neighborhood drug store with the classic five-day boxes of azithromycin for $10,[78] rather than boxes actually branded as a Zithromax Z-Pak. Automatic substitution is led by the pharmacist, who is often allowed to substitute a generic for a branded drug when available, and the public enjoys billions of dollars of savings with no action required on the part of either patients or doctors.[79] Automatic substitution laws, known as state "drug product selection" (DPS) laws, exist in all fifty states to permit this action. In some states, automatic substitution is *required* when the generic equivalent is available. The patient's incentives are also usually aligned with those of insurers and others involved in the payment process, who wish to pay less whenever possible and thus heavily promote the use of generics in their own lists of covered drugs. When generic substitution works, it works well, and generally to the benefit of patients – given the complexity of the system, it is impressive.

Today, almost 90 percent of all prescriptions in the United States are filled using generic medication,[80] and 81 percent of all small-molecule drugs – your standard pills and potions – have a generic equivalent.[81] When a generic is introduced into a market previously monopolized by a brand-name drug, the generic drug normally enters at a 20 percent discount from the branded medication within six months of launch, and the price falls quickly from that point.[82] Eventually, most generics are priced at an 80 to 85 percent discount from their name-brand equivalents.[83] Prices can even fall to 10 percent of the original cost when many generics enter the market.[84] And, as noted previously, the brand-name drugs sold at the higher price quickly lose substantial market share. As an example, one recent study on the introduction of generic Lipitor found that the introduction of just a couple of generics decreased the number of brand-name prescriptions by 18 percent just one month

[78] *See Medicine Use and Shifting Costs of Healthcare: A Review of the Use of Medicines in the United States in 2013*, IMS Inst. for Healthcare Informatics at 15 (Apr. 2014), www.imshealth.com/en/thought-leadership/ims-institute/reports/use-of-medicines-in-the-us-2013#ims-form ("The average co-pay for 78.6% of all retail dispensed prescriptions was $10 or less.").

[79] *See* Michael A. Carrier, *A Real-World Analysis of Pharmaceutical Settlements: The Missing Dimension of Product Hopping*, 62 Fla. L. Rev. 1009, 1017 (2010).

[80] *See Implementation of the Generic Drug User Fee Amendments of 2012 (GDUFA): Hearing Before the H. Comm. on Oversight & Gov't Reform*, 114th Cong. 1 & chart.1 (2016) (statement of Janet Woodcock, Director, Ctr. for Drug Evaluation & Res., U.S. Food & Drug Admin.); *see also* IMS Inst. for Healthcare Informatics, *supra* note 78, at 51.

[81] *See* Ernst R. Berndt & Murray L. Aitken, *Brand Loyalty, Generic Entry and Price Competition in Pharmaceuticals in the Quarter Century after the 1984 Waxman-Hatch Legislation* 4, 6 (Nat'l Bureau of Econ. Research, Working Paper No. 16431, 2010), www.nber.org/papers/w16431.pdf.

[82] *See ibid*. at 9–10, 10 fig.2.

[83] *See Facts about Generic Drugs*, U.S. Food & Drug Admin., www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/UnderstandingGenericDrugs/ucm167991.htm (last updated June 28, 2016).

[84] *See* Berndt & Aitken, *Brand Loyalty*, *supra* note 81, at 9, 10 fig. 2.