

Prescription Drugs: High Costs, Tough Choices

A Background Brief Prepared by

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For

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Difficult times for residents and state budgets

Across Northwest states, economic recession, worsened by the aftermath of the September 11 attacks, has increased unemployment rates and tightened state budgets. Recent tax cuts have exacerbated this situation.

Nationwide, nineteen states have reported their current year spending has exceeded budgeted levels, 17 states are expecting a budget shortfall of 5 percent or more, and revenues for fiscal year 2002 are below estimates in 44 states.¹ More than two-thirds of the states have considered or implemented budget cuts for the current or upcoming fiscal year,² with many states focusing on public health care programs, citing concerns about rising costs.

Times are difficult for residents too: over the last year, unemployment increased over 0.5 percent in every state. The Western U.S. had the largest increase in unemployment, increasing more than 1.5 percent.³ At the same time, employment in most major industries dropped – with manufacturing, transportation and public utilities experiencing widespread declines.⁴ Cuts to public health care programs only increase the difficulties for those state residents who lose their jobs or health insurance.

Prescription drugs: the real cost driver

Although health care costs across the nation in all types of health care programs have been rising, much of this cost increase is due to the rising costs of prescription drugs. Across the nation, prescription drugs are the fastest growing cost in health care spending,⁵ creating a crisis for private and public programs alike.

Drug costs have disproportionately contributed to the sharp upturn in overall health care costs over the last few years.⁶ Prescription drug spending accounted for over a quarter of the growth in overall health care spending in 2000 and is one of the reasons that in 2000 and 2001, health insurance premiums rose at the fastest pace in over a decade.⁷ Reasons for rising prescription drug costs include:

- Drug prices that often rise faster than inflation;
- Increased marketing of medicines to doctors and consumers;
- Investment by pharmaceutical manufacturers in spin-off formulations of existing drugs that maintain patent – and therefore market – protections, but not necessarily improve treatment; and
- An aging population with increased prevalence of chronic conditions.⁸

Total U.S. spending on prescription drugs tripled from 1990 to 2000. Consumer spending on outpatient prescription drugs at retail outlets in the U.S. rose more than 17 percent from 2000 to 2001, the fourth year in a row of rapid growth.⁹ Prescription drug expenditures are projected to continue to rise faster than any other medical service over the next decade. Other factors that have increased health care spending include rising hospital costs¹⁰ and new medical treatments.¹¹

State Medicaid programs have not escaped this trend of rising health care costs due to prescription drug spending.

Medicaid spending on prescription drugs nationally increased at an average of 18 percent a year from 1997 to 2000, slightly lower than the average annual increase in spending on outpatient prescription drugs at retail outlets during the same period.¹² And in a survey of Medicaid officials, 48 states cited pharmaceutical costs as one of the top reasons for Medicaid cost increases in 2001.¹³ Other factors that have increased Medicaid spending include general medical inflation, increases in provider payment rates to catch up with inflation, and increased enrollment.¹⁴

Strategies states are using to reduce prescription drug spending

Purchasing pools

Drug manufacturers often will pay a rebate to large volume purchasers.¹⁵ The savings negotiated typically depend on the volume of drugs purchased over a given period – the larger the amount purchased, the greater the rebate.¹⁶ 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. By including the under- and uninsured, people without prescription drug coverage benefit from the state-negotiated savings, and states benefit by increasing the size of the purchasing pool.

State-wide or multi-state purchasing pools can also be combined with prescription drug formularies to further increase savings (see discussion of formularies on the next page).

Numerous states already have state purchasing pools in the works. Texas, Georgia and Massachusetts have passed legislation to create multi-agency purchasing programs and are in the process of setting up these programs.¹⁷

Two major multi-state coalitions are underway. A multi-state purchasing pool led by West Virginia and including Louisiana, Maryland, Mississippi, Missouri, New Mexico and South Carolina began negotiations in Spring of 2001. West Virginia was the first to sign on, in March 2002, and expects to double its current rebates and save \$25 million over the next three years. Other states will sign on and negotiate lower discounts in October 2002.¹⁸ The pool will include both public employees and the Children's Health Insurance Program (CHIP), and eventually the private sector may be allowed to join the pool as well.

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.¹⁹

Legislators in a number of other states have passed or are considering legislation on bulk purchasing pools as well. These states include Alabama, Iowa, Maryland, and Vermont.²⁰

Pacific Northwest states also are moving toward pooled prescription drug purchasing. In 2002, the Washington state legislature passed a resolution urging Northwestern states to consider joint purchasing agreements to address the challenge of the high cost of prescription medication.²¹ Washington Citizen Action also led a wide coalition of over 35 organizations representing seniors, labor, health care providers, community, and faith based organizations in support of legislation that would pool purchases among state agencies and open the pool up to the uninsured. The bill passed the Senate and received widespread support, but was never brought to a vote in the House.

In 2001, the Idaho state legislature passed a resolution urging the governor and the Department of Health and Welfare to work with other states to purchase prescription drugs at economical rates.²²

Formularies

A formulary is a list of drugs covered by a particular program. The list identifies preferred medications for treatment of specific diseases, and is usually subject to periodic review and modification. A formulary guides the prescribing practices of doctors, and can be used as a tool to negotiate lower drug prices from manufacturers.

When a formulary is applied to a large pool of purchasers, it can significantly shift drug purchasing patterns in favor of those drugs on the formulary. Manufacturers give discounts in exchange for being listed on a formulary. The larger the pool a formulary covers, the larger the price discount it can receive.

With proper consumer protections that allow doctors to quickly prescribe any drug essential to a patient's quality of life and health, drug formularies can help control drug costs.

When reviewing how a formulary will affect consumers, it is important to look at what a doctor has to do to prescribe a drug not on the formulary. The time required to do so varies widely. With some formularies, the doctor simply has to write "prescribe as written" along with a prescription, and consumers can quickly get a drug not on the formulary.

Physicians sometimes must receive prior approval to prescribe drugs not on the formulary – a process called prior authorization. When the prescriber needs to go through time consuming processes like filling out paper work or calling a phone bank, these processes can create delays for consumers and barriers to health care access.

Oregon is implementing a formulary for the Oregon Health Plan.²³ This formulary allows doctors to simply write "dispense as written" to prescribe a drug not included in the formulary. Other formularies, such as those used in the Florida and Michigan Medicaid programs, have more complicated procedures.²⁴

Different formularies use different criteria to select the preferred drugs. For example, Oregon's formulary evaluates drugs on their cost and effectiveness. Among classes of drugs found to be equally effective on a clinical basis, the most cost-effective are placed on the formulary, giving doctors an incentive to prescribe them.

Creating statewide or regional preferred drug lists could lessen administrative complexity as well as complexity for consumers and doctors. Doctors and program administrators often must interact with multiple formularies; a regional formulary would streamline this difficulty. Having a regional drug list could also increase states' purchasing power.

Price regulation

Federal price reforms and state programs have used a wide array of strategies to reduce prescription drug prices.

Examples of federal actions

The largest federal drug discount program is the Medicaid drug rebate program. The Omnibus Budget Reconciliation Act of 1990 requires pharmaceutical manufacturers to pay state Medicaid programs a rebate for covered outpatient drugs reimbursed by Medicaid. The program saves state Medicaid programs more than \$3 billion each year.²⁵

Federal officials have used the bully pulpit to seek voluntary price reductions. For example, in June, 2002, U.S. Health and Human Services Secretary Tommy Thompson warned pharmaceutical manufacturers they might face new price limits on prescription drugs as a result of consumer concerns about rising pharmaceutical bills.²⁶

U.S. Senators have proposed legislation to control prescription drug costs by allowing pharmacists, individuals, and wholesalers to re-import U.S.-made prescription drugs from Canada. Senator Byron Dorgan says the U.S. would spend \$38 billion less on prescription drugs if consumers paid Canadian prices.²⁷ This legislation would lower costs by simply increasing access to existing lower prices in Canada.

Examples of state actions

Examples of state strategies include: programs that open up Medicaid pharmaceutical rates to a wider population, discount programs based on state-negotiated manufacturer rebates, and state-mandated discounts through pharmacies.

One state example is the Maine Rx Program. The program is designed to reduce drug prices for state residents by allowing the state to negotiate drug manufacturer rebates. Under the program, the state would negotiate with pharmaceutical companies for rebates on prescription drugs equal to or larger than those set by federal law for the Medicaid program. The state would pass the rebate to pharmacies, which would offer discounts to Maine Rx enrollees.²⁸

Initially, participation in the Maine program by drug manufacturers is voluntary. The state will encourage pharmaceutical manufacturers to participate in the program by publishing the names of manufacturers that refuse to participate, and placing drugs from those non-participating manufacturers on a prior authorization list in the Medicaid program. The state is authorized to impose mandatory price controls if it is unable to win significant price concessions from manufacturers by January, 2003.²⁹

PhRMA brought a lawsuit against the program. In May 2001, a U.S. appeals court upheld the program, and PhRMA appealed the case to the Supreme Court in July of 2001.³⁰ The Supreme Court postponed deciding whether or not to hear the case until the U.S. solicitor general issued a report. On May 31st, 2002, the solicitor general advised the U.S. Supreme Court not to review the lower court ruling that would allow the state to implement the program,³¹ but on June 28th, 2002, the Supreme Court agreed to hear the case.³²

Other states have used state legislation to create pharmacy-based discount programs that require pharmacies to charge participants a discounted rate. Since these programs do not provide pharmacies with a discount from drug manufacturers, the savings from this strategy come from pharmacies. Some pharmacists have said discount programs require them to provide drugs below cost. States using this approach can anticipate opposition and possible litigation from pharmacists and chain drug stores.³³ A similar program proposed by Washington State was ruled invalidated by the courts.

Assessing strategies to reduce prescription drug spending

States contemplating strategies to reduce prescription drug spending might consider a variety of possible goals, including:

- Removing or not creating barriers that restrict consumer access to needed prescription drugs
- Reducing the cost of prescription drugs to consumers and public budgets
- Supporting the decision making autonomy of both consumers and their health care providers
- Deriving savings that can be reinvested into health care

Endnotes

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