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PREPAID PRESCRIPTION PLANS AND OTHER CURRENT RETAIL-DRUGGIST LEGAL PROBLEMS

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It is indeed a privilege for me to appear before you today, to offer my contribution to this convention's review of some major developments in the community-pharmacy level of drug distribution. After giving a considerable amount of thought to the topics which are of most timely interest, everyone I consulted agreed that my efforts might be most profitably channeled to three areas of prime concern to everyone here today -- prepaid prescription plans; hospital drug diversion; and finally, some comments on the scope of lawful activity by trade associations in dealing with marketing practices and policies.

I.

A high degree of tribute is properly paid to Willard Simmons, NARD's Executive Secretary, and to Herman and Sidney Waller, NARD General Counsel, for the prudent manner which they have dealt with the issue of prepaid prescription plans -- this contemporary development in the field of retail drug distribution. The approach of these leaders has been guided by the effect of prepaid prescription on NARD members, an approach which has sometimes become "lost in the shuffle" by some enthusiastic supporters of prepaid prescription plans. The judgment of these NARD leaders has also been consistent with NARD's role as champion for "free choice" by individual community pharmacists. Hopefully, the information here made available will allow "free choice" to be exercised by NARD members on an informed basis, with the benefit of all pertinent information which NARD has gathered on this subject to date.

It is appropriate to advance the introductory comment that this is not strictly a "position paper" by NARD on prepaid prescription plans, simply because there is no "position" stated. The facts are not all in; many problems need to be solved; many questions need to be answered. The aim is a more modest one of pointing out what NARD views as the major pros and cons of prepaid prescription plans.

As we shall see, the issues involved in any general discussion of prepaid prescription plans are not primarily legal ones but economic ones; the most important question is not "Are they lawful?", but rather "Will they work on a long-range basis?" Or to put the question in insurance terms, "Are they economically sound from an actuarial standpoint?"

What are prepaid prescription plans?

The term "prepaid prescription plan" generally refers to a plan which contemplates that community pharmacists and consumers or classes of consumers (such as unions) will be afforded an opportunity to pay a stated fee or schedule of fees to an organization which will grant the consumer-member specified benefits incident to the purchase of prescription drugs from a member pharmacy. This may take the form of the consumer paying the first $1-$2 of the prescription price to the member pharmacist, with the pharmacist securing the balance due from the administrator of the plan. The money collected by the administrator from consumer-members and pharmacist-members is used to run the plan, that is, to pay out benefits and to meet administration expenses. The administrator of the plan must formulate (a) the specific benefits available to consumer members and (b) costs to the consumer-members and to the pharmacist-members, striking

a balance sufficient to make the plan break even over the long term. This potential for success in turn depends on securing widespread consumer participation, with maximum benefits for a minimum price.

The September 13, 1965, issue of American Druggist contains a valuable analysis of the PAID plan for prepaid prescriptions administered by CPhS, Inc., and deserves careful study by NARD members. This article points out that the PAID administrator's membership contracts are with individual pharmacies, each pharmacy in a chain, but not with each individual pharmacist.

Prepaid prescription plans are like prepaid health insurance plans in many ways. Major medical plans available through such nationally prominent underwriters as Mutual of Omaha, Blue Cross, Travelers, Continental Casualty and many others include out-of-hospital prescription insurance benefits as a part of overall coverage. One important difference is that the community pharmacist does not become a paying member of a major medical plan -- the transaction is solely between the consumer-insured and the health insurance underwriter. However, the American Druggist article points out in reference to the California-type plan that "in some states where not prohibited or otherwise regulated by law or contract, a [consumer] member may even take his Rx to a [non-member] pharmacy" to secure benefits.

The comparison between prepaid prescription plans and major medical plans is pertinent, however, because any organization which plans both to finance and operate a prepaid prescription plan must frankly recognize that it is going into the health insurance business. Any such plan depends on actuarial bases for determining risks, benefits, and costs, coupled with the need to comply with diverse state laws and regulations governing such factors as reserve requirements for health insurance underwriters. This requirement for reserves sufficient to meet benefit claims will be satisfied according to the manner in which the plan is developed, whether the necessary "deep pocket" is secured through arrangements with health insurance underwriters or through subscriptions by pharmacists.

Have no illusion that this is a simple field; health insurance has many complexities, which are best handled with insurance experts, not drug distribution experts. If any pharmaceutical association plans to support such a health insurance program, prudence dictates that any corporation organized to underwrite the plan secure the assistance of health insurance expertise to supervise this health insurance business. Moreover, organizations considering the possibility of becoming agents for prepaid prescription plan should investigate the application of state laws governing licensing and regulation of insurance agents.

What has been the record of prepaid prescription plans in recent years?

NARD has made investigations into the record of past performance of prepaid prescription plans. The results of such efforts have not been encouraging. NARD furnished an officer of one of the leading health insurance underwriters in the United States with a vast store of information on the history of such plans implemented both in the United States and Canada. This corporate officer stated in a recent letter to Willard Simmons;

> "From what we can gather from all sources . . . it seems clear to us that this type of [prepaid prescription] program will not stand on its own. Alone it is too expensive to administer economically and not attractive enough to the general public to assure the desired level of participation."

NARD, as we shall see shortly, is not yet prepared to accept such a bleak conclusion as the last rites for prepaid prescription, simply because ample operating experience is still lacking. But it would be sheer folly for NARD members to ignore this conclusion by a leading health insurance expert. It is useful to explore some of the more important reasons for this lack of success, with the thought that success or failure in the future will depend on how these and other obstacles are handled.

What are the principal problems involved?

First of all, there is a serious antitrust problem which would involve any effort to stabilize or provide uniform prices for prescriptions charged by member pharmacists. The upshot of this very legitimate concern by U. S. Justice Department officials has resulted, in the California PAID Plan, of participating pharmacists agreeing only to charge a member its "usual and ordinary price" for prescription drugs. Under these circumstances, there is the lack of closely predictable charges or benefits to be paid out even for the same prescription drug, a factor which may or may not be of controlling significance to the success of the plan, but will result in added administration costs as necessary to ensure that pharmacists are in fact charging the "usual and ordinary price" to member consumers, and not overcharging in violation of the contract terms. The member pharmacist must be prepared to accept audits of his prescription records, and generally to accept the scrutiny of the administrator over his comparative plan and non-plan prescription prices to ensure that no disparity exists.

Administration expenses generally required to administer a prepaid prescription plan are relatively high, a factor which directly influences the benefits which can be paid out for every dollar of premiums paid in by the consumer member.

Problems also arise from an insurance-risk standpoint which involve the question of assessing charges to consumers in return for prescription benefits. If prepaid prescription plans simply tend to draw "high-risk" consumers such as senior citizens, and chronically ill folks who require more drugs, the cost to supply this class of citizens with prescriptions would obviously be greater than to supply a class of healthy persons who only rarely require prescription drugs. But to have a successful plan which appeals to a broad spectrum of the community or any specific group, the plan has to be attractive price-wise not only to the heavy users of drugs but also to the light users.

Competition is another important factor. Out-of-hospital prescription benefits are included in many major-medical plans, as previously mentioned. The potential price competition through discount chain stores must be considered: "Let us show you how you can save on your prepaid prescription bill." There will surely emerge competition between prepaid prescription plans if the concept is eventually proven economically feasible. Likewise, the public reception to prepaid prescription plans may prove to be different as geographic differences, population differences, and spending differences vary from state to state. In various parts of the country, regional "credit card" plans provide for deferred payment of prescriptions purchased from member pharmacies.

It is also useful to consider the effect of prepaid prescription plans on efforts to secure supplemental prescription protection under Medicare, a move which would inure to the benefit of all pharmacists.

What does the community pharmacist stand to gain and to lose from participation in a prepaid prescription plan?

On the one hand, the community pharmacist reasonably expects that by participating in a prepaid prescription plan or plans, the cost to him will be outweighed by the return -- the added prescription volume to his pharmacy -- generated because of such participation. The theory on which the appeal to pharmacists rests is that physicians will prescribe more freely to consumer-members, the consumer-members will fill more prescriptions and hence the pharmacist-member will enjoy increased prescription volume. This theory may ultimately prove accurate, but it still remains to be proven. Perhaps a more important consideration exists that the consumer-members will divert their business from non-member pharmacies to member pharmacies. The latter factor loses its competitive appeal as more and more pharmacists in the community become members of any given plan.

The community pharmacist stands as a major contributor to the reserves and administration expenses of the plans or plan it joins, as they are presently formulated. If the plan is a failure, the pharmacist

of course may lose his commitment of money. If more money is needed to run the plan, it is reasonable to expect that there will be as much temptation to raise the member fees for pharmacists as to raise the fees to consumers. At a very minimum, pharmacists should avoid any commitment to a prepaid prescription plan which includes any provision for assessments of an amount which they cannot afford to risk, or any commitment for carrying accounts receivable which would hazard the operation of the pharmacy.

What is NARD doing about prepaid prescription plans?

Back in the Winter of 1963-64 at Willard Simmons' direction, I completed an extensive legal review of the problems arising from prepaid prescription plans, at the request of a prominent state pharmaceutical association here in the East. I pointed out that a prepaid prescription plan could be developed which passes antitrust muster, and offered to work, on behalf of NARD, with this state association in exploring the possibility of developing a commercially feasible plan. This particular proposal never materialized, so it was with a great deal of interest that I watched the developments of our California friends in their efforts to develop the CPhS idea into reality. NARD has made my assistance available to the California association in connection with

efforts to overcome the antitrust obstacles raised by the Justice Department. We praise their ambitious efforts to break ground where the task ahead is a formidable one.

NARD has been working on this problem not only from a legal standpoint, but also from the standpoint of exploring the economic potential of such plans. This work continues. As further information is secured, NARD members will be kept advised.

The foremost consideration is that NARD members know the facts, know and understand the contract terms of prepaid prescription plans, and know the likelihood of success of such plans. It is in this context that NARD is looking forward to detailed public disclosure of all facets of the California PAID plan.

Prepaid prescription plan membership is a matter of "free choice" to NARD members. NARD will do its best service to its members in making this "free choice" an informed choice. If you observe a note of caution expressed, your obervation is correct. If you observe a positive approach, this observation is also correct.

II.

Let us now devote our attention briefly to another problem -- this time a legal one of which you are all generally aware.

Hospital drug diversion is a problem which has been under close scrutiny by NARD for a long while. The 1964 NARD Convention highlighted this problem as one of major responsibility to all levels of drug distribution.

Hospital drug diversion raises serious legal dangers to drug suppliers and to non-governmental institutional purchaser-resellers under the Robinson-Patman Price Discrimination Act, where the following elements exist:

1. A supplier sells the same drugs to profit and non-profit hospitals, clinics or similar institutions and to community pharmacists located in the same trading area; and,

2. The institutional purchaser pays a lower price for the drugs than the neighboring community pharmacists; and

3. The institutional purchaser resells the drugs to non-patients of the hospital such as private non-hospitalized patients of physicians, the public at large, in competition with the disfavored community pharmacists; and

4. As a consequence, this price differential gives rise to adverse competitive effects at the retail level of drug distribution in that trading area.

These are the salient elements of potentially unlawful hospital drug diversion, shorn of all the sophisticated developments in the law.

If these elements exist, there is a real danger that the drug supplier may be engaging in price discrimination in violation of Section 2(a) of the Robinson-Patman Act. The institutional purchaser likewise may be in violation of Section 2(f) if it "knowingly induced" the price discrimination prohibited by Section 2(a).

The point to be emphasized is that our federal price discrimination laws do not prohibit a drug supplier from granting preferred functional discounts to institutional purchasers for those drugs which are resold to hospitalized patients. The community pharmacy level of competition is not adversely affected in these circumstances because of the functional difference in the use of the drugs; those drugs sold for the profit or non-profit institutions' "own use" fall outside our area of inquiry. 1/ There must be drug resales by the institutional purchasers to non-patients as just discussed for the Robinson-Patman Act to come into play, with its yardstick of "competitive effects."

A more complex legal variation of unlawful hospital drug diversion arises where the institutional purchaser, instead of reselling the drugs to non-patients in the community, is used as a channel or "straw purchaser" through which a community pharmacist surreptitiously secures

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1/ Shell Oil Co., 54 FTC 1274, 1279 (1958); Cf. Secatore's, Inc. v. Esso Standard Oil Company, 171 F.Supp. 665 (D. Mass., 1959); Sano Petroleum Corp. v. American Oil Company, 187 F.Supp. 345 (E.D. N.Y. 1960). See Non-Profit Institutions Act of 1938, 15 U.S.C. §13(c).

a preferred discount from his drug supplier. 2/

Whether unlawful drug diversion involves the institutional resale to a community pharmacist under the complex "indirect purchaser" doctrine of Robinson-Patman law, or resale to the public at large, a "side effect" of the unlawful conduct is the false image created in the eyes of the public. If the consumer secures a prescription at a lower price as a consequence of unlawful diversion practices, the consumer does not realize that the disfavored community pharmacist is in effect forced to subsidize the lower drug price charged through institutional diversion channels. Basic competitive fairness is lacking where competitors are not paying a price for the drugs which is consistent with the law. In the same context, any non-profit institution which enjoys an exemption from federal income taxation has the "competitive edge" over taxpaying community pharmacists, when both classes are selling to the public at large in the same trading area.

While the Federal Trade Commission has never squarely litigated a proceeding which charges unlawful hospital drug diversion, the law is indeed sufficiently clear to give suppliers and hospital administrators clear guidelines on compliance with the Robinson-Patman Act.

2/ A typical "indirect purchaser" case arising under the Robinson-Patman Act is American News Co., F.T.C. Dkt. 7396 (Jan. 10, 1961) modified, 300 F.2d 104 (2nd Cir. 1962); Cf. Klein v. Lionel Corp., 237 F.2d 13 (3rd Cir. 1956).

During this year which has elapsed since the 1964 NARD Convention, a widespread campaign of education has taken place to curb the problem of unlawful hospital drug diversion. The drug trade press has performed yeoman service to our industry in highlighting the problem, and I venture to suggest that no responsible drug manufacturer is now unaware of the general legal requirements governing sales to profit and non-profit institutions. Earlier this year, in a speech before the Georgia Pharmaceutical Association, I suggested that drug manufacturers profitably might consider "notice-type" legends and labeling to place institutional purchasers on notice as to the limiting nature of any preferred functional discount which they receive. This general discussion may be worth repeating today.

In this connection, standard hospital price lists, invoice forms, or packaging labels might contain a "notice type" legend which would help to shift the practical burden of Robinson-Patman compliance more on the shoulders of the institutional purchasers under discussion. Such a "notice" might state:

> "Special discounts available to profit and private non-profit hospitals and institutions are not granted for drugs purchased for resale to non-patients."

A somewhat analogous procedure with somewhat similar implications is advantageously used by many suppliers, who, from time to time, grant special price concessions in order to meet, in good faith, the equally

lower price of a competitor. This procedure is to secure some evidence of the competitor's lower price so as to protect the supplier. 3/ To be sure, the use by drug suppliers of such a notice-type disclosure or similar contractual assurance from hospital purchasers confers no absolute immunity from Section 2(a) liability on the drug supplier, in the event the hospital purchaser thereafter resells in disregard of such notice or assurance. Section 2(a) is not a statute which takes into account "good faith" in determining whether a price discrimination exists in the first instance. But it is reasonable to expect that the Federal Trade Commission might, under appropriate circumstances, take such efforts by the supplier into account in deciding whether to charge the drug supplier under Section 2(a) or the institutional purchaser under Section 2(f), where a violation of the law is suspected. In following the above course of action, it is my view that drug suppliers would shift a fair measure of practical responsibility on to profit and non-profit hospitals and related institutions to comply with the Robinson-Patman Act. 4/

NARD has also invited drug retailers and drug wholesalers to come forward with details of suspected unlawful drug diversion in their

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3/ Cf. Forster Co. v. Federal Trade Commission, 335 F. 2d 47 (1st Cir. 1964).

4/ Cf. Max Factor & Co., FTC Dkt. 7717 (July 22, 1964); see 173 ATRR p. B-1.

trading area. We have followed up instances of suspected diversion with letters to the suppliers and institutions involved, explaining the requirements of the Robinson-Patman Act, and the suggestion that they have their legal counsel review their pricing practices to ensure compliance with the law. I might say here that we have had some encouraging results, which seem to speak well for the drug industry's desire to comply with the laws of the land.

Is unlawful drug diversion a problem in your trading area today? If not today, it may well be a formidable economic problem tomorrow . . . or next month . . . or next year. I like to think that important segments of the drug industry and the hospital service industry have already learned the important ground rules of pricing in this complex area of the law. But I also know that as I speak here today, community pharmacists in a great many different trading areas throughout the United States are suffering grave competitive injury arising from unlawful diversion practices in their own community.

NARD's vigorous campaign of education will continue. It is only reasonable to expect that there will be isolated cases where education will be ignored. Enforcement of the law against willful violators must complement a program of education in order to have an effective program of self-regulation in any industry. But the final responsibility remains on the shoulders of every single member of the drug industry --

pharmacist, wholesaler, manufacturer, hospital, clinic, nursing home, and physician -- to put his own house in legal order. Self-regulation and voluntary compliance with the law is the very cornerstone on which our free enterprise system will flourish. For the unfortunate alternative is more governmental regulation in the public interest to fill the need which any industry itself creates through disregard of the law. I am confident that the drug industry will meet this challenge.

To conclude these particular thoughts, perhaps it would be worth while to repeat the following statement attributed to Pastor Niemoeller, head of the German Protestant Church during Hitler's rise to power:

> "In Germany they first came for the Communists, and I didn't speak up because I wasn't a Communist. Then they came for the Jews, and I didn't speak up because I wasn't a Jew. Then they came for the trade unionists, and I didn't speak up because I wasn't a trade unionist. Then they came for the Catholics, and I didn't speak up because I was a Protestant. Then they came for me, and by that time no one was left to speak up."

III.

I should like to shift our attention now to another problem of recurring significance to pharmaceutical associations across the United States -- the problem of what state and local associations may and may not do under our federal antitrust laws to influence the play of market forces. The issue may arise in a number of ways. A druggist in a community may be selling products below cost in violation of valid state

sales below cost statutes, or disregarding manufacturer's enforced fair trade prices in a Fair Trade State, or granting preferred discounts to union groups, or engaging in "discount" prescription advertising where prohibited by state law, or engaging in false and misleading advertising, and so on. Not uncommonly, competing pharmacists may raise a cry of "foul" before state or local associations and urge direct remedial action without a full knowledge of the legal consequences. The association may have a grievance committee to which the matter is referred, or the pressure for action may otherwise be felt by association executives. Let us further assume that some of the practices are in violation of a state or federal law while others may not be in violation of the law, but are simply in the area of "hard competition."

Let me state some rules of thumb which should be religiously followed: no trade association should assume the role of an extra-judicial enforcer of the law by imposing group-boycott sanctions against the "offender." 5/ If a violation of the law is suspected, the trade association has completed its duty if the matter is referred to appropriate law enforcement authorities, federal or state, for appropriate action. If fair trade contracts are being disregarded, this is a matter of legitimate concern to the manufacturer alone. Any group action taken by a

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5/ Federal Trade Commission v. Fashion Originators' Guild Association, 312 U.S. 457 (1941).

trade association of community pharmacists to coerce enforcement of fair trade contracts, [6] to "blacklist" recalcitrant suppliers, [7] to refuse to deal with suppliers selling to the recalcitrant druggists, [8] are fraught with antitrust dangers. Group action by competitors to stabilize or fix prices raises comparable Sherman Act dangers as we are vividly reminded by the Utah and Northern California Pharmaceutical Association cases.

Education is an additional -- and powerful -- tool of a trade association. Trade association efforts to remedy unsavory conduct are profitably -- and legally -- channeled to vigorous action to promote stronger trade regulation laws in the state or federal legislature. [9]

While these may appear to be obvious ground rules, let me point out that I am aware of two antitrust proceedings during this last year which involved allegations of this type under discussion against two pharmaceutical associations.

6/ United States v. Frankfort Distilleries, Inc., 324 U. S. 293, 296-97 (1945).

7/ New York Pharmaceutical Conference, 11 F.T.C. 446, 450 (1928).

8/ Ibid; see Arkansas Wholesale Grocer's Ass'n, 10 F.T.C. 155, 162-63 (1926); Standard Oil of Calif. v. Moore, 251 F.2d 188, 211 (9th Cir. 1957).

9/ Eastern R. R. Presidents Conference v. Noerr Motor Freight, Inc., 365 U.S. 127 (1961); See annotation at 10 L. Ed. 2d 1386.

IV.

I should like to conclude with an observation which is based on my four years of antitrust counseling for NARD and many prior years of exposure to the drug industry. On balance, I firmly believe that the retail drug industry is enjoying a healthy vitality which we sometimes tend to forget. The advent of drug chains did not spell the demise of independent community pharmacy; nor did net pricing; neither did the emergence of mail order prescription groups; nor did the increasing role of food chains in selling health and beauty aids; nor did a host of other competitive factors which have emerged during this century. These problems and others have been and will continue to be met with all serious effort and ability that can be mustered. But the ultimate outcome is certain -- the independent community pharmacist has an assured role in the bright future of our national economy. NARD will toil long and hard to this end, for it is dedicated to the competitive and economic future of the independent community pharmacist.