



State Initiatives Using Purchasing Power to Achieve Drug Cost Containment

By Jane Horvath for NASHP

California Gov. Gavin Newsom's recent announcement that his state will pool its purchasing power to lower prescription drug costs has garnered considerable attention and rekindled interest in similar, longstanding efforts by states.

"...the rising prices of prescription drugs affect not only the state ... but all Californians including businesses and families, who are forced to make unconscionable sacrifices in order to access life-saving and life-preserving treatments ... a major cause of skyrocketing prescription drug prices is bargaining asymmetry." California Executive Order N-01-19.

Gov. Newsom's call for a more unified and stronger bargaining power reflects the new urgency for state action to constrain drug costs. It's easy to see why state and local governments have a keen interest in drug costs – states and local tax dollars can contribute to the pharmacy benefit of up to 25 or 30 percent of a state's population.¹

While concern over drug costs and spending continues to grow, state interest in bulk purchasing and drug discount negotiation strategies has spanned decades. There were 27 state laws enacted between 1999 and 2004, directing state agencies to implement a variety of multi-agency or multi-

state drug purchasing and payer cost containment strategies.² Several early state programs grew into large and lasting programs, while other programs have come and gone.³ States are looking for better purchasing strategies and stronger leverage to achieve concessions in their negotiations with drug manufacturers and in other parts of the prescription drug supply chain.

Models for State Action

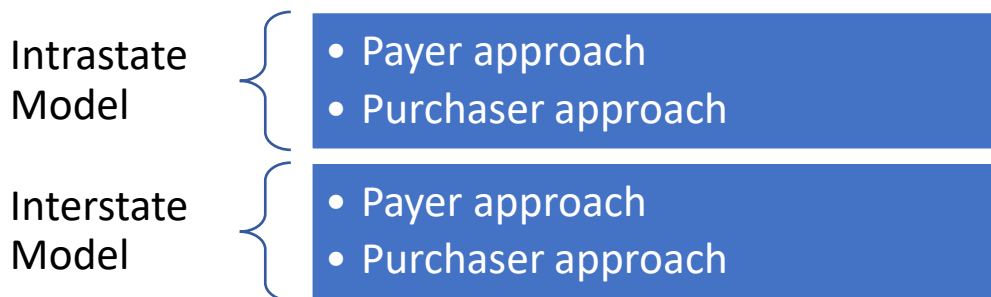
State efforts to date can be characterized as one of two types or models of state action:

- **Intrastate activity** that increases market leverage by aggregating covered lives of more than one state program, such as state and local employees, corrections, and public health; and
- **Interstate activity**, such as multi-state Medicaid supplemental rebate organizations that increase market leverage by aggregating covered lives of programs in multiple states.

Either intrastate or interstate can be further refined by whether participants are purchasers or payers. Purchasers take possession of the drug products for dispensing, such as departments of corrections or public health vaccination programs or student health services on higher education campus. These entities buy, own, stock and dispense medication.

Alternately, an interstate or intrastate program could be comprised of payers – entities that pay for drugs once dispensed by a retail pharmacy or administered by a physician's office, such as commercial- or employer-sponsored health plans. Payers reimburse purchasers. For example, payers such as Medicaid or Aetna reimburse physicians and pharmacists for drugs the physician or pharmacist bought, owned, and dispensed to the enrollee of the payer. Physicians and pharmacists submit claims for payment/reimbursement for drugs dispensed.

Payer and purchaser prescription drug price concession programs are structured differently. The need for enabling legislation, an executive order, or final regulations, will vary by state and by implementing/organizing agency within a state.



Interstate Purchaser Model

The Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP), which operates out of the Minnesota procurement agency, has operated since 1985. The program is a purchasing cooperative that negotiates manufacturer and wholesaler discounts on behalf of thousands of governmental facilities and agencies in all 50 states. Minnesota state law limits MMCAP membership to non-profit entities that have authority to use their own state's procurement system. There is no membership fee -- eligible entities register with MMCAP and pay service- or purchase-related administrative fees to it.⁴

Importantly, MMCAP represents purchasers – entities and facilities that buy and stock drugs for dispensing or administration. MMCAP does not deal in rebates on paid claims for government payer programs, such as Medicaid. Members can buy all pharmacy products from MMCAP. The organization's bargaining power is clearly stronger when a larger number of members purchase more of their total pharmacy products through MMCAP.

MMCAP negotiates with wholesalers for certain discounts and negotiates directly with generic and brand-name drug manufacturers. Members can choose from among three wholesalers for order fulfillment. Members do not align their formularies, so discounts are based on estimated volume. If members agree on a specific product over other products in a class, there can be greater discounts based on volume and moving market share to a preferred product. MMCAP has found that it is very difficult for different facilities and/or agencies to agree on a common formulary or to preferred drugs within a category or class of drugs.

Among 11 membership types or categories,⁵ the largest membership segment is public health, which makes up more than 44 percent of the membership. MMCAP membership segments are designed to align with all drug manufacturers' categories of discounts and rebates, which they define roughly by market segments (e.g., hospital, government program etc.) There is no uniformity among manufacturer discount and rebate categories referred to as classes of trade (COTs), so MMCAP has created broad COTs to group their members in order to align, as much as possible, with industry COT terminology.⁶

The larger the MMCAP COT, the better the discounts. That's why the program works to keep COTs as broad as possible, but still aligns with how different manufacturers structure their COTs. Importantly,

there is no actual requirement for members to prefer MMCAP products in their operations or formularies.

MMCAP purchases a variety of supplies for health facilities in addition to drugs. For drugs, MMCAP contracts with wholesalers.⁷

Interstate Payer Models

[Medicaid Supplemental Rebate Pools](#): The more well-known interstate payer models are exclusive to Medicaid. There are three multi-state supplemental rebate pools:

- The National Medicaid Pooling Initiative (NMPI) started in 2003, with 10 states currently participating;
- Top Dollar (Top\$) initiated in 2005 with seven states currently participating; and
- Sovereign States Drug Consortium (SSDC) instituted in 2006 with 12 states currently participating.

Participating states are generally those with smaller populations that may lack the staff to manage a preferred drug list and contract negotiations.

Supplemental Medicaid rebates are provided in addition to the federal minimum and best price rebates. Current federal law does not affect supplemental rebates, however, the Centers for Medicare & Medicaid (CMS) reviews and approves all supplemental rebate agreements regardless if they contain a pooled agreement or supplemental agreement of individual states that are not in the pool. Supplemental rebates are voluntary for states and manufacturers.

The pools negotiate rebates based on their volume of pooled lives. Pools do not negotiate based on an agreement of the members to treat certain drugs similarly. For example, all members agree that a drug will be taken off a state's preferred drug list (PDLs) if there is no supplemental rebate. Discounts could be more significant if states would further aggregate their negotiating leverage.

NMPI and Top\$ are administered by the same company, Provider Synergies, a subsidiary of Magellan Pharmacy Management Company. NMPI and Top\$ share the same site and offer the same service.⁸ There is very little public information about the cost-savings associated with these programs or what differentiates the two pools.

Although it negotiates rebates, Provider Synergies is a PDL management contractor. The core service it offers is state pharmacy benefit formulary management, which is very different from a core focus on negotiating rebates. While Medicaid must cover all drugs a manufacturer produces, states use PDLs to make some drugs more easily accessible to patients. Non-PDL drugs may require prior authorization or apply other utilization management strategies.

SSDC is managed by Change Healthcare, a health information technology (IT) company. Change Healthcare solicits manufacturer rebate bids on behalf of its members. The bids are reviewed by all participating states, which then contract directly with the manufacturers of their choice, based on the rebate bids and their state-specific PDL.

Northwest Consortium: This organization was created in 2006 by the states of [Oregon](#) and [Washington](#). The program is administered by [Moda Health](#), and Ardon Health serves as the specialty pharmacy

contractor. The multifaceted consortium was created to allow states' agencies, local governments, businesses, labor organizations, and uninsured consumers to pool their purchasing power to obtain less costly prices for prescription drugs. The program began with a discount card for point-of-service pharmacy discounts at participating pharmacies. This card enables an individual to obtain discounts at the pharmacy counter. Pharmacies that participate in the program benefit from increased customer traffic because of their participation.

The Northwest Consortium now has a group purchase organization (GPO) and a pharmacy benefit manager (PBM), which operate on behalf of purchasers and payers respectively. Participating Oregon agencies include corrections, Medicaid, workers compensation, public employees and retirees and public schools. In Washington, participating programs include Medicaid, state employees and retirees, and workers compensation. The program currently handles the 340B Drug Discount Program. Additionally, the consortium program has grown from a pharmacy-based discount card program and GPO, to a PBM for payers that negotiate price concession rebates with a role in the 340B program, which serves hundreds of safety net providers in the consortium.

Participating employer groups enroll employees in the discount card program or use the Northwest Consortium PBM function to manage the pharmacy benefit for employer groups. The consortium PBM provides 100 percent transparency – the manufacturer rebates are passed through in full to consortium payers.⁹

In 2017, the Northwest Consortium served more than 1 million covered lives and administered \$800 million in volume.¹⁰ The consortium is currently looking for ways to expand participation.

Intrastate Models

Washington State: The Washington State Health Care Authority, the state's largest purchaser of health care, administers the Washington Prescription Drug Program (WPDP). The program coordinates the pharmacy benefit for Medicaid, state employees and retirees, school employees, and workers compensation. These state agencies also participate in the Northwest Consortium. All agencies use a unified preferred drug list, or formulary, called the Washington Preferred Drug List. The Medicaid Drug Utilization Review Board serves as the program's pharmacy and therapeutics (P&T) committee. P&T committees review drugs to determine if they should be covered and can make recommendations about how they should be covered, for example, only for certain conditions or with prior authorization. In addition to managing costs for multiple health coverage programs through negotiating manufacturer, wholesaler, or pharmacy discounts, the program develops treatment and prescribing protocols to optimize care and treatment as well as manage costs. The treatment protocols apply to participating state programs and are widely available to providers in these communities.

California: California operates both purchaser and payer drug programs. The programs are administered by several state departments and local governmental programs. The Department of General Services and the Department of Health Care Services are tasked with responding to the Governor's Executive Order N-01-19. The governor has tasked the Department of Health Care Services with moving the Medi-Cal (Medicaid) pharmacy benefit out of individual managed care organizations into its fee-for-service program and negotiating supplemental rebate agreements with manufacturers based on its large group of covered lives.¹¹ Prior to the governor's order taking effect, Medi-Cal lives were distributed among

Medi-Cal contracting managed care organizations (MCOs), and each MCO negotiated separately for manufacturer rebates or relied on MCO-specific PBM contractors to obtain drug rebates.

Part of the governor's charge was placed with the Department of General Services (DGS), in consultation with the California Pharmaceutical Collaborative (CPC). DGS coordinates the multiagency CPC, which acts as a statewide workgroup of the DGS Statewide Pharmaceutical Program California. The CPC is tasked with the following responsibilities:

- Coordinate best-value clinical treatment protocols among collaborative members;
- Leverage state, local, and other government efficiencies and methodologies to achieve best-value procurement, purchasing, and negotiation with manufacturers for discounts on pharmaceuticals;
- Establish and monitor performance and quality standards for protocols, guidelines, and contracts created for member agencies;
- Work with member departments to track state expenditures on specified high-cost drugs to inform the budget process;
- Recommend high-cost pharmaceuticals for cost-value review by independent research organizations;
- Track new pharmaceuticals currently under US Food and Drug Administration review, which are likely to come out onto the market in the near future and those that may become high cost; and
- Act as a discussion forum where pharmaceutical issues of interest can be identified and addressed.

The collaborative's executive committee includes representatives from the departments of Corrections, Veterans' Affairs (CalVets), and Health and Human Services, Finance, as well as the Government Operations Agency, and the Labor and Workforce Development Agency.

Other state and local government agency collaborative participants include the Department of Industrial Relations, state retirees (CalPERS), Association of Counties, State University System, Covered California (the state's Affordable Care Act exchange program), Department of Managed Care, Department of State Hospitals, Department of Developmental Services, and the University of California system.

Purchasers' Program: The program for purchasers is established by law.¹² The departments of corrections and rehabilitation (California Correctional Health Care Services and Division of Juvenile Justice), state hospitals (psychiatric), and developmental services must participate. Other state and local governmental agencies can participate voluntarily. Agencies that have elected to participate include the state university system, the Department of Public Health, and the Emergency Medical Services Authority.

The program purchases drugs for participating agencies at a cost between 63 to 69 percent less than "suggested wholesale price," which is the price the manufacturer suggests wholesaler use when selling to retail pharmacies. The agencies then dispense the drugs directly to their patients. In general, the suggested wholesale price would be higher than the wholesale acquisition cost (WAC), but lower than the retail price. The term "suggested wholesale price" is not widely used to describe prices within the supply chain. More common terms are list price, WAC, or average wholesale price (AWP).

All participating entities (except the Department of Corrections) employ a unified formulary – the participants agree to use the products that are part of the procurement. Unified formularies and a commitment to the use of certain drugs over therapeutic alternates are important to assure a drug wholesaler or manufacturer that a certain level of volume or market share will be utilized by the CPC. Guaranteeing a certain level of market share is what motivates the wholesaler or manufacturer to offer better discounts than would occur in the absence of any attempt by a group of purchasers to buy and use quantities of a product independently.

DGS uses a Group Purchasing Organization (GPO) vendor – currently Managed Healthcare Associates -- as a broker for generic and some brand-name prescription products. Additionally, the state negotiates purchase contracts directly with wholesalers and manufacturers; participating state departments purchase desired quantities at the negotiated contract price directly from the supplier (similar to the MMCAP program). Program volume was \$300 million in 2013.¹³

Payers' Program: DGS contracts with PBMs that negotiate rebates from manufacturers on behalf of many covered lives. Participating departments conduct a joint procurement for a PBM service that manages claims processing and other routine PBM functions on behalf of health plan payers. The current PBMs are Magellan and InMedRx. These PBMs provide full pharmacy services to CDCR's adult parolee program and re-entry program, and offer alternative fill services for CDCR's Juvenile Justice and Adult Operations and CalVet homes. The Office of AIDS' AIDS Drug Assistance Program also coordinates with DGS to procure PBM services for its clients. Contracts are either bid or negotiated per DGS authority.¹⁴

Massachusetts: Established in 1992, the [State Office of Pharmacy Services](#) (SOPS) was the first statewide initiative to privatize, standardize, and consolidate multiple pharmacy care entities in a state, to improve cost-effectiveness while retaining state oversight, control, and accountability. SOPS administers the pharmacy services for almost 50 state facilities for the departments of Public Health, corrections, developmental services, and mental health, sheriffs, and soldiers' homes. SOPS contracts with CompleteRx to operate the pharmacy services that include drug purchasing. This office also runs a naloxone purchasing and payer discount program for state offices and agencies, including law enforcement.

Like Massachusetts, many states have a designated agency that coordinates the purchase of drugs to greater or lesser extents – particularly for state run-facilities. There are also some states where opioid reversal agents are purchased (or contracted for discounts) from an agency other than a state's pharmacy procurement agency. Some state drug procurement agencies handle bulk purchase contracting discounts while others also contract with PBMs for state payer programs (e.g., state employee health programs.) It is beyond the scope of this paper to catalogue all the different ways states assign prescription drug procurement responsibilities, but there is a great deal of variability in state drug procurement operations in both scope of responsibilities and where the responsibility lies within state government.

[Louisiana Public Health Hepatitis C \(Hep C\) Drug Procurement:](#) The Louisiana State Health Department is in the process of completing a unique procurement process exclusively for hepatitis C drugs. The procurement¹⁵ will serve the Medicaid and corrections populations where hepatitis C infection prevalence is high. The state issued a solicitation of offers (SFO) to contract for the direct purchase of one or more new hepatitis C treatments at a deeply discounted price from one or more manufacturers.

The state describes the concept as a subscription model similar to Netflix – for a set fee, the state can use as much product each month as needed.

Three manufacturers submitted bids to Louisiana’s SFO. In March 2019, Louisiana announced their selection of Asegua Therapeutics LLC (a subsidiary of Gilead Sciences, Inc.) as their hepatitis C subscription model partner. Louisiana will have five years of unrestricted access to Asegua Therapeutics’ antiviral treatment. The winning contractor will also support the state’s efforts to increase the number of people treated each year through expanded community outreach and provider training, among other strategies. Louisiana aims to treat more than 10,000 Medicaid-enrolled and incarcerated individuals by the end of 2020.

The budget for the procurement will be equal to what the state currently spends on hepatitis C treatment for Medicaid and corrections populations (gross costs before rebates). The Medicaid part of the initiative will be handled through rebates on drugs dispensed, which is the normal Medicaid rebate process. In a year when the spending cap is exceeded, all products dispensed after the cap is exceeded are rebated at 100 percent. The corrections portion will be operated through the 340B program and the unit price of the product may have to be lowered if and when corrections nears its budgeted spending limit. About 16 states already access 340B pricing for their corrections populations through agreements with state-operated 340B clinics or hospitals.

Ideas for Future Market-based Strategies

Should states maximize the use of successful payer and purchaser pools? The Northwest Consortium has a variety of cost-containment strategies and a growing membership that can improve its negotiating strength. The consortium is currently focused on outpatient drugs – retail and physician-administered. Its strategies are payer-oriented – negotiated pharmacy discounts and manufacturer rebates.

In contrast, the enduring MMCAP is anchored in procuring drugs for state residential and in-patient facilities and government clinics – rather than drugs dispensed in a retail or physician office setting.

There may be value in other states consolidating their purchasing and payer strategies around these two existing programs, which already leverage multiple agencies’ purchasing power. It may also be of interest to states to explore whether or not the existing Medicaid drug purchasing pools could broaden their scope to benefit other agencies with drug-purchasing responsibilities.

When deciding whether to participate in any payer or purchaser pools for prescription drugs, states would need to conduct analyses using the data available to understand whether the pool discounts actually result in the best price option for states’ agencies. Such cost analyses are a challenge given the opaqueness of prescription pricing. Even if a purchasing pool can offer substantial discounts, it can be difficult to assess if that results in the best option for a state agency without knowing the baseline drug costs. There are inherent data sharing challenges related to drug costs, but the collaborative purchasing power offered through these pools maybe worth the effort for states to conduct their own analyses to explore the potential advantage for them to participate.

Can Medicaid supplemental rebate pools do more to maximize state savings? It may be worth reexamining Medicaid supplemental rebate pools.

- Are state financial benefits optimized?

- What if pooled states used a common PDL to drive market share and rebates?
- Is there a benefit to paying for what is essentially a PDL management company rather than a company solely focused on rebates?
- What is the relative value of the PDL management versus rebate negotiations in the cost of the contracted service?

Different Models of Multi-State Procurement of Selected High-Cost/High-Spend Products

Does the Vaccine for Children (VFC) structure provide savings opportunities? States may want to consider the structure of the VFC program in their search for cost savings, despite the fact it is a federal program operated on behalf of states, its operational model may be useful.

Under VFC, there is one wholesaler that administers the program. It buys and stores childhood vaccines for the Centers for Disease Control and Prevention (CDC) at CDC-negotiated prices. It does physician-level fulfillment/restocking as requested by VFC-registered physicians. The wholesaler manages these specialty drugs (vaccines are biologics and can require special handling) and ensures that products get to individual, private, and pediatric practices across the country. Using the systems created for the VFC program, the wholesaler can track utilization and anticipate purchase volume for the CDC.

The VFC approach may be a model for multi-state purchasing of specialty products to treat diseases like cystic fibrosis, multiple sclerosis, or even products like long-acting contraceptives and insulins. States could procure amounts needed for state-funded programs or, in a more complicated model, procure products for commercial payers as well.

Alternately, a state with a large population may consider state-only exclusive contracting for high-cost or high-volume products for use in the state (for only public programs or including commercial payers).

In any scenario, the likely discount will be no more than the Medicaid best price and that price point will have to come from the manufacturer. Sole-source product discounts are not likely to be discounted more than the base Medicaid rebate – about 23 percent of WAC – because a sole-source product has no market competition. However, a 23 percent discount can be significant when applied to expensive products.

In this scenario, Medicaid would benefit from a lower pharmacy payment. Rather than paying market price, the pharmacist or provider acquires the discounted product from the wholesaler/product supplier. The pharmacist or provider then bills Medicaid the program price, rather than market price. As a result, the Medicaid claims payment amount is lower than in the absence of the program and the back-end federal rebate is not affected.

There would be extensive logistical details to work out given that the VFC program does not offer a template for payments from multiple sources (e.g., member cost sharing or insurer reimbursement). VFC program eligibility targets children who are enrolled in Medicaid and are American Indian or Native Alaskan who are uninsured or underinsured, and the product is free to the provider and free to the child. VFC products are not used in children with private insurance coverage so the payment system is not established for commercial payers. However, the CDC does allow the Children's Health Insurance Program (CHIP), which is also publically funded, to participate in VFC even though the program's enrollees are outside of targeted VFC eligibility. To participate, CHIP must pay for VFC products in advance, based on estimates of enrolled children who will use the product in a calendar quarter. There

are CDC systems in place to establish the estimated doses for the advanced payment and to track doses that have been administered at the physician level, as well as the doses that have not been used. There is a reconciliation process that gives state CHIP programs a credit for the doses it paid for, but not used, by its enrollees. The state can use the credit towards a future advanced payment for a VFC product. Perhaps a commercial insurer would establish a CHIP-like advanced payment system to purchase specific high-cost drugs in bulk that are sent directly to physicians if the transaction promised to yield a cost savings. However, it would be a shift from the current system that requires billing and payment at the provider level.

High-cost drugs are a burden on state and commercial payers. As noted, incorporating commercial payers would require modification of the basic VFC model. If the product is a physician-administered drug, then billing and payment are more straightforward – providers order from the program wholesaler (as in VFC) and charge insurers their acquisition cost (which insurers will know and set fee limits in their payment systems). If the product is not provider-administered but a retail product sold by a pharmacy, that may or may not be more complicated. Pharmacies would be able to stock the product using the program wholesaler and would have to bill at their acquisition cost, and that acquisition cost will have been negotiated by the state/s.

The program becomes more complicated if there are payers or providers that do not want to participate, although payer network contracts could make participation a network contract requirement.

Choice of products could cause some providers to decline participation if they have bundled drug supply contracts with wholesalers or specialty pharmacies, for example if they purchase all drugs from one wholesaler or purchase several drugs from one manufacturer for a bundled discount. However, if the VFC-like program is successful in lowering prices, physicians may consider breaking the bundled arrangement.

Research is needed to identify the products where expenditures are significant, and discounts are minimal, because of the manufacturer's sole-source position in the market. Research is also needed to discover the prevalence of bundled discounts that include the targeted product.

Can states leverage the 340B program for lower costs of some high cost specialty products? The 340B program provides Medicaid-level price concessions on all drugs used in outpatient settings by thousands of eligible, safety net providers across the country. It may be possible to consider leveraging 340B pricing for certain high-cost treatments.

Due to the federal requirement that 340B drugs can only be used to treat patients of a 340B clinic or hospital, CF patients would need to use doctors linked to 340B entities. In the last decade, more 340B hospitals have purchased community-based oncology clinics to obtain oncolytics at very low prices. Those clinic oncologists must become part of the 340B hospital. Here is an example of how it might work: A state wants to lower the costs of cystic fibrosis (CF) treatments for state and commercial payers. It may be possible to have CF specialists officially linked to 340B entities and have those entities supply the treatments for CF patients.

Most states have numerous 340B hospitals and clinics. It may be that creating legal arrangements between community CF specialists and 340B entities for the purpose of making a patient eligible for

340B pricing may be feasible without having the patient travel far or requiring the 340B entity to purchase the CF specialty practice.

There would be several legal issues to explore and resolve, such as any federal requirements for 340B entities' affiliations with community providers and criteria for 340B patient eligibility. To work under this scenario, 340B entities would have to agree to participate and then bill government and other payers for the CF drug at rates that reflect the 340B discount. Additionally, supply chain contractual issues may come into play in a 340B scenario as well and would have to be resolved. A final point here is that Congress appears to have a growing level of interest in how the 340B program is used. The concern is generally around hospital profit maximization that does not benefit low-income patients. There may be changes to the federal program as a result of this Congressional scrutiny, but a state program to improve patient access and lower state and private health plan costs does not seem to be the focus of current Congressional 340B concerns.

It is also important to consider that 340B entities are subject to recertification each year by the federal government to continue to qualify for benefits of the 340B designation.¹⁶ Prior to expanding its reach, a 340B entity will need to be cognizant of the expansion's potential to affect its certification as a health provider of the underserved.

Other Ideas

Should states look at the cost and value of repackagers? If they have not done so already, states' procurement offices may also want to focus on repackaging services. Repackagers take large quantity packages and repackage products for specific purposes, e.g., blister packs and individual prescription packages for hospitals, nursing facilities, and physician practices. Repackagers may purchase products from wholesalers in large quantities and repackage them for physician dispensing or administration or individual prescriptions for use in residential facilities or hospitals. To the extent that repackagers have a role that affects state procurement, it is important to make sure that states are maximizing the value of those services.

Are vendor savings analytics clear and undistorted? While this is not relevant for every state or state agency, states that are looking for a purchasing agent or formulary management company need to be sure their vendor analytics are set to the best baseline. Analytics that evaluate procurement savings in terms of average wholesale price (AWP) may have the appearance of more significant savings than if the analysis were based on WAC. For example, AWP has been considered to be an unreliable number because of how it is reported and validated. If AWP is used, it would be important for a state to have the vendor benchmark the savings to what the state program pays the pharmacy. For instance, vendor-negotiated savings of 23 percent off AWP for a drug may not be terribly significant if the state only pays pharmacies AWP minus 19 percent – it actually becomes a net savings of just 4 percent, which is quite different than a savings of 23 percent. States need to be sure they are examining the net cost rather than the discount.

Additionally, the savings gained by different state purchasers that use a new group purchase organization (GPO) will vary depending on how they currently obtain drugs. A GPO will likely offer substantial savings to a state purchaser if the state purchaser (such as a jail or university health clinic) is purchasing from a local retail pharmacy or already participates in a GPO. Alternately, if a state

purchaser already purchases economically, a new proposed vendor may not be able to match its current savings.

Should states consider intra-state transparency legislation to facilitate better purchasing? Recently, many states have proposed drug transparency laws that require manufacturers to provide price information for certain types of drugs, or drugs that meet a certain price threshold. Not surprisingly, manufacturers have pushed back on these provisions, citing competitive interests. State payers, however, have an interest as stewards of public funds to be able to account for how dollars are spent in all public programs. As a fiduciary of state taxpayers, states could promulgate transparency regulations that apply to most government programs,¹⁷ so agencies that purchase drugs within a state are able to share comparable unit cost information. Such a rule could prohibit a state agency from entering into an agreement that limits its ability to share information with other state agencies.

However, a regulation that provides interagency transparency on net drug costs may reduce a manufacturer's willingness to offer substantial discounts.

Conclusion

How a state chooses to proceed will depend in part on their current purchasing strategies. It is important to keep in mind that price concessions/savings will be greater if states, agencies, or departments in a group can unify their formularies so that manufacturers (through a PBM or GPO) can see that the group is likely to improve sales of a product. Improving sales of a drug is what motivates a manufacturer to negotiate discounts.

It is also important to understand how each member of a purchasing group currently obtains drug price concessions – so a group can start its collaboration thinking about how to improve the savings the member with the best purchase price in the group achieves.

Finally, all state purchasers need to understand how the “best price” provision of the Medicaid drug rebate program limits the negotiating power of all payers and purchasers other than Medicaid. Briefly stated, brand-name manufacturers are obligated to give the Medicaid program in every state their deepest discount in the US market. Manufacturers protect themselves from this Medicaid requirement by refusing to negotiate price concessions outside of Medicaid that are deeper or better than the minimum they are required to pay Medicaid programs under federal law – which is roughly 23 percent less than their average wholesale price. The best price provision has grown into a protection for manufacturers against having to negotiate deep discounts outside Medicaid – except under exceptional market conditions.

Notes

¹ Percentage varies by state but includes state and local employees, dependents and retirees, Medicaid, corrections, public health, education and higher education employees, and tax expenditures for employer and employee health care premiums.

² Indiana State Budget Agency Report to Budget Committee Concerning a Regional or Multi-State Prescription Drug Aggregate Purchasing Program <https://www.in.gov/legislative/igareports/agencyarchive/reports/BUDAG04.pdf>

³ The National Conference of State Legislatures: Pharmaceutical Bulk Purchasing: Multi-state and Inter-agency Plans <http://www.ncsl.org/research/health/bulk-purchasing-of-prescription-drugs.aspx>

⁴ A brief description of Minnesota Multistate contracting Alliance for Pharmacy http://www.mmd.admin.state.mn.us/MMCAP/background/Documents/MMCAP_New_Member_App/MMCAP%20Overview%20Presentation_12022016_1.pdf, accessed 1/17/2019.

⁵ In order of size of class of trade (COT): Public health (44%), corrections (19%), COT other (7%), mental health (8%), education (6%), public safety (4%), developmental disabilities (1%), emergency (<1%), hospital/clinic (3%), student health (4%), and targeted programs (2%)

⁶ Class of trade (COT) has no official or standardized structure or terminology. COTs are defined completely by the creator of the category and the same COT – say mental health facilities – may not describe the same set of class entities from one manufacturer to another.

⁷ Florida State Legislature report on Feasibility of Consolidating Statewide Pharmaceutical Services http://www.opaga.state.fl.us/MonitorDocs/Reports/pdf/Feasibility_of_Consolidating_Statewide_Pharmaceutical_Services.pdf

⁸ Provider Synergies LLC description of TOP\$ <http://www.providersynergies.com/services/medicaid/default.asp?content=TOPS>

⁹ Oregon Prescription Drug Program Board Meeting, October 2018 <https://www.oregon.gov/oha/PEBB/docs/boardattachments/20181016/PB%20Attachment%205%20-%20Oregon%20Prescription%20Drug%20Program%20-%20October%2016%2C%202018.pdf>

¹⁰ Washington Healthcare Authority's Description of the Washington Prescription Drug Program (WPDP) <https://www.hca.wa.gov/about-hca/prescription-drug-program/partners>

¹¹ California Executive Order N-01-19 <https://www.gov.ca.gov/wp-content/uploads/2019/01/EO-N-01-19-Attested-01.07.19.pdf> accessed 1/17/2019

¹² California Government Code §14977-14982: Chapter 12. Purchase of Prescription Drugs for Government Agencies

https://leginfo.ca.gov/faces/codes_displaySection.xhtml?lawCode=GOV§ionNum=14982

¹³ This number was also provided to author in 2018.

¹⁴ California Government Code § 14979: Chapter 12. Purchase of Prescription Drugs for Government Agencies https://leginfo.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14979.&lawCode=GOV

¹⁵ Louisiana Department of Health, Office of Public Health's Solicitation of Offers: Pharmaceutical Manufacturer(s) to Enter Into Contract Negotiations to Implement Hepatitis C Subscription Model <http://ldh.la.gov/index.cfm/newsroom/detail/5018>

¹⁶ Health Resources & Services Administration (HRSA) 340B Drug Pricing Program Requirements <https://www.hrsa.gov/opa/program-requirements/index.html>

¹⁷ Medicaid supplemental rebates could be shared, but federally-required manufacturer rebates can only be provided to entities or people involved in the administration of the rebate program. Similarly, there are federal confidentiality rules for 340B pricing.