

# State Initiatives On Prescription Drugs: Creating A More Functional Market

A group of state leaders weighs in on bringing the state, federal, and private sectors together for much-needed reforms.

**by the Reforming States Group**

**ABSTRACT:** In response to unrelenting increases in prescription drug spending and use, many states are developing and implementing innovative policy solutions. The Reforming States Group (RSG), a nonpartisan organization of senior executive and legislative leaders from more than forty states and provinces formed in 1992, proposes a series of actions to improve the functioning of this market by introducing more explicit information on quality, effectiveness, and price and by experimental waiving of federal regulations.

ESCALATING DRUG SPENDING has become a major concern among state policymakers and their constituents.<sup>1</sup> States are experiencing unrelenting increases in prescription drug spending and use in Medicaid, insurance coverage for state employees, and programs to aid seniors in purchasing essential drugs.<sup>2</sup> These cost pressures, adding to states' fiscal crises, are forcing states to consider dropping other services and reducing the number of eligible people.<sup>3</sup>

Most analyses of this increased spending point to the combined effect of an aging population; unit price increases for existing drug products; the introduction of new, more expensive agents; widespread marketing efforts by manufacturers; advocacy by various interests; and increases in the use of drugs as a substitute for other health services. Underlying these cost drivers, however, is a dysfunctional market in which information on price and relative effectiveness either is not available or is obscured from purchasers, prescribers, and consumers. Consumers with drug coverage, including Medicaid recipients, rarely pay the true costs of those drugs, and those who prescribe them are often unaware of their costs.<sup>4</sup>

Price comparisons for state Medicaid programs are further obscured by the rules governing the rebate program. The 1990 federal statute requiring manufacturers to offer rebates to states with open formularies prohibits states from sharing price information with one another.<sup>5</sup> Furthermore, because each manufacturer applies the rebate after the fact for its entire line of products, states can determine the net price for each drug only after its sale.

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*Members of the Reforming States Group Steering Committee in 2002 and 2003 are listed at the end of the paper.*

Equally important is the lack of timely, accurate, and independent information for prescribers and purchasers on the relative effectiveness of different pharmaceutical agents. Food and Drug Administration (FDA) approval of new products is based only on their being safe and effective relative to placebo and not to existing therapies. Prescribers receive much of their information about new agents from the manufacturers. In addition, purchasers, including states, may rely on pharmacy benefit managers (PBMs), which frequently select drugs for their formularies based on the size of the rebates, which may not be passed along to the purchaser or consumer.<sup>6</sup>

Rapidly increasing drug costs present special challenges for the relationship between states and the federal government. The lack of a Medicare drug benefit means that for many states drug spending for the dually eligible is exceeding that of inpatient and physician care.<sup>7</sup> Overall, in 2002 Medicaid programs spent more than \$30 billion on prescription drugs, with \$16 billion spent for dually eligible recipients alone.<sup>8</sup> High drug costs also have led at least thirty-four states (as of March 2003) to establish or authorize programs to provide pharmaceutical coverage or assistance, primarily to low-income elderly people or people with disabilities who do not qualify for Medicaid.<sup>9</sup> Other federal law (such as rebate restrictions) or statutes guaranteeing the best price to certain federal programs further restrict states' actions. However, the states cannot wait for the federal government to join them in solving these problems.

## What Some States Have Done To Address The Problem

Several states have taken the lead in addressing both spending increases and lack of access to pharmaceuticals, just as states led health care reform in the early 1990s.<sup>10</sup> State officials are learning from their colleagues' bold experiments in improving access (by reducing costs for consumers through Medicaid waivers) and controlling expenditures for existing state programs (by relying on techniques to improve purchasing power rather than strict regulatory solutions).

■ **Vermont.** In December 2000 Vermont received waiver approval from HCFA (now the Centers for Medicare and Medicaid Services, or CMS) to expand its Medicaid program to offer seniors and other adults who do not meet Medicaid income-eligibility requirements the ability to purchase drugs at Medicaid's discounted price.<sup>11</sup> The Pharmaceutical Research and Manufacturers of America (PhRMA) sued, contending that the federal government improperly approved the waiver. A federal appeals court ruled for PhRMA, stating that there was no net expenditure of Medicaid funds; the state merely acted as a "conduit" in the discount program, recouping all of its spending from drug company rebates.<sup>12</sup>

In March 2002 Vermont implemented a preferred drug list (PDL) with prior authorization. A state-appointed Drug Utilization Board (composed of seven physicians and four pharmacists) developed the PDL, relying on the use of literature on the relative efficacy of drugs in each of thirty classes. Manufacturers that match

the price of preferred drugs in a particular class may have their product added to the list. Physicians prescribing a nonpreferred drug must seek prior authorization from the state before the drug will be covered. In the first four months of the PDL's operation, the state estimates savings of \$1.6 million.<sup>13</sup>

■ **Maine.** Maine has also taken a diversified approach. In May 2000 the state required drug manufacturers to grant discounts for the benefit of Maine citizens participating in a new program, Maine Rx. The program expands eligibility for discounts that are required for Medicaid recipients under federal law (approximately 20–25 percent off retail).<sup>14</sup> Any drug company refusing to grant such discounts risks having the commissioner of human services sanction it by publicizing its refusal and subjecting its products to Medicaid's prior authorization requirements. A federal district court preliminarily enjoined the state from implementing Maine Rx, saying that it both interfered with interstate commerce and was preempted by the Medicaid statute. The Court of Appeals overturned this injunction, reserving PhRMA's right to renew its complaint if in practice the Maine program harmed Medicaid recipients. In May 2003 the U.S. Supreme Court, with separate opinions by several concurring judges, affirmed the appellate court.<sup>15</sup> The Court held that there was no interference with interstate commerce. As to preemption, the plurality said, "At this stage of the proceeding, the severity of any impediment that Maine's program may impose on a Medicaid patient's access to the drug of her choice is a matter of conjecture." The Court also emphasized that it was not deciding whether the secretary's approval was necessary for the Maine program to go into effect; it is possible that the next move may be the secretary's. When this paper went to press, the governor, attorney general, and legislative leaders had said that they hoped to launch Maine Rx by the end of 2003.<sup>16</sup> It was unclear what the CMS and PhRMA would do.

In the meantime, the state fully implemented its Healthy Maine Prescriptions (HMP) program under the authority of a waiver, based on Vermont's, granted in January 2001. After the federal court ruling in the Vermont case, Maine appropriated funds to subsidize a small percentage of what beneficiaries paid for drugs. A federal appeals court in December 2002 ruled against the program.<sup>17</sup>

■ **Florida.** In May 2001 Florida Governor Jeb Bush signed legislation allowing the state to negotiate additional rebates in exchange for steering Medicaid recipients toward certain drugs on a preferred list. Under this policy, the state abandoned the system of federally negotiated discounts from drug manufacturers. Drug companies that want their products included in Florida's formulary must agree to replace federally negotiated rebates, either via "supplemental cash rebates" or, as Pfizer has done, by providing programs such as disease management services and health education. PhRMA has filed suit in federal court to block the plan.<sup>18</sup> Florida reports savings of \$500 million in its drug budget over two years from a combination of its PDL and related initiatives.<sup>19</sup>

■ **Oregon.** Oregon, under legislation signed by Gov. John Kitzhaber in August 2001, created a PDL. An independent state commission, with substantial experience

assessing medical technology, compares the relative effectiveness of different drugs in a particular drug class. The panel commissioned the federally designated Evidence-Based Practice Center at the Oregon Health and Science University to evaluate research on the comparative effectiveness of the drugs in question.<sup>20</sup> Once effectiveness is determined, the state Medicaid agency conducts a cost analysis and determines which drugs will be preferred in a given class. Practitioners serving Medicaid patients may override the PDL with a note on the prescription if they decide that a patient requires a drug that is more expensive than but, at best, as effective as the treatment recommended by the agency. Oregon officials estimate savings of \$2.4 million in the first six months of the program while ensuring that patients are receiving the best medications.<sup>21</sup>

■ **Michigan.** The Michigan Pharmaceutical Best Practices Initiative demonstrated substantial savings with no evidence of harm to patients since February 2002.<sup>22</sup> A pharmacy and therapeutics committee, physicians and pharmacists appointed by Gov. John Engler, reviewed scientific and clinical information and recommended multiple drugs in each therapeutic class as the preferred drugs within the Medicaid fee-for-service program. Physicians can prescribe these drugs without prior authorization. Manufacturers of drugs that are not on the preferred list can offer supplemental rebates to bring the state's payments in line with those of the preferred drugs and avoid prior authorization. PhRMA unsuccessfully sued in state court to stop the program, and several manufacturers have refused to participate.<sup>23</sup> A federal lawsuit directed against Health and Human Services (HHS) Secretary Tommy Thompson for granting the state a waiver was recently denied.<sup>24</sup> Michigan officials say that the state's PDL is saving them \$800,000 per week.<sup>25</sup>

■ **Multistate initiatives.** Several multistate initiatives are also under way. West Virginia and six other states are exploring joint purchasing; in the fall of 2001 these states issued a common request for proposals for a pharmaceutical administrator.<sup>26</sup> In February 2003 the newly elected governors of Michigan and Vermont announced their decision to operate a joint purchasing program for their Medicaid programs, relying on each state's previous experience with PDLs.<sup>27</sup> The National Legislative Association on Prescription Drug Prices, a group of legislative leaders from states primarily in the northeast, is exploring the creation of a nonprofit PBM to serve as purchaser for the nine states. Unlike most established PBMs, the proposed organization would have transparent financial relationships with drug manufacturers and would return all negotiated savings to the states.

## How The Problem Of Drug Costs Could Be Solved

The early experience of states that enacted innovative policies suggests elements that might lead to effective policy elsewhere. Research synthesis plays a critical role in many of the approaches now under way, especially to PDLs for prior authorization.<sup>28</sup> States look to researchers to supply evidence with immediate policy relevance, especially evidence from systematic review of medical literature, re-

views produced, notably, by the Evidence-Based Practice Centers and the international Cochrane Collaboration.<sup>29</sup> States' use of the relatively new scientific discipline of research synthesis could encourage manufacturers to prioritize research on agents that are major improvements over existing therapies rather than developing "me-too" drugs or modifications of drugs that mainly prolong patent protection.

States have responded to the perverse conjunction between their revenue shortfalls and the pharmaceutical industry's earnings by introducing reforms to improve the balance between buyers and sellers. Most states have, to date, used a market approach to address the conjunction: increasing the information and mobilizing purchasing power that public agencies use on behalf of consumers.

State action to increase competition in drug pricing is finding a receptive audience among some private-sector purchasers and health plans that are also experiencing double-digit increases in drug spending.<sup>30</sup> If states can find ways to collaborate with these private partners as many did in the aftermath of the failure of the Clinton health reform plan in the mid-1990s, even more innovation is possible.<sup>31</sup>

Similarly, many states are partnering with physicians to implement reforms.<sup>32</sup> Many physician leaders recognize that burgeoning drug spending greatly reduces states' ability to provide inflation adjustments to doctors and hospitals. This collaboration also involves health professionals directly in developing systems of cost containment that preserve the quality of care, in commissioning research syntheses that enable providers to improve practice decisions and systems of care, in providing consumers with clear information on how to make informed choices among alternative treatments, and in working together to remove federal barriers to value-based purchasing of pharmaceuticals.

## **Obstacles To Solving The Problem**

Many well-financed and well-connected organizations oppose such changes, beginning with the pharmaceutical manufacturers. In response to state reforms, PhRMA recently increased its attention to state issues, both by lobbying and by bringing lawsuits. If these efforts fail, PhRMA could promote federal legislation that raises costs for state taxpayers.

Wholesalers, PBMs, and retail and mail-order outlets have considerable interest in what states accomplish in drug pricing reform. Complicated economic relationships have developed among these groups, including rebates, undisclosed incentive payments to promote certain manufacturers' drugs, and vertical integration of the supply chain by manufacturers.<sup>33</sup> Such activities have further obscured pricing information for consumers and for large-scale purchasers.

■ **Selected advocacy groups.** PhRMA spends substantial sums cultivating its relationship with selected patient advisory groups and has even created such groups. These advocacy groups for patients, seniors, and other consumers have concerns that may not be in the best interests of the people they purport to serve. The

*Baltimore Sun* described the work of these groups as “astroturf lobbying,” in contrast to grassroots consumer efforts.<sup>34</sup> Astroturf advocates assert that any state policy that reduces individual choice of medications, even when grounded in the best scientific evidence, reduces the quality of care.

■ **Political climate.** Federal inaction or action can impede innovations in state policy. Most important, today’s political and economic climate might make it impossible to enact a Medicare prescription drug program, requiring continued state subsidy of drugs for the poorest seniors. Congressional action may be desirable if federal courts erect additional barriers to state policy to increase consumers’ access to affordable prescription drugs.

## Actions RSG Urges To Solve The Problem

Throughout its history, the RSG has identified solutions that state policymakers can use to address the most vexing health system problems.<sup>35</sup> The RSG Steering Committee now proposes actions that state officials, in collaboration with colleagues in the federal government and the private sector, can take to improve access to prescription drugs for the populations for whom they purchase. These actions would begin to introduce much-needed market reforms, especially timely and accurate information about effectiveness and pricing and transparency in the transactions that occur throughout the supply chain.

■ **Systematic review collaboration.** Prior authorization is proving to be an effective way of controlling costs and improving outcomes. However, states that develop PDLs as part of prior authorization or voluntary compliance programs have been separately conducting their own reviews of the research literature on drug effectiveness for each therapeutic class. This can be expensive, time-consuming, and inaccurate. Furthermore, once the evidence is assembled, it must be updated with the most recent clinical studies.

The RSG recommends that states consider pooling their resources to produce these reviews in a more timely and complete fashion. Once the information is assembled, each jurisdiction should determine how to apply the findings locally, including whether to use prior authorization or voluntary action by physicians, to implement the findings. This approach can be applied by states that want to collaborate further with joint purchasing strategies or to rely on PBMs to manage their pharmacy program. Basing policy decisions on a systematic and unbiased review of the clinical evidence has the further benefit of providing protection against legal and other challenges to the state action.

■ **Federal collaboration.** The RSG recommends that state leaders identify and convey to their federal colleagues changes in federal law and regulation for Medicaid that would allow state innovation to flourish. The HHS secretary should use his waiver authority to permit more and varied experiments to continue across the states. He should also conduct thorough and objective evaluations of those programs and disseminate the findings.

■ **Policy collaboration.** State policymakers are hard-pressed to find workable solutions. They cannot wait for articles evaluating new approaches to appear in peer-reviewed journals. The RSG recommends that associations of public officials and research organizations develop and disseminate timely information about successful strategies for improving quality and reducing spending. This information would include reports on the development of PDLs and other reforms that rely on the evolving international standards for the quality of the evidence and evidence reviews. It also would include strategies to counteract likely opposition from PhRMA and its agents, such as methods to improve communication and coalition building.

■ **Legal collaboration.** States that undertake innovative approaches will continue to face legal challenges from drug companies and advocates. The RSG recommends that attorneys general and policymakers from those states more formally share information and strategies as they prepare to defend themselves.

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 Members of the RSG Steering Committee in 2002 and 2003 include Linda Berglin, Minnesota Senate; Neil L. Bergsman, Maryland Department of Budget and Management, and president, National Association of State Budget Officers (NASBO), 2002–2003; Charlie Brown, Indiana House of Representatives; Harriette L. Chandler, Massachusetts Senate; B.F. “Chris” Christiaens, Montana Senate; Eileen L. Cody, Washington House of Representatives; Angela Coron, California Department of Health Services; Gene Davis, Utah Senate; Mark Gibson, cochair, RSG Steering Committee, 2001–2002, and Office of the Governor of Oregon; Richard N. Gottfried, New York State Assembly; Lee Greenfield, Hennepin County Health and Community Integration; Toni Nathaniel Harp, Connecticut Senate; James K. Haveman Jr., Michigan Department of Community Health; John A. Heaton, New Mexico House of Representatives; John A. Hurson, Maryland House of Delegates; Jane Kitchel, Vermont Human Services Agency; Mary E. Kramer, Iowa Senate; Pamela S. Maier, Delaware House of Representatives; William N. Martin, vice-chair, RSG Steering Committee, 2001–2002, and North Carolina Senate; B. Joyce McRoberts, Idaho Department of Health and Welfare; S. Peter Mills, Maine House of Representatives; Angela Z. Monson, Oklahoma Senate; Thomas L. Moore, South Carolina Senate; Bob Nakagawa, Fraser Health Authority, British Columbia; John T. Nilson, Saskatchewan Ministry of Health; Carmen Hooker Odom, North Carolina Department of Health and Human Services; Gerry A. Oligmueller, Nebraska Department of Administrative Services, and president, NASBO, 2001–2002; Sheila Peterson, vice-chair, RSG Steering Committee, 2003–, and North Dakota Office of Management and Budget; Sandy Praeger, Kansas Insurance Department; Raymond D. Rawson, chair, RSG Steering Committee, 2003–, and Nevada Senate; Elizabeth H. Roberts, Rhode Island Senate; Peggy Rosenzweig, cochair, RSG Steering Committee, 2001–2002, and Wisconsin Senate; J. Thomas Schedler, Louisiana Senate; Charles K. Scott, Wyoming Senate; Mark L. Shurtleff, Utah Office of the Attorney General; Betty Sims, Missouri Senate; Kathy W. Stein, Kentucky House of Representatives; Jean I. Thorne, Oregon Department of Human Services; Donne E. Trotter, Illinois Senate; Gregg Underheim, Wisconsin State Assembly; Leticia Van de Putte, vice-chair, RSG Steering Committee, 2003–, and Texas Senate; Therese M. Vaughan, Iowa Insurance Division, and president, National Association of Insurance Commissioners; and Robert S. Zimmerman Jr., Pennsylvania Department of Health.

## NOTES

1. The fastest-growing spending category in the National Health Accounts in 2001 was prescription drugs. At 15.7 percent, it was nearly double the overall rate of increase of health spending. K. Levit et al., "Trends in U.S. Health Care Spending, 2001," *Health Affairs* (Jan/Feb 2003): 154–156.
2. According to a recent Kaiser Commission survey, forty-five states cited increased drug spending as one of the three most significant factors increasing their Medicaid costs, and twenty-five of those states ranked drugs as the single most significant factor. V. Smith et al., *Medicaid Spending Growth: Results of a 2002 Survey* (Washington: Kaiser Commission on Medicaid and the Uninsured, September 2002).
3. States are facing a collective budget deficit of \$68.5 billion in FY 2004. National Conference of State Legislatures, *State Budget Update: February 2003* (Denver: NCSL, February 2003). On dropping services, see P. McMahon, "States Reduce Services, Drop Many from Medicaid Rolls," *USA Today*, 12 March 2003.
4. L. Korn et al., "Improving Physicians' Knowledge of the Costs of Common Medications and Willingness to Consider Costs when Prescribing," *Journal of General Internal Medicine* (January 2003): 31–37.
5. 42 USC, Chapter 7, Subchapter 19, Sec. 1396r-8(b)3D. Created by the Omnibus Budget Reconciliation Act (OBRA) of 1990, the Medicaid Drug Rebate Program requires a drug manufacturer to enter into and have in effect a national rebate agreement with the HHS secretary for states to receive federal funding for out-patient drugs dispensed to Medicaid patients. State agencies are prohibited from disclosing the identity of a specific manufacturer or wholesaler and the prices charged for drugs by such.
6. M. Freudenheim, "Documents Detail Big Payments by Drug Makers to Sway Sales," *New York Times*, 13 March 2003; and M. Freudenheim, "Drug-Plan Manager to Refuse Promotion Money from Makers," *New York Times*, 18 March 2003.
7. John Folkemer, executive director, Office of Planning and Finance, Maryland Department of Health and Mental Hygiene, personal communication, 27 March 2003.
8. S. Dale and J. Verdier, *State Medicaid Prescription Drug Expenditures for Medicare-Medicaid Dual Eligibles*, Issue Brief no. 627 (New York: Commonwealth Fund, April 2003).
9. NCSL, "State Pharmaceutical Assistance Programs," [www.ncsl.org/programs/health/drugaid.htm](http://www.ncsl.org/programs/health/drugaid.htm) (9 April 2003).
10. Detailed descriptions of state programs in Vermont, Maine, Michigan, and Oregon are available by request to [mmf@milbank.org](mailto:mmf@milbank.org).
11. Under the Vermont Pharmacy Discount Program, people enrolled in Medicare, regardless of income and without drug coverage, or any other person with income up to 300 percent of the federal poverty level and without drug coverage was able to purchase drugs at the Medicaid rate and at the time of purchase received an additional discount equal to the expected Medicaid rebate that the state would get from manufacturers under the federal Medicaid drug rebate provisions. In essence, these new Medicaid enrollees were offered this one benefit with a 100 percent copayment. The rebate component resulted in the beneficiary paying 82.5 percent of the discount from retail prices, although the actual amount varied by drug and Medicaid-allowed amount. This translated to an estimated 25 percent below retail. R. Sneyd, "Drug Industry Sues to Block Vt. Program," *Rutland Herald*, 12 December 2000.
12. *Pharmaceutical Research and Manufacturers of America v. Thompson*, 251 F.3d 219 (D.C. Cir. 2001).
13. R. Winslow, L. McGinley, and C. Adams, "States, Insurers Prescribe Fixes for Soaring Medication Costs," *Wall Street Journal*, 11 September 2002.
14. "The mechanics of the Maine Rx program are not complex. The Commissioner of DHS...will negotiate with pharmaceutical manufacturers to obtain discounts for qualified residents. The discounts take the form of rebates triggered by each sale of a Maine Rx covered drug to a Maine Rx cardholder at a participating Maine Rx pharmacy. Maine Rx does not mandate any particular rebate amount—the Commissioner is simply to use his 'best efforts' to leverage the State's market power into the most generous discount manufacturers are willing to provide. The initial goal is a rebate equal to or greater than the rebate Maine typically receives when it purchases drugs through its Medicaid program...with an ultimate goal of rebates approximating those provided to the federal government. 22 Me. Rev. Stat. Ann. Sec. 2681(4); Pet. App. 88." Quoted from *Pharmaceutical Research and Manufacturers of America v. Concannon*, "Brief of Respondents on Writ of Certiorari," 8.
15. *Pharmaceutical Research and Manufacturers of America v. Walsh*, no. 01-188 (Slip opinion at [www.supremecourtus.gov/opinions/02pdf/01-188.pdf](http://www.supremecourtus.gov/opinions/02pdf/01-188.pdf) (21 May 2003).
16. P. Carrier, "Funds to Start Maine Rx Long Gone," *Portland Press Herald*, 21 May 2003, 1A.
17. *Pharmaceutical Research and Manufacturers of America v. Thompson*, 313 F.3d 600 (D.C. Cir. 2002). The court ruled

- that the secretary of HHS never formally approved the modification of the Maine waiver, which added a 2 percent state contribution. The state had not yet received approval when this paper went to press.
18. In September 2002 the Eleventh Circuit Court of Appeals upheld a lower court ruling approving the Florida law over PhRMA's objections. *Pharmaceutical Research and Manufacturers of America v. Meadows*, 304 F.3d 1197 (11th Cir. 2002).
  19. National Governors' Association, *Preferred Drug Lists and Supplemental Rebates: Managing Care and Containing Costs*, Issue Brief (Washington: NGA Center for Best Practices, March 2003).
  20. The Agency for Healthcare Research and Quality (AHRQ) designates thirteen Evidence-Based Practice Centers around the United States. See AHRQ, "Evidence-Based Practice Centers," March 2003, [www.ahrq.gov/clinic/epc/index.html](http://www.ahrq.gov/clinic/epc/index.html) (9 April 2003).
  21. Jim Edge, acting assistant administrator, Oregon Office of Medical Assistance Programs, personal communication, 31 March 2003. The information is based on data since 1 September 2002. Savings are lower than officials hoped because only four drug classes were at that point subject to the program and the switch rate by physicians was lower than the state had expected.
  22. The state reports that its general request for physicians to report cases in which their patients were adversely affected has produced no documented case. David Viele, deputy director of budget and financial administration, Michigan Department of Community Health, personal communication, 25 March 2003. On the other hand, a recent survey of twenty-four advocates reported substantial implementation problems with potential harm to patients. C. Bernasek et al., *Case Study: Michigan's Medicaid Prescription Drug Benefit* (Washington: Kaiser Commission on Medicaid and the Uninsured, 23 January 2003). Several studies published in peer-reviewed journals have examined the similar reference drug pricing policy in British Columbia, and they have found no adverse effect on patients. See T. Hazlet and D. Blough, "Health Services Utilization with Reference Drug Pricing of Histamine2 Receptor Antagonists in British Columbia Elderly," *Medical Care* 40, no. 8 (2002): 640-649.; S. Schneeweiss et al., "Outcomes of Reference Pricing for Angiotensin-Converting-Enzyme Inhibitors," *New England Journal of Medicine* 346, no. 11 (2002): 822-829; and P. Grootendorst et al., "Impact of Reference-Based Pricing of Nitrates on the Use and Costs of Antianginal Drugs," *Canadian Journal of Medicine* 165, no. 8 (2001): 1011-1019.
  23. The state appeals court permitted the program to continue during the litigation, which was ultimately decided in the state's favor. *PhRMA v. Department of Community Health*, 657 NW 2d 162 (Michigan Court of Appeals, 2002).
  24. D. Durbin, "State Discounted Drug Plan Upheld," *Detroit Free Press*, 29 March 2003.
  25. Winslow et al., "States, Insurers Prescribe Fixes for Soaring Medication Costs."
  26. West Virginia led the effort, which includes New Mexico, South Carolina, Maryland, Louisiana, Missouri, and Mississippi. J. Wallace, "Proposed Drug Pool to Save \$25 Million; Seven States' Plan for Prescriptions Awaits Approval," *Charleston Daily Mail*, 26 March 2002.
  27. P. Landers, "States Jointly Seek Drug Discounts under Medicaid," *Wall Street Journal*, 20 February 2003.
  28. I. Chalmers, L. Hedges, and H. Cooper, "A Brief History of Research Synthesis," *Evaluation and the Health Professions* 25, no. 1 (2002): 12-37.
  29. For information on the Cochrane Collaboration, see [www.cochrane.org](http://www.cochrane.org).
  30. Segal Company, *2003 Segal Health Plan Cost Trend Survey*, 2002, [www.segalco.com/publications/surveysandstudies/2003trendsurvey.pdf](http://www.segalco.com/publications/surveysandstudies/2003trendsurvey.pdf) (9 April 2003). For examples of private-sector use of reference pricing, see J. Bennett, "U.S. Companies Are Examining How Europe Limits Drug Costs," *Wall Street Journal*, 26 March 2003.
  31. Reforming States Group, *Information for Accountability in Health Care Purchasing: A Report on Collaboration between the Private and Public Sectors* (New York: Milbank Memorial Fund, 1996).
  32. NGA, *Preferred Drug Lists*.
  33. U.S. General Accounting Office, *Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies*, Pub no. GAO-03-196 (Washington: GAO, January 2003).
  34. T. Craig, "Community Leaders Decry Lobby Firm's Fax," *Baltimore Sun*, 9 March 2002.
  35. For a history of the RSG, see K. Anderson, "The Reforming States Group and the Promotion of Federalism," *Milbank Quarterly* 76, no. 1 (1998): 103-120.