The Best Medicine at the Best Price

Proven State Strategies for Lowering Rx Costs and Protecting Public Health Care Programs

By Dana Warn

Northwest Federation of Community Organizations (NWFCO)

January 2003

Acknowledgements

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Executive summary

Across the Northwest, economic recession has increased unemployment rates and tightened state budgets. As Northwest states face state budget challenges, these states have cut or threatened to cut vital public health care programs.

Recent cuts to Northwest public health care programs include: capping enrollment, cutting dental coverage, and increasing cost sharing requirements for Medicaid consumers. These cuts limit access to public health care programs, just when residents — dealing with rising unemployment — need them most. These cuts often increase long term costs to the state, because people must defer care, and easily treatable problems can become crises. But these cuts do nothing to address the fastest rising costs in health care today: prescription drugs.

Prescription drug costs are rising rapidly across the nation and the Northwest, in all types of health care programs. Meanwhile, the prescription drug industry continues to be one of the most profitable in the world, despite the recent economic downturn.

While some states have implemented strategies that harm consumers and don't address rising prescription drug prices, other states have started negotiating lower prescription drug prices from the extremely profitable pharmaceutical companies — and they are already saving money. By using multi-agency and multi-state prescription drug purchasing pools and/or preferred drug lists, states have projected or realized savings of 5 to 15 percent of their total prescription drug costs.

By using these strategies, the Northwest states of Idaho, Montana, Oregon, and Washington would likely realize similar savings. Saving between 5 and 15 percent of their total prescription drug costs would have resulted in Northwest states saving between $55 million and $165 million for the most recent year of available data. Any group allowed to purchase with state agencies should receive a similar percentage savings. For the most recent year of available data, between 5 and 15 percent savings would have resulted in the uninsured in the Northwest saving between $43 and $130 million. The uninsured would likely save a higher percentage than state agencies, as the uninsured already pay the highest prices for prescription drugs.

As prescription drug costs continue to rise, the exact amount state agencies and the uninsured could save by using these strategies will rise as well. Rather than slashing Medicaid and making health care more difficult to access, Northwest states should change how they purchase prescription drugs by pooling their prescription drug purchases, opening these pools up to the underinsured and uninsured, private entities, and local units of government, and creating a shared preferred drug list with proper consumer protections.

Background

Difficult times for residents and state budgets

Across Northwest states, economic recession, worsened by the aftermath of the September 11 attacks, has increased unemployment rates and tightened state budgets. Recent tax cuts have exacerbated this situation.

Nationwide, 19 states have reported their current year spending has exceeded budgeted levels, 17 states are expecting a budget shortfall of 5 percent or more, and revenues for fiscal year 2002 were below estimates in 44 states.[1] More than two-thirds of the states have considered or implemented budget cuts for the current or upcoming fiscal year,[2] with many states focusing on public health care programs, citing concerns about rising costs.

Times are difficult for residents, too. Over the last year, unemployment increased over 0.5 percent in every state. The western U.S. had the largest increase in unemployment, increasing more than 1.5 percent.[3] At the same time, employment in most major industries dropped — with manufacturing, transportation, and public utilities experiencing widespread declines.[4] Cuts to public health care programs only increase the difficulties for those state residents who lose their jobs or health insurance.

Northwest state challenges

Current projections show a Montana general fund deficit of nearly $250 million for the 2004-2005 budget,[5] and Governor Martz's proposed budget includes deep cuts, a $93 million transfer from the permanent coal trust, and no tax increases.[6] These cuts come shortly after a previous round of across the board budget cuts, including almost $70 million in cuts to the Department of Public Health and Human Services (DPHHS) programs alone since April, 2002.[7] And the state is seeking a waiver that will allow it to make deeper cuts to the Medicaid program in the future.

Oregon has recently proposed or made budget cuts in K-12 and higher education, Medicaid, and TANF,[8] in addition to transportation, arts and environmental protection spending.[9] A biennial legislature, Oregon has held five special sessions to deal with budget shortfall issues. In the fifth special session, the legislature cut $310 million across the board from state agencies. Most of these cuts will be rescinded if Measure 28 is enacted by the voters and special election on Jan. 28, 2003. Around $88 million of these cuts come from the Department of Human Services.[10] Unemployment in Oregon is the highest in the country, at 7.0 percent, well over the national average of 5.7 percent.[11]

In 2002, Idaho experienced a significant budget shortfall, and the deficit for 2003-2004 could reach as much as $200 million.[12] Governor Kempthorne ordered $55 million cut from the $2 billion 2001-02 state budget, and $100 million cut in basic spending for 2003, to accommodate lower than expected tax collections[13] — although in 2001 Idaho permanently cut $114 million in taxes.[14] Budget diffi-

culties also hit families hard. In October 2002, Idaho's unemployment was 5.5 percent.[15] In rural Idaho, jobs in timber and mining have become scarcer, and increased employment in the lower-wage service and tourism industries has not been an adequate replacement.[16] Plants are also closing or preparing for huge layoffs in this tough economy.

In Washington, Boeing plans to layoff up to 30,000 workers companywide in response to a downturn in the airline industry, with an additional 5,000 to be cut primarily from the Puget Sound area in 2003.[17] The Office of Financial Management says the Boeing layoffs alone could mean a drop in state revenue of up to $900 million,[18] and tax cuts from 1994 to 2000 reduced 2001-2003 state revenue by $2.4 billion.[19] The projected deficit for the 2003-2005 biennium is around $1.6 billion just to maintain current services. Adding three other customary services brings the deficit to $2.5 billion[20] — but could grow even larger. State revenue problems are projected to continue into the foreseeable future.[21] The state's unemployment rate has increased over the years as well, to 6.7 percent,[22] well above the national average of 5.7 percent,[23] creating tough times for Washington residents.

The problem

Prescription drugs: the real cost driver

Although health care costs across the nation in all types of health care programs have been rising, much of this cost increase is due to the rising costs of prescription drugs. Across the nation, prescription drugs are the fastest growing cost in health care spending,[24] creating a crisis for private and public programs alike.

Drug costs have disproportionately contributed to the sharp upturn in overall health care costs over the last few years.[25] Prescription drug spending accounted for over a quarter of the growth in overall health care spending in 2000 and is one of the reasons that, in 2000 and 2001, health insurance premiums rose at the fastest pace in over a decade.[26] Reasons for rising prescription drug costs include:

- Drug prices that often rise faster than inflation;
- Increased marketing of medicines to doctors and consumers;
- Investment by pharmaceutical manufacturers in spin-off formulations of existing drugs that maintain patent — and therefore market — protections, but not necessarily improve treatment; and
- An aging population with increased prevalence of chronic conditions.[27]

Total U.S. spending on prescription drugs tripled from 1990 to 2000. Consumer spending on outpatient prescription drugs at retail outlets in the U.S. rose more than 17 percent from 2000 to 2001, the

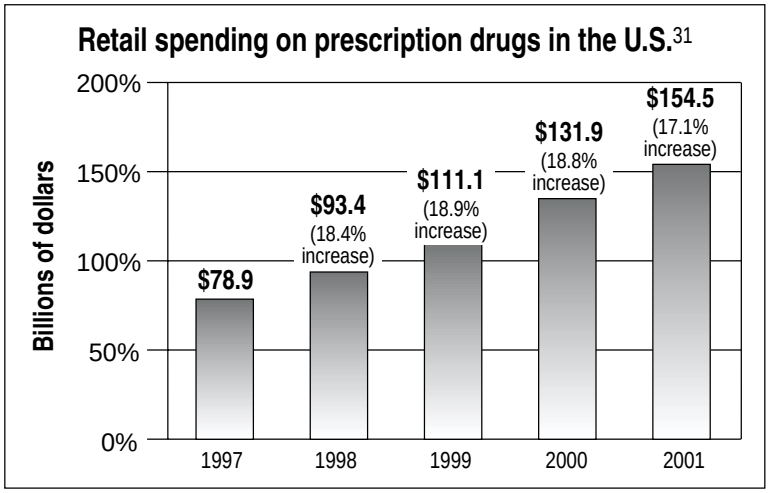
Kay Unmuth
Bellevue, Washington

I retired in 1993 after a lifetime of working. During the last several years, I ran my own home business and purchased a small residential property for additional income. I sold this property to pay off my condo and invest for the future.

I currently take ten prescription drugs on a regular basis: five for back pain, several for my chronic sinus infection, one for my heart, and one anti-migraine medication. This medicine has grown very expensive. For example, when I started taking the anti-migraine pills they were $10.76 each. Now they cost $21.34 — almost twice as much.

My monthly retirement income is $1,366 and my monthly drug costs are $371.10 — 35 percent of my income. While the income has remained fairly constant over the years, my annual drug costs have almost tripled — going from $1,559 in 1995 to $4,453 in 2001. I constantly have to price shop to find prescriptions that are affordable.

It bothers me that after working so hard to be self-sufficient and financially stable I continue to struggle with health care costs. At the same time, the drug companies can just charge what they want and earn the highest profit margin on the planet. It just doesn't seem fair.



fourth year in a row of rapid growth.[28] Prescription drug expenditures are projected to continue to rise faster than any other medical service over the next decade. Other factors that have increased health care spending include rising hospital costs[29] and new medical treatments.[30]

State Medicaid programs have not escaped this trend of rising health care costs due to prescription drug spending.

Medicaid spending on prescription drugs nationally increased at an average of 18 percent per year from 1997 to 2000, slightly lower than the average annual increase in spending on outpatient prescription drugs at retail outlets during the same period.[32] And in a survey of Medicaid officials, 48 states cited pharmaceutical costs as one of the top reasons for Medicaid cost increases in 2001.[33] Other factors that have increased Medicaid spending include general medical inflation, increases in provider payment rates to catch up with inflation, and increased enrollment.[34]

State examples of increasing prescription drug costs

In Idaho, pharmaceutical costs account for 12.4 percent of the Medicaid budget, and from fiscal year 1994 to fiscal year 1998, total drug costs grew almost 17 percent.[35]

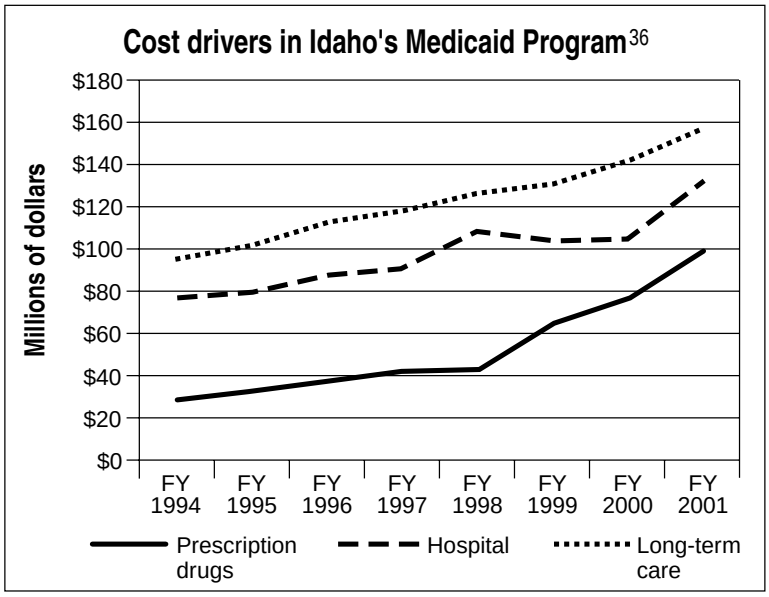
Lina Boswell
Boise, Idaho

I am a disabled diabetic and I have prescription drug coverage through my husband, Herb's insurance policy. Since he retired in 1985, Herb and I have been struggling to live on a low monthly pension.

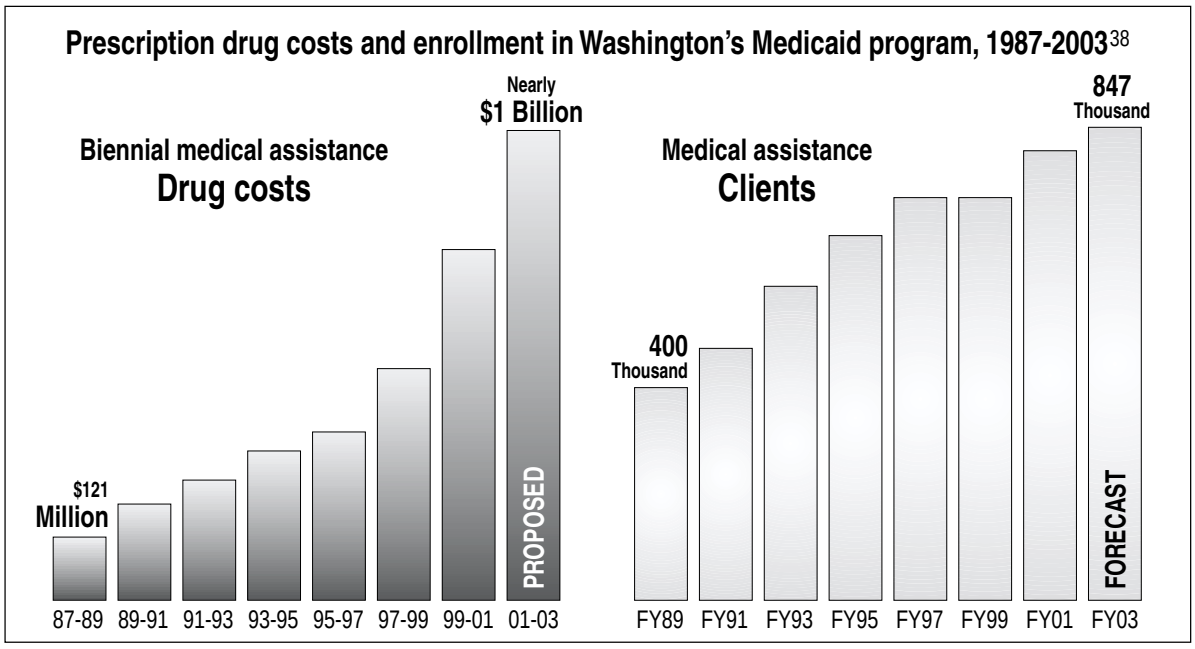
Our insurance policy makes us cover the first $500 on each regular illness. I should have regular check-ups with my doctor, but I cannot afford them. Each check-up costs me $60 for the visit and $90 for the blood test. My prescription drug co-payment costs are even higher. I pay 20 percent of the first $500 (it used to be the first $2,500 in the '80s). After I reach the $500 limit I have to pay for the medication entirely out of my own pocket. Since my monthly prescription cost is $350, I reach the cap in February and must purchase the rest of the year's prescriptions myself.

As a result of these costs, I have cut back on my medicine by 70 percent, and reduced my visits to the doctor, putting my health and life at a great risk. I applied for Medicaid, but was denied assistance, despite my inability to work.

It's getting worse. My insurance company keeps increasing the premiums (they went from $35/month in 1985 to $265/month in 2002) and lowering the coverage. If my insurance would cover my prescriptions or if I had more money, then we could buy the prescriptions in three-month supplies and save 30 percent. Instead, we have to scrape by month to month and pay higher and higher prices for medication.



Prescription drug spending is a large cost driver in Washington; prescription drug spending in state programs increased over 20 percent from 1998 to 1999.[37] From 1987 to 2003 the Department of Social and Health Services projected an eight-fold increase in the prescription drug costs paid by medical assistance, while the number of enrollees in medical assistance programs was only projected to double.



Vital health care programs targeted for cuts

Northwest states have dealt with rising prescription drug costs by cutting access to public health care programs. Unfortunately, these cuts do little to address the underlying problem of skyrocketing prescription drug prices.

Recent cuts to Northwest public health care programs include: capping enrollment in the Children's Health Insurance Program (CHIP), cutting adult dental coverage, increasing out-of-pocket spending requirement for Medicaid consumers, cutting immigrant health care programs, and applying for waivers that allow states to bypass federal Medicaid rules through increased cost sharing, benefit reductions, and waiting lists.

Cuts to public health care have economic impacts as well. A study of the economic impact of Medicaid on South Carolina found a state cut of 4 percent in the Medicaid budget would cause the state to lose over 2,400 jobs and more than $60 million in state income associated with the Medicaid program.

All of these strategies limit consumers' access to health care, creating greater health care problems rather than targeting the rising cost of prescription drugs.

The public health care cuts states are implementing limit access, harm consumers, and do little or nothing to address the major source of cost increases. And these cuts cost states in other ways. When consumers cannot get adequate health care, easily treatable conditions can rapidly become serious emergencies and cost more in the long term.

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Rising numbers of uninsured need health care now more than ever

States are cutting health care programs just when people need them most. As unemployment rises, public health care programs become ever more crucial for low-income families. A recent analysis of the connection between unemployment and the uninsured found for every 100 people who lose their job, the number of people without health insurance rises by 85. If states cap or cut enrollment in public health care programs, the uninsured rate would be even greater.[40]

Cuts reduce the security that these public health care programs provide, and create other costs for states. Low-income people often live on very tight budgets, and are vulnerable to unexpected

Judie Shelby
Billings, Montana

I make only $545 a month so even a slight increase in prescription drug costs is more than I can afford. Right now I barely have enough to eat. Since my food stamps were recently cut, I cannot afford to eat balanced meals with fresh vegetables or meat. If I ever had to go into the hospital, I could never afford the co-pay of $100. That's 20 percent of my monthly income that already doesn't meet my needs.

Two years ago I fell in an airport and broke my hip. I spent numerous days in the hospital and eventually had hip replacement surgery. Without a limit on cost sharing, I would have been homeless as I wouldn't have been able to afford even my subsidized rent.

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expenses. Medicaid and CHIP provide convenient access to affordable health care, which helps to stabilize family economies, and to stabilize our communities.

• *Limiting access to CHIP puts our children at risk.* Unmet health care needs reduce children's ability to grow into productive, healthy adults. For many low-income working families, CHIP is the only affordable health insurance option for children.

• *Limiting access and cutting benefits can lead to serious problems that may have been prevented, and increase long term health care costs.* Due to high premiums and high deductibles, private insurance is inaccessible for many low-income, working families. Without coverage, many people postpone or forgo care; easily treatable illnesses can turn into serious or life-threatening ones. Often people must turn to more expensive emergency room care. But the ER is not designed to provide follow-up care or comprehensive care — the very forms of health care that people with health insurance depend on to stay healthy and to minimize illnesses.

- *Excessive cost-sharing excludes families from accessing care.* Cost-sharing (such as premiums, co-payments, and co-insurance) is an impediment to low-income families seeking health care. A study of Washington's Basic Health Plan found that a $10 premium increase cut enrollment by 13 percent. Even small increases in cost-sharing result in major decreases in enrollment, and harm to families.

State cuts to public health care programs

- *Montana removed the annual cap on cost-sharing for Medicaid recipients*. Beginning April 1, 2002, Montana more than doubled the out of pocket maximum — from $200 to $500. Then in August 2002, the cap was removed. These new policies affect all Medicaid consumers, regardless of income level, and especially impact those with the most serious health problems.
- *Montana is requesting a waiver of numerous federal Medicaid standards.* This waiver would negatively impact consumers by allowing changes such as increases in cost sharing, and limits to the number of doctor visits.
- *Washington cut health care programs that provided Medicaid coverage to legal immigrants and undocumented immigrant children.* Thousands of people lost coverage due to the cuts.
- *Oregon has received a waiver that will negatively impact the Oregon Health Plan (OHP) and its users.* The waiver divides OHP into separate benefit packages, significantly increasing cost-sharing and decreasing benefits for some consumers.
- *Idaho cut adult access to dental services from its Medicaid program and limited consumers' access to prescription drugs*. Idaho has increased the number of prescription drugs that require prior authorization.

MONTANA

In a 2001 ranking of the states, Montana's Medicaid program spent the least state money per person in poverty.[41] States with lower spending rates tend to have some combination of more restrictive Medicaid eligibility, fewer benefits, and lower provider rates.[42] Despite attaining this rank, Montana has increased cost-sharing, is now in the process of drafting a Medicaid waiver request, and has proposed numerous cuts in public health care programs to deal with budget shortfalls.

Beginning April 1, 2002, Montana implemented a coinsurance policy that made Montana's Medicaid cost sharing requirements the highest in the country.[43] Usually, cost-sharing, if used, most often applies to higher income beneficiaries. But Montana's policy even applied to beneficiaries with no income at all.[44] Many Medicaid consumers were charged a 5 percent coinsurance on numerous medical services, and the out-of-pocket maximum has more than doubled — from $200 to $500. This change affected the elderly, disabled, and parents. These sweeping and harmful changes were only projected to save the state $140,000 in fiscal year 2002.[45]

In response to public outcry, Montana removed the co-insurance policy in August, 2002. The Department of Public Health and Human Services reported numerous problems with the policy — including that some recipients did not receive needed prescription drugs, which aggravated their health conditions and caused them to seek other high-cost services such as emergency room services,[46] resulting in higher costs to the state.

Unfortunately, when the department ended the coinsurance policy, it also removed the annual limit on cost-sharing — there is now no out-of-pocket maximum. Before April, 2002, when the annual limit on cost-sharing was $200, nearly 5,000 Medicaid recipients met the cap each year. Clients who were previously protected by the cap likely have the most serious health care needs, and higher cost-sharing requirements may force them to defer care, again resulting in aggravated conditions and increased long term costs to the state.

The August, 2002, cost sharing policy changes returned other cost-sharing requirements to levels similar to the requirements before April, 2002. For example, for prescription drugs, cost-sharing is now one to five dollars per prescription, with a maximum total cost-sharing per month per recipient of $25.

On October 9th, 2002 the Montana Department of Public Health and Human Services submitted a concept paper to begin the waiver application process.[47] The changes proposed include: limiting the number of prescription drugs a recipient can receive each month, limiting the number of primary care visits per year, reducing benefit packages, and increasing cost-sharing.

Since April, 2002, over $70 million has been cut from the DPHHS budget, and Governor Martz's proposed budget for the 2004-2005 biennium includes numerous additional cuts to public health care programs, such as eliminating the Medicaid hospice program, changing Medicaid eligibility standards, reducing the amount paid to Medicaid providers, and reducing mental health services.[48]

Sarah Cassidy
Missoula, Montana

I have been fortunate to have the Mental Health Services Plan (MHSP) to provide prescription drug coverage and pay for my visits to a private therapist. I suffer from an anxiety disorder that requires expensive medication to treat. Right now my medications would cost me $530 per month, but with MHSP I only pay $49 in co-pays. After December 1, 2002, the cuts enacted by the Montana Special Session put a $250 a month cap on prescription drugs for MHSP recipients. I don't know how I'm going to make up the difference.

I am working for a temp agency and have been able to find part-time work for $8 an hour. However, I don't work every week and it's difficult to make ends meet. I don't have access to any other health insurance; without MHSP I could never afford the few services I need.

I know I will have to choose between rent and food and medicine next month and I don't want to be homeless again. If I can't afford my prescriptions, I'll end up in the state mental hospital and that will end up costing the state even more.

When the state helps me pay for treatment, I can get back on my feet and be independent. These cuts will hurt many Montanans who are functioning with a little help from MHSP, but who will end up institutionalized without this help.

OREGON

Between the legislative sessions, Oregon's Emergency Board makes policy and budget decisions normally the responsibility of the full legislature. The November, 2002, legislative Emergency Board meeting cut $23 million from the Oregon Department of Human Services budget to rebalance existing budget problems. As a result, low income families, couples and adults who receive Oregon Health Plan benefits will lose access to mental health, chemical dependency, and dental services as well as durable medical equipment and supplies.[49]

In addition to the above cuts, over $88 million in cuts will be made on February 1st, 2003 if a temporary tax increase initiative does not pass in January. These cuts only address the budget problem for the remainder of the current two-year budget, which ends June 30th, 2003. General fund spending cuts result in further losses of federal matching funds, bringing the total cut to the department to about $162 million.[50]

If Measure 28 fails, possible cuts include: eliminating Medicaid long-term care for some clients receiving in-home hourly and 24-hour care services, lowering reimbursement rates, severely cutting or eliminating numerous mental health services, eliminating coverage for certain conditions for OHP and CHIP recipients, and eliminating prescription drug coverage for approximately 118,000 OHP recipients.[51]

In addition, Oregon has been working out the details of a waiver since the summer of 2001,[52] and on October 15, 2002, Department of Health and Human Services Secretary Tommy Thompson approved Oregon's waiver.

Joanne Hume
Scapoose, Oregon

I was a school bus driver for 24 years, but had to quit working when my health took a turn for the worse. Since then, I've had two surgeries on my legs, a stint put in my kidney, and three surgeries on my shoulder.

I have to take medicine for a variety of reasons: to help my heart, to improve the blood flow to my legs, to regulate my blood pressure, and to combat the side effects of all my other medications. If I didn't have prescription drug coverage through the Oregon Health Plan, this medication would cost me over $530 a month.

Already I would be out on the streets if I didn't live with my son. My income is only $625 a month, which comes from disability, widow's benefits, and food stamps. There is no way that I would be able to afford prescription drugs on my own. They are just too expensive.

As a result of the waiver, changes to the program will likely include: splitting the OHP into tiers with different levels of coverage and different application processes, denying coverage to those who cannot afford cost sharing requirements, significantly reducing benefits — as low as 58 percent of the current program, enrollment caps, and increasing cost sharing, including premiums and co-payments — as high as $250 for some procedures.[53]

IDAHO

Idaho cut adult dental services from its Medicaid program. As of April 1st, 2002, Idaho Medicaid consumers can only receive selected emergency dental services. The changes to CHIP and Medicaid were both done without a public hearing process.

Many of Idaho's Medicaid changes limit access or benefits, rather than raising new revenues or reducing costs. And Idaho's new policies around Medicaid prescription drug use are no exception.

Starting April 1st, 2002, Idaho attempted to limit access to prescription drugs by requiring prior authorization if a patient received more than four prescription drugs a month, and requiring Medicaid recipients to use 75 percent of their prescription before seeking refills. Prior authorization is a time consuming process for doctors, pharmacists and patients, and can result in life-threatening delays. Although the four-drug maximum went into effect April 1st, it was put on hold three days later, after the Department of Health and Welfare was unable to process the hundreds of claims and voluminous paper work submitted.[54] In place of this policy, Idaho has expanded the number of drugs that require prior authorization.

Peggy Peterson
Boise, Idaho

I am a 55-year-old single mother and grandmother. My entire life, I worked three jobs just to support my family. However, in 1989, after years of abuse from my husband, my back and hip gave out and I could no longer work. I eventually developed arthritis throughout my entire body and suffered two heart attacks. Needless to say that after all this, I am permanently disabled.

I've tried various medications to ease the pain that accompanies arthritis, but they either didn't work or had bad side effects. I finally found a medication that had no side effects and worked wonderfully for the pain; Medicaid covered my prescription since I couldn't afford it. However, the last time I went to get my prescription filled, I was informed that this medication was no longer on the Medicaid approved list. I didn't know what to do. I couldn't afford to pay for the prescription because I live on $585 a month. I left the pharmacy without the medicine I need to help me live.

When I told my friend what happened, she called Medicaid to see what could be done. She found out that my medicine is still covered by Medicaid and that it now requires prior authorization. The system is confusing and complicated for me and my doctor.

Why is the state trying to save money at the expense of my health? The legislature should find other ways to cut budget costs instead of by making us suffer.

WASHINGTON

Washington has proposed or begun implementing numerous cuts and access limiting cost control measures in its public health care programs.

At the end of the 2002 session the Washington legislature cut state-funded programs that provided Medicaid coverage to legal immigrants and undocumented immigrant children. In October 2002, approximately 2,400 adults and 25,000 children lost Medicaid coverage due to these cuts.[55,56] The state directed those losing Medicaid coverage to apply for the state Basic Health Program (BHP), and provided some temporary reductions in the paperwork requirements for these enrollees. But how many people cut off of Medicaid will transfer to BHP is unclear. BHP requires cost-sharing at a level likely to make it impossible for many to enroll. Washington health care advocates say many will lose health care coverage in the process. By early November, 2002, only approximately 47 percent of those who lost coverage due to the cuts had enrolled in BHP.[57]

Washington also has increased the difficulty patients and doctors must go through for prescription drugs. On February 1st, 2002, Washington's Medicaid program began requiring prior authorization when a consumer receives a prescription not on the preferred drug list, or when a consumer receives more than five prescriptions for brand name drugs.[58] This means prescribers must consult with the Therapeutic Consultation Service (TCS) to prescribe more than four brand name drugs for a Medicaid consumer or to prescribe non-preferred drugs. This is time consuming for doctors, pharmacists and patients, and can result in harmful delays. Numerous complaints have been filed since the program started.

Sue Stauffer
Seattle, Washington

One day in 1990 when I was at work, I reached across the desk and heard a loud snap in my neck. I later found out that I had permanent nerve damage in my neck due to the repetitive stress of holding a phone receiver between my neck and shoulder for over 30 years. Besides this nerve damage, I suffer from degenerative disk disease, vascular and heart disease, severe sleep apnea, and severe anxiety attacks and depression.

Because of my poor health condition, I have high medical bills and am unable to work. I had to use my 401k account to pay for medical bills and now I have no retirement funds left. Thankfully I receive Medicaid to help with prescriptions drug costs, which last year totaled over $8,600.

Now the state's trying to save money by limiting Medicaid clients to four brand-name prescriptions. For someone like me, that will make a huge difference in my health. Generic drugs sometimes have different fillers or dosages. I've had painful reactions to generic forms of my regular medication.

I'm supposed to be able to get authorization for my prescriptions if my doctor goes through a prior authorization process for each medication. It's such a headache, but I need the drugs that I take in the exact form that works — no substitutions, no generics. But every time my drugs run out, I have to go through the same process all over again, as if it never happened! I'm afraid I'm going to lose my doctor because I make him do this paperwork time after time.

Some people say that health care costs are rising so quickly because people are taking too many drugs. I don't think this is true. In fact, I don't even take prescriptions when I have a choice. Last year I told my doctor to stop prescribing my pain medication because ibuprofen worked just as well. If we could do something to control the cost of drugs, then we would be able to keep health care expenses lower.

Washington's program is modeled after a Florida program that has been in place longer. A class action suit was filed in federal district court in Miami, saying patients should get advance notice and the chance to appeal before the state cuts off their drugs. A study done of the Florida Medicaid program found more than 150,000 denials for exceeding the four drug limit in a six-month period.[59]

In addition to the above cuts, Washington has submitted a waiver request that would allow the state to waive key federal requirements of the Medicaid program by increasing cost sharing, capping enrollment, and reducing services.

In November 2001, Governor Locke submitted a waiver request[60] that did not specify what changes would be made or how they would be decided. The waiver was not accepted, and more detail was requested.

Robert Darthez
Black Diamond, Washington

Shortly before I turned 65, I was diagnosed with non-Hodgkin's Lymphoma. I underwent chemotherapy for three and a half years, which depleted my immune system and left me vulnerable to infections. I also developed insulin dependent diabetes as a result of the chemotherapy. Fortunately, now that I am 74, I seem to be cancer free.

I take several prescription drugs, as does my wife; however, neither Medicare or our supplemental insurance covers these prescriptions. My main expense is a drug which controls a fungal infection in my lungs. It runs me $450 per month. I also must take antibiotics and kidney medication sporadically. All in all, our prescription drug costs for 2001 were $7,500, about 25 percent higher than they were in 1999.

My wife and I have a fixed annual income of about $35,000, 20 percent of which goes toward medication. Every year the cost of prescriptions increases by double digits, making it increasingly difficult to afford.

On August 12th, 2002, Washington submitted another waiver proposal, noting it will include: co-payments for prescription drugs and non-emergency use of the emergency room, premiums, enrollment freezes, and reduced benefit packages.[61]

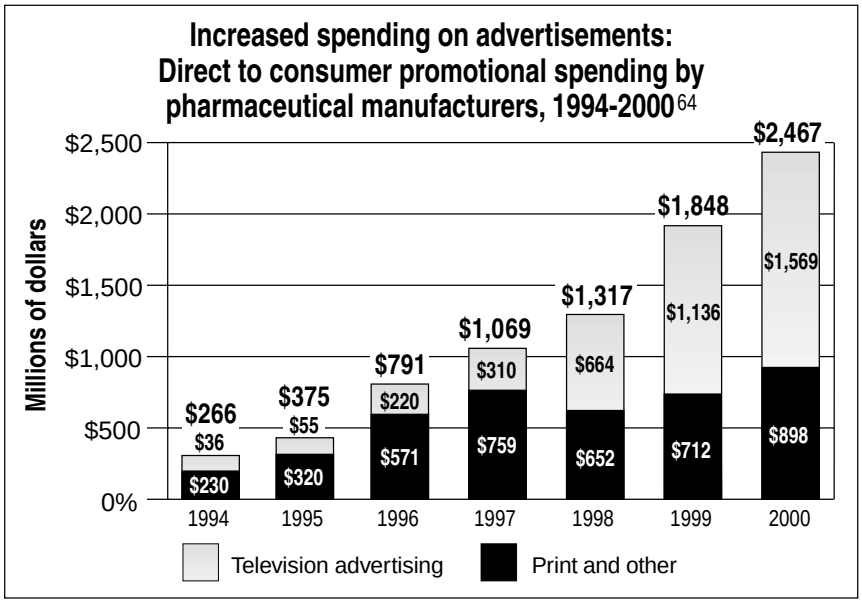
If approved, Washington's waiver could result in waiting lists, unaffordable costs of coverage and services for Medicaid recipients, and increasing numbers of uninsured Washington residents. These changes would hurt residents already facing rising unemployment, when they most need public safety net programs.

Although the governor's budget had not been released at press time, a prioritization of government activities released in November, 2002, ranked the state funded Basic Health Program and federally funded optional services such as hearing, vision, and non-emergency dental care as low priorities in the 2003-2005 budget.[62]

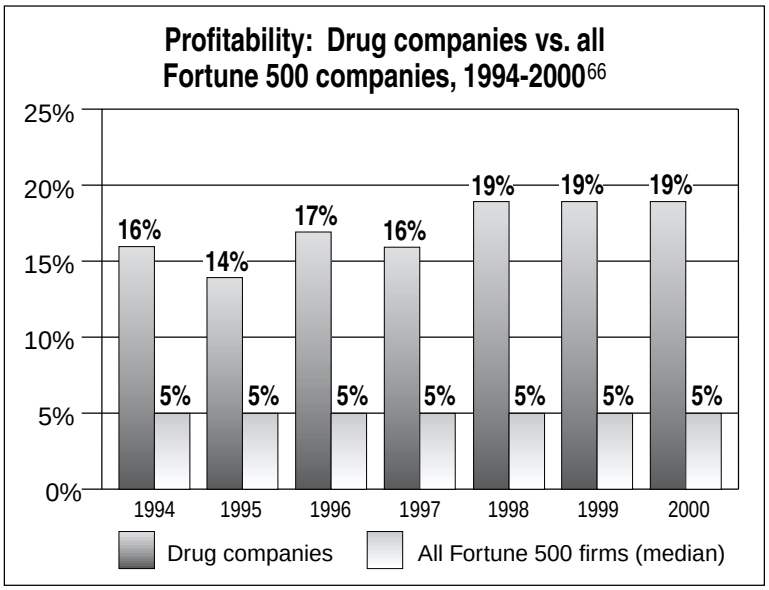
Focus on prescription drug companies

An industry of excessive profits and extensive investigations

Prescription drug spending is rising for several reasons that center on prescription drug companies: their price increases that far exceed the pace of inflation, their work to delay the introduction of generics by extending patent protections and spinning off new formulations of their drugs,[63] and their increased spending on advertising, especially television advertising.



Pharmaceutical companies are still the most profitable industry, ranking number one in all three categories of Fortune Magazine's ranking system: return on revenues, return on assets, and return on shareholders' equity.[65] Drug companies have held this title for some time, and the drug industry's median profit margin exceeded that of all Fortune 500 firms by three to four times in the 1990s.



Several prescription drug companies have recently been the subject of investigations, fines and lawsuits — particularly pertaining to pricing schemes — and the U.S. government has increased its scrutiny of the business practices of pharmaceutical companies.[67]

In the largest fraud settlement in history, TAP Pharmaceutical Products has agreed to pay $875 million for charges of illegally manipulating the Medicare and Medicaid programs by inflating the reported price of its prostate cancer drug Lupron.[68] To settle

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The Health and Human Services Inspector General estimates that inaccurate reporting of drug prices costs taxpayers more than $1 billion per year just in overpayments for the few drugs Medicare now covers — mostly cancer drugs administered in a doctor's office.[70]

Numerous class action lawsuits have been filed against drug manufacturers. Many of the cases fall into three areas of anti-competitive conduct: drug manufacturer efforts to suppress competition, fraud related to drug pricing, and deceptive marketing.[71] All of these strategies increase prescription drug spending. For example, drug companies enter into deals with generic companies to delay the introduction of generic versions of their drugs. For BuSpar alone, it is estimated that the manufacturer made $160 million in additional sales by delaying generic introduction for four months.[72]

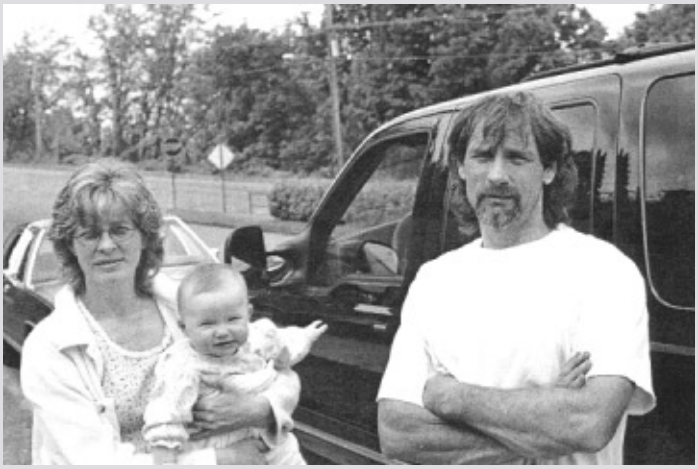
Drug companies also make use of legal loopholes a priority and delay the introduction of generics as long as possible. Drug companies can extend the length of their monopoly by marketing minor modifications of existing drugs. Half of the drugs introduced in the 1990s were new formulations or combinations of already approved drugs.[73]

Undisclosed and uneven prices

Under the current pricing system, people without prescription drug coverage pay the most for prescription drugs and are affected most by rising prices, as they have no access to the rebates and discounts larger purchasers can negotiate.

Drug prices are currently established through a complex web of arrangements between drug manufacturers and different private and public sector purchasers — like retail pharmacies, insurers, health maintenance organizations, hospitals, and government agencies.[74] Most of these agreements and pricing schemes are proprietary. Manufacturers sell the same prescription drug at a wide range of prices to different purchasers, and many of these prices are not available to the public.

Under the current pricing system, people without prescription drug coverage pay the most for prescription drugs and are affected most by rising prices,[75] as they have no access to the rebates and discounts larger purchasers can negotiate.



Robert Schwartz
Bellingham, Washington

My name is Robert Schwartz and I am a self-employed general contractor. My wife April and I have two children — a ten year old and an eight month old.

After leading an overall healthy life, my kidneys mysteriously stopped working in January of 1998. The doctors tried various combinations of steroids, cancer chemotherapy agents, and other drugs — none of which were very successful. For a period of six months I was unable to work, so April had to run our company by herself. Then, in 2000, my doctor suggested cyclosporin, an immune system suppressant given to transplant patients so that their bodies will not reject transplanted organs. My kidneys immediately functioned better and gave me hope of recovery.

The problem is that cyclosporin costs $1,700 per month, which I must pay out of pocket because I can't afford insurance. Our family's monthly bill is around $3,000, and there is little left over. Now we have an additional $1,700 to pay with the same income.

Approximately one in five Northwest residents are without prescription drug coverage.[76] Rising prescription drug prices pose particular problems for the uninsured. A Department of Health and Human Services study found that in Oregon, the median difference between retail prescription drug prices and prices charged to third party payers like health plans was 8.2 percent, even higher than the national median difference of 7.4 percent.[77]

Northwest residents lacking insurance for prescription drugs[78]

State	Age 65+ lacking Rx coverage	Lacking any health insurance	Privately insured w/no drug coverage	Total lacking drug coverage	Percent lacking drug coverage
Idaho	51,000	225,000	58,000	334,000	26%
Montana	41,000	174,000	36,000	251,000	28%
Oregon	154,000	479,000	147,000	780,000	23%
Washington	233,000	717,000	273,000	1,223,000	21%
NW region	**479,000**	**1,595,000**	**514,000**	**2,588,000**	**23%**

And Americans pay more for prescription drugs than their counterparts just across the border. A comparison of the ten best-selling prescription drugs shows that drug companies set higher prices for the same drug in the U.S. than they do in other countries.

The high price of prescription drugs decreases the ability of the uninsured to access them. The uninsured are more likely to not fill prescriptions than those who have drug insurance.[79] This lack of access to prescription drugs creates health problems for the uninsured. Studies have linked reduced access to prescription drugs to increased hospitalization, increased use of long-term care, and increased adverse health outcomes.

Bob Dye
Pocatello, Idaho

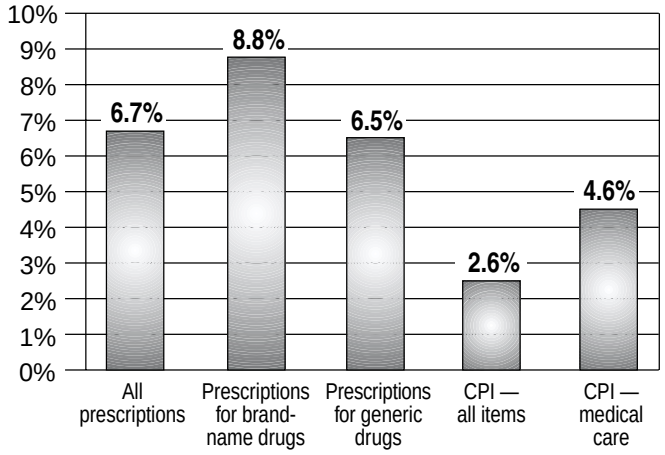
As a husband and father of four in Pocatello, I am deeply concerned with the rising costs of prescription drugs. This is a concern I've lived with daily after being diagnosed with ankylosing spondylitis, an arthritic disease that has fused my spine together.

Severe arthritis is very painful and requires several expensive medications, not only to live with the pain, but also to reduce other effects, such as insomnia. Up until June of 2001, I received my prescriptions through Medicaid. Now that I receive Social Security Disability (SSD), I am no longer eligible for the program.

Today I receive $690 a month from SSD, which I must use to provide food and shelter for my family, pay for doctor visits, and fill $300 worth of prescriptions every month. Of course, $690 does not go that far. To cut costs, I don't take my medicine as prescribed. I often take half a dose or skip doses, and just try to live with the pain as long as I can.

Besides health risks, the high cost of medicine has affected my ability to contribute to my community. I normally volunteer at the local police department. However, without medicine, I can only work for a few hours before the pain becomes unbearable. This depresses me and affects my family life. If drugs were affordable, I could avoid all of these things.

Prescription drug prices rise faster than inflation: Average annual percent change in retail brand-name prescription prices vs. CPI, 1991-1998[80]



This is a particular problem for seniors and others who live on fixed incomes adjusted to keep up with inflation. Prescription drug prices frequently rise faster than the rate of inflation. Last year the price of these drugs rose more than two times the rate of inflation.

For a single senior receiving Social Security, the annual benefit will increase 2.6 percent, or $264, from $10,224 for 2001 to $10,488 in 2002.[81] In 2001, the average cost per year of the prescription drugs most frequently used by seniors was $956, and the average price increase of these drugs a couple was 6.1 percent from January 2000 to January 2001.[82] If drug prices continue to rise at an average of 6.1 percent, each drug would cost an average of $57 more per year in 2002.

Cheryl Perkins
Auburn, Washington

I've suffered from allergies and other respiratory conditions as long as I can remember, but when I was 27, my health took a serious turn for the worse. I was diagnosed with diverticulitis, and underwent four surgeries. The diverticulitis led to diabetes, kidney problems, and diabetic retinopathy. On top of all this, I suffered a heart attack that required a triple bypass. My health got so bad that I had to retire early from my job as a Washington state employee. Now I require 24 different medications to stay healthy.

I receive $2,000 a month from my pension, of which I pay $327 per month for disability coverage and another $400 per month for prescription drug co-payments and doctor's visits. I finally qualified for Medicare, but it will not help with the increasing costs of prescription drugs.

Recently I was diagnosed with macular degeneration, which will add to the list of medications I need. I won't be able to afford these medications if the prices continue to skyrocket. Then how will I stay healthy?

Ten best-selling prescription drugs: Prices in Canada vs. the U.S.[83]

Drug	Drug is used for	Price per pill in Canada	Price per pill in U.S.	Percent U.S. price exceeds Canadian price
Prisolec	Heartburn/Ulcer	$1.47	$3.31	125%
Prozac	Depression	$1.07	$2.27	112%
Lipitor	High cholesterol	$1.34	$2.54	90%
Prevacid	Ulcer	$1.34	$3.13	134%
Epogen	Anemia	$21.44	$23.40	9%
Zocor	High cholesterol	$1.47	$3.18	116%
Zoloft	Depression	$1.07	$1.98	85%
Zyprexa	Mood disorder	$3.39	$5.27	55%
Claritan	Allergies	$1.11	$1.96	77%
Paxil	Depression	$1.13	$2.22	88%

Per capita spending on pharmaceuticals by country[84]

Country	Per capita spending
Canada	$251
U.K.	$251
U.S.	$408

Overall, drugs are more expensive in the U.S. Per-person spending on drugs in the U.S. is almost twice that of other countries like the U.K. and Canada.

The U.S. government does not currently regulate the price pharmaceutical manufacturers can charge for prescription drugs. But there are federal laws requiring manufacturers to give minimum price discounts to federal agencies, as well as laws requiring manufacturers to pay rebates to state Medicaid programs in order to have their drugs covered by Medicaid.[85] The 340B program uses the same formula as Medicaid to extend these benefits to many federally funded clinics, health departments and hospitals. They often negotiate lower prices and save on dispensing fees at retail pharmacies, making 340B prices a bit lower than Medicaid prices.[86]

Federal agencies generally purchase prescription drugs though the federal supply schedule of prices for pharmaceuticals — prices that are set to be better than or equal to the best price a manufacturer charges to a nonfederal customer under similar conditions.[87] On average these prices are estimated to be 42 percent lower than factory prices.[88] The rebates that state Medicaid programs receive was recently estimated to be about 19 percent of their total prescription drug spending.[89]

Strategies states are using to reduce prescription drug spending

Since prescription drugs are becoming an increasingly larger portion of health care spending in all health care programs, many states have developed strategies to address the problem.

Unfortunately, some of the proposed or implemented strategies work by making it difficult for health care consumers to access much needed prescription drugs.

Other strategies work to negotiate savings from the extremely profitable pharmaceutical companies. These strategies save states money while protecting public health care programs and consumers.

Examples of harmful strategies Northwest states have implemented recently

Numerous states have addressed prescription drug spending increases by making prescription drugs harder for consumers to access. This hurts consumers and does little to control rising prescription drug prices.

Montana dramatically increased cost sharing for prescription drugs. Beginning April 1, 2002, Montana implemented a new coinsurance policy for many programs, including prescription drugs. The new policy made Montana's Medicaid cost sharing requirements the highest in the country.[90] Some Medicaid consumers were charged a 5 percent co-pay on prescription drugs, and the out-of-pocket maximum more than doubled — from $200 to $500. This change affected the elderly, disabled, and parents, and meant many could not access prescription drugs. Due to problems resulting from the coinsurance policy, it was lifted in August, 2002, but the annual limit on cost-sharing was lifted as well. Without an annual limit on cost sharing, costs could rise dramatically for some Medicaid recipients.

Idaho expanded its prior authorization program. In Idaho, the Medicaid program limited access to prescription drugs by requiring prior authorization if a patient receives more than four prescription drugs a month, and requiring Medicaid recipients to use 75 percent of their prescription before seeking refills. Although the four-drug maximum went into effect April 1st, it was put on hold three days later, after the Department of Health and Welfare was unable to process the hundreds of claims and voluminous paper work submitted.[91] To replace this program, Idaho increased the number of drugs which require prior authorization.

Washington increased the difficulty patients and doctors must go through for prescription drugs. On February 1st, 2002, Washington's Medicaid program began requiring prior authorization when a consumer receives a prescription not on the preferred drug list, or when a consumer receives more than four prescriptions for brand name drugs.[92]

With proper consumer protections that allow doctors to quickly prescribe any drug essential to the patient's quality of life and health, preferred drug lists can help control drug costs while maintaining access to needed medicines.

These access-limiting strategies are particularly troubling in light of a recent study that found Medicaid consumers in states using multiple access limiting strategies to reduce prescription drug costs had trouble acquiring needed prescription drugs.[93] Cost sharing and complex prior authorization requirements can create insurmountable barriers.

Strategies states can use to save money while protecting public health care programs and consumers

PREFERRED DRUG LISTS

A preferred drug list is a list of drugs covered by a particular program. The list identifies preferred medications for treatment of specific diseases, and is usually subject to periodic review and modification. A preferred drug list guides the prescribing practices of doctors, and can be used as a tool to negotiate lower drug prices from manufacturers.

When a preferred drug list is applied to a large pool of purchasers, it can significantly shift drug purchasing patterns in favor of those drugs on the preferred drug list. Manufacturers give discounts in exchange for being listed on a preferred drug list. The larger the pool a preferred drug list covers, the larger the price discount it can receive.

With proper consumer protections that allow doctors to quickly prescribe any drug essential to the patient's quality of life and health, preferred drug lists can help control drug costs while maintaining access to needed medicines.

When reviewing how a preferred drug list will affect consumers, it is important to look at what a doctor has to do to prescribe a drug not on the preferred drug list. The time required to do so varies widely. With some preferred drug lists, the doctor simply has to write "prescribe as written" along with a prescription, and consumers can quickly get a drug not on the preferred drug list.

Physicians sometimes must receive prior approval to prescribe drugs not on the preferred drug list — a process called prior authorization. When the prescriber needs to go through time consuming processes like filling out paper work or calling a phone bank, these processes can create delays for consumers and barriers to health care access.

Oregon is implementing a preferred drug list for the Oregon Health Plan.[94] This preferred drug list allows doctors to simply write "dispense as written" to prescribe a drug not included in the preferred drug list. Other preferred drug lists, such as those used in the Florida and Michigan Medicaid programs, have more complicated procedures.[95]

PURCHASING POOLS

Drug manufacturers often will pay a rebate to large volume purchasers.[96] The savings negotiated typically depend on the volume of drugs purchased over a given period — the larger the amount purchased, the greater the rebate.[97] Rebates effectively reduce the price purchasers pay. So a movement is afoot to pool purchases among larger and larger groups of buyers.

States are pooling purchases among state agencies that purchase prescription drugs. And states are pooling their purchases together into multi-state coalitions to negotiate even larger rebates. Further, states can open these pools up to the under- and uninsured. By including the under- and uninsured, people without prescription drug coverage benefit from the state-negotiated savings, and states benefit by increasing the size of the purchasing pool.

State-wide or multi-state purchasing pools can also be combined with prescription drug preferred drug lists to further increase savings.

The solution

Northwest states can save money without harming residents by changing how they purchase prescription drugs

Regional and statewide purchasing pools, and preferred drug lists with proper patient protections, can save states money without hurting residents.

Numerous state programs purchase prescription drugs. Typical programs in Northwest states include: Medicaid programs, state employee health care programs, worker's compensation programs, AIDS prescription drug programs, and prison health care programs. Many of these programs differ in aspects of how they currently purchase drugs.[98]

By pooling prescription drug purchases across these agencies and between states, or by creating agency, state or regional preferred drug lists, Northwest states can save money and protect public health care programs.

Other states are already saving money using purchasing pools and preferred drug lists

Two major multi-state coalitions are underway. A multi-state purchasing pool called RXIS currently includes West Virginia, Missouri, New Mexico, and Delaware. Many other states have expressed interest, including Louisiana, Maryland, Mississippi, and South Carolina. The states began negotiations in spring of 2001, and West Virginia was the first to sign on, starting on July 1st, 2002. The pool currently includes the following agencies: West Virginia's Public Employees Insurance Agency and CHIP; Missouri's consolidated health care plan; New Mexico's risk management division, retiree health care authority, public schools insurance authority, and Albuquerque public schools; and may later expand to other programs. Both public payers and private entities can join; new requests for information on how to join come in weekly.[99]

By pooling purchases, West Virginia expects to double its current rebates and save $25 million over the next three years — saving about 8 percent on drug costs in their first year of operation.

RXIS has an administrative services only contract with Express Scripts Inc — members pay an administrative fee, and receive 100 percent of their rebates directly. The sliding scale administrative fee is based on the number of people covered — as more people join, the fees decrease.[100] West Virginia's Public Employees Insurance Agency has 210,000 members,[101] and RXIS currently covers over 502,000 people.[102,103] By pooling purchases, West Virginia expects to double its current rebates and save $25 million over the next three years — saving about 8 percent on drug costs in their first year of operation.[104]

The Georgia Medicaid program saved 10 percent on their prescription drug costs in their state's first full fiscal year using multi-agency purchasing and a multi-agency preferred drug list.

Another coalition, called the New England Tri-state Prescription Drug Purchasing Coalition — comprising Maine, New Hampshire, and Vermont — plans to start by implementing a purchasing initiative for the states' Medicaid populations, initially including 330,000 individuals. The uninsured and public employees may be added later. The coalition estimates it will save 10 to 15 percent annually on prescription drug costs by pooling purchases.[105]

Legislators in a number of other states have passed or are considering legislation on bulk purchasing pools as well. These states include Alabama, Iowa, Maryland, and Vermont.[106]

Numerous states have state purchasing pools in the works. Georgia started phasing in a multi-agency prescription drug purchasing program in 2000, and Texas and Massachusetts have passed legislation to create multi-agency purchasing programs and are in the process of setting up these programs.[107]

Georgia's program pools the prescription drug purchases of the Medicaid and CHIP programs, the State Health Care Benefit Plan, and the Board of Regents. Together these agencies cover two million people. After pooling purchases, the pooled agencies also phased in use of a preferred drug list. The Medicaid program was the first agency to start the new purchasing system — in October 2000. The Georgia Medicaid program saved 10 percent on their prescription drug costs in their state's first full fiscal year using multi-agency purchasing and a multi-agency preferred drug list.[108]

Since implementing the preferred drug list, weekly prescription drug spending has decreased steadily — Michigan's Department of Community Health spends $800,000 less per week on prescription drugs than it would without the program, and the Medicaid program is saving 10 to 12 percent on overall drug expenditures.

Several states have implemented preferred drug lists, and many others are planning to in the near future.

In February, 2002, Michigan's Department of Community Health started phasing in a preferred drug list program, called the Michigan pharmaceutical products list. The program covers 1.5 million Michigan residents that receive pharmacy benefits through the Department of Community Health — including Michigan's Medicaid program, and CHIP. Since implementing the preferred drug list, weekly prescription drug spending has decreased steadily — Michigan's Department of Community Health spends $800,000 less per week on prescription drugs than it would without the program, and the Medicaid program is saving 10 to 12 percent on overall drug expenditures.[109]

Vermont's preferred drug list saved the covered programs about $2.8 million in the first seven months, and is on target to meet the projected savings range of 5 to 9 percent.

In March, 2002, Vermont began phasing in use of a preferred drug list for Medicaid and a few other state programs that cover a total of 134,000 people.[110] The program was projected to save between 5 and 9 percent on the agencies' prescription drug spending.[111] While phasing in therapeutic classes, Vermont's preferred drug list saved the covered programs about $2.8 million in the first seven months,[112] and is on target to meet the projected savings range of 5 to 9 percent.

In August, 2002, Oregon began implementing a preferred drug list for the Oregon Health Program (OHP) which covers around 150,000 people. OHP's preferred drug list is expected to save around $17 million in the first year — about 5 percent of the program's prescription drug spending. Data from the first two months show a shift toward preferred drugs and suggest the program will meet their savings estimate.[113]

Summary of examples of projected or realized savings from current purchasing pools and preferred drug lists[114]

Name of program	Type of program	Approx. number enrolled in program	Agency reporting savings	Projected or realized savings
RXIS	Multi-state prescription drug purchasing pool	502,000	West Virginia's pub. employees insurance agency	8%
Georgia Dept. of Community Health prescription drug program	State agencies' purchasing pool and preferred drug list	2,000,000	Medicaid	10%
Michigan pharmaceutical products list	Preferred drug list	1,500,000	Medicaid	10-12%
Vermont Medicaid preferred drug list	Preferred drug list	134,000	Medicaid	5-9%
Oregon Health Plan practitioner managed prescription drug plan	Preferred drug list	150,000	Medicaid	5%

In addition to Oregon, other Pacific Northwest states are taking steps to change how they purchase prescription drugs.

In 2002, the Washington state legislature passed a resolution urging northwestern states to consider joint purchasing agreements to address the challenge of the high cost of prescription medication.[115] Washington Citizen Action also led a coalition of over 35 organizations representing seniors, labor, health care providers, community, and faith-based organizations in support of legislation that would pool purchases and create a shared preferred drug list among state agencies and open the pool up to the uninsured. The bill passed the Senate and received widespread support, but was never brought to a vote in the House.

OHP's preferred drug list is expected to save around $17 million in the first year — about 5 percent of the program's prescription drug spending.

Northwest states can save money by pooling prescription purchases: Larger volume purchasers save more money

Group	Approximate number of people the program(s) serve
RXIS[117]	502,000
Washington state agencies[118] and the uninsured[119]	2,720,000
Oregon state agencies and the uninsured[120]	1,482,000
Idaho state agencies and the uninsured[121]	540,000
Montana state agencies and the uninsured[122]	380,000
Northwest Rx purchasing pool including state agencies and the uninsured	**5,122,000**

In 2001, the Idaho state legislature passed a resolution urging the governor and the Department of Health and Welfare to work with other states to purchase prescription drugs at economical rates.[116]

Because larger volume purchasers generally receive greater savings, and Northwest state programs currently purchase prescription drugs for over five million residents — over ten times the size of the pool served by the RXIS — Northwest states could attain even greater savings by pooling their purchases and opening the pool up to the under- and uninsured, or using a shared preferred drug list.

Northwestern states can save money and help the uninsured by pooling the prescription drug purchases of their state agencies and opening these pools up to the underinsured and uninsured. The savings ranges in the following tables are based on the percent savings other states have projected or realized by pooling prescription drug purchases or using preferred drug lists, as discussed above.

Summary of estimated amount Northwest states could save by creating a purchasing pool or preferred drug list[123]

	Total prescription drug spending: All selected agencies	Total prescription drug spending: All selected agencies and uninsured residents	5% savings		10% savings		15% savings	
			Selected agencies	Agencies & uninsured	Selected agencies	Agencies & uninsured	Selected agencies	Agencies & uninsured
Idaho	$128,540,000	$236,040,000	$6,427,000	$11,802,000	$12,854,000	$23,604,000	$19,281,000	$35,406,000
Montana	$95,340,000	$199,540,000	$4,767,000	$9,977,000	$9,534,000	$19,954,000	$14,301,000	$29,931,000
Oregon	$225,330,000	$467,530,000	$11,266,500	$23,376,500	$22,533,000	$46,753,000	$33,799,500	$70,129,500
Washington	$649,310,000	$1,063,110,000	$32,465,500	$53,155,500	$64,931,000	$106,311,000	$97,396,500	$159,466,500
Northwest Regional	**$1,098,520,000**	**$1,966,220,000**	**$54,926,000**	**$98,311,000**	**$109,852,000**	**$196,622,000**	**$164,778,000**	**$294,933,000**

State-by-state prescription drug spending and potential savings

MONTANA PRESCRIPTION DRUG PURCHASING

State agencies that purchase prescription drugs include the Department of Public Health and Human Services (DPHHS) AIDS Drug Assistance Program and Medicaid, the Montana State Fund Worker's Compensation Program, and the State Employee Health Plan.

Together these programs purchase prescription drugs for over 126,000 people.

Estimated prescription drug savings for uninsured Montana residents and selected state agency programs[124]

Payors	Current spending on prescription drugs	5% savings	10% savings	15% savings
Uninsured Montana residents	$104,200,000	$5,210,000	$10,420,000	$15,630,000
Medicaid Program in the Department of Public Health and Human Services	$76,040,000	$3,802,000	$7,604,000	$11,406,000
State Employee Health Plan in the Administration Dept.	$13,370,000	$668,500	$1,337,000	$2,005,500
AIDS Prescription Drug Program in the Department of Public Health and Human Services	$350,000	$17,500	$35,000	$52,500
Workers' Compensation and other programs in the Montana state fund	$5,580,000	$279,000	$558,000	$837,000
Total: All selected agencies	**$95,340,000**	**$4,767,000**	**$9,534,000**	**$14,301,000**
Total: All selected agencies and uninsured residents	**$199,540,000**	**$9,977,000**	**$19,954,000**	**$29,931,000**

The worker's compensation program has enrollees purchase directly through pharmacies, the AIDS Drug Assistance Program purchases through the 340B program, and the Department of Corrections contracts out to McKesson Medmanagement. In addition to the programs listed in the table above, the Department of Corrections also purchases prescription drugs, but data on prescription drug spending were not available. So the amount Montana could save by joining a regional purchasing pool is even larger.

IDAHO PRESCRIPTION DRUG PURCHASING

State agencies that purchase prescription drugs include the Department of Health and Welfare AIDS drug assistance and Medicaid programs, the Department of Corrections, and the State Employee Health Plan.

Together these programs purchase prescription drugs for over 206,000 people.

The AIDS drug assistance program uses the 340B program, the state employee health program uses

Estimated prescription drug savings for uninsured Idaho residents and selected state agency programs[125]

Payors	Current spending on prescription drugs	5% savings	10% savings	15% savings
Uninsured Idaho residents	$107,500,000	$5,375,000	$10,750,000	$16,125,000
Medicaid Program in the Dept. of Health and Welfare	$109,710,000	$5,485,500	$10,971,000	$16,456,500
State Employee Health Plan in the Office of Insurance Mgmt.	$17,140,000	$857,000	$1,714,000	$2,571,000
AIDS Prescription Drug Program in the Dept. of Health and Welfare	$850,000	$42,500	$85,000	$127,500
Prison Health Services in the Department of Corrections	$840,000	$42,000	$84,000	$126,000
Total: All selected agencies	**$128,540,000**	**$6,427,000**	**$12,854,000**	**$19,281,000**
Total: All selected agencies and uninsured residents	**$236,040,000**	**$11,802,000**	**$23,604,000**	**$35,406,000**

Regence BlueShield of Idaho, and the Department of Corrections purchases through Correctional Medical Service in St. Louis, Missouri. In addition to the programs listed in the table above, the State Insurance Fund's worker's compensation program also purchases prescription drugs, but data were unavailable. So the amount Idaho could save by joining a regional purchasing pool is even larger.

OREGON PRESCRIPTION DRUG PURCHASING

State agencies that purchase prescription drugs include the Department of Human Services Medicaid and AIDS Drug Assistance Programs, the State Employees' Benefits Board, and the Department of Corrections.

Estimated prescription drug savings for uninsured Oregon residents and selected state agency programs[126]

Payors	Current spending on prescription drugs	5% savings	10% savings	15% savings
Uninsured Oregon residents	$242,200,000	$12,110,000	$24,220,000	$36,330,000
Medicaid Program in the Department of Human Services	$190,060,000	$9,503,000	$19,006,000	$28,509,000
State Employee Health Plan in the Public Employee's Benefit Board	$30,000,000	$1,500,000	$3,000,000	$4,500,000
AIDS Prescription Drug Program in the Department of Human Services	$1,270,000	$63,500	$127,000	$190,500
Prison Health Services in the Department of Corrections	$4,000,000	$200,000	$400,000	$600,000
Total: All selected agencies	**$225,330,000**	**$11,266,500**	**$22,533,000**	**$33,799,500**
Total: All selected agencies and uninsured residents	**$467,530,000**	**$23,376,500**	**$46,753,000**	**$70,129,500**

Together these programs purchase prescription drugs for over 702,000 people.

The AIDS drug assistance program uses the 340B program, and the Department of Corrections uses the Minnesota Multi-State Contracting Alliance for Pharmacy. Over 60 percent of the Oregon Medicaid enrollment is in managed care programs. The worker's compensation program in Oregon is funded

directly by employers, so does not go through the state budget. Oregon does not collect pharmacy data from their Medicaid managed care plans, so this data could not be included in the above table. Other state purchasers include wholesale purchases for County Health Department tuberculosis program, at over $93,000 per year. So the amount Oregon could save by joining a regional purchasing pool is even larger.

WASHINGTON PRESCRIPTION DRUG PURCHASING

Washington state agencies that currently purchase or provide prescription drugs include: the Washington State Health Care Authority (HCA), Department of Health (DOH), Department of Social and Health Services (DSHS), Labor and Industries (L&I), Department of Corrections (DOC), and Washington Department of Veterans Affairs (WDVA).

These programs provide prescription drugs to over 1.2 million state residents.

Estimated prescription drug savings for uninsured Washington residents and selected state agency programs[127]

Payors	Current spending on prescription drugs	5% savings	10% savings	15% savings
Uninsured Washington residents	$413,800,000	$20,690,000	$41,380,000	$62,070,000
Medicaid Program in the Department of Social and Health Services	$497,010,000	$24,850,500	$49,701,000	$74,551,500
State Employee Health Plans under the Health Care Authority	$102,680,000	$5,134,000	$10,268,000	$15,402,000
State Health Care Program under the Health Care Authority	$24,640,000	$1,232,000	$2,464,000	$3,696,000
AIDS Prescription Drug Program in the Department of Health	$5,720,000	$286,000	$572,000	$858,000
Workers' Compensation in the Department of Labor and Industries	$19,260,000	$963,000	$1,926,000	$2,889,000
Total: All selected agencies	**$649,310,000**	**$32,465,500**	**$64,931,000**	**$97,396,500**
Total: All selected agencies and uninsured residents	**$1,063,110,000**	**$53,155,500**	**$106,311,000**	**$159,466,500**

Data from the Washington DOC and WDVA were not available. The state also purchases prescription drugs through a managed care program called Healthy Options in the DSHS, but this program's prescription drug spending data were not available. So the amount Washington could save by joining a regional purchasing pool is even larger.

Conclusion

Northwestern states should change how they purchase prescription drug by pooling the prescription drug purchases of their state agencies, opening these pools up to the underinsured and uninsured, private entities, and local units of government, and creating a shared preferred drug list with proper consumer protections. By doing so, these states can save money, help the underinsured and uninsured, and retain the strength of important public health care programs.

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About the organizations releasing this report

Northwest Federation of Community Organizations (NWFCO) is a regional federation of four statewide, community–based social and economic justice organizations located in the states of Idaho, Montana, Oregon, and Washington: Idaho Community Action Network (ICAN), Montana People's Action (MPA), Oregon Action (OA), and Washington Citizen Action (WCA). Collectively, these organizations engage in community organizing and coalition building in 14 rural and major metropolitan areas, including the Northwest's largest cities (Seattle and Portland) and the largest cities in Montana and Oregon.

Idaho Community Action Network (ICAN) serves as a powerful, consolidated voice for Idaho's poor, with chapters and membership clusters in six Idaho communities, including the state's three largest cities and numerous rural towns. Through ICAN, low-income Idaho families have a voice in the decisions that impact their lives. In addition to its direct action work, ICAN runs a statewide, volunteer-driven food program that helps low-income families supplement their monthly budgets. ICAN's community organizing model integrates the provision of food with training, leadership development, and action on issues.

Founded in 1982, **Montana People's Action** (MPA) is a statewide economic justice organization with over 6,000 member families in Billings, Bozeman, and Missoula. For over two decades MPA has been the primary voice for low- and working-income Montanans around the issues of housing, access to credit and banking services, access to health care, economic development policy, and income security.

Oregon Action (OA) is a statewide, non-partisan network of people and organizations dedicated to economic justice for all through individual and group empowerment. Oregon Action was founded in 1997 to build on the history and values of Oregon Fair Share, which for twenty years organized low and moderate income people to win consumer and community reforms.

Washington Citizen Action (WCA) is a social and economic justice organization with over 50,000 individual members statewide. In addition to its dynamic grassroots membership, WCA also includes permanent coalition partners from other community organizations, labor, senior, religious, and people of color organizations. WCA has both a legislative and non-legislative issue agenda that focuses on increasing access to health care and living wage jobs.

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