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UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

COMMISSION AUTHORIZED

BUREAU OF COMPETITION

May 30, 1989

The Honorable John C. Bartley
Massachusetts House of Representatives
State House
Boston, Massachusetts 02133

Dear Mr. Bartley:

The staff of the Bureau of Competition of the Federal Trade Commission is pleased to present its views on Massachusetts Senate Bill 526, entitled "An Act Providing For Accessibility To Pharmaceutical Services."[1] S. 526, if enacted, would require prepaid health benefits programs that include coverage of pharmaceutical services, and provide those services through contracts with pharmacies, either to allow all pharmacies to provide services to program subscribers on the same terms, or to offer subscribers the alternative of obtaining covered pharmaceutical services from any pharmacy they choose.

S. 526 appears intended to guarantee consumers greater freedom to choose where they will obtain covered pharmacy services. Thus, on quick inspection, it might be viewed as pro-consumer. However, we believe that S. 526 actually may reduce competition in the markets for both pharmaceutical services and prepaid health care programs, raise costs to consumers, and restrict consumers' freedom to choose health benefits programs that they believe best meet their needs. The bill also appears to conflict with previously enacted statutes in Massachusetts that authorize the formation and operation of prepaid health care programs whose efficient operation is predicated on limiting the number of health care providers -- including providers of pharmaceutical services -- that may participate in such programs.

We believe that competition in the market for prepaid health care programs assures that subscribers to such programs will have access to a sufficient number of providers of pharmacy services. However, even if the legislature concludes that such competition needs to be modified through regulation, there are means to achieve that aim that would be substantially less restrictive of competition and consumer choice than the provisions of S. 526. For these reasons, S. 526 appears likely to have as its primary effect the protection of some pharmacies from an aspect of marketplace competition, at the expense of consumers.

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

I. Interest and Experience of the Federal Trade Commission

§ 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 prepayment programs and among 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 containing costs. In addition to its law enforcement efforts to foster the development of procompetitive health care programs, such as HMOs, which involve selective contracting with a limited panel of health care providers, the Commission has brought several law enforcement actions against anticompetitive efforts to prevent or eliminate such programs.[3] The Commission also has supported federal "override" legislation that would have exempted PPOs from restrictive state laws and regulations that

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 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 Effect on Competition vi (1977).

[3] 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; Eugene M. Addison, M.D., No. C-3243 (FTC consent order issued Nov. 15, 1988).

restrict or prevent the development of PPO programs, such as "freedom of choice" or "any willing provider" provisions, which prevent PPOs from selectively contracting with a limited panel of providers.[4] The Commission's staff, on request, also has submitted comments to federal and state government agencies [illegible] unnecessarily with the operation of such procompetitive arrangements.[5]

II. The Proposed Legislation

S. 526 requires that "every carrier . . . providing or offering any group medical or other group health benefits contract or insurance which also provides or offers coverage for pharmaceutical services"[6] must provide those pharmaceutical

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[4] See Statement of George W. Douglas, supra note 2; Letter from James C. Miller III, Chairman, Federal Trade Commission to Representative Ron Wyden (July 29, 1983) (commenting on H.R. 2956).

[5] The Commission's staff has submitted comments with respect to a state prohibition of exclusive provider contracts between HMOs and physicians, noting that such a prohibition could be expected to hamper procompetitive 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 procompetitive 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).

[6] There is some question as to the applicability of S. 526 to different types of third-party payors of health care benefits. For example, it is not entirely clear whether S. 526 would apply to programs offered by commercial insurance companies. On the one hand, the bill does not specify insurance companies in its enumeration of the types of firms that are included within the meaning of "carrier." On the other hand, the bill amends chapter 175 of the Massachusetts General Laws, which deals with accident and health insurance, and refers to "any group . . . health benefits contract or insurance which also provides or offers

services through one or more of four types of arrangements specified in the bill: (1) direct provision of these services by in-house employees of the carrier; (2) contracts with groups of pharmacy services providers, with the proviso that "all eligible" providers be given an opportunity to participate on the same terms as contracting providers; (3) the requirement that the carrier also must offer subscribers an alternative whereby they may obtain pharmaceutical services from "participating provider organizations" which give all tangible pharmacy providers[7] an opportunity to participate"; and (4) use of an "affiliated non-profit clinic pharmacy."

Options (1) and (4) describe the ways that group or staff model HMOs -- which provide services to subscribers only at a few centralized locations -- typically operate. Thus, these types of HMOs, which are in number of plans and number of subscribers, probably would be largely unaffected by S. 526.[8] Most prepaid health care programs, however, do not provide covered services at only a few locations. Consequently, these programs would have to offer their covered pharmaceutical benefits through one of the other two options provided in S. 526. Because of this, S. 526, if enacted, may affect a large number of prepaid health care programs and their subscribers.

III. Analysis of S. 526

S. 526 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 of prepaid health care programs that limit the number of providers that may participate in the

coverage for pharmaceutical services." (emphasis added). Similarly, although the bill states that covered "carriers" include health maintenance organizations, medical service corporations, and nonprofit hospital service corporations, the statutes that authorize and regulate these entities indicate that they are considered to be insurance companies, which are governed by Chapter 175, which S. 526 amends, in a part. See Mass. Gen. Laws Ann. ch. 176G, § 2 (West 1987); ch. 176C, § 2 (West 1987); ch. 176A, § 1 (West 1987).

[7] The term "tangible pharmacy provider" is not defined in the bill.

[8] Some of these HMOs could be affected if, for example, they provide pharmaceutical coverage through an affiliated clinic pharmacy that is not non-profit.

programs. To understand why S. 526 could have such adverse effects requires some explanation of how competition operates in the markets for health care services and prepaid health care programs, and the interrelationship of these markets.[9]

A. The Market for Pharmaceutical Services and the Prepaid Health Care Market

Providers of pharmacy services compete for the business of patients who need to have their prescriptions filled. Subscribers of prepaid health care programs that provide coverage for prescription drugs represent an increasingly important source of business for pharmacies.[10] One way in which pharmacies compete for this segment of business is by seeking arrangements with payors that give them preferential, or even exclusive, access to a program's subscribers. Payors offer such preferential or exclusive arrangements to selected pharmacies (often pharmacy chains or networks of independent pharmacies) that offer the payor the lowest prices and best service. The payors include incentives in their subscriber contracts (e.g., lower deductibles and copayments) for subscribers to use the selected pharmacies or, in some cases, pay for services only if they are obtained at a contracting pharmacy. This assures the selected pharmacies of more business volume than if those subscribers spread their purchases among many providers.

This increased volume permits the pharmacies to take advantage of economies of scale, such as quantity discounts for large volume purchases, and to reduce their normal markup over cost for each prescription filled under the program. Third-party

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[9] Some payors may even cease offering coverage for prescription drugs at all, if the costs of complying with any of the options in S. 526 are too high for them to make such coverage available to subscribers at a competitive premium level.

[10] 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, 122 (Summer 1988). Almost one-half of the $34.0 billion expenditure for drugs and medical sundries was for prescription drugs. Over three-fourths of prescriptions are paid for by third-party programs. Statement of Roko A. Solis, Chairman and Chief Executive Officer, Super Rexall Drug Stores, Inc., on behalf of Drug Store Seminar, May 1, 1990. 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," 9 Health Care Financing Review 1, 25 (Summer 1987).

payors find such arrangements attractive because pharmacies compete to offer lower prices and additional services. These benefits, in turn, help make the payor's programs more competitive in the prepaid health care market.[11] In addition, administrative costs to the payor may be less in this type of arrangement than where the payor must deal with all or most of the pharmacies doing business in a program's service area. Similarly, it may be easier for a payor to implement cost-control programs, such as claims audits and utilization review, where it has a limited number of pharmacies whose records must be reviewed.

Subscribers who choose these programs benefit to the extent that the lower pharmaceutical costs offered by the contracting pharmacies are reflected in lower premium costs. Subscribers selecting such programs make a conscious choice that, for them, the benefits of lower premiums, lower deductibles and copayments, and perhaps broader coverage outweigh whatever minor 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. Subscribers can change payors or programs, and obtain their health care coverage from another source that offers a better alternative if the service availability in a particular program is insufficient or inconvenient. Subscribers' ability to "vote with their feet" if they are dissatisfied provides the necessary incentive for payors to assure that subscribers are satisfied with their access to covered health care services.

B. Effects of S. 526 on the Market for Pharmaceutical Services and on the Prepaid Health Care Market

S. 526, if enacted, may make it difficult or impossible for many payors to offer subscribers prepaid health care programs that have the cost and coverage advantages described above. As mentioned previously, the in-house and affiliated clinic pharmacy approaches are feasible only for a few types of programs. One of S. 526's remaining options is to open the program to all pharmacy firms or groups willing to contract on the same terms. Without the expectation of obtaining a substantial portion of subscribers' business, however, contracting pharmacies may be unable to achieve the scale economies that permit them to offer lower price terms or

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[11] In the event that competition among prepaid health care programs or among providers of pharmaceutical services is reduced, for example by regulatory constraints, the benefits associated with permitting prepaid health care programs to enter into arrangements with a limited number of health care providers may be diminished.

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. Since all other pharmacies could "free ride" on the first pharmacy's proposal, innovative providers of pharmacy services probably would be unwilling to bear the costs of developing a proposal. This provision of S. 526 therefore may substantially reduce competition among pharmacies for this segment of their business.

The higher prices that some programs would have to pay for pharmacy services, as well as the increased administrative costs would be expected to raise the premiums that those payors must charge for programs that include pharmacy benefits, or might force them to reduce their benefits in order to avoid raising premiums. Either of these effects could reduce some payors' ability to compete, since their programs would be less attractive than before relative to other programs whose operations, and costs, would remain unaffected by S. 526.

The disadvantages to subscribers of requiring payors to open their programs to all pharmacies may include higher premium costs or the loss of broader coverage provisions, including lower deductibles and copayments for pharmacy services, that programs otherwise could provide due to the cost savings obtained through limiting provider participation. Thus, requiring payors to allow all pharmacies to participate in their programs may either raise prices to consumers or eliminate the choice they otherwise would have to select a program that gives them certain coverage and payment benefits in exchange for agreeing to limit their choice of pharmacies. Subscribers already may select other types of prepayment programs, such as indemnity insurance, that do not limit the pharmacies from which they may obtain covered services. Thus, requiring open pharmacy participation may reduce the number and variety of prepayment programs available to consumers without providing any additional consumer benefit.

The final option for payors under S. 526 is to offer subscribers, in addition to any program that limits pharmacy participation, an alternative under which subscribers essentially would be entitled to use any pharmacy. This option also gives subscribers little additional choice since they already may choose a program that does not limit where they may obtain covered pharmaceutical (and other) services when they select a prepaid health care program. Moreover, complying with this

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12 Even if an employer pays the entire premium cost of its employees' coverage, higher premiums could represent a loss to consumers since those monies could be used to pay for additional

option of S. 526 may entail substantial administrative burdens and expenses for payors. As discussed previously, the pharmacy costs and administrative expenses of an "open-panel"[13] program are likely to be higher than those where the provider panel is limited. Consequently, either the premiums for the payor's open-panel alternative would need to be higher, or the benefits reduced. Since subscribers who enroll in prepaid health care programs that limit provider participation do so in order to obtain the cost and coverage advantages that such programs provide, it is questionable whether many of those subscribers would opt for an alternative that eliminated those advantages with regard to pharmacy benefits.

Massachusetts already has recognized the benefits of programs that limit participation by providers, including pharmacies, by enacting various statutes that authorize the formation and operation of such programs. Just last year, Massachusetts adopted legislation authorizing "preferred provider arrangements,"[14] which permits payors offering such programs to contract selectively with health care providers, including [illegible][15] those providers is based primarily on cost, availability and quality of covered services."[16] In addition, the legislature adopted statutory provisions authorizing nonprofit hospital corporations, medical service corporations, HMOs, and commercial insurance companies to "establish, maintain, operate, own, or offer" preferred provider arrangements approved by the Insurance Commissioner. Similarly, for more than a decade, Massachusetts 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. Adoption of S. 526 would appear to be anomalous in

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13 An "open-panel" program does not restrict the number of providers that may participate in it, although all participating providers must agree to the program's payment terms and other requirements of participation. Other programs, such as indemnity insurance, do not even have participation agreements with providers, so that subscribers may obtain covered services from essentially any licensed provider of those services.

14 Mass. Gen. Laws Ann. ch. 176I (West 1989 Supp.)

15 The statute defines "health care providers" as including, among others, registered pharmacists, persons licensed to engage in the sale, distribution, or delivery, at wholesale, of drugs or medicines, and stores registered and licensed for transacting retail drug business. Ch. 176I, § 1, referencing Mass. Gen Laws Ann. ch. 112 (West 1983 and 1989 Supp.).

16 Ch. 176I, § 4.

light of these statutes, since it might prevent many such programs from operating, at least with regard to covered pharmacy services, in the ways envisioned and authorized by existing statutes.

Finally, if the legislature concludes that subscribers who voluntarily select health care prepayment programs that limit their choice of pharmacies nevertheless require additional protection to assure that they have adequate sources for pharmacy services, alternatives exist that are less restrictive of competition and less harmful to consumers than S. 526's approach. For example, the state could require payors to demonstrate, as part of their current regulation under the insurance laws, that their programs provide adequate access to services for their subscribers, leaving the payors free to decide precisely how to meet the requirement. This approach would meet the concern that subscribers have adequate access to services, while leaving the payors free to compete for subscribers on the basis of how successfully they please subscribers in providing such access. In fact, this type of approach is similar to what Massachusetts appears to have adopted in authorizing the establishment and operation of preferred provider arrangements and HMOs.[17]

In summary, we believe that S. 526 may reduce competition in the markets for both prepaid health care programs and pharmaceutical services provided to such programs. As a consequence, it may raise prices to consumers and unnecessarily restrict their freedom to choose health benefits programs that they believe best meet their needs.

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[17] Mass. Gen. Laws Ann. ch. 176I, § 2(c) (West 1989 Supp.) provides that preferred provider arrangements must meet "standards [apparently to be promulgated by the Commissioner of Insurance] for assuring reasonable levels of access of [sic] health care services and geographical distribution of preferred providers to render those services." Massachusetts law requires HMOs to include in their subscriber contracts information on "the locations where, and the manner in which health services and any other benefits may be obtained." Mass. Gen. Laws Ann. ch. 176G, § 7(4) (West 1987). These HMO subscriber contracts are subject to disapproval by the Insurance Commissioner if "the benefits provided therein are unreasonable in relation to the rate charged." (Ch. 176G, § 16) and the Commissioner is authorized to promulgate rules and regulations as necessary to carry out the provisions of the act. (Ch. 176G, § 17).

We hope these comments are of assistance.

Sincerely yours,

Jeffrey I. Zuckerman
Director