POLICY PIONEER HEALTH BRIEF

Prescriber Dispense Makes Sense:

Massachusetts Can Lower Prescription Drug Costs by Joining 45 States that Allow Direct Dispensing

By Josh Archambault, Josh Windham and Dr. Jeff Gold

Introduction

For years, headlines have highlighted lawmakers' concerns over prescription drugs. As drugs have become a larger percentage of overall healthcare spending, patients with insurance plans with a deductible must pay more out-of-pocket for routine medications. When drugs cost patients more, patients are less likely to take them, often leaving serious health problems untreated.

While these problems are complex, Massachusetts lags behind the rest of the country on at least one potential solution: direct prescriber dispensing.

Part of the reason drugs cost so much is that middlemen — commercial pharmacies and pharmacy benefit managers — add substantial costs over wholesale prices. Allowing prescribers to dispense routine drugs — often at a fraction of the price — would give patients a more affordable option. As a policy matter, this is low-hanging fruit in Massachusetts' quest to reduce prices and increase access to care.

Problem: Massachusetts Mostly Bans Prescriber Dispensing, Which Increases Costs

National survey data show that three in 10 adults are not taking their prescribed drugs due to price concerns, with 18 percent not filling their prescriptions due to the price, 21 percent taking an over-the-counter drug instead to try to save money, and 15 percent cutting pills in half or skipping a dose.[1]

High drug prices are due, at least in part, to the middlemen between prescribers and patients: retail pharmacies. When prescriptions are funneled through commercial and hospital pharmacies—especially when pharmacy benefit managers are involved—those middlemen mark up the price of the drug over the wholesale cost of the drug.

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Following eight years of working at a major medical system, **Dr. Jeff Gold** decided to open the first independent Direct Primary Care practice in Massachusetts–Gold Direct Care PC. Based in Salem, Massachusetts, he currently cares for 700 patients and has an Internal Medicine physician partner and recently added a Family NP. He also runs Starseed Group LLC which hopes to have DPC doctors, benefits advisers, TPAs, and self-funded employers collaborate to build employer-sponsored plans that have DPC as the "seed" of the plan with direct contracting for all other services. Dr. Gold has been intimately involved in helping other Massachusetts primary doctors escape the fee-for-service world. He is a cofounder in both the New England DPC Alliance as well as National DPC Alliance. He also is a member of the Direct Primary Coalition.

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These increased costs affect millions of Massachusetts patients. State data shows that, from 2019 to 2020 alone, per-member spending on drugs jumped 8.6 percent for the 71 percent of enrollees with commercial insurance in the Commonwealth[2] and now averages almost $1,000 annually.[3] For patients with high deductible plans — almost half of all those insured in Massachusetts (and 59 percent of small business enrollees)[4] — that cost is almost entirely out-of-pocket for the patient.

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Solution: Allow Prescriber Dispensing to Give Patients a More Affordable Option

Direct prescriber dispensing offers at least one potential solution. The American Medical Association supports the practice as long as physicians prescribe "based solely on medical considerations" and respect "the patient's freedom to choose where to fill prescriptions."[5]

Given the cost benefits, it stands to reason that many patients would choose to purchase medications from their prescriber. Ninety-two percent of prescribers who dispense report the cost of the drugs they dispense to be the same or lower than what patients would pay in a pharmacy.[6] Eighty-one percent of patients who purchase drugs from their prescriber share that perception.[7]

To give a real-world example, Kansas physician Dr. Josh Umbehr, who stores about 300 different drugs on site, compiled the following table about prices at his practice (Atlas) in April 2020:

Medication	Quantity	Retail Price	Wholesale Price	Atlas Price
Amoxicillin/Clavulanate 875mg/125mg	1 bottle (20 pills)	$61.09	$7.40	$8.14
Hydrochlorothiazide 12.5mg	1 bottle (30 pills)	$14.36	$0.79	$0.87
Omeprazole 20mg	1 bottle (30 pills)	$45.83	$0.90	$0.99
Loratadine 10mg	1 bottle (30 pills)	$11.00	$0.92	$1.01
Cyclobenzaprine 10mg	1 bottle (30 pills)	$19.38	$0.72	$0.79
Pioglitazone 15mg	1 bottle (30 pills)	$76.77	$3.59	$3.63
Rosuvastatin 10mg	1 bottle (30 pills)	$147.65	$1.48	$1.63
Sumatriptan 25mg	1 pack (9 pills)	$91.76	$4.95	$5.45
Tamsulosin 0.4mg	1 bottle (30 pills)	$65.99	$1.47	$1.61
Azithromycin 250mg	1 pack (6 pills)	$33.04	$3.99	$4.39

Of course, savings are not a guarantee and patients should be informed of their right to choose where to fill their prescription. But giving patients more choices is better than the status quo, under which there is little meaningful price competition.

Indeed, a comprehensive national study found that almost half of all physicians who directly dispense do so at lower prices than pharmacies, compared with just 8 percent who reported higher prices.[8]

Unfortunately, Massachusetts is one of only five states (along with Texas, New York, New Jersey, and Vermont) that ban prescribers from offering patients this option.[9] The law prohibits prescribers from "general dispensing to patients."[10] A family physician might want to dispense an

antibiotic; an ophthalmologist might want to dispense eye drops after surgery; a dermatologist might want to dispense a topical cream for a rash — all of this is illegal in Massachusetts.

There are a couple of exceptions. Prescribers can dispense "a single dose or quantity" as "necessary for the immediate and proper treatment of a patient until it is possible for the patient to have a prescription filled by a pharmacy." Or they can dispense schedule VI (routine, non-addicting drugs) up to a 30-day supply as free samples.[11] But these are quite narrow and don't help ordinary patients.

To truly reap the benefits of prescriber dispensing, Massachusetts must eliminate its general ban. Montana provides a recent example of what that could look like in practice.[12] In 2021, Montana eliminated its dispensing ban in response to an Institute for Justice lawsuit challenging the ban's constitutionality.[13] The bill passed with broad support—especially after the Montana Pharmacy Association admitted its opposition to previous reforms bills was rooted in economic "protectionism."[14]

Lawmakers should not wait around for a lawsuit. (The Institute for Justice is also currently litigating a constitutional challenge to Texas's ban.[15]) They should be proactive and eliminate Massachusetts' irrational ban on their own.

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Other Potential Benefits of Direct Dispensing

Lawmakers should know that there are other benefits to direct prescriber dispensing besides cost.

No Added Safety Risk — In the past, prescriber dispensing's opponents — namely, organized pharmacy associations — have cited concerns over patient safety. But the nation's first peer-reviewed study of the practice, a 2014 study by tenured pharmacology professor and former pharmacist Dr. Mark Munger, found that prescriber dispensing is safe.[16]

Patients experienced negative reactions to drugs at identical rates whether purchasing them from prescribers or pharmacists. Further, only 6 percent of patients with a serious reaction to a prescriber-dispensed medication sought ER care, compared with 15 percent for pharmacist-dispensed drugs. This may be because patients have a closer relationship with their prescriber, so when a problem arises they feel comfortable calling them for help or asking questions. Or it may be because a patient can take a first dose with a provider and be monitored in office for any immediate reaction.

Utah removed its general ban on prescriber dispensing after hiring Dr. Munger to conduct this research.

Improves Patient Experience, Price Transparency and Saves Time — Allowing patients to purchase common drugs directly from their prescriber puts decision-making back in patients' hands and gives them the freedom to choose a simpler, less time-consuming option. And, for patients who choose that option, it also reduces the number of miles they must drive to pick up a prescription, reducing congestion, greenhouse gas emissions, and pollution.

Reduces Staff Time Spent Coordinating With Pharmacies — Staff at prescribers' offices often spend hours each week on the phone with pharmacies trying to figure out if prescriptions have been filled or dealing with mundane issues with prescription paperwork. Legalizing prescriber dispensing would give them that time back.

Frees up Pharmacists to Focus on Complicated Cases — Pharmacists are important resources for complicated patients on multiple drugs, but they often spend hours a week on run-of-the-mill cases that prevent them from using their expertise to add the most value for patients. The American Pharmacists Association has repeatedly highlighted the problem of burnout and its impact on patient care.[17] Allowing pharmacists to more efficiently partner with patients' providers where it makes sense is a better use of time and resources.

Historically, pharmacists have added an extra set of eyes on prescriptions to look for drugs that should not be combined, but the software they use to look for potentially adverse drug interactions is now widely available to all providers, including physicians.

Increases Prescription Adherence — Patients with chronic conditions often struggle with prescription adherence, which can lead to even more expensive health problems and visits down the line. One well-known way to promote adherence is to connect patients more directly with their prescriber, which allows them to ask questions, gives providers a chance to offer advice about the drug or how to take it, and thereby gives patients more buy-in on the treatment. Knowing that a patient actually obtained the medication, moreover, makes the prescriber more likely to follow up with the patient.

Given all this, it's no surprise that prescriber dispensing increases patients' adherence.[18]

Levels the Playing Field with Big Pharmacy Chains — The irony is that, as big pharmacy chains like CVS and Walgreens shift toward offering more primary care in their stores, they can effectively offer direct dispensing. But in Massachusetts, all other providers remain banned from doing so. Eliminating the ban would level the playing field and allow *all* providers in the Commonwealth to better serve their patients.

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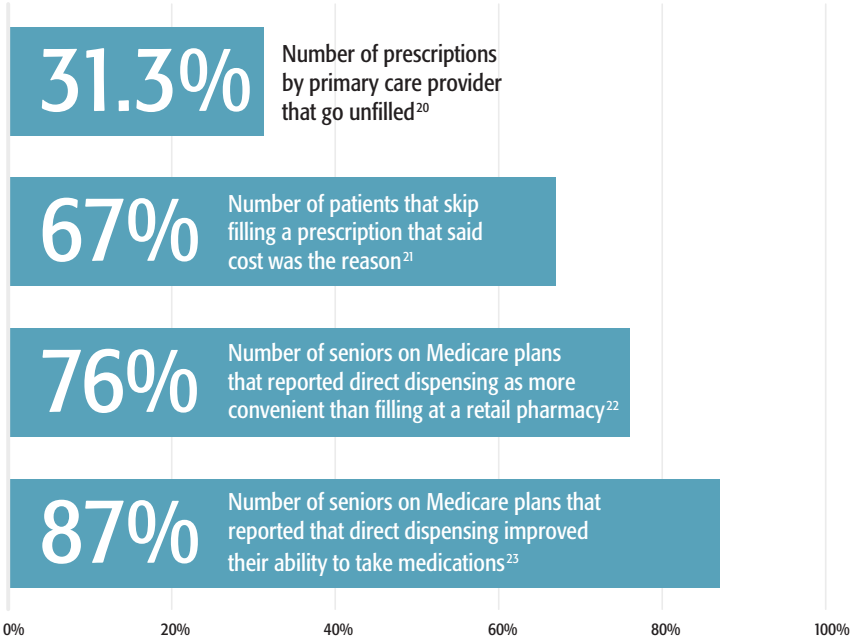
↑29% Increase in medication adherence for seniors on Medicare plans that allowed direct dispensing[19]



Potential Policy Considerations

There are several regulatory approaches Massachusetts could take that would be better than the current general ban.

One approach offered last session was H2235 (An Act to Improve Access to Prescription Medication), which would have allowed physicians to prescribe routine, non-addicting drugs as long as they informed patients of their right to choose where to fill their prescriptions and complied with any labeling, storage, or recordkeeping requirements the Massachusetts Department of Health chose to adopt.[24]

But there are other viable approaches, too. For example, in his 2014 study, Munger found that five states required prescribers to comply with all the same regulations as pharmacies, 26 required them to comply with only some of the same regulations, and 16 required them to register with a state licensing board.[25]

To give lawmakers a full sense of the options, here are some factors to consider:

Labeling, Storage, and Recordkeeping: There are already federal requirements on each of these actions. Therefore, one option would be to avoid imposing additional state requirements or to simply reincorporate the federal requirements by reference. Some states prefer to have their own standards, though, and require prescribers to comply with some or all of their state's pharmacy practice requirements.

Registration: While many states do not require registration for prescribers who dispense, some require registration so they can oversee the practice. If Massachusetts allowed prescriber dispensing for all drugs, one less-restrictive option would be to require registration solely for prescribers who dispense federally controlled substances (i.e., addicting drugs like opioids) under an active DEA registration.

Continuing Education: Some states require prescribers to take continuing education that includes basic training on dispensing. (Similar courses are already common for things like pediatric vaccines administered in office.) If Massachusetts chose to require continuing education, it could task either the Department of Health or the Board of Registration of Pharmacy with administering courses.

Repackaging: Some prescribers may want to repackage the drugs they buy wholesale for direct dispensing. As with labeling, storage, and recordkeeping, repackaging is already regulated under federal law. For example, the U.S. Consumer Product Safety Commission (CPSC) governs the Poison Prevention Packaging Act of 1970 (PPPA).[26] The PPPA already requires special (child-resistant and adult-friendly) packaging of most oral prescription drugs.[27] If Massachusetts chose to regulate repackaging, it would need to spell those standards out.

Dispensing for Profit: Dispensing for profit is already legal in the vast majority of states. It's legal in Massachusetts, too — for pharmacies. Other providers should be given a chance to compete on a level playing field. When they do, they will of course be subject to the same ethical and professional standards that govern all other parts of their practice. If lawmakers find these standards insufficient, they may choose to set some guardrails around pricing, but any guardrails must equally apply to commercial pharmacies.

Who Can Dispense: The more prescribers who can dispense, the more choices patients will have. Today, 45 states allow physicians to dispense, while 38 states allow nurse practitioners to do so.[28] If Massachusetts eliminates its dispensing ban, it should consider doing so for both physicians and nurse practitioners — whom the state recently allowed to practice independently.[29]

Conclusion

Massachusetts has struggled for years with health care affordability and coverage. The General Court says it is looking for ways to lower costs, save patients money, and increase competition in the health care market. Direct prescription dispensing is one potential solution to these problems. Massachusetts should update its laws and legalize prescriber dispensing.

Appendix

Bill Language that Would Allow Direct Dispensing

SECTION 1: Section 9 of Chapter 94C of the General Laws is hereby amended by striking out subsection (b), as so appearing, and inserting in place thereof the following:

(b) Notwithstanding section 17, a practitioner registered under section 7 may, in the good faith exercise of the practitioner's clinical judgment, dispense by delivering to an ultimate user:

(1) Any prescription medication not regulated under this chapter;

(2) Any prescription medication classified by the department as schedule VI subject to such regulations as to safe storage, labeling, and recordkeeping as the department may adopt;

(3) Any prescription medication classified by the department as schedule II–V subject to such regulations as to safe storage, labeling, recordkeeping, dosage, and quantity as the department may adopt.

Before dispensing a prescription medication under this section, a practitioner must inform the ultimate user of their right to purchase the medication from any other practitioner registered under section 7.

This section shall not be construed to restrict a practitioner from dispensing any prescription medication necessary to respond to a medical emergency.

Endnotes

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4 Massachusetts Center for Health Information and Analysis, "Massachusetts Employer Survey," CHIA, (June 2022), Available at: https://www.chiamass.gov/assets/docs/r/survey/Massachusetts-Employer-Survey-CHIA-2021.pdf Note from survey: "The 2021 IRS deductible thresholds were used to define HDHPs ($1,400 for single coverage and $2,800 for family coverage)."

5 American Medical Association, "Code of Medical Ethics Opinion 9.6.6—Prescribing & Dispensing Drugs & Devices," AMA, Available at: https://www.ama-assn.org/delivering-care/ethics/prescribing-dispensing-drugs-devices

6 Mark Munger, et al., "National Evaluation of Prescriber Drug Dispensing, Pharmacotherapy," Utah Division of Occupational and Professional Licensing (2014) Available at: https://dopl.utah.gov/PrescriberDrugDispensing.pdf

7 Ibid.

8 Munger, et al.

9 Mass. Gen. Laws Ann. ch. 94C, § 9(b)

10 Mass. Gen. Laws Ann. ch. 94C, § 19(b); *see also* Mass. Gen. Laws Ann. ch. 94C, § 9(b). The ban covers all "controlled substances," which are defined in Massachusetts to include all medications for which a prescription is required. 105 Mass. Code Regs. § 700.002(F)

11 Mass. Gen. Laws ch. 94C, § 9(b); 105 Mass. Code Regs. 700.010(A)(1)

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17 APhA Media Relations, "Pharmacist Burnout Hits Breaking Point, Impacting Patient Safety," American Pharmacists Association (2021) Available at: https://pharmacist.com/APhA-Press-Releases/apha-pharmacist-burnout-hits-breaking-point-impacting-patient-safety

18 Palacio, et al., "Impact of a Physician-Led Point of Care Medication Delivery System on Medication Adherence," American Journal of Managed Care (2016); 22(7): e264–9

19 Ibid.

20 Robyn Tamblyn et.al., "The Incidence and Determinants of Primary Nonadherence with Prescribed Medication in Primary Care: A Cohort Study," *Annals of Internal Medicine* (2014), Available at: https://pubmed.ncbi.nlm.nih.gov/24687067/

21 Truven Health Analytics, "Truven Health Analytics — NPR Health Poll Finds Costs is Top Cause of Unfilled Prescriptions," Truven-NPR, (2017) Available at: https://www.prnewswire.com/news-releases/truven-health-analytics-npr-health-poll-finds-cost-is-top-cause-of-unfilled-prescriptions-300516467.html

22 American Journal of Managed Care (2016)

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25 Munger, et al. Note that in some states they had to both register and be subject to some of the pharmacy regulations — falling into two categories.

26 15 U.S.C. §§ 1471 *et seq.*

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