Health Cost Containment and Efficiencies

NCSL Briefs for State Legislators

No. 9 June 2010

Prescription Drug Agreements and Volume Purchasing

Preferred Lists, Rebates, Multi-State Purchasing and Effectiveness Review of Medicine

Cost Containment Strategy and Logic

Medicaid programs spent at least $24 billion to purchase prescription drugs in 2009. Many states now use a combination of approaches to control the cost of prescription drugs. States typically draw from a menu of four purchasing options that feature negotiation, evaluation and volume buying:

1. Expanded use of preferred drug lists,
2. Expanded use of manufacturer price rebates,
3. Multistate purchasing and negotiations, and
4. Use of scientific studies on comparative effectiveness of products.[1]

Expanded use of preferred drug lists (PDLs). Preferred drug lists provide a consistent method for public programs—such as Medicaid, public employee benefits or state-only subsidy programs—to define which prescription products are covered automatically by insurance or benefit programs as "preferred" and which other products for the same medical conditions are "non-preferred." The non-preferred drugs often require an extra approval step or a higher patient copayment. In the public sector, the lists are developed by publicly designated committees, using medical research to judge the effectiveness of drugs and, in some cases, their cost effectiveness. One goal is to encourage physicians to increase the use of preferred drugs. While 45 states already use PDLs, about half have "carved out" or protected, from PDLs, entire classes of medical conditions such as mental health, HIV/AIDS and cancer. Because many of these drugs have high per-patient costs, several states have recently expanded PDL requirements to allow evaluation of products to treat these diseases and conditions.

Expanded use of manufacturer price "supplemental rebates." All Medicaid programs receive a basic, standardized rebate from drug manufacturers for both brand-name and generic products. As of 2003, however, states can directly negotiate with pharmaceutical manufacturers and companies classified as drug relabelers for additional or "supplemental" Medicaid rebates. These extra state rebates often are applied to brand-name "preferred products" because of their generally higher sales volume. Although the state supplemental and federal unit rebate amounts are confidential and cannot be disclosed, they can be as high as 25 percent above the basic federal rebate, reducing state costs by tens of millions of dollars. In 2005, for example, 30 states reported collecting a total additional $1.3 billion in state supplemental rebates.

State Medicaid programs are using preferred drug lists, supplemental rebates and multi-state purchasing arrangements to save between 8 percent and 12 percent on overall Medicaid drug purchases (savings to states nationwide average $1.8 billion annually).

Multi-state purchasing and negotiations. Twenty-seven state Medicaid programs have voluntarily joined a multi-state "buying pool," primarily as a cost containment and efficiency strategy that influences buying and bargaining power with manufacturers. In Louisiana, New York and Washington, Medicaid has pooled administrative efforts with other in-state agencies such as public employee and workers' compensation programs.

Use of scientific-based comparative effectiveness evaluation for product selection. Several states have formally combined resources as members of the Drug Effectiveness Review Project (DERP), housed in Oregon.[2] Reviewers comb through drug studies to help policymakers purchase the most effective—sometimes less expensive—medicines. Member states pay approximately $75,000 per year for three years to fund the research and access project findings. The project's published "head-to-head comparisons" of medicines are based on science, not spending; however, states use the results to manage parts of their annual drug budgets. Non-member states can examine or apply the research results without paying to become partners.[3,4]

Target of Cost Containment

All four purchasing approaches are designed to help state government public-sector programs operate more efficiently and cost effectively. They aim to reduce overall state spending, but not deny coverage or services to individual patients. Some approaches, such as multi-agency buying or multi-state PDLs, can be shared with other large purchasers such as local governments or private employers. In some cases, savings can be passed indirectly to individual patients in the form of reduced copayments or coinsurance (Table 1).

Table 1. Percentage of Total National Prescription Drug Expenditures by Type of Payer, 2002-2010

Type of Payer	2002	2004	2006	2008	2010
Public funds	25%	28%	34%	37%	40.2%
Private health Insurance	50	48	44	42	40.2
Consumer out-of-pocket	26	25	22	21	19.6

Source: CMS Office of the Actuary, *National Health Expenditures*, January 2010; 2010 figures are projections.

Federal Health Reform

The Patient Protection and Affordable Care Act, signed March 2010, includes significant financial changes to Medicaid prescription drug rebate policy. As a result, every state will need to recalculate costs, savings and purchasing arrangements for current and upcoming fiscal years. The new law:

- Increases by 8 percent (to a total of 23.1 percent of average manufacturer price [AMP]) only the federal portion of manufacturer rebates for brand-name covered outpatient drugs in Medicaid.
- For brand drugs approved exclusively for pediatric use or for clotting factors, minimum rebates increase to 17.1 percent of AMP.
- Manufacturers of generic drugs used by outpatients are subject to a 2 percent increase (to a total of 13.1 percent of AMP) in required rebates.
- Also, for the first time, the federal law extends the prescription drug rebates to outpatient drugs dispensed to enrollees of Medicaid managed care organizations (Sections 1206 and 2501).

The changes, retroactive to Jan. 1, 2010, will generate more revenue for Medicaid nationwide. The Congressional Budget Office calculated that requiring rebates on drugs used in managed care settings would save a total of $420 million in 2011, $710 million in 2012 and $790 million in 2013[5] With about 33 million (or 71 percent) of the overall Medicaid population enrolled in managed care arrangements, the new application of manufacturer rebates required to be paid to each Medicaid program for their managed care population will be a significant net savings or cost reduction for most states. However, the state Medicaid share of revenue from existing state-negotiated supplemental rebates will be reduced; exact amounts have not yet been determined and are subject to future negotiations with manufacturers.

Comparative Effectiveness Review (CER). While the Drug Effectiveness Review Project (DERP) has operated under state jurisdiction since 2003, federal health reform included a new provision titled "Patient-Centered Outcomes Research." It includes are variety of medical practices beyond pharmaceuticals and emphasizes that informing patients and clinicians is an important focus of CER. Furthermore the legislation stipulates that findings from CER cannot, by themselves, determine Medicare coverage policy. Controversy still exists about the role of federally-funded research findings and expert conclusions in narrowing patient care options. These future federal efforts are beyond the scope of the information in this report.

State Examples

- At least 45 states have implemented one or more of these strategies. Table 2 (page 4) indicates combinations of strategies that are applicable to Medicaid and other state purchasing programs.
- As of mid-2010, three multi-state Medicaid bulk buying pools and one state-based pool were operating (see below). Each uses common preferred drug lists and obtains supplemental rebates from manufacturers. All lists include selected brand-name products. Use of generics is emphasized but not required for some conditions. Patient treatment decisions remain in the hands of physicians and state agency pharmacy officials.
- Nationwide, Medicaid buying pools included states with about 32 percent of enrolled beneficiaries (18 million) and 38 percent of the nation's Medicaid pharmaceuticals spending.[6] The pools include:
  - The "National Medicaid Pooling Initiative" (NMPI) started in 2003 and serves 11 states.
  - Top Dollar Program (TOP$)[SM] was started by Provider Synergies and serves seven states.
  - The Sovereign States Drug Consortium (SSDC) is a seven-state nonprofit structure; 100 percent of all supplemental rebate revenues are returned to member states. Vermont currently hosts program administration.
- The Northwest Prescription Drug Consortium (NPDC), started in 2007, combines non-Medicaid state pharmaceutical programs in Oregon and Washington.
- Medicaid directors report that a "significant majority of states impose prior authorization on certain drugs. Only 3.4 percent of Medicaid prescription drug claims required prior authorization." This means 96.6 percent of patient prescriptions did not require such authorization. Those that do account "for 7.5 percent of total Medicaid prescription drug spending."[7]

Non-State Examples

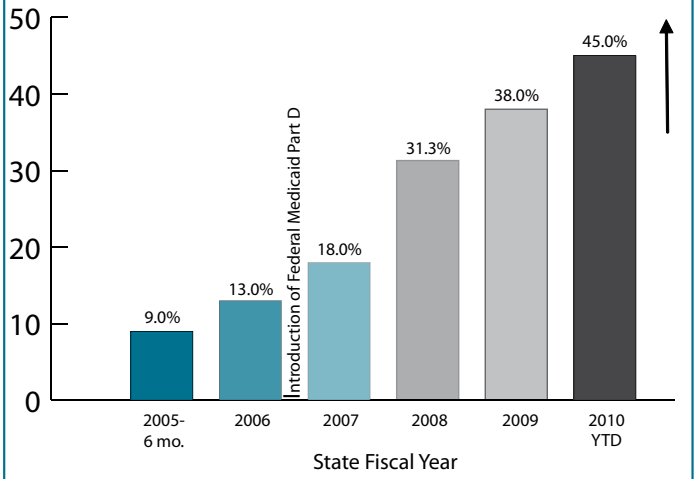
Several peer-reviewed studies that consider the effectiveness of formularies focus on incentives such as prior authorization or charging a higher or "tiered" copayment for brand-name drugs "used to steer utilization to drugs" on the lists. For example, Medco Health claimed an 11 percent savings in a 2005 *Health Affairs* article.[8]

Evidence of Effectiveness

The combined use of preferred drug lists, supplemental rebates, selected prior authorization for non-preferred drugs and multi-state purchasing arrangements is saving some states an estimated 8 percent to 12 percent on overall Medicaid drug purchases. States also report savings in state-only non-Medicaid programs. In most cases, the savings represent only state money and are ongoing over several years. Specific examples include the following.

- Iowa Medicaid reported saving "nearly $100 million in state dollars over four years after implementing a PDL in 2005; an average of 21 percent of the drug budget." The use of supplemental rebates has yielded more than $37 million annually (Figure 1).[9]

Figure 1. Iowa Medicaid Prescription Drug Savings as Percent of Total Spending



Source: Iowa Department of Human Services, Medicaid (quarters are cumulative, April 8, 2010.

- For FY 2009, the seven states in the Sovereign States Drug Consortium represented 1.2 million eligible Medicaid patients and more than $1.3 billion in state expenditures. Iowa's share of savings was "nearly $35 million."[10]

- Texas Medicaid estimated that its PDL resulted in savings of 6.6 percent ($116 million) in FY 2007, up from $108 million in FY 2006. The 59 drug classes on the Medicaid PDL represent approximately 68 percent of all Medicaid pharmacy expenditures, which totaled $1.76 billion in FY 2007.[11]

- Georgia's Department of Community Health in 2008 calculated it saved at least $20 million a year because doctors gave patients a different, lower-cost drug after seeking prior approval.[12]

- Vermont reported that, for FY 2008, the state received an additional 4.7 percent ($5.3 million) in state-negotiated supplemental rebates, using the Sovereign States Drug Consortium and the Vermont PDL. That amount was in addition to the standard federal Medicaid formula rebate, based on an $112.4 million pharmaceutical budget.

- Utah's Medicaid PDL, in its first year (2008), reduced spending by $546,000. Savings fell short of original estimates, however, because the initial law allowed physicians to write "dispense as written" on prescriptions without authorization, thereby eliminating a pharmacist's discretion to substitute generic products. In 2009, the law was expanded to include all drug classes; this is expected to reduce Medicaid drug spending by more than $1 million by 2010.[13]

- New York documented Medicaid savings on prescription drugs of $82.5 million for 2007. Of the savings, $80.5 million were the result of multi-state negotiated supplemental rebates. The remaining savings, $1.95 million, were due to a shift in use from more expensive non-preferred drugs to less expensive preferred drugs for a given medical treatment. Use of preferred ACE Inhibitors (for controlling blood pressure), for example, increased from 72 percent to 98 percent, and the market share for preferred beta blockers increased from 54 percent to 84 percent. [14,15]

- Indiana saved approximately $29.81 million through Sept. 30, 2007, based on cumulative estimated savings from the Medicaid PDL. Supplemental rebate savings after five years of operation totaled an additional $31.54 million.[16]

- In 2006, Washington launched a "joint purchasing project" for three agencies: the Medicaid, workers' compensation and state employee health plan programs. All three agencies agreed that, "on average each one percent increase in generic fill rate can decrease pharmacy spending by an equivalent one percent." Within the first two years of PDL program implementation, state officials reported savings of $20 million to $24 million annually in fiscal years 2005 through 2007. The results represent savings of about 5 percent of prescription drugs costs. The Medicaid fee-for-service program alone saved $13.7 million in 2006.[17]

- The federal Centers for Medicare and Medicaid Services have supported state-created PDLs and multi-state pooling, stating that "these pooling plans will help lower drug costs for the states involved."[18]

- Officials at the Veteran's Administration "use Drug Effectiveness Review Project reviews to inform decisions about drug coverage." The federal Agency for Healthcare Research and Quality (AHRQ) funds DERP's parent organization to assist in "stakeholder outreach."[19]

KEY: Multi-State Definitions

DER = Drug Effectiveness Review Project
DER# = Former member in '06 to '09
MED = Medicaid Evidence-based Decisions Project
NMPI = National Medicaid Pooling
##= Former member of pool
NWDC = Northwest Rx Consortium
SSDC = Sovereign States Drug Con.
TOP$ = Top Dollar Rx Purchasing

Exempt Conditions

CAN = Cancer treatment drugs
Hep-C = Hepatitis drugs
IMM = Immunosuppressive drugs (v)
HIV = HIV and AIDS drugs
MH = Mental health treatment drugs

Notes:
Not all features may be in operation in individual states
(i) Arizona uses a capitated managed care payment structure for almost all Medicaid enrollees and therefore does not pay for individual prescription drugs. Virtually all the Medicaid managed care companies use a preferred drug list.
(ii) New York's FY'10 budget discontinues participation in the National Medicaid Pooling Initiative, "allowing the state to negotiate supplemental rebates directly with manufacturers."
(iii) North Carolina launched a PDL and joined NMPI in April 2010.
(iv) Wisconsin's PDL includes Senior Care pharmaceutical assistance program and Badger Care children's health program.
(v) Immunosuppresives are used to inhibit or prevent activity of the immune system to treat conditions including arthritis, MS, lupus and organ transplants.

Table 2. State Prescription Drug Cost and Efficiency Strategies

State/ Jurisdiction	PDL-Medicaid Date Started	Examples of Exempt Conditions	PDL-State-Only Programs	State-Negotiated Supplemental Rebate	Multi-State Pool	Comparative Effectiveness Reviews
Alabama	✓ '03	MH/HIV		✓ '03		✓ MED
Alaska	✓ '04			✓ '04	✓ NMPI	✓ DER #, MED
Arkansas	✓ '04			✓ '04	✓ NMPI##	✓ DER, MED
Arizona	✓ (i)					
California	✓ '88	HIV/CAN		✓ '88		✓ DER #
Colorado	✓ '07	MH/HIV/CAN		✓ '08		✓ DER
Connecticut	✓ '02	MH/HIV	✓	✓ '04		
Delaware	✓ '05			✓ '05	✓ TOP$	
Florida	✓ '01	MH/HIV/CAN		✓ '01		
Georgia	✓	MH/	✓	✓ '09	✓ NMPI##	
Hawaii	✓ '04	MH/ HIV/ Hep-C/ IMM		✓ '04	✓ NMPI##	
Idaho	✓ '05			✓ '03	✓ TOP$	✓
Illinois	✓ '02	MH/HIV	✓	✓ '02		
Indiana	✓ '02	MH/	✓ CHIP	✓ '04		
Iowa	✓ '03	MH/HIV/CAN		✓ '04	✓ SSDC	
Kansas	✓ '02	MH/CAN		✓ '02		✓ DER #
Kentucky	✓ '02			✓ '04	✓ NMPI	
Louisiana	✓ '00	MH/HIV/CAN	✓ agencies	✓ '02	✓ TOP$	
Maine	✓ '00	MH	✓	✓ '03	✓ SSDC	
Maryland	✓ '03			✓ '03	✓ TOP$	✓ DER
Massachusetts	✓ '02	MH		✓ '04		
Michigan	✓ '01	MH	✓	✓ '03	✓ NMPI	✓ DER #
Minnesota	✓ '02			✓ '04	✓ NMPI	✓ DER #, MED
Mississippi	✓ '04	MH		✓ '06		
Missouri	✓ '02			✓ '04		✓ DER, MED
Montana	✓ '06			✓ '04	✓ NMPI	✓ DER
Nebraska	✓			✓ '09	✓ TOP$	
Nevada	✓ '03	MH/HIV		✓ '04	✓ NMPI	
New Hampshire	✓ '02			✓ '04	✓ NMPI	
New Jersey						
New Mexico	✓ Y '02			✓ '02		
New York	✓ Y '05	MH/HIV	✓ agencies	✓ '06	✓ NMPI (ii)	✓ DER, MED
North Carolina	✓ '10 (iii)			✓ '10	✓ NMPI	DER #
North Dakota						
Ohio		MH/HIV		✓ '03		
Oklahoma				✓ '03		✓ MED
Oregon	✓ '01	MH/HIV/CAN	✓	✓ '09	✓ SSDC, NWDC	✓ DER, MED
Pennsylvania	✓ '06			✓ '05	✓ TOP$	
Rhode Island				✓ '07	✓ NMPI	
South Carolina	✓ '04		✓ '05	✓ '07	✓ NMPI	
South Dakota			✓			
Tennessee	✓ '03		✓	✓ '03	✓ NMPI##	
Texas	✓ '03		✓	✓ '03		
Utah	✓ '07	MH, IMM	✓	✓ '07	✓ SSDC	
Vermont	✓ '01	MH case-by-case	✓ [all]	✓ '06	✓ SSDC	
Virginia	✓ '04		✓	✓ '04		
Washington	✓ '01	MH/HIV/CAN	✓ '03	✓ '02	✓ NWDC	✓ DER, MED
West Virginia	✓ '02	MH	✓	✓ '02	✓ SSDC	✓ MED
Wisconsin	✓ '03		✓ (iv)	✓ '05	✓ TOP$	✓ DER, MED
Wyoming	✓ '03			✓ '08	✓ SSDC	✓ DER
District of Columbia	✓			✓	✓ NMPI	

Sources: NCSL research, 2009, 2010; NASMD; National Association of Chain Drug Stores; CMS Medicaid Pharmacy Supplemental Rebate Agreements, March 2010.

Complementary Strategies

- **Prescriber Education Programs.** At least six states have established prescriber education programs or "academic detailing" initiatives to distribute scientific and clinical data about the effectiveness and costs of pharmaceuticals and medical devices. Programs operate in Maine, Massachusetts, New York, Pennsylvania, South Carolina, Vermont and the District of Columbia; pilot programs are under way in Idaho and Oregon. Pennsylvania's Independent Drug Information Services program is the largest, operating as a partnership between the state and Harvard Medical School. Under the program, state-employed pharmacy experts visit prescribers to explain the range of products, comparative patient results and pricing. Medicaid, public employee health benefits and the state-subsidized pharmaceuticals program (PACE) for seniors and people with disabilities use the program. Studies of existing state programs indicate that every $1 invested in these programs results in a $2 return on investment.[20] A 2010 analysis of the programs notes that states with a preferred drug list and a prescriber education program should coordinate to ensure that their preferred drug list and the evidence-based recommendations of the prescriber education program are in line.[21]

- **Step Therapy.** Some major purchasers, including commercial insurers and Medicaid programs, have imposed a strategy to shift patients to alternative prescription drugs, requiring an enrollee to try one drug before the plan will pay for another drug. Step therapy (and Fail First requirements) aims to control costs by requiring that enrollees use more common drugs that usually are less expensive. Progression to a new medication is based upon failure of the former medication to provide symptomatic relief or cure—hence "fail first." Step therapy currently is used in approximately 28 percent of employer programs, in all 50 state Medicaid programs and in many Medicare Part D programs. Cost containment results depend upon the individual products and treatment categories subject to step therapy.

Challenges to Cost Containment

- Medicaid programs generally are required to cover the costs of "all medically necessary" prescription drugs; treating physicians have the final say more than 90 percent of the time.

- One national consumer advocacy organization concludes that "many PDLs are ineffective. PDL committees may be biased by inaccurate information, or prescribing rules may not be properly enforced."[22]

- A study by the National Pharmaceutical Council of preferred-drug lists in 47 Medicaid programs concluded, "Savings in the drug budget appear to be completely offset by increased expenditures elsewhere in the system."[23] Another industry-funded study concluded, "A comprehensive review of the research found that the preponderance of studies showed an actual *increase* in overall health-care costs."[24]

- State supplemental rebates on brand-name drugs can have the unintended effect of lowering rates of generic use in many Medicaid programs below that of private insurers.

- Supplemental rebates can be available from and negotiated with generic drug manufacturers, but are less commonly used by some states.

For More Information

Cauchi, Richard. *Pharmaceutical Preferred Drug Lists (PDLs) - State Medicaid and Beyond*. Denver: National Conference of State Legislatures, Nov. 1, 2009.

Clancy, Carolyn. *AHRQ Outcomes and Effectiveness Reports*. Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services, Maryland, July 2009.

The Commonwealth Fund, *Stretching State Health Care Dollars: Pooled and Evidence-Based Pharmaceutical Purchasing*, New York: The Commonwealth Fund, October 2004; http://www.commonwealthfund.org/usr_doc/782_Silow-Carroll_stretching_pooledRx.pdf.

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Future Updates

The latest information on this topic, including major changes in Medicaid manufacturer rebates for 2010 and beyond, is available in an NCSL online supplement at www.ncsl.org/?tabid=19934.

Notes

1. A companion brief, *Use of Generic Prescription Drugs and Brand Name Discounts*, addresses the related strategies of brand-name and generic prescription drug use.

2. The Drug Effectiveness Review Project (DERP) members as of June 2010 include Arkansas, Colorado, Idaho, Maryland, Missouri, Montana, New York, Oregon, Washington, Wisconsin and Wyoming. Other recent members were Kansas ('09), Maryland ('09), Michigan ('08), Minnesota ('08) and North Carolina ('08).

3. DERP is a nonprofit multi-state project of the Oregon Evidence-Based Practice Center *Project* headed by former Oregon governor John Kitzhaber. It provides reports but does not purchase prescription drugs.

4. In 2006, 38 states reported that drug comparative effectiveness reviews (CERs) are useful when developing Medicaid pharmacy policy. This includes 12 of the 15 states participating in the Drug Effectiveness Review Project.

5. Congressional Budget Office, Budget Options: Volume 1: Health Care (Washington, D.C.: CBO, December 2008): 141.

6. Not every product is purchased through the multi-state pools—certain specialty and rarely used drugs may be exempt. Managed care contracts may also include drugs purchased through large or multi-state private insurance contracts.

7. Jeffrey S. Crowley and Deb Ashner, *State Medicaid Outpatient Prescription Drug Policies: Findings from a National Survey, 2005 Update* (Washington, D.C.: Kaiser Family Foundation, October 2005).

8. Kaiser Family Foundation, *Cost Containment Strategies For Prescription Drugs: Assessing The Evidence In The Literature* (Washington, D.C.: KFF, March 2005).

9. Department of Human Services, Iowa Medicaid Enterprise, "Results Iowa: Accountability for Iowa," State of Iowa, updated August 2009; http://www.resultsiowa.org/humansvs.html.

10. Seven states currently are in the group representing 1.2 million eligibles and more than $1.3 billion in drug expenditures. Nearly $35 million was saved in SFY 2009 through the prescription drug list and the rebate program.

11. Texas Health and Human Services Commission, *Texas Medicaid Preferred Drug List Annual Report, FY 2007* (Austin, Texas: THHSC, March 2008); http://www.hhsc.state.tx.us/hcf/vdp/0308_PreferredDrugListAnnualReport2007.pdf.

12. "Augusta News," *The Augusta Chronicle*, Sept. 5, 2008; http://chronicle.augusta.com/stories/090508/met_472033.shtml.

13. Advisory Board Company and Kaiser Family Foundation, "Utah Preferred Prescription Drug List Savings Less Than Projected," *Medical News Today*; www.medicalnewstoday.com/articles/122282.php.

14. According to the 2007 New York Medicaid Annual Report of the drugs subject to the PDP, 97.7 percent of claims were for preferred drugs that did not require prior authorization (Appendix 9). This extremely high percentage is attributable to the wide selection of preferred drugs within a class, prescriber familiarity with PDLs used by other insurance programs and prescriber awareness of the Medicaid PDP. The remaining 2.3 percent (105,286 claims) were for non-preferred drugs that required prior authorization. These claim counts include both the initial prescription and refills, which do not require another prior authorization so the number of claims is greater than the number of PA requests. Of the total PA requests, 20.3 percent were for beta blockers used primarily for cardiovascular indications, 17.7 percent were for antihistamines used to treat allergies and 16.7 percent were for long acting narcotics used to treat moderate to severe pain. All other classes comprised 14percent or less of the total number of PA requests. When prescribers were asked why they were ordering a non-preferred drug, they most often cited contraindications preventing transition of a patient to a preferred drug, patient specific adverse reactions to the preferred drug and prescriber preference. In 2.8 percent of calls, the prescriber agreed to change the prescription to the preferred drug after consultation with CCC staff.

15. New York Department of Health, *Medicaid: Letter to Pharmacy Providers* (New York: NYDH, Aug. 1, 2008); http://www.emedny.org/info/newsletter/Pharmacy_Provider_Letter_Signed.pdf.

16. Savings do not count federal rebates and are calculated before administrative costs are deducted. Felice R. Slaughter and Mark Sutcliffe, "Evaluation of the Indiana Medicaid Preferred Drug List (PDL) Program," no.8 (Indianapolis: ACS Health Management Solutions, July 18, 2008).

17. Ray Hanley, interview with author, Jan. 8, 2009, and C. Silow-Carroll, et al., *States in Action: A Quarterly Look at Innovations in Health Policy* (New York: The Commonwealth Fund, Spring 2006); http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=362631&#washington.

18. U.S. Department of Health and Human Services, "HHS News Release," May 27, 2005.

19. Daniel Fox, *The Convergence of Science and Governance* (Berkeley, Calif.: University of California Press, 2010).

20. Rachel Brand, *Marketing Drugs: Debating the Real Cost* (National Conference of State Legislatures, State Legislatures, September 2008); http://www.ncsl.org/?tabid=13788.

21. Jennifer Reck, *A Template For Establishing And Administering Prescriber Support And Education Programs* (Hallowell, Maine: Prescription Policy Choices, 2008); http://www.policychoices.org/reports.shtml.

22. Christine Barber and Robert W. Seifert, *Saving Money by Improving Medicaid* (Boston, Mass.: Community Catalyst, January 2009); http://www.communitycatalyst.org/doc_store/publications/medicaid_cost_containment_Jan2009.pdf.

23. W.J. Moore and R.J. Newman, "Drug Formulary Restrictions as a Cost-Containment Policy in Medicaid Programs," *Journal of Law and Economics* 36 (1993): 72.

24. Richard A. Levy and David Cocks, "*Component Management Fails to Save Health Care System Costs: The Case of Restrictive Formularies*" (Reston, Va.: National Pharmaceutical Council, 1999, 2nd ed.); http://npcnow.org/App_Themes/Public/pdf/Issues/pub_related_research/pub_component/component/20Management%20Fails%20to%20Save%202nd%20Ed.pdf.

About this Project

NCSL's Health Cost Containment and Efficiency Series describes multiple alternative state policy approaches, with an emphasis on documented and fiscally calculated results. The project is housed at the NCSL Health Program in Denver, Colorado. It is led by Richard Cauchi, program director, and Martha King, group director, with Barbara Yondorf as lead researcher.

NCSL gratefully acknowledges the financial support for this publication series from The Colorado Health Foundation and Rose Community Foundation of Denver, Colorado.

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