

Promoting Preferred Pharmacy Networks

0.4% of Retail
Prescription Drug
Spending (0.04% of Total
Health Spending)

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Authors: Amanda Starc, Northwestern University;
Ashley Swanson, University of Wisconsin–Madison

Issue Summary: The price of pharmaceutical products can vary substantially across pharmacies, even within narrowly defined product categories. As a result, there is significant scope for consumers to lower drug costs if they fill their prescriptions at particular locations. Insurers can create preferred pharmacy networks via selective contracts. The use of preferred pharmacy networks helps nudge policyholders toward locations with lower out-of-pocket costs and increases insurers' bargaining leverage with pharmacies, which can lower the overall price of their members' prescriptions. In the Medicare Part D market, plans with preferred pharmacy networks reduce spending on prescription drugs by approximately 2%. While around 95% of Medicare Part D insurers use preferred pharmacy networks, only half of employers are using narrow or preferred pharmacy networks. Expanding the use of preferred pharmacy networks would lower prescription drug costs for individuals in the US with commercial health insurance.

Policy Recommendation: We encourage employers to pursue and commercial insurers to adopt preferred pharmacy networks. On average, when Medicare Part D plans switch to preferred pharmacy networks, consumers pay lower premiums and lower out-of-pocket prices for drugs, with no concurrent reduction in access to drugs or pharmacies.

Potential Savings: Based on relevant experience with the Medicare Part D market, we estimate the adoption of preferred pharmacy networks will lower drug spending in private insurance plans by approximately 2%. Roughly half of all commercial plans do not have preferred pharmacy networks. Lowering drug spending among this cohort by 2% would result in a savings of more than \$1.34 billion. This represents a reduction of approximately 0.4% of total expenditures in the US on retail prescription drugs.

Related Literature and Evidence:

Preferred Pharmacy Networks and Drug Costs (forthcoming). *American Economic Journal: Economic Policy* (Amanda Starc and Ashley Swanson).

Yes, Commercial Payers Are Adopting Narrow Retail Pharmacy Networks (2017). *Drug Channels Institute* (A. J. Fein).

Background

The price of generic and branded drugs varies significantly across retail pharmacies. For popular branded drugs like Crestor, prices can vary by up to 34% across pharmacies. The variation in prices across pharmacies for identical generic drugs can be even larger. For example, prices for levothyroxine, a generic drug used to treat hyperthyroidism, can vary by up to 40%. Variation in prices across pharmacies on this scale means that payers and consumers can save significant amounts if consumers fill their prescriptions at locations with the lowest prices.

The variation in pricing of pharmaceutical products across pharmacies reflects, in part, variation in insurers' bargaining leverage with pharmacies. If insurers can successfully steer their policyholders to fill their prescriptions at pharmacies with lower prices, the insurers can gain bargaining leverage with respect to pharmacy price negotiations, and ultimately lower the prices of the prescriptions filled by their policyholders.

Selective contracting—the formation of contracted provider networks—is a common tool insurers use to decrease health care costs. However, the cost savings from selective contracting must be weighed against potential welfare losses driven by reductions in individuals' access to providers (in this case, pharmacies). Policy makers and insurers must also consider how the use of selective contracting will impact insurers' enrollment.

Preferred pharmacy networks have become increasingly common. Within Medicare Part D, the proportion of plans with preferred networks increased from 13% in 2011 to 95% in 2019. However, the use of selective contracting is less common in the market for employer-sponsored coverage. Approximately 50% of employer-sponsored plans have limited or preferred pharmacy networks (Fein 2017). As a result, there is significant scope for lowering prescription drug prices at the 50% of insurance plans that do not currently participate in selective contracting with pharmacies.

Evidence Base

The use of preferred pharmacy networks can lower total prescription drug spending and out-of-pocket costs. However, for preferred pharmacy networks to lower prices, insurers must successfully steer their policyholders to preferred locations. Research suggests that plans can steer policyholders to preferred pharmacies by offering lower copayments at those locations. For example, policyholders in Medicare Part D plans with preferred pharmacy networks generally have out-of-pocket costs that are \$6 to \$8 lower per prescription than out-of-pocket costs for identical products at non-preferred locations.

When insurers can effectively steer their policyholders to preferred pharmacies, they can increase their bargaining leverage over drug prices. Part D plans that take advantage of preferred pharmacy networks are able to negotiate 1.9% to 2.3% lower prices.

One concern is that, when plans adopt preferred pharmacy networks, consumers may have to travel farther to get to preferred pharmacies. Indeed, the closest preferred pharmacy is four minutes farther from the average Medicare Part D beneficiary than the closest in-network pharmacy. However, evidence from the Medicare Part D context suggests that the average beneficiary does not travel farther when her plan adopts a preferred pharmacy network. In fact, the average enrollee benefits, due to reduced out-of-pocket costs at preferred pharmacies.

Policy Recommendation

Expanding the use of preferred pharmacy networks across private insurance products will lower drug costs without reducing consumers' access to convenient pharmacies.

Potential Savings

Total spending on retail prescription drugs in 2018 was \$335 billion. Of this, \$134.3 billion was attributable to spending by the commercially insured. Based on relevant experience with the Medicare Part D market, we estimate that adoption of preferred pharmacy networks will lower drug spending in commercial insurance plans by approximately 2%. Roughly half of all commercial plans do not have preferred pharmacy networks. Therefore, applying this 2% reduction to the 50% of plans without selective pharmacy networks would lower drug spending by more than \$1.34 billion. This represents a reduction of approximately 0.4% of retail prescription drug expenditures in the US.

Addendum

This addendum was prepared by the Health Care Affordability Lab at Yale.

Preferred pharmacy networks, which nudge enrollees towards pharmacies with lower out-of-pocket costs, continue to hold promise in generating savings for insurers and policyholders in the commercial market. New research has shed light on how reliably preferred pharmacy networks steer patients, as well as access gaps that policymakers should guard against.

While there hasn't been new research on preferred pharmacies in commercial insurance markets, the strongest new evidence on steering comes from [Xu et al. \(2022\)](#), which compared the same Medicare Part D beneficiaries before and after their plan adopted a preferred network to estimate a causal effect on pharmacy choice. Among beneficiaries without a Low-Income Subsidy (LIS), who faced an average out-of-pocket gap of \$129 a year between preferred and nonpreferred pharmacies, adopting a preferred network raised preferred pharmacies' share of claims by 3.7 percentage points in the first year. LIS beneficiaries, whose cost sharing is capped by law, faced no such incentive and did not switch. Switching among non-LIS beneficiaries was larger where the financial incentive was bigger and where preferred pharmacies were closer or in urban areas. This supports the brief's premise that lower copays can steer cost-exposed enrollees, but shows the effect is moderate and depends on convenient access to a preferred pharmacy.

A companion simulation study, [Xu et al. \(2023\)](#), quantified the cost to Medicare when steering fails. For the roughly two-thirds of LIS beneficiaries who kept using nonpreferred pharmacies, Medicare paid an average of \$170 more per year in low-income cost sharing subsidies than it would have had they switched. These findings suggest preferred pharmacy networks can steer cost-exposed Medicare beneficiaries and save them money where incentives are strong enough—but for low-income beneficiaries, whom the incentives do not reach, they instead shift costs onto the program.

Other research highlights which pharmacies are left out of preferred pharmacy networks and the implications for patient access. A preliminary analysis finds that in 2024, 36% of rural Part D beneficiaries lived in a county with no preferred pharmacy, versus 5% of beneficiaries overall ([MedPAC 2026](#)). Associational evidence by [Guadamuz et al. \(2025\)](#) finds that from 2014 to 2023, independent pharmacies, along with pharmacies in low-income, Black, or Latino neighborhoods, were far less likely to be designated as “preferred.” Pharmacies that weren't preferred by most Part D plans were 70 to 350% more likely to close than pharmacies preferred by most plans. Notably, the authors do not conclude that plans should stop using preferred networks; rather, they recommend that policymakers expand them and set network adequacy standards so pharmacies in underserved areas are not systematically excluded.

New policy developments have changed the landscape of Part D plans with preferred pharmacy networks. The number of standalone Part D drug plans (PDPs) will fall to 360 in 2026, down from 464 in 2025 ([KFF 2025](#)). The share of PDPs offering a preferred pharmacy network is set to fall to 79% in 2026, down from its 98% peak in 2023, based on an analysis of CMS plan files by [Drug Channels \(2025\)](#). The report attributes this contraction to the broad redesign of Part D under the Inflation Reduction Act of 2022. Among other provisions, the law raised the income ceiling for full LIS eligibility from 135% to 150% of the federal poverty level. As Xu et al. show, LIS beneficiaries are insulated from preferred network incentives, so a larger LIS population slightly shrinks the pool of cost-exposed enrollees plans can steer. These changes are specific to Part D, however, and do not weaken the case for preferred networks in commercial and employer plans.

References

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