



Washington Research Council

PB 03-03 February 17, 2003

BRIEFLY

E2SHB 1214 would create a Prescription Drug Quality and Purchasing Board to oversee a new state drug-purchasing consortium.

However, the governor already has the power to implement consolidated drug purchasing administratively without further legislative authorization, and Governor Locke plans to use this power.

A consortium implemented administratively by the governor would operate more cheaply and with greater flexibility. In addition, the governor would have greater control over state drug purchasing activities than he would were authority vested in a separate board. This is the better way to go.

Board with Drugs

Introduction

The state faces a large budget gap for the 2003-05 biennium. Increasing medical costs are a significant contributor to the situation. Expenditures on prescription drugs have received particular attention.

The governor has proposed that the Medical Assistance Administration (MAA) join with the Health Care Authority (HCA) and the Department of Labor and Industries (L&I) to consolidate purchasing of drugs. His budget projects that such an effort might save the state \$58 million in the 2003-05 biennium. This consolidation can be accomplished administratively, without explicit legislative authority.

The governor has also proposed that the state establish a new Medicaid program to provide a limited prescription drug benefit to certain low-income seniors. This initiative does require explicit legislation.

Many lawmakers are taken with the idea of a drug consortium. In 2002 supporters pushed a bill (HB 2431) to create a consortium, and their efforts continue in this session.

The House recently passed a bill that would consolidate drug purchasing among state agencies and implement a preferred drug list. The bill would allow people outside of state government to join the consortium as well. The bill also establishes the senior drug benefit requested by Governor Locke.

Engrossed Second Substitute House Bill 1214

Engrossed Second Substitute House Bill 1214 passed the house on February 7 and now is before the Senate.

E2SHB 1214 would create a Prescription Drug Quality and Purchasing Board within the Health Care Authority. This Board is to adopt a preferred drug list and to organize a drug-purchasing consortium.

The consortium will consolidate purchasing for the state's fee-for-service health care programs. (Managed care plans will not be part of the consortium.) The three largest groups for which the state funds health care are Medical Assistance clients, state and school district employees, and workers compensation claimants. Nearly 80 percent of Medical Assistant clients are served through fee-for-service programs, while less than 30 percent of state and school district employee health benefits are fee-for-service (through the Uniform Medical Plan). All workers compensation clients are fee-for-service.

The bill will also create a new prescription drug benefit under Medicaid for low-income seniors.

Washington Research Council

108 S Washington St., Suite 406

Seattle WA 98104-3408

206-467-7088

fax: 206-467-6957

www.researchcouncil.org

Preferred Drug List

The preferred drug list would identify for each therapeutic drug class the particular drug or drugs that are most cost effective. To aid in the creation of the list, the Board is to establish a Pharmacy and Therapeutics (P&T) Committee. The P&T committee is to review evidence on the efficacy of prescription drugs and determine which particular drug or drugs are most clinically effective for various therapeutic classes.

State programs that purchase health care will adopt the preferred drug list. Any pharmacist filling a prescription under one of these programs will be required to substitute the preferred drug for any non-preferred drug unless the prescription has been explicitly marked "dispense as written," or the drug is a refill of an antipsychotic, antidepressant, chemotherapy, antiretroviral, or immunosuppressive drug. A pharmacist who makes such a substitution is required to inform the prescribing physician that this has happened. (Notice is required only on the initial filling of the prescription, not on refills.)

Drug Purchasing Consortium

The preferred drug list is the primary lever in a scheme to harness the bargaining power of the state to negotiate lower prices for prescription drugs.

In each therapeutic drug class, the board will place the least expensive of the P&T Committee-identified most effective drugs on the preferred drug list. Other drugs in the therapeutic class may then qualify for the list by matching the price of this least expensive alternative. The price reductions are to be implemented through a system of rebates that drug manufacturers will pay to the state.

Local government units, private entities, and individuals who lack other prescription drug coverage will be allowed to join the consortium.

A Medicaid drug benefit for low-income seniors

The Department of Social and Health Services is directed to apply to the federal government for waivers of Medicaid regulations so as to be able to offer a Medicaid drug benefit to certain low-income seniors who do not currently qualify for Medicaid.

This new program is not to be an open-ended entitlement. State spending will be limited to funds explicitly appropriated by the legislature. How the state will fund this benefit is not yet clear. E2SHB 1214 does state that the new Medicaid benefit cannot be funded from premiums or copays collected from clients of existing Medicaid programs.

This program will sunset within twelve months of the implementation of a prescription drug benefit under Medicare.

The administrator of the Health Care Authority is directed to establish a statewide clearinghouse for senior prescription drug information. The clearinghouse will provide seniors with education and help on public and private programs that provide financial assistance towards prescription drug purchases by seniors. The clearinghouse will also educate seniors about the preferred drug list, how to purchase drugs cost-



CHART 1
Fee For Service Prescription Drug Expenditures
by Selected State Agencies in 2000

Agency	Total Health Ex- penditure	Total Rx Ex- penditure
Department of Social and Health Services	\$1,974,620,068	\$497,012,159
Department of Labor and Industries	\$380,000,000	\$19,262,073
Health Care Authority	\$187,072,000	\$41,955,550
Department of Corrections	\$55,050,630	\$6,837,221
Department of Veterans Affairs	\$14,719,527	\$909,764
Department of Health	\$7,732,294	\$5,718,746
Pre-rebate	\$2,619,194,519	\$571,695,513
Post-rebate		\$489,438,613

Source: Washington State Prescription Drug Project, WRC

effectively, and the potential for dangerous drug interactions.

Management and Education

The Board is to establish drug utilization and management policies and prescriber and consumer education policies. The utilization and management policies might function much like the Intensive Benefit Management program currently employed by MAA.

The education policies are intended to elicit better compliance by prescribers

with the preferred drug list.

Therapeutic Consultation Services

E2SHB 1214 ends point-of-sale reviews of certain Medicaid prescription drug purchases as of July 1, 2005, under the Medical Assistance Administration's Therapeutic Consultation Services (TCS) program. (The TCS program and point-of-sale reviews are described below.) These reviews have been unpopular with patients, physicians, and pharmacists.

Amendment on the House Floor

On the House floor, 1214 was amended to include the sentence:

The administrator shall not require that any supplemental rebate offered by a pharmaceutical manufacturer for prescription drugs purchased for medical assistance program clients under chapter 74.09 RCW be extended to state purchased health care programs other than medical assistance, or to private individuals or entities participating in the consortium.

This amendment was necessary for the bill to be consistent with federal Medicaid laws. It has the effect of breaking Medical Assistance away from the other state purchased health care programs. Any rebates negotiated for Medical Assistance cannot be extended to other state programs.

In effect this means that Medical Assistance is out of the consortium. Medical Assistance can share research on the clinical effectiveness of drugs with other state agencies. But when it comes to bargaining with drug companies over rebates, Medical Assistance must go it alone.

Chart 1 shows fee-for-service drug purchases in 2000 for state purchased health care programs of various departments. The total expendi-

ture on prescription drugs, net of rebates under the federal Medicaid rebate agreement, was nearly \$500 million. Medicaid, through the Department of Health and Human Services, represented more than 80 percent of the total.

The idea that the state should pool all of its purchases to exert market power and extract volume discounts from drug manufacturers is seductive. But, as Chart 1 makes clear, most of the state's drug purchasing volume is in the Medicaid program. A state consortium that does not include Medicaid may well have little bargaining power, and it is unclear whether any parties outside of state government will see much advantage in joining such a consortium.

Fiscal Impact

Chart 2 summarizes the estimated fiscal impacts of the bill in the form passed out of the House Appropriations Committee as reflected in the fiscal note published by the Office of Financial Management. OFM has not prepared an updated fiscal note to reflect the amendment that was made on the House floor.

2003-05

For the 2003-05 biennium, the bill is expected to reduce cash revenues by \$19.1 million. The \$2.4 million reduction in Health Care Authority revenue is the sum of a \$3.6 million reduction in premiums paid by employees and retirees due to lower drug expenditures and a \$1.2 million gain in revenue from administrative fees paid by local governments, private entities, and individuals who choose to join the consortium.

The \$16.8 million reduction in DSHS revenue reflects reduced Medicaid reimbursements, due to lower reimbursable drug expenditures.

E2SHB 1214 is estimated to reduce expenditures for the biennium by \$56.4 million; of this, \$19.2 million is from the general fund. Expenditures for the Health Care Authority increase by \$2.1 million. This reflects \$6.3 million added to the Authority's administrative expenses and \$4.2 million reduced from expenditures on drugs through the Uniform Medical Plan.

The chart shows that E2SHB 1214 is expected to reduce the Department of Labor and Industries expenditures by \$23.9 million for the 2003-05 biennium. This number, however, is deceptive because it is based on the special accounting convention that L&I uses for the workers compensation program. The program accrues all of the medical costs associated with an injury in the year that the claim is made, even though the associated medical payments may be paid out over a number of years. On a cash flow basis, E2SHB 1214 is expected to save L&I \$4.6 million in the 2003-05 biennium. The \$23.9 million figure, in addition to this immediate cash savings, includes the discounted present value of future drug expenditure reductions for all existing claimants.

E2SHB 1214 reduces DSHS expenditures for the 2003-05 biennium by \$34.6 million overall. This combines a \$36.4 million reduction



CHART 2

	2003-05		2005-07		2007-09	
	GF-State	Total	GF-State	Total	GF-State	Total
Estimated Receipts						
Washington State Health Care Authority	-	(2.36)	-	(2.25)	-	(2.27)
Dept. of Social and Health Services	-	(16.78)	-	1.80	-	1.80
<i>Total Receipts</i>	-	(19.15)	-	(0.45)	-	(0.47)
Estimated Expenditures						
Washington State Health Care Authority	(1.42)	2.09	(2.04)	2.57	(2.05)	2.37
Dept. of Labor and Industries	-	(23.88)	-	(6.86)	-	(6.86)
Dept. of Social and Health Services	(17.80)	(34.59)	(0.70)	2.19	(0.70)	2.19
Dept. of Health	-	0.01	-	-	-	-
<i>Total Expenditures</i>	(19.22)	(56.37)	(2.74)	(2.10)	(2.75)	(2.30)

Source: OFM Fiscal Note, 1214 2S HB, WRC

in outlays for drugs with a \$1.8 million increase in administrative expenses.

2005-07 and 2007-09

E2SHB 1214 has much smaller impacts on receipts and expenditures during the 2005-07 and 2007-09 biennia than it has during 2003-05. Two factors are at play. First, with regard to L&I, the windfall cost savings on existing claims booked in 2003-05 was a one-time gain.

Second, on July 1, 2005, the program of point-of-sales reviews under TCS ends. MAA estimated that this adds \$50.4 million to expenditure in each of the subsequent biennium. This offsets the saving that Medical Assistance is expected to enjoy from the preferred drug list. (As we suggest below, however, the effect of ending the point-of-sale reviews may not be as large as MAA estimates.)

In 2005-07 the net effect of the bill is to reduce state receipts by \$0.4 million and to decrease expenditures by \$2.1 million. In 2007-09 the corresponding reductions are \$0.5 million and \$2.3.

Because of the elimination of Medical Assistance from the consortium, the ability to negotiate discounts as great as expected in the fiscal note is questionable. Thus the Department of Labor and Industries and the Health Care Authority might well see smaller drug expenditure savings than have been projected. Similarly, the revenue that the Health Care Authority receives from private parties joining the consortium might well be lower than expected.

Therapeutic Consulting Service

The 2001-03 biennial budget provided funds to DSHS to aggressively pursue savings and efficiencies within the Medical Assistance Programs. The result has been the Medical Assistance Administration's multifaceted Utilization and Cost Containment Initiative (UCCI).

The Therapeutic Consultation Service program, which attempts to constrain state Medicaid expenditures on prescription drugs, is a major piece of UCCI.

TCS has three primary components. The first component is a sys-

tem of "triggered" point-of-sale (POS) reviews. Under certain circumstances, the pharmacist submitting a claim for a Medicaid patient will receive a computer alert that the prescribing physician must consult with a Medical Assistance Administration clinical pharmacist before the prescription can be filled. The clinical pharmacist reviews with the physician the patient's entire drug profile. The clinical pharmacist may suggest alternatives that he believes to be more appropriate or cost effective. The physician, however, has the final say as to the drugs the patient receives.

The POS reviews are triggered either if the patient has received more than four brand name drugs within the month or if the prescribed drug is not MAA's preferred drug within its therapeutic drug class. (At the present time MAA has preferred drugs in two drug classes, H2 Receptor Antagonists and Proton Pump Inhibitors.)

TCS's second component is Intensive Benefits Management. Under this program MAA clinical pharmacists conduct targeted reviews of individual medication regimens and may provide continuing case management. Patients may be targeted because they are high drug utilizers, because of their specific disease state, or because of their physician's prescribing behavior.

TCS's third component is called Therapeutic Academic Service. This program analyzes pharmacy claims data to identify physicians who are high volume Medicaid providers and whose prescribing pattern varies from what MAA believes to be most cost-effective. Clinical pharmacists then meet face-to-face with these physicians and educate them regarding standard clinical treatment guidelines.

How much did TCS save?

TCS began February 1, 2002. MAA has estimated that in the first five months the program saved \$6.4 million. In a recent report prepared for the legislature, the Lewin Group reviewed the MAA estimate. Lewin notes that substitution of generics for brand name drugs will reduce the rebates the state receives under the federal drug rebate system and that MAA's estimate fails to account for this. Using somewhat different assumptions than MAA, Lewin estimates the savings from TCS to be \$7.5 million before adjusting for rebates and \$6.6 million net of rebates.

In both cases the methodologies used in estimating TCS savings are fairly simple and of necessity rely on somewhat arbitrary assumptions. Lewin is correct in netting out the rebate reduction. On the other hand, MAA's choices of baselines in projecting spending patterns absent TCS seem to be more appropriate than Lewin's choices. This suggests an estimate of \$5.5 million for the TCS savings (calculated by subtracting a \$0.9 million rebate reduction from MAA's \$6.4 million estimate).

Even this estimate may be too large. Neither the Lewin nor the MAA estimate includes MAA overhead associated with TCS. And as Lewin notes other policy initiatives may have contributed to the savings attributed to TCS: "It is important to consider the other pharmacy initiatives that took place during this time period that also could have affected costs." In particular Lewin cites MAA's Quality Review Services (QRS) program. "Many of QRS's efforts focus on changing the



utilization of prescription drugs; therefore, it is difficult to separate the effect of QRS's efforts from the change in utilization that has resulted from TCS when examining aggregated data."

Discussion

The governor has the power to implement consolidated drug purchasing and preferred drug lists administratively without further legislative authorization. Governor Locke plans to use this power.

The question then is: "Why bother to pass a new law?"

Legislative advocates of the drug-purchasing consortium envision that many private citizens want to participate in the state plan. The Prescription Drug Quality and Purchasing Board created by the bill would provide the superstructure to support a consortium that extends well beyond state government.

The inability of Medical Assistance to be part of the state drug-purchasing consortium, however, seriously limits the leverage that the consortium will be able to bring to bear on drug costs. Consequently few outside of state government will find the consortium attractive relative to private sector alternatives.

A consortium implemented administratively by the governor would operate more cheaply and with greater flexibility. In addition, the governor would have greater control over state drug purchasing activities than he would were authority vested in a separate board. This is the better way to go.

