Joining Forces to Purchase Pharmaceuticals in Bulk

BY COLLEEN BECKER

States purchase drugs for their Medicaid programs, correctional facilities, state employees and retirees—making them some of the largest buyers of pharmaceuticals. As prices continue to increase, on average, faster than inflation, one strategy attracting the attention of policymakers is the consolidated, or bulk, purchasing of prescription drugs.

Buying products in bulk through interagency or interstate agreements gives states a way to enhance their purchasing power. While some states are exploring how to aggregate the buying power of their own agencies, others are looking to establish partnerships with other states.

States have been searching for ways to gain leverage in negotiations with manufacturers and administrators of pharmacy benefits for decades. In the early 2000s, several initiatives sprung up. Five multi-state bulk buying pools are still operating today. Of the five, three are made up of state Medicaid programs: the National Medicaid Pooling Initiative (NMPI), the Top Dollar Program (TOP$) and the Sovereign States Drug Consortium (SSDC).

The NMPI was the first interstate contract of its kind. Approved by the Centers for Medicare and Medicaid Services (CMS) in 2004, today the NMPI includes 10 states and the District of Columbia. According to the plan administrator, the program covers 3.8 million people and has supplemental rebate agreements with over 90 drug makers.

The TOP$ program began in 2005 and is a similar, but separate, state Medicaid pharmaceutical purchasing pool. Today there are seven member states.

In both programs, supplemental, or additional, rebates for medicine are given to the state by participating manufacturers. States select drugs that are covered under these agreements to tailor a preferred drug list (PDL)—a list of medications that...
The third Medicaid drug purchasing pooling initiative, SSDC, is a membership of 12 state Medicaid programs. In this arrangement, participating states contract with a third party to assist with annual negotiations, although it is not a requirement. A key difference between the SSDC and the other programs is that in the SSDC, states contract directly with the drug manufacturer, whereas for NMPI and TOP$, states contract with the plan administrator.

The other two bulk purchasing agreements apply to private, commercial payers rather than Medicaid. They are the Minnesota Multistate Contracting Alliance for Pharmacy, or MMCAP Infuse, and the Northwest Prescription Drug Consortium (NPDC).

MMCAP Infuse has 13,000 members in all 50 states and Washington, D.C., and members consist of local public health agencies, correctional facilities, educational institutions, nursing facilities and others. The NPDC is a joint effort between Oregon and Washington that offers a prescription drug discount card for participating state agencies, local governments, businesses, labor organizations and uninsured consumers in those states.

An example of an interagency contract, the Washington State Health Care Authority (HCA) consolidates the purchasing power of its agencies. It covers drugs for public employees, school employees and Medicaid clients, and is the largest purchaser of health care in the state, covering 2.5 million residents. The HCA oversees the Washington Prescription Drug Program, which obtains rebates with a uniform PDL used by all member agencies. According to the Kaiser Family Foundation, at least 17 states had a uniform PDL in 2019.

Not all arrangements are a one-size-fits-all approach and as these initiatives become increasingly attractive, legislators may want to carefully consider whether a bulk purchasing agreement is the best deal for their constituents and their state’s budget.

**State Action**

Although some interstate bulk purchasing agreements have been in place for some time, a few states are looking at them with renewed interest. In the past, state action was largely implemented through the approval of a Medicaid state plan amendment. For 2020, at least one state, Massachusetts, has introduced legislation to create a study commission to examine the practicality of a bulk purchasing and distribution system.

There is also significant interest in pooling the risk among state agencies. The New Mexico Interagency Pharmaceuticals Purchasing Council was established through legislation in 2019. One of the council’s primary goals is to identify ways state agencies can leverage their purchasing clout. Another objective is for these strategies to eventually be applied to the private sector.

By issuing an executive order, California Governor Gavin Newsom directed state agencies, including Medi-Cal, the state Medicaid program and biggest drug purchaser, to coordinate strategies for procuring pharmaceuticals. One specific goal is for the numerous managed care organizations (MCOs) contracted by Medi-Cal to negotiate as a single purchaser rather than as separate entities.

**Federal Action**

In contrast to state agencies, commercial payers and other government programs such as the Veterans Administration, current law prohibits the Department of Health and Human Services (HHS) from negotiating directly with manufacturers for lower prices on behalf of Medicare Part D beneficiaries. This is referred to as the “non-interference clause.” One bill under consideration in Congress is HR 3, the Elijah E. Cummings Lower Drug Costs Now Act. It would allow the secretary of HHS to negotiate prices directly with drug manufacturers for up to 250 medicines every year. Since it would affect all insurance types, consumers with both public and private coverage would benefit from these prices.

Although it would not allow HHS to negotiate lower costs, there have also been ongoing discussions around a bipartisan bill known as the Prescription Drug Pricing Reduction Act (PDPRA) of 2019. The PDPRA contains several directives, but for Medicare Part D enrollees, it would cap annual out-of-pocket costs at $3,100 and reduce the amount they are responsible for after their deductible is met.