Drug coverage will become more prevalent as more uninsured families gain health insurance as a result of the 2010 Patient Protection and Affordable Care Act. Drug therapy is arguably the most efficient method to treat most illnesses — often substituting for more expensive hospital and surgical treatments. Broader use of prescription drugs for chronic illness could reduce medical costs by avoiding expensive emergency room visits, costly complications and hospitalizations.

Executive Summary

Most health plans provide some prescription drug benefits. Drug coverage is expected to increase as states expand Medicaid eligibility and millions of Americans obtain health insurance due to the Affordable Care Act.

Americans filled an estimated 3.8 billion retail prescriptions in 2011 — about 12 per person in the United States, on average. Sixty percent of all Americans take a prescription drug in any given year, and nearly all seniors do. Drug therapy is arguably the most efficient method to treat most illnesses — often substituting for more expensive hospital and surgical treatments. Compared to other therapies, drugs are a relative bargain — but they can be expensive. Efforts to rein in the runaway cost of health care must focus on appropriate, but efficiently-administered, use of prescription drugs.

Specialized firms called pharmacy benefit managers (PBMs) help plan sponsors design and manage drug benefits, including which drugs are covered and which pharmacies participate in the drug plan. Regardless of how a program is structured, enrollees initially purchase most of their drugs at local pharmacies, which are reimbursed for the cost by the drug plans.

As drug coverage has become more widespread, so too have calls to impose additional regulations on drug plans and the firms managing them. A reason sometimes given for increasing drug plan regulation is the need for transparency to prevent drug plan managers from excessive mark-ups for drugs at the expense of patients and health plans. In the guise of protecting consumers, there are frequent calls for state and federal lawmakers to enact laws that hamper the efficient management of prescription drug benefits.

For instance, Mississippi transferred regulatory authority over drug plans from the state’s insurance commissioner to the Board of Pharmacy. A similar initiative failed in Oregon. These efforts are short-sighted and unnecessary. Because state pharmacy boards are controlled by pharmacists, giving them authority over drug plans creates conflicts of interest that could undermine drug plans’ ability to negotiate lower prices with pharmacy networks.

Barriers to Efficient Networks. Drug plans are increasingly experimenting with limited or “narrow” pharmacy networks in order to lower drug prices through bargaining with specific drug dispensers. In return for exclusive access to enrollees, a smaller number of pharmacies compete to become network drug providers. But
these networks sometimes run afoul of state laws that allow any pharmacy willing to abide by the terms of the contract to fill prescriptions for enrollees. These any-willing-pharmacy laws are costly to taxpayers, employers and patients alike. The Federal Trade Commission notes that these laws reduce the drug plans’ bargaining power, leading to higher drug prices and higher premiums for consumers.

**Barriers to Mail-Order Pharmacies.** Drug plans use a variety of incentives to encourage patients to use efficient mail-order pharmacies for medications treating chronic conditions. Plan sponsors often charge higher deductibles for retail purchases or offer lower copayments for mail-order drugs. Some plans limit the number of times a prescription may be refilled at a retail pharmacy.

Unfortunately, some states are enacting laws that interfere with the ability of drug plans to reward enrollees that use the plan’s mail order option by barring drug plans from offering lower prices for mail-order dispensing. This unnecessarily raises costs for consumers, insurers and employers. Obviously, these laws mostly aim to benefit local community pharmacies rather than consumers.

**Barriers to Cost-Effective Formularies.** Numerous drug therapies are available to treat most conditions, but some cost more than others. Thus it makes sense for drug plan sponsors to determine which drug therapies are included in a formulary. Though somewhat controversial in the past, formularies that exclude, substitute or discourage certain drugs are now commonplace in state Medicaid programs, Medicare Part D plans and employer plans. Patients (and their doctors) occasionally complain that drug plans substitute cheaper drugs (or generics) for expensive drugs prescribed by doctors. Claims of unauthorized drug substitution are rare, and most of them are ultimately determined to be unfounded.

**Barriers to Lower Cost Dispensing Fees.** Consumers who are not in a drug plan do not pay a separate dispensing fee when purchasing drugs. The costs of dispensing a drug — counting tablets, filling bottles and administrative tasks — are included in the retail cost. By contrast, dispensing fees in state-managed, conventional Medicaid plans are set by the state. State officials and state legislatures often yield to political pressure and set dispensing fees that are much higher than what private drugs plans could negotiate if allowed to do so. Consider, average Medicaid dispensing fees range from $1.75 in New Hampshire to $10.64 in Alabama, averaging about $4.22 per prescription across the country. By contrast, privately managed Medicare Part D plans negotiate fees with pharmacies of about $2 per prescription.

When the fees are set too high, taxpayers pay pharmacies more than they would in a competitive market.

**Barriers to Efforts to Combat Fraud.** Health care fraud is a problem faced by all third party payers — drug plans are no exception. Estimates vary, but about 10 percent of Medicare claims could be either fraudulent or abusive, bordering on fraud. Concealed among the billions of claims filed electronically, fraudulent charges often look just like legitimate claims.

Companies that process electronic payments have learned how to detect transaction patterns that deviate from the norm. Computer algorithms can examine thousands of medical claims for services or medications for obvious irregularities. Sometimes a pattern emerges well after a series of fraudulent claims are processed and paid. Regulations requiring Medicare drug plan administrators to pay claims within 14 days make it difficult to detect fraud before a claim has been paid. At the very least, drug plans need the authority to delay paying questionable claims to providers suspected of fraud. Plans also need greater authority to exclude or suspend suspected fraudulent providers from networks and conduct routine audits of participating pharmacies.

Congress and state legislatures should avoid well-meaning, but ill-conceived, regulations intended to protect consumers, which often have the opposite result. A better way to ensure desirable outcomes is to promote a competitive environment free of market distortions that favor one party over another.

**Conclusion.** The goal of policymakers should be to allow competitive bidding among drug plan stakeholders in an environment free of perverse regulations that unduly advantage one party over another. Ultimately, society is better off when prices, profitability and services delivered are determined through this competitive process.

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**About the Author**

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Introduction

Most health plans provide some prescription drug benefits. Drug coverage will become more prevalent as more uninsured families gain health insurance as a result of the 2010 Patient Protection and Affordable Care Act (ACA). Consumers benefit enormously from access to affordable drugs. Drug therapy is arguably the most efficient method to treat most illnesses — often substituting for more expensive hospital and surgical treatments. Broader use of prescription drugs for chronic illness could reduce medical costs by avoiding expensive emergency room visits, costly complications and hospitalizations.

As drug coverage has become widespread, so have calls to impose additional regulations on drug plans and the firms that manage them. In the guise of protecting consumers, there are frequent calls for state and federal lawmakers to enact laws that hamper efficient management of prescription drug benefits. These efforts are short-sighted.

Spending on Drugs

Americans see their doctors more than a billion times each year. They make another 136 million visits to hospital emergency rooms and 96 million visits to outpatient departments annually.1 About two-thirds of visits to physicians’ offices result in a prescription.2 The reason for many of these visits include: 1) the patient needs to begin drug therapy; 2) the patient needs a prescription renewed; or 3) the patients did not consistently take the prescribed drugs.

An estimated 3.8 billion retail prescriptions were filled in 2011 — about 12 per person in the United States, on average.3 More than six in ten Americans take a prescription drug in any given year — including 90 percent of all seniors.4 A handful of therapeutic drug classes account for two-thirds of seniors’ drug spending. In fact, just five therapeutic drug classes used by seniors totaled $58.5 billion in 2009.5 Drug spending for all adults on the top five therapeutic drug classes was $147 billion, accounting for about half of all prescription drugs purchased.6 These drugs are generally prescribed for chronic conditions.

Americans spend more than $271 billion dollars on prescription medicines annually.7 Total spending on drug therapy approaches $300 billion dollars, including over-the-counter (OTC) drug remedies.8 This is a significant increase from the $40 billion spent on prescription drugs alone in 1990.9 The ACA is likely to significantly boost drug expenditures by increasing the number of individuals with medical coverage. [See the sidebar, “Health Reform and Drug Expenditures.”]

Historically, drug expenditures were one of the fastest growing components of medical care, increasing at rates that far exceed inflation.10 Although individual drugs can be expensive, they make up only about 10 percent of total medical expenditures. By contrast, expenditures on physician services account for twice as much as drugs, and inpatient hospital care accounts for three times the cost of drug spending.11 [See Figure I.]

Health Reform and Drug Expenditures

The ACA is likely to significantly boost drug expenditures by increasing the number of individuals with health coverage. Beginning in 2014, individuals earning between 100 percent and 400 percent of the federal poverty level will qualify for highly subsidized individual health coverage if they lack access to an affordable employee health plan and do not qualify for public coverage, such as Medicare or Medicaid. The Congressional Budget Office estimates that 19 million uninsured individuals will enroll in private health coverage as a result of the ACA.12 In addition, many states are expected to expand Medicaid eligibility to uninsured individuals with incomes up to 138 percent of the federal poverty level. The Congressional Budget Office estimates the new law will add 11 million Medicaid enrollees.13 Even if some states do not expand Medicaid eligibility, when the individual mandate requiring all legal U.S. residents to obtain health coverage takes effect in 2014, millions of previously Medicaid-eligible individuals who were not enrolled are likely to join the program through outreach efforts.14 As a result, state Medicaid spending on drugs will likely rise — as will drug expenditures by health plans.15
State governments, employers and households looking for ways to control health care spending must focus on appropriate, but efficiently-administered, prescription drugs.

The Role of Private Drug Plans in Reducing Drug Costs

Drug prices often vary from one state to the next, from one city to the next, even one pharmacy to the next. Within the same therapeutic class, there may be multiple drugs with vastly different costs. An employer that decides to begin providing drug benefits faces an enormous undertaking. Plan sponsors must negotiate drug prices and dispensing fees with area pharmacies, then reimburse them for all prescriptions filled by enrollees.

Rather than undertake the difficult task of implementing a drug plan themselves, health plan sponsors often employ firms that specialize in designing and managing drug benefits. These firms are called Pharmacy Benefit Managers (PBMs). Drug plan sponsors — including insurers, employers, Medicare Part D drug plans and many state Medicaid programs — hire PBMs because they can manage drug plans more efficiently than health plans. PBMs can also negotiate lower prices from drug manufacturers because they have multiple clients and, therefore, possess far more bargaining power than individual firms.

A health plan responsible for reimbursing health care providers has an incentive to encourage the use of appropriate drugs, because skimping on drug therapies often leads to higher medical costs. Thus it makes sense for health plans to coordinate with PBMs to manage chronic diseases, to analyze the effectiveness of drugs, and to track patient compliance. PBMs help plan sponsors determine which drug therapies to include in drug plan formularies and devise ways to encourage enrollees to use cost-effective alternatives that have been shown to work. [See the sidebar, “Drug Formularies.”] They also check for drug interactions and inappropriate or duplicate prescriptions. Finally, PBMs assemble pharmacy networks, negotiate prices with drug makers, process payments and contract with mail-order pharmacies.

Regulatory Efforts that Hinder Efficient Drug Programs

As drug benefits have become more common, so too have the calls upon lawmakers to impose additional regulations on drug plans and the firms managing them. Though purportedly designed to protect consumers, much of this legislation actually weakens health plans’ ability to efficiently manage prescription drug benefits.

Advocates claim that expanded PBM and drug plan regulations would diminish conflicts of interest and enhance transparency. Drug plan administrators, however, counter that unfettered competition will
result in lower drug costs and greater efficiency. As one analyst concluded, “…the case for PBM regulations appears weak. The market for PBM services is highly competitive…”

Many stakeholders argue for increased regulation of drug plans in order to gain a negotiating advantage. Special interests have intensely lobbied Congress and state legislatures to restrict the ability of PBMs to negotiate effectively. Indeed, when the Lewin Group released a report highlighting methods to improve the efficiency of state Medicaid drug programs, pharmacy trade associations responded swiftly. Representatives for community pharmacists even alleged that Lewin’s results were “bought and paid for” by drug plans.

**Pharmacy Board Regulation.** Traditionally, state insurance commissions regulate insurance sold within the state, including health and drug plans. Some states are taking steps to transfer regulatory authority from insurance commissions to state pharmacy boards. A successful 2011 legislative initiative in Mississippi transferred regulatory authority over drug plans from the state’s insurance commissioner to the Board of Pharmacy. A similar initiative failed a year later in Oregon. State pharmacy boards are primarily made up of pharmacists, who naturally ally themselves with and identify more closely with pharmacy interests. Thus, this legislation undermines the ability of PBMs to negotiate lower prices and dispensing fees with pharmacy networks in Mississippi — increasing costs for consumers. The new law also grants the Mississippi Board of Pharmacy the power to demand sensitive information on PBMs’ business practices that many fear could be disclosed to pharmacy trade groups. Indeed, in a letter to Rep. Mark Formby of the Mississippi House of Representatives, the Federal Trade Commission concluded:

> Our analysis of SB-2445 suggests that its passage may increase pharmaceutical prices for Mississippi consumers. FTC [Federal Trade

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**Drug Formularies**

Pharmacy benefit managers do more than merely reimburse for prescriptions. PBMs also consider drug prices and efficacy in developing drug formularies — the list of drugs preferred by each health plan. Formularies often categorize preferred drugs into a hierarchy or drug tier. A formulary’s Top Tier or Tier 1 drugs are typically those deemed most cost effective. Plan sponsors encourage enrollees to use Tier 1 drugs through lower cost-sharing or by making them free. By contrast, lower tiered (Tier 3 and Tier 4 or nonpreferred) drugs are often brand-name drugs for which lower cost therapeutic or generic alternatives are available. For example, numerous nonsedating antihistamines are now available in generic form or have been FDA-approved for sale over the counter. Thus, many drug plans discourage the use of the costly prescription antihistamine, Clarinex, requiring preapproval or higher cost-sharing, or excluding it from the formulary entirely.

Drug makers and PBMs conduct intense negotiations to determine whether a drug becomes preferred, nonpreferred or excluded from the formulary — in addition to considering a drug’s therapeutic value. If two drugs from the same class have similar efficacy and cost about the same, drug makers compete for the chance to become the preferred provider through negotiation and competitive bidding.

Understandably, competing manufacturers want the highest possible price for their products. By contrast, drug plan administrators and plan sponsors want the lowest possible prices. Likewise, health plan members presumably want access to the broadest range of drugs with the lowest cost-sharing. Pharmacies want to attract as many customers as possible in drug plans that pay the highest dispensing fees and reimbursements. The actual price paid by drug plans to drug makers and pharmacies is ultimately a function of each respective firm’s bargaining power.

This process is not only competitive, it is occasionally adversarial. As a result, some drug makers and pharmacy trade groups have proposed self-serving regulations designed to disadvantage PBMs.
Commission] staff recommends that
the Mississippi legislature seriously
consider whether there are benefits
to consumers from the additional,
more restrictive regulations in
SB-2445 that would outweigh the
competitive harm and consumer costs
identified herein.30

The Pharmaceutical Care
Management Association, the trade
association representing PBMs,
worded it more succinctly, warning
the legislation was like “letting the
fox guard the henhouse.”31

**Transparency Regulations.**
Proponents of expanded regulations
sometimes complain that drug
plans lack transparency regarding
costs.32 In both the insurance and the
health care industries, the negotiated
prices are considered proprietary
information. Insurers and health plans
are loath to disclose what they pay
for specific procedures at specific
hospitals lest their competitors use the
information to gain an advantage.

Purportedly, PBMs have a conflict
of interest. They could enrich
themselves with rebates, while
passing through higher (negotiated)
base prices to health plan sponsors.
This could increase PBM profits at
the expense of plan sponsors and
consumers.33 However, one survey
found that a majority of employee
health plan sponsors already require
PBMs to disclose and “pass through”
all rebates, discounts or payments.34
Indeed, many health plan sponsors
now demand price transparency
from drug plan administrators.35
Contractual obligations and the risk
of litigation reduce the likelihood of
abuse by drug plan administrators.36

**Barriers to Efficient Networks.**
Increasingly, PBMs and health plans
have experimented with limited or
“narrow” pharmacy networks as
leverage to negotiate lower drug
prices from pharmacies competing to
become one of the exclusive network
drug providers.37 Opponents of this
practice argue that “open” pharmacy
networks offer enrollees more choices
and more convenience, and promote
competition. However, PBMs and
drug plans counter that the individual
pharmacies in exclusive networks
agree to deeper discounts in return for
the business.38

State and federal laws can interfere
with negotiations between drug plans,
drug makers and pharmacies. Such
consumer protection laws are actually
costly to taxpayers, employers and
patients.39

Nearly two-thirds of states have
any-willing-provider laws that apply
to managed care plans.40 Nearly
one-fourth of states have passed
regulations specific to drug plans.41
Similarly, freedom-of-choice laws
allow enrollees to fill a prescription
at almost any pharmacy with a will to
abide by networks’ contract terms,
rather than requiring them to fill
prescriptions at selected pharmacies,
or use the drug plans’ mail-order
pharmacy.

These regulations may apply to
all health plans statewide, while
some restrictions apply only to state
Medicaid drug benefits. Texas, for
example, made significant changes
to the way Medicaid drugs are
dispensed.42 Recent changes to
the Texas Medicaid drug program
require drug plans to ensure patients
live no more than 15 miles from an
in-network pharmacy. In addition,
enrollees must live within 70 miles of
a 24-hours pharmacy.43

When drug plans create pharmacy
networks they negotiate for the
lowest possible prices. Negotiated
prices are the result of bargaining
power — the ability of the drug plan
to deny business to a firm if their
bid isn’t favorable. However, any-
willing-provider and freedom-of-
choice laws reduce the drug plans’
bargaining power.44

Any-willing-provider laws
prevent health plan sponsors
from selectively negotiating and
contracting with pharmacies to
create exclusive networks.45 The
Federal Trade Commission notes
that these laws reduce bargaining
power, which leads to higher drug
prices and higher premiums.46
These laws protect less-efficient
pharmacies from competition. The
Lewin Group calculated that if an
any-willing-provider mandate were
enacted nationwide, it would increase
prescription mail-order pharmacy
costs 3 percent.47 Thus, any-willing-
provider and freedom-of-choice laws
typically benefit local pharmacies
rather than consumers.48

The savings achieved by adopting
an exclusive network range from
$0.50 to $1.50 per claim.49 For
instance:

- When Express Scripts created
  a tiered network and steered
  patients to preferred drug stores,
  the firm reported savings of 5
  percent or more.50
- Humana guarantees its clients
  a 10 percent savings from its
  highly limited network (which
  includes Walmart stores).51

Laws that restrict PBMs from
building exclusive networks increase
the number of pharmacies for which
claims must be adjudicated and paid,
boosting administrative costs about 43 percent.\textsuperscript{52} When plans are forced to reimburse any drug store that submits a claim, fraud is a possibility. Fraudulent drug stores might buy stolen identities or collaborate with dishonest enrollees to file claims for drugs not dispensed.\textsuperscript{53} Thus, the freedom to assemble and operate an exclusive provider network not only saves money on drugs, it also reduces overhead and aids in fraud control. [See the section below on combating fraud.]

For health plan enrollees, there are trade-offs between cost and convenience.\textsuperscript{54} Smaller networks may require consumers to patronize a pharmacy a few miles out of their way, or force patients to fill prescriptions at a pharmacy other than one conveniently located inside their local grocery store. When properly designed, however, limited networks provide lower prices and convenient access. For example, Humana contracted with Walmart’s pharmacy to supply drugs in the Medicare Part D plan. The firm subsequently found 90 percent of individuals living within a suburban zip code were five miles or less from a Walmart pharmacy. Seven in ten individuals in rural areas lived less than 10 miles from a Walmart.\textsuperscript{55}

Enrollees, insurers and employers share in the savings that result from strong negotiating positions.\textsuperscript{56}

**Barriers to Mail-Order Pharmacies.** Although drug store chains still sell the most medications, mail-order pharmacies now account for about 18.5 percent of the retail drug market.\textsuperscript{57} Mail-order pharmacies fill about 260 million prescriptions annually.\textsuperscript{58} Moreover, a 90-day supply from a mail-order pharmacy typically costs the same as a 30-day to 60-day supply at a community pharmacy. Generic drugs are deeply discounted. In many cases, ordering quantities of 100 tablets costs only a few dollars more than 30 tablets.\textsuperscript{59}

Mail-order pharmacies purchase drugs in large quantities, are highly automated and make fewer errors than walk-in pharmacies.\textsuperscript{60} High-volume, mail-order pharmacies benefit from economies of scale and low overhead (no need for expensive retail real estate). Mail-order pharmacies offer the lowest cost-sharing on prescription drugs for patients with chronic conditions. Patients also have the convenience of mail delivery.\textsuperscript{61}

Drug plans offer a variety of incentives that encourage patients to use mail-order pharmacies for maintenance medications. Most plan sponsors charge higher deductibles for retail purchases, or offer lower copayments for mail-order dispensing. Some plans limit the number of times a prescription may be refilled at a retail pharmacy before patients are required to obtain maintenance medications through the mail. Some drug plans will only reimburse patients for maintenance medications filled through a mail-order pharmacy.\textsuperscript{62}

Unfortunately, some states are enacting laws that interfere with the ability of drug plans to reward enrollees that use the plan’s mail order option. New York state recently passed Assembly Bill 5502, which allows consumers to fill prescriptions at either local or mail-order pharmacies without incurring additional cost-sharing or fees. In other words, the state took away the incentives drug plans used to encourage enrollees to use lower-cost mail-order pharmacies. As the *New York Times* announced, “Mom-and-pop pharmacies will be better able to compete with mail-order companies because of a bill that Gov. Andrew M. Cuomo has signed into law.”\textsuperscript{63} The law was designed to benefit local community pharmacies — not consumers. As one consultant described it:

“Imagine that your local bookstore owner lobbied your state Senate to pass a law preventing you from buying a book less expensively via Amazon.com. You would immediately recognize that the bookstore was trying to protect its business at your expense. This is precisely what has happened for prescription drugs in New York.”\textsuperscript{64}

These retail-choice laws may increase convenience for some enrollees, but they drive up costs for all health plan members and their plan sponsors. Maryland passed similar legislation. If retail choice was required nationwide, mail-order prescription costs would rise more than 5 percent.\textsuperscript{65}

Understandably, state and local politicians want to protect local community pharmacies from competition. The Federal Trade Commission, however, opposes such laws, believing they ultimately raise consumer prices. Regarding the New York law, the Federal Trade Commission stated, “We are concerned, however, that the Bill will have the unintended consequence of harming consumers. By reducing competition between pharmacies, this legislation likely will raise
Unnecessary Regulations that Increase Prescription Drug Costs

prices for, and reduce access to, prescription drugs, which are an increasingly important component of medical care.\(^6\)

**Barriers to Cost-Effective Formularies.** There are numerous drug therapies available to treat most conditions, but some cost more than others. Thus it makes sense for PBMs to compare both a drug’s cost and efficacy, and advise plan sponsors which drug therapies should be included in a drug plan formulary, and offer incentives to encourage enrollees to use the most cost-effective alternatives that have been shown to work.\(^5\)

Though somewhat controversial in the past, formularies that exclude, substitute or discourage certain drugs are now commonplace in state Medicaid programs, Medicare Part D plans and employer plans. Patients (and their doctors) occasionally complain that drug plans substitute cheaper drugs (or generics) for expensive drugs prescribed by doctors. Although generic substitution is legally allowed in most states, therapeutic substitution of a different drug from the same class is illegal without authorization from the prescribing physician. In a study for the Texas Senate, all PBMs and insurers surveyed denied substituting prescribed drugs without prior approval from patients’ physicians.\(^6\)

The study found claims of unauthorized drug substitution were rare and usually unfounded.\(^6\)

In recent years, many states have passed regulations that allow greater generic drug substitution when appropriate:\(^7\)

- More than one-fourth of states require that pharmacists dispense a generic if available.
- About three-fourths of states permit generic substitution by pharmacists.
- However, all states allow physicians to block generic substitution and restrict a prescription to a brand-name drug.

Regulations designed to boost access to generic drugs have been a tremendous success. Two-thirds of the drugs dispensed by the Veterans Affairs (VA) health system are generic, but they represent only 8 percent of the VA’s prescription costs.\(^7\) According to one estimate, the U.S. health care system saved $824 billion over the past decade from the use of generic drugs.\(^7\) Indeed [see Figure II].\(^3\)

- In 2000, the average price of a generic prescription drug was $19.33 versus $65.29 for a brand-name prescription drug.
- In 2010, the disparity jumped to an average price of $44.14 for a generic prescription drug compared to $166.01 for a brand-name prescription drug.

Today Americans fill nearly eight in ten (78 percent) of their prescriptions with generic drugs, compared to about 19

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**Figure II**

**Average Price of Prescription Drug**

<table>
<thead>
<tr>
<th>Year</th>
<th>Generic</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>$19.33</td>
<td>$65.29</td>
</tr>
<tr>
<td>2010</td>
<td>$44.14</td>
<td>$166.01</td>
</tr>
</tbody>
</table>

percent in 1985. Generic drugs are generally 80 percent to 85 percent less than the original branded drug.

The number of generic equivalents available will increase over the next few years as many widely used drugs lose patent protection and face generic competition. Indeed, many of the current top-selling brand-name drugs will lose patent protection by the end of 2014.

Biotechnology firms genetically engineer and patent organisms that produce so-called biologics — pharmaceuticals and other therapies. A new issue is whether to allow generic substitution of “biosimilars” — subsequent versions of biologics. Biotech firms are lobbying state legislatures for laws that would prevent pharmacists from substituting generic versions of these biologics in place of the brand-name version. Lobbyists for the biotech drug companies have been busy: in the first month after state legislatures convened in early January of 2013, such bills were already introduced in eight states, according to the New York Times.

For example, South Dakota’s state employee health plan will only reimburse the equivalent cost of a generic if a nongeneric drug was dispensed when there was a suitable generic substitute available. Though generic drugs are widely prescribed, there are potential savings from even wider use in state Medicaid programs:

- Generic drugs make up 64 percent of all Medicaid prescriptions, but less than one-fifth (18 percent) of Medicaid drug spending.
- Medicaid enrollees pay an average cost of $20 for a generic prescription drug, compared to an average of $201 for name-brand medications (including drugs for which there are no generic equivalents).

By contrast, Express Scripts, a large PBM, reports that the generic fill rate for its clients is 79 percent — precisely the national average. For Express Scripts Medicare Part D enrollees, the yearly cost of a name-brand prescription was nearly seven times (6.73) greater than for a generic. Express Scripts believes that for every 1 percent increase in its generic fill rate, it realizes a 1.5 percent to 2 percent increase in savings.

Across all 50 states, the proportion of generic prescriptions filled in conventional state-managed Medicaid drug programs averages just over two-thirds (68 percent), compared to 80 percent for drug programs run by Medicaid health plans.

**Generic Drugs**

A 100 percent generic fill-rate is not always the ideal way to save money or ensure quality. The appropriate use of generic drugs — including those circumstances when a newer, patented drug is more suitable — will vary from patient to patient and from drug to drug. In many cases newer drugs are more effective than older, less expensive drugs. Numerous studies by Columbia University professor Frank Lichtenberg have found that increased spending on newer, patented drug therapies is often offset by reduced spending on inpatient care. Lichtenberg has repeatedly argued that reduced mortality is associated with the introduction of innovative (patented) drugs. PBMs should have protocols for those situations when a physician believes a patented drug is more appropriate.
The lowest users of generic drugs are Tennessee (47 percent), Maryland (62 percent) and New York (63 percent). If all states encouraged generic alternatives when the therapeutic effectiveness is the same, the savings would be substantial.83 [See the sidebar, “Generic Drugs.”]

Barriers to Lower-Cost Dispensing Fees. Consumers who purchase medications without insurance coverage do not pay separate dispensing fees. The cost of dispensing a drug — counting tablets, filling bottles and administrative tasks — are included in the retail cost. The $4 price for selected 30-day generic prescriptions at Walmart, Target, Kroger and other pharmacies, for example, includes an implicit dispensing fee. Private drug plans typically negotiate dispensing fees with a pharmacy network or chain. By contrast, state officials set dispensing fees in conventional Medicaid plans managed by state officials. Many states also establish a statutory dispensing fee rather than allowing PBMs to negotiate fees. As a result, there is less price competition.

States often yield to political pressure and set dispensing fees for conventional Medicaid programs higher than they would be in a competitive market. Politicians often protect local constituents — including local pharmacies — from competition for Medicaid business.87 Pharmacy lobbyists encourage state legislators to protect jobs by boosting Medicaid dispensing fees far above what a private PBM would negotiate.88 Paying negotiated dispensing fees would lower reimbursements to pharmacies and reduce Medicaid administrative costs.

Under the old reimbursement model, pharmacies that filled a Medicaid prescription were paid approximately $7.35 plus the cost of the drug. By contrast, a PBM might negotiate a dispensing fee that is two-thirds less. Indeed, the Texas Pharmacy Business Council, which represents pharmacies, complained that in some cases privately-run PBMs could drive down Medicaid dispensing fees as much as 80 percent if they were allowed to negotiate them down to market rates. The Choice and Access Now Coalition opposed moves to allow PBMs to negotiate dispensing fees in Illinois and California.89 These special interest groups ignore the fact that reimbursements and dispensing fees are not being cut due to legislation, but due to negotiated contracts in a free market.

State reimbursement rates to pharmacies filling Medicaid prescriptions vary more than is warranted by market conditions and business costs:

■ Across the country, the average Medicaid dispensing fee is $4.22 per prescription.90
■ However, fees range from $1.75 in New Hampshire to $10.64 in Alabama.91
■ Dispensing fees sometimes climb even higher — as high as $14.01 — much more than the rate PBMs pay pharmacies for prescriptions covered by private drug plans.92 [See Figure III and the Appendix.]
By contrast, the privately-managed Medicare Part D plans pay pharmacies a fee of about $2 for every prescription they fill, or about $1.90 for a short-term supply of pills and $2.20 for an extended supply of drugs.93

Because dispensing fees vary from region to region, state officials should allow PBMs for Medicaid to negotiate dispensing fees with pharmacy networks the same way they do for private drug plans. Dispensing fees would not necessarily be the same in every state or every pharmacy; however, they should reflect local market conditions, such as the cost of doing business and competition.

**Barriers to Efforts to Combat Fraud.** All third-party payers experience some level of health care fraud and drug plans are no exception.94 Most estimates place the level of fraudulent or abusive claims in Medicare at about 10 percent.95 Medicaid likely experiences a similar amount.

Health care expenditures totaled about $2.7 trillion dollars in 2012. Providers bill most of this electronically and claims are typically paid electronically. Submitting medical bills to insurers, health plans and PBMs requires only a limited amount of supporting documentation. Consequently, fraudulent claims are easy to disguise and submit for payment. Concealed among the billions of claims submitted to more than one million providers, fraudulent claims often look just like legitimate claims.96

Electronic payment processing companies have learned how to detect transaction patterns that deviate from the norm. Computer algorithms can sort through thousands of medical claims to look for obvious irregularities in services or medications. For example, a company might red flag a pattern of oral contraceptives being prescribed to male Medicare beneficiaries, as these drugs are ordinarily used only by women of childbearing age. To become patterns, characteristics must occur repeatedly in atypical combinations. But ferreting out fraudulent claims often involves analysis of retrospective data — that is, a pattern may not emerge until long after a series of fraudulent claims have been processed and paid.

Drug plans that manage Medicare benefits should be allowed to suspend payments if there is a credible allegation of fraud. They also need greater authority to conduct routine audits of participating pharmacies and the right to expel, exclude or suspend suspected fraudulent providers from networks. Any-willing-pharmacy regulations make this process difficult if not impossible.

**Conclusion**

Drug therapy can often successfully replace more expensive surgical treatments. Broader use of prescription drugs for chronic illness can reduce health care costs by limiting the need for expensive emergency room visits, costly complications and hospitalization. However, poorly managed drug plans can be more costly than necessary. Prescription drug plans, in careful collaboration with employers, insurers and patients, can easily lower drug bills by employing some or all of the strategies detailed in this report. Moreover, Congress and state legislatures should avoid the well-meaning, but ill-conceived regulations intended to protect consumers, but which often have the opposite result. A better way to ensure desirable outcomes is to promote a competitive environment free of market distortions that favor one party over another.

Society is always better off when prices, profitability and services delivered are determined in a free market environment. Policymakers should authorize a process of competitive bidding among drug plan stakeholders in an atmosphere free of perverse regulations.
## Appendix Table
State Medicaid Prescription Dispensing Fees

<table>
<thead>
<tr>
<th>State</th>
<th>Fee or Lower Tier</th>
<th>Upper Tier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>$10.00</td>
<td>$10.64</td>
</tr>
<tr>
<td>Alaska</td>
<td>$3.45</td>
<td>$11.46 **</td>
</tr>
<tr>
<td>Arizona</td>
<td>$2.00</td>
<td>$8.75</td>
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<td>Arkansas</td>
<td>$5.51</td>
<td></td>
</tr>
<tr>
<td>California</td>
<td>$7.25</td>
<td>$8.00 +</td>
</tr>
<tr>
<td>Colorado</td>
<td>$1.89</td>
<td>$4.00 +</td>
</tr>
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<td>Connecticut</td>
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<td></td>
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<td>Delaware</td>
<td>$3.65</td>
<td></td>
</tr>
<tr>
<td>District of Columbia</td>
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<td></td>
</tr>
<tr>
<td>Florida</td>
<td>$3.73</td>
<td>$7.50</td>
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<td>Georgia</td>
<td>$4.33</td>
<td>$4.63</td>
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<td>Hawaii</td>
<td>$5.00</td>
<td></td>
</tr>
<tr>
<td>Idaho</td>
<td>$11.51</td>
<td>$15.11 **</td>
</tr>
<tr>
<td>Illinois</td>
<td>$3.40</td>
<td>$6.35 *</td>
</tr>
<tr>
<td>Indiana</td>
<td>$3.00</td>
<td></td>
</tr>
<tr>
<td>Iowa</td>
<td>$6.20</td>
<td></td>
</tr>
<tr>
<td>Kansas</td>
<td>$3.40</td>
<td></td>
</tr>
<tr>
<td>Kentucky</td>
<td>$4.50</td>
<td>$5.00 *</td>
</tr>
<tr>
<td>Louisiana</td>
<td>$5.77</td>
<td></td>
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<tr>
<td>Maine</td>
<td>$3.35</td>
<td>$5.35</td>
</tr>
<tr>
<td>Maryland</td>
<td>$2.56</td>
<td>$3.51 *</td>
</tr>
<tr>
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<td>$3.00 +</td>
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<td>$3.91</td>
<td>$4.91 *</td>
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<td>$3.73</td>
<td>$3.99</td>
</tr>
<tr>
<td>State</td>
<td>Fee or Lower Tier</td>
<td>Upper Tier</td>
</tr>
<tr>
<td>------------</td>
<td>------------------</td>
<td>------------</td>
</tr>
<tr>
<td>New Mexico</td>
<td>$2.50</td>
<td>$3.65</td>
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<tr>
<td>New York</td>
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<tr>
<td>North Carolina</td>
<td>$4.00</td>
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<td>North Dakota</td>
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<td>$5.60      *</td>
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<tr>
<td>Ohio</td>
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<td>Oregon</td>
<td>$9.68</td>
<td>$14.01     **</td>
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<tr>
<td>Pennsylvania</td>
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<td></td>
</tr>
<tr>
<td>Rhode Island</td>
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<td>$3.40      +</td>
</tr>
<tr>
<td>South Carolina</td>
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<td></td>
</tr>
<tr>
<td>South Dakota</td>
<td>$4.30</td>
<td>$5.55</td>
</tr>
<tr>
<td>Tennessee</td>
<td>$2.50</td>
<td>$6.00      **</td>
</tr>
<tr>
<td>Texas</td>
<td>$6.50</td>
<td></td>
</tr>
<tr>
<td>Utah</td>
<td>$3.90</td>
<td>$4.40      ++</td>
</tr>
<tr>
<td>Vermont</td>
<td>$4.75</td>
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</tr>
<tr>
<td>Virginia</td>
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<td>$5.00</td>
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<td>Washington</td>
<td>$4.24</td>
<td>$5.25</td>
</tr>
<tr>
<td>West Virginia</td>
<td>$2.50</td>
<td>$8.25      *</td>
</tr>
<tr>
<td>Wisconsin</td>
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<tr>
<td>Wyoming</td>
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</tr>
<tr>
<td><strong>Average</strong></td>
<td>$4.22</td>
<td>$6.59</td>
</tr>
</tbody>
</table>

Note: * denotes generic drugs; ** denotes higher fee for low-volume pharmacies. 
+ denotes institutional pharmacy; ++ denotes higher fees for rural pharmacies.

Unnecessary Regulations that Increase Prescription Drug Costs

Endnotes


2. A drug was either provided or prescribed in 64.8 percent of office visits. The average number of prescriptions written is 2.25 per patient when they receive one during the course of an office visit. David A. Woodwell and Donald K. Cherry, “National Ambulatory Medical Care Survey: 2002 Summary,” National Center for Health Statistics, Advance Data from Vital and Health Statistics, Number 346, August 26, 2004.


10. Growth in drug spending has slowed in recent years. See Janet Lundy “Prescription Drug Trends.”

11. Ibid.


13. Ibid.


16. For a good background on PBMs, see Edward C. Lawrence, Jane Qing/Jiang Qu and Ellen N. Briskin, “An Overview of Pharmacy Benefit Managers: Focus on the Consumer,” University of Missouri — St. Louis, June 1, 2012. Available at http://www.rxobserver.com/wp-content/


19. Ibid.


21. A preferred drug on a formulary may garner 85 percent of the health plan’s business for that therapeutic drug class.


36. Kevin C. Green, “Regulation of Pharmacy Benefit Managers: An Economic Analysis of Regulation and Litigation as Agents of Health Care Change.”

Unnecessary Regulations that Increase Prescription Drug Costs

38. Ibid.

39. When applied to drug plans, this is referred to as “any willing pharmacy.”


49. Although a typical drug plan network may include 60,000 pharmacies, a narrow pharmacy network may include fewer than 50,000 pharmacies — sometimes much less. See Lauren Flynn Kelly, “As Pharmacy Networks Slim Down, Payers Have a Lot to Chew On, Suggests Experts,” Drug Benefit News, Vol. 13, Issue 12, June 22, 2012.

50. Ibid.

51. The estimated savings is 20 percent for self-funded clients who also adopt the Rx4Value formulary. Ibid.


55. Lauren Flynn Kelly, “As Pharmacy Networks Slim Down, Payers Have a Lot to Chew On, Suggests Experts.”

56. Thomas Gryta, “What is a ‘Pharmacy Benefit Manager’?”


58. Ibid.


65. This provision also requires PBMs to reimburse for 90-day prescriptions through local pharmacies. See Lewin Group, “Mail-Service Pharmacy Savings and the Cost of Proposed Limitations in Medicare and the Commercial Sector,” Pharmaceutical Care Management Association, September 2006. Available at http://www.lewin.com/~/media/Lewin/Site_Sections/Publications/3480.pdf.


67. Thomas Gryta, “What is a ‘Pharmacy Benefit Manager’?”


76. Some well-known drugs that have recently lost patent protection include Prozac and Zoloft (for depression), Claritin, Allegra and Zyrtec (for allergy relief), Zocor (to lower blood cholesterol), and Prevacid and Prilosec (for ulcers and gastric reflux disease).


79. Ibid.


Unnecessary Regulations that Increase Prescription Drug Costs


87. A recent poll found about 80 percent of voters do not support compensating drug stores beyond what private drug plans pay for Medicaid prescriptions. The same poll found voters did not support cutting reimbursements to doctors and hospitals. See Jon McHenry and Whit Ayres, “Voter Attitudes Regarding Medicaid Pharmacy Spending.”

88. For instance, when the Texas Legislature began to debate reforming its Medicaid drug program, the Pharmacy Choice and Access Now Coalition opposed moving Medicaid drug reimbursements from the Vendor Drug Program to managed care.


97. “Fraud, Waste, and Abuse Detection in Retail Pharmacy: The Drugstore Lobby vs. Employers.”


The NCPA is a nonprofit, nonpartisan organization established in 1983. Its aim is to examine public policies in areas that have a significant impact on the lives of all Americans — retirement, health care, education, taxes, the economy, the environment — and to propose innovative, market-driven solutions. The NCPA seeks to unleash the power of ideas for positive change by identifying, encouraging and aggressively marketing the best scholarly research.

Health Care Policy.
The NCPA is probably best known for developing the concept of Health Savings Accounts (HSAs), previously known as Medical Savings Accounts (MSAs). NCPA President John C. Goodman is widely acknowledged (Wall Street Journal, WebMD and the National Journal) as the “Father of HSAs.” NCPA research, public education and briefings for members of Congress and the White House staff helped lead Congress to approve a pilot MSA program for small businesses and the self-employed in 1996 and to vote in 1997 to allow Medicare beneficiaries to have MSAs. In 2003, as part of Medicare reform, Congress and the President made HSAs available to all nonseniors, potentially revolutionizing the entire health care industry. HSAs now are potentially available to 250 million nonelderly Americans.

The NCPA outlined the concept of using federal tax credits to encourage private health insurance and helped formulate bipartisan proposals in both the Senate and the House. The NCPA and BlueCross BlueShield of Texas developed a plan to use money that federal, state and local governments now spend on indigent health care to help the poor purchase health insurance. The SPN Medicaid Exchange, an initiative of the NCPA for the State Policy Network, is identifying and sharing the best ideas for health care reform with researchers and policymakers in every state.

Taxes & Economic Growth.
The NCPA helped shape the pro-growth approach to tax policy during the 1990s. A package of tax cuts designed by the NCPA and the U.S. Chamber of Commerce in 1991 became the core of the Contract with America in 1994. Three of the five proposals (capital gains tax cut, Roth IRA and eliminating the Social Security earnings penalty) became law. A fourth proposal — rolling back the tax on Social Security benefits — passed the House of Representatives in summer 2002. The NCPA’s proposal for an across-the-board tax cut became the centerpiece of President Bush’s tax cut proposals.

NCPA research demonstrates the benefits of shifting the tax burden on work and productive investment to consumption. An NCPA study by Boston University economist Laurence Kotlikoff analyzed three versions of a consumption tax: a flat tax, a value-added tax and a national sales tax. Based on this work, Dr. Goodman wrote a full-page editorial for Forbes (“A Kinder, Gentler Flat Tax”) advocating a version of the flat tax that is both progressive and fair.

A major NCPA study, “Wealth, Inheritance and the Estate Tax,” completely undermines the claim by proponents of the estate tax that it prevents the concentration of wealth in the hands of financial dynasties. Senate Majority Leader Bill Frist (R-TN) and Senator Jon Kyl (R-AZ) distributed a letter to their colleagues about the study. The NCPA recently won the Templeton Freedom Award for its study and report on Free Market Solutions. The report outlines an approach called Enterprise Programs that creates job opportunities for those who face the greatest challenges to employment.

Retirement Reform.
With a grant from the NCPA, economists at Texas A&M University developed a model to evaluate the future of Social Security and Medicare, working under the direction of Thomas R. Saving, who for years was one of two private-sector trustees of Social Security and Medicare.

The NCPA study, “Ten Steps to Baby Boomer Retirement,” shows that as 77 million baby boomers begin to retire, the nation’s institutions are totally unprepared. Promises made under Social Security, Medicare and Medicaid are inadequately funded. State and local institutions are not doing better — millions of government workers are discovering that their pensions are under-funded and local governments are retrenching on post-retirement health care promises.

Pension Reform.
Pension reforms signed into law include ideas to improve 401(k)s developed and proposed by the NCPA and the Brookings Institution. Among the NCPA/Brookings 401(k) reforms are automatic enrollment of employees into companies’ 401(k) plans, automatic contribution rate increases so that workers’ contributions grow with their wages, and better default investment options for workers who do not make an investment choice.
The NCPA’s online Social Security calculator allows visitors to discover their expected taxes and benefits and how much they would have accumulated had their taxes been invested privately.

Environment & Energy.
The NCPA’s E-Team is one of the largest collections of energy and environmental policy experts and scientists who believe that sound science, economic prosperity and protecting the environment are compatible. The team seeks to correct misinformation and promote sensible solutions to energy and environment problems. A pathbreaking 2001 NCPA study showed that the costs of the Kyoto agreement to reduce carbon emissions in developed countries would far exceed any benefits.

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“The NCPA generates more analysis per dollar than any think tank in the country. It does an amazingly good job of going out and finding the right things and talking about them in intelligent ways.”

Newt Gingrich, former Speaker of the U.S. House of Representatives

“We know what works. It’s what the NCPA talks about: limited government, economic freedom; things like Health Savings Accounts. These things work, allowing people choices. We’ve seen how this created America.”

John Stossel, host of “Stossel,” Fox Business Network

“I don’t know of any organization in America that produces better ideas with less money than the NCPA.”

Phil Gramm, former U.S. Senator

“Thank you . . . for advocating such radical causes as balanced budgets, limited government and tax reform, and to be able to try and bring power back to the people.”

Tommy Thompson, former Secretary of Health and Human Services

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