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Unnecessary Regulations that Increase Prescription Drug Costs

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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.

Dallas Headquarters:
12770 Coit Road, Suite 800
Dallas, TX 75251
972.386.6272

www.ncpa.org

Washington Office:
601 Pennsylvania Avenue NW,
Suite 900, South Building
Washington, DC 20004
202.220.3082

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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.

About the Author

Devon M. Herrick is a senior fellow with the National Center for Policy Analysis. His focus includes Internet-based medicine, patient empowerment, medical privacy and health technology-related issues. His research includes health insurance coverage and pharmaceutical drug issues. He spent six years working in health care accounting and financial management for a Dallas-area health care system. Herrick received a Doctor of Philosophy in political economy and a Master of Public Affairs degree from the University of Texas at Dallas. He also holds graduate degrees in finance and economics from Amberton University and Oklahoma City University, as well as a Bachelor of Science degree in accounting from the University of Central Oklahoma.

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.

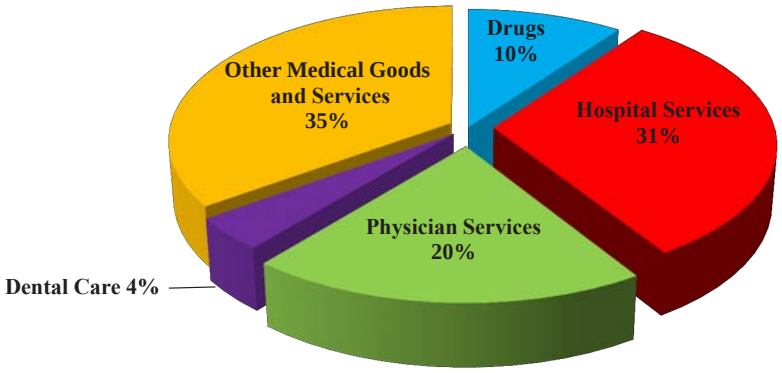
Americans spend more than $271 billion dollars on prescription medicines annually.[7] Total spending on drug therapy approaches $300 billion dollars, including over-the-counter (OTC) drug remedies.[8] This is a significant increase from the $40 billion spent on prescription drugs alone in 1990.[9] The 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]

Figure I
Drug Spending as a Proportion of All Health Care Expenditure (2008)



Source: "National Health Expenditures by Type of Service and Source of Funds, CY 1960-2011," Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, page last modified January 9, 2013. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE2011.zip.

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.[16] 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.[17] 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.[18] 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.[19]

Regardless of how the program is structured, enrollees initially purchase most of their drugs at local pharmacies, which are reimbursed for the cost of each prescription filled, plus a dispensing fee. Enrollees with chronic conditions are generally encouraged to utilize mail-order pharmacies for their medications to reduce costs and provide better, more consistent service.

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…"[24]

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.[25] Representatives for community pharmacists even alleged that Lewin's results were "bought and paid for" by drug plans.[26]

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.[27] A similar initiative failed a year later in Oregon.[28] State pharmacy boards are primarily made up of pharmacists, who naturally ally themselves with and identify more closely with pharmacy interests.[29] 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

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.[20]

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.[21]

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.[22] As a result, some drug makers and pharmacy trade groups have proposed self-serving regulations designed to disadvantage PBMs.[23]

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 willing 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.[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.[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.[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.[55]

Enrollees, insurers and employers share in the savings that result from strong negotiating positions.[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.[57] Mail-order pharmacies fill about 260 million prescriptions annually.[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.[59]

Mail-order pharmacies purchase drugs in large quantities, are highly automated and make fewer errors than walk-in pharmacies.[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.[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.[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."[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."[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.[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

prices for, and reduce access to, prescription drugs, which are an increasingly important component of medical care."[66]

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.[67]

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.[68] The study found claims of unauthorized drug substitution were rare and usually unfounded.[69]

In recent years, many states have passed regulations that allow greater generic drug substitution when appropriate:[70]

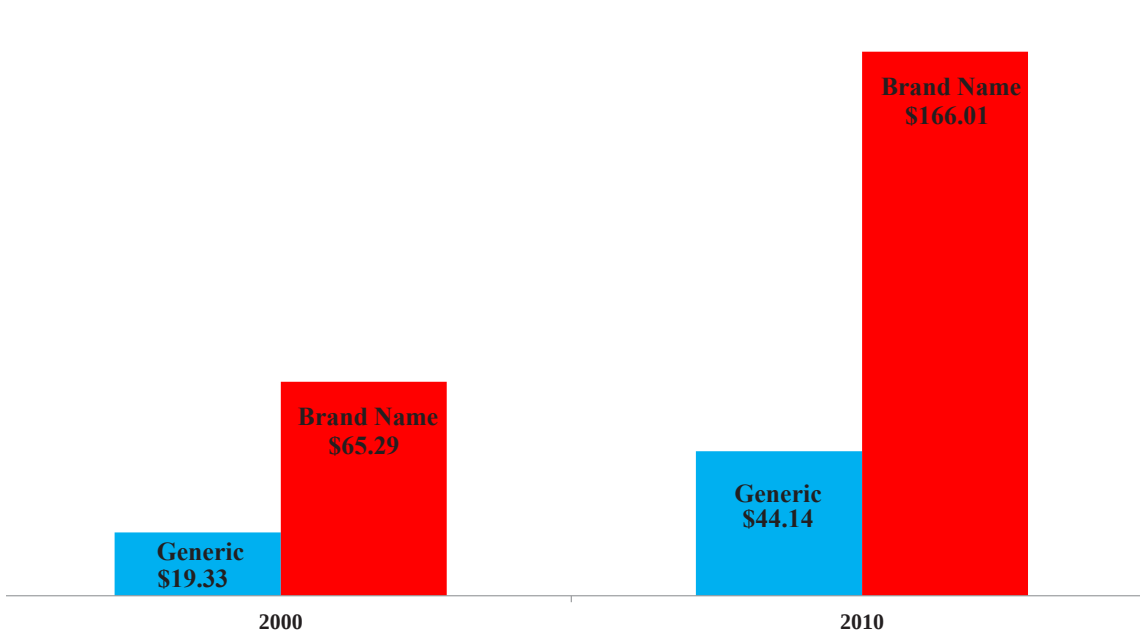
- More than one-fourth of states require that pharmacists dispense a generic if available.
- About three-fourths of states permit generic substitution by pharmacists.
- However, all states allow physicians to block generic substitution and restrict a prescription to a brand-name drug.

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.[71] According to one estimate, the U.S. health care system saved $824 billion over the past decade from the use of generic drugs.[72] Indeed [see Figure II]:[73]

- 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

Figure II
Average Price of Prescription Drug
(Generic vs. Brand Name)



Source: Somnath Pal, "Trends in Generic Drugs," *U.S. Pharmacist*, Vol. 37, No. 6, June 20, 2012, pages 8-10.

percent in 1985.[74] Generic drugs are generally 80 percent to 85 percent less than the original branded drug.[75]

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.[76] Indeed, many of the current top-selling brand-name drugs will lose patent protection by the end of 2014.[77]

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*.[78] A similar battle is being waged at the federal level regarding whether to allow biosimilar drugs to be substituted if the original biological drug is prescribed. The FDA is currently considering an approval process for biosimilars. Biotech drugs now account for about one-fourth of drug spending.[79] Without the ability to substitute biosimilars, drug makers will have little incentive to develop these drugs — to the detriment of taxpayers, employers and consumers alike.

One goal of regulations encouraging generic substitution is to lessen the financial impact on state employee health plans and state Medicaid programs, as well as employers and consumers. 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:[80]

> *"Medicaid prescriptions are 64 percent generic, but generics are less than one-fifth of Medicaid drug costs."*

- 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).

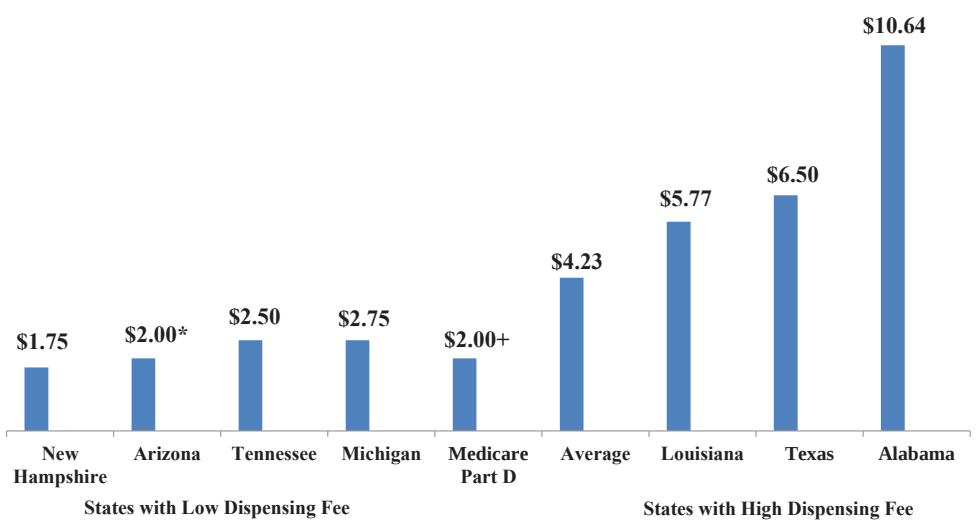
By contrast, Express Scripts, a large PBM, reports that the generic fill rate for its clients is 79 percent — precisely the national average. For Express Scripts Medicare Part D enrollees, the yearly cost of a name-brand prescription was nearly seven times (6.73) greater than for a generic. Express Scripts believes that for every 1 percent increase in its generic fill rate, it realizes a 1.5 percent to 2 percent increase in savings.[81]

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.[82]

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.[84] 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.[85] Lichtenberg has repeatedly argued that reduced mortality is associated with the introduction of innovative (patented) drugs.[86] PBMs should have protocols for those situations when a physician believes a patented drug is more appropriate.

Figure III
State Medicaid Prescription Dispensing Fees



* Arizona has a small fee-for-service program;
\+ Medicare Part D for comparison purposes only.

Source: "Medicaid Covered Outpatient Prescription Drug Reimbursement Information by State – Quarter Ending September 2012 ," Center for Medicare & Medicaid Services, U.S. Department for Health and Human Services. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Downloads/reimbursementchart4q2012.pdf.

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.

> *"PBMs have reduced losses to waste, fraud and abuse to about 1 percent of costs."*

As a result, PBMs have reduced losses to waste, fraud and abuse to about 1 percent of costs, whereas losses for health care generally are an estimated 7 percent to 10 percent.[97]

At the very least, PBMs need the authority to delay payments on suspect claims or providers.[98] Medicare Part D requires claims to be paid within 14 days, making it difficult to detect fraud before the funds have been issued. Proposed federal legislation would also hinder the ability of PBMs to conduct pharmacy audits and reduce the number of years drugstores are required to retain transaction records.[99]

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

		Fee or Lower Tier	Upper Tier	
Alabama		$10.00	$10.64	
Alaska		$3.45	$11.46	**
Arizona		$2.00	$8.75	
Arkansas		$5.51		
California		$7.25	$8.00	+
Colorado		$1.89	$4.00	+
Connecticut		$2.00		
Delaware		$3.65		
District of Columbia		$4.50		
Florida		$3.73	$7.50	
Georgia		$4.33	$4.63	
Hawaii		$5.00		
Idaho		$11.51	$15.11	**
Illinois		$3.40	$6.35	*
Indiana		$3.00		
Iowa		$6.20		
Kansas		$3.40		
Kentucky		$4.50	$5.00	*
Louisiana		$5.77		
Maine		$3.35	$5.35	
Maryland		$2.56	$3.51	*
Massachusetts		$3.00	$10.00	
Michigan		$2.75	$3.00	+
Minnesota		$3.65		
Mississippi		$3.91	$4.91	*
Missouri		$4.09		
Montana		$6.40		
Nebraska		$3.27	$5.00	
Nevada		$4.76		
New Hampshire		$1.75		
New Jersey		$3.73	$3.99	

State Prescription Dispensing Fees, con't.				
		Fee or Lower Tier	Upper Tier	
New Mexico		$2.50	$3.65	
New York		$3.50		
North Carolina		$4.00	$9.00	
North Dakota		$4.60	$5.60	*
Ohio		$1.80		
Oklahoma		$4.02		
Oregon		$9.68	$14.01	**
Pennsylvania		$4.00		
Rhode Island		$2.85	$3.40	+
South Carolina		$3.00		
South Dakota		$4.30	$5.55	
Tennessee		$2.50	$6.00	**
Texas		$6.50		
Utah		$3.90	$4.40	++
Vermont		$4.75		
Virginia		$3.75	$5.00	
Washington		$4.24	$5.25	
West Virginia		$2.50	$8.25	*
Wisconsin		$3.44	$3.94	*
Wyoming		$5.00		
Average		$4.22	$6.59	

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

Source: "Medicaid Covered Outpatient Prescription Drug Reimbursement Information by State Quarter Ending September 2012," Center for Medicare and Medicaid Services, U.S. Department of Health and Human Services, November 20, 2012. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Downloads/reimbursementchart4q2012.pdf.

Endnotes

[1.] "Health, United States, 2011, with Special Features on Socioeconomic Status and Health," Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, DHHS Publication No. 2012-1232, May 2012, Table 96. Available at http://www.cdc.gov/nchs/data/hus/hus11.pdf#096.

[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.

[3.] SDI Health, LLC reported in StateHealthFacts.org, Kaiser Family Foundation. Available at http://www.statehealthfacts.org/profileind.jsp?sub=66&rgn=1&cat=5.

[4.] Agency for Healthcare Research and Quality, "Prescription Medicines-Mean and Median Expenses per Person with Expense and Distribution of Expenses by Source of Payment: United States, 2010," Medical Expenditure Panel Survey Household Component Data. Available at http://meps.ahrq.gov/mepsweb/data_stats/tables_compendia_hh_interactive.jsp?_SERVICE=MEPSSocket0&_PROGRAM=MEPSPGM.TC.SAS&File=HCFY2010&Table=HCFY2010%5FPLEXP%5FA&VAR1=AGE&VAR2=SEX&VAR3=RACETH5C&VAR4=INSURCOV&VAR5=POVCAT10&VAR6=MSA&VAR7=REGION&VAR8=HEALTH&VARO1=4+17+44+64&VARO2=1&VARO3=1&VARO4=1&VARO5=1&VARO6=1&VARO7=1&VARO8=1&_Debug=.

[5.] Anita Soni, "Expenditures for the Top Five Therapeutic Classes of Outpatient Prescription Drugs, Medicare Beneficiaries, Age 65 and Older, U.S. Civilian Non-institutionalized Population, 2009," Medical Expenditure Panel Survey Statistical Brief 363, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, March 2012. Available at http://meps.ahrq.gov/mepsweb/data_files/publications/st363/stat363.pdf.

[6.] Anita Soni, "Expenditures for the Top Five Therapeutic Classes of Outpatient Prescription Drugs, Adults Age 18 and Older, U.S. Civilian Non-institutionalized Population, 2009," Medical Expenditure Panel Survey Statistical Brief 362, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, March 2012. Available at http://meps.ahrq.gov/mepsweb/data_files/publications/st362/stat362.pdf.

[7.] Agency for Healthcare Research and Quality, "Prescription Medicines-Mean and Median Expenses per Person with Expense and Distribution of Expenses by Source of Payment: United States, 2010," Medical Expenditure Panel Survey Household Component Data, U.S. Department of Health and Human Services. IMS Health, a private firm specializing in data collection and dissemination, estimated total spending on prescription drugs in 2009 was $300 billion. Fred Doloresco, Cory Fominaya, Glen T. Schumock et al., "Projecting future drug expenditures—2011," *American Journal of Health System Pharmacy*, Vol. 68, 2011, e1-e12. Available at http://www.imshealth.com/deployedfiles/ims/Global/Content/Insights/Researchers/AJHP_Drug_Expenditure_Forecast_2011.pdf. IMS Health estimated total market in 2011 $320 billion. "The Use of Medicines in the United States: Review of 2011," IMS Institute for Healthcare Informatics, April 2012. Available at http://www.imshealth.com/ims/Global/Content/Insights/IMS%20Institute%20for%20Healthcare%20Informatics/IHII_Medicines_in_U.S_Report_2011.pdf.

[8.] In 2010, an estimated $23 billion in over the counter products were sold. See Booz & Company, "The Value of OTC Medicine to the United States," Consumer Healthcare Products Association, January 2012. Available at http://www.yourhealthathand.org/images/uploads/The_Value_of_OTC_Medicine_to_the_United_States_BoozCo.pdf.

[9.] Janet Lundy "Prescription Drug Trends," Kaiser Family Foundation, publication No. 3057-08, May 2010. Available at http://www.kff.org/rxdrugs/upload/3057-08.pdf. Amount is not adjusted for inflation. Adjusting for inflation, annual drug spending would equal about $80 billion in 1990.

[10.] Growth in drug spending has slowed in recent years. See Janet Lundy "Prescription Drug Trends."

[11.] Ibid.

[12.] Jessica Banthin, Holly Harvey and Jean Hearne, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," Congressional Budget Office, July 2012, Table 1. Available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf.

[13.] Ibid.

[14.] "The Uninsured in America," BlueCross BlueShield Association, Publication W20-04-035, January 2005. Available at http://www.coverageforall.org/pdf/BC-BS_Uninsured-America.pdf.

[15.] For example, see Devon Herrick, "Medicaid Expansion Will Bankrupt the States," National Center for Policy Analysis, Brief Analysis No. 729, October 25, 2010. Available at http://www.ncpa.org/pdfs/ba729.pdf.

[16.] For a good background on PBMs, see Edward C. Lawrence, Jane QingJiang 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/

uploads/2012/05/lawrencestudy.pdf.

[17.] Devon Herrick, "Shopping for Drugs: 2007," National Center for Policy Analysis, Policy Report No. 293, November 16, 2006. Available at http://www.ncpa.org/pdfs/st293.pdf.

[18.] Thomas Gryta, "What Is a 'Pharmacy Benefit Manager'?" *Wall Street Journal*, July 21, 2011. Available at http://online.wsj.com/article/SB10001424053111903554904576460322664055328.html.

[19.] Ibid.

[20.] For example, see "Pharmacy Clinical Policy Bulletins Aetna Non-Medicare Prescription Drug Plan," Aetna, August 17, 2012. Available at http://www.aetna.com/products/rxnonmedicare/data/2012/RESP2012/NSAscpb_2012.html.

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

[22.] "Independent Pharmacies Must Unify to Fight PBM Industry," *Drug Topics*, February 22, 2011. Available at http://drugtopics.modernmedicine.com/news/independent-pharmacies-must-unify-fight-pbm-industry.

[23.] For instance, Mississippi Senate Bill 2445 transferring regulatory authority over PBMs from the state Insurance Commissioner to the Mississippi Board of Pharmacy was introduced by two pharmacists — Mississippi state Sens. Nolan Mettetal and Robert Dearing. See, "PBMs Confront Would-Be Pharmacist Regulators on Mississippi Battlefield," *Drug Benefit News,* Vol. 12, No. 8, April 15, 2011. Available at http://aishealth.com/nlpdf/dbn87grt3.pdf.

[24.] Kevin C. Green, "Regulation of Pharmacy Benefit Managers: An Economic Analysis of Regulation and Litigation as Agents of Health Care Change," Selected Works, BePress.com, January 2008.

[25.] John Norton, "Lewin Group/PBMs' Medicaid Pharmacy Report Misses the Mark; Recommendations Threaten Patient Health and Access," January 20, 2011. Available at http://ncpanet.wordpress.com/2011/01/20/lewin-grouppbms%E2%80%99-medicaid-pharmacy-report-misses-the-mark-recommendations-threaten-patient-health-and-access/.

[26.] "Lewin's Medicaid Pharmacy Managed Care Report: Bought and Paid for by PBMs Threatens Patient Health, Compromises State Medicaid Programs, Reduces Patient Access to Pharmacies," National Community Pharmacists Association, January 2011. Available at http://www.ncpanet.org/pdf/leg/jan11/lewin_group_report_final.pdf.

[27.] The law was Senate Bill 2445. "Pharmacy group responds to Barbour signing S.B. 2445," *Mississippi Business Journal*, May 2, 2011. Available at http://msbusiness.com/blog/2011/05/02/pharmacy-group-responds-to-barbour-signing-sb-2445/.

[28.] Nick Budnick, "Pharmacist-Backed Bill by Portland Rep. Jules Bailey Likely to Stall in Face of Drug Manager Lobbyists, Ad Campaign," *The Oregonian*, February 8, 2012. Available at http://www.oregonlive.com/health/index.ssf/2012/02/pharmacist-backed_bill_by_port.html. Also see Oregon House Bill 4122, 2012 (Regular Session). Available at http://legiscan.com/OR/bill/HB4122/2012.

[29.] Senate Bill 2445 was introduced by two pharmacists — Mississippi state Sens. Nolan Mettetal and Robert Dearing. See, "PBMs Confront Would-Be Pharmacist Regulators on Mississippi Battlefield."

[30.] See Susan S. DeSanti, Joseph Farrell and Richard A. Feinstein, letter in response to a request for comments on the likely competitive effects of Mississippi Senate Bill 2445, Office of Policy Planning, U.S. Federal Trade Commission, March 22, 2011. Available at http://www.ftc.gov/os/2011/03/110322mississippipbm.pdf.

[31.] "Don't Let the Fox Guard the Henhouse," Pharmaceutical Care Management Association, March 2001. Available at http://www.pcmanet.org/images/stories/uploads/2011/March2011/pcma_foxadfinal.pdf.

[32.] Troy Filipek, "PBM Transparency could be Inevitable," *Managed Healthcare Executive*, February 1, 2009. Available at http://managedhealthcareexecutive.modernmedicine.com/news/pbm-transparency-could-be-inevitable.

[33.] Brian M. Kalish, "Keeping Rx Transparency on Track," *Employee Benefit Advisor,* October 1, 2012. Available at http://eba.benefitnews.com/news/pbm-consultants-questions-pharmacy-management-2727877-1.html.

[34.] Joanne Wojcik, "Most Rx-Plans Require Pass through Pricing" *Business Insurance,* September 15, 2006.

[35.] Daniel C. Opinante, "Traditional PBM Pricing Vs. Pass-Through…Look Before You Leap!" *Self-Funding Magazine*, March 8, 2010. Available at http://www.selffundingmagazine.com/article/traditional-pbm.html.

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

[37.] "As Pharmacy Networks Slim Down, Payers Have a Lot to Chew On, Suggests Experts," *Drug Benefit News*, Vol. 13, No. 12, June 22, 2012.

[38.] Ibid.

[39.] When applied to drug plans, this is referred to as "any willing pharmacy."

[40.] These include Alabama, Arkansas, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Massachusetts, Minnesota, Mississippi, Montana, New Hampshire, New Jersey, New Mexico, North and South Carolina, North and South Dakota, Oklahoma, Texas, Virginia and Wyoming. See, "Managed Care State Laws and Regulations, Including Consumer and Provider Protections," National Conference of State Legislatures, Table I, September 2011. Available at http://www.ncsl.org/issues-research/health/managed-care-state-laws.aspx.

[41.] Susan S. DeSanti, Joseph Farrell and Richard A. Feinstein, letter in response to a request for comments on the likely competitive effects of New York Assembly Bill 5502-B, Office of Policy Planning, U.S. Federal Trade Commission, August 8, 2011. Available at http://www.ftc.gov/os/2011/08/110808healthcarecomment.pdf.

[42.] "Pharmacy-Related Changes from the 82nd Legislature," Texas Health and Human Services Commission, *RxUpdate*, Vol. 21, No. 3, Summer 2011. Available at http://www.txvendordrug.com/downloads/newsletters/2011-q3.pdf.

[43.] Daniel Weiss, "State Medicaid Changes Squeeze Independent Pharmacies," Pharmacy Times, March 20, 2012. Available at http://www.pharmacytimes.com/news/State-Medicaid-Changes-Squeeze-Independent-Pharmacies.

[44.] Alain Enthoven and Kyna Fong, "Medicare: Negotiated Drug Prices May Not Lower Costs," National Center for Policy Analysis, Brief Analysis No. 575, December 18, 2006. Available at http://www.ncpa.org/pub/ba575.

[45.] Christine Piette Durrance, "The Impact of Pharmacy-Specific Any-Willing-Provider Legislation on Prescription Drug Expenditures," *Atlantic Economic Journal,* Vol. 37, No. 4, August 2009, pages 409-423.

[46.] "Improving Health Care: A Dose of Competition," Federal Trade Commission and the U.S. Department of Justice, July 2004. Available at http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf.

[47.] 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.

[48.] Robert L. Ohsfeldt et al., "The Spread of State Any-willing-provider Laws," *HSR: Health Service Research*, Vol. 35, No. 5, December 1998.

[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.

[52.] F. J. Hellinger, "Any-Willing-Provider and Freedom-of-Choice Laws: An Economic Assessment," *Health Affairs*, Vol. 14, No. 4, 1995, pages 297-302.

[53.] "Fraud, Waste and Abuse Detection in Retail Pharmacy: The Drugstore Lobby vs. Employers," Pharmaceutical Care Management Association, July 2011.

[54.] "Effects of Using PBMs on Health Plans, Enrollees, and Pharmacies," U.S. General Accounting Office, GAO-03-196, January 10, 2003.

[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'?"

[57.] Mail-order prescriptions are typically written for 90-day supplies, and thus are multiplied by three. See, "Channel Distribution by U.S. Dispensed Prescriptions," IMS Health, February 23, 2012. Available at http://www.imshealth.com/deployedfiles/ims/Global/Content/Corporate/Press%20Room/Top-Line%20Market%20Data%20&%20Trends/2011%20Top-line%20Market%20Data/Channels_by_RX.pdf.

[58.] Ibid.

[59.] Devon Herrick, "Shopping for Drugs: 2007."

[60.] J. Russell Teagarden et al., "Dispensing Error Rate in a Highly Automated Mail-Service Pharmacy Practice," *Pharmacotherapy*, Vol. 25, No. 11, 2005, pages 1629-1635. Also see Elizabeth Allan Flynn, Kenneth N. Barker and Brian J. Carnahan, "National Observational Study of Prescription Dispensing Accuracy and Safety in 50 Pharmacies," *Journal of the American Pharmacists Association*, Vol. 43, No. 2, March-April 2003, pages 191-200.

[61.] Sue Stock, "Patients, pharmacies adapt to drugs by mail," *News & Observer*, April 10, 2011. Available at http://www.newsobserver.

com/2010/04/11/430578/patients-pharmacies-adapt-to-drugs.html.

62. "Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacies," U.S. Federal Trade Commission, August 2005.

63. Anemona Hartocollis, "New Law Bans Mail-Order Drug Mandates," *New York Times*, December 13, 2011.

64. Adam J. Fein, "The Unexpected Losers from New York's Anti-Mail Bill," Drug Channels, June 28, 2011. Available at http://www.drugchannels.net/2011/06/unexpected-losers-from-new-yorks-anti.html.

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.

66. Susan S. DeSanti, Joseph Farrell and Richard A. Feinstein, letter in response to a request for comments on the likely competitive effects of New York Assembly Bill 5502-B, Office of Policy Planning, U.S. Federal Trade Commission, August 8, 2011. Available at http://www.ftc.gov/os/2011/08/110808healthcarecomment.pdf.

67. Thomas Gryta, "What is a 'Pharmacy Benefit Manager'?"

68. Texas Department of Insurance, "Pharmacy Benefit Managers: A Study of Prescription Drug Management Practices and Policies," Report on House Bill 4402 and Senate Bill 704, Section 2, 81st Legislature, Regular Session, 2009, August 2010. Available at http://www.tdi.texas.gov/reports/life/documents/pbmstudy.pdf.

69. Joint Interim Report to the 80th (Texas) Legislature, Health and Human Services Committee and State Affairs Committee, Texas Senate, December 2006. Available at http://www.senate.state.tx.us/75r/senate/commit/c610/c570.c610.InterimReport79.pdf.

70. Richard Cauchi, Martha King and Barbara Yondorf, "Use of Generic Prescription Drugs and Brand-Name Discounts," Health Cost Containment and Efficiencies, National Conference of State Legislatures, NCSL Briefs for State Legislators No. 8, June 2010. Available at http://www.ncsl.org/portals/1/documents/health/GENERICS-2010.pdf.

71. William M. Welch, "VA Offers Medicines at Bargain Prices," *USA Today*, June 18, 2003.

72. "Economic Analysis of Generic Pharmaceuticals 1998-2008, $824 Billion in Health Care Savings," Generic Pharmaceutical Association, May 2009. Available at http://www.gphaonline.org/about-gpha/about-generics/case/ generics-providing-savings-americans.

73. Somnath Pal, "Trends in Generic Drugs," *U.S. Pharmacist*, Vol. 37, No. 6, June 20, 2012, pages 8-10.

74. Michael Kleinrock, "The Use of Medicines in the United States: Review of 2010," IMS Institute for Health; and Joseph P. Cook, Graeme Hunter and John A. Vernon, "Generic Utilization Rates, Real Pharmaceutical Prices, and Research and Development Expenditures," National Bureau of Economic Research, Working Paper Number 15723, February 2010.

75. "Facts about Generic Drugs," U.S. Food and Drug Administration, September 19, 2012. Available at http://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/understandinggenericdrugs/ucm167991.htm/.

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).

77. Alaric DeArment, "As Innovators Prep For Patent Cliff, Generics Prosper From Patent Losses," *Drug Store News,* February 18, 2011. Alex Brill of the American Enterprise Institute predicted Medicaid would waste $289 million to $433 million annually on drugs that went off-patent in 2011 and 2012. See Alex Brill, "Overspending on Multi-Source Drugs in Medicaid," American Enterprise Institute, AEI Health Policy Studies Working Paper 2011-01, March 28, 2011. Available at http://www.aei.org/paper/100207.

78. Andrew Pollack, "Biotech Firms, Billions at Risk, Lobby States to Limit Generics," *New York Times*, January 28, 2013. Available at http://www.nytimes.com/2013/01/29/business/battle-in-states-on-generic-copies-of-biotech-drugs.html.

79. Ibid.

80. Analysis by the National Community Pharmacists Association. See John M. Coster, "Changes in Medicaid Reimbursement: Implications for Generic Manufacturers and Pharmacies," *U.S. Pharmacist*, Vol. 36, No. 6 (Generic Supplement), June 20, 2011, pages 12-20.

81. "Generic Utilization," Drug Trend Report, Express Scripts, 2013. Available at http://www.drugtrendreport.com/medicare-medicaid/medicare-overview/generic-utilization.

82. Joel Menges, Shirley Kang and Chris Park, "Potential Federal and State-by-State Savings if Medicaid Pharmacy Programs Were Optimally Managed," Lewin Group, February 2011. Available at http://www.lewin.com/~/media/lewin/site_sections/publications/medicaidpharmacysavingsreport_rev.pdf.

[83] A recent poll found 85 percent of voters favor generic-first dispensing policies for Medicaid. Jon McHenry and Whit Ayres, "Voter Attitudes Regarding Medicaid Pharmacy Spending," Ayres, McHenry & Associates, Inc., December 10, 2010. Available at http://pcmanet.org/images/stories/uploads/2010/12/Medicaid-Pharmacy-Poll-Memo.pdf. One report identified 20 commonly-used brand drugs for which there were therapeutically equivalent generic drugs available. Of the 20 drugs studied, Medicaid paid an average of $95 more for every brand medication sold when there was a generic available. Had state Medicaid programs substituted generics for these 20 drugs, they would have achieved savings of $329 million in 2009. Data from 2009. See Alex Brill, "Overspending on Multi-Source Drugs in Medicaid," American Enterprise Institute, AEI Health Policy Studies Working Paper 2011-01, March 28, 2011. Available at http://www.aei.org/paper/100207.

[84] Frank Lichtenberg, "Benefits and Costs of Newer Drugs: An Update," National Bureau of Economic Research, Working Paper No. 8996, June 2002.

[85] Frank R. Lichtenberg, "Why Has Longevity Increased Faster in Some States than Others? The Role of Medical Innovation and other Factors," Manhattan Institute, Medical Progress Report Number 4, July 2007. Available at http://www.manhattan-institute.org/html/mpr_04.htm.

[86] Frank R. Lichtenberg, "The Impact of New Drug Launches on Longevity: Evidence from Longitudinal Disease-Level Data from 52 Countries, 1982-2001," National Bureau of Economic Research, Working Paper Number 9754, June 2003.

[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.

[89] Joel Menges, Shirley Kang and Chris Park, "Potential Federal and State-by-State Savings if Medicaid Pharmacy Programs Were Optimally Managed."

[90] "Medicaid Covered Outpatient Prescription Drug Reimbursement Information by State Quarter Ending September 2012," Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, updated November 21, 2012. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Downloads/reimbursementchart4q2012.pdf.

[91] Some states pay even higher fees to low volume or rural pharmacies. See

"Medicaid Prescription Reimbursement Information by State — Quarter Ending December 2010," Center for Medicare & Medicaid Services, U.S. Department of Health and Human Services. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Downloads/prescription-reimbursement-by-state-chart-4Q2010.pdf.

[92] Daniel R. Levinson, "Comparing Pharmacy Reimbursement: Medicare Part D to Medicaid," U.S. Department of Health and Human Services, Office of Inspector General, Publication OEI-03-07-00350, February 2009.

[93] Dispensing fees at long-term care pharmacies were generally twice as high as retail pharmacies. See Stuart Wright, "Medicare Part D Pharmacy Discounts for 2008," U.S. Department of Health and Human Services, Office of the Inspector General, Memorandum Report: OEI-02-10-00120, November 17, 2010. Available at http://oig.hhs.gov/oei/reports/oei-02- 10-00120.pdf.

[94] For example, see "Fraud, Waste, and Abuse Detection in Retail Pharmacy: The Drugstore Lobby vs. Employers," Pharmaceutical Care Management Association, July 2011. Available athttp://pcmanet.org/images/stories/uploads/2011/July2011/PCMA_Fraud_Waste_and_Abuse_in_Retail_Pharmacy_July_2011.pdf.

[95] By contrast, credit card companies suffer losses of less than 1 percent. See Tristram Korten, "Cracking Down on $70 Billion Worth of Medicare Fraud," Fast Company, November 19, 2011. Available at http://www.fastcompany.com/1793537/cracking-down-70-billion-worth-medicare-fraud.

[96] Thad Trousdale, "Health Care Fraud & the FBI," *Missouri Medicine*, Vol. 109, No. 2, March/April 2012, pages 102-105. Available at http://www.omagdigital.com/display_article.php?id=1045833.

[97] "Fraud, Waste, and Abuse Detection in Retail Pharmacy: The Drugstore Lobby vs. Employers."

[98] The U.S. Department of Health and Human Serviced recently announced payers can suspend payments as soon as fraud is detected. See Kelly Kennedy, "Medicare Changes Payment Plan to Fight Drug Fraud," *USA Today*, December 13, 2011. Available at http://usatoday30.usatoday.com/news/washington/story/2011-12-13/medicare-changes-fight-prescription-fraud/51887946/1.

[99] H.R. 4215, H.R. 1971 and its companion bill Senate Bill 1058, were opposed by drug plan managers as an obstacle to protecting drug plans against fraudulent drug stores and unscrupulous pharmacists. See Grover Norquist and Mattie Duppler, "Letter to Representative Cathy McMorris Rodgers," Americans for Tax Reform, April 24, 2012. Available at http://costofgovernment.org/files/files/04242012lt_HR1971pbm.pdf.

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.

NCPA President John C. Goodman is called the "Father of HSAs" by *The Wall Street Journal*, WebMD and the *National Journal*.

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.

Educating the next generation.

The NCPA's Debate Central is the most comprehensive online site for free information for 400,000 U.S. high school debaters. In 2006, the site drew more than one million hits per month. Debate Central received the prestigious Templeton Freedom Prize for Student Outreach.

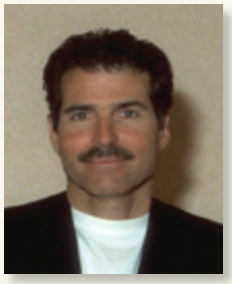
Promoting Ideas.

NCPA studies, ideas and experts are quoted frequently in news stories nationwide. Columns written by NCPA scholars appear regularly in national publications such as the *Wall Street Journal*, the *Washington Times*, *USA Today* and many other major-market daily newspapers, as well as on radio talk shows, on television public affairs programs, and in public policy newsletters. According to media figures from Burrelles*Luce*, more than 900,000 people daily read or hear about NCPA ideas and activities somewhere in the United States.

What Others Say About the NCPA

"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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