



Prescription Policy Choices

Best Practices  
model policies

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## **MODEL POLICIES: ALTERNATIVES TO PRESCRIPTION DRUG CAPS**

There are many alternatives to adopting monthly or yearly caps on prescription drug prescriptions which also save money. Most states will be able to achieve savings in Medicaid and other state health care programs by adopting one or more of the following innovations:

### **PURCHASING POOLS**

States can use the leverage of larger numbers of “covered lives” to negotiate for discounts in drug costs through purchasing pools that include several programs in one state (such as Medicaid, elderly assistance, state employees, workers’ compensation) or one or more programs in several states. This strategy is most effective when combined with a Preferred Drug List (PDL) to promote clinically appropriate alternatives that are the most cost effective in each individual state. Examples are the ***Sovereign States Drug Consortium - SSDC (Iowa, Maine & Vermont)***, a first in the nation, state-administered Medicaid supplemental drug rebate pool which received federal approval in July 2006, and the ***Northwest Prescription Drug Consortium (Oregon & Washington)*** initiated in August 2006. Two other Medicaid pools have been approved by CMS besides the SSDC;<sup>1</sup> a 2005 survey found that 6 of 37 states surveyed reported pooling drug purchasing across several states, and 3 states pooled purchasing across several state programs.<sup>2</sup>

- **Cost savings:** Vermont reported its Medicaid program achieved actual cost-savings of \$1 million due to its participation in a purchasing pool in 2004. Maine also reported savings of \$1 million for the period between November 2005 and July 2006. Other states have registered a range of estimated cost-savings from their participation in purchasing pools in 2006: Iowa (\$1.8 million), West Virginia (\$16 million), and Maryland (\$19 million). In concert with its PDL, Iowa expects its total savings to reach \$11 million a year. New York estimated total savings as high as \$392 million for 2006-07.<sup>3</sup>

### **AVOIDING THE MIDDLEMAN**

States negotiating rebates, whether through inter- or intra-state purchasing pools, can insure that they achieve the greatest savings by directly negotiating rather than going through a middleman vendor such as a pharmacy benefit manager. At a minimum, states should require transparency, a fiduciary relationship, and annual audits with any PBM they contract with to insure that they receive the full value of any negotiated discounts, rebates or other financial consideration.

- **Cost savings:** Several recent reports have pointed to the value of transparency requirements in achieving savings for state government. A plan prepared for the Governor of Oregon by the Heinz Family Philanthropies recommended Oregon “require the greatest level of transparency possible” with PBMs as well as annual audits of the PBMs and insurance companies the state contracts with to insure that rebates are passed through.<sup>4</sup>

A report to the Illinois Commission on Government Forecasting and Accountability recommended the state stop using PBMs entirely, or at least require a fiduciary relationship. By directly negotiating pharmacy benefits in its state employee health plan instead of paying a PBM \$2.81 per enrollee per month to negotiate on its behalf, the report estimated savings of \$1.35 per claim or about \$10 million per year.<sup>5</sup> In South Dakota, well over \$800,000 has been saved in state health insurance costs in a single year as the direct result of a more transparent business model required by their law.<sup>6</sup> The University of Michigan dropped the five benefit managers it had been working with, hired a single new manager that has less control over how the drug plan is administered, and imposed strict new transparency rules, enabling UM to hold its drug spending to \$43 million in 2003, or \$8.6 million less than it would have paid under the previous plans.<sup>7</sup>

### **PREFERRED DRUG LISTS (PDL)**

At least 40 states have some PDL policies that apply to Medicaid and at least 13 states also have sought to use PDLs for other programs, such as programs to provide reduced-price drugs to the elderly or disabled.<sup>8</sup> Another recent study put the number of states with “enforceable” Medicaid PDLs at 34.<sup>9</sup> PDLs combined with a prior authorization (PA) program can effectively cut program costs without negatively affecting patient health, as long as needed medications can still be prescribed in a timely manner.

- *Cost savings:* Maine’s PDL, which has been in place for many years and is one of the most comprehensive, has kept state Medicaid drug cost increases below 3% annually, at a time when the Federal government estimates average annual increases around 13%.<sup>10</sup> West Virginia implemented a PDL in 2003 and saw zero percent growth in its pharmaceutical expenses in 2004 compared to a prior annual growth rate of 16%.<sup>11</sup> The Georgia Medicaid program reduced its prescription-drug costs by \$20.6 million over a one-year period by requiring enrollees to get permission before filling prescriptions for anti-ulcer medications called proton pump inhibitors (PPIs).<sup>12</sup> Florida has achieved significant savings for its 2.2 million Medicaid recipients with its PDL. Between 2000 and 2002, savings reached almost \$500 million.<sup>13</sup>

### **PROMOTING GENERICS**

States have a variety of policies to promote generic use, including requiring the generic to be dispensed when available unless the treating medical provider overrides; generics are also promoted through preferred drug lists, lower co-pays, and academic detailing.<sup>14</sup> Even though many states already have policies to promote generics, significantly more could be saved in the next several years because the patents of many top-selling brand name drugs are expiring - in fact, drugs currently accounting for more than \$38 billion in sales will lose patent protection by 2009.<sup>15</sup>

- *Cost savings:* On average, a generic drug costs about \$45 less than a brand name drug and it is estimated that for each 1% increase in generic fill rate, pharmacy spend decreases by 1%.<sup>16</sup> According to the generic drug industry, Massachusetts saved more than \$150 million by changing a policy related to the way doctors can prescribe brand drugs when a generic is available, and Texas saved more than \$223 million simply by changing its prescription pads, making it easier for doctors to prescribe generics. Florida saved roughly \$30 million by eliminating special brand name “carve outs” in its Medicaid program.<sup>17</sup> The Georgia prior authorization program for anti-ulcer medications increased the use of generics from 31% to 79% for net savings of \$20.6 million the first year.<sup>18</sup>

## COMMUNICATING EFFECTIVENESS AND SAFETY EVIDENCE

Academic detailing and other programs aim to provide better information to medical providers and consumers about which drugs are the most effective and have the least adverse effects, and the costs of these drugs. Pennsylvania has operated an academic detailing program since October 2005. Maine has required internet posting of all clinical trials results, including adverse results since October 2005 and a state public education campaign on safety & effectiveness. More than a dozen states are involved in the Oregon Drug Effectiveness Review Project. New York's PDL law requires the state to join the Oregon project.

- *Cost savings:* Although it is early in the implementation of Pennsylvania's program to be able to calculate savings, a formal benefit-cost analysis of a 4-state Medicaid study involving 435 doctors showed savings of \$2 for every \$1 the program cost, based on just Medicaid paid claims data.<sup>19</sup> The challenge in implementing this program is the need to invest money in order to save money, and figuring out how to come up with the initial financing. One option is to use funds collected in settlements in Medicaid fraud cases such as the 2004 global settlement of the Neurontin marketing case.

## 340(B) PRICING UNDER THE FEDERAL PUBLIC HEALTH ACT

Another policy option for increasing savings and expanding access to prescription drugs is to maximize participation in 340B pricing under the federal Public Health Act. The 340B price is 19% below the average Medicaid "best price" net or rebates, 39% below the average insurance reimbursement, and 51% less than AWP.<sup>20</sup> One obvious strategy to maximize savings even in a pilot program is to target the most costly aspects of the pharmacy program, such as transplant recipients, hemophiliacs, People Living With HIV/AIDS, or other categories of patients with expensive and chronic disease states. 340B programs are ongoing in several states, including Oregon, Texas, Massachusetts, and Connecticut.<sup>21</sup>

- *Cost savings:* An Oregon pilot project allows the Medicaid programs to gain access to 340B pricing for AIDS Drug Assistance Program patients. This will result in an approximate 10% savings, yet the actual dollars saved will be greater due to the high morbidity and high costs of the patient population. In addition, the State will realize greater indirect savings due to an increase in prescription adherence and the resulting improvement in outcomes. This same model can be used for HIV positive prisoners to create savings for the State Corrections Department.<sup>22</sup> The Texas Department of Corrections has a contractual relationship with two hospitals that are 340B eligible providers and has been able to access drugs for inmates at "dramatically reduced prices."<sup>23</sup>

## FALSE CLAIMS ACTS

The Federal False Claims Act has been used in litigation against PBMs, chain drugstores and pharmaceutical manufacturers for fraudulent pricing and billing practices including drug switching, false reporting of Medicaid 'best price', short-filling prescriptions, failure to pay rebates, kickbacks and side deals. States involved in these federal cases, or bringing claims under similar state laws, have recovered millions of dollars.

- *Cost savings:* A 2006 report concludes that every dollar invested by the government in investigation and prosecution of federal health care fraud returns \$15 back to the American people.<sup>24</sup> States frequently share in these recoveries. For example, in August 2006 the drug manufacturer GlaxoSmithKline agreed to a \$70 million settlement with Arizona, California, Connecticut, Montana, Nevada and New York over allegations that the company artificially inflated average wholesale prices of prescription drugs. Thirty-four

other states and the District of Columbia also will be eligible to receive part of the settlement.<sup>25</sup> Recent changes in federal law create a financial incentive (an additional share of any recovery based on Medicaid funding formulas) for states to enact false claims laws that are as effective as the federal law. The additional recovery could be considerable. For example, in the recent Serono settlement, New York state recovered \$80 million. If New York had a qualifying False Claims Act, however, it would have gotten \$96 million -- an additional 20% over its initial recovery, or \$16 million.<sup>26</sup>

(Updated April 2008)

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<sup>1</sup> Maine Governor Baldacci's press release, August 2, 2006.

<sup>2</sup> Crowley & Ashner, "State Medicaid Outpatient Prescription Drug Policies: Findings of a National Survey, 2005 Update," (October 2005).

<sup>3</sup> National Conference of State Legislators at <http://www.ncsl.org/programs/health/bulkrx.htm#SSDC>.

<sup>4</sup> Lewis, "The Oregon Blueprint," at 11-12.

<sup>5</sup> "Potential for Savings on Pharmacy Benefit Management Costs," Illinois Commission on Government Forecasting and Accountability, prepared by Winkelman Management Consulting (April 2006) at 11-16.

<sup>6</sup> Email communication between Deborah Bowen, then South Dakota Insurance Commissioner, and RxPlus Pharmacies, February 2006; confirmed in telephone communication between Debra Bowen, now SD Social Services Director, and Ann Woloson of Prescription Policy Choices (August 7, 2006 email communication from Ann Woloson).

<sup>7</sup> Katz, David. "Drug Discount Peddlers" CFO.com 10/28/05

<http://www.cfo.com/printable/article.cfm/5079733?f=options> and Saxl, Michael. "Making PBMs Work for North Dakota" <http://www.legis.nd.gov/assembly/59-2005/docs/saxlpresentation.ppt>

<sup>8</sup> "Pharmaceutical Preferred Drug Lists (PDLs) - State Medicaid and Beyond," Compiled by Richard Cauchi, Program Director, NCSL Health Program, revised 9/15/2005.

<sup>9</sup> Lewis, "The Oregon Blueprint," at 13.

<sup>10</sup> "MaineCare Cost Trend Analysis, FYs 1998-2004," Maine Governor's Office of Health Policy & Finance.

<sup>11</sup> Pew Center on the States, "Special Report on Medicaid 2006," accessed on September 11, 2007 at

<http://www.governing.com/medicaid/drug.htm>.

<sup>12</sup> See Medical News Today reporting on January 2005 study in the American Journal of Managed Care, see:

<http://www.medicalnewstoday.com/medicalnews.php?newsid=18888>

<sup>13</sup> Pew Center on the States at <http://www.governing.com/medicaid/drug.htm>.

<sup>14</sup> Crowley & Ashner, "State Medicaid Outpatient Prescription Drug Policies: Findings of a National Survey, 2005 Update," (October 2005).

<sup>15</sup> Express Scripts Report, 2005.

<sup>16</sup> Ibid.

<sup>17</sup> Source: Generic Drug Association, accessed at:

[http://www.gphaonline.org/AM/Template.cfm?Section=State\\_Affairs&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENTID=1967](http://www.gphaonline.org/AM/Template.cfm?Section=State_Affairs&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENTID=1967)

<sup>18</sup> Medical News Today reporting on January 2005 study in the American Journal of Managed Care, see:

<http://www.medicalnewstoday.com/medicalnews.php?newsid=18888>

<sup>19</sup> Email from Dr. Jerry Avorn, March 22, 2006; see "Economic and Policy Analysis of University-Based Drug 'Detailing,'" by Stephen B. Soumerai and Dr. Jerry Avorn, *Medical Care*, Vol. 24, No.4, April 1986. Dr. Avorn noted in my conversation with him that The Cochrane Group also did a formal evaluation of academic detailing studies and judged the intervention effective in improving prescribing.

<sup>20</sup> Lewis, "The Oregon Blueprint" at 18.

<sup>21</sup> Ibid.

<sup>22</sup> Email communication to Sharon Treat from Jason Hardaway, Wellpartner, 3/22/06

<sup>23</sup> Lewis, Oregon BluePrint at 66.

<sup>24</sup> Taxpayers Against Fraud report accessed at: <http://www.taf.org/FCA-2006report.pdf>

<sup>25</sup> "GlaxoSmithKline Settles Civil Suits for \$70 Million," REUTERS NEWS SERVICE, August 11, 2006; Wall Street Journal; see this and other articles excerpted and posted at

[http://www.kaisernetwork.org/daily\\_reports/rep\\_index.cfm?DR\\_ID=39086](http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=39086)

<sup>26</sup> See Taxpayers Against Fraud materials at <http://www.taf.org/cashbackstatefca.htm>