UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION

COMMISSION AUTHORIZED

OFFICE OF
CONSUMER AND
COMPETITION ADVOCACY

June 26, 1992

The Honorable Patrick Johnston
California State Senate
State Capitol, Room 2068
Sacramento, California 95814

Dear Senator Johnston:

The staff of the Federal Trade Commission is pleased to respond to your request for views on the effects of Senate Bill 1986 ("S.B. 1986" or the "Bill"). This Bill would limit the ability of health insurance companies to arrange for pharmacy services through contracts with non-resident pharmacy firms, by prohibiting exclusive contracts with them and by requiring that resident firms be allowed to contract to provide services on the same terms as a non-resident firm. Although S.B. 1986 may be intended to assure consumers greater freedom to choose where they obtain covered pharmacy services, it appears likely to have the unintended effect of denying consumers the advantages of cost-reducing arrangements in the provision of pharmaceutical services.

I. Interest and experience of the staff of the Federal Trade Commission.

The Federal Trade Commission is empowered to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[2] Pursuant to this statutory mandate, the Commission encourages competition in the licensed professions, including the health care 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 care professionals.

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

[2] 15 U.S.C. §41 *et seq.*

The Commission has observed that competition among third party payors and health care providers can enhance consumer choice and service availability and can reduce health care costs. 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 suppress or eliminate health care programs, such as HMOs, that use selective contracting with a limited panel of health care providers.[4] The staff of the Commission has submitted, on request, comments to federal and state government bodies about the effects of various regulatory schemes on the competitive operation of such arrangements.[5]

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[3] [illegible] 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., Medical Service Corp. of Spokane County, 88 F.T.C. 906 (1976); 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); Forbes Health System Medical Staff, 94 F.T.C. 1042 (1979); Medical Staff of Doctors' Hospital of Prince George's County, 110 F.T.C. 476 (1988); Eugene M. Addison, M.D., 111 F.T.C. 339 (1988); Medical Staff of Holy Cross Hospital, No. C-3345 (consent order, Sept. 10, 1991); Medical Staff of Broward General Medical Center, No. C-3344 (consent order, Sept. 10, 1991); see also American Society of Anesthesiologists, 93 F.T.C. 101 (1979); Sherman A. Hope, M.D., 98 F.T.C. 58 (1981).

[5] The staff of the Commission has commented on a prohibition of exclusive provider contracts between HMOs and physicians, noting that the prohibition could be expected to hamper pro-competitive [illegible] services that such competition would stimulate. Letter from Jeffrey I. Zuckerman, Director, Bureau of Competition, to David A. Gates, Commissioner of Insurance, State of Nevada (November 5, 1986). Similarly, the staff suggested to the U. S. Department of Health and Human Services ("HHS") that, in view of the pro-competitive and cost-containment benefits of HMOs and PPOs,

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Some of these comments have addressed proposals similar to S.B. 1986.[6]

II. Description of Issues Raised by California Senate Bill 1986.

S.B. 1986 deals with pharmacy services provided to consumers through contracts between health insurance[7] companies and non-resident pharmacies which provide pharmacy services by mail [illegible] requiring that pharmacy services be obtained exclusively from a contracting nonresident pharmacy.[8] Nonresident contracting

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[5](...continued) proposed Medicare and Medicaid anti-kickback regulations should not prohibit various contractual relationships that HMOs and PPOs commonly have with limited provider panels. Comments of the Bureaus of Competition, Consumer Protection, and Economics [illegible] Medicare and Medicaid Anti-Kickback Statute at 6-13 (December 18, 1987). HHS has since adopted "safe-harbor" regulations that recognize some of these contractual arrangements as appropriate. 56 Fed. Reg. 35,952 (July 29, 1991).

[6] The staff submitted comments to the Massachusetts House of Representatives concerning legislation, similar to S.B. 1986, that would have required prepaid health care programs to contract with all pharmacy suppliers on the same terms (or offer subscribers the alternative of using any pharmacy they might choose), noting that the bill might reduce competition in both pharmaceutical services and prepaid health care programs, raise costs to consumers, and restrict consumers' freedom to choose health care programs. Letter from Jeffrey I. Zuckerman, Director, Bureau of Competition, to Representative John C. Bartley (May 30, 1989, commenting on S. 526). The staff submitted a similar comment on a similar bill in Pennsylvania. Letter from Mark Kindt, Director, Cleveland Regional Office, to Senator H. Craig Lewis (June 29, 1990, commenting on S. 675). And earlier this year, the staff commented on a New Hampshire bill that would apply similar restrictions to an HMO's contracts for pharmacy services. Letter from Michael Wise, Acting Director, Office of Consumer and Competition Advocacy, to Paul J. Alfano (March 17, 1992, commenting on H. B. 470).

[7] Termed "disability insurance" in California law.

[8] Proposed new §10123.20 of the Insurance Code. The Bill defines "nonresident pharmacy" implicitly as one that would have to be registered pursuant to existing California law regulating (continued...)

pharmacies would have to notify insureds that the contract is not exclusive and that services may be obtained from other pharmacies. In addition, insurers that contract for pharmacy services from nonresident pharmacies would have to provide to other potential suppliers (on written request) the terms and conditions under which those services are provided, and would be required to contract with any pharmacy "that agrees to meet the rate and payment terms applicable to the nonresident pharmacy under those terms and conditions which are fair and reasonable to both parties."[9] Limitations and conditions for receiving [illegible] deductible, copayment, or coverage) would have to be the same for using a nonresident pharmacy and for using a resident pharmacy that has entered a matching contract.[10]

By specifying that "rate and payment terms" must be matched, the Bill's language suggests that other terms, such as those setting out required levels or standards of service, need not be. Thus, a resident pharmacy might demand the same rate and payment terms, while providing a different level or type of service. The qualifying clause, requiring terms to be "fair and reasonable to both parties," introduces further uncertainty about the Bill's effect. It may be intended to give the insurer a legal ground for objecting to a demand for equal treatment on the grounds that certain terms would not be "fair and reasonable" in a contract [illegible] phrase might support a resident pharmacy's demand that terms in a

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[8](...continued) services by out-of-state pharmacies; <u>see</u> Business and Professions Code, §4050.1 <u>et seq.</u> The Bill only restricts arrangements for [illegible] contracts for service by mail order, with pharmacy providers that are residents would apparently be permitted without limitation.

Proposed new §10123.20. The matching requirement would apparently apply only if the health insurance company has actually entered a contract with a nonresident pharmacy provider. As with the proposed ban on contract exclusivity, residents and nonresidents might be treated differently. There is no parallel [illegible] matching a contract entered with a provider that is a resident.

[10] Proposed new §10123.19. It is not clear whether this language means that limitations and conditions must be the same for use of contract pharmacy services from a resident and from a nonresident pharmacy, or that limitations and conditions on services from resident pharmacies, whether or not under contract, must be the same as those for service from contracting, non-resident pharmacies.

contract with a nonresident be modified in the matching contract to be "fair and reasonable" for its particular situation.

This comment will focus on the "any willing provider" aspects of the Bill, that is, its limitations on exclusive contracting between providers and health insurance companies and its provisions to allow other providers to match a contract that has been entered. The Bill may also raise some issues, which this comment will not address directly, related to the general subject of the regulation of mail-order pharmacy service, as well as to differing treatment of resident and nonresident firms. Rivalry between mail order pharmacies and other providers, such as chain and independent pharmacies, has drawn considerable interest, but few systematic studies of differences in costs and services have appeared, and those that have been reported are difficult to interpret.[11] State laws that treat resident and non-resident firms differently may raise issues of constitutional law,[12] which this comment will not address, and competition issues about the effects of limiting the range of consumers' choices. These competition issues are similar to those raised by "any willing provider" requirements.

III. Competitive importance of programs using limited provider panels.

An exclusive service contract is an example of a health care delivery program that relies on a limited panel of providers. Over the last twenty years, financing and delivery programs that provide services through a limited panel of health care providers have proliferated, in response to increasing demand for ways to moderate the rising costs associated with traditional fee-for-service health care. These programs may provide services directly or arrange for others to provide them. The programs, which include HMOs and preferred provider organizations, typically involve contractual agreements between the payor and the participating health care providers. Many sources now offer limited-panel programs. Even commercial insurers, which in the

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[11] For example, one study sponsored by a third-party claims processor found that mail order service was associated with somewhat lower unit costs, but somewhat higher overall costs (to the employer sponsoring the repayment plan), suggesting that mail order arrangements might produce not only some efficiencies and [illegible] lower prices, but also some changes in [illegible]. See [illegible], Mail-order Pharmaceuticals, 44 Am. J. Hosp. Pharm. 1870, 1873 (1987).

[12] See Chemical Waste Management v. Hunt, __ U.S. __, 60 U.S.L.W. 4433 (No. 91-471, June 1, 1992).

past did not usually contract with providers, and Blue Cross or Blue Shield plans, which do not usually limit severely the number of providers who participate in their programs, now frequently also offer programs that do limit provider participation.

The popular success of programs that limit provider participation is probably due largely to their perceived ability to help control costs. Economic studies have confirmed that, under health care arrangements that permit selective contracting, competition helps to moderate cost increases.[13] In addition, subscribers may benefit from broader product coverage and lower out-of-pocket payments that these cost savings may make possible. Competition among different kinds of third party payor arrangements, including those that limit provider participation and those that do not, should ensure that cost savings are passed on to consumers. This principle would apply [illegible] health care payment programs and health care providers, including providers of pharmaceutical services.

Pharmacy providers compete for the prescription business of patients. An increasingly important source of that business is represented by subscribers to prepaid health care programs.[14]

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[13] Although no studies have been found of selective contracts for pharmacy services to health insurance policyholders, studies have examined the competitive effects of selective contracting in other health care settings, in particular California's experience with permitting hospitals to contract selectively. See, e.g., J. C. Robinson and C. S. Phibbs, An Evaluation of Medicaid Selective Contracting in California, 8 J. of Health Economics 437 (1989). This study found that shifting from cost-reimbursement to permitting selective contracting moderated increases in hospital costs, particularly in more competitive local markets. This study concentrated on Medicaid experience; however, further studies based on private health insurance experiences, including a forthcoming study by RAND and UCLA, confirm these findings.

[14] In 1989, an industry representative estimated that about one-third of consumers' expenditures on prescription drugs would be paid for by third-party programs. Statement of Boake A. Sells, Chairman and Chief Executive Officer, Revco Drug Stores, Inc., quoted in Drug Store News, May 1, 1989, p. 109. More recent trade press reports suggest that proportion may now be over 40 percent. See Drug Store News, Feb. 17, 1992, p. 17; May 6, 1991, p. 51. In 1990, payments by private insurance for "drugs and other medical non-durables" were $8.3 billion of the $54.6 billion total spent for those items that year. K. R. Levit, et al., National Health Expenditures, 1990, 13 Health Care Financing Review 29, 49 (Fall 1991). Total expenditures for drugs and other medical non-durables

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Pharmacies, pharmacy chains, or groups of pharmacies may pursue this business by seeking access to a program's subscribers on a preferential, or even an exclusive, basis. A pharmacy provider may perceive several advantages to such arrangements. A preferential or exclusive arrangement may assure the provider of sales volumes large enough to make possible savings from economies of scale; at a minimum, it could facilitate business planning by making sales volume more predictable. The arrangement may reduce [illegible] the number of third party payors with whom the provider deals, and may reduce marketing costs that would otherwise be incurred to generate the same business. To get access to the business and the advantages represented by these programs, pharmacies compete with each other, offering lower prices and additional services, to get the payors' contracts.

Third party payors find such arrangements attractive because [illegible] payor. Not only might the amounts paid out for services be lower, but in addition administrative costs might be lower for a limited-panel program than for one requiring the payor to deal with, and make payments to, all or most of the pharmacies doing business in a program's service area. A payor might find it easier to implement cost-control strategies, such as claims audits and utilization review, if the number of pharmacies whose records must be reviewed is limited. And lower prices and additional services would help make the payor's programs more attractive in the prepaid health care market.

Consumers too may prefer limited-provider programs if the competition among providers leads to lower premiums, lower deductibles, or other advantages. Consumer preference for limited-panel programs would presumably mean that, in the consumers' view, these advantages would outweigh the disadvantages of limiting the choice of pharmacies, such as reduced convenience or the occasional need to use a provider that is not part of the payor's contracted service. Limitations on pharmacy choice are unlikely to be so severe that consumers' access to pharmacy providers is inadequate. For just as competitive forces encourage pharmacies to offer their best price and service to a payor in order to gain access to its subscribers, competition would also encourage payors to establish service arrangements that offer the level of pharmacy

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[14] (...continued)
[illegible] to \$91.0 billion by the year 2000. S. T. Sonnenfeld, et al., Projections of National Health Expenditures through the Year 2000, 13 Health Care Financing Review 1, 25 (Fall 1991).

accessibility that subscribers want. Consumers' ability to change programs or payors if they are dissatisfied with service availability would give payors an incentive to assure that the arrangements they make for delivery of covered health care services are satisfactory.

IV. Effects of S. B. 1986.

S. B. 1986, if enacted, may limit firms' ability to reduce the cost of delivering health care without providing any substantial public benefit. The bill may make it more difficult for third-party payors to offer programs that include pharmaceutical services that have the cost savings and other advantages discussed above.

The Bill may tend to discourage contracts for pharmacy services with firms that may be competitively important, namely those that are nonresident. The Bill would [illegible] exclusive contract with a nonresident firm and offering incentives for consumers to use its services. Thus the Bill would deny two means of ensuring that a contracting pharmacy would obtain a substantial portion of subscribers' business. Without that volume, a would-be contracting provider may be unable to offer lower price terms or additional services. And by letting any other provider match the terms of a contract with a nonresident pharmacy, the Bill may further dampen the incentives for pharmacies to compete with each other. Because all other pharmacies could "free ride" on its contract, a nonresident provider may be unwilling to bear the costs of developing an innovative proposal.

This dampening of competition for pharmacy service contracts could cause third party payors to pay higher prices for pharmacy services and incur the higher administrative costs of dealing with a large number of providers. Facing these higher costs, third party payors may decide not to make these services available. Thus a result of the prohibitions of S.B. 1986 may be to limit consumers' ability to select among alternative delivery systems for pharmaceutical services.

IV. Conclusion.

In summary, we believe that Senate Bill 1986, if enacted, may discourage competition among pharmacies, in turn raising prices to consumers and unnecessarily restricting consumer choice in prepaid health care programs, without providing any substantial public benefit. We hope these comments are of assistance.

Sincerely yours,

Michael O. Wise
Acting Director