Lessons in Leadership:

The Oregon and Washington Experiences with Perscription Drugs

by Kathleen O'Connor, MA

Of the 210 different bills on prescription drug costs and access that were considered in 39 different states, only Oregon's and Washington's were nearly identical. Oregon's bill passed and Washington's did not. We wondered why. The answer seems to be leadership.

The Problem

"Until 1998, prescription drugs were just another quiet blip on the healthcare landscape," observes Richard Cauchi, program manager, Health Policy, National Conference of State Legislatures, a bi-partisan clearinghouse and research organization for state legislatures across the country. "There was a lot of activity in 1999 and 2000 when most states had surpluses in their budgets and were reaping the benefit of the tobacco settlement. At least 10 states used their tobacco dollars to fund subsidies for state prescription drug programs and states were bold in what they could do with their budgets, because of the strength of the economy."

That all changed in 2001 when escalating prescription drug costs ran head-on into a downturn in the economy. State strategies changed drastically toward cost containment.

Legislative approaches to containing drug costs come in three basic forms. "There are subsidy forms, which require means testing; price controls, as passed in Maine, and the evidence-based medicine approach with a preferred drug list that passed in Oregon, but failed in Washington," indicates Dr. Art Zoloth, Pharm.D., vice president, Northwest Pharmacy Services. Dr. Zoloth also served for 22 years as the director of Pharmacy at Virginia Mason Medical Center in Seattle and for 8 years on the Washington State Board of Pharmacy.

"While many states and most insurers have formularies with preferred lists of drugs, what the evidence-based approach does is examine patient outcomes on similar drugs within the same class of drugs to see how patients really respond to the medication. Most formularies are based on

price breaks not on patient outcomes," Zoloth observes. "The evidence-based approach levels the playing field by countering the huge advertising budgets of the pharmaceutical industry and uses science rather than marketing or simply costs of the drugs. It brings quality into play and drives out unnecessary healthcare expenses associated with drugs, thus bringing value and quality to the consumer."

"These bills were the first to their kind in the nation," says Kurt Furst, executive advisor for Prescription Drugs for the Oregon Health Plan. "These evidence-based medicine bills are very threatening to the pharmaceutical industry because this they compare the newer drugs to the older drugs and shows there is often not much difference between them in terms of effectiveness. What we were trying to do is find a new way to crack the formulary or rebate approach to containing healthcare costs."

Medicaid is the fastest growing part of most state budgets, so states are trying to find ways to cut costs. "We are facing in Oregon what nearly every other state is facing: 30% of our Medicaid costs are for prescription drugs," Furst says. "We found that one of the most frequently used cost control efforts—requiring physicians to have prior authorization before prescribing a specific medication—was not working that well. We also had safeguards in our program so doctors can override the prior authorization right there with the patient if the patient insists. But, with this bill, we wanted to drive the pharmaceutical industry to bring out more comparative data on the effectiveness of their products."

The Oregon Approach

It is said that all healthcare is local and all politics is local. Leadership, advocacy and lobbying efforts varied significantly between Oregon and Washington in trying to accomplish the same goal.

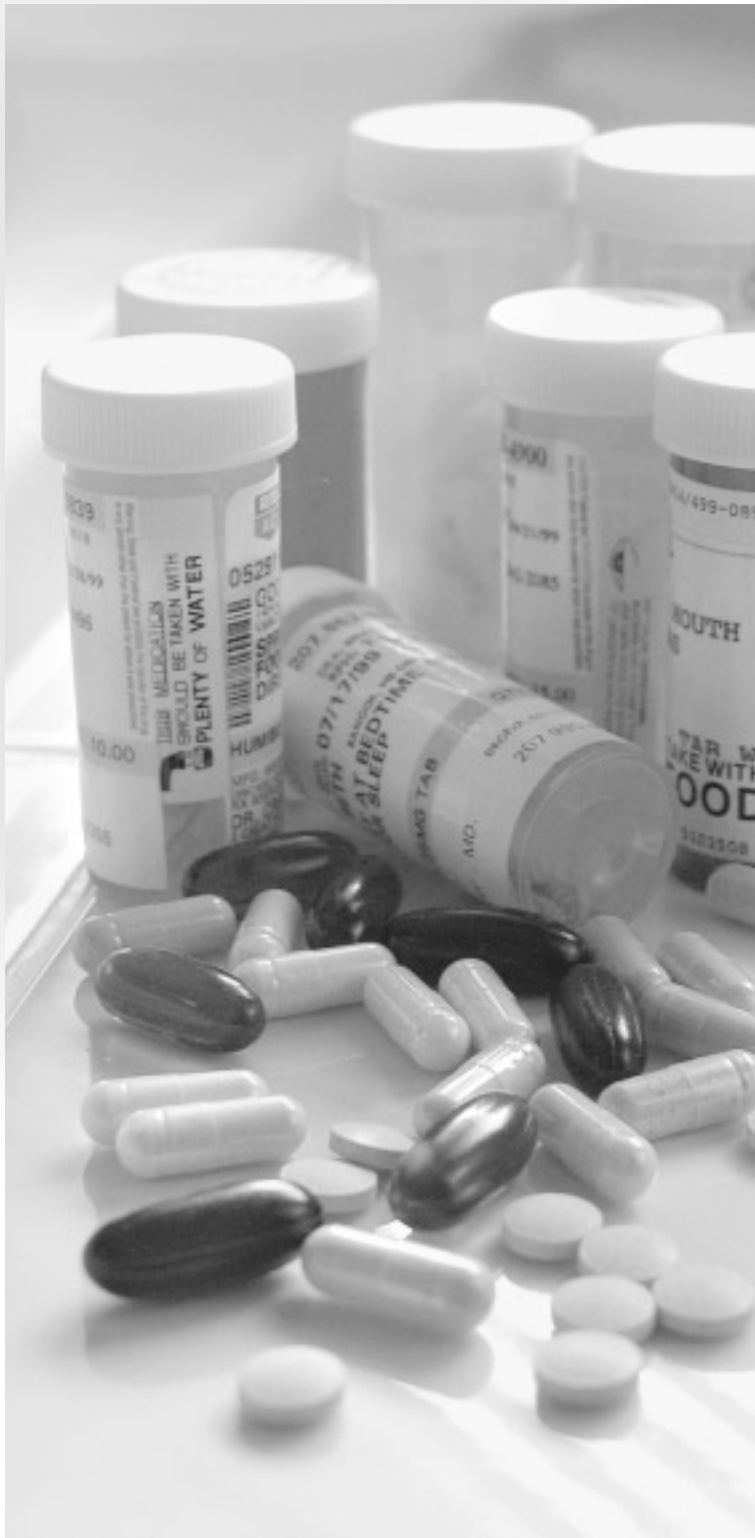
"Despite the governor's support and the support of multiple stakeholder groups and legislators, we were never able to have a public hearing on any formulary bills during the 2001 session," says John Santa, M.D., administrator, Office of Oregon Health Policy and Research.

"The entire legislative session was a challenge and political struggle between the governor and the pharmaceutical companies, but this issue was a priority for the governor."

In fact, Kitzhaber introduced the bill at the last minute on the last day of session and insisted on passage of the bill before he would let the Legislature adjourn. It was a very high priority for the Oregon governor as compared to the priorities of Washington's governor.

"The bill would not have passed without the governor's insistence that the legislature do something substantive on prescription drugs. The bill passed at 1 A.M. during the last day of session. It never had a public hearing," Santa indicated.

Willingness to compromise was also essential. The Oregon bill started by using a formulary based on reference pricing and evidence-based medicine, according to Santa. Oregon had a state prohibition against formularies, but repealed it during the 2001 session, with a provision it could be revisited in 2007. "By repealing the formulary prohibition," Santa said, "we succeeded in framing the issue in terms of the marketplace and evidence-based

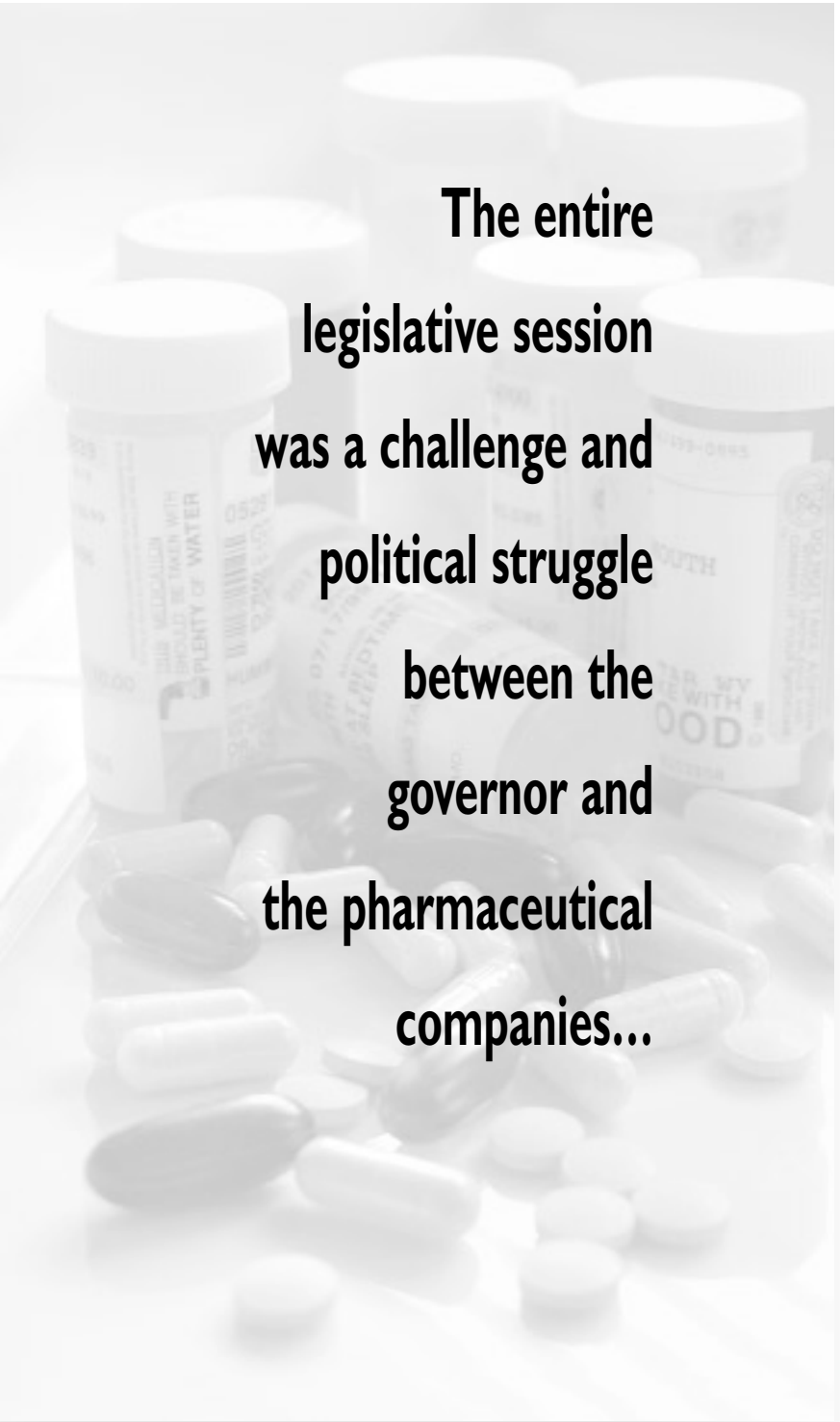


outcomes of what actually works best for the patients. The pharmaceutical industry defeated the reference pricing provisions of the bill, which limited the cost of a certain class of drugs to the one determined to be most effective for the best price. Some disease classifications were also exempted from the bill, notably mental health, cancer and AIDS. That was one of the other compromises. We kept a very liberal exception process, which was key in bringing in consumer stakeholders," Santa stressed.

Santa thinks one of the important reasons for success of the bill in Oregon was its origin. He thinks Oregon had more success with consumers and stakeholder groups because the bill and all the research that led to the development of the bill came out of the work of the Health Resources Commission. The Commission, composed of volunteer physicians, pharmacists and consumers, did a lot of research on formularies during 1999-2000 and was shared that information with consumer groups. "Because we had been working on this for so long," Santa said, "we had a lot of credibility with the public."

"We had also seen the pharmaceutical industry at work in earlier sessions when the industry tried to organize consumer advocacy groups in 2000. But, when the governor found out that these consumer/advocacy groups were being funded by the pharmaceutical industry, he demanded accountability of these groups and pointed to the inherent conflict of interest," Santa said.

There was never the organized resistance in Oregon by two groups that were most vocal during the end of the legislative session in Washington: minorities and the biotechnology industry.



The Washington Story

"I think the biggest difference between Oregon and Washington," says Representative Eileen Cody, R.N., D., and chair, House Health Care Committee who introduced the bill, "is that Governor Kitzhaber kept the legislature in session until something passed. The Oregon bill never had a hearing, so it was not as open a process. Oregon also does not have as active a biotechnology industry as we have in Washington. What killed our bill in Washington was the last minute opposition of the biotechnology industry."Other differences are striking. First, the bill did not emerge from a period of research; Washington State no longer has a health services commission. The bill, while similar to the Oregon bill, had no obvious track record of documented research on which it was based.

Secondly, Washington had more consumer groups funded by the pharmaceutical industry, such as the Health Care Access Alliance. They were never confronted by a strong governor, or any other leadership, pointing out their conflict of interest, as Governor Kitzhaber had done with some consumer groups in Oregon.

Another major difference was the reaction of some minority communities: that some medications react differently in people of color and therefore formularies discriminate against people of color.

"But we know the current drugs aren't tested on African Americans any more than they are tested on women," Cody says. "The drug companies themselves don't even have that data. Just like they don't have that data on women or children."

What finally stalled the bill was the reaction of the biotechnology industry. "They made the case that the bill would dry up venture capital investment in the biotech industry and we would lose jobs," said Cody, "and that doomed the bill. They came in at the last minute and there was no organized counter voice."

The Association of Washington Business, Washington State's Chamber of Commerce, also weighed in against the bill, because of lack of unanimity among several features of the bill.

The Lesson

Looking at these two states that share a common border, see-saw over the highest unemployment in the country, and have relatively similar economies (agriculture, timber and fisheries), one would have thought there would be more similarities in outcomes between two almost identical bills.

What made the difference between these two bills in these two states?

The first is leadership. Governor Kitzhaber cared about healthcare and the quality of patient care, as well as the cost of healthcare to Oregon's budget. He kept the legislature in session until it passed a bill. He kept the issue on the table and used his bully pulpit. Governor Locke did not. Health care has been a high priority for Kitzhaber, whereas it has not been a priority for Locke.

The second is credibility. The Oregon bill came out of two years of research by a respected entity: Oregon Health Resources Commission. When the so-called 'Clinton Health Care Reform' failed in the mid-90s, Washington State dismantled its Health Services Commission. Consequently, Washington State did not have a comparable independent agency to conduct research on health policy issues. This means that while the bills were crafted with some of the same data from national studies, there was no one vocal, local source in Washington State that had documented studies to show to local consumer advocacy organizations about what evidence-based medicine is and what it means to consumer groups.

Third, Washington had organized and active consumer groups funded by the pharmaceutical industry with little organized countervailing voice, such as an Office of Health Policy and Research. While there was a coalition of supporters for the bill, it was neither large enough nor vocal enough nor sufficiently established to make an impact.

The real killer was the last minute opposition of Washington's Biotechnology Industry. Washington State is ranked 9th in the nation for the size of its biotechnology industry. The issue was framed in terms of price controls, venture capital investment, and jobs for the state's economy. The arguments came at the end of session in a recession-ridden State. It was the proverbial last straw.

Where to From Here?

"We're going to re-introduce a similar bill again this session," says Cody. " The State has implemented part of this already. The bill last session was more technical than it needed to be. But we cannot ignore the cost of prescription drugs. Prescription drug costs are the issue everyone is hearing all over the country during this election."

Washington is not alone in its attempt to control prescription drug costs. "Heath care costs are at the top of most governors' agendas," stresses Joan Henneberry, Director of Health Policy Research, National Governors' Association. "We are going to see more states join together for purchasing pools and some kind of legislation in every state to control drug costs in one way or another."

No one knows what the outcome will be for the drug bill in Washington's 2003 Legislative session. With Medicaid being the fastest growing part of state budgets, consumer and senior demand for affordable healthcare, and increasing larger state deficits, the battle to control prescription drug costs will only loom larger on the legislative landscape.

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