortably within the philosophy underlying and the structure of existing labor jurisprudence.

Having demonstrated that both antitrust and labor laws prohibit collective action by pharmacists, Section II.B finally presents independents’ current legislative proposals for reform. Specifically, it outlines the history and nature of the legislative initiatives that independents have championed to permit them to bypass the constraints that labor and antitrust law currently impose.
A. The Current Legal Landscape

1. Antitrust Law

Antitrust law is the primary mechanism through which the U.S. legal system safeguards competition. Cooperation among competing sellers is governed by section 1 of the Sherman Act, which declares illegal "[e]very contract, combination . . . or conspiracy, in restraint of trade or commerce."\(^{37}\) Implementing this landmark statutory provision, courts have differentiated between those trade restraints they view as inherently anticompetitive—and thus illegal per se—and those that they must evaluate under a fact-specific, rule-of-reason standard.\(^{38}\) Arrangements treated as per se illegal are those, such as horizontal price-fixing conspiracies, "whose nature and necessary effect are so plainly anticompetitive that no elaborate study of the industry is needed to establish their illegality."\(^{39}\) Not per se illegal, however, are agreements "[w]here the competitive effect of [the] alleged restraint is not readily apparent."\(^{40}\) This latter category of agreements "can only be evaluated by analyzing the facts peculiar to the business, the history of the restraint, and the reasons why it was imposed."\(^{41}\) A court will allow such an arrangement where the procompetitive effects outweigh the anticompetitive effects of the restraint at issue.\(^{42}\)

Since the seminal case United States v. Socony-Vacuum, cartels, or "group[s] of competitors who have agreed to limit or eliminate their competition in some economically relevant dimension,"\(^{43}\) have fallen into the former category of per se illegality.\(^{44}\) Such agreements are considered "so inherently pernicious that proof of the actual practice alone carries with it proof of the unreasonableness and illegality of the restraint."\(^{45}\) Under this standard, a group of pharmacists who band together to negotiate collectively with PBMs are effectively limiting or

39 Nat’l Soc’y of Prof’l Eng’rs v. United States, 435 U.S. 679, 692 (1978); see also N. Jackson Pharmacy, Inc. v. Caremark Rx, Inc., 385 F. Supp. 2d 740, 745 (N.D. Ill. 2005) (“Per se treatment is appropriate for a restraint ‘that falls into the category of agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm cause or the business excuse for their use.’” (citations omitted) (quoting Nw. Wholesale Stationers, Inc. v. Pac. Stationery & Printing Co., 472 U.S. 284, 289 (1985) (internal quotation marks omitted))).
40 N. Jackson Pharmacy, Inc., 385 F. Supp. 2d at 745.
41 Nat’l Soc’y of Prof’l Eng’rs, 435 U.S. at 692.
42 U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, supra note 38, at 71.
43 Peter C. Carstensen, Buyer Cartels Versus Buying Groups: Legal Distinctions, Competitive Realities, and Antitrust Policy, 1 WM. & MARY BUS. L. REV. 1, 9 (2010).
ARE INDEPENDENT PHARMACIES IN NEED OF SPECIAL CARE?

eliminating competition by fixing prices. This behavior is designated as per se illegal irrespective of any showing of the actual economic effect of the group’s activities.

While prohibiting pharmacists from forming cartels, current antitrust laws do allow certain types of collaboration. Under the 1996 Statements of Antitrust Enforcement Policy in Healthcare, pharmacies can in many instances form pharmacy-owned PBM joint ventures, joint buying arrangements for purchasing pharmaceuticals from wholesalers and manufacturers, and PPOs. Many of these arrangements are deemed procompetitive and thus legal under antitrust laws, as they improve efficiencies and health care quality by utilizing electronic health records and shared support mechanisms. Except for per se illegal agreements, such as those involving price fixing or boycotts, the Department of Justice (DOJ) and Federal Trade Commission (FTC) evaluate joint collaboration on a case-by-case basis under the rule-of-reason standard.

46 Janet D. Steiger, Comm’r, Fed. Trade Comm’n, Prepared Remarks Before the National Association of Retail Druggists (Apr. 22, 1996); see also Competition in the Healthcare Marketplace: Hearing Before Subcomm. on Consumer Protection, Product Safety, & Ins. of the S. Comm. on Commerce, Sci., & Transp., 111th Cong. 6–7 (2009) [hereinafter Healthcare Competition Hearing] (statement of Richard A. Feinstein, Dir., Bureau of Competition, Federal Trade Commission) (“The FTC recognizes that certain forms of collaboration . . . have the potential to foster proconsumer innovations in healthcare organization . . . Properly applied, antitrust standards distinguish between price-fixing by healthcare providers, which is likely to increase costs, and effective clinical integration among providers that has the potential to achieve cost savings and improve outcomes.”).

47 For example, as then-Commissioner, Christine A. Varney, explained as to pharmacy-PBM joint ventures:

[There may be significant procompetitive benefits from the emergence of pharmacy-owned PBM joint ventures. . . . Absent these ventures, community pharmacies might be unable to participate in PBMs, and PBM consumers might have less choice in their selection of a pharmacist.

These ventures may also improve the efficiency and competitiveness of their members by aggregating buying power. . . . A joint buying group alone could not achieve these savings, because only a PBM has the power to solicit discounts based on share shifting (e.g., preferential listing on the formulary). The savings from the joint buying arrangement should enable community pharmacies to compete more effectively.


49 Id. Furthermore, while typically courts deem most market-allocation, price-fixing, and bid-rigging agreements to be per se illegal, in the health care context, courts have been very generous in applying the rule-of-reason standard rather than a per se rule. This is because generally courts disfavor per se treatment “in the context of business relationships where the economic impact of certain practices is not immediately obvious,” Fed. Trade Comm’n v. Ind. Fed’n of Dentists, 476
standard considers a variety of factors in determining legality, including: (1) whether the pharmacies together have market power; (2) whether the activities produce efficiencies; and (3) whether the collaboration produces anticompetitive effects that outweigh any associated efficiencies.51

Dissatisfied with options for collaboration under the current antitrust laws, professionals have argued that the activities of “learned professions” do not constitute “trade or commerce” within section 1 of the Sherman Act.52 Despite historical support for such an approach,53 in Goldfarb v. Virginia State Bar, the Supreme Court switched course, ruling that there is no “support for the proposition that Congress intended any such sweeping exclusion” and that “[t]he nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act”54 Unable to escape antitrust law’s confines through the doctrine of

U.S. 447, 458-59 (1986). This same ambiguity often exists in the health care context. See Deborah Haas-Wilson, Managed Care and Monopoly Power: The Antitrust Challenge 77 (2003). Courts particularly rely on this principle in cases implicating medical judgment or health care quality. ABA Section of Antitrust Law, Antitrust Health Care Handbook 51 (4th ed. 2010). But see U.S. Dep’t of Justice & Fed. Trade Comm’n, supra note 38, at 3 (“The Agencies emphasize that it is not their intent to treat such [health] networks either more strictly or more leniently than joint ventures in other industries, or to favor any particular procompetitive organization or structure of health care delivery over other forms that consumers may desire.”).

50 In his testimony before the Senate Subcommittee on Consumer Protection, Product Safety, and Insurance, Richard Feinstein, FTC Director of the Bureau of Competition, stated that as long as a group of health care providers “cannot exercise market power,” collaboration “is unlikely to raise significant antitrust concerns, because it has the potential to benefit consumers rather than harm them.” Healthcare Competition Hearing, supra note 46, at 7 (statement of Richard A. Feinstein, Dir., Bureau of Competition, Federal Trade Commission). Courts have held that under the rule-of-reason standard, market power, or the power “to force a purchaser to do something that he would not do in a competitive market,” such as raise prices and reduce output, is a key consideration in determining legality. See, e.g., Ill. Tool Works Inc. v. Indep. Ink, Inc., 547 U.S. 28, 36 (2006); Eastman Kodak Co. v. Image Technical Servs., Inc., 504 U.S. 451, 464 (1992).


54 421 U.S. at 787. The Goldfarb Court ambivalently warned that it might later retreat back to its historically deferential posture towards professional activity. Id. at 788 n.17 (“The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts that originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently. We intimate no view on any other situation than the one with which we are confronted today.”).
Are Independent Pharmacies in Need of Special Care?

Professional immunity, some health care professionals, who fit squarely within the NLRA's independent-contractor exclusion, have argued instead that they fall within the labor exemption, which gives private-sector employees the right to organize.

2. The Labor Exemption

The NLRA gives private-sector employees the "right to self-organization, to form, join, or assist labor organizations, to bargain collectively through representatives of their own choosing, and to engage in other concerted activities for the purpose of collective bargaining or other mutual aid or protection." To reconcile the conflicting policies of labor and antitrust, Congress and the courts have created statutory and non-statutory exemptions to protect labor organizations and employees engaged in collective-bargaining activities from the reach of antitrust laws.

Only "employees," defined as those who "work[] for [an employer] for hire," are protected under the NLRA and thus receive antitrust immunity. Independent contractors who, in contrast to employees, are "entrusted to...
undertake a specific project but who [are] left free to do the assigned work and to
choose the method for accomplishing it,"\(^{59}\) are explicitly excluded from
coverage.\(^{60}\) While there is much controversy over the bounds of the independent
contractor exception and employers’ attempts to squeeze certain groups of
workers within it, independents fit squarely outside the bounds of immunity
under current labor jurisprudence.

The National Labor Relations Board (NLRB) applies the traditional common
law right-to-control test—the same test used to determine vicarious liability in
tort suits\(^{61}\) to distinguish employees from independent contractors.\(^{62}\) There is
some variation in application, but courts typically balance ten factors laid out in
the Restatement (Second) of Agency,\(^ {63}\) with a particular focus on “the employer’s
right to control the physical conduct of the individual.”\(^ {64}\) Where an employer has
control over both the manner and means of the worker’s labor, a court is likely to
find the worker to be an employee.\(^ {65}\) Oppositely, where a worker is able to

\(^{59}\) Black’s Law Dictionary 839 (9th ed. 2009).

\(^{60}\) Harvey M. Adelstein & Harry T. Edwards, The Resurrection of NLRB v. Hearst:
Independent Contractors Under the National Labor Relations Act, 17 U. Kan. L. Rev. 191, 192


\(^{62}\) Adelstein & Edwards, supra note 60, at 192–93. The Restatement (Second) of
Agency § 220 (1958) states that “[a] servant [i.e. an employee] is a person employed to perform
services in the affairs of another and who with respect to the physical conduct in the performance
of services is subject to the other’s control or right to control.”

\(^{63}\) These factors are:

a. the extent of control which, by the agreement, the master may exercise
over the details of the work;

b. whether or not the one employed is engaged in a distinct occupation or
business;

c. the kind of occupation, with reference to whether, in the locality, the work
is usually done under the direction of the employer or by a specialist
without supervision;

d. the skill required in a particular occupation;

e. whether the employer or the [worker] supplies the instrumentalities, tools,
and the place of work for the person doing the work;

f. the length of time for which the person is employed;

g. the method of payment, whether by the time or by the job;

h. whether or not the work is part of the regular business of the employer;

i. whether or not the parties believe they are creating the relation of master
and servant; and

j. whether the principal is or is not in business.

Restatement (Second) of Agency, supra note 62, § 220.

\(^{64}\) Nancy E. Dowd, The Test of Employee Status: Economic Relations and Title VII, 26 Wm.
& Mary L. Rev. 75, 80 (1984).

\(^{65}\) See John Bruntz, The Employee/Independent Contractor Dichotomy: A Rose Is Not Always
a Rose, 8 Hofstra Lab. & Emp. L.J. 337, 350 (1991) (“[T]he test which has been consistently

210
ARE INDEPENDENT PHARMACIES IN NEED OF SPECIAL CARE?

dictate the circumstances surrounding his employment, a court is likely to find the worker to be an independent contractor without statutory protection. Under the factors considered by the NLRA’s right-to-control test, pharmacists clearly constitute independent contractors rather than employees of MCOs or PBMs, and thus it would be anomalous for a court to bestow upon them the benefit of the labor exemption under existing labor jurisprudence. Whether one analyzes all ten factors or simply considers control over the manner and means of work, independent pharmacists are not employees of insurers, but rather are uncovered independent contractors. MCOs and PBMs restrict neither how pharmacists design and operate their businesses nor the services pharmacists provide. Furthermore, pharmacists are free to sell additional products, such as food and beauty supplies, as well as medication to cash-paying customers, without insurers’ approval. Likewise, insurers play no part in the provision of ancillary services, such as home delivery, which pharmacists offer without insurer compensation. While the NLRB has yet to consider formally whether pharmacists are “employees” of insurers, the NLRB has considered and rejected a similar argument in the physician-HMO context. Given that PBMs exert even less control over independents than HMOs do over physicians, the chances of the NLRB or courts construing the definition of “employee” sufficiently broadly to encompass independents are slim.

Moreover, not only does the labor exemption currently exclude independents from coverage, but independents’ stated goals are in tension with the motivations and values behind the labor-law framework within which this exemption is applied has been the common law right to control test. Control has been construed to mean control of both the result and the ‘manner and means’ by which the purported employee brings about the result.” (quoting Lorenz Schneider Co. v. Nat’l Labor Relations Bd., 517 F.2d 445, 451 (6th Cir. 1975)); Marc Linder, Dependent and Independent Contractors in Recent U.S. Labor Law: An Ambiguous Dichotomy Rooted in Simulated Statutory Purposelessness, 21 COMP. LAB. L. & POL’Y J. 187, 194 (1999).

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66 Dowd, supra note 64, at 80–81.
67 See supra note 63.
68 Pharmacists are subject to the same test for employee status as all other workers under the NLRA. Thus, of course, the NLRB may indeed consider pharmacists working at others’ pharmacies, such as chain stores and supermarkets, to be employees of the stores at which they work. They, however, still would not be employees of PBMs or insurers.
69 In AmeriHealth Inc./AmeriHealth HMO, 329 N.L.R.B 870 (1999), the NLRB considered whether a group of primary-care and specialty physicians were employees rather than independent contractors within the meaning of section 2(3) of the NLRA. Rejecting the argument that the HMO substantially controlled the physicians’ manner and means of work, the NLRB analogized the relationship to that between an advertising agency and a freelance advertisement photographer, as contrasted to a master and servant. Id. at 885. That said, the NLRB acknowledged that it was “not necessarily precluding a finding that physicians under contract to HMOs may, in other circumstances, be found to be statutory employees.” Id. at 870 n.1. For a more comprehensive analysis of how physicians have argued that they should be considered to be employees under the NLRA, see Micah Berman, Note, The “Quality Health Care Coalition Act”: Can Antitrust Law Improve Patient Care?, 53 STAN. L. REV. 695, 707–11 (2000).
situated. Passed during the New Deal — when policymakers’ feared a recurrence of the Great Depression — the NLRA is geared at bettering employees’ wages, hours, and working conditions; protecting the free flow of commerce by channeling the disruptive nature of industrial disputes into the collective-bargaining process; and preventing the recurrence of depressions. 70

Although it may be true that an antitrust exemption for independents would fulfill some of the NLRA’s goals, such arguments do not comport with those independents currently advance in arguing for an exemption—and thus would need to be assessed on their own terms. Rather, as explained below, 71 independents seeking an antitrust exemption purport to be motivated, at least primarily, by the desire to restore the market to competitive equilibrium and to bolster patient welfare and health care quality 72 — not to remedy disruptive disputes or to improve their own wages, even if at the expense of consumers. The drafters of the NLRA never intended the Act to address issues concerning product or service quality, let alone that of the crucial service of health care. As David Wales of the FTC testified before Congress:

The labor exemption . . . was not created to solve issues regarding the ultimate safety and quality of patient care . . . [but] to raise incomes and improve working conditions of union

70 Section 1 of the NLRA states in pertinent part:

The inequality of bargaining power between employees who do not possess full freedom of association or actual liberty of contract, and employers . . . substantially burdens and affects the flow of commerce, and tends to aggravate recurrent business depressions. . . . Experience has proved that protection by law of the right of employees to organize and bargain collectively safeguards commerce from injury, impairment, or interruption, and promotes the flow of commerce by removing certain recognized sources of industrial strife and unrest, by encouraging practices fundamental to the friendly adjustment of industrial disputes arising out of differences as to wages, hours, or other working conditions, and by restoring equality of bargaining power between employers and employees.

National Labor Relations Act (NLRA), 29 U.S.C. § 151 (2006); see also United States v. Silk, 331 U.S. 704, 713 (1947) (“The aim of the Act was to remedy the inequality of bargaining power in controversies over wages, hours and working conditions.”).

71 See infra Part III.

72 Community Pharmacy Fairness Act of 2011, H.R. 1839, 112th Cong. (2011); Quality Health Care Coalition Act of 2011, H.R. 1409, 112th Cong. (2011). In fact, not only is collective bargaining an inappropriate way to achieve such goals, but relying on collective bargaining to do so creates a perverse conflict of interests for those engaged in bargaining. If, in their negotiations with PBMs, pharmacists secured the types of benefits that would assist patients, such as broader formulary lists and reduced preapproval requirements, they presumably would have to compensate for these concessions through reductions (or smaller gains) in their own fee schedules and reimbursement rates. Awkwardly, this position forces pharmacists to choose between their own interests and those of their customers.
members. The law protects, for example, the United Auto Workers’ [UAW] right to bargain for higher wages and better working conditions, but we do not rely on the UAW to bargain for safer, more reliable, or more fuel-efficient cars. Congress has addressed those types of concerns in other ways, as well as relying on competition in the market among automobile manufactures to encourage product improvements.73

With little hope of exemption under the NLRA, health care providers, including independents, have turned to Congress, looking for a legislative basis for an antitrust exemption.

B. Congressional Proposals for Reform

Supported by a strong pharmacy lobby, several congressmen have introduced bills proposing antitrust exemptions for independent pharmacies.74 The year 2005 saw the introduction of the bipartisan Community Pharmacy Fairness Act of 2005.75 This bill, premised on an effort “[t]o ensure and foster continued patient safety and quality of care,” would have “ma[de] the antitrust laws apply to negotiations between groups of independent pharmacies and health plans and health insurance issuers in the same manner as such laws apply to protected activities under the National Labor Relations Act.”76 Limited in that it exempted federal programs from coverage,77 the bill was politically popular, with 113 cosponsors, but neither the House nor Senate passed the bill.78 Undeterred, advocates introduced the very similar Community Pharmacy Act of


76 Id. The bill defined an independent pharmacy as one that is “not owned (or operated) by a publicly traded company.” Id. § 2(h)(3).

77 Id. § 2(g) (exempting, for example, “[t]he Medicaid Program under title XIX of the Social Security Act (42 U.S.C. §§ 1396 et seq.)” and “[t]he SCHIP program under title XXI of the Social Security Act (42 U.S.C. §§ 1397aa et seq.).”)

2007\(^{79}\) and the Community Pharmacy Fairness Act of 2009\(^{80}\) during the following two Congresses. Again, the bills were fairly popular with 180\(^{81}\) and 99\(^{82}\) cosponsors respectively. While the 2009 iteration never emerged from committee,\(^{83}\) the House Committee on the Judiciary favorably received the 2007 version and recommended its passage.\(^{84}\) Despite these strong showings of support, neither bill became law.\(^{85}\) More recent iterations of the bill, including the Community Pharmacy Fairness Act of 2011\(^{86}\) and the Preserving Our Hometown Independent Pharmacies Act of 2011,\(^{87}\) have had less support.

In addition to lobbying for their own exemption, independent pharmacies also have campaigned with other groups, such as physicians, to press for an industry-wide exemption for all health care providers.\(^{88}\) Again, several iterations of essentially equivalent bills have been introduced in Congress over the years, with varying degrees of support,\(^{89}\) only eventually to die. The precise reason for


\(^{81}\) Steve Berberich, Druggists Unite to Speed Payments, GAZETTE (Md.) (July 20, 2007), http://www.gazette.net/stories/072007/businew211348_32356.shtml.


\(^{83}\) Id.

\(^{84}\) For the House Committee on the Judiciary’s report, see H.R. REP. NO. 110-898 (2008).


\(^{86}\) Community Pharmacy Fairness Act of 2011, H.R. 1839, 112th Cong. (2011). Similarly to the previous iterations, the bill exempts from antitrust coverage (with some express exclusions) “any independent pharmacies who are engaged in negotiations with a health plan regarding the terms of any contract under which the pharmacies provide health care items or services for which benefits are provided under such plan.” Id. § 2(a).


\(^{88}\) Health care providers are defined under the Quality Health Care Coalition Act of 2011 as those who “provide[] health care items or services, treatment, assistance with activities of daily living, or medications to patients and who, to the extent required by State or Federal law, possesses specialized training that confers expertise in the provision of such items or services, treatment, assistance, or medications.” Quality Health Care Coalition Act of 2011 § 3(5), H.R. 1409, 112th Cong. (2011).

\(^{89}\) While some iterations have been relatively successful — one bipartisan bill passed the House only to fail in the Senate — others have faced a greater struggle to gain traction. For example, in 2003, Representative Ron Paul (R-Tex.) introduced a revised Quality Health Care Coalition Act of 2003 in the House. See Quality Health Care Coalition Act of 2003, H.R. 1247, 108th Cong. (2003). This iteration of the bill, similarly to the Community Pharmacy Fairness Acts, explicitly renounced any impact on the NLRA, stating that “[n]othing in this [bill] shall be construed as changing or amending any provision of the National Labor Relations Act, or as affecting the status of any group of persons under that Act.” Id. § 3(b)(2). As a result, the bill’s provisions were broader than its predecessor in that the exemption was not limited to the activities
ARE INDEPENDENT PHARMACIES IN NEED OF SPECIAL CARE?

the bills’ respective failures is unclear — and, in the case of the 2009 iteration, may have had much to do with a lack of support from party leadership given its failure to be reported out of committee. Still, it is not implausible that the failures to pass were motivated by the economic arguments put forth by opponents of the bills, most notably the FTC, which strongly opposed the bills on the ground that they would not achieve the procompetitive and health care quality-enhancing benefits claimed by their supporters.

The statutory language of the most recent version of the bill, the Quality Health Care Coalition Act of 2011 suggests that, if enacted, it would include in its ambit both pharmacists working at chain pharmacies and independents. That said, only independents and their affiliated associations, such as the National Community Pharmacists Association, have testified on behalf of previous enjoyed by bargaining units under the NLRA. Instead, it stated: “Any health care professionals who are engaged in negotiations with a health plan regarding the terms of any [health care] contract ... shall, in connection with such negotiations, be exempt from the Federal antitrust laws.” Id. § 3(a). Again, the bill exempted many federal programs from its reach, id. § 3(c), but it gained much less traction than its 1999 predecessor and had only one cosponsor. See 150 CONG. REC. H6997 (daily ed. Sept. 9, 2004). Understated, in 2005, 2007, and 2009, representatives introduced similar bills. See Quality Health Care Coalition Act of 2009, H.R. 1493, 111th Cong. (2009) (introduced by Representatives Paul and Price); Quality Health Care Coalition Act of 2007, H.R. 3341, 110th Cong. (2007); Quality Health Care Coalition Act of 2005, H.R. 3074, 109th Cong. (2005). All three died in committee without hearings. See H.R. 3074 (109th): Quality Health Care Coalition Act of 2005, GovTrack, http://www.govtrack.us/congress/bill.xpd?bill=h109-3074 (last visited Nov. 13, 2012); H.R. 3341 (110th): Quality Health Care Coalition Act of 2007, GovTrack, http://www.govtrack.us/congress/bill.xpd?bill=h110-3341 (last visited Nov. 13, 2012); H.R. 1493 (111th): Quality Health Care Coalition Act of 2009, GovTrack, http://www.govtrack.us/congress/bill.xpd?bill=h111-1493 (last visited Nov. 13, 2012). On April 7, 2011, Representatives Ron Paul (R-Tex.), John Conyers (D-Mich.), and Jeff Miller (R-Fla.) introduced yet another iteration of the bill — this time the Quality Health Care Coalition Act of 2011. See H.R. 1409. Again, the bill purports “[t]o ensure and foster continued patient safety and quality of care by clarifying the application of the antitrust laws to negotiations between groups of health care professionals and health plans and health care insurance issuers.” Id. Like those bills previously introduced by Representative Paul, it does not intertwine the health care exemption with the NLRA’s labor exemption, keeping the two entirely separate and stating that the bill “shall not be construed as changing or amending any provision of the National Labor Relations Act, or as affecting the status of any group of persons under that Act.” Id. § 2(b)(2). The bill also exempts several federal programs from its reach. Id. § 2(c).

90 See generally William N. Eskridge, Jr., Interpreting Legislative Inaction, 87 MICH. L. REV. 67, 99 (1988) (arguing that because there are a “variety of reasons, unrelated to the merits or legislative support, for the failure of an idea or a measure in Congress,” little can be concluded from legislative inaction).

91 See generally id. (“The legislative agenda is severely limited; to gain a place on that agenda, a measure must not only have substantial support, but be considered urgent by key people (such as the President and/or the party leadership in Congress). ... A bill can effectively be killed by a hostile committee or subcommittee chair in either chamber.”).

92 See, e.g., supra note 73 and accompanying text; infra note 141 and accompanying text.

93 H.R. 1409. The text of the bill simply refers to all “health care professionals,” id. pmbl., § 2, and does not contain a provision exempting providers in excess of a given size. But see, e.g., Community Pharmacy Fairness Act of 2011, H.R. 1839, 112th Cong. § 2(i)(3) (2011).
versions of the bill, and the impact on larger pharmacies has been under-scrutinized. This is not surprising, as an antitrust exemption for Wal-Mart and Rite Aid to join together and collectively bargain with MCOs presumably would be politically unpopular.

Although no bill has yet become law and more recent iterations have enjoyed less success than those before them, the almost uninterrupted introduction of these bills, the tenacious lobby advocating their passage, and their bipartisan support and periods of near-success demonstrate that an antitrust exemption is a live, important issue deserving of serious scholarly attention. The next Part explores the substantive arguments for and against a legislative antitrust exemption to evaluate whether such protective legislation is warranted. After considering the economic realities of the pharmaceutical supply chain, conventional economic theory, and the principles underlying antitrust regulation, this Note concludes that these congressional proposals have, at least for now, met their proper fate.

III. ECONOMIC ANALYSIS OF THE PROPOSED ANTITRUST EXEMPTION

Certain antitrust exemptions, such as the labor exemption, are premised, at least in part, on the idea that the market at issue should be removed from the bounds of competition to achieve some ancillary societal goal at the expense of economic efficiency. In contrast, independents have met antitrust doctrine on its own terms. In other words, independents have not argued that the health care market should eschew economic efficiency as its overarching goal; rather, independents have argued that market imperfections prohibit unrestrained competition from best achieving this goal of efficiency. Specifically, the crux of independents’ argument is that an exemption would counteract failures and imperfections in the pharmaceutical market and that this improvement, in turn, would increase health care quality at equal or lower cost to consumers. This Part argues, however, that conventional economic theory and empirical data predict otherwise. Section III.A responds to independents’ claim that an exemption definitively would not increase health care costs. Section III.B addresses independents’ argument that an exemption would increase consumers’ quality of health care irrespective of any cost increases. After concluding that both of the arguments advanced by independent pharmacies are flawed, this Note reasons that an antitrust exemption is not wisely grounded in economic policy.

A. Market Price and Health Care Costs

Independents’ first argument for an exemption is premised on the notion that

94 For example, the labor exemption is largely premised not on economic arguments but rather on the principle that human labor is not a commodity. See Harry Shulman, Labor and the Anti-Trust Laws, 34 ILL. L. REV. 769, 774 (1940).
ARE INDEPENDENT PHARMACIES IN NEED OF SPECIAL CARE?

the pharmaceutical market suffers from heavily entrenched PBM monopsony, "[a] market situation in which one buyer controls the market."\(^95\) They allege that allowing independents to counteract this anticompetitive market power would bring the market back into equilibrium, keeping independents in business without passing additional costs on to consumers. Subsection III.A.1 applies conventional economic theory to show how an antitrust exemption for independents effectively would legitimize the formation of a sellers’ cartel and likely increase health care costs. Following a description of the argument of countervailing market power in Subsection III.A.2, Subsection III.A.3 concludes that an antitrust exemption cannot be justified on the ground that the creation of a bilateral monopoly would reduce the harmful effects of PBMs’ aggregation of market power. Finally, Subsection III.A.4 reinforces this economic analysis by showing that existing empirical data supports the conclusion that an exemption indeed would raise costs as conventional economic models predict.

1. Antitrust Doctrine and Sellers’ Cartels

Today, the foremost policy of U.S. antitrust law has become the protection of "competition, not competitors."\(^96\) As such, it prohibits cartelization activities, such as collective-bargaining agreements, which seek to immunize certain competitors from market forces at the expense of consumer welfare. Because the collective bargaining of independent pharmacies falls directly within the scope of this prohibition, the cartelization of independents would contravene the current policy underlying antitrust laws, such as that driving the enforcement of the


Monopsony is often thought of as the flip side of monopoly. A monopolist is a seller with no rivals; a monopsonist is a buyer with no rivals. A monopolist has power over price exercised by limiting output. A monopsonist also has power over price, but this power is exercised by limiting aggregate purchases. Monopsony injures efficient allocation by reducing the quantity of the input product or service below the efficient level.

96 It is ironic that this phrase, "competition, not competitors" has come to stand for modern antitrust policy of protecting consumer welfare and economic efficiency, given that the Supreme Court first used this phrase in Brown Shoe Co. v. United States, 370 U.S. 294, 344 (1962), a case that is criticized today as doing exactly the opposite: protecting small, locally owned businesses at the expense of economic efficiency. As the meaning behind the phrase has evolved over time, however, the Court has quoted this Brown Shoe language in numerous widely cited antitrust opinions of the modern era, including Leegin Creative Leather Products, Inc. v. PSKS, Inc., 551 U.S. 877, 906 (2007); Copperweld Corp. v. Independent Tube Corp., 467 U.S. 752, 767 n.14 (1997); Brooke Group Ltd. v. Brown & Williamson Tobacco Corp., 509 U.S. 209, 224 (1993); Atlantic Ritchfield Co. v. USA Petroleum Co., 495 U.S. 328, 338 (1990); and Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc., 429 U.S. 477, 488 (1977).
Sherman Act.

During the Warren Court era of the 1960s, antitrust law often focused on the protection of small business to the detriment of economic efficiency.\(^97\) The 1970s and 1980s, however, witnessed a shift in policy to the “Chicago School” line of thinking,\(^98\) which views consumer welfare as the sole legitimate objective of antitrust.\(^99\) In his canonical book, *The Antitrust Paradox*, Robert Bork put forth a multifaceted argument supporting the principle that the antitrust laws’ statutory language, legislative history, and structural features all point towards consumer welfare being the only tenable criterion on which antitrust should rest.\(^100\) Moreover, Bork maintained that the goal of consumer welfare as a legislative policy best “renders the law internally consistent,” “makes for ease of judicial administration,”\(^101\) and “permits courts to behave responsibly and to achieve the virtues appropriate to law.”\(^102\)

Under traditional economic theory, consumer welfare\(^103\) is highest when the

\(^97\) This populist ideology is embodied by Judge Hand’s *Alcoa* opinion:

> [G]reat industrial consolidations are inherently undesirable, regardless of their economic results. In the debates in Congress Senator Sherman himself in the passage quoted in the margin showed that among the purposes of Congress in 1890 was a desire to put an end to great aggregations of capital because of the helplessness of the individual before them. . . . Throughout the history of these statutes it has been constantly assumed that one of their purposes was to perpetuate and preserve, for its own sake and in spite of possible cost, an organization of industry in small units which can effectively compete with each other.


\(^100\) BORK, supra note 97, at 56–69.

\(^101\) Id. at 69.

\(^102\) Id. at 89. Another scholar who has vigorously championed consumer welfare as antitrust’s only guiding policy concern is Judge Richard A. Posner of the Seventh Circuit. Posner rejects populist concerns surrounding antitrust law, questioning smallness as a virtue and the merit of noneconomic arguments. See RICHARD A. POSNER, ANTITRUST LAW 2 (2d ed. 2001) (arguing that there is no “justification for using the antitrust laws to attain goals unrelated or antithetical to efficiency, such as promoting a society of small tradespeople, a goal that whatever its intrinsic (and very dubious) merit cannot be attained within the framework of antitrust principles and procedures”).

\(^103\) It is important to note that the term “consumer welfare” is a bit of a misnomer. The key inquiry is the total effect of consumer and producer surplus—not just that of consumers. See J. Thomas Rosch, *Monopsony and the Meaning of “Consumer Welfare”: A Closer Look at*
market operates under perfectly competitive, and thus non-regulated, conditions. Under perfect competition, the intersection of the market demand and the market supply curves determines the competitive market price and output. Each individual seller is a “price taker” in that it takes the market price as given and cannot unilaterally change the price of its goods by withholding or increasing output. Applying this model to the pharmaceutical industry, an individual pharmacist in a competitive market cannot unilaterally influence reimbursement rates or the quantity of sold pharmaceuticals. From an allocative efficiency standpoint, this outcome is socially optimal, maximizing the sum of consumer and producer surplus.

In contrast to the price-taking seller in a competitive regime, a cartel acts like a multiplant monopoly, with an ability to determine market price through restricting quantity. Because a monopolist is the only seller in the market, it faces the market’s downward-sloping demand curve. Therefore, while the competitive seller’s output is determined only by the price that he can demand for each unit, Weyerhaeuser, 2007 COLUM. BUS. L. REV. 353, 355 ("Judge Bork, like other Chicago School adherents, believed that consumer welfare could only be maximized when total (societal) surplus was maximized. In his view, antitrust policy and rules should guard against all practices and transactions creating allocative inefficiencies; thus, the antitrust laws could and would facilitate the maximization for consumer wealth in the aggregate without regard to distribution."). Although this Note proceeds using this definition of consumer welfare — that of allocative efficiency — it is important to recognize that this view is not shared by all. See id. at 354 ("To some, consumer welfare focuses on the effects of the anticompetitive conduct on consumers in the relevant market. According to this view, antitrust liability ultimately turns on whether the seller will have market power over consumers purchasing the output in the relevant market."). Still, many have noted that the precise definition of this term “is largely an academic debate with no real world impact because there is very little difference between the two standards.” Id. at 355; see also Thomas O. Barnett, Substantial Lessening of Competition—The Section 7 Standard, 2005 COLUM. BUS. L. REV. 293, 297 ("[T]he consumer welfare and total welfare standards can diverge, although I think it is a rare case in practice."). Although many of the same arguments would apply, a full explanation as to how the theoretical economic analysis would diverge when one definition is substituted for the other is beyond the scope of this Note.

104 See MARC ALLEN EISNER, ANTITRUST AND THE TRIUMPH OF ECONOMICS: INSTITUTIONS, EXPERTISE & POLICY CHANGE 116 (1991) ("The ascendence of the Chicago school also shaped the prevailing understanding of policy by virtue of its faith in the self-sufficiency of markets and its distinct antistatism. As noted earlier, the fundamental assumption underlying this position is that the most efficient level of activity is the market. Managers tend to act rationally, seeking out new and greater efficiencies as a means of maximizing profits.").


106 Id. at 525 ("Monopoly means that society will have the wrong mix of products in the sense that a different mix would make consumers happier.").

107 A multiplant monopoly is where a monopolist has more than one plant, among which it allocates its production. See RICHARD LIPSEY & ALEC CHRYSTAL, ECONOMICS 159 (12th ed. 2007). When one “assum[es] that 100 percent of the sales of a good are incorporated into the cartel,” the cartel can be treated “as a multiplant monopoly, where the member firms are analogous to the plants operated by a monopolist.” STEPHEN MATHIS & JANET KOSCIANSKI, MICROECONOMIC THEORY: AN INTEGRATED APPROACH 447 (2002).
"[f]or the monopolist, the decision to sell an additional unit of output is determined not merely by the price he can demand for that unit alone, but also the fact that each additional unit sold drives down the price he receives for all the other units he sells." 108 Because to increase sales, the monopolist must lower the price for all units sold, the monopolist's revenue curve is downward sloping and lies underneath the demand curve. Accordingly, when maximizing profits by producing at the point at which marginal revenue equals marginal cost, 109 the monopolist will sell a lower quantity of output at a higher price than that which it would under competitive conditions. 110

When competitors join together and centralize decision-making to engage in collective bargaining, they can act essentially as a single firm and thus achieve the anticompetitive results just described of a single-seller monopoly. 111 Because consumer welfare is impaired by such an aggregation of seller power, U.S. antitrust laws declare cartelization per se illegal. 112 As explained earlier, when an agreement is considered illegal per se, the actual effects on price and output of the good or service at hand are irrelevant to the court's analysis because these agreements are considered to be "so 'plainly anticompetitive,' and so often 'lack[ing]... any redeeming virtue,' that they are conclusively presumed illegal." 113

Current U.S. antitrust policy — in attempting to "maximize consumer welfare by promoting the efficient use of scarce resources," 114 — is at odds with laws that "protect individual competitors from the consequences of normal market forces, from aggressive competition by others, [or] from more efficient competitors." 115 Since focusing on consumer welfare as the guiding principle of

109 Analogously to a monopolist, a cartel, which is made up of multiple sellers, will restrict the output of every member firm in the cartel so that the marginal cost of production for every member firm is equal to marginal revenue.
110 Areeda, supra note 105, at 525.
111 Id. at 527.
112 See BORK, supra note 97, at 66–67.
114 The efficient use of resources in a competitive market results in "high output, low prices, high quality, varied services, access, innovation, and efficiency in production and distribution."
ABA SECTION OF ANTITRUST LAW, supra note 49, at 8.
115 Id. at 8. As Judge Posner has explained,

Antitrust enforcement is not only an ineffectual, but a perverse, instrument for trying to promote the interests of small business as a whole. Antitrust objectives and the objectives of small business people are incompatible at a very fundamental level. The best overall antitrust policy from a small-business standpoint is no antitrust policy. By driving a wedge between the prices and costs of the larger firms in the market... monopoly enables the smaller firms
ARE INDEPENDENT PHARMACIES IN NEED OF SPECIAL CARE?

antitrust, the Supreme Court explicitly has rejected the theory that courts should protect or subsidize inefficient small firms at the expense of a more efficient allocation of resources that flows from free-market conditions. Instead, antitrust law seeks to stimulate, rather than retard, competition in order to "lower prices, encourage[] greater innovation, and generate[] faster responses by business to changing consumer needs and desires." 117

Applying this model to the health care industry, an exemption that would allow pharmacy owners who were formerly in competition with each other to cartelize by collectively negotiating pharmaceutical reimbursement rates would sacrifice consumer welfare for that of small business. Such an approach would fly directly in the face of our current antitrust policy, which is rooted in a concern for consumer welfare. First, pharmacists would prosper at the expense of PBMs and consumers. In effect, PBMs would have to pay higher reimbursement rates to pharmacists, which PBMs then would demand from MCOs. MCOs would, in turn, pass these added costs on to plan subscribers (the consumers) through higher insurance premiums. Second, because pharmacists would not only increase prices, but also would sell a lower than allocatively efficient level of output, resources would not be "automatically funneled into the production of goods consumers find most valuable." 118 In economic terms, while pharmacists would be made better off as a result of cartelization, they would not be made sufficiently better off to compensate for the accompanied loss in welfare of consumers.

Because it is important both to society as a whole and to individual patients in particular that pharmaceuticals are not sold in suboptimal quantities or at above-optimal prices, increased costs and decreased output are particularly troubling. Conventional microeconomic theory dictates that when faced with cost increases, patients almost certainly will fill fewer prescriptions. A large body of research in both the United States and Canada has correlated increased copayments and associated prescription costs with prescription noncompliance and reduced drug use. 119 At least one study has found that the primary reason for to survive even if their costs are higher than those of the large firms. The only kind of antitrust policy that would benefit small business would be one that sought to prevent large firms from underpricing less efficient small firms by sharing their lower costs with consumers in the form of lower prices. Apart from raising in acute form the question whether society should promote small business at the expense of the consumer, such a policy would be unworkable.

POSNER, supra note 102, at 26.

116 BORK, supra note 97, at 56.

117 Muris, supra note 98.


unfulfilled prescriptions among Medicare beneficiaries is medication cost.\textsuperscript{120} Unfortunately, cost increases are most likely to impact populations with the least income and job security, such as the poor and elderly, who are also the populations most prone to disease.\textsuperscript{121} The failure to follow through with needed medication only serves to further strain our health care system; researchers consistently have found that prescription nonadherence is associated with increased total health care costs,\textsuperscript{122} poorer health care outcomes, and greater use of urgent care and inpatient health facilities.\textsuperscript{123}

In sum, under the conventional economic models on which antitrust doctrine is predicated, by allowing pharmacists to boycott collectively any PBM or insurer that fails to meet fee demands, the proposed exemption would increase pharmaceutical prices by raising fees paid to smaller, more inefficient pharmacies at the expense of consumers' pocketbooks. Independents counter, however, that while conventional antitrust doctrine assumes a perfectly competitive market, the pharmaceutical supply chain is rife with market imperfections, particularly PBMs' exertion of market power. The next Subsection will evaluate independents' argument that traditional economic analysis is inapplicable because the idealized economic model does not accurately reflect the nature of the competition in the pharmaceutical market.

2. The Argument of Countervailing Market Power in Response to Monopsony

Theoretically, negotiations of the reimbursement schedule between pharmacists and PBMs should occur within a competitive market, with no individual PBM — and also no individual pharmacist — unilaterally being able

\textsuperscript{120} See Jae Kennedy et al., Unfilled Prescriptions of Medicare Beneficiaries: Prevalence, Reasons, and Types of Medicines Prescribed, 14 J. MANAGED CARE PHARMACY 553 (2008) (finding that of a sample of 1.6 million Medicare beneficiaries who did not fill their prescriptions, 55.5% stated their failure to do so was due to the fact that they "thought it would cost too much" (internal quotation marks omitted)).

\textsuperscript{121} See, e.g., Ira B. Wilson et al., Cost-Related Skipping of Medications and Other Treatments Among Medicare Beneficiaries Between 1998 and 2000: Results of a National Study, 20 J. GEN. INTERNAL MED. 715, 720 (2005) ("[C]ost-related skipping of medications and other treatments is associated with several different factors, including poverty and poor health. If a prescription drug plan requires significant cost sharing, certain vulnerable subgroups will almost certainly continue to experience relatively high cost-related medication skipping rates, particularly low-income seniors whose income or assets may not qualify for any low-income subsidies because their income or assets make them ineligible.").

\textsuperscript{122} Researchers have found that medication adherence results in overall health care savings even when accounting for the increased costs associated with patients purchasing needed medications. M. Christopher Roebuck et al., Medication Adherence Leads to Lower Health Care Use and Costs Despite Increased Drug Spending, 30 HEALTH AFFAIRS 91, 91 (2011).

\textsuperscript{123} Id.; see also Elliot et al., supra note 119, at 602 (stating that reduced drug use associated with increased costs is linked with increased morbidity, hospitalization, and costs).
ARE INDEPENDENT PHARMACIES IN NEED OF SPECIAL CARE?

to affect the market price of a given quantity of medication.124 As demonstrated by various complaints filed by pharmacists in federal district court against MCOs, however, independents allege that this illustration of a perfectly competitive pharmaceutical market does not reflect the actual market in which negotiations between an independent pharmacy and a PBM occur. According to independents, a handful of PBMs, who would individually be price-takers in a competitive regime, control the market and are able to force below-market prices on independents in their negotiations for reimbursement rates.125 This allows them to circumvent true negotiation, which should result in competitive prices.126 Instead, a PBM can force a reimbursement rate on an independent that is not only “far below” that which “would apply in a true competitive market,” but also “generally below any measure of [an] Independent Pharmacist’s actual costs including their variable, marginal, and/or actual costs.”127 As a result, “fewer goods are transacted, wealth is transferred from the party without market power [(i.e., the seller)] to the party with market power [(i.e., the buyer)], and there is a loss of social welfare.”128

Independents argue that they can effectively counteract PBMs’ monopsony power—and thus restore the market to competitive equilibrium—by exerting countervailing market power through a bilateral monopoly—a market characterized by the possession of market power by both sellers and buyers.129 Theoretically, facilitating a bilateral monopoly does counteract to some extent the effects of a monopsony power. Because “the buyer and seller” are unable “simultaneously . . . [to] exploit their respective market power,”130 meaning that

125 See Healthcare Competition Hearing, supra note 46, at 28–36 (statement of David Balto, Senior Fellow, Center for American Progress Action Fund).
126 In addition to extracting below-competitive market prices, PBMs allegedly also use their market power to compel pharmacists to bear additional costs, such as forcing them to buy software from the PBM and charging them for processing fees. See, e.g., Plaintiffs’ Reply to Defendants Caremark RX, Inc. and Caremark Inc.’s Motion To Dismiss Plaintiffs’ Second Amended Class Action Complaint at 5, N. Jackson Pharmacy, Inc. v. Caremark Rx, Inc., 385 F. Supp. 2d 740 (N.D. Ill. Nov. 1, 2004) (1:04-CV-05674), 2004 WL 5549836.
127 Plaintiffs’ Memorandum in Support of Class Certification at 15, N. Jackson Pharmacy, Inc., 385 F. Supp. 2d. 740 (CV 03-HS-2696-NE, CV 03-HS-2697-NE), 2005 WL 2016439 (making such allegations). This can be contrasted to “conditions of perfect competition,” under which “a firm always maximizes profits (or minimizes losses) by producing that output at which its marginal cost equals the market price. This occurs because the perfectly competitive firm accepts the market price as given since it is, by definition, too small to affect market price by any variations in output.” Philip Areeda & Donald F. Turner, Predatory Pricing and Related Practices Under Section 2 of the Sherman Act, 88 HARV. L. REV. 697, 702 (1975).
128 Alexander, supra note 108, at 1614.
130 Blair & Boylston Herndon, supra note 11, at 1006.
neither the monopolist nor the monopsonist outcome is tenable, some accommodation is necessary. Accordingly, profit incentives force the seller and buyer to cooperate, either in the form of vertical integration or through the bargaining process.\textsuperscript{131} If done through the latter, by making a credible threat of refusal to sell unless the buyer raises prices, the now legalized sellers’ cartel will be able to move price and output to competitive or near competitive levels.\textsuperscript{132} As a result of this negotiation, consumers are better off than had the monopsony conditions alone prevailed.

In making this argument, independents do not dispute that the same result could be achieved through vigorous enforcement of antitrust laws against PBMs’ alleged monopsony power. Independents claim, however, that federal law enforcement essentially has “dropped the ball” in bringing action against monopsonist PBMs. As a result, monopsonist PBMs continue to use market power to engage in anticompetitive activity,\textsuperscript{133} offering independents unfavorable terms through contracts of adhesion.\textsuperscript{134} Independents argue that by exerting countervailing market power through an antitrust exemption, they will act procompetitively by bringing reimbursements in line with competitive levels.\textsuperscript{135} In response to the objection that these additional costs would be passed through higher insurance rates on to consumers, independents argue that PBMs already are extracting supracompetitive profits through their exercise of market power. Because “PBMs have great flexibility in determining how much they shift over to patients and taxpayers,”\textsuperscript{136} any decision to increase rates as a result would be “strictly a decision of the PBM.”\textsuperscript{137} As discussed in the Subsections that follow, however, the argument advanced by independents rests on faulty assumptions that are belied by empirical evidence.

\textsuperscript{131} ROGER D. BLAIR & JEFFREY L. HARRISON, MONOPSONY IN LAW AND ECONOMICS 128 (2010).

\textsuperscript{132} Cf. Carstensen, supra note 43, at 25–26 (“[I]f a group of small, powerless buyers face a monopoly or oligopoly supplier, then individually they are powerless to bargain for better prices and larger outputs. The small buyers are compelled to pay the monopoly or oligopoly price demanded by the sellers. However, if these individual buyers can group together and make a credible threat that they would withhold their purchases unless lower prices and greater quantity were offered, they might succeed in bargaining down prices and increasing output. . . such that the market moves toward the price and output that would exist if the industry was competitive.”).

\textsuperscript{133} Healthcare Competition Hearing, supra note 46, at 28, 30–31 (statement of David Balto, Senior Fellow, Center for American Progress Action Fund).

\textsuperscript{134} Id.

\textsuperscript{135} Community Pharmacies Hearing, supra note 73, at 15 (statement of Mike James, Vice President, Association of Community Pharmacies Congressional Network & Pharmacist/Owner, Person St. Pharmacy, Raleigh, N.C.); Leo Mallard, Give Local Pharmacies a Level Playing Field, BALTIMORE SUN, July, 8, 2007, at 19A.

\textsuperscript{136} Community Pharmacies Hearing, supra note 73, at 15.

\textsuperscript{137} Id. at 10 (testimony of Rep. Ric Keller, Ranking Member, Task Force on Antitrust and Competition).
ARE INDEPENDENT PHARMACIES IN NEED OF SPECIAL CARE?

3. Questioning Independents' Assumptions: PBM Monopsony

The argument of countervailing market power rests on three fundamental assumptions. First, PBMs exercise unequal bargaining power vis-à-vis pharmacists. Second, this power translates into a decrease in consumer welfare as defined by antitrust law. And third, the most effective way for independents to counteract the anticompetitive effects of PBM monopsony and restore the market to competitive equilibrium is to cartelize. Examining each of these assumptions in turn, this Subsection challenges the claim that there is sufficient evidence that PBMs exercise monopsony power, which necessarily translates into a decrease in consumer welfare. Moreover, this Subsection asserts that even accepting independents' claim of inefficient monopsony, Congress would be remiss to remedy this market failure by sanctioning collective bargaining for the purpose of creating a bilateral monopoly.

a. Extent of Monopsony Power Among PBMs

The first dubious assumption on which independents' argument rests is that there is sufficient evidence that PBMs have monopsonistic power in the pharmaceutical market to support such drastic legislative action. Although the pharmacy lobby claims that the PBM market is "tremendously concentrated," a strong body of evidence points in the opposite direction. Supporters of an exemption emphasize that there are only a couple of PBMs controlling the market, but this claim fails to account for the fact that FTC-promulgated statistics reflect that "[t]here are approximately 40 to 50 PBMs operating in the United States," not just a few. Without the critical assumption of overly concentrated PBM market, the countervailing market-power argument is a nonstarter.

138 By alleging that a handful of PBMs control the market — rather than a single monopsonistic firm — pharmacists are in actuality referring to an oligopsony rather than a monopsony. That said, for simplicity (and because independents often still use the word "monopsony," albeit incorrectly, to refer to PBMs' behavior), "monopsony" is used throughout the Note.

139 While, historically, antitrust law chiefly has focused on anticompetitive agreements among sellers, "buying power, is economically objectionable for the same policy reasons that underlie antitrust’s opposition to monopoly." Clark C. Havigursh, Antitrust Issues in the Joint Purchasing of Health Care, 1995 UTAH L. REV. 409, 411. Instead of focusing on the output side of the market, however, as a monopolist would do, a monopsonist, or buyers' cartel, focuses on the input side of the market. Accordingly, the fundamental objective is the mirror image of a monopolist’s: "to eliminate competition in some aspect of their input purchasers in order to reduce the prices associated with such purchases or otherwise control supplier conduct." Carstensen, supra note 43, at 9–10. In short, a monopsonist, exerting its market power, extracts goods from a seller at lower than competitive price.

140 Healthcare Competition Hearing, supra note 46, at 28 (statement of David Balto, Senior Fellow, Center for American Progress Action Fund).

141 Id. at 13 (statement of Richard A. Feinstein, Dir., Bureau of Competition, Federal Trade Commission).
Additionally, existing economic models, empirical data, and anecdotal evidence support the view that independents' bargaining leverage may not be as low as independents suggest. One economic study found that during the time period studied, "independents themselves appear[ed] to have greater bargaining power individually than chain pharmacies." One explanation for this might be that certain laws not only prohibit health plans from offering mail order as an only option, but also provide that consumers must be able to frequent a certain number of pharmacies in a given geographical area. In rural areas, where there are limited numbers of pharmacies, many of which are independent, a PBM theoretically may be forced to accept whatever terms the independent demands. Additionally, there have been reports suggesting that the contract-of-adhesion model does not reflect reality; independent pharmacies have in fact rejected proposed insurer contracts due to low reimbursement rates rather than blindly accepted the rates offered, regardless of how meager.

Moreover, that PBMs are forcing pharmacists to agree to reimbursement rates below costs defies economic logic. As Caremark Rx, Inc. and Caremark Inc. remarked in response to antitrust litigation brought by two plaintiff pharmacies:

If, in fact, reimbursement rates were below their 'marginal, variable and/or actual costs' as Plaintiffs allege, no rational business person would seek to 'receive a greater volume of business' at such rates. The fact that Plaintiffs have continued to enter into those contracts belies the contention that reimbursement rates are below their costs.

143 See infra note 272 and accompanying text.
144 Preserving Our Hometown Independent Pharmacies Act of 2011: Hearing Before the H. Subcomm. on Intellectual Property, Competition, & the Internet of the Comm. on the Judiciary, 112th Cong. 53 (2012) (statement of Richard Feinstein, Dir., Bureau of Competition, Federal Trade Commission) ("I just want to make the point that there are places in those networks where they have to deal with independent pharmacies, because there are rural locations, for example, where the independent pharmacies may be the only one [sic] in a town."); id. at 141 n.31 (statement of Peter J. Rankin et al., Charles River Associates International).
145 See supra note 144.
147 Motion of Caremark Rx, Inc. & Caremark Inc. To Dismiss the Second Amended Complaint, at 11, N. Jackson Pharmacy, Inc. v. Caremark Rx, Inc., 385 F. Supp. 2d 740 (ND. Ill. Oct. 1, 2004) (1:04-CV-05674), 2004 WL 5549835 (citations omitted). Ultimately, the case was not resolved by the district court, but went to arbitration. See In re Pharmacy Benefit Managers
ARE INDEPENDENT PHARMACIES IN NEED OF SPECIAL CARE?

It is dubious that independents would agree to reimbursement rates below their costs, forcing them to operate at a loss unless for instance, the independents believed such losses would only be short term. Moreover, such a strategy may be contrary to PBMs’ own interests given its potential to force all of their suppliers out of business. Finally, evidence shows that at least a group of independents remain profitable. In the congressional hearings on the Community Pharmacy Fairness Act of 2007, Charles River Associates (CRA) International, a leading global consulting firm, presented evidence that in 2005, independent pharmacies enjoyed, on average, a gross profit margin rate of 19.3% on sales to commercial insurers, including Medicare managed care plans. Not only did this figure increase 1.5% from the previous year, but this growth also coincided with an increase in independents’ overall gross profit margin on prescriptions from 21.2% in 2004 to 22.7% in 2005. Moreover, in 2003, the number of independent pharmacies increased by over 400, which CRA International testified “would have been unlikely to occur had the market for their services not been profitable.” Again in 2008, independently owned community pharmacies’ total sales increased on average by 7.6%, amounting to $3.9 million.

Finally, to the extent that concentrations of market power do exist, the FTC and DOJ vigilantly have worked to break up and monitor aggregations of market power in the insurance industry. One way in which the FTC has done so is by

Antitrust Litig., 582 F.3d 432 (3d Cir. 2009) (reinstating a district-court order compelling arbitration).

148 Motion To Dismiss, supra note 147, at 11.
149 Community Pharmacies Hearing, supra note 73, at 30 (statement of Peter J. Rankin, Principal, Charles River Associates International).
150 Id.
151 Id. at 31. Moreover, at least some of the pharmacies that are closing have not folded from bankruptcy but rather have sold their businesses for a profit. See Chain Drug Stocks on Upswing, CHAIN DRUG REV., June 30, 2008, at 23 (quoting research analyst as saying “[p]harmacy operations are expected to be a key focus, reflecting what we see as CVS’s ability to succeed in the rapidly growing managed care arena and its ongoing purchase of prescription files from independent pharmacies” (internal quotation marks omitted)); Andrea Chang, Big Chains a Headache for Small Drugstores, L.A. TIMES (Oct. 8, 2008), http://articles.latimes.com/2008/oct/08/business/ft-drugstore8 (quoting a pharmacy owner as saying, “We get offers, I would say probably not every week, but at least once or twice a month... Usually it’s just a little feeler-type letter: ‘Why don’t you sell to us now while you still can make some money?’” (internal quotation marks omitted)); Ralph de la Cruz, Independent Drugstores: Going, Gone?, L. A. TIMES—TELEGRAM, Oct. 23, 1997, available at 1997 WLNR 1402045 (“‘Chain stores are coming into the independent market and making very attractive offers,’ Tilley said. Tilley, who owns Zweber Apothecary pharmacies, said he’s been approached five times by chains.”). These confounders cast doubt on the independent pharmacists’ arguments that the magnitude of closures reveals an inability of independents to compete with chains or mail-order pharmacies.

227
proactively reviewing proposed mergers and acquisitions that potentially could threaten competition in the health care industry. For example, in 2004, the FTC investigated Caremark Rx’s proposed acquisition of Advance PCS. In approving the transaction, and thus closing its investigation, the FTC found that post-merger Caremark Rx would continue to face robust competition from Medco and Express Scripts (two other national PBMs) as well as several other health plans and retail pharmacy chains offering PBM services. Moreover, the FTC concluded that “there [was] no reason to expect a monopsony or oligopsony outcome . . . even if the acquisition enable[d] the merged PBM (or PBMs as a group) to reduce the dispensing fees they pay to retail pharmacies.” The FTC based this finding on the fact that (1) each PBM negotiated contracts individually with each retail pharmacy company and that (2) “the post-acquisition share of the merged firm for all purchases of prescription dispensing services would be below the level at which an exercise of monopsony power [was] likely to be profitable.” Other PBMs have not fared as well as Caremark Rx and Advance PCS when faced with FTC scrutiny; several FTC investigations of PBM activity have resulted in consent orders restricting the transactions.

When one recognizes the flaws inherent in independents’ claims, it becomes clear that larger chains are driving some smaller, independent pharmacies out of business not because of some inherent market unfairness, but rather because larger pharmacies, including those owned by chain stores and supermarkets, benefit from economies of scale, which allow them to offer the same pharmaceuticals at lower prices. Independents themselves have attributed their

154 Id.
155 Id.
156 Id.

157 For example, in Merck & Co., Inc., 127 F.T.C. 156, 159 (1999), the FTC found that when Merck (a leading pharmaceutical manufacturer) acquired Medco (a PBM), it substantially lessened competition in violation of section 7 of the Clayton Act, as amended 15 U.S.C. § 18 (2006), and section 5 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 45. As a result, the FTC issued a consent order directing Merck and Medco to maintain and disclose an open formulary with information regarding the relative costs of listed drugs and prohibiting them from communicating proprietary and other nonpublic information. Merck, 127 F.T.C. at 162, 164.

158 Chang, supra note 151, at 1. Consolidation in the drugstore industry is driven in part by the cost savings that can be found when different functions, such as distribution, purchasing and management, are combined.”); see also Community Pharmacies Hearing, supra note 73, at 2 (statement of Rep. John Conyers) (“We are told and we will hear today, how they are being driven out of business because they can’t compete with large retail pharmacies and cannot survive with the low reimbursement rates that are given to them now. . . . Small pharmacies have suffered because of higher administrative costs, approximately some $15 billion a year.”). According to one 2008 study, “independent drugstores in the state of Florida charged an average of 15 percent more for four widely used prescription drugs than the statewide average.” New Study: Independent Drugstores Charge 15% More for Prescription Drugs; New ‘Collective Bargaining’ Rights Would Empower Them To Raise Costs Even More, Bus. Wire, Nov. 3, 2008.
market struggles to the fact that they cannot compete with chains’ competitive prices. Although much of this may very well be attributed to greater average bargaining power (at least in certain markets), there may be other explanations as well. For example, one reporter quoted an independent pharmacy owner as candidly admitting that “[a] chain store can afford to sell prescription drugs at lower prices, because once they get a customer in the store, they can make money selling them thousands of other products. Most independent pharmacists do not have that luxury.”159 Chain stores benefit from more efficient computer systems,160 high-tech dispensing technology,161 and the ability conveniently to offer consumers the opportunity to buy a wide variety of “front end” items, such as beauty supplies and toiletries.162 By saving labor costs and procuring revenue from additional products, chains offer consumers lower prescription prices irrespective of any bargaining-power differential. Again, this is not to say that such a differential does not exist, just that it is unclear to what extent lower prices are a result of greater bargaining leverage stemming from greater market share. Thus, at a minimum, a legislative exemption would be a blunt tool to address this perceived problem. The evidence that PBMs benefit from monopsony and that they use this aggregation of market power to drive independents out of business is too speculative to support legislative reform.

b. Impact on Consumer Welfare

The second major assumption on which independents’ arguments rest is that PBMs’ and chain pharmacies’ monopsony power translates into higher prices and lower output, or, in economic terms, a reduction in allocative efficiency. Even if...
PBMs and/or chain pharmacies do exercise monopsony market power, it is not evident that this market power reduces the level of output and/or translates into higher prices in the market downstream. There are several reasons why this might be the case. First, although there may be numerous sellers and one buyer in a given market, if the supply curve of pharmacists is elastic (i.e., flat) the quantity demanded will no longer dictate reimbursement rates. The same quantity of pharmaceuticals is demanded regardless of the reimbursement rate. Since controlling quantity will no longer influence the reimbursement rate when the supply curve is elastic, the single buyer cannot exercise monopsony power.

Second, the supply curve in the pharmaceutical industry may not mimic the conventional economic model. Typically, the “supply curve identifies the amount of services [or goods] that will be supplied at every price when suppliers can make marginal adjustments in the quantity supplied in response to price changes.” In some industries, however, this is not the case and suppliers face a decision that is all or nothing, in which they must choose between supplying a given quantity of goods or no goods at all. If the seller is forced onto the all-or-nothing supply curve, the monopsonist will be able to achieve even greater returns than in the typical monopsony scenario because it can now reduce average reimbursement rates without simultaneously reducing output. Because short-run output remains the same as it would under competitive conditions, the resulting short-term effects will be distributional, with the buyer capturing the entire producer surplus. Several scholars have posited that this scenario may indeed hold true in the health provider context, where the quantity of services provided may not be left entirely to the health care provider’s discretion.

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163 See Blair & Boylston Herndon, supra note 11, at 1001–02 for a discussion of this phenomenon in the context of physician cartels.
164 Id.
165 Id. at 1002–03.
166 Id. at 1003. The all-or-nothing supply curve “traces out the average cost curve since the supply decision ultimately becomes a choice between operating at the indicated quantity or shutting down.” Id. at 1002 n.42. This is because “a supplier will choose to operate as long as it is able to cover its average costs.”
167 While output is not reduced in the short run, this may not be the case in the long run, as sellers may leave the industry for another in which price is not below average cost. See Roger D. Blair & Jeffrey L. Harrison, Antitrust Policy and Monopsony, 76 CORNELL L. REV. 297, 319 (1991). This would not be the case if the seller could “peg[] a price that [would] permit[] just the right number of sellers to comfortably stay in business.” Id. However, “[t]his argument rests on unrealistic assumptions about the availability of information and the rationality of business conduct.”
168 Blair & Boylston Herndon, supra note 11, at 1003.
169 Cf. id. at 1002–03 (“There may be instances in which a health plan is able to push physicians onto their all-or-none supply curve. Physicians may face an all-or-none decision when the purchaser of their services is a dominant health plan that is concerned about coverage as well as price and, therefore, desires to maintain the same quantity of physician services while imposing a lower reimbursement rate. Because the health plan negotiates services for a collection of patients, a physician’s refusal to provide the stipulated services to one of the health plan’s subscribers may
ARE INDEPENDENT PHARMACIES IN NEED OF SPECIAL CARE?

Ironically, in seeking an antitrust exemption, independents have in fact argued that they face all-or-nothing decisions in the face of monopsonist PBMs. 170

Finally, often despite being able to extract below-competitive prices in the "upstream" market, a monopsonist (or a member of a buyers' cartel that has monopsony power) is not always the only seller in the resale market downstream. 171 In this world, a monopsonist does not impact directly the prices that individual members of the cartel will charge consumers for the outputs. 172 This is because "[d]ownstream prices are a function of the market or markets in which such sales are made." 173 If the downstream market is competitive, a monopsonist still will be forced to sell to consumers at a competitive level of

result in deselection by the health plan, thereby losing access to all of its subscribers. Physicians will continue to participate in the health plan, even if they object to these terms, when they are financially dependent on the dominant insurer. When confronted with lower reimbursement rates, the terms of the contract with the health plan, in addition to ethical and reputational considerations, constrain the physician's ability to restrict the services provided to a particular patient. For example, the physician's contract with a health plan often specifies certain minimum service requirements that the physician must meet."); see also Blair & Harrison, supra note 167, at 319.

170 In re Pharmacy Benefit Manager (PBM) Antitrust Litig., No. 1:04-cv-05674, 2006 WL 5502869 (N.D. Ill. Apr. 7, 2006) ("Defendant PBMs present Plaintiffs with take-it-or-leave it contracts that set the prices for reimbursement and impose other anticompetitive terms."); see also Allison Dabbs Garrett & Robert Garis, Leveling the Playing Field in the Pharmacy Benefit Management Industry, 42 VAL. U. L. REV. 33, 46 (2007) ("The retail pharmacies are generally offered a 'take it or leave it' deal to be included in the network, with only the largest pharmacy chains having any ability to negotiate with the PBMs."). Physicians have made the same argument in their dealing with insurers as well. See, for example, Kartell v. Blue Shield, 749 F.2d 922 (1st Cir. 1984), in which physicians argued that Blue Shield offered insurance contracts on a take-it-or-leave-it basis.

171 As one scholar notes, this arrangement still will be economically attractive to a monopsonist: "When buyers can make an 'all or nothing' offer to a producer that has increasing marginal cost, the buyer can offer to buy a large volume at a price equal to the average cost of production. It will be rational for the producer to accept this offer and deliver the same quantity that it would have delivered at a market price equal to the marginal cost of its last unit. This means the buyer can induce a level of production comparable to the competitive level, but at the same time transfer all [of] the infra-marginal gain (Riccardian Rents) to themselves." Carstensen, supra note 43, at 21.

172 Where the monopsonist (or a member of a buyers' cartel) does not sell in a competitive downstream market, but rather is the only seller in the resale market, consumers are likely to face supercompetitive prices. This is because

"[t]he monopsony buyer, unlike the competitive buyer, can reduce the purchase price by scaling back its purchases. Because the monopsonist ordinarily reduces its buying power by purchasing less, it sells less downstream. This reduction in its own output will, if it has market power on the selling side, mean higher prices for customers. Thus, lower buying prices upstream may translate into higher seller prices downstream."


output at a competitive price. Therefore, unless PBMs act both as monopsonists in the upstream market and monopolists in the downstream market, economists have posited that the consumer-harm argument loses steam. While the monopsonist still will have extracted a surplus from the seller who sold its inputs at a below-competitive price, in the short run, "there is no efficiency harm because there is the same production and price is not increased." There is at least some reason to believe that this scenario might accurately reflect reality in the case of PBMs. Even assuming that PBMs exert monopsony power vis-à-vis pharmacists, PBMs still may not exert sufficient monopoly power in the downstream market to "resell" the pharmaceuticals to plan sponsors and consumers at above-market rates.

Given the failure of independents to account for such contingencies in their analysis, it cannot be taken as a foregone conclusion that PBMs' bargaining power necessarily translates into the type of harm to consumers that the antitrust laws were designed to prevent or the magnitude of harm that independents assert. This analysis is not to say that such aggregations of buying power are innocuous or that they should be permitted to exist absent intervention. It also is not to assert the necessary existence of such conditions that may mitigate the harmful effects on consumer welfare. It is to say, however, that independents' economic analysis is underdeveloped and under-theorized. Sophisticated economic models are needed to predict an intermediate buyer's ability to effect a change in the welfare of primary-market consumers downstream. Still, even if one rejects entirely the above analysis put forth by economists, independents' lobbying efforts rest on an additional premise. Assuming, arguendo, the existence of an inefficient PBM monopsony, the next Subsection examines and ultimately rejects independents' presumption that the legalization of independent pharmacy cartels would be the appropriate mechanism to return the market to equilibrium.

174 This scenario will hold true where either: (1) "buyers can compel the producers to deliver approximately the same output at the lower price" or (2) "buyers compete in a resale market with many other producers such that the resale is set competitively and the cartel has no incentive or capacity to raise the prices of its output." Id. at 21.

175 This outcome will be different if after purchasing discrete units of goods from sellers, buyers resell those goods in a market in which they are the only sellers. See id. at 20. In this world, when buyers reduce the price that they pay for their inputs, output of that commodity in the resale market (i.e., sales to individual consumers) declines. Id. Here, a buyers' cartel harms consumers by reducing production and increasing prices charged to consumers. Id. at 20–21.

176 Id. at 21. "[T]he contemporary economic welfare model is not concerned" with "transfer[s]of surplus from seller to buyer" without any accompanying impact on consumers. See id. at 21 & n.83.

177 See Healthcare Competition Hearing, supra note 46, at 14 (statement of Richard A. Feinstein, Dir., Bureau of Competition, Federal Trade Commission) (noting that "[t]he FTC found in its most recent antitrust investigation of the PBM industry, that competition among PBMs for contracts with plan sponsors is "vigorous").

ARE INDEPENDENT PHARMACIES IN NEED OF SPECIAL CARE?

c. The Promise of Bilateral Monopoly in Returning the Market to Equilibrium

Finally, even when one accepts that the PBM market is anticompetitive, in that PBMs constitute a monopsony and this power translates into a reduction in consumer welfare, independents' argument still rests on the critical assumption that the cartelization of pharmacists — and thus the creation of a bilateral monopoly — is the only (or, alternatively, best) way to counteract these anticompetitive forces. Although superficially attractive, the argument that Congress should legalize cartels of pharmacists in order to facilitate the formation of a bilateral monopoly is subject to several fallacies.

First, while the economic effects can be predicted to some extent in the case of a perfect bilateral monopoly, where there is one seller and buyer, the analysis becomes significantly less clear when the model accounts for multiple buyers and sellers with market power, which would be the case in the pharmaceutical supply chain. As noted by two scholars:

In the extreme case of bilateral monopoly, we know what the welfare consequences are. In cases involving substantial concentration (i.e. oligopoly or oligopsony), it is not clear that the formation of countervailing power is desirable. This ambiguity follows from the lack of a unified theory of oligopoly. Since we cannot be sure a priori what the welfare effects of oligopoly are, it is not possible to say what the consequences of the countervailing oligopsony power will be. 179

Therefore, as long as the given industry's "very specific behavioral characteristics" remain unidentifiable or unstable, economists are unable to predict accurately the precise effects of a sanctioned oligopsony. 180 Such uncertainty makes this policy choice risky.

Second, others have expressed concern that sanctioning the formation of countervailing market power in an intermediate market creates great risk that this power will spill over into the downstream output market, ultimately hurting consumers. 181 This conclusion is intuitive: allowing pharmacists to collude on the reimbursement rates received from PBMs for their sale of pharmaceuticals will translate into collusion with respect to other consumer goods sold in pharmacies. As noted by one scholar: "[T]here may be something approaching economies of scale in collusive activities. Thus, the costs of gathering together and deciding on a common plan could be spread over plans associated with both

179 BLAIR & HARRISON, supra note 131, at 140–41.
180 Id. at 141.
181 Id. at 138–39. Blair and Harrison discuss this risk in general terms rather than apply their insights to one particular market. See id.
buying and selling." 182 In other words, once independents already have expended resources to collude with respect to the reimbursement rates obtained from a given PBM, the costs of colluding with respect to other areas of their businesses declines. Furthermore, once pharmacists begin collaborating in one market, it will be more difficult to detect where they have overstepped their bounds and reached a tacit agreement elsewhere. 183 As the risk of detection and cost per agreement declines, the likelihood of such an agreement increases. 184

Furthermore, there is concern that even in the case of a perfect bilateral monopoly, where there is a single buyer and seller, the monopolist and monopsonist will not have exactly equivalent market power. In order "for bilateral monopoly to benefit society, bargaining strengths of buyers and sellers must be approximately equal. If either side has a disproportionate share of the bargaining power, it will be able to tilt the balance in its favor to the detriment of society." 185 Accordingly, although "the bilateral monopoly is, at least theoretically, closer to the competitive equilibrium than the pure monopoly equilibrium," "[e]ven in the perfect bilateral monopoly situation, where there is only one buyer and one seller, the equilibrium price will likely be above the perfectly competitive price." 186

Finally, given that agreements between insurers and health care providers are not immune from antitrust scrutiny, pharmacies are able to fight any suspected anticompetitive activity through litigation. This reduces the need to fight collusion through collective bargaining, which, as explained above, theoretically may bring the market closer to equilibrium, but is unlikely to produce the competitive prices characteristic of a market plagued neither by monopoly nor monopsony. 187 Since Group Life, pharmacists certainly have taken advantage of their right to bring private claims under the Sherman and Clayton Acts. 188 Independent and community pharmacies might charge that, unlike chain pharmacies, they do not have sufficient financial resources to engage in expensive litigation, but past experience proves otherwise. 189 For example, in

182 Id. at 139.
183 Id.
184 Id.
185 JAMES W. HENDERSON, HEALTH CARE ECONOMICS AND POLICY 62 (5th ed. 2010).
186 Alexander, supra note 108, at 1620.
187 ABA SECTION OF ANTITRUST LAW, supra note 49, at 19 ("[A]ny person (including federal and state governments) who is injured or threatened by a violation of federal antitrust law may bring a civil suit in federal court to enjoin conduct violating the antitrust laws, and any such person who is injured in his or her business or property by such a violation may commence a federal civil action to recover three times the party’s actual damages.").
189 Another version of this argument is that exercising countervailing market power is "a less restrictive method" of bringing the market back into competitive balance than "the more problematic alternatives of bringing a costly and unpromising antitrust suit." Havighurst, supra note 139, at 445.
ARE INDEPENDENT PHARMACIES IN NEED OF SPECIAL CARE?

North Jackson Pharmacy, Inc. v. Express Scripts, Inc., independent pharmacists brought a class action against a pharmaceutical manufacturer and three PBMs alleging that the defendants agreed both amongst themselves and with other PBMs to fix prices in the sale of pharmaceuticals to the class of independents.\(^{190}\) Similarly, in Bellevue Drug Co. v. Advance PCS, several independent pharmacies and two not-for-profit organizations, each composed of thousands of independent community-pharmacy owners, brought suit against a PBM, alleging that it had engaged with competitors in a horizontal agreement with the effect of restraining trade in the drug dispensing industry.\(^{191}\)

It is for these reasons that economists have advised against combating a perceived monopsony through creation of a countervailing market power. As Peter Rankin, Principal at CRA International, an economics and management consulting firm, testified before Congress, “The regulatory agencies and most economists have regularly dismissed the concept of combating perceived competitive imbalances in market power by creating ‘countervailing’ market power. The appropriate response, instead, is to determine if there is a legitimate competitive imbalance and address the economic factors creating that imbalance.”\(^{192}\) Thus, because it is not clear that the PBM market is anticompetitive, and, even if it were, litigation directly challenging PBM monopsony would serve as a more appropriate mechanism for independents and law enforcers to combat anticompetitive activity and fully remedy market failures, an antitrust exemption for independent pharmacies is neither warranted nor advised.

4. Empirical Evidence

Empirical data also supports the conclusion that an antitrust exemption will not result in lower health care costs. According to research, if it had been passed, the Quality Health Care Coalition Act of 2000 would have “rais[ed] annual medical costs by as much as $29-$141 billion over a five-year period as a result of higher physician fees, changes in practice patterns, and the ripple effect on

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\(^{190}\) 345 F. Supp. 2d 1279, 1283 (N.D. Ala. 2004). Acknowledging that under Socony-Vacuum, a horizontal conspiracy to fix prices at below market-rate levels is a per se violation of the Sherman Act, the district judge denied the defendants’ motion to dismiss and ruled that the plaintiffs’ amended complaint “afford[ed] no sound basis for ruling out the possibility that the Plaintiffs w[ould] be able to establish facts which establish a right of recovery for violation of the Sherman Act.” Id. at 1296.


government program costs.”193 More specifically, the Congressional Budget Office (CBO) estimated that if passed, the Quality Health Care Coalition Act of 1999 would have (1) elevated private health insurance premiums;194 (2) decreased federal tax revenues by $145 million in 2001 and $3.6 billion between 2001 and 2010 as a result of reductions in taxable income and fringe benefits;195 (3) increased federal direct spending by several billion dollars across a number of federal programs by 2011;196 and (4) increased various federal agencies’ discretionary spending by $150 million over ten years.197 Under the CBO’s assumption that one-third of pharmacists would have taken advantage of their newfound immunity, pharmacists’ collective activity alone would have raised private health insurance expenditures by 0.1%, with the average pharmacist increasing his or her net margin by fifteen percent.198

The CBO also ran cost estimates for the Community Pharmacy Fairness Act of 2007, which would have exempted only independent pharmacies (rather than all health professionals) from antitrust laws for five years.199 First, the CBO estimated that the bill, if enacted, would have increased payments for prescription drugs dispensed by independent pharmacies by one percent commencing in 2010—the year that most affected contracts would have been

193 Thomas J. Greaney, Whither Antitrust? The Uncertain Future of Competition Law in Health Care, 21 Health Affairs 191 & n.27 (2002) (citing various studies with “different assumptions about effects on utilization management, percentage of physicians that would take advantage of the legislation, and spillover effects”).
194 Cong. Budget Office, H.R. 1304: Quality Health-Care Coalition Act of 2000, at 2–3 (2000). As a corollary to the elevated private-insurance premiums, the Congressional Budget Office (CBO) predicted that employers sponsoring health plans would have passed these higher costs on to employees in the form of decreased wages and fringe benefits. Id. at 3. These reductions would have in turn affected the federal tax revenues. Id. at 7.
195 Id. at 1, 7. Because the bill, as passed by the House, contained a three-year sunset provision, the CBO estimated that “the full effects that the antitrust exemption could have on the health insurance market [were] likely not to be realized.” Id. at 2. Despite this, the CBO concluded:

[T]he effects of the legislation would likely persist beyond the third year for several reasons: contracts negotiated during the first three years might extend beyond the period; health plans might go through an adjustment period while re-establishing utilization controls in the post-sunset period; and, since fee levels for health professionals would have been established at higher levels than would occur under current law, the market would take some time to re-adjust once the original antitrust treatment were restored.

Id.
196 Id. at 1, 7.
197 Id. at 1.
198 Id. at 5.
ARE INDEPENDENT PHARMACIES IN NEED OF SPECIAL CARE?

renegotiated. The CBO predicted that as a result of these cost increases, group health insurance premiums would have risen, and employers would have passed these increases on to workers in the form of reductions in the scope or generosity of health insurance benefits, such as higher copayments and deductibles as well as reductions in taxable income and fringe benefits. Because of these reductions in taxable income, the bill, if enacted, would have depressed federal tax revenues by $5 million in 2009 and by $120 million from 2008 to 2018. Federal direct spending for health benefits also would have increased by $488 million from 2008 to 2013 and by $520 million from 2008 to 2018. The combined effect of reduced tax revenues and increased direct spending would have served to reduce government surpluses or to increase government deficits by $640 million between 2008 and 2018. Therefore, neither economic theory nor empirical evidence can support an antitrust exemption on the basis that it would reduce or preserve health care costs.

B. Quality of Care

Still, supporters of the exemption claim in the alternative that while an exemption may increase pharmaceutical prices, a simultaneous boost in the quality of patient care would offset this escalation and thus be procompetitive. Indeed, the pharmacy lobby has packaged the exemption proposals as attempts “[t]o ensure and foster continued patient safety and quality of care.” While not always expressed in economic terms, this argument too is predicated on claims of market failure and imperfection. Independents claim that while they provide superior service as compared to chain and mail-order pharmacies — service that drastically increases quality of health care — market imperfections prevent this enhanced quality from being reflected in the allocation of goods and services in the marketplace as it would in a perfectly competitive market.

This Section argues, however, not only that these claims of quality deficiency are overblown, but also that collective bargaining by independents is an improper mechanism through which to improve health care quality. Subsection III.B.1 explains the relationship between competition and quality, demonstrating that restraining market competition will lead to inefficient

200 Id. at 3. In formulating this approximation, the CBO accounted for the fact that health providers would want to both establish an attractive list of in-network pharmacies and to meet their adequacy-of-network requirements. Id. at 3-4.
201 Id. at 4.
202 Id.
203 Id. at 1.
204 Id.
outcomes. Subsection III.B.2 then considers and rejects independents’ contention that collective bargaining must be permitted to correct these market failures and improve quality of care.

1. Market Efficiency and Quality of Care

In order to “play[] to consumers’ fears, as well as those of policy makers and politicians,” the medical lobby has packaged its exemption platform on the notion that the closing of small pharmacies hurts not only their owners, but also patient welfare. In part, these claims are built on those of monopsony rejected above. According to independents, because their pharmacists build strong relationships with their patients, they provide care superior to that of chain and mail-order pharmacies. As a result, when PBMs force independents out of business, patient health care declines. Moreover, independents claim that even if they are not forced out of business, PBMs have cut independents’ reimbursement levels so drastically that independents are forced to “increase volume, reduce the level of service, increase waiting times, and reduce staff,” all of which reduce patient satisfaction, compromise the pharmacist-patient relationship, and damage the level of care. While chain and supermarket pharmacies too have reported frustration with PBMs, independents allege that larger entities often have circumvented these pressures through exercising superior bargaining power or by

206 HAAS-WILSON, supra note 49, at 38; Peter J. Hammer & William M. Sage, ANTITRUST, HEALTH CARE QUALITY, AND THE COURTS, 102 COLUM. L. REV. 545, 611 (2002). In finding restraints on trade anticompetitive (absent procompetitive justifications in rule-of-reason cases), the courts largely stick to this economic model. Therefore, courts presume that “[c]ompetition in the health care markets [will] . . . lower health care prices, reduce health care costs, and improve health care quality.” Id. at 612; see also id. at 612, 636 (concluding, after conducting “a comprehensive empirical review of judicial review of judicial opinions in medical antitrust litigation between 1985 and 1999, with specific attention to courts’ handling of quality and other nonprice concerns,” that “[o]f the opinions that expressed general beliefs about the role of competition, the vast majority adhered to traditional economic assumptions”); see also Fed. Trade Comm’n v. Ind. Fed’n of Dentists, 476 U.S. 447, 459-62 (1986) (taking as given traditional economic assumptions when conducting its rule-of-reason analysis); Ambrose v. Acton Health Plans, No. 95 CIV. 6631 (DLC), 1996 U.S. Dist. LEXIS 7274, at *21-*22 (S.D.N.Y. May 28, 1996) (expressing faith in the market’s ability to strike appropriate market-price tradeoffs); Koefoot v. Am. Coll. of Surgeons, 652 F. Supp. 882, 904 (N.D. Ill. 1986) (“[T]he ‘best’ product or service will be selected by consumers where when their choice is made in an open market free of restraints.”).

207 CARLE F. AMERINGER, THE HEALTH CARE REVOLUTION: FROM MONOPOLY TO MARKET COMPETITION 177 (2008) (discussing, in particular, the American Medical Association’s strategy of introducing bills, such as the Quality Health-Care Coalition Act, with a “quality” focus).

208 Independents believe that this pharmacist-patient relationship is responsible for the fact that independents’ patients are “more likely to take their medicines on-time, more likely to take them properly, more likely to refill meds before they run out and more likely to avoid harmful drug interactions [than those of mail-order or chain pharmacies].” COMMUNITY PHARMACIES HEARING, supra note 73, at 80 (statement of David Balto, Senior Fellow, Center for American Progress Action Fund).

209 Id. at 88.
ARE INDEPENDENT PHARMACIES IN NEED OF SPECIAL CARE?

operating their own PBMs.\(^{210}\)

Given the dismissal of claims that PBMs constitute a monopsony in Section III.A, these contentions that the market power of PBMs diminishes quality should be dismissed easily as well. This is because microeconomic theory dictates that “absent identifiable market failures,” competition will yield consumers’ desired “range of price-quality combinations.”\(^{211}\) In other words, it is not within the province of an economist’s role to determine whether a high-priced but high-quality good is preferable to one that is low priced and of low quality. Rather, the goal is more limited: to preserve competitive conditions in which consumers can “effectively vote with their wallets and their feet, deciding which products to buy and from which sellers.”\(^{212}\) When everything functions as it should, society’s resources should be “naturally directed into the production of those products that consumers value most highly.”\(^{213}\)

Applying this concept to the pharmaceutical company, the market if competitive should reflect the proper quality/cost tradeoffs through consumers’ purchase of insurance. Therefore, even assuming that independents provide a greater level of service, consumers indicate their willingness to forgo the superior service for the associated cost savings by frequenting mail-order and chain pharmacies and purchasing insurance plans that emphasize cost savings over a broad range of pharmacy choices. All else being equal, every consumer presumably would prefer the customized service provided by independents and the superior health outcomes that independents assert they produce. But, at some point in the tradeoff, the conflicting desire for low-cost health care and greater output of health care goods and services prevails.\(^{214}\)

Although quality-of-care claims premised on the monopsony power of


\(^{211}\) Hammer & Sage, supra note 206, at 611. In economic terms, allocative efficiency is “achieved when each good is produced up to the point where the value consumers place on the last unit produced is equal to the cost of producing the last unit.” HAAS-WILSON, supra note 49, at 38.

\(^{212}\) HAAS-WILSON, supra note 49, at 39.

\(^{213}\) Id.

\(^{214}\) As Professor George Priest has noted:

In many respects, no two consumers are alike and each consumer would prefer products and services most closely designed to meet his or her preferences. Over some range, however, the cost reductions from taking advantage of scale economies prevail over the magnitude of differences in consumer values and preferences for individually designed products. Large business emerges where the cost savings from scale economies prevail.

PBMs rest on shaky ground, independents also point to a variety of other PBM practices that they perceive to diminish invidiously health care quality, and which they hope to correct through collective bargaining. In doing so, independents contest an “assumption of conventional antitrust economics: that markets with active competition over price and output will also compete effectively over quality.” First, independents point to a heavily entrenched practice of PBM self-dealing and vertical consolidation. These claims are heavily targeted towards PBMs’ operation of their own mail-order facilities, which “give[s] them an additional opportunity to profit from transactions by health plan participants.” One of independents’ most frequent contentions is that PBMs disturbingly have forced or heavily incentivized a large number of vulnerable patients (particularly the elderly in rural areas) to fill their prescriptions through PBM-owned mail-order programs. Accusing mail orders of being “shady operators that threaten neighborhood pharmacists,” pharmacists charge that mail-order restrictions not only prevent patients from being able to fill prescriptions immediately, but also inhibit the personal pharmacist-patient relationship that many patients want and that is necessary to effective care. Mike James, the

215 Sage & Hamner, supra note 53, at 257.  
216 Garrett & Garis, supra note 170, at 61, 66–68.  
217 Id. at 66.  
218 Community Pharmacies Hearing, supra note 73, at 17 (testimony of Mike James, Vice President, Association of Community Pharmacies Congressional Network & Pharmacist/Owner, Person St. Pharmacy, Raleigh, N.C.); Starrs, supra note 162 (quoting a pharmacy owner as saying “I think our biggest competition is mail-order and online prescriptions, and some PBMs have their own pharmacies . . . . And a lot of managed-care plans will require that clients buy from PBMs or make it so difficult for them that they don’t have many other choices”). Though independents claim their main issue with mail-order pharmacies is the disturbing health consequences for their patients, their rhetoric in the debate make clear that their economic interests are front and center. For example, independents claim that when PBMs do not officially require patients to use their mail-order facilities, they put retail pharmacies at a distinct disadvantage by charging below-competitive prices for mail-order prescriptions and offering gimmicks such as allowing patients the opportunity to obtain a three-month supply of medication at a time through mail order, while only allowing retail pharmacies to dispense a one month supply. Community Pharmacies Hearing, supra note 73, at 15 (testimony of Mike James, Vice President, Association of Community Pharmacies Congressional Network & Pharmacist/Owner, Person St. Pharmacy, Raleigh, N.C.). Independents believe that these practices are unethical, as PBMs’ mail-order divisions directly compete against the independent pharmacies with whom they contract. Id. at 15, 17. Absent sufficient evidence of market failure, however, questions are raised as to whether this attitude is paternalistic and detrimental to consumers’ ability to choose the quality/price mix they find most appealing. See, e.g., M. Joseph Sirgy & Dong-Jin Lee, Ethical Foundations of Well-Being Marketing, in CONTEMPORARY ISSUES IN BUSINESS ETHICS 49, 55 (Mary W. Vilcox & Thomas O. Mohan eds. 2007); cf. Michael D. Bromberg, Flexibility in Antitrust Enforcement, 12 HEALTH AFFAIRS 150, 150 (1993) (discussing the need for “consumers to vote with their pocketbooks based on their own values and perceptions of quality, access, and cost options” with regard to available health care plans).  
219 Lisa Wangsness, A Big Push on Mail-Order Drugs Savings, Efficiency Hailed, Disputed, BOSTON GLOBE, Feb. 2, 2009, at A1; see also Community Pharmacies Hearing, supra note 73, at 17 (statement of Mike James, Vice President, Association of Community Pharmacies

240
ARE INDEPENDENT PHARMACIES IN NEED OF SPECIAL CARE?

Vice President of the Association of Community Pharmacies Congressional Network and an independent himself, testified before Congress that this relationship is critically important when “[t]he pharmacist is the only health care professional who knows all of the patient’s medications, their interactions, and whether there are low cost generics available to address the patient’s needs.”

Finally, independents point to the lack of transparency and asymmetric information in PBM practices, which exacerbates or creates agency problems. According to independents, without proper and full information, consumers, employers, and pharmacists are unable to make the decisions necessary for the market to run properly. It is true that even absent monopsony, competition only works if:

1. Consumers know about or can learn about the prices and qualities of products offered by various sellers;
2. Consumers have the incentive to search for the sellers offering the best deals;
3. Sellers know about or can learn about their consumers; and
4. Sellers can enter profitable markets and exit unprofitable ones.

Independents correctly may argue that the market is not accurately pricing the higher level of quality they offer if any one of these four conditions does not hold true.

In part, these allegations are those of intentional deceit, which

Congressional Network & Pharmacist/Owner, Person St. Pharmacy, Raleigh, N.C.) (“The take-over by PBMs is also resulting in movement . . . to mail-order prescription programs. This has provided a perverse outcome for patients, who have no say in how their pharmacy benefits will be delivered, and are afraid to complain in fear of losing their benefit. These patients are denied their traditional right to seek personal and confidential professional assistance from local, hometown pharmacy professionals.”).

220 Community Pharmacies Hearing, supra note 73, at 17 (testimony of Mike James, Vice President, Association of Community Pharmacies Congressional Network & Pharmacist/Owner, Person St. Pharmacy, Raleigh, N.C.).

221 Not only does information failure inhibit the running of an efficient market, but it also can entrench monopsony itself. Garrett & Garis, supra note 170, at 63 (“Arguably, the market power that PBMs wield stems both from market share and also from the paucity of information available to those who deal with the PBMs.”).

222 HAAS-WILSON, supra note 49, at 39; see also Sage & Hammer, Competing on Quality of Care: The Need To Develop a Competition Policy for Health Care Markets, 32 U. Mich. J.L. Reform 1069, 1089 (1999) (“[A]ntitrust laws assume that competitive mixes are allocatively efficient. This assumption implies that markets will determine the appropriate prices for medical services, the appropriate tradeoffs between price and quality, and the appropriate tradeoffs among different quality attributes. However, failures endemic in health care markets make it necessary to seriously question this assumption.”).

223 Independents complement their claims of intentional deceit with that of inherent and inevitable market failure in health care markets. For example, David Balto, a staunch advocate of an exemption, explained in his testimony before the Ohio Senate Insurance, Commerce, and Labor
independents posit is widespread and systematic. According to independents, employers and MCOs are being tricked by informational asymmetries in their dealings with PBMs. The primary contention is that “PBMs, which are ostensibly hired by health plans as the agents for those plans to negotiate with manufacturers and retail pharmacies, hide from their own clients what they pay for prescriptions and often fail to disclose appropriate information regarding rebates.”224 Similarly, another advocate has argued that “the self insured employer never sees on their monthly itemized statement how much was actually paid to the provider but only what they were charged for the product or service by the PBM.”225 Furthermore, “[p]articipating network pharmacies are contractually prohibited from directly contacting the clients (the employers) of the PBM’s [sic] and disclosing the compensation that they receive directly from the PBM[,] thereby eliminating a vital component of the free market system necessary to maintain competitive forces in the marketplace.”226 Other allegations include PBMs “[u]sing aggressive marketing tactics to steer patients

Committee:

[T]here is a tremendous need for reform in the PBM market. The fundamental elements for a competitive market are transparency, choice, and a lack of conflicts of interest. This is especially true when dealing with health care intermediaries such as PBMs and health insurers where information may be difficult to access, there are agency relationships, and securing adequate information may be difficult to access . . . . Transparency is necessary for consumers to evaluate products carefully, to make informed choices, and to secure the full range of services they desire.


224 Garrett & Garis, supra note 170, at 61.


226 Id.; see also David Balto, Bending the Cost Curve: Regulating Healthcare Middlemen, HILL (Sept. 4, 2009 1:29 PM), http://thehill.com/blogs/congress-blog/healthcare/57371-bending-the-cost-curve-regulatinghealthcare-middlemen (“A lack of transparency is one of the key problems in the pharmacy benefit management industry. For example, PBMs often charge the health plans they serve significantly more for the drugs than they pay the pharmacies that distribute the drugs to patients. PBMs also may switch patients to a drug other than the one their doctor prescribed[,] sometimes a drug more expensive for the health plan and patient[,] to take advantage of rebates the PBM receives from drug manufacturers, which are often hidden from the PBM’s customers.”) (internal quotation marks omitted); Robert I. Garis et al., Examining the Value of Pharmacy Benefit Management Companies, 61 AM. J. HEALTH-SYS. PHARMACISTS 81, 85 (2004) (“What seems clear from this navigation of the PBM maze is that prescription benefit plan sponsors (either private employers or government entities) should insist on full disclosure of cash flows to and through the PBM that is administering their drug benefit. Without this level of scrutiny, the plan sponsor cannot be sure if its PBM is providing a good service for a fair price or is acting primarily in its own interest.”).
ARE INDEPENDENT PHARMACIES IN NEED OF SPECIAL CARE?

to [their own] pharmacies”; “[t]aking advantage of access to independent pharmacies’ claims data in order to target their customers and steer them to [their own] pharmacies”;\(^\text{227}\) participating in crooked pricing and deceptive advertising schemes; and forcing “gag clauses” on pharmacists, prohibiting them from informing patients about non-formulary-listed medications.\(^\text{228}\) These claims boil down to the fact that “restrictions on pricing transparency ‘increase the difficulty of discovering the lowest cost seller,’” who also offers the highest degree of quality.\(^\text{229}\)

Independents also allege that the consumers themselves are being deceived. As one advocate writes, “America is . . . being told that money grubbing community pharmacies are overcharging them. Little does the typical American know that this argument is a classical ruse, a method to distract them so they don’t feel the boney fingers of shadowy figures inside their pockets seizing their wallets.”\(^\text{230}\) According to independents’ allegations, PBMs’ deceitful practices compound already-existing agency problems, as consumers already “find it difficult to evaluate the cost and quality of health services” given “the technical nature of medical information and the complexity of diagnoses and treatment alternatives.”\(^\text{231}\) The message of independents is clear: if consumers, MCOs, and employers cannot adequately evaluate quality and cost, the market falls victim to inefficient resource allocation. Although intuitively plausible, one should not take independents’ arguments pertaining to these market failures for granted, but rather, should examine critically the set of assumptions about the market on which these arguments are based.

\(^{227}\) Ohio Hearing, supra note 223. Indeed, commentators have noted that “[i]n health care, a variety of circumstances undermine the neoclassical assumption that buyers and sellers possess adequate information to assess the quality and costs of the services provided.” Thomas L. Greaney, The Affordable Care Act and Competition Policy: Antidote or Placebo, 89 OR. L. REV. 811, 818 (2011).

\(^{228}\) Mila Ann Aroskar, Ethical Aspects of Pharmacy Practice in Managed Care, in MANAGED CARE PHARMACY PRACTICE, supra note 3, at 507, 509; see also Community Pharmacies Hearing, supra note 73, at 87 (statement of David Balto, Senior Fellow, Center for American Progress Action Fund) (discussing provisions that “prevent[] pharmacies from informing consumers of less expensive and more appropriate prescriptions”); Healthcare Competition Hearing, supra note 46, at 56–57 (statement of Mark Riley, Nat’l Treasurer, National Community Pharmacists Association) (explaining that “[m]ail-order is steeped in deceptive pricing schemes that are intended to dupe employers into believing that they are saving money”).


\(^{230}\) Benamoz, supra note 225, at 1.

\(^{231}\) Thomas L. Greaney, Quality of Care and Market Failure Defenses in Antitrust Health Care Litigation, 21 CONN. L. REV. 605, 633–34 (1989) (“[T]he considerable uncertainty that attends medical treatment makes judgment on causation (and hence costs and benefits of treatment) difficult. In addition, information is asymmetrically distributed among providers, patients, and payers. This characteristic may permit physicians to induce demand for their services; at a minimum it makes information costly for buyers to acquire.”).
2. Questioning Independents' Assumptions: Quality of Care

Independents’ argument relating to quality enhancement relies primarily on two assumptions: (1) independents provide superior health care quality as compared to chain and mail-order pharmacies, but are unable to compete with them under current market conditions; and (2) collective bargaining would be able to compensate for these distortions by delivering an optimal level of care to consumers, as under perfect competition. This Subsection examines each of these assumptions in turn.

a. Superior Health Care Quality

The first assumption is that while independents provide superior health care services, they are unable to compete with mail-order and chain pharmacies due to the PBMs’ lack of transparency and deceptive trade practices. There is little evidence, however, supporting the assertion that independent and community pharmacies provide superior health care as compared to chain or even mail-order pharmacies. While a retail pharmacist can provide in-person medication counseling, which a mail-order pharmacist cannot, it is not obvious why a pharmacist at an independent pharmacy would provide superior counseling to one at a chain or supermarket pharmacy. Simply because an independent pharmacist may know more patients’ names or faces does not result necessarily in a superior level of treatment quality.

Moreover, from a safety standpoint, mail-order services offer vastly lower error rates. Because mail-order pharmacies benefit from economies of scale, they can afford immensely superior processing and dispensing equipment, with built-in infrared scanners that check and re-check each prescription bottle for accuracy. Highly automated prescription dispensing systems can achieve accuracy rates twenty-three times higher than those reported in a benchmark study of retail community pharmacies. Furthermore, because mail-order pharmacies are so large — some physically as big as six football fields — they can hire pharmacists who only handle medications for a given disease, such as cancer or diabetes. These pharmacists review each patient’s file, highlight any potential drug interactions, and verify that no cheaper alternative exists. Finally, mail-order pharmacists are available to answer patients’ questions twenty-four hours per day. Given the fact that independents have not been able to offset the objective data indicating that chain or mail-order pharmacies

235 Id.
236 Id.
ARE INDEPENDENT PHARMACIES IN NEED OF SPECIAL CARE?

actually may provide higher quality care with any empirical support to the contrary, it would be imprudent to conclude that the provision of preferential treatment to independents in their negotiations with PBMs would improve health care quality.

Finally, to the extent that independents actually do provide a higher quality of care, it is unclear that collective bargaining is the answer. First, higher reimbursement rates effected through collective bargaining may have unintended consequences when one takes at face value independents’ assertion that health care quality is the ultimate goal. First, as the price increases to use independents to fulfill the needs of MCOs’ customers, the law of demand dictates that PBMs will seek to substitute the services of independents where possible.237 No doubt PBMs will be constrained to some extent in their endeavors given requirements that insurance plans include a certain number of pharmacies per any given area. That said, to the extent that PBMs currently are exceeding such requirements, they logically will seek to reduce the number of PBMs in their networks in favor of chain pharmacies who may now have relatively less economic clout. To the extent that such substitution is impossible, PBMs may seek to increase the incentives for patients to use alternative mechanisms of fulfilling their prescriptions, such as mail-order pharmacies, which independents say so perniciously impact health care quality.238

Moreover, not only does economic theory dictate that competition keeps prices in check, it also predicts that competition stimulates innovation, leading to higher quality — an argument that independents have not countered successfully in their lobbying efforts.239 As the Ninth Circuit stated in Freeman v. San Diego Association of Realtors, the failure of some competitors is inherent in the nature of competition: “Inefficiency is precisely what the market aims to weed out. The Sherman Act, to use it bluntly, contemplates some roadkill on the turnpike to Efficiencyville.”240 Or in the words of Judge Posner, “[b]usiness failures are an

237 Cf. RONALD G. EHRENBERG & ROBERT S. SMITH, MODERN LABOR ECONOMICS: THEORY AND PUBLIC POLICY 492–94 (7th ed. 2000) (explaining how unions incentivize firms to substitute capital for labor, train nonunion workers, or subcontract services currently provided by union employees).

238 It still may be worth it financially for independents to enter into such arrangements (i.e., the increased reimbursement may compensate sufficiently for any decrease in business).

239 This is not to say that there are not arguments that independents can make, though they almost certainly would be controversial and thus in need of further analysis. For example, in the labor context, one theory in favor of the beneficial societal impact of unions is “that employers are not as knowledgeable about how to maximize profits as standard economic theory assumes. Because management finds it costly to search for better (or less costly) ways to produce, so the argument goes, we cannot be sure that it will always use labor in the most productive way possible…. When unions organize and raise the wages of their members, firms may be ‘shocked’ into the search for better ways to produce.” EHRENBERG & SMITH, supra note 237, at 516.

240 322 F.3d 1133, 1154 (9th Cir. 2003); see also Novell, Inc. v. Microsoft Corp., 505 F.3d 302, 315 (4th Cir. 2007) (“[T]he Sherman Act does not protect competitors from being destroyed
indispensable means of imparting incentives for efficient business behavior, by placing the costs of mistakes on the firms that make them."²⁴¹

Evidence shows that on this road to "Efficiencyville," competition has forced pharmacists to be more efficient. Those pharmacies that have done the best, thriving in recent years, have carved out niches for themselves by appealing to customers drawn to independents who provide more personalized service;²⁴² who invest in new technologies that have improved patient care while reducing operating costs;²⁴³ and who specialize in unique products and services, such as home delivery,²⁴⁴ curb service,²⁴⁵ hard-to-find medical items (e.g., shoes for diabetics),²⁴⁶ the compounding of medications from scratch,²⁴⁷ nutrition services,²⁴⁸ and patient charge accounts.²⁴⁹ These pharmacies are fulfilling one of the primary roles of small businesses in the U.S. economy: not just to stimulate economic growth but rather "to meet the demand of limited sets of through competition; on the contrary, such destruction can signal healthy functioning of the enterprise system."²⁴⁸

²⁴¹ POSNER, supra note 102, at 28.
²⁴³ Birk, supra note 161 ("His independent pharmacy in Beverly Hills will be among the first in the region to employ Parata Max, the latest generation of robotic pill dispensers from a pharmacy-automation manufacturer based in North Carolina. Scheduled to be unveiled this week at a trade show in Las Vegas, the machine can fill about 200 prescriptions an hour with a miscount of 1 in 10,000"); Resilient, supra note 242 ("The ability of community pharmacies to modify their business operations through greater efficiencies has been critical. Technological advancement has played a prominent role. For example, 67% use point-of-sale systems, 42% use integrated voice response systems, and 31% use automated dispensing counters"); Sonnenberg, supra note 242, at 10C ("Already focused on individualized care, the independents are striving to take the lead in medication adherence. The association has already developed a technology software company called Mirixa that helps facilitate pharmacies' review of medications to determine whether certain drugs are redundant or should modified.").
²⁴⁴ Birk, supra note 161, at C1; R. Leonard Felson, Small Pharmacies Struggle To Survive, N.Y. TIMES, Aug. 15, 1993, at 13CN; Nichols, supra note 242; Resilient, supra note 242; Sonnenberg, supra note 242, at 10C.
²⁴⁵ Starrs, supra note 162.
²⁴⁶ Best, supra note 242, at C1.
²⁴⁸ Resilient, supra note 242.
²⁴⁹ Id.; Starrs, supra note 162.
ARE INDEPENDENT PHARMACIES IN NEED OF SPECIAL CARE?

consumers for particularized products or services” where the cost of coordination prevents larger business from satisfying that demand.  

Accordingly, existing evidence calls into question both the assumption that independents provide superior quality and that their continued existence is threatened by PBMs.

b. The Promise of Collective Bargaining in Increasing Quality of Care

Even if independents could demonstrate a clear quality advantage, they still would need to prove that an antitrust exemption would be the best — or at least a good — way to improve patients’ quality of care. There is no guarantee, however, that if Congress exempted pharmacists from antitrust laws, these pharmacists would focus their efforts on attempts to secure real gains for consumers, such as lower medication prices and preapproval requirements or expanded PBM formularies.

The only available evidence points exactly in the opposite direction. Where pharmacists in the past flagrantly have disregarded antitrust laws, they have colluded not to secure gains for consumers but rather only to raise reimbursement levels to increase their own profit margins. For example, in the mid- to late-1990s, the Asociacion de Farmacias Region de Arecibo (AFRA), a Northern Puerto Rican association composed of 125 pharmacies, colluded to set the price schedule associated with a government-sponsored insurance program for the indigent. In threatening to boycott the plan administrator if it did not accede to the association’s fee demands, AFRA obtained an immense twenty-two percent increase over the price levels that members would have obtained under the prior fee schedule. Similarly, in the 1980s, the Chain Pharmacy Association of New York State attempted along with several individual pharmacies to participate in a group boycott of the New York State Employees Prescription Program. After agreeing amongst themselves to refuse to participate in the plan at the proposed reimbursement levels, the pharmacies coerced the State of New York into paying additional sums in excess of seven million dollars for prescription drugs. In case after case, where pharmacists have disregarded antitrust laws, it has been to benefit their own fee schedules and reimbursement rates rather than to obtain direct quality enhancements for consumers.

250 Priest, supra note 214, at 7.
252 Id. at 270.
254 Id. at 496–97.
Even if one accepts the dubious possibility that pharmacists could secure transparent gains for consumers through collective bargaining, bargaining is an ill-fitted mechanism to employ in trying to accomplish that goal. The drafters of the NLRA never intended the Act to address issues concerning product or service quality, let alone that of the crucial service of health care. Instead, "collective bargaining rights are designed to raise the incomes and improve the working conditions of union members." Collective bargaining is not set up as a natural mechanism for achieving higher levels of quality because bargaining over wages is inherently self-interested. If pharmacists, in their negotiations with PBMs, secured the types of benefits that would assist patients — such as broader formulary lists and reduced preapproval requirements — they would have to compensate for these concessions through reductions (or smaller gains) in their own fee schedules and reimbursement rates. Inevitably, this would place pharmacists in the conflicted position of having to choose between interests of their customers and of themselves.

Finally, independents gloss over the fact that current antitrust regulations already permit other forms of quality-enhancing, procompetitive collaboration. Under the 1996 Statements of Antitrust Enforcement Policy in Healthcare, pharmacies, in many instances, can form pharmacy-owned PBM joint ventures, joint buying arrangements in the purchase of pharmaceuticals from wholesalers and manufactures, and PPOs. Because many of these arrangements improve efficiencies and health care quality by utilizing electronic health records and shared support mechanisms, they are legal under antitrust laws. Specifically with regards to joint purchasing arrangements, the DOJ and FTC have recognized that such collaboration frequently creates economies of scale (and thus benefits rather than harms consumers). To eliminate


256 See supra Section III.B.
257 See supra note 73 and accompanying text.
259 See supra note 46–49 and accompanying text.
261 U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, supra note 38 at 53 ("Such collaborative activities typically allow the participants to achieve efficiencies that will benefit consumers. Joint purchasing arrangements usually involve the purchase of a product or service used in providing the ultimate package of health care services or products sold by participants. . . . Through such joint purchasing arrangements, the participants frequently can obtain volume discounts, reduce
ARE INDEPENDENT PHARMACIES IN NEED OF SPECIAL CARE?

uncertainty among providers who fear antitrust exposure from forming such a cooperative, the DOJ and FTC, through guidelines, have “set[] forth an antitrust safety zone that describes joint purchasing arrangements . . . that will not be challenged, absent extraordinary circumstances, by the [two] Agencies under the antitrust laws.”262 The agencies have pledged that “absent extraordinary circumstances,” they will not challenge “any joint purchasing agreement among health care providers,” provided the following two conditions are met:

1. the purchases account for less than 35 percent of the total sales of the purchased product or service in the relevant market; and

2. the cost of the products and services purchased jointly accounts for less than 20 percent of the total revenues from all products or services sold by each competing participant in the joint purchasing arrangement.263

Moreover, the FTC and DOJ further have identified a set of conditions under which “[j]oint purchasing arrangements . . . that fall outside the antitrust safety zone” remain unlikely to “raise antitrust concerns.”264 While pharmacists are typically acting as sellers rather than buyers in their negotiations with PBMs, transaction costs, and have access to consulting advice that may not be available to each participants on its own.”).

262 ld. at 54. In addition to relying on the published Guidelines, pharmacists have the option of directly requesting advisory opinions from the FTC that are customized to their own specific fact situations. FED. TRADE COMM’N, GUIDANCE FROM STAFF OF THE BUREAU OF COMPETITION’S HEALTH CARE DIVISION ON REQUESTING AND OBTAINING AN ADVISORY OPINION (2011), available at http://www.ftc.gov/bc/healthcare/industryguide/advop-general.pdf; see, e.g., Letter from Michael D. McNeely, Assistant Dir., Federal. Trade Comm’n, to Allen Nichol (Aug. 12, 1997), available at http://www.ftc.gov/os/1997/08/newjerad.htm (stating that the FTC would not recommend a challenge to a proposal to implement two “pharmacist service networks,” which would offer health education and monitoring services to patients with diabetes and asthma); Letter from Richard A. Feinstein, Assistant Dir., Health Care Services and Products, Bureau of Competition, Fed. Trade Comm’n, to Paul E. Levenson (July 27, 2000), available at http://ftc.gov/bc/adops/neletfi5.shtm (advising that the FTC would not challenge a proposal to establish a network of independent pharmacists that would provide medical management of patients with chronic or long-term illnesses in order to increase medication compliance and reduce patient error).

263 U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, supra note 38, at 54–55. While the first of these conditions ensures that the joint purchasing arrangement will not “be able to drive down the price of the product or service being purchased below competitive levels,” “[t]he second condition addresses any possibility that a joint purchasing arrangement might result in standardized costs, thus facilitating price fixing or otherwise having anticompetitive effects.” ld. at 55.

264 ld. at 57 (identifying three “safeguards [that] will reduce substantially, if not completely eliminate, use of the purchasing arrangement as a vehicle for discussing and coordinating the prices of health care services offered by the participants” and stating that “[t]he adoption of these safeguards also will help demonstrate that the joint purchasing arrangement is intended to achieve economic efficiencies rather than to serve an anticompetitive purpose”).

249
these guidelines still apply in their dealings with wholesalers and manufacturers in purchasing pharmaceuticals. Accordingly, these guidelines may be used by independents in reducing the cost of their inputs, thus raising profits margins. With such procompetitive mechanisms to increase simultaneously market efficiency and health care quality, there is no reason to allow pharmacists to resort to the formation of cartels, whose quality-enhancing effects are highly questionable and rest on unsound economic policy.

CONCLUSION

The pharmaceutical industry has changed dramatically in response to the explosion in managed care and MCO efforts to cut costs. Pharmacists have reacted by charging that such measures for cost cutting not only shut small community pharmacists out of the market, but also negatively impact the quality of care that they can provide. In response to these concerns, legislative representatives have put forth numerous bills over the past two decades hoping to secure an exemption under the antitrust laws for pharmacists so that they can bargain collectively with PBMs and MCOs. While these attempts have failed to date, some of the bills have enjoyed bipartisan political support, and providers have demonstrated their tenacity in continuing to fight for an exemption.

Notwithstanding the effectiveness of the pharmacy lobby in pushing its agenda in Congress, such an exemption would be unwise from an economic and public-policy perspective. In their quest for an exemption, independents have not identified any sufficiently compelling societal goal to trump the gains created by free-market competition. Permitting independent pharmacy cartels would be antithetical to the policies underlying our nation’s antitrust laws, which have recognized explicitly that in order to safeguard competition and further consumer welfare, those businesses that are less than maximally efficient are destined to struggle or fail. This conclusion is supported by empirical data suggesting that an exemption for pharmacists significantly would increase health care costs without a necessary boost in health care quality. Furthermore, it is not clear from the relative bargaining power wielded by health care providers or the industry success of independent pharmacies that an exemption is needed. Many report that the insurance market is indeed competitive and that pharmacists may not be in as precarious positions as some suggest. In addition, under current laws that pertain to health care providers, pharmacists already have a variety of tools at their disposal to collaborate where such collaboration would be procompetitive.

Because collusive behavior directly harms consumers in favor of a select group of producers, academics and practitioners alike have criticized harshly exemptions similar to that proposed by the various iterations of the Quality
Health Care Coalition Act. Commentators argue that while “exemptions proposed to Congress are normally justified on the basis of one or more of a handful of economic arguments[,] . . . these claims often lack substantial documented empirical support.” Instead, exemptions tend to be special-interest-group legislation designed to benefit a few at the expense of many. Consistent with public-choice theory, small groups, like the pharmacy lobby, who are more willing to organize and spend money on lobbying efforts tend to monopolize the legislative process at the expense of diffuse, unorganized groups such as health care consumers. Because Congress has designed many of these exemptions to benefit select groups of producers, rather than consumers, exemptions end up serving as “a form of indirect subsidy for favored actors . . . [who] will be made wealthier without serving the sought-for public interest goals.”

It is important to note that this is not to say that the preservation of small business in the United States, even at the expense of other values, such as economic efficiency and lower prices, is not a laudable goal—or one that is undeserving of legislation. This question is not at the heart of this Note and must be evaluated on its own terms. It is to say, however, that it is disingenuous to advance these goals under the catch phrases of “economic efficiency,” “lower prices,” and “greater health care quality” when these claims remain unsupported by the evidence. To do so is to cloak a subsidy in an antitrust exemption imbibed with consumer-welfare arguments. Once the true issues and values at stake are brought to the forefront, we as a society can engage in a more honest and open
debate as to what we wish to achieve and best mechanisms to obtain those goals. For example, if we value small business and want to keep independents alive, is collective bargaining the best route or would a more honest approach be to grant a direct subsidy to the desired group through the structuring of our tax system? Moreover, if we want to preserve small business, do we want to help those in all sectors of society equally or is there something about independent pharmacists that make them particularly worthy of attention?

Finally, even though collective bargaining may not be a logical method of addressing pharmacists’ concerns, pharmacists may very well have legitimate concerns about the conduct of PBMs and MCOs in the pharmaceutical arena. The place to address these grievances, however, is not through legislation that would offer a broad antitrust exemption. Lawmakers should regulate PBMs’ anticompetitive practices directly and continue to fight anticompetitive activity through litigation rather than leave the fate of vulnerable patients up to the unsupervised market power of the PBMs. For example, state legislators have passed laws including, but certainly not limited to regulating or banning requirements that beneficiaries obtain drugs solely by mail order, setting PBM disclosure and transparency requirements, mandating that networks include a certain number of pharmacies in a set geographical area or preventing discrimination against pharmacies that agree to meet a plan’s terms and conditions, and recognizing that PBMs have certain fiduciary duties with respect to covered entities. Such direct targeting is preferable to sanctioning the cartelization of independent pharmacies. Through these efforts to restrain the anticompetitive practices of PBMs, the interests of pharmacists and lawmakers may align to resolve pharmacists’ concerns about their bargaining power while truly improving patients’ quality of care.

271 See id. at 298–99.
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