Comment on “Estimating the Budgetary Impact of H.R. 4577, the ‘Ensuring Seniors Access to Local Pharmacies Act of 2014” (“PCMA Study”)

The National Community Pharmacists Association (“NCPA”) has requested that Microeconomic Consulting and Research Associates (“MiCRA”) provide comments on a report released by Pharmaceutical Care Management Association (“PCMA”) on the likely impact of the Any Willing Pharmacy (“AWPH”) provision proposed in HR 4577. According to the PCMA study, the AWPH provision would "eliminate the need for pharmacies to propose company-specific discounts as a condition of offering their enrollees preferred cost sharing arrangements" (p. 2), and that as a result they "would expect prevailing reimbursement rates to equilibrate, with a lag for recontracting, at levels meaningfully above prevailing preferred network discounts". Hence, the authors assume that a specific outcome will result from the AWPH provision, *i.e*., that current preferred pharmacies will react to an AWPH provision by raising their drug prices to the level charged by the higher-cost, current non-preferred pharmacies to obtain participation in Part D networks as non-preferred pharmacy outlets. Thus, rather than continuing to price at levels that effectively keep non-preferred pharmacies out of preferred networks, they will find it more profitable to price at the higher-than-current level bid by the higher-cost, non-preferred pharmacies who will be permitted to participate under the AWPH provision.

In a prior comment submitted to Center for Medicare and Medicaid Studies (“CMS”), MiCRA shows this presumed result is not a foregone conclusion. A current preferred pharmacy must compare the profits it would earn by continuing to "underprice" non-preferred pharmacies with the profits it would earn by pursuing higher prices. Whether they pursue one or the other strategy under an AWPH rule is likely to depend on several factors, including the magnitude of their cost-advantage over the existing non-preferred pharmacies, the amount of market share or volume they would lose to those firms at the presumed higher price, and the elasticity of demand facing individual Part D prescription drug plans (“PDPs”).

Also problematic is PCMA's theoretically baseless and inconsistently described statistical methodology for estimating the impact of the proposed AWPH provision. When introducing its methodology for calculating the cost impact of the proposed provision PCMA assumed that the "with-AWPH" prices should equal "the midpoint of the spread between preferred and non-preferred contracts observed in the Part D marketplace" (p. 2). PCMA's *actual* calculation assumes, however, that under an AWPH provision the entire spread between preferred and non-preferred pharmacy costs erodes rather than one-half that amount which would result if PCMA had actually used its intended methodology. Thus, PCMA projects that the current difference of 6.1% between preferred and non-preferred pharmacy costs "would erode from 2015 to 2017, and that pricing would remain at the level of non-preferred pharmacy for the balance of the scoring window" (pp. 3-4). Had the authors actually assumed that prices would rise to the midpoint between preferred and non-preferred pharmacies as asserted, the eroded savings would be only 3%, and the cost of the AWPH provision to CMS would be only a fraction of the estimated $21.32 billion in lost savings. Equally troubling is that neither the actual nor intended formula used to calculate the price increase is supported by any theoretical rationale.

In addition, the authors mischaracterize CMS's conclusions from its study on preferred versus non-preferred pharmacy costs in Part D networks. The authors implicitly assume that CMS's study demonstrates unambiguously that non-preferred pharmacies charge higher prices to the Government than preferred pharmacies. In fact, the CMS study to which PCMA cites found that "when both mail and retail pharmacies are included, some sponsors' preferred network pharmacies are offering somewhat higher negotiated prices than are offered by their non-preferred network pharmacies. Thus, our hypothesis that preferred network pharmacy negotiated prices are lower than non-preferred network pharmacy negotiated prices was *not* confirmed" (emphasis added, p. 4).[1] Since CMS was unable to

[1] The CMS study can be found at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/PharmacyNetwork.pdf.

clearly establish that preferred pharmacies were in fact offering lower prices than non-preferred pharmacies to Part D PDPs *at all*, the PCMA study misleads by relying on a simple point estimate of the difference in cost to the Government which, in fact, CMS concludes was neither statistically meaningful nor reliable. Because the prices offered by preferred pharmacies were not statistically significantly below those offered by preferred pharmacies, if PCMA were to report a confidence interval for their estimate of the budgetary impact of the AWPH provision, it would necessarily include a budgetary impact of zero or negative amounts. [2]

PCMA also assumes that the current regime of "company-specific discounts as a condition of offering [Part D PDP] enrollees preferred cost sharing arrangements" results in preferred pharmacies offering lower prices than they would charge were they to lose their ability to condition discounts on exclusion of other pharmacies from preferred networks. Restated, the offer of discounts in return for a commitment to less quantity or share from the other would-be participating pharmacies constitutes a form of loyalty or market share discount. The theoretical economics literature on this type of "loyalty discount" shows that their effects are at best ambiguous, and if applied to this industry, a number of studies demonstrate that this form of "discounting" could be used to both exclude other pharmacies from preferred networks and *raise* prices above levels that would prevail in the absence of such discounts.[3]

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[2] The CMS study reports that for a sample of thirteen Part D PDPs' retail and mail order pharmacy data, the pharmacy weighted-average-unit costs (WUC) for preferred pharmacies was above that for non-preferred pharmacies for several Part D PDPs (See Table 1, p. 5). The average non-preferred and preferred pharmacies' WUCs were $1.48 and $1.39 respectively, which yields a mean difference in costs of $0.08. The standard deviation of this difference in costs can be calculated from Table 1 as $0.17. Hence, a 95% confidence interval around the mean difference of $0.08 using a student's t distribution is bounded below at negative $0.02, meaning that CMS could not demonstrate statistically that preferred pharmacies offered any savings.

[3] See, *e.g.*, Janusz Ordover & Greg Shaffer, 'Exclusionary Discounts' (CCP Working Paper No. 07-13, 2007); Roman Inderst and Greg Shaffer, 'Market Share Contracts as Facilitating Devices' (RAND Journal of Economics, 2010); Giacomo Calzolari, 'On the Anticompetitive Effects of Quantity Discounts' (International Journal of Industrial

Organization, 2011); Patrick Greenlee & David Reitman, 'Competing with Loyalty Discounts' (EAG Discussion Paper 04-2, 2004); Einer Elhauge, 'How Loyalty Discounts can Perversely Discourage Discounting' (Journal of Competition Law and Economics, March 2009).