Ideas in Action

By Dana Warn

February 2005

The Best Medicine at the Best Price:
Pooling Rx Purchases in Idaho

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, Idaho's 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. The state of Idaho should change how it purchases prescription drugs by creating the largest purchasing pool possible. The pools should include state agencies, the underinsured and uninsured, private entities, local units of government, and labor organizations; and Idaho should join with other states to increase their savings.

continued on page 2

Idaho Community Action Network

Idaho Community Action Network (ICAN)
3450 Hill Road
Boise, ID 83703
Voice: (208) 385-9146
Fax: (208) 336-0997
Web: http://myweb.cableone.net/ican/

Taking Action Making Change

Northwest Federation of Community Organizations (NWFCO)
1265 S. Main St, #305
Seattle, WA 98144
Voice: (206) 568-5400
Fax: (206) 568-5444
Web: http://www.nwfco.org

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 currently covers over 700,000 people.[6] By pooling purchases, West Virginia expects to double its current rebates and save $25 million[7] 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 program. 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 — 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

Summary of 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

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.

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

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

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

Idaho prescription drug purchasing

Proposed legislation will allow the Department of Health and Welfare to negotiate prescription drug discounts on behalf of Idahoans who are at or below 250 percent of the Federal Poverty Level. While this is a great step forward, Idaho should create a much larger purchasing pool that includes all state agencies that purchase prescription drugs, all uninsured and underinsured state residents, private entities, local units of government, and labor organizations. Doing so would save money for state agencies that can be reinvested in public health care, and produce savings for all members of the prescription drug purchasing pool.

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

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

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. As prescription drug spending increases, as it does annually, the exact amount the state will save increases.

A pool covering Idaho's state agencies would pool the negotiating power of over 200,000 people. An additional 334,000 Idaho residents don't have prescription drug coverage[23] 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. If Idaho were to further expand the pool by purchasing with other states, all pool participants could save even more.

By creating the largest purchasing pool possible, and by pooling with other states, Idaho can save money for reinvestment in public health care programs. The larger the purchasing power of the pool, the deeper discounts it can negotiate.

Conclusion

Idaho should change how it purchases prescription drugs by pooling the prescription drug purchases of state agencies, and opening these pools up to the underinsured and uninsured, private entities, labor organizations, and local units of government. Idaho Washington State should also join with other states to increase negotiating power and savings. By doing so, Idaho 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.

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

6 West Virginia Pharmaceutical Cost Management Council, Annual Report, December 29, 2004.

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

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.

10 U.S. Department of Health and Human Services, "HHS Approves First-Ever Multi-State Purchasing Pools for Medicaid Drug Programs," April 22, 2004.

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.

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

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

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 Spending is the 2001 total spending on prescription drugs. Spending on the uninsured is from 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. Savings range based on savings other states have realized and projected (see discussion in text, above). See further details in "The Best Medicine at the Best Price: Proven State Strategies for Lowering Rx Costs and Protecting Public Health Care Programs," NWFCO, 2003, available at: www.nwfco.org.

23 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.