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SOME ANTITRUST IMPLICATIONS OF THIRD PARTY PRESCRIPTION PAYMENT PROGRAMS

by

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TABLE OF CONTENTS

	Page
ACKNOWLEDGEMENTS	ii
TABLE OF CONTENTS	iii
LIST OF TABLES	vii
LIST OF FIGURES	viii
CHAPTER I. THE THIRD PARTY PAYMENT CONCEPT	1
Background	2
Types of Coverage	4
Reasons for Growth	8
Drug Benefits	15
Organized Pharmacy Reactions	20
National Pharmacy Insurance Council	21
CHAPTER II. SURVEY OF STATE PHARMACEUTICAL ASSOCIATION ACTIVITIES	23
Methodology	23
Hypotheses	24
Survey Results	26
Concern About Antitrust	33
CHAPTER III. FEDERAL ANTITRUST LAW	34
Statutes	34
Case Developments in General	38
Case Developments in Pharmacy	49
Inter v. Intrastate Commerce	53
Prescription: Commodity v. Pharmaceutical Service	57
Professional Exemption	58

TABLE OF CONTENTS - Cont.

	Page
CHAPTER IV. ASSOCIATION ACTIVITIES	62
Historical View	62
Potential Antitrust Violations	64
Statistical Reporting	64
Price Activities	76
Price Reporting	78
Cost Accounting	82
Pharmacy Associations and Specific Programs	83
CHAPTER V. ANALOGIES TO GOVERNMENT VENDOR PROGRAMS	97
Federal Programs	97
Veterans Administration	97
Office for the Civilian Health and Medical Program of the Uniformed Services	100
The Public Health Service	101
State Programs	103
CHAPTER VI. FUTURE EXPECTATIONS	118
Judicial Background	118
Pharmacy's Reactions	119
Congressional Recommendations	123
State Developments	133
Recent Federal Action	142
National Health Insurance	143
CHAPTER VII. RECOMMENDATIONS	147
Legislative	147
Judicial	149
Administrative and Organizational	151
Professional and Economic	159

TABLE OF CONTENTS - Cont.

	Page
CHAPTER VIII. SUMMARY AND CONCLUSIONS	162
Summary	162
Conclusions	167
BIBLIOGRAPHY	169

APPENDICES

Appendix		Page
A	INTRODUCTORY LETTER TO ASSOCIATION EXECUTIVES	184
B	COVER LETTER - MAIL SURVEY	186
C	QUESTIONNAIRE - MAIL SURVEY	188
D	COVER LETTER - SUMMARY REPORT	194
E	REPORT TO RESPONDENTS	196
F	VETERANS ADMINISTRATION: PHARMACY AGREEMENT	202
G	MEDICAID SERVICES STATE BY STATE, MARCH 1971	205
H	PREPAID PRESCRIPTION PROGRAM NEGOTIATION ACT.....	207
I	NARD ANTITRUST GUIDELINES FOR THIRD PARTY PREPAID PRESCRIPTION PROGRAMS	210
J	CORRESPONDENCE: EARL W. KINTNER TO MILES W. KIRKPATRICK	212
K	REPORT OF THE SUBCOMMITTEE ON ENVIRONMENTAL PROBLEMS AFFECTING SMALL BUSINESS TO THE SELECT COMMITTEE ON SMALL BUSINESS, HOUSE OF REPRESENTATIVES	216
L	JUSTICE DEPARTMENT - PAID PRESCRIPTIONS "RELEASE" LETTER	218

TABLE OF CONTENTS - Cont.

Appendix		Page
M	PHYSICIANS AGREEMENT - R. I. MEDICAL SOCIETY PHYSICIANS SERVICE	221
N	NPIC CLAIM FORM	223
O	NPIC BYLAWS	225
P	NAPPP CONSTITUTION AND BY-LAWS	239

LIST OF TABLES

Table		Page
I	Number of Persons with Health Insurance Protection By Type of Coverage - As a Percent of Total Population	6
II	Sources of Health Care Expenditures for Selected Years	11
III	Out-of-Hospital Drug Coverage	17
IV	Third Party Payment Informational Programs	27
V	Association Third Party Guidelines	28
VI	Actual Reimbursement Method Preferences	29
VII	Executive Opinion on Reimbursement Preferences	29
VIII	Assessment of NPIC Productivity to Date	30
IX	Assessment of NPIC's Future Role	30
X	Personnel Conducting Cost Studies	31
XI	Use or Intended Use of Cost Study Data	32
XII	Executives' Assessment of Problem Areas	33

LIST OF FIGURES

Figure		Page
I	Trends in Percent of Total Population with Types of Health Insurance Coverage	9
II	Public Funds Contribution to Total National Health Expenditures as Percent 1940-1970 (FY)	12
III	Private Funds Direct Payments Contribution to Total National Health Expenditures as Percent 1940-1970 (FY)	13
IV	Private Funds Insurance Benefits Contribution to Total National Health Expenditures as Percent 1950-1970 (FY)	14

CHAPTER I

THE THIRD PARTY PAYMENT CONCEPT

Traditionally, health care services for people in America were contracted on a private basis. The physician-patient relationship was such that the medical practitioner based his charge for services, in part at least, on the patient's socio-economic status as well as the ailment itself, the amount of time and skill involved in the treatment, and other similar factors. Upon making these determinations, the physician submitted a bill to the patient and was paid directly. This has been referred to as the direct payment system.

As simple and uncomplicated as this traditional system may have been, there were extensive pressures for the development of a system whereby insurance carriers or other third parties would pay the vendors and providers of health care services.

This chapter deals with the development of health care insurance in this country including developments in the coverage of pharmaceutical services under such programs.

The effect of the development of third party prescription programs upon the practice of pharmacy and the reaction of some pharmacists and of organized pharmacy to these programs also are considered.

Background

Although the United States Marine Hospital Service was established by Congress in 1798 and required compulsory deductions for hospital service to be made from seamen's wages, "the first company organized specifically to write health insurance was founded in 1847."[1] This was the Massachusetts Health Insurance Company of Boston.

Developments in the health insurance field in the latter half of the nineteenth and early twentieth century were related largely to accident and disability coverages, such as income protection for loss of work from certain diseases. One of the key developments, and one considered by some to be the start of modern health insurance, occurred during the Great Depression and its resultant socio-economic cataclysm. This was a plan for prepayment of hospital expenses by school teachers in Dallas, Texas. "The plan was set up by Justin Ford Kimball for the Baylor University Hospital in February, 1929."[2]

For a prepayment of fifty cents a month, the hospital plan provided twenty-one days of hospitalization in a

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1. 1970 Source Book of Health Insurance Data, Health Insurance Institute, New York, 1971, p. 5.

2. Walter J. McNerney, "Health Insurance and Prepayment Plans," in Leslie J. DeGroot, Ed., Medical Care, Charles C. Thomas, Springfield, Ill., 1966, p. 325.

semi-private room. In addition to teachers, other groups of employees in the Dallas area were quick to join the plan, which soon gained nationwide attention. A later extension of this type program was the development of community-wide plans in which subscribers had a choice of hospitals to select in their particular area. This was a major departure from the Baylor University prototype. In 1932, the "first city-wide Blue Cross plan tried out with a group of hospitals in Sacramento, California."[3]

The American Hospital Association obviously had an interest in these developments.

> In 1933 the American Hospital Association began to encourage the development of such plans and took steps to control and approve arrangements for prepayment. Out of the American Hospital Association grew the Blue Cross Commission - now the Blue Cross Association.[4]

An added impetus to the already demonstrated trend in health insurance interest was provided in the decade of the forties. Collective bargaining units, anxious to find new benefits due to frozen wages, looked toward welfare bargaining. This included negotiating fringe benefits such as health insurance programs for their members.

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3. 1970 Source Book, op. cit., p. 53.
4. McNerney, op. cit., p. 326.

While early efforts were surrounded by controversy, the issue of whether welfare bargaining was included in the "other conditions of employment" on which management had to negotiate under the Taft-Hartley Act was decided in 1948 in the Inland Steel Company case.[5] This case also provided a broad interpretation of "wages" as "emoluments of value."

A series of related cases decided soon after the Inland Steel Company clarified a number of associated issues as well. The union's right to negotiate changes in a company-initiated plan was recognized.[6] When no plan existed and a union indicated its desire to bargain on the subject, it was held an employer was not free to institute a welfare plan by unilateral action.[7]

Generally, these precedents helped to generate demand for increasing numbers of health insurance programs as well as broader coverages.

Types of Coverage

Health insurance coverage generally is categorized into five broad types of protection. These include:

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5. 77 NIRB 1 (1948), aff'd, 170 F.2d 247 (7th Cir. 1949).
6. Raymond Munts, Bargaining for Health, The University of Wisconsin Press, Madison, 1967, p. 249.
7. Ibid., p. 250.

hospital expense; surgical expense; regular medical expense; major medical expense; and disability income (short-term and long-term). The Health Insurance Institute reported the growth in the number of persons with health insurance protection in the United States by type of coverage.[8]

In 1940, about 12,312,000 persons had hospital expense protection. This figure had grown to 175,221,000 by 1969. Surgical expense coverage rose from 5,350,000 to 162,144,000 during the same period of time. Regular medical expense coverage was provided for 3,000,000 persons in 1940. The 1969 figure reached 134,930,000. The earliest year for which major medical expense data are available is 1955, when 5,241,000 people were covered by this type of insurance. In 1969, about 72,292,000 were covered. Disability income coverage was held by 37,793,000 people in 1950 and by 66,080,000 in 1969.

In Table I these data are transformed into a more meaningful growth indicator showing percentages of the United States population covered by the different types of protection over time. Hospital expense coverage was available to about 9.3 percent of the nation's population in 1940, while 86.8 percent were covered in 1969.

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8. 1970 Source Book, op. cit., p. 16.

Table I

NUMBER OF PERSONS WITH HEALTH INSURANCE PROTECTION BY TYPE OF COVERAGE - AS A PERCENT OF TOTAL POPULATION

(000)

Year and Total Population*	Hospital Expense**	Percent of Population	Surgical Expense**	Percent of Population	Regular Medical Expense**	Percent of Population	Major Medical Expense**	Percent of Population	Disability Income**	Percent of Population
1940 132,457	12,312	9.295	5,350	4.039	3,000	2.265	--	--	--	--
1950 151,868	76,639	50.464	54,156	35.659	21,589	14.215	--	--	37,793	24.885
1960 179,992	130,007	72.220	117,304	65.170	86,889	48.273	27,448	15.249	--	--
1969 201,921	175,221	86.770	162,144	80.300	134,930	66.820	72,292	35.802	66,080	32.725

*Source: Statistical Abstract of the United States, 1970, U.S. Department of Commerce, Bureau of the Census, p. 5 (as of July 1 each year) (total resident population excluding Armed Forces abroad).

**Source: 1970 Source Book of Health Insurance Data, Health Insurance Institute, New York, p. 16.

Surgical coverage rose from slightly over 4 percent to over 80 percent during the comparable period. Regular medical expense coverage was provided to 2.3 percent of the people in 1940 while 67 percent were covered in 1969. Major medical expense coverage rose from about 15 percent to more than 35 percent in less than a decade. These data are presented graphically in Figure I, page 9.

Reasons for Growth

A variety of explanations and reasons have been offered for this growth. Among these is the increased effort by organized labor to include health insurance as a part of fringe benefit packages.

> During World War II, the freezing of wages spurred the growth of various fringe benefits for employees, including group health insurance. When the war ended, a pattern had been established. Group health insurance had become a standard health and welfare benefit under collective bargaining.9

Consumers have had more programs from which to choose, since by 1965, "In addition to the Blue Cross and Blue Shield Plans, there (were) more than 1800 voluntary insuring organizations in the United States."10

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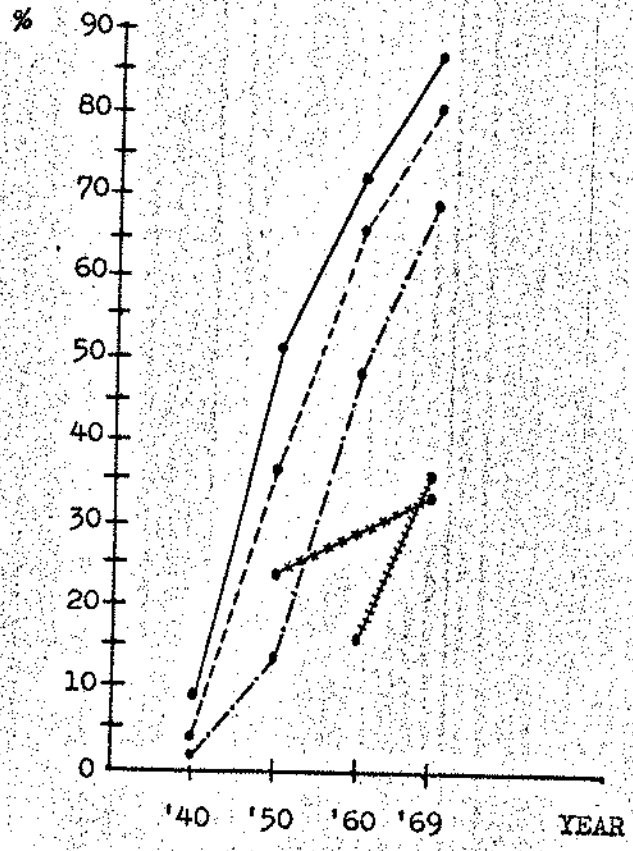
9. Modern Health Insurance, Health Insurance Institute, New York, 1969, p. 11.

10. McNerney, op. cit., p. 329.

Figure I

TRENDS IN PERCENT OF TOTAL POPULATION WITH TYPES OF HEALTH INSURANCE COVERAGE



Hospital Expense

Surgical Expense

Regular Medical Expense

Major Medical Expense

Disability Income

Source: See Table I.

The desirability of decreasing out-of-pocket expenditures by consumer-patients also may be a contributing factor. As shown in Table II, the direct payments percentage of the total amount of health care expenditures in the United States decreased from 76.3 percent in 1940 to 34.1 percent in 1970.

From 1950 to 1970, the insurance benefits percentage of the total rose from 7.4 percent to 20.5 percent. The public funds share from 1940 to 1970 rose from 20.5 percent to 37.2 percent.

The public expenditure pattern evidences a marked increase during the latter half of the decade of the sixties. The single most important influencing factor in this growth was the enactment of Title XVIII (Medicare) and Title XIX (Medicaid) amendments to the Social Security Act in 1965.

Figures II, III and IV are graphic presentations of the trends in public funds, private funds direct payments, and private funds insurance benefits contributions to total health expenditures.

Table II

SOURCES OF HEALTH CARE EXPENDITURES FOR SELECTED YEARS

Fiscal Year	Total Amount Health Expenditures (Billions) $	Public Funds $ (Billions)	Public Funds % of Total	Private Funds Direct Payments $ (Billions)	Private Funds Direct Payments % of Total	Private Funds Insurance Benefits[1] $ (Billions)	Private Funds Insurance Benefits[1] % of Total	Other[2] $ (Billions)	Other[2] % of Total
1940	3.8	.8	20.5	2.9	76.3	--	--	.09	2.4
1945	7.9	2.6	32.6	4.9	62.0	--		.4	5.1
1950	12.1	3.1	25.3	7.1	58.7	.9	7.4	.5	4.1
1955	17.9	4.4	24.7	9.4	52.5	2.3	12.8	.7	3.9
1960	26.4	6.4	24.3	13.1	49.6	4.7	17.8	.8	3.0
1965	38.9	9.5	24.5	17.6	45.2	8.3	21.3	1.0	2.6
1970	67.2	25.0	37.2	22.9	34.1	13.8	20.5	1.3	1.9

[1]Includes any insurance benefits and expenses for prepayment (insurance premiums less insurance benefits).

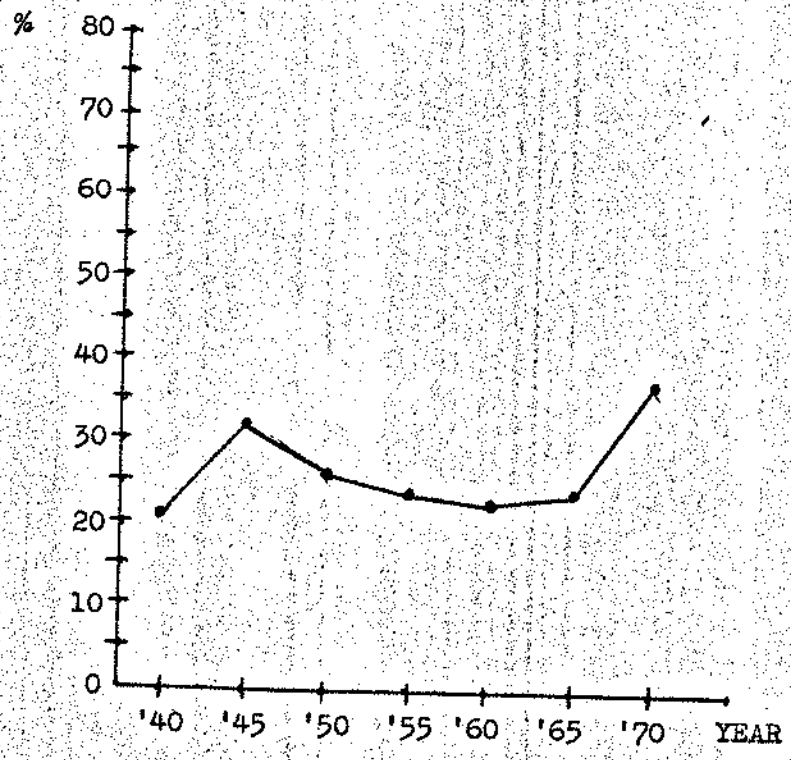
[2]Includes industrial in-plant services and philanthropy.

Data Source: Barbara S. Cooper and Mary McGee, "National Health Expenditures, Fiscal Years 1929-70 and Calendar Years 1929-69," Research & Statistics Note, No. 25, 1970, U.S. Department of Health, Education and Welfare, December 14, 1970.

NOTE: Sums of the categories in dollars and percentages vary from the total or 100 percent due to the exclusion of expenditures for medical research and medical facilities construction.

Figure II

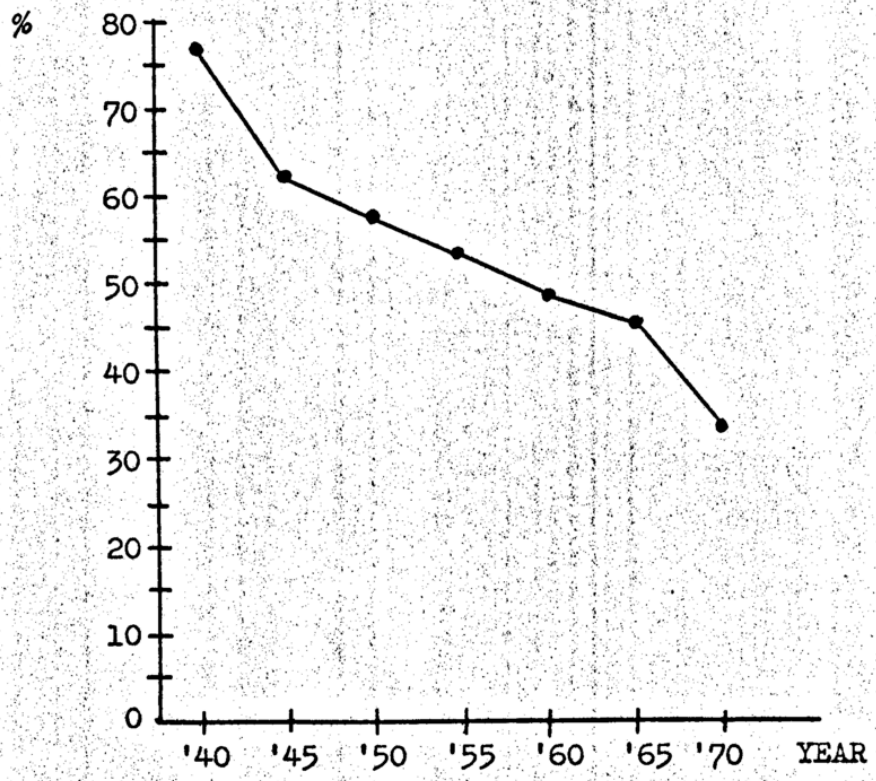
PUBLIC FUNDS CONTRIBUTION TO TOTAL NATIONAL HEALTH EXPENDITURES AS PERCENT 1940-1970 (FY)



Source: See Table II.

Figure III

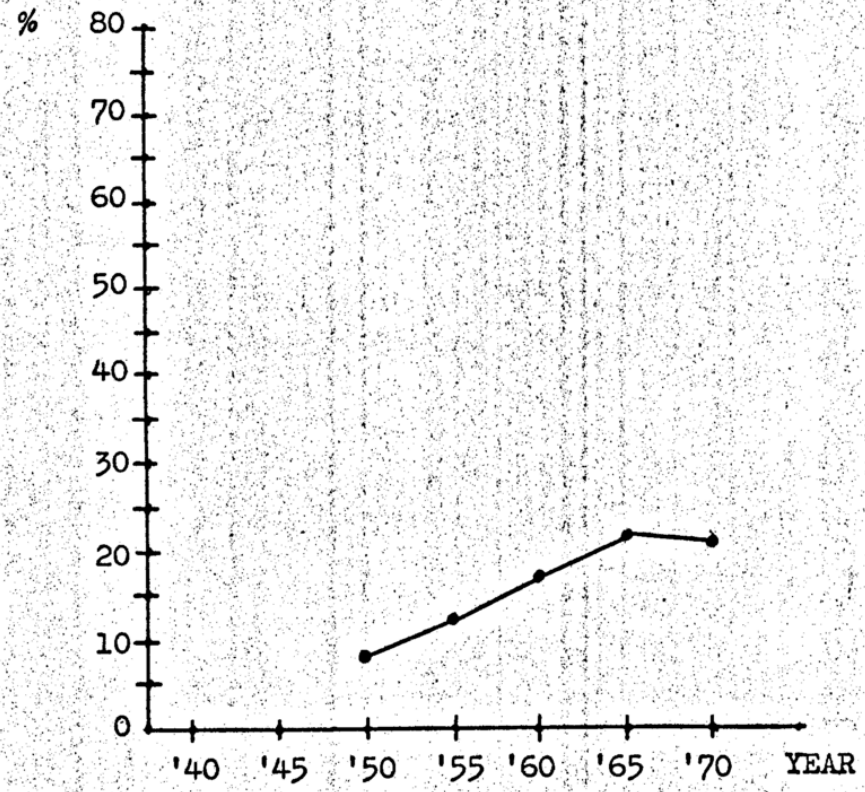
PRIVATE FUNDS DIRECT PAYMENTS CONTRIBUTION TO TOTAL NATIONAL HEALTH EXPENDITURES AS PERCENT 1940-1970 (FY)



Source: See Table II.

Figure IV

PRIVATE FUNDS INSURANCE BENEFITS CONTRIBUTION TO TOTAL NATIONAL HEALTH EXPENDITURES AS PERCENT 1950-1970 (FY)



Source: See Table II.

Drug Benefits

Widespread concern among pharmacists and organized pharmacy about provisions for prescribed drugs in health insurance policies grew in the decade of the sixties, when this type coverage gained in popularity.

There was, however, considerable interest in drug prepayment earlier, as evidenced by the following sampling of headlines in the American Druggist during the fifties: "APhA Mulls National Prepaid Rx Study" (140:2) July 27, 1959, p. 21; "Rising Demand Seen for Rx Prepayment" (138:10) November 17, 1958, p. 17; "Rx Insurance Plan Would Give Subscribers 50% Off Usual Price" (137:12) June 16, 1958, p. 14; "First Rx Prepayment Plan Reports: More Subscribers Needed to Meet Cost" (138:12) December 15, 1958, p. 5; "Rx Prepay Test is Started in California" (140:8) October 19, 1959, p. 23.

At the 1959 annual convention, the American Pharmaceutical Association House of Delegates adopted a resolution urging an immediate study of all established and proposed plans. The stimulus for this resolution was a report of the APhA Committee on Social and Economic Relations in which problems related to the Green Shield Plan in Windsor, Ontario were discussed.[11]

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11. "Resolution vs. resolute action," Journal of the American Pharmaceutical Association (21:8) August 1960, p. 469.

> The beginnings of the true prepaid RX format goes back about six years. At that time, there were sporadic instances of coverage involving prescriptions only, whereas most coverage for RX's was tied up to major medical or basic hospital policies. The Blues (Blue Cross Association) started a program in Wisconsin, but it dropped the plan before it became effective because of anti-trust problems.[12]

In the late sixties Collins reported, "...roughly 35% of the total population is covered for prescription expenditures as a part of major medical programs. However, only 1 to 2% really have prescription costs paid for on a first-dollar basis."[13]

Data provided in Table III indicate nearly 40 percent of the United States civilian population had out-of-hospital drug coverage of some kind by private insurance carriers in 1968.

A 1969 journal article describing third party prescription plans highlights the rapid growth of insurance coverage in this area.

> Five years ago the only substitute for cash payment for prescriptions acceptable to the pharmacist was the

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12. Sidney Waller, "Third Party Payment Plans," NARD Journal (91:16) August 18, 1969, p. 27.

13. Thomas M. Collins, "What Third Party Pay is All About," Pharmacist's Management Journal (3:1) January 1969, p. 25.

Table III

OUT-OF-HOSPITAL DRUG COVERAGE

Type of Plan	Number of People Covered (in thousands) Persons of All Ages	Persons Under Age 65	Persons 65 and Older
Net Total, All Plans	79,280	76,748	2,557
Insurance Companies			
Total (gross)	64,523	62,989	1,534
Group Policies	59,379	57,979	1,400
Individual Policies	5,144	5,010	134
Blue Cross-Blue Shield	14,849	14,077	772
Independent Plans:	3,770	3,519	251
Community	1,350	1,280	70
Employer-Employee Union	2,400	2,220	180
Private Group Clinic	20	19	1
Percent of U.S. Civilian Population with Coverage	39.9%	42.8%	13.1%

Source: Louis S. Reed, "Private Health Insurance, 1968: Enrollment Coverage, and Financial Experience," Social Security Bulletin (32:12) December, 1969, p. 21.

> I.D. card of the welfare recipient. Today, the proliferation of government and private third party prescription programs exposes the pharmacist to such a large number of different programs as to leave him confused.[14]

The earliest plan established solely to provide for the prepayment of drug charges was Prescription Services Incorporated (PSI) of Windsor, Ontario. This plan began in 1958 and was sponsored by area pharmacists to provide prepaid prescription services.

In August, 1964, California Pharmaceutical Services, Inc. was chartered in California. Originally organized to be operated by the California Pharmaceutical Association, the nonprofit corporation reorganized and unveiled the first nationwide prepaid prescription program in 1966 under the name PAID Prescriptions.

PAID functions as an agent for several insurance carriers, administering drug programs for them.

Another California organization, Prepaid Prescription Plans, Inc. (PPP), was established in 1966. A profit making enterprise, PPP is an indemnity type of plan as contrasted with most other prepaid drug programs. Policy holders are reimbursed in the amount of a percentage of the total charge for the pharmaceutical services. The percent, or coinsurance rate, is negotiated between the group and

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14. "CSA examines six 3rd party Rx plans," Chain Store Age (45:9) September, 1969, p. 76.

PPP. The patient pays the pharmacist directly at the time of the transaction.

Pharmaceutical Card System, Inc. (PCS) was formed in 1969 to process prescription benefit claims. Income for this profit motivated venture is derived from a nominal charge assessed against each claim processed. As with PAID, the main thrust of PCS' activities is essentially that of a clearinghouse for insurance companies.

PSI, PAID, PPP, and PCS represent programs underway or in planning stages at various levels.[15]

Pharmacy's dilemma arising from prepaid prescription programs is suggested by some of the titles of articles appearing in the pharmaceutical press: "Justice Dept Spells Out 'Rx Fee' Stand," American Druggist (150:3) August 3, 1964, p. 14; "Rx-Only Insurance Is Held Unrealistic," American Druggist (143:1) January 9, 1961, p. 17; "The Perils of Third Party Prescription Payment," Drug & Cosmetic Industry (106:6) June 1970, p. 42. Record keeping provisions; variability in qualifications and coverage; exclusions; and method and amount of reimbursement are aspects of third party plans which furnish considerable uncertainty and trepidation to providers of pharmaceutical services.

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15. For a more complete discussion of the development of these programs see: Waller, op. cit., pp. 27-30; Chain Store Age, op. cit., pp. 76-78; "Statement of the National Pharmacy Insurance Council to the Select Committee on Small Business of the United States House of Representatives, 92nd Congress, 2nd Session, Washington, D.C., July 8, 1971," pp. 4-9.

Organized Pharmacy Reactions

Nick Avellone, Chairman of the National Association of Retail Druggists' Executive Committee, called third party payment "the number one concern in pharmacy today."[16]

One aspect of this concern was discussed on several occasions by Lewis Bernstein, Chief, Special Litigation Section, Antitrust Division, U.S. Department of Justice. "Discussing the antitrust aspects of prepaid prescription plans, Mr. Bernstein emphasized that agreement by professional pharmacists upon the amounts of the dispensing fees constitute criminal offenses."[17]

Carl Roberts, Director of the Legal Division of the American Pharmaceutical Association, issued the following warning: "If they wish to avoid possible antitrust difficulties, pharmaceutical associations should refrain from disseminating any public judgments about specific third-party drug programs..."[18] The warning was issued during a Chicago meeting of the National Pharmacy Insurance Council.

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16. "The number one concern in pharmacy today," American Druggist (160:9) November 3, 1969, p. 15.

17. Ibid., p. 17.

18. "Don't 'judge' Rx plans, assns told," American Druggist (160:8) October 20, 1969, p. 30.

National Pharmacy Insurance Council

The National Pharmacy Insurance Council (NPIC) was organized in October, 1969:

> To develop Policy Guidelines for prepayment and insurance programs which will assure high quality pharmaceutical services to the public and uniform, efficient and economical claims processing mechanisms as incentives for pharmacist participation.[19]

In general, the NPIC is an organization of organizations. Its membership is composed of representatives of forty-six state associations, as well as national and specialty pharmaceutical associations with interest in the basic objectives of the council. These include the American College of Apothecaries, the American Society of Hospital Pharmacists and the American Pharmaceutical Association.

The confusion surrounding the different programs, benefits, claims processing, and so forth, encouraged the NPIC founders to seek means of standardizing administrative procedures as well as improving efficiency for the benefit of pharmacies, underwriters and beneficiaries alike.

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19. NPIC Bylaws, National Pharmacy Insurance Council, 2215 Constitution Avenue, N.W., Washington, D.C., 20037.

Toward this end, a NPIC universal claim processing form has been developed and used. The National Association of Retail Druggists declined the initial invitation to participate in the NPIC based largely upon that group's counsel citing potentially serious antitrust law implications.

These antitrust issues and a general lack of detailed information about third party payment programs and attendant problems motivated this research project.

CHAPTER II

SURVEY OF STATE PHARMACEUTICAL ASSOCIATION ACTIVITIES

Amidst the confusion and misunderstandings about third party payment programs under which prescription medication was being provided, pharmacists and pharmacy's professional organizations still had to follow some course of action.

Due to the generally local nature of most programs, state pharmaceutical organizations were considered a promising source of information on activity in this area, both past and future.

This chapter contains the results of a study involving state pharmaceutical association executives. The study was conducted to evaluate the current and short run future courses of action undertaken, or about to be undertaken, by state pharmaceutical associations; and to evaluate the perceived and actual roles of state associations in providing leadership and direction in this increasingly important matter.

Methodology

On June 11, 1970 letters were sent to the chief executive officer of each of the fifty state pharmaceutical associations and to the chief executive officer of the

District of Columbia Pharmaceutical Association (Appendix A, page 184). This communication served to introduce the author and the research project in which he was participating. Cooperation of recipients was elicited in advance of the questionnaire mailing. Each letter was individually typed and personally addressed as well as signed by the researcher.

Four days later, a cover letter (Appendix B, page 186) and the questionnaire (Appendix C, page 188) were mailed first class and accompanied by a self-addressed, stamped, return envelope.

Hypotheses

The mail questionnaire was designed to obtain data to test the following hypotheses:

1. More than 90 percent of the state pharmaceutical associations have conducted a part of at least one educational program relating to third party prescription programs during the previous year.
2. Less than 50 percent of the state pharmaceutical associations have taken any official action or stand on negotiating, endorsing, or sponsoring private third party prescription programs.
3. Executive officers of more than 75 percent of the state pharmaceutical associations will cite

possible legal implications as a consequence of negotiating, endorsing or sponsoring private third party prescription programs.

4. At least 75 percent of the state pharmaceutical associations have neither prepared and distributed or published, nor adopted and distributed or published third party program guidelines for their membership.

5. Less than 50 percent of the associations have taken some affirmative action with respect to third party program guidelines.

6. State pharmaceutical association members in community practice in not more than 20 percent of the states have been polled individually on their reimbursement method preferences.

7. More than 90 percent of the respondents whose association members have not been polled will believe most community practitioners would prefer "usual and customary" reimbursement for prescriptions under third party programs.

8. More than 50 percent of the respondents will rate the NPIC accomplishments to date negatively.

9. The future role of the NPIC will be considered relatively ineffective or totally ineffective by more than 50 percent of the respondents.

10. Less than 25 percent of the associations whose executives responded, plan to or have been involved in a dispensing cost study.

11. Not less than 75 percent of the respondents will favor some concerted action by pharmacists.

Survey Results

Thirty-six (36) questionnaires were returned, a response rate of 70.6 percent. However, due to the nature of third party payment program requirements imposed by state law in one jurisdiction, that executive's reply was eliminated from the tabulation and analyses.

Thirty-two (32) respondents reported programs dealing at least in part with third party prescription plans were conducted in one or more of the categories during the previous year (Table IV).

Since 91.4 percent (32/35) of the associations whose executives responded did conduct some program during the prior one year period, Hypothesis No. 1 is supported.

In answer to the question about any official action or stand on any private third party prescription program(s), ten (10) respondents reported action had been taken while

Table IV

THIRD PARTY PAYMENT INFORMATIONAL PROGRAMS

Programs conducted in:		Categories
One category	9	Statewide Association Meetings and Conventions
Two categories ...	11	Regional or Local Meetings
Three categories..	9	Continuing Education Programs
Four categories...	3	Other
None	3	
	n = 35	

twenty-five (25) answered "no." One of the affirmative replies referred to action against any endorsement.

The affirmative responses accounting for 28.6 percent (10/35) of the replies, and Hypothesis No. 2 is supported.

Sixteen (16) of the negative replies cited legal restrictions, with five (5) of these specifically mentioning antitrust laws. This amounts to 45.7 percent (16/35). Thus, Hypothesis No. 3 is not supported.

Information about what, if anything, has been done by associations to provide third party program guidelines for their members is summarized in Table V.

Hypothesis No. 4 is not supported since negative answers and "prepared only" were obtained from 74.3 percent (26/35) of the respondents.

Table V

ASSOCIATION THIRD PARTY GUIDELINES

Guidelines--	
Prepared and Published or Distributed	3
Adopted and Published or Distributed	5
Prepared and Adopted and Distributed	1
Prepared only	3
None	23
n =	35

Since only 34.3 percent (12/35) of the respondents report affirmative action with respect to third party program guidelines, Hypothesis No. 5 is supported.

Seven (7) respondents reported a poll of their community practitioner members' reimbursement preferences had been conducted. Twenty-eight (28) replied such a poll had not been undertaken. This 20 percent activity among the responding state associations supports Hypothesis No. 6.

Reported preferences in those states where polls were conducted are enumerated in Table VI:

Table VI

ACTUAL REIMBURSEMENT METHOD PREFERENCES

Fixed fee	2½*
Variable fee	1
Fixed percentage markup ...	0
Usual and customary fee ...	3½*
	n = 7

*In one state the poll resulted in a tie between these two choices.

Twenty-five (25) of the respondents answering "no" believed the following choices would have been made if a poll was taken:

Table VII

EXECUTIVE OPINION ON REIMBURSEMENT PREFERENCES

Fixed fee	4
Variable fee	6
Fixed percentage markup ...	0
Usual and customary fee ...	15
	n = 25

As the usual and customary method of reimbursement was selected by only 60.0 percent (15/25) of the respondents, Hypothesis No. 7 is not supported. There were three non-responses to this question.

Respondent rankings assigned to the NPIC's productivity to date appear in Table VIII, while assessments of its future role are shown in Table IX.

Table VIII

ASSESSMENT OF NPIC PRODUCTIVITY TO DATE

Highly Satisfactory	4
Fairly Satisfactory	10
Neither Satisfactory nor Unsatisfactory	14
Relatively Unsatisfactory ...	2
Highly Unsatisfactory	3
n =	33

Table IX

ASSESSMENT OF NPIC'S FUTURE ROLE

Highly beneficial spokesman for the profession	16
Only moderately helpful	6
Of questionable value	5
Relatively ineffective	1
Totally ineffective	1
n =	29

The negative ratings for the NPIC activity to date accounted for 15.2 percent (5/33) of the responses. Consequently, Hypothesis No. 8 is not supported.

Similarly, Hypothesis No. 9 is not supported as only 6.9 percent (2/29) of the respondents considered the future role of the NPIC to be relatively or totally ineffective.

Two respondents did not assess NPIC's productivity to date, while six did not respond to the future role question.

Studies of the cost of dispensing a prescription had been conducted or were being planned in twenty-eight jurisdictions (26 had been conducted and two planned). Data in Tables X and XI show the type personnel who conducted these studies and the intended use of the information obtained.

Table X

PERSONNEL CONDUCTING COST STUDIES

Conducted by:	
Association personnel	15
University faculty member(s)..	9
Insurance company	1
No response	3
	n = 28

Hypothesis No. 10 is not supported since 80 percent (28/35) of the state association executives from whom completed questionnaires were received indicated "involvement" in a dispensing cost study, irrespective of

the personnel conducting the study.

Table XI

USE OR INTENDED USE OF COST STUDY DATA

Information for Welfare Department	8
Information for Insurance Carriers	4
Information for Members	5
No specific response since study not yet carried out	2
No response	9
	n = 28

Twenty-seven (27) respondents favored concerted action by pharmacists to make their negotiation position stronger while six (6) did not favor such action. Two (2) nonresponses were received on this question. Three of the "yes" respondents qualified their approval within the limits of legal restrictions. Five "no" respondents also mentioned legal restrictions as the reason for their opposition to concerted action. The 81.8 percent (27/33) affirmative response supports Hypothesis No. 11.

A general compilation of replies to the question: "What aspect of third party prescription programs do you consider most important to pharmacy?" is shown in Table XII. Some respondents provided no answer while others answered in several categories:

Table XII

EXECUTIVES' ASSESSMENT OF PROBLEM AREAS

Adequate reimbursement	13
Freedom of choice	6
Proliferation of paper work	5
Greater pharmacy control	3
Prompt reimbursement	3
Many or all aspects important	2
Proliferation of programs ...	2

Concern About Antitrust

Irrespective of how certain activities may be construed by an observer, responses to parts of the questionnaire clearly indicate concern among state pharmaceutical association executives for antitrust implications resulting from their activities.

These concerns manifested themselves in responses to questions dealing with official action by associations which relate to private programs as well as in the broad area of concerted action.

In an effort to obtain meaningful information to aid in resolving some of the problems associated with the uncertainty of legally permissable association activities, a legal review of relevant antitrust law was conducted.

The results of this legal research are discussed in subsequent chapters.

CHAPTER III

FEDERAL ANTITRUST LAW

As a prelude to regarding antitrust problems as they relate to third party prescription payment programs, a background is necessary in the statutory and judicial developments in the area of antitrust law generally. Because of the wide variations and number of different state acts, this paper is limited to federal antitrust law and associated implications. This chapter reviews some relevant background material.

Statutes

The Sherman Antitrust Act[1] was enacted in 1890:

> ....to prevent undue restraints of trade in interstate commerce, to maintain its appropriate freedom in the public interest, to afford protection from the subversive or coercive influences of monopolistic endeavors. As a charter of freedom the act has a generality and adaptability comparable to that found to be desirable in constitutional provisions.[2]

The relevant prohibitions contained in the Sherman Act are:

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1. 26 Stat. 209.

2. Chief Justice Hughes in Appalachian Coal Co., Inc. v. U.S., 288 U.S. 344 (1932).

> Sec. 1
>
> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is hereby declared to be illegal. Every person who shall make any such contract or engage in any such combination or conspiracy shall be deemed guilty of a misdemeanor....
>
> Sec. 2
>
> Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a misdemeanor....

Two significant antitrust laws were enacted in 1914. These were the Federal Trade Commission Act (FTC Act)[3] and the Clayton Act.[4] The FTC Act authorizes the creation and establishment of a five member commission to be appointed by the President, by and with the advice and consent of the Senate. Its powers include the following:

> Sec. 5
>
> Unfair methods of competition in commerce, and unfair or deceptive acts or practices in commerce, are hereby declared unlawful.
>
> The commission is hereby empowered and directed to prevent persons, partnerships, or corporations.... ....from using unfair methods of

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3. 38 Stat. 717.

4. 38 Stat. 730.

competition in commerce and unfair or deceptive acts or practices in commerce.

Sec. 6

That the commission shall also have power--

(a) To gather and compile information concerning, and to investigate from time to time the organization, business, conduct, practices, and management of any corporation engaged in commerce, excepting banks and common carriers subject to the Act to regulate commerce, and its relation to other corporations and to individuals, associations, and partnerships.

The Clayton Act specifies four types of business practices to be illegal: (1) Under Sec. 2, price discrimination, "where the effect of such discrimination may be to substantially lessen competition or tend to create a monopoly in any line of commerce...;" (2) exclusive dealing and tying contracts under Sec. 3; (3) stock acquisition in competing companies under Sec. 7 where a lessening of competition may result; and (4) interlocking directorates in competing concerns, forbidden under Sec. 8.

The basic antitrust statutes have been subject to numerous amendments over the years. In 1936, the Robinson-Patman Act[5] modified Sec. 2 of the Clayton Act. According to one author, the Robinson-Patman Act has two

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5. 49 Stat. 1526.

primary objectives:

1. To prevent unscrupulous suppliers from attempting to gain an unfair advantage over their competitors by discriminating among buyers; and

2. To prevent unscrupulous buyers from using their economic power to exact discriminatory prices from suppliers to the disadvantage of less powerful buyers.[6]

The 1937 Miller-Tydings Act,[7] an amendment to the Sherman Act, provided:

> That nothing herein contained shall render illegal, contracts or agreements prescribing minimum prices for the resale of a commodity which bears, or the label or container of which bears, the trade mark, brand, or name of the producer or distributor of such commodity and which is in free and open competition with commodities of the same general class produced or distributed by others, when contracts or agreements of that description are lawful as applied to intrastate transactions, under any statute, law or public policy now or hereafter in effect in any State.

In modifying the FTC Act, the McGuire Amendment[8] of 1952 enacted the "non-signer" clause among its provisions:

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6. Earl W. Kintner, An Antitrust Primer, The Macmillan Company, New York, 1964, p. 60.

7. 50 Stat. 693.

8. 66 Stat. 631.

> ....which authorize contracts and agreements prescribing minimum or stipulated prices for the resale of commodities and to extend the minimum or stipulated prices prescribed by such contracts and agreements to persons who are not parties thereto.

A related statute, the Webb-Pomerene Act,[9] allowed American exporters to act together in export markets under the supervision of the Federal Trade Commission.

Case Developments in General

Soon after enactment of the first of the antitrust laws, it was decided an agreement upon prices between competitors is illegal per se. This issue was decided in two railroad cases. In U.S. v. Trans-Missouri Freight Association[10] railroads which were in competition agreed among themselves to abide by rates decided upon in monthly meetings of the association, and to change them only after the association had been given due notice. The agreement in U.S. v. Joint Traffic Association[11] provided deviating from agreed upon rates would make the offender liable to a fine unless adequate prior notice had been given. In

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9. 40 Stat. 516.
10. 166 U.S. 290 (1897).
11. 171 U.S. 505 (1898).

both cases, the Circuit Courts of Appeals upheld like contentions the agreements did not constitute a prohibited restraint of trade since contracts left discretion with individual members to change the rates after due notice.

Both decisions were reversed by the United States Supreme Court in five to four decisions. The majority opinion stated any agreement as to rates between competitors was a restraint of trade and came within the prohibitions of the Sherman Act under which every contract in restraint of trade was unlawful, and not only those constituting unreasonable restraints. Justice Peckham wrote in part:

> The term is not of such limited signification....the term includes all kinds of those contracts which in fact restrain or may restrain trade....A contract may be in restraint of trade and still be valid at common law. Although valid, it is nevertheless a contract in restraint of trade....By the simple use of the term 'contract in restraint of trade' all contracts of that nature whether valid or otherwise would be included.[12]

Justice Peckham provided the following rule in dealing with the argument a general prohibition against any agreement on rates would result in destructive competition:

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12. 166 U.S. 290, @328.

> The natural, direct and immediate effect of competition is to lower rates and to thereby increase the demand for commodities, the supplying of which increases commerce....It cannot be said that destructive competition is bound to result...unless an agreement or combination to avoid it is entered into by otherwise competing roads. It is not only possible but probable that good sense would prevail....and while making no agreement....each road might yet make such reasonable charges for the business done by it as the facts might justify. An agreement... which directly and effectually stifles competition must be regarded....as one in restraint of trade....notwithstanding there are possibilities that....competition may be indulged in until the weaker roads are completely destroyed and the survivor thereafter raises rates.[13]

The reasonableness of the rates agreed upon did not enter into the consideration:

> And this is so even though the rates provided for in the agreement may, for the time be not more than are reasonable. They may easily, and at any time, be increased.[14]

The public character of the railroads may have categorized them as a special case. The rule was extended, however, to include all contracts involving

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13. 171 U.S. 505, @577.

14. 171 U.S. 505, @571.

interstate commerce in Addyston Pipe & Steel Co. v. U.S.[15] In this case six steel pipe manufacturers entered into an agreement allocating markets in various geographic areas of the country. Prices were to be raised and bonuses collected on sales in those areas which constituted about three-quarters of the country. A predetermined formula provided the bonus sharing ratio.

In writing the Circuit Court of Appeals decision, Judge Taft reviewed the common law precedents and concluded:

> We can have no doubt that the association of the defendents, however reasonable the prices they fixed, however great the competition they had to encounter, and however great the necessity for curbing themselves by joint agreement from committing financial suicide by ill-advised competition, was void at common law, because in restraint of trade and tending to a monopoly.[16]

The United States Supreme Court affirmed this decision unanimously. However, the question of reasonableness of prices was not completely discredited as a defense.

> Even if the objection thus set up would, if well founded in fact, constitute a defense [with regard to reasonableness of prices], we agree with the Circuit Court of Appeals....

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15. 175 U.S. 211 (1898).

16. 85 Fed. 271, @291.

> The facts....set forth show conclusively that the effect of the combination was to enhance prices beyond a sum which was reasonable.[17]

In 1911 Standard Oil Company of New Jersey v. U.S.[18] became an antitrust landmark case. It was in this case Chief Justice White enunciated the "rule of reason" for judging the legality of business contracts and arrangements alleged to be in restraint of trade. In the present case, the government urged per se application of Sec. 1 of the Sherman Act. Consequently, all contracts or combinations in restraint of trade would be illegal. White rejected this idea, however, contending every contract or combination in restraint of trade was not illegal. Only unreasonable restraints of trade were unlawful under the Sherman Act:

> In substance, the propositions urged by the government are reducible to this: That the language of the statute embraces every contract, combination, etc., in restraint of trade, and hence its text leaves no room for the exercise of judgment, but simply imposes the plain duty of applying its prohibitions to every case within its literal language. The error involved lies in assuming the matter to be decided. This is true because, as the acts which may come under the classes stated

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17. 175 U.S. 211, @235-238.

18. 221 U.S. 1 (1911).

> in the 1st section and the restraint of trade to which that section applies are not specifically enumerated or defined, it is obvious that judgment must in every case be called into play in order to determine whether a particular act is embraced within the statutory classes, or effect causes it to be a restraint of trade within the intendment of the act.
>
> If the criterion by which it is to be determined in all cases whether every contract, combination, etc., is a restraint of trade within the intendment of the law, is the direct or indirect effect of the acts involved, then of course the rule of reason becomes the guide, and the construction which we have given the statute, instead of being refuted by the cases relied upon, is by those cases demonstrated to be correct. This is true, because as the construction which we have deduced from the history of the act and the analysis of its text is simply that in every case where it is claimed that an act or acts are in violation of the statute the rule of reason, in the light of the principles of law and the public policy which the act embodies, must be applied.[19]

In U.S. v. Trenton Potteries Co.[20] the defense asked the jury be charged:

> The essence of the law is injury to the public. It is not every restraint of competition and not every restraint of trade that works an injury to the public; it is only an undue and

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19. 221 U.S. 1, @63-66.

20. 273 U.S. 392 (1927).

> unreasonable restraint of trade that has such an effect and is deemed to be unlawful.[21]

The district court in refusing the request held an agreement on prices between competitors was in itself an undue and unreasonable restraint of trade.[22] The Circuit Court of Appeals was not in agreement and reversed on the ground the rule of reason required only those contracts and combinations be held unlawful which by reason of intent or inherent nature of the contemplated acts prejudiced the public interest by unduly restricting competition or unduly obstructing the course of trade.[23] The United States Supreme Court reaffirmed Addyston Pipe in reversing this decision. Chief Justice Stone stated the per se doctrine on behalf of an unanimous Court:

> The aim and result of every price fixing agreement, if effective, is the elimination of one form of competition. The power to fix prices, whether reasonably exercised or not, involves power to control the market and to fix arbitrary and unreasonable prices. The reasonable price fixed today may through economic and business changes become the unreasonable price of tomorrow. Once established, it may be maintained

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21. 273 U.S. 392, @395.

22. 273 U.S. 392, @396.

23. 300 Fed. 550, @553 (1924).

> unchanged because of the absence of competition secured by the agreement for a price reasonable when fixed. Agreements which create such potential power may well be held to be in themselves unreasonable or unlawful restraints without the necessity of minute inquiry whether a particular price is reasonable or unreasonable and without placing on the government in enforcing the Sherman Law the burden of ascertaining from day to day whether it has become unreasonable through the mere variation of economic condition.[24]

Price fixing was not directly involved in U.S. v. Appalachian Coal Co. Inc.[25] Rather, the likely effect of a plan on price structure was considered. A common selling agency was proposed by small coal producers. The district court found "the selling agency will not be able....to fix the market price of coal."[26] However, the combination was enjoined on the ground the plan would eliminate competition among the defendents and have a tendency to stabilize prices, raising them to a higher level than would prevail under conditions of free competition. The United States Supreme Court reversed the lower court since there was no evidence of attempts to fix prices and it was found no possibility of a "monopolistic menace" existed.

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24. 273 U.S. 392, @397-398.

25. 288 U.S. 344 (1932).

26. 288 U.S. 344, @365.

> A cooperative enterprise otherwise free from objection, which carries with it no monopolistic menace, is not to be condemned as an undue restraint merely because it may affect a change in market conditions, when the change would be in mitigation of recognized evils....The fact that the correction of abuses may tend to stabilize a business, or to produce fairer price levels, does not mean that the abuses should go uncorrected or that cooperative endeavor to correct them necessarily constitutes an unreasonable restraint of trade.[27]

The plan had not actually been operative when this decision was rendered. Recognizing illegal restraints could develop in the actual operation of the plan, the court advised the government to seek a future remedy "if it should appear that the plan is used to the impairment of fair competitive opportunities."[28]

This may well be considered a deviation from the per se doctrine.

In a subsequent case in which the depressing effect of "distress gasoline" on the market served as the justification for a purchasing arrangement among powerful and weaker oil companies, Justice Douglas chose not to modify the earlier decision. He said in U.S. v. Socony Vacuum Oil Co.:[29]

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27. 288 U.S. 344, @373-374.

28. 228 U.S. 344, @378.

29. 310 U.S. 150 (1940).

> The only essential thing in common between the instant case and the Appalachian Coal case is the presence in each of so-called demoralising or injurious practices. The methods of dealing with them were quite divergent....The increase in the spot market prices was to be accomplished by a well organised buying program....regular ascertainment of the amounts of surplus gasoline; assignment of sellers among the buyers; regular purchases at prices which would place and keep a floor under the market. Unlike the instant case, the plan in the Appalachian Coals case was not designed to operate vis a vis the general consuming market and to fix prices on that market. Furthermore, the effect, if any, of that plan on prices was not only incidental but wholly conjectural....Hence this Court expressly reserved jurisdiction in the District Court to take further proceeding....if price-fixing were involved.[30]

Although not considered by the court, it is noteworthy the cases differed in one way which may be significant. In one case the parties were distressed producers attempting to survive in the marketplace, while the combination of strong oil companies was formed to permit them to protect their own prices by buying surplus gasoline from weaker firms. Justice Douglas went beyond Trenton Potteries by indicating any attempt at tampering with the price structure was illegal without reference to the market power of the combination:

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30. 310 U.S. 150, @221.

> The reasonableness of prices has no constancy due to the dynamic quality of the business facts underlying price structures.... But the thrust of the rule is deeper and reaches more than monopoly power. Any combination which tampers with price structures is engaged in an unlawful activity. Even though the members of the price fixing group were in no position to control the market, to the extent that they raised, lowered, or stabilized prices they would be directly interfering with the free play of market forces.[31]

In effect, this opinion is contra the main reasoning supporting the decision in the Appalachian Coals case. In a practical sense, the distinction has been inconsequential. Evidence relating to the existence of collusion has generally been a decisive factor in price fixing cases. Courts, armed with such evidence, have generally condemned the arrangement almost summarily.

The per se rule seems to have been a result of several considerations. These include:

> (1) that because of the continually changing nature of prices the courts were not a suitable instrument for the determination of their reasonableness or otherwise; (2) that it was inadvisable to rely upon private interested parties to maintain reasonable prices when they possessed the power to use prices to their advantage; and (3) that in the absence of an alternative mechanism which would ensure the fairness of

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31. Ibid.

> prices, the 'law of competition' was the only regulator and it should not be diluted in any manner. In asserting that any agreement on prices was illegal as a matter of law the Court did not take the position that under no circumstances such an agreement could be justified. What is asserted was that only the legislature could examine the circumstances and grant exemptions. Failing such an exemption Justice Peckham's observation remained valid, namely that in the pursuit of their self interest it was 'not only possible but probable that good sense would prevail' and that while making no agreements each competing firm 'might yet make such reasonable charges for the business done by it as the facts might justify.'[32]

Other types of per se violations will be discussed subsequently in relation to their respective applicability to pharmacy-related situations.

Case Developments in Pharmacy

The Northern California Pharmaceutical Association v. U.S.[33] and U.S. v. Utah Pharmaceutical Association[34] cases are landmarks in pharmaceutical antitrust annals.

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32. M. Tariq Siddiqi, "Restraint of Trade and Monopoly Under the U.S. Antitrust Laws 1890-1965," Ph.D. dissertation, Syracuse University, 1966, pp. 30-31.

33. 306 F.2d 379 (9th Cir. 1962), cert. denied 371 U.S. 862 (1962).

34. 201 F. Supp. 29 (D.Utah, 1962), affirmed per curiam 371 U.S. 24 (1962).

Distribution of a prescription pricing schedule to members of a pharmaceutical association was held to be a conspiracy by the association to fix the prices of prescription drugs as commodities for retail sale.

While this point might appear quite controversial, it is not, even in light of dicta in the Utah Pharmaceutical case. The court said:

> There might be some legitimate argument whether the use of the schedule for pricing prescription drugs was reasonable if the schedules primarily dealt with matters other than the price of drugs or if their major concern or effect was with reference to services rather than drugs.[35]

The Sherman Act covers services as well as commodities and it is well to note neither the United States Supreme Court nor lower federal courts have classified the professions as to status under the antitrust laws. No Supreme Court case has held the practice of a profession constitutes a "trade or commerce" within the meaning of the Sherman Act.[36]

Related to this, American Medical Association v. U.S.[37] is among a line of cases in which self-regulatory

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35. 201 F. Supp. 29, @34.

36. S. Chesterfield Oppenheim, "Legal Advisory Opinion on Antitrust Aspects of NPIC," September 24, 1969, p. 10.

37. 317 U.S. 519 (1943).

programs have been condemned by the courts as anticompetitive boycotts. While some self-regulatory activity seems justified, the intent and effect of such group activity is of paramount importance.

It is clear professional status and practice will not serve as a defense to conduct prohibited by the Sherman Act.

The Court of Appeals in the Northern California case rejected the idea the conduct charged in the indictment was merely the regulation of the practice of pharmacy as a learned profession. It concluded the professional status of pharmacy was "utterly irrelevant in the instant case."[38] This was based on the holding there was a conspiracy to fix the prices of prescription drugs as articles of trade or commerce.

The following qualification in the holding is noteworthy:

> We do not decide that every action of professionals is within the reach of the Sherman Act. We do decide that an agreement among professionals to fix a commodity price is.[39]

In the Utah Pharmaceutical case, the court agreed the dispensing of prescriptions is professional practice

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38. 306 F.2d 379, @384.

39. 306 F.2d 379, @386.

of pharmacy though warning:

> The fact that a pharmacist in filling a prescription is engaged in the practice of a learned profession does not immunize the defendants from the application of Section 1 of the Sherman Act.[40]

The Sherman Act applies to drugs and to the transactions affecting them. There is no antitrust exemption resulting from the drugs being handled by a member of the pharmacy profession.

Another contention by defendants in the Northern California case was conditions in the marketing of pharmaceutical products required regulation of the drug pricing structure through association. The court said:

> It is precisely such use of uncontrolled private economic and quasi-political power in the market place which the Sherman Act condemns. Such regulatory power, if it is to exist at all, resides under our system in democratically controlled legislatures. The Sherman Act forbids appellants to appropriate a segment of that power to their private association.[41]

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40. 201 F. Supp. 29, @33.

41. 306 F.2d 379, @386.

Inter v. Intrastate Commerce

To be sure, the concept of interstate commerce has been considered extensively in the courts. The interpretation has broadened with each succeeding decision, to the extent fewer and fewer activities may be categorized as intrastate commerce, whether considered under the category of affecting interstate commerce or involving goods or services in the flow of interstate commerce.

The earliest decisions interpreted interstate commerce to be the actual crossing of state lines by goods. Manufacturing prior to shipment and local retailing after receipt by a dealer were not thought to be interstate commerce.

In U.S. v. E. C. Knight Co.,[42] a refining company had obtained practically a complete monopoly for the manufacture of refined sugar in the United States. This action was not considered a restraint upon interstate commerce. The United States Supreme Court ruled manufacturing was not a part of interstate commerce.

The Court had numerous opportunities to interpret the commerce clause in a number of varied situations before and since the turn of the century. Early decisions excluded certain commodities from interstate commerce because of the potential harm to the national interest:

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42. 156 U.S. 1 (1895).

Lottery tickets - Champion v. Ames[43]; Obscene material - U.S. v. Popper[44]; White slave traffic - Hoke v. U.S.[45]; Impure, unwholesome or adulterated food or drugs - Hipolite Egg Co. v. U.S.[46]

In Hopkins v. United States[47] the members of the Kansas City Live Stock Exchange fixed the commissions to be charged for the sale of livestock shipped from other states. It was held no antitrust violation took place since the agreement was beyond the realm of interstate commerce.

In Carter v. Carter Coal Co.,[48] production was ruled to constitute a purely local activity. The Court discussed the issue of direct v. indirect effect on commerce.

The issue of what constituted interstate commerce was squarely faced in U.S. v. Sullivan[49]; a case involving a pharmacist in Columbus, Georgia. Defendant was convicted

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43. 188 U.S. 321 (1903).
44. 98 Fed. 423 (1899).
45. 227 U.S. 308 (1913).
46. 220 U.S. 45 (1911).
47. 171 U.S. 578 (1898).
48. 298 U.S. 238 (1936).
49. 332 U.S. 689 (1948).

for violating Section 301 (k) of the Federal Food, Drug and Cosmetic Act of 1938. He misbranded two pill boxes, each containing 12 sulphathiazole tablets, by failing to label with all required directions for use, warnings and hazards. The tablets were shipped to a wholesaler in Atlanta from Chicago in properly labeled bottles of 1,000 quantity. Six months after the shipment to Georgia, Sullivan purchased a bottle, transferred it to his pharmacy, and removed the 12 tablets placed in the pill boxes.

The Court of Appeals reversed the conviction on the basis the Act forbids misbranding only while holding for the first sale after interstate shipment. The Supreme Court reversed and upheld the conviction, interpreting the Act to cover any holding for sale.

The doctrine was expanded to encompass those activities which fall into the category of affecting interstate commerce irrespective of how local in nature they may be. "If it is interstate commerce that feels the pinch, it does not matter how local the operation which applies the squeeze," is how the Court expressed the view in U.S. v. Women's Sportswear Manufacturers Association.[50]

Beet sugar refiners in California fixed the prices to be paid local growers in Mandeville Island Farms, Inc. v. American Crystal Sugar Co.[51] Though all the California

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50. 366 U.S. 460 (1949).

51. 334 U.S. 219 (1948).

grown sugar beets were refined in California, a large portion was later shipped in interstate commerce. The defendant contended since the price fixing concerned only the local sales of sugar beets which were later refined into sugar before entering interstate commerce, there was no federal antitrust violation. This argument was rejected by the United States Supreme Court. Hence the manufacture of goods to be shipped interstate is interstate commerce.

The issue involving the status of retail sales within the framework of the antitrust laws also has been clearly defined. Goods shipped interstate pursuant to a specific order are considered in the flow of interstate commerce until delivery to the customer. The specific customer doctrine has been consistently employed in retail sale cases. The United States Supreme Court held in Standard Oil Company v. Federal Trade Commission[52] gasoline shipped from an out of state refinery to a terminal in Michigan where it was held to accumulate over the winter was still in the flow of interstate commerce even though it was not shipped to the terminal pursuant to specific prior orders from customers.

With these precedents, very few combinations in restraint of trade may be found at any level in the chain of distribution which are not interstate commerce.

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52. 340 U.S. 231 (1951).

One would be hard pressed to support a contention pharmacy practice or the sale of prescription drugs to consumers does not constitute an activity which affects interstate commerce or involves goods or services in the flow of interstate commerce.

The Northern California and Utah Pharmaceutical cases seem to bear out the interstate commerce nature of pharmacy.

Prescription: Commodity v. Pharmaceutical Service

References to the "commodity" in the Northern California and Utah Pharmaceutical cases likely established a firm precedent for future cases in this field.

Looking at either the value of human labor or the practice of a profession aspects, one might reach a supporting conclusion.

Sec. 6 of the Clayton Act[53] states:

> That the labor of a human being is not a commodity or article of commerce. Nothing contained in the antitrust laws shall be construed to forbid the existence and operation of labor, agricultural, or horticultural organizations, instituted for the purpose of mutual help, and not having capital stock or conducted for profits, or to forbid or restrain individual members of such organizations from lawfully carrying out the legitimate objects thereof; nor shall such organizations,

53. 49 Stat. 1526.

> or the members thereof, be held or construed to be illegal combinations or conspiracies in restraint of trade under the antitrust laws.

The Government relied in large measure on the high percentage of precompounded medications provided to patients in the Northern California case. The contention was the only service performed was the dispensing function, usually performed by a salaried, employee pharmacist. The pharmacy rather than the individual pharmacist received the payment for the medication. It was concluded fixing prices for the drug products as commodities amounted to a "business or commercial activity" prohibited by the antitrust laws.

Though the Government stipulated to the fact the dispensing of a prescription is a professional service by a member of a learned profession, the Utah Pharmaceutical case was brought for adopting and distributing a prescription pricing schedule for prescription drugs rather than a minimum fee schedule for professional services.

Thus the prices were fixed for a commodity and not for a professional service.

Professional Exemption

Sec. 6 of the Clayton Act above suggests clearly one of its purposes was the exemption of certain labor union

activities from the antitrust laws.

While it has been argued often, the United States Supreme Court has not encouraged the suggestion Sec. 6 exempts professional services from the antitrust laws. In fact in U.S. v. National Association of Real Estate Boards,[54] the Court held there is no protection afforded to individuals who combine to establish prices or fees to be charged for their services.

The issue arose but was not dealt with completely in American Medical Association v. U.S.[37] The basic question here as well as in other cases revolved around whether particular professional services come within the definition of "trade or commerce" as used in the Sherman Act. While the United States Court of Appeals held the practice of medicine does qualify under the Act, the United States Supreme Court did not consider the question. Rather, it affirmed the conviction based upon a prepaid medical plan being "trade or commerce." The alleged conspiracy to obstruct this plan was ruled to be an unlawful restraint of trade.

No case has been decided yet by the Supreme Court on the precise question whether the practice of a profession is "trade or commerce."

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54. 339 U.S. 485 (1950).

There have been oblique references and comments, however, which encourage some to believe when the question is squarely faced there will be an exemption for professional activity. Mr. Justice Jackson's statement in U.S. v. Oregon State Medical Society[55] has been one such form of encouragement. He said, "This Court has recognized that forms of competition usual in the business world may be demoralizing to the ethical standards of a profession."[56]

In a 1970 decision, Friends of Animals, Inc. v. American Veterinary Medical Association,[57] the prime issue was avoided again. The court stated the test is not whether or not the professions constitute "trade or commerce" within the meaning of the Sherman Act, but whether the plaintiff in the instant case is so engaged. The court found it "unnecessary to decide whether the practice of veterinary medicine is 'trade or commerce' within the purview of the Sherman Act."[58]

The Court exempted one service activity, professional baseball, from the antitrust laws in Toolson

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55. 343 U.S. 326 (1952).

56. 343 U.S. 326, @336.

57. 310 F. Supp. 1016 (S.D.N.Y. 1970).

58. Ibid.

v. New York Yankees.[59] This exempt status for professional baseball was reaffirmed in Salerno v. American League of Professional Baseball Clubs[60] and Flood v. Kuhn.[61]

These developments provide background and a basis for investigating association activities.

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59. 346 U.S. 356 (1953).

60. 1970 Trade Cas. par. 72,996 (S.D.N.Y. 1969), aff'd. 1970 Trade Cas. par. 73,276 (2d Cir. 1970), cert. denied, 39 U.S.L.W. 3294, January 11, 1971.

61. 309 F. Supp. 793 (S.D.N.Y. 1970).

CHAPTER IV

ASSOCIATION ACTIVITIES

A meaningful assessment of the legal constraints and limitations imposed upon pharmacy associations with respect to third party payment programs for prescription medication may be reached only after a review of prior decisions involving associations. A sampling of those cases bearing most directly upon the present study are presented in this chapter.

Historical View

Before examining associations and their freedom of activity or lack thereof, it is well to review the patterns which have developed from earlier days.

The concept of "strength in numbers" is the basis for many organizations.

> Business and professional men join together since certain goals may be achieved more easily and fully through group action rather than by individual action. Thus in recent years, legislative activities on the national level have been much more effectively carried on by associations and, in some instances, even groups or consortiums of associations.[1]

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1. George D. Webster, The Law of Associations, American Society of Association Executives, Washington, 1971, p. 1.

Many of the business associations of today emerged from the medieval merchant and craft guilds. These were buyers and sellers and producers, respectively.

The guild system disappeared with the development of the industrial or factory produced system of manufacturing. Speed and quantity of production replaced the slow, quality workmanship for which guild members were known to strive.

Business associations in this country date to the eighteenth century, the oldest such society being the New York Stock Exchange, established in 1792. The nineteenth century and early twentieth century saw early growth among business associations with World War II providing a strong stimulation in this area. Among the reasons for this was the intense need for rapid dissemination of industry-wide information for defense purposes. Additionally, the associations grew in numbers and stature by providing the federal government with contract specifications for defense production as well as serving as a communications vehicle.[2]

Professional societies exhibited a growth pattern fairly similar to the business associations. The American Medical Association (1847), the American Pharmaceutical Association (1852) and the American Bar Association (1878) are among the still active early professional societies.

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2. Ibid., pp. 1-7.

The idea of scientific and learned societies whose prime aim is the collection and dissemination of knowledge dates at least to the birth of this nation. The American Philosophical Society, founded in 1743 in Philadelphia by Benjamin Franklin, and the American Academy of Arts and Sciences, founded in Boston in 1790, are the two oldest scientific societies in continuous existence in America.

As the nation's economy took on greater specialization and dimension, the growth and role of associations and societies showed commensurate growth.

Potential Antitrust Violations

Several broad areas are bases for antitrust suits involving associations. These include: the activity of statistical reporting; price activities including protecting and limiting competition, price reporting and professional fee schedules; and collective and cooperative buying and selling.

Applicable case law will be discussed under appropriate headings.

Statistical Reporting

One author has portrayed the importance of industry statistics as follows:

> I believe it is an accepted principle of business in this country that it is wise to have an intelligent adaption of supply and demand. It is obviously to the disadvantage of the producer and also of his customers to fail to take advantage of an increasing demand which will permit increased production, just as it is against his interest to produce goods substantially in excess of any demand reasonably in prospect. The result of the first course is that if the producer fails to get the advantage of his market opportunities his customers suffer from the resulting unnecessary shortage and price instability. The result of the other course is to create prices below the cost of production with injury to the producer and his employees as well as to his customers who have bought his goods at higher prices....One of the important functions of statistics is to afford a producer that broad survey of the situation which enables him to guard intelligently against improvident production in excess of prospective demand and toward an increase in his production when the market will absorb an increased production.[3]

To conduct business operations intelligently, meaningful data about the industry, markets and trends are necessary. Providing this information for the membership may be one goal of an association.

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3. Walker D. Hines, First Annual Report of the President of the Cotton-Textile Institute, Inc., 1927, pp. 12-13, as reported in Webster, op. cit., p. 139.

Attributes of an ideal statistical reporting system include:

> It does not order, it advises. It does not coerce, it persuades. It does not issue mandates or even instructions. It uses only the moving eloquence of a reasoned appeal to the self-interest of its members. It does not tell its members what they must do. It tells them what, if influenced by a decent regard for their own interest, they will be glad to do. It assumes that members are intelligent men, that they can think about the problems of their business, and if the facts out of which these problems arise are placed fairly before them, and if the significance of these facts is pointed out, a proper and profitable line of action will result.[4]

Interested parties must have access to the information, and the American Column & Lumber v. U.S.[5] and U.S. v. American Linseed Oil Company[6] cases suggest secrecy is undesirable.

Informational reports were required from all members in the American Column & Lumber case, and failure to report resulted in a member not receiving final association

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4. J. Meade, "Lawful Restraint of Trade Through Education," The Analyst, 252 (1929).

5. 257 U.S. 377 (1921).

6. 262 U.S. 371 (1923).

reports.[7] Reporting provided each member with details about amounts of stock held, sales volume, and prices charged by every other association member.

The Court held a combination and conspiracy in restraint of interstate commerce based largely on reporting of "market conditions as to the next few months; what the production of each will be for the next 'two months'...with...significant suggestions to both future prices and production."[7]

It noted:

> Genuine competitors do not make daily, weekly, and monthly reports of the minutest details of their business to their rivals....This is not the conduct of competitors, but is so clearly that of men united in an agreement...to act together and pursue a common purpose under a common guide.[7]

The issue and results were quite similar in the Eastern States Retail Lumber Dealers' Association v. U.S.[8] The Court expressed concern about identification of the parties contributing the data and analysis and discussion of reports at association meetings.

An outside agency conducted the statistical reporting activity for the trade association in the American Linseed

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7. 257 U.S. 377, @ 395-396, 399, 410.

8. 234 U.S. 600 (1914).

Oil Company[9] case. The participation agreement among members provided penalties for failure to file required reports. Association members also reported on all matters and conditions within their knowledge affecting the industry.

The Court said the competitors had:

> ....suddenly become parties to an agreement which took away their freedom of action by requiring each to reveal to all the intimate details of its affairs....subjected themselves to an autocratic Bureau....agreed to furnish a schedule of prices and terms and adhere thereto....agreed, under penalty of fine, to attend a monthly meeting and report upon matters of interest.[10]

Consequently, it was held this program constituted a violation of the Sherman Act.

However, the Court may not have obviated all statistical reporting activity by saying:

> We are not called upon to say just when or how far competitors may reveal to each other the details of their affairs. In the absence of purpose to monopolize, or the compulsion that results from contract or agreement, the individual certainly may exercise great freedom; but concerted action through combination presents a

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9. 262 U.S. 371, @380.

10. 262 U.S. 371, @389.

> wholly different problem and is forbidden when the necessary tendency is to destroy the kind of competition to which the public has long looked for protection. The situation here questioned is wholly unlike an exchange where dealers assemble and buy and sell openly; and the ordinary practice of reporting statistics to collectors stops far short of the practice which defendants adopted. Their manifest purpose was to defeat the Sherman Act without subjecting themselves to its penalties.[11]

A clear statement sustaining the legality of association statistical reporting was developed in 1925 in Maple Flooring Manufacturers Association v. U.S.[12] and Cement Manufacturers Protective Association v. U.S.[13]

> It is not, we think, open to question that the dissemination of pertinent information concerning any trade or business tends to stabilize that trade or business and to produce uniformity of price and trade practice. Exchange of price quotations of market commodities tends to produce uniformity of prices in the markets of the world. Knowledge of the supplies of available merchandise tends to prevent overproduction and to avoid the economic disturbances produced by business crises resulting from overproduction. But the natural effect of the acquisition of wider and more scientific knowledge of

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11. 262 U.S. 371,@ 390.

12. 268 U.S. 563 (1925).

13. 268 U.S. 588 (1925).

business conditions, on the minds of the individuals engaged in commerce, and its consequent effect in stabilizing production and price, can hardly be deemed a restraint of commerce, or, if so, it cannot, we think, be said to be an unreasonable restraint, or in any respect unlawful.

It is the consensus of opinion of economists and of many of the most important agencies of government that the public interest is served by the gathering and dissemination, in the widest possible manner, of information with respect to the production and distribution, cost and prices in actual sales, of market commodities, because the making available of such information tends to stabilize trade and industry, to produce fairer price levels, and to avoid the waste which inevitably attends the unintelligent conduct of economic enterprise. Free competition means a free and open market among both buyers and sellers for the sale and distribution of commodities. Competition does not become less free merely because the conduct of commercial operations becomes more intelligent through the free distribution of knowledge of all the essential factors entering into the commercial transaction. General knowledge that there is an accumulation of surplus of any market commodity would undoubtedly tend to diminish production, but the dissemination of that information cannot, in itself, be said to be restraint upon commerce in any legal sense. The manufacturer is free to produce but prudence and business foresight based on that knowledge influence free choice in favor of more limited production. Restraint upon free competition begins when improper use is made of that information through any concerted

action which operates to restrain the freedom of action of those who buy and sell.

It was not the purpose or the intent of the Sherman Antitrust Act to inhibit the intelligent conduct of business operations, nor do we conceive that its purpose was to suppress such influences as might affect the operations of interstate commerce through the application to them of the individual intelligence of those engaged in commerce, enlightened by accurate information as to the essential elements of the economics of a trade or business, however gathered or disseminated. Persons who unite in gathering and disseminating information in trade journals and statistical reports on industry; who gather and publish statistics as to the amount of production of commodities in interstate commerce; and who report market prices, are not engaged in unlawful conspiracies in restraint of trade merely because the ultimate result of their efforts may be to stabilize prices or limit production through a better understanding of economic laws and a more general ability to conform to them, for the simple reason that the Sherman Law neither repeals economic laws nor prohibits the gathering and dissemination of information. Sellers of any commodity who guide the daily conduct of their business on the basis of market reports would hardly be deemed to be conspirators engaged in restraint of interstate commerce. They would not be any more so merely because they became stockholders in a corporation, or joint owners of a trade journal, engaged in the business of compiling and publishing such reports.

We do not conceive that the members of trade associations become such conspirators merely because they

> gather and disseminate information such as is here complained of, bearing on the business in which they are engaged, and make use of it in the management and control of their individual businesses; nor do we think that the proper application of the principles of decision of Eastern States Retail Lumber Association v. United States, or American Column & Lumber Co. v. United States, or United States v. American Linseed Oil Co. leads to any such result.[14]

The Court established the following criteria for legal statistical surveys:

> The cost of production, prompt information as to the cost of transportation, are legitimate subjects of inquiry and knowledge in any industry. So, likewise, is the production of the commodity in that industry, the aggregate surplus stock, and the prices at which the commodity has actually been sold in the usual course of business....trade associations or combinations of persons or corporations which openly and fairly gather and disseminate information as to the cost of their product, the volume of production, the actual price which the product has brought in past transactions, stocks of merchandise on hand, approximate cost of transportation from the principal point of shipment to the points of consumption, as did these defendants, and who, as they did, meet and discuss such information and statistics without, however, reaching or attempting to reach any agreement or any concerted action with respect to prices or production or restraining competition, do not thereby engage in unlawful restraint of commerce.[15]

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14. 268 U.S. 563, @ 582-584.
15. 268 U.S. 563, @ 586.

While it did not involve an association statistical reporting program, United States v. Container Corporation of America[16] is noteworthy. This 1969 case involved competitors exchanging their most recent prices whenever this information was requested. The price information was supplied in anticipation of receiving subsequent reciprocal treatment.

Accordingly, the Court stated "the essence of the agreement was to furnish price information whenever requested."[17] In effect, this served to "stabilize prices though at a downward level."[17] It was concluded "knowledge of a competitor's price usually meant matching that price"[17] with the resulting "limitation or reduction of price competition."[17] This interference with free market determination of price was ruled unlawful per se.

"Price is too critical, too sensitive a control to allow it to be used even in an informal manner to restrain competition."[17]

It thus appears the government is not required to show affirmative evidence of an agreement to fix prices. In concurring, Mr. Justice Fortas noted, "(a)bsent per se violation, proof is essential that the practice resulted

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16. 393 U.S. 333 (1969).

17. 393 U.S. 333; major concurring and dissenting opinions in this case are found at @ 335-341.

in an unreasonable restraint of trade."[17] He further commented:

> In this case, the probability that the exchange of specific price information led to an unlawful effect upon prices is adequately buttressed by evidence in the record. This evidence, although not overwhelming, is sufficient in the special circumstances of this case to show an actual effect on pricing....[17]

Mr. Justice Marshall dissented strongly to the proposition of condemnation without sufficient proof of an agreement on exchanging price information.

> Per se rules always contain a degree of arbitrariness. They are justified on the assumption that the gains from imposition of the rule will far outweigh the losses and that significant administrative advantages will result. In other words, the potential competitive harm plus the administrative costs of determining in what particular situations the practice may be harmful must far outweigh the benefits that may result. If the potential benefits in the aggregate are outweighed to this degree, then they are simply not worth identifying in individual cases.
>
> I do not believe that the agreement in the present case is so devoid of potential benefit or so inherently harmful that we are justified in condemning it without proof that it was entered into for the purpose of restraining price competition or that it actually had that effect.[17]

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17. 393 U.S. 333; major concurring and dissenting opinions in this case are found at @335-341.

One author, though concerned about the effect of a doctrine whereby the exchange of current price information alone constitutes a *per se* violation of Section 1 of the Sherman Act, has provided the following guidelines to associations with respect to statistical reporting:

> Even in view of the *Container* case, properly conducted programs are still appropriate association functions. However, the following guidelines should be observed in conducting such programs:
>
> 1. Participation in the program should be voluntary.
> 2. Nonmembers of the association should be allowed to participate in this association program, even though some reasonable price differential may be charged.
> 3. Data collected should be of past transactions or activities.
> 4. Data should be collected by an independent (not connected with any one company) third party.
> 5. The confidentiality of an individual company's data should be preserved.
> 6. After data has been collected it should be compiled in composite form so as to conceal the identity of any company or of any specific transaction.
> 7. The data should be distributed in composite form.
> 8. Access to the composite data probably should be made available to all those with a valid business reason for the information.[18]

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18. Webster, *op. cit.*, p. 139.

Price Activities

A well established pattern of government prosecutions has developed where associations were held to have attempted to fix and stabilize prices. Price fixing was discussed in part under the general antitrust concepts considered in Chapter III.

Some examples of penalties in association antitrust cases include:

Fines of from $5,000 to $12,500 were imposed upon a linen supply association and its member firms found guilty of price fixing in U.S. v. Independent Towel Supply Co.[19]

A bowling proprietors' association was fined $2,500 for price fixing and stabilization of prices in U.S. v. Columbus Bowling Proprietors' Association.[20]

Where there have been repeated cases of price fixing, a suit may successfully be brought to dissolve the guilty association and enjoin further such violations. This was the result in the Independent Towel Supply Co. case.

In U.S. v. Automotive Service Dealers Association[21] a $1,000 fine was levied against the chairman of the trade association.

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19. 1970 Trade Cas. par. 73,281 (N.D. Ohio, Sept. 23, 1970).

20. (1961-70 Transfer Binder) Trade Reg. Rep. par. 45,068, @ 52,698.

21. Ibid., par. 45,067, @ 52,649.

Individuals and firms have been subject to fines and, in some instances, corporate officers and executives have been imprisoned. Injunctive relief, barring further performance of the price fixing act is a frequent penalty.

In two related criminal cases, a baking company was fined $12,500 and $24,000 for involvement in collusive bidding on sales to the government. This was the result in U.S. v. Ward Baking Co.[22]

Fines of $20,000 each were levied against three corporations and two firms paid $15,000 each in U.S. v. McDonough Co.,[23] a price fixing conspiracy case. Four company executives were sentenced to 90-day jail sentences in addition to fines of $5,000 each.

Judge Underwood held:

> It seems to the Court, in cases of this character that a fine is not a sufficient deterring factor to cause others who might contemplate violating the Sherman law and those who are involved here today...there ought to be a further deterrant factor.[24]

Some pharmacy related cases also have resulted in a diversity of penalties.

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22. 376 U.S. 327 (1964).

23. 1959 Trade Cas. par. 69,482 (N.D. Florida, 1959).

24. Ibid., par. 75,885.

Hanson reports as early as 1906 the NARD had an action brought against it by the Justice Department. At least one consent decree has been entered subsequently with the FTC.[25]

The Northern California Pharmaceutical Association was subject to a $30,000 fine and Donald K. Hedgpeth was fined $1,000 in the Northern California case to be discussed subsequently.

While no fines were levied in the Utah Pharmaceutical companion case, the association was prohibited from engaging in price-fixing activities in the future.

Related cases in Arizona and Idaho were settled by consent decree after the unsuccessful appeals in California and Utah.

Price Reporting

As reported earlier, the exchange of price information among competitors is not illegal per se. However, the misuse of this information to restrain competition would constitute a violation of Section 1 of the Sherman Antitrust Act.

The line of cases involving statistical reporting clearly indicates an acceptance of the exchange of closed or past prices.

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25. Arthur B. Hanson, "Antitrust Looks at Profession of Pharmacy," Journal of the American Pharmaceutical Association (NS1:11) November, 1961, p. 680.

The use of future price information in material distributed to competitors, however, does not seem to be acceptable. It is possible for such a price to become the basis for an implicit agreement to fix prices. Such an agreement could be sufficient to impose liability upon the parties involved.

The Federal Trade Commission's position has been made quite clear in this regard. An association already barred by an outstanding order from agreeing to suggest resale prices, was advised sponsorship of catalogs listing manufacturers' suggested resale prices and distributed to member-dealers would be a violation of the order.[26] The publication by an automotive repair association of a flat-rate repair manual for use by its members to determine labor charges was similarly disapproved by the FTC.[27] The Commission expressed concern about the implicit danger the "association's manual would facilitate price-fixing between competing repair shop operators."[28] (Emphasis added)

In each case, an informational exchange program using future prices was involved. As has been emphasized previously, there is always a possibility for restraint upon commerce which would violate Section 1.

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26. Advisory Opinion Digest No. 200 (1967-70 Transfer Binder), Trade Reg. Rep. par. 18,244 (FTC 1968).

27. Ibid., No. 201 par. 18,245.

28. Ibid.

The FTC disapproved of a trade association publishing and disseminating to its members a standard rate and service pricing manual for electronics servicemen. The Commission opinion stated:

> While the adoption and dissemination by the association of such a manual may be motivated by a purpose to remove evils affecting the industry, it appears to go further than is reasonably necessary to accomplish the desired result. Even though use of such a manual be accompanied by disclaimers, there is implicit therein too grave a danger that it will serve as a device through which service rates and fees would become uniform and stable throughout the industry. While adoption of a means likely to create competitive uniformity in terms of service pricing may be a convenience to trade association members, this factor is far outweighed by the benefits to the public of the intense competition between competing servicemen, and it is this competition which the law protects.[29]

One author has made the following observation of the development of case law on this subject:

> An information-exchange program which allows a seller to make intelligent decisions for the future on the basis of an <u>informed guess</u> as to what his competitor <u>might</u> do in the future, arouses our suspicion far less than one which enables him to make such decisions on the basis of certainty as to what his competitors <u>will</u> do in

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29. <u>Ibid</u>., No. 158, par. 18,148.

> the future, whether based on the competitors' reports as to what his future action will be or on a report of his past performance so detailed that his future conduct becomes predictable with certainty.[30]

Generally, associations are prohibited from making a conscious effort to exert control over prices. Particularly, this route may not be used as a means to exclude from the market those currently not in it or not members. Consequently, any price information exchange among competitors which would serve to reduce or restrict competition is a violation.

The recommendation of a price list or pricing mechanism by an association which may serve as a restraint on interstate commerce, also is prohibited. The Northern California Pharmaceutical Association v. U.S.[31] and U.S. v. Utah Pharmaceutical Association[32] cases served to focus upon this important issue.

The results in the Northern California and Utah Pharmaceutical cases have caused speculation on the possible

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30. John Galgay, "Antitrust Considerations in the Exchange of Price Information Among Competitors," Antitrust Bull. 617,@ 620-621 (1963).

31. 306 F.2d 379 (9th Cir. 1962), cert. denied 371 U.S. 862 (1964).

32. 201 F. Supp. 29 (D. Utah, 1962), affirmed per curiam 371 U.S. 24 (1962).

result had professional fee schedules for services been involved instead of price schedules for prescriptions as commodities. Though the courts have skirted the basic issue on any number of occasions, it does seem, in principle at least, there is little difference between business and professional activity with respect to this matter. The central question is not whether a particular profession's activities constitute "commerce," but rather, the effect of an association developing a fee schedule for use by its membership.

Cost Accounting

Some authors have supported the proposition cost accounting systems are valuable to a trade association. Indeed, the FTC since its infancy has encouraged better understanding and use of cost accounting systems. Among the pamphlets issued by the FTC in 1916 were the following: "A System of Accounts for Retail Merchants" and "Fundamentals of a Cost System for Manufacturers."

The development and promotion of a uniform cost accounting system or cost accounting is not in itself an illegal activity for a trade association. However, the use of such a system for some illegal purpose does become a violation of antitrust laws. As an example, the application of cost accounting techniques to fix prices or as the basis of an illegal agreement is not permissible.

The FTC implicated a uniform cost accounting program combined with an average-cost analysis and price recommendations in Limited Typothetae of America.[33] The court held the combination of factors served to encourage price fixing.

Cost accounting practices were upheld in Vitrified China Association, Inc.,[34] despite the avowed purpose of the program, which was to bring about adjustments in price in line with actual cost data.

The prime requisite for determining the legality of a particular plan to develop or implement any cost accounting system is the purpose or effect of the program. Using the basic tests for statistical reporting and price information dissemination, conclusions can readily be reached about the liklihood a plan's purpose and effect are legal.

Pharmacy Associations and Specific Programs

In 1776, Adam Smith wrote:

> People of the same trade seldom meet together, even for merriment and diversion, but the conversation ends in a conspiracy against the public, or in some contrivance to raise prices.[35]

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33. 6 F.T.C. 345 (1923).
34. 49 F.T.C. 1571 (1953).
35. Adam Smith, Wealth of Nations, Cannan, Editor, London, 1904, Vol. 1, p. 130.

Events in recent years have created concern about the applicability of Adam Smith's appraisal to pharmacy organizations in their relationships with administrators of third party prepaid drug programs.

Results of the survey reported in Chapter II clearly substantiate interest and concern among pharmacy organizations at the state level in activities related to third party payment programs for providing prescription medication and pharmaceutical services.

The degree and extent of involvement in these activities or reluctance to do so for reasons of possible antitrust implications is also fairly extensive and noteworthy.

The Northern California and Utah Pharmaceutical cases have been given considerable coverage above and serve to highlight at least one aspect of antitrust concern faced by pharmacy organizations in recent years. Related cases include: U.S. v. Nassau-Suffolk Pharmaceutical Society, Inc.,[36] and U.S. v. Hawaii Retail Druggists Association.[37] These cases all involved the use of a price list or pricing method which may tend to result in the restraint of interstate commerce.

Responses reported in Chapter II document the fact cost of dispensing studies had been conducted or were

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36. 1963 Trade Cas. par. 70,936 (E.D.N.Y. 1963).

37. Ibid., par. 70,914 (D. Hawaii, Nov. 19, 1963).

planned in twenty-eight of the thirty-five states (80 percent) from which replies were received. Results of some of these studies have been published in the pharmaceutical press and as independent publications over the years. In addition to state pharmaceutical associations, some national organizations have undertaken sponsorship of similar studies. A jointly sponsored cost of dispensing analysis was conducted in 1970 for the National Association of Retail Druggists and the National Association of Chain Drug Stores.

The national scope of concern is evidenced by the formation in 1969 of the National Pharmacy Insurance Council (NPIC), a representative organization consisting of state, national and specialty pharmacy groups (Appendix O, page 225). A more local or regional group, though national in name, was organized in 1971. This is the National Association for the Protection of the Pharmaceutical Profession (NAPPP) (Appendix P, page 239). Both NPIC and NAPPP will be the subject of more complete consideration in subsequent chapters.

An added indication of the concern for the impact of third party payment programs upon the delivery of health care and the practice of pharmacy is the interest being shown by politicians at all levels of government.

"Third Party Prepaid Prescription Programs" is the title for the hearings conducted July 7 - 9, 1971 by a subcommittee of the Select Committee on Small Business of

the House of Representatives. The more than 300 pages of testimony, exhibits and supporting data as well as the subcommittee's report will be considered in detail in Chapter VI. However, the opening comments of the Chairman of the subcommittee are noteworthy at this juncture:

> ....The purpose of the hearings is to investigate these programs and the impact of their operation upon independently owned retail pharmacies....The committee has received numerous complaints over the last few years in regard to third party programs. Retail pharmacists have written the committee that these programs are forcing many small drugstores out of business while causing a severe economic and administrative burden on those fortunate enough to survive. If these allegations are sustained by the facts, and that is what this subcommittee intends to ascertain, then there is a serious threat to an important segment of the small business community and, indeed, to the very health and welfare of the Nation.[38]

The concerns of individual pharmacists and of pharmacy organizations are manifestations, in part at least, of the recent proliferation of third party payment programs and the growing numbers of beneficiaries-patients-clients

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38. "Third Party Prepaid Prescription Programs," Hearings Before the Subcommittee on Environmental Problems Affecting Small Business of the Select Committee on Small Business, House of Representatives, Washington, D.C., July 7, 8, and 9, 1971, pp. 1-2.

obtaining drug products and pharmaceutical services from pharmacies.

Individuals may be covered by one of any number of a variety of plans. Private insurance companies provide prescription coverage under certain group policies and individual policies as well. Blue Cross-Blue Shield plans provide one or more types of prescription coverage. In addition, there are prepayment plans offered under community programs; some established through employer-union negotiation, locally, regionally or nationally; others may be included in a private group clinic.

Just as the types of sponsorship and membership groups vary, procedures and practices in administering the many programs differ widely in a broad range of material factors. These include such items as: scope of benefits, requirements for participation, basis for payment of benefits, and underwriting procedures.

The pharmacist-vendor under the various programs generally is required to function under different guidelines depending upon the requirements of the plan under which the patient-client is enrolled. These rules usually are developed unilaterally by the program administrator, possibly in consultation with union or company officials, but generally not with any pharmacist(s).

Individual pharmacy owners agree to participation criteria established by the plan administrator. Their

pharmacies may then be classified as "participating" pharmacies to be differentiated from those not so enrolled. Contracts are between the administrator and the pharmacy. The negotiation of terms amounts to the pharmacist either accepting the proffered program as presented or not participating in the plan.

The specific items of prime concern center around bases for determining the pharmacist's charge, including acquisition cost; the method and time involved in reimbursement; professional practice prerogatives, including the maintenance of quality standards; determination of eligibility; and the time and expense involved with at times burdensome paperwork.

If a fixed fee payment method is adopted, the amount of said fee is determined unilaterally by the plan administrator, without knowledge or concern for the reasonableness of the fee with respect to any given pharmacy, or all pharmacies for that matter. Basically, all pharmacies are considered to be equal, in effect, with respect to services provided, record keeping, staff qualifications or the like. Some programs do provide a modification of the fee method of reimbursement by providing for a base fee, with one or more increments added for ancillary services by the pharmacy. To date this idea is not in widespread use.

Related to the fee itself is the matter of the cost base upon which the fee is affixed or added. While a

fixed fee is not a function of the cost of ingredients, the cost factor contributes to the total charge for a given prescription, irrespective of who pays for it.

An administrator may designate a particular means for defining acquisition cost irrespective of whether or not it coincides with the cost experience of a given pharmacy. As an example, acquisition cost may be established as Red Book,[39] "Average Wholesaler Price" (AWP) or Blue Book,[40] "Average Wholesale Price" (AWP). AWP is a dollar figure derived by the publishers of the price reference volumes for those drug products for which their manufacturers have not provided a suggested price to be charged by wholesalers when serving accounts which do not purchase direct from the manufacturer.

Alternatively, the lower price available to those who buy direct from the manufacturer may be designated as acquisition cost according to the agreement for a particular plan. These prices are readily available not only in Red Book and Blue Book, but also in individual manufacturers' catalogs which are widely distributed.

A pharmacy's actual acquisition cost may provide the basis for reimbrusement under any given plan. In the

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39. Drug Topics Red Book, 1972 Edition, Topics Publishing Co., Inc., Oradell, N.J.

40. American Druggist 1971 Blue Book, American Druggist, New York.

situation where this means of establishing cost is used, the pharmacist may have to agree to detailed auditing of purchasing records and related financial data from time to time, by the plan administrator or designee.

The amount and types of added paperwork imposed by the various plans also cause pharmacists problems. The paperwork aspect is just one more example of how variability among requirements can result in costly duplication of effort, delay and confusion. Virtually every insurance carrier, labor union or citizens group has a different form to complete, requiring essentially the same basic information as is elicited by the other forms. The pharmacy must acquire, store, use and process each kind in conformity with the rules and requirements of each plan's administrative authority.

There is wide variation, too, in the payment mechanism even after the appropriate forms have been properly executed. Most frequently, the vendor-pharmacist submits his bill for the entire amount due for a given time period, usually one month, directly to the administrative agency responsible for the given program or plan. Payment is received directly.

Policies containing deductible clauses in the prepaid prescriptions sections may require the pharmacist to collect a specific amount from the patient-subscriber at the time the medication is dispensed. This copayment

amount is then deducted from the total charge for that prescription. The plan is billed for the outstanding balance. This necessitates the processing of two separate transactions, the copayment and the amount paid by the plan.

Beneficiaries may be enrolled in still another type program which operates in a manner similar, procedurally, to the nonparticipating pharmacy requirements generally. The patient with a deductible policy pays the pharmacist directly the full amount to which the pharmacy is entitled. The patient then submits documentary evidence of payment for a bona fide prescription under the plan to the administrator. The difference between the total expended and the deductible amount or an amount computed by a predetermined formula is remitted to the patient.

Whichever method is followed results in added administrative processing and paperwork by the pharmacy's employees. The National Pharmacy Insurance Council has developed a uniform claim form in the hope of lending some assistance and relief to the pharmacists and to the administrators of plans as well. Universal acceptance at all levels is not imminent at this writing.

Recognizing a need for improved claims administration in the area of prepaid drug programs, service agencies have been developed to provide administrative and claims processing for insurers and other prepayment plan operators.

Among them are PAID Prescriptions (PAID) and Pharmaceutical Card System, Inc. (PCS), now a subsidiary of Foremost-McKesson, Inc.

After filling the prescription for the plan participant and completing the appropriate, required claim form, the participating pharmacist may experience long delays before being reimbursed. Complaints fix the waiting period from weeks to several months. Needless to say, during the credit period extended to the plans, creditors of the pharmacist require him to meet his financial obligations to them as do employees, municipalities and other taxing institutions, and so forth. Though pharmacists may be led to believe payments will be processed within a much shorter time period when enrolling in the program, there is usually no guarantee the time limit will be honored. Similarly, there is no recourse for the pharmacist short of cancelling participation in the program or litigating for the past due balances. The former alternative can serve to alienate clientele who are enrolled and have been participating in the program through this pharmacy. The latter alternative is also quite cumbersome and expensive. Generally, pharmacists are unable to receive interest on the past due amounts.

Many plans establish limits upon the quantity of medication which may be dispensed at any one time. These may be expressed in terms of a time period for the dosage

regimen or total number of dosage units. As an example, the upper limit may be a 34 day supply or 100 doses to be provided at one time. The effect of such control mechanisms upon the professional prerogatives of the prescribing physician and the pharmacist has been a matter of concern for some pharmacists.

Recent legislative activity in many parts of this country to repeal antisubstitution statutes and regulations has created further concern about the establishment of professional standards through the mechanism of third party payment program participation contracts. A participating pharmacist may be permitted to dispense any drug product professional judgement dictates would be appropriate for a given patient. However, the cost of acquiring this particular product may exceed maximum cost established by the administrator of a prepayment plan or a governmental formulary commission for drug products containing ingredients with the same chemical names. Once more the possibility exists a pharmacist will have outside influences restricting his exercise of professional judgement and expertise.

As noted previously, individual pharmacists are powerless as individuals to have much impact upon program administrators with respect to the many broad areas of concern outlined above.

The Justice Department has been opposed quite strongly to any group action among pharmacists in this area for reasons of likely violations of antitrust laws. The possible consequences and effect upon prescription prices resulting from unilateral action by program administrators, insurance carriers, labor unions, and so forth, have not been the subject of much study and discussion to date. Potential group action by pharmacists and by organized pharmacy has been the subject of comment.

Lewis Bernstein, Chief, Special Litigation Section Antitrust Division, U.S. Department of Justice has articulated his office's warning to pharmacists and pharmacy organizations on several occasions, including: the University of Mississippi School of Pharmacy Conference on Pre-Paid Prescription Plans in April, 1966; the Annual Convention of the National Association of Retail Druggists, October, 1969; and the National Association of Chain Drug Stores Pharmaceutical Conference in November, 1969.

Bernstein said at the NARD meeting:

> The desire to be more certain about the extent of liability to be assumed has led most plans to adopt a prescribed dispensing fee, plus the pharmacist's cost of the drug. The prevalence of the dispensing fee concept makes the opportunities for antitrust law violations more numerous. To avoid any antitrust violation, the fee must be unilaterally adopted by the plan. While the plan's sponsor may

> solicit suggestions from individual pharmacists, it cannot seek suggested prices from groups of druggists without raising some question of antitrust violation. The individual pharmacist must make his own decision as to whether the price proposed by the plan is acceptable to him. Such decision must not be based on the group's decision....if druggists' groups agree on the price to be suggested to the plan, if it should be adopted, it then becomes a price fixed by agreement among competitors. For this reason carriers cannot solicit agreements from groups of pharmacists as to what an acceptable price would be without exposing themselves to participation in a criminal offense.
>
> I now turn to the question of boycotts. It is clearly illegal for druggists to combine and announce that none of them will accept a proposed plan unless the fee is increased or some other feature adopted or eliminated. Concerted action by professionals to refrain from dealing with a particular plan is illegal per se.[41]

When questioned the day after his speech about the advisability of fostering legislation to correct existing inequities, Mr. Bernstein responded in part:

> Well, certainly, it is reasonable to expect the Justice Department to be very sympathetic to the concept of preserving the entities among retailers. I said that yesterday. The advisability of recommending legislation does not appear to me to be in order to accomplish this.

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41. Lewis Bernstein, "Antitrust Aspects of Prepaid Prescription Plans," NARD Journal (91:22) November 17, 1969, p. 117.

> One of the basic concepts of the free enterprise system is that you have the opportunity for individual decision. That is the way the competitive forces work.
>
> Prior to prepaid prescription plans, each individual druggist was dealing with an individual customer for the prescription and if you want to preserve that system of distribution, as I am sure you do, as I am sure we do, then we must continue to let the free enterprise system work and the only way it can work is when you have individual decisions by individual druggists.
>
> If enough individual druggists decide that a plan is unprofitable, in the long run, they will not accept the plan and then, also in the long run, that plan will be rejected. This is the way the free enterprise and competitive system works.
>
> It is for that reason I don't recommend that we have any new legislation.[42]

The position of pharmacists and organized pharmacy associations with respect to third party prescription payment programs in the private sector have been presented along with the general relationships of antitrust to association activities.

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42. Ibid., pp. 83-84.

CHAPTER V

ANALOGIES TO GOVERNMENT VENDOR PROGRAMS

Discussions heretofore have considered private prescription programs and plans. In addition to private health insurance coverage for prescribed drugs, there are public programs for the financing of prescription drug costs. These represent federal and state supported programs, primarily, as well as some city and county programs.

Those programs financed by federal and state funds will be described briefly along with the mode of participation by pharmacists and possible antitrust problems.

Federal Programs

Reimbursement for outpatient prescription medication for eligible civilian recipients is provided directly by the federal government principally through programs of the Veterans Administration, the Department of Defense and the Public Health Service.

Veterans Administration

Veterans Administration (VA) programs provide outpatient prescription coverage through VA pharmacies

where convenient to the patient in person, as well as by mail. In addition, prescriptions are dispensed from participating community pharmacies under a Hometown Care Program.

Local physicians, dentists and osteopaths, designated as "fee-basis" practitioners, may prescribe any drug needed to treat the patient within the guidelines concerning recipents' service-connected disability or disease.

The VA executes a pharmacy agreement with state pharmaceutical associations, entitled "Professional Relations Agreement Between Veterans Administration And _____ (Name of State Pharmaceutical Association)" (see Appendix F, page 202). The state pharmaceutical association in turn enrolls participating pharmacies for the program and provides the list of cooperating pharmacies to the VA. All communications, billing and administrative details are conducted directly between the VA and the pharmacies.

The state pharmaceutical association is required to establish a three-member Pharmaceutical Liaison Committee to serve in an advisory capacity to the VA.

Requirements for participation are liberal in that, "All legally qualified pharmacies will be eligible to participate in the VA pharmacy program." The participation requirement continues: "Prescription services supplied by pharmacies will be performed by fully qualified, registered pharmacists." (Appendix F, page 202).

The VA provides a uniform fee schedule to all participating pharmacies in which maximum fees and the method for determining them are enumerated. No payments in excess of the authorized charge will be made. The agreement stipulates the VA will not be charged an amount exceeding what is charged to the general public for similar prescriptions. The agreement contains the following statement with respect to the negotiability of the pricing schedule:

> The fee schedule is established by the Veterans Administration and is not subject to negotiation. Recommendations of the association as to appropriateness and equitability of the general fee schedule and the basis for establishing prescription charges will be considered by the Veterans Administration. (Appendix F)

Data provided for the year 1967 by the Veterans Administration and cited by the Task Force on Prescription Drugs show 431,742 prescriptions were provided that year under the Hometown Care Program. The average charge per prescription was $6.37.[1] The comparable price per prescription nationally that same year was $3.66 according to The Lilly Digest.[2]

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1. Task Force on Prescription Drugs, "Current American and Foreign Programs," U.S. Department of Health, Education and Welfare, Washington, December, 1968, p. 19.

2. The Lilly Digest, 1967, Eli Lilly & Co., Indianapolis, p. 7.

Office for the Civilian Health and Medical Program of the Uniformed Services

Office for the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) - Military Medicare - established provisions for outpatient drug coverage in 1966. Eligible recipients are families of members of the uniformed services, retirees and their families, and families of persons who died while on active duty.

There is no restriction on which pharmacies may participate in this program. Willingness to operate within the OCHAMPUS regulations is sufficient. These regulations and guidelines include delineation of quantities which may be dispensed. Generally, the maximum to be provided is the amount needed to treat an episode of illness. Maintenance drugs may be dispensed in amounts up to a 100 day supply.

One of the instructions to participants requires dispensing the lowest cost drug consistent with the requirements of the practitioner. This implies if the physician prescribes by using the generic name of a drug, the pharmacist will dispense the lowest cost chemical equivalent in stock which fulfills the practitioner's requirements.

Pharmacies may provide prescription medication and insulin to eligible beneficiaries who produce evidence of eligibility to participate in this program. The amount

which may be billed to OCHAMPUS is computed by a predetermined procedure. For prescriptions, the pharmacist adds the dispensing fee for the state in which he practices to the actual acquisition cost of the drug product. From this total, the amount of the coinsurance payment (20 to 25 percent depending upon recipient's classification) is deducted. The patient pays the coinsurance amount directly and the pharmacy bills OCHAMPUS for the balance.

State by state dispensing fees are established by the agency to conform, to some extent at least, with current levels of prescription gross margins in the respective states. No provision is made for negotiation or advice by any group or individual pharmacist.

Approximately 85,000 prescriptions were dispensed under this program in 1967, at an average cost to the federal government of $3.22 per prescription. "This figure, increased to include the amount paid by the beneficiary, indicates an average prescription price of $4.15."[3]

The Public Health Service

The Public Health Service (PHS), Division of Direct Health Services and Division of Indian Health, provide

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3. Task Force on Prescription Drugs, op. cit., p. 8.

prescriptions for personnel under their jurisdiction through community pharmacy vendor programs. These pharmacies are in outlying, sparsely populated areas primarily, where it would not be economically feasible to have PHS personnel providing direct service.

The local physican and community pharmacist are utilized by the Division of Direct Health Services in its outpatient offices and designated physician programs. The supervising PHS office contracts with a physician to serve where a physician is needed in the area. As many local pharmacies as may wish to participate enter into another agreement for service. Patients may receive their prescription medication at any participating pharmacy without charge.

The pharmacist returns the duplicate copy of the prescription form to the contract physician who forwards a voucher to the PHS on behalf of the pharmacist. Payment is made directly to the pharmacist.

A prescription pricing chart, adapted from the VA schedule, serves as an indicator of maximum charges. In no case can the amount charged exceed what would be charged a regular customer. A usual professional fee is permitted in lieu of the pricing schedule provided the restriction against charging more than regular customers pay is followed.

Veterans Administration: Pharmacy Agreement

PROFESSIONAL RELATIONS AGREEMENT BETWEEN VETERANS ADMINISTRATION AND _____

(Name of State Pharmaceutical Association)

The _____ and the Veterans Administration, to assure the availability of necessary local pharmaceutical services for veterans, agree as follows:

1. *Pharmaceutical Liaison Committee*

a. The association will establish a three-member Pharmaceutical Liaison Committee for each VA jurisdictional[1] area within the State to function in a liaison and professional relations capacity. Coordinating its activities with the _____ Pharmaceutical Association, the Pharmaceutical Liaison Committee(s) will consider and submit recommendations on professional matters within the scope of VA services provided by private pharmacies; cooperate with the Veterans Administration to assure the availability of high quality pharmacy services whenever and wherever needed; provide for liaison between the Veterans Administration and participating pharmacies by such means as the association's publications, conventions, meetings and other regularly available media; in general assist with the maintenance of effective VA-Pharmaceutical Association professional relations; and perform such other functions as may be agreed on from time to time.

b. The _____ Association will advise the Clinic Director of the VA field station of jurisdiction of the names of members appointed to serve on this committee, and any changes in committee membership.

c. If the Pharmaceutical Liaison Committee meets at the specific request of the Veterans Administration, each member attending may be paid at an all-inclusive rate not to exceed $50 a day or fraction thereof. Payment to committee members will be made by the VA field station upon submission of a properly prepared invoice. Such payments are limited to three committee members unless otherwise approved by the Clinic Director of the field station of jurisdiction.

d. It is understood that any general mailing of an informational or instructional nature to participating pharmacies which may be required will be prepared and mailed by the Veterans Administration. Whenever feasible and appropriate, such mailing will be coordinated with the Pharmaceutical Liaison Committee.

e. Clerical and operational aspects of prescription services will be administered directly between the Veterans Administration and individual pharmacies. It is mutually understood that participating pharmacies may bring to the attention of the Pharmaceutical Liason Committee for forwarding, if indicated, any matter for consideration by the Veterans Administration.

2. *Participation by Pharmacies*

All legally qualified pharmacies will be eligible to participate in the VA pharmacy program. Prescription services supplied by pharmacies will be performed by fully qualified, registered pharmacists.

3. *Listing of Pharmacies*

The _____ Association will submit periodically, but not less frequently than once each year, the names and addresses of new pharmacies, discontinued pharmacies, or changes in names and/or addresses of pharmacies.

4. *Choice of Pharmacy*

Veterans for whom local pharmacy services are authorized by the Veterans Administration may select any qualified pharmacy to fill their prescriptions. Such pharmacies may include pharmacies in VA facilities when feasible.

5. *Eligibility of Veterans*

The Veterans Administration will determine the eligibility of veterans to receive pharmaceutical services. Prescriptions accepted and filled will bear a statement, signed by the prescribing physician or dentist, that he has been authorized by the Veterans Administration to treat the disability for which the prescription is written.

6. *Schedule of Prescription Fees*

a. A uniform schedule of prescription fees will be furnished individual pharmacies. Fees listed therein represent maximum fees authorized. It is understood that charges to the Veterans Administration will not exceed those charged for similar prescriptions to the general public.

b. The fee schedule is established by the Veterans Administration and is not subject to negotiation. Recommendations of the association as to appropriateness and equitability of the general fee schedule and the basis for establishing prescription charges will be considered by the Veterans Administration.

7. *Distribution of Instructions and Fee Schedule*

a. Based on best available information, the Veterans Administration will distribute the fee schedule and instructions to all known pharmacies withinn the State. Each pharmacy will be invited to accept and return a signed agreement and notice of intention to accept VA prescriptions. The absence of a signed agreement will not preclude payment for properly authorized and documented prescriptions filled in accordance with the instructions.

[1] Jurisdictional areas are territories served by VA outpatient clinics or hospitals authorizing outpatient services for veterans.

Congress added two significant amendments to the Social Security Act in 1965. These were Title XVIII which established Medicare and Title XIX under which Medicaid was created.

Title XVIII created a comprehensive federal program of hospital and medical insurance for persons 65 and over. Though the possibility has been suggested frequently since the effective date of July 1, 1966, no provisions have been made to date for including outpatient prescription drug benefits under Medicare.

Title XIX is a federal-state program to help provide medical services to the needy and the medically indigent. Medicaid is the responsibility of the Medical Services Administration in the Social and Rehabilitation Service of the U.S. Department of Health, Education and Welfare.

Programs as adopted by individual states are administered locally. They are designated State Medical Assistance Programs. Individual states have a number of alternatives with respect to eligibility for benefits as well as the types of benefits to be provided.

In order to participate, states are required to provide certain services, while others are optional. For the categorically needy, the following services must be provided:

(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases) paid on a reasonable cost basis

(2) outpatient hospital services

(3) other laboratory and X-ray services

(4) (a) skilled nursing-home services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older, and

(b) effective July 1, 1969, for individuals under age 21 eligible under the plan for such periodic screening and diagnostic services as are needed to identify physical and mental defects, and provide health care treatment and other measures designed to correct or ameliorate defects and chronic conditions, as may be provided in regulations of the Secretary

(5) physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere

(6) effective July 1, 1970, home health services for <u>any</u> individual who, under the State plan, is entitled to skilled nursing-home services.[5]

Choices are available to the states with respect to mandatory services for the medically needy as opposed to the categorically needy. They may provide the first five of the

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5. <u>Questions and Answers - Medical Assistance "Medicaid"</u>, U.S. Department of Health, Education and Welfare, Social and Rehabilitation Service, Medical Services Administration, Washington, D.C., 1968, pp. 11-12.

services listed above or seven of the first 14 optional services enumerated in Section 1905(a) of P.L. 89-97. If they include either inpatient hospital care or skilled nursing-home services among the seven, physicians' services must be provided for patients in the hospital or nursing home.[6]

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6. Ibid., p. 12. This reference also contains a list of medical services. The medical care services provided under current programs may be classified as follows:
   1. Inpatient Hospital Care
   2. Outpatient Hospital Care
   3. Laboratory and X-ray Service
   4. (A) Skilled Nursing Home Services
      (b) Early and periodic Screening, Diagnosis, and Treatment for eligibles under 21 together with the indicated health care
   5. Physicians' Services
   6. Medical or Remedial Care provided by licensed practitioners
   7. Home Health Care Services
   8. Private Duty Nursing Services
   9. Clinic Services
   10. Dental Services
   11. Physical Therapy and related services
   12. Pharmaceutical Services (prescribed drugs)
   13. Diagnostic Screening, Preventive, and Rehabilitative Services
   14. Inpatient Hospital and Skilled Nursing Home Services for persons over 65 in an institution for tuberculosis or mental diseases
   15. Other Medical or Remedial Care recognized under State Law.

   A state participating in a Title XIX program must provide the basic services 1 through 5 above for the categorically needy and, for the medically needy, 7 of the 14 services as listed in Title XIX, Section 1905(a) of PL 89-97.

   Effective July, 1970 in addition to the basic services, a State plan for medical assistance under Title XIX of the Social Security Act, as amended, must (for both categorically and medically needy):

   (Cont.)

"Prescribed drugs,"[7] is one category among the optional programs which states* may include in their respective plans.

> As of June 30, 1971, 52 of the 54 jurisdictions had Title XIX programs in operation, with approved state plans. Six of the 52 jurisdictions with Title XIX programs do not currently provide pharmaceutical benefits through the vendor payment system.[8]

These states are indicated on the U.S. Department of Health, Education and Welfare report entitled "Medicaid Services State By State, March 1971."[9] (Appendix G, page 205) Alaska and Arizona have no basic required Medicaid services while Arkansas, Idaho, Oklahoma, South

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6. (Cont.)
   (1) Provide for inclusion of home health services for any individual who, under the plan, is entitled to skilled nursing home services.
   (2) Specify that there will be provision for assuring necessary transportation of recipients to and from providers of services and describe the methods that will be used. This applies to the categorically needy and to the medically needy if the plan includes the latter group.

7. Questions and Answers, op. cit., p. 10.

8. Pharmaceutical Benefits Under State Medical Assistance Programs, National Pharmaceutical Council, Washington, D.C., 1971, p. 3.

9. "Medicaid Services State By State, March 1971," U.S. Department of Health, Education and Welfare, Social and Rehabilitation Service, Medical Services Administration, mss. 801-71.

*Reference to "states" includes the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

Dakota, Texas and Wyoming do not provide pharmaceutical benefits through vendors.

During 1967, a total of $182,584,000 was spent nationally under these programs for prescribed drugs.[10] In 1970, expenditures in this category were $395,402,000, or 8.2 percent of all vendor medical bills paid under Title XIX programs.[11]

The percentage share of medical costs attributable to prescribed drugs varied widely among the states. This type of service accounted for 0.1 percent of the total in Oklahoma, while Tennessee showed a 31.9 percent figure.[12]

The rate of federal financial participation in a state's medical vendor activities also varies. Contribution percentages range from approximately 50 percent to 83 percent.[13]

Many other differences exist among the states with respect to approaches to reimbursement, cost and quality control, administration and the like.

Formularies or drug lists are used in some states and not in others. The type of formulary and means by

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10. Ibid., Chart I.

11. U.S. Department of Health, Education and Welfare, National Center for Social Statistics, Report B-5 (FY-70).

12. Ibid.

13. Medicaid Services, op. cit.

which the system is implemented also vary a great deal. The number of drugs included in a reference list is a variable, as is the use for which the list is intended. Some may serve simply as guides for medical and pharmacy practitioners while, alternatively, a list may exclude items and prescription drug products for which reimbrusement is not authorized. Another approach has been listing disease entities for which drug therapy is authorized. There is no uniformity among jurisdictions in determining which diseases are to qualify for inclusion, however.

Other variations occur in quantity dispensing limits; prescription renewal requirements, if permitted; coverage for nonlegend drug products; dollar limits per prescription; and determination of prices. Prescribing by generic name or pricing on some basis related to generic-named products also may be mandated or, at least, encouraged.

No consistent pattern emerges when the vendor payment systems in participating states are examined.

A review of published data[14] describing the forty-six state prescription programs shows twenty-seven states provide for a dispensing fee to be added to the cost to the pharmacy for the drug product(s) being dispensed. Determination of the cost is still another variable among the states.

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14. Pharmaceutical Benefits, op. cit.

Other pricing techniques are predicated upon charts, formulae, and combinations of systems.

In two states, Connecticut and Rhode Island, the professional fee to be charged by the pharmacist depends upon whether the patient resides in customary residential quarters or is confined to a nursing home.

The highest professional fee established for pharmacists is the $2.30 rate in California. Kansas pharmacists are entitled to from 93 cents to $2.22, depending upon an evaluation of their operational data.

To be consistent for purposes of comparison of prescription prices under various federal and state programs, it should be noted in 1967 for Title XIX programs:

> The average varied from a low of $2.94 in Illinois to a high of $4.74 in New Mexico. Although exact comparisons are not possible, it was estimated that average prescription prices in welfare programs were roughly 10% lower in those states using formularies.[15]

All aspects of Title XIX programs are constantly under study or the cause for expression of concern by one or more individuals or groups, be they political, governmental, labor or private.

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15. Donald D. Jones and J. F. Follmann, Jr., Health Insurance and Prescription Drugs, Health Insurance Association of America, 1971, pp. 86-87.

Though accounting for a significantly lower percentage of vendor medical bills[16] than inpatient hospital care (39.7 percent), nursing home care (27.1 percent) or physicians' services (11.9 percent), prescribed drugs, as a sector of the total, is also subject to scrutiny and critical evaluation.

In a 1970 report of the U.S. Senate Finance Committee, the following appears under the heading "Recommendations for Improvement-Medicaid":

> Cut Drug Costs
>
> Require that drugs be provided on substantially the same basis which would have been established under the provisions of the medicaid amendment adopted by the Senate in 1967. That provision, sponsored by Senator Russell B. Long, would establish a formulary of the United States, with drugs deemed appropriate for inclusion determined by a high-level qualified formulary committee. Federal matching would be limited to the amounts charged for lower-cost products of each drug in the formulary which were determined to meet all official standards and to be of proper quality. Exceptions to the limitations could be made upon a satisfactory showing that a particular higher-cost product had 'distinct, demonstrated therapeutic advantages' over the lower-cost products of the same drug or where a physician prescribed a drug product by its official or established name and the name of the manufacturer.
>
> In accordance with a section of the Social Security Amendments of 1967, which called for a study of the

16. HEW, NCSS Report B-5, op. cit.

> proposal by the Department of Health, Education, and Welfare, a report was submitted to Congress in January 1969 by the Department's Task Force on Drugs recommending adoption of the basic provisions of the 'Long Amendment.' If that recommendation is followed, many millions of dollars in prospective medicaid drugs expenditures should be saved.[17]

Interestingly, Senator Long had proposed something additional in his formulary amendment (No. 929) to HR 17550, the 1970 Social Security Act Amendments. Section 1134(b) provided a mechanism whereby pharmacists could negotiate through pharmaceutical associations for restructuring fees under applicable provisions of Title XVIII and Title XIX.

A study of available data[18] on the structure and procedural aspects of state Title XIX programs shows twenty-three of the forty-six states (50 percent) which provide prescription coverage have a mechanism for obtaining direct input into program administration from organized pharmacy in their respective states. These include those jurisdictions in which there is reported "official" representation or participation of the state

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17. "Medicare and Medicaid - Problems, Issues, and Alternatives," Report of the Staff to the Committee on Finance United States Senate, Russell B. Long, Chairman, February 9, 1970, pp. 127-128.

18. Pharmaceutical Benefits, op. cit.

pharmaceutical association on one or more of the advisory groups to the administering agency or body.

Since data for each state are not uniformly presented in the source document, it is possible a larger number of state associations have something more than a lobbyist voice into program operations, policy or other related matters. The twenty-three associations considered here are those whose representatives were designated as such on advisory bodies, either as full appointed participants or ex officio.

It is not possible to assess the degree of participation among these representatives nor the effect of their presence. Whether having a place on a particular board is tantamount to providing general technical advice or serving as advocate or negotiator for the pharmaceutical association is a rather important distinction. The significance of the difference is obvious.

As with the wide variations existing in other phases of Title XIX programs, it is not unlikely pharmaceutical association representation would cover the entire scope of possibility.

The existence, in so many states, of a mechanism for organized pharmacy to provide input into important aspects of the prescribed drug vendor programs is significant.

This leads to considering the possible impact of a 1961 United States Supreme Court case. Professor Oppenheim[19] heralds Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.[20] as a landmark decision which:

> has opened the door to alternative means whereby such groups may concertedly engage in political activity to obtain new federal, state or local legislation, to achieve an equitable recognition of professional and business interests of pharmacists under third-party plans.[21]

In enunciating the Noerr doctrine, the Supreme Court unanimously held:

> the Sherman Act does not prohibit two or more persons from associating together in an attempt to persuade the legislature or the executive to take particular action with respect to a law that would produce a restraint or a monopoly.[22]

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19. S. Chesterfield Oppenheim, "Antitrust Policy and Third-Party Prepaid Prescription Drug Plans," The George Washington Law Review (40:2) December 1971, pp. 266-268.

20. 365 U.S. 127 (1961).

21. Oppenheim, op. cit., p. 266.

22. 365 U.S. 127,@136.

The Court pointed out:

> a holding that the Sherman Act forbids associations for the purpose of influencing the passage or enforcement of laws... would substantially impair the power of government to take actions through its legislature and executive that operate to restrain trade. In a representative democracy such as this, these branches of government act on behalf of the people and, to a very large extent, the whole concept of representation depends upon the ability of the people to make their wishes known to their representatives.[23]

The doctrine was affirmed in United Mine Workers v. Pennington[24] with the following declaration: "Noerr shields from the Sherman Act a concerted effort to influence public officials regardless of intent or purpose."[25]

Oppenheim concludes under the doctrine,

> a pharmaceutical association can lawfully act in concert to seek legislative or executive action on its own initiative or to favor or oppose legislation introduced by others, irrespective of whether the concerted efforts of the association are designed solely to advance the professional and business interest of pharmacies and

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23. 365 U.S. 127,@ 137.

24. 381 U.S. 657 (1965).

25. 381 U.S. 657,@ 670.

> pharmacists, or also, in purpose and effect, are disadvantageous to conflicting competitive third-party interests.[26]

The Northern California Pharmaceutical Association and its members were enjoined from continuing the practices alleged in the Northern California[27] case. This included any price fixing related activities.

According to Bernstein,[28] approximately one year after the Northern California case decree was entered, a member of the Northern California Pharmaceutical Association petitioned for a modification by the court. In his argument he noted he was a member of the California Pharmaceutical Association as well as the defendant Association and served as the former organization's Social Welfare Committee Chairman. This required him to meet with representatives of the Department of Social Welfare of the State of California to discuss administration of the program under which the Department provided drugs to welfare recipients.

Furthermore, under the program the Department of Social Welfare maintained a schedule of fees and allowances to be paid to pharmacists providing prescriptions for welfare recipients.

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26. Oppenheim, op. cit., p. 268.
27. 306 F.2d 379 (9th Cir. 1962), cert. denied 371 U.S. 862 (1964).
28. Lewis Bernstein, "Antitrust Aspects of Pre-Paid Plans Sponsored by Pharmaceutical Associations," Presented at the University of Mississippi, April 7, 1966, pp. 7-9 (unpublished).

The petitioner contended without a modification of the decree he could not function in his capacity as Committee Chairman. In addition, it was argued, he and other members who were subject to the decree could not provide drug cost data to the Department of Social Welfare, nor could they articulate the pharmaceutical profession's reactions to policies and interpretations by the Department of Regulations enforcing compliance with the prescription price schedule.

The court refused to grant any modification. Members of the Association were allowed as individuals to petition the State through the Department of Social Welfare for changes in policies or for increased allowances for prescription drugs. However, there could be no consultation among themselves concerning price schedules for the purpose of presenting a joint petition.

CHAPTER VI

FUTURE EXPECTATIONS

Events throughout the decade of the sixties and into the 1970's provide at least some bases for projecting potential future developments in the general area of professional pharmacy associations' roles in planning and evaluating third party payment programs.

Judicial Background

The review of antitrust statutes and cases generally, as well as specific professional and trade association cases predating the first major pharmacy cases on this topic, have been documented and discussed in earlier chapters.

Similarly, much has been discussed concerning the precedent established by the Northern California,[1] Utah Pharmaceutical,[2] and related cases.

Likewise, consideration has been given to the thus far unalterable position of the Justice Department concerning any collective price-related activities and boycotts.

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1. 306 F.2d 379 (9th Cir. 1962), cert. denied 371 U.S. 862 (1962).

2. 201 F. Supp. 29 (D. Utah, 1962), affirmed per curiam 371 U.S. 24 (1962).

Pharmacy's Reactions

Reactions from individuals and pharmacy groups have manifested themselves in a number of ways--editorials, guidelines, legislative proposals, formation of organizations, and congressional committee testimony as well.

One leader of the pharmacy profession had these comments in 1969:

> As the professional fee system becomes universal, the door should then be opened for a re-examination of the position of the Justice Department concerning the right of pharmacists to bargain collectively in placing a dollar figure on the value of their services. Every other skilled worker has this right including lawyers as well as bricklayers. Why not pharmacists? The fact that pharmacy is a profession is to our mind irrelevant as it must become to our professional societies - local, state and national.[3]

The National Association of Retail Druggists (NARD) reacted to the situation after the House Select Small Business Subcommittee on Environmental Problems Affecting Small Business hearings in the summer of 1971. The first of two positive approaches to a solution offered by the

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3. Linwood F. Tice, "Collective Strength," American Journal of Pharmacy (141:3) May-June, 1969, p. 3.

NARD was the submission of a proposed bill entitled, "Prepaid Prescription Program Negotiation Act" (Appendix H, page 207) to the Chairman of the Subcommittee. The bill was designed to permit representative or advisory groups of pharmacists to negotiate with third party prepaid prescription program administrators and sponsors about reimbursement and program operation without liability for antitrust violations.

Simultaneously, the NARD sought advice from the Federal Trade Commission and the U.S. Department of Justice Antitrust Division regarding a set of guidelines (Appendix I, page 210) for the interim until remedial legislation, such as has been proposed, is enacted.

In his letter (Appendix J, page 212) to the agencies urging flexibility in dealing with negotiation by associations with third party payment personnel, Earl Kintner, NARD Washington Counsel stated:

> It is our considered judgment that a fair balance of the public interest considerations which motivated congressional passage of the antitrust laws and the public interest considerations which favor the survival of the independent small businessman provide a meaningful predicate for establishing guidelines which would permit retail pharmacists to obtain fair treatment under prepaid prescription programs. Admittedly, this will require cooperation and consultation by both the Federal Trade Commission and the Department of Justice in recognizing an area of

> flexibility in the interpretation of the antitrust laws.
>
> In an effort to facilitate this consultation and cooperation, I am submitting proposed guidelines, which are essential to ameliorate, if only on a temporary basis, the many problems confronting retail pharmacists. It should be pointed out that the guidelines have been designed to preclude the possibility of boycott activity on the part of retail pharmacists.[4]

In rejecting the guidelines on behalf of the Justice Department, Assistant Attorney General McLaren wrote to Mr. Kintner:

> We find that we cannot endorse these guidelines at this time and under present circumstances. We fear that within them there is inherent the concept that pharmacists can agree upon the pricing factors to be furnished to administrators of third-party plans. Obviously, such administrators are currently free to obtain such information from individual pharmacists in specific markets.
>
> We continue to believe that the problems of retailing pharmacists in connection with these programs can be resolved after a thorough study has been made by an appropriate task force composed of representatives of all interests. We have been in communication with the HEW Dept. in an effort to encourage and expedite such a study.[5]

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4. Earl W. Kintner, correspondence, July 29, 1971.

5. "Antitrust Div. Rejects NARD Guidelines for Third-Party," F-D-C Reports, "The Pink Sheet" (33:39) September 27, 1971, T&G-3.

On April 11, 1972, Representative Louise Day Hicks introduced the NARD recommended bill in the second session of the 92nd Congress as HR 14304. It was referred to the Committee on the Judiciary.

Contemporaneous with the announcement of Mrs. Hicks' introduction of HR 14304, the NARD solicited the assistance and cooperation of state and metropolitan pharmaceutical associations by the distribution of a resolution of support for the bill, to be adopted by the respective organizations.

At this writing, only speculation is possible as to the possible passage of this legislation and its potential impact. The likelihood of passage is greater now than in any era in recent history.

Similarly vague or speculative is the overall effect of this specific legislation if enacted into law.

Clearly, HR 14304 is intended to permit some group action according to (1) its title, "Prepaid Prescription Program Negotiation Act," (2) its preamble, "To permit collective negotiation by professional retail pharmacists with third-party prepaid prescription program administrators and sponsors, and (3) its Declaration of Purpose.

The type(s) or scope of group action is not clearly defined. The "limited exemption" from antitrust laws construed literally applies only to collective negotiation.

Section 4(a) further limits: (1) the parties with whom groups of pharmacists may negotiate and (2) the subjects which may be considered. Pharmacists may negotiate with program administrators or sponsors only concerning reimbursement for dispensing prescriptions and administrative and operational features of programs.

The question arises despite the reimbursement definition in the bill how broadly the Justice Department and the U.S. Supreme Court will interpret "method or formula" for payment.

An inherent problem associated with the reimbursement issue centers around expanding the limited exemption to related activities which might otherwise constitute unlawful acts of price fixing. These would include accounting and reporting programs which would afford an organization better information for purposes of negotiating, a permissible activity, yet unlawful under some conditions.

Perhaps a more meaningful exemption to pharmacy would result from an amendment including permission to exchange certain cost and price information consistent with the purposes of negotiation.

Congressional Recommendations

Pursuant to H. Res. 5 and 19, a select subcommittee was created to conduct studies and investigations of the problems of small business. On July 7, 8, and 9, 1971,

hearings were held on third party prepaid prescription programs before the Subcommittee on Environmental Problems Affecting Small Business of the Select Committee on Small Business, House of Representatives.

Representative Joel L. Evins served as Chairman of the Select Committee on Small Business and the Subcommittee was chaired by Representative William L. Hungate. The purpose of the hearings is noted in Chapter V from the opening statement by the Subcommittee chairman.

Testimony was taken from more than two dozen persons representing organizations of pharmacy, insurance firms, individual pharmacists, Justice Department, and the Federal Trade Commission. In addition, many prepared statements, reports, exhibits, correspondence and related documents were received for the record. The printed report of the hearings contains 356 pages of statements, testimony, exhibits and related materials, as well as 14 pages of appendices.

Justice Department and Federal Trade Commission speakers underscored the previously discussed policies and positions of their respective governmental bodies. Bruce B. Wilson, Deputy Assistant Attorney General, U.S. Department of Justice Antitrust Division, told the Subcommittee:

> The law is, I believe, clear that druggists may not band together in an attempt to control the prices of the products they sell. I believe that these decisions represent sound public policy in as much as they preserve competitive options for the consuming public.[6]

He stated further:

> History indicates that unwise governmental attempts to protect various interests from the forces of change often have the unhappy effect of increasing consumer costs without achieving commensurate public benefits. And, while superficial analysis might lead one to expect that increases in consumer costs resulting from authorizing price fixing would automatically promote the long-term profits of the affected industry, such has not always been the case. Relieved of the need to compete on price, such protected industries have often been marked by relative inefficiency, due to their failure to innovate. In such cases, the day of judgment is merely postponed at great cost to the consuming public.
>
> Thus, it has been our experience that the sounder course of public policy is not to attempt to protect existing interests from the forces of socially desirable change by creating exemptions from the antitrust laws. Rather it is better to attempt to devise systems which meet the changing needs of the public in a manner which promotes efficiency while

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6. "Third Party Prepaid Prescription Programs," Hearings Before the Subcommittee on Environmental Problems Affecting Small Business of the Select Committee on Small Business, House of Representatives, 92nd Congress, 1st Session, Washington, D.C., July 7, 8, and 9, 1971, p. 230.

allowing all producers a fair opportunity to compete on the basis of their ability to satisfy consumer demands.

I do not wish this statement to be misunderstood. Small businessmen, such as the independent druggists, are capable of making important contributions to the public interest. To the extent that prepaid prescription plans become a significant factor in the provision of health services, it behooves us to try to make sure that the plans do not impose burdens which adversely affect the fortunes of the independent druggist for reasons unrelated to efficiency. Programs designed by large entities can impose burdens that are tolerable, if inconvenient, for large suppliers, but intolerable for smaller suppliers. Prepaid prescription drug plans should, therefore, be designed to provide for prompt reimbursement to participating druggists with a minimum of administrative burden. Such plans can best meet the goals of our nation if they are administered efficiently and with respect for the legitimate interests and needs of all those groups participating in the plan.

In conclusion, it appears to us that prepaid prescription drug plans may represent the beginning of a significant change in one aspect of this nation's health care system. At the present time, however, it is too early to make any prediction as to the manner in which these type of plans will eventually evolve or how significant they will become on a national basis. In view of their potential importance and the economic and social issues that they raise, we believe that a careful study of the problems should be undertaken prior to the enactment of new legislation. While various aspects of these plans have been studied by some of the interests involved, we believe that there is a need for a more

> comprehensive review. Such a study would be undertaken by a Task Force on which both the public agencies and interested private groups could be represented. Naturally, the Department of Justice would stand ready to provide such a Task Force with advice on any antitrust questions that might arise.[7]

Fred L. Woodworth, Assistant Director, Office of Policy Planning and Evaluation, spoke on behalf of the Federal Trade Commission. His statement included the following:

> ...While the Commission has not developed a definitive position about the application of the antitrust laws (including Section 5 of the Federal Trade Commission Act) within the prepaid prescription plan context, it generally shares the Justice Department's recognition that the plans may be formulated and operated in ways that present serious problems in terms of well-established antitrust policy and precedent....
>
> Despite our concern about small business problems, the Commission is not in the possession of data or information which enables it to evaluate the possible relationship between the advent of third party prescription programs, and the competitive problems which may now be confronting small druggists. It is most important for government policy in this important area to have the benefit of a very careful, empirical inquiry into the economic impact traceable to the third party plans, as distinguished from results which

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7. Ibid., pp. 231-232.

> may be caused by other factors, if this is possible.
>
> The Commission has a third perspective from which it views the development of third party prepaid prescription drug plans. Related to its responsibilities and concerns in the consumer protection area, it favors the development and implementation of methods and systems by which prescription drugs--as well as other health needs--are made available to consumers effectively, safely, and with the sort of information which it would need in order to evaluate the performance of the plans generally (or of individual plans) in terms of the consumer benefits which they may produce. In this area also, the Commission is optimistic that the inquiry which your Committee is making will serve to illuminate the difficult policy issues which exist in this field.
>
> The Commission strongly supports the purposes of these hearings, which are intended to illuminate a most demanding set of policy questions....[8]

Testimony on behalf of the Blue Cross Association was presented by Waldo A. Stevens, Senior Vice President, Blue Cross Association. In his statement he said:

> In the prototype out-of-hospital drug program, we recommended use of the dispensing fee type of provider reimbursement. Other forms may have been easier to introduce and to administer as a short-range consideration. However, long-range durability in prepaid programming requires a proper balancing of market and provider interests. To have confidence in any health benefit

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8. Ibid., pp. 300-301.

program, the market requires reasonable predictability of cost. The dispensing fee approach contains this element.

Our belief in the integrated benefit concept brought us into the prepaid drug market. We believe that any current or future market will not be satisfied to buy fractions of the health package from separate sources, as evidenced in the past by the welfare packages of many employers being splintered among several carriers.

From the provider viewpoint, we see health services furnished in a pluralistic manner. Certain services are complementary, while others are alternative options which provide an element of choice. Because prescription drugs closely relate to almost every other form of health care, we feel they should be an integral part of health prepayment programming. Our ability to offer subscribers a unified, comprehensive health prepayment package facilitates this interrelationship.

There is a secondary consideration; a drug prepayment program standing alone has difficulty supporting the basic overhead of sales, membership records, invoicing and volume disbursement.

In developing our program, a number of decisions had to be made requiring expertise which our years of experience in health care did not always provide. To counter this void, we enlisted the aid of outside experts as consultants, examined articles and attended conferences regarding the practice of pharmacy, giving special attention to what the leaders of the profession had to say with regard to prepaid prescription programs. We also utilized the knowledge of pharmacists within Blue Cross and

> added other pharmacists to our staffs for the express purpose of establishing our programs.[9]

On November 29, 1971, the Report of the Subcommittee[10] was committed to the Committee of the Whole House on the State of the Union and ordered to be printed. (Appendix K, page 216).

The conclusions and recommendations of the Subcommittee are summarized below:

> Conclusions
>
> The subcommittee is of the opinion that the position of independent retail pharmacies may rapidly deteriorate under the present development and implementation of prepaid prescription programs.
>
> While prepaid prescription programs are a relatively new phenomenon, the impact of which is impossible to fully assess at this time, the subcommittee concludes that many present practices employed in administering them are unduly onerous and, in particular, that by their very nature, they involve an imbalance of power between plan carriers and individual druggists which is especially serious in the case of independent small business pharmacists.
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> Of particular concern to the subcommittee in this connection is

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9. Ibid., pp. 289-290.

10. "Third Party Prepaid Prescription Programs," A Report of the Subcommittee on Environmental Problems Affecting Small Business to the Select Committee on Small Business, House of Representatives, 92nd Congress, 1st Session, Washington, D.C., November 29, 1971.

the present interpretation of the antitrust laws which permits program sponsors and administrators jointly to determine pharmacy fees and contract terms and conditions, while prohibiting independent pharmacies, which are most affected by such programs, from having any collective voice in the development of such plans. The independent pharmacy is, therefore, subject to the demands and dictates of third parties who may not appreciate and understand the particular problems of small business.

This subcommittee is of the opinion that the present situation must be altered in the immediate future to protect tnis vital sector of the small business community. The subcommittee feels that such changes can be made without adverse effects on consumers or program sponsors and administrators.

As a result of the pharmacist's inability to collectively negotiate with program administrators, a multitude of problems has surfaced....

Recommendations....

1. That program administrators--usually insurance companies--and representatives of affected Federal agencies meet with representative groups of independent pharmacists for the purpose of developing a uniform claim form, thereby eliminating time-consuming paperwork now required of druggists.
2. That the administrative procedures of prepaid prescription programs be reexamined with a view to cutting redtape to a minimum.
3. That the professional fee to be paid to pharmacists compounding prepaid prescriptions be flexible and based on variable factors rather than rigid and inflexible.

4. That program sponsors and administrators revise their procedures for reimbursement so that participating pharmacies can receive prompt reimbursement for prepaid prescriptions.

5. That, to insure that the operation of third party plans is equitable to all parties--pharmacists, program sponsors and consumers--the Federal Trade Commission, in consultation with the Department of Justice, Department of Health, Education, and Welfare, the public insurance carriers, and pharmacy representatives, develop antitrust guidelines implementing a system of consultation between pharmacy representatives and plan administrators. Keeping in mind the narrow line between permissible consultation and prohibited negotiation, such consultation should include matters affecting professional fees and pharmacy costs.

6. That this committee be advised by appropriate parties no later than February 1, 1972, on action taken in connection with this report and the recommendations of the subcommittee.[11]

It is reasonable to consider these conclusions and recommendations as forces working positively in the direction of some form of exemptive legislation or an indepth study in the fairly near future.

As evidence of this possibility, HEW Secretary Elliot L. Richardson has endorsed the proposal by the NARD, the NPIC and other groups, and mentioned by McLaren above, to

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11. Ibid., pp. 9-10.

appoint a special task force to study third party drug payment programs.

State Developments

Because of the wide range of variables existing among the state acts, the scope of this analysis has been limited of necessity to federal cases and developments.

However, in the context of what lies ahead in the third party prescription payment era, some state cases are worthy of note at this time. There is no reason to expect more such state actions will not arise. They will undoubtedly have an impact, individually or collectively, upon an emerging body of law in this still relatively new subject area.

The state cases to be considered here are B&L Pharmacy, Inc. v. Metropolitan Life Insurance Co.[12] (UAW Peoria Case), and Blue Cross v. Commonwealth ex rel. State Corporation Commission[13] (Virginia Blue Cross Case), decided in their respective jurisdictions in 1970.

On October 1, 1969, the 750,000 United Auto Workers (UAW) and their families (for a total of 2,500,000 persons) became eligible for drug benefits under a nationwide UAW - auto industry contract.

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12. 46 Ill. 2d 1,262 N.E. 462 (1970).

13. 211 Va. 180, 176 S.E.2d 439 (1970).

Several administrators of the plan served in various geographical areas. They included Blue Cross and Blue Shield, and the Aetna, Equitable, John Hancock, Metropolitan and Travelers insurance companies.

> Although separate contracts have been issued to participating pharmacies by each of the major carrier organizations, their terms are similar in most respects.[14]

Though varying in exact dollar amounts, reimbursement plans generally provided for cost plus a professional fee. Beneficiaries paid deductibles up to $2.00 per prescription.

The potential far reaching effects of this program were evaluated at the time it was announced by one writer this way:

> The experience gained from the UAW program is sure to be applied by these organizations in the establishment of third-party drug coverage for large blocks of the general public.[15]

In Peoria, Illinois, the plan involved UAW members employed by Caterpillar Tractor Company, the city's largest employer, and was administered by Metropolitan Life Insurance Co. The plan, known as MediMET, provided a

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14. "Auto workers drug program gets started," American Druggist (160:8) October 20, 1969, p. 16.

15. Ibid.

$2.10 professional fee above cost to "Participating Providers" who agreed to the program and whose names appeared on a list distributed to beneficiaries. The patients paid a $2.00 deductible amount directly to the pharmacists.

An employee or family member who chose to bring prescriptions to a nonparticipating pharmacy would be reimbursed 75 percent of the usual price of the prescription, and pharmacies were subject to inspection of records for compliance.

Pharmacist Ed Berow of B&L Pharmacy, Inc., and approximately 30 other Peoria pharmacists refused to participate in the plan. Mr. Berow instituted the suit in the name of the corporation, B&L Pharmacy. The allegations stated UAW, Caterpillar Tractor Co., Metropolitan Life Insurance Co., Walgreen, Super-X, and all other participating pharmacies conspired to violate the Illinois antitrust laws by fixing prescription prices in the area and by implementing a boycott of nonparticipating pharmacies.

In denying the defendant's dismissal motion and granting a temporary injunction against further application of the plan, Circuit Court Judge Robert Hunt stated:

> The non-participating druggist to be competitive and to remain solvent in the trade, would tend to be forced to adopt the same method of computing prices for his pharmaceutical goods. He would be required to adopt the cost-plus-$2.10

> fee for all his customers, or lose a substantial portion of his prescription trade and related merchandise trade.
>
> A reasonable interpretation of the evidence would seem to indicate that this is a new plan which is becoming popular as an addenda to group insurance policy plans, whether acquired by collective bargaining procedures or adopted voluntarily by various groups of persons working for employers....
>
> The economic pressures upon the pharmacist will be such that all will have to be willing to conform to the cost plus plan eventually in order to retain a substantial part of their pharmaceutical trade.[16]

The bases for defendant's motion were reliance upon labor and insurance exceptions to the antitrust act. It was further argued the plan was a mandatory subject of collective bargaining, thus preempted by federal law.

A direct appeal from the Circuit Court order was granted by the Illinois Supreme Court. The lower court decision was reversed and remanded with directions to vacate the injunction and dismiss the suit.

The court did not discuss the effects of the plan on competition. The contention the MediMET plan was exempt from the proscriptions of the state antitrust act was accepted.

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16. 46 Ill. 2d 1, @7.

One author commented:

> ...However, this evidence supported the plaintiff's contention that MediMET unreasonably restrained trade. In retrospect, the failure to discuss the nature of that restraint or its effects probably indicated an admission by the Illinois Supreme Court that the activity, in the absence of an exception, was a per se offense.[17]

Having expanded the labor exception and construed the insurance exception rather broadly, a wide range of activities are now opened to the insurers. They, as well as unions and employers, are likely to be protected from antitrust violations under contracts they may write.

There is no limit to the future ramifications if such a posture becomes commonplace among a majority of state courts as well as the federal courts.

The facts of the Virginia Blue Cross case begin in September, 1967. At that time, a prepaid drug plan for out-of-hospital prescriptions was offered by the Virginia Blue Cross Board of Directors. Participating pharmacies were allowed a $1.85 professional fee to be added to acquisition cost. This amount was to be paid by the 55 hospitals participating in the plan. Payments were made

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17. "Pharmaceutical Service Plan Act Exemptions Under the Illinois Antitrust Act," Northwestern University Law Review (65:6) January-February 1971, p. 942.

directly to pharmacies, except payment for prescriptions from a nonparticipating pharmacist were made to the subscriber or the pharmacy at Blue Cross' option.

Support was solicited from the Virginia Pharmaceutical Association (VPhA) after the $1.85 fee had been decided upon unilaterally by Blue Cross. After explanation of the plan to VPhA's Executive Council and the association membership, which included 70 percent of all Virginia pharmacists, it was approved in principle by both bodies. The $1.85 fee was unanimously agreed by the Council to be acceptable.

Endorsements containing the drug plan were submitted to the Virginia State Corporation Commission and approved by their Bureau of Insurance. However, standard participating pharmacist agreements were not submitted for approval, thus precipitating a protest from a pharmacist-legislator.

A public hearing was held in 1969 to review the approval already granted by the Commission. The Blue Cross-pharmacist contract was disapproved for several reasons, including the allegation it constituted illegal price fixing.

Disapproval was affirmed by the Virginia Supreme Court which held the fixed fee was illegal <u>per se</u> price fixing under the Sherman Act as well as a violation of the state antitrust law for preventing price competition among

hospitals purchasing drugs from pharmacies and for promoting price uniformity among competing pharmacists.

Professor S. Chesterfield Oppenheim had this to say about the case:

> It is undisputable that the United States Supreme Court in a series of landmark decisions has generally condemned as unlawful, in and of itself, an agreement, combination or conspiracy to fix prices (citation omitted), to divide markets (citation omitted), or to allocate customers (citation omitted). This illegal per se doctrine applies also to group boycotts and to tying arrangements in which the sale of one product is conditioned upon the buyer's purchase of a different tied-in product (citation omitted). But, these absolute prohibitions apply only to situations in which the sole purpose is one of suppressing competition (citation omitted). If that is the case, it is immaterial whether the motives of the participants are good or evil, or whether the effect of a price-fixing agreement is to raise or decrease prices, or whether the arrangement serves business convenience.
>
> The Virginia Supreme Court, however, labeled the Blue Cross plan with the catchword 'price fixing' and completely ignored many qualifications of the illegal per se doctrine in opinions of the United States Supreme Court. It also ignored the threshold question of what constitutes culpable price fixing in purpose and effect as contemplated by the Sherman Act (citation omitted)....
>
> When one considers the realities of the massive private third-party plans, it is readily seen how artificial it is to apply to those programs the same criteria for judging their antitrust status as have been applied to the purchase and sale of industrial

> commodities and services (citation omitted). Yet this is precisely what the Virginia court has done. Instead of considering whether a third-party plan like Virginia Blue Cross has redeeming social values relevant to the health professions, the court judged the plan as though it concerned competitive processes which inherently must brand uniform professional fees illegal per se price fixing.[18]

This is a vastly different decision than was reached by the Illinois court in the UAW Peoria case, and it offers an alternative possibility for future direction in various jurisdictions as well as federally.

Headlines such as, "Pharmacist Suit to Block Georgia UAW Rx Plan,"[19] "Georgia Pharmacist Attacks 'Medimet' Rx Plan,"[20] and "Group fights 3rd party 'dictation',"[21] and "Conn. RxMen seek U.S. antitrust suit against MediMet prescription plan,"[22] along with their respective stories

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18. S. Chesterfield Oppenheim, "Antitrust Policy and Third-Party Prepaid Prescription Drug Plans," The George Washington Law Review (40:2), December, 1971, pp. 248-249.

19. "Pharmacist Suit to Block Georgia UAW Rx Plan," F-D-C Reports, "The Pink Sheet," (32:8) February 23, 1970, p. T&G-8.

20. "Georgia Pharmacist Attacks 'Medimet' Rx Plan," NARD Journal (92:9) May 4, 1970, p. 12.

21. "Group fights 3rd party 'dictation'," American Druggist (164:1) July 12, 1971, p. 35.

22. "Conn. RxMen seek U.S. antitrust suit against MediMet prescription plan," American Druggist (165:5) March 6, 1972, p. 28.

suggest state courts may have more actions of this nature as prepaid prescription plans continue to proliferate.

The first two articles cited above refer to a 1970 suit commenced by pharmacy owner, Frank L. Garriott, Jr. and Holland and Knight, Inc. in Atlanta Superior Court. Defendants were Caterpillar, General Motors Corp., Metropolitan Life Insurance Co., Walgreen, Super-X, and Reed Cut Rate Drugs.

In general, the allegations were a price-fixing scheme was arranged to fix the prescription dispensing fee; a boycott of nonparticipating pharmacies was urged; pharmacists were threatened with loss of business by not enrolling; and defendants conspired to gain access to pharmacy records, thus insuring acquisition costs will be made uniform.

To date, no results have been noted in the literature concerning this case.

The latter two articles reference the organization of the National Association for the Protection of the Pharmaceutical Profession (NAPPP) in April, 1971, and their subsequent request in February, 1972 to the United States Attorney for Connecticut to institute an antitrust suit against Metropolitan Life Insurance Company.

NAPPP, chartered as a Connecticut corporation on April 28, 1971, has as its purpose:

> ....to preserve and promote the professional aspects of pharmacy and, in particular, to prevent laymen and lay organizations from dictating conduct of the profession in any of its aspects, including the economic.[23]

Though membership is welcome and solicited from pharmacists anywhere in the nation, the concentration of members is from the State of Connecticut. Early impetus for the organization came as a result of dissatisfaction with the MediMET plan in Connecticut.

Most of the allegations parallel rather closely those in the previous case, with one notable exception. The NAPPP is seeking an order requiring Metropolitan to enter into good faith negotiations over matters of administration of the plan.

Definitive action in this case has not been taken to date.

Recent Federal Action

The most recent case to arise was brought as a "class action" in the Federal District Court in Ohio by Jephson Drug Co. against Blue Cross of Northeast Ohio.[24]

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23. Constitution and By-laws of the National Association for the Protection of the Pharmaceutical Profession, Inc., Article I, Section 2.

24. "Fed up with arbitrary Blue Cross rules, pharmacist brings 'class action' suit," American Druggist (165:9) May 1, 1972, p. 42.

In alleging a Sherman Act violation by contracts with participating pharmacists which constitute price fixing and restraint of trade, plaintiff raises an issue involving the Blue Cross interpretation of acquisition cost determination.

The original 1969 contract provided reimbursement based upon a $1.95 professional fee added to acquisition cost. In 1971 Blue Cross adopted an auditing policy whereby cash discounts, merchandise, travel credits or similar benefits are considered trade discounts. Consequently, by across the board application of this policy, acquisition cost of individual drug products have been reduced.

Collectively, these state cases and the recent federal action give some indication of what might lie ahead, at least the necessity for more clearly defined rules of conduct and program guidelines.

National Health Insurance

Numerous proposals for national health insurance programs have been forthcoming in recent years and several are before the 92nd Congress. While it is only speculation, consideration must be given to the effect of such legislation upon the participating pharmacist's role in negotiating and administering a drug plan.

Each of the major legislative proposals for national health insurance is likely to have a somewhat different effect upon the basic issue.

The Health Security Act (S 3 or HR 22) is a compulsory universal health program for all, financed through payroll taxes and general revenue appropriations. It is intended to replace existing Medicare, Medicaid and private insurance plans.

A five member Health Security Board created under the Act would contract with providers of health services. Pharmacists as well as other providers would be subject to satisfying the requirements adopted by the Board in the interest of quality care and patient safety.

Drug coverage for out-of-hospital patients would be limited to treatment for certain chronic diseases and conditions as outlined in the Act.

The Board is required to prepare a drug list for institutional patients and a conditions list for out-patients. They also must determine maximum charges for the various listed drugs.

With respect to the topics of prime concern, reimbursement and attendant procedures, Sec. 86(b) and Sec. 129(c)5 are noteworthy. The former section requires reimbursement to pharmacists based on cost plus a dispensing fee. Professional representatives are to be consulted in establishing the fee schedules which are to afford reasonable compensation.

The latter section authorizes the Board to work with pharmacy to develop and test improved administrative practices and methods for reimbursing independent

pharmacies for covered drugs.

The National Health Insurance and Health Service Improvement Act of 1971 (S 86) is a compulsory plan providing for a broadening of Title XVIII coverage. Contracts are authorized with comprehensive health service systems which meet certain criteria, including use of subprofessional personnel where applicable.

Only maintenance drugs, as defined in the Act, are provided for ambulatory patients.

The Secretary of Health, Education, and Welfare (HEW) is directed under the Act to study administrative and control matters including alternative methods of payment for drugs and supplies.

The Department of HEW will establish the dispensing allowance and acquisition allowance portions of the payment for drugs by regulation. A one dollar copayment provision would be required by the Act, and is subject to annual adjustment.

A five member Expert Committee on Drug Coverage is created to advise HEW on administrative and related drug program matters.

The Health Care Insurance Act (S 987 and HR 4960) - American Medical Association "Medicredit" plan - establishes a voluntary program financed through a system of tax credits. A catastrophic coverage provision is included. There is no requirement for drugs for out-of-hospital patients under the provisions of a qualified health insurance plan.

The National Health Care Act of 1971 (S 1490 and HR 4349) provides minimum standards for health policies to be purchased on a voluntary basis.

Drug coverage includes legend drug products and certain specified nonlegend medications. Except for state plans which comprise one part of the three program package, no formularies, drug lists or cost restrictions are specified. Reimbursement under a state plan cannot exceed a reasonable charge which is based upon the prevailing charge in a locality which is specified as the amount at the seventy-fifth percentile of a low to high distribution of actual charges over a year.

The National Health Insurance Partnership Act of 1971 (S 1623 and HR 7741) - Nixon Administration Bill - requires employers to provide basic health care insurance available to their employees.

No provisions have been made under this bill for outpatient prescription drug coverage.

Even the limited number of programs providing drug coverage makes it clear there is a potential for greater involvement through negotiation and plan administration by organized pharmacy.

CHAPTER VII

RECOMMENDATIONS

Recommendations stemming from this analysis fit into a number of different categories. They have been classified for discussion purposes into four classes: legislative, judicial, administrative and organizational, and professional and economic.

Legislative

In an effort to provide relief for pharmacists who may be subjected to inequitable conditions by the dictates of third party plan administrators or carriers, passage of HR 14304, Rep. Hicks' "Prepaid Prescription Program Negotiation Act," seems to be a means to the end of providing a voice for participating pharmacists.

The background and introduction to this Act have been reviewed already. Section 4(a) is worthy of note at this juncture, however:

> It shall not be unlawful under any antitrust law for any group or association of professional pharmacists to negotiate collectively with a third-party prepaid prescription program administrator or sponsor with respect to their reimbursement for dispensing prescriptions under such programs or with respect to the administrative

and operational features of such programs.[1]

This bill seems to be all encompassing since by its definition of "third-party prepaid prescription program or plan," it includes federal and state government programs as well as private plans.

Recognizing the political obstacles possibly affecting the plight of HR 14303, an alternative or adjunct course of legislative action also is indicated.

Since several of the proposals for national health insurance programs contain provisions for outpatient prescription drug coverage, and a variety of advisory committees or boards are recommended, amending these acts before passage may overcome at least part of any future inequities.

Of course, even a statutory board which includes pharmacy group representatives would not necessarily be exempt from antitrust provisions. Nonetheless, the public policy aspects of such an arrangement might serve to overcome Justice Department legal arguments.

The testimony before the Hungate Committee and the recommendations in the report arising from them have been considered in detail earlier. These recommendations should be thoroughly explored and implemented to the extent

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1. "Prepaid Prescription Program Negotiation Act," HR 14304, 92nd Congress, 2nd Session, introduced April 11, 1972.

feasible. The degree to which legislative committee recommendations are honored by the members of the Congress is not easily determined. It cannot be overlooked, however, since this report expressed the majority view of a House of Representatives subcommittee.

The subcommittee requested administrators, government representatives and groups of pharmacists to develop uniform claim forms; paperwork minimization; flexible reimbursement based on variable factors; prompt payment; government-professional guidelines; and an action report by February 1, 1972.

Finally, all local, state, regional and national pharmaceutical associations should encourage the sponsorship, support and passage of any and all exemptive type legislation.

Judicial

Recommending judicial reform is analogous to suggesting all arguments for a position not sustained by courts in the past now be accepted.

However, it should be emphasized analysis of given fact situations as well as interpreting and construing statutes is largely subjective.

While courts generally have taken the posture negotiated fees constitute price fixing per se, a preponderance of evidence favoring public policy benefits may encourage a change. Organized pharmacy's position

must be supported by more than speculation and oratory, however. Data are needed to show the beneficial effects to society. These redeeming social values may provide impetus for judicial change.

A review of the federal and state cases previously cited show clearly there have been cases in which the decision could have gone either way. This is a crossroads era in which changes can, and might well be, forthcoming.

Professor Oppenheim states his position on the adoption of a rule of reason approach this way:

> This writer's prior analysis stressed the factual differences in the concerted action of the pharmaceutical associations in Northern California and Utah Pharmaceutical Association compared with the unilateral offer of the third-party carrier in prepaid drug plans and the recently declared reservations of the Antitrust Division in recognizing the limitations of the implied conspiracy doctrine in Interstate Circuit as modified by Theatre Enterprises. Applying that analysis to a third-party prepaid prescription drug plan in which there is no predetermined agreement of pharmacists as to the reimbursement amount and no group boycott, this writer believes that, absent an explicit antitrust exemption, an extended rule of reason inquiry is not in conflict with illegal per se antitrust prohibitions. Such an approach by the Antitrust Division and the Federal Trade Commission could justify a properly circumscribed area of permissible

> collective negotiation between pharmacist groups and the third-party carrier comparable to that proposed in the antitrust exemption and compatible with guidelines proposed by NARD. ....The Supreme Court's insistence in Maple Flooring Manufacturers Association v. United States that 'each case arising under the Sherman Act must be determined upon the particular facts disclosed by the record' is a guidepost to which the Court still adheres. The rule of reason, as Justice Douglas observed in White Motor, 'normally requires an ascertainment of the facts peculiar to the particular business....' That principle is equally applicable to the facts peculiar to the pharmacy profession and a third-party prepaid drug benefit plan involving the pharmacist's professional services in dispensing prescriptions.[2]

He has added much to the armamentarium of the advocates of judicial reform on this vital subject area.

Administrative and Organizational

Within the existing organizational structures of federal agencies, means or mechanisms are available whereby evaluations of proposed activities may be received in advance of their becoming operational.

Greater use of such avenues should be explored by those pharmacy groups concerned, and utilized where

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2. S. Chesterfield Oppenheim, "Antitrust Policy and Third-Party Prepaid Prescription Drug Plans," The George Washington Law Review (40:2) December, 1971, pp. 264-266.

applicable.

Under the Department of Justice Business Review Procedure, a government review of proposed business conduct may be requested from the Antitrust Division. The party submitting the request may ask for an indication of the Antitrust Division's enforcement intentions at the time of the review. This provides a measure of quasi-approval of the program or activity, thus avoiding subsequent litigation in certain cases. This is similar to the FTC Advisory Opinion procedure.

Two informal "release letters" have been issued by the Antitrust Division which deal with prepaid prescription plans. These were for the Kansas Blue Shield Plan and PAID Prescriptions, Inc. of California (Appendix L, page 218). Usual and customary reimbursement was authorized under both plans.

It is recommended greater use be made of this procedure by pharmacy associations.

NARD Guidelines submitted to the FTC and the Justice Department Antitrust Division in 1971, though subsequently rejected by the Justice Department, might be reintroduced effectively through the review procedure mechanism. The idea should be explored at least.

Whether concomitant with, or apart from a pharmacy organization, exemption under federal and/or state antitrust laws, formation of one or more forms or types of subsidiary organizations is advisable.

Some states have enacted specific enabling legislation pertaining to one such organization form.

Chapter 450, Wisconsin Statutes contains the following provision:

450.13

Prepaid prescription plans authorized.

(1) The Wisconsin pharmaceutical association may establish in the state a nonprofit plan on a prepayment or other basis for the pharmaceutical services of the general population, or any segment of it, through contracts with pharmacists, members of the public, any branch of government, and others; provided only that free choice of the public in the selection of a pharmacist shall be retained in such contracts, and that the responsibility of the pharmacist to the individual patient together with all other contract and tort relationships between pharmacist and patient, shall remain the same as if contractual arrangements between them were direct. Any person covered by or insured under such plan, or someone acting for him, shall be free to choose for pharmaceutical services any pharmacist licensed to practice in this state who has agreed to abide by the terms of such plan. No such pharmacist shall be required to participate exclusively in any such plan.

(2) Any such plan shall be subject to all applicable provisions of ss. 200.26 and 209.04 (11).

(3) This section shall apply exclusively to a corporation or other organization organized, recognized or operated under 450.12 or this section.

(4) The Wisconsin pharmaceutical association may:

(a) Establish a nonprofit pharmaceutical service plan within its corporate structure;

(b) Approve for itself and its members a pharmaceutical service plan established by a nonpharmaceutical organization, when the association finds a plan of the latter type to be in the public health interest; or

(c) Organize a corporation with authority to establish a nonprofit pharmaceutical service plan, which corporation shall be subject to subs. (1) and (2).

(5) So as to encourage experimentation in the health and economic interests of the general public, any plan organized or approved under this section may operate on a service, indemnity or a combined service and indemnity basis.[3]

Under Illinois Law:

It is unlawful for any person, except a pharmaceutical service plan corporation chartered in accordance with the provisions of this Act and operating in accordance with authority from the Director (of Insurance) to establish, maintain or operate a pharmaceutical service plan, or to solicit subscribers to or enter into contracts with respect to a pharmaceutical service plan. This prohibition, however, shall not be construed as preventing the organization, establishment and operation of corporations organized in accordance with the provisions of 'The Voluntary Health Service Plans Act' approved June 27, 1951, as amended or 'The Medical Service Plan Act' approved July 25, 1945, as amended or 'The Dental Service Plan Act,' approved August 2, 1965, as amended; nor shall it be construed as preventing a person from furnishing pharmaceutical services for the prevention of disease among employees

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3. Wisconsin Statutes, 1971, Chapter 450, Sec. 450.13.

> or from furnishing such pharmaceutical service as is required under the workmen's compensation laws and related legislation, when the employee is not charged for such services; nor shall it be construed to prohibit an insurance company, or other corporation or society which is subject to the supervision of the Director, from operating in accordance with the laws governing insurance companies, or such corporations or societies; nor shall it be construed to prohibit the continued operation of any pharmaceutical, dental, medical, or health service plan in existence and functioning upon the effective date of this Act.[4]

These statutes are included to provide examples of how pharmaceutical service plan organizations are recognized in some jurisdictions.

State pharmaceutical association executives responding to the mail survey discussed in Chapter II, generally favored the National Pharmacy Insurance Council and indicated optimism concerning NPIC's future role.

Coupled with evidence of the direction of events in the third party payment area, greater emphasis and a larger role for NPIC is desirable. Many factors contribute to this recommendation.

As an organization of organizations, NPIC has a much wider range of resources to bring to bear upon any central issue or problem than an association at the level of any given state, county, city or town.

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4. Illinois Revised Statutes, 1969, Chapter 32, Sec. 691.14.

Further, the communications network developed within the NPIC framework serves to provide one central agency for receiving, collating, analyzing and disseminating meaningful information about any and all aspects of third party drug plan programs--legal, economic, professional.

As a national clearinghouse for recognizing and evaluating as well as initiating new informational and program input, NPIC is in a position to direct a greater degree of efficiency into various programs around the country.

From the standpoint of efficiency and administrative cost minimization, NPIC is in a position to maintain and store a wider range of information as it is received from the various constituent organizations. Requests for information about the effectiveness of a particular aspect of a plan in states where it may have been attempted can be answered with sufficient data to permit an informed, advance judgement by the inquiring state group before launching a similar program.

Similarly, updated dispensing cost information from around the nation could be pooled, analyzed and presented in an appropriate manner for private plan administrators, government agencies, and quasi-governmental bodies. More on cost data distribution appears below in the next category.

The National Association for the Protection of the Pharmaceutical Profession, Inc. (NAPPP) has been discussed previously in terms of organization, scope, activity and pending litigation. This group certainly has been a force and a voice in one geographic location and has had national exposure through the pharmaceutical press and participation in the Hungate Committee hearings.

Duplication of effort at varying levels may be desirable and NAPPP, or associations modeled after this prototype, might be a useful adjunct to a central national clearinghouse as proposed for NPIC. However, the need for two "competing" forces at the national level is not indicated at this time.

While cooperation and the expertise obtained from intense activity for more than one year are very much needed, NAPPP's joining as a member of NPIC has more merit than continued independent activity at the "national" level.

The proposal is made without disparagement and, in fact, with the intent of generating a spirit of cooperation and unity among formidable forces in this emerging specialty area.

Another form of organization seemingly is within the scope of the Wisconsin and Illinois statutes presented above. It is in the nature of a service corporation, designed to permit an organization of pharmacists to

provide a facet of health care through its membership. A group patterned after a standard Blue Shield or Physicians Service organization and using a modification of the Physicians Agreement (Appendix M, page 221) which encompasses pharmaceutical service, could control quality of care as well as cost of service, as presently is done with physicians. It is noted reimbursement under this agreement provides for usual and customary charges within limits.

The final administrative body or organization being recommended to meet the existing need, is not another organization, but rather an existing body.

As shown previously in Chapter V, one-half of the state Title XIX vendor programs have a formal mechanism for obtaining advice on operations, reimbursement and the like from organized pharmacy. These quasi-governmental bodies need only be expanded to other states, and perhaps in scope, to provide a valuable network of personnel who are knowledgeable in a broad range of matters relating to third party drug plans from the standpoint of the vendors as well as the recipients and administering agencies.

This would be appropriate as one example of the potential application of the Noerr doctrine. Such an arrangement would be satisfactory whether a formal relationship exists, such as is outlined above, or if advice is provided only on an ad hoc basis.

Any or all of these structures can, in some way, contribute to a more clearly defined body of knowledge in the prepaid drug plan field.

Professional and Economic

This section should be prefaced by emphasizing no recommendations are intended to support acts of defiance in contravention of any statute of the federal or state governments, nor the regulations on any agency thereunder.

Within the framework of antitrust laws as presently construed, and even if they are modified by act or interpretation, meaningful cost analyses still must be conducted and maintained by or for organized pharmacy on a continuing basis.

The constant updating of dispensing cost data is essential to maintain parity over time. As one form of statistical reporting, the dissemination of these data may be made to members of the sponsoring groups. These pharmacists, having the added knowledge about costs of dispensing can better determine the value of participating in a given plan which is offering a particular fee; defining acquisition costs in a particular manner; and imposing particular record keeping and paperwork requirements.

These would be historical data serving only to inform all association members or readers of the results of study and analysis. No specific pharmacist would be likely to

be able to anticipate how other pharmacists would react to the information when coupled with the participation agreement of a plan. Absent any conspiratorial activity, the coincidental, contemporaneous withdrawal from or rejection of a given plan could not be ruled a boycott.

Such studies serve to reinforce informed, individual choices, reached through interpretation of a factual analysis.

Organized pharmacy must continue to work toward the goal of a single uniform claim processing form. NPIC has taken the initiative in this regard and developed a claim form in 1971 (Appendix N, page 223) with the cooperation of the American Pharmaceutical Association (APhA), National Association of Chain Drug Stores (NACDS), and the National Association of Retail Druggists (NARD).

Though all the above groups have agreed to the use of a single form, acceptance and approval has not been received yet from all carriers and plan sponsors. Continually, recommendations are received for improving certain facets of the form which is adaptable to any type of administrative procedure, from totally manual to completely electronic data equipment processes. The effort to develop this type of claim processing form must be continued.

To facilitate uniform claim processing, the NPIC and the National Association of Boards of Pharmacy (NABP) cooperatively have coded all pharmacies in the nation with

a six digit code number.

Organized pharmacy must take the initiative to inform the public, legislators and program sponsors that price uniformity for prescription services may not be bad for the public. Professional competition based upon services related to patient health might be more beneficial from a public policy standpoint than the possible competitive restriction.

The final recommendation is a suggestion to organized pharmacy to improve public and professional relations, particularly with respect to the value of services rendered with third party programs -- to the administrators and beneficiaries alike.

Concerted action within the framework of the law is indicated.

CHAPTER VIII

SUMMARY AND CONCLUSIONS

This study was conducted to probe: (1) the extent to which negotiation or sponsorship of prepaid drug plans by individual pharmacy associations or groups of associations might constitute violations of one or more of the federal antitrust laws; (2) the antitrust status of providing pharmaceutical services at the same professional fee for all pharmacies; (3) the current and short-run future courses of action undertaken, or about to be undertaken, by state pharmaceutical associations; (4) the perceived and actual roles of state associations in providing leadership and direction in this increasingly important area, as well as to consider the importance of identifying the parties to a third party payment transaction and their relationships to each other for purposes of contracting, reimbursement, service definition, and cost and quality control.

Summary

Legal research was commenced by reviewing the relevant antitrust laws bearing upon the present issues - the Sherman Act and the FTC Act. The Clayton Act, Robinson-Patman Act, Miller-Tydings Act, and McGuire Amendment were among the

statutes studied and dismissed for lack of applicability.

Case decisions in federal courts generally related to the subject of antitrust violations were studied. Where available, cases of a type analogous to what could subsequently be cause for litigation involving pharmacy organizations, were given particular emphasis and study.

Subsequently, cases determining parameters within which trade and professional associations might operate were studied and evaluated in light of the issues surrounding organized pharmacy and the third party plan administrators.

Finally, antitrust cases directly involving pharmacy associations and, as they developed, issues related to third party payment programs, were analyzed.

A variety of texts, reports, law journal articles, congressional hearings testimony, congressional committee reports, and articles from the lay and pharmaceutical and medical literature were reviewed.

In an effort to gain an insight into how executive officers of state pharmaceutical associations reacted to current trends in the field of third party drug prepayment programs, a questionnaire was distributed to all states and the District of Columbia in the summer of 1970. Responses were tabulated, analyzed and interpreted in light of the basic issues.

Results of legal research indicate most of the prohibitions fall into Section 1 of the Sherman Act which declares illegal:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade....

Price fixing and group boycotts are the two activities most clearly defined by the courts as violations. Agreements among competing pharmacists to fix the price of prescription drugs in private third party programs are illegal per se.

This rule seems applicable irrespective of the interpretation one gives to what pharmacists do, sell prescription drugs vis a vis render a professional service.

Pharmaceutical associations are forbidden to boycott any particular prepaid drug plan in any way. This is another type of per se violation which must be avoided. Any decisions not to participate in a plan must be made by an individual pharmacist independent of other prospective participants. This issue is particularly critical since "agreements" frequently are created by the courts by application of circumstantial evidence to a given case.

Though requested to review their position in favor of prosecuting such cases, the Justice Department has maintained a rigid policy. If a substantial effect or possibility of an effect on interstate commerce can be shown, price fixing is a violation.

It is also the position of the Justice Department a fixed professional fee is more likely to violate antitrust laws than usual and customary reimbursement.

Private sponsors may not seek price suggestions from groups of pharmacists without violating antitrust laws.

The Justice Department further emphasizes the need for refraining from concerted action against a particular plan.

Dissemination of statistical data involving dispensing costs as well as information related to various plans among members is permissible as long as the tenents outlined above are not violated.

Organizations have been developed which deal exclusively with issues and problems related to third party programs. The National Pharmacy Insurance Council (NPIC) and the National Association for the Protection of the Pharmaceutical Profession (NAPPP) have emerged to provide some legal voice to prospective participating pharmacists.

Results of the mail survey to state pharmaceutical association executives show a decisive majority of more than 90 percent of the states involved in presenting informational programs for their members.

Paradoxically, official actions or stands were not taken in 25 of the 35 states responding, largely for reasons

of legal implications. Some respondents made specific reference to the antitrust laws.

Over one out of three of the state associations have taken some action with respect to preparation, adoption, publication or distribution of third party payment program guidelines for their members.

Usual and customary and fixed fee reimbursement methods were preferred in those states where opinion studies had been made among the membership. Where no such measure was available, executives estimated their members would select usual and customary.

Generally, NPIC was rated favorably on past performance and given high expectation ratings for the group's future role.

Where cost studies had been conducted, association personnel and university faculty members were designated most frequently as having made the analysis.

These data were used most often for welfare department information, member information, and insurance carrier information.

Association executives selected adequate reimbursement, freedom of choice, and proliferation of paperwork as the aspects of third party prescription programs they considered most important to pharmacy.

Conclusions

Third party prescription payment programs, prepaid pharmaceutical service plans, or any other designation affixed to them, pose a number of unique problems -- legally, professionally and economically.

This conclusion is supported by factors previously discussed. The expansion and growth of this type coverage, often as the result of collective bargaining, is one such factor.

Not only are the numbers of beneficiaries growing, but there is a marked increase in the number of different plans as well as claims processing organizations.

Since each new program often has provisions which differ from others, including eligibility requirements, forms, and techniques, the participating pharmacist is faced with an increasing burden.

The formation of the NPIC and the interest generated in its activity suggest rather strongly this is a problem area worthy of much more attention from the Congress, the state legislatures and the courts at every jurisdictional level. The profession of pharmacy and consumer groups should be viewing this area closely also.

Similarly, the establishment of the NAPPP highlights a growing area of concern and a need for guidance in providing adequate protection for the pharmacist vendor under the many prepaid drug schemes.

Increased litigation in state and federal courts is clear evidence this is an important area and one in which new law is likely to be written relatively soon.

Judicial review and reform appear to be the least likely means of effecting change in the overall position. From what has been discussed previously, a judicial determination in favor of pharmacy's negotiative rights can be supported by precedent to at least the extent of the present position of the courts.

Irrespective of what legislative or judicial activities may take place, individual pharmacists will be required to be better informed about attendant matters than ever before.

These matters include: prerequisites for participation; extent of covered clientele; reimbursement amounts and frequency of payment; acquisition cost determination; and so forth. It is unlikely any reform will include a diminishing of the effect against group boycotts. All decisions about whether to participate will be up to the individual.

Finally, the Hungate Committee recommendation for a government study should be implemented as soon as possible. Panels should include governmental, insurance company, and professional personnel as well. The amount of influence and pressure borne by a Congressional committee should encourage some positive action. The time may be right to strike a balance.

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APPENDICES

APPENDIX A

INTRODUCTORY LETTER TO ASSOCIATION EXECUTIVES

SAMPLE COPY

THE UNIVERSITY OF WISCONSIN
MADISON 53706

SCHOOL OF PHARMACY
Pharmacy Building
425 North Charter Street

June 11, 1970

Mr. Farraway Looker, Executive Secretary
Orefornia State Pharmaceutical Association
123 Professional Boulevard
Anytown, Orefornia 12345

Dear Mr. Looker:

Your help is needed to determine the profession's collective feelings about an area of vital interest and concern. In a few days you will receive a questionnaire eliciting information about your association's activities in the general area of third party prescription programs. The replies of all state pharmaceutical association executives will be analyzed and reported collectively as one phase of my Ph.D. research in pharmacy administration.

The brief questionnaire is designed to obtain current state by state data so the composite report will reflect the national picture "like it is."

As a pharmacist (licensed in Rhode Island, Wisconsin and Massachusetts), attorney (member of the Massachusetts Bar), and faculty member (formerly Associate Professor, Massachusetts College of Pharmacy), I appreciate both the growing impact of third party programs and the heavy demands of correspondence on your time as a professional association executive officer. Moreover, your cooperation is necessary to make this a meaningful project which will be useful to pharmacy.

Your reply will be identified for tabulation purposes only and will not be identified in the final report.

Sincerely,

Norman A. Campbell
AFPE Fellow

APPENDIX B

COVER LETTER - MAIL SURVEY

THE UNIVERSITY OF WISCONSIN
MADISON 53706

SCHOOL OF PHARMACY
Pharmacy Building
425 North Charter Street

June 15, 1970

Dear State Pharmaceutical Association Executive:

Here is the third party prescription program questionnaire referred to in my letter of June 11.

Receipt of your reply in the enclosed stamped, addressed envelope not later than June 30 will facilitate completion of the report this summer.

Should you wish to receive a copy of the composite tabulation, please check the appropriate block on the last page of the questionnaire.

Your cooperation is appreciated.

Sincerely,

Norman A. Campbell
AFPE Fellow

Enclosures (2)

APPENDIX C

QUESTIONNAIRE - MAIL SURVEY

STATE: _____

THIRD PARTY PRESCRIPTION PROGRAM QUESTIONNAIRE

1. Please list those programs your association conducted in whole or in part during the past year which related, in part at least, to third party prescription programs. A brief description of the nature of the programs in the following broad categories will be appreciated.

STATEWIDE ASSOCIATION MEETINGS AND CONVENTIONS:

REGIONAL OR LOCAL MEETINGS:

CONTINUING EDUCATION PROGRAMS (PLEASE SPECIFY TYPES):

OTHER (PLEASE SPECIFY):

(Use reverse side of page if additional space needed.)

1.A. If no programs on this topic were conducted, please briefly indicate why not.

2. Has your association taken any official action or stand on negotiating, endorsing, or sponsoring any private third party prescription program(s)? Yes_____ No_____.

If "yes," please provide details:

If "no," please indicate briefly why not.

3.A. Has your association prepared and distributed or published guidelines to members to assist them in making individual appraisals of plans being offered to them for participation?

Yes_____ No_____

3.B. Has your association adopted and distributed or published guidelines to members to assist them in making individual appraisals of plans being offered to them for participation?

Yes_____ No_____

If "yes," to either A or B, please check the one or more appropriate choices below:

Guidelines--prepared by this association_____
adopted from elsewhere_____
published_____
distributed to members_____

If "no," to both A and B, is such a service planned for the near future?

Yes_____ No_____

4. Have members of the association in community practice been polled individually to determine their preferences with respect to reimbursement methods under third party prescription programs?

Yes_____ No_____

If "yes," what percentage of this membership category responded?

_____%

Which of the below was most favored by your members?

a. fixed fee_____
b. variable fee_____
c. fixed percentage markup_____
d. usual and customary_____
e. other (specify)_____

Comments:

If "no," which choice above do you personally feel most of your community practitioners would select? (circle one):

a b c d e (specify)_____

5. How would you rate the productivity of the National Pharmacy Insurance Council to date?

Highly Satisfactory_____
Fairly Satisfactory_____
Neither satisfactory nor unsatisfactory_____
Relatively unsatisfactory_____
Highly unsatisfactory_____

What do you forsee as the future role of the National Pharmacy Insurance Council?

Highly beneficial spokesman for the profession_____
Only moderately helpful_____
Of questionnable value_____
Relatively ineffective_____
Totally ineffective_____

6. Has any study been conducted or is a study planned to determine the cost of dispensing a prescription in your state? Yes_____ No_____

If "yes," by whom (title) and when? What, if anything, is (was) the state association's involvement in this study?

If the association is (was) involved in such a study, please outline briefly how the results will be (were) used.

7. Do you favor concerted action by pharmacists to make their negotiation position stronger when dealing with carriers of such programs? Yes_____ No_____

If "yes," what type(s) of action do you forsee as being effective?

If "no," why not.

8. What aspect of third party prescription programs do you consider most important to pharmacy? Why?

Classification Data:

9. What is the approximate number of voting members in your association? _____
About how many are pharmacy owners? _____
About how many are nonowner practicing pharmacists? _____
Other _____

What percentage of the members of the executive committee are pharmacy owners? _____%

10. Title of person completing questionnaire:

_____

COMMENTS:

Please send me a copy of the tabulation [ ]

THANK YOU. YOUR HELP IS APPRECIATED.

APPENDIX D

COVER LETTER - SUMMARY REPORT

THE UNIVERSITY OF WISCONSIN
MADISON 53706

SCHOOL OF PHARMACY
Pharmacy Building
425 North Charter Street

August 12, 1970

Enclosed is your copy of a summary report of the results from the Third Party Prescription Program Questionnaire you and your association executive colleagues completed earlier this summer.

I hope this information will be useful. Since the report presents composite data, no comparisons with your replies have been made. However, you should be able to do this fairly easily from your own information.

Thank you again for your participation in this study.

Sincerely,

Norman A. Campbell
AFPE Fellow

NAC:lrf

Enclosure

APPENDIX E

REPORT TO RESPONDENTS

THIRD PARTY PRESCRIPTION PROGRAM STUDY

REPORT TO RESPONDENTS

August 12, 1970

N. A. Campbell

I. GENERAL:

Thirty-four (34) questionnaires were returned by August 12th. Due to the nature of Third Party Payment requirements imposed by state law in one state, that executive's reply was eliminated from the tabulation and analyses.

II. RESULTS:

1. Thirty-one respondents reported programs dealing at least in part with third party prescription plans were conducted in one or more of the listed categories during the past year:

Programs conducted in:		Categories
One category	9	Statewide Association Meetings and Conventions
Two categories	11	Regional or Local Meetings
Three "	9	Continuing Education Programs
Four "	2	Other
None	2	
	n = 33	

2. In answer to the question about any official action or stand on any private third party prescription program(s), nine (9) respondents reported action had been taken while twenty-four (24) answered "no". One of the affirmative replies referred to action against any endorsement. Sixteen (16) of the negative replies cited legal restrictions with five (5) of these specifically mentioning antitrust laws.

3. The following breakdown indicates what, if anything, has been done by associations to provide third party program guidelines for their members:

Prepared and Published or Distributed	3
Prepared only	2
Adopted and Published or Distributed	5
Prepared and Adopted and Distributed	1
None	22
	n = 33

4. Seven (7) respondents reported a poll of their community practitioners' reimbursement preferences had been taken. Twenty-six (26) replied such a poll had not been conducted.

Where polls were conducted, the preferences were as follows:

Fixed fee	3*
Variable fee	1
Fixed percentage markup	0
Usual and customary	4*
Other	0

*In one state the poll resulted in a tie between these two choices. Twenty-three (23) of those answering "no" felt the following choices would have been made if a poll was taken:

Fixed fee	4
Variable fee	5
Fixed percentage markup	0
Usual and customary	14
Other	0
No response	3
	n = 26

5. The following are the rankings assigned the NPIC's productivity to date, and in terms of future role expectations:

	To Date
Highly Satisfactory	3
Fairly Satisfactory	10
Neither satisfactory nor unsatisfactory	14
Relatively unsatisfactory	1
Highly unsatisfactory	3
No response	2
	n = 33

Future Role

Highly beneficial spokesman for the profession	15
Only moderately helpful	5
Of questionable value	5
Relatively ineffective	1
Totally ineffective	1
No response	6
	n = 33

5. Studies of the cost of dispensing a prescription have been conducted or are being planned in twenty-six jurisdictions (24 have been conducted and two planned). The following tables report by whom studies were conducted and the use to which results were (will be) put:

CONDUCTED BY:

Association personnel	14
University faculty member(s)	8
Other	1*
No response	3
	n = 26

*insurance company

USE OR INTENDED USE:

Information for Welfare Dept.	6
Information for insurance carriers	4
Information for members	5
Other	0
Planned	2
No response	9
	n = 26

7. Twenty-five (25) respondents favored concerted action by pharmacists to make their negotiation position stronger while six (6) did not favor such action. Two (2) nonresponses were received on this question. Three of the "yes" respondents qualified their

pproval within the limits of legal restrictions. Five "no" espondents also mentioned legal restrictions as the reason for heir opposition to concerted action.

. The following is a general compilation of replies to the uestion: "What aspect of third party prescription programs do ou consider most important to pharmacy?" Some respondents rovided no answer while others answered in several categories:

Adequate reimbursement	13
Freedom of choice	6
Proliferation of paper work	4
Greater pharmacy control	3
Many or all aspects important	2
Prompt reimbursement	2
Proliferation of programs	1

* * * * * * *

APPENDIX F

VETERANS ADMINISTRATION: PHARMACY AGREEMENT

Veterans Administration: Pharmacy Agreement

PROFESSIONAL RELATIONS AGREEMENT BETWEEN VETERANS ADMINISTRATION AND _____

(Name of State Pharmaceutical Association)

The _____ and the Veterans Administration, to assure the availability of necessary local pharmaceutical services for veterans, agree as follows:

1. *Pharmaceutical Liaison Committee*

a. The association will establish a three-member Pharmaceutical Liaison Committee for each VA jurisdictional[1] area within the State to function in a liaison and professional relations capacity. Coordinating its activities with the _____ Pharmaceutical Association, the Pharmaceutical Liaison Committee(s) will consider and submit recommendations on professional matters within the scope of VA services provided by private pharmacies; cooperate with the Veterans Administration to assure the availability of high quality pharmacy services whenever and wherever needed; provide for liaison between the Veterans Administration and participating pharmacies by such means as the association's publications, conventions, meetings and other regularly available media; in general assist with the maintenance of effective VA-Pharmaceutical Association professional relations; and perform such other functions as may be agreed on from time to time.

b. The _____ Association will advise the Clinic Director of the VA field station of jurisdiction of the names of members appointed to serve on this committee, and any changes in committee membership.

c. If the Pharmaceutical Liaison Committee meets at the specific request of the Veterans Administration, each member attending may be paid at an all-inclusive rate not to exceed $50 a day or fraction thereof. Payment to committee members will be made by the VA field station upon submission of a properly prepared invoice. Such payments are limited to three committee members unless otherwise approved by the Clinic Director of the field station of jurisdiction.

d. It is understood that any general mailing of an informational or instructional nature to participating pharmacies which may be required will be prepared and mailed by the Veterans Administration. Whenever feasible and appropriate, such mailing will be coordinated with the Pharmaceutical Liaison Committee.

e. Clerical and operational aspects of prescription services will be administered directly between the Veterans Administration and individual pharmacies. It is mutually understood that participating pharmacies may bring to the attention of the Pharmaceutical Liaison Committee for forwarding, if indicated, any matter for consideration by the Veterans Administration.

2. *Participation by Pharmacies*

All legally qualified pharmacies will be eligible to participate in the VA pharmacy program. Prescription services supplied by pharmacies will be performed by fully qualified, registered pharmacists.

3. *Listing of Pharmacies*

The _____ Association will submit periodically, but not less frequently than once each year, the names and addresses of new pharmacies, discontinued pharmacies, or changes in names and/or addresses of pharmacies.

4. *Choice of Pharmacy*

Veterans for whom local pharmacy services are authorized by the Veterans Administration may select any qualified pharmacy to fill their prescriptions. Such pharmacies may include pharmacies in VA facilities when feasible.

5. *Eligibility of Veterans*

The Veterans Administration will determine the eligibility of veterans to receive pharmaceutical services. Prescriptions accepted and filled will bear a statement, signed by the prescribing physician or dentist, that he has been authorized by the Veterans Administration to treat the disability for which the prescription is written.

6. *Schedule of Prescription Fees*

a. A uniform schedule of prescription fees will be furnished individual pharmacies. Fees listed therein represent maximum fees authorized. It is understood that charges to the Veterans Administration will not exceed those charged for similar prescriptions to the general public.

b. The fee schedule is established by the Veterans Administration and is not subject to negotiation. Recommendations of the association as to appropriateness and equitability of the general fee schedule and the basis for establishing prescription charges will be considered by the Veterans Administration.

7. *Distribution of Instructions and Fee Schedule*

a. Based on best available information, the Veterans Administration will distribute the fee schedule and instructions to all known pharmacies withinn the State. Each pharmacy will be invited to accept and return a signed agreement and notice of intention to accept VA prescriptions. The absence of a signed agreement will not preclude payment for properly authorized and documented prescriptions filled in accordance with the instructions.

[1] Jurisdictional areas are territories served by VA outpatient clinics or hospitals authorizing outpatient services for veterans.

Veterans Administration: Pharmacy Agreement—Continued

b. Pharmacies completing and returning the notice of intention to accept VA prescriptions will be furnished a certificate of acknowledgment which may be posted in the pharmacy. No other sign, notice, or announcement of any kind, or in any other place, or in any media will be used to advertise VA prescription services.

8. *Effective Date and Termination*

This agreement will become effective ———— and remain in effect until terminated by either party after 30 days notice in writing.

Name of Pharmaceutical Association	Name of Clinic Director
by ————	————
Official Title	Official Title
Date: ————	Date: ————

APPENDIX G

MEDICAID SERVICES STATE BY STATE, MARCH 1971

BASIC REQUIRED MEDICAID SERVICES: State Medicaid programs are required by law to offer at least these Basic Medicaid Services: inpatient hospital care, outpatient hospital services, other laboratory and X-ray services, skilled nursing home services for people 21 or older; home health services for any eligible individual who is entitled to skilled nursing home services; screening and treatment for individuals under 21 as may be provided in regulations of the Secretary, and physicians' services. Transportation is required by Federal regulation.

MEDICAID SERVICES STATE BY STATE, MARCH 1971[1]

Services provided only under the Medicare buy-in or the screening and treatment program for individuals under 21 are not shown on this chart.

Definitions and limitations vary from State to State. Details are available from local welfare offices and State Medicaid agencies.

MAP	BASIC* REQUIRED MEDICAID SERVICES SEE ABOVE		Additional services for which Federal financial participation is available to States under Medicaid.																ICF
	● offered for people receiving federally supported financial assistance + offered also for people in public assistance categories[2] who are financially eligible for medical but not for financial assistance		Clinic services	Prescribed drugs	Dental services	Prosthetic devices	Eyeglasses	Private duty nursing	Physical therapy and related services	Other diagnostic, screening, preventive, & rehabilitative services	Emergency hospital services	Family planning services	Skilled nursing home services for patients under 21	Optometrists' services	Podiatrists' services	Chiropractors' services	Care for patients 65 or older in institutions for mental diseases	Care for patients 65 or older in institutions for tuberculosis	Institutional services in intermediate care facilities
78	●	Alabama	●			●					●			●				●	AL
50		Alaska																	AK
64		Arizona																	AZ
79	●	Arkansas			●			●	●						●	●	●	●	AR
50	+	California		+	+	+	+	+	+		+		●	●		●			CA
68	●	Colorado		●					●				●	●	●	+			CO
50	+	Connecticut	+	+	+	+	+	+	+	+			●			●	●	●	CT
50	●	Delaware	●	●					●			+		+	+	+	+	+	DE
50	+	D.C.	+	+		+							●				●	●	DC
61	●	Florida		●										●					FL
70	●	Georgia		●		●								+					GA
50	+	Guam	+	+			+							+					GU
51	+	Hawaii		+	+	+	+		+	+		+			●	●	●		HI
72	●	Idaho										+	+	+				+	ID
50	+	Illinois	+	+	+	+	+	+	+		●	●	●	●	●	●			IL
55	●	Indiana	●	●	●	●	●	●					●	●	●	●			IN
58	●	Iowa		●	●	●	●		●			+	+		+	+	+	+	IA
50	+	Kansas	+	+	+	+	+		+	+		+	+				+	+	KS
73	+	Kentucky		+	+						●		●				●	+	KY
73	●	Louisiana	●	●		●					●	●		●	●		●		LA
69	●	Maine	●	●		●		●	●	●	●	●	●	●					ME
50	+	Maryland	+	+	+	+	+		+	+		+	+	+	+	+	+	+	MD
50	+	Massachusetts	+	+	+	+	+	+	+	+				+	+	+	+	+	MA
50	+	Michigan		●					+		+	●							MI
57	+	Minnesota	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	MN
83	●	Mississippi		●									●	●				●	MS
60	●	Missouri		●	●							●			●				MO
67	●	Montana		●	●	●	●	●	●			●			●				MT
58	+	Nebraska	+	+	+	+	+	+	+	+		●			●	●		●	NB
50	●	Nevada	●	●	●	●	●	●	●		●	●			●			●	NV
59	+	New Hampshire	+	+	+	●	+	●	●	●	+	+	+	+	+	+			NH
50	●	New Jersey	●	●	●	●	●		●	●		●			●				NJ
73	●	New Mexico		●	●	●	●	●			●		●	●	●				NM
50	+	New York	+	+	+	+	+	+	+	+		+		+	+	+	+	+	NY
73	+	North Carolina		+	+		+					+	+	+	+	+	+	+	NC
71	+	North Dakota	+	+	+	+	+	+	+	+		+	+	+	+	+	+	+	ND
54	●	Ohio	●	●	●	●	●		●				+	●	●	●	●		OH
69	+	Oklahoma												●	●	●	●	●	OK
57	●	Oregon	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	OR
55	+	Pennsylvania	+	●	●	●	+					+	●	+	●	+		+	PA
50	+	Puerto Rico	+	+	+							+		●	●		+		PR
50	+	Rhode Island		+	+	+	●						●				●	●	RI
78	●	South Carolina		●		●						●	●	●	●	●			SC
70	●	South Dakota	●			●	●		●			●	●				●	●	SD
74	●	Tennessee		●								●		●	●	●	●	●	TN
65	●	Texas				●						●	●	●	●	●	●	●	TX
70	+	Utah		+	+	+	+	+	+			+	+	+	+	+		+	UT
65	+	Vermont	+	+		+			+			+	+		+				VT
50	+	Virgin Islands	+	+	+	+	+		+				+	+	+	+	+	+	VI
64	+	Virginia	+	+	+	+	+						+	+	+	+	+	+	VA
50	+	Washington	+	+	+	+	+	+	+	+		●	●	●	●	●	●	●	WA
77	●	West Virginia	●	●	●	●	●	●	●	●			●	●	●	+			WV
56	+	Wisconsin		+	+	+	●	●	+	●							+		WI
63	●	Wyoming							●									●	WY
	25	●	10	22	12	18	13	9	14	8	9	14	15	17	16	8	13	13	32
	27	+	18	24	20	17	20	10	17	9	8	19	16	17	18	13	21	15	32
	52	Total	28	46	32	35	33	19	31	17	17	33	31	34	34	21	34	28	

[1] People qualifying as aged, blind, disabled, or members of families with dependent children (usually families with at least one parent absent or incapacitated).

[2] FMAP: Federal Medical Assistance Percentage: Rate of Federal financial participation in a State's medical vendor payment expenditures on behalf of individuals and families eligible under Title XIX of the Social Security Act. Percentages effective from July 1, 1971, through June 30, 1973, are rounded.

[1] data from approved state plans as of March 1971.

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE — Social and Rehabilitation Service — Medical Services Administration
msa-801-71** — public information officer

APPENDIX H

PREPAID PRESCRIPTION PROGRAM NEGOTIATION ACT

COPY OF BILL RECOMMENDED AND ENDORSED BY THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

92nd CONGRESS
2d Session

H. R. 14304

IN THE HOUSE OF REPRESENTATIVES

April 11, 1972

Mrs. HICKS of Massachusetts introduced the following bill; which was referred to the Committee on the Judiciary

---

A BILL

To permit collective negotiation by professional retail pharmacists with third-party prepaid prescription program administrators and sponsors.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Prepaid Prescription Program Negotiation Act".

Declaration of Purpose

Sec. 2. It is the purpose of this Act to provide a limited exemption from liability under the antitrust laws to permit groups or associations of professional retail pharmacists to negotiate collectively with program administrators or sponsors for reimbursement in the dispensing of prescription drugs under government or private third-party prepaid prescription programs.

Definitions

Section 3. As used in this Act, the term--

(1) "antitrust law" means the Federal Trade Commission Act and each statute referred to in section 4 of such Act (15 U.S.C. 44) as "Antitrust Acts" and all amendments to such Act and such statutes and any other Act of Congress in pari materia, including but not limited to section 3 of the Act of June 19, 1936 (15 U.S.C. 13a);

(over)

(2) "Third-party prepaid prescription program or plan" means any program or plan which provides for reimbursement by a third-party insurer, in whole or in part, directly to a participating pharmacist for prescription charges for the dispensing of prescription drugs to consumer participants in the plan or program, and includes Federal and State government, as well as private programs or plans.

(43 "reimbursement" means the method or formula for paying professional retail pharmacists for the dispensing of prescription drugs to consumer participants in a third-party prepaid prescription program or plan.

Antitrust Exemption

Sec. 4. (a) It shall not be unlawful under any antitrust law for any group or association of professional pharmacists to negotiate collectively with a third-party prepaid prescription program administrator or sponsor with respect to their reimbursement for dispensing prescriptions under such programs or with respect to the administrative and operational features of such programs.

(b) Nothing contained in this Act shall exempt from any antitrust law activities on the part of groups or associations of professional pharmacists or third-party program administrators or sponsors, which are otherwise cognizable under the antitrust laws and not directly related to third-party prepaid prescription programs.

APPENDIX I

NARD ANTITRUST GUIDELINES FOR THIRD PARTY PREPAID PRESCRIPTION PROGRAMS

APPENDIX

Antitrust Guidelines For Third Party Prepaid Prescription Programs

1. Representative Pharmacy Groups.

It is permissible for retail pharmacists to form representative or advisory groups of such pharmacists in their respective areas for the purpose of gathering information useful to parties responsible for the administration, implementation and operation of third party prepaid prescription programs. Such information could include operational costs of retail pharmacies, costs incurred in dispensing prescription drugs and costs related to professional services performed by retail pharmacists.

For the purposes of these guidelines, a "third party prepaid prescription program" or "plan" means any program or plan which provides for reimbursement by a third party insurer in whole or in part directly to a participating pharmacist for prescription drug charges for the dispensing of prescription drug items to consumer participants in the plan or program. This includes government as well as private programs or plans.

2. Pharmacy Representatives - Third Party Program Administrators or Sponsors.

Representative or advisory pharmacy groups are authorized to convey such information as is contemplated by Guide 1 herein to third party prepaid prescription program administrators or sponsors, and to discuss with the latter any proposals relating to the terms of third party prepaid prescription programs.

3. Scope of Representative or Advisory Group Activity.

Representative or advisory groups of pharmacists are permitted to function only with respect to activities directly related to third party prepaid prescription programs.

Nothing contained in these guidelines should be interpreted to permit advisory or representative groups of retail pharmacists to enter into any binding agreements in their collective capacity relating to the terms of prepaid prescription programs with program administrators or sponsors. Nor may the advisory or representative groups of pharmacists engage in any boycott activity relating to a proposed or existing third party program. Such representative or advisory groups may report to pharmacists and the general public the information that has been conveyed to third party program administrators, as well as the nature and details of the program as finally determined by the third party program administrator or sponsor. However, no endorsements or criticisms of any existing or proposed program may be included in such informational reports.

APPENDIX J

CORRESPONDENCE: EARL W. KINTNER TO MILES W. KIRKPATRICK

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CYNTHIA H. MILLIGAN

July 29, 1971

RECEIVED
University of Rhode Island
AUG 23 1971
Dept. of Pharmacy Administration

onorable Miles W. Kirkpatrick
hairman
ederal Trade Commission
ashington, D.C. 20580

ear Mr. Chairman:

I am Washington Counsel to the National Association of Retail)ruggists (NARD), a trade association comprised of approximately 40,000 ndependent retail pharmacy owners. On behalf of my client, I am submitting o both antitrust enforcement agencies of the Federal Government a proposal esigned to deal with many of the inequities confronting retail pharmacists nder third party prepaid prescription programs in the context of existing ntitrust laws. As you are no doubt aware, the House Select Small Business ubcommittee on Environmental Problems Affecting Small Business, chaired y Congressman William L. Hungate, conducted hearings on July 7-9, 1971, ddressed to these problems.

Numerous witnesses appeared before the Subcommittee to detail the nyriad problems confronting pharmacists as a result of the administration nd operation of both government and private third party prepaid prescription rograms. A critical factor compounding these problems -- and in many nstances a direct causal factor -- is the present interpretation of antitrust rinciples so as to preclude groups of retail pharmacists from fairly present- ng their views to prepaid drug plan sponsors or administrators.

It is our considered judgment that a fair balance of the public interest considerations which motivated congressional passage of the antitrust laws and he public interest considerations which favor the survival of the independent small businessman provide a meaningful predicate for establishing guidelines

which would permit retail pharmacists to obtain fair treatment under prepaid prescription programs. Admittedly, this will require cooperation and consultation by both the Federal Trade Commission and the Department of Justice in recognizing an area of flexibility in the interpretation of the antitrust laws.

In an effort to facilitate this consultation and cooperation, I am submitting proposed guidelines, which are essential to ameliorate, if only on a temporary basis, the many problems confronting retail pharmacists. It should be pointed out that the guidelines have been designed to preclude the possibility of boycott activity on the part of retail pharmacists. These guidelines are appended to this letter.

Although the proposed guidelines attempt to provide a meaningful framework for the interim resolution of some of the many problems confronting retail pharmacists under these programs, they would permit only a limited degree of flexibility in the present interpretation of the antitrust laws. In short, retail pharmacists would be granted a vehicle for conveying critical information to program administrators or sponsors, a need amply demonstrated by the July 7-9, 1971 hearings. It should be noted that a distinct further problem in this whole area is the need for a mechanism to assure that a third party administrator or sponsor will react to discussions with, and information submitted by, pharmacy groups in good faith. The guideline approach does not readily lend itself to this type of mechanism. Indeed, more than likely, legislation would be required to assure that discussions and the transference of information take place in an atmosphere of good faith.

We cannot overemphasize that some form of interim relief is essential. Although the task force approach suggested by the Antitrust Division to the House Small Business Subcommittee has merit, it would be premature at this juncture to pursue such a recommendation without having the views and judgment of the Subcommittee with respect to this proposal; the proposal provides a long range approach which will not meet present needs. Moreover, the Subcommittee may treat the task force recommendation as one part of a multi-faceted approach to the situation. Consequently, establishing guidelines on an interim basis

would prove quite helpful in addressing some of the most pressing problems and at the same time not undercut any of the proposals or recommendations which might emanate from the Subcommittee.

We request that you advise us if our proposed guidelines will constitute permissible action under the antitrust laws. The situation faced by thousands of small business pharmacists is not dissimilar to that faced in 1963 House Select Small Business Committee hearings on the cooperative advertising problems of pharmacists who were unable, under then current rigid interpretations of the Robinson-Patman Act, to take advantage of cooperative advertising offered by drug suppliers. The federal enforcement agencies agreed that individual pharmacists might pool such allowances and advertise common prices, in order to take the same advantage of such allowances as their larger chain competitors. We believe that this same flexibility could be used to meet a substantial need for groups of druggists to confer and advise in third party programs.

We would appreciate any helpful advice that can be given in this situation.

Sincerely,

Earl W. Kintner

Enclosure

cc: Honorable Richard W. McLaren
Honorable William L. Hungate

APPENDIX K

REPORT OF THE SUBCOMMITTEE ON ENVIRONMENTAL PROBLEMS AFFECTING SMALL BUSINESS TO THE SELECT COMMITTEE ON SMALL BUSINESS, HOUSE OF REPRESENTATIVES

Union Calendar No. 332

92d Congress, 1st Session - - - - - - House Report No. 92-683

THIRD PARTY PREPAID PRESCRIPTION PROGRAMS

A REPORT

OF THE

SUBCOMMITTEE ON ENVIRONMENTAL PROBLEMS AFFECTING SMALL BUSINESS

TO THE

SELECT COMMITTEE ON SMALL BUSINESS

HOUSE OF REPRESENTATIVES

NINETY-SECOND CONGRESS

FIRST SESSION

PURSUANT TO

H. Res. 5 and 19

RESOLUTIONS CREATING A SELECT COMMITTEE TO CONDUCT STUDIES AND INVESTIGATIONS OF THE PROBLEMS OF SMALL BUSINESS

The National Association
of Retail Druggists
440 National Press Bldg.
Washington, D.C. 20004
AC 202-347-7495

NOVEMBER 29, 1971.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE

65-006 O WASHINGTON : 1971

LETTERS OF TRANSMITTAL

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON SMALL BUSINESS,
Washington, D.C., November 18, 1971.

Hon. CARL ALBERT,
The Speaker, House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: Transmitted herewith is a report of the Subcommittee on Environmental Problems Affecting Small Business entitled "Third Party Prepaid Prescription Programs."

This report is submitted with the approval of the full committee.

With kindest regards and best wishes, I am,

Very sincerely yours,

JOE L. EVINS,
Member of Congress, Chairman.

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON SMALL BUSINESS,
Washington, D.C., November 18, 1971.

Hon. JOE L. EVINS,
Chairman, Select Committee on Small Business, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Transmitted herewith is a report of the Subcommittee on Environmental Problems Affecting Small Business entitled "Third Party Prepaid Prescription Programs."

The report, transmitted to you as chairman of the Select Committee on Small Business, has the approval of the subcommittee.

With kind regards,

WILLIAM L. HUNGATE,
Chairman, Subcommittee on Environmental Problems Affecting Small Business.

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DONALD B. ROE, *Subcommittee Counsel*
JOHN M. FINN, *Minority Counsel*

CONTENTS

	Page
CHAPTER I. BACKGROUND AND PURPOSE OF HEARINGS	1
Introduction	1
Scope and Purpose of Hearings	1
Places and Dates	2
CHAPTER II. FINDINGS	3
Antitrust Considerations	3
Fixed Fee and Acquisition Costs	4
Reimbursement	5
Administrative Burdens	6
Pressure To Compromise Quality of Professional Services	6
Consumer Aspects	7
Future of Independent Pharmacies	7
CHAPTER III. CONCLUSIONS AND RECOMMENDATIONS	9
Conclusions	9
Recommendations	10

Union Calendar No. 332

92D CONGRESS, 1st Session } HOUSE OF REPRESENTATIVES { REPORT No. 92-683

THIRD PARTY PREPAID PRESCRIPTION PROGRAMS

NOVEMBER 29, 1971.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. EVINS, from the Select Committee on Small Business, submitted the following

REPORT

[Pursuant to H. Res. 5 and 19]

THIRD PARTY PREPAID PRESCRIPTION PROGRAMS

CHAPTER I. BACKGROUND AND PURPOSE OF HEARINGS

INTRODUCTION

With the opening of the 92nd Congress and the organization of the House Small Business Committee, the chairman of the committee, Representative Joe L. Evins, Democrat, of Tennessee, announced that the Subcommittee on Environmental Problems Affecting Small Business would conduct investigations and hearings pertaining to problems which small businessmen were experiencing as a result of the recent implementation of third party prepaid prescription programs. The members of the subcommittee were designated by Chairman Evins as follows:

Representative William L. Hungate, Democrat, of Missouri, Chairman;
Representative Neal Smith, Democrat, of Iowa;
Representative Charles J. Carney, Democrat, of Ohio;
Representative Bob Bergland, Democrat, of Minnesota;
Representative James D. (Mike) McKevitt, Republican, of Colorado;
Representative Frank Horton, Republican, of New York; and
Representative Manuel Lujan, Jr., Republican, of New Mexico.

Additionally, Chairman Evins and Representative Silvio O. Conte, Republican, of Massachusetts, ranking minority member, are ex officio members of the subcommittee.

SCOPE AND PURPOSE OF HEARINGS

The committee has received numerous complaints over the last few years in regard to third party programs. Retail pharmacists have written the committee complaining that these programs are forcing many small drugstores out of business while causing a severe economic and administrative burden on those fortunate enough to survive. Complaints focused on: inadequate professional fees; length of time for reimbursement; multiple claim forms; and refusal of plan administrators to discuss problems with druggists.

Congress has charged the House Small Business Committee to conduct studies and investigations of the problems of all types of small business, and to obtain all facts possible in relation thereto which are of public interest and which will aid Congress in enacting remedial legislation. It was with this duty in mind that these hearings were scheduled.

H. Rept. 92-683 -2

PLACES AND DATES

Hearings were held in Washington, D.C., on July 7, 8, and 9, 1971. Testimony was received from various trade organizations, State and local pharmacy associations, individual druggists, private insurance carriers and administrators of third party plans, and government agencies.

In addition to numerous individual pharmacists from such States as Tennessee, Ohio, California, New York, and Illinois, the subcommittee received testimony from representatives of the following organizations: National Association of Retail Druggists, Blue Cross Association, Metropolitan Life Insurance Co., National Pharmacy Insurance Council, Metropolitan Detroit Pharmaceutical Association, Illinois Pharmaceutical Association, Missouri Pharmaceutical Association, National Association for the Protection of the Pharmaceutical Profession, Ohio State Pharmaceutical Association, Department of Justice, and the Federal Trade Commission.

The subcommittee received testimony from as many interested parties as possible including written statements from witnesses who were unable to attend and present oral testimony.

CHAPTER II. FINDINGS

Prepaid prescription plans are an extension of other third party prepaid medical programs such as medical and conventional out-of-hospital health insurance programs. Basically, prepaid prescription plans contemplate a program which reimburses the pharmacist for all or part of the subscriber-patient's prescription cost, although the subscriber is usually required to pay a small "deductible" which is sometimes referred to as a "co-pay." This amount normally runs between $1 and $2 per prescription.

Prepaid prescription plans in the private sector are programs for reimbursement directly to a contract member pharmacy for the cost of the drug plus a fixed fee for the pharmacist's professional services in filling the prescription. The method of determining costs and fixed fees varies considerably from plan to plan, although in most instances these methods are set forth in a contract between a member pharmacy and the insurance carrier, or plan administrator.

ANTITRUST CONSIDERATIONS

The independent retail pharmacists indicated that a basic problem in regard to prepaid prescription programs has been the inability to collectively voice their position with respect to the operation of such programs. The Department of Justice has warned that pharmacists may not collectively approach plan administrators to discuss aspects of plans which will affect pricing. This policy is based on the Department's interpretation of the antitrust laws that such discussions might be a violation of the Sherman Act. Therefore, plan administrators have refused to meet with representative pharmacy groups. On the basis of this interpretation and advice and counsel of their attorneys, pharmacists have been forced to resort to dealing with plan administrators and sponsors on an individual basis. This has proved ineffective because plan administrators will not negotiate or discuss fees with an individual pharmacist.

Insurance carriers who administer prepaid prescription plans formulate a program in conjunction with a sponsor, usually a union or corporation, and then present the predetermined contract to independent pharmacies on a take-it-or-leave-it basis. The only choice given to an independent pharmacist is either to participate in the program as dictated by the plan administrator or forego a sizable portion of his business, depending on the number of his usual customers who become members of such programs.

The committee finds that the antitrust laws have been interpreted to preclude the independent retail pharmacist from attempting to deal collectively with large insurance carriers which administer plans and equally large prepaid prescription plan sponsors.

Although it does not appear that unilateral price fixing by plan administrators involves any collective conspiracy on the part of com-

petitors, the effect on consumers and a competitive free economic system is basically the same. Regardless of who sets the price, and whether or not this price is reasonable, the end result is the same: the price to be paid by consumers (the amount of the co-pay) is the same for all drugstores. The effect of this may be to eliminate competition among pharmacists in regard to prescriptions, which would be in direct conflict with the intent of Congress in enacting antitrust legislation.

A solution to the problem would be to develop an antitrust policy whereby plan administrators and sponsors may be permitted, under definitely defined guidelines of the antitrust laws, to consult with representatives of pharmaceutical groups with respect to a wide range of factors involved in such programs, including a reasonable range of compensation in light of the professional and other services to be performed by the pharmacist.

While the committee is fully cognizant of the danger of antitrust violations, as were many of the witnesses testifying in behalf of independent druggists, the committee believes it may be possible to devise a system whereby some input from individual pharmacists on matters affecting price can be presented to plan carriers by representative pharmacy associations without doing violence to the antitrust laws.

In this connection, the committee noted that a principal witness for the independent druggists suggested that a fair appraisal of the antitrust laws might permit consultation between representatives of pharmaceutical groups with respect to a wide range of factors involved in these programs, including price. In presenting the proposal, it was freely acknowledged that there is a narrow line between such consultation and prohibited price negotiation and it was specifically further acknowledged that such discussions could not "bind" individual member pharmacists either to cooperate with or to boycott such plans. The committee would go further and stress that it is not merely of concern that such representatives may not, indeed cannot, "bind" members; they cannot even suggest or impliedly encourage such concerted action under existing law.

The subcommittee notes that the Department of Health, Education, and Welfare has conducted a study of this problem in connection with the programs it administers (see, *Reports of the 1971 Advisory Council on Social Security*, House Document No. 92–80), but the subcommittee has no knowledge of any study that has been made which included careful consideration of antitrust aspects of prepaid prescription plans, both private and public. The subcommittee is also mindful that the trend in the direction of greater use of such plans is expected to increase rapidly, so it does not wish to encourage a proliferation of redundant studies. It is therefore imperative that a study be convened promptly for the purpose of developing antitrust guidelines implementing a system of consultation between pharmacy representatives and plan administrators. Such a study should be organized and directed by the Federal Trade Commission in consultation with the Department of Justice; and the Department of Health, Education, and Welfare; insurance carriers, pharmacy representatives and the public.

FIXED FEE AND ACQUISITION COSTS

One of the most frequent complaints by pharmacists is the amount of the fixed fee and the method used to determine acquisition costs.

In nearly all instances, sponsors or program administrators determine a flat fee to be paid a member pharmacist for his professional services in filling a prescription. This fee is the same, irrespective of the cost of the drug or the number of units dispensed.

Typically, plans limit prescriptions to a 34-day supply or 100-unit dosage. In some instances, plan administrators require pharmacists to pay a sales tax from this fixed fee. Thus, in the case of a $10 prescription for which a pharmacist receives a fixed fee of $2, a 4% sales tax amounting to 40¢ would be deducted from the fee, leaving a balance of $1.60. Such an arrangement clearly is inequitable to the pharmacist.

In addition to the fixed fee, the member pharmacist is reimbursed for acquisition costs, which in most instances are determined by the plan administrator. In some cases, this means the lowest cost drug which the pharmacist then has in stock, even though the pharmacist dispenses a more expensive drug which, in his professional opinion, he feels is of better quality. Pharmacists state they are thereby placed in a dilemma of either filling a prescription with a drug which they may feel is of poor quality, or dispensing a better quality drug without being fully reimbursed.

The fixed fee concept may have the effect of ignoring the wide variability and the cost and quality of professional services rendered by pharmacists. These variables can be identified and grouped in such a manner as to more accurately reflect real cost. It is unrealistic and inequitable to require an identical fixed fee for drugstores which have different characteristics (such as an urban location as compared with a rural location).

At least one plan now does have a dual fee system which pays more to pharmacists providing such complete professional services as 24-hour emergency prescription and delivery service, individual prescription records, and which has a program of continuing education for its pharmacists. The subcommittee finds such incentives laudable, and urges all plan carriers to consider their use. In this way such plans could in fact lead to improved pharmacy services instead of contributing to their deterioration, as some fear now is the case.

Although plan administrators refuse to negotiate or confer individually with independent pharmacists, large chainstore operations encompassing numerous drugstores in one area are afforded a more advantageous position to obtain the fee they feel is necessary. This is because it is incumbent upon plan administrators to obtain participation of chainstores in order to have many convenient outlets for prescription services for member-patients. While no hard evidence of such price discrimination was presented to us, such a danger requires vigilant attention to be prevented.

REIMBURSEMENT

Following the filling of a prescription, a member pharmacist files a claim for reimbursement with the particular insurance underwriter administering the plan. In many cases, the pharmacist is required to wait from 20 to 60 days before he receives reimbursement, and in some instances this may take up to six months. A few plans are able to provide reimbursement to a majority of pharmacists within a matter of 10 to 14 days. However, in no case does the pharmacist receive interest on the money due him, although he is required

to pay for drugs he has purchased and to meet his payroll requirements. This may mean he will have to borrow sufficient cash in order to continue in business and meet the demands of his creditors.

Reimbursement is made directly to the pharmacy in the case of a contract member pharmacy or participating pharmacy. If a member-patient procures a prescription from a non-participating pharmacy, within a defined area reimbursement is made to the patient, and in most cases reflects only 75 percent of the cost of the prescription. Therefore, a patient is penalized if he wishes to do business with a pharmacist who chooses not to participate in the plan.

In some instances, reimbursement is handled by an intermediary, or agent, under contract with a plan administrator. In these circumstances, the pharmacists may be required to pay an additional fee to the agent who processes the claims.

ADMINISTRATIVE BURDENS

Member-pharmacists are required to perform a tremendous amount of paperwork in connection with prepaid prescription programs. In some cases, they are required to keep a listing or inventory and actual cost of drugs (in addition to those already required by all levels of government in connection with narcotics). In nearly every case, the member-pharmacist is required to stock one or more forms which are transmitted to plan administrators for reimbursement.

In some instances, the subcommittee was told the time required by a pharmacist to perform the necessary paperwork exceeds the time required to fill the prescription. The additional burden of processing paperwork constitutes a cost in terms of time consumed by pharmacy personnel, which cost is not reimbursed by the insurance carrier. Pharmacies which heretofore kept patient record cards have abandoned reportedly the same because of the added administrative burdens of prepaid prescription programs. This is a serious loss to member-patients of beneficial services which had been provided previously.

It is clear that a simplified and uniform system must be devised for filing claim forms. Recordkeeping by pharmacies should be reduced to a minimum, and indiscriminate investigative procedures by plan administrators of customer prescription records should be revised and standardized so as to alert the pharmacists as to their responsibilities and duties. Such procedures should also recognize that some jurisdictions may prohibit investigations of certain records.

PRESSURE TO COMPROMISE QUALITY OF PROFESSIONAL SERVICES

As previously mentioned, plan administrators, or State agencies in the case of medicaid, may require a member-pharmacist to dispense the lowest cost drug he then has in stock. Where this type of requirement is found, druggists assert they may face pressure to compromise their professional judgment, by dispensing a drug which they may feel is ineffective or otherwise unsafe to use.

Some States prohibit pharmacists from prescribing drugs or altering a prescription made by a physician, although some of these jurisdictions will permit a pharmacist to substitute a drug with another of the same formula but a different trade name.

A pharmacist, because of this professional training and experience, should be free to dispense those drugs which, in his professional judgment, he feels to be of sufficient quality.

There can be no doubt that pharmacy is a profession on an equal footing with law or medicine. A pharmacist is required to complete long and arduous training and education, and must successfully pass a rigorous state pharmacy examination.

To allege that pharmacists merely transfer pills from one bottle to another is to totally ignore the professional knowledge required to accurately and competently complete a physician's requirement for his patient's medicines.

Pharmacists also perform valuable services to the community in working with drug abuse programs and assisting law enforcement officers in detection and identification of drugs. This valuable service cannot be emphasized enough in light of the drug abuse problem so prevalent in our society.

CONSUMER ASPECTS

An underlying issue in connection with prepaid prescription plans is the position of the member-patient with regard to the cost of prescriptions. It is important to note that the basic principle of prepaid prescription plans may result in reducing the cost of health services, which the committee finds most commendable. However, certain aspects of these programs may, in fact, be adverse to the member-patient in terms of both cost and professional services.

The fixed, uniform co-pay in effect reduces the member-patient's incentive to discern competitive differences between member pharmacies, at least in regard to price. The public pays the same for each prescription, regardless of where purchased (if a participating pharmacy, which is the general rule). In some of the larger cities this may not apply since some pharmacies reportedly advertise that the full amount of the co-pay will not be charged.

Pharmacists assert that requirements by plan administrators in regard to dispensing the lowest cost drug then in stock may also seriously affect the consuming public. The patient who once relied on the pharmacist's professional judgment in selecting the appropriate brand of drug, where the physician has not so designated, may no longer have the same confidence that he can continue to rely on that independent judgment.

The fact that most plans require the member-patient to purchase drugs from a participating pharmacy or receive less than the full amount of reimbursement places an undue hardship on the member-patient of a plan. He may be required to drive considerable distance in order to find a participating pharmacy, particularly if the customer lives in a rural community.

FUTURE OF INDEPENDENT PHARMACIES

Probably the most severe adverse consumer aspect of prepaid prescription plans is the possibility of the eventual loss of many independent retail pharmacies, if the present administration of such plans is continued as it now exists. While the subcommittee was not presented direct evidence that these plans have already led to the

closing of independent pharmacies, it must be noted that the plans are a relatively new phenomenon and it may still be true that their improper administration has caused serious economic hardships. The subcommittee cannot ignore, moreover, the fact that the number of pharmacies has been steadily decreasing over the last decade from 51,448 in 1958 to 46,244 in 1967, and further decreases are indicated, even though the number of prescriptions has increased, as has the population.

The local independent retail pharmacy has long been a vital force in the local community for the betterment of the public's health care. In most instances, the pharmacist is available 24 hours a day for emergency service. He provides a vital link between the patient and his physician.

In addition to being a professional, the local pharmacist is a small businessman, and as such is a viable part of the Nation's economy. He provides jobs within his local community for youth and persons needing additional employment. The local pharmacist is usually a strong supporter of local civic affairs and sponsors many youth and athletic activities. The future of the independent pharmacist is of vital concern to the Nation.

Chapter III. Conclusions and Recommendations

CONCLUSIONS

The subcommittee is of the opinion that the position of independent retail pharmacies may rapidly deteriorate under the present development and implementation of prepaid prescription programs.

While prepaid prescription programs are a relatively new phenomenon, the impact of which is impossible to fully assess at this time, the subcommittee concludes that many present practices employed in administering them are unduly onerous and, in particular, that by their very nature, they involve an imbalance of power between plan carriers and individual druggists which is especially serious in the case of independent small business pharmacists.

Of particular concern to the subcommittee in this connection is the present interpretation of the antitrust laws which permits program sponsors and administrators jointly to determine pharmacy fees and contract terms and conditions, while prohibiting independent pharmacies, which are most affected by such programs, from having any collective voice in the development of such plans. The independent pharmacy is, therefore, subject to the demands and dictates of third parties who may not appreciate and understand the particular problems of small business.

The subcommittee is of the opinion that the present situation must be altered in the immediate future to protect this vital sector of the small business community. The subcommittee feels that such changes can be made without adverse effects on consumers or program sponsors and administrators.

As a result of the pharmacists' inability to collectively negotiate with program administrators, a multitude of problems has surfaced.

In some areas, fixed fees are inadequate and require a pharmacist to absorb the sales tax. The method of determining acquisition costs, in some instances, may dampen a pharmacist's initiative to purchase drugs at the lowest wholesale price. Some plans are entirely too slow in reimbursing a participating pharmacy and may require administrative procedures greatly out of proportion to practical and realistic requirements.

The subcommittee is of the opinion that prepaid prescription programs may be a decisive factor in the future existence of independent pharmacies. It is important that these problems be recognized and adequately dealt with at this early stage in the development of such programs.

Program administrators and sponsors are to be commended for developing and initiating an ingenious concept to assist the Nation's health care needs. The subcommittee is cognizant of plan administrators' efforts to cooperate with independent pharmacies and of the fact that some problems will be solved in due course of time. However, in spite of commendable efforts by administrators and sponsors,

independent pharmacies are experiencing severe problems due to circumstances beyond their control, and in some instances beyond the control of administrators and sponsors. These problems must be acknowledged by all concerned and appropriate action taken to assure an equitable participation in these programs by independent pharmacists.

RECOMMENDATIONS

The recommendations of the subcommittee are as follows:

1. That program administrators—usually insurance companies—and representatives of affected Federal agencies meet with representative groups of independent pharmacists for the purpose of developing a uniform claim form, thereby eliminating time-consuming paperwork now required of druggists.

2. That the administrative procedures of prepaid prescription programs be reexamined with a view to cutting redtape to a minimum.

3. That the professional fee to be paid to pharmacists compounding prepaid prescriptions be flexible and based on variable factors rather than rigid and inflexible.

4. That program sponsors and administrators revise their procedures for reimbursement so that participating pharmacies can receive prompt reimbursement for prepaid prescriptions.

5. That, to insure that the operation of third party plans is equitable to all parties—pharmacists, program sponsors and consumers—the Federal Trade Commission, in consultation with the Department of Justice, Department of Health, Education, and Welfare, the public, insurance carriers, and pharmacy representatives, develop antitrust guidelines implementing a system of consultation between pharmacy representatives and plan administrators. Keeping in mind the narrow line between permissible consultation and prohibited negotiation, such consultation should include matters affecting professional fees and pharmacy costs.

6. That this committee be advised by appropriate parties no later than February 1, 1972, on action taken in connection with this report and the recommendations of the subcommittee.

APPENDIX L

JUSTICE DEPARTMENT - PAID PRESCRIPTIONS

"RELEASE" LETTER

STANT ATTORNEY GENERAL
ANTITRUST DIVISION

Department of Justice

Washington

October 1, 1968

James Robert Nielsen, Esq.
General Counsel
Paid Prescriptions
Post Office Drawer 5335
Carmel, California 93921

Dear Mr. Nielsen:

This responds to your request of September 18, 1968 under the Business Review Procedure for an expression by the Department of Justice of its enforcement intentions concerning the proposed course of business conduct to be followed by Paid Prescriptions, Inc. We have previously furnished you with a copy of the text of the Business Review Procedure of the Department.

In your letters of September 16 and 18, 1968 you have described the manner in which Paid Prescriptions has been restructured and the changes that are proposed to be made in the terms of the Participating Pharmacy Agreements which establish the drug prices and professional fees to be paid to participating pharmacists.

We understand from your representations that the prices for drugs and professional fees to be paid to pharmacists with which Paid Prescriptions proposes to contract have been unilaterally determined by Paid Prescriptions and that any changes in such drug prices or professional fees will also be determined unilaterally. We further understand that Paid Prescriptions does not contemplate inviting or acquiescing in any concerted action among pharmacists or any pharmaceutical associations pursuant to which pharmacists will jointly act in determining whether to enter into the proposed contract with Paid Prescriptions or in determining the drug prices or professional fees to be charged for prescriptions furnished to persons who are beneficial members of Paid Prescriptions, Inc.

This is to advise you that on the basis of the information submitted the Department does not propose to initiate any criminal proceedings under the federal antitrust laws if the proposed revisions in the prepaid prescription program are carried out in the manner described in your letters and the accompanying documents.

Sincerely yours,

EDWIN M. ZIMMERMAN
Assistant Attorney General
Antitrust Division

RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

444 WESTMINSTER MALL, PROVIDENCE, RHODE ISLAND 02901

Physicians Agreement

The undersigned Physician, in consideration of the mutual promises herein contained, hereby agrees with RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE, (referred to herein as "Physicians Service") as follows:

(1) That the Physician shall render professional services in accordance with the respective agreements from time to time in force between Physicians Service and its subscribers, to those subscribers accepted by him as his patients.

(2) That Physicians Service shall pay to the Physician compensation as hereinafter specified for services rendered by him to its subscribers.

(3) That in the case of those agreements between Physicians Service and its subscribers (a) where payment is provided on the basis of fee schedules, the Physician will accept the amounts specified therein as payment in full for services rendered to those subscribers entitled to service benefits under said agreement, and as partial payment in all other cases as provided therein; and (b) where payment is provided on the basis of the usual and customary charges, the Physician shall accept as full payment and Physicians Service shall pay directly to the Physician, his usual charges, provided that said charges (a) are for covered services; (b) are those regularly made to the majority of the Physician's patients; and (c) do not exceed the nearest actual charge reported by at least 90% of the Physicians practicing in Rhode Island.

(4) If, in the event of unusual circumstances, a Physician provides services which are unusually complicated, he may apply for and shall receive special consideration by the Physicians Service Claims Committee as to such service and Physicians Service shall pay to the Physician in such case, such additional compensation, if any, as shall be approved by said Committee.

(5) The Physician may change his usual charges as recorded with Physicians Service provided such changes are submitted in writing at least ninety (90) days in advance of an annual rate filing. The Professional Advisory Committee will review and recommend to the Board of Directors approval of the requested changes in usual charges provided said charges are not in excess of the revised prevailing level of fees incorporating the proposed changes, as recalculated on an annual basis. Approved changes shall be implemented at the beginning of the next subsequent rating year. If changes submitted are disapproved, the Physician shall have the right to resign forthwith.

(6) Nothing in this agreement shall affect the professional relationship between the Physician and his patient, nor shall it restrict the Physician in the exercise of his right to refuse to treat any patient for appropriate professional reasons.

(7) This agreement shall be effective when accepted by Physicians Service and shall continue in effect thereafter until terminated by the Physician or Physicians Service by ninety days' notice in writing.

PHYSICIAN.....

ADDRESS.....

ACCEPTED: RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

DATE:..... BY.....

President

RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

444 WESTMINSTER MALL, PROVIDENCE, RHODE ISLAND 02901

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PHYSICIAN.....

ADDRESS.....

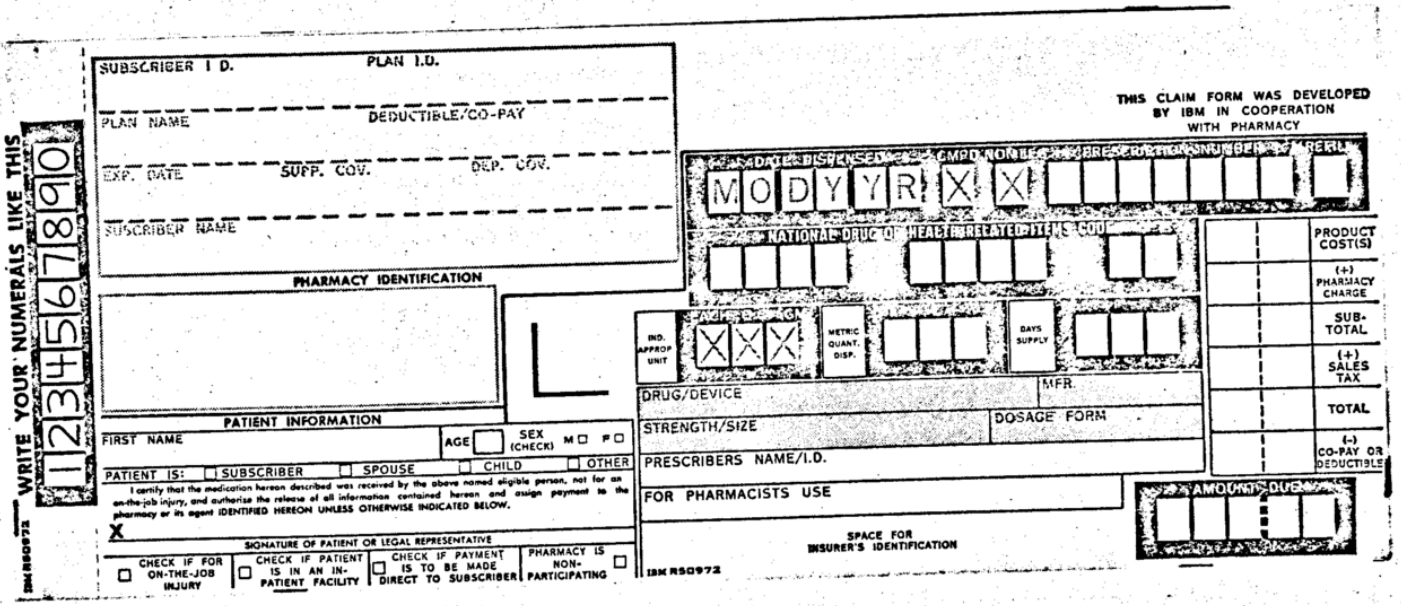
ACCEPTED: RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

DATE:..... BY.....

President

APPENDIX N

NPIC CLAIM FORM



WRITE YOUR NUMERALS LIKE THIS

1 2 3 4 5 6 7 8 9 0

IBM RS0972

SUBSCRIBER I D. PLAN I.D.

PLAN NAME DEDUCTIBLE/CO-PAY

EXP. DATE SUPP. COV. DEP. COV.

SUBSCRIBER NAME

PHARMACY IDENTIFICATION

PATIENT INFORMATION

FIRST NAME AGE SEX (CHECK) M ☐ F ☐

PATIENT IS: ☐ SUBSCRIBER ☐ SPOUSE ☐ CHILD ☐ OTHER

I certify that the medication hereon described was received by the above named eligible person, not for an on-the-job injury, and authorize the release of all information contained hereon and assign payment to the pharmacy or its agent IDENTIFIED HEREON UNLESS OTHERWISE INDICATED BELOW.

X

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

☐ CHECK IF FOR ON-THE-JOB INJURY | ☐ CHECK IF PATIENT IS IN AN IN-PATIENT FACILITY | ☐ CHECK IF PAYMENT IS TO BE MADE DIRECT TO SUBSCRIBER | PHARMACY IS NON-PARTICIPATING ☐

L

THIS CLAIM FORM WAS DEVELOPED BY IBM IN COOPERATION WITH PHARMACY

DATE DISPENSED MO DY YR X X

CMPD NON DEC

PRESCRIPTION NUMBER

REFIL

NATIONAL DRUG OR HEALTH RELATED ITEMS CODE

IND. APPROP UNIT X X X

METRIC QUANT. DISP.

DAYS SUPPLY

DRUG/DEVICE MFR.

STRENGTH/SIZE DOSAGE FORM

PRESCRIBERS NAME/I.D.

FOR PHARMACISTS USE

SPACE FOR INSURER'S IDENTIFICATION

IBM RS0972

	PRODUCT COST(S)
	(+) PHARMACY CHARGE
	SUB-TOTAL
	(+) SALES TAX
	TOTAL
	(-) CO-PAY OR DEDUCTIBLE

AMOUNT DUE

APPENDIX O

NPIC BYLAWS

NATIONAL PHARMACY INSURANCE COUNCIL

BYLAWS

ARTICLE I
NAME

SECTION 1. The name of this organization shall be the National Pharmacy Insurance Council (hereinafter sometimes referred to as "Council").

SECTION 2. The principal office of the Council shall be located at 2215 Constitution Avenue, Northwest, Washington, D.C. 20037.

ARTICLE II
PURPOSES

SECTION 1. The Council shall be a non-profit organization within the meaning of Section 501 (c) (6) of the Internal Revenue Code of 1954 as amended. Its purposes shall not contravene those set forth therein.

ARTICLE III
OBJECTIVES

SECTION 1. The objectives of this Council shall be:

1. To establish effective liaison for the profession of pharmacy with all persons, sponsors, associations, companies, government agencies or other parties involved in pharmaceutical services or interested in prepaid pharmaceutical programs.

2. To provide and exchange information on pharmaceutical services and prepaid pharmaceutical programs for dissemination to the profession, government agencies and others concerned with third-party payment.

3. To develop guidelines for prepaid pharmaceutical programs which will assure high quality pharmaceutical services to the public; and uniform, efficient and economical claims processing mechanisms which will serve as incentives for pharmacist participation.

4. To conduct socio-economic research on all aspects of pharmaceutical services which may be involved in prepaid pharmaceutical programs.

5. To conduct or engage in all lawful activities in furtherance of the foregoing objectives or incidental thereto.

ARTICLE IV
SEAL AND INSIGNIA

SECTION 1. The corporate seal of the Council shall have inscribed the name of the Council, the year of its creation, and the words "Corporate Seal, District of Columbia".

ARTICLE V
ORGANIZATION

SECTION 1. The Council shall be composed of Delegates and a Board of Governors.

ARTICLE VI
DELEGATES

SECTION 1. Delegates shall be appointed by the state pharmaceutical associations and the national organizations represented in the American Pharmaceutical Association, House of Delegates, which agree to participate in the Council. Each organization shall appoint one Delegate. No Delegate shall be entitled to compensation from the Council for serving as a Delegate.

SECTION 2. Term of Office

1. The term of office of each Delegate to the Council shall be determined by the organization appointing him.

SECTION 3. Duties of Delegates

1. Each Delegate to the Council shall:

   a. Attend all meetings of the Council and represent the views of the organization which appoints him on matters before the Council.

   b. Submit at least thirty (30) days in advance of a Council meeting any proposition his organization desires to have submitted.

   c. Report to his organization promptly the actions taken by the Council.

   d. Report to the Council actions taken by his organization.

ARTICLE VII
BOARD OF GOVERNORS

SECTION 1. The Board of Governors shall be composed of seven (7) members elected by the Delegates and additional members appointed as hereinafter provided.

The following organizations may each appoint one member to the Board of Governors:

American Pharmaceutical Association

National Association of Chain Drug Stores, Inc.

National Association of Retail Druggists

SECTION 2. Term of Office

1. Each appointed member of the Board of Governors shall serve at the pleasure of the organization which appoints him. Each member of the Board of Governors elected by the Delegates shall serve for a period of two (2) years.

2. No person shall be permitted to serve as an elected member of the Board of Governors for more than two (2) consecutive terms, provided, however, that there shall be no restriction on the number of non-consecutive terms which an individual may serve as an elected member of the Board of Governors.

3. No member of the Board of Governors shall be entitled to compensation from the Council for serving as a member of the Board of Governors.

4. The initial Board of Governors shall be constituted as provided in the Articles of Incorporation. The initial Board of Governors shall hold office until the first annual meeting of the Council and until its successor Board of Governors is appointed and elected and shall qualify.

5. No member of the Board of Governors shall serve as a Delegate concurrently.

SECTION 3. Election of Governors

1. The election of Governors not appointed in accordance with the procedure set forth in Article VII, Section 2.1, is as follows:

a. Nominations. The Chairman shall, prior to an annual meeting of the Council, appoint a nominating committee of five (5) Delegates who shall propose two (2) names for each Governor who is a Member-at-Large and whose term of office is due to expire. For election of Regional Governors to the Board, whose term of office is due to expire, the Chairman shall appoint a nominating committee of at least three (3) Delegates from the respective region who will propose two (2) names of qualified persons. Only nominations submitted in writing to the respective nominating committee at least thirty (30) days in advance of the annual meeting shall be considered. The nominating committees shall submit their report at the annual meeting of the Council.

b. Election. The names of the candidates for Governor shall be submitted by mail to each Delegate within two (2) months after the annual meeting, together with instructions that the Delegate indicate on a ballot enclosed for that purpose his choice of candidates for the Board positions to be filled, and that he return this ballot by mail within thirty (30) days of the date printed on the ballot.

c. Counting. The ballots shall be counted and verified; thereafter, the names of the successful candidates shall be communicated to all Delegates.

d. Installation. The Governors thus elected by a majority of the votes cast shall be installed at the first annual meeting of the Council following their election.

SECTION 4. Absence.

1. Any member of the Board of Governors unable to attend a meeting of the Board shall, in a letter addressed to the Chairman, state the reason for his absence.

If a Governor is absent from two (2) consecutive meetings for reasons which the Board of Governors has failed to declare to be sufficient, his resignation shall be deemed to have been tendered and accepted.

SECTION 5. Resignation

1. Any Governor may resign at any time by giving written notice to the Chairman. Such resignation shall take effect at the time specified therein, or, if no time is specified, at the time of receipt.

SECTION 6. Vacancies

1. Any vacancy occurring among elected members of the Board of Governors shall be filled by a vote of the majority of the remaining members to complete the unexpired term. Any vacancy occurring among appointed members of the Board of Governors shall be filled by the organization no longer represented as a result of the vacancy.

ARTICLE VIII

DUTIES AND POWERS OF MEMBERS OF THE BOARD OF GOVERNORS

SECTION 1. The Board of Governors shall supervise the affairs of the Council. In addition to the powers and authority expressly conferred upon them by these Bylaws, the Board may exercise all such powers of the Council and do all such lawful acts and things as may be in furtherance of the objectives of the Council as set forth in the Articles of Incorporation and these Bylaws.

SECTION 2. Duties of Governors

1. Governors of the Council shall:

   a. Attend all meetings of the Board of Governors and the Council.

b. Actively participate in furthering the objectives of the Council.

c. Actively participate in developing policy guidelines.

d. Perform such other duties as may be prescribed by the Council.

SECTION 3. Policy Guidelines

1. Policy guidelines of the Council shall be developed by the Board of Governors and submitted to the Delegates for consideration. Policy guidelines shall become effective upon ratification by a majority of the Council.

ARTICLE IX
CHAIRMAN OF THE BOARD OF GOVERNORS

SECTION 1. The member of the Board of Governors appointed by the American Pharmaceutical Association shall be the Chairman of the Council and the Board of Governors.

SECTION 2. The Chairman of the Board of Governors shall preside at all meetings of the Board of Governors and the Council; he shall see that all orders and resolutions of the Board of Governors and the Council are carried into effect; he shall execute contracts and other documents requiring a seal, under the seal of the Council; he shall keep in safe custody the seal of the Council; and when authorized by the Board of Governors, affix the seal to any instrument requiring the same, and the seal, when so affixed, shall be attested to by the signature of the Director. He shall submit a report of the operations

of the Council for the fiscal year to the Council at the annual meeting; he shall report to the Board of Governors all matters within his knowledge which the interest of the Council may require to be brought to their attention; he shall be an ex-officio member of all committees and shall have the usual general powers and duties of his office.

ARTICLE X
COMMITTEES

SECTION 1. Appointment

1. The Chairman shall annually appoint such standing, special or subcommittees as he may find necessary.

2. These committees shall meet only as authorized.

ARTICLE XI
STAFF

SECTION 1. Director

1. The administration and management of the Council shall be in a staff head employed by the American Pharmaceutical Association. He shall have the title of Director of the National Pharmacy Insurance Council. The Director shall manage and administer the functions and activities of the Council and perform such other duties as may be specified by the Board of Governors.

ARTICLE XII
MEETINGS OF THE BOARD OF GOVERNORS

SECTION 1. Meetings

1. The Board of Governors shall meet at the call of the Chairman or upon the written application of a majority of the Governors to the Chairman.

SECTION 2. Quorum

1. A majority of the Governors shall constitute a quorum for the transaction of business.

ARTICLE XIII
MEETINGS OF THE COUNCIL

SECTION 1. Meetings

1. The Council shall meet at least once annually and at such other times as may be designated by the Board of Governors, upon forty-five (45) days notice to the Delegates.

SECTION 2. Quorum

1. A majority of the Delegates shall constitute a quorum for transaction of business.

SECTION 3. Voting

1. Each Delegate shall be entitled to one (1) vote. No Delegate shall act as proxy of another Delegate nor as Delegate for more than one (1) organization.

An alternate Delegate may function in place of the original Delegate when authorized to do so by his organization. Such authorization must be established in writing and submitted to the Director prior to a Council meeting.

ARTICLE XIV
FISCAL AGENT

SECTION 1. The American Pharmaceutical Association shall act as the Fiscal Agent for the National Pharmacy Insurance Council and shall submit annual financial reports to the Board of Governors and an audited annual report after the close of the fiscal year.

ARTICLE XV
FISCAL YEAR

SECTION 1. The fiscal year of the Council shall be the calendar year.

ARTICLE XVI
VOTING BETWEEN MEETINGS

SECTION 1. All matters to be decided by vote of the Council or the Board of Governors may, in the discretion of the Chairman, be voted upon by mail, telegraph or telephone ballot. Except as otherwise required by law or as specified in these Bylaws a majority of the votes cast shall decide a question. The record of all votes taken shall be entered upon the minutes of the Board of Governors or the Council.

ARTICLE XVII
DISSOLUTION

SECTION 1. Upon dissolution of the Council, after payment of or due provision for all then existing liabilities of the Council, any assets remaining shall be distributed to the American Pharmaceutical Association.

ARTICLE XVIII
AMENDMENTS

SECTION 1.

1. Every proposition to alter or amend these Bylaws shall be submitted to the Director in writing and subject to one of the following procedures to be selected at the discretion of the Board of Governors:

   a. A copy of any amendment proposed for consideration shall be distributed to the Delegates at least forty five (45) days prior to the date of a Council meeting. It shall be read and voted upon at the Council meeting and upon receiving the affirmative vote of two-thirds (2/3) of the Delegates, it shall become a part of the Bylaws; or

   b. A copy of any ammendment proposed for consideration shall be mailed to the Delegates together with a mail ballot which shall be returned within thirty (30) days of the date printed on the ballots, and upon receiving the affirmative votes of two-thirds (2/3) of the Delegates, it shall become a part of the Bylaws.

ARTICLE XIX
RULES OF ORDER

SECTION 1. The latest Revised Edition of Roberts Rules of Order, where not inconsistent with these Bylaws, shall govern the conduct of the Council set forth above.

APPENDIX P

NAPPP CONSTITUTION AND BY-LAWS

CONSTITUTION AND BY-LAWS
OF THE
NATIONAL ASSOCIATION FOR THE PROTECTION OF THE PHARMACEUTICAL PROFESSION, INC.

ARTICLE I

NAME

Section 1. The name of this organization shall be THE NATIONAL ASSOCIATION FOR THE PROTECTION OF THE PHARMACEUTICAL PROFESSION, INC.

OBJECT

Section 2. The purpose of the Association is to preserve and promote the professional aspects of pharmacy and, in particular, to prevent laymen and lay organizations from dictating conduct of the profession in any of its aspects, including the economic.

GOVERNMENT

Section 3. The overall policy decisions shall be made by the General Membership of the Association at General or Special Meetings called in accordance with this Constitution.

An Executive Board, elected by the Membership, shall act as agent for the Membership to carry out the general policy decisions adopted by the Membership, and to do all things which the Executive Board shall deem necessary to that end.

ARTICLE II

MEMBERSHIP

Section 1. Any registered pharmacist shall be eligible for Membership in the Association. Such persons shall become a member upon complying with such requisites as the Executive Board by resolution may, from time to time, adopt and upon payment of such annual dues or initiation fees as shall have been established.

ARTICLE III

MEMBERSHIP MEETINGS

GENERAL MEETING

Section 1. General meetings are hereby defined as those to which

all members of the Association are entitled to attend. Every member in good standing shall have the right to speak and vote with equal force at each General Meeting. The General Meeting shall take place not less frequently than once every ninety (90) days, and may be called more frequently upon Motion of the Membership at any General Meeting, or upon the direction of the Executive Board by giving at least ten (10) days' notice of such meeting to all members in good standing by mail.

Section 2. The General Meeting shall be composed of the officers of the Association and the members in good standing, and no general meeting shall be deemed in order unless one-third (1/3) or more of members in good standing are present. All disputes as to the conduct of the General Meeting shall be resolved in accordance with Roberts' Rules of Order.

Section 3. Dues and assessments shall be set by the Membership at the General Meeting.

Section 4. All funds and other property of the Association shall be held by it in the name of the Association and used only for purposes of effectuating the objectives of the Association, as set forth in this Constitution and as determined by the Executive Board and/or the Membership at General Meetings.

ARTICLE IV

OFFICERS AND OATH OF OFFICE

Section 1. The Association shall elect the following officers: President, Vice-President, Secretary and Treasurer. The Executive Board shall consist of the officers so elected and, in addition, three (3) members from the General Membership.

Upon being installed, each officer of the Association shall take the following oath:

"I, ... , do truly promise to the best of my ability and on my honor that I will perform the duties of the office to which I have been elected.

That I will carefully preserve and guard all Association property that may be left in my charge; and that upon the expiration of my term of office, I will turn over such property to my duly elected and installed successor."

Section 2. Any member of the Association may be elected to any office provided he is a member in good standing at the time of his nomination.

Section 3. The terms of office shall be for one (1) year. Regular elections shall take place at a General Meeting to be called for that purpose eleven (11) months after the installation of officers elected at the prior meeting. In the event of a vacancy during the term of office, the remaining officers shall function until the office is filled at an election to be held at the next General Meeting following such vacancy.

Section 4. Nominations shall be made by a nominating committee appointed by the Executive Board prior to the General Meeting at which the election is to be held. After the list of nominees prepared by the nominating committee has been presented to the General Meeting, the list shall be open to additional nominations made at large from the floor. The nomination list for each office shall be open for new nominations again immediately prior to the vote for each office.

Section 5. Election of officers shall be held immediately following completion of the nominations. Voting for the office of President shall be held first and shall be followed by voting for the officers in the order set forth in the Constitution.

All elections for officers shall be by secret ballot. Counting of the secret ballot shall be done openly immediately following the completion of voting by the Executive Board. Any candidate or representative of any candidate may witness the counting of the ballots.

Announcement of the results of the secret ballot shall be made immediately following the tabulation of the votes to the General Meeting.

Ballots cast in the election of officers shall be held for one (1) year following such ballot.

Should an office become vacant before the expiration of the term of office, the Executive Board is empowered to appoint a temporary replacement and a new officer shall be elected at the next General Meeting.

The candidates receiving the largest number of votes shall be deemed elected. In the event there is a tie vote for any office, there shall be a run-off between the two candidates receiving the largest number of votes.

ARTICLE V

DUTIES OF THE EXECUTIVE BOARD

Section 1. The affairs of the Association shall be administered and represented by the Executive Board (hereinafter referred to as the Board).

Section 2. The Board shall conduct and transact business only if a quorum is present at a meeting. A majority of the Board shall constitute a quorum.

ARTICLE VI

DUTIES AND POWERS OF OFFICERS

Section 1. THE PRESIDENT shall call and preside at all meetings of the Association, preserve order, enforce its laws. He shall decide all parliamentary questions and usage, appoint or cause to be appointed or elected required committees and see that the Constitution of the Association is maintained and observed. He shall have the deciding vote whenever the members shall be equally divided on any question.

Section 2. THE VICE-PRESIDENT shall assist the President in the discharge of his office, fill his place in his absence, and have such other duties as are customarily incident in his office.

Section 3. THE SECRETARY shall keep correct minutes of all General Meetings, which shall be read at the beginning of each meeting; keep a correct list of all standing and special committees with notes of their functions and when they are to report; keep all letters, dispatches, documents in his possession and read them so ordered by the President; keep the roll of officers and members and read their names when ordered by the President; mark the absentees; handle the Association's correspondence. He shall notify all members of time and place of all General Meetings in the most effective manner at his disposal.

Section 4. THE TREASURER shall receive all money income of the Association; he shall keep a correct amount of all receipts and disbursements of the funds of the Association; he shall maintain and record each member's record of payments in such a manner that clear report thereon may be rendered at the meetings whenever he is called upon to do so; he shall keep a correct list of the names and addresses of members of the Association; he shall pay out no monies other than those ordered paid by the Association.

ARTICLE VII

DISCIPLINE

Section 1. The Executive Board shall exercise original jurisdiction to try officers or members for violation of any section of the Constitution and submit their findings and recommendations for disciplinary action to the membership as a whole at the next General Meeting. The General Meeting shall be the final arbiter in all disciplinary action. The Executive Board shall adopt a code of procedure for such matters subject to the approval of the General Meeting.

Section 2. If a member of the Executive Board is the subject of a charge or brings a charge to the attention of the Board, then that member of the Board shall not sit on the Board for adjudication, but the remaining board members shall appoint a substitute for the proceeding. All charges shall be submitted in writing to the Secretary in duplicate, one copy of which shall be forwarded by the Secretary to the person charged before any adjudication may proceed. Trial may not begin until the fourteenth day following service in writing of the charges to the individual so charged. Grounds for charges other than violation of a provision of the Constitution shall be set by a committee appointed by the membership at the first General Meeting and which shall report its recommendations to the President and the membership within three months thereof.

ARTICLE VIII

ORDER OF BUSINESS AT GENERAL MEETINGS

1. Calling of meeting to order
2. Roll call of officers
3. Reading of minutes
4. Applications for membership
5. Initiation of new members
6. Payment of assessments
7. Communications and bills
8. Reports of committees and officers
9. Reading of monthly membership, financial, trustees' and other reports
10. Nomination of officers
11. Election of officers
12. Enstallation of officers
13. Unfinished business
14. New business; welfar of Association
15. Receipts and disbursements
16. Adjournment

ARTICLE IX

AMENDMENT

Section 1. This Constitution may be amended by a vote of three-quarters (3/4) of all members of good standing cast at a General Meeting following a General Meeting at which a majority of members have proposed such amendment to the Constitution.

SOME ANTITRUST IMPLICATIONS OF THIRD PARTY PRESCRIPTION PAYMENT PROGRAMS

by NORMAN AMBROSE CAMPBELL

(Under the supervision of Professor Robert W. Hammel)

This study was conducted to probe: (1) the extent to which either negotiation or sponsorship of prepaid drug plans by individual pharmacy associations or groups of associations might constitute violations of one or more of the antitrust laws; (2) the antitrust status of providing pharmaceutical services at the same professional fee for all pharmacies; (3) the current and short-run future courses of action undertaken, or about to be undertaken, by state pharmaceutical associations; (4) the perceived and actual roles of state associations in providing leadership and direction in this increasingly important area, as well as to consider the importance of identifying the parties to a third party payment transaction and their relationships to each other for purposes of contracting, reimbursement, service definition, and cost and quality control.

To gain insight into how the chief executive officers of state pharmaceutical associations reacted to conditions in the field of third party prescription prepayment programs, a mail questionnaire was sent to each state and the District of Columbia. Useable returns were received

from 35 respondents. The results show a decisive majority of more than 90 percent of the state associations involved in presenting informational programs about third party payment matters to their members. Official actions or stands were not taken in 25 of the states largely for reasons of legal implications. Some respondents made specific reference to antitrust laws.

Practitioners in the six states where polls were conducted showed preferences for usual and customary, then fixed fee methods of reimbursement. Executive officers in the remaining states reported usual and customary as the choice their members likely would prefer.

The National Pharmacy Insurance Council generally was rated favorably on past performance and given high expectation ratings for the group's future role. Cost study data collected on behalf of the associations most often were used for the information of welfare departments, association members, and insurance carriers. Association executives selected adequate reimbursement, freedom of choice, and proliferation of paperwork as the aspects of third party prescription programs they considered most important to pharmacy.

The legal research aspects of this study revealed the Sherman Act and Federal Trade Commission Act to have the greatest potential application to third party prescription plans. Case law investigation first involved decisions in the federal courts in the general field of antitrust.

Where available, cases seeming to have the closest relationship to possible future pharmacy organization cases were given particular attention.

Subsequently, trade and professional association cases were studied to establish general parameters. Finally, those cases bearing on pharmacy organizations directly were considered. The impact of proposed legislation nationally also was analyzed.

Price fixing and group boycotts in particular have been established firmly as violations. Agreements among competing pharmacies to fix the prices of prescriptions in private third party prescription payment programs are illegal per se. The Justice Department position on these matters and the potential violation of using a fixed fee are rigid. Sponsors may not seek price suggestions from pharmacy groups without violating antitrust laws as well.

The "Prepaid Prescription Program Negotiation Act" offers only limited relief from the problem if this proposed statute is construed literally. A judicial shift from the per se doctrine to the rule of reason can be supported by the facts attendant on the usual third party program. The establishment of a national study committee as recommended by the Hungate Committee and pharmacy organizations, coupled with adoption of recommendations therefrom, could ameliorate pharmacy's current dilemma.

APPROVED _____

DATE _____