Cut Costs Not Services

Oregon Strategies for Lowering Rx Costs and Protecting Public Health Care Programs

By Dana Warn

Oregon Action (OA)

Northwest Federation of Community Organizations (NWFCO)

April 2003

Acknowledgements

Stories collected by Stephanie Cho and RuthAlice Anderson of Oregon Action.

Cut Costs Not Services:

Oregon Strategies for Lowering Rx Costs and Protecting Public Health Care Programs

By Dana Warn

Oregon Action (OA)
Northwest Federation of Community Organizations (NWFCO)

April 2003

Table of contents

Executive summary

In Oregon and across the Northwest, economic recession has increased unemployment rates and tightened state budgets. Oregon faces serious state budget challenges, and has made drastic and deep cuts to public health care programs and human services. These cuts limit access to public health care programs, just when residents — dealing with rising unemployment — need them most. And these cuts often increase long-term costs to the state, because people must defer care, and easily treatable problems can become crises. But Oregon can save money without harming consumers by doing more to address the fastest rising cost in health care today: prescription drugs.

Prescription drug costs are rising rapidly across the nation and Oregon, 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, Oregon would likely realize similar savings. Most of the existing prescription drug purchasing programs reviewed in this report are either purchasing pools, or preferred drug lists. If Oregon creates a larger program that both pools prescription drug purchasing and creates a shared preferred drug list, Oregon could save even more. The exact amount Oregon would save depends on which state agencies pool their prescription drug purchases. Any group allowed to purchase with state agencies should receive a similar percentage savings. 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, Oregon should change how it purchases prescription drugs by pooling state agency prescription drug purchases, opening this pool 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

Oregon faces serious budget challenges. Economic recession, worsened by the aftermath of the September 11 attacks, has increased unemployment rates and tightened the state's budget. Oregon has recently proposed or made budget cuts in K-12 and higher education, Medicaid, and TANF,[1] in addition to transportation, arts, and environmental protection spending.[2] A biennial legislature, Oregon held five special sessions in 2002 to deal with budget shortfall issues. In September 2002, in the fifth special session, the legislature cut $310 million across the board from state agencies.[3] In response to the December economic forecast, then Governor Kitzhaber called for another across the board budget cut of over $111 million to correct the deficit.[4] In March, 2003, the Office of Economic Analysis projected revenues for the 2001-03 biennium that were over $244 million lower than previous forecasts,[5] suggesting the problems are far from over.

Times are difficult for Oregon residents. Unemployment is on the rise at 7.5 percent, well over the national average of 5.7 percent.[6] Oregon also has high hunger and food insecure rates — 13.7 percent of Oregon households were food insecure from 1999 to 2001, the third-highest food insecurity rate in the nation.[7] Cuts to public health care programs only increase the difficulties for state residents facing food insecurity and unemployment.

The problem

Prescription drugs: a major cost driver

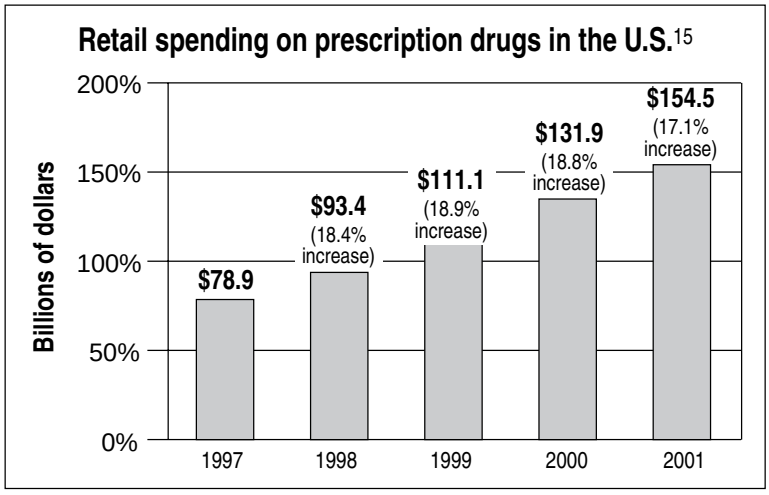
Although health care costs across the nation in all types of health care programs have been rising, much of this increase is due to the rising costs of prescription drugs. Across the nation, prescription drugs are the fastest growing cost in health care spending,[8] creating a crisis for private and public programs alike.

Drug costs have disproportionately contributed to the sharp upturn in overall health care costs over the last few years.[9] 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.[10] 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 do not necessarily improve treatment; and
- An aging population with increased prevalence of chronic conditions.[11]

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 fourth year in a row of rapid growth.[12] 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[13] and new medical treatments.[14]

Retail spending on prescription drugs in the U.S.[15]



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.[16] And in a survey of Medicaid officials, 48 states cited pharmaceutical costs as one of the top reasons for Medicaid cost increases in 2001.[17] Other factors that have increased Medicaid spending include general medical inflation, increases in provider payment rates to catch up with inflation, and increased enrollment.[18]

Idella Mims

I'm an 85-year-old widow, mother, grandmother, and great-grandmother. I recently sold my house because otherwise I couldn't afford my medications. I have glaucoma, and my eyes keep getting worse. I take drops for my eyes and I have to be careful not to miss any drops, or I might go blind. I pay $300 a month for two tiny eye drop bottles. The price of my prescriptions really strains my budget, but I do not want to go blind.

I was in the catering business for 38 years. I catered for presidents, and wealthy people still remember my name and send me flowers on my birthday. I had no idea prescription drugs would cost me this much, and force me to sell my home.

I'm here and ready to fight because something needs to be done about the high costs of medicine.

Vital Oregon health care programs targeted for cuts

Oregon has made drastic cuts to public programs, limiting consumers' access to health care and creating greater health care problems. When consumers cannot get adequate health care, easily treatable conditions can rapidly become serious emergencies and cost the state far more in the long term.

Cuts to public health care have serious economic impacts: a recent study found for every $1 million cut in state Medicaid spending, Oregon loses over 32 jobs and $3 million in business activity.[19] 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.[20]

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 in General Fund spending from the Oregon Department of Human Services 2001-2003 budget to rebalance existing budget problems. Because of lost federal matching funds, this resulted in a total cut of over $47 million. As a result, low income families, couples, and adults who receive Oregon Health Plan (OHP) benefits will lose access to mental health, chemical dependency, and dental services as well as durable medical equipment and supplies.[21]

Cuts to public health care have serious economic impacts: a recent study found for every $1 million cut in state Medicaid spending, Oregon loses over 32 jobs and $3 million in business activity.

In December, 2002 the DHS shouldered over $28 million in cuts from the 2001-2003 General Fund, resulting in a total cut of over $36 million.[22] And over $88 million in General Fund cuts were made after Measure 28 did not pass. With the loss of federal matching funds, this resulted in a $171 million cut for the 2001-2003 biennium alone.[23] The cuts included: 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.[24]

Some of these cuts were temporarily funded again by an emergency spending package passed on March 4, 2003. Prescription drug coverage was restored for OHP Standard and some former Medically Needy clients[25] — about 100,000 people — but funding was only guaranteed until June. There was a delay in restoring coverage, until March 17th for OHP standard, and until April 1st for the former Medically Needy recipients. The legislature financed the restoration of cuts from numerous departments by borrowing money from Oregon's share of the national tobacco settlement and from an education reserve fund.[26]

In addition, Oregon has been working out the details of a demonstration waiver since the summer of the 2001;[27] and on October 15, 2002, Department of Health and Human Services Secretary Tommy Thompson approved Oregon's waiver.

Changes as a result of the waiver include:[28] splitting the Oregon Health Plan (OHP) into OHP Standard and OHP Plus, with different levels of coverage and different application processes; denying coverage to those who cannot afford cost sharing requirements; significantly reducing benefits; and increasing cost sharing, including premiums and co-payments — including a $250 co-pay for inpatient hospital admission.[29]

Rising numbers of uninsured need health care now more than ever

Oregon is 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

Karen Jenkins

I'm a 58-year-old single mother. Because of my worsening health, I can't work a full time job. I have health coverage through the Oregon Health Plan, which used to reliably cover my prescription drugs. Like many other Oregonians, my prescription drug coverage was cut on March 1st. I had to stop taking three of my medications immediately, and was quickly running out of my other prescriptions. I went from complete prescription drug coverage to a $900 bill each month. I can't afford to pay that. I didn't know what I was going to do. Now I have prescription drug coverage again, but only temporarily.

My greatest fear is what will happen if I cannot take my prescription drugs. I have heart problems and kidney problems, and am diabetic. If I can't take my prescription drugs, I will end up in the hospital, which will be much more expensive for the state. I still have a child at home and she needs me. What will she do if something happens to me?

Rose Spears

I'm a 50-year-old single mother and grandmother. Like many others, my prescription drug coverage was recently cut from the Oregon Health Plan. Most of the people I know got a letter from the state telling them their coverage had ended. My pharmacy had to tell me. Since I get monthly automatic refills because I'm an insulin dependent diabetic and need regular medications, my pharmacy called me and told me I didn't have prescription drug coverage anymore, and my medications would cost $912. I told them to put the prescriptions back on the shelf because I can't afford them.

When Measure 28 failed, I went from a $35 dollar co-pay to no prescription drug coverage and a $912 prescription drug bill. I only get $728 a month to live on and my rent alone is $373. Without prescription drug coverage, my medications cost more money than I have each month to live on.

Without my medications, I can't control my blood sugar. Soon after I ran out of medication I ended up the emergency room because my blood sugar skyrocketed. I had to be hospitalized. Hospitalization is a really expensive way to treat diabetes, and will cost the state much more in the long run. Now I have heard I will have prescription drug coverage again, but only temporarily. I do not know if I will have access to my prescription drugs before I need to be hospitalized again. What will happen next time? I'm trying to figure out how to survive without prescription drug coverage but every place I go they say they can't help me because their programs have been cut as well, because of Oregon's budget. Prescription drugs are not a luxury or a choice for me — they are a necessity that I can't survive without.

the connection between unemployment and the uninsured found for every 100 people who lose their jobs, 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.[30]

Cuts reduce the security that public health care programs provide, and create other costs for states. Because low-income people live on very tight budgets, they are vulnerable to unexpected expenses. Medicaid and CHIP provide convenient access to affordable health care, which helps stabilize family economies and stabilize communities.

- Limiting access and cutting benefits can lead to serious problems that might 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.

Taneisha White

I am a single mother with four children. My youngest daughter was born with chronic asthma and a heart condition. She is only eight years old and she takes 10 prescription drugs regularly.

I have insurance with good benefits including prescription drug coverage. However, my co-pay is $249 per month. And I have health expenses as well.

This means that my bills are often paid late. I frequently have to borrow money from family or friends to pay my utility bills. Sometimes, I have had the utilities shut off because money for the bill went to pay for prescriptions.

I have three other children besides my daughter. Because I must spend so much on her care, my children lose out on things other children take for granted. They see fewer movies than their friends. There's no money for family outings and getaways. Nonetheless, they know that their sister's life is more important than the latest movie or video game and are very understanding. Do you know how hard it is for your children to have to be "understanding" and to learn not to ask for anything that costs money?

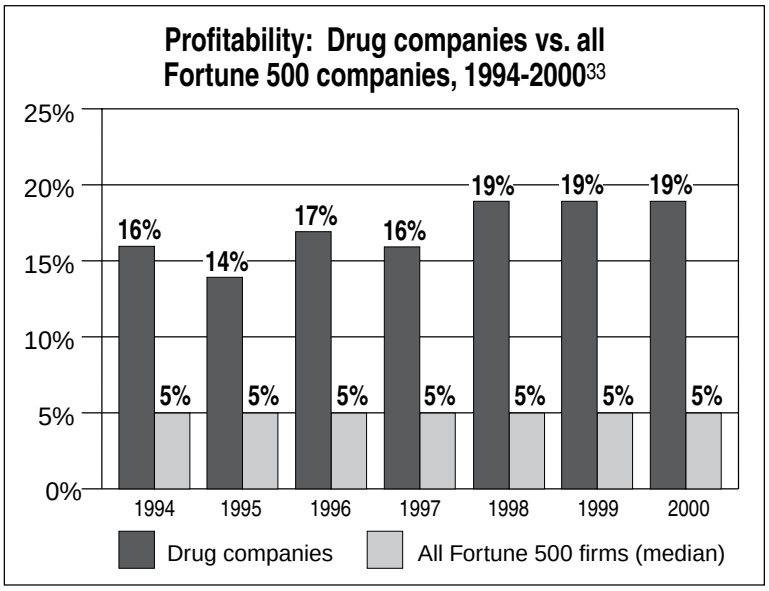
If my daughter didn't take her prescriptions she would be hospitalized. She frequently is hospitalized as it is. For example, without several of her medications, my daughter would die. The only reason she can go to school is because of medication that keeps her blood pressure and heart rate down to normal. Other medications help keep her lungs uncongested and help her breathe. She also needs steroids that open her airways in an emergency. Her doctors say she needs additional medication...but how can I afford more? Then again, how can I not?

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.

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;[31] 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.[32] 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.[34]

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.[35] To settle charges under the False Claims Act, TAP will pay over $560 million to the federal government for Medicare and Medicaid violations, and $25.5 million to the states and the District of Columbia for Medicaid liabilities.[36]

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.[37]

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.[38] 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.[39]

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 companies also aggressively use legal loopholes 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.[40]

Undisclosed and uneven prices

Drug prices are currently established through a complex web of arrangements between drug manufacturers and different pri-

vate and public sector purchasers — like retail pharmacies, insurers, health maintenance organizations, hospitals and government agencies.[41] 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,[42] as they have no access to the rebates and discounts larger purchasers can negotiate. Approximately one in five Oregon residents are without Rx drug coverage, with a similar rate throughout the Northwest.[43] 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.[44]

Oregon residents lacking insurance for prescription drugs[45]

Age 65+ lacking Rx coverage	Lacking any health insurance	Privately insured with no drug coverage	Total lacking drug coverage	Percent lacking drug coverage
154,000	479,000	147,000	780,000	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.

Khanh Le

I am a voter and a citizen of United States. I am a freshman at University of Oregon through scholarships.

My mother and I moved to America on August 28, 1992. Like many other immigrants, we work hard. Both my mom and I do not have health care, but it hurts my mom more because she is 64 years old. Knowing little English, my mom has to work at a hotel for $6.90 an hour. During an average month, she earns no more than $800 for the both of us. From this amount, $550 pays our rent and the rest of the money is used for necessities such as phone, electric, garbage collection, and food.

With my mother's income, there is not enough money to purchase health insurance. My mom is afraid to go to the doctor because of the cost. I know she has arthritis but some of her other health problems have not been diagnosed because we can't afford to go to a doctor. Because we don't have insurance, her prescription drugs costs are extremely high. She regularly has to choose between purchasing food and prescription drugs. Nobody should have to choose between food and health care.

It makes me feel helpless to watch my mother's health deteriorate each day while living in such a wealthy nation and not having access to health care. There are many hard working immigrants who are in the same situation as my mom. There is an old saying: "a healthy worker is a good worker."

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.[46] 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.

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.

Ten best-selling prescription drugs: Prices in Canada vs. the U.S.[49]

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%

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.[47] 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 was 6.1 percent from January 2000 to January 2001.[48] 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.

Ruth Beale

I am a 78-year-old mother, grandmother, and great grandmother. I am a survivor of one stroke and have severe arthritis. I spend $80 a month on my prescriptions, and my entire monthly income is $700. My rent is $420 a month. I am lucky because I have enough time to spend about 10 hours a week calling pharmacies all over Portland to find the best price on my prescription drugs —sometimes I save as much as 50 percent by getting one prescription here and another one there. However, no amount of calling has made my prescription for Celebrex affordable, so I do the best I can with over-the-counter pain medication.

Every month I go to different pharmacies across town, using my walker and the bus to get around. I spend about 20 hours a week going from pharmacy to pharmacy, from downtown to the other side of town just for my medications. I help care for an elderly woman three times a week, and I would love to be able to do more, but I spend most of my time working out ways to afford my prescription drugs.

Per capita spending on pharmaceuticals by country[50]

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 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.[51] 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.[52]

Federal agencies generally purchase prescription drugs through 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.[53] On average these prices are estimated to be 42 percent lower than factory prices.[54] The rebates that state Medicaid programs receive was recently estimated to be about 19 percent of their total prescription drug spending.[55]

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. This hurts consumers and does little to control rising prescription drug prices. 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.[56] Cost sharing and complex prior authorization requirements can create insurmountable barriers.

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.

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

PURCHASING POOLS

Drug manufacturers often will pay a rebate to large volume purchasers.[57] The savings negotiated typically depend on the volume of drugs purchased over a given period — the larger the amount purchased, the greater the rebate.[58] Rebates effectively reduce the price purchasers pay. So a movement is afoot to pool purchases among larger and larger groups of buyers.

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.

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.

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.[59] 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.[60]

The solution

Oregon can save money without harming residents by changing how state agencies purchase prescription drugs

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

By pooling prescription drug purchases across state agencies and between states, or by creating agency, state or regional preferred drug lists, Oregon 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 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 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.[61]

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.[62] West Virginia's Public Employees Insurance Agency has 210,000 members,[63] and RXIS covers over 502,000 people.[64,65] 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.[66]

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.

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 New England Tri-state Prescription Drug Purchasing Coalition estimates it will save 10-15 percent annually on prescription drug costs by pooling purchases.[67]

Vermont, Michigan, Wisconsin, and other states are setting up a multi-state Medicaid prescription drug purchasing pool. Although Vermont and Michigan do not have a specific estimate on the additional amount they will save by using a preferred drug list and a purchasing pool, both states are anticipating higher savings.

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.[68]

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.[69]

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 2 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.[70]

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.[71]

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.

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.[72] The program was projected to save between 5 and 9 percent on the agencies' prescription drug spending.[73] While phasing in therapeutic classes, Vermont's preferred drug list saved the covered programs about $2.8 million in the first seven months,[74] and is on target to meet the projected savings range of 5 to 9 percent.

Vermont, Michigan, Wisconsin, and other states are setting up a multi-state Medicaid prescription drug purchasing pool.[75] Although Vermont and Michigan do not have a specific esti-

mate on the additional amount they will save by using a preferred drug list and a purchasing pool, both states are anticipating higher savings. The National Legislative Association on Prescription Drugs is developing a nonprofit group that would take the place of for-profit pharmaceutical benefit managers. The new drug benefit manager will work with New York, Maine, Massachusetts, Connecticut, Rhode Island, Vermont, New Hampshire, Pennsylvania, Hawaii, and the District of Columbia.[76] And numerous other states have programs in the works as well.

Summary of examples of projected or realized savings from current purchasing pools and preferred drug lists[78]

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	W. Virginia's pub. emplys 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 and purchasing pool	1,500,000	Medicaid	10-12% + additional savings for purchasing pool
Vermont Medicaid preferred drug list	Preferred drug list and purchasing pool	134,000	Medicaid	5-9% + additional savings for purchasing pool
Oregon Health Plan practitioner managed prescription drug plan	Preferred drug list	150,000	Medicaid (Oregon Health Plan)	5%

In August 2002, Oregon began implementing a preferred drug list for the Oregon Health Plan (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.[77]

Oregon Governor Kulongoski has contacted governors of Northwest states, asking them to meet with him to exchange information on creating a regional purchasing pool.[79]

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 Northwest states to consider joint purchasing agreements to address the challenge of the high cost of prescription medication.[80]

Washington Citizen Action is leading a coalition of over 35 organizations representing seniors, labor, health care providers, community, and faith based organizations in support of legislation that would pool prescription drug purchases and create a shared preferred drug list among state agencies and open the pool up to the uninsured. This legislation, SHB 1214, was passed by the House on February 7, 2003.

Oregon can save money by pooling prescription purchases with other states: Larger volume purchasers save more money[82]

Group	Approximate number of people the program(s) serve
RXIS	502,000
Oregon state agencies[83] and the uninsured	1,482,000
Idaho state agencies[84] and the uninsured	540,000
Montana state agencies[85] and the uninsured	380,000
Washington state agencies[86] and the uninsured	2,720,000
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.[81]

Because larger volume purchasers generally receive greater savings, and a Northwest pool of state programs and the uninsured would likely cover over five million residents — over 10 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.

Oregon 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.

Oregon's estimated prescription drug purchases[87]

Agency	Estimated 2002 cost
Medicaid Fee-for-service	$205,229,376
Medicaid Managed Care	$177,160,444
Public Employees Benefit Board (PEBB)	$55,763,169
Kaiser (PEBB and PERS)	$26,335,201
Public Employees Retirement System (PERS)	$23,321,520
Worker's Compensation Division	$22,457,760
Oregon Medical Insurance Pool	$9,766,484
Department of Corrections	$6,406,579
Oregon Health Division	$4,837,056
Oregon State Hospital	$4,318,800
Oregon Youth Authority	$1,300,823
University of Oregon	$1,050,374
Oregon State University	$863,760
Office of Alcohol and Drug Abuse Programs	$630,545
State Veterans' Home	$172,752
Portland State University	$104,261
Vocational Rehabilitation Division	$77,738
Western Oregon University	$38,005
Oregon Institute of Technology	$32,802
Eastern Oregon University	$20,283
State Office for Services to Children and Families	$3,455
Estimated total	**$539,891,188**

Oregon prescription drug purchasing

Numerous Oregon agencies and programs purchase prescription drugs — with differing prices and strategies. The amount the state would save by pooling prescription drug purchasing and creating a shared preferred drug list depends on which agencies are included. The table on page 20 estimates the amount the state could save if major state purchasers of prescription drugs are included, based on agency spending estimates for 2002 and projected or realized savings from existing programs as discussed above. Most of the existing prescription drug purchasing programs reviewed in this report are either purchasing pools, or preferred drug lists. If Oregon creates a larger program that both pools prescription drug purchasing and creates a shared preferred drug list, Oregon could save even more.

Some agencies were not included in the table because of how they purchase prescription drugs. For example, the Department of Corrections uses the Minnesota Multistate Contracting Alliance for Pharmacy — an existing purchasing pool — to purchase prescription drugs. Worker's compensation benefits in Oregon are paid by insurers and self-insured employers and do not go through the state budget except to the extent that the state is an employer. Other programs have access to specific discounts, or are relatively small purchasers of prescription drugs. Oregon is currently reviewing how different agencies purchase prescription drugs.[88]

Estimated annual prescription drug savings for selected state agency programs[89]

Agency	Estimated 2002 costs	5% savings	10% savings	15% savings	20% savings
Medicaid Fee-for-service	$205,229,376	$10,261,469	$20,522,938	$30,784,406	$41,045,875
Medicaid Managed Care	$177,160,444	$8,858,022	$17,716,044	$26,574,067	$35,432,089
Public Employees Benefit Board (PEBB)	$55,763,169	$2,788,158	$5,576,317	$8,364,475	$11,152,634
Kaiser (PEBB and PERS)	$26,335,201	$1,316,760	$2,633,520	$3,950,280	$5,267,040
Public Employees Retirement System (PERS)	$23,321,520	$1,166,076	$2,332,152	$3,498,228	$4,664,304
Oregon Medical Insurance Pool	$9,766,484	$488,324	$976,648	$1,464,973	$1,953,297
Total	**$497,576,195**	**$24,878,810**	**$49,757,619**	**$74,636,429**	**$99,515,239**

The uninsured and private purchasers of prescription drugs can save as well if they are allowed to purchase with state agencies. Larger volume purchasers generally receive greater savings — so if more groups are allowed to join the purchasing pool, the percentage each group will save will likely increase. Because the uninsured already pay the highest prices for prescription drugs, they will likely save a higher percentage than other purchasers. Uninsured Oregon residents spend an estimated $242 million on prescription drugs each year.[90]

As prescription drug costs continue to rise, the exact amount state agencies and the uninsured could save by pooling prescription drug purchases will rise as well.

Conclusion

Oregon should change how it purchases 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.

Endnotes

1 National Conference of State Legislators, "State Fiscal Update, April 2002," April 16, 2002.

2 *Ibid.*

3 Oregon Center on Policy Priorities, "E-mail Update," November 19, 2002.

4 Oregon Department of Human Services, "The DHS Budget," January 14, 2003.

5 Department of Administrative Services, Office of Economic Analysis, State of Oregon, *Oregon Economic and Revenue Forecast*, March, 2003.

6 David Cooke, "Oregon's Unemployment Rate Rises to 7.5 Percent in January," Employment Department, State of Oregon, February 28, 2003.

7 Mark Nord *et al*., "Household Food Security in the United States, 2001,"United States Department of Agriculture, Food Assistance and Nutrition Research Program, October 2002. Data for three years were combined to provide more reliable statistics at the state level.

8 Kaiser Daily Health Policy Report, January 8, 2002.

9 The National Institute for Health Care Management, *Prescription Drug Expenditures in 2001: Another Year of Escalating Costs*, April, 2002.

10 *Ibid*.

11 *Ibid*.

12 *Ibid*.

13 Robert Pear, "Propelled by Drug and Hospital Costs, Health Spending Surged in 2000," *New York Times*, January 8, 2002.

14 Kaiser Daily Health Policy Report, "Medications, New Treatments, Devices Responsible for Premium Increases in 2001, Study Says," April 25, 2002.

15 Scott-Levin data compiled by American Institute for Research (AIR), as cited in The National Institute for Health Care Management's *Prescription Drug Expenditures in 2001: Another Year of Escalating Costs*, May 2002.

16 *Ibid*.

17 Kaiser Commission on Medicaid and the Uninsured, *Medicaid Budgets Under Stress*, October, 2001.

18 *Ibid*.

19 Families USA, *Medicaid: Good Medicine for State Economies*, January, 2003.

20 Moore School of Business at University of South Carolina, "Economic Impact of Medicaid in South Carolina," January, 2002.

21 Bobby Mink, Director of the Oregon Department of Human Services, message to DHS employees, November 15, 2002.

22 Oregon Department of Human Services, "The DHS Budget," January 14, 2003.

23 Oregon Department of Human Services, proposed reductions by county, available at http://www.hr.state.or.US/budget/reductions.html.

24 Department of Human Services, *HB 5100 Unspecified Reductions*, November 14, 2002.

25 Jean Thorne, "DHS Director's Weekly Message," Oregon Department of Human Services, March 5, 2003.

26 Timothy Egan, "Drug Benefits Are Restored Temporarily in Oregon," *New York Times*, March 5, 2003.

27 Kaiser Daily Health Policy Report, "Oregon Legislative Panels Approve Plan to Expand Oregon Health Plan," May 3, 2002.

28 Oregon Department of Human Services slideshow, "Oregon Health Plan: Medicaid Demonstration," December 6, 2002.

29 Charles Beggs, "Health Plan Expansion is on Track," *Eugene Register Guard*, May 1, 2002.

30 The Henry J. Kaiser Family Foundation, *Rising Unemployment and the Uninsured*, December, 2001.

31 The National Institute for Health Care Management, *Prescription Drug Expenditures in 2001: Another Year of Escalating Costs*, April, 2002.

32 *Fortune Magazine*, April 1, 2002.

33 "Fortune 500 Industry Rankings," *Fortune Magazine*, April issues, various years, as cited in Henry J. Kaiser Family Foundation's *Prescription Drug Trends: A Chartbook*, Washington, DC, July 2000, 72. Note: Percent is the median percent net profit after taxes as a percent of firm revenues for all firms in the industry.

34 Judith Waltz, "Multimillion Dollar Settlement Signals Government's Increased Scrutiny of Pharmaceutical Industry," *Drug Benefit Trends* 13 (11) 2001, 15-16.

35 Kaiser Daily Health Policy Report, January 8, 2002.

36 Judith Waltz, "Multimillion Dollar Settlement Signals Government's Increased Scrutiny of Pharmaceutical Industry," *Drug Benefit Trends* 13 (11) 2001, 15-16.

37 Melody Peterson, "Pfizer's Chief Is Subpoenaed in an Inquiry on Drug Pricing," New York Times, January 8, 2002.

38 Families USA, *Collusion and Anticompetitve Practices: A Survey of Class Action Lawsuits Against Drug Manufacturers*, 2002.

39 Families USA, *The Drug Industry: Facts and Figures*, April, 2002.

40 Michie I. Hunt, *Prescription Drugs and Intellectual Property Protection*, National Institute for Health Care Management, August, 2000.

41 John Hansen, *United States Prescription Drug Pricing and Reimbursement Policies*, U.S. General Accounting Office.

42 Anna Cook, "Why Different Purchasers Pay Different Prices for Prescription Drugs," memorandum prepared for the DHHS Conference on Pharmaceutical Pricing Practices, Utilization and Costs, August, 2000.

43 Alan Sager and Deborah Socolar, *A Prescription Drug Peace Treaty*, October 5, 2000.

44 Department of Health and Human Services, *Prescription Drug Coverage, Spending, Utilization and Prices, Appendix C*, April, 2000, available at http://aspe.hhs.gov/health/reports/drugstudy/.

45 1998 data. Alan Sager and Deborah Socolar, *A Prescription Drug Peace Treaty*, October 5, 2000.

46 Henry J. Kaiser Family Foundation, *Prescription Drug Trends*, Washington, DC, September 2000.

47 Social Security Online, "Frequently Asked Questions," November 2001, available at http://www.ssa.gov.

48 Families USA, *Enough to Make Sick: Prescription Drug Prices for the Elderly*, Washington, DC, June, 2001.

49 *USA Today*, November 10, 1999, as cited in *Playing Fair: State Action to Lower Prescription Drug Prices*, Center for Policy Alternatives, Washington, DC, June 2000, 2.

50 The Henry J. Kaiser Family Foundation, *Prescription Drug Trends: A Chartbook*, Washington, DC, July, 2000, 27.

51 John Hansen, *United States Prescription Drug Pricing and Reimbursement Policies*, U.S. General Accounting Office.

52 William Von Oehsen III, "Pharmaceutical Discounts Under Federal Law," Public Health Institute, Washington, DC, May, 2001.

53 *Ibid*.

54 Alan Sager and Deborah Socolar, *A Prescription Drug Peace Treaty*, October 5, 2000.

55 U.S. General Accounting Office, *Prescription Drugs: Expanding Access to Federal Prices Could Cause Other Price Changes*, August, 2000.

56 Peter Cunningham, "Affording Prescription Drugs: Not Just a Problem for the Elderly," Center for Studying Health System Change, April, 2002.

57 Anna Cook, *Why Different Purchasers Pay Different Prices for Prescription Drugs*, Mathematical Policy Research, August 8-9, 2000.

58 Samantha Ventimiglia, *Pharmaceutical Purchasing Pools*, National Governors' Association Issue Brief, October 24, 2001.

59 National Governors' Association Center for Best Practices, *Oregon Agrees on Prescription Drug Pricing Plan*, Washington, DC.

60 "Michigan Program Designed to Cut Drug Costs," CNN website, January 21, 2002, available at http://www.cnn.com/2002/HEALTH/01/21/medicaid.prescriptions.ap/index.html.

61 Felice Joseph, Pharmacy Benefits Administrator, West Virginia Public Employees Insurance Agency, personal communication, November, 2002.

62 *Ibid*.

63 Jim Wallace, "Proposed Drug Pool to Save $25 Million," *Charleston Daily Mail*, March 26, 2002.

64 State of West Virginia Public Employees Insurance Agency Request for Proposal for Pharmacy Benefit Management Services, October 17, 2001.

65 Felice Joseph, Pharmacy Benefits Administrator, West Virginia Public Employees Insurance Agency, personal communication, November, 2002.

66 Michael Waldholz, "States Use Their Purchasing Power as Leverage to Limit Drug Prices," *The Wall Street Journal*, July 21, 2002.

67 Samantha Ventimiglia, *Pharmaceutical Purchasing Pools*, National Governor's Association Issue Brief, October 24, 2001.

68 National Conference of State Legislatures, *2002 Prescription Drug Discount, Bulk Purchasing, and Price-Related Legislation*, June 14, 2002.

69 *Ibid*.

70 Laurie Garner, Director of Pharmacy Services, Georgia Department of Community Health, personal communication, October 9, 2002.

71 James Haveman, Director, Michigan Department of Community Health, "Michigan's Pharmaceutical Best Practices Initiative" presentation, Portland, Oregon, October 11, 2002, available at http://oregonrx.org/Gov_Summit/states_and_provinces.htm.

72 Mike Powers, Pharmacist, First Health, Vermont, personal communication, November, 2002.

73 Stephen Kappel, "Fiscal Note: H.31 An Act Relating to the Prescription Drug Cost-Containment and Affordable Access," Vermont Joint Fiscal Office, July 1, 2002.

74 Mike Powers, Pharmacist, First Health, Vermont, personal communication, November, 2002.

75 Amy Bailey, "Michigan, Vermont to Buy Drugs Together As a Way to Cut Medicaid Costs," Associated Press, February 21, 2003.

76 Milt Freudenheim, "States Organizing a Nonprofit Group to Cut Drug Costs," *New York Times*, January 14, 2003.

77 Kurt Furst, Office of Oregon Health Policy and Research, personal communication, November, 2002.

78 See endnotes in above discussion of the same information included in the table.

79 Dana Haynes, "Wholesale Drug Plan Unveiled," *Statesman Journal*, Salem, Oregon, February 9, 2003.

80 *Senate Joint Memorial 8001*, State of Washington, 2002 regular session.

81 *House Concurrent Resolution No. 26*, State of Idaho, 2001 regular session.

82 Alan Sager and Deborah Socolar, *A Prescription Drug Peace Treaty*, October 5, 2000. Provides an estimate of the number of people without prescription drug coverage.

83 Enrollment data provided by state agencies. Oregon agencies: The Oregon Health Program; Public Employees Benefit Board State Employee Health Plan; AIDS Prescription Drug Program in the Department of Human Services; Prison Health Services in the Department of Corrections.

84 Enrollment data provided by state agencies. Idaho agencies: The Medicaid Program in the Department of Health and Welfare; The State Employee Health Plan in the Office of Insurance Management; AIDS Prescription Drug Program in the Department of Health and Welfare; Prison Health Services in the Department of Corrections.

85 Enrollment data provided by state agencies. Montana agencies: The Medicaid Program in the Department of Public Health and Human Services; The State Employee Health Plan in the Administration Department; AIDS prescription drug program in the Department of Public Health and Human Services; Worker's Compensation and other programs in the Montana State Fund.

86 *Washington State Prescription Drug Project Phase I Final Report*, June 29, 2001.

87 Oregon Health Plan Policy and Research, "Oregon's Estimated Prescription Drug Purchases," January 3, 2001. The table includes estimates of 1999 data, adjusted to 2002 estimates based on increases in prescription drug prices.

88 Kurt Furst, Office of Oregon Health Policy and Research, personal communication, March 2003.

89 Data taken from: Oregon Health Plan Policy and Research, "Oregon's Estimated Prescription Drug Purchases," January 3, 2001. Savings percentages based on existing programs as referenced and discussed in above section, "Other states are already saving money using purchasing pools and preferred drug lists."

90 Alan Sager and Deborah Socolar, *A Prescription Drug Peace Treaty*, October 5, 2000.

About the organizations releasing this report

Oregon Action is a statewide community organization dedicated to economic justice. Through leadership development and community organizing, we support people's voices in the decisions that impact their lives. A broad-based, multi-racial organization, we build united power for the common good. We place special emphasis on empowering under-represented peoples, particularly Oregon's low- and moderate-income people and people of color. We provide the organizational power base for participatory democracy, just communities, and a fair economy.

The Fair Share Research & Education Fund is a supporting organization affiliated with Oregon Action. Contributions to FSRE are tax-deductible and support our research, public education and outreach activities.

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.

For more information, contact:

The Northwest Federation of Community Organizations
1905 S Jackson St • Seattle, WA 98144
Voice: (206) 568-5400 • Fax: (206) 568-5444
Web: http://www.nwfco.org

This report is available electronically at www.nwfco.org.