

PURCHASING POOLS COMBINED WITH A PREFERRED DRUG LIST

Facing double-digit annual increases in prescription drug costs in their Medicaid budgets, states are looking at every alternative to cut costs. One very effective policy that saves money without restricting access to needed medicines is to join a purchasing pool. States are leveraging their collective covered lives to negotiate for discounts in drug prices 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. States negotiate rebates from the drug manufacturers based on actual utilization; the more states in a pool, the more utilization, and, thus, the greater the rebate negotiated. This strategy is most effective when directly negotiated so that states control access to prescribing data and rebate information, and when combined with a Preferred Drug List (PDL) to promote clinically appropriate alternatives that are the most cost effective in each individual state.

EXAMPLES OF MULTISTATE PURCHASING POOLS

Sovereign States Drug Consortium: Iowa, Maine & Vermont

The Sovereign States Drug Consortium (SSDC) is a first in the nation, state-administered multi-state Medicaid supplemental drug rebate pool. It received approval from the federal Centers for Medicaid and Medicare Services (CMS) on July 20, 2006. Each state in the consortium has its own PDL; preferred products may be generics, low cost brands, or higher cost brands where the drug manufacturers provide a financial incentive to have their products preferred. One of the key components to the SSDC is that any state can participate regardless of whether it administers its Medicaid pharmacy benefit through internal or contractual resources. Another distinction is that the process is completely transparent: all participating states have access to all bids by pharmaceutical manufacturers; bids are collectively reviewed and states independently decide which approach is most appropriate. In contrast to vendor-administered pools which are "owned" by the vendor, SSDC is entirely owned by the participating states. Pool activities include data compilation, rebate bid solicitation, bid review and clinical criteria development. The Consortium is actively seeking additional member states.¹ As of June 2007, Utah was seeking federal approval to join.²

Northwest Prescription Drug Consortium: Oregon & Washington

This program was initiated, and an RFP seeking bids was announced, in August 2006. The consortium came into effect in 2007 and began joint purchasing. It brings together the Oregon prescription-drug plan, a purchasing pool for low-income people 55 and older to access below-market price drugs, with a similar plan in Washington State. Oregon's drug purchases for Medicaid are not part of the two-state cooperative.

Other Purchasing Pools

In addition to the SSDC, two other Medicaid pools have been approved by CMS.³ These are the “National Medicaid Pooling Initiative” (NMPI) with 10 member states as of mid-2006 and the “Top Dollar Program” (TOP\$) with 7 member states as of mid-2007. Another pool, the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP), negotiates purchasing for agencies and clinics (excluding Medicaid) in 43 states.⁴

COST SAVINGS ASSOCIATED WITH PURCHASING POOLS

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 2006-07.⁵

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 prices rather than going through a middleman vendor such as a pharmacy benefit manager (PBM). The Sovereign States pool is following this model. At a minimum, states should require transparency, a fiduciary relationship, and annual audits with any PBM or other vendor they contract with to insure that they receive the full value of any negotiated discounts, rebates or other financial consideration. The Northwest pool has built transparency requirements into its vendor RFP.

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.⁶ 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.⁷ In South Dakota, well over \$800,000 has been saved in state health insurance costs in a single year as the result of a more transparent business model required by law.⁸

PREFERRED DRUG LISTS (PDLs)

Purchasing pools are most effective when coordinated with a PDL, since in this way the pool can negotiate the best prices with manufacturers by guaranteeing preferred status for particular drugs that the state determines meet its clinical requirements. According to the National Conference of State Legislatures, as of late 2005, more than three-

quarters of the states had enacted, authorized or created some type of PDL as part of a cost containment strategy. 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.⁹ Another recent study put the number of states with “enforceable” Medicaid PDLs at 34.¹⁰ PDLs combined with a prior authorization (PA) program can effectively cut program costs without negatively affecting patient health, as long as best practices are followed and needed medications that are not on the preferred list 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%.¹¹ 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%.¹² 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).¹³ Florida has achieved significant savings for its 2.2 million Medicaid recipients with its PDL. Between 2000 and 2002, savings reached almost \$500 million.¹⁴

(Updated April 2008)

¹ “Iowa Joins Maine, Vermont in Prescription Drug Purchasing Pool,” posted Aug 04, 2006, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=38939; see also Maine Governor Baldacci’s press release, August 2, 2006.

² National Conference of State Legislators, “Pharmaceutical Bulk Purchasing: Multi-state and Inter-agency Plans, 2008 edition,” accessed on April 20, 2008 at <http://www.ncsl.org/programs/health/bulkrx.htm#SSDC>.

³ Maine Governor Baldacci press release, August 2, 2006.

⁴ National Conference of State Legislators at <http://www.ncsl.org/programs/health/bulkrx.htm#SSDC>.

⁵ National Conference of State Legislators at <http://www.ncsl.org/programs/health/bulkrx.htm#SSDC>.

⁶ Lewis, “The Oregon Blueprint” at 11-12.

⁷ “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.

⁸ 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).

⁹ “Pharmaceutical Preferred Drug Lists (PDLs) - State Medicaid and Beyond,” Compiled by Richard Cauchi, Program Director, NCSL Health Program, revised 9/15/2005.

¹⁰ Lewis, “The Oregon Blueprint,” at 13.

¹¹ “MaineCare Cost Trend Analysis, Fiscal Years 1998-2004,” Maine Governor’s Office of Health Policy & Finance.

¹² Pew Center on the States, “Special Report on Medicaid 2006,” accessed on September 11, 2007 at <http://www.governing.com/medicaid/drug.htm>.

¹³ 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>

¹⁴ Pew Center on the States at <http://www.governing.com/medicaid/drug.htm>.