



MONTHLY ISSUE BRIEF

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Strength In Numbers:

States combine purchasing power to reduce the cost of medication

by Rumman Chowdhury, CSG/ERC Research Assistant

The skyrocketing cost of medical coverage has states considering various methods of cutting expenses without reducing services. One of the most significant cost factors for states is prescription drug coverage, according to the Kaiser Family Foundation. Prescription drug expenditures grew 15 percent in 2002. Prescription drug pooling, where states combine their purchasing power to buy drugs in bulk from pharmaceutical companies at discounted prices, has emerged as one of the more popular healthcare cost-cutting methods for state governments.

Who uses drug pools?

Approximately twenty states use bulk purchasing of medications. Even more are members of some sort of supply pool.



Pools usually cover large groups of state-compensated consumers, such as state employees, retirees, or Medicaid patients. There are currently three major multi-state bulk buying pools:

- The RX Issuing States (RXIS) program, which covers public employees and consists of West Virginia, **Delaware**, Missouri, New Mexico, and Ohio;
- The National Medicaid Pooling Initiative (NMBP), which includes **Vermont**, Michigan, Nevada, **New Hampshire**, Minnesota, Hawaii, Montana, and Alaska;
- The Minnesota Multi-State Contracting Alliance for Pharmacy (MMCAP). ERC states that are members of MMCAP

include **Delaware, Maine, New Hampshire, New York, Pennsylvania, Rhode Island, and Vermont.**

MMCAP, which includes over 40 states, contracts with over 150 pharmaceutical manufacturers. It purchases for a wider audience, providing for all government-run health care facilities, including state hospitals and local clinics. The program provides hospital supplies, vaccines, and equipment in addition to prescription medication.

How states can benefit

“The largest beneficiaries,” says Trudi Matthews, Associate Director for State Health Policy at CSG, “are small to mid-size states seeking a greater market share.” Mid-size states often have high coverage costs for prescriptions, but lack the purchasing clout of a more populous state to negotiate better prices. Pooled purchasing promises cost savings, however, legal and political negotiations can slow the process.

The benefits of pooling include the following:

- Increased market share: By controlling more of the market, states can negotiate better prices.
- Efficiency: Administrative costs will decrease as the number of states and recipients increase and processes are streamlined.

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The Monthly Issue Briefs are published by CSG/ERC to provide information on issues of concern to the member jurisdictions of the ERC.

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● Quality improvement: Most pools utilize a Pharmacy Benefits Manager (PBM) or Pharmacy Benefits Administrator (PBA), an experienced third party who will negotiate with pharmaceutical companies on behalf of states. The two groups vary in revenue structure - unlike PBAs, PBMs derive their income from manufacturer rebates. By using the PBA/PBM's best practices and experience, states can purchase better medications and formulate more effective plans.

"There were no costs associated with the program - it was totally seamless. Each state can create its own benefit design."

- Debbie McCall, Human Resources Administrator
State of Delaware Personnel Office, Benefits Unit

In 2004, ERC states participating in drug pools saved money, among them:

- Vermont - \$1 million,
- New Hampshire - \$250,000,

Source: NGA Center for Best Practices

- Delaware - \$1.9 million.

Source: Presentation by Tom Susman, Director of West Virginia's Public Employees Insurance Agency, at The Council of State Governments Annual Meeting, October 23-26, 2003.

Models of Prescription Drug Pooling: Inter- vs. Intra-state

Interstate

Ideal for small to midsize states, interstate pooling requires years of planning and preparation.

"While the benefits can be significant, states have

to be sure they can invest the time and

effort to make it worthwhile," says Matthews. States join pools contingent on executive or legislative approval. In combining to form a pool, states must rework Medicaid and/or state employee benefits and existing legislation. They must agree on a PBM, develop a mutually agreeable plan, and begin negotiations.

The main benefits of an interstate plan are the combined use of resources, shared costs, and increased populations served. However, joining a pool can result in a loss of autonomy. All the needs of each state cannot always be met, which is why similar size states with similar needs form the most successful pools.

Intrastate

Larger states can streamline prescription drug administration by creating an umbrella organization within state government to serve their constituents.

Rather than having each group individually negotiate plans, states can combine the market power of the purchasers by negotiating collectively. While the market share may not be as significant as an interstate pool, states are able to individually tailor their benefits plan.

In the ERC, **Maine** has developed an intrastate system known as MaineRx. Under the program, the state asserts the authority to require drug makers to sell their products to the state at Medicaid prices. Although the pharmaceutical industry sued to block the program, the US Supreme Court decided in the state's favor. A similar program exists in Georgia, and includes all public employees as well as the state Board of Regents, Medicaid and the State Children's Health Insurance Program (SCHIP) recipients.

Massachusetts developed the Massachusetts Alliance for State Pharmaceutical Buying (MASPB) a decade ago. MASPB, like MMCAP, negotiates prescription drugs as well as other products for use by all state run facilities. In 2001, the state opened its pool to others, and California became its second member.

Legislative, Industry, and Medical Concerns

When combining to form a pool, federal and state regulations must be considered. The federal Centers for Medicare and Medicaid Services restricts which populations it will allow states to pool with Medicaid to negotiate prices. For example, Medicaid rebates cannot be applied to state employees or prisoners, but can include some low-income individuals. In order to comply and still provide services, some states have developed a multi-tiered system for various groups.

Industry representatives have questioned the legality of some purchasing pools.

Tips for a successful purchasing pool

Administrators and legislators have much to consider when developing a pool. Political and legal red tape between states can be a hindrance to an effective, timely program. The National Governor's Association Center for Best Practices has compiled a list of design suggestions based on the experiences of other states:

Volume: The larger the number of beneficiaries, the greater the discount potential

Technological Capacity: Groups must be capable of analyzing usage and prescription habits

Leadership Cooperation: Interstate legislation must be similar, and state leaders must be willing to work together

Similar Preferred Drug Lists: In order to serve all states equally, recipients must use the same products

Single Negotiating Entity: States must agree on and remain with one bargaining group

Similar Plans and Plan Sizes: Similar organization and size can aid in dividing plan costs and ensuring benefits do not disproportionately serve one state

Prioritized Savings Strategies: States must agree on which savings they would prefer, among them, lower administrative fees, improved drug lists, rebate sharing, or benefits management

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The Pharmaceutical Research and Manufacturers of America (PhRMA) sued Maine over their MaineRx program. PhRMA contended that the law violates federal law by reducing Medicaid patients' access to medication. The state's preferred drug list did not include all drugs covered by Medicaid. They also argued that the pool limited interstate commerce by regulating who sold drugs in the state. The Supreme Court decided in the state's favor.

Another concern raised by industry officials regards limited drug access. Especially in the case of mental health patients, the prescription can vary based on the effectiveness of different drugs. In some cases, certain drugs may have adverse effects. By creating a preferred drug list, states may inadvertently restrict patients from taking the drugs they need.

| Pharmaceutical Bulk Purchasing Pool Membership, 1999-2004 | |
|---|---------------------------|
| State | Initiative |
| Maine | Maine Rx, member of MMCAP |
| New Hampshire | Member of NMBP |
| Vermont | Member of NMBP |
| Massachusetts | MASBP |
| Rhode Island | Member of MMCAP |
| Connecticut | None |
| New York | Member of MMCAP |
| New Jersey | None |
| Pennsylvania | Member of MMCAP |
| Delaware | Member of MMCAP |
| Puerto Rico | None |
| Virgin Islands | None |

Source: NGA Center for Best Practices

Pooling: A Long-Term Solution

Importing drugs from Canada is another method of lowering the cost of prescription medication. However, importation has not been as popular as originally predicted.

Federal regulators warn that imported drugs are illegal and potentially unsafe. While some states, such as **Vermont**, **Kansas**, **Missouri**, **Wisconsin** and **Illinois**, as part of the I-SaveRx program, have instituted Canadian import programs, other states are wary.



Aside from state concern over the legality of imports and the safety of the medications, accessibility can present a challenge. The program usually requires ordering via the Internet, and seniors, the largest sector of the population which consistently orders medication, are often not comfortable

with the technology. I-SaveRx has processed only 6,300 orders since it began in October 2005. In comparison, 22 million prescriptions were filled in 2004 through US drug manufacturers' programs.

Expanding Prescription Drug Pooling

According to the NCSL, legislation currently exists in 17 states to institute or expand some form of bulk purchasing. In the ERC, **Connecticut**, **Maine**, **Massachusetts**, **New Hampshire**, **New York**, and **Rhode Island** are considering bulk purchasing bills.

Among them is an innovative twist on existing cost-reduction methods. **Connecticut** State Senator Edith Prague introduced SB 44, a plan to purchase drugs in bulk from Canadian pharmacies. The measure is currently under consideration in committee.

An impetus for states to join or create drug pools is the upcoming Medicare Part D changes specified in the 2003 Medicare Modernization Act (MMA). Under the changes, the federal government will provide assistance for "dual-eligibles" - low-income individuals enrolled in both Medicare and Medicaid. By doing so, the size of each state's covered population will decrease, reducing market share. According to the Council of State Government's *State News*, in 2002 state Medicaid programs provided drug coverage to more than 6 million dual eligibles.

Although pooling has been successful in many states, it only addresses a part of the problem - ballooning medical costs. States are exploring various options, most recently submitting billions of dollars of cost-cutting proposals to Congress regarding Medicaid. However, some fear that these initiatives are only a temporary fix. "Unfortunately," Matthews says, "we can't seem to find the silver bullet." ■