Medicaid: Someone You Know Needs it

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Idaho Community Action Network

Idaho Community Action Network (ICAN)

Taking Action Making Change

Northwest Federation of Community Organizations (NWFCO)

Idaho Lags Behind Region and Nation in Prescription Drug Savings

Executive summary

With prescription drug prices on the rise across the nation in all types of healthcare programs, more and more states are pooling the prescription drug purchases of their state agencies, and are joining together with other states to negotiate large prescription drug discounts. As this report details, numerous states are already saving substantial sums using purchasing pools. But Idaho lags behind the Northwest and the nation in negotiating prices from prescription drug manufacturers.

Idaho's plans to begin collecting supplemental rebates,[1] depending on how they are implemented, are likely a step in the right direction. However, Idaho can save more on prescription drugs by pooling the prescription drug purchasing of state agencies and banding together with other states — as numerous states have already done — to increase their negotiating power. States already using purchasing pools report saving around 15 percent of their total prescription drug costs. By pooling purchases, Idaho would likely save around 15 percent of total drug costs as well. Using data from 2001, this would have resulted in nearly $19 million in savings for selected state agencies. As prescription drug costs continue to rise, the exact amount Idaho could save will rise as well. Pooling purchases will save Idaho money that can be reinvested in public health care programs.

Strategies states are using to reduce prescription drug spending

Prescription drugs are becoming an increasingly larger portion of health care spending in all health care programs.[2] 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.[3] 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.

Many states have developed strategies to deal with rising drug prices, and to get the best price available.

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

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prescription drug prices. These access limiting strategies are particularly troubling in light of day recent study that found Medicaid consumers in states using multiple access limiting strategies to reduce prescription drug costs had trouble acquiring needed prescription drugs.[4] Strategies like 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.

Drug manufacturers often will pay a rebate to large volume purchasers.[5] The savings negotiated typically depend on the volume of drugs purchased over a given period — the larger the amount purchased, the greater the rebate.[6] 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. Under the current prescription drug pricing system, people without prescription drug coverage pay the most for prescription drugs and are affected most by rising prices,[7] as they have no access to the rebates and discounts larger purchasers can negotiate. Access to state negotiated prices makes prescription drugs affordable to more state residents.

State-wide or multi-state purchasing pools are often combined with prescription drug preferred drug lists to further increase savings.

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.

West Virginia PEIA reported that they saved around $7 million during their first full year in the multi-state purchasing program, easily meeting their savings projection. "We are extremely pleased with the results of this program," said PEIA director Tom Susman.

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.

Many other states are already saving money using multi-state and multi-agency purchasing pools

Nationwide:

Numerous states have multistate or multiagency purchasing pools in the works.

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

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 includes the following agencies: West Virginia's Public Employees Insurance Agency (PEIA) 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. Other programs are expected to join imminently.[8] Both public payers and private entities can join; new requests for information on how to join come in weekly.[9]

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.[10] West Virginia's PEIA has 210,000 members,[11] and RxIS currently covers over 700,000 people.[12] By pooling purchases, West Virginia PEIA projected it would double current rebates and save $25 million over the first three years — saving about 8 percent on drug costs in their first year of operation.[13] West Virginia PEIA reported that they saved around $7 million during their first full year in the multi-state purchasing program, easily meeting their savings projection. "We are extremely pleased with the results of this program," said PEIA director Tom Susman.[14]

Vermont, Michigan, and other states are setting up a multi-state Medicaid prescription drug purchasing pool. Building off of the already successful preferred drug lists implemented by Michigan and Vermont, this purchasing pool will allow these states to save even more money by working together.

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.[15]

Georgia started phasing in a multi-agency prescription drug purchasing program in 2000. 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.[16]

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.

Vermont, Michigan, and other states are setting up a multi-state Medicaid prescription drug purchasing pool.[17] Building off of the already successful preferred drug lists implemented by Michigan and Vermont, this purchasing pool will allow these states to save even more money by working together. Michigan estimates it can save tens of millions of dollars through the purchasing pool, even if only one other state joins the pool.[18]

Here is some background on the preferred drug lists that Michigan and Vermont will be pooling:

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.[19]

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.[20] The program was projected to save between 5 and 9 percent on the agencies' prescription drug spending.[21] While phasing in therapeutic classes of drugs, Vermont's preferred drug list saved the covered programs about $2.8 million in the first seven months,[22] and is on target to meet the projected savings range of 5 to 9 percent.

The National Legislative Association on Prescription Drugs is developing a nonprofit group that would take the place of the for-profit pharmaceutical benefit managers that many states use to negotiate prices and manage benefits in these purchasing pools. The non-profit would work to ensure payments and rebates from drug companies benefit the states, not the for-profit middlemen.[23] 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.[24]

And numerous other states have programs in the works as well. 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.[25] Texas and Massachusetts have passed legislation to create multi-agency purchasing programs and are in the process of setting up these programs.[26]

In 2003, Washington and Oregon both passed legislation that will lower prescription drug costs for these states while providing access to lower cost prescription drugs for thousands of low to moderate income seniors and people with disabilities.

These programs will save Oregon and Washington money that can be reinvested in public health care programs, in addition to helping thousands of uninsured individuals.

Northwest states:

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In Washington, Senate Bill 6088 was signed into law on June 26, 2003. The legislation requires the state to negotiate price discounts with prescription drug manufacturers on behalf of state agencies and on behalf of Washington residents age 50 and above or eligible for Social Security benefits, with income below 300 percent of the federal poverty level. This legislation essentially pools the prescription drug purchasing of state agencies and certain state residents without prescription drug coverage, saving money for both.

In Oregon, Senate Bill 875 was signed into law on August 29, 2003. The legislation creates a purchasing pool that includes state agencies, local governments, and uninsured residents 55 and older with incomes under 185 percent of the federal poverty level. The legislation also calls for Oregon to cooperate with other states or regional entities in the bulk purchase of prescription drugs, and calls for a review after one year to investigate further expansion of the program.

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.

These programs will save Oregon and Washington money that can be reinvested in public health care programs, in addition to helping thousands of uninsured individuals.

In short, states across the nation and the Northwest are pooling prescription drug purchases to save money and protect public healthcare programs. Unfortunately, Idaho lags behind.

Idaho could save money and protect public programs by pooling purchases with other states

The Idaho Department of Health and Welfare is working on a system to negotiate supplemental rebates for prescription drugs provided to Medicaid beneficiaries, although few details about the program have been revealed yet, and a start date for the program was not available at press time.[27] While this program — depending on how it is implemented — is likely a step in the right direction, Idaho can do much more to negotiate lower prices with prescription drug manufacturers by working with other states to increase negotiating power.

Idaho residents lacking insurance for prescription drugs[28]

Age 65+ lacking Rx coverage	Lack any health insurance	Privately insured with no drug coverage	Total lacking drug coverage	Percent lacking drug coverage
51,000	225,000	58,000	334,000	26%

Jolene Poen
Downey, Idaho

One day at work I passed out on a scaffolding. An ambulance took me to the hospital and everyone assumed it was just heat stroke. The next day, when I was getting ready for work, I passed out. I called my doctor and went in for testing. It turned out that a heart problem was responsible for my passing out. The doctors ran a few more procedures and said the problem was fixed.

I felt healthy and returned to work, but after three days I passed out again. Another ambulance came to pick me up and, before the ambulance left, my employer told me I was no longer welcome in his plant. I was too high of a risk. He did pay my benefits through the union for six months, though. After that, I had no medical coverage.

My health and welfare worker helped me find a special program for the aged and disabled, and now that it's been two years, I receive Medicare as well as Medicaid. If it had not been for this very kind man who listened to my situation, I would have been left without any medical coverage.

I'm still struggling with my condition but it is better than it was. Before I got on Medicaid, I would pass out two to three times a week. Now I have a personal care provider and it's down to two times a month because I don't have to put myself at as much risk anymore.

My life literally depends on Medicaid. The legislature shouldn't cut public healthcare programs; cuts to programs like Medicaid would be extremely harmful to me and many others in similar situations. Idaho can save money and protect public programs by joining a prescription drug purchasing pool, as many states have already done.

Creating or joining an existing prescription drug purchasing pool has an added benefit for Idaho: these pools can also be opened up to the uninsured, as states including Oregon and Washington have already done, providing critical access to prescription drugs for more Idaho residents. Approximately one in four Idaho residents are without Rx drug coverage.[29]

State agencies that purchase prescription drugs in the state of Idaho 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 purchased prescription drugs for over 206,000 people in 2001.

Estimated prescription drug savings for uninsured Idaho residents and selected state agency programs, based on 2001 data[30]

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

Numerous states are already saving money using purchasing pools; many states report saving 10 to 15 percent of their total prescription drug costs annually. As prescription drug costs continue to rise, the exact amount Idaho could save rises as well. By pooling the prescription drug purchases of Idaho state agencies, and joining with other states, Idaho too can save critical funds that can be reinvested in public healthcare programs — protecting Medicaid for Idaho's families.

Endnotes

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

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

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

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

18 National Conference of State Legislatures, "Pharmaceutical Bulk Purchasing: Multi-state and Inter-agency Plans," December 12, 2003.

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

23 National Conference of State Legislatures, "Pharmaceutical Bulk Purchasing: Multi-state and Inter-agency Plans," December 12, 2003.

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

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

26 *Ibid*.

27 Shawna Kittridge, Pharmacy Services Specialist, Idaho Department of Health and Welfare, personal communication, December , 2003; Idaho Administrative Bulletin, December 3, 2003, volume 03-12, page 66-67.

28 1998 data. Alan Sager and Deborah Socolar, *A Prescription Drug Peace Treaty*, October 5, 2000.

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

30 Sources: Spending was provided the Department of Health and Welfare. Spending is the 2001 total spending on prescription drugs. Spending on the uninsured is from an October 2000 study by Sager and Socolar, Boston U. School of Public Health, A Prescription Drug Peace Treaty: Cutting Prices to Make Prescription Drugs Affordable for All and to Protect Research — State by State Savings. This study is based on drug manufacturers' own reports of their revenues. The authors' worksheet refers to these payments as "self-pay" and they are assumed to enjoy no discounts or rebates. This ignores discounts or rebates that might be paid to insurers for some patients — probably very few counted as self-pay but were in fact insured. See Appendix on Methods of the report cited above. Notes on purchasing: the AIDS drug assistance program uses the 340B program, the state employee health program uses 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.

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. 1265 South Main Street Suite #305, Seattle, WA 98144, Voice: (206) 568-5400, Fax: (206) 568-5444, Web: http://www.nwfco.org.

Idaho Community Action Network (ICAN) serves as a powerful, consolidated voice for Idaho's poor, with chapters and membership clusters in 12 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. 1311 West Jefferson, Boise, ID 83702, Voice: (208) 385-9146, Fax: (208) 336-0997, Web: http://www.nwfco.org/idaho/icn.html