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UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
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COMMISSION AUTHORIZED

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June 29, 1990

The Honorable H. Craig Lewis
Senate of Pennsylvania
The Commonwealth of Pennsylvania
The State Capitol
Harrisburg, Pennsylvania 17120-0030

Dear Senator Lewis:

The staff of the Federal Trade Commission is pleased to present its views on Pennsylvania Senate Bill 675, entitled the "Pharmaceutical Services Freedom of Choice Act."[1] This bill, if enacted, would require any health insurance policy[2] or employee benefit plan that covers pharmaceutical services to offer those services through certain types of arrangements with pharmaceutical providers that are specified in the bill. Under the proposal, plans or policies that now offer, or wish to offer, pharmaceutical services through contractual arrangements with a limited number of pharmacies would be required to allow all other pharmacies to participate on the same terms, and to allow subscribers to obtain pharmaceutical services from any pharmacy willing to participate as a provider under the terms of the plan or policy. While S.B. 675 appears intended to guarantee consumers greater freedom to choose where they obtain covered pharmacy services, the proposed legislation appears likely to have the unintended effect of denying consumers the benefits of cost-reducing arrangements in the provision of pharmaceutical services.

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[1] These comments represent the views of the staff of the Cleveland Regional Office and the Bureau of Competition of the Federal Trade Commission, and do not necessarily represent the views of the Commission or any individual Commissioner.

[2] While the proposed provisions of S.B. 675 apply to both health insurance policies and employee benefit plans, we do not comment on the aspects which relate to health insurance policies.

I. INTEREST AND EXPERIENCE OF THE STAFF OF THE FEDERAL TRADE COMMISSION

The Federal Trade Commission is empowered under 15 U.S.C. § 41 *et seq.*, to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce. Pursuant to this statutory mandate, the Commission encourages competition in the licensed professions, including the health professions, to the maximum extent compatible with other state and federal goals. For more than a decade, the Commission and its staff have investigated the competitive effects of restrictions on the business arrangements of hospitals and state-licensed health professionals.

The Commission has observed that competition among health care benefit programs and health care providers can enhance consumer choice and the availability of services, and lower the overall cost of health care. In particular, the Commission has noted that the use by prepaid health care programs of limited panels of health care providers is an effective means of promoting competition among such providers.[3] The Commission has taken law enforcement action against anti-competitive efforts to prevent or eliminate health care programs, such as Health Maintenance Organizations (HMOs), which involve selective contracting with a limited panel of health care providers.[4] The staff of the Commission, on request, has submitted comments to federal and state government agencies explaining that various

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[3] Federal Trade Commission, Statement of Enforcement Policy With Respect to Physician Agreements to Control Medical Prepayment Plans, 46 Fed. Reg. 48982, 48984 (October 5, 1981); Statement of George W. Douglas, Commissioner, On Behalf of the Federal Trade Commission, Before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, United States House of Representatives, on H.R. 2956: The Preferred Provider Health Care Act of 1983 at 2-3 (October 24, 1983); Health Care Management Associates, 101 F.T.C. 1014, 1016 (1983) (advisory opinion). *See also* Bureau of Economics, Federal Trade Commission, Staff Report on the Health Maintenance Organization and Its Effects on Competition (1977).

[4] *See, e.g.*, American Medical Association, 94 F.T.C. 701 (1979), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided court*, 455 U.S. 676 (1982) [order modified 99 F.T.C. 440 (1982) and 100 F.T.C. 572 (1982)]; Medical Service Corp. of Spokane County, 88 F.T.C. 906 (1976) (consent order); Forbes Health System Medical Staff, 94 F.T.C. 1042 (1979) (consent order); Medical Staff of Doctors' Hospital of Prince George's County, No. C-3226 [FTC consent order issued Apr. 14, 1988, 53 Fed. Reg. 18,273 (May 23, 1988)]; Eugene M. Addison, M.D., No. C-3243 (FTC consent order issued Nov. 15, 1988).

regulatory schemes would interfere unnecessarily with the operation of such arrangements.[5]

II. HEALTH CARE FINANCING AND DELIVERY SYSTEMS THAT LIMIT PROVIDER PARTICIPATION AND SUBSCRIBERS' CHOICE OF PROVIDERS

During the last twenty years, in response to increasing demand from employers and consumers for alternatives that could moderate the increases in health care costs associated with traditional fee-for-service medicine, health care financing and delivery programs have proliferated that either directly provide, or arrange for the provision of, covered health care services through a limited "panel" of health care providers. Among these programs, which typically involve contractual agreements between the payor and "participating" health care providers, are health maintenance organizations and preferred provider organizations. Even commercial insurers, which do not generally contract with providers, and Blue Cross or Blue Shield plans, which, while generally contracting with providers, do not severely limit the number of providers who may participate in their programs, now frequently also offer programs

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[5] The Commission's staff submitted comments with respect to a state prohibition on exclusive provider contracts (a means of limiting a plan's provider panel) between HMOs and physicians, noting that such a prohibition could be expected to hamper pro-competitive and beneficial activities of HMOs, and deny consumers the improved services that such competition would stimulate. Letter from Jeffrey I. Zuckerman, Director, Bureau of Competition, Federal Trade Commission, to David A. Gates, Commissioner of Insurance, State of Nevada (November 5, 1986). Similarly, the staff submitted comments to the Department of Health and Human Services suggesting that, in view of the pro-competitive and cost-containment benefits of HMOs and PPOs, proposed Medicare and Medicaid anti-kickback regulations should not be written or interpreted so as to prohibit various common contractual relationships that HMOs and PPOs have with limited provider panels. Comments of the Federal Trade Commission's Bureaus of Competition, Consumer Protection, and Economics Concerning the Development of Regulations Pursuant to the Medicare and Medicaid Anti-Kickback Statute at 6-13 (December 18, 1987). The staff also submitted comments to the Massachusetts House of Representatives concerning legislation similar to S.B. 675, under which all pharmacies would have the right to contract on the same terms with a carrier, and noted that such a provision might reduce competition in both the pharmaceutical services and prepaid health care programs, raise costs to consumers, and restrict consumers' freedom to choose health benefit programs. Letter from Jeffrey I. Zuckerman, Director, Bureau of Competition, Federal Trade Commission, to Representative John C. Bartley (May 30, 1989, commenting on S. 526).

that do limit provider participation. By having a range of such programs available, payors are attempting to meet the needs and preferences of their customers. Consumers select different program options depending on their personal preferences and anticipated health needs.

The popular success of programs that limit provider participation is likely due to their perceived ability to help control the large and rapid increases in the costs of health care services, and to subscribers' desire for the broader coverage and lower out-of-pocket payments that these cost savings make possible. Competition among prepaid health care programs that limit provider participation, as well as programs that do not, should ensure that cost savings generated by these programs are passed on to consumers. This is true for all types of health care providers, including providers of pharmaceutical services.

Pharmacies that compete for the prescription business of patients, and subscribers of prepaid health care programs that cover prescription drugs represent an increasingly important source of business for pharmacies.[6] Pharmacies, pharmacy chains or groups of pharmacies, may acquire this segment of business by seeking access to subscribers in a payor's program. Pharmaceutical providers seek preferential, or even exclusive, access to a program's subscribers. Such arrangements may facilitate business planning by making the volume of sales more predictable and may reduce transaction costs by reducing the number of insurance providers with whom they are dealing or may reduce marketing costs otherwise necessary to generate the same business. Payors offer such preferential or exclusive arrangements to selected pharmacies, and include incentives in their subscriber contracts (*e.g.*, lower deductibles and co-payments) for subscribers to use the selected pharmacies or, in some cases (such as in many HMO contracts), pay for services only if they are obtained at a contracting pharmacy.

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[6] In 1987, payments by private insurance for "drugs and medical sundries" were $4.7 billion of the $34.0 billion total spent for those items that year. S. W. Letsch, *et al.*, *National Health Expenditures, 1987*, 10 HEALTH CARE FINANCING REVIEW 109, 115 (Winter 1988). Industry representatives estimated that about one-third of the $23.6 billion consumers were expected to spend on prescription drugs in 1989 would be paid for by third-party programs. Statement of Boake A. Sells, Chairman and Chief Executive Officer, Revco Drug Stores, Inc., quoted in 11 DRUG STORE NEWS 109 (May 1, 1989). Total expenditures for drugs and medical sundries are projected to increase to $42.1 billion by 1990. Division of National Cost Estimates, Office of the Actuary, Health Care Financing Administration, Department of Health and Human Services, *National Health Expenditures*, 1986-2000, 8 HEALTH CARE FINANCING REVIEW 1, 25 (Summer 1987).

Third-party payors find such arrangements attractive because, in order to win the contracts, pharmacies compete to offer lower prices and additional services which they can offer because of the advantages noted above. These benefits, in turn, help make the payor's programs more attractive in the prepaid health care market. In addition, administrative costs to the payor may be less in this type of arrangement than those in which the payor must deal with, and make payments to, all or most of the pharmacies doing business in a program's service area. Likewise, it may be easier for a payor to implement cost-control strategies, such as claims audits and utilization review, where it has a limited number of pharmacies whose records must be reviewed.

Subscribers may prefer to choose these limited-provider programs if the lower pharmaceutical costs offered by the contracting pharmacies are reflected in lower premium costs, lower deductibles or broader coverage. Subscribers who make such a choice presumably decide that these benefits outweigh whatever inconvenience they may encounter from having a more limited choice of pharmacies. Nor are subscribers likely to face inadequate access to providers, including pharmacies, despite a program's use of a limited provider panel. The same competitive forces that encourage pharmacies to make their best price and service offer to a payor, in order to gain access to subscribers to its programs, also induce payors to offer the level of pharmacy accessibility that subscribers want. Subscribers can change payors or programs if the service availability in a particular program is insufficient or inconvenient. Subscribers' ability to "vote with their feet" if they are dissatisfied provides an incentive for payors to assure that subscribers are satisfied with their access to covered health care services.

The Commonwealth of Pennsylvania has recognized the beneficial nature of prepaid health care programs that limit provider participation. For example, for more than a decade Pennsylvania has, by statute, authorized the formation and operation of HMOs, which provide services to subscribers through selected health care providers with whom the HMO generally has a contractual agreement.[7] Adoption of S.B. 675 would appear to be anomalous in light of these statutes, since it might prevent many such programs from operating, at least with regard to covered pharmacy services, in precisely the ways envisioned and authorized by the statutes.[8]

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[7] *See, e.g.*, the Health Maintenance Organization Act, 40 P.S. § 1551 *et seq.* (1989 Supp.); the Health Care Cost Containment Act, 35 P.S. § 4491 *et seq.* (1989 Supp.), *infra* note 10.

[8] *See* the Health Maintenance Organization Act at § 1554, authorizing the Secretary to require renegotiation of contracts by the HMO with providers whenever, *e.g.*, "he determines that they provide for excessive payments, or that they fail to

III. CONCLUSION

Senate Bill 675, if enacted, may reduce the choices available to consumers and raise their costs without providing any substantial public benefit. The bill may make it more difficult, or even impossible, for many third-party payors to offer, and consumers to select, programs including pharmaceutical coverage that have the cost savings and other advantages discussed above. The bill would require all employee benefit plans to open their programs to all pharmacists that wish to contract on the same terms. Correspondingly, subscribers could not be limited as to the participating pharmacies at which they could fill prescriptions or be charged a different co-payment fee, receive different coverage, or incur different conditions, depending on which providers they use. Opening the programs to all pharmacies wishing to participate on the same terms may affect both cost and coverage in prepaid health care plans. Without the expectation of obtaining a substantial portion of subscribers' business, contracting pharmacies may be unable to offer lower price terms or additional services to payors. Moreover, since any pharmacy would be entitled to contract with a payor on the same terms as other contracting pharmacies, there would be little incentive for pharmacies to compete in developing attractive or innovative proposals in the first place. Because all other pharmacies could "free ride" on the first pharmacy's proposal, innovative providers of pharmacy services may be unwilling to bear the costs of developing a proposal.

The higher prices that payors may have to reimburse pharmacies for their subscribers' covered pharmacy services, as well as the increased administrative costs associated with having to deal with many more pharmacies, in turn, may raise the prices that those payors must charge (*i.e.*, their premiums) for their prepaid health care programs that include pharmacy benefits, or may force them to reduce their benefits in order to avoid raising the premiums.[9] Given the choices that subscribers already have to select other types of prepayment programs, such as indemnity insurance, that do not limit the pharmacies from which they may obtain covered services, requiring open pharmacy participation may reduce the number and variety

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include reasonable incentives for cost control, or that they otherwise substantially and unreasonably contribute to the escalation of the costs of providing health care services to subscribers . . . ."

[9] The General Assembly has recognized that the continuing rise in the cost for health care services has produced a "major crisis" in the Commonwealth and has passed the Health Care Cost Containment Act, 35 P.S. § 449.1 *et seq.* (1989 Supp.), to address the causes of the escalation of health care costs. Insofar as the proposed legislation would raise costs to consumers, it would appear to be in conflict with a prior legislative finding and declaration.

of prepayment programs available to consumers without providing any additional consumer benefit.

In summary, we believe that S.B. 675 may raise prices to consumers and unnecessarily restrict consumer choice in prepaid health care programs. We hope these comments are of assistance.

Sincerely yours,

Mark D. Kindt
Regional Director
Cleveland Regional Office