Addendum to State Initiatives to Promote Cost-Effective Use of Pharmacy Benefits

Recent State Legislative and Executive Activities to Reduce Pharmaceutical Costs within Medicaid and/or State Employee Health Programs

Multi-State Pharmaceutical Purchasing Alliances

- WV, LA, MS, MO, NM, SC: led by West Virginia, the coalition unites participating entities to create joint purchasing opportunities, counter detailing and utilization activities, pharmaceutical strategies, and advocacy activities. The working group is divided into two subcommittees, Medicaid and state public employees.

To participate in the coalition, each state must review its own legislative enabling statutes. Several of the states have passed laws authorizing them to join a multi-state or multi-governmental purchasing consortium to purchase pharmaceutical products or other medical services.

October 17, 2001: the group issued a joint request for proposal (RFP) for a multi-state contract for pharmacy benefit manager (PBM) services. In developing the RFP, the group included minimum levels of rebates and maximum levels on administrative fees.

The RFP includes the public employee health benefit plans of Louisiana, Mississippi, Missouri, New Mexico, and South Carolina. Other interested states still have the opportunity to participate in the initiative.

Intrastate Pharmaceutical Purchasing Initiatives – Legislative Action Needed

- GA, MA, TX: enacted laws to create intrastate multi-agency and multi-program pharmaceutical purchasing pools to gain greater pharmacy price discounts for eligible populations.
  - Georgia: consolidated the state’s public health insurance programs under one agency to streamline administrative functions and combine health care insurance program purchasing into one unit to maximize purchasing power.

  State employee health benefit plan, Medicaid, and SCHIP issued a joint request for proposal (RFP) for a multi-program contract for pharmacy benefit manager (PBM) services (chose Express Scripts).

  - Massachusetts: fiscal 2000 budget created a state aggregate or bulk purchasing program to combine senior pharmacy assistance participants, Medicare and Medicaid enrollees, state workers, uninsured and underinsured individuals into one purchasing pool. The state estimated that as many as 1.6 million individuals would be covered, with eventual total savings for individuals and government as high as $200 million. MA has not implemented.

  - Texas: June 2001, enacted law to establish a multi-agency bulk purchasing system for prescription drugs. Combines pharmaceutical purchasing for the Departments of Health and Mental Health, state employees, retirees, teachers, prison system and any other agency that purchases pharmaceuticals.
Creates the Interagency Council on Pharmaceuticals Bulk Purchasing, and it would use the state’s existing distribution networks, including wholesale and retail distributors, to distribute the pharmaceuticals.

Council is directed to explore various purchasing options, including expanding Medicaid purchasing through federally qualified health centers. The law also includes provisions to require manufacturer and wholesaler price reporting and enforcement mechanisms for the state attorney general. The state estimates approximately $13 million in cost savings for the first two years. The law took effect September 1, 2001.

Preferred Drug Lists/ Governor Appointed Pharmacy and Therapeutics Advisory Boards

- FL, LA, KY OR: enacted laws to establish Medicaid Pharmaceutical and Therapeutics Committee to develop preferred drug lists for Medicaid beneficiaries.
  - Florida: new law allows Florida to negotiate state supplemental rebates on prescription drugs for Medicaid beneficiaries. Under Florida’s new law, the state will continue to participate in the federal Medicaid drug rebate program, however, the state will now negotiate directly with drug companies to obtain additional rebates.

  FL law also requires the state to create a preferred drug list (PDL). All FDA approved drugs with federal rebates are available to Medicaid patients, but those not on the PDL require prior authorization. The PDL was recommended by an appointed committee, which considers both medical effectiveness and cost when determining which drugs to include on the list.

  Florida expects to save the state $214 million per year, or about 15 percent of its Medicaid drug budget through its own negotiations.

  - Louisiana: established 19 member Medicaid Pharmaceutical and Therapeutics Committee to develop a preferred drug list (PDL) for Medicaid beneficiaries. Physicians must call the Committee to get prior authorization if he/she feels the drug is medically necessary. Committee will be comprised of physicians and pharmacists and may contract with pharmacy schools to handle prior authorization requests.

    Louisiana Department of Health will track drug requests to determine any pattern of certain drugs called in for prior authorization. Committee will meet on a regular basis to determine if they need to amend their list. The program is estimated to save the state as much as $60 million annually.

- Kentucky: Governor issued an executive order establishing a Pharmacy and Therapeutics Advisory Committee that will advise the governor and the Cabinet for Health Services on the development and administration of a new drug review process.

  The order will allow the state to place certain costly medications on a prior authorization list upon the recommendation of the Committee when the use of the drug presents a financial burden to the state or poses a significant safety issue.
As part of the executive order, the Governor has asked the Cabinet for Health Services to issue an emergency regulation to further reduce pharmacy costs, including:

1. Spell out changes in the drug review process;
2. Require prior authorization for brand name drugs for which there are available generic forms; and
3. Clarify when a drug is a “new” drug and cannot be placed on prior authorization, under terms of existing statute.

The existing Drug Management Review Advisory Board will remain in place and focus on drug utilization review, disease management and provider education.

- **Oregon**: enacted law directing the Oregon Office of Medical Assistance Programs to create a "Practitioner-managed Prescription Drug Plan" under the Oregon Health Plan. The Oregon Health Plan, which provides insurance coverage to 350,000 low-income Oregonians, will spend nearly $900 million a year on prescription drugs during the next two-year budget.

The Governor also appointed individuals to a Health Resources Commission, who are not subject to legislative confirmation. The Commission is comprised of 15 individuals, including practicing and academic physicians, clinical and academic pharmacists, health care researchers, advocates, and hospital pharmacists. The Commission is charged with identifying specific classes of drugs.

The new law deletes current state law that prohibits them from developing a drug formulary - a list of preferred drugs bought at discount prices. The law allows the state to select the most effective drug within a group of drugs to be used as a reference drug. Prescription drugs costing more than the reference drug would be reimbursed only at the price of the reference drug under this new plan. The first criterion in developing the reference drug list will be a drug’s effectiveness, while the second issue will be cost. The law, however, contains a broad exception whereby a physician could prescribe an alternative drug, to be fully reimbursed, if the physician thought it was medically necessary.

Savings from the formulary are estimated to be about $7 million for the first two years.

**Mandatory Generic Substitution/Prior Authorization**

- **ME, MA, WA**: executive branch action to limit brand-name drug use within state Medicaid programs and to establish prior authorization.

- **Maine**: the state implemented an aggressive prior authorization program in January and placed 55 medications on the prior authorization list. After implementation of the program, average prescription drug costs per Medicaid
beneficiary declined from $52 to $42 per week. In the program’s first six months, Maine Medicaid saved $5 million in program costs.

- **Washington**: Washington State Medicaid plans to implement the Therapeutic Consultation Service program to pressure physicians to prescribe more generic medications by limiting beneficiaries to four brand-name drug products per month. Under the new program, if a patient attempted to fill a fifth brand-name prescription in a month, the pharmacist would contact the physician, who would then have to contact a pharmacist hired by the state for approval.

The state recently signed a contract with the pharmacy benefit manager (PBM), Consultec, to run the program and provide on-call pharmacists six days a week. State officials say the program would save $30 million a year and lead to better patient care.

- **Massachusetts**: Massachusetts State Medicaid will require Medicaid beneficiaries to use generic drugs when available. Medicaid beneficiaries will be required to use generic medications in place of brand name drugs when they are available except when medical necessity is demonstrated and physicians obtain prior authorization from state administrators.

Under current procedures, the state requires pharmacists to prescribe generic medications to Medicaid beneficiaries unless doctors request brand name medications.

The state estimates that the new system requiring physicians to prescribe generics when available would save the state $10 million in the first year.

**Waste and Abuse/Disease Management**

- **TN**: launched study of Medicaid pharmacy program to reduce costs.

  - **Tennessee Waste and Abuse**: hired Applied Health Outcomes to conduct an analysis on medications prescribed to TennCare beneficiaries with mental health conditions and to those beneficiaries who are also covered under Medicare (dual eligibles).

  TN hired Prudent Rx Inc. to study waste and abuse in the TennCare pharmacy program. Prudent Rx estimates it could save the state $300,000 to $400,000 per month by catching billing errors and outright fraud among pharmacists.

  **Tennessee Disease Management for Dual Eligibles**: carved out pharmacy benefit for dual eligibles (and mental health conditions). Hired the PBM, Consultec, to manage benefit for this population. Although duals only 13 percent of managed care enrollees, account for 35 percent of drug expenditures within program.

  TN launched Centers of Excellence initiative in August 2001 to bring together physicians and other leading clinicians within the state to prioritize key disease states that could benefit from implementation of evidence-based
education and intervention programs. With the goal of improving quality of health care for TennCare enrollees (including dual eligibles), at least two major disease-based Centers of Excellence will be launched by end of year.

TennCare pharmacy carve out provides benefits for over 200,000 dual eligibles who account for over $60 million per month in prescription costs. To improve efficiency and quality, TN has partnered with Applied Health Outcomes (consulting firm) to develop the program.

As a part of this initiative, TennCare is working with about a dozen pharmaceutical manufacturers to provide disease management services to TennCare beneficiaries (including dual eligibles) and evidence based data on outcomes. State is also working with the National Pharmaceutical Council on this initiative. These manufacturers are funding this part of the initiative. Applied Health Outcomes is liaison between state and pharmaceutical manufacturers.

**Cost Sharing**

- GA, KY: action to propose or implement increased prescription drug cost sharing requirements for Medicaid beneficiaries.
  - **Georgia**: three-tiered copayment structure requires 50 cents for generic drugs, 50 cents for preferred brand-name drugs, and 50 cents to $3 for nonpreferred brand-name drugs.
  - **Kentucky**: considering implementing three-tiered copayment structure for Medicaid beneficiaries, which would require payments between $3 and $5 depending on the type of medication.

**Combination of Approaches**

- Many states are combining cost containment strategies.
  - **Vermont**: As part of the New England Tri-State Prescription Drug Purchasing Coalition, Vermont has contracted out its Medicaid pharmacy benefits to a pharmacy benefit manager (PBM-First Health Services). Through the PBM, Vermont will be using a preferred drug list, prior authorization, and physician counter detailing. The PBM will also link directly to the state fiscal agent system to get real time patient prescription information on drug interactions and errors and prior authorization requests. It is estimated that the tri-state initiative will save 10 percent to 15 percent a year on prescription drug costs.

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