Ideas in Action

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The Best Medicine at the Best Price:

Pooling Rx Purchases in Washington State

Executive summary

Prescription drug costs are rising rapidly across the nation and the Northwest, in all types of health care programs. To deal with these costs, many states have started negotiating lower prescription drug prices from the extremely profitable pharmaceutical companies — and they are already saving money. Larger volume purchasers can negotiate larger savings, so states are creating large purchasing pools. 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, Washington State agencies would likely realize savings between 5 and 15 percent of their total prescription drug costs as well. 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. Washington State should change how it purchases prescription drugs by pooling the prescription drug purchases of state agencies; opening these pools up to the underinsured and uninsured, private entities, local units of government, and labor organizations; and joining with other states to increase their savings.

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Purchasing pools and preferred drug lists save states money

Many groups have combined their prescription drug purchasing in order to use larger volumes of purchases to negotiate larger savings. Drug manufacturers will pay a rebate to large volume purchasers of prescription drugs.[1] The savings negotiated typically depend on the volume of drugs purchased over a given period — the larger the amount purchased, the greater the rebate.[2] 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, private entities, units of local government, and labor organizations. By opening up the pool, people without prescription drug coverage benefit from the state-negotiated savings, and all participants 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.

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 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.

Other states are already saving money by changing how they purchase prescription drugs

Several major multi-state purchasing pools are underway. A multi-state purchasing pool called RXIS includes West Virginia, Missouri, New Mexico, Delaware, and Ohio. Many other states have expressed interest in joining, 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 1, 2002. Agencies in the pool include: 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. The pool has been expanded several times, and more organizations may join later. Both public payers and private entities can join; new requests for information on how to join arrive weekly.[3]

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.[4] West Virginia's Public Employees Insurance Agency has 210,000 members,[5] and RXIS covers 700,000 people.[6,7] 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.[8]

The National Medicaid Pooling Initiative (NMPI), also called the Michigan Multi-State Pooling Agreement (MMSPA) covers Medicaid recipients in eight states: Michigan, Vermont, Alaska, Nevada, New Hampshire, Minnesota, Hawaii, and Montana. The pooled purchasing program covers about 1.5 million people, and purchases around $2 billion in prescription drugs annually. Other states are considering joining in as well.[9] Initially the program included Michigan, Alaska, Nevada, New Hampshire and Vermont. This pool of five states projected that together they would save $12 million in 2004.[10]

Several states have projected the savings they expect from the pro-

Examples of projected or realized savings from purchasing pools and preferred drug lists[21]

Name of Program	Type of Program	Approximate number enrolled in program	Agency reporting savings	Projected or realized savings
RXIS	Multi-state prescription drug purchasing pool	700,000	West Virginia's Public employees insurance agency	8 percent
National Medicaid Pooling Initiative (NMPI)	Multi-state prescription drug purchasing pool	1,500,000	Michigan Medicaid	10 percent
NMPI	Multi-state prescription drug purchasing pool	1,500,000	Hawaii Medicaid	9 percent
NMPI	Multi-state prescription drug purchasing pool	1,500,000	Montana Medicaid	5 percent
Georgia Department of Community Health prescription drug program	State agencies' purchasing pool and preferred drug list	2,000,000	Medicaid	10 percent
Michigan pharmaceutical products list	Preferred drug list	1,500,000	Medicaid	10 to 12 percent
Vermont Medicaid preferred drug list	Preferred drug list	134,000	Medicaid	5 to 9 percent

gram. Here are some examples: Hawaii spends about $100 million annually on prescription drugs for the 37,500 residents enrolled in Medicaid. The state estimates it will save $9 million annually in prescription drug costs — a 9 percent annual savings.[11] Montana spends roughly $95 million annually on prescription drugs and estimates it will save over 5 percent of this by joining the pool.[12] Michigan has already reduced its prescription drug costs substantially by using a preferred drug list (see below). Michigan estimates the purchasing pool will save them additional tens of millions of dollars in Medicaid prescription drug costs each year — as much as $50 million. This could result in a further 10 percent savings for Michigan.[13]

Another coalition, called the New England Tri-state Prescription Drug Purchasing Coalition —

Estimated prescription drug savings for uninsured Washington residents and selected state agency programs[22]

Payors	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**

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 10-15 percent annually on prescription drug costs by pooling purchases.[14]

Legislators in a number of other states have passed or are considering legislation on bulk purchasing pools as well. And many states have state purchasing pools in the works.

Georgia started phasing in a multi-agency prescription drug purchasing program in 2000.[15] 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]

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 which administers 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.[17]

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.[18] The program was projected to save between 5 and 9 percent on the agencies' prescription drug spending.[19] While phasing in drugs by therapeutic classes, Vermont's preferred drug list saved the covered programs about $2.8 million in the first seven months,[20] and is on target to meet the projected savings range of 5 to 9 percent.

Washington can save money without harming residents by changing the purchasing of prescription drugs

Washington prescription drug purchasing

In 2003, the Washington State Legislature passed legislation that lays the foundation for a strong purchasing pool. The legislation requires the state to negotiate price discounts with prescription drug manufacturers on behalf of uninsured Washington residents age 50 and above or eligible for Social Security benefits, with income below 300 percent of the federal poverty level (FPL). And the legislation encourages state agencies to work together to negotiate lower prescription drug

prices as well. Because of recent federal Medicare legislation, the state has not implemented the pool for residents eligible for Medicare discount drug cards, so now very few uninsured residents can benefit from the program.

The current pool could be much larger, produce more dramatic savings for more participants, and cover far more under and uninsured state residents. The 2005 session provides the opportunity to expand and improve the existing prescription drug pool.

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.

Data from the Washington Department of Corrections and Department of Veteran's Affairs were not available. The state also purchases prescription drugs through a managed care program called Healthy Options in the Department of Social and Health Services, but this program's prescription drug spending data were not available. So the amount Washington could save by pooling state agency purchases is even larger. As prescription drug spending increases, as it does annually, the exact amount the state will save increases.

A pool covering Washington State agencies would pool the negotiating power of over 1.2 million people.[23] An additional 1.2 million Washington residents don't have prescription drug coverage[24] and could increase the size of the pool. And local units of government, private entities, and labor organizations would further enlarge the power of the group. The RXIS multi-state purchasing pool currently combines the purchasing power of only 700,000 people and is saving 8 percent on prescription drug purchases a year. A Washington State pool of state agencies and the uninsured would be nearly four times the size of RXIS.

By creating the largest purchasing pool possible, and by pooling with other states, Washington can save even more. The larger the purchasing power of the pool, the deeper discounts it can negotiate. If Washington were to further expand the pool by purchasing

with other states, all pool participants could save even more.

Conclusion

Washington State should change how it purchases prescription drugs by pooling the prescription drug purchases of state agencies, opening these pools up to the underinsured and uninsured, private entities, labor organizations, and local units of government. Washington State should also join with other states to increase negotiating power and savings. By doing so, Washington State can save money, help the underinsured and uninsured, retain the strength of important public health care programs, and generate savings for all groups included in the purchasing pool.

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

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

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

4 *Ibid*.

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

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

7 Felice Joseph, Pharmacy Benefits Administrator, West Virginia Public Employees Insurance Agency, personal communication, November 2002; West Virginia Pharmaceutical Cost Management Council, *Annual Report*, December 29, 2004.

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

9 National Conference of State Legislatures, "Pharmaceutical Bulk Purchasing: Multi-state and Inter-agency Plans, 2004," updated January 5, 2005.

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11 "State Hopes to Join Pool to Cut Medicaid Drug Costs," *The Honolulu Advertiser*, April 23, 2004.

12 "Montana Governor Martz Announces Plan to Cut Cost of Medicaid Prescription Drugs," State of Montana Press Release, May 1, 2004.

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15 *Ibid*.

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

17 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.

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

19 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.

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

21 See endnotes in above discussion of the same information included in the table (endnotes 3-20).

22 *Washington State Prescription Drug Project Phase I Final Report*, June 29, 2001. Savings range based on savings other states have realized and projected (see discussion in text, above).

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

24 Sager and Socolar, Boston University 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, 2000.*