SELECTIVE CONTRACTING IN PRESCRIPTION DRUGS: THE BENEFITS OF PHARMACY NETWORKS

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ABSTRACT

Selective contracting in health care involves contractual arrangements among insurers and health care providers that give covered individuals a financial incentive to obtain health care from a limited panel of providers. Although selective contracting has been an important strategy of health insurance plans for decades, it has only recently expanded to prescription drug coverage. Drug plans now create pharmacy networks that channel customers to in-network pharmacies. Pharmacies compete to be part of the networks by offering discounts on the drugs they sell to covered customers and drug plans. Although networks can lower prescription drug costs for drug plans and consumers, opponents have argued that they also reduce access to care because consumers can only visit certain providers. In this Article, I use the principles of economic theory, the conclusions of previous empirical studies, the determinations of the FTC, and proprietary data I obtained from the largest pharmacy benefit manager in the United States to analyze both the claims in support of pharmacy networks and the arguments against them. I find that pharmacy networks significantly lower the cost of prescription drugs for drug plans and consumers. Moreover, pharmacy networks have almost no effect on most consumers' access to pharmacies; the overwhelming majority of consumers live near retail pharmacies that are included in exclusive pharmacy networks.

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INTRODUCTION

Selective contracting in health care involves contractual arrangements among insurers and health care providers that give covered individuals a financial incentive to obtain health care from a limited panel of providers. Although insurance plans such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs) have engaged in selective contracting for decades, only recently has the practice expanded to prescription drug plans. The drug plans form exclusive arrangements with retail pharmacies that promise to steer insured individuals to in-network pharmacies. The pharmacies, eager to be part of an exclusive network that will offer significant sales, compete aggressively to be included in the network by offering price discounts for filling prescriptions. As a result, selective contracting can lower the cost that both drug plans and consumers pay for prescription drugs.

Although pharmacy networks can reduce prescription drug costs for drug plans and consumers, these savings come at the expense of the retail pharmacies that must either offer price discounts to be part of exclusive networks or lose sales by not being included in the networks. As a result, pharmacy representatives have alleged various harms created by pharmacy networks. Some have argued that the networks reduce

consumers' access to care by limiting their choice of pharmacies. Others have suggested that smaller independent pharmacies may be excluded from networks. Responding to these arguments, many states and the federal government have enacted regulations that limit the ability of health insurers and/or prescription drug plans to contract selectively.

In this Article, I use the principles of economic theory, the findings from previous empirical studies, the conclusions of the FTC, and a proprietary dataset to analyze both the claims in support of pharmacy networks and the arguments against them. I obtained data from Express Scripts Holding Company, the nation's largest pharmacy benefit manager (PBM) that manages over a billion prescriptions each year for more than 100 million people. No prior study has ever reported or analyzed this data or similar data from another PBM to explore how pharmacy networks work in practice.

I find that exclusive pharmacy networks reduce the prices for many drugs, leading to reductions in the overall spending on pharmaceuticals. When drug plans have the ability to exclude pharmacies from their network and steer patients elsewhere, pharmacies compete aggressively for selective contracts by offering price discounts for filling prescriptions. In general, more exclusive networks produce greater competition because they promise to channel more patients to network pharmacies. As a result, more exclusive networks generate even steeper price discounts. Indeed, data from Express Scripts confirm that clients that choose more exclusive network options pay less for the prescription drug costs of their covered individuals.

I also determine that concerns about consumers' access to care are largely unfounded. Competition among drug plans and PBMs compels them to offer plan sponsors the amount of accessibility that consumers prefer; drug plans and PBMs that did not offer the desired level of accessibility would lose out in the competitive market. Moreover, consumers do not appear to value accessibility as much as they do lower prices; when confronted with different plan options that vary in their degree of provider choice and price, most consumers choose the options that offer fewer provider choices and a lower price. Nevertheless, pharmacy networks have almost no effect on most consumers' access to pharmacies. Express Scripts' data reveal that the overwhelming majority of consumers live near retail pharmacies that are included in exclusive pharmacy networks. In fact, the Express Scripts networks far exceed pharmacy convenience of access standards established by the Centers for Medicare and Medicaid Services (CMS). Thus, well-designed pharmacy networks provide customer convenience and lower the cost of healthcare.

The Article proceeds as follows. Section I discusses the history of selective contracting in both medical services and prescription drug coverage. It also explains the three basic forms of pharmacy networks: open networks, narrow networks, and preferred networks. Section II discusses challenges to selective contracting in

prescription drug coverage. Most states and the federal government have enacted various laws that undermine pharmacy networks. Moreover, pharmacy groups continue to pursue litigation that aims to restrict exclusive pharmacy networks. In Section III, I analyze both the claims that selective contracting will generate cost savings for prescription drugs and the arguments that exclusive networks reduce consumers' access to care. Section IV presents a case study from Express Scripts Holding Company. I analyze Express Scripts' data to describe various aspects of how pharmacy networks work in practice: the exclusivity of the networks, the cost savings generated by the networks, and consumers' access to care under the networks.

I. HISTORY OF SELECTIVE CONTRACTING IN HEALTH CARE

Since the advent of managed care in the 1980s, insurance companies have engaged in selective contracting to lower the price of health services.[3] Heath insurers created plans such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs) that formed exclusive arrangements with health care providers that narrowed insured patients' choices of providers for covered services. This selective contracting created intense competition among physicians, hospitals, and other health care providers as they competed for insurers' contracts. To secure these contracts and the increased business they represented, providers offered health services at discounted prices.

The competition that results from selective contracting in health insurance is exactly what economic theory would predict. When insurers have the ability to exclude providers from their network and steer patients elsewhere, providers have significant incentives to compete aggressively for selective contracts.[4] Obtaining an exclusive agreement with an insurer offers the possibility of significant customers and sales. Health care providers compete for exclusive agreements by offering attractive services and lower prices. Indeed, a substantial body of empirical research has shown that selective contracting by managed care plans such as HMOs and PPOs has lowered the prices that both insurers and patients pay for health care.[5]

[3] *See* Michael A. Morrissey, *Competition in Hospital and Health Insurance Markets: A Review and Research Agenda*, 36 HEALTH SERVICES RES. 191, 192 (2001).

[4] Letter from Federal Trade Commission (FTC) Staff to Patrick C. Lynch, Rhode Island Attorney General, and the Hon. Juan M. Pichardo, Rhode Island State Senate 4 (Apr. 8, 2004) (*available at* http://www.ftc.gov/os/2004/04/ribills.pdf).

[5] *See* Morrissey, *supra* note 2, at 191.

Selective contracting has now extended from medical services to prescription drug coverage. Just as physicians, hospitals, and other health care providers have competed to be part of exclusive networks of covered providers for over 30 years, pharmacies now compete to be included in exclusive networks of pharmacies. The justification of pharmacy networks is identical to the economic theory behind provider networks: exclusive arrangements between prescription drug plans and retail pharmacies promise to steer insured individuals to in-network pharmacies. The pharmacies, eager to be part of an exclusive network that will offer significant sales, compete aggressively to be included in the network by offering price discounts for filling prescriptions.

In practice, much of the negotiation with retail pharmacies about network inclusion and price discounts is handled by pharmacy benefit managers (PBMs). PBMs contract with health plan sponsors to manage the prescription drug benefits of their members. To reduce prescription drug costs, PBMs assemble networks of retail pharmacies where the individuals covered by the prescription drug plan can fill prescriptions.[6] The drug plans offer covered individuals significant financial incentives to fill prescriptions at the network pharmacies; plans generally will not cover prescriptions filled at out-of-network pharmacies, and consumers often pay lower co-pays at preferred network pharmacies. And, because inclusion in a network generally leads to significant revenues for the pharmacies, pharmacies compete to be included in a PBM's network by offering discounts to the PBM.[7] Pursuant to contracts negotiated with plan sponsors, PBMs pass on these savings to reduce health plan costs and drug prices for consumers.[8] Confirming the lower prices, an extensive FTC study of the PBM industry found that consumers covered by a PBM-administered drug plan pay significantly less for both brand name and generic drugs than do consumers without prescription-drug insurance.[9]

The attractiveness of any network to a provider—either heath care provider or pharmacy—depends critically on its exclusivity. The fewer competitors that are included in the network, the more customers and sales a particular provider or

[6] FEDERAL TRADE COMMISSION, PHARMACY BENEFIT MANAGERS: OWNERSHIP OF MAIL-ORDER PHARMACIES 3-6 (Aug. 2005), *available at* http://www.ftc.gov/reports/pharmbenefit05/050906pharmbenefitrpt.pdf.

[7] *Id.*

[8] *Id.* at 59.

[9] *Id.* at 36.

pharmacy can expect to receive. In contrast, individual providers or pharmacies would have no reason to bid aggressively to be part of a network that included all of the competitors in an area; customers would continue to visit their usual provider or pharmacy because their insurance plan would not give them any incentive to visit a different one. PBMs and drug plans typically have a variety of networks that differ in their degree of exclusivity and, in turn, the prices that consumers and health plans pay for pharmaceuticals.[10]

These pharmacy networks take three basic forms: (1) open networks; (2) preferred networks; and (3) narrow networks. Many pharmacy networks are "open networks" that are open to any pharmacy that agrees to offer basic discounts to the prescription drug plan and its members. In addition, many plans create a "preferred network" within the broader open network. To be part of the preferred network, pharmacies offer steeper discounts than the non-preferred pharmacies in the open network.[11] Prescription drug plans, in turn, steer their members to the preferred pharmacies through lower co-pays and cost-sharing. Finally, some pharmacy networks are "narrow" or "limited" networks. In contrast to a preferred network that is a subset within a broader open network, a narrow network is a stand-alone network of a limited number of pharmacies. Prescription drug plans will generally not cover prescriptions filled outside of the narrow network. As a result, pharmacies offer significant discounts to be part of narrow networks that require customers to fill prescriptions at in-network pharmacies.[12] Thus, while pharmacies may offer discounts to be part of any pharmacy network, in general, the more exclusive the network, the larger the cost savings for both drug plans and consumers.

II. CHALLENGES FOR PHARMACY NETWORKS

Exclusive pharmacy networks have generally been popular among drug plans and consumers, but controversial among retail pharmacies. The networks lower prescription drug costs for drug plans and consumers, but these savings come at the expense of the retail pharmacies that must either offer price discounts to be part of exclusive networks or lose sales by not being included in the networks. As a result,

[10] Letter from FTC Staff to Terry G. Kilgore, Member of the Commonwealth of Virginia House of Delegates 5 (Oct. 2, 2006)(*available at* http://www.ftc.gov/be/V060018.pdf).

[11] VISANTE, HOW PHARMACY NETWORKS COULD SAVE MEDICARE, MEDICAID, AND COMMERCIAL PAYERS $115 BILLION (2013), *available* at http://www.rxobserver.com/wp-content/uploads/2013/02/visante-pcma-pharmacy-networks-study-1-24-13.pdf; Adam Fein, *Walmart's Booming Preferred Network Models*, DRUG CHANNELS (August 25, 2011), http://www.drugchannels.net/2011/08/walmarts-booming-preferred-network.html.

[12] VISANTE, *supra* note 10; Fein, *supra* note 10.

pharmacy representatives have alleged various harms created by network pharmacies. Some pharmacy representatives have argued that the networks limit consumers' access to their choice of pharmacies. Others have suggested that smaller and independent pharmacies may be the pharmacies excluded from networks.[13] Consequently, many pharmacy groups have supported legislative efforts and pursued litigation to undermine pharmacy networks. In this section, I discuss state and federal legislation and representative legal cases that aim to restrict exclusive pharmacy networks.

A. Legislative Efforts

In response to arguments from health providers and retail pharmacy representatives, many states have enacted regulations that limit the ability of health insurers and/or prescription drug plans to contract selectively. These laws fall into two related categories. "Any-willing-provider" (AWP) laws require plans to accept into their network any provider (or pharmacy) that is willing to accept the plan's terms and conditions. For example, if a pharmacy agrees to the terms a prescription drug plan pays the pharmacies in its network, the plan must accept the pharmacy and pay it the same rate it pays the other network pharmacies. "Freedom-of-choice" (FOC) laws compel plans to reimburse providers (or pharmacies) for any service they provide, even if they are not in the plan's network.[14] Thus, under an FOC law, if a covered individual fills a prescription at a non-network pharmacy, the plan must pay the pharmacy the same rate that it would pay its network pharmacies. To the extent that the non-network pharmacy charges more than network pharmacies, the individual consumer must pay the difference. States have enacted AWP and FOC laws for decades and most states now have some version of the laws in their insurance codes.[15]

The purpose of AWP and FOC laws is to force both health insurers and prescription drug plans to do business with all providers.[16] Although large pharmacy

[13] NATIONAL COMMUNITY PHARMACISTS ASSOCIATION, COMMUNITY PHARMACISTS ENDORSE BIPARTISAN PHARMACY COMPETITION AND CONSUMER CHOICE ACT (2011), *available* at http://www.ncpanet.org/index.php/news-releases/2011-news-releases/994-community-pharmacists-endorse-bipartisan-pharmacy-competition-and-consumer-choice-act.

[14] Michael G. Vita, *Regulatory Restrictions on Selective Contracting: An Empirical Analysis of "Any Willing Provider" Regulations*, 20 J. HEALTH ECON. 955, 956 (2001), *available* at http://www.ftc.gov/be/healthcare/wp/17_vita_any-willing-provider.pdf.

[15] Jill A. Marsteller et al., *The Resurgence of Selective Contracting Restrictions*, 22 J. HEALTH POL. POL'Y & L. 1133 (1997).

[16] Jonathan Klick & Joshua D. Wright, *The Effect of Any Willing Provider and Freedom of Choice Laws on Health Care Expenditures* 6-8 (U of Penn, Inst for Law & Econ Research

chains have sometimes lobbied for AWP and FOC laws to guarantee that they are not excluded from any pharmacy network,[17] most of the support for the laws has come from independent and community pharmacies. Proponents of the laws argue that managed care plans and PBMs force many independent and community providers out of the market because they only allow larger providers and pharmacy chains into their networks.[18] They assert that excluding these smaller providers will reduce the quality of health care because smaller community providers deliver more personal comprehensive care.[19] Proponents also argue that excluding providers from exclusive networks will increase drug prices as competition is reduced in the prescription drug market.[20]

AWP and FOC laws take various forms in different states. Some laws only apply to specific providers, such as pharmacists or optometrists, while other states' laws apply to all health care providers.[21] Similarly, whereas many laws cover arrangements made by any health or drug plan, other states' laws cover only networks of health care providers formed by HMOs or PPOs or networks of pharmacies developed by PBMs.

Federal policymakers, to a limited extent, have also been persuaded by the arguments against selective contracting. Congress included an AWP provision in Medicare Part D that requires part D drug plans to permit the participation of any

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Paper No. 12-39, 2012), *available* at http://ssrn.com/abstract=2183279 or http://dx.doi.org/10.2139/ssrn.2183279.

[17] Testimony of Gary M. Slovin & Mihoko E. Ito on behalf of Walgreens, H.B. 65 HD1 (February 26, 2013), *available at* http://www.capitol.hawaii.gov/session2013/Testimony/HB65_HD1_TESTIMONY_CPC-JUD_02-27-13_.PDF.

[18] Gene A. Blumenreich, *United States Supreme Court Upholds "Any Willing Provider" Statutes*, 71 AM. ASS'N NURSE ANESTHETISTS J. 259 (2003); Marsteller et al., *supra* note 14, at 1133.

[19] Cathy McMorris Rodgers & Anthony Weiner, *Local Pharmacies Play Essential Role in Care*, ROLL CALL (2011), http://www.rollcall.com/issues/56_133/local_pharmacies_play_essential_role_care-206186-1.html.

[20] NATIONAL COMMUNITY PHARMACISTS ASSOCIATION, *supra* note 12.

[21] Klick & Wright, *suprra* note 15, at 6-8.

pharmacy that meets the terms of the plan.[22] Recently, "The Pharmacy Competition and Consumer Choice Act of 2011" proposed similar legislation on the national level.[23] Although never enacted, the bill would have put in place a federal AWP law that would prohibit plans 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. . . ."[24]

B. Litigation

Independent pharmacies have also filed numerous lawsuits to undermine the use of preferred and narrow networks. The claims generally name as defendant a state health department, a federal agency, or a drug plan that has established a pharmacy network.

Many pharmacy associations and independent pharmacies have brought cases against state health departments, arguing that independent pharmacies have been excluded from the network of pharmacies serving Medicaid patients. For example, the Florida Pharmacy Association and several independent Florida pharmacies have filed a lawsuit against the state's Agency for Health Care Administration to force the state to include independent Florida pharmacies in the network of qualified Medicaid pharmacies.[25] The claim argues that the Agency has entered into contracts with HMOs and other organizations that exclude independent and community Florida pharmacies from their Medicaid networks. The plaintiffs allege that, as a result, Medicaid patients can only fill prescriptions at pharmacies in the network that includes only CVS, Wal-Mart, and a select number of other pharmacies that are affiliated with other managed care organizations. The plaintiffs argue that exclusion of independent

[22] CENTERS FOR MEDICARE AND MEDICAID SERVICES, PRESCRIPTION DRUG BENEFIT MANUAL CH. 50.8.1 (2011), *available* at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/MemoPDBManualChapter5_093011.pdf.

[23] Christine Piette Durrance, *The Impact of Pharmacy-Specific Any-Willing-Provider Legislation on Prescription Drug Expenditures*, 37 ATLANTIC ECON. J. 409 (2009).

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

[25] Florida Pharmacy Association v. State of Florida, Agency for Health Care Administration, Circuit Court of the 2nd Judicial Circuit, Leon County, FL (2012), *available* at http://miamiherald.typepad.com/files/fpa-press-release-lawsuit.pdf. *See also* Pharmacists Society of the State of New York et al. v. State of New York et al., case number 5548-12, in the Supreme Court of the State of New York, County of Albany.

pharmacies from the Florida Medicaid State Health Plan is in violation of federal and state FOC requirements.

Other lawsuits have been aimed at the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) challenging the lawfulness of the establishment under Medicare Part D of preferred pharmacy networks. For example, Southwest Pharmacy Solutions, an organization representing more than 500 pharmacies in 7 states, recently filed a claim arguing that CMS wrongfully allowed insurers offering Part D plans to form preferred networks of pharmacies. The plaintiffs argue that the preferred networks exclude independent pharmacies, in violation of the Medicare Part D AWP provision.[26]

Other suits involve claims between independent pharmacies and insurers that utilize preferred pharmacy networks. For example, specialty pharmacy MedfusionRx recently filed suit against insurer Aetna Inc., claiming the insurer excluded the pharmacy from its retail pharmacy network.[27] MedfusionRx alleges that Aetna removed the pharmacy from its retail network and instead moved it to a different network with higher fees and lower reimbursement rates. The pharmacy claims that because of this change, many of its former customers are no longer allowed to fill prescriptions at the pharmacy. MedfusionRx argues that excluding the pharmacy from the retail network is in violation of Mississippi AWP laws.

These and hundreds of other claims have had varying outcomes.[28] Thus despite the widespread use of selective contracting in health care, the threat of litigation remains a challenge for drug plans utilizing preferred and narrow pharmacy networks.

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[26] *Sw. Pharmacy Solutions, Inc. v. Centers for Medicare & Medicaid Servs.*, 718 F.3d 436 (5th Cir. 2013). *See also Farmville Disc. Drug, Inc. v. Sebelius*, 4:12-CV-109-D, 2013 WL 1246815 (E.D.N.C. Mar. 27, 2013).

[27] MedfusionRx LLC, Plaintiff/Petitioner v. Aetna, Inc., and CVS Caremark Corporation;, Defendants/Respondents., 2012 WL 3619616 (S.D.Miss.). *See also* Carolina Bolado, *Aetna Hit With Suit Over New Specialty Pharmacy Network*, LAW 360 (August 9, 2012), *available at* http://www.law360.com/articles/368492/aetna-hit-with-suit-over-new-specialty-pharmacy-network.

[28] INDEPENDENT SPECIALTY PHARMACY COALITION, ANY WILLING PROVIDER CASES, COMPLAINTS, AND LEGAL RESOURCES (2013), *available* at http://www.ispcoalition.org/awp-cases.html.

III. ECONOMIC ANALYSIS OF SELECTIVE CONTRACTING IN PHARMACY NETWORKS

Exclusive pharmacy networks are premised on the idea that selective contracting will generate cost savings for consumers and drug plans. However, opponents argue that exclusive networks reduce consumers' access to care because consumers can only visit certain providers.[29] In this section, I use the principles of economic theory, the findings from previous empirical studies, and the conclusions of the FTC to analyze both the claims in support of pharmacy networks and the arguments against them.

A. The Effect of Pharmacy Networks on Drug Spending

Basic economic theory predicts the effect that selective contracting in pharmaceutical markets will have on drugs prices and overall drug spending. Pharmacies will compete to be part of exclusive networks that will channel customers to network pharmacies. The more customer traffic directed towards pharmacies (which depends on both the number of covered customers and the exclusivity of the network), the more intensely pharmacies will compete to be part of the network. Pharmacies compete by offering discounts and other price concessions on the drugs they sell to covered customers and drug plans. Thus, economic theory predicts that exclusive pharmacy networks will lower the prices that consumers and plans pay for pharmaceuticals.

The basic premise behind selective contracting in pharmaceutical markets can be seen in countless other markets. Consider the market for hotel rooms. The quoted rate for a customer booking one room is typically significantly higher than the rate quoted to a company or association that is booking a block of 300 rooms for an upcoming event. The obvious reason for this price difference is that the hotel is willing to offer a price discount in order to secure 300 reservations from the company or association members. Network pharmacies are no different than hotels in this example; pharmacies are willing to offer price discounts to secure customers covered by the drug plan.

The FTC has repeatedly reinforced the economic theory behind pharmacy networks:[30]

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[29] Letter from David A. Balto to Andrew M. Cuomo, Governor, New York 3 (Oct. 17, 2011), *available at* http://www.truthrx.org/wp-content/uploads/2011/11/NY-AMMO-Letter-Cuomo.pdf.

[30] Letter from FTC Staff to Patrick C. Lynch and the Hon. Juan M. Pichardo, *supra* note 3, at 4.

> When insurers have a credible threat to exclude providers from their networks and channel patients elsewhere, providers have a powerful incentive to bid aggressively. Inclusion in a restricted panel offers the provider the prospect of substantially increased sales opportunities. Without such credible threats, however, providers have less incentive to bid aggressively, and even managed care organizations with large market shares may have less ability to obtain low prices.

The FTC has also explained how more exclusive networks generate even steeper price discounts. It has determined that health care providers compete more intensely to be part of a more restricted network: "HMOs, which have more limited panels than PPOs, induce more intense price competition among providers than would PPOs of equivalent size."[31] Similarly, the FTC has concluded that more restrictive pharmacy networks generate more intense competition: "The more exclusive the network, the larger the discount retail pharmacies will offer, believing that great exclusivity is likely to bring them more customers."[32] Network exclusivity "ensures that the network can direct a sufficient patient volume to its providers to justify price concessions."[33]

Moreover, the FTC has indicated that AWP and FOC laws restricting selective contracting hurt consumers by raising the prices of pharmaceuticals:[34]

> FTC staff have expressed concerns about potential anticompetitive effects and consumer harms associated with AWP and FOC laws before. These laws can make it more difficult for health insurers or PBMs to negotiate discounts from providers; if plans cannot give providers any assurance of favorable treatment or greater volume in exchange for lower prices, then the incentive for providers to bid aggressively for the plan's business – to offer better rates – is undercut. AWP and FOC laws

[31] *Id*.

[32] FEDERAL TRADE COMMISSION & UNITED STATES DEPARTMENT OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION 14 (2004), *available at* http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf.

[33] FEDERAL TRADE COMMISSION & UNITED STATES DEPARTMENT OF JUSTICE, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE Statement 9- 5 (1996), *available at* http://www.ftc.gov/bc/healthcare/industryguide/policy/statement9.pdf.

[34] Letter to Senator James L. Seward, New York Senate, 3 (March 31, 2009*), available at* http://www.ftc.gov/os/2009/04/V090006newyorkpbm.pdf.

> also can limit competition by restricting the ability of insurance companies to offer consumers different plans, with varying levels of choice. These restrictions on competition may result in insurance companies paying higher fees to providers, which, in turn, generally results in higher premiums, and may increase the number of people without coverage.

Numerous empirical studies confirm that selective contracting reduces the price of health care services. Many studies have investigated the impact of selective contracting by managed care plans on the prices of health care services.[35] In what is often regarded as one of the strongest studies of selective contracting by managed care plans, Melnick et. al examined the hospital transaction prices negotiated by a large California PPO.[36] They found that the PPO was able to negotiate lower prices for health care services by channeling more patients to the network hospital; the larger the share of the hospital's business accounted for by the PPO, the greater the leverage the PPO had with the hospital. The researchers also found that the PPO was able to negotiate lower prices for health services when there were more hospital competitors; in markets with more hospital competitors, the PPO is able to make a credible threat to channel its covered patients to another hospital. Thus, selective contracting by managed care plans results in lower prices as providers bid aggressively to be part of an exclusive network.

Other studies have examined the impact of selective contracting in pharmacy networks on drug prices. A recent empirical study by health care consulting firm Visante found that preferred and narrow networks lower prescription costs for consumers because pharmacies will offer discounts to be in the more exclusive networks.[37] Specifically, they found evidence that preferred networks lower prescription costs by an estimated 5 percent compared to open networks.[38] Additionally, they found that pharmacies will offer the steepest discounts to be part of the most exclusive narrow networks.[39] Compared to open networks, narrow networks can lower prescription costs by an estimated 10 percent.[40]

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[35] For a review, *see* Morrissey, *supra* note 2, at 191.

[36] G. A. Melnick et al., *The Effects of Market Structure and Bargaining Position on Hospital Prices*, 11 J. HEALTH ECON. 217 (1992).

[37] VISANTE, *supra* note 10.

[38] *Id*.

[39] *Id*.

Another recent analysis by the Centers for Medicare and Medicaid Services (CMS) examined Medicare Part D Prescription Drug Plans that have a preferred pharmacy network.[41] CMS found that prescription drug costs were approximately 6 percent cheaper at preferred pharmacies compared to non-preferred pharmacies. Moreover, the more potential customers the plans can channel to the preferred pharmacies, the greater the savings. For the four largest part D drug plans, preferred pharmacies offered prescription drug prices that were about 8 percent less than the prices offered by non-preferred pharmacies.

Other studies have empirically tested the impact of AWP or FOC laws that limit selective contracting on healthcare and pharmaceutical spending. One study found an increase in overall healthcare spending in states that passed stringent AWP or FOC laws.[42] Another study examining pharmacy-specific AWP laws found increased pharmaceutical spending in states that passed AWP laws that limited exclusive pharmacy networks.[43] In the most recent study of the impact of AWP and FOC laws on health care spending, Klick and Wright found that these laws are associated with an overall increase in health care spending of at least 3 percent.[44] Moreover, they found that AWP and FOC laws increase pharmaceutical drug spending by 5.8 percent.[45]

Thus, the empirical findings support the economic theory behind selective contracting in pharmaceutical markets. As pharmacies compete to be part of exclusive pharmacy networks, they reduce prices for many drugs, leading to reductions in the overall spending on pharmaceuticals. Laws that limit exclusive networks restrict the

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[40] *Id*.

[41] CENTERS FOR MEDICARE AND MEDICAID SERVICES, PART D CLAIMS ANALYSIS: NEGOTIATED PRICING BETWEEN PREFERRED AND NON-PREFERRED PHARMACY NETWORKS (2013), *available at* https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/PharmacyNetwork.pdf; Adam Fein, *New CMS Study: Preferred Pharmacy Networks are Cheaper (Except When They're Not)*, DRUG CHANNELS (July 11, 2013), *available at* http://www.drugchannels.net/2013/07/new-cms-study-preferred-pharmacy_11.html.

[42] Vita, *supra* note 13, at 955.

[43] Durrance, *supra* note 22, at 409.

[44] Klick & Wright, *supra* note 15, at 6-8.

[45] *Id.* at 13.

ability of PBMs and drug plans to negotiate discounts with pharmacies. As a result of such laws, spending on pharmaceuticals increases.

B. The Effect of Pharmacy Networks on Customer Access

Opponents of pharmacy networks also allege that selective contracting reduces consumers' access to care because consumers can only visit specific network pharmacies.[46] They argue that PBMs or drug plans that severely limit the number of pharmacies in their network may impose a cost on consumers that have to travel significant distances to reach a network pharmacy.

However, there are several reasons to believe that exclusive pharmacy networks do not create access to care problems. First, drug plans and PBMs compete intensely for contracts with health plan sponsors and consumers.[47] A drug plan or PBM that did not offer the accessibility that consumers wanted in their pharmacy network would lose business to other competitors that provided more accessibility. Thus, competition among drug plans and PBMs compels them to offer the amount of accessibility that consumers prefer.

The FTC has determined that competitive forces ensure that restricted networks will not significantly limit consumers' access to pharmacies:[48]

> Limitations on choice are unlikely to be so severe that consumers' access to pharmacy services is inadequate. Just as competitive forces encourage pharmacies to offer their best price and service combination to a payer to gain access to its subscribers, competition also encourages payers (and employers) to establish pharmacy service arrangements that offer the level of accessibility that subscribers prefer.

Indeed, empirical evidence confirms that competitive networks offer many choices and do not restrict consumers' access to pharmacies. In its own empirical examination, FTC concluded that most PBMs contract with 90 percent of the retail

[46] Letter from David A. Balto to Andrew M. Cuomo, *supra* note 28, at 3.

[47] Statement of the Federal Trade Commission, *In re Caremark Rx, Inc./AdvancePCS*, File No. 0310239 (Feb.11, 2004) *available at* http://www.ftc.gov/os/caselist/0310239/040211ftcstatement0310239.pdf.

[48] Letter from FTC Staff to Patrick C. Lynch and the Hon. Juan M. Pichardo, *supra* note 3, at 4.

pharmacies and all of the retail chain pharmacies in the regions that they serve.[49] In fact, in the next section I show that the largest PBM includes over 93 percent of retail pharmacies in its network.

Moreover, evidence suggests that consumers do not value accessibility as much as they do lower prices. PBMs and drug plans typically offer different networks of pharmacies that vary in their degree of exclusivity and, in turn, the prices that consumers pay for pharmaceuticals.[50] Consumers that value expanded accessibility and choice of pharmacy can choose broader networks while consumers that prioritize lower drug prices over expansive accessibility can choose narrow or preferred networks. Empirical evidence shows that, when confronted with different plan options that vary in their degree of provider choice and price, most consumers choose the options that offer fewer provider choices but at a lower price.[51]

The FTC has reiterated that many consumers prefer lower prices over increased accessibility:[52]

> Not all consumers, however, will necessarily desire such broad access if this expanded access is costly. Many employers offer a choice between higher cost, higher benefit plans, and lower cost, lower benefit plans, and many employees choose the latter. [citation omitted]. Consumer preference for such programs presumably means that, in at least some consumers' view, the advantages of lower premiums and/or lower out-of-pocket costs outweigh the disadvantages of limiting the choice of provider.

Thus, competition among drug plans and PBMs compels them to offer the amount of accessibility that consumers prefer; drug plans and PBMs that did not offer the desired level of accessibility would lose out in the competitive market. Indeed,

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[49] FEDERAL TRADE COMMISSION & UNITED STATES DEPARTMENT OF JUSTICE, *supra* note 31, at 12.

[50] Letter from FTC Staff to Terry G. Kilgore, *supra* note 9, at 5.

[51] *See, e.g.*, Anne Wilde Mathews, *Price, Price, Price: Health-Insurance Shoppers Have Priorities*, WALL ST. J. (July 14, 2013), http://online.wsj.com/article/SB10001424127887323300004578555560447477062.html; Dennis P. Scanlon et al., *Impact of Health Plan Report Cards on Managed Care Enrollment*, 21 J. HEALTH ECON. 19, 36-37 (2002); Nancy Dean Beaulieu, *Quality of Information and Consumer Health Plan Choices*, 21 J J. HEALTH ECON. 43, 44, 55-57 (2002).

[52] Letter from FTC Staff to Patrick C. Lynch and the Hon. Juan M. Pichardo, *supra* note 3, at 5.

empirical evidence indicates that pharmacy networks have almost no effect on most consumers' access to pharmacies; the overwhelming majority of consumers live near retail pharmacies that are included in exclusive pharmacy networks. Moreover, most consumers prefer more exclusive networks that restrict access to some pharmacies but provide pharmaceuticals at lower prices.

IV. CASE STUDY: PHARMACY NETWORKS OF EXPRESS SCRIPTS

To confirm the predictions of economic theory, the conclusions of previous empirical studies, and the assertions of the FTC, I obtained proprietary data from Express Scripts , the largest PBM in the United States.[53] No prior study has ever reported or analyzed this data or similar data from another PBM to explore how pharmacy networks work in practice. In this section, I explain what the data reveals about the exclusivity of pharmacy networks, the cost savings generated by the networks, and consumers' access to care under the networks.

Express Scripts manages more than a billion prescriptions each year for more than 100 million people. The company's clients include managed care organizations, health insurers, third-party administrators, employers, union-sponsored benefit plans, workers' compensation plans, and government health programs.[54] Express Scripts acts as an intermediary between its clients, covered individuals, pharmaceutical manufacturers, and retail pharmacies. Like other PBMs, Express Scripts incorporates several practices that reduce the costs associated with prescription drug spending: establishing networks of local pharmacies where members can obtain medication based on their pharmacy benefit design; developing drug formularies and negotiating discounts and rebates from drug manufacturers; providing access to mail order pharmacies; evaluating prescribing patterns to ensure consumers obtain appropriate drugs for the lowest price; and processing claims for their health plan sponsor clients.[55]

Express Scripts has provided data about the pharmacy networks it has developed for its clients.[56] Express Scripts provided only aggregate data about the percentage of pharmacies included in the different networks, the proximity of network pharmacies to covered individuals, and cost savings among the different networks.[57]

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[53] Express Scripts, Standard Network Data (2013)(on file with author).

[54] *Id*.

[55] *Id*.

[56] *Id*.

[57] *Id*.

The data included no identifying variables because of the confidential nature of individual client contracts.[58] The Express Scripts data is current as of July 17, 2013.

Express Scripts offers various network options to its clients. Although some clients require a customized network to meet their specific needs and population of covered individuals, many clients choose from Express Scripts' standard network options. The options vary in how many pharmacies are included in a network, and in turn, in the cost savings they generate for clients. There are approximately 70,000 retail pharmacies in the United States. Express Scripts' broad network option includes over 93 percent of all retail pharmacies, while their standard narrow network option includes approximately 81 percent of all retail pharmacies in the network.[59] Table 1 reports the percentage of pharmacies included in Express Scripts' standard networks in urban areas, suburban areas, and rural areas.

TABLE 1: PERCENTAGE OF PHARMACIES INCLUDED IN EXPRESS SCRIPTS' STANDARD NETWORK OPTIONS

	% of Total Urban Pharmacies	% of Total Suburban Pharmacies	% of Total Rural Pharmacies
Standard Broad Network	92.1%	94.1%	94.9%
Standard Narrow Network[60]	77.1%	78.5%	85.0%

[58] *Id*.

[59] The primary difference between the two network options is that the standard narrow network excludes one large national retail chain pharmacy. When this large chain is disregarded, the narrow network still includes 92 percent of all other retail pharmacies in the network.

[60] If the large national chain is disregarded, the percentage of pharmacies included in Express Scripts' standard narrow network rises substantially.

	% of Total Urban Pharmacies	% of Total Suburban Pharmacies	% of Total Rural Pharmacies
Standard Narrow Network (excluding a national chain not included in the Narrow Network)	90.3%	92.6%	94.0%

As basic economic theory would predict, Express Scripts generates greater savings for clients who choose more exclusive network options. Pharmacies compete to be part of Express Scripts' exclusive networks by offering discounts and other price concessions for prescription drugs. As a result, Express Scripts' clients who use more exclusive networks pay less when prescriptions are filled at in-network pharmacies. Although exact cost savings depend on both the specific prescription drugs covered by the clients' drug plan and the pharmacies included in the network, in general, clients choosing the standard narrow network pay approximately 1 percent less for prescription drugs than they would pay if they chose the broad network offering.

Moreover, some of Express Scripts' clients choose an option that includes a preferred set of pharmacies within a pharmacy network. Under these preferred network plans, covered individuals can fill prescriptions at any pharmacy within network, but they will pay less (through lower co-pays) at the preferred pharmacies within that network. Because the preferred network is more exclusive than even the narrow network, Express Scripts' clients that choose this option save approximately 4.5 percent of prescription drug costs compared to clients that choose only the broadest retail network. Table 2 summarizes the average savings that Express Scripts' clients achieve for the different network options.[61]

TABLE 2: COST SAVINGS FOR VARIOUS PHARMACY NETWORKS OFFERED BY EXPRESS SCRIPTS

	Savings compared to Standard Broad Network
Standard Broad Network	--
Standard Narrow Network	approximately 1%
Preferred Network Option	approximately 4.5%

Finally, to address concerns that more exclusive networks reduce consumers' access to care because they can only visit specific network pharmacies, I obtained Express Scripts' data on the distance between network pharmacies and covered individuals. The Center for Medicare and Medicaid Services (CMS) has established access standards that ensure pharmacy networks have a sufficient number of retail pharmacies so patients have convenient access to drugs. CMS has established that "convenient access" implies that individuals living in an urban area live within 2 miles of a network pharmacy, individuals living in a suburban area live within 5 miles of a network pharmacy, and individuals living in a rural area live within 15 miles of a

[61] Express Scripts, Standard Network Data (2013)(on file with author).

network pharmacy.[62] CMS requires that networks provide the defined convenient access to pharmacies for 90 percent of their urban and suburban covered individuals and 70 percent of their rural covered individuals.[63]

Table 3 reports the percentage of individuals covered under Express Scripts' standard broad network and standard narrow network that have convenient access to network pharmacies, as defined by CMS.[64] Although the narrow network offers convenient access to slightly less of the covered population, both of Express Scripts' networks far exceed the CMS requirements for convenient access. Regardless of whether they live in urban, suburban, or rural areas, over 98 percent of the individuals covered under Express Scripts' networks have convenient access to network pharmacies.

TABLE 3: PERCENTAGE OF COVERED INDIVIDUALS WITH "CONVENIENT ACCESS" TO NETWORK PHARMACIES

	Individuals Living in Urban Areas	Individuals Living in Suburban Areas	Individuals Living in Rural Areas
CMS requirement for convenient access	***90%***	***90%***	***70%***
Express Scripts' Standard Broad Network	98.9%	99.7%	98.1%
Express Scripts' Standard Narrow Network	98.5%	99.6%	98.0%

Thus, data from Express Scripts, the nation's largest PBM, reveals that exclusive pharmacy networks operate exactly as economic theory would predict. Pharmacies compete to be part of exclusive networks that will bring them more customers by offering discounts for prescription drugs. As a result, Express Scripts' customers that choose more exclusive network options pay less for the prescription

[62] Letter from Cynthia Tudor, Director of Medicare Drug Benefit C & D Data Group, to all Part D Sponsors, 2 (Dec. 22, 2010), *available at* http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/HPMSMEMORetailHIAccess.pdf.

[63] *Id*.

[64] Express Scripts, Standard Network Data (2013)(on file with author).

drug costs of their covered individuals. Moreover, concerns about access to care are largely unfounded: far more individuals covered under Express Scripts' networks have convenient access to network pharmacies than would be required under governmental standards. This result demonstrates how the intense competition among PBMs for sophisticated clients ensures that PBMs will offer the accessibility that consumers want in their pharmacy networks. Thus, well-designed pharmacy networks can more than satisfy customer convenience and lower the cost of healthcare.

CONCLUSION

All available evidence suggests that the benefits of pharmacy networks clearly exceed the costs. Using the principles of economic theory, the conclusions of previous empirical studies, the determinations of the FTC, and proprietary data from the largest pharmacy benefit manager in the United States, I find that pharmacy networks significantly lower the cost of prescription drugs for drug plans and consumers. When drug plans have the ability to exclude pharmacies from their network and steer patients elsewhere, pharmacies compete aggressively for selective contracts by offering price discounts for filling prescriptions. In general, more exclusive networks produce greater competition because they promise to channel more patients to network pharmacies. As a result, more exclusive networks generate even steeper price discounts.

However, because these cost savings come at the expense of both the pharmacies that must offer price discounts to be part of exclusive networks and the pharmacies that are excluded, pharmacy networks are unpopular among retail pharmacies. As a result, pharmacy representatives have alleged various harms created by network pharmacies. Their primary argument is that networks reduce consumers' access to care by limiting their choice of pharmacies. Responding to these arguments, many states and the federal government have enacted regulations that limit the ability of health insurers and/or prescription drug plans to contract selectively.

However, I find that concerns about consumers' access to care are largely unfounded. Competition among drug plans and PBMs compels them to offer the amount of accessibility that consumers prefer; drug plans and PBMs that did not offer the desired level of accessibility would lose out in the competitive market. As a result, the overwhelming majority of consumers live near retail pharmacies that are included in exclusive pharmacy networks.

The conclusions of this analysis are critical for policymakers considering further limitations on selective contracting in healthcare. Well-designed pharmacy networks provide customer convenience and lower the cost of prescription drugs. It would be reckless for states to enact regulations that would undo these cost savings and

increase prescription drug prices in our current state of ever-increasing healthcare costs.