Approved: 4-5-93
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on March 31, 1993 in Room 526-S of the Capitol.

All members were present except:

Committee staff present: William Wolff, Legislative Research Department
Emalene Correll, Legislative Research Department
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Kansas Senator Sheila Frahm, Senate Majority Leader
Bob Williams, Executive Director, Kansas Pharmacists Association
Marily Rhudy, Pharmacist - Topeka
Tom Hitchcock, Executive Secretary, Board of Pharmacy
Dave Charay, Health Benefits Administrator, Kansas State Employees Health Care Commission
Bill Sneed, Legislative Counsel, Health Insurance Association of America
Deborah Origer, Executive Director, Principal Health Care of Kansas City
Harry Helser, Kansas AFL CIO
Patricia M. Kimes, Academy of Managed Care Pharmacy
James P. Schwartz, Jr., Kansas Employer Coalition on Health

Others attending: See attached list

Hearing on **SB 84** - Civil penalties for the violation of pharmacy act.

SB 84 was amended by the House Committee which added the provisions of **HB 2117** - that would provide no policy, contract, plan, or agreement delivered to any group in Kansas which provides benefits or services, or both, for hospital and medical services offered by an accident and health insurance company, by a nonprofit medical and hospital service corporation, by a health maintenance organization except those which own and operate its own pharmacies and is in operation on the effective date of this act, by a preferred organization, by an individual practice association, or by a similar mechanism, may deny a registered pharmacy or licensed pharmacist the right to participate as a provider for any policy, contract, plan, or agreement on the same terms and conditions as offered to any other provider of pharmacy services, as well as other provisions. The Chair noted the House Public House and Welfare Committee passed the bill out of Committee without testimony, and to have the bill go to a conference committee without House or Senate conferees having an opportunity to hear testimony would be a disservice.

Senator Sheila Fraham appeared before the Committee with written testimony from Robert Moser, M.D., Greeley and Wallace County Family Practice Clinics, in support of **SB 84.** Dr. Moser expressed concern that people in rural areas do not have easy access to prescription drugs as those people that live in urban areas, that state programs currently underway will close the local rural pharmacies, and that the high cost of prescription drugs should be addressed to the manufacturers and wholesalers and not at the expense of the professional who provides service for the care of the patient. (Attachment 1)

Bob Williams, KPA, appeared in support of **SB 84** and stated that the provisions amended into the bill by the House 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. He also noted 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, and that 20 plus states have passed similar pro-competitive legislation and was unaware of any instances whereby pharmacies have been unwilling to bid for contracts. (Attachment 2) During Committee discussion regarding mandating insurance benefits, it was noted that the statute requiring an impact study would not differentiate between provider mandates and benefit mandates.

Marily Rhudy, Topeka Pharmacist, expressed support for **SB 84** and noted that the bill will not provide Kansas pharmacies with any price advantage, or that not all pharmacies may participate in some of the employer sponsored plans, however, it is important that those pharmacies who chose to play by the same rules as the corporate owners be able to do so. (Attachment 3)

Tom Hitchcock, KSBP, expressed support of the bill with the exception of New Section 4 and 5. (Attachment 4)

Dave Charay, Kansas State Employees Health Care Commission, appeared in opposition to **SB 84** because the bill as amended could eliminate the option of pharmacy networks through which in-state as well as out-of-state insurers can control the cost and quality of services provided to state of Kansas active and former employees who contract with the state of Kansas. He noted that prescription costs are the most rapidly rising component of health care costs as well as for the state of Kansas Employee Health Plan -- 33% as compared to a general increase of 20% for the entire health plan. By eliminating the volume discounts that pharmacy networks can and do provide, this cost will increase much faster than experienced in the past. It was pointed out that 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 benefits program, and passage of this bill could result in the state being forced to eliminate the drug care program. (Attachment 5) Committee discussion related to the national average increase of prescription drugs which was estimated at 25% to 30% in comparison to the 33% increase of the Kansas Employee Health Plan, usage of managed care prescription drugs and the difference in cost due to the high mark-up of drugs.

William W. Sneed, HIAA, testified in opposition to **SB 84** and called attention to KSA 40-2248 and KSA 40-2249 that would require a fiscal impact report on these amendments so that the legislature could fully evaluate any social benefit versus social cost for such mandates. (Attachment 6) Committee discussion related to whether the pharmaceutical companies ever testified on the bill, rate of drugs based on volume, lack of pharmacies in rural communities, mail-order drugs, and availability of medication in rural areas.

Deborah Origer, Principal Health Care of Kansas City, testified in opposition to **SB 84**. Ms. Origer believes legislation that is proposed in the bill will hamper HMO operations and marketability, and that 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 would become more complicated with the addition of each additional provider. It was pointed out that the ability of national companies to negotiate contracts with providers and guarantee them certain amounts of business in return for that dollar is helping slow down the escalating cost of health care for consumers, and that the competitive forces in place now are working. (Attachment 7) Senator Ramirez made reference to testimony of Bob Williams that referred to 20 plus states that have passed similar pro-competitive legislation and requested more information be provided on that type of legislation. In regard to managed care, another member felt it was not the solution to everything, and the reason so many people are going to managed care, is not because they choose to, but because that is all they can afford. In regard to the availability of prescription drugs, another member brought attention to the fact of the difference between western Kansas and Kansas City.

Others testifying in opposition to **SB 84** were Harry Helser, AFL CIO (Attachment 8), Patricia Kimes representative of the Academy of Managed Care Pharmacy (KC MO.) (Attachment 9), and Jim Schwartz, KECH (Attachment 10) Written testimony in opposition to the bill was received from Robert C. Harder, Secretary of KDHE and Chairman of Health Care Commission (Attachment 11), and John Ensley, local counsel for Medco Containment Services, Inc. (Attachment 12)

The Chair asked for consideration of the minutes of March 15, 16, 17, 18, 19, 22, and 23, 1993. Senator Langworthy made a motion the minutes be approved as written, seconded by Senator Hardenburger. The motion carried.

The meeting was adjourned at 11:30 A.M.

GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH AND WELFARE DATE: 3-31-93

NAME	ADDRESS	COMPANY/ORGANIZATION
George LaHood	Overland Park Ks 6717 Shawnee Mission Pkwy	LaHood & Assoc Inc
Mike Marcotte	Same	Same
Ted Boy	McPherson KS	Farmers Alliance
Patricia Kimes	6950 Manchester	Academy of Mgd Care Pharm
Marily Rhudy	Lawrence Ks 302 Homestead	KS Pharmacists Assn
GARY G. COLEMAN	OVERBROOK, KS RT #2 BOX 144 66524	KPhA
JOHN BAUGHMAN	2432 ATCHISON LAWRENCE KS	KPhA
Mark Uncin	1908 Twilight Topeka, KS	Mulvane Plaza Pharmacy
Chip Wheelen	Topeka	KS Med Society
Bill Tarrer	Wichita	Boeing
HARRY SPRONG	K.C.	HUMANA
Debbie Origer	KC	Principal Health Care
Robert R Williams	TOPEKA	KPhA
Fred Palenske	~~BCBS of KS~~ Topeka	BCBS of KS
Cheryl Allard	Overland Park	~~Kaiser Permanente~~
Bill Sneed	TOPEKA	KHA
Dick Brock	"	Ins Dept
~~JERRY SLAUGHTER~~	TOPEKA	KMS
Dave Chaney	Topeka	HCC
Robert Harder	Topeka	KDHE
Brad Smoot	Topeka	BCBS

Honorable Sheila Frahm
Senate District 1
Kansas Senate
State Building
Topeka, Kansas

Dear Mrs. Frahm,

I have some concerns I would like to voice in favor of SB 84. Currently, as I have heard, this is also referred to as the pharmacy freedom of choice bill.

First let me introduce myself. I am a solo Family Practice doctor in Tribune and Sharon Springs where I provide medical and obstetrical care for those communities as well as obstetrical care for those from Leoti and other surrounding areas. My main practice is in Tribune, but I see patients every Monday and Wednesday afternoon in Sharon Springs. Luckily, I have another Family Practice doctor joining me in July. I have been out here for 4 1/2 years now, the last 2 years in solo practice.

Government as well as private citizens are currently concerned about our health care system. The current buzz word is "accessibility". I think this is an important concept in all phases of the health care system but I also feel quality and service are important. The bill SB 84 purpose is very important when regarding accessibility and quality in regards to prescription medications.

The large unions, insurance companies and certain pharmaceutical mail order warehouses would want us to believe that cost is the main issue here. They want to lock-in their health subscribers to one pharmacy, usually a mail order house (or at least not the local pharmacy in rural Kansas), where the formulary is predetermined, then the selected drugs are bought in large volumes for lower prices and generic drug use is encouraged. No one should have a problem with lower prescription prices but we must ask ourselves what is the true cost of this service. I see several problems with this type of system; first as it affects my patients, secondly how it affects my local community and finally as it affects our state.

First, I believe such as system results in a treatment delay for many common problems. Granted, the other agencies hope their subscribers will use their system for maintenance drug prescriptions but it affects medicines purchased for acute problems as well. For example, our local ASCS office now has a prescription drug program they are required to use or pay out-of-pocket for prescriptions purchased elsewhere. If an ASCS employee has a child with strep throat they would have to wait 2-3 days to receive the prescription by mail or pay out-of-pocket to buy it at our local pharmacy across the street from their office. Where is the savings in such a program. No one is going to wait the 2-3 days to treat their child in such a circumstance. Do these programs figure the cost of delaying such treatments in their savings? With these types of plans by-passing our local pharmacies is our access improved or made worse?

Currently there exists a state law requiring pharmacists to counsel patients regarding their prescription medications when they are dispensed. How is it these mail-order houses can circumvent this with a toll-free number that isn't even manned 24 hours daily. There seems to be a double standard applied here. Also, since these plans usually have a formulary and any drugs

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ordered not on these formularies are going to cost the patient more out-of-pocket again. These formularies are usually sound and most generic drugs are safe, but shouldn't the prescribing doctor have the final say regarding treatment?

Secondly, these programs are going to close our local rural pharmacies. The primary reason local pharmacies cannot be the subscribers provider is because the insurance company sets the filling fee the pharmacist receives more than 2 dollars below what the government reports the pharmacist needs to break even. They also want them to sell the drug at 15% less what it costs the pharmacist to procure it. In other words they want to control the cost of prescription drugs at the cost of our local pharmacies rather than at the manufacturing and distribution level. Our local pharmacies survive because 20% of their prescription business is for maintenance therapies. Even if people in these plans pay out-of-pocket for acute medicine therapies that is not enough business to keep our local pharmacies in business. Therefore as more of these mail order pharmacy plans become operational our smaller communities will see our pharmacies close. I can guarantee you that when this happens the physicians will not be far behind. I base this on my current experience providing medical care in a Rural Health Clinic in Sharon Springs where there is no local pharmacy. Because of this, extra time is taken with each patient visit to find which pharmacy they use and to call in their prescriptions for delivery. If the pharmacy delivery driver has left for the day it will be a full 24 hours before the patient receives their medications unless they travel 30 miles in any direction to get it filled that night. The extra time for each patient as a result and the inherent delays in getting medications to these patients is frustrating to me the physician. I would not practice full time in such a situation as few physicians would.

Finally, I see the proliferation of these plans as a threat to our state economy when you consider the possible volume of business being done outside our state line and at the expense of businesses within our state. Our local pharmacies provide employment, income to our communities and state and make access to medications readily available. We need to address our concern regarding drug prices to the manufacturers and wholesalers and not at the expense of the professional who provides a vital part of our local health care patient education and oversight to their medical treatment.

I thank you for your time in discussing this issue and hope to see SB 84 passed to become an asset to accessible health care in Kansas.

Sincerely,

Robert Moser, M.D.
Greeley Co./Wallace Co. Family Practice Clinics

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ROBERT R. (BOB) WILLIAMS, M.S., C.A.E.
EXECUTIVE DIRECTOR

TESTIMONY

SB 84

Senate Public Health & Welfare Committee

My name is Bob Williams. I am the Executive Director of the Kansas Pharmacists Association. Thank you for this opportunity to address the committee regarding Senate Bill 84. Because I have testified on the Board provisions contained in SB 84 previously, I will not address these issues at this time unless there are additional questions.

I would, however, like to address those provisions amended into SB 84 by the House.

Those provisions 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 arrangements.

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.

These provisions were supported by a clear majority in the House Financial Institutions & Insurance Committee and the House Public Health & Welfare Committee. The House of Representatives passed the bill on a 104-13 vote. In each instance the same opposing arguments were raised.

SB 84 is not anti managed care nor is it anti managed competition. To some individuals the definition of managed care/competition is closed networks. Those

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that advocate a closed network for pharmaceutical benefits have a limited understanding of what is entailed in pharmaceutical care. Closed networks are in fact having a disastrous effect on pharmaceutical care and increasing overall health care costs. We have found that closed pharmacy networks create barriers to patients getting their needed medication. I have a stack of letters from pharmacists and patients identifying numerous instances whereby they have been unable to get their medication because a network pharmacy was closed, didn't deliver or was 30 miles away. By affording alternatives to more costly forms of health care such as surgery and extended hospital stays, prescription medication is one of the most cost-effective means of controlling health care costs. However, taken inappropriately, it can have devastating effects.

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 their prescribed medications properly. The article further indicates that non-compliance is costing this country $15 billion a year in direct medical costs, lost wages and productivity.

This position is further supported in an article which appeared in the December 1992 issue of the American Association of Preferred Provider Organizations. According to this article "More than any other aspect of medical care, pharmaceutical utilization affects other areas of patient management and can have a major impact on treatment outcomes." For that reason one of their many recommendations for plan design includes the freedom to choose a pharmacy that is readily accessible in order to foster medication compliance. We should be encouraging patients to utilize more community pharmacies--not limiting their use.

For some reason the AFL/CIO is opposed to this legislation. We find this difficult to understand in that they fought very hard for a freedom of choice

provision in the workers compensation reform hearings. Furthermore, I have a stack of petitions which have been signed by patients in support of SB 84, many of whom I am sure are AFL/CIO members.

I understand that Dave Charay, Benefits Manager for the State Employee Health Care Plan, will be testifying in opposition to SB 84. The Drug Benefit Plan for State employees is a prime example of our concerns. A couple of years ago the State of Kansas entered into a contractual arrangement with Dillon Supermarkets to provide maintenance medication to State employees via a mail order plan. A community pharmacist is prohibited from participating even if they are willing to accept the same level of reimbursement. Those employees wishing to purchase their maintenance medication from their community pharmacist are penalized with higher co-payments and deductibles. To add insult to injury the Dillon Supermarkets are owned by the Kroger food chain which means the State of Kansas is using tax dollars (of which community pharmacists pay a considerable amount) to support an out-of-state corporation which has the potential to put community pharmacists out of business. Kansas pharmacists have a hard time understanding that one.

In both the House Insurance and Public Health & Welfare Committee deliberations, Dr. Wolfe asked what incentive a pharmacy would have to bid on a contract if that pharmacy knew all other pharmacies would be allowed to participate at the same rate. Pharmacy has its roots in the retail sector. In an effort to capture the market, when a new pharmacy moves to town their first move is to lower prescription prices, not increase them. The pharmacy profession is such a competitive profession that SB 84 is more than likely to encourage low bids on contracts in an effort to capture that market.

Lastly, I ask you to consider the toll these managed monopolies are having on rural health care and the resulting increase in health care costs. According to the

January 1886, Vol. 39 issue of the Vanderbelt Law. "...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 costs to the uninsured public. To the extent these programs are uneconomical to...pharmacists, they have contributed to a reduction in a 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."

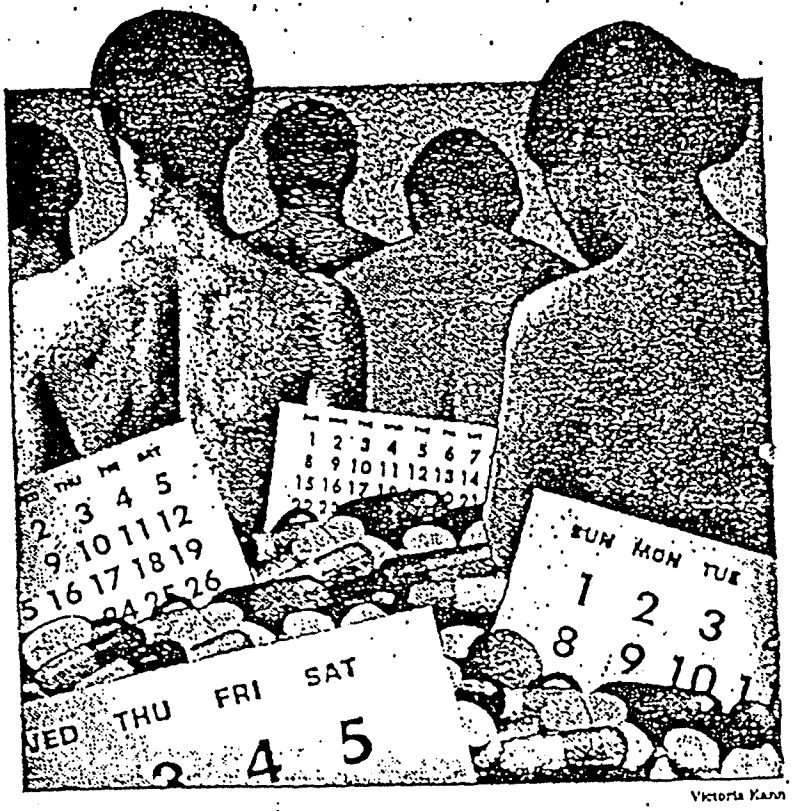
Rural hospitals are closing and physicians are not locating in rural communities. This committee has conducted a number of hearings on bills to deal with the rural health care crisis and now these managed monopolies are threatening the existence of rural community pharmacies.

In conclusion I would like to say that 20 plus states have passed similar pro-competitive legislation. I am unaware of any instances whereby pharmacies have been unwilling to bid for contracts. 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 ar doing to them. 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. We encourage you to support Senate Bill 84. Thank you.

Personal Health

Jane E. Brody

Curable killer: ignoring the doctor's orders.



Victoria Kann

ONE of the most serious and costly epidemics in America today arouses almost no public concern and is all but ignored by health officials. Unlike AIDS or polio, it is not caused by infection and it can be cured. But few have put their minds to bringing it under control.

It is an epidemic of illness, disability and occasionally death from what the medical profession calls noncompliance: the failure of patients to follow doctors' preventive or therapeutic orders. Each year, studies have indicated, 125,000 people with treatable ailments die simply because they did not take prescribed medications properly or at all.

In the mid-1980's, the United States Chamber of Commerce estimated that such failures accounted for more than $15 billion a year in direct medical costs and in lost wages and productivity. That number can only have risen sharply since then, given the growing number of elderly people with chronic ailments requiring sustained treatment to avert complications. The elderly have one of the highest rates of noncompliance, with more than 55 percent of patients over 65 failing to take prescribed medication as directed, according to the National Council on Patient Information and Education.

Over all, the council has reported, 30 to 50 percent of all prescriptions dispensed by doctors are taken incorrectly by patients. One patient in five never even bothers to have the prescription filled. One in seven stops taking medication too soon, and nearly a third who do get their prescriptions the first time neglect to get refills ordered by their doctors.

When it comes to making behavioral changes, experts believe that the statistics are far worse. Taking a pill one or more times a day is hardly arduous or time-consuming, yet half of all patients either neglect to do it or do it incorrectly. Changing one's eating, smoking, drinking or exercise habits is far more disruptive, so it is not surprising that relatively few patients make such changes.

Sharing the Blame

Usually it is the patient who gets the blame for failing to follow a doctor's orders. Doctors angrily regard them as an affront to their medical authority or even a waste of their precious time. But are patients the sole or even the main culprits?

Doctors themselves are notoriously poor patients. "When doctors become ill and see other physicians," said Dr. Marshall Becker, a public health expert at the University of Michigan, "their level of compliance is lower than other people with the same condition." He and other experts say doctors deserve a larger share of blame for failing to motivate patients, provide them with adequate knowledge and follow up to assure the right things are being done.

These are some of the most common reasons for noncompliance, as revealed by various studies and doctor-patient experiences:

¶The illness causes fewer symptoms than the treatment. Uncomfortable side effects prompt many patients to stop taking medicine, especially for illnesses like high blood pressure that have few or no symptoms, even though they can have life-threatening consequences. When the treatment is prescribed to prevent an illness from developing, noncompliance is even more common.

¶Symptoms of the illness disappear before the treatment regimen is complete, prompting the patient to discontinue treatment.

¶Patients resent being dependent on drugs. In an article in The Hastings Center Report, Peter Conrad, a sociologist at Brandeis University, said some patients come to identify the treatment with their infirmity and stop one as a way of denying the other. Some stop taking their medication to see if it is still needed.

¶Many patients, particularly those with a chronic ailment, feel a need to take control of their disorder and may adjust the prescribed treatment to suit their needs or their perceptions of their illness.

¶Some patients are "unreasonably optimistic," said Dr. Becker. They may have very high cholesterol or high blood pressure, may be heavy smokers who never exercise, yet believe that heart attacks happen only to other people.

¶The costs of treatment or the demands of work and family may preclude following the doctor's advice. Or physical limitations may get in the way of the treatment.

¶Some patients [illegible]pable of following their doct[illegible]vice, especially when it involves changing ingrained habits. Physicians are likely to prescribe all-or-nothing changes, instead of introducing the new behavior in small increments.

¶Physicians often fail to take adequate time and show compassion in prescribing the therapy, leaving the patient with the impression that it does not matter all that much. A patient may misunderstand the doctor's advice or forget what was said minutes after leaving the office. The doctor may exaggerate the benefits of therapy, prompting the patient to stop when rapid improvement does not occur. Or the doctor may minimize or fail to mention side effects, prompting the patient to stop when new discomforts appear.

Improving the Odds

There is much that doctors can do to improve communication with their patients: adequately explaining the nature of the health problem, the role that therapy can play and the possible side effects of the prescription.

For their part, patients can take steps to assure that they are getting their money's worth from medical care and doing the best possible job to recover quickly or ward off serious complications.

Helping Yourself

☑ Tape-record or write down what the doctor says, repeat the prescription schedule and ask specifically about possible side effects and what to do if they occur.

☑ Let the doctor know if a prescribed medicine or therapy simply will not fit into your home or work life, if it conflicts with your beliefs, or if past experiences with it have been unfavorable.

☑ Ask for a referral to a support group that deals with your ailment. If the doctor calls for changes in diet, smoking or exercise habits and you feel you cannot make such changes on your own, get a referral to a dietitian, an exercise consultant or a smoking or weight-control program.

☑ Ask what to do if you miss a dose of medication or a therapy session and whether you should discontinue treatment when you feel better.

☑ Even if the doctor does not tell you to do so, call midway through the treatment to report what and how you are doing.

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PHARMACEUTICAL
FOCUS

Pharmaceutical Benefits: To Carve or Not to Carve

By

Kenneth R. Cohen and Richard A. Levy, PhD

The following article is the first in a new department that will appear in each issue of the AAPPO Journal entitled Pharmaceutical Focus. The series is intended to create a forum for exploring issues relative to integrating and managing supplemental benefits such as the pharmaceutical benefit in health care plans. Currently, only about half of all preferred provider organizations (PPOs) have managed pharmacy benefit programs, and of those, 74 percent utilize "carve-out" pharmaceutical benefit plans, usually with separate management and fee structures.[1] As a result of these arrangements, most PPO administrators have little practical experience with managed pharmaceutical benefits. It is essential to their organizations' survival that this experience be gained. This article will examine why this is so, and will offer guidelines for the development of a viable carved-out pharmaceutical benefit program.

Pharmaceuticals and Outpatient Therapy

In recent years, utilization of hospitalization has decreased, with more patients being treated in outpatient settings. This major shift has been made possible largely as a result of two factors: the adoption of managed care techniques and the advent of new pharmaceuticals.

These developments have initiated the following important new trends that will prevail into the 21st century: an increased volume of outpatient visits; an increase in the severity and complexity of illnesses treated on an outpatient basis; and a greater reliance on the outpatient use of pharmaceuticals as the primary treatment modality.[2] In such an environment, successful PPOs will be those that effectively manage outpatient pharmaceutical benefits not as an isolated cost center, but as an integrated part of the overall treatment regimen.

Kenneth R. Cohen is Vice President of Managed Care and Richard A. Levy, PhD is Vice President for Scientific Affairs at the National Pharmaceutical Council (NPC) in Reston, VA. The NPC is a research/educational association of research-intensive multi-national pharmaceutical companies. In addition, Mr. Cohen is a member of the Editorial Board of the AAPPO Journal.

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DETACH HERE

Managing the Outpatient Pharmaceutical Benefit

In an era when outpatient care is becoming a primary treatment modality, sophisticated pharmacy management will be required to control overall costs and to achieve quality outcomes. Pharmaceutical therapies themselves have become increasingly complex, with many seriously ill outpatients maintained on multiple medications. Currently, PPOs are doing very little to insure that medications are taken correctly, stored properly or understood well by these patients who critically rely upon them.

Pharmacy benefit management has become as complex as the pharmaceutical therapies themselves.

Pharmacy counseling for Medicaid patients will be mandated in 1993, but there is little agreement as to how much is required or appropriate, or how well existing systems can serve the true needs of patients. While such counseling is a positive step to manage pharmaceutical care, further investigations are required to insure that quality products are dispensed to the right patients at the right time, place and cost.

Pharmacy benefit management has become as complex as the pharmaceutical therapies themselves. Techniques for the economical utilization of medicines are usually beyond the scope of all but the most highly trained and experienced individuals. General health care benefit managers lack the understanding, skills and time to master such a process. Most benefit managers think that since medications are a small part of the overall budget, they require little attention. General managers may fall prey to offers of "quick fixes" that save money in the pharmacy budget. Without the proper feedback from the overall system, these savings can seem quite attractive; but the system as a whole may be economically disadvantaged.

For example, savings in a pharmaceutical budget can be quickly erased by poor compliance, especially in critical therapeutic situations. Medications not taken properly can lead to further physician visits, utilization of more and costlier medications, increased laboratory and testing costs and eventually to increased hospitalization. Indirect costs, such as loss of workplace productivity, childcare, transportation expenses and disenrollment, may be as great or even greater than costs directly attributed to treatment.

Carve-out Pharmaceutical Benefits

One growing trend within the PPO industry today to properly control pharmaceutical costs and quality is to "carve-out" the pharmaceutical benefit. This trend entails separating the pharmacy plan from the main health care plan, by using separate management and utilization review strategies, actuarial tables and fee schedules.

Carve-outs are popular in pharmaceutical and other areas, such as mental health, dental and vision care, for the following reasons:

- An opportunity exists to isolate and better control costs.
- A concentration of expertise can be applied to the carve-out, attracting an experienced and capable workforce.
- Micro-management of a carve-out benefit may provide opportunities to reduce costs through techniques such as formularies and contracting.

However, despite apparent advantages, the results of carving-out a pharmaceutical benefit can be far different than anticipated. More than any other aspect of medical care, pharmaceutical utilization affects other areas of patient management and can have a major impact on treatment outcomes. Carved-out pharmaceutical plans are often isolated from other cost centers with little or no ability to assess the impact on overall treatment costs. Other problems with pharmaceutical carve-outs include:

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- Separate management for the carve-out plan is usually disconnected from the provider community, often leading to provider-relation issues.
- The managers of a pharmaceutical carve-out seldom have access to confidential patient profiles. Decisions made by these managers, operating in an environment removed from the site of care delivery, may lead to problems with therapeutics, patient acceptance of pharmacy restrictions, and legal issues.
- Multiple layers of internal management can be costly; alternatively, outside management of the carve-out benefit adds another cost, i.e., the profit of the outside contractor.

These positive and negative factors should be carefully weighed prior to implementing a carve-out pharmaceutical benefit.

Guidelines for Plan Design

Regardless of whether or not a pharmaceutical benefit is based on a carve-out design, it must contain certain key features that meet the needs of both employers and patients. These qualities are reflected in the following "checklist"[3] of what the plan should do:

- Cover medications that are not only clinically effective, but will also reduce overall medical care cost.
- Allow prescribers the flexibility to select medications that meet the unique needs of an individual patient.
- Give plan members the freedom to choose a pharmacy that is readily accessible in order to foster medication compliance.
- Encourage personalized counseling by the pharmacist, written instruction sheets and medication monitoring.
- Monitor patient compliance with the therapy.
- Maintain and utilize patient medication records to prevent unnecessary drug interactions and other potential problems.
- Employ strict quality assessment standards.
- Conduct appropriate drug utilization review.
- Promote rational controls on patient utilization.

These guidelines are appropriate for all PPO pharmaceutical benefit designs, whether or not they are carve-out plans. Two additional guidelines should be applied specifically to carve-out plans.

- A carve-out benefit of any type, especially one such as pharmaceuticals that will impact other parts of the total health care program, demands the use of an integrated data management system. In such a system, every provider must enter complete data from their part of the medical encounter. These data must be entered in a common language; it must be on-line, and readily accessible to others who are making key care decisions.
- There must be a center of control (case manager or gatekeeper) who will actually assume responsibility for tracking, balancing and coordinating costs and savings among the multiple service areas within the overall plan.

In the design of any pharmaceutical benefit component, PPOs must remember that the underlying basis of the PPO industry is to provide quality health care to patients. In this era of outpatient treatment, high-quality services cannot be accomplished without proper pharmaceutical management. And, serving the patient well will always be the hallmark of success.

References

1. *Marion Merrell Dow Managed Care Digest: PPO Edition.* Kansas City, MO: Marion Merrell Dow;1992:24.
2. *Integrating a Pharmacy Benefit Program into a Managed Healthcare Plan.* Fort Lee, NJ: Health Care Communications, Inc. and The American Association of Preferred Provider Organizations;1991:2.
3. *Integrating a Pharmacy Benefit Program into a Managed Healthcare Plan.* Fort Lee, NJ: Health Care Communications, Inc. and The American Association of Preferred Provider Organizations;1991:8.

2-8

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.

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.

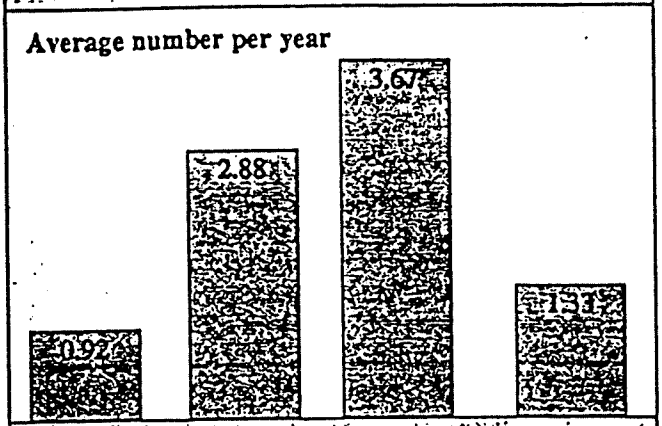
The "Rx-to-OTC switch" started long before the FDA began its OTC Drug Review Program in 1972, which was anticipated to increase the number of medications available without a prescription. Although the switching of prescription drugs to OTC status continues abroad, the trend has slowed recently in the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

2-16

The card that failed by doubling Rx use

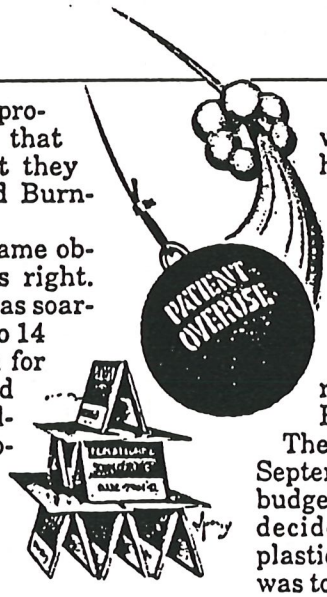
A South Carolina Rx program for state employees and retirees has highlighted what could happen with plastic card programs. When compared with indemnity coverage for drugs, plastic cards tend to increase patients' use of pharmaceuticals.

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

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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.
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Box 1773, Topeka, Kansas 66601

KANSAS
St. John News

MAY - 3 1979

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

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THE KANSAS PHARMACISTS ASSOCIATION
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ROBERT R. (BOB) WILLIAMS, M.S., C.A.E.
EXECUTIVE DIRECTOR

TESTIMONY

SB 84

House Public Health & Welfare Committee

My name is Bob Williams. I am the Executive Director of the Kansas Pharmacists Association. Thank you for the opportunity to address the committee regarding Senate Bill 84.

The Kansas Pharmacists Association supports SB 84. New Section 1 provides the Board of Pharmacy alternatives to licensure revocation and suspension in disciplinary matters by allowing them to fine in an amount not to exceed $500 for each violation.

Paragraph (g) on page 5 of the bill provides an exemption to the law passed last year which requires non-resident pharmacies to register with the Kansas Board of Pharmacy. There are isolated instances when an individual is traveling through Kansas or vacationing in Kansas and receives his/her medication from a pharmacy in another state. The Kansas Pharmacists Association sees no need for these non-resident pharmacies to register with the Kansas Board of Pharmacy in these isolated instances.

Additionally, the Kansas Pharmacists Association offers an amendment to SB 84 which is attached to my testimony. This amendment is the same language as contained in House Bill 2117.

Essentially what this amendment would do is prevent any health insurance company, non-profit medical and surgical plan corporation, nonprofit hospital service plan corporation, health maintenance organization or a preferred provider organization from denying a Kansas registered pharmacy or licensed pharmacist the

2-20

right to participate as a provider in a plan as long as that pharmacy is willing to accept the same level of reimbursement terms and conditions as offered to any other pharmacy. This amendment would also prevent any third party from punishing a patient from going to a non-participating provider by requiring different copayments or deductibles.

Pharmacy has its roots in the retail sector. It has become common practice for retail operations to accept their competitor's coupons and promise to sell their merchandise for the same price as their competitor. Pharmacies functioned much the same way before insurance companies began creating monopolies under the umbrella term "managed care".

Unfortunately, these monopolies have created barriers to pharmaceutical care. I have a stack of letters from pharmacists citing numerous examples of how a patient's care has been compromised because community pharmacies have been locked out of networks. As a result of their involvement in closed networks during the 1980's, the American Association of Preferred Provider Organizations now recommends that their plan members be given the freedom to choose a pharmacy that is readily accessible in order to foster medication compliance. This amendment is not anti managed care, as some would have you believe, but very much supportive of the managed care concept.

HB 2117 was passed favorably by the House Committee on Financial Institutions & Insurance on 10-4 vote. As a result of some procedural problems, and following discussion with House leadership, the decision was made not to run the bill as it came out of committee due to format concerns. We encourage the House Committee on Public Health & Welfare's adoption of SB 84 and our amendment.

Thank you.

Amendment to SB 84

Section 1. No policy of group health insurance providing benefits for hospital and medical expenses delivered in this state that is offered by an accident and health insurance company, by a nonprofit medical and surgical plan corporation, by a nonprofit hospital service plan corporation, by a health maintenance organization, by a preferred provider organization, by an individual practice association or by a similar mechanism may:

(1) Deny an registered pharmacy or licensed pharmacist as defined in K.S.A. 65-1626 and amendments thereto the right to participate as a provider for any policy or plan on the same terms and conditions as are offered to any other provider of pharmacy services under the policy or plan;

(2) prevent any person who is a party to or beneficiary of any health insurance policy from selecting a registered pharmacy to furnish the pharmaceutical services offered under any policy or plan, if the pharmacy is a provider under the same terms and conditions of the policy or plan as those offered to any other provider of pharmacy services; or

(3) permit or mandate any difference in coverage for or impose any different conditions, including copayment fees, whether the prescription benefits are provided through direct contact with a pharmacy or by use of an out-of-state mail order service so long as the provider selected is a participant in the plan involved.

Sec. 2. All health benefit programs, as defined in section 1, shall provide an annual period of enrollment of at least 30 days during which period any pharmacy registered under article 16 of chapter 65 of Kansas Statutes Annotated may elect to participate in the plan under the terms and conditions then offered unless the pharmacy has lost its status as a provider due to its failure to comply with the terms and conditions of its provider agreement. Health benefit programs are not required to provide actual notice of the period of open enrollment to the pharmacy.

Sec. 3. Any provision in an accident and health insurance policy offered in this state which violates the provisions in section 1 is void.

Sec. 4. The department of insurance shall enforce the provisions of this act.

Section 5. This act shall take effect and be in force from and after its publication in the statute book.

March 31, 1993

Good morning. My name is Marily Rhudy. I am here today to testify in favor of SB 84, described as a "Freedom of Choice" pharmacy bill. I am a practicing community pharmacist here in Topeka where I own two independent pharmacies in medical clinic settings. My home is in Lawrence, Ks; I am a constituent of Senator Sandy Praeger and Representative Barbara Ballard who are both good friends and respected colleagues. My qualifications to speak today include being a Past President of the Kansas Pharmacist's Association as well as being the Immediate Past President of the American Pharmaceutical Association headquartered in Washington DC, representing 190,000 pharmacists in this country.

Understand too, that as well as being a pharmacist-provider of prescription drugs, I am also a consumer of health care as the mother of seven young children, and a payor of health care as the employer of 25 individuals in my practice. I hope then, that I can bring to bear on this discussion a common sense approach to this issue as a provider, a consumer and a payor of health care benefits.

I was raised in a small town in western Kansas where there once were three fine old-fashioned "drug stores". One drug store

Senate PH&W
Attachment #3
3-31-93

remains in Hill City, but I fear, not for long. When I opened my first pharmacy in Topeka in 18 years ago, there were 16 small independent "mom and pop" pharmacies and a couple of large chain drug stores. Today, of those 16 locally owned operations, only 4 remain. While one may argue that the demise of those businesses may be due to any number of factors be assured that the "managed care" element has had the most substantial influence. Not for one moment do I expect this Committee or any government agency to assure me continued success. It is not the responsibility of federal or state government , any insurance company, any employer or any union group to provide me with a competitive advantage to stay in business, simply because it isn't "fair" to do otherwise. We are not here today, asking for an unfair advantage; we are here today, asking you to level the playing field in terms of access to prescription services.

Although prescription drugs are expensive, health care experts agree that the community pharmacy operates in a highly competitive environment. Note the discounts, coupons, come-on's that each of you see in newspapers and television ads. The prescription drug business is very price sensitive, well advertized and incredibly competitive. All consumers benefit from that competition; the

State of Kansas benefits from that competition both in the Medicaid Prescription Drug Program and the prescription benefit for the state's employee. Pharmacists are proud of the high quality, cost effective provision of pharmaceuticals in this country; the US drug distribution system in this country is second to none. I have met my counter-parts, presidents of the Mexican Pharmacists Association, the Canadian Pharmacists Association and over 60 other countries; they are all envious of our distribution process.

SB 84 will not provide Kansas pharmacists with any price advantage; many of us will chose not to participate in some of the employer sponsored plans currently available because we simply cannot afford to accept the low fees offered. However, it is important that those pharmacies who chose to play by the same rules as the corporate owners of pharmacies do, ought to be able to do so.

Opponents to this bill will tell you that it will cost them more money to administer the programs; not so. Over ninety percent of US pharmacies are already on line to prescription claims processors who electronically, live time, point of sale, adjudicate claims; no additional administrative burden exists in my opinion. Many of you here have a "drug card" that is as simple and accurate as any credit card in your wallet.

Opponents may tell you that we ought to wait for national health care reform. While my input in the current reform debate was been modest, I think all reasonable people know that the biggest crisis of the 20th century, will not be solved in 100 days. Our APHA staff in Washington is convinced that reform will occur at the state level and national solutions, long time in coming, will be very broad, vanilla and global. We cannot afford to wait out Ms. Clinton's Health Care Reform Task Force recommendations; congressional approval and local implementation.

Let's go back to rural Kansas, say in Hill City or Joe Hamm's in Kensington, Ks or Roger Miller's in Bonner Springs or Walt Ritzman in Larned. Rural Kansans want to live in those small towns with a few essentials: a grocery store, a school, a couple of churches, maybe even a small hospital or nursing home, and of course, a drug store. But those drug stores cannot afford to stay open for the dwindling number of customers who still pay cash; we cannot continue to shift the cost of "managed cost" to the few remaining uninsured in this state. Those drug stores must not be prevented from serving their patients because of the heavy-handed influence of a corporate sponsor and provider that run them out of business.

Who will fill the late night antibiotic for a child with an earache or a pain medication for an acutely injured patient if those stores have had to close their doors. Pharmacists cannot afford to sit idle while a mail order operation in Los Vegas or Houston fills prescriptions for their clients. My parents would hate to see the old McCauley/Wise Rexall Drug finally fold because Graham county residents are driving to one of the large chains in Hays for the prescriptions. Remember that if SB84 is successful those small stores will not be paid a penny more than their competition; they aren't asking you for a hand out or a leg up; just remove the hurdles, the artifical barriers and the flawed economics of sending business to an out of state provider or corporate owner.

Back to Topeka; urban by some standards? I recently lost a contract to do business at one of my stores; after 10 years of provided marginally profitable services to many good friends and old customers, I can do so no longer. I have been written out of $600,000 worth of business in 93 that I did in 92. I didn't lose that business on price; my bid was competitive; I lost it to a large chain. That may just be business; but it gets personal; many of those patients desire to do business with me; they are my patients; I know their health, their families and I care about them. If I am willing to provide the service at no additional cost, why can't I do so?

We have stopped saving the many stories of elderly and infirm patients who are forced to mail off their prescriptions and did not get them on time; or who forget why they were taking their meds; or who called for help in understanding the prescriptions side effects; they are legion. We still provide services, but at no charge; those are my friends and patients but they cannot have their prescriptions filled at my stores.

All opponents to SB 84 and most proponents will argue this issue based upon cost; that's reasonable. But optimal care is also an issue. Don't overlook the many important (and life saving) relationships that exist between a pharmacist and her patients. I won't go into detail about the APhA vision or mission for pharmacy; some would find it academic. The pharmacy community believes that pharmacy is the profession responsible for the provision of drugs to provide optimal therapeutic outcomes. To state it more simply,

I draw upon a lesson from my youngest child Mason. His class was asked to bring their parents to school to introduce them; kind of like the Wausau commercial that you have all seen. One other child in that class has a father who is also a pharmacist; Paul introduced his dad as "a pharmacist, he sells medicine." Mason introduced me as his mother "a pharmacist, she helps sick people get better." The national professional society of pharmacists believes that Mason is right on target. The personal relationship that a patient has with his pharmacist is critical to his compliance and overall wellness.

Thank you for your attention. We need your help. I am eager to answer your questions.

Kansas State Board of Pharmacy

LANDON STATE OFFICE BUILDING
900 JACKSON AVENUE, ROOM 513
TOPEKA, KANSAS 66612-1231
PHONE (913) 296-4056

STATE OF KANSAS

JOAN FINNEY
GOVERNOR

SB 84 TESTIMONY
SENATE PUBLIC HEALTH & WELFARE COMMITTEE
MARCH 31, 1993

MADAM CHAIRMAN, MEMBERS OF THE COMMITTEE, MY NAME IS TOM HITCHCOCK AND I SERVE AS THE EXECUTIVE SECRETARY FOR THE BOARD OF PHARMACY. I APPEAR BEFORE YOU TODAY ON BEHALF OF THE BOARD IN SUPPORT OF SB 84 AS AMENDED WITH THE EXCEPTION OF NEW SECTION 4 AND 5.

THE BILL CONSISTS OF THREE (3) CHANGES IN THE PHARMACY ACT. THE FIRST CHANGE APPEARS ON PAGE 1, LINES 13 THROUGH 27, IN THE FORM OF A NEW SECTION. THIS SECTION WILL ALLOW THE BOARD TO SANCTION CIVIL FINES AGAINST A PHARMACIST, PHARMACY OR DISTRIBUTOR IN AN AMOUNT NOT TO EXCEED $500 FOR EACH VIOLATION. IN COMPARISON, THE KANSAS BOARD OF NURSING AND HEALING ARTS BOTH HAVE THE ABILITY TO IMPOSE CIVIL FINES AS DO 33 BOARDS OF PHARMACY IN OTHER STATES.

THE SECOND CHANGE IS ON PAGE 2, LINE 22, WHICH STRIKES THE REQUIREMENT THAT SOME RECORD KEEPING BE RECORDED ON THE FACE OF A TRANSFERRED PRESCRIPTION. IF THE TRANSFER WERE A CONTROLLED SUBSTANCE (CS) PRESCRIPTION, SUCH RECORD KEEPING WOULD NOT BE IN COMPLIANCE WITH FEDERAL DEA REGULATION 21 C.F.R. 1306.26(a)(1).

THE THIRD CHANGE IS ON PAGE 5, LINES 23 THROUGH 29. THIS ADDITIONAL SUBSECTION WILL ALLOW THE BOARD TO PROMULGATE REGULATIONS TO EXEMPT FROM REGISTRATION A NONRESIDENT PHARMACY WHICH SUPPLIES SOMEONE IN THIS STATE A PRESCRIPTION ONLY IN ISOLATED TRANSACTIONS.

THE BOARD OF PHARMACY RESPECTFULLY REQUESTS THE FAVORABLE PASSAGE OUT OF COMMITTEE SENATE BILL 84 AS AMENDED.

THANK YOU.

Senate P H & W
Attachment # 4
3-31-93

STATE 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 Public Health and Welfare Committee

FROM: Dave Charay D.C.
Health Benefits Administrator

DATE: March 31, 1993

SUBJECT: Testimony on SB 84

Madam Chairman, members of the Committee, thank you for the opportunity to present testimony. My name is Dave Charay. I am the Health Benefits Administrator for the Kansas State Employees Health Care Program. I am appearing today in opposition to SB 84, as amended.

As amended, SB 84 could eliminate the option of pharmacy networks through which in-state as well as out-of-state insurers can control the cost and quality of services provided to State of Kansas active and former employees who contract with the State of Kansas.

Prescription costs are the most rapidly rising component of health care costs and for the State of Kansas Employee Health Plan. For example, in calendar year 1993, prescription drug costs increased 33% as compared to a general increase of 20% for the entire health plan. In 1992, the prescription drug program dispensed 564,885 prescriptions that resulted in billed charges of $19,960,048 and payments to local pharmacies of approximately $16,859,821. In comparison, the mail order prescription drug portion of the program dispensed 10,218 prescription drugs which resulted in payments of $778,126. It is important to note that 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 amended 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

Senate PH&W
attachment #5

Landon State Office Building, Room 553-S., 900 S.W. Jackson, Topeka, Kansas 66612-1251, (913) 296-7483, fax (913) 296-2664

3-31-93

both volume and cost projections of providers and suppliers. SB 84, as amended, 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 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 benefits program. With the networks which are in place at present, the Health Care Commission is projecting a twenty percent increase for future plan years. Elimination of cost effective network options would increase these cost and obligations. The net effect would be that the long range fiscal effect of SB 84, as amended, 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 care program. Drugs would then by covered under major medical which could result in employees paying more of the cost since they would lose the volume discount managed care prescription drug networks provide; therefore, we urge the Committee to oppose SB 84 as amended.

DC:bcl

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

MEMORANDUM

TO: Senator Sandy Praeger, Chairman
Senate Public Health and Welfare Committee

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

DATE: March 31, 1993

RE: Senate Bill 84

Madam 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. S.B. 84 deals with several technical changes to the Kansas Pharmacy Act. The House Public Health and Welfare Committee amended H.B. 2117 into S.B. 84, and it is those amendments which concern my client. Please accept this memorandum as our testimony in regard to S.B. 84.

As we have analyzed this bill, if such amendments 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 such amendments are inappropriate and would respectfully request your unfavorable action on these amendments.

Senate P. H & W
Attachment #6
3-31-93

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 these amendments. (Copy of statute attached.) As you can see, these laws require a fiscal impact 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.

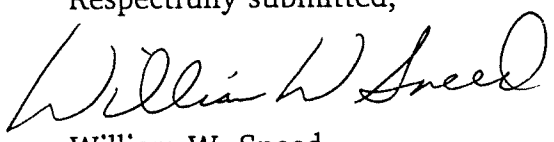
Next, we would remind the Committee that this bill would only affect somewhere between thirty to forty percent of the programs found within the State of Kansas. Inasmuch as Kansas cannot dictate terms to qualified plans exempted under federal law, this law will only affect those insurers doing business in the state, and will not affect self-insuring programs or HMO's who own and operate their own pharmacies. 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 these amendments. 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

(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

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

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 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 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 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 dr 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; an 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

volume purchasing directly from manufacturers, through highly specialized dispensing ar 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 a. 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 dr 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 comprehensi 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:

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

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.

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

	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	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	20.83	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	6.6	5.77
Maint Generic	4.2%	0.3	22.1	21.76	73.0	18.4	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	8.3%	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		56.5	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	28.81	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

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.

ithodology

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	$198,518	$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 m 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 controlle 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%

iscounts 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

or a retired population. In the baseline retail environment, these retirees average 1 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.

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move out of state when they retire, and retirees who move south each winter are 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.

SENATE HEALTH AND WELFARE COMMITTEE

SENATE BILL NO. 84

MARCH 31, 1993

Senate H&W
attachment # 7
3-31-93

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.

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.

Thank you.

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

OFFICE OF
CONSUMER AND
COMPETITION ADVOCACY

COMMISSION AUTHORIZED

March 17, 1992

Mr. Paul J. Alfano
Senate Legal Counsel
State House, Room 302
Concord, New Hampshire 03301

Dear Mr. Alfano:

The staff of the Federal Trade Commission is pleased to submit this response to your request for views on the impact House Bill 470 might have on competition in New Hampshire.[1] This bill would require any health maintenance organization ("HMO") that solicited bids for pharmacy preferred providers to contract with any pharmacy that met the bid the HMO accepted. Although H.B. 470 appears intended to provide consumers greater freedom to choose where they obtain covered pharmacy services, it appears likely to have the unintended effect of frustrating arrangements that might provide those services at lower cost.

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

The Federal Trade Commission is empowered[2] 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 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

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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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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 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

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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).

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on the competitive operation of such arrangements.[5] Some of these comments have addressed proposals similar to House Bill 470.[6]

II. Description of N. H. House Bill 470.

The bill would require an HMO that solicits bids for "preferred provider" pharmacy services to accept as preferred providers all pharmacies that "meet the bid acceptable" to the HMO. It apparently envisions that, if an HMO solicited bids and accepted at least one, then any bid that matched that bid would also have to be accepted. The bill does not say that the matching bid must be submitted during the initial bidding process. Thus, it may permit a pharmacy to meet a winning bid after the bidding process is over.

The bill refers to bids that are "acceptable," rather than to bids that are "accepted." This usage suggests that another mechanism might be intended. Conceivably, an HMO could set

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[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 that, in view of the pro-competitive and cost-containment benefits of HMOs and PPOs, 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 H.B. 470, under which all pharmacies could contract with a carrier on the same terms, noting that it 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, to Representative John C. Bartley (May 30, 1989, commenting on S. 526). Most recently, 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).

criteria defining what kind of bid would be "acceptable" before inviting or receiving the bids; then, any bidder that met those criteria would be entitled to a preferred provider contract. It would be difficult to administer such a mechanism unless the HMO announced those criteria in advance and thereby limited its bargaining possibilities. As a practical matter, the outcome of this "meet the criteria" interpretation might differ little from the "meet the winning bid" interpretation; a bid that met the criteria announced would also meet a winning bid.

The bill would add this provision to the list of practices forbidden to HMOs.[7] No similar requirement appears in New Hampshire's laws governing insurance,[8] medical service corporations and non-profit health service corporations,[9] or preferred provider organizations.[10]

III. Competitive importance of programs using limited provider panels

Over the last twenty years, in response to increasing demand for ways to moderate the rising costs associated with traditional fee-for-service health care, financing and delivery programs that provide services through a limited panel of health care providers have proliferated. 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 do 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. By offering a range of programs, payors are trying to meet their customers' demands. Consumers can select different program options depending on their personal preferences and anticipated health needs.

The popular success of programs that limit provider participation is probably due to their perceived ability to help control costs, as well as to subscribers' desire for both the broader product coverage and lower out-of-pocket payments that

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[7] N. H. Rev. Stat. Ch. 420-B:12.

[8] N. H. Rev. Stat. Ch. 415.

[9] N. H. Rev. Stat. Ch. 420, Ch. 420-A.

[10] N. H. Rev. Stat. Ch. 420-C.

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these cost savings may make possible. Competition among health care programs, both 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 programs and providers, including providers of pharmaceutical services. Competition among pharmacies, not just for individual consumers' retail business but also for participation on a payor's limited panel of providers, can benefit the consumer.

Pharmacies compete for the prescription business of patients, and an increasingly important source of that business is represented by subscribers to prepaid health care programs.[11] 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. The pharmacy providers 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.

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 lower prices and additional services help make the payor's programs more attractive in the prepaid health care market. Moreover, the payor's administrative costs may 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. Finally, it

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[11] 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 were projected to increase to $91.0 billion by 2000. S. T. Sonnenfeld, *et al.*, *Projections of National Health Expenditures through the Year 2000*, 13 Health Care Financing Review 1, 25 (Fall 1991).

may be easier for a payor to implement cost-control strategies, such as claims audits and utilization review, if the number of pharmacies whose records must be reviewed is limited. Payors may offer such preferential or exclusive arrangements in several ways. They may contract with selected pharmacies and then offer their subscribers incentives, such as lower deductibles and co-payments, to use the selected pharmacies. Or, in some cases such as in many HMO contracts, they may pay for services only if they are obtained at a contracting pharmacy.

Subscribers may prefer limited-provider programs if the lower costs are reflected in lower premiums, lower deductibles, or broader product coverage. Subscribers who choose limited-panel programs presumably decide that these benefits outweigh the inconvenience of a more limited choice of pharmacies. But subscribers' access to providers, including pharmacies, is unlikely to be inadequate, even for programs that use a limited provider panel. 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 also encourages payors to offer the level of pharmacy accessibility that subscribers want. If the service availability in a particular program is insufficient or inconvenient, subscribers can change payors or programs. 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.

IV. Effects of House Bill 470.

House Bill 470, if enacted, may make it more difficult, or even impossible, for HMOs to offer programs with pharmaceutical coverage that have the cost savings and other advantages discussed above. Opening HMO programs to all pharmacies wishing to participate on the same terms may affect both cost and coverage. To the extent that opening programs to all pharmacies reduces the portion of subscribers' business that each contracting pharmacy can expect to obtain, these pharmacies may be less willing to offer HMOs lower prices or additional services. Moreover, since any pharmacy would be entitled to contract on the same terms as other contracting pharmacies, there would be little incentive for pharmacies to compete in developing attractive or innovative proposals. Because all other pharmacies could "free ride" on the winning pharmacy's proposal formulation, innovative providers of pharmacy services may be unwilling to bear the costs of developing a proposal. Thus the bill could substantially reduce competition for this segment of pharmacies' business.

Reduced competition among pharmacies for HMO business could mean higher prices for pharmacy services to HMOs. The higher

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prices that HMOs may have to pay for covered pharmacy services, as well as the increased administrative costs associated with having to deal with many more pharmacies, may raise the prices HMOs must charge subscribers for prepaid health care programs, or may force HMOs to reduce their pharmacy benefits to avoid raising those prices.

Moreover, requiring HMOs to open their programs to more pharmacy suppliers may not give the consumer benefits from greater choice. Subscribers may already choose other types of prepayment programs, such as indemnity insurance, that do not limit the pharmacies from which they may obtain covered services. Indeed, by reducing HMOs' competitiveness with other kinds of third party payment programs, requiring HMOs to grant open pharmacy participation may reduce the number, variety, and quality of prepayment programs available to consumers without providing any additional consumer benefit.

New Hampshire's statutes governing prepaid health care programs do not now prohibit limiting provider participation. For example, New Hampshire's statute applying to HMOs contains nothing that would prohibit limited panels.[12] The recently adopted law applying to preferred provider contracts,[13] which clearly permits discrimination based on economic factors, also appears to envision limited panels. It appears that New Hampshire has recognized the potential cost-saving efficiencies of new forms of organizing health care reimbursement.[14] House Bill 470 would make it more difficult to achieve those efficiencies.

IV. Conclusion.

In summary, we believe that House Bill 470, if enacted, may raise prices to consumers and unnecessarily restrict consumer choice in prepaid health care programs, without providing any

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[12] N. H. Rev. Stat. Ann. Ch. 420-B.

[13] N. H. Rev. Stat. Ann. Ch. 420-C, §420-C:5.

[14] A recent federal court decision about competition between rival HMOs in New Hampshire describes how HMOs with limited panels negotiating to obtain discounts from providers and working to control costs can promote competition, including competition among different kinds of health care plans. U. S. Healthcare v. Healthsource, 1991-2 Trade Cas. [CCH] ¶69,697 (D. N.H. January 30, 1992).

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substantial public benefit. We hope these comments are of assistance.

Sincerely yours,

Michael O. Wise
Acting Director

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ATTACHMENT B

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 of 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).

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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.

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.

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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(1) (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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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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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 the 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

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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.*

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.

Although substantial savings might also be obtained through negotiations with 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.

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 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

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 imp f 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 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:

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

TABLE 1
1992 BASELINE RETAIL COSTS PER PERSON

RETAIL	PCT OF FILLS	FILLS/ PERSON	AWP$/ Rx	RETAIL $ Rx	DAYS/ Rx	DAYS/ PERSON	COST/ PERSON
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.

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	90.0	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

Fig 4

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	20.83	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	18.4	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	48.55	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

	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	34.72	11.0	9.8	30.19
Acute Mult-Source	11.6%	0.7	15.55	16.75	11.0	7.7	11.73
Acute Generic	17.4%	1.1	7.31	9.33	11.0	11.6	9.84
Total Acute	43.3%	2.6	18.86	19.72		28.9	51.76
Maint Single Source	26.3%	1.6	34.21	33.54	30.0	47.8	53.46
Maint Multi-Source	6.3%	0.4	27.69	27.85	30.0	11.4	10.56
Maint Generic	7.7%	0.5	9.10	10.94	30.0	13.9	5.08
Total Maintenance	40.2%	2.4	28.45	28.35		73.1	69.11
MAIL							
Maint Single Source	10.8%	0.7	83.2	74.92	73.0	47.8	49.09
Maint Multi-Source	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	18.4	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	42.56	33.7	105.2	132.76
Total Multi-Source	19.4%	1.2	23.72	23.91	22.1	25.9	28.06
Total Generic	29.2%	1.8	9.90	11.53	24.8	44.0	20.42
Total	100.0%	6.1	30.56	29.89	28.9	175.1	181.2
Retail Baseline	100.0%	7.5	26.00	32.15	23.4	175.1	241.12
Pct. Change from Retail		-19.1%	17.5%	-7.0%	23.7%		-24.8%

PPO Reimbursement = AWP - 10% + $2.75
Mail Reimbursement = AWP - 13% + $2.50
50% of maintenance medications through mail service
29% of prescriptions filled with generics

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

RETAIL	PCT OF FILLS	FILLS/ PERSON	AWP $/ Rx	RETAIL$ Rx	DAYS/ Rx	DAYS/ PERSON	COST/ PERSON
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	$198,518	$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:

- o Network administrative expense = 1% of premium income
- o 1,000 subscribers
- o 7.5 prescriptions per year
- o 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	16.6%	0.0%	16.6%	0.0%	16.6%	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%

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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 15 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

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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 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.

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.

Aetna

Public Affairs Division
151 Farmington Avenue
Hartford, CT 06156

Jonathan M. Topodas
Counsel
Government Relations, RE4C
203-273-8383

AETNA PHARMACY COMPARISON BASED ON SB 235

We have compared the actual costs of pharmacy between Aetna health plans in Wisconsin, an "open panel" state and Texas, a "closed" panel state in order to show the negative cost impact of legislation that produces an "open" panel environment such as Arkansas Senate Bill 235.

For <u>just</u> five selected drugs (Zantac, Ortho-novum, Seldane, Premarin and Zovirax) for a member/participant population of 27,000, the yearly savings for Texas (the "closed" state) amounted to $21,600.

For <u>all</u> prescription drugs, the saving generated in Texas by the closed panel approach amounts to approximately 7.6%. And for the entire year 1990, the total savings in Texas amounted to $52,321.

Aetna

Public Affairs Division
151 Farmington Avenue
Hartford CT 06156

Jonathan M. Topodas
Counsel
Government Relations, RE4C
203-273-8383

March 4, 1991

The Honorable Bill Clinton
Room 250
State Capitol Building
Little Rock, AR 72201

Dear Governor Clinton:

Aetna Life Insurance Company, which covers approximately 25,000 Arkansas residents under our various employer health plans, respectfully requests that you veto SB 235.

Health insurance cost increases are a major concern of employers today. Consequently, legislation which contributes to this price spiral can have a devastating effect on the business community, particularly on small employers. Arkansas Senate Bill No. 235 is such a bill, and we urge you to veto it.

Contrary to the slogans of the proponents, Arkansas residents currently enjoy freedom of choice with respect to their selection of pharmacists. The issue is whether consumers will continue to enjoy the freedom to choose a pharmacist providing lower-cost products as a result of that pharmacist's participation in a pharmacy network.

If such a network is forced by SB 235 to accept all pharmacists, then the economic stimulus to provide volume discounts (the savings of which are passed on to consumers) would be lost and competition would be reduced.

We share the views of the Federal Trade Commission and the Arkansas Attorney General (Opinion No. 91-047, March 1, 1991) that bills like SB 235 are anti-competitive. As the Attorney General correctly notes, "...it is my opinion that Senate Bill 235 is anti-competitive..."

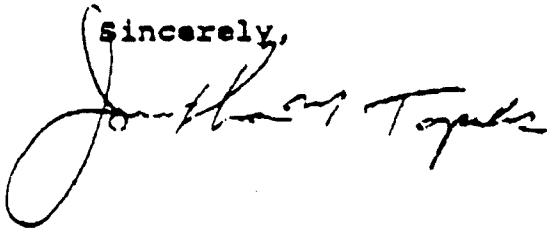
Participating providers in a health plan network are selected based on the size of the coverage area and the quality of the provider (e.g., their credentials and practice patterns). Enactment of SB 235 would take away the consumer's right to take advantage of this selection process.

The enactment of Senate Bill No. 235 would constitute a giant step backward for consumers. Whenever health insurance premiums rise, a certain segment of the market cannot afford the cost. As a result, employers, and especially small employers, are forced to drop their coverage. Thus, ever increasing health care costs equate to an increase in the number of uninsureds.

Please help employers manage the high cost of health insurance and help employees retain their coverage by a veto of Senate Bill No. 235.

Thank you for your consideration.

Sincerely,



Kansas AFL-CIO

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

UNION YES

Senate Public Health & Welfare Committee
Chairman, Senator Sandy Praeger
SB 84

I am Harry Helser, representing the Kansas AFL CIO, and I appear before you today to oppose SB 84 which 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 or more pharmacies. The pharmacies agree 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 a price increase to consumers, because SB 84 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 SB 84 and offer them the best deal they can, at the time the contracts come up for renewal.
Thank you.

Harry Helser
Kansas AFL CIO

KANSAS SOLIDARITY

Senate PH&W
Attachment # 8
3-31-93

Senate Public Health and Welfare Committee
Senate Bill No. 84
March 31, 1993

From: Academy of Managed Care Pharmacy
Patricia M. Kimes
~~Director of Pharmacy Services~~
~~Humana Prime Health~~
~~10450 Holmes~~
~~Kansas City, Missouri 64131~~
~~Phone: (816) 941-2800 ext 379~~

Madame Chair, Members of the Committee:

My name is Patricia Kimes, ~~and I am the Director of Pharmacy Services for Humana Health Care Plans, Kansas City.~~ I am here today representing the Academy of Managed Care Pharmacy in opposition to Senate Bill No. 84. The Academy of Managed Care Pharmacy, or AMCP, is the national professional society of pharmacists promoting the development and advancement of pharmaceutical care in managed health care environments. Current membership exceeds 1,200 which represents approximately 190 health care organizations, providing comprehensive health care coverage for over 40 million individuals in the United States.

It would appear on the surface that any pharmacist, who is willing to participate in a managed care provider plan, at the same costs would not increase costs to the managed care company. 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.

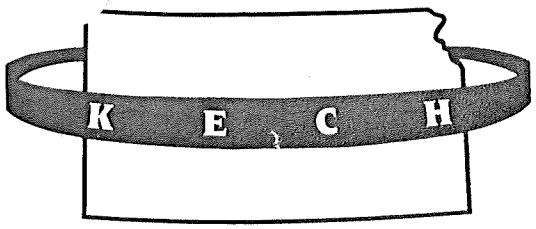
This legislation only addresses any insurance company's, or any employer group's (that purchases a drug benefit), ability to direct business in return for a lower cost from the provider. Our only leverage in obtaining a lower cost of doing business is guaranteeing some portion of business to the contracted 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.

In 1989, and again in 1992, the FTC gave opinions regarding legislation proposed by the states of Massachusetts and New Hampshire which would have eliminated the HMO's ability to selectively contract with pharmacies. The FTC concluded that this legislation would be anti-competitive in that it would "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 need." Therefore, the **FTC concluded that it would not be in the consumer's best service to enact Any Willing Provider Legislation.**

Senate PH&W
Attachment #9
3-31-93

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.

The individual's freedom of choice is exercised at the time they select a health care plan. AMCP believes it is appropriate to let the consumer, not government, make the choice between an HMO, or health insurance which offers open access.



Kansas Employer Coalition on Health, Inc.
1271 S.W. Harrison • Topeka, Kansas 66612-2302 • (913) 233-0351

Testimony to Senate Public Health and Welfare Committee

on SB 84

by James P. Schwartz Jr.
Consulting Director
March 31, 1993

I am Jim Schwartz, consulting director for the Kansas Employer Coalition on Health. The Coalition is over 100 employers across Kansas who share concerns about the cost of health care for our 350,000 Kansas employees and dependents.

Masquerading as a freedom crusader, SB 84 is really an attempt to weaken price competition in managed care plans.

This nation is moving toward a system of "managed competition" for health services. 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 SB 84. Under the bill, pharmacists who are reluctant to participate in a network could sit on the sidelines and raid 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 for pharmacists who contracted with the network in good faith. When pharmacists realize that contracts can be

Senate PH&W
Attachment # 10
3-31-93

raided, they will no longer agree to tough contractual terms. There goes the contract. There goes the network. There goes managed competition for pharmacy.

The issue at stake here is much larger than pharmacy. That's why lobbyists from other provider groups are here today. If pharmacists are allowed to raid managed care contracts, then every other healing artist will queue up for the privilege, too. At stake is nothing less than the viability of managed competition itself.

Managed competition promises to create an accountable, cost-effective market for health care. As this competition heats up, it's not surprising that some groups long for the old days of weak market forces and look to government to turn back the clock. But 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 SB 84.

S .E OF KANSAS

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

Dave Charay,
Benefits Administrator

KANSAS STATE EMPLOYEES HEALTH CARE COMMISSION

M E M O R A N D U M

TO: Members of the Public Health and Welfare Committee

FROM: Robert C. Harder, Chairman,
Health Care Commission

DATE: March 31, 1993

SUBJECT: Testimony on SB 84

Madam Chairman, members of the Committee, my name is Robert Harder, Chairman of the Health Care Commission and I come to you today to express my opposition to this bill.

As I am sure all of you are aware, the cost of medical care and especially the drug component of medical care, has been increasing at a much greater rate than the overall cost of living. One of the most promising methods of challenging this constant increase in cost is managed care. The principal idea behind managed care is to direct plan participants to the most effective care, both in terms of cost and quality.

Under a managed care system, such as an HMO or PPO, the system must contract with medical and drug providers. To remain price competitive, the managed care system normally must receive discounts from its contracting providers. The primary reason that most providers are willing to sign a contract to provide services or drugs as a discount rate is the promise by the managed care system to direct more patients to the contracting providers. The managed care system can promise an increase in patients because it limits the number of providers within its managed care system.

This bill, if enacted, will destroy the managed care systems ability to assure drug providers that the managed care system can direct more patients to the contracting providers since the managed care system could no longer control the number of drug providers participating in the network. In the first few years after this bill is passed, there might be an increase in the number of pharmacies who would provide drugs at the discounted rate required by the managed care system, but as the pharmacies saw that they were giving discounts without gaining any new business, the number of participating pharmacies would decrease. Kansas would soon be paying much more for their drugs.

Senate P/H & W
Attachment #11
3-31-93

Landon State Office Building, Room 553-S., 900 S.W. Jackson, Topeka, Kansas 66612-1251, (913) 296-7483, fax (913) 296-2664

As Chairman of the Kansas State Employee Health Care Commission, I have seen the cost of drugs for State employees and their dependents increase drastically over the last few years. This has resulted in higher copayments and higher premiums for plan participants. Passage of this bill would undoubtedly result in immediate increases in the premiums of all HMOs, other than HMO Kansas, offered through the employees health program.

Although the passage of this bill would have much less affect on the operations of current Blue Cross plans and the HMO Kansas Plan offered State employees since most pharmacies are participating in these plans, this bill would eliminate future consideration of managed care networks within these plans. In addition, passage of this bill would be one more road block in the Commission's attempt to get more than one organization to respond to the Health Care Commission's request for proposals for a fully insured drug plan.

RCH/DC:bcl

cc: Health Care Commission Members

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OF COUNSEL
ROBERT A. McCLURE

TESTIMONY BEFORE SENATE COMMITTEE ON
PUBLIC HEALTH AND WELFARE

Senate Bill 84

Medco Containment Services, Inc.

March 31, 1993

Senator Praeger 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.

SB 84 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, SB 84 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 SB 84, there would be little incentive for pharmacies to compete in developing attractive or innovative proposals that reduce costs.

Senate PH&W
Attachment #12
3-31-93

Administration Costs Will Increase

SB 84 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 SB 84 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. SB 84 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 New Jersey. In finding the New Jersey legislation anti-competitive, the FTC noted:

> Although the bill may be intended to assure consumers greater freedom to choose where they obtain pharmacy services, it appears likely to have the unintended effect of denying consumers the advantages of cost-reducing arrangements and limiting their choices in the provision of health care services.
>
> ...
>
> The Commission has observed that competition among third-party payors and health care providers can enhance the range of services available to consumers in the market

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.

...

Economic studies have confirmed that, under health care arrangements that permit selective contracting, competition helps to moderate cost increases. Competition among different kinds of arrangements for providing services, including those that limit provider participation and those that do not, would tend to ensure that the gains from these cost savings would be passed on to the consumers of health care services, either as lower out-of-pocket costs or improved services.

...

A preferential or exclusive arrangement may assure the provider of enough business to make possible savings from economies of scale, for example, by spreading fixed costs over a larger volume of sales. At a minimum, it could facilitate business planning by making sales volumes more predictable.

...

Since any provider would be entitled to contract on the same terms as other providers, there would be little incentive for providers to complete in developing attractive or innovative proposals. Because all other providers can "free ride" on a successful proposal formulation, innovative providers may be unwilling to bear the costs of developing a proposal.

...

Reduced competition among providers for access to the business represented by limited panel programs can result in higher prices for services through those programs. The higher prices for services, as well as the increased administrative costs associated with having to deal with

many more providers, may mean that subscribers to prepaid health care programs could face higher prices or reduced services.

...

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 "any willing provider" requirements may inhibit competition among pharmacy providers, in turn raising prices to consumers and unnecessarily restricting consumer choice 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 SB 84, 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 SB 84.

OFFICE OF
CONSUMER AND
COMPETITION ADVOCACY

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

March 29, 1983

The Honorable E. Scott Garrett
Chairman, Assembly Insurance Committee
The State Assembly
61 Spring Street
Newton, NJ 07860

Dear Chairman Garrett:

The staff of the Federal Trade Commission[1] is pleased to submit this response to your request for views on the possible competitive effects of Assembly Bill No. 1221. This bill could limit the ability of several kinds of health benefit plans to arrange for prescription drug services through contracts with providers, by requiring that services be available through any provider willing to meet the plan's terms. The bill would prevent limiting the panel of providers, and thus would discourage contracts with providers in which lower prices are offered in exchange for the assurance of higher volume. The bill also could inhibit the realization of cost savings, such as reduced transaction and auditing costs, made possible by the ability to contract selectively. Although the bill may be intended to assure consumers greater freedom to choose where they obtain pharmacy services, it appears likely to have the unintended effect of denying consumers the advantages of cost-reducing arrangements and limiting their choices in the provision of health care 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.

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[1] These comments are 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.

12-5

For several years, the Commission and its staff have investigated the competitive effects of restrictions on the business practices of hospitals and state-licensed health care professionals.

The Commission has observed that competition among third-party payors and health care providers can enhance the range of services available to consumers in the market 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 health maintenance organizations ("HMO's"), 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.

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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, 92 F.T.C. 101 (1978); 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 HMO's and physicians, noting that the prohibition could be expected to hamper pro-competitive and beneficial activities of HMO's and deny consumers

(continued...)

Several of these comments have addressed "any willing provider" requirements for pharmacy and other health care service contracts.

II. Description of A.B. 1221.

This bill would require HMO's, hospital and medical service plans, and health insurance plans that offer a prescription drug benefit to permit plan subscribers to obtain drugs from any pharmacy.[7] In addition, it would require that any pharmacy be permitted to participate in a preferred or contract provider program if the pharmacy was willing to accept the program's terms.[8] It would require that copayments, fees, or other conditions be the same for all participating pharmacies, including mail order pharmacies, and would forbid requiring the use of mail order pharmacies.[9] The bill states explicitly that

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[5](...continued)
the improved services that such competition would stimulate. See, e.g., Letter from Bureau of Competition to David A. Gates, Commissioner of Insurance, State of Nevada (November 5, 1986).

[6] The staff submitted comments to the Massachusetts House of Representatives about legislation to require 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). Letter from Bureau of Competition to Representative John C. Bartley (May 30, 1989, commenting on S.B. 526). The staff has submitted similar comments on similar legislation in Pennsylvania (letter from Cleveland Regional Office to Senator H. Craig Lewis (June 29, 1990, commenting on S.B. 675)), New Hampshire (letter from Office of Consumer and Competition Advocacy to Paul J. Alfano (March 17, 1992, commenting on H.B. 470)), and California (letter from Office of Consumer and Competition Advocacy to Senator Patrick Johnston (June 26, 1992, commenting on S.B. 1986)). See also letter from Office of Consumer and Competition Advocacy to Montana Attorney General Joseph P. Mazurek (February 4, 1993), commenting on a broad "any-willing-provider" requirement on PPO's.

[7] Assembly, No. 1221 ("A-1221"), §§1(a)(1), 2(a)(1), 3(a)(1), 4(a)(1), 5(a)(1), 6(a)(1).

[8] A-1221, §§1(a)(2), 2(a)(2), 3(a)(2), 4(a)(2), 5(a)(2), 6(a)(2).

[9] A-1221, §§1(a)(3), 1(a)(4), 2(a)(3), 2(a)(4), 3(a)(3), 3(a)(4), 4(a)(3), 4(a)(4), 5(a)(3), 5(a)(4), 6(a)(3), 6(a)(4).

it is not intended to add to or increase the scope of benefits provided under group contracts or by HMO's.

This comment will focus on the "any willing provider" aspects of the bill, that is, its requirement that all providers be permitted to participate in contracts to provide services, and on its effective prohibition of exclusive contracting for pharmacy services.[10] Our concern here is principally with the ultimate effects on the consumer that result from competition, or lack of it, among providers of health care services, including pharmacies. This comment addresses the effects on consumers of the bill's regulation of contracts in which insurance companies and health care plans such as HMO's act as purchasers of health care services.[11]

III. Competitive importance of programs using limited provider panels.

Over the last twenty years, financing and delivery programs that provide health care 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

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[10] A-1221, §§1(b), 2(b), 3(b), 4(b), 5(b), 6(b).

[11] The bill may also raise some issues, which this comment will not address directly, related to the regulation of mail-order pharmacy service. 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. 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] The Commission has no jurisdiction over the business of insurance. Contracts between health plans and service providers, and regulations of those contracts, do not involve the "business of insurance" for purposes of the antitrust exemption of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15, and the exclusion from Federal Trade Commission jurisdiction, 15 U.S.C. §46. See Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979).

programs may provide services directly or arrange for others to provide them. The programs, which include HMO's and preferred or contract provider panels under other kinds of plans, typically involve contractual agreements between the payer and the participating health care providers. Many sources now offer limited-panel programs. Even commercial insurers, which in the 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 appears to be 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] Competition among different kinds of arrangements for providing services, including those that limit provider participation and those that do not, would tend to ensure that the gains from these cost savings would be passed on to the consumers of health care services, either as lower out-of-pocket costs or improved services.[14] This principle would apply to all types of health care payment programs and health care providers.

Providers compete, ultimately, for the business of patients. A pharmacy or other provider may pursue the business of subscribers to PPO or HMO programs by seeking access to those subscribers on a preferential, or even an exclusive, basis. The provider may perceive several advantages to such arrangements. A preferential or exclusive arrangement may assure the provider of enough business to make possible savings from economies of scale,

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[13] Studies have examined the competitive effects of selective contracting, 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. Health Econ. 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 confirm these findings. See, e.g., D. Dranove et al., Is Hospital Competition Wasteful? 23 RAND J. Econ. 247 (1992); see also G. Melnick et al., The Effects of Market Structure and Bargaining Position on Hospital Prices, 11 J. of Health Econ. 217 (1992).

[14] In addition, employers that realize savings in their health care costs may pass those savings on to buyers of their firms' goods and services.

for example, by spreading fixed costs over a larger volume of sales. At a minimum, it could facilitate business planning by making sales volumes 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 and other providers compete with each other, offering lower prices and additional services, to get the payors' contracts.

Third-party payors may find such arrangements attractive because they would benefit from the providers' competition. Lower prices paid to providers could mean lower costs for the 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 providers 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 providers 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 programs with limited or preferred provider panels, if the competition among providers leads to lower prices (which may take the form of lower premiums or deductibles) or other advantages. Consumer preference for such programs would presumably mean that, in the consumers' view, these advantages would outweigh the disadvantages of limiting the choice of providers, such as reduced convenience or the occasional need to use a provider that is not part of the payor's contracted service. Limitations on choice are unlikely to be so severe that consumers' access to providers is inadequate. For just as competitive forces encourage providers to offer their best price and service combination 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 accessibility that subscribers want. To the extent that consumers can change programs or payors if they are dissatisfied with service availability, payors have an incentive to assure that the arrangements they make for delivery of covered health care services satisfy consumers.[13]

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[13] For consumers in employer-provided health care programs that offer no choices of different levels of service availability, changing programs could require changing jobs. But employers have an incentive to add options if their employees are dissatisfied.

12-10

IV. Effects of "any willing provider" requirements on limited-panel programs.

"Any willing provider" requirements and bans on exclusive or preferential contracting may limit firms' ability to reduce the cost of delivering health care without providing any substantial public benefit. They may make it more difficult for third-party payors to offer programs that have the cost savings and other advantages discussed above.

Because the bill would require that pharmacy services be available from any registered pharmacy, it would rule out entering exclusive contracts with a panel of particular pharmacy providers. It would also forbid offering an incentive, such as a lower copayment or fee, to use particular providers' 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 achieve economies of scale and offer lower price terms or additional services.

Even in the absence of economies of scale, requiring that programs be open to all providers wishing to participate on the same terms could discourage efforts to offer lower prices or additional services. Since any provider would be entitled to contract on the same terms as other providers, there would be little incentive for providers to compete in developing attractive or innovative proposals. Because all other providers can "free ride" on a successful proposal formulation, innovative providers may be unwilling to bear the costs of developing a proposal. Thus "any willing provider" requirements may substantially reduce provider competition for this segment of their business.

Reduced competition among providers for access to the business represented by limited panel programs can result in higher prices for services through those programs. The higher prices for services, as well as the increased administrative costs associated with having to deal with many more providers, may mean that subscribers to prepaid health care programs could face higher prices or reduced services.

Moreover, requiring programs to be open to more providers may not give the consumer any additional advantages of greater choice, if consumers may already choose other types of prepayment programs with fewer limits on the providers from which they may obtain covered services. Indeed, requiring open participation may reduce the options available to consumers without providing any additional consumer benefit.

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 A-1221 may be to limit consumers' ability to select among alternative delivery systems for pharmaceutical services.

V. Conclusion.

In summary, we believe that "any willing provider" requirements may inhibit competition among pharmacy providers, in turn raising prices to consumers and unnecessarily restricting consumer choice without providing any substantial public benefit. We hope these comments are of assistance.

Sincerely,

Michael O. Wise
Acting Director

L. Daniel Jorndt
President

Walgreen Co.
Corporate Offices
200 Wilmot Road
Deerfield, Illinois 60015
708-940-3002

March 25, 1993

Senator Paul Burke
President of the Senate
Room 359-E
State Capitol
Topeka, KS 66612

Dear Senator Burke:

Walgreens is concerned about an Amendment to Senate Bill 84 which is before the Senate. This amendment concerns Freedom of Choice for pharmacies. Similar legislation was considered but not passed by the Kansas House of Representatives during this Session (House Bill 2117). If passed, this so-called "freedom of choice" legislation could increase the costs of prescription drugs in Kansas. S.B. 84 would disrupt the competitive process used to contract for pharmacy services at a time when employers and other payors of healthcare benefits need to manage and control costs. Because of the potential to increase healthcare costs, there should have been a hearing on the amendment to S.B. 84 which did not occur.

Walgreens operates traditional community pharmacies and a state of the art mail service facility. All of our pharmacies provide a level of pharmacy care second to none. There can be no quality of care issue that would justify enacting the amendment to S.B. 84. This legislation seeks to restrain the cost efficient delivery of pharmacy services. It could also discourage employers from offering prescription benefits in their health plans.

I respectively ask you to consider my views in your deliberations on this important piece of legislation and vote "no" to a bill that encourages higher healthcare costs and was not part of the hearing process.

Very truly yours,

12-13

Wausau Insurance Companies

A Member of the Nationwide® Group

February 5, 1993

The Honorable William M. Bryant, Chairman
Committee on Financial Institutions
and Insurance
Kansas House of Representatives
Room 112-S
State Capitol
Topeka, Kansas 66612

Re: Oppose Kansas HB 2117
Pharmacy "Freedom of Choice" Bill

Representative Bryant, Wausau Insurance Companies is a major provider of employee benefits for employers in Kansas. Our Kansas employees, retirees and their families use a regional prescription drug program to purchase prescription drugs and pharmaceutical supplies. This program is designed to provide safe, effective prescription drugs in a cost-efficient manner.

House Bill 2117, however, places restrictions on our attempts to control prescription drug costs. It would require prescription drug programs to permit any licensed pharmacy or pharmacist to participate in the program.

This would hinder our ability to contract for services with pharmacies willing to reduce costs in return for increased volume. It would also eliminate any incentive for pharmacies to compete in developing attractive or innovative proposals that reduce costs.

A similar proposal was vetoed by the Governor of the State of California. The Federal Trade Commission and the Health Insurance Association of America also concluded that such legislation would undermine the cost containment efforts that many health care service plans have implemented for their prescription drug services, and would result in increased costs for pharmacies and ultimately higher premiums for employers and individuals.

2000 WESTWOOD DR • WAUSAU WI 54401-7881 • (715) 845-5211
MAILING ADDRESS: PO BOX 8017 • WAUSAU WI 54402-8017

12-14

We feel this is unacceptable in an environment where health care costs are approaching crisis levels. We respectfully urge you to oppose HB 2117. We would appreciate hearing your position on this bill.

Sincerely,

Gay R. Baumgart, F.L.M.I.
Government Affairs
gb/93/feb/15ksh2117

cc: Committee Members

Southwestern Bell Corporation

February 15, 1993

Ronald D. Hovis
Director Benefits

The Honorable William M. Bryant, Chairman
Committee on Financial Institutions and Insurance
Kansas House of Representatives
State Capitol, Room 112-S
Topeka, Kansas 66612

Re: House Bill No. 2117

Dear Chairman Bryant:

Southwestern Bell is a communications corporation employing 60,000 employees both nationally and internationally. Approximately 3,500 of those employees reside in the state of Kansas. These employees utilize and purchase medical services and prescription drugs through Company-sponsored benefit plans. This letter serves to communicate our opposition to House Bill No. 2117.

If enacted into law, this Bill, which seeks to impose restrictive conditions on prescription drug programs, would reduce competition, raise health care costs, and ultimately restrict consumer choice, all without any corresponding public benefit, because:

Competition Will Be Reduced

Pharmacies would have little incentive to compete in developing attractive or innovative proposals that reduce costs because they would be entitled to contract on the same terms as other contracting pharmacies.

Administration Costs Will Increase

An "any willing provider" arrangement may entail substantial administrative burdens and expenses for payors. These costs have to be passed on in the premium, or the benefits to our employees will have to be reduced.

One Bell Center
St. Louis, Missouri 63101

Phone 314 235-7020

12-16

The Marketplace is Working

Payors who have entered into preferential arrangements or exclusive contracts with pharmacies are able to assure those pharmacies of 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, Benefits Will Be Reduced

Requiring a payor to open programs to all pharmacies may include 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.

Southwestern Bell Corporation supports and practices the concept of managed care through the provision of provider networks, which also include networks of pharmacies. This bill would prohibit the provision of effective cost containment practices of this nature. In order that we may continue to provide comprehensive levels of benefits, we must make the most efficient use of our benefit dollars. Therefore, Southwestern Bell Corporation respectfully urges you to oppose House Bill No. 2117.

Sincerely,

(FOR) RON HOVIS

2-17

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.

12-18

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.

12-19

CAREMARK

February 15, 1993

Prescription Service Division

Caremark Inc.
111 Barclay Boulevard
Lincolnshire, IL 60069
708.634.7600
Fax 708.634.7914

The Honorable William M. Bryant
Chairman
House Committee on Financial Institutions
and Insurance
Kansas House of Representatives
Room 112-S
State Capitol
Topeka, KS 66612

Dear Chairman Bryant:

I am writing as a follow-up to my testimony before the Committee on February 8, 1993 in opposition to House Bill 2117. At that time you requested that I provide data demonstrating the price savings to a plan which utilizes a sole pharmacy provider versus a limited network of pharmacy providers versus an open panel of pharmacy providers.

As I mentioned at the hearing, the best way to demonstrate the pricing differential is to look at typical per-prescription contract pricing. While there is a range of contract pricing available under any of the three scenarios, based upon group size and demographics, we list below representative pricing for brand-name drugs:

1. Sole Provider - Average Wholesale Price (AWP) less 15%, plus a $3.00 dispensing fee.

2. Limited Network - Average Wholesale Price (AWP) less 5% , plus a $3.00 dispensing fee.

3. Open Panel - "Usual and Customary" (Typically in the range of AWP plus 2%, plus $3.00 dispensing fee).

Applying the 3 pricing scenarios to a prescription with an Average Wholesale Price of $100, we see that the sole provider would charge $88, the limited network provider would charge $98 and the open panel provider would charge $105.

In this simplified example, we see that sole provider pricing offers a 16% savings over open panel, while limited provider panel pricing offers a 7% savings over open panel. These savings, when multiplied over 100's or 1000's of prescriptions, results in substantial discounts to plan sponsors.

By allowing any non-preferred provider a free ride into one of the negotiated arrangements (sole or limited provider) would cause the preferred provider to re-evaluate the contract in subsequent years and refuse to offer discounts without the guaranteed volume to justify it. This would undoubtedly lead to a collapsing of prices toward the open panel's "usual and customary" level, which was the very situation that existed during the many years before managed care options were available.

For these reasons, Caremark Inc. again respectfully requests the Committee to reject HB 2117. Thank you for your consideration.

Very truly yours,

Clifford E. Berman, R.Ph., J.D.
Director, Professional Services

cc: Members of the House Committee
on Financial Institutions and Insurance

Bechtel

50 Beale Street
San Francisco, CA 94105-1895
Mailing address: P.O. Box 193965
San Francisco, CA 94119-3965

February 12, 1993

The Honorable William M. Bryant, Chairman
Committee on Financial Institutions and Insurance
Kansas House of Representatives
Room 112-S
State Capitol
Topeka, Kansas 66612

Subject: House Bill No. 2117

Dear Chairman Bryant:

I am writing to you in my capacity as Manager of Benefits Design and Administration, Bechtel Corporation to state my opposition to the Kansas House Bill No. 2117.

Bechtel Corporation is a national engineering and construction firm and our benefits program includes a mail order drug program in which employees may purchase maintenance type drugs for a low co-payment. Bechtel is able to offer this program because the prescription drugs are purchased on a discounted basis from a national licensed pharmacy, managed by Medco Containment Services, Inc. Passage of House Bill No. 2117 would eliminate the advantage of this discount arrangement and would likely cause us to consider termination of our mail order program and thus deprive our employees and their families of an important benefit.

It is our opinion that this Bill will reduce competition, raise our health care costs and ultimately restrict consumer choice. We, therefore, urge you to oppose this legislation.

Sincerely,

Susan Grisso

Susan Grisso, Manager
Benefits Design & Administration

SG:mjr

AMERICAN MANAGED CARE PHARMACY ASSOCIATION

2300 Ninth Street South, Suite 210 • Arlington, Virginia 22204 • 703-920-8480 FAX: 703-920-8491

EXECUTIVE SUMMARY

PROPOSED HB 2117 IS PROTECTIONIST LEGISLATION

Managed care, home-delivered pharmacy services provide cost-affordable prescription medicines with value-added services consistent with good pharmacy practice focusing on pharmaceutical care and appropriate outcomes. Kansas' organized retail druggists allege that they can provide this optimal combination of quality and cost as well. The proper place to decide between these claims is the free marketplace, not the Kansas State Legislature. Proposed HB 2117 is protectionist legislation that can drive up the cost to Kansas consumers. Only the local retail drug store industry will profit from this kind of legislation, and this will be at the expense of Kansas consumers.

MANAGED CARE PHARMACIES PROVIDE THE HIGHEST QUALITY PROFESSIONAL SERVICES TO KANSAS CONSUMERS

In state after state, retail druggists allege that out-of-state home delivered pharmacy services somehow lack the quality of local pharmacy. However, when independent objective observers examine these allegations and anecdotes, they reject them. The American Medical Association amply documents the high quality of dispensing provided by mail service pharmacies: ". . . MSPs [mail service pharmacies] are less vulnerable to drug diversion than retail pharmacies. . . . Presently, the practice of obtaining drugs from mail service pharmacies appears to be relatively safe." [Resolution adopted by the House of Delegates, American Medical Association, 1987] "The Committee found no evidence that there was any difference in safety between have a prescription filled by mail and through an in-state pharmacy." [Joint Committee of the Michigan State Legislature, 1989]

PROPOSED HB 2117 WOULD INCREASE COSTS TO KANSAS CONSUMERS

Such restrictive legislation can mean higher prices and less health benefit plan pharmacy services for Kansas. When all the data are collected, the conclusion is simple: managed care, mail service pharmacies *are* successful in reducing overall prescription costs. "Note that mail order supplies an average 73 days supply compared to an average supply of 30 days in retail, resulting in a 'corrected' dispensing fee of $1.04 per 30 days supply (and) over 11% claims cost savings compared to unmanaged retail." [Wyatt Company study, 1992]

RESTRICTIVE LEGISLATION SUCH AS PROPOSED HB 2117 DISRUPTS THE COMPETITIVE PROCESS

By requiring that a health benefits plan permit local drug stores to provide pharmacy services to health plan members, even though these drug stores were unable or unwilling to offer the same combination of high professional quality, administrative services, and cost effectiveness in the competitive bidding process. Health insurance plans may be forced to accept the inefficiencies of dealing with a myriad of local drug stores that purport to be able to match the quality and cost effectiveness of the pharmacies that *were* willing to undergo the competitive process. The Federal Trade Commission, in comments on a proposed California bill [California SB 1986, a bill which failed passage on 7/1/92] similar to proposed HB 2117, concluded that such legislation ". . . 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 benefit."

PROPOSED HB 2117 IS AN UNCONSTITUTIONAL VIOLATION OF THE COMMERCE CLAUSE OF THE UNITED STATES

This legislation is constitutionally suspect under the Commerce Clause of the U.S. Constitution because of the discriminatory burden it places on interstate commerce, and because this legislation is anticompetitive rather than designed to further public health and safety (see Pike v. Bruce Church, Inc., 397 U.S. 137, 142 (1970)).

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12-23

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.

12-25

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,

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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...)

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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, non-resident pharmacies.

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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,[11] and those that have been reported are difficult to interpret. 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.

II. 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).

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

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Pharmacies, pharmacy chains, or groups of pharmacies may pursue this business by seeking access to a program's subscribers on a preferential, or even an exclusive, basis. A pharmacy provider may perceive several advantages to such arrangements. A preferential or exclusive arrangement may assure the provider of sales volumes large enough to make possible savings from economies of scale; at a minimum, it could facilitate business planning by making sales volume more predictable. The arrangement may reduce 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