Approved: February 9, 1993
Date

MINUTES OF THE HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson William Bryant at 3:30 p.m. on February 8, 1993 in Room 527-S of the Capitol.

All members were present except:

Committee staff present: William Wolff, Legislative Research Department
Bruce Kinzie, Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee:
Representative Tom Bruns
Bob Williams, Pharmacists Association
Peter Stern, Prescription Network of Kansas
Gary Coleman, Pharmacist
Charles R. Henderson, Consumer
Bill Sneed, HIAA
Dave Charay, Health Care Commission
Clifford Berman, Caremark Inc's Prescription Service Division
John Ensley, Medco Containment Services, Inc.
Debbie Origer, Kansas Managed Health Care
Harry Spring, Humana
Jim Schwartz, Ks Employers Coalition on Health

Hearing on HB 2117: Freedom of choice of pharmacy under health care insurance

Representative Tom Bruns stated in his testimony that the purpose of the proposed legislation which has already been passed in 20 states is to ensure the continuation of one of the most important aspects of medical care--the relationship between a pharmacist and the patients he fills prescriptions for. One of the key elements of pharmacy is counseling regarding side effects of the medication, explaining the doctor's orders, and advising the patient of possible reactions due to the interaction of other medications he is taking or dietary restrictions. Under mandated pharmacy coverage, only emergency medicine ma be obtained from a community pharmacy. Maintenance drugs would not appear in the records of the community pharmacy and many times the interaction of these with emergency drugs such as antibiotics can prove fatal. Open panels which means opening up contacts and not contracting exclusively with a finite group, allows an unrestrictive and competitive marketplace. Closed panels restrict competition and have a detrimental effect on rural communities and create monopolies (Attachment 1).

Bob Williams, Executive Director of the Kansas Pharmacists Association, described the bill as pro consumer and would prevent prescription plans from interfering with a beneficiary's selection of a pharmacy provider if that pharmacy elects to participate under the same terms and conditions of the policy or contractual arrangement. The bill would also prevent the plan from penalizing the consumer with a higher co-payment or deductible regardless of the provider selected by the beneficiary (Attachment 2).

Mr. Williams also presented two signed petitions supporting the "Freedom of Choice" statewide campaign which would allow the purchase of any prescribed medication at any pharmacy the customer chooses (Attachment 3).

Written testimony from Mike Pflughoeft, R.Ph., was received (Attachment 4).

Peter Stern, Executive Director of a prescription benefit management and administration company known as Prescription Network of Kansas (PNK), described an alternative view of pharmacy provider network arrangements and options that can maintain cost containment as an essential element of health plan design and can also maintain ample access for members of a health plan (Attachment 5)

Gary Coleman, practicing pharmacist in Topeka and Past President of the Kansas Pharmacy Service stated Corporation, stated that HB 2117 is critical to the continued and improved performance to provide proper

communication and medication counseling to patients and their families (Attachment 6). The establishment of the bill would empower the citizens of Kansas as beneficiaries to select the pharmacy of their choice provided that the pharmacy elects to participate as a provider under the same terms and conditions of the policy or contractual arrangement.

Charles R. Henderson, Lawrence, appeared as a consumer who has been informed by his health insurance plan that his pharmacy for more than 20 years has been denied entry into the new Retail Pharmacy Program adopted by his insurance company (Attachment 7).

Bill Sneed, representing Health Insurance Association of America, explained that the bill would require a new mandated service thus requiring a fiscal impact report according to current statute so that the Legislature may fully evaluate any social benefit versus social cost for such mandates (Attachment 8). The bill would only affect 50 to 60% of the programs found within the state. Inasmuch as Kansas cannot dictate terms to qualified plans exempted under federal law, this law will only affect those insurers doing business in the state and will not affect self-insuring programs. This would force those Kansas citizens utilizing an insured plan to pay higher pharmaceutical costs. The bill would have an adverse effect on costs and will disallow the current public benefit generated from existing cost-saving arrangements.

Dave Charay, Health Benefits Administrator of the Kansas State Employees Health Care Commission, stated that the bill would eliminate the option of pharmacy networks through which in-state as well as out-of-state insurers that contract with the agency could control the cost and quality of services provided to State of Kansas active and former employees (Attachment 9). The bill defeats the idea of managed care and the ability to negotiate future contracts containing attractive discounts would be severely compromised by its passage.

Clifford Berman, Director of Professional Services with Prescription Service Division of Caremark, Inc., explained their opposition to the bill: a) would encourage higher cost prescriptive care; b) actually denies consumers their freedom of choice (Attachment 10).

John Ensley appeared as a representative of Medco Containment Services, Inc., which is the nation's largest mail-service pharmacy. The bill would regulate competition in the health care marketplace. The bill would force prescription drug programs to allow any licensed pharmacy to participate in the program, notwithstanding that the pharmacy did not compete in the bidding process. If passed, the bill would reduce competition, raise health care costs and ultimately restrict consumer choice without any public benefit (Attachment 11).

Deborah Origer, Executive Director of Principal Health Care of Kansas City, appeared on behalf of the Governmental Affairs Committee of the Kansas Managed Care Association. The passage of the bill would hamper HMO operations and marketability. This type of mandate will result in a higher percentage of each health care dollar being spent on administrative costs, in that tracking claims and enforcement of plan protocols becomes more complicated with the addition of each additional provider. HMO's lose their bargaining power to negotiate the best possible discounts as they can no longer guarantee the same amount of business to each participating pharmacy (Attachment 12).

Harry Spring, Humana Prime Health, stated their company operates 10 wholly-owned pharmacies as a part of its network of services. He described their ability to control costs and quality by using this method. This legislation only addresses any insurance company's, or any employer group's (that purchase a drug benefit), ability to direct business in return for a lower cost from the provider. This legislation would take away Humana's ability to negotiate for business as well as increase the administrative costs in dealing with an increased number of pharmacies regarding customer service, and communicating policies and procedures regarding administering the drug benefit (Attachment 13).

Jim Schwartz, consulting director for the Kansas Employer Coalition on Health, defined managed competition as a well-managed network of providers who will compete for patronage on the basis of price and quality of services. Such competition relies on contracts between providers and clients, offering firm prices in return for some volume of business. This bill would damage this practice (Attachment 14).

Jim DeHoff, AFL-CIO, stated that the passage of this bill would result in an increase to consumers because the incentive for pharmacies to negotiate will be taken away (Attachment 15). Every pharmacy has a right to contract with the groups listed in HB 2117 and offer them the best deal they can, at the time the contracts come up for renewal.

The Committee requested acturarial information regarding costs of pharmaceutical services in states which have adopted the bill and those who use the plan used by Kansas at this time. It was noted that the large contracts used by the managed care organizations are sent out of state rather than using organizations within

the state being invited to bid.

Representative Helgerson moved that the minutes of February 2 and 3, 1993, be approved. Motion was seconded by Representative Cox. Motion carried.

The next meeting is scheduled for February 9, 1993.

GUEST LIST

COMMITTEE: T & V   DATE: 2-8-93

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATIO
John Hanna	134-N Statehouse	Associated Press.
Joseph Zelinski III	HHA Coventry Manor	Concerned Citizen
John M. Baughman	LAWRENCE KS 2432 Atchison Ave	Ks Pharmacists Assoc.
George Goebel	Topeka, Ks.	AARP-SLC-CCTF
Jim Schwartz	Topeka	KECH
Dave Charay	HBA ~~For~~	DA
JEFF SOVNICH	TOPEKA	KNLS
BILL SNEED	TOPEKA	HIAA
Bill, Jamee	Wichita	BOEING
John Ensley	Topeka	Medco
Cliff Berman	Lincolnshire, IL	Caremark Inc.
Barb Lapsley	1003 LSOB	Ks Com Fut HC Inc
Bill Roy	1083 LSOB	" " " " "
David Haverlick	Topeka	KDA
PETER STERN	TOPEKA	PRESC. NTWK, OF KS,
E. Eugene Stephens RPh	Topeka (DSOB)	SKS-DMS
Mr & Mrs Charles R. Henderson	Lawrence, Ks	Consumers.
Jean Taylor	Topeka	Wk. Advocacy Inter.
HARRY SPRONG	K.C., MO.	HUMANA
Debbie Origer	Kansas City,	Principal Health Care
Harry & Helen Wayne Mayhew	Wichita Topeka Lawrence	KCARE-CPO " " "
Jeri Lee Roth		
Rebecca Rice	Topeka	KPhA
Joe Furjanic	Topeka	KCA
GARY G. COLEMAN	Topeka	KPLA
Danielle Koe	Topeka	Delta Dental
LARRY MAGILL	"	P.I.A.K.

Name	Address	Organization
Tom S. Fellers	620 SE Madison	EBA

STATE OF KANSAS

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TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER: COMMERCIAL & FINANCIAL INSTITUTIONS
PUBLIC HEALTH & WELFARE

Committee on
Financial Institutions and Insurance
Rep. William M. Bryant, DVM Chairman

There is danger in medication cost-controls. Everyone is concerned about rising health care costs. It is a mistake to embrace proposals that focus solely on cutting cost without considering their potential effects on patient care.

Open panel contracts do not increase pharmacy costs. An actual cost study by the Wisconsin Pharmacist Ass. (Wisconsin has a "Pharmacy - Freedom of Choice"), showed that professional fees, whether open panel or closed panel are nearly the same:

Open panel - $2.97
Closed panel - $3.01

(Source: NARD Journal - 1990)

Of the 5 billion dollars spent on health care in this country, 40% is for Hospitals; 20% for Doctors; and 5% for pharmaceuticals. A pretty small piece of the pie, but very significant to the uninsured.

The Insurance Industry claims that an open panel eliminates competition--rather ironic coming from a business that is notoriously exempt from the rigors of the market place. Rather than eliminate competition, open panels foster competition, ie., with everyone open for business--is this not "Competition"? On the contrary--closed panels will eventually result in monopoly.

Increase Administration Costs? Another fallacy with electronic claim transmission, and the pharmacists paying 10 to 15 cents for each prescription processed.

Cost cutting? If the insurance companies were truly interested in costs, they should turn to the drug companies. Possibilities exist, such as:

1. Formulary-similar to what hospitals have used for years. Only the "brands" listed would be paid for.

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Attachment 1
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2. Generic Drugs--explaining when policies are sold that generics must be used, not ripping the pharmacies off later when they are not.

3. Medicaid style rebates from drug companies. When their products are dispensed to a medicaid patient - the state is reimbursed the difference between what the state paid out and the lowest price that drug company charges anyone else. Med-Cal (California Medicaid) expects to receive $103 million in drug rebates in fiscal year 1992-1993.

4. Eliminate discriminatory pricing given preferred competitors. (See Attachment I) No only would this create a level playing field--but it would help the "uninsured" immensely.

Attachment I

The NARD testimony noted that previous congressional efforts to gather information to assess the impact of the equal access law have been frustrated, but "now it will be available for the subcommittee and others. Thus, any allegations about pricing based on anecdotal information, half-truths, pseudo-facts, wishful thinking, or outright distortions by opponents of equal access to fair pricing should be readily disregarded."

NARD Details Scope of Discriminatory Pricing, Profiteering

As part of its extensive testimony before the House Energy and Commerce Subcommittee on Health and the Environment on the Medicaid equal access law, NARD shared startling data with lawmakers on the scope of discriminatory pricing enjoyed by preferred competitors in the prescription drug marketplace, as well as some of the markups on these products. July 1992 invoices obtained by NARD for identical products sold at the same volume on the same day to a retail pharmacy and to a mail order pharmacy revealed, in one case, a product that carries an AWP of $309.59, but the mail order pharmacy paid only $18.59. On average, the mail order pharmacy prices were nearly 48 percent off AWP.

Hospitals enjoy even larger price breaks, NARD testified, and mark up the drugs far in excess of retail prices. NARD's testimony noted that during one study, "it was determined that hospitals were actually billing private citizens and third-party payers, including Medicare and Medicaid, three to five times the retail charge for prescription drugs to the general public."

A 1991 invoice from a Michigan hospital obtained by NARD and provided as evidence to the subcommittee showed an extreme price differential of $42.12 for the cost of the drug to a retail pharmacy, while the hospital paid only 36 cents. "With such incredibly low acquisition costs, preferred purchasers such as hospitals could absorb cost increases well in excess of 100 or 200 percent and their pharmacies would still retain their well-earned reputations as hospital profit centers," said NARD. "Interestingly, those who object to the fundamental fair-

Mail Order Discriminatory Pricing

Product	AWP	Mail Order Price	Discount off AWP
Aerobid Inhaler System	$40.79	$2.58	93.67%
Albuterol Sol., 3ml	$31.19	$12.81	58.93%
Alupent Sol., 2.5ml	$37.43	$32.17	14.05%
Atrovent MDI Inhaler	$24.89	$21.39	14.06%
Azmacort Inhaler	$34.95	$28.84	17.48%
Kaon Cl-10 Tab., 750mg	$22.31	$18.41	17.48%
M.T.E.-5 Conc.	$34.00	$9.79	71.21%
Levothroid Tab., 300mcg	$227.45	$21.63	90.49%
Nitrol Oint., 2%	$9.03	$7.45	17.50%
Proventil Inhaler	$20.35	$12.54	38.38%
Proventil Inhaler Ref.	$18.76	$11.56	38.38%
Theo-Dur SA Tab., 300mg	$124.14	$58.28	53.05%
Theo-Dur Sprink. Cap. 200mg	$20.87	$9.80	53.04%
Thyroid Tab., 3gr	$243.24	$20.09	91.74%
Thornalate+Nebulizer	$27.74	$2.63	90.52%
Valcenase A/Q Nasal Spr.	$28.62	$17.62	38.43%
Vanceril Inhaler	$26.51	$16.32	38.44%
Ventolin Inhaler	$20.35	$17.49	14.05%
Intal Nebulizer Amp.	$79.84	$68.63	14.04%
Bancap HC Cap	$309.59	$18.59	94.00%
Source: McKesson invoices		Average	47.95%

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HOUSE COMMITTEE ON
FINANCIAL INSTITUTIONS AND INSURANCE
REP. WILLIAM BRYANT, CHAIRMAN
HOUSE BILL 2117

This is not a unique bill. It has already been passed into law in ~~five~~ 20 states. The purpose of this Bill is to ensure the continuation of one of the most important aspects of medical care - the relationship between a Pharmacist and the patients he fills prescriptions for. Each patient is an individual with an individual problem. Each patient is unique and the illness each patient has, and the medication the doctor has prescribed, are the most important things on the patient's mind. That patient has a right to know about the medications. Not only the first time they are prescribed, but any subsequent time there are questions:

1. Over the counter medications.
2. Drug interactions.
3. Drug reactions they have.
4. Drug reactions they read about.
5. Drug reactions they heard about, and
   of course the always asked after a few days, "could this new medicine have caused me to gain weight?"

The key element in Pharmacy care; counseling with the patient. Community pharmacists provide a crucial service for Kansans, especially in rural communities. Community pharmacists can counsel patients as to:

*side effects of the medications,
*explain the doctor's orders,
*keep a profile of other medications the patient is taking and dietary restrictions that can cause adverse reactions.

The recent episode of the reactions of Seldane with an antibiotic and an antifungal is a case in point. The community pharmacist would be better able to interrupt and/or stop such a dosage regimen. According to studies, 125,000 people die each year because the patients do not take, or improperly take, prescribed medications. In addition, community pharmacists can save money in direct medical costs for each prescription dispensed.

When a patient has mandated pharmacy coverage, only emergency medicine may be obtained from a community pharmacist. Seldane, is often prescribed on a long term basis, therefore a "maintenance drug". Should this patient, with no record of Seldane usage on record with her community pharmacy, the prescribing and therefore "emergency coverage" of Erythromycin or an Antifungal drug, would not appear on the interaction screen. The results are definite and several deaths have occurred because of this very drug interaction.

Open panels, that is opening up contracts and not contracting exclusively with a finite group, allows an unrestrictive and competitive marketplace. Closed panels restrict competition and have a detrimental effect on rural communities and create monopolies.

House Bill #2117 ensures freedom of choice for Kansans in selecting pharmacies in their communities and promotes quality pharmacy care with a personal touch.

TESTIMONY

HB-2117

HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE

February 8, 1993

Thank you Chairman Bryant for this opportunity to address the committee. My name is Bob Williams, I am the Executive Director of the Kansas Pharmacists Association. I am appearing before the Committee this afternoon in support of HB-2117.

HB 2117 is a pro consumer bill that would prevent prescription plans from interfering with a beneficiary's selection of a pharmacy provider, if that pharmacy elects to participate as a provider under the same terms and conditions of the policy or contractual arrangement.

The bill would also prevent the plan from penalizing the consumer with a higher co-payment or deductible regardless of the provider selected by the beneficiary.

The pharmacy community is dedicated to cost savings and competition. One only has to look at the advertising section of a newspaper on any given day to see the competitive nature of the pharmacy profession. Pharmacists have also been procompetitive by forming volume purchasing groups and have taken a leadership role in the formation of drug utilization review programs which have the potential to save millions of dollars.

Financial Institutions
& Insurance
February 8, 1993
Attachment 2

According to an article which appeared in the September 16, 1992 issue of the *New York Times Health*, each year studies indicate that 125,000 people with treatable ailments die simply because they did not take prescribed medications properly. The article further indicates that noncompliance is costing this country $15 billion a year in direct medical costs, lost wages and productivity. Much of the noncompliance problem could be avoided by the utilization of community pharmacies.

Pharmacists provide essential health care services to their patients by reviewing prescriptions prior to dispensing, maintaining patient profiles, advising patients on proper drug utilization, and counseling patients in the interaction between a prescribed drug and nonprescription medication. Exclusive contracts, based on excessive volume created only by economic pressures and limited access to pharmacy services, reduces the opportunity for meaningful face-to-face interaction in pharmacist-patient relationships.

Opponents to HB 2117 would have you believe that they need to enter into these exclusive provider contracts in order to control health care costs. Furthermore they would have you believe that this form of "managed competition" is THE answer to controlling health care costs. According to the January 1986, Vol. 39, issue of the *Vanderbilt Law*,

> "The ability of third party payors to impose uneconomical terms on . . . pharmacies results from two factors: first, the economic power of the group purchasers (usually large insurance carriers), combined with their natural desire to reduce costs; and second, the weak bargaining power of . . . pharmacists, who are precluded by the antitrust laws from joining together to

bargain collectively. As a result the . . . pharmacist confronts the business dilemma of either acceding to an unprofitable third party agreement or losing a significant amount of new and existing patronage.

". . . pharmacists who enter third party payor agreements often attempt to negate the resulting economic loss by charging higher prices to uninsured patient-purchasers. The burden falls heavily upon uninsured patient-purchasers who do not have insurance coverage, including the non-Medicaid poor. Rather than reduce consumer drug prices generally, third party programs shift cost to the uninsured public. To the extent these programs are uneconomical to . . . pharmacists, they have contributed to a reduction in the number of . . . pharmacies. Because pharmacies, particularly in rural or lower income areas, often provide the only readily accessible source of health care counseling, this result has substantial adverse societal impacts."

With third party prescriptions representing only 35.6% of total prescription sales in the west north central states*, that means the remaining 64.4% of us without third party coverage for prescription drugs are footing the bill. Certainly these "managed monopolies" are not the answer and threaten pharmacies cost savings ability. Both the Kansas Commission on the Future of Health Care and the Joint Legislative Committee on Health Care Decisions for the 90's have been conducting hearings regarding the lack of health care services in rural Kansas communities. Rural hospitals are closing, physicians are not locating in rural communities and now

these "managed monopolies" are threatening the existence of rural community pharmacies.

The opponents to HB-2117 would also have you believe that HB-2117 would be preempted by the ERISA Act (Employee Retirement Income Security Act). The ERISA Act was intended as either a tax or employee protection measure. ERISA was not passed for the purpose of allowing insurance companies and employers to "blackball" certain pharmacists. The Act was never intended to promote anti-competitive programs, nor was it created to allow insurance companies to create monopolies. On the contrary, it was passed to help protect employees. HB-2117 in no way interferes or conflicts with federal statutes and, in fact, supports and encourages the spirit of ERISA, that being to protect workers from being denied access to medical and/or pharmaceutical services, as well as to assure those individuals the opportunity to select pharmaceutical providers of their choice. In those states where similar legislation has been adopted, we are unaware of any lawsuit directly related to violations of the ERISA Act.

Additionally, we are aware that the Health Insurance Association of America (HIAA) commissioned the Wyatt Company to conduct a study entitled "Cost Analysis of Three State Mandates to Regulate the Provision of Prescription Drug Benefits" where the Wyatt Company's goal was to illustrate the detrimental effects of legislation such as HB-2117. I have attached to my testimony an article published by the National Association of Retail Druggists which points out a number of flaws in the Wyatt study. We also find it curious that the insurance industry points its finger at pharmacy for increasing prescription drug costs when, in fact, a study by the

National Association of Chain Drug Stores showed that, on the average, it costs $1.25 more to dispense a third party prescription than a private pay prescription.

In conclusion I would like to say that 20 plus states have passed similar procompetitive legislation. The experimentation in the last decade with restricted networks, exclusive networks, discriminatory or mandatory mail order drug programs--all sacrifice consumer access, the cornerstone of competition, in an illusory pursuit of cost savings. Patients have become so complacent about taking their medication that it is costing this country $15 billion annually and pharmacists are forced to raise prices to private pay patients because they are not allowed to participate in monopolistic insurance programs. As we rapidly move towards health care and insurance reform we must begin to put people back into the equation and begin to think about what we are doing to them.

Thank you.

*Lilly Digest 1992 a summary of the 1991 operations of 1,294 independent community pharmacies. Eli Lilly & Company, Lilly Corporate Center, Indianapolis, IN 46285.

The following states have passed health care provider consumer access laws:

Arkansas	New Hampshire
Connecticut	New Jersey
Florida	North Dakota
Georgia	Oklahoma
Louisiana	Rhode Island
Maine	South Dakota
Maryland	Tennessee
Montana	Texas

Columbia Drug

R. E. LAYTON, JR. OWNER

(316) 251-1150 / 131 West 8th / COFFEYVILLE, KANSAS 67337

Jan. 30, 1993

Kansas Pharmacists Assn.
1308 W 10th
Topeka, Ks. 66604

Dear Mr. Williams:

I want to express my disappointment upon seeing people¶ of our city lose their freedom of choice.

This I thought was the cornerstone of Pharmacy that our patients whould always have the right to have prescriptions filled whereever they choose.

We have one industry and the federal employeees that now must go to the national name chains for service. I lost a post office employee that had been our customer for ten years.

It seem this a basic right that people should not lose.

Sincerely,

R.E. Layton

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Cost Savings

Switching drugs to over-the-counter status saves healthcare dollars

Modifications in the Food and Drug Administration's (FDA) regulatory system could expedite the switching of prescription drugs to over-the-counter (OTC) status, saving money and enhancing the self-medication movement.

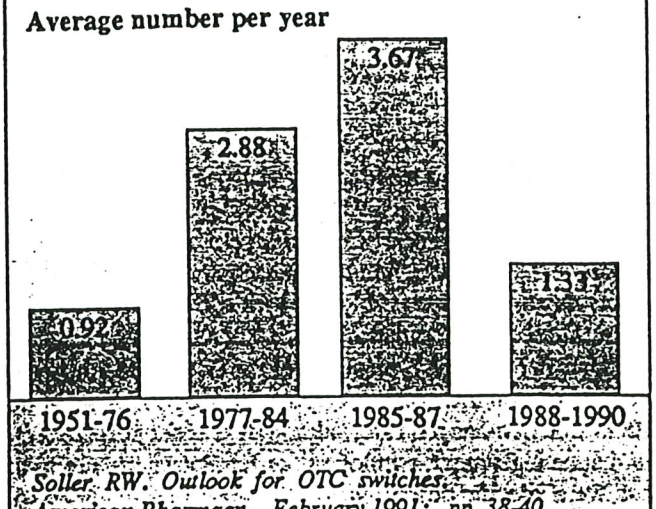
The "Rx-to-OTC switch" started long before the FDA began its OTC Drug Review Program in 1972, which was anticipated to increase the number of medications available without a prescription. Although the switching of prescription drugs to OTC status continues abroad, the trend has slowed recently in the United States (see Table).

Self medication is one of the most common and least costly components of the health care system. In 60% of the cases, Americans treat their ailments without professional help and often with OTC products, which represent less than two cents of the health care dollar.

According to one study, if consumers saw a physician rather than using an OTC product just 2% of the time, it would result in 300 million additional office visits each year — more than a 60% increase.

Moving from prescription to nonprescription status can result in substantial cost savings; in the first two years after hydrocortisone 0.5% was available without a prescription, American consumers saved $600 million. Twelve switches of cough/cold medications to OTC status saves the healthcare system $750 million each year, according to Professor Peter Temin of the Massachusetts Institute of Technology.

Number of drugs moving from prescription to over-the-counter status per year — selected eras 1951-1990.



Soller RW. Outlook for OTC switches. American Pharmacy. February 1991: pp. 38-40.

Pharmacist screening for prescription problems saves $2.32 per prescription

Community pharmacists who screened for and corrected prescription problems saved an average of $2.32 in direct medical care costs for each prescription dispensed and $123 each time the pharmacist corrected a problem, according to a Purdue University study.

Catching prescriber errors, pointing out drug interactions, and answering patients' questions are examples of interventions performed.

Omission errors — such as inadequate specification of dosage form or strength, or ordering dosage forms or strengths not available — accounted for 45.6% of the problems identified. Wrong doses or dosage regimens, and other errors of commission accounted for 36.4% of the problems. The third largest category of problems identified by pharmacists was drug interactions (7.6%). Addressing patients' concerns about therapy represented the largest single category in the remaining 10.2% of the problems.

The study concluded that "extra-distributive, cognitive activities" performed by community pharmacists have substantial economic value, and incentives should be created "to encourage and reward pharmacists who consistently perform such services."

Anon. Study finds pharmacists lower total health costs. American Druggist. April 1991: p. 14.

Compiled by National Pharmaceutical Council Fall 1991

In Brief...

Where Little TPAs Come From

Ever wonder just who third-party health administrators are, where they come from, and how they've gotten to be experts on such things as pharmacy reimbursement? According to Fred Hunt, president of the Society of Professional Benefits Managers, very few people wake up one morning and decide to become TPAs. "Rather," he says, "it's a business you tend to grow into. Most new TPAs were old insurance agents, brokers, or members of the group department of an insurance company. They become TPAs on the day when they approach a big client with a 50 percent premium increase and the client says, 'No way! Either get me a better deal or I'm getting a new agent!' As he's recovering from the shock, the agent starts thinking about all this self-funding stuff. So he hangs out a TPA shingle, takes on claims processing, organizes provider networks (like pharmacists), negotiates rates, and then comes back to his client with a better deal."

Most surprisingly, the TPA business has never been better. "Our members say they are incredibly busy," says Hunt, "with old business and especially with new business. In the nine years I've been with the society, we've grown 900 percent—and those are new TPAs bringing in new business."

Continued on page 3

Open Panel Contracts Do *Not* Increase Pharmacy Costs

A popular truism among insurers, HMOs, and other third-party payors is that closed-panel provider contracts save money. Low unit reimbursements can be negotiated if volume can be guaranteed. By contracting exclusively with a finite group, volume can be guaranteed. But, say insurers, if contracts can be opened up, the volume lever goes away and unit reimbursement goes back up.

Sounds logical, but is it true? The Wisconsin Pharmacists Association decided to test the alleged truism empirically; it's ideally situated to do so since Wisconsin has had an open panel law for several years. The study measured pharmacy costs in a six-state area, using Wisconsin as the control state.

The study's major finding stands the truism on its head. In terms of professional fees, the average for all plans, whether open or closed, is virtually identical. In fact, it's slightly lower for open panel plans, at $2.97; closed panels average a fee of $3.01. Significantly, the open panel fees start out quite a bit higher than the closed panel fees, $3.19 for open vs. $2.71 for closed. This finding supports pharmacy's long-held position that the best mechanism for controlling costs is an unrestricted, highly competitive marketplace. Where the market is allowed to operate, costs come down. Where competition is eliminated—that is, in closed panel plans—costs creep upward.

Consumer Resistance to Managed Care

A poll of leading health care journalists conducted by Scott-Levin Associates of Newtown, Pennsylvania suggests growing consumer disaffection against access constraints and managed care cost-cutting approaches. The poll quotes Glenn Ruffenbach of *The Wall Street Journal* as saying, "As third-party mediation of doctor-patient relationships becomes more common, people are going to realize how much of a Big Brother is in there, and they are not going to be happy about it."

William Boyles, editor of *Health Market Survey*, says the term "managed care" has taken on a negative connotation, while Russell Jackson, editor of *Managed Care Outlook*, predicts a "coming outcry from public dissatisfaction with the constraints of managed care." Both journalists, however, believe that managed care is inevitable.

Perhaps the most negative view of public perception was voiced by *Newsweek* columnist Jane Bryant Quinn, who says consumer resistance is growing to the cost-cutting approaches favored by HMOs and PPOs. In addition, Quinn detects a growing fear among enrollees that "the plans want them only when they are well, but that the plans may fail to provide sufficient health care just when it's needed."

Third-Party Rx ™ is published monthly by NARD, 205 Daingerfield Road, Alexandria, VA 22314. 703-683-8200. Editorial offices: 22 49th St., Weehawken, NJ 07087. Editor: Robert McCarthy. Second class postage pending at Alexandria, VA and additional mailing offices. Subscription rates: NARD members, $25 per year; nonmembers, $50 per year; foreign, $70 per year. Contributions and gifts to NARD are not deductible as charitable contributions for federal tax purposes. Postmaster: Send address changes to Third-Party Rx, 205 Daingerfield Road, Alexandria, VA 22314.

8 of 2

The card that failed by doubling Rx use

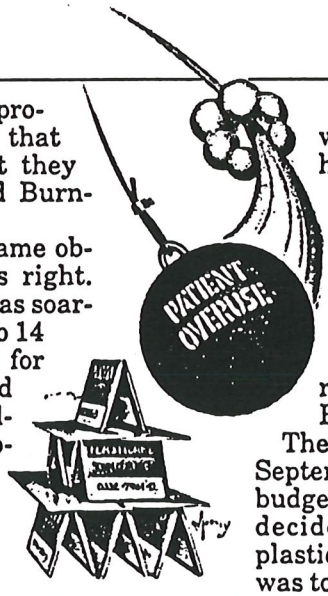
A South Carolina Rx program for state employees and retirees has highlighted what could happen with plastic card programs. When compared with indemnity coverage for drugs, plastic cards tend to increase patients' use of pharmaceuticals.

Under the old indemnity system, state employees and retirees paid up front for their drugs and filed claims with Blue Cross and Blue Shield. The covered beneficiaries averaged six prescriptions yearly, said Robert Burnside Jr., executive director of the South Carolina Pharmaceutical Association.

Enter card plan: In January 1989, however, the state instituted a plastic card program with a co-pay of $4 for generic drugs and $7 for brand-name medications. There was no drug formulary or drug utilization review.

SCPhA warned that the card plan would increase Rx use, but the state chose to brush aside the caution, hoping the plan would be "revenue neutral"—that is, cost no more than the old program. "We told them that was pie-in-the-sky, but they didn't believe us," said Burnside.

By September, it became obvious that SCPhA was right. Prescription drug use was soaring to an estimated 12 to 14 Rxs per covered person for the year. This resulted in a projected $10 million shortfall in the program, to rise to $15 million in 1990.



"Beneficiaries felt that the plastic card was like a credit card—that for $7 they could get anything they wanted," said Burnside. Also, the state had cut back on other health-care benefits for the employees, increased deductibles, and granted only minimal salary raises. "So I think that in the back of a lot of employees' minds was the idea, 'This is the way I'm going to get some of my money back.' "

So, beneficiaries, who in the past might have bought an over-the-counter medication for such ailments as a cough, decided that "for $4 [co-pay] let me get the real stuff, and for $7 give me the real, real stuff," Burnside explained.

The upshot was that by September 1989 the state budget and control board decided to jettison the plastic card program; it was to revert to an indemnity plan on Jan. 1 of this year.

Burnside pointed out that the indemnity system benefits pharmacists, who are reimbursed on the basis of usual-and-customary charges. The plastic card program paid average wholesale price less 9.5% plus a $4 dispensing fee. This is lower than the state's $4.05 Medicaid fee.

Martha Glaser

Third party costs more than cash and carry, chains show

Now a formal study proves what pharmacists have known all along—it costs more to dispense a third-party prescription than a privately paid one. In fact, it's $1.25 more, according to a survey commissioned by the National Association of Chain Drug Stores.

The study, conducted by the Purdue University School of Pharmacy in Indiana, will be used by NACDS to lobby Congress for changes in third-party reimbursement schedules, according to Ronald Ziegler, president of NACDS.

Drugstore chains operating at peak efficiency, said Ziegler, can no longer make allowance for the difference in prescription repayments. "There have been great accomplishments in increasing efficiency in the chain drug industry," he noted. "But the amount of efficiency that can be wrung out is quickly nearing its limit."

At a New York press conference reporting the study findings, Ziegler said reimbursement losses mainly hurt smaller chain drugstores. "Many small independent drugstores, in fact, are going out of business; they just can't operate," he told reporters. "[They're] getting very close to the point ... where [they] can no longer be viable."

Ziegler also criticized pharmaceutical manufacturers, blaming them for higher drug prices. Legislators and third parties are unfairly singling out the retail pharmacist in cost-containment moves, harming business in the process, he said. "There is a phenomenal amount of money tied up for a long time in third-party receivables."

The study polled 695 chain drugstores nationwide. The debate over the catastrophic health-care legislation, now largely repealed, had pushed the association into underwriting the study, said NACDS board chairman Gerald Heller.

Daniel M. Bergin

9 of 2

Press Clipping Division
Kansas Press Service, Inc.
Affiliate of Kansas Press Association
Box 1773, Topeka, Kansas 66601

KANSAS
Kingman Journal

APR - 3 1990

Holder Pharmacy to close April 20

In a surprise move, Mitch Holder announced Saturday that after 12 years in business in Kingman, he is closing his pharmacy as of April 20.

Holder said that the increase in the number of patients using insurance cards which cover prescriptions and allow the insurance companies to dictate that pharmacies accept fees which are extremely low, and the rapid increase in drug costs that have made it difficult for patients to afford medications, led him to his decision to close his business.

For the past two years Holder's has operated his pharmacy out of ALCO Discount Store. Prior to that he was located on Main Street in Kingman.

Ron Forrester, ALCO manager, stated that no plans could be announced at this time concerning the pharmacy being re-opened after Holder closes April 20. Forrester emphasized that the closing of Holder's affected prescription drugs only, and most over-the-counter medications will remain on sale at ALCO.

In an advertisement taken out in the *Journal*, Holder expressed his thanks to all who had faithfully supported his business for the past 12 years. "We will help each of you any way we can to make the transition from our pharmacy to another as easy as possible," stated Holder.

Press Clipping Division
Kansas Press Service, Inc.
Affiliate of Kansas Press Association
Box 1773, Topeka, Kansas 66601

KANSAS
St. John News

MAY - 3 1989

One less business to kick around

St. John residents won't have the St. John Pharmacy to kick around anymore.

Many St. John residents acted with disbelief on Monday when they learned that the town's only prescription drug outlet closed its doors. The business has no plans of reopening.

The decision to close the business should not have come as any great surprise to anyone.

Afterall, St. John residents said the same things about the St. John Pharmacy that they have said at one time or another about most every St. John business.

"The prices are too high."

"The business is not open when it's convenient for me."

"It took too long to get what I need."

The litany of negativeism goes on and on. What businesses in St. John haven't those words been spoken about?

With attitudes like that, even Donald Trump would have trouble making money in a place like St. John.

People in small towns want the conveniences they can find in the big city, but they also want the competitive prices offered by big city merchants. Seldom can hometown shoppers have it both ways.

There's a price to be paid for living in a small town. Small town residents often have to pay for the convenience of being able to find the things they need at home.

The sad irony about the situation involving the pharmacy is that now St. John residents will be paying a high price for the inconvenience of not having a place to have prescriptions filled.

Unless someone is eventually found to come in and rescue the pharmacy, not a single dollar of prescription drug business will stay in St. John. Such a thought of that ever happening in a town like St. John defies logic.

A large percentage of St. John's population consists of senior citizens. Many prescriptions are written for people in this age group. The city's senior citizens will be especially inconvenienced by having to look elsewhere for a prescription outlet.

The decision to close the pharmacy may have been based on more than economic factors. The public may never know because pharmacist Charles Carden has not decided to publically explain his reason for closing the pharmacy. It really doesn't matter now.

There is little doubt that if there's one business St. John could support, it would be a pharmacy.

If the decision to close the pharmacy was based solely on economic factors, St. John residents have nobody to blame but themselves. rda

Northside Family
HEALTH MART
Lyman Rd. at N. Topeka Blvd.
Topeka, Ks. 66608

PETITION

I should have the right to purchase my prescribed medication at any pharmacy I choose. I support the "Freedom of Choice" statewide campaign and, in addition, will support legislation in the state of Kansas on this issue.

THE COMMUNITY PHARMACY IS THE BEST PLACE TO GET YOUR MEDICINES!

	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Connie Cole	3630 NW 35th	66608 Topeka
2.	Richard Caldwell	1634 NW 39th	66618 Topeka
3.	Diana Swafford	1731 N.W. Polk	66608 Topeka
4.	Margaret A McElroy	3318 N. Kansas	66617 Topeka KS
5.	Alexia Harrington	RR2 Box 451	Meriden KS 66512
6.	Robert Harrington	" "	" "
7.	Nancy Hillman	Rt. Box 46	Meriden Ks 66512
8.	Opal Sanderson	2667 N.E Kanwaka	Topeka
9.	Betty A Little	3505 N Topeka	Blvd City
10.	Laura A. Foltz	431 N.W. 60th St. Pl.	Topeka, Ks 66617
11.	Norman J Rodgway	2336 NW Humphrey Rd	Silver Lake, Ks 66539
12.	Esther M. Newton	1315 N Polk	Topeka
13.	Sharon L Beckwith	1897 NE Burgess ct	Topeka, KS 66608
14.	Roland L. Beckwith	1897 NE Burgess ct	Topeka, KS 66608
15.	Brenda Hart Rios	2213 NE 39th	Tpeka Ks 66617
16.	Demetta Jacobson	120 NE Coachlight Dr	Topeka, Ks 66617
17.	Mary Bergquist	2011 NW 59TH TERR	Topeka KS 66618
18.	Brad Blaylock	227 SW Taylor	Topeka 66603
19.	Kimberly Campbell	Rte 1, Box 7	Meriden, Ks 66512
20.	Randy Hendricks	1825 NW West St	Topeka KS 66608
21.	Dora Wilson	1031 N Madison	Top Kan 66608
22.	Patricia C. Ortega	3119 NW Wilder Rd	Topeka KS 66617
23.	Greg Crockett	420 N.W 35TH	TOPEKA, KS. 66617
24.	Marcia Reed	440 N.W. Hamilton Ln	Topeka KS 66617
25.	John W Nichols	4400 S.W. Marlboro Rd	Topeka Ks 66610

Keep original and send a copy to: *Kansas Pharmacists Assoc., 1308 SW 10th St., Topeka, KS 66604.*

Northside Family
HEALTH MART
Lyman Rd. at N. Topeka Blvd.
Topeka, Ks. 66608

Financial Institutions & Insurance
Attachment 3
February 8, 1993

PETITION

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THE COMMUNITY PHARMACY IS THE BEST PLACE TO GET YOUR MEDICINES!

	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Rose Mary Wright	118 N.W. Gay St.	Topeka, Ks. 66608-1844
2.	Gary Purdy	1605 SW [illegible]	Topeka KS 66604
3.	Sallie Myers	1933 N.W. Wilcox	Topeka KS 66608
4.	Ronald [illegible]	1427 NW. HARRISON St.	Topeka Ks 66608
5.	Dean E. Young	3420 N.W. Country Lane	Topeka 66618
6.	Gena [illegible]	3645 Green Hill Rd	Topeka 66618
7.	Mary Randol	3722 Rochester	Topeka 66617
8.	Bonnie [illegible] Bailey	1816 N.E. Burgess Ct	Topeka Ks 66608
9.	Christopher C Wheeler	1050 NE 27th	TOPEKA KS 66617
10.	Pearl J. Foster	6729 NE Indian Creek Rd.	Topeka Kansas 66617-2101
11.	Carol [illegible]	1471 NW. Taylor #12	Topeka Ks 08
12.	Cher [illegible]	3915 N.E. Kimbol	Topeka Ks 17
13.	Freddy [illegible]	426 Rodgers St	Topeka Ks
14.	Sheryl Myer	1819 NW POLK	Topeka 66608
15.	[illegible]	5144 NW Rochester	Topeka 66617
16.	Pat Law	Rt 2 Box 358	Meriden Ks
17.	Natalie Wilkerson	1536 NW Valencia Rd	Topeka
18.	Linda Shull	2421 NW King	Topeka
19.	Gayla Thompson	302 Spruce LN	Topeka
20.	M. E. Carney	6035 NW North Hills Dr	Topeka
21.	Jean Evans	7420 NE Indian Cr Rd	Topeka
22.	Joyce Cain	3517 NE Edgewood Dr.	Topeka
23.	Rick DeHart	1605 NW 8 ST	Topeka
24.	Larry Vawter	1959 NW LANE	TOPEKA
25.	Erma [illegible]	3860 NW Wilder Rd	Topeka

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Northside Family HEALTH MART
Lyman Rd. at N. Topeka Blvd.
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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.		3630 NW 35th	Topeka, Ks 66618
2.		1181/2 NW Jay	Topeka, Ks 66608
3.	Paula Fleming	3901 NE Loma Ct	Topeka KS 6661 7
4.		1411 NW 34th	Topeka, Ks 66619
5.		Route 3 - Box 199	Topeka, Ks 66617
6.		5831 NW 24th	Topeka, Ks 66618
7.			
8.		RT 1 Box 447A	To Meriden KS 66512
9.		248 N. 58th	Topeka, Ks. 66617
10.		3040 NW 6 Cir	Topeka KS 66618
11.		10275 Y Rd	Meriden Ks 66512
12.		10275 Y Rd	Meriden Ks 66512
13.		RR 5	Topeka Ks 66617
14.		505 NW 48th Terr	Topeka 17
15.		505 NW 49th Terr	Topeka 17
16.		RR 2	Meriden, Ks
17.		5921 NE Indian Creek Rd	Topeka, Ks 17
18.		2914309	
19.		4510 NW Westgate	Topeka, Ks 66618
20.		1514 William	Topeka Kans
21.		120 NE 66th	Topeka KS
22.		331 NE Golden	Topeka Ks
23.		" "	" "
24.		521 NE 43rd st	Topeka. Ks.
25.		Box 25 RR 2	Meriden Ks

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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Kim Hammerly	Box 140	Meriden Ks. 66512
2.	Helen Curwick	117 J Grant	Topeka KS 66608
3.	Sherman B. Knuppel	6845 N.E. Indian Crk Rd	Topeka Kansas
4.	Eleanor Knuppel	6845 N.E. Ind. Cr. Rd.	Topeka, Ks.
5.	Bertha Goldberg	RT 1 Box 114	Grantville Ks
6.	John T. Tuckness	1947 N.W. Lane	Topeka Kansas 66608
7.	Beverly J Johnson	Rt, Box 99	Grantville Ks 66429
8.	Regina R. Beehn	5537 NW Topeka	Topeka, KS 66617
9.	Lupe Nunez	184 N. E Coachlite	Topeka, Ks 66617
10.	Alvia L. Arthur	1828 NW Fillmore	Topeka KS 66608-1635
11.	Kathi J. Ingersoll	1730 N W Tyler	Topeka KS 66608
12.	Bob Shirley	Box 123	Grantville, Ks 66429
13.	STEVE HATFIELD	RR 1 Box 175	OZAWKIE KS 66070
14.	Deborah Kaelin	RR 1, Box 144	Meriden KS 66440
15.	John C. Wheeler	738 Poplar	Topeka
16.	Kathryn E. Wheeler	738 Poplar	Topeka
17.	Marlene A. Collins	132 n. E. Lake	Topeka
18.	Lynn Mueller	4110 NE Tarton	Topeka
19.	Elsie Lesser	445 NW 35th St	Topeka
20.	Jo Shughart	1218 N Madison	Topeka 66618
21.	Luke J McClure	Rt. #1 Box 310	Meriden 66512 KS
22.	Georgia Platt	518 Sandra	Top 66608
23.	Jane Keeler	5827 NW Rochester	Topeka 66617
24.	Doris Brown	710 NW 35th St	Topeka, KS
25.	Thomas L. Mosier	1509 N Logan	Topeka KS 66608

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PETITION

I SHOULD HAVE THE RIGHT TO PURCHASE MY PRESCRIBED MEDICATION AT ANY PHARMACY I CHOOSE. I SUPPORT THE "FREEDOM OF CHOICE" STATEWIDE CAMPAIGN AND, IN ADDITION, WILL SUPPORT LEGISLATION IN THE STATE OF KANSAS ON THE ISSUE.

THE COMMUNITY PHARMACY IS THE BEST PLACE TO GET YOUR MEDICINES

	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Stephen Jones	424 Jefferson	Lyndon, Ks 66451
2.	Marjorie Gregory	R. R. #4	Lyndon, Ks. 66451
3.	[illegible]	Rural Route 3 Box 41	Lyndon, KS 66451
4.	[illegible]	409 Research	Manhattan, KS 66502
5.	Darlene Gilliland	502 Cedar Crest	Manhattan, KS 66502
6.	Daryl Edwards	303 W. 8th St.	Lyndon, Ks. 66451
7.	[illegible]	621 Topeka Ave	Lyndon KS 66451
8.	Ralph L Swanson	915 Lincoln	Osage City Kan 66451
9.	Marvin Dean Felton	822 Topeka Ave	Lyndon, KS
10.	Shirley Brasier	RR	Lyndon, Ks
11.	Betty Warren	Box 724	Lyndon Kansas
12.	Marjorie Dlugosh	Box 211	Lyndon, Ks. 66451
13.	Bobbie Edwards	303 W. 8th St.	Lyndon, Ks.
14	Wayne N Culbertson	923 Jeff.	Lyndon, Ks. 66451
15	Dennis P Hitt	620 Washington	Lyndon, Ks. 66451
16	Phyllis J. Knight	R.R. P.O. Box 6	Lyndon, Ks. 66451
17	Deborah L. Tomlinson	P.O. Box 252	Lyndon, KS 66451
18	R. M. Rasmusson	Box 76	Lyndon KS. 6645
19	Margaret Rich	P.O. Box 3	Lyndon, Ks. 66451
20	Mary Ann Gettmer	822 Topeka	Lyndon Ks 66451
21	Alva E. Dillard	P.O. Box #207	Melvern, Ks 66510
22	Michael N. Felton	RR 1 Box 5A	Lyndon, Ks 66451
23	Jane M Smith	R1 Box 13	Vassa. Ks 66543
24	Charlotte Edwards	P.O. Box 181	Lyndon, Ks. 66451
25	Ellis Eglish	920 Cedar	Lyndon 66451
26	Geri Mathey	303 Wash	Lyndon 66451
27	Clyde a Jeter c/o Virginia D Mathey Power of attorney	303 Wash	Lyndon 66451
28	Ronald Butts	RR #1	Melvern 66510
29	Virgie Sims	402 E 10th	Lyndon 66451
30	Richard Ryan	820 Elm	Lyndon 66451
31	Gladys Ryan	820 Elm	Lyndon KS.
32	Bonnie Gadner	920 Topeka	Lyndon KS.

5 of 5

FEB - 3 '93

K. PH. A.

PETITION

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THE COMMUNITY PHARMACY IS THE BEST PLACE TO GET YOUR MEDICINES!

	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	[illegible]	RR 1 PO Box 129	Vassar Kansas 66543
2.	Molly K. Frazier	RR 1 Box 21	Vassar, Kansas 66543
3.	Mary B. Swanson	635 Topeka Ave.	Lyndon, Ks 66451
4.	[illegible]	P.O. Box 634	Lyndon, KS 66451
5.	Lori Montgomery	Box 56 Rt 1	McLouth Ks 66510
6.	Opeta Shuler	Rt 1 Bx 97A	Vassar, KS 66543
7.	Clyde Nelson	315 E 6th	Lyndon, KS 66451
8.	Lucille Nelson	315 E. 6th	Lyndon, Ks. 66451
9.	Virgie Sims	H02 E 10th	Lyndon KS 66451
10.	Barbie Kuntze	228 W. 5th St.	Lyndon K. 66451
11.	Norman L Allen	2828 SE Maryland	Topeka Ks 66605
12.	Nita J. Crumpton	RR 1 Quenemo	Quenemo Kans 66528
13.	Katherine M. Johansen	410 E 10th	Lyndon, KS.
14.	Melody Buchanan	230 W. 10th	Lyndon KS. 66451
15.	Shirley Echel	305 W 5th	Lyndon Ks 66451
16.	Jill Fasdall	920 Topeka	Lyndon KS
17.	Patti Wechsler	617 Topeka	Lyndon Ks.
18.	Betty Murphy	[illegible] Box 170	Scranton Ks 66537
19.	Carla Scott	PO Bx 395 Lyndon	Ks. 66451
20.	Ashley Bledsoe	PO Bx 395 Lyndon	Ks. 66451
21.	Dale Barnhart	Box 238 Lyndon	828-3627
22.	John Scott	Alabama Terr	759-3455
23.	Carla Scott	Alabama Terr	Quenemo, Ks. 759-3455
24.	John David Scott	Alabama Terr	Quenemo, Ks. 759-3455
25.	Eldana Scott	Alabama Terr.	Quenemo, Ks. 759-3425

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[illegible] Carlton RT 4 OSAGE CITY, KS

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PETITION

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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	[illegible]	6H7 - O K	
2.	[illegible]	731 S. Inman	Liberal, Ks
3.	[illegible]	1634 Nelson Ct	Liberal, KS
4.	Barbara Poersch	1100 S. Sherman	Liberal, Ks.
5.	[illegible]	917 N CHARLTON	LIBERAL KS
6.	[illegible]	1012 E. 8th	Liberal, KS.
7.	Mary Hubbard	225 So. Roosevelt	Liberal, KS.
8.	Julie Clingan	806 W 7th	Liberal, KS
9.	[illegible]	4x20 Vine	[illegible]
10.	[illegible]	417 W 4th	[illegible]
11.	Debra Taylor	807 Maple	Liberal, Ks.
12.	[illegible]	1035 N Pershing	Liberal Ks
13.	[illegible]	611 So Otla	Liberal KS
14.	Harold E Adler	1005 A. Penn	Liberal, Kan
15.	Gayle Cain	Box 229	Guymon OK
16.	[illegible]	431 E Sherman Ct 3	Liberal Ks
17.	[illegible]	617 S. Jordan	Liberal Ks
18.	[illegible]		Liberal, KS
19.			
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743

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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Jim Lathom	839 S Calhoun	Liberal, Ks
2.	Earlene Boston	HCR3, Box 22	Elmwood, Ok.
3.	Glenna Parham	15 W 6th Apt H	Liberal, Ks.
4.	[illegible]	1215 W 2nd	Liberal
5.	[illegible]	1916 Windsor Ln	Liberal
6.	Jack Preston	716 S Calhoun	"
7.	June Robison	113 Hoover	Liberal Kans.
8.	[illegible]	215 W Walnut	Liberal Ks
9.	J M McVey	508 DON ST	KISMET KS
10.	Pearl McVey	508 Don St	Kismet KS
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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	[illegible]	Rt 2 Box 49	Turpin OK 739[illegible]
2.	[illegible]	Rt 1 Box 73B	Guymon OK 7384[illegible]
3.	[illegible]	P.O. Box 114	Liberal, KS 67905
4.	[illegible]	P.O. Box 856	Hooker, OK 73945
5.	[illegible]	222 N. KANSAS	Liberal, KS 67901
6.	[illegible]	1031 Holly Dr	Liberal KS 67901
7.	[illegible]	1031 S. Holly DR	Liberal KS 67901
8.	[illegible]	Rt 2 Box 79	Turpin OK 739[illegible]50
9.	[illegible]	8318 Jordan	Liberal, Kans.
10.	[illegible]	710 Elm	Liberal Kans.
11.	[illegible]	Rt 1 Box 114	Hugoton KS
12.	[illegible]	1206 OKla	Liberal, Kansas
13.	[illegible]	Rt 2 Box 2[illegible]	Turpin, OK
14.	[illegible]	R.R#1, Box 13	Liberal, Ks
15.	[illegible]	P O 2	Liberal, K.
16.	[illegible]	1029 N Clay	Liberal KS 67901
17.	[illegible]	228 S. Roosevelt	Liberal KS 67901
18.	[illegible]	210 N Pershing	Liberal, Ks. 67901
19.	[illegible]	2310 6th	Dodge Ct, Ks. 67801
20.	[illegible]	2310 6th	Dodge Ct. Ks 67801
21.	[illegible]	620 N Lincoln	Liberal, Ks 67901
22.	[illegible]	628 W 5th	Liberal KS 67901
23.	[illegible]	1401 N. New York #224	Liberal KS 67901
24.	[illegible]	314 North Kansas	Liberal Kans 67901
25.	[illegible]	909 W. 7th	Liberal Ks 67901

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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Laura Watson	1155 South New York	Liberal Ks 67901
2.	Betty Halsted	101 S. Sherman	Liberal Ks.
3.	Lila Thayer	502 N. Cain	Liberal, KS
4.	Kori Navarro	1010 N Prospect	Liberal, KS
5.	Marla Hodges	706 S. Oklahoma	Liberal Ks
6.	Willie Phillips	1104 N Clay.	Liberal KS.
7.	Darlene Bauer	804 S. Pershing	Liberal KS
8.	Mary Underwood	908 N Missouri	Liberal KS
9.	[illegible]	619 west 3rd	Liberal Ks
10.	[illegible]	311 [illegible]	Liberal, Ks
11.	Madeline Ford	316 Harvard	Liberal, Ks
12.	[illegible]	1100 Carlton	Liberal Ks
13.	[illegible] Walker	1603 nelson	Liberal Ks
14.	Beck Mattern	Box 605	Beaver OK
15.	Ruth Mattern	Box 605	Beaver OK
16.	Linda Shank	15 S Cain	Liberal KS
17.	[illegible] Hague	512 N New York	Liberal, Ks.
18.	[illegible] Shelton	909 W. 2nd	Liberal
19.	[illegible]	502 N. MO	Liberal
20.	[illegible]	502 N. Mo	Liberal, Ks
21.	Maggie M. [illegible]	1226 N. Carlton	Liberal Ks
22.	[illegible] Rhoades	607 Nottingham	Liberal Kans
23.	Gladys [illegible]	Tyrone Okla	
24.	Norma [illegible] Shank	1106 Maple, Lib Ks	→
25.	[illegible]	228 W. Curtis	Lib Ks

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20 of 3

PETITION

I should have the right to purchase my prescribed medication at any pharmacy I choose. I support the "Freedom of Choice" statewide campaign and, in addition, will support legislation in the state of Kansas on this issue.

THE COMMUNITY PHARMACY IS THE BEST PLACE TO GET YOUR MEDICINES!

	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Gary E. Kauk	415 N Sherman	Liberal Ks 67901
2.	Teresa Garza	R. R. 1 Box 14	Kismet, Ks 67859
3.	[illegible]	811 W 7th	Liberal Ks 67901
4.	Derek L. [illegible]	1503 Clay Ct	Liberal
5.	Harold & Laura Rowe	1811 N. Calhoun	Liberal Ks. 67901
6.	Gary McCune	1405 N. Roosevelt	Liberal, Ks. 67901
7.	LaNelda Shrank	530 N. Calvert	Liberal, KS 67901
8.	Lorey Howell	[illegible] West 11	Liberal Ks 67[illegible]
9.	Terry Arland	P.O. Box 231	Kismet, Ks 67859
10.	Dorothy Randall	323 W 3rd	Liberal, Ks 67901
11.	[illegible] Potter	P.O. Box 1003	Beaver OK 73932
12.	William E Massey	901 N Sherman	Liberal Kan
13.	Roy L. [illegible]	Box 866	Beaver Okla
14.	[illegible]	337 S New York	Liberal Ks 6790[illegible]
15.	[illegible] Smith	123 Wilson	Liberal, Ks 6790[illegible]
16.	[illegible] Smith	123 Wilson	Liberal Ks 67901
17.	John [illegible]	2116 Rose Lane	Liberal, Ks
18.	[illegible] Patrick	2121 Dahlia	Lib Ks
19.	[illegible]	20 S. Prospect	Liberal Ks
20.	Ellen [illegible]	1410 [illegible]	Liberal, Ks.
21.	[illegible]	704 S Webster	Liberal Ks
22.	Vernon E. Ralston		
23.	Lizzie L. Webb	517 N. York	Liberal KS 67901
24.	Lila Anna [illegible]	1006 S. [illegible]	Liberal Ks 67901
25.	Richard Smith	615 W Ohio	Liberal, Ks 67901

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FIRST

RECEIV

FEB -5 '93

PETITION

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THE COMMUNITY PHARMACY IS THE BEST PLACE TO GET YOUR MEDICINES!

	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Marietta M. Heinen	Rt. 1, Box 162	Valley Falls, KS 66088
2.	Linda L Bowers	P.O. Box 202	Valley Falls Meriden 66512
3.	Janice Terrell	1604 Willow	Valley Falls
4.	Nancy Allen	304 Elm	Valley Falls
5.	Barbara Peterson	510 Oak	Valley Falls, KS 66088
6.	Mary Dimmitt	R#1 Box 82	Oskaloosa 66070
7.	Elizabeth Lange	307 Walnut	Valley Falls
8.	Katherine McGee	R. 2 Box 293	VF, KS 66088
9.	Leota Fay Martin	Rt 2 Box 115	Meriden Ks 66512-9609
10.	Barbara Lowing	Rt 2 Box 215	Valley Falls 66088
11.	Jarvon Terrell	RR 1 Box 67	Valley Falls 66088
12.	Arlene Gier	Rt 1 Box 191	Valley Falls, Ks
13.	Gordon Rupprechgen	RR 2 Box 65	Valley Falls, Ks 66088
14.	John A Hutchings	6726 Rock Post Rd	Topeka Ks 66619
15.	Jean Noble	R.R. 2 Box 290	Valley Falls, KS, 66088
16.	Robert L Vana	P.O Box 189	Valley Falls, Ks 66088
17.	Frank E. Shrimplin	902 Frazier	Valley Falls, KS 66088
18.	Glen Cropper	1,000 Sycamore	Valley Falls, Ks 66088
19.	Edith Shrimplin	902 Frazier	Valley Falls KS 66088
20.	Charles R. Smith	Rt 1, Box 174	Valley Falls
21.	Dorothy Sheldon	501 16th	Valley Falls KS
22.	Georgann Ukena	810 Frazier	Valley Falls
23.	Kathleen D. Schwartz	1105 Oak	Valley Falls KS
24.	Susan Springer	1201 Oak	Valley Falls, KS.
25.	Lynn Seidl	600 Louisa	Valley Falls KS 66088

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1293

RECEIVED

FEB -5 '93

PETITION

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THE COMMUNITY PHARMACY IS THE BEST PLACE TO GET YOUR MEDICINES!

	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Charles E. Jesse	509 Wisconsin	Lawrence, Ks 66044
2.	[illegible]	[illegible]	[illegible]
3.	Betty L Armbruster	2101 Vermont St	Lawrence, KS 66044
4.	Robert A Kaw	313 Mill Creek Ct.	Lawrence, KS 66049
5.	[illegible]	3323 Iowa Lot 325	Lawrence, KS 66046
6.	Helen Knotts	2020 W 27 apt	Lawrence Ks. 66046
7.	Janice Leslie	1420 W 2nd St Ter	Lawrence, Ks 66044
8.	Carl D Brown	2455 melrose ln apt 2	Lawrence KS 66047
9.	Mel Holmes	13600 200th ST	Linwood KS 66052
10.	Bertie J. Bay	1900 W 9th St	Lawrence Ks 66046
11.	Pauline Johnston	3103 Stratford Rd	Lawrence KS 66047
12.	Rose Hoffmeyer	0421 Matthews Ct	Lawrence, KS. 66047
13.	Jerry L. Maxwell	2832 MAINE CT	LAWRENCE KS 66046
14.	Ray Cline	3807 BRUSHCREEK	LAWRENCE KS 66047
15.	[illegible]	985 E. 1587 Rd	Lawrence KS 66046
16.	Mary E. Coleman	246 E 750 Rd	Baldwin, KS 66006
17.	Isabelle M. Abel	1842 W. 28th St	Lawrence, Ks 66047
18.	Lauralyn Brolle	1336 Tennessee	Lawrence, KS 66044
19.	Mabel Bamber	2604 W 24th Terr	" " 66047
20.	Carolyn Grover	2723 W 24 Terr	" " 66047
21.	Mrs Juanita Boles	RR 5 Box 103A	Lawrence, KS 66046
22.	Joyce Blank	2501 Cimarron	Lawrence, Ks. 66046
23.	P. A. Designs	1630 Rose Ln	Lawrence, Ks 66044
24.	A. J. Armbruster	834-4 Avalon	Lawrence, KS 66044
25.	Mary A Jackson	1335 Valley Ln	Lawrence, KS 66044

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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Randall K-McKinney	1306 Walnut	Emporia, KS 66801
2.	Gill A. Panabi	644 Washington	Emporia, KS 66801
3.	Eugene DeDonder	649 County Road	Emporia, KS 66801
4.	Joni Hensley	1001 Lafayette St	Emporia, KS 66801
5.	Mary Filson	1518 Berkeley Rd	Emporia, KS 66801
6.	Kari Wichita	1036 Washington	Emporia, Ks 66801
7.	Norma Jean Johnson	1929 Morningside	Emporia KS 66801
8.	Marsha Tabares	923 Lincoln St.	Emporia, KS 66801
9.	Leo DeDonder	2029 W 8th	Emporia Ks 66
10.	Helen DeDonder	"	"
11.	[illegible]	RR #4 Box [illegible]	Reading KS 66868
12.	Jerry DeDonder	RR #1 Box [illegible]	Reading KS 66868
13.			
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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Barry Rabenstein	7822 W 118	OP KS 66210
2.	Arnold Kalanoff	11009 Buena Vista	Leawood, Ks 66211
3.	Jeane Kalanoff	11009 Buena Vista	Leawood Ks 66211
4.	Debby Greenstein	7822 W 118	O.P. KS 66210
5.	Jack Bresel	8112 W. 97th Ter	O.P. KS 66212
6.	Barbara Bresel	8112 W. 97th Ter	O.P. KS 66212
7.	Kristy Katz	8105 W 97th Ter	OP KS 66212
8.	Glenn E. Katz	8105 W. 97 TH TERR	OP. KS 66212
9.	Marjorie L. Katz	8105 W. 97 Terr.	OP Ks. 66212
10.	Jessie M Lewis	6515 Santa Fe Dr.	O.P. Ks. 66202
11.	Mary Farrell	4619 Richards Dr	Shawnee KS 66216
12.	Paul Stetzer	7938 Washington	KC MO 64114
13.	Lisa Winfield	13105 Flint	Lenexa KS 66215
14.	Laurie Horah	6552 W. 89th St. #205	Overland Park, KS 66212
15.	Norman Brase	8112 W 97th Ter	O.P. Ks 66212
16.	Rosie Unash	9427 Hayes Dr.	OP KS 66212
17.	Dora Palermo	11447 W. 112 Ter	OP KS 66210
18.	Mike Royall	7575 W 108th #434	OP KS 66212
19.	Frank Klein	11808 England	OP KS 66210
20.	Judy Hensley	12015 W. 68th St.	Shawnee, Ks. 66216
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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Robert Dove	RR2 Box 228B	Horton, KS.
2.	Karen Bunning	214 Kickapoo	Hiawatha, Ks
3.	William a. Neal	350 E. 8th	Horton, Ks
4.	Mary Louise Monson	Box 166	Everest, Kans
5.	Billie J. Erpelding	Box 56	Muscotah, KS
6.	Barbara Jan's	155 West 14th	Horton, Ks. 66439
7.	Charles Scalapino	Box 118	Everest Ks 66424
8.	Sue Kidd	R1. Box 97	Horton, Ks. 66439
9.	Susi Pelisek	Rt 2 Box 14	Horton KS 66439
10.	Bessie Odem	424 W. 12th	Horton Ks 66439
11.	[illegible]	1201 5th Ave. W	Horton Ks.
12.	Jay & Phyllis Alexander	RR5 Box 50 Htr	Hiawatha Ks
13.	Jeanie Stuebe	RR1	Horton, KS
14.	[illegible]	1750 Utah Ave E	Horton Ks.
15.	Steven C. Compton	R.R.5 Box 74	Hiawatha, Ks. 66434
16.	Nadine D Ewing	Rt 2 Box 16	Horton, Ks
17.	Evelyn J. Robinson	342 E. 8th	Horton, Ks
18.	Eileen Knudson	R-2	Horton, Kansas
19.	James D Allen	700 W/O 2nd St.	Horton Ks
20.	Jean M. Rasbeck	1701 Euclid #32	Horton, Ks.
21.	Leroy Jensen	R1 Box 170	Everest Ks
22.	Del Oaks	Rt 2 Box 226	Horton, Ks.
23.	Warren Smith	Box 75	Whiting Ks.
24.	Ruth Smith	Box 75	Whiting Ks.
25.	Darlene Ramirez	848 4th Ave West	Horton Kans.

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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Deborah R. Strong	1031 Central	Horton, Ks. 66439
2.	Edward Rork	R R 1,	Horton Kan
3.	Cora Button	137 W. 11th	Horton Ks.
4.	Wallis Moore	R1	Horton Ks
5.	David Roderbt	234 E. 8th	Horton, Ks
6.	Elaine Salverson	Rt 5	Hiawatha Ks.
7.	Irene Mydland	1401 Central	Horton, Ks 66439
8.	Mary Jean Hail	1401 Central	Horton, Ks 66439
9.	Myla Mace	302 E. 9th	Horton, KS 66439
10.	Elenor Nelson	1601 Central	Horton, Ks. 66439
11.	Catherine Wilbur	RR#1	Horton Ks 66439
12.	Marsha Lyshnowski	220 W 14th	Holton Ks 66439
13.	Lessie B Jones	Rt#1 Box 11	Netawaka Ks 66516
14.	Michelle Haskell	RR1 Box 83A	Horton, Ks 66439
15.	Karen Sechler	RR1 Everest, KS	66424
16.	Isabelle L. Thomas	RR1 Box 177	Horton Ks. 66439
17.	[illegible]	1045 3rd W	Hi 66439
18.	Lori Stinton	RR1, Box 90	Horton, KS. 66439
19.	Jesse Tollefson	RR5, Hiawatha, Kansas	
20.	Cynthia Ayler	Muscotah, KS	Kansas 66058
21.	Michele Hankles	Muscotah KS	Kansas 66
22.	Joyce Rucklin	~~Horton~~ 1345 3rd Ave. W.	Horton Ks 66439
23.	Ruth Ross	RR 5 Box 131	Hiawatha
24.	Lori Lee	334 E. 8th	Horton, KS. 66
25.	Ben Lemmon	825 1st Ave West	Horton, Ks. 664

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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Donna J Kunneau	17th & Euclid Apt 26	HORTON, KS 6643[illegible]
2.	Lucy E Reinstra	934 3rd Ave W.	Horton, Ks 6643[illegible]
3.	Rebecca A Higley	Orchard Heights #7	Horton, Ks. 66439
4.	[illegible]	1785 1st Ave East	Horton KS 66439
5.	Vera W. Swallow	1443 1st ave East	Horton K. 66439-181[illegible]
6.	Byron L. Wiggins	345 W 12th	Horton, Ks 66439
7.	Doreen Wiggins	345 W. 12th St.	Horton, Ks 66439
8.	[illegible]	222 W. 17th	Horton, Ks 66439
9.	William R Patterson Jr.	480 7th Ave West	Horton, Ks. 66439
10.	Hazel Meerpohl	120 E. 11th	Horton, Ks. 66439
11.	Ruth C. Russell	Arbor Knoll #10	Horton Ks 66439
12.	Myrvin L Scott	345 W. 9th	Horton, KS 66439
13.	Irene Selman	425 W. 14	Horton KS. 66439
14.	Lester Seyler	Box 90 RFD #1	Everest, Kans 66424
15.	Cheryl Harris	400 E 10th	Horton KS
16.	L.D. Nevins	245 W 12th	" "
17.	Jimmy D Resnick	1330 2nd Ave E.	" "
18.	Sarah Knudson	Rt 5 Hiawatha Box 83	Hiawatha, Ks. 66434
19.	Wilma L Ross	1231 1st ave E.	Horton KS 66439
20.	Rose Tallpen	Rt 5 Hiawatha	KS 66434
21.	Debbie Shaw	Horton, Kans.	66439
22.	Patricia Swartz	Everest Kansas	66424
23.	C M Mapes	Horton Kan.	
24.	Joyce J Denison	Horton Kans	66439
25.	Norman Ross	Hiawatha Ks	66434

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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Shirley Myers	749 NE 54th	Topeka, Ks 66617
2.	Earlene Reichart	6340 NE Indian Creek Rd	Topeka Ks 66617
3.	David DeWoss	511 Rodgers	Topeka, KS 66607
4.	P.M. Stauffer	Rt#1 Box 396	Meriden KS 66512
5.	Audrey McKinley	3909 NE Cortez Ct.	Topeka 66617
6.	Fred Woodard	749 N.E. 54th St	Topeka 66617
7.	Marlene Taylor	2628 NW 35	Topeka 66618
8.	Patricia F. Wagner	3722 NW St. Ives	Topeka 66618
9.	Sue Ann Miller	1900 NW Lyman #255	Topeka, KS. 66608
10.	[illegible]	1415 N Monroe	Topeka KS 66608
11.	Cleta Bernstetter	P.O. Box 181	Meriden, Ks. 66512
12.	Donald S Carr	2338 SW High	Topeka, KS 66611
13.	Michelle Blanchard	2618 N.E. 37th St	Topeka, KS 66617
14.	Vickey L Mull	312 N.E. Fairchild	Topeka
15.	Sheila Thomson	6531 SW 28 Ter	Topeka
16.	Connie Wallin	4936 NW Haven	Topeka 66617
17.	Angela Novak	2306 NE Kaw Vly. Rd.	Topeka, Ks 66617
18.	WANDA J. YANDELL	1905 NW WILCOX CT	TOPEKA, KS. 66608
19.	Jacqueline Brigham	Rte 3	Topeka 66617
20.	Arthur C Johnson	4401 NW Beale Rd.	Topeka - 66618
21.	Jeanette Thorpe	1900 W. Lyman #227	Topeka 66608
22.	Hale Eubanks	323 Lyman	Topeka 66608
23.	Carol Rose	314 1/2 E St John	Topeka 66608
24.	Beverly J. Todd	1017 N. Van Buren	Topeka Ks 66608
25.	Paul F Bowen	2425 SE 45th ST	Topeka, KS 66609

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Northside Family HEALTH MART

Lyman Rd. at N. Topeka Blvd.
Topeka, Ks. 66608

1993

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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Violetta M Stull Wales	2011 NW Taylor	Topeka Ks 66608-1990
2.	[illegible]	4127 N. Topeka	Topeka KS 66617
3.	[illegible]	2329 NW 35	Topeka, Ks 66618
4.	[illegible] Boatman	1445 NE 46	Topeka, Ks 66617
5.	Helen Daniels	825 S.W. Jackson	Topeka Ks
6.	John P Bailey	112 N.E. Burgess	Topeka, Kan
7.	[illegible] Neely	38425 E Howard Dr	Topeka KS 66605-1935
8.	John N. Kent	3637 NW 25TH ST.	TOPEKA, KS 66618-2707
9.	Cheryl Bleier	320 NW Rolyan Rd	Topeka, KS 66617
10.	Roxanne Gilbert	1010 NE Coachlight Dr.	Topeka, Ks. 66617
11.	Margaret A. Farr	5450 N.W. Green Hills Rd	" " 66618
12.	Elizabeth Johnson	P.O. Box 04 ~~Holton~~	Valley Falls Ks 66088
13.	[illegible]	Rt 2 Box 8	Ozawkie, Ks 66070
14.	David [illegible]	Rt. 1 Box 100	Perry KS
15.	Cheryl Sweet	Rt 1 Hoyt Ks.	Hoyt KS
16.	Deloras Werner	2121 N Buchanan	Topeka Ks 66608
17.	Becky Marcum	4320 NW Valley Rd	Topeka KS 66618
18.	Jane L Bjornehard	2618 NE 37th	Topeka Ks 66617
19.	Michael Kupfer	1211 Mundell	Topeka Ks. 66618
20.	Virginia Rhoads	178 NW Holman	Topeka KS 66608
21.	Annette Leach	P.O. Box 90	Lecompton, Ks
22.	[illegible] Leach	328 Halderman	Lecompton Ks
23.	Sharon Mitchell	3501 NE Mundy Rd	Topeka Ks
24.	Lynn Dahn	4440 NE Indian Creek Rd	Topeka, KS
25.	Donald J Kaberline	3231 NW Brickyard	Topeka KS

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Neighborhood Family

HEALTH MART

Lyman Rd. at N. Topeka Blvd.
Topeka, Ks. 66608

3 of 3

PETITION

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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Sheila Sales	3630 NW 35th	Topeka, Ks 66618
2.	Tom + Doris Samuelson	5240 N.E. Indian Creek Rd	Topeka, Ks 66617
3.	Ann Christensen	3506 N.E. Oakwood Dr.	Topeka, Ks. 66617
4.	Ramona A Flower	1415 NE Madison	Topeka KS 66608
5.	Margaret Dean	P.O. Box 25	Silver Lake KS 66539
6.	Lovelyn Ostrander	3124 N.W. 66th	Topeka, Ks 66618
7.	Karen Tanner	1308 N Princeton	Topeka, KS 66608
8.	[illegible]	2121 N.E 56th	Topeka Ks 66617
9.	Keith Cushing	3660 NE Wenonah Rd	Topeka, Ks. 66617
10.	Marilyn L. Young	3430 NW Countryclub	Topeka KS 66618
11.	Anna M Harper	1030 NE Colliers Rd	Topeka, KS 66617
12.	Wilford Harper	1030 NE Colliers Road	Topeka, KS 66617
13.	[illegible]	1177 NW Lincoln	Topeka, KS 66608
14.	Annetta Griffin	1111 N W Lyman Rd	Topeka, Ks 66608
15.	C L Webber	212 E Main	Meriden KS
16.	C H. Baker	2149 NE 70th	Topeka Kans
17.	Pearl Wood	1620 N St. Fredith Rd	Topeka Ks
18.	Brenda Vineyard	1203 12th St.	Valley Falls, Ks.
19.	Irma L. Blankenship	Box 157	Lecompton Ks
20.	Kenneth Unspaugh	RT1. BOX 124	HOLTON KS.
21.	Betty J. Severtson	111 NE coachlight	Topeka, Ks 66617
22.	[illegible]	Rt 2 Box 128A	Meriden KS
23.	Mary Dell	5843 NW West Brooke Dr	Topeka Ks
24.	Catherine Hockenbarger	1225 nw Quincy	Topeka Ks
25.	Vicki Cornelison	3611 NE Meriden Rd	Topeka Ks

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Northside Family
HEALTH MART
Lyman Rd. at N. Topeka Blvd.
Topeka, Ks. 66608

2143

PETITION

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THE COMMUNITY PHARMACY IS THE BEST PLACE TO GET YOUR MEDICINES!

	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Judy Woolbarger	4420 nw Greenhills Pl	Topeka Kan 66618
2.	Lydia S. Arson	720 NW 39th St	Topeka Ks
3.	Helen Andrews	2327 NW 39	Topeka
4.	Anita D. Gilstrap	409 N.E. OHIO	Topeka KS.
5.	Freda L. Smith	1216 N.W. Porta Dr.	Topeka, Kans
6.	John Tilghman	3675 NE Rockaway Dr	Topeka, KS
7.	Helen Harris	3110 N. Kansas	Topeka, Ks. 66617
8.	Joseph Bridget	2011 NW 54th Terr	Topeka Ks 66618
9.	Deanna Huske	RR#1 Box 622P	Meriden, KS 66512
10.	Bertha A Lehnus	1801 Greenhills Rd Apt 7	Topeka, KS 66608
11.	Pearl M. Wise	1231 NW 62nd	Topeka, KS 66618
12.	Kathryn Gibbs Kelly	1035 N. Monroe	Topeka Ks 66608
13.	Mickey Woodrow	906 NE Dogwood Ln	Topeka Ks 66617
14.	Marilyn Holloway	1735 NW Lyman #25	Topeka, KS 66608
15.	Linda Pendarvis	3546 N.E. 45th Ct.	Topeka 66618
16.	Bella A Lawson	4209 NW Topeka	Topeka 66617
17.	Mary A. Hartman	1735 NW Lyman #33	Topeka 66608
18.	William F. McCoy	1431 N. W. Hunter Dr	topeka 66618
19.	Laura Kelley	5921 NE Indian Creek Rd	Topeka 66617-1649
20.	Doris Brown	128 E Lyman	Topeka Ks 66608
21.	Elizabeth P. Tomicki	2240 N.E. 35	Topeka 66617
22.	Chuck Harper	6221 SE 44	Tecumseh 66542
23.	Virginia L Williams	4838 NW Haven	" " 66617
24.	Barbara J. Holt	309 NE Iowa Ave	Topeka 66616
25.	Sharon L Williams	1938 NE Quincy	Topeka 66608

Keep original and send a copy to: *Kansas Pharmacists Assoc., 1308 SW [illegible]*

Northwest Family
HEALTH MART
Lyman Rd. at N. Topeka Blvd.
Topeka, Ks. 66608

2293

PETITION

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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Rhonda L Bell	Rt1 Box 601 Meriden	Meriden KS 66512
2.	Rebecca Kelly Choitz	903 ONE Maple Rd	Topeka 66617
3.	Melvin F. Smith	Rt 1 Box 365A	Hoyt, Ks. 66440
4.	Wendy Parmon	205 N. Q 35th	Topeka Ks. 66617
5.	Diane M Willingham	1409 NW Eugene	Topeka Ks 66608
6.	Jim Insell	635 NE 43rd	Topeka. Ks 6661 7
7.	Vickie L. Rubarsky	1859 NE Burgess Ct	Topeka Ks 66608 1186
8.	Jacob A Fleenor	5220 NW Topeka	Topeka Kans 6617-
9.	Karla Hughes	5800 S. Topeka #6	Topeka, Ks. 66619
10.	Shelly Shepherd	Rt 2 Box 417	meriden, KS 6651
11.	Mrs E.P. Walker	3816 Rochester Rd	Topeka, Ks
12.	Linda S Mynek	4320 NE Croco Rd	Topeka, Ks.
13.	Edith Dean	2001 N Clay	Topeka, Ks
14.	Arthur O Price	530 E Lyman	Topeka Ks
15.	Quentin Knipp	382 WALNUT LANE	OZAWKIE Ka
16.	Anne Culbertson	7428 SE Camp Creek	Overbrook KS 66524
17.	[illegible]	301 Sabre Pl.	Ozawkie, KS
18.	Doris J. Palmberg	1344 NE 54th	Topeka, Ks.
19.	Sandra K Hoover	1105 N.W Gordon	Topeka, Ks 66608 1520
20.	Lenny Terry	RR #2 Box 264 F	Wamego Ks 66509
21.	Jack B Callahan	1109 Starlite Circle	Topeka, Ks. 66608 1571
22.	Teresa Keller	3122 NW Rochester	Topeka Ks 66617
23.	Larry D. Snider	1870 NE Bugers Ct.	Topeka Ks 66608
24.	Dorothy M Vagts	3728 N.W. Rochester Rd	Topeka, Ks 66617
25.	Lee Jackson	1900 NW Lyman Rd Lot 222	Topeka KS 66608

Keep original and send a copy to: *Kansas Pharmacists Assoc., 1308 SW 10th St., Topeka, KS 66604*

Northside Family

HEALTH MART

Lyman Rd. at N. Topeka Blvd.
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3393

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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Patti Porteous	R#3	Topeka, KS
2.	Harry Pease	R#3	Topeka Ks
3.	Leslie Coleman	323 Quinton	Topeka KS
4.	Shawndell Ragsdale	Rt 1 Box 123	Meriden Ks 66512
5.	Craig Sisco	Rt 1	Meriden, KS 66512
6.	Ambra Sisco	Rt 1	meriden, Ks 66512
7.	Peggy Myers	RR#2 Box 448	Meriden, KS 66512
8.	Lois Brady	RR 1 Box 300	Hoyt KS 66440
9.	Edward S. Kaniecki	2240 N.E. 35TH ST	TOPEKA KS.
10.	Cindy Heughbarks	3513 nw Rochester	Topeka KS
11.	D. Bernard "Hamish"	6440 NE Indian Cr.	Topeka, Ks 66617
12.	John M Owsley	2320 N Clay	Topeka Ks
13.	Roberta Gasley	1111 NE Madison	Topeka Ks
14.	Colleen Reed	4016 NW Menninger	Topeka Ks 66617
15.	Dana Cummings	521 NE 43rd st.	Topeka. Ks 66617
16.	Erika Thompson	1117 Starlight Circle	Topeka Ks 66607
17.	Samuel W. Chase Sr.	921 N.E. Madison Ave	Topeka Ks 6608
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Northside Family
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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	[illegible]	RT 1 Box 108	Hiawatha, Ks 66434
2.	Charlotte Lanum	R2	Meriden KS 66512
3.	Robert K. Jones	5224 NW 44th	Topeka 66618
4.	Chris Hamm	3807 1/2 N KS	Topeka 66617
5.	Leslie Lobb	RT	Silver Lake 66539
6.	Steve Coloma	Rt 2	Overbrook 66524
7.	Kim Casto	Rt 2	Meriden KS 66512
8.	Teri Isco	Rt 1 Owen St	Meriden KS 66512
9.	Joanne Lacey	Rt 2 Box 367	Meriden KS 66512
10.	Susan Ragsdale	3301 Sherwood Dr	Lawrence KS.
11.	Virgil Lacey	Rt 2 Box 367	Meriden Ks 66512
12.	Gary Gordon	Rt 1 Box 646	Perry, Ks 66073
13.	Scott Perry	735 N.W. 58th	Top KS 66617
14.	Willa Annis	Box 111	Perry KS 66073
15.	Margaret Vanmatter	Box 67	Perry, Ks 66073
16.	Colleen Briggs	2543 E Calhoun Bluff Rd	Topeka, Ks.
17.	Patrick L Pierce	3708 NE OAKWOOD Dr.	TOPEKA KS 66617
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3543

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THE COMMUNITY PHARMACY IS THE BEST PLACE TO GET YOUR MEDICINES!

	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Shirley Myer	749 NE 54th	Topeka, Ks 66617
2.	Earlene Reichart	6340 NE Indian Creek Rd	Topeka Ks 66617
3.	David DeVoss	511 Rodgers	Topeka, KS 66607
4.	P.M. Stoffram	Rt#1 Box 396	Meriden, Ks 66512
5.	Audrey McKinley	3909 NE Cortez Ct.	Topeka 66617
6.	Fred Cochrane	749 N.E. 54th St	Topeka 66617
7.	Marlene Taylor	2628 NW 35	Topeka 66618
8.	Patricia F. Rayner	3722 NW St. Ives	Topeka 66618
9.	Sue Ann Miller	1900 NW Lyman #255	Topeka, KS. 66608
10.		1415 N Monroe	Topeka KS 66608
11.	Cleta Bernritter	P.O. Box 181	Meriden, Ks. 66512
12.	Gerald S. Carr	2338 SW High	Topeka, KS 66611
13.	Michelle Blanchard	2618 N.E. 37th Ter	Topeka, KS 66617
14.	Vickey L. Mills	312 N.E. Fairchild	Topeka
15.	Cheri Dawson	6531 SW 28 Ter	Topeka
16.	Connie Wallin	4936 NW Haven	Topeka 66617
17.	Angela Novak	2306 NE Kaw Vly. Rd.	Topeka, KS 66617
18.	WANDA J. YANDELL	1905 NW WILCOX CT	TOPEKA, KS. 66608
19.	Gordine Brigham	Rte 3	Topeka 66617
20.	Arthur C. Johns	4601 NW. Beaty Rd.	Topeka - 66618
21.	Pamela Thorpe	1900 W. Lyman St #227	Topeka 66608
22.	Kate Eubanks	323 Lyman	Topeka 66608
23.	Carol Moore	314 1/2 E St John	Topeka 66608
24.	Beverly J. Todd	1017 N. Van Buren	Topeka Ks 66608
25.	Paul F. Bowen	2425 SE 45th ST	Topeka, KS 66609

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~~Attachment 7A~~

PETITION

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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Violetta M Stahl Wales	2011 NW Taylor	Topeka KS 66608-1990
2.	[illegible]	4127 N. Topeka	Topeka KS 66617
3.	[illegible]	2329 NW 35	Topeka, Ks 66618
4.	[illegible]	1445 NE 46	Topeka, Ks 66617
5.	[illegible]	825 N. W Jackson	Topeka Ks
6.	John P Bailey	112 N.E. Burgess	Topeka, Kan
7.	Neeley	38425 E Howard Dr	Topeka KS 66605-1935
8.	John N. Kent	3637 NW 25TH ST.	TOPEKA, KS 66618-2707
9.	Cheryl Bleier	320 NW Rolyan Rd	Topeka, KS 66617
10.	Roxanne Gilbert	1040 NE Coachlight Dr.	Topeka, Ks. 66617
11.	Margaret A. Fors	5450 N.W. Green Hills Rd	" " 66618
12.	Elizabeth Johnson	P.O. Box 54 ~~Valley Falls~~	Valley Falls 66088
13.	[illegible]	Rt 2 Box 8	Ozawkie, KS 66070
14.	[illegible]	Rt. 1 Box 100	Perry KS.
15.	[illegible]	Rt 1 Hoyt Ks.	[illegible] 66418
16.	[illegible]	2121 N Buchanan	Topeka Ks 66608
17.	[illegible]	4320 NW Valley Rd	Topeka, KS 66618
18.	[illegible]	2618 NE 37th	Topeka Ks 66617
19.	[illegible]	1211 Mandell	Topeka Ks. 66618
20.	[illegible]	178 NW Holman	Topeka KS. 66608
21.	[illegible]	P.O. Box 90	Lecompton, Ks
22.	[illegible]	328 Halderman	Lecompton Ks
23.	[illegible]	3501 NE Menoken Rd	Topeka Ks
24.	[illegible]	4440 NE Indian Creek Rd	Topeka, KS
25.	[illegible]	3231 NW Brickyard	Topeka KS

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2793

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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Charla Taylor	3630 NW 35th	Topeka, Ks 666618
2.	Tom + Doris Jamison	5240 N.E. Indian Creek Rd	Topeka, K 66617
3.	Ann Christensen	3506 N.E. Oakwood Dr.	Topeka, Ks. 66617
4.	Ramona A Flower	1415 NE Madison	Topeka Ks 66608
5.	Margaret Dean	P.O. Box 25	Silver Lake KS 66539
6.	Lovedyn Ostrander	3124 N.W. 66th	Topeka, Ks 66618
7.	Karen Tanner	1308 N Quincy	Topeka, Ks. 66608
8.	[illegible] Schiffelbein	2121 N.E. 56th	Topeka Ks 66617
9.	Keith Cushing	3660 NE Wenonah Rd	Topeka, Ks. 66617
10.	Marilyn F. Young	3430 NW Countryclub	Topeka Ks 66618
11.	Anna M Harper	1030 NE Collins Rd	Topeka, KS 66617
12.	Wilford Harper	1030 NE Collins Road	Topeka, KS 66617
13.	[illegible] Taylor	1177 [illegible] Lincoln	Topeka KS 66608
14.	Annetta Griffin	1111 NW Lyman Rd	Topeka, Ks 66608
15.	A L Webber	212 E Main	Meriden KS
16.	C H. Baker	8149 NE 70th	Topeka Kans
17.	Pearl Wood	1620 N St. Meadowlark	Topeka Ks
18.	Brenda Vineyard	1203 12th St.	Valley Falls, Ks.
19.	Norma L. Blankinship	Box 157	Lecompton Ks
20.	Kenneth Anspaugh	RT1. BOX 124	HOLTON KS.
21.	Betty J. Severtson	111 NE Coachlight	Topeka, Ks 66617
22.	[illegible] Dunkle	Rt 2 Box 128A	Meriden KS
23.	Mary Bell	5843 NW Westbrooke Dr	Topeka Ks
24.	Catherine Hockenbarger	1225 NW Quincy	Topeka Ks
25.	Dirk Cornelison	3611 NE Meriden Rd	Topeka Ks

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2873

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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	Judy Woofenbarger	4420 NW Greenhills Pl	Topeka Kan 66618
2.	Lyda S. Anson	720 NW 39th st	Topeka Ks
3.	Helen Andrews	2327 NW 39	Topeka
4.	Krista D. Williams	409 NE. OHIO	Topeka KS
5.	Freda L. Smith	1910 N.W. Portal Dr	Topeka, Kans
6.	John Tilghman	3675 NE Rockaway Tr	Topeka, KS
7.	Selma Morris	3110 N. Kansas	Topeka, Ks. 66617
8.	Joseph Bradgett	2011 NW 59th TERR	Topeka Ks 66618
9.	Deanna Huske	Rt#1 Box 622	Meriden, KS 66512
10.	Bertha A Lehne	6881 Greenhills Rd	Topeka, KS 66608
11.	Pearl M. Wiggs	1231 NW 62nd	Topeka, KS 66618
12.	Kathryn O'Reilly	1035 N. Monroe	Topeka Ks 66608
13.	Mickey Woodrow	906 NE Dogwood Ln	Topeka Ks 66617
14.	Marilyn Holloway	1735 NW Lyman # 25	Topeka, KS 66608
15.	Frida Pendarvis	3546 N.W. 45th Ct.	Topeka 66618
16.	Billie A Lawson	4209 NW Topeka	Topeka 66617
17.	Mary A. Hartman	1735 NW Lyman #33	Topeka 66608
18.	William F. McCoy	1431 N. W. Hunter Dr	topeka 66618
19.	Laura Lolley	5921 NE Indian Creek Rd	Topeka 66617-1649
20.	Doris Brown	128 E Lyman	Topeka Ks 66608
21.	Elizabeth B. Kanicki	2240 N.E. 35	Topeka 66617
22.	Chuck Haynes	6221 SE 44	Tecumseh 66542
23.	Virginia L Williams	4838 NW Haven	" " 66617
24.	Barbara J. Holt	309 NE Twiss Ave	Topeka 66616
25.	Sharon L Williams	1938 NE Quincy	Topeka 66608

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Northside Family HEALTH MART
Lyman Rd. at N. Topeka Blvd.
Topeka, Ks. 66608

2993

PETITION

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1.	Rhonda L Bell	Rt1 Box 601 ~~Meriden~~	Meriden KS 66512
2.	Rebecca Ruth Shortz	903 ONE Maple Rd	Topeka 66617
3.	Melvin F. Smith	Rt 1 Box 365A	Hoyt, Ks. 66440
4.	Wendy Parmann	205 N. Q. 35th	Topeka Ks. 66617
5.	Diane M Willingham	1409 NW Eugene	Topeka Ks 66608
6.	Jim Knell	635 NE 43	Topeka Ks 6661 7
7.	Vickie L. Rubarsky	1859 NE Burgess Ct	Topeka Ks 66608 1186
8.	Jacob R Fleenor	5220 NW Topeka	Topeka Kans 6617-
9.	Karla Hughes	5800 S. Topeka #6	Topeka, Ks. 66619
10.	Sheila Shepherd	Rt 2 Box 417	meriden, KS 66512
11.	Mrs E.W. Walker	3816 Rochester Rd	Topeka, Ks
12.	Linda S Mynek	4320 NE Croco Rd	Topeka, Ks.
13.	Edith Dean	2001 N Clay	Topeka, Ks
14.	Arthur O Price	530 E Lyman	Topeka Ks
15.	Kenneth W Knipp	382 WALNUT LANE	OZAWKIE Ks
16.	Anne Coleman	7428 SE Camp Creek	Overbrook Ks 66524
17.	[illegible]	301 Scenic Pl.	Ozawkie KS
18.	Doris J. Palmberg	1344 NE 54th	Topeka, KS.
19.	Sandra K Flowers	1105 N.W Gordon	Topeka, Ks 66608-1520
20.	Larry Terry	RR#2 Box 204F	Wamego Ks-66509
21.	Jack B Callahan	1109 Starlite Circle	TOPEKA, KS. 66608 1571
22.	Teresa Keller	3122 NW Rochester	Topeka Ks 66617
23.	Terry D. Snider	1870 NE Rogers Cir.	Topeka Ks 66608
24.	Dorothy M. Vagts	3728 N.W. Rochester Rd	Topeka, Ks 66617
25.	Lee Jackson	1900 NW Lyman Rd Lot 222	Topeka KS 66608

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2.	Harry Pease	R#3	Topeka Ks
3.	Leslie Coleman	323 Quinton	Topeka KS
4.	Shawndell Rogdale	Rt 1 Box 123	Meriden KS 66512
5.	Craig Sisco	Rt 1	Meriden, KS 66512
6.	Ambra Sisco	Rt 1	meriden, ks 66512
7.	Peggy Myers	RR#2 Box 448	Meriden, KS 66512
8.	Peter Brady	RR1 Box 300	Hoyt KS 66440
9.	Edward S. Kaniki	2240 N.E. 35TH ST	TOPEKA KS.
10.	Cindy Heighbarks	3513 nw Rochester	Topeka KS
11.	B. Bernard "Hamish	6440 NE Indian Cr.	Topeka, KS 66617
12.	John M Crusley	2326 N Clay	Topeka Ks
13.	Roberta Tagley	1111 NE Madison	Topeka Ks
14.	Colleen Reed	406 NW Mennninger	Topeka KS 66617
15.	Dania Cummings	521 NE 43rd St.	Topeka. Ks 66617
16.	Erika Thompson	1117 Starlight Circle	Topeka Ks 66608
17.	Samuel W. Chase Sr.	921 N.E. Medicor Ave	Topeka KS 66608
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	CONSUMER SIGNATURE	STREET ADDRESS	CITY/STATE/ZIP
1.	[illegible]	RT1 Box 128	Shawnee Mission KS 66219
2.	Charlotte Lanum	R2	Meriden KS 66512
3.	Robert K. Jones	5224 NW 44th	Topeka 66618
4.	Chris Hamm	3807 1/2 N KS	Topeka 66617
5.	Leslie Tyler	RT	Silver Lake 66539
6.	[illegible]	RT 2	Overbrook 66524
7.	Kim Casto	Rt 2	Meriden KS 66512
8.	Teri Isco	Rt 1 Owen St	Meriden KS 66512
9.	Joanne Lacey	Rt 2 Box 367	Meriden KS 66512
10.	Susan Ragsdale	3201 Shawnee Dr	Lawrence KS.
11.	Vince Lacey"	Rt 2 Box 367	Meriden Co 66512
12.	Gary Gordon	Rt 1 Box 646	Perry, Ks 66073
13.	Scott Perry	735 N.W. 58th	Top KS 66617
14.	Willa Annis	Box 111	Perry KS 66073
15.	Margaret Vanmatter	Box 67	Perry, Ks 66073
16.	Colleen Geiger	2343 1/2 Calhoun Bluff Rd	Topeka, Ks.
17.	Patrick L Pierce	3708 NE OAKWOOD Dr.	TOPEKA KS 66617
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3243

Testimony Outline
Mike Pflughoeft R.Ph.
1309 Polk
Great Bend, Ks 67530

2/8/93

re: HB 2117 Pharmacy Freedom of Choice

1. Closed Pharmacy networks increase the difficulity of obtaining health care for rural Kansans. Forcing Kansans to obtain prescription medications from a specified "contract pharmacy" or "mail order house" eliminates their freedom to chose the most important component of having the prescription filled---THEIR PHARMACIST!!!

2. Closed Pharmacy networks often lead to non-compliance with the prescribed drug regimen and negative healthcare outcomes due the time delay of "mail order" or the distance which must be traveled to obtain the medication from a "contract Pharmacy"

3. Closed Pharmacy networks have forced over 400 long standing patient's away from our Pharmacy.

Financial Institutions
Attachment 4 Insurance
February 8, 1993

PETER STERN

Testimony before the House Financial Institutions and Insurance Committee of the Kansas Legislature

RE: HB-2117
February 8, 1993

Chairperson Bryant and members of the Financial Institutions and Insurance Committee: I am testifying in favor of House Bill 2117, which concerns the ability of pharmacies to participate in a pharmacy provider network. I am Executive Director of a prescription benefit management and administration company, known as Prescription Network of Kansas (PNK). Our clients include employers, managed care organizations (MCOs) and third party administrators (TPA).

We use what is known as an open pharmacy network, which allows any pharmacy that agrees to a reimbursement level determined by a PNK client (e.g., employer, MCO) to participate in the network. This network arrangement increases the potential for a given health plan's beneficiaries to use the pharmacy of their choice without sacrificing the need for cost containment (which should focus not only on price considerations -- ingredient cost and pharmacists fees -- but also on various plan design elements aimed at controlling utilization and optimizing drug therapy).

Following are two assumptions regarding limited pharmacy network arrangements that exist in today's health benefits market. In conjunction with each of these, I offer an alternative view of pharmacy provider network arrangements and options that can maintain cost containment as an essential element of health plan design and can also maintain ample access for members of a health plan.

Assumption #1 - Limited pharmacy networks are an important key to price discounting, which will save health plan costs.

A 1992 study by the Wyatt Company for the Health Insurance Association of America argues that allowing any pharmacy to participate in a provider network will diminish the economic advantages of a restricted network, because smaller discounts will be available from pharmacies. From an economic theory perspective, this may or may not be true. In reality, a vast majority of pharmacy networks use electronic claims technology which imposes a ceiling on reimbursement for any participating network pharmacy. Insurance companies may assume that only certain pharmacies will accept their discount arrangement on a specific prescription benefit plan. However, if out-of-network pharmacies are given the opportunity to accept the discounted reimbursement, some may wish to join the network. In this case, all network pharmacies are still limited to the same electronically controlled reimbursement set by the plan.

Financial Institutions & Insurance
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Price savings in pharmacy plans are not due to networks per se, but to the price discount itself. The use of an open pharmacy network does not preclude insurance companies/MCOs from developing a competitive range of reimbursement levels. In doing so, it is preferable to use incentives for pharmacies to maximize dispensing of generics and to address utilization problems and patient compliance with drug therapy.

I should mention here that while the Wyatt study attempts to prove that pharmacy PPOs save money compared to a "unmanaged retail environment", some of the assumptions used to arrive at the study's conclusions are flawed. For example, a 21% savings attributed to pharmacy PPOs was assumed based on a standard generic dispensing rate of 26% (versus 19% for general retail). This PPO generic dispensing rate is low compared to national and regional standards. One large open pharmacy network in Kansas generally quotes having a 28%-29% generic dispensing rate; PNK's is 31% across all clients. In comparison, Wyatt's hypothetical pharmacy PPO is losing money for a health plan, not saving money. Also, Wyatt uses a baseline of "unmanaged" indemnity plans to compare to PPOs. There are a great number of plans that have reimbursement controls that are not limited network PPOs or unmanaged indemnity plans. No comparison is offered between these network designs. While other assumptions also cloud some cost savings options available in pharmacy network and plan design, this study is not the direct topic of discussion. It is, however, a paper that continues much of the confusion and the fallacies that exist regarding pharmacy plans and cost savings potential.

One other point regarding price discounts in restricted pharmacy networks -- many plans focus on the discounts at the expense of understanding all the elements that affect prescription plan costs. Various utilization and patient outcome-related interventions must be included for effective prescription plan management. A sole focus on prescription prices seldom leads to control of total prescription plan costs.

Assumption #2 - Certain pharmacies will give greater discounts to insurance companies and MCOs than others.

When insurance companies set up a network, it is common to take the low reimbursement bids and exclude pharmacies with relatively high bids. Does this mean pharmacies not accepted into the network will not be willing to accept the final reimbursement set by the insurance company? Not necessarily.

In the first place, there are a number of instances where only a limited number of pharmacies are given the opportunity to bid on a prescription plan. In this case, many pharmacies have no chance to bid and usually find out about the plan after it becomes effective, when they begin to lose customers that must use the health plan's network pharmacies. Secondly, if a pharmacy does have the opportunity to bid and is not accepted, there may be a willingness to participate at the network reimbursement rate. Each pharmacy can make this decision based on financial and other considerations, but should have the option to participate. Again, regardless of the number of pharmacies in the network, in a great majority of cases, the reimbursement limit is set electronically.

A few other comments about discounting. First, in this reimbursement environment, rampant cost shifting is occurring. While third party plans and their beneficiaries may get reimbursement/price discounts, other patients must pay for this discounting through higher prices in order for pharmacies to maintain their needed revenue levels. Second, it may be true that a pharmacy may discount more if given the opportunity for a greater volume of business through a health plan. However, discounts and bid requests are becoming so low that the aforementioned cost shifting is more of a necessity and both chain and independent pharmacies are having difficulty breaking even on prescriptions filled under these discount arrangements. Although some pharmacies may participate at these low reimbursement levels, to an increasing degree, it is not economically advantageous for the pharmacies or for consumers who pay for prescriptions out-of-pocket.

In conclusion, I would like to reiterate that pharmacy networks do not have to be limited to be effective at controlling total prescription plan costs. To rely on a system that focuses on a continual decline in pharmacy reimbursement misses the point when it comes to cost control and appropriate pharmaceutical care for patients. Though limited pharmacy networks are being used, the use of open networks with comprehensive managed care controls holds great value and does not limit plan beneficiaries' access to the pharmacy of their choice.

Northside Family HEALTH MART

LYMAN RD. & N. TOPEKA BLVD.
TOPEKA, KANSAS 66608
913-354-7606

TESTIMONY

February 8, 1993

HB 2117

HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE

Thank you Chairman Bryant for this opportunity to address the committee. My name is Gary Coleman. I am a practicing pharmacist, a former pharmacy business owner and Past President of the Kansas Pharmacy Service Corporation. I am appearing before the committee this afternoon in support and to seek your support of House Bill 2117.

House Bill 2117 is a pro-consumer bill that is essential and critical to enable Kansas consumers and our patients to seek the services provided by the pharmacy or pharmacist of their choice.

Our pharmacy business, Northside Family HealthMart, a full-line Drug Center located in Topeka for 26 years, is a Kansas business built on attentive pharmacy services, competitive prices, friendliness and convenient hours. Our HealthMart was named among 244 outstanding independent pharmacies in the United States by Drug Topics magazine in 1991 for professional pharmacy services.

HB 2117 is critical to our continued and improving performance to provide proper communication and medication counseling to our patients and their families.

Without the adoption of House Bill 2117 Kansas citizens and your constituents will have no control over their lives to select the trusted pharmacist/patients relationship we all feel is our given right.

Today, as a decision maker for our business, I feel powerless to compete with exclusive contracts, closed panels, and out-of-state mail order pharmacies mandated by large insurance

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carriers conducting business in Kansas today. Our business customer base is diminishing due to these mandated programs. In 1992 our customer base of Goodyear employees was reduced by 37% due to an exclusive no-copay contract through Metropolitan Life Insurance Company with the Topeka Walgreen Drug Company. Together with our established pharmacy services and reputation, customer loyalty and reduced co-pays or no co-pays, in some instances, we have managed to retain some of the Goodyear employee customer base. The present Goodyear business for our pharmacy business is an unprofitable program. Our professional dispensing fee of $3.25, mandated by Metropolitan Life has been the same fee for over 13 years. As business owners we are paralyzed in this dilemma and threatened by antitrust laws to discuss a reasonable dispensing fee.

Metropolitan Life has continued to reduce our dispensing fees with little or NO CONCERN to advocate or manage the drug product cost component by an incentive generic selection by the employee. Metropolitan Life would have you believe their prescription drug program with the Goodyear Company is a "managed care" program to control health care costs. Metropolitan has certainly demonstrated no innovation to control prescription costs. I approached Goodyear Corporate, through the Kansas Pharmacy Service Corporation, in 1983 and again in 1984, with a comprehensive cost control program. We never received a reply from Corporate Goodyear or Metropolitan Life.

If mandated anti-competitive insurance programs such as Mail-Order, Exclusive Contracts, and "Managed Monopolies" are allowed to proliferate in our state, Kansas small businesses will be paralyzed to compete and in time be virtually eliminated to provide needed health services for rural counties in Kansas.

Chairman Bryant, I am submitting to you and your committee several petition signatures signed by our concerned customers who will support legislation such as House Bill 2117. Our citizens need your committee's help to support this important Pro-Consumer bill.

As an important tax base contributor to the Kansas economy and a Kansas small business, I am asking your committee to very seriously consider the adoption of House Bill 2117. The establishment of House Bill 2117 would empower our Kansas citizens as beneficiaries to select the pharmacy of their choice provided that the pharmacy elects to participate as a provider under the same terms and conditions of the policy or contractual arrangement.

THANK YOU.

Feb. 8, 1993
Topeka, Ks

TO: Insurance Committee

Dear Committee Members

My wife and I live in rural Douglas County. We have been a customer of our local pharmacist since the late 1960's. For well over twenty years we have received reliable service from his pharmacy.

In January I was informed by my health insurance plan, that they would have a new Retail Pharmacy Program for 1993. To obtain the maximum benefits of this program I must now purchase our prescription drugs from a nationwide network of Preferred Pharmacies. I must now have all our prescriptions rewritten.

Also in January I was informed by our long time pharmacist that he had been denied entry into this network of Preferred Pharmacies. If he is willing to accept the same terms and conditions as are offered to any other provider of Pharmacy services under the policy or plan, his denial of entry is an action that I can not understand.

Today I give this testimony with hope and respect for the member of this committee that they will review and give full and just consideration of proposed House Bill No. 2117

I urge and would appreciate your support. Passage of this bill would allow me and my family to become consumers of equal access.

Thank You
Charles R. Henderson
R-6 Box 110
Lawrence, Ks 66046

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MEMORANDUM

TO: Representative William Bryant, Chairman
House Financial Institutions and Insurance Committee

FROM: William W. Sneed
Legislative Counsel
Health Insurance Association of America

DATE: February 8, 1993

RE: House Bill 2117

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am Legislative Counsel for the Health Insurance Association of America ("HIAA"). The HIAA is a health insurance trade association consisting of over 300 insurance companies that write over 80% of the health insurance in the United States today. Please accept this memorandum as our testimony in regard to H.B. 2117.

As we have analyzed this bill, if H.B. 2117 were enacted insurance companies would be mandated to allow any pharmacy and/or pharmacist the right to participate as a provider, notwithstanding the fact that the contract had encompassed an arrangement whereby a particular vendor at a discounted rate would provide a network for the supply of pharmaceuticals to the insureds. In a time where cost containment on health care services is so vital, we believe H.B. 2117 is inappropriate and would respectfully request your unfavorable action on this bill.

First, inasmuch as this bill would require a new mandated service, my client would contend that K.S.A. 40-2248 and K.S.A. 40-2249 require a fiscal impact report on H.B. 2117. (Copy of statute attached.) As you can see, these laws require a fiscal impact

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report so that the Legislature may fully evaluate any social benefit versus social cost for such mandates. Thus, we believe that this law requires such a report to be prepared, and would respectfully request that such a fiscal impact report be provided.

Next, we would remind the Committee that this bill would only affect somewhere between fifty to sixty percent of the programs found within the State of Kansas. Inasmuch as Kansas cannot dictate terms to qualified plans exempted under federal law, this law will only affect those insurers doing business in the state, and will not affect self-insuring programs. Thus, those Kansas citizens who are not utilizing a self-insurance plan would not be affected by this bill, and based upon our cost analysis, this would force those Kansas citizens utilizing an insured plan to pay higher pharmaceutical costs.

In regard to costs, it is our opinion that this bill will have an adverse effect on costs and will disallow the current public benefit generated from existing cost-saving arrangements. Attached is a report prepared by The Wyatt Company under date of June 26, 1992 which analyzed various state mandates that would regulate the provisions of prescription drug benefits. It is the conclusion of this report that such restrictions deflate the purchasing power of the insured, thereby reducing the economic value ultimately seen in cost savings to the insured. As you will see in the report, it is the opinion of The Wyatt Company based upon their analysis that such intrusions into this area will ultimately create a disservice to the buying public and will diminish the cost saving benefits generated by these arrangements.

Based upon the foregoing, I respectfully request that the Committee act disfavorably on this bill. I appreciate the opportunity to appear before the Committee, and if you have any questions please feel free to contact me.

Respectfully submitted,

William W. Sneed

William W. Sneed

(h) The amounts specified in this section apply only to those employers who qualify for tax credits under K.S.A. 1992 Supp. 40-2246.

History: L. 1990, ch. 157, § 6; July 1.

40-2245. Same; part II coverage benefits; employer contributions. (a) Part II coverage shall consist of optional benefits. All such optional benefits shall contain incentives to encourage the employee to utilize intelligently services in a cost effective way and disincentives to discourage noncost effective use of services.

(b) At least one part II option shall reduce the deductible of the part I coverage.

(c) Employers may contribute toward the cost of part II coverage, and may include the cost of part II contributions when calculating tax credits available under this act.

(d) The small employer health benefit plan may establish that certain options shall not be available to an employee who is not covered by a certain other option or options.

History: L. 1990, ch. 157, § 7; July 1.

40-2246. Same; employer income tax credit, computation of amount, reduction of deductions, election to claim, carry forward; no inclusion of employer expenses in employee income; application date. (a) A credit against the taxes otherwise due under the Kansas income tax act shall be allowed to an employer for amounts paid during the taxable year for purposes of this act on behalf of an eligible employee as defined in K.S.A. 1992 Supp. 40-2239 and amendments thereto to provide health insurance or care.

(b) The amount of the credit allowed by subsection (a) shall be $25 per month per eligible covered employee or 50% of the total amount paid by the employer during the taxable year, whichever is less, for the first two years of participation. In the third year, the credit shall be equal to 75% of the lesser of $25 per month per employee or 50% of the total amount paid by the employer during the taxable year. In the fourth year, the credit shall be equal to 50% of the lesser of $25 per month per employee or 50% of the total amount paid by the employer during the taxable year. In the fifth year, the credit shall be equal to 25% of the lesser of $25 per month per employee or 50% of the total amount paid by the employer during the taxable year. For the sixth and subsequent years, no credit shall be allowed.

(c) If the credit allowed by this section is claimed, the amount of any deduction allowable under the Kansas income tax act for expenses described in this section shall be reduced by the dollar amount of the credit. The election to claim the credit shall be made at the time of filing the tax return in accordance with law. If the credit allowed by this section exceeds the taxes imposed under the Kansas income tax act for the taxable year, that portion of the credit which exceeds those taxes may be carried over to the tax in succeeding tax years until the credit is used. The credit shall be applied first to the earliest income years possible.

(d) Any amount of expenses paid by an employer under this act shall not be included as income to the employee for purposes of the Kansas income tax act. If such expenses have been included in federal taxable income of the employee, the amount included shall be subtracted in arriving at state taxable income under the Kansas income tax act.

(e) This section shall apply to all taxable years commencing after December 31, 1991.

History: L. 1990, ch. 157, § 8; July 1.

40-2247. Same; exemption from insurance premium tax. No premium tax shall be due or payable on a health benefit plan established under this act.

History: L. 1990, ch. 157, § 9; July 1.

40-2248. Mandated health benefits; impact report to be submitted prior to legislative consideration. Prior to the legislature's consideration of any bill that mandates health insurance coverage for specific health services, specific diseases, or for certain providers of health care services as part of individual, group or blanket health insurance policies, the person or organization which seeks sponsorship of such proposal shall submit to the legislative committees to which the proposal is assigned an impact report that assesses both the social and financial effects of the proposed mandated coverage. For purposes of this act, mandated health insurance coverage shall include mandated optional benefits. It shall be the duty of the commissioner of insurance to cooperate with, assist and provide information to any person or organization required to submit an impact report under the provisions of this act.

History: L. 1990, ch. 162, § 1; July 1.

40-2249. Same; contents. The report required under K.S.A. 1992 Supp. 40-2248 for

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assessing the impact of a proposed mandate of health coverage shall include at the minimum and to the extent that information is available, the following:

(a) The social impact, including:

(1) The extent to which the treatment or service is generally utilized by a significant portion of the population;

(2) the extent to which such insurance coverage is already generally available;

(3) if coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;

(4) if the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

(5) the level of public demand for the treatment or service;

(6) the level of public demand for individual or group insurance coverage of the treatment or service;

(7) the level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts; and

(8) the impact of indirect costs which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage.

(b) The financial impact, including:

(1) The extent to which insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service;

(2) the extent to which the proposed coverage might increase the use of the treatment or service;

(3) the extent to which the mandated treatment or service might serve as an alternative for more expensive treatment or service;

(4) the extent to which insurance coverage of the health care service or provider can be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders; and

(5) the impact of this coverage on the total cost of health care.

History: L. 1990, ch. 162, § 2; July 1.

40-2250. Insurance coverage to include reimbursement for services performed by advanced registered nurse practitioners in certain counties. Notwithstanding any provision of an individual or group policy or contract for health and accident insurance delivered within the state, whenever such policy or contract shall provide for reimbursement for any services within the lawful scope of practice of an advanced registered nurse practitioner within the state of Kansas, the insured, or any other person covered by the policy or contract, shall be allowed and entitled to reimbursement for such service irrespective of whether it was provided or performed by a duly licensed physician or an advanced registered nurse practitioner. Notwithstanding the foregoing provisions, reimbursement shall not be mandated with respect to services performed by an advanced registered nurse practitioner in Douglas, Johnson, Leavenworth, Sedgwick, Shawnee or Wyandotte county unless at the time such services are performed such county is designated pursuant to K.S.A. 76-375, and amendments thereto, as critically medically underserved or medically underserved in primary care as defined by K.S.A. 76-374, and amendments thereto.

History: L. 1990, ch. 162, § 3; July 1.

40-2251. Statistical plan for recording and reporting premiums and loss and expense experience by accident and health insurers; compilation and dissemination. The commissioner of insurance shall develop or approve statistical plans which shall be used by each insurer in the recording and reporting of its premium, accident and sickness insurance loss and expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid the commissioner and other interested parties in determining whether rates and rating systems utilized by insurance companies, mutual nonprofit hospital and medical service corporations, health maintenance organizations and other entities designated by the commissioner produce premiums and subscriber charges for accident and sickness insurance coverage on Kansas residents, employers and employees that are reasonable in relation to the benefits provided and to identify any accident and sickness insurance benefits or provisions that may be unduly influencing the cost. Such plans may also provide for the recording and reporting of expense experience items which are specifically applicable to the state. In promulgating such plans, the commissioner shall give due consideration to the rating systems, classification criteria and insurance and subscriber plans on file with the commissioner and, in order that such plans

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A COST ANALYSIS OF THREE STATE MANDATES TO REGULATE THE PROVISION OF PRESCRIPTION DRUG BENEFITS

Prepared for
The Health Insurance Association of America

The Wyatt Company
June 26, 1992

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(Continued)

A COST ANALYSIS OF THREE STATE MANDATES TO REGULATE THE PROVISION OF PRESCRIPTION DRUG BENEFITS

Executive Summary

Background

Insurance plans that traditionally paid for prescription drugs on the basis of unregulated charges are now using their market power to help consumers purchase pharmaceutical products in a more prudent manner. Although specific arrangements differ, they generally include financial incentives for beneficiaries to use a limited network of community and mail service pharmacies that have agreed to provide prescriptions and related administrative services at a discount. These arrangements help control the cost of medical care and medical insurance for the consumer, while fostering information systems that can be used to coordinate and enhance the quality of medical care.

Prescription drugs now account for about 10 percent of covered medical charges for active employees and their dependents. For retirees with primary coverage from Medicare, prescription drugs account for 30 to 50 percent of the medical charges not paid by Medicare. Awareness of these prescription drug costs is heightened by a new accounting standard about to be implemented for employer-sponsored retiree medical plans. For plan years that begin after December 1992, these plans must report their retiree medical liabilities on an accrual basis rather than the pay-as-you go basis that has been common. When employers calculate their retiree medical liabilities, many will find that they face liabilities of $10,000 or more per retiree in prescription drug costs alone.

In 1991 the Health Insurance Association of America (HIAA) commissioned Th Wyatt Company to examine the costs associated with six state legislative mandates intended to regulate managed health care practices. This study, an extension to that report, examines the cost impact of three state mandates that would regulate managed care practices in the provision of prescription drug benefits. The study analyzes the lost savings that would result if health insurance plans were required to comply with the following mandates:

1. *Any willing pharmacy provider.* These laws would require establishment of a specific, objective set of criteria for selection of participating pharmacies and would allow any pharmacy that met these criteria to participate in the preferred provider organization (PPO).

2. *Benefit differentials.* These laws would restrict the magnitude of payment differences for prescriptions filled in network and nonnetwork pharmacies. Such payment incentives are the principal means that plan sponsors use to encourage the use of network pharmacies.

3. *Same state license.* These laws would limit participating pharmacies to those with an in-state license. Mail service pharmacies, as currently structured, would not meet this requirement because they serve national populations from a limited number of sites.

Study Overview

The initial objective of this study is to estimate the percentage savings that tightly managed pharmacy PPOs and mail service organizations can provide relative to the

unmanaged retail environment. Following this analysis of PPO and mail service savings, we examine the extent to which each of the state mandates would erode the savings that are currently available.

To calculate managed care savings, it is first necessary to estimate the baseline cost of prescription drugs in an unmanaged retail environment. This is complicated because traditional indemnity plans do not compile complete information about drug utilization and expenditures. These plans typically pay prescription drug benefits along with other medical benefits after a deductible is satisfied -- a deductible that currently averages $200 for a single person. A large portion of prescription drug charges fall below this $200 threshold, and beneficiaries often neglect to submit other claims for payment. The deductible and coinsurance provisions of a traditional indemnity plan can also suppress prescription drug utilization.

We developed a baseline retail cost model to serve as a standard of comparison for PPO and mail service savings. The model required assumptions concerning the annual number of prescriptions per person, the mix of drugs dispensed in the acute and maintenance categories, and the percentage of prescriptions filled in generic and trade forms. Similar cost models were developed for PPO and mail service arrangements. The discounts assumed for PPO and mail service models are available from multiple vendors with a national reputation and market presence -- we consider these discounts typical.

The PPO cost model indicates:

- Savings of 18.6 percent from the retail baseline considering the PPO discount alone.

- Savings of 21.2 percent from retail when this managed care plan is able to increase the generic dispensing rate from the retail baseline of 19.3 percent to a PPO standard of 26.4 percent.

Mail service is not generally appropriate for acute medications that must be filled immediately, but about two-thirds of all prescription fills are for maintenance medications. These medications are prescribed for chronic conditions and they must be provided on a regular basis.

The mail service cost model indicates:

- Savings of 11.1 percent when half of the maintenance medications are furnished through mail service and all other prescriptions are filled in the community pharmacy retail setting.

- Savings of 24.8 percent when half of the maintenance medications are furnished through mail service and all other prescriptions are filled in the PPO network described above.

These savings are contrasted with the apparent reduction in costs that occurs by moving back to a traditional indemnity plan that requires a deductible and submission of paper claims. In this modified retail scenario, claims submissions are 35 percent below the retail baseline, because some prescriptions are not filled and others are not submitted for payment. This apparent "savings" to the insurance plan occurs because some beneficiaries are less likely to fill their prescriptions, and because they forget to submit some claims for payment. If mandates make it difficult for employers to implement effective managed care programs for prescription drug benefits, many employers will seek plan savings through traditional indemnity cost sharing.

Mandate 1: Any Willing Pharmacy Provider

Wyatt constructed a pharmacy revenue requirement model and analyzed pharmacy behavior for a pharmacy network with 30 percent of a market's prescriptions. The model assumed that 40 percent of community pharmacies currently participate in the network, and that they offer a discount from retail of 18.6 percent. *Scenario 1 of this model produces an overall savings to the plan and plan members of 16.7 percent. (Savings are reduced from the 18.6 percent level because 5 percent of claims are out of network, and one percent of premium costs are consumed by network administration.) This savings would be reduced or eliminated if networks were mandated to accept any willing pharmacy provider.*

Given the above assumptions, expansion of the network to include all pharmacies would completely eliminate the economic advantage of the network to both pharmacies and consumers. As network participation approaches 100 percent, pharmacies can offer smaller and smaller discounts because the potential gains in market share are so small. At 100 percent pharmacy participation the health plan must still pay the fixed costs of network administration, but network pharmacies no longer have an incentive to give even a small discount.

Mandate 2: Benefit Differentials

We borrowed the benefit differential model from our previous study of state mandates to estimate the impact of moving from a 30 percent benefit differential to 20 and 15 percent differentials. The estimates from this model are illustrative, because controlled research on the response of beneficiaries presented with these differentials has not been performed. The model suggests that moving from a 30 percent differential to a 20 percent differential would reduce utilization of network pharmacies from 95 percent of the total to 88.9 percent. A benefit differential of only 15 percent would reduce network utilization to 85.6 percent of total prescriptions.

The direct cost impact of moving from a 30 percent to a 15 percent differential is to increase average plan and beneficiary payments from 82.3 percent of retail to 84.1 percent of retail. Although this estimated cost impact is less than 2 percent of total claims cost, this mandate would also precipitate other costs. First, differences in cost sharing arrangements for in-network and out-of-network prescriptions create costly administrative complexities in the calculation of benefit differentials. Second, beneficiary utilization of out-of-network pharmacies can severely undercut the health plan's negotiating position with pharmacies.

Mandate 3: Same State License

Same state license laws represent a threat to the viability of mail service pharmacies -- a threat that would vary with the extent of the regulation imposed. Requiring that beneficiaries receive mail service only from in-state pharmacies would represent a substantial increase in the operating costs of even the largest mail service providers, because it would require opening additional pharmacies. At the other end of the spectrum, compliance with certain state-mandated facility standards might impose relatively small costs on mail service providers. Rather than attempt to calculate these costs that would vary according to the individual mandate, the individual state, and the particular mail service provider, we modeled a range of savings that mail service can currently produce for a retired population.

This model assumed a retiree population requiring an average of 15 prescriptions per year in the retail setting, 70 percent of which are for maintenance medications. *The prescription drug expense for these retirees is reduced by 21.2 percent when 90 percent of the maintenance drug volume is furnished under the mail service option. In this scenario, mail service alone produces savings of more than $100 per retiree each year. These savings could be eliminated by a same state license mandate that imposed substantial costs on mail service plans.*

Although substantial savings might also be obtained through negotiations w community pharmacy networks, a plan's ability to negotiate discounts depends on competitiveness of the prescription drug market. The existence of mail service organizations does much to enhance this competition. Moreover, mail service fills some special needs that are poorly served through networks. Retired and disabled persons in rural areas, retirees who move out of state when they retire, and retirees who move south each winter are all problematic for health plans. It is difficult to obtain network discounts for these people because they represent only a small portion of the market in the areas which they reside. Moreover, those with disabilities can benefit greatly from the convenience of mail delivery.

Overall Conclusions

Managed care arrangements for prescription drugs, as for other medical benefits, give health care consumers the opportunity to obtain better value for the money they spend in the health care market place. PPO and mail service programs generally furnish beneficiaries more prescription drugs for less cost -- and they do so with an emphasis on quality. The information systems developed through these programs are opening new opportunities for monitoring, managing and improving the quality of care that beneficiaries receive.

Prescription drugs can no longer be viewed as an inconsequential part of the medical plan -- they represent major expenditures, particularly for retirees. In many ways the question is not whether the health plan should be able to pursue managed care opportunities, but whether employers will be able to continue funding medical benefits that are not managed. The new financial accounting standard for retiree medical plans is especially pertinent here, because employers must find a way to address this large cost that will be such a major factor in their profitability.

A COST ANALYSIS OF THREE STATE MANDATES TO REGULATE THE PROVISION OF PRESCRIPTION DRUG BENEFITS

Full Report

Background

In 1991 the Health Insurance Association of America (HIAA) commissioned The Wyatt Company to examine the costs associated with six state legislative mandates intended to regulate managed health care practices. These mandates would impose various restrictions on the way that preferred provider organizations (PPOs) and utilization review (UR) organizations are structured and operated. The result of that effort was a June 1991 report that estimated the administrative costs and medical claims costs that would result from such mandates.

This study, an extension to that report, examines three state mandates that address managed care in the context of prescription drug benefits. The study analyzes what the cost impact would be if managed care organization were required to comply with the following mandates:

1. Any willing pharmacy provider. These laws would require establishment of a specific, objective set of criteria for selection of participating pharmacies, and would allow any pharmacy that met these criteria to participate in the PPO.

2. Benefit differentials. These laws would restrict the magnitude of paymen differences for prescriptions filled in network and nonnetwork pharmacies. Such payment incentives are the principal means that plan sponsors use to encourage the use of network rather than retail pharmacies.

3. Same state license. These laws would limit participating pharmacies to those with an in-state license. Mail service pharmacies, as currently structured, would not meet this requirement because they serve national populations from a limited number of sites.

As in the original study, we attempt to estimate the prescription drug savings that are feasible under a variety of managed care scenarios and the extent to which these state mandates might reduce these savings. We focus on measurable savings that result from pricing discounts, generic substitution, and beneficiary choice to use in-network services. Other savings would result from those components of managed care that are intended to ensure quality of care and better compliance with prescription drug treatment regimens. We can offer only limited information about savings associated with these aspects of prescription drug managed care, but a growing literature suggests that they may be substantial.

Context of Managed Pharmacy Benefits

The costs of employer-sponsored health care have been escalating rapidly in recent years, and the costs of prescription drug benefits have risen even faster than other medical costs. The Wyatt Company's Compare™ Survey shows that the costs of health insurance for an employee with family coverage increased by about 15 percent between 1990 and 1991. A national survey of retail pharmacy outlets shows that the average prices consumers paid for prescriptions increased by 21 percent during this same period. Indeed, increases

in average price per prescription understate the actual increases in prescription drug spending because there also has been a steady increase in utilization. According to estimates prepared by the Health Care Financing Administration, the average number of prescriptions per aged person increased by 30 percent between 1976 and 1988.

Prescription drugs now account for about 10 percent of covered medical charges for active employees and their dependents. For retirees with primary coverage from Medicare, prescription drugs account for 30 to 50 percent of the medical charges not paid by Medicare. Awareness of these prescription drug costs is heightened by a new accounting standard that will be implemented this year. For plan years that begin after December 1992, employer-sponsored retiree medical plans must report retiree medical liabilities on an accrual basis rather than the pay-as-you-go cash basis that has been common. The value of a fully accrued medical benefit for a retiree varies widely, but a crude rule of thumb puts it in the $30,000 - $40,000 range. Of this total, it is not uncommon to find prescription drug liabilities in excess of $10,000 per retiree.

These facts are forcing employers to make critical choices about how they will control their spending for health care benefits. Some employers have responded by eliminating health care benefits, some have shifted a greater portion of costs to employees, and many have sought to preserve health care benefits by managing them more carefully. Coinciding with employers' growing concern about prescription drug costs is the development of new health care delivery systems that introduce economies into the purchase and delivery of the benefit.

In a traditional indemnity plan, the beneficiary purchased prescriptions at a retail pharmacy, paid cash to the pharmacy, and submitted the receipt to the health insurance plan for reimbursement. This arrangement produces several adverse consequences from both efficiency and quality-of-care perspectives.

First, health plan spending for prescription drugs was constrained because some beneficiaries hesitated to fill prescriptions that were below the plan deductible (known as the "hesitancy effect"), and because many prescriptions that were filled were never submitted as claims. This second factor is known as the "shoebox effect," because of the popular image that beneficiaries take their paper claims home and place them in a shoebox with the intention of filing them at a later date. Many of these claims are either lost or forgotten.

Although the hesitancy and shoebox effects are believed to reduce claims submission by as much as 30 to 40 percent, they also have adverse consequences. When prescriptions are never filled, the beneficiary fails to comply with the drug treatment prescribed by the physician. Studies show that failure to comply with drug treatment accounts for up to 15 percent of hospital admissions -- an adverse consequence from both cost and quality perspectives. This failure to comply may also be costly to the plan if adverse outcomes require additional medical care.

A second set of problems with the traditional reimbursement arrangement grows from the lack of information and incentives necessary to sustain a competitive market. Drug store receipts typically do not include sufficient information for the medical plan to determine whether prescription drug charges are reasonable, whether a generic medication might be available, or whether the pattern of prescription drug fills meets standards for quality care. Traditional plans simply check to see that the deductible is met, and then pay a fixed percentage of what was charged to the beneficiary. Given this lack of information, it is virtually impossible to manage the benefit to achieve either cost or quality objectives.

In this traditional environment, beneficiaries are not given financial incentives or the information needed to act as prudent purchasers of prescription drugs; third party payers are not empowered with information or the ability to steer market share to those

pharmacies that offer discounts and collaborate with the plan to manage costs; and pharmacies are given little incentive to compete on the basis of price or quality of care.

The advent of new computer and communications technologies has made it possible to manage the prescription drug benefit in a manner that benefits all parties to the prescription drug transaction. In the case of full online claims adjudication, network pharmacies can now bill the health plan electronically at the point of sale. This point of sale technology reduces the hesitancy effect and eliminates the shoebox effect. This also delivers timely information to the beneficiary, pharmacist, and health plan. The beneficiary now knows at the point of sale whether the prescription is covered, and what the out-of-pocket costs will be if the prescription is filled in generic or trade forms. The pharmacist is able to confirm the beneficiary's eligibility and submit the claim for electronic "adjudication", which indicates precisely what the plan will pay. The third party payer gains extensive information that creates the potential for more cost-effective management of the pharmacy benefit.

Point-of-sale technology also enables management of generic dispensing through 'Maximum Allowable Cost' or 'MAC' programs -- which limit payable charges for multisource products to fixed amounts below the most costly available generics. Electronic claims submission and adjudication allows careful monitoring of the extent to which generics are being substituted for trade drugs. Many PPO and mail service contracts now include performance guarantees for the percentage of prescriptions that network pharmacies will fill with lower cost generics.

During the same period that new technologies were facilitating the development of pharmacy PPOs, mail service firms introduced an additional element of competition into the prescription drug market. These firms are able to achieve economies of scale through

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volume purchasing directly from manufacturers, through highly specialized dispensing and packaging systems, and through advanced information systems that collect clinical and reimbursement information. These organizations still account for less than 10 percent of the private sector drug volume dispensed in the U.S., but their very presence has enhanced competition and established a new standard of efficiency.

In recent years, third-party payers have experimented with various managed care arrangements designed to maintain comprehensive coverage of prescription drug benefits, while encouraging more prudent purchasing decisions. In contrast to the alternative of shifting costs to employees and retirees, these arrangements frequently represent an enhanced benefit in terms of the proportion of total prescription drug dollars paid by the health plan.

Study Overview

Model Development

The initial objective of this study is to estimate the percentage savings that tightly managed pharmacy PPOs and mail service organizations can provide relative to the unmanaged retail environment. Total savings to both beneficiaries and their third-party payers are considered. We do not attempt to quantify savings that may result when enhanced drug treatment compliance helps the beneficiary avoid hospitalization or other medical services.

Key determinants of modeled savings are price discounts, generic substitution, and the market penetration achieved by preferred providers. The first part of our analysis presents a variety of scenarios illustrating the savings that can be achieved when prescriptions are filled through PPO and mail service pharmacies.

Following this analysis of PPO and mail service savings, we examine the impact of each state mandate. We consider the plan sponsor's ability to steer beneficiaries to preferred providers, the extent of discounts that these preferred providers might offer when that steerage effect is weakened, and the likelihood that these arrangements would remain viable under the proposed mandates.

Data, Measurement, and Assumptions

The models used for this study require empirical data, standards for measurement, and assumptions. Wyatt's role in negotiating PPO and mail service contracts gives us current market information concerning the pricing discounts and generic substitution rates common among PPO and mail service vendors. We also collected plan data from five national carriers who market managed care products with a prescription drug component. Combining the data from PPO vendors, mail service organizations, and carriers with managed care products, the data for this report draw on the actual experience of managed care organizations that offer prescription drug benefits to over 59 million people. The price discounts and generic substitution rates used in these models are not extreme values; rather they reflect the current experience of prominent managed care vendors with a national presence.

Average Wholesale Price (AWP) is used as a yard stick against which we measure prescription drug retail prices and discounts. AWP has been likened to a "sticker price" -- it is not a price at which prescription drugs are actually bought and sold, but it does furnish a useful standard for comparing ingredient costs of drugs dispensed in different settings. Pharmacies generally acquire their stock at a considerable discount from AWP, and sell them in a retail environment at a substantial markup over AWP. PPO and mail service contracts typically provide for reimbursement of prescriptions dispensed according to a formula based on AWP.

Assumptions are used in this report both for purposes of simplifying the models and for purposes of testing a range of scenarios for potential savings. For example, we assume that the average supply of maintenance medications dispensed in a mail service setting does not differ for trade drugs with no generic substitute, those with a substitute, and the generic drug. The data used for this project show some minor differences among these categories, but an average supply is used for all these categories. Another kind of assumption concerns the range of scenarios to model. Few if any of today's indemnity plans have achieved the full potential for generic substitution, mail service market penetration, or channeling of beneficiaries into preferred provider arrangements.

Limitations of the Study

This study focuses on the cost savings that can be accomplished through PPO and mail service discounts, and through generic substitution. Managed care also addresses quality of care, including drug utilization review, information systems that integrate treatment profiles from medical and pharmacy providers, and provider education. This study does not evaluate the success of such programs.

A second limitation of this study is that we estimate cost savings using relative rather than absolute terms. The number of prescriptions per person will vary widely from plan to plan depending on plan demographics, community practice patterns, and beneficiary cost sharing. For example, one national card plan reports that the average number of prescription fills per year is 15 for an over-65 population, but one large retiree medical plan is reporting 30 per year. Similar issues occur in considering the average supply and average charges per prescription. Rather than attempt to define national standards for these parameters that vary from plan to plan, we have stated them as assumptions and calculated savings in percentage terms.

Finally, this study does not attempt to determine whether some prescription drug delivery systems are better than others at identifying and eliminating waste. This study takes the perspective that prescription drugs are prescribed by physicians for a good reason, and the underlying medical need for prescription drugs is independent of the reimbursement mechanism or delivery system under which a beneficiary may obtain the prescription. Consequently, we do not attempt to identify savings that might be accomplished through the identification and elimination of unnecessary prescriptions.

Savings Under Managed Care Arrangements

In order to estimate the savings associated with PPO and mail service arrangements, we must determine baseline prescription drug costs in the unmanaged retail setting. The baseline retail cost scenario is intended to be free of the shoebox and hesitancy effects, and the costs are intended to include all costs, whether paid by the health plan or by the beneficiary. The basic premise of this scenario is that beneficiary access to prescription medications is not hampered by cost sharing or other utilization constraints, and the pharmacy is paid at the full retail charge.

Prices, utilization, and generic substitution rates associated with the retail market are difficult to observe, because the typical indemnity plan yields only partial information. Given this situation, we constructed the baseline retail cost scenario from the claims experience of two large national data bases. The first data base included drug charges taken from a network that requires submission of paper claims by the beneficiary (the plan requires this in order to retain the shoebox effect). Unlike the typical paper claims, these included days supply together with the National Drug Code number – information that allowed us to calculate the relationship between retail charges and the AWP for each claim. It also allowed us to calculate the generic substitution rates in a retail setting where there are no financial incentives to substitute the generic product.

The second data base was that of a national card program with comprehensive benefits. This data base was not appropriate for estimating retail pricing or generic substitution, but it furnished better estimates of the average days supply of acute care and maintenance medications that occur when comprehensive pharmacy benefits are delivered in a community pharmacy setting. Taken together, these data bases yielded the profile of baseline 1992 retail costs presented in Table 1. This scenario indicates a generic substitution rate of just over 19 percent, and a relationship between AWP and retail prices that is closely approximated by the following formula:

$$\text{Retail price} = (\text{AWP} \times 1.0825) + \$4.00$$

This baseline model assumes an average of 7.5 prescription fills annually per covered person. This utilization rate is based on a population that includes both active employees and retirees, minimal cost sharing, and full submission of claims into the reporting system. Based on this level of utilization, the model projects a 1992 annual retail claims cost of $241.12 per person. This baseline cost serves as a benchmark for evaluating the savings of PPO and mail service delivery systems.

PPO Savings

Although the PPO market for prescription drug benefits is still evolving, substantial savings are currently available. Of course the network with the best discount may not offer sufficient geographic coverage, a commitment to generic substitution, or good performance on various other measures related to cost and quality. The discount level we selected for the PPO model is available from several national vendors with good records of performance on these measures.

The reimbursement formula used for the PPO models is as follows:

$$\text{Prescription payment} = (\text{AWP} - 10\%) + \$2.75$$

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TABLE 1
1992 BASELINE RETAIL COSTS PER PERSON

	PCT OF FILLS	FILLS/ PERSON	AWP$/ Rx	RETAIL $ Rx	DAYS/ Rx	DAYS/ PERSON	COST/ PERSON
RETAIL							
Acute Single Source	11.6%	0.9	35.52	42.45	11.0	9.6	36.92
Acute Multisource	13.4%	1.0	15.55	20.83	11.0	11.0	20.88
Acute Generic	10.0%	0.8	7.31	11.91	11.0	8.3	8.97
Total Acute	35.0%	2.6	19.80	25.44		28.9	66.77
Maint Single Source	42.5%	3.2	34.21	41.03	30.0	95.7	130.85
Maint Multisource	13.2%	1.0	27.89	34.19	30.0	29.7	33.88
Maint Generic	9.3%	0.7	9.10	13.85	30.0	20.9	9.63
Total Maintenance	65.0%	4.9	29.34	35.76		146.3	174.35
Total Single Source	54.1%	4.1	34.49	41.34	25.9	105.2	167.76
Total Multisource	26.6%	2.0	21.68	27.47	20.4	40.7	54.75
Total Generic	19.3%	1.4	8.17	12.84	20.1	29.1	18.61
Total	100.0%	7.5	26.00	32.15	23.4	175.1	241.12

Retail Price = AWP + 8.25% + $4.00

Assumes no incentives for generic substitution.

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This payment formula yields total savings of 18.6 percent when compared to prescription drugs purchased for a similar population in a retail environment (Table 2). This savings is accomplished on the basis of price discounts alone -- the generic substitution rate is held constant at the same level used for the retail model.

When generic drugs are substituted for trade drugs, the savings can be enhanced as demonstrated by Table 3. In this model the average AWP for multisource trade drugs is $21.96 compared to an average of $8.15 for generic substitutes. Even after the PPO's dispensing fee is taken into account, the plan cost of a multi-source trade drug is still more than twice the cost of the generic substitute. Table 3 shows the impact of increasing the generic substitution by just seven percentage points above the 19.3 percent baseline rate of Table 2. This scenario produces savings of 21.2 percent compared to the 18.6 percent PPO savings based on price discounts alone.

Mail Service Savings

About 65 percent of all prescriptions and over 80 percent of the total prescription days supplied by our modeled plans are for maintenance medications. These are medications required on a long-term basis to treat chronic conditions such at diabetes, hypertension, and arthritis. Mail service plans can do little to address the costs of acute medications, but these plans do offer considerable savings for chronic medications.

Mail service savings result from deep price discounts, reduced dispensing fees, dispensing prescriptions in larger quantities, generic substitution, and the elimination of separate charges for claims administration. Table 4 indicates an 11.1 percent mail service savings in claims costs compared to the retail baseline. This mail service scenario is premised on a blend of retail and mail service delivery systems, with half of the

TABLE 2
1992 COST PER PERSON IN A PPO

PPO	PCT OF FILLS	FILLS/ PERSON	AWP $/ Rx	PPO $/ Rx	DAYS/ Rx	DAYS/ PERSON	COST/ PERSON
Acute Single Source	11.6%	0.9	35.52	34.72	11.0	9.6	30.19
Acute Multisource	13.4%	1.0	15.55	16.75	11.0	11.0	16.78
Acute Generic	10.0%	0.8	7.31	9.33	11.0	8.3	7.03
Total Acute	35.0%	2.6	19.80	20.57		28.9	54.00
Maint Single Source	42.5%	3.2	34.21	33.54	30.0	95.7	106.95
Maint Multisource	13.2%	1.0	27.89	27.85	30.0	29.7	27.59
Maint Generic	9.3%	0.7	9.10	10.94	30.0	20.9	7.61
Total Maintenance	65.0%	4.9	29.34	29.16		146.3	142.15
Total Single Source	54.1%	4.1	34.49	33.79	25.9	105.2	137.14
Total Multisource	26.6%	2.0	21.68	22.27	20.4	40.7	44.38
Total Generic	19.3%	1.4	8.17	10.10	20.1	29.1	14.64
Total	100.0%	7.5	26.00	26.15	23.4	175.1	196.15
Retail Baseline	100.0%	7.5	26.00	32.15	23.4	175.1	241.12
Pct. Change from Retail				-18.6%			-18.6%

PPO Reimbursement = AWP - 10% + $2.75

TABLE 3
1992 COST PER PERSON IN A PPO
WITH 7% INCREASE IN GENERIC SUBSTITUTION

	PCT OF FILLS	FILLS/ PERSON	AWP $/ Rx	PPO $/ Rx	DAYS/ Rx	DAYS/ PERSON	COST/ PERSON
PPO							
Acute Single Source	11.6%	0.9	35.52	34.72	11.0	9.6	30.19
Acute Multisource	9.3%	0.7	15.55	16.75	11.0	7.7	11.73
Acute Generic	14.1%	1.1	7.31	9.33	11.0	11.6	9.84
Total Acute	35.0%	2.6	18.86	19.72		28.9	51.76
Maint Single Source	42.5%	3.2	34.21	33.54	30.0	95.7	106.95
Maint Multisource	10.1%	0.8	27.89	27.85	30.0	22.7	21.12
Maint Generic	12.4%	0.9	9.10	10.94	30.0	27.8	10.15
Total Maintenance	65.0%	4.9	28.45	28.35		146.3	138.22
Total Single Source	54.1%	4.1	34.49	33.79	25.9	105.2	137.14
Total Multisource	19.5%	1.5	21.96	22.52	20.9	30.5	32.85
Total Generic	26.4%	2.0	8.15	10.08	19.9	39.4	19.99
Total	100.0%	7.5	25.09	25.33	23.4	175.1	189.98
Retail Baseline	100.0%	7.5	26.00	32.15	23.4	175.1	241.12
Pct. Change from Retail			-3.5%	-21.2%			-21.2%

PPO Reimbursement = AWP - 10% + $2.75

TABLE 4
1992 COSTS FOR RETAIL WITH MAIL OPTION

	PCT OF FILLS	FILLS/ PERSON	AWP $/ Rx	PPO $/ Rx	DAYS/ Rx	DAYS/ PERSON	COST/ PERSON
RETAIL							
Acute Single Source	14.3%	0.9	35.52	42.45	11.0	9.6	36.92
Acute Multisource	16.5%	1.0	15.55	20.63	11.0	11.0	20.88
Acute Generic	12.4%	0.8	7.31	11.91	11.0	8.3	8.97
Total Acute	43.3%	2.6	19.80	25.44		28.9	66.77
Maint Single Source	26.3%	1.6	34.21	41.03	30.0	47.8	65.42
Maint Multisource	8.2%	0.5	27.89	34.19	30.0	14.9	16.94
Maint Generic	5.7%	0.3	9.10	13.85	30.0	10.4	4.82
Total Maintenance	40.2%	2.4	29.34	35.76		73.1	87.18
MAIL							
Maint Single Source	10.8%	0.7	83.2	74.92	73.0	47.8	49.09
Maint Multisource	1.5%	0.1	67.9	61.54	73.0	6.8	5.77
Maint Generic	4.2%	0.3	22.1	21.76	73.0	16.4	5.50
Total Maintenance	16.5%	1.0	66.39	60.26		73.1	60.36
SUMMARY							
Total Single Source	51.4%	3.1	44.88	46.55	33.7	105.2	151.43
Total Multisource	26.2%	1.6	22.47	27.39	20.6	32.7	43.59
Total Generic	22.3%	1.4	10.54	14.25	27.5	37.2	19.29
Total	100.0%	6.1	31.33	35.34	28.9	175.1	214.3
Retail Baseline	100.0%	7.5	26.00	32.15	23.4	175.1	241.12
Pct. Change from Retail		-19.1%	20.5%	9.9%	23.7%		-11.1%

Retail Price = AWP + 8.25% + $4.00 Fee
Mail Reimbursement = AWP - 13% + $2.50
50% MAIL SERVICE PENETRATION OF MAINTENANCE MARKET

maintenance medications and all acute medications still delivered through traditional retail channels. Although mail order supplies only 73.1 of the 175.1 prescription days per capita under this scenario, the plan and beneficiary share a substantial savings.

The discounts available through mail service plans are generally the best in the industry, with the reimbursement formula used here rather typical:

Reimbursement = (AWP -13%) + $2.50

The 13 percent discount from AWP is very favorable compared to the discounts available from community pharmacies, and the fixed dispensing fee is spread over a longer average days supply. In this mail service model, the maintenance medications dispensed through mail service average a 73 day supply compared to an average supply of 30 days dispensed in the retail community pharmacy setting. Although a lower percentage of maintenance medications have generic substitutes, many mail service firms have a good reputation for making such substitutions whenever possible. In this model, the mail service firm is able to substitute generics 25 percent of the time for maintenance medications compared with a 14 percent generic substitution rate for maintenance medications dispensed through retail channels.

Integrated PPO/Mail Service Plans

Table 5 illustrates the potential savings in claims costs that can be achieved by integrating the PPO and mail service options. Mail service can furnish convenience and maximum price discounts to beneficiaries who are dependent on maintenance medications, while the PPO can furnish the acute medications and initial fills for maintenance prescriptions. Some health plans boost the use of mail order by requiring that all maintenance medications after the first fill be through mail service.

TABLE 5
1992 COSTS FOR INTEGRATED PPO WITH MAIL SERVICE
OVERALL GENERIC SUBSTITUTION AT 28%

	PCT OF FILLS	FILLS/ PERSON	AWP $/ Rx	PPO $/ Rx	DAYS/ Rx	DAYS/ PERSON	COST/ PERSON
RETAIL							
Acute Single Source	13.7%	0.9	35.52	34.72	11.0	9.6	30.19
Acute Multisource	11.0%	0.7	15.55	16.75	11.0	7.7	11.73
Acute Generic	16.6%	1.1	7.31	9.33	11.0	11.6	9.84
Total Acute	41.3%	2.6	18.86	19.72		28.9	51.76
Maint Single Source	30.1%	1.9	34.21	33.54	30.0	57.4	64.17
Maint Multisource	7.2%	0.5	27.89	27.85	30.0	13.6	12.67
Maint Generic	8.8%	0.6	9.10	10.94	30.0	16.7	6.09
Total Maintenance	46.1%	2.9	28.45	28.35		87.8	82.93
MAIL							
Maint Single Source	6.3%	0.5	83.2	74.92	73.0	36.3	39.27
Maint Multisource	1.2%	0.1	67.9	61.54	73.0	5.5	4.62
Maint Generic	3.2%	0.2	22.1	21.76	73.0	14.8	4.40
Total Maintenance	12.6%	0.8	66.39	60.26		58.5	48.29
SUMMARY							
Total Single Source	52.1%	3.3	42.33	40.41	31.8	105.2	133.64
Total Multisource	19.4%	1.2	23.30	23.58	21.8	26.8	29.02
Total Generic	28.6%	1.8	9.51	11.21	23.7	43.1	20.33
Total	100.0%	6.4	29.27	28.61	27.6	175.1	183.0
Retail Baseline	100.0%	7.5	26.00	32.15	23.4	175.1	241.12
Pct. Change from Retail		-15.3%	12.6%	-10.4%	18.1%		-24.1%

PPO Reimbursement = AWP - 10% + $2.75
Mail Reimbursement = AWP - 13% + $2 50
40% of maintenance medications through mail service

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The integrated PPO/mail service model presented in Table 5 incorporates the PPO and mail service discounts described above, as well as relatively high generic substitution in both settings. Overall, this integrated plan is achieving a generic substitution rate of 29.2 percent; it is supplying half of total maintenance medications through mail service, and saving 24.8 percent of claim costs for the plan sponsor and beneficiary when compared to the retail baseline of Table 1.

Prescription Drug Benefits under an Indemnity Plan

Both the PPO and mail service approaches can offer a comprehensive prescription drug benefit to covered persons while achieving savings through price discounts and generic substitution. These managed care plans often offer a richer benefit than that offered under a traditional major medical plan. Today's typical indemnity plan has an individual deductible of $200 and a family deductible of $400. Consequently, many prescription drug claims fall below the deductible. After the deductible is satisfied, the plan typically pays 80 percent of covered charges up to an out-pocket-maximum of $1,000 per individual and $2,000 per family.

Moreover, the traditional indemnity plan normally requires the beneficiary to pay for the prescription and submit a paper claim for reimbursement. This fosters the shoebox and hesitancy effects that are estimated to reduce claims submissions by 30 to 40 percent. Table 6 illustrates the 35 percent reduction in submitted charges that might result simply from these two factors. This apparent plan "savings" is greater than that modeled in any of the managed care scenarios. Under this scenario, savings result from decreasing utilization and shifting costs to beneficiaries through the shoebox effect.

TABLE 6
1992 SUBMITTED CHARGES UNDER AN INDEMNITY PLAN

	PCT OF FILLS	FILLS/ PERSON	AWP $/ Rx	RETAIL$ Rx	DAYS/ Rx	DAYS/ PERSON	COST/ PERSON
RETAIL							
Acute Single Source	11.6%	0.6	35.52	42.45	11.0	6.2	24.00
Acute Multisource	13.4%	0.7	15.55	20.83	11.0	7.2	13.57
Acute Generic	10.0%	0.5	7.31	11.91	11.0	5.4	5.83
Total Acute	35.0%	1.7	19.80	25.44		18.8	43.40
		0.0					
Maint Single Source	42.5%	2.1	34.21	41.03	30.0	62.2	85.05
Maint Multisource	13.2%	0.6	27.89	34.19	30.0	19.3	22.02
Maint Generic	9.3%	0.5	9.10	13.85	30.0	13.6	6.26
Total Maintenance	65.0%	3.2	29.34	35.76		95.1	113.33
		0.0					
Total Single Source	54.1%	2.6	34.49	41.34	25.9	68.4	109.05
Total Multisource	26.6%	1.3	21.68	27.47	20.4	26.5	35.59
Total Generic	19.3%	0.9	8.17	12.84	20.1	18.9	12.09
Total	100.0%	4.88	26.00	32.15	23.4	113.8	156.73
Retail Baseline	100.0%	7.5	26.00	32.15	23.4	175.1	241.12
Pct. Change from Baseline		-35.0%				-35.0%	-35.0%

Retail Price = AWP + 8.25% + $4.00

Assumes no incentives for generic substitution.

$200 deductible and 20% beneficiary cost sharing above deductible.

Mandate 1: Any Willing Pharmacy Provider

Background

These laws would require a managed care pharmacy plan sponsor to establish a specific, objective set of criteria for selection of participating pharmacies and to allow any pharmacy that met these criteria to participate. The underlying premise for analyzing the claims impact of this provision is that expanding the percentage of pharmacies in the PPO will lead pharmacies to offer less of a discount than they would if they anticipated that network beneficiaries would be directed to a more limited pharmacy network.

From a purely economic perspective, an independent pharmacy or chain elects to participate in a PPO based on:

(1) the anticipated number of new prescriptions that will be channeled to the pharmacy, and

(2) the proportion of current business that the pharmacy anticipates losing if no discount is offered (if beneficiaries are free to go out-of-network, then the pharmacy might attempt to retain this business at the non-discounted retail price).

Based on differing levels of pharmacy participation, Wyatt developed an economic model that projects the extent to which the PPO savings described in the previous section would be eroded by an "any willing pharmacy provider" mandate. This model demonstrates that there is a point at which further expansion is not economically feasible for either the health insurance plan or the pharmacy providers.

Methodology

The model is based on several assumptions that determine the point at which the PPO network arrangement is no longer viable to the insurer or the pharmacies, but the exact point is not the essential finding of this model. The important finding of this exercise is that such a point exists, and the viability of PPO networks is threatened by laws that promote unrestricted network growth.

Wyatt constructed a pharmacy revenue requirement model and analyzed pharmacy behavior toward a typical PPO network with 30 percent of a market's prescriptions. The model assumes that 40 percent of the community pharmacies participate under Scenario 1 -- a scenario that presumes adequate geographic accessibility together with a discount from retail of 18.6 percent. (Table 7) This discount is based on actual market observations, and is consistent with the PPO models presented in the previous section. It is assumed that pharmacies wish to maintain their current average net margins, and that pharmacies have an unlimited capacity to fill prescriptions in order to meet demand.

Scenario 1 represents the best estimate of current pharmacy participation levels in operation today. Scenario 4 depicts the worst-case scenario in which all pharmacies participate in the network, while Scenarios 2 and 3 fall between these extremes. Network pharmacies gain no market share under Scenario 4, and it is no longer in their best interest to offer the network a discount. The value of out-of-network benefits on line 17 assumes the availability of a major medical plan which covers prescription drugs at an 80 percent level of reimbursement.

Conclusions

Under Scenario 1, the 18.6 network discount yields an overall claims cost reduction of 17.7 percent, because 5 percent of claims are out of network and discounted. Claims

TABLE 7
PPO MARKET SHARE
NETWORK SIZE, AND CLAIMS SAVINGS

Key Steerage Assumptions	Scenario 1	Scenario 2	Scenario 3	Scenario 4
1. Percentage of Prescriptions filled in Network	30.0%	30.0%	30.0%	30.0%
2. Percentage of Pharmacies in Network	40.0%	60.0%	80.0%	100.0%
3. Network Prescriptions from New Claimants	18.0%	12.0%	6.0%	0.0%
4. Network Prescriptions from Known Claimants	12.0%	18.0%	24.0%	30.0%
Modeling Detail				
5. Pharmacy's Current Prescriptions per Year	100.000	100.000	100.000	100.000
6. Non-Network Prescriptions	88.000	82.000	76.000	70.000
7. Network Prescriptions from New Claimants	18.000	12.000	6.000	0
8. Network Prescriptions from Known Claimants	12.000	18.000	24.000	30.000
9. Potential Prescriptions (lines 5 & 7)	118.000	112.000	106.000	100.000
10. 1992 Retail Charge Per Prescription	$32.15	$32.15	$32.15	$32.15
11. 1992 Network Charge Per Prescription	$26.17	$28.16	$30.16	$32.15
12. Effective Discount (from Table 2)	18.6%	12.4%	6.2%	0.0%
13. Network Use	95.0%	95.0%	95.0%	95.0%
14. Network Co-Pay	15.0%	15.0%	15.0%	15.0%
15. Value of Network Benefits	85.0%	85.0%	85.0%	85.0%
16. Out-of-Network Use	5.0%	5.0%	5.0%	5.0%
17. Value of Out-of-Network Benefits	80.0%	80.0%	80.0%	80.0%
18. Reimbursement - Plan	69.7%	74.7%	79.7%	84.8%
19. Reimbursement - Member	12.6%	13.5%	14.4%	15.3%
20. Reimbursement - Combined	82.3%	88.2%	94.1%	100.0%
21. Claims Cost Reduction	17.7%	11.8%	5.9%	0.0%

cost reductions evaporate as the network grows to include all pharmacies (Scenario 4), because participating pharmacies can no longer anticipate increased market share.

Table 8 shows that plan savings are further reduced due to the fixed costs of network administration. In this example, the marginal value of the network discount to the plan and plan member is 16.7 percent for Scenario 1, and -1.0 percent for Scenario 4. Under this worst case scenario, the incentive for pharmacies to grant a discount has disappeared, but fixed costs of network administration remain.

Mandate 2: Benefit Differentials

Background

Some states have placed restrictions on the maximum difference in benefit payments for drugs dispensed by participating and nonparticipating pharmacies. Such provisions may deflate the purchasing power of PPO plan sponsors by limiting their ability to steer beneficiaries to participating providers, thereby reducing the economic value of the contractual relationship between the sponsor and the pharmacy. The most common mandate, which applies not only to pharmacy but to PPO arrangements in general, limits the payment levels between in-network and out-of-network benefits to no more than 20 percent.

In the case of pharmacy PPOs, this mandate is particularly troublesome. It not only threatens the ability of the plan sponsor to steer beneficiaries to network pharmacies, it also presents administrative complexities in determining whether the plan is in compliance. Unlike the networks that are common for other medical services, a typical pharmacy network requires a fixed copayment per prescription. Nonnetwork prescriptions are either not covered at all or are covered under a traditional indemnity plan. If covered under an

TABLE 8
IMPACT OF ANY WILLING PROVIDER MANDATE ON MARGINAL VALUE OF PPO

	Non-PPO Model	PPO Scenarios 1	2	3	4
Network: % Pharmacies	N/A	40.0%	60.0%	80.0%	100.0%
Claims Cost Reduction	N/A	17.7%	11.8%	5.9%	0.0%
Network Adm.	N/A	$2,363	$2,363	$2,363	$2,363
Marginal Value of PPO with 15% Base Retention					
Projected Claims	$241,125	$196,518	$212,720	$226,923	$241,125
Projected Premiums	$283,676	$236,331	$253,040	$269,748	$286,457
% Non-PPO Premium	100.0%	83.3%	89.2%	95.1%	101.0%
Marginal Value	N/A	16.7%	10.8%	4.9%	-1.0%

Assumptions:

- Network administrative expense = 1% of premium income
- 1,000 subscribers
- 7.5 prescriptions per year
- Full retail cost = $32.15/prescription

indemnity plan, beneficiary cost sharing depends on whether the deductible has been met and on the level of coinsurance required by the indemnity plan. In short, it may be difficult to determine whether one plan is richer than the other, and the answer to this question may differ depending on the size of the prescription and whether the indemnity deductible has been satisfied.

Recently, some network plans have been implementing substantial benefit differentials based on traditional cost sharing arrangements. Some of these plans take advantage of point-of-service technologies to pay in-network services under the provisions of a major medical plan that includes a deductible and 80 percent coverage of in-network services, while some plans are keeping network drug benefits in a carveout plan with its own deductible and a beneficiary coinsurance requirement of 10 to 20 percent. In either of the new arrangements, nonnetwork prescription fills might require up to 50 percent coinsurance.

Methodology

In our previous study of state benefit mandates we examined the impact of benefit differentials between in-network and out-of-network services. At that time we surveyed actuarial opinion concerning the differentials that are considered optimal to encourage use of network providers, and we developed a model that was applied to the full range of medical benefits. We are not aware of studies that have examined this dynamic as it applies to pharmacy benefits, although we are aware from discussions with industry sources that a 30 percent benefit differential is considered strong enough to move 95 percent of utilization into the network when the network offers good geographic coverage.

Consequently, we borrowed the benefit differential model from our previous study to compare the impact of moving from a 30 percent benefit differential to 20 percent and

15 percent differentials. The estimates from this model are illustrative because controlled research on beneficiary response to these pharmacy reimbursement options has not been performed.

Conclusions

Modeled estimates of three levels of pharmacy benefit differential are presented in Table 9. In this model, the 30 percent benefit differential between in-network and out-of-network services corresponds with the level of PPO savings developed in Table 2. Under this scenario the plan and beneficiary share the advantages of an 18.6 percent network discount, and the 30 percent benefit furnishes sufficient incentive to channel 95 percent of utilization into network pharmacies. The result of this arrangement is that the plan and beneficiary together pay 82.3 percent of what they would have paid in the unmanaged retail setting.

The model suggests that moving to a 20 percent differential would reduce utilization of network pharmacies from 95 percent of the total to 88.9 percent. Assuming that the same discounts can be retained for in-network services, this would increase the sum of plan and member payments to 83.5 percent of the baseline retail level of Table 1. A benefit differential of only 15 percent would reduce network utilization to 85.6 percent of total prescriptions and increase average pharmacy payments to 84.1 percent of the retail level.

All of this assumes that decreases in network utilization would not result in a reduction of the discount that network pharmacies are willing to offer. This is contrary to the findings of Tables 7 and 8, which demonstrate that it is not in the economic interest of pharmacies to offer discounts unless they are able to anticipate an increase in market share. Consequently, reducing the benefit differential would not only increase plan and beneficiary costs due to increased payments for out-of-network services, it would tend to reduce the

TABLE 9

IMPACT OF BENEFIT DIFFERENTIALS ON TOTAL REIMBURSEMENT

	30% Differential (Baseline)		20% Differential		15% Differential	
	In-Net	Out-Net	In-Net	Out-Net	In-Net	Out-Net
Network Savings	18.6%	0.0%	18.6%	0.0%	18.6%	0.0%
Network Use	95.0%	5.0%	88.9%	11.1%	85.6%	14.4%
Value of Network Benefits	90.0%	60.0%	90.0%	70.0%	90.0%	75.0%
Reimbursement - Plan		72.6%		72.9%		73.5%
Reimbursement - Member		9.7%		10.6%		10.6%
Reimbursement - Total		82.3%		83.5%		84.1%
Change from Baseline		0.0%		-1.1%		-1.7%

discounts offered by network pharmacies. Finally, no administrative cost impact -- a potentially significant factor -- was estimated for this mandate.

Mandate 3: Same State License

Background

In an extreme form, same state licensure would mean that the dispensing pharmacy must be located within the state's boundaries, a condition that would severely limit the ability of mail service providers to offer the discounts they currently offer. In less extreme forms, the state might require that at least one pharmacist in the mail order facility be licensed in the state to which the prescription is sent, and that a defined set of facility standards be met. The immediate and intended effect would be to eliminate mail service pharmacies from competing on an equal footing with retail pharmacies.

From a consumer perspective, it is clear that mail service firms have been an important factor in introducing competition into the retail market. With 65 percent of prescriptions and an even higher percentage of total days supply in the maintenance medication category, there is considerable potential for mail service. Mail service is especially important to vulnerable populations such as the elderly and disabled. These populations use a high percentage of the total maintenance medications dispensed through mail service. For many of these users, mail service furnishes not only a means of reducing their costs but also a convenient way to receive their medications on a routine basis.

Methodology

To demonstrate the importance of mail service pharmacies to special populations, we constructed 5 scenarios that show mail service savings compared to the retail baseline

for a retired population. In the baseline retail environment, these retirees average 1[illegible] prescriptions per year and 70 percent of all prescriptions are for maintenance medications.

Conclusions

Same state licensing requirements would increase the operating costs of mail service pharmacies and narrow the cost advantage they offer in comparison to community pharmacies. A same state licensure law that required a mail pharmacy to locate within the state of the beneficiary would be a costly requirement for even the largest mail service firms. Less onerous licensing requirements would impose considerably less compliance costs.

Table 10 illustrates the range of savings that might be lost to a retired group making regular use of mail service. When 90 percent of maintenance medications are furnished under the mail discount the prescription drug expense for these retirees is reduced by 21.2 percent. In this example, mail service alone produces savings of more than $100 per retiree each year.

The mail service savings would be even greater for populations that use more prescriptions, or for plans that have negotiated better discounts. As noted above, some retiree groups use as many as 30 prescriptions per retiree per year. The discount arrangement assumed in Table 10 is widely available (AWP -13% plus a fee of $2.50). One national medical plan recently negotiated a mail service discount of AWP -22% with no dispensing fee.

Although substantial savings might also be obtained through negotiations with community pharmacy networks, mail service fills some special needs that are poorly served through network arrangements. Retired and disabled persons in rural areas, retirees who

TABLE 10

1992 COSTS PER RETIREE WITH

VARIOUS LEVELS OF MAIL SERVICE PENETRATION OF MAINTENANCE DRUG MARKET

MAIL SERVICE SHARE OF ALL MAINTENANCE DRUGS DISPENSED	PCT OF FILLS	FILLS/ PERSON	AWP $/ Rx	REIMB $/ Rx	DAYS/ Rx	DAYS/ PERSON	Rx/ PERSON	PCT SAVINGS
90% MAIL	1.000	9.4	40.04	40.92	38.6	364.5	386.04	21.2%
70% MAIL	1.000	10.7	35.81	38.34	34.2	364.5	409.14	16.5%
50% MAIL	1.000	11.9	32.45	36.30	30.6	364.5	432.24	11.8%
30% MAIL	1.000	13.1	29.73	34.64	27.7	364.5	455.34	7.1%
10% MAIL	1.000	14.4	27.47	33.27	25.3	364.5	478.44	2.4%
0% MAIL (Full Retail Baseline)	1.00	15.00	26.48	32.67	24.3	364.5	489.99	0.0%

Assumptions:

70% of prescriptions in baseline retail setting are for maintenance medications.
Utilization averages 15 prescriptions per retiree in baseline retail setting.
Retail service maintenance prescriptions average 30 days and mail service averages 73 days.

move out of state when they retire, and retirees who move south each winter are al problematic for health plans. It is difficult to obtain network discounts for these people because they represent only a small portion of the market in the areas which they reside. Moreover, those with disabilities can benefit greatly from the convenience of mail delivery.

The indirect effect of restricting mail service programs could be the most significant impact of a same state license mandate. Community pharmacies might be far less willing to offer discounts if they perceive that mail service firms are no longer competitive.

Overall Conclusions

Managed care arrangements for prescription drugs, as for other medical benefits, give health care consumers the opportunity to obtain better value for the money they spend in the health care market place. PPO and mail service programs generally furnish beneficiaries more prescription drugs for less cost -- and they do so with an emphasis on quality and convenience. The information systems developed through these programs are opening new opportunities for monitoring, managing and improving the quality of care that beneficiaries receive. For the first time it is possible to link the detailed prescription drug data with medical claims -- creating important opportunities for coordinating the care of medical providers; informing patients and physicians when there are contraindications for the drugs prescribed; and educating physicians and patients.

Prescription drugs can no longer be viewed as an inconsequential part of the medical plan -- they represent major expenditures, particularly for retirees. In many ways the question is not whether the health plan should be able to pursue managed care opportunities, but whether employers will be able to continue funding medical benefits that are not managed. The new financial accounting standard for retiree medical plans is especially pertinent here, because employers must find a way to address this large cost that will be such a major factor in their profitability.

TE OF KANSAS

KANSAS STATE EMPLOYEES
HEALTH CARE COMMISSION

COMMISSIONERS:
Robert C. Harder, Chairman
Ron Todd
Susan M. Seltsam

Dave Charay,
Benefits Administrator

MEMORANDUM

TO: Members of the House Financial Institutions and Insurance

FROM: Dave Charay, Health Benefits Administrator

DATE: February 8, 1993

SUBJECT: Testimony on HB 2117

On behalf of the Kansas State Employees Health Care Commission, I am appearing today in opposition to HB 2117.

As introduced, HB 2117 could eliminate the option of pharmacy networks through which in-state, as well as out-of-state insurers that contract with the Kansas State Employees Health Care Commission, could control the cost and quality of services provided to State of Kansas active and former employees.

Prescription costs are the most rapidly rising component of health care cost and for the State of Kansas Employee Health Plan. For example, for calendar 1993, prescription drug cost increased 33% as compared to a general 20% increase for the entire health plan. The prescription drug benefits offered by Blue Cross and Blue Shield of Kansas averaged $1.4 million dollars per month in calendar year 1992 or a total of $16,859,821. Acquisition cost of prescription drugs was reduced by approximately fifteen percent during calendar year 1992 due to network participation and volume purchase arrangements. By eliminating the volume discounts that pharmacy networks can and do provide, this cost will increase much faster than we have experienced in the past.

This bill defeats the idea of managed care. Limited networks allow our insurance providers to trade volume for discounts in cost. However, significant volume is required to allow providers to offer attractive discounts and still maintain high quality standards. Discounts for future years are based upon both volume and cost projections of providers and suppliers. HB 2117 states that all pharmacies would have the opportunity to accept the same terms and conditions offered to any other provider -- superficially appearing revenue neutral. However, while the bill may have little impact in the initial year of operation, the volume experienced by the network providers could drop to a point where future cost discounts would not be feasible. The ability to negotiate future

Financial Institutions & Insurance

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February 8, 1993
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contracts containing attractive discounts would be severely compromised by passage of this bill.

The cost of the State of Kansas Employee Health Plan is borne by each agency and funded by the general fund of the State. At present, the State of Kansas pays the majority of the premium cost of the benefit program. With the networks which are in place at present, the Health Care Commission is projecting a twenty percent increase for future plan year. Elimination of cost effective network options would increase these costs and obligations. The net effect would be that the long range fiscal effect of HB 2117 would be the acceleration of prescription drug cost for the Kansas State Employee's health plan.

Passage of this bill could result in the State being forced to eliminate the drug card program. Drugs would then be covered under major medical which would result in employees paying more of the cost since they would lose the volume discount managed care prescription drug networks provide.

DC:bcl

cc: R. Harder
R. Todd
S. Seltsam
J. Rickerson
R. Roberts

Statement of
Caremark Inc. Prescription Service Division
Opposing House Bill 2117
to the
House Committee on Financial Institutions and Insurance
February 8, 1993

Mister Chairman, Members of the Committee on Financial Institutions and Insurance, my name is Clifford Berman and I am speaking on behalf of Caremark Inc's Prescription Service Division. The Prescription Service Division is one of the nation's leading mail service pharmacies and serves patients across the country. By way of background, I am both an attorney and a pharmacist and I serve as Director of Professional Services with Prescription Service Division.

Caremark Opposes Adoption of House Bill 2117

Caremark opposes adoption of House Bill 2117 for the following reasons:

1. At a time when cost-containment in health care services is a critical national priority, HB 2117 sends the wrong message by actually encouraging higher cost prescriptive care.

2. Legislation such as HB 2117, while commonly referred to as "freedom of choice" legislation, actually denies consumers their freedom to choose.

1. HB 2117 Encourages High Cost Prescriptive Care

Health plans and insurers have long sought ways to control the ever spiralling cost of health care. One sure way of accomplishing this goal has been to enter into contractual arrangements with limited or even exclusive provider panels. The savings that result from such arrangements are a function of both marketplace competition and basic economics. When providers must compete to become the selected provider to a health plan, they must do so by offering the

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provider, in consideration of a large expected volume of business from the plan, will be willing to offer lower prices. Further, in the pharmacy business, that higher volume of expected business gives the pharmacy the buying power necessary to obtain volume discounts from manufacturers which it can pass along to the plan.

HB 2117, however, would open up these limited provider panels to all comers and thereby undercut the prescription volume to be realized by the selected provider. Absent this expected volume, the provider would have no incentive to agree to accepting lower reimbursement in the first place, nor would it have the ability to obtain volume purchasing discounts.

This can only result in the inability of providers to offer competitive prices, leaving patients with higher prescription costs. These higher costs will take the form of increased premiums or discontinued coverage.

I would like to emphasize that these are not just the views of Caremark, but also those of the Federal Trade Commission's Bureau of Competition ("FTC"). Attached to this Statement are copies of two recent FTC Opinions, commenting on "freedom of choice" bills from the states of Pennsylvania and Massachusetts. In each instance, the FTC determined that open panel provisions, while appearing to be pro-competitive on their face, would ultimately lead to reduced competition in the prescription market and to higher costs to the consumer.

Also instructive is the 1988 opinion of the Arkansas Attorney General in response to an earlier "freedom of choice" law. A copy of that opinion is attached to this Statement. Your Attorney General found the "freedom of choice" law to be unconstitutional under both the Supremacy and Commerce Clauses and also noted its anticompetitive effect on the prescription market.

2. **HB 2117 Denies Freedom of Choice**

In addition to its anti-competitive nature HB 2117 also denies consumers their true "freedom of choice". It is essential to understand consumers are always free to take their prescriptions to be filled at any retail pharmacy if they are willing to personally pay the retail price. Many consumers, however, have instead chosen to obtain insurance coverage as a means of reducing their prescription

drug costs. In doing so, they are free to choose from any number of differing types of policies, some of which offer exclusive providers, others which offer limited provider panels and still others which offer open pharmacy provider panels.

What HB 2117 would create, however, is a situation where there is only one choice: open provider panels. This is a denial of freedom of choice. As the FTC stated in speaking to this issue:

> 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 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.

And, as the FTC concluded, freedom of choice bills:

> restrict consumer's freedom to chooses health benefits programs that they believe best meet their needs.

Summary

In summary, HB 2117 is anti-competitive legislation which will ultimately lead to higher prescription costs to consumers and deny them their true "freedom of choice". Accordingly, Caremark respectfully urges this Committee to reject HB 2117. Thank you for your consideration of our views.

APPENDIX

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

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-competitive. For the reasons we discuss below, however, 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 access needs to be assured through regulation rather than market competition, 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.

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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

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 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 promoting competition among such providers.[2] As part of its 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

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[2] 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 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).

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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 providers.[4] The Commission's staff, on request, also has submitted comments to federal and state government agencies explaining that various regulatory schemes would interfere 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 those services "in-house" by 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 basis; (3) contracts with "select provider[s]," but with the requirement that the carrier also must offer subscribers an alternative whereby they may obtain pharmaceutical services from "a participating provider organization or group, which gives 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 HMO programs, which are in the minority in most states in both 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

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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 not subject to the state insurance laws, of which Chapter 175, which S. 526 amends, is 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 services through an affiliated clinic pharmacy that is not non-profit.

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program.[9] 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.

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, 115 (Winter 1988). Industry representatives estimate that, currently, about one-third of the $23.6 billion consumers spend on prescription drugs are 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).

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.[12] 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 coverage or other employee benefits.

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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 providers of pharmaceutical services,[15] so long as selection of 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 regulatory 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

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UNITED STATES OF AMERICA
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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.

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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. 18273 (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).

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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. § 449.1 *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

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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

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AG 89-17
10-19-88

STATE OF ARKANSAS
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Opinion No. 88-217

October 19, 1988

The Honorable Mike Wilson
State Representative
1202 Main Street
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Jacksonville, AR 72076

Dear Representative Wilson:

This is in response to your request for an opinion concerning Act 489 of 1987, codified at A.C.A. § 11-5-114 (Supp. 1987). Specifically, you have posed four questions about the statute which are as follows:

(1) Is it constitutional?

(2) If so, are the criminal sanctions contained therein enforceable as a valid exercise of the State's police power?

(3) If constitutional, can the statute's terms and conditions relating to prescription drugs be imposed upon health plans subject to ERISA?

(4) If constitutional, is the statute enforceable against a church employer or church affiliated entity furnishing services to church employers for their employees?

In the interests of logic and clarity, this opinion will address these issues in the following order: (1) Is the statute preempted by the provisions of ERISA?; (2) To the extent the statute is not preempted, (such as with respect to church plans), is it otherwise constitutional?; and, (3) Are the criminal sanctions found in the statute a proper exercise of the police power? For the reasons that follow,

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it is my opinion that to the extent ERISA is applicable, it preempts the statute. As such the statute to that extent is unconstitutional under the Supremacy Clause. Because ERISA does not apply to church plans, however, it must be determined whether the statute is otherwise constitutional as applied in situations where ERISA does not control. In that regard it is my opinion the statute presents a serious constitutional question as to whether it places an undue burden on interstate commerce under the Commerce Clause. Additionally, the criminal sanctions imposed by the statute may be questioned as a valid exercise of the police power.

The statute in question, A.C.A. §11-5-114 (Supp. 1987), provides:

> (a) It shall be unlawful for any employer providing pharmacy services, including prescription drugs, to employees as a part of a health care program to require the employee to obtain drugs from an out-of-state mail order pharmacy as a condition of obtaining the employer's payment for the prescription drugs or to impose upon an employee not utilizing an out-of-state mail order pharmacy designated by the employer a co-payment fee or other condition not imposed upon employees utilizing the designated out of state mail order pharmacy.
>
> (b)(1) This section shall not apply to any employer who;
>
> (A) Offers, as a part of a health care program, health insurance coverage to employees which provides for payment of an equal portion of the cost to the employee for prescription drugs regardless of the supplier, if the health insurance plan allows the employee freedom of choice in determining where the drugs are purchased; or
>
> (B) Had in force effective January, 1, 1987, a mail order prescription drug plan for employees.
>
> (2) The provisions of this section shall not be applicable to health care programs in existence on March 30, 1987.
>
> (C) Any person or entity violating the

> provisions of this section shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not less than one hundred dollars ($100.00) nor more than one thousand dollars ($1,000.00). Each violation shall constitute a separate offense.

The statute requires the health care provider to provide and pay for prescription drugs on an equal basis, without regard to whether the drugs are obtained locally, or through an out-of-state mail order pharmacy, (which is presumably much cheaper). The statute prohibits the requiring of the cheaper out-of-state pharmacy supplier.

1. PREEMPTION BY ERISA

The issue of whether a state law which regulates the providing of prescription drugs by a health care plan is preempted by the provisions of ERISA, was squarely discussed in General Motors Corporation, et al. v. Caldwell, 647 F.Supp. 585 (N.D. Ga. 1986). The act in issue in Caldwell regulated contracts between plan administrators and participating pharmacies, and also sought to establish a pricing formula whereby plan beneficiaries could not obtain prescription drugs at a more favorable rate than persons not enrolled in a plan. The court noted that:

> ERISA preempts any and all state laws insofar as they may now or hereafter relate to any employee benefit plan. 29 U.S.C. §1144(a). The Supreme Court has explicated the scope of ERISA preemption in Shaw v. Delta Airlines, 462 U.S. 85 (1983). Here, the Court stated that:
>
> > [a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or a reference to such a plan.

647 F.Supp. at 587.

The Court in Caldwell went on to hold that "the Act clearly relates to employee benefit plans and is subject to preemption by ERISA." 647 F.Supp. at 587. The court came to this conclusion in light of the United States Supreme Courts decision in Metropolitan Life Insurance Company v. Massachusetts, 471 U.S. 724 (1985), that even a state statute which has only an indirect impact on employee

benefit plans will be preempted by ERISA. In my opinion a similar conclusion must be reached here. The statute clearly relates to an employee benefit plan and is therefore preempted.

The court in Caldwell was then faced with the question of whether the Georgia law came within the exemption to the ERISA preemption provision, (29 U.S.C. §1144(2)(B)), which operates so as not to preempt any law regulating insurance, banking or securities. The court, analyzing the question under three factors enunciated in Union Labor Life Insurance Co. v. Pireno, 458 U.S. 119, and in light of the decision in Group Life and Health Insurance Company v. Royal Drug Company, 440 U.S. 205 (1979) reh. denied, 441 U.S. 971 (1979), held that the law in question did not regulate the business of insurance. In my opinion, the same conclusion must be reached with respect to A.C.A. §11-5-114. It is not a law which regulates the business of insurance, but is a law which "relates to" an employee benefit plan. The statute is thus preempted by the provisions of ERISA, and is unconstitutional under the Supremacy Clause.

The ERISA preemption provision, however, does not preempt state laws which would govern three types of plans listed in 29 U.S.C. §1003(b). These include governmental plans, church plans, and plans maintained solely for the purpose of complying with workmen's compensation, unemployment compensation, or disability insurance laws. With respect to these types of plans, the Arkansas statute is not preempted and governs if it is otherwise constitutional. This now becomes our inquiry.

You have noted several possible constitutional infirmities with the statute including violations of equal protection, the anti-trust laws, and impairment of the obligation of contracts. You have also indicated that a first amendment issue may be presented. It is my opinion that none of these constitutional bases present a tenable theory for challenging the statute. Violations of equal protection are rarely found in cases involving economic regulations, (which presumably is the purpose of §11-5-114), New Orleans v. Dukes, 472 U.S. 297 (1976); the federal anti-trust laws do not govern governmental action, United States v. Yellow Cab Co., 69 F.Supp. 170 (N.D. Ill. 1946), rev on other grounds 332 U.S. 218 (1947); impairment of the obligation of contracts is not found with a statute only retrospective in effect. U.S. Trust Co. of New York v. New Jersey, 431 U.S. 1 (1977) reh. denied 431 U.S. 975 (1977); and in my opinion no first amendment issue is presented.

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Whether §11-5-114 places an undue burden on interstate commerce under the Commerce Clause is entirely another question. Even though the law might be deemed non-discriminatory, as it does not prohibit the use of out of state mail order pharmacies, but just requires similar payment provisions for local pharmacies, it still affects interstate commerce. Without the statute in place, health care plan administrators would continue to furnish the beneficiaries with out of state pharmaceuticals at a favorable price to the plan and ultimately its beneficiaries. With the statute in place, plan administrators are required to pay equally for pharmaceuticals supplied to beneficiaries who choose to obtain them locally. It is conceivable that many beneficiaries would obtain them locally because of convenience and speed of delivery, and because paid for to the same extent by the plan as mail order pharmaceuticals. Because those beneficiaries would purchase drugs locally by virtue of the act, that same amount of prescription drugs will not be sold in interstate commerce. Thus, the statute affects interstate commerce. This fact is significant in light of the Supreme Court's statement concerning the Commerce Clause in Freeman v. Hewitt, 329 U.S. 429 (1946):

> This limitation on State power ... does not merely forbid a state to single out interstate commerce for hostile action. A state is also precluded from taking any action which may fairly be deemed to have the effect of impeding the free flow of trade between states.

329 U.S. at 252.

It being acknowledged that the law affects interstate commerce, the inquiry becomes whether it places an "undue burden" upon it. Analysis of this question must take into account the purposes of the legislation, as it has been held in Huron Portland Cement Co. v. Detroit, 362 U.S. 440 (1960) that:

> In determining whether the state has imposed an undue burden on interstate commerce it must be borne in mind that the Constitution when 'conferring upon Congress the regulation of commerce ... never intended to cut the states off from legislating on all subjects relating to the health, life, and safety of

> their citizens, though the legislation might indirectly affect the commerce of the country.' [citation omitted].

362 U.S. at 443, 444.

The regulation in issue in Huron concerned the control of pollution. Conversely, the court noted in Hood v. Dumond, 336 U.S. 525 (1949) that:

> This court consistently has rebuffed attempts of states to advance their own commercial interests by curtailing the movement of articles of commerce, either into or out of the state, while generally supporting their right to impose even burdensome regulations in the interest of local health and safety.

336 U.S. at 535.

It appears that the Arkansas statute was not enacted to further public health and safety. There is no indication that it addresses any concern about the quality or safety of the out of state mail order drugs. It is my opinion that the act is aimed at competition, as evidenced by its cost regulation. This fact does not place the act in good constitutional stead.

Similarly, the aim of the legislation is the key factor in determining whether a proper exercise of the police power exists. This concept was the sole basis for the opinion in Union Carbide and Carbon Corp v. White River Distrib., 224 Ark. 558, 275 S.W.2d 455 (1955). At issue in Union Carbide was whether the "Fair Trade Act," which in part gave a supplier the right to fix the price of its product in Arkansas, was an abuse of the state's police power. The court found an abuse of the power, and stated:

> Full and free competition is the long recognized basis of our economy ... We can think of no way in which the public welfare was being jeopardized under the system of free competition prior to 1937 which suggested the necessity or advisability of imposing the restrictions contained in [the act], and we can think of none that exists today. To the contrary, we believe it is generally recognized that the interest of the public is best served by the opportunity to

> buy commodities in a freely competitive market. We recognize that competition is preserved to a degree under the provisions of the Act, but it must be admitted that it is also restricted to a degree. The Act can be sustained only if it enhances the general welfare and not if it restricts it to only a small extent.

224 Ark. at 562, 563.

The court also quotes a passage from 11 Am. Jur., p.1077 which states:

> The mere assertion by the legislature that a statute relates to the public health, safety or welfare does not in itself bring that statute within the police power of a state, for there must always be an obvious and real connection between the actual provisions of the police regulations and its avowed purpose and the regulation adopted must be reasonably adapted to accomplish the end sought to be attained. A statute or ordinance which has no real, substantial or rational relation to the public safety, health, moral, or general welfare is a palpable invasion of rights secured by fundamental law and cannot be sustained as a legitimate exercise of the police power.

224 Ark. at 566.

It is therefore my opinion that the statute in question, because it is aimed at competition rather than some aspect of the public welfare, is a questionable exercise of the state's police power, and a court faced with the question could properly decide that it is unconstitutional as preempted by ERISA, and to the extent not preempted, unconstitutional under the Commerce Clause.

The foregoing opinion, which I hereby approve, was prepared by Assistant Attorney General Elana L. Cunningham.

Sincerely,

STEVE CLARK
Attorney General

28 8/10

cc:

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TESTIMONY BEFORE HOUSE COMMITTEE ON
FINANCIAL INSTITUTIONS AND INSURANCE

House Bill 2117

Medco Containment Services, Inc.

February 8, 1993

Mr. Chairman and members of the committee. My name is John Ensley, and I am local counsel for Medco Containment Services, Inc. Medco is the nation's largest mail-service pharmacy. Medco provides affordable prescription medicines to thousands of Kansas patients through its competitively bid contracts with Kansas employers, such as Boeing, Southwestern Bell Telephone, and Kansas City Community College.

HB 2117 has been labeled by its retail pharmacist proponents as "freedom of choice" legislation. However, the bill regulates only one thing - competition in the health care marketplace. The bill would force prescription drug programs to allow any licensed pharmacy to participate in the program, notwithstanding that the pharmacy did not compete in the bidding process. If passed, HB 2117 will reduce competition, raise health care costs, and ultimately restrict consumer choice, all without any corresponding public benefit.

Competition Will Be Reduced

Under the existing system, competing pharmacies are willing to offer low prices in return for the high volume of business as the preferred provider. Under HB 2117, there would be little incentive for pharmacies to compete in developing attractive or innovative proposals that reduce costs.

Attachment 11
Financial Institutions & Insurance
Feb. 8, 1993

Administration Costs Will Increase

HB 2117 could result in substantial administrative burdens and expenses for program sponsors or payors. Rather than dealing with one pharmacy, one administrative system, and one invoice, plan administrators under HB 2117 would be forced to accept the inherent inefficiencies of dealing with a myriad of local drug stores. These increased costs have to be passed on in the insurance premium or the health benefits reduced. HB 2117 may also have the unfortunate effect of discouraging Kansas companies from offering prescription drug benefits in their health plans.

The Marketplace Is Working

Payors who have entered into preferential arrangements or exclusive contracts with pharmacies are able to assure those pharmacies more business volume than if those subscribers spread their purchases among many providers. This volume permits the pharmacies to take advantage of economies of scale, such as quantity discounts for larger volume purchases, and reduction of their normal markup over cost for each prescription filled under the program.

Costs will Increase And Benefits Will Be Reduced

Requiring a payor to open programs to all pharmacies may result in higher premium costs or the loss of broader coverage provisions, including lower deductibles and co-payments for pharmacy services, that programs otherwise could provide due to the cost savings obtained through limiting provider participation.

The anti-competitive and anti-consumer nature of this type of legislation has been consistently recognized by the Federal Trade Commission. I have provided you with copies of two recent FTC opinion letters concerning similar legislation introduced in California and Pennsylvania. In finding the California legislation anti-competitive, the FTC noted:

> 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.
>
> ...
>
> 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

2-11

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.

...

Economic studies have confirmed that, under health care arrangements that permit selective contracting, competition helps to moderate cost increases. 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 providers participation and those that do not, should ensure that cost savings are passed on to consumers.

...

Third-party payors find such arrangements attractive because they benefit from the pharmacies' competition. Lower prices paid to pharmacy providers could mean lower costs for a third party payor... 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.

...

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.

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.

The cost of health care in Kansas continues to increase. Managed-care pharmacies are one innovative answer to these rising costs. Protectionist legislation, such as HB 2117, is a major step backward from the national goal of affordable healthcare and will only serve to hasten the pace of runaway health care costs. We urge you to reject HB 2117.

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Mail-order pharmacies on rise

■ The drug business suddenly is crowded with new players, each vying for a piece of a mushrooming $4 billion market

By MARIANN CAPRINO
The Associated Press

NEW YORK — The race is on to sell drugs by mail.

A sleepy, back-office operation just a decade ago, the mail-order drug business suddenly is crowded with new players, each vying for a piece of a mushrooming $4 billion market.

It doesn't mean the postman is about to replace your neighborhood pharmacist, but it is changing the way millions of Americans on health plans get prescription medicines.

Seventy percent of all prescriptions are for "maintenance drugs," taken regularly for such chronic ailments as arthritis and high blood pressure.

It is this business mail-order pharmacies are after. They sign up big corporate clients — like General Electric, Alcoa and Mobil — with the promise of cutting companies' health-care-benefit drug bills by up to 20 percent.

Savings come in many ways. Mail-order pharmacies buy in bulk and therefore can muscle significant discounts from drug manufacturers. They work to substitute cheaper brand-name equivalents or generic drugs. Even large mail-order pharmacies with geographically dispersed clients can operate out of just a few places, minimizing overhead.

These centralized pharmacies aren't mere store rooms crowded with jar-filled shelves. They are state-of-the-art operations that use computers to monitor patients, robots to retrieve pills and machines to count them.

Mail-order pharmacists don't have to walk over garden hoses or point customers in the direction of the deodorant counter. Instead, they oversee quality control.

Sophisticated computer technology allows them to retrieve a patient's file, track allergies to medication and check whether the patient is taking other drugs that may not be compatible.

Medco Containment Systems Inc. of Montvale, N.J., is the industry's leader with a 50 percent share of the market. Plans to expand were cut short this month when a $411 million merger with rival Diagnostek Inc. collapsed.

Other leaders include Baxter International and Express Pharmacy Services, owned by the Thrift Drug chain, a division of J.C. Penney & Co.

In recent months, more players have emerged, including:

■ Walgreen Co., which operates 1,700 drug stores nationwide, decided to put a new and concentrated emphasis on mail-order sales. The company, which has a dispensing center in Phoenix, opened a high-tech pharmacy in Orlando, Fla., in September.

■ Fay's Inc., which owns 300 drug stores in the Northeast, in October created Postscript, a mail-order division that will begin operating in April from Pennsylvania.

■ Value Health Inc., an Avon, Conn.-based managed care company, acquired the Iowa mail-order drug concern Stokeld Health Services Corp. about two weeks ago.

"We see tremendous growth," said Bob Halaska, president of Walgreen's Healthcare Plus subsidiary.

Indeed, the American Managed Care Pharmacy Association predicts mail-order sales will increase 33 percent this year. The group conservatively projects 1995 industry sales of $6.5 billion.

Walgreen's targeting of the mail-order market illustrates the pressure on drug stores from this new source of competition.

"You'll see greater emphasis by other drug store chains to look very carefully and seriously at getting involved in this business," said Delbert Konnor, executive vice president of the trade group.

It's unclear how far the newcomers will get. Opening a pharmacy isn't particularly difficult; handling big corporate accounts is.

The growth of mail-order drugs comes as American corporations are crusading to curtail spiraling health-care costs. As a result, employers increasingly are demanding detailed accountings of their employees' prescription drug use. Providing this information requires a substantial investment in technology.

"Data processing is the key to business," said James Manning, Medco's chief financial officer. "That's why smaller players don't go far. They can't make the $30 to $40 million investment in data base systems you have to make to handle 15 different plan designs."

Medco employs 200 people in its data processing operation alone.

Its sales force numbers just 25, while 40 others oversee 1,300 accounts covering nearly 29 million employees and retirees.

"The business has evolved from being a commodity business of dispersing drugs out of a pharmacy to being a drug benefit management service," Manning said.

Big drugmakers initially were reluctant to deal with mail-order companies.

But Manning said they realized "the payors of the world are going to be a significant factor in the future in determining which drugs are prescribed."

While drugs account for only 7 percent of the nation's health care bill, they are the largest out-of-pocket health-care expense for individual consumers.

Medco pharmacists will call doctors and urge them to switch to a "preferred" drug, the medicine that carries the lowest price, when choice is a factor. Manning said doctors comply about 40 percent of the time.

Despite Medco's prominence, Fay's, for one, is undaunted by its Goliath-sized competition.

"Fewer than 20 percent of the employers that could incorporate mail-order drug programs have done so," said Fay's Vice President David Eilerman. "Business is growing rapidly, but the market is unsaturated."

For now.

Savings come in many ways.
■ Mail-order pharmacies buy in bulk, enabling them to muscle significant discounts from drug manufacturers
■ They work to substitute cheaper brand-name equivalents or generic drugs.
■ Medco pharmacists will call doctors and urge them to switch to a "preferred" drug, the medicine that carries the lowest price, when choice is a factor.
■ James Manning, Medco's chief financial officer, said doctors comply about 40 percent of the time.

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THE KANSAS CITY STAR

SUNDAY, January 10, 1993

MEDICAL MONEY-SAVERS

Tips can keep costs down

■ Break your New Year's resolutions yet? Well, it's never too late to start saving money.

The National Emergency Medicine Alliance, a consumer group, says America's health costs could be cut $40 billion in 1993 if we all followed these tips:

■ Rely on "front-line" primary physicians: Don't get routine care from hospital emergency rooms or seek new specialists for every ache and pain.

■ Insist on generic drugs: Generics save 30 percent or more over brand name drugs. Additional savings come from mail-order prescription services.

■ Talk to your doctor on the phone: Most trips to the doctor are for simple problems such as colds that don't require an office visit. Take advantage of your doctor's phone hours.

■ Know your insurance before you need it: Find out before elective surgery if your insurance covers the operation. Healthy adults can save on premiums by increasing their deductible. Coordinate insurance with your working spouse, so you don't duplicate coverage.

■ Beware of unnecessary tests and hidden conflicts of interest: An estimated 40 percent of medical tests aren't needed. If a test or radiation treatment or physical therapy is ordered, ask your doctor if he or she has a financial stake in it.

■ Always get a second opinion on surgery and never accept hospital bills at face value: Second opinions result in recommendations of no surgery in one fourth of cases. Most hospital bills contain errors, many with substantial overcharges.

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Letter dated June 26, 1992 from the Federal Trade Commission, by the staff of the Office of Consumer and Competition Advocacy to the California State Senate

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

OFFICE OF
CONSUMER AND
COMPETITION ADVOCACY

COMMISSION AUTHORIZED

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 submit this response to your request for views on the effects of Senate Bill 1986 ("S.B. 1986" or the "Bill").[1] 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.

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[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.

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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] 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., 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 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, 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,

(continued...)

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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 order (or other means of delivery). The Bill would prohibit 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 Concerning the Development of Regulations Pursuant to the 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 services from contracting pharmacies (concerning such matters as 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 with that particular resident pharmacy. On the other hand, the phrase might support a resident pharmacy's demand that terms in a

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

[9] 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 provision in the Bill or other California law that would require 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, nonresident 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 lower prices, but also some changes in purchasing and usage habits. See Enright, 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).

11/9/11

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 to all types of 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

(continued...)

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 transaction costs by reducing 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 they benefit from the pharmacies' competition. Lower prices paid to pharmacy providers could mean lower costs for a third party 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 o 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)
were projected to increase 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 nonresidents. The Bill would rule out entering an 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

Letter dated June 29, 1990 from the Federal Trade Commission, by the staff of the Cleveland Regional Office and its Bureau of Competition, to the Pennsylvania State Senate

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UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
CLEVELAND REGIONAL OFFICE

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.

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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. 18273 (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 $73.6 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. § 449.1 *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

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HOUSE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
HOUSE BILL NO. 2117
FEBRUARY 8, 1993
KANSAS MANAGED CARE ASSOCIATION

Mr. Chairman, Members of the Committee:

My name is Deborah Origer, and I am the Executive Director of Principal Health Care of Kansas City, an HMO and PPO managed care company. On behalf of the Governmental Affairs Committee of the Kansas Managed Care Association, I appear today in opposition of this bill. The Kansas Managed Care Association consists of 16 member companies operating HMO or PPO networks in 62 Kansas counties and providing care or coverage for 365,000 Kansas residents. We have prepared a summary outlining the reasons we oppose this bill, and I would like to quickly review that today.

In summary, the Kansas Managed Care Association believes legislation like that proposed in House Bill No. 2117, commonly referred to in our industry as "open pharmacy" or "any willing provider" legislation, will hamper HMO operations and marketability. This type of a mandate will result in a higher percentage of each health care dollar being spent on administrative costs, in that tracking claims and enforcement of Plan protocols becomes more complicated with the addition of each additional provider. Efficiency is further reduced because HMOs lose their bargaining power to negotiate the best possible discount, as the HMO can no longer guarantee the same amount of business to each participating pharmacy. As a result, this type of open pharmacy legislation is termed "anti-managed care" in that it only serves to undo the objectives set forth by the managed care industry and the benefits derived through them.

While those supporting "open pharmacy" legislation contend that selective contracting is anti-consumer and impedes access to prescription drug benefits, these bills actually protect independent pharmacists from marketplace competition at the expense of consumers. HMOs and other managed care entities have become an increasingly important source of business for pharmacies that compete for patients needing prescriptions filled. Pharmacies, either independently or in groups, compete for business by seeking contracts which give them preferential or exclusive access to an HMO's or PPO's membership. Because managed care plans pay for services only if obtained at contracting pharmacies, those pharmacists are assured they will gain more business volume than if subscribes spread their purchases among numerous providers. This increased volume allows pharmacies to offer price discounts (by decreasing the normal markup amount over wholesale prescription costs) in exchange for large volume purchases.

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In return for this guaranteed volume of business, HMOs obtain the lowest price and most efficient service. Managed care companies' administrative expenses are also decreased when dealing with a restricted number of pharmacies. Utilization management programs and claims audits also can be administered more efficiently if a limited number of pharmacists' records are reviewed. In addition, limiting the number of participating pharmacies enables HMOs to promote a rational drug formulary, encourage more efficient pharmacy staffing patterns, and foster closer coordination between participating pharmacies and providers.

The apparent intent of "open pharmacy" measures is to promote greater choice for consumers and to expand accessibility to pharmaceutical services. The real impact, however, is to diminish competition for both pharmacy services and HMOs/PPOs and to raise the cost of drug coverage for employers and employees. These bills also run contrary to existing federal and state HMO enabling statutes authorizing the formation of prepaid health care programs whose efficiency is based on the ability to limit the number of health care providers, including pharmacists, that may participate.

Accessibility to pharmacies is not the problem. For example, Principal Health Care has over 200 participating pharmcies in the Kansas City area. State and federal law requires accessibility of services and competition will assure that HMO members have sufficient access to pharmacies. If the availability of pharmacies is insufficient or inconvenient, members have the option of disenrolling from the plan to join one which has more accessibility. This potential disenrollment provides an incentive to HMOs to assure satisfaction with accessibility to services in order to retain members.

Various studies also confirm that open pharmacy panels lead to higher drug costs for HMOs and premiums for subscribers. According to the Wisconsin data, the open panel pharmacy law was quite inflationary, with prescription drug benefit-related premiums rising 17.22 percent in 1987-88 and 18.56 percent in 1988-89. During that period, drug premiums for HMOs with closed panels rose only 12 percent. More recently, Aetna Health Plans compared drug costs for its Wisconsin (mandated open panel) and its Texas (selectively contracting) HMOs. For five drugs alone (Zantac, Ortho-novum, Seldane, Premarin and Zovirax), the annual savings were $21,000 for a 27,000-member Texas HMO. For all drugs, savings in Texas were about 7.6 percent or $52,321 over the Wisconsin open panel HMO.

I would like to finish by quoting from a March 17, 1992 letter written by Michael O' Wise, Acting Director of the Federal Trade Commission, to Paul J. Alfano, Legal Counsel for the Senate of New Hampshire.

"The Commission has observed that competition among health care benefit programs and health care providers can ensure consumer choice and service availability and can reduce health care costs. In particular, the commission has noted the use by pre-paid health care programs of limited panels of health care providers is an effective means of promoting competition among such providers." Mr. Wise goes on to argue that opening programs to all willing providers results in pharmacies being less willing to offer HMOs lower prices, as well as creating little incentive for pharmacies to compete in developing attractive or innovative proposals. Mr. Wise feels that this will result in higher prices for pharmacy services to HMOs, as well as increased administrative costs associated with having to deal with more pharmacies. He goes on to say that subscribes may already chose other types of programs, such as indemnity insurance, that do not limit the pharmacies from which they might obtain covered services, and that this type of legislation would reduce the number, variety, and quality of pre-payment programs available to consumers without providing any additional consumer benefit. The Federal Trade Commission has commented on many "open pharmacy" bills.

A final note, although I am not an attorney, I would like to refer you to a recent decision by Chief Judge Patrick Kelly of the United States District Court in Wichita, that dismissed a case brought by a Wichita hospital against Kansas Blue Cross/Blue Shield related to the Blue's decision not to contract with that hospital. His opinion read "Courts have repeatedly found such provider agreements to be important tools of the vital public policy of limiting the growth of health care costs."

Thank you.

Nancy Spring

Comments re: Kansas House Bill No. 2117

From: Patricia M. Kimes
Director of Pharmacy Services
Humana Prime Health
10450 Holmes
Kansas City, Missouri 64134
Phone: (816) 941-8900 ext 377

Pat Kimes

February 8, 1992

Humana Prime Health is a federally-qualified HMO in Kansas City, Missouri, serving members in Kansas and Missouri. Prime Health is an option of healthcare insurance, offered by Humana Health Care Plans. Humana Health Care Plans also offers MedPlan, a state-qualified HMO in Kansas, and preferred provider insurance in both Kansas and Missouri. Our membership in both states in Humana Prime Health is approximately 85,000 lives. Our membership in MedPlan is approximately 15,000 lives.

We currently operate both HMOs in a closed panel environment. A closed panel means that we direct members to use services by a specific list, or panel of providers, including primary care physicians, referral physicians, hospitals, and pharmacies. We see this as a way to contain costs in providing our members with healthcare benefits.

The costs for pharmaceuticals for the drug benefit have increased 20% during our last fiscal year, and we are projecting an increase of 15% during our current fiscal year. Those costs increases are due to a variety of reasons. However, we have escalating administrative costs, as we try to manage the pharmaceuticals. Those costs are what I would like to bring to the attention of the legislators.

Humana Prime Health operates 10 wholly-owned pharmacies as a part of its network of services. We are able to maintain many programs within our pharmacies to control cost and quality. These programs require a close working relationship between pharmacists and medical providers. These programs also require an immense amount of data, consolidated from all pharmacy providers, retrieved in a timely manner, and communicated between administrative and clinical personnel. We have found that these programs help us save costs, which enables us to provide the drug benefit, in a more cost-efficient manner.

It would appear on the surface that any pharmacist, who is willing to participate in our plan, at the same costs would not increase our costs. An argument may be made that many independent retail pharmacies are unable to do business with insurance companies, for a variety of reasons other than that pharmacy's willingness to work at the rate paid by the insurance company. An argument may also be made that opening the network of pharmacies would increase consumer convenience, or in some manner protect that consumer's safety. This legislation does not address any of these issues.

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This legislation only addresses any insurance company's, or any employer group's (that purchases a drug benefit), ability to direct business in return for a lower cost from the provider. Our only leverage in obtaining a lower cost of doing business is guaranteeing some portion of business to the contracted pharmacy. In an open access system, there is no reason for anyone to believe that any amount of business would result from a pharmacy offering an attractive price to the insurance company. This is true amongst all of the providers of healthcare with whom that HMO contracts for their business. This is the case with hospitals, medical providers, laboratory services, radiology services, rehabilitative therapy services, and pharmacy services.

We are faced with an enormous amount of pressure to provide the most amount of benefit for the least cost. This legislation would take away our ability to negotiate for business as well as increase our administrative costs in dealing with an increased number of pharmacies regarding customer service, and communicating policies and procedures regarding administering the drug benefit. I believe that this legislation, would in the long-term, increase the costs of healthcare to all purchasers of healthcare insurance.

Kansas Employer Coalition on Health, Inc.
1271 S.W. Harrison • Topeka, Kansas 66612 • (913) 233-0351

Testimony to House Financial Institutions and Insurance Committee

on HB 2117

(Requires health plans to accept willing pharmacists and allows individuals open access to any pharmacist)

by James P. Schwartz Jr.
Consulting Director
February 8, 1993

I am Jim Schwartz, consulting director for the Kansas Employer Coalition on Health. The Coalition is 110 employers across Kansas who share concerns about the cost of health care for our 350,000 Kansas employees and dependents.

The Coalition opposes HB 2117.

I believe all of us can agree that soaring health-care costs are a threat to the nation's economy. The strategy for reforming the health system favored by President Clinton, many members of Congress and health-care consumer and provider interests nationwide is called "managed competition." We will be hearing that term a great deal this year. In a nutshell, managed competition means that well-managed networks of providers will compete for patronage on the basis of price and quality of services. Such competition relies on contracts between providers and clients, offering firm prices in return for some volume of business.

A contract can assure volume by steering patients to pharmacists who participate in the network. For example, if you were a pharmacist and you agreed to participate in a network, you would allow a discount on your services in return for additional patients that the network could send you. The network can assure you of this volume because the contract with patients is exclusive in some way, or at least includes incentives for patients to patronize network pharmacists.

This arrangement is severely damaged by the terms of HB 2117. Under the bill, pharmacists who are reluctant to participate in a network could sit on the sidelines and raid

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the contract at will. Likewise, patients would be allowed to patronize any pharmacist who wishes to crash the party. The effect is to dilute the promised volume from pharmacists who contracted with the network in good faith. When pharmacists realize that contracts can be raided, they will no longer agree to tough contractual terms. There goes the contract. There goes the network. There goes managed competition for pharmacy.

Managed competition promises to create an accountable, cost-effective market for health care. As this competition heats up, it's not surprising that some providers long for the old days of weak market forces and look to government to turn back the clock.

Masquerading as a freedom crusader, HB 2117 is an attempt to preserve a system that has been friendly to providers, but increasingly unaffordable for consumers. Difficult changes must come to health care, including prescription drugs. Let's try managed competition before resorting to even tougher controls. We urge you to oppose HB 2117.

Kansas AFL-CIO

110 W. 6th St. Topeka, KS 66603 (913)357-0396

House Financial Institutions & insurance Committee
Chairman, Bill Bryant and Committee Members
HB #2117

I am Jim DeHoff, Executive Secretary of the Kansas AFL CIO, I appear before you today to oppose HB 2117.

HB 2117 is a direct attempt to undermine one of the few cost containment measures of Health Care increases.

In the past few years, Labor-Management groups, HMO, Preferred Provider Organizations and Insurance Companies have been able to get reductions in the costs of prescription drugs, by negotiating an exclusive contract for all the prescriptions of these groups with one pharmacy company. The pharmacy agrees to the price reduction of the prescription because of the increase in business. This is common business practice. We do the same thing with hospitals and doctors.

All of you are concerned with the rising cost of workers compensation and how to control the costs. One proposal that Labor & Management have agreed on is the use of preferred providers.

Passage of this legislation would result in an increase to consumers, because HB 2117 will be taking the incentive away for pharmacies to negotiate, if the same terms are offered automatically by law to other pharmacies.

Please remember that every pharmacy has a right to contract with the groups listed in HB 2117 and offer them the best deal they can, at the time the contracts come up for renewal.

Thank you.

Jim DeHoff
Kansas AFL CIO

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