Legal Backgrounder

WLF Washington Legal Foundation

Advocate for freedom and justice®
2009 Massachusetts Avenue, NW
Washington, DC 20036
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Vol. 27 No. 4 March 23, 2012

THE ANTI-COMPETITIVE EFFECTS OF "ANY WILLING PROVIDER" LAWS

by
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This analysis evaluates the antitrust law ramifications of proposals requiring pharmacy benefit managers ("PBMs") to open up their networks to "any willing provider" meeting the same terms and conditions as other network members. Providers which have failed to meet a PBM's terms have frequently sought the enactment of any-willing-provider ("AWP") legislation (or comparable administrative action). A recent federal proposal, The Pharmacy Competition and Consumer Choice Act of 2011 ("the Act")[1]— provides a useful model for this analysis. Both economic analysis and available empirical evidence suggest the bill will harm consumers by restricting competition.

PBMs work with pharmaceutical manufacturers, retail pharmacies, and health plan sponsors to facilitate agreements among them that efficiently provide consumers with prescription-drug access at a lower cost than would be available otherwise. The Federal Trade Commission ("FTC") described them as "an important development in providing consumer access to prescription drugs." DOJ & FTC, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, ch. 7, at 11 (2004). PBMs now play an integral role in the provision of prescription drugs to insured consumers.

PBMs help to obtain the best prices for consumers by negotiating with pharmaceutical manufacturers on behalf of plan sponsors. *Id*. They obtain discounts from pharmaceutical manufacturers because they have the ability to provide volume purchases of the manufacturers' prescription drugs. PBMs also administer pharmacy benefit services by acting as liaisons between health insurers and pharmacies. For example, when a patient fills a prescription at a retail pharmacy, the pharmacy transmits the patient's insurance information to a PBM, which then verifies the patient's coverage and copayment amount as well as the reimbursement the PBM and the pharmacy have negotiated. *Id*. The PBM transmits this information to the pharmacy, and separately bills the insurer. PBMs in this way serve to facilitate efficient exchange, reduce costs, and ensure payment to pharmacies.

PBMs also facilitate administration of pharmacy services on behalf of health plan sponsors. *Id*. When a retail pharmacy enters into an agreement with a PBM, it joins a network the PBM has created. Many networks are highly exclusive. The greater a network's exclusivity, the more customers a member pharmacy can expect. The prospect of a large number of customers creates intense competition for exclusive networks; this competition leads pharmacies bidding for network membership to offer higher discounts in order to join the network.[2] It is well understood that cost savings resulting from this exclusivity are generally passed on to consumers in the form of lower premiums, lower out-of-pocket costs, and better services.[3]

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Despite the intense competition created by bidding for network membership, the exclusivity of PBMs' networks raises questions about whether consumers have sufficient choices when looking for pharmacies to fill their prescriptions. Additionally, critics make issue of smaller independent pharmacies' inability to join networks.[4] To combat the impact of exclusive networks on independent pharmacies, the same critics propose adoption of AWP laws. Such laws require PBMs to open their networks to any health care providers, including pharmacies, willing to accept the terms of a given plan. *See* Letter from FTC Staff to Sen. James L. Seward, N.Y. Senate 2 (Aug. 8, 2011). Proponents of AWP legislation argue consumers benefit from prohibiting selective or exclusive networks in the form of increased choice, decreased costs, and higher quality service.[5] In addition to the consumer benefits, proponents claim AWP legislation levels the competitive playing field by giving independent community pharmacies the opportunity to compete with larger pharmacies.[6]

The FTC and the Department of Justice ("DOJ") have extensive experience in assessing competition in the health care industry. The agencies held hearings on the issue in 2003,[7] including a panel discussion of the competitive issues surrounding PBMs. Following the hearings, the FTC and DOJ jointly issued a report discussing their findings. *See* DOJ & FTC, *supra*. The agencies concluded AWP legislation is likely to harm consumers because it makes negotiating discounts more difficult for health insurers and restricts their ability to structure plans with different offerings that respond to differences in consumer demand.[8]

Until recently, the pursuit of AWP laws has been limited to state legislatures, but proponents have expanded their efforts to include a national solution. Specifically, the Pharmacy Competition and Consumer Choice Act of 2011 includes a typical AWP provision prohibiting PBMs from "exclud[ing] an otherwise qualified pharmacist or pharmacy from participation in a particular network provided that the pharmacist or pharmacy . . . accepts the terms, conditions and reimbursement rates of the PBM . . ."[9] As with state AWP proposals, the Act could lead to higher health care costs for consumers with no countervailing benefits. As a result, it is likely to decrease consumer choice and reduce access to high-quality, affordable health care for many consumers despite the Act's goals of preserving patient choice and restoring competition in pharmacy services.[10]

The Economics of AWP Laws

Economic Analysis Suggests AWP Laws Hinder Competition. AWP laws prohibit PBMs from selective and exclusive network contracting, thereby reducing both the incentive and the ability of health care providers to vigorously compete with each other to provide the highest quality, lowest cost goods and services. Many providers rely upon the exclusivity of their networks to bring them the highest volume of consumers possible. The prospect of a large consumer base gives providers the incentive to bid aggressively to join exclusive networks. Letter to Rep. McHenry, supra note 8, at 11.

This competition-enhancing effect of exclusive networks is well documented in the economics literature.[11] As the FTC has explained, "Many pharmacies trade higher customer volume for lower prices by offering deeper discounts to PBMs as the exclusivity of the network increases." Letter to Rep. McHenry, *supra*, at 11. Under AWP laws, providers know they cannot be turned away, do not face a significant loss of customers, and therefore have a reduced incentive to offer PBMs the most competitive terms.[12] That reduction in competition harms consumers. Further, opening networks to any willing provider reduces the magnitude of sales providers can expect. Letter from FTC Staff to Rep. Terry G. Kilgore, Va. House of Delegates 10 (Oct. 2, 2006). Thus, they cannot expect to maintain the same economies of scale as with contracts that promise high-volume sales, and they cannot offer the same discounts as they would with more exclusive agreements. Letter to Attorney Gen. Lynch, *supra*, at 4.

AWP laws significantly reduce providers' incentive to engage in price competition. Absent AWP requirements, providers compete to successfully negotiate contracts that maximize their benefits. However, if AWP rules apply, a provider's competitive efforts will allow the same terms to be made available to its competitors without the same investment. This reduces the incentive to invest in innovative, competitive proposals from the outset. Letter to Rep. Kilgore, *supra*, at 11. Such reduced competition is likely to lead to "the suppression of efficient service networks, not the expansion of real consumer choice." *Id*.

  ISBN 1056 3059

As the FTC explained, AWP laws "preempt competition among providers, instead of protecting the interest of patients. In other words, such laws appear to protect competitors, not competition or consumers." Letter to Attorney Gen. Lynch, *supra* note 8, at 6 (internal footnote omitted). AWP laws do not foster competition; rather, they hinder an important part of the competitive process by prohibiting selective and exclusive contracts that increase providers' incentives to compete, reduce costs, and generate significant benefits for consumers.

Empirical Evidence Regarding Any Willing Provider Laws. Empirical evidence supports the claim that AWP laws have anticompetitive effects. Empirical studies on the topic in peer reviewed journals suggest that AWP laws are associated with higher per capita spending, as predicted by theoretical models in which these laws limit the ability of insurers to secure better prices from providers while incurring higher transactions costs.

The first study, by Michael Vita, examines total per capita health expenditures, as well as per capita hospital and physician expenditures for the period 1983-1997. It shows, after controlling for differential baseline spending levels and time trends across states, that per capita health spending is more than one percent greater in states after they pass stringent AWP laws relative to their baseline spending levels and compared to states with no such laws. These results are robust to the inclusion of a variety of variables, including demographic and economic controls. These effects are above and beyond any increase in spending these laws create by reducing the penetration rate of managed care in a state.[13] Although there are some concerns that the passage of AWP laws may be a reaction to healthcare spending rather than a result of it, exploration of pre-existing trends does not suggest this possibility is driving the effect Vita identified.

An even more relevant study is provided by Christine Piette Durrance, who focuses on pharmacy-specific AWP laws. Christine Piette Durrance, *The Impact of Pharmacy-Specific Any-Willing-Provider Legislation on Prescription Drug Expenditures*, 37 ATLANTIC ECON. J. 409 (2009). This study adopts state of the art panel data methods to isolate the change in spending associated with the passage of AWP laws over the period 1988-1998. Durrance differentiates between laws that do and do not apply to pharmacies, finding that state per capita spending on pharmaceuticals is more than six percent higher when states pass pharmacy-specific AWP laws as compared to states not passing these laws. Further, she finds that total per capita health spending is more than four percent higher. These effects are statistically significant and practically large. Examination of the presence of pre-existing trends suggests that these effects are indeed causal and are not driven by the possibility that AWP laws respond to increased spending.

The empirical research on the topic consistently indicates that AWP laws increase per capita healthcare spending generally and pharmaceutical expenditures in particular directly. The related literature on the effect of these laws on HMO penetration also suggests these laws may increase spending indirectly given that the laws lead to lower penetration and HMOs control costs better than indemnity insurance plans. These results are consistent with economic theory regarding selective contracting.

The FTC and DOJ's conclusions from the healthcare hearings are consistent with the empirical evidence. Furthermore, in their joint report, they found PBMs have contributed substantially to providing consumers with access to prescription drugs. DOJ & FTC, *supra*, ch. 7 at 11. This finding is supported by empirical evidence suggesting that consumers with prescription drug service administered by PBMs save considerably more on drug costs than consumers who pay cash. *Id*. For these reasons, the FTC has been persistent in its efforts to educate states concerning the likely anticompetitive effects arising from AWP legislation. *See* discussion *supra* note 8.

Conclusion

AWP laws at the state and federal level likely lead to less competition and higher prices for consumers while providing no compensating benefits. Selective and exclusive network contracting is a fundamental part of the competitive process which leads to minimizing cost and maximizing consumer welfare. Advocates of AWP proposals understandably seek greater consumer choice and competition among health care providers; however, AWP laws amount to intervention in a competitive process by prohibiting efficient contracting and will ultimately be counterproductive to those goals.

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ENDNOTES

[1] H.R. 1971, 112th Cong. (2011); S. 1058, 112th Cong. (2011). We will refer to both of proposals collectively as "the Act" throughout unless discussing an aspect of bill that does not apply to the other.

[2] *See generally* Kenneth G. Elzinga & David E. Mills, *The Distribution and Pricing of Prescription Drugs*, 4 INT'L J. ECON. BUS. 287 (1997) (explaining the competition-enhancing effects of exclusive provision of prescription drugs); Benjamin Klein & Kevin M. Murphy, *Exclusive Dealing Intensifies Competition for Distribution*, 75 ANTITRUST L.J. 433 (2008) (explaining the competition-enhancing effects of exclusive dealing generally).

[3] Deborah Platt Majoras, Chairman, Fed. Trade Comm'n, Current Topics in Antitrust Economics and Competition Policy 12 (Feb. 8, 2005).

[4] A group of community pharmacies participating in the Medicare prescription drug benefit program has raised this issue in a recently filed complaint in the Eastern District of North Carolina. The pharmacies allege a regulation issued by the U.S. Department of Health and Human Services allowing establishment of "preferred" pharmacies that offer lower copayments and coinsurance than "non-preferred" pharmacies violates Medicare Part D's "any willing provider" provision. Complaint, *Farmville Discount Drug, Inc. v. Sebelius*, No. 5:12-cv-00097-D (E.D.N.C. Feb. 28, 2012). It should be noted that the complaint focuses upon the harm the preferred plans cause to community pharmacies. *Id.* ¶¶ 1, 31, 35. These concerns, of course, are about the welfare of particular small rivals and not about competition or consumer welfare. In fact, smaller competitors are complaining about the more competitive environment resulting from a rule that allegedly circumvents an "any willing provider" requirement.

[5] *See* Letter from David A. Balto to Andrew M. Cuomo, Governor, New York 3 (Oct. 17, 2011); *see also McMorris Rodgers Introduces Pharmacy Competition and Consumer Choice Act*, U.S. HOUSE OF REPRESENTATIVES, (May 24, 2011) (explaining Representative Cathy McMorris Rodgers's expectations that a proposed law will "protect America's community pharmacists and lower costs for their consumers").

[6] *See Community Pharmacists Endorse Bipartisan Pharmacy Competition and Consumer Choice Act*, NAT'L CMTY. PHARMACISTS ASS'N (May 24, 2011).

[7] *See Competition in the Health Care Marketplace*, FED. TRADE COMM'N (last updated July 8, 2009) (providing an overview of the hearings and links to the agenda, materials, and press releases related to them).

[8] *Id.* ch. 6, at 30. In 2005, the FTC advised Representative Patrick T. McHenry of North Carolina that the state's proposed bill, which included an AWP provision, was "likely to limit a PBM's ability to reduce the cost of prescription drugs without providing consumers any additional protections." Letter from FTC Staff to Rep. Patrick T. McHenry, N.C., U.S. House of Representatives 14 (July 15, 2005). In its letter to Rhode Island, the FTC advised that the state's AWP provisions would very likely harm consumers by decreasing access to pharmaceutical services. Letter from FTC Staff to Attorney Gen. Patrick C. Lynch, R.I. 7 (Apr. 8, 2004). Notably, the FTC indicated that the competitiveness of the market made the bills unnecessary because it was unlikely that the limitations on choice made access to pharmacy services inadequate. *Id.* at 5.

[9] H.R. 1971, 112th Cong. § 2 (2011); S. 1058, 112th Cong. § 2 (2011).

[10] *See* Cathy McMorris Rodgers & Anthony Weiner, *McMorris Rodgers and Weiner: Local Pharmacies Play Essential Role in Care*, ROLL CALL (June 6, 2011, midnight).

[11] *See, e.g.*, Elzinga & Mills, *supra* note 2, at 297 ("[F]or third-party payers, and consumers of prescription drugs under their coverage, intervention by . . . PBMs is unambiguously beneficial . . . ."); Klein & Murphy, *supra* note 2.

[12] *See* Letter to Rep. McHenry at 11 n.44; Letter to Attorney Gen. Lynch, *supra* note 8 at 5 ("From the perspective of a pharmacy negotiating the terms on which it is willing to deal with health insurers and employee benefit plans, this means that a pharmacy . . . faces no threat of sales losses if it fails to bid aggressively for inclusion in the payers' networks.").

[13] Numerous studies agree that managed care penetration reduces health care spending. On this point, see, for example, Gaskin and Hadley, *The Impact of HMO Penetration on the Rate of Hospital Cost Inflation, 1985-1993*, 34 INQUIRY 205 (1997) and Glenn Melnick et al, *Managed Care, Competition, and Hospital Cost Growth in the U.S., 1986-1993* (RAND Working Paper, 1997). Michael A. Morrisey & Robert L. Ohsfeldt, *Do "Any Willing Provider" and "Freedom of Choice" Laws Affect HMO Market Share?*, 40 INQUIRY 362 (2003), among other studies show that restrictions on selective contracting reduce managed care penetration rates. Taken together, these studies suggest that any willing provider laws can have two effects on healthcare spending: (1) the direct effects discussed in the text above, and (2) indirect effects through a reduction in managed care participation as suggested in this footnote.