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

OFFICE OF
CONSUMER AND
COMPETITION ADVOCACY

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.*

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).

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.

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

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).

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

Sincerely yours,

Michael O. Wise
Acting Director