States Lead Battle to Contain Drug Costs

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The pharmaceutical industry makes the world a better place. The United States – indeed, the world – benefits from the investment and innovative spirit behind the discovery of drugs that treat or cure disease. Of course, innovation comes at a cost – and what a cost. Prescription drug prices figure prominently in the rising costs of health care in the United States. Drug research and development grow ever more complex and yield more costly failures than blockbuster successes. Price controls in other countries limit the manufacturer’s ability to spread the high cost of developing one drug across others without disturbing profit margins. With few controls in the United States, Americans apparently subsidize the cost of drugs used throughout the world.¹ The tolerance of American drug purchasers and consumers is wearing thin, however. Resistance is most obvious among seniors who lack prescription drug benefit coverage, but appears across the spectrum of consumers of health care.

The most notable efforts to contain drug prices through litigation and legislation have occurred at the state rather than the federal level. As purchasers of health benefits for their employees, state governments are sensitive to rapid increases in drug prices. State obligations as administrators of public insurance programs like Medicaid also motivate the drive to contain costs. As of 2003, 49 states have passed or considered

discount programs, bulk purchasing, or price-related legislation. Maine and Florida have experimented with requiring manufacturers to extend existing rebate agreements to include drugs purchased by the state for low-income persons not eligible for traditional Medicaid coverage.

States have contributed, if not driven, efforts to legalize the reimportation of FDA-approved drugs from other countries. Despite laws that prohibit reimportation and warnings about the safety of drugs dispensed outside the United States, the popularity of pharmacies in Canada and Mexico signals a popular revolt of sorts motivated by the capitalist spirit of pursuing the lowest price available. In several states, federal and state legislators have subsidized travel to Canada to allow citizens to purchase drugs more cheaply. California and Minnesota have enacted reimportation legislation through which Canadian pharmacies serve the prescription drug needs of categories of consumers. As purchasers of health benefits and medications for state prisons, agencies, and hospitals, revenue-strapped states are highly motivated to maximize the value of each dollar committed to health care and, like many individual consumers, have identified reimportation as a legitimate option.

States have also initiated changes in the pharmacy benefit management (PBM) industry. State attorneys general have pursued legal action against PBMs that result in sizeable payments to states. Medco, the largest PBM in the country, recently agreed to pay $29.3 million to 20 states in response to allegations of fraudulent concealment of

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3 Id.
5 NCSL, supra note 2.
financial incentives with pharmaceutical manufacturers. Legislation requiring greater transparency in agreements between PBMs and pharmaceutical manufacturers is under consideration in several states.\(^6\) The actions have prompted calls from within the industry for greater voluntary disclosure.

Aggressive action by state attorney generals to reduce Medicaid fraud implicates current marketing practices of individual drug manufacturing companies. Many actions arise from requirements under the federal Medicaid Drug Rebate statute that all pharmaceutical manufacturers whose products are provided to Medicaid recipients provide "Best Price" information to the Center for Medicare and Medicaid Services (CMS). CMS uses the "Best Price" formula to calculate rebates payable to the various state Medicaid programs. Thus, the price reported by the manufacturers directly affects the amount of rebate payments to state Medicaid programs and reimbursement to providers.

In May 2004, Glaxo SmithKline entered into a settlement agreement with New Jersey following allegations that the company employed pricing schemes to defraud state and federal Medicaid programs.\(^7\) The national litigation alleged specifically that Glaxo SmithKline sold pharmaceutical products to privately-operated health management organizations at deeply discounted prices, concealed the transactions, and then under-reported price information to CMS. The deception ultimately diminished the amount of money the company was required to pay federal and state Medicaid programs.

\(^6\) Id.
In another example, separate lawsuits against Dey (a subsidiary of Merck) and Schering-Plough yielded more than $45 million in settlement agreements to Texas. Each case benefited from 1997 amendments to the Texas Medicaid Prevention Act\(^8\) that enabled whistleblowers to assist the state in its pursuit of drug companies’ price reporting schemes that enriched retail pharmacies, clinics, distributors and wholesalers at the expense of the state Medicaid program. The state settled a similar suit against Bayer Corp. and GlaxoSmithKline Inc. for $9 million in January 2004 and participated in the multistate action against Medco. In May 2004, the Texas Attorney General named Abbott Laboratories (Abbott), B. Braun Medical, and Baxter Healthcare in a civil Medicaid action involving false reports of the wholesale price of certain drugs and devices.

Other states have launched investigations into industry pricing practices. The attorneys general in New York and Illinois are investigating the decision of Abbott to increase the price of Norvir, a popular protease inhibitor, by 400 percent in December 2003. The outcome of the state’s investigation may have repercussions for the entire pharmaceutical industry.

No matter what forces explain the pricing practices of the pharmaceutical industry, the fact remains that American consumers are increasingly unable or unwilling to absorb price increases at recent rates. The failure of Congress to include within the Medicare reform legislation the authority for the administering agency to negotiate for lower drug prices suggests that the federal government is an unlikely source of innovative policy approaches. State government appears a more likely source of efforts to influence the price of prescription drugs for the greatest number of people.