Grant Thornton LLP

Cost of Dispensing Study
An independent comparative analysis of U.S. prescription dispensing costs

Executive Summary
January 2007

Commissioned by:

Coalition for Community Pharmacy Action
Executive Summary

A. Objective and Overview of the National Cost of Dispensing Study

Grant Thornton LLP was engaged by the Institute for the Advancement of Community Pharmacy (IACP), doing business as the Coalition for Community Pharmacy Action (CCPA) on behalf of the National Association of Chain Drug Stores (NACDS) and the National Community Pharmacists Association (NCPA), to perform an independent study to identify and quantify the costs incurred by pharmacies across the United States in dispensing prescriptions. The primary purpose of the study was to provide a comparative analysis of dispensing costs across all states and types of payers, including Medicaid. To perform this study, Grant Thornton partnered with The MPI Group.

Data were submitted for over 24,400 pharmacies, of which 23,152 provided complete and usable data and are included in the computations shown in this report. The survey requested data for the six months from March through August of 2006, a period selected to avoid any unusual, one-time expenses that some pharmacies may have incurred during the implementation of Medicare Part D. The 23,152 pharmacies reported filling more than 832 million prescriptions during this time, of which over 65 million – or 7.8% – were paid by Medicaid. National computations include data from all states.

The Cost of Dispensing Model uses five cost elements, which are explained in detail in the full report:

- Prescription department salaries and benefits
- Other prescription department costs
- Facilities costs
- Other store/location costs
- Allocated corporate overhead, where applicable

The overall cost of dispensing for all prescriptions reported by the pharmacies was computed first. The cost of dispensing specific to Medicaid prescriptions was then calculated by adjusting the overall COD to reflect differences in time required to fill Medicaid prescriptions, as reported by pharmacists, and the interest costs associated with carrying Medicaid receivables.

This report focuses on four views of the overall COD and the Medicaid COD:

- Cost of dispensing on a per-prescription basis.
- Cost of dispensing on a per-store basis (that is, every store is counted equally, regardless of its prescription volume).
- Cost of dispensing for prescriptions filled by stores in rural locations and in urban locations.
- Cost of dispensing on a per-prescription basis and a per-store basis by state.
The full report provides detailed information about development of the survey instrument, distribution and tabulation of surveys, review of the data, confidentiality considerations, and the computational model for determining the cost of dispensing.

Most charts in the report show cost of dispensing (COD) in two ways – per prescription and per pharmacy. One reason these numbers can vary significantly is that high-volume pharmacies typically have a lower COD than low-volume pharmacies. Therefore, the COD per prescription can be lower than the COD per pharmacy because lower-cost prescriptions make up a larger proportion of the population used to compute the COD. On the other hand, the COD per pharmacy treats every pharmacy equally, regardless of its prescription volume; a lower-volume, higher-cost pharmacy has the same impact on the COD per pharmacy as a higher-volume, lower-cost pharmacy. The COD per pharmacy provides the reader with information about the costs of the stores, regardless of how many prescriptions each one dispensed.

The overall COD was calculated for more than 832 million prescriptions dispensed by 23,152 pharmacies in all 50 states, the District of Columbia and Puerto Rico. The average (mean) overall COD per prescription was $10.50; the average overall COD per pharmacy was $12.10. This difference indicates there are substantial variations in the number of prescriptions filled per pharmacy and that pharmacies with the greatest volume of prescriptions have significantly lower dispensing costs compared with pharmacies with the lowest volumes. It is apparent that total prescription volume is a key variable related to a pharmacy’s cost of dispensing.

| COD per prescription ¹ | 832,377,163 | $10.50 | $9.86 | $8.48 | $11.70 |
| COD per pharmacy ² | 23,152 | $12.10 | $10.86 | $9.07 | $13.50 |

¹ Weighted data by volume of prescriptions; each prescription COD as one value (i.e., a pharmacy with 5,000 prescriptions has 5,000 values in the array of COD data).
² Unweighted data; each pharmacy's COD as one value, regardless of the pharmacy's prescription volume.
³ Mean is the average value
⁴ Median is the midpoint value of responses
⁵ Percentiles: The 25th percentile is the value below which 25% of responses fall. The 75th percentile is the value below which 75% of responses fall.

The Medicaid cost of dispensing was similarly computed for more than 65 million prescriptions filled by the 22,123 pharmacies that reported Medicaid prescriptions and for which a Medicaid COD could be computed. The national average COD was $10.51 per prescription and $12.81 per pharmacy. The average COD for Medicaid prescriptions does not differ significantly from the overall COD shown in the table above. However, the Medicaid COD per pharmacy is $0.71 higher.
than the overall COD per pharmacy, suggesting that lower-cost, higher-volume pharmacies fill a disproportionately greater percentage of Medicaid prescriptions. As noted below, this may also be affected by lower-cost rural pharmacies’ filling more Medicaid prescriptions than urban stores on a per-pharmacy basis.

| Medicaid COD per prescription 1 | 65,037,250 | $10.51 | $9.87 | $8.52 | $11.62 |
| Medicaid COD per pharmacy 2 | 22,123 | $12.81 | $11.22 | $9.36 | $14.06 |

1. Weighted data by volume of Medicaid prescriptions for which a Medicaid COD could be computed; each Medicaid prescription COD as one value.
2. Unweighted data; each pharmacy’s Medicaid COD as one value, regardless of its Medicaid prescription volume.
3. 1,029 pharmacies reported no Medicaid prescription volume and/or did not provide sufficient information to compute a Medicaid COD.

Of the 23,152 pharmacies in the database, 19,811 were classified as urban and 3,185 as rural by matching the stores’ zip codes with Metropolitan Statistical Areas (156 pharmacies could not be classified by MSA). Rural stores’ overall COD and Medicaid COD, per prescription, were approximately 8% below the COD’s of urban pharmacies, but the overall prescription volume, per store, was about the same for both the urban and rural pharmacies. On the other hand, rural pharmacies filled 55% more Medicaid prescriptions per store than urban pharmacies. The majority of the 8% difference in COD between urban and rural pharmacies with comparable prescription volumes appears to be caused by lower payroll costs in rural stores.

Survey respondents were asked to estimate the average work time for all activities required to dispense a prescription for each type of payer – Medicaid, Medicare Part D plans, other third-party plans, and customers with no third-party payer. Survey respondents for which a Medicaid COD could be computed reported that, on average, prescriptions paid by Medicare Part D are the most time-consuming (12.5 minutes), followed by Medicaid (11.7 minutes), other third-party payers (10.6 minutes) and prescriptions paid directly by customers (8.7 minutes).

Similarly, the survey asked respondents to report the average time to receive payment for Medicaid, other third-party (including Medicare Part D), and customer-paid prescriptions. The responses for Medicaid varied significantly from one state to another, but on average, the pharmacies reported receiving payment from Medicaid 19.9 days after billing, compared with 23.7 days for other third parties (including Medicare Part D). On a state-by-state basis, the survey shows that Medicaid programs’ days to pay range from a high of 50.6 days average (30 days median) in Illinois to a low of 9.9 days average (10 days median) in Texas. The COD model used in this study added approximately $.01 per day to the COD for each day payment was outstanding, based on the average prescription selling price and interest rates applicable during the study period.

The full report, for which this is the Executive Summary, presents more detailed data nationally and for most states. State-level information for Alaska, the District of Columbia, Hawaii, Maine, North Dakota, and Puerto Rico is omitted, either because the number of pharmacies for which complete data were submitted was very small or due to confidentiality concerns if the data were presented fully.
Grant Thornton LLP is the U.S. member firm of Grant Thornton International, one of six global accounting, tax and business advisory organizations. Grant Thornton is the leading accounting firm serving mid-cap, small-cap and privately held companies and other organizations, and is a preferred provider of specialist financial, tax and advisory services.

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The MPI Group, Inc. is a Cleveland, Ohio based research firm which is rapidly becoming one of the world’s fastest-growing, most respected management intelligence firms, completing surveys, studies and white papers for organizations around the globe. MPI is currently at work on projects in industries ranging from manufacturing to information technology to distribution to healthcare, on topics ranging from performance benchmarks to financial process metrics to customer value analysis and ROI.

The Coalition for Community Pharmacy Action (CCPA) is an alliance between the National Association of Chain Drug Stores (NACDS) and the National Community Pharmacists Association (NCPA), which together represent more than 55,000 community pharmacies. CCPA’s mission is to ensure that patients have continued access to affordable medicines and prescription care from their trusted and accessible health professional - the community pharmacist.

CCPA’s sponsorship of this project was made possible by a significant financial contribution from the Community Pharmacy Foundation. The Community Pharmacy Foundation’s primary purpose is to assist community pharmacy practitioners by providing resources for research and development to encourage new capabilities and continuous improvements in the delivery of patient care. CCPA acknowledges the generosity of the Foundation and its directors for this support.

The National Community Pharmacists Association (NCPA), founded in 1898, represents the nation’s community pharmacists, including owners of more than 24,000 pharmacies, more than 68,000 pharmacists and more than 280,000 full-time employees. The nation’s independent pharmacies, independent pharmacy franchises, and independent chains dispense nearly half of the nation’s retail prescription medicines.

The National Association of Chain Drug Stores (NACDS) represents the nation’s leading retail chain pharmacies and suppliers, helping them better meet the changing needs of their patients and customers. Chain pharmacies operate more than 37,000 pharmacies, employ 114,000 pharmacists, and fill more than 2.3 billion prescriptions yearly. Other members include more than 1,000 suppliers of products and services to the chain drug industry.
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