Issue Brief

Health Policy Studies Division
Contact: Samantha Ventimiglia, 202/624-5376
or sventimiglia@nga.org
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Pharmaceutical Purchasing Pools

Summary

State drug expenditures for public employees, dependents and retirees, Medicaid beneficiaries, and the uninsured are rising each year. According to the Segal Company Health Plan Cost Trend Survey, prescription drug benefit trend rates are projected to rise 19.7 percent for active plan members and retirees under age 65 and 20.9 percent for retirees age 65 and older. These trend rates are similar for mail order and retail pharmacies.[1] As pharmaceutical expenditures rise in state employee benefit and Medicaid programs, states and state agencies are uniting to develop approaches that will curb the rise in pharmaceutical costs for beneficiaries in their states.

To gain better control of prescription drug costs, states are investigating and forming purchasing alliances to negotiate pharmaceutical prices, discounts, and rebates* with manufacturers. Additionally, state governments are reviewing options to pool purchases among multiple state agencies and health insurance programs. Purchasing cooperatives can be effective in obtaining lower health care prices and improving quality of care through greater market power.

This *Issue Brief* examines aggregate or bulk pharmaceutical purchasing* cooperatives and their potential to reduce state pharmaceutical expenditures. Purchasing alliance design and implementation strategies are reviewed as well as the policy decisions surrounding multi-state coalitions and interagency or multi-program cooperatives.

Background

According to a recent study from the National Institute for Health Care Management Foundation, prescription drug expenditures rose 18.8 percent between 1999 and 2000. Total expenditures in 2000 were $131.9 billion compared to $111.1 billion in 1999. The bulk of rising costs can be attributed to increased utilization of new therapies and increased volume in overall use.[2]

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* See glossary at the end of the paper for further explanation of asterisked terms.

In 1998 state Medicaid programs spent $11.7 billion on pharmaceuticals, a $1.5-billion increase from 1997.[3] Furthermore, Medicaid payments for outpatient prescription drugs rose to $14.5 billion from an estimated $4.8 billion in 1990, an increase of about 15 percent annually.[4]

The cost impact on individual state programs can be dramatic. For example, Louisiana's Medicaid drug costs increased from $245 million in 1996 to approximately $453 million in 2000. The state estimates that prescription drug costs under its Medicaid program will exceed $1.1 billion by fiscal 2005 to 2006.[5]

Using Market Power to Control Costs[6]

Under current state-funded pharmaceutical assistance programs, states receive manufacturer rebate amounts between 2 percent and 45 percent of the states' net drug spending.[7] Within the Medicaid program, the minimum rebate the states receive is 15.1 percent or matches the best price available in the private marketplace, whichever is greater. The rebate amounts typically depend on the volume of products purchased. Therefore, aggregate purchasing from multiple state public programs enables these coalitions to use market power to maximize manufacturer rebates and lower prescription drug costs. The U.S. Departments of Defense (DOD) and Veterans Affairs (VA) have experimented with pooled prescription drug purchasing. Though both agencies receive discounts on drug purchases, they received the largest discounts when they contracted jointly to purchase particular drugs from manufacturers for their individual health care systems.

DOD and VA drug expenditures for fiscal 1999 totaled approximately $2.4 billion for patients in their health care systems.[8] Though the agencies are the largest direct federal pharmaceutical purchasers, their combined purchases are less than 2 percent of total domestic prescription drug sales. According to a May 2000 U.S. General Accounting Office (GAO) report, if DOD and VA jointly procured all of their prescription drugs, and not only 2 percent, they would increase their market power and leverage to extract greater discounts from pharmaceutical manufacturers.[9]

In 1999 the Congressional Commission on Service Members and Veterans Transition Assistance recommended that the two agencies jointly procure all prescription drugs and develop a single clinically based formulary[*].[10] The commission estimated that joint drug purchases by the agencies for all medications could save $1.9 billion over five years, or approximately $383 million per year. The commission did not, however, estimate individual savings for each agency.[11] More recently, the Congressional Budget Office (CBO) estimated that joint procurement with a joint formulary and merged mail-order pharmacy services would save the DOD and VA a total of $26 million in outlays in 2002 and almost $1.4 billion through 2011.[12]

As pharmaceutical expenditures for the two federal agencies are expected to rise, the VA and DOD are expanding their joint pharmaceutical contracts. From October 1998 through April 2000, the agencies granted 18 joint pharmaceutical manufacturer contracts estimated to save $40 million during fiscal 2000.[13] Since April 2000, the VA and DOD had 30 joint pharmaceutical contracts. As of January 2001, the agencies sought another 14 joint contracts, which are estimated to save an additional $30 million in annual pharmaceutical expenditures. The current and planned joint contracts will reduce the departments' total combined drug costs by approximately $170 million per year.[14]

Intrastate Multi-Program Purchasing Pools

Several states, including **Massachusetts**, **Texas**, **and Georgia** have enacted laws to create intrastate multi-agency and multi-program pharmaceutical purchasing pools to gain greater pharmacy price discounts for eligible populations. Actual progress in implementing these programs is variable by state.

Massachusetts

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.[15] Although the state has not yet implemented its aggregate purchasing plan, in June 2001, the current administration invited the state legislature to renew dialogue on this issue.

Texas

In June 2001, Texas enacted a similar law that would establish a multi-agency bulk purchasing system for prescription drugs. The law would combine pharmaceutical purchasing for the departments of health and mental health, state employees, retirees, teachers, prison system and any other agency that purchases pharmaceuticals. The law 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. The 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.[16]

Georgia

Georgia has been implementing an intrastate multi-program purchasing cooperative since the fall of 2000. Most of Georgia's public health insurance programs are experiencing rising pharmaceutical expenditures. For example, from fiscal 1999 to fiscal 2000, Georgia's Medicaid pharmacy expenditures increased by almost 23 percent to about $539 million. Similarly, pharmacy costs for state employees enrolled in the State Health Benefit Plan have increased by about 20 percent annually since 1999.[17]

In 1999 Governor Roy Barnes introduced a proposal to consolidate the state's public health insurance programs under one agency. The Department of Community Health[18]serves as the lead planning agency for all health issues. The Governor's initiative, passed by the state legislature, streamlines administrative functions and combines health care insurance program purchasing into one unit to maximize purchasing power. As part of the consolidation initiative, in February 2000, the State Health Benefit Plan for state employees, the Board of Regents Health Plan for higher education health insurance programs, the Georgia Medicaid program, and the state children's health insurance program, PeachCare for Kids, issued a joint request for proposal (RFP) for a multi-program contract for pharmacy benefit manager[*] (PBM) services.

After a competitive bid process and extensive review, the state chose Express Scripts Inc. as the PBM. Express Scripts will work with the Georgia Department of Community Health to administer the pharmacy benefit to these program populations. The Department of Community Health and Express Scripts Inc. began services for Medicaid and PeachCare for Kids beneficiaries in October 2000.

Georgia's Additional Cost Containment Strategies

The following January 2001, the department restructured the pharmacy benefit plan for the Board of Regents Health Plan and the State Health Benefit Plan by creating a pharmacy benefit card program with a three-tier copayment* structure. The new three-tier structure requires $10 for generic* drugs, $20 for preferred brand-name* drugs, and a $35 minimum and $75 maximum for nonpreferred brand-name drugs. Copayments for preferred brand-name and generic drugs are subject to a monthly limit. Under the previous pharmacy benefit, plan members paid for their drugs up front and then submitted claims for payments to the program. These claims were applied to a required deductible* ($300/$900) and were subject to coinsurance* amounts paid by the plan and the beneficiary.* The new cost-sharing structure was executed in January 2001 for the Board of Regents Health Plan and July 2001 for State Health Benefit Plan enrollees. The Department implemented a single preferred drug list, or formulary, in July across all drug programs.

The Department of Community Health also implemented a new cost-sharing* structure for Medicaid and PeachCare for Kids enrollees.* The new 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.

By ensuring that prescription medications are used appropriately and cost effectively, this new benefit management improves the health of populations served by the Department of Community Health. The restructured services will reduce program benefit costs and improve access, utilization, and disease management services.

Multi-State Prescription Drug Purchasing Alliances

Minnesota Multi-State Contracting Alliance for Pharmacy[19]

Background

Since 1985, the Minnesota Department of Administration, Materials Management Division, has administered the Minnesota Multi-State Contracting Alliance for Pharmacy (MMCAP). MMCAP pools pharmacy purchasing for multiple agencies and nonfederal governmental units across more than 38 states. Participating entities are eligible to obtain pharmaceuticals through MMCAP using contracts established with drug manufacturers and other vendors. As more states and entities join MMCAP alliance and increase its market power, their ability to negotiate better prices with drug manufacturers increases.

MMCAP Structure

MMCAP membership is available to facilities run by state agencies, cities, townships and counties. More than 2,600 facilities currently receive services from MMCAP. MMCAP's member facilities, which purchase pharmaceuticals from the entity's contracts, must purchase them for their "own use" as defined by Abbott Labs v. Portland Retail Druggists, 425 U.S. 1. Member

facilities, such as corrections facilities and student health centers, generally, are direct providers of services to clientele. MMCAP offers a wide range of services to member facilities, including flu vaccine, returned goods processing, vials and containers, and hospital supplies.

MMCAP is funded through administrative fees from contracted drug manufacturers, and these funds are used exclusively to support this program. There is no membership fee for participating agencies. MMCAP pays for all travel and expenses related to participation by member state staff in MMCAP sponsored activities. MMCAP facilities receive a credit from MMCAP, based on any excess administrative fee from the previous contract year that was not used to support the program. In contract year 1999 to 2000 (May 1, 1999 to April 30, 2000), the credit was almost $2 million. These credits are issued through the designated wholesale distributor, and therefore, offsets the cost for the facility during the next contract year.

MMCAP Operation

Annual pharmaceutical sales volume is approximately $600 million. Minnesota maintains contracts with more than 130 pharmaceutical manufacturers for more than 6,039 products. To ensure timely and accurate orders, the MMCAP uses two contracted vendor wholesalers with distribution centers located throughout the United States. Each participating state agency is associated with one of these vendors. Each state designates one pharmacist and one agency purchasing official as state coordinators.

MMCAP releases an RFP directly to the drug manufacturers. The manufacturers then submit their proposals for review at an annual contract award meeting where the state coordinators from each participating state work on pharmaceutical awards. All expenses related to the annual award meetings are covered by MMCAP. The MMCAP Advisory Panel, composed of pharmacists and purchasing officials from a number of facilities, such as student health and corrections, meet on a regular basis. MMCAP members must purchase pharmaceutical products from the MMCAP contract, not from any other nongovernmental contract.

Legislative Requirements

State agencies interested in participating in MMCAP must have an executed agreement with the Minnesota purchasing pool organization. Additionally, the participating state agency must be permitted by its state statutes to purchase goods from state contracts or have an agreement with its state purchasing authority to allow the agency to purchase goods from state contracts. Although it varies across states, membership is typically available to facilities run by state agencies, cities, townships, and counties.

New England Tri-State Prescription Drug Purchasing Coalition

The tri-state initiative unites **Maine, New Hampshire** and **Vermont** into a single entity to collectively address rising prescription drug costs for people covered by public programs and uninsured and underinsured individuals. Prescription drug expenditures for the three state Medicaid programs are estimated at $387 million. The governors from the three states met in February 2000 to discuss common health care concerns, including rising prescription drug expenditures.[20]

As a result of that meeting, the three governors established the first multi-state prescription drug contracting initiative to gain efficiencies in their prescription drug programs. Common concerns with their state health care systems and similarities in their socioeconomic and geographic

characteristics prompted the governors' decisions. Each state already had a number of initiatives to reduce prescription drug costs and provide coverage for the uninsured, elderly and low-income populations who do not qualify for Medicaid.

Following successful implementation of the purchasing initiative for the states' Medicaid populations, the coalition plans to include additional individuals, such as state employees and the uninsured.

Background

Initially, the governors appointed a working group of cabinet members and other senior state officials from their states. The appointed working group comprised several state agencies: the Commissioners' of Health and Human Services, the Governors' assistants, representatives from the Departments of Insurance, Vermont's contracted pharmacy consultant, State Medicaid Directors, representatives from the Divisions of Personnel, Medicaid pharmacists, and representatives from Planning and Research. After analyzing aggregate pharmaceutical purchasing, the working group determined that aggregating various populations from the three states could be beneficial and could lower pharmacy costs for several populations in a multi-state effort. These populations include individuals without access to pharmacy benefit coverage; Medicaid beneficiaries; Medicare beneficiaries; state employees, retirees and dependents; college and university employees, retirees and dependents. Collectively, these groups represent more than 1 million individuals in the three coalition states. By aggregating these groups into a single PBM, the coalition hoped to improve benefit management, quality of care, and their ability to control expenditures and to negotiate rebates with manufacturers.

After the working group recommended using a PBM to implement the multi-state coalition, the governors issued an RFP to PBM companies. The RFP working group consisted of multiple state agencies: Maine's Director of Quality Management and Medicaid pharmacist; New Hampshire's Medicaid Administration Director, Medicaid pharmacist, Contract Administrator, and Governor's assistant; and Vermont's State Medicaid Director, Medical Director, and Contract Administrator. The coalition was assisted by Vermont's and New Hampshire's pharmacy consultant, Health Management Associates. The tri-state coalition believes PBMs can control rising drug expenditures through cost-management tools and expertise utilized by the private sector. Through the final PBM contract, the three states intend to improve the techniques for providing, managing, and paying for benefits available through the various pharmacy programs. The pharmacy consultant, Health Management Associates, facilitated the implementation. Other than the PBM, the coalition did not include private-sector representatives.

Coalition Objectives

The tri-state coalition's primary goals include enhancing quality of care; controlling pharmacy expenditures for covered populations; reducing program administrative costs; and improving access. The coalition projects substantial savings through better management and administrative cost savings. Drug costs for the uninsured and public beneficiaries will be lowered through a number of cost-management strategies including:

- negotiation of price and rebates;
- greater efficiency in pharmacy claims processing;
- reduction of claims processing for ineligible populations;

- reduction of administrative costs;
- cost avoidance of claims for individuals with third-party liability for pharmacy services;
- preservation of health through prospective drug utilization review (PRO-DUR) to prevent inappropriate drug dispensing and/or use;
- prevention of payment for fraudulent or duplicate claims; and
- maintenance of positive relationships with providers.

These management strategies will help improve overall quality through more aggressive clinical management. Although the coalition selected only one vendor (PBM), each state will procure individually with that vendor and maintain separate contractual relationships.

Legislative Requirements

Legislation was not required, as it is not necessary to manage Medicaid pharmacy expenditures. However, the coalition had the support of the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) for the multi-state initiative and kept them informed of their activities.

Pharmacy Benefit Manager Selection

The coalition determined that the most comprehensive approach to managing quality and health care costs for their populations was through a PBM. In May 2001, the states selected First Health Services Corporation of Virginia. Each state will contract separately with First Health Services for populations that it determines are most appropriate. The contracts are expected to begin operating by November 1, 2001. It is estimated that the tri-state initiative will save 10 percent to 15 percent a year on prescription drug costs. Initially, the purchasing initiative will include the 330,000 individuals covered by the Medicaid program in the three states. After the first year, small businesses and other groups, such as local governments, can join the cooperative.

Other Cost Containment Strategies Employed by Tri-State Coalition States

Maine Medicaid

The Maine Medicaid program processes about 3.4 million pharmacy claims annually for 181,000 individuals. The Medicaid program's annual pharmacy budget is approximately $165 million.[21] To better manage Medicaid pharmacy costs, 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.[22] In the program's first six months, Maine Medicaid saved $5 million in program costs.

New Hampshire Medicaid

In state fiscal 2000, the New Hampshire Medicaid program provided prescription drugs to about 82,000 beneficiaries at a total drug budget of $77.7 million. New Hampshire's current cost management strategies include voluntary managed care, mandatory generic substitution[*] requirements, minimal copayments, and mandatory therapeutic drug utilization review[*] edits. The reviews are intended to prevent overdosing, overuse, duplicative therapy, and drug-to-drug interactions. The state does not use prior authorization.[23]

Vermont Medicaid

In state fiscal 2001, the Vermont Medicaid program expects to provide prescription drugs to about 126,000 individuals. The state's current cost management strategies include minimal copayments for traditional Medicaid beneficiaries, as well as coinsurance, mandatory therapeutic drug utilization review edits—which are intended to prevent overdosing, overuse, duplicative therapy, and drug-to-drug interactions—and limited prescription drug coverage for the state's Medicaid expansion populations. For all Medicaid beneficiaries, the state has a generic substitution requirement.[24]

"Southern States Coalition" Pharmacy Working Group

A number of southern states expressed interest in forming a "Southern States Coalition" pharmacy purchasing pool. These states included **Alabama, Arkansas, Georgia, Louisiana, Maryland, Mississippi, Missouri, New Mexico, North Carolina, South Carolina, Tennessee, Washington, West Virginia and Wyoming**. The coalition unites participating entities to create joint purchasing opportunities, counter detailing and utilization activities, pharmaceutical strategies, and advocacy activities. Local school districts and city and town governments may be able to join the coalition. The coalition conducted a survey among the interested states and their various agencies. Sixteen surveys were returned reflecting information from nine states. Of the nine states, 4.9 million lives would be covered if all move forward with this program. There are nine employee and retiree groups; five Medicaid systems; one worker's compensation plan; and one senior citizens plan.[**] Collectively, these states had $2.6 billion in pharmacy expenditures annually. The pharmacy working group represents individuals from a variety of regions.

Background

West Virginia Governor Bob Wise directed the West Virginia Public Employees Insurance Agency Director to form the "Southern States Coalition" pharmacy working group and launch this project by working with states that had similar concerns about health care. The working group is divided into two subcommittees, Medicaid and state public employees. The two subcommittees are necessary to ensure a concentrated focus on the different aspects relative to each entity.

The working group explored several options, including jointly pursuing the integrated services of a PBM; negotiating services for additional individuals under one participating state's current PBM contract; and becoming its own PBM.

The states involved with the working group already have combined a number of cost-management tools within their state programs, including drug formularies, PBMs, and various drug utilization review (DUR) processes.

Implementation Tools

Initially, the individual interested states were using their own consultants, and there were a number of consultants observing and providing feedback during the working group meetings. In August 2001, West Virginia contracted with the New England Tri-State Coalition's consultant, Health Management Associates, to assist the working group in developing an RFP for PBM services. The "Southern States Coalition's" RFP initially includes state employee plan beneficiaries and intends to combine state Medicaid populations in the future to further increase its purchasing power.

As a part of the initiative, the working group is also reviewing other cost management tools, such as multi-state disease management and provider education programs. True savings from utilization management and provider education will be from multiple states working together as one entity. The costs will be determined as participating states determine the details of services they wish to purchase.

Legislative Requirements and Pharmacy Benefit Management

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. The coalition considered piggybacking on a participating state's current benefit management contract or developing contracts on its own. After considering these options, the group decided to issue a joint RFP for a multi-state contract for PBM services. In developing the RFP, the group included minimum levels of rebates and maximum levels on administrative fees.

A primary implementation obstacle is that participating states have the responsibility to operate their insurance programs, as well as Medicaid. The time necessary to dedicate to the process may not be available. During the group's inception, many state legislatures were in session creating another obstacle. Furthermore, some interested states indicated their budgets would not allow the expense. States must decide whether they want to participate in the coalition and, if they do, they must dedicate their time and effort. Each state must have the political will to proceed.

On October 17, 2001, the West Virginia Public Employees Insurance Agency issued the RFP to PBM companies for a multi-state pharmaceutical purchasing effort. The public employee health benefit plans of Louisiana, Mississippi, Missouri, New Mexico, and South Carolina were included in the original RFP. Other interested states still have the opportunity to participate in the initiative.

Conclusion

States are continuing to explore ways to reduce their pharmaceutical expenditures. According to the Tri-State Coalition participants, receiving contract approval and a carefully crafted implementation process are critical to the success of any multi-state purchasing effort. States or entities exploring purchasing cooperative approaches should seek the support and guidance from an experienced pharmacy consultant when designing an alliance. States exploring purchasing options must have their governor's support and must designate specific agency contacts and point people to ensure consistency and effectiveness.

For a successful coalition, states must be committed to purchasing initiatives and possess:

- the political will to proceed;
- budgetary ability;
- no legislative restrictions;
- professional consultation; and
- staff time to commit to the effort.

Glossary of Technical Terms*

Beneficiary: An individual who receives benefits from or is covered by a health insurance policy or program, such as a state pharmacy program. Also called an enrollee.

Brand-name Drugs: A drug that is the product of a specific pharmaceutical company. This also is known as proprietary trademark name. No other pharmaceutical company can manufacture brand-name drugs until the patent expires.

Bulk Purchasing: A concept under which quantities of a product are purchased and received in sufficiently large volumes to achieve economies of scale that may result in a discount on the price of the product. This is otherwise known as volume discount.

Coinsurance: The part of covered health care costs for which the health coverage beneficiary has a financial responsibility, usually according to a fixed percentage.

Copayment: Requires a health plan beneficiary to pay a specific charge for a specific service, such as $5 to fill a prescription. The beneficiary is typically responsible for this payment at the time service is rendered.

Cost Sharing: Requires a health plan beneficiary to pay some portion of the medical or pharmaceutical cost. The term includes copayments, deductibles, annual fees, and premiums.

Deductible: The amount a program participant must pay before health services are completely covered by the health plan or program.

Drug Formulary: A list that identifies preferred medications for treatment of specific diseases. The list is usually subject to periodic review and modification. An open formulary allows coverage for both formulary and nonformulary medications. A closed formulary limits coverage to only those medications on the preferred list.

Drug Utilization Review (DUR): A quantitative evaluation of prescription drug use, physician prescribing practices, or patient drug use, to determine the appropriateness of drug therapy. DUR often focuses on patient overutilization.

Enrollee: An individual who receives benefits from or is covered by a health insurance policy or program, such as a state pharmacy program. Also called a beneficiary.

Generic Drug: A chemically equivalent duplication of a brand-name drug whose trademark patent has expired. Generic drugs must have the identical composition of active ingredients of the brand-name drug. Generics must meet official standards of identity, purity, and quality of the active ingredient(s) of their brand-name counterparts.

Generic Substitution: Dispensing a generic medication in place of a brand-name drug.

Manufacturer Rebate: A monetary amount returned to a payer (such as Medicaid or state employee benefits programs) by a covered individual or purchases by a provider from a pharmaceutical manufacturer based upon use and volume.

Medicaid Rebate: Under federal law (P.L. 101-508, OBRA 1990), pharmaceutical manufacturers must enter into rebate agreements with the federal government for the Medicaid program to cover their products. Generally, the rebates are based on the average price paid by wholesalers, known as the average wholesale price (AWP). Specifically, the rebate is based on either the AWP minus 15.1 percent for brand name drugs and 11 percent for generics or the best price—the lowest price

paid for a drug product by any purchaser other than federal agencies and state pharmaceutical assistance programs—which ever results in a lower price.

Prior Authorization: The process of obtaining prior approval from a health insurance plan or state program for a service or medication before prescribing or dispensing certain medication. Prior authorization for a service or medication does not guarantee coverage.

Additional Resources:

NGA state pharmaceutical assistance programs information:

Chart on State Pharmaceutical Assistance Programs:

http://www.nga.org/center/divisions/1,1188,C_ISSUE_BRIEF^D_843,00.html

State Pharmaceutical Assistance Programs:

http://www.nga.org/center/divisions/1,1188,C_ISSUE_BRIEF^D_2013,00.html

Addendum to State Pharmaceutical Assistance Programs: The Maine Rx Program:

http://www.nga.org/center/divisions/1,1188,C_ISSUE_BRIEF^D_2287,00.html

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*National Pharmaceutical Council, *Pharmaceutical Benefits under State Medicaid Assistance Programs,* December 1998.

** Interested state agencies include: **Alabama:** Retirement Systems of Alabama, State of Alabama State Employees' Insurance Board Arkansas Employee Benefits Division; Division of Financing and Administration; **Georgia:** Georgia Department of Community Health; **Louisiana:** Louisiana State Employees Group Benefits Program, Louisiana Department of Treasury; **Maryland:** Maryland Department of Budget and Management; Segal Company representing the State of Maryland State Employees; **Mississippi:** Mississippi Division of Medicaid, Mississippi State Insurance Administrator, Department of Finance and Administration; **Missouri:** Missouri Office of Administration, Division of Budget and Planning; **North Carolina:** North Carolina Medicaid, North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan; **South Carolina:** South Carolina Silver R_x, South Carolina Office of Insurance Services, State Employee Health Plan; **Tennessee:** Tennessee TennCare; **Washington:** Washington State Health Care Authority; Washington State Medicaid Agency; **West Virginia:** West Virginia Bureau of Senior Services, West Virginia Public Employees Insurance Agency; **Wyoming:** Wyoming Department of Health.

[1] The Segal Company, *Segal Health Plan Cost Trend Survey,*(segalco.com, 2001).

[2] National Institute for Health Care Management Research and Educational Foundation, *Prescription Drug Expenditures in 2000: The Upward Trend Continue,* (Washington, D.C., May 2001).

[3] Mary Guiden, *What's Behind the Medicaid Cost Explosion?* (Stateline.org, February 16, 2001).

[4] Diane Rowland, "Prescription Drug Coverage for the Medicare Population" (testimony before the Subcommittee on Health, U.S. House Committee on Energy and Commerce, on behalf of the Kaiser Commission on Medicaid and the Uninsured, February 15, 2001).

[5] "Facing Escalating Costs, Louisiana Looks to Reform 'Generous' Medicaid Drug Benefit," news release of the Kaiser Daily Health Policy Report, Washington, D.C., April 30, 2001.

[6] The U.S. Department of Defense (DOD) and Veterans Administration (VA) purchase and receive products directly unlike most state programs. Therefore, greater efficiencies may be possible and the full amount of any discounts are received by the DOD and VA because no intermediary, such as a wholesale distributor, is involved in the process. In addition, the VA established a national formulary.

[7] U.S. General Accounting Office, *State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets,* HEHS-00-162, Washington, D.C.: September 2000.

[8] Congressional Budget Office, "Budget Options," Washington, D.C., February 2001.

[9] U.S. General Accounting Office, *DOD and VA Health Care: Jointly Buying and Mailing Out Pharmaceuticals Could Save Millions of Dollars*, HEHS-00-121, Washington, D.C.: May 25, 2000.

[10] Congressional Budget Office.

[11] U.S. General Accounting Office.

[12] Congressional Budget Office.

[13] Ibid.

[14] Ibid.

[15] National Conference of State Legislatures, *Massachusetts Senior Pharmacy Assistance Programs: 1999 Changes*, (ncsl.org, 1999).

[16] National Conference of State Legislatures, *2001 Prescription Drug Discount, Bulk Purchasing, and Price-Related Legislation,* (nscl.org, July 20, 2001).

[17] Georgia Department of Community Health, *Fiscal Year 2000 Annual Report,* (communityhealth.state.ga.us, July 2001).

[18] The Georgia Department of Community Health is a combined agency that includes Medicaid, state employees, and the state children's health insurance program.

[19] http://www.mmd.admin.state.mn.us/mmcap.htm

[20] http://www.hlthmgt.com/tristate/rfp/tri-staterequestforproposal.doc

[21] Ibid.

[22] http://www.state.me.us/dhs/pressee.htm

[23] http://www.hlthmgt.com/tristate/rfp/tri-staterequestforproposal.doc

[24] Ibid.