

Prescription Drug Bulk Purchasing: recent history and state actions

NCSL Fiscal Analysts

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presented by Richard Cauchi
Program Director, Health Program, Denver
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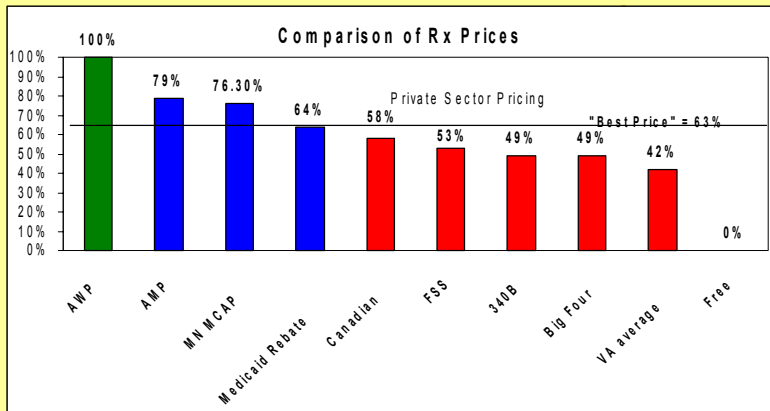
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Bulk Pharmaceutical overview

- Bulk buying is a logical, traditional step for many high volume commodities.
- But pharmaceutical marketplace has special factors beyond just volume.
 - Strong role of "single source" drugs.
 - Exclusive or preferred status highly sought by Rx manufacturers in private market.
 - Medicaid emphasizes "all medically necessary products" should be available. (federal law OBRA '90)
- Can states save real money? Do they already?

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Comparison of Federal & Commercial Prices

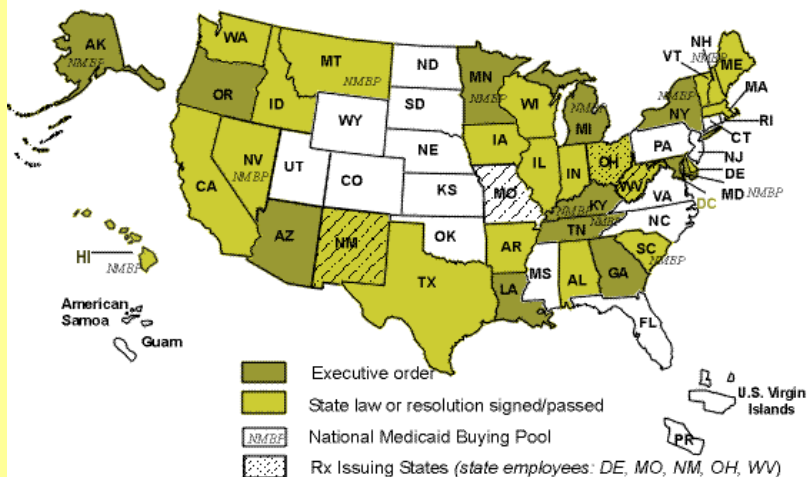


Source: Data derived from Prices for Brand-Name Drugs Under Selected Federal Programs, Congressional Budget Office (June 2005); Pharmaceutical Discounts under Federal Law: State Program Opportunities, William H. von Oehsen (May 2001). Bill von Oehsen (202) 466-6550. Adopted & expanded by NCSL, 10/2005

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State bulk purchasing plans and laws, 1999-2006 [up to 32 states]

Pharmaceutical Bulk Purchasing Laws and Initiatives, 1999-2006



© NCSL : updated 8/16/06 (Does not include 43 states in the Minn. Multi-state pool)

Minnesota Multi-State



Minnesota Multi-State Contracting
Alliance for Pharmacy

- MMCAP is “a voluntary group purchasing organization operated by the State of Minnesota serving government-based healthcare facilities. The goal of MMCAP is to provide member organizations the combined purchasing power to receive the best prices available for” Rx.
 - Started in 1985; now made up of 43 states
 - Primary users: state correctional facilities, state mental health facilities, state public health facilities, etc.
 - contracts with over 150 pharmaceutical manufacturers (2004).
 - member facilities purchase over \$800 million per year.

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MN Multi-State: operating details

- MMCAP's niche: “provide, through volume contracting and careful contract management, the best value in pharmaceuticals and related products to eligible governmental health care facilities.”
- Does not use formulary or PDL; members “encouraged” to exclusively use MMCAP contract pricing.
- Generally does not serve Medicaid programs. (except for some inpatients of public facilities.)
- Savings: about 23.7% below AWP for Brand name; AWP - 65% for generics. (Exact formula is WAC -2.57% brands; WAC -44% generics)
+ “administrative savings”: lower inventories, fewer small orders.
- Restricted to “own use” - States cannot “lessen competition”; Rx cannot be resold to walk-in patients.
- federal law: Robinson-Patman Act (15 USC 13a)

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Medicaid: “The National Multi-state Pooling Initiative”

- 1st operational Rx buying pool- started by Michigan & Vermont.
- Contract with First Health Services for Medicaid drugs.
 - 10 states have CMS approval- **Alaska, Hawaii, Michigan, Minnesota, Montana, Nevada, New Hampshire, New York, Tennessee, Vermont.**
- Uses common Preferred Drug List based on the Michigan PDL (some variations among states).
- Strategy: negotiate supplemental rebates for Medicaid.

<u>Est. Savings</u>	MI = \$8 mil.	NV = \$1.9 mil.
VT = \$1 mil.* <small>*Switched to Sovereign Pool 1/06</small>	AK = \$1 mil	NH = \$250 k.

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"TOP \$" -- 2nd Medicaid Pharmaceutical Purchasing Pool

- **Louisiana, Maryland & West Virginia** formed a buying pool in Dec.; CMS approved May '05.
- Administered by Provider Synergies, using "overlapping" PDLs & supplemental rebates. Each state has clinical oversight.

<u>Est. Savings</u> <i>(w/ bulk + PDL + rebates)*</i>	LA = \$27 mil. In 2006	MD = \$19 mil. In 2006	WV = \$16 mil. In 2006 <i>*CMS Release 5/05</i>
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Sovereign States Drug Consortium

- SSDC was announced October 2005, led by Maine and Vermont.
- formed by **MedMetrics**, a non-profit PBM, started by U. Massachusetts Medical School.
- Medicaid Pool operational as of March 2006; includes **IA, ME** and **VT**.
- CMS plan approval letters dated July 20, 2006
 "We believe this amendment is consistent with the objectives of the Medicaid program and is designed to increase the efficiency and economy of the Medicaid program and benefit Medicaid beneficiaries".
- <https://www.rxssdc.org/>

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State Employee Plan Pooling: Pharmacy Working Group / RXIS

- Discussions among Southern & Midwestern states, began March '01. 12 to 17 states "interested".
- WV Public Employee Insurance Agency in the lead.
- "**RX Issuing States**": 5 states have picked a PBM. Now operational in **DE, MO, NM, OH and WV**. 700,000 covered lives spending \$600+ million /yr.
- Future goal to involve other state agencies + Medicaid?

Savings: (<i>bulk only</i>)	WV = \$8.3 mil. (5% of total)	DE = \$1.9 mil.	MO = \$1.4 mil (2% of total)
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Northwest Prescription Drug Consortium

- Will bring together the **Oregon** prescription-drug plan, for low-income people 55 and older to access below-market price drugs, with a similar plan in **Washington**.
- Not yet operational - Announced July 2006; expected to begin joint purchasing within the year.
- "More than 5 million people are eligible for the programs" -Gov. Kulongoski 7/26/06
- OR & WA do not use restricted Preferred Drug Lists or prior authorization.

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National Legislative Association for Rx Prices NLA-Rx: Created a Non-Profit PBM

- Designed a PBM "with a public and charitable purpose." Potential clients: Medicaid; other state/local gov't.
- **United Scripts Administrators** has established a partnership with NW Pharmacy Services.
 - Started in VT; works with WA based Rx network.
 - "Our clients benefit from a fully transparent, non-profit approach to pricing."
 - network of more than 55,000 independent and chain pharmacies

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Georgia inter-agency including Medicaid (Established Oct. 2000)

Georgia contracted with Express Scripts, Inc. a PBM, to administer the pharmacy benefits and claims for Medicaid, SCHIP, Public Employees and the College Board of Regents Plan. Costs are controlled through the implementation of several initiatives, including: an aggressive maximum allowable cost (MAC) program,

- the most-favored-nations program with improved enforcement,
 - a three-tiered co-payment strategy applied to a preferred drug list,
 - PDLs for each plan, and
 - an expanded prior authorization program,
 - a policy of cost avoidance for members with other health insurance
 - a supplemental drug rebate program
 - a host of other clinical programs; a point-of-sale system,
- Georgia's Medicaid program spent \$1,136,007,007 on prescription drugs in FY 2004 - a 900 percent increase over the last decade.

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Other Examples of Single-state Rx bulk purchasing laws

- **TX:** All-agency Bulk Purchasing Commission
(Law enacted 2001; no purchases yet)
- **MA:** "aggregate purchasing" law intended to combine Medicaid, state agencies + uninsured
(Passed 1999, 2001, 2003, 2004; still not implemented)
- **CA:** 2002 law establishes "central purchasing agency" for Rx; not fully implemented;
 - 2005 enacted bill to "expand state role as purchasing agent" with formularies. Vetoed by Gov. on Oct 7 '05.
- **IL:** 2003 law authorized. Governor's inter-agency plan announced in mid-2004.

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Strong opposition to "restrictive" features included in bulk plans.

- Prior authorization restrictions are opposed by patient groups and industry
- CO Gov. Owens' veto of SB 1, 2006:
 - "would have the effect of establishing a prescription drug formulary for our Medicaid recipients and place the state in the pharmacy business"
 - "restricting Medicaid recipients' access to needed prescription drugs and interfering with the doctor/patient relationship would have a highly negative impact on patients' health."

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State Studies of bulk Rx

■ TEXAS - 2006

- Report by Health & Human Service Commission
- Focus on TOP\$ Program, as current PDL contractor.
- Estimates savings of \$2-3 mil/yr.; could use same PDL so no disruption; federal approval should be simple.
- But, no savings until 2008; total pool w/ Texas of 2.8 million in '06, which is same as Texas est. of 2.7 mil. in 2007.
- Conclusion: Decide after Nov. '06, w/ new analysis.

■ VIRGINIA - 2003

- Report by Heinz Philanthropies and Mercer Consulting
- Conclusion: coordinated contracting for 4 agencies: potential savings of \$36.2-\$49.7 million out of \$387 million budget (2003)

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State Legislative Medicaid Cost containment strategies

■ Preferred Drug Lists & Formularies

- In Medicaid, "formularies" cannot bar the use of approved products.
(State-only programs can bar use.)
- PDL approach: many states include cost factors; require prior approval but not a bar on use.
39+ states now have authorized or implemented.
NCSL analysis, 2005
- "PhRMA v. Thompson" lawsuit in federal court challenged Michigan Medicaid list and rebates - MI's win was closely watched by many states.

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State Legislative Medicaid Cost containment strategies - *continued*

State Supplemental Rebates

- Extra rebate as a way to achieve a lower price. Upheld by federal courts, but requires CMS federal "state plan amendment."
- "The Bush administration has currently approved around 30 state plans to negotiate extra, or supplemental rebates with manufacturers. States generally achieve negotiated discounts greater than those established by law for Medicaid by relying on a private pharmacy benefit manager to negotiate discounts based on a list of preferred drugs established by the state for their Medicaid beneficiaries." - *HHS News release 5/27/05*
- Most states followed Florida or Michigan laws; many use PBM or PBA to negotiate.

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Summary/ conclusions

- Multi-state Bulk Rx plans are popular idea.
- Implementation limited to 20 states.
 - 16 operational Medicaid plans
 - 5 operational Public Employee plans
- Bulk savings alone are limited but real: 2-5% of spend.
- Every operational plan uses PDLs, prior authorization, supplemental rebates.
 - Other laws, OR, WA do not use PDLs.

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NCSL Rx Resources

Reports (updated August '06)

Prescription Drug Bulk Purchasing Laws:

www.ncsl.org/programs/health/bulkrx.htm

Rx Overview: lists 40+ NCSL reports and presentations

www.ncsl.org/programs/health/pharm.htm

Contact:

Richard Cauchi (303) 856-1367 - dick.cauchi@ncsl.org

