Any Willing Pharmacy (AWP) Policies Undermine Competition and Raise Costs

Health plans and pharmacy benefit managers contract with independent, chain, mail-order, and specialty pharmacies to provide patients with access to a range of high-quality pharmacies, while balancing savings for patients and payers. PBMs require pharmacies to compete on service, price, convenience, and quality to be included in preferred networks. Pharmacies that agree to participate in such arrangements are designated as "preferred," and become members of a preferred pharmacy network.

How preferred pharmacy networks provide value to patients and payers:

- ***Exclusivity.*** Pharmacies participating in a preferred network can count on a predictably higher volume of sales. Increased sales mean that the pharmacy can pass savings on to patients by setting lower product prices and/or lower dispensing fees—while still meeting its bottom line.

- ***Enhanced Level of Services.*** Plan sponsors typically require preferred pharmacies to deliver higher levels of service, (e.g., enhanced clinical review and management) and access (e.g., longer operating hours).

- ***Emphasis on Quality.*** Participating pharmacies are typically required to comply with quality of care factors measured by Medicare Star Ratings or recommendations from standard-setting bodies such as the National Committee for Quality Assurance (NCQA), URAC, or the Pharmacy Quality Alliance (PQA).

- ***Value-Based Innovation.*** Preferred pharmacy networks are more likely to participate in value-based care activities, such as those with accountable care organizations and preferred provider organizations, where services are rated on quality, cost, and efficiency factors.

- ***Reduction of Fraud, Waste and Abuse.*** Preferred networks enhance a plan sponsor's ability to exclude pharmacies that pose a higher risk of engaging in fraud, waste or abuse.

The utilization of pharmacy networks is growing and effective in driving down costs.

- Preferred networks are gaining traction among employer sponsored plans. In 2013, only 18 percent of these plans were using preferred networks**. By 2017, over half of all employer-sponsored plans were utilizing these exclusive networks.**[1]

- Restrictions on pharmacy networks would cost employers and commercial health plans **$35.56 billion between 2019 and 2028**,[2] diminishing their ability to offer quality health insurance to employees.

The FTC has found that AWP laws undermine competition and raise consumer prices.

According to the Federal Trade Commission, networks and selective contracting generate significant savings that are passed on to consumers in the form of lower premiums, lower out-of-pocket costs, and better services, while AWP laws lead to higher drug prices because:

- When a retail pharmacy "faces no threat of sales losses if it fails to bid aggressively for inclusion in the payers' networks," it has no incentive to offer its most competitive terms.

- Opening networks to any willing provider reduces the volume of sales for all network participants, ultimately resulting in smaller discounts.[3]

PBMs offer their clients a choice of selective networks as a way to reduce costs.

- A selective network provides plan sponsors a great degree of economic control over prescription fulfillment, while maintaining adequate access to pharmacies for members. A pharmacy will offer deep discounts, or a lower dispensing fee to participate in a more exclusive network due to increased volume of business.

- CVS Health found that its network programs have saved payers 4 percent on retail drug costs and that narrow networks tailored to plan sponsors' beneficiaries can reduce retail drug spending by 5-8 percent.[4]

- Express Scripts' clients saved 4.5 percent on pharmacy costs using networks with 20,000 pharmacies.[5]

AWP requirements are not needed to maintain consumer access to pharmacies.

- Proponents of AWP laws claim that these policies are needed to ensure patient access to retail pharmacies. The data tell a different story:

    - Today, consumers have unprecedented levels of access to retail pharmacies. **Since 2005, the number of retail pharmacies has increased 6,000 stores and currently stands at 63,000, and of that number over 23,000 are independent pharmacies.[6]**

    - According to Medicare, **90 percent of Medicare Part D Beneficiaries live within 5 miles of a retail pharmacy and in urban areas that number drops to only 1.1 miles.[7]**

- **Put simply, there is no evidence that consumer access to pharmacies is a problem. Preferred pharmacy networks benefit both plan sponsors and patients.**

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[1] Adam Fein. (2018). *The 2018 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers.*
[2] Visante. (2015). *Increased Costs Associated with Proposed State Legislation Impacting PBM Tools.* Available at: https://www.pcmanet.org/increased-costs-associated-with-proposed-state-legislation-impacting-pbm-tools/.
[3] Federal Trade Commission. (March 7, 2014). Letter to the Centers for Medicare and Medicaid Services, Department of Health and Human Services.
[4] CVS Health (2016). "Made-To-Order Networks". Available at: http://investors.cvshealth.com/~/media/Files/C/CVS-IR-v3/reports/cvs-health-insights-executive-briefing-made-to-order-networks-october-2016.pdf.
[5] Joanna Shepherd. (2014). "Selective Contracting in Prescription Drugs: The Benefits of Pharmacy Networks." *Minnesota Journal of Law, Science & Technology.*
[6] Quest Analytics analysis of NCPDP data, January 2018.
[7] Adam Fein. (2018). *The 2018 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers.*