

Stateline

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Michigan Reps. David Woodward (right) and Aldo Vagnozzi unveil a Democratic plan to make prescription drugs more affordable for seniors and working families. Vagnozzi has introduced the Great Lakes Alliance for Affordable Drugs Act, which proposes a multistate compact for purchasing prescription drugs. Across the region, leaders in both parties have been seeking ways to curb prescription drug expenditures. (photo: Michigan House Democratic Caucus)



Joining forces

States work on forming prescription drug purchasing pools to cut costs

by Jacqueline M. Kocinski

As states work to get out from under crippling budget deficits, skyrocketing growth in Medicaid expenditures has necessarily become a target for policymakers. And with spending on prescription medication driving cost increases for Medicaid and other state health programs — pharmaceuticals are consuming about 15 percent of state budgets — many states are looking at new ways of tackling this complex problem. Basic economic principles, such as influencing market share, are being applied as states consider joining together in order to get more bang for their buck.

The state of Michigan made national news last month in announcing the formation of a multistate prescription drug purchasing pool for Medicaid. Other states in the region continue to examine this possibility and other cost-saving proposals.

During the 2002 legislative session, Iowa lawmakers passed a bill calling for the state's Health Department to convene a task force that would examine the feasibility of establishing an interstate prescription drug purchasing cooperative for Medicaid. The group, which included representatives of relevant state agencies, pharmacists and pharmaceutical companies, issued its final report to the governor and General Assembly in January.

Sen. Maggie Tinsman, a Republican from Davenport, was one of four legislative members of the task force. A longtime advocate of a regional joint purchasing venture, Tinsman has

high hopes for the work of the group, which met via teleconference with state officials from Illinois, Minnesota, Missouri, Nebraska, North Dakota, South Dakota and Wisconsin. The purpose was to ascertain what cost-saving initiatives those states may already have under way and to see whether there was interest in joining Iowa in a drug purchasing cooperative.

As a next step, the task force has recommended that governors establish a drug selection commission to formulate a common reference list of standard pharmaceuticals used by Medicaid recipients.

"If you had a joint list or similar list, the thought is each state would be in a better position to negotiate with drug manufacturers, even if you're doing this state by state," explains Tinsman, adding that she favors joint purchasing among cooperating states.

Multistate agreement in place

Unlike Iowa, Michigan already has a preferred drug list in place. Designed to save at least \$45 million from an annual pharmaceutical bill that tops \$1 billion, the approved list of drugs is organized into classes, and prescribing physicians are restricted to using these medications unless they obtain state approval for "medically necessary" alternatives. Drug makers are asked to meet the price of any best-in-class pharmaceutical not on the list.

Having this formulary has allowed Michigan to move past the investigative stage that Iowa finds itself in and actually enter into a multistate purchasing agreement. In late February, the governors of Michigan and Vermont announced that their states would join together to form the nation's first such pharmaceutical pooling program for Medicaid. Within days, South Carolina and Wisconsin announced tentative plans to join the two states.

Democrat Gov. Jim Doyle's budget proposal includes a provision directing the Wisconsin Department of Health and Family Services to explore creating a preferred drug list. The Badger State has seen prescription drug spending for Medicaid rise 43 percent over the last three years.

As these states combine their purchasing power, a common pharmacy benefits manager will negotiate with drug manufacturers on their behalf, with the goal of achieving more value for the dollar than the states could achieve independently.

(Please turn to page 7)

Inside

Around the Region

Tuition costs rise; review of state tax systems

Feature Stories

School consolidation bills considered

Feature Story

Legislators mull sentencing reforms

Feature Story

Public safety vs. the public's right to know

Feature Story

Partnerships aim to improve environment

Profile

Ohio Senate President Doug White

First Person

Minnesota Rep. Tony Sertich

CSG News & Events

Holden begins term as MGC chair

MLC Issue Briefs

MLC report on states' venture capital strategies

Next month

With crucial final budget decisions approaching, states consider a wide range of often-unpleasant options

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Some plans call for purchasing pools that go beyond Medicaid

(Continued from page 1)

Pharmacy benefit managers, or PBMs, serve as middlemen between purchasers and manufacturers, working to negotiate discounts known as supplemental rebates. However, PBMs have been the target of some criticism in recent years. Some say PBMs negotiate deals that ultimately benefit themselves and the drug companies. Critics charge that these managers contribute to increasing health costs by forming agreements with manufacturers and steering patients toward higher-cost medications.

The bipartisan National Legislative Association on Prescription Drug Pricing is now working to



Sen. Maggie Tinsman

create a nonprofit pharmacy benefits manager. This is being done in an effort “to respond to the desire on the part of some states to negotiate for lower prices for their own drug purchases and those in the private sector who want a better deal,” says Cheryl Rivers, a former Vermont state legislator who now heads the legislative association. She is encouraging states to not sign up for a long-term PBM contract, in order to keep their options open if a better deal comes along six months or a year down the road.

The association began as a group of New England lawmakers concerned about rising drug prices in their states. Now a national entity, the organization brings state legislators together to share ideas at quarterly meetings and serves as an information clearinghouse, promoting model legislation for the use of preferred drug lists and joint state negotiations.

Rivers points out that it is not a requirement that states wishing to join forces share a common preferred drug list: “I don’t think [cooperation] needs to mean that states can’t make their individual decisions, but I do think there will be times when, if states share information about the benefits of one drug or another and they negotiated at the same time, that the number of differences will be reduced. That would allow states to leverage greater discounts if they’re able to negotiate greater market share movement.”

Rivers also hopes that states will look beyond just Medicaid drug purchasing as they form multistate agreements. “We’re trying to move states in the direction where they fully leverage their bargaining power in all of their purchases for drugs,” she says.

Michigan Rep. Aldo Vagnozzi sees the merits of this idea. This year, he introduced legislation to establish a Great Lakes Alliance for Affordable Drugs. The Democrat from Farmington Hills says the measure would authorize the state to enter into a pharmaceutical purchasing compact that would encompass programs beyond Medicaid, in order to assist uninsured

Midwestern states lead way in creation of drug repository programs

by Tim Anderson

Like a lot of legislation, the idea for a drug repository program in Ohio resulted from the real-life experience of a constituent and the willingness of an elected state official to listen.

Kirk Schuring, then a Republican representative from Canton who has since been elected to the state Senate, got a call from a man who had lost his wife to cancer.

“He was obviously sad about his wife’s passing,” Schuring recalls, “but he also had feelings of anger and frustration because he had to end up throwing away thousands of dollars worth of prescription medication for cancer.”

The drugs were unused and properly sealed, but no process was in place to allow them to be used safely by other cancer patients. Both the constituent and Schuring thought the state could do better. Four years later, in January 2003, Republican Gov. Bob Taft signed legislation making Ohio the first state in the nation to create a repository program for prescription drugs.

Instead of going unused, medications like the ones left to Schuring’s constituent can end up in the hands of needy Ohioans. The drugs can be donated by any person, as well as a pharmaceutical manufacturer or health care

facility, to a pharmacy, hospital or nonprofit clinic that makes the voluntary decision to participate in the state program. Recipients only have to pay a handling fee. Before the legislation passed in Ohio, some changes were made to the original bill in order to address concerns about patient safety and the liability of program participants.

Other states in the Midwest have considered bills in 2003 similar to the Ohio measure. In Nebraska, legislation introduced by Sen. Vickie McDonald would create a repository program specifically for cancer drugs. McDonald lost her husband to cancer in 2001, and she too was left with thousands of dollars in valuable prescription drugs that had to go unused.

“We wanted to start with cancer drugs, see how the program works and then consider expanding it,” McDonald says. As of late February, the bill had received committee approval and was going to be considered by the full Unicameral.

A measure proposed in Indiana this year would establish a regional drug repository program. Both McDonald and Schuring are hopeful that other states will consider replicating their ideas for repository programs as a way of improving access to prescription drugs for sick, needy and uninsured individuals.

individuals and senior citizens who find themselves without prescription drug coverage. “We would work out an agreement for pharmacies to receive their drugs through the state at a reduced cost, and they would pass on the savings to consumers,” he explains.

Curbing drug costs

Vagnozzi was compelled to take action following what he calls “a very shocking experience.” The Michigan lawmaker lost his own drug coverage for which he had been paying a deductible of \$3 per prescription. Just one of the medications he takes costs \$133 a month. “I knew prices were high, but that really drove it home to me.”

Vagnozzi has since regained his prescription drug coverage, but he remains committed to helping others currently experiencing high out-of-pocket pharmacy costs and is hopeful that some form of his legislation will be approved. “The price of prescription drugs is a bipartisan concern,” Vagnozzi adds.

His contention is backed by a recent study by the Kaiser Commission on Medicaid and the Uninsured. It reported that 45 states either have implemented or are planning drug cost control measures for fiscal year 2003. What they do and how they do it, however, can determine whether states find themselves defending those actions in court.

The Pharmaceutical Research and Manufacturers of America has challenged states’ preferred drug lists,

as well as Maine’s Rx initiative, which attempts to use the state’s Medicaid program as leverage to obtain discounts on drug prices for those who are not Medicaid recipients. The key to avoiding such legal entanglements may be to make sure pharmacy manufacturers are provided an opportunity to present evidence supporting inclusion of their products in whatever program a state designs.

PhRMA also insists that growth in spending on medicines is not evidence of a problem, but a direct result of extraordinary success in expanding the role of prescription drugs in treating disease. Many consumer advocates agree that state efforts to curtail drug expenditures should not limit access to lifesaving medications or otherwise compromise a patient’s ability to obtain the best care available.

Ultimately, Tinsman says, states are running out of time to address rising drug expenditures. “If the Midwestern states don’t join together, the risk is our costs are going to go up and up and up, and we’re going to have to pay, because it’s an entitlement program. It’s going to attack funding for everything else.” Tinsman calls drug spending “the Pac-Man of all state budgets,” eating up dollars that might otherwise go to preventative health, social service programs and education.

“We’re all having a terrible time with our budgets. Still, we want to provide health care to the poor, disabled and senior citizens. Let’s see if we can’t do it in a more cost-effective way.”