Since 2007, 20 states enacted reforms to reduce the costs of physician-dispensed prescriptions.

Exhibit 1 shows the 14 states that adopted price-focused reforms as well as the six states that adopted reforms focused on price and utilization of physician-dispensed prescriptions. The exhibit also shows the six states that prohibit or limit the practice of physician dispensing. (For all but Florida, the prohibitions predate 2007. The Florida Legislature banned physician dispensing of Schedule II and III opioids in 2011.)

### Price-Focused Reforms

The high and rising costs of physician dispensing motivated these reforms. (See below for studies published by WCRI, NCCI, and the California Workers’ Compensation Institute [CWCI] prior to 2012, such as CWCI, 2005; Neuhauser et al., 2006; Lipton et al., 2011; Wang and Victor, 2010; and Wang and Liu, 2011.) WCRI studies consistently showed that prices paid for physician-dispensed drugs were typically substantially higher than what was paid for the same drug when obtained at a pharmacy (Wang, 2012; Wang, Thumula, and Liu, 2013). For example, Exhibit 2 shows the prices paid in 2011 for the most common physician-dispensed drug—hydrocodone-acetaminophen, generic—when dispensed at pharmacies or at physicians’ offices.

Price-focused reforms often limited the reimbursement of repackaged drugs to the fee schedule amount for the same drug based on the average wholesale price (AWP) set by the original manufacturer of the drug—not the typically much higher AWP set by the repackager. The reforms adopted generally reduced prices of physician-dispensed drugs. Exhibit 3 shows average prices paid before and after the reforms for hydrocodone-acetaminophen (Vicodin) in a number of the states that adopted price-focused reforms.

### Utilization-Focused Reforms

States enacting utilization-focused reforms typically set limits on the number of days’ supply of the drug to be dispensed by the physician. Refills would have to be filled at pharmacies. In addition, the Florida Legislature sought to reduce the prescribing of unnecessary opioids by banning physician dispensing of stronger opioids (Schedules II and III).
WCRI found evidence that suggests many of the physician-dispensed opioids were probably unnecessary (Thumula, 2013 and 2014). If the physician-dispensed opioids were necessary, we would expect that the physicians would not change their prescribing practices, but that their patients would get their prescriptions for stronger opioids filled at pharmacies. If the stronger opioids were unnecessary, we would expect no increase in pharmacy dispensing of stronger opioids, but a change in the prescribing practices of physician dispensers to weaker pain medications.

WCRI found little change in pharmacy-dispensed stronger opioids and a substantial substitution to weaker pain medications by physician dispensing. There was little such change in prescribing practices among physicians whose patients had prescriptions for pain medications filled at pharmacies.

Sustainability of Price-Focused Reforms?
WCRI studies annually monitor the change in prices and utilization of physician-dispensed drugs in the period shortly after the adoption of price-focused reforms. Recent studies raise serious questions about whether the price reductions are sustainable. In some cases, the evidence suggests that prices paid for physician-dispensed drugs may be raised even higher than before the reforms.

How can price-focused reforms be less effective in reducing prices? The problem arises through the creation of an opportunity to, once again, assign a much higher average wholesale price (AWP) to a physician-dispensed drug—a practice targeted by the reforms enacted in many states using language limiting reimbursement to a price based on the AWP of the original manufacturer.

How can a new and higher AWP be set for physician-dispensed drugs? Consider a drug where the most common strengths are 5 milligrams and 10 milligrams. If a new strength, say 7.5 milligrams, comes to market, the original manufacturer of that new strength can assign a new AWP, and this AWP could be much higher than the 5-milligram and 10-milligram AWPs set by their original manufacturers.
That is exactly what is seen in the data. For example, prior to the reforms in Illinois, there were two common strengths when cyclobenzaprine HCL was prescribed—5 and 10 milligrams. The average prices paid for cyclobenzaprine HCL of 5 and 10 milligrams ranged from $0.99 to $1.74 per pill.

Prior to 2012, 7.5-milligram cyclobenzaprine HCL was rarely seen in the market. The 7.5-milligram products were introduced in 2012, and almost all were dispensed by physicians at an average price of $3.79 per pill in post-reform Illinois. The market share of physician-dispensed cyclobenzaprine HCL of 7.5 milligrams increased from 0 percent in the third quarter of 2012 to 21 percent in the first quarter of 2013.

In California prior to 2012, 7.5-milligram cyclobenzaprine HCL was also rarely seen in the market. The average prices paid for 5- and 10-milligram cyclobenzaprine HCL, the two common strengths, ranged from $0.35 to $0.70 per pill. Since the introduction of the 7.5-milligram products in 2012, the market share of physician-dispensed cyclobenzaprine HCL of 7.5 milligrams increased from 0 percent in the fourth quarter of 2011 to 47 percent in the first quarter of 2013, when it became the drug’s most common strength dispensed by physicians. The average price paid for the new strength was $2.90 to $3.45 per pill.

Similar evidence was found in the data for a new strength of tramadol HCL (150 milligrams extended release), which appeared in 2012. By the end of 2012, the new strength of tramadol HCL extended release became one of the most common physician-dispensed drugs. The average price paid in California for the new strength was $5.94 to $7.41 per pill, compared with $1.58 per pill for the same extended-release drug of other strengths.

WCRI found little change in pharmacy-dispensed stronger opioids and a substantial substitution to weaker pain medications by physician dispensing.
Because these new-strength drug products were almost all dispensed by physicians at much higher prices, the shift in strength was not likely to have been driven by new evidence about superior medical practices. Rather, it is likely that financial incentives drove some physicians to choose a new strength for their patients. The speed of response to price-focused reforms by the physician-dispensing supply chain raises serious questions about the sustainability of price-focused reforms.

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References:


