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The State Legislators Desktop Reference to Prescription Drug Policy

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The State Legislators Desktop Reference to Prescription Drug Policy

After nearly a decade of seeing state revenues steadily grow, most states are facing a significant budget shortfall. The good news is that federal help is on the way. The recently passed Medicare bill shifts some of the burden of providing prescription drug coverage for poor seniors (the so-called "dual eligibles") in 2006 from state Medicaid programs to the federal Medicare program.

But 2006 is still two years off, and states are facing budget crunches now. State legislators are looking for places to cut their spending, and state purchases of pharmaceuticals have become one of the leading candidates.

However, squeezing savings from the drug budget will be harder than it looks. The prescription drug market is very complex and overrun with federal and state laws that can take years to fully understand. As a result, what might seem like a simple legislative change that would save the states money could lead to significant unintended consequences—and additional costs.

Legislators need to be prudent stewards of taxpayer dollars, but they also must ensure that vulnerable populations receive appropriate care. This Desktop Reference will help state legislators identify effective actions that may save the state money without reducing access to needed medicines.

Merrill Matthews Jr., Ph.D.
Jim Frogue, MA

Medicare Reform Legislation

Explanation.

Medicare reform legislation that passed Congress at the end of 2003 will pick up a portion of the cost of providing seniors with either discounts on the price they pay for prescription drugs or prescription drug coverage. However, most of that help won't begin until 2006.

Issues.

The states provide prescription drug coverage to seniors who qualify both for Medicare because of their age and Medicaid because they have very low incomes, the so-called "dual eligibles." According to the Kaiser Commission on Medicaid and the Uninsured, states spent 6 percent of their Medicaid budgets, or $13.4 billion, in 2002 providing drug coverage for the dual eligibles.

While the federal government will take over providing this coverage in 2006, it also takes back—referred to as a "claw-back"—most of the money the states would have spent, an estimated 77 percent. When factoring in the new administrative costs—states must determine who qualifies for low-income assistance, handle the subsidies for low-income seniors who join the prescription drug program and handle the transitional discount card program—states are expected to save only $17 billion over 10 years.

However, states also have been looking for and implementing ways to provide low-income seniors (and in some cases

those under age 65) with access to low-cost or free prescription drugs or with some type of drug coverage. The creation of the transitional discount card, from mid-2004 to 2006, and the new prescription drug coverage (called Medicare Part D) beginning in 2006 should relieve states of any obligation and cost of providing additional access and/or coverage.

Medicaid Restrictive Formularies

Explanation.

A restrictive formulary is a limited list of medications. Medications not on the list would not be covered by a state Medicaid program unless a physician specifically requested permission to prescribe it and the state granted that permission. Restrictive formularies seek to steer patients and their doctors toward lower-priced drugs in the hope of saving state money.

Issues.

Since the early 1990s, federal law has allowed states to "prior authorize" drugs in the Medicaid program, a process that requires doctors to get prior approval before dispensing drugs. But that option was intended to be very limited, primarily to prevent fraud and abuse. Recently, states have broadened the scope of their interpretation of the law in an effort to limit access to several commonly prescribed drugs. The goal is to discourage doctors, who want to avoid additional government paperwork, from using expensive medications, even if they are the most appropriate.

However, most of the increase in spending on drugs has come from increased utilization, not higher prices. Only

about 10 percent of total health care spending is for prescription drugs. The fastest-growing component of health care spending—more than a third—is for hospitals, and for Medicaid long-term care services, which continue to strain state budgets.

Spending on pharmaceuticals can save health care dollars while saving and improving the quality of lives. For example, it is estimated that every dollar shifted from older to newer drugs saves about $7 in other health care costs. And research has shown that restricting access to medications can increase overall health care costs by increasing the number of hospital, emergency room and physician visits. A survey by Project Patient Care and Harris Interactive estimates that in 2001 alone, formulary restrictions caused 1.1 million Americans to experience negative health outcomes and 1.9 million to experience side effects.

Restrictive formularies also can decrease patient access to appropriate care. In fact, a group of patients filed a class action suit against the state of Florida claiming that the state was denying them access to needed drugs as guaranteed under the federal agreement that created the Medicaid rebate program. The state settled with the patients out of court, agreeing to a provision that, while imposing some limitations, still ensures patient access. Ironically, most states in the 1990s legislated against HMOs' attempts to control costs by controlling access to care; yet states that impose restrictive formularies are doing the same thing.

Positive Steps.

States considering restrictive formularies are trying to save money, but there are better ways to save.

One way is to focus on outcomes. Disease management programs in which a health care professional educates patients and coordinates their care and support are promising. Such programs are reducing costs and improving patient outcomes by targeting the most expensive users with costly chronic medical conditions such as asthma, congestive heart failure, diabetes, coronary artery disease and depression. (See the Disease Management Association of America [www.dmaa.org]).

Another way is to focus on patients using many prescriptions and to carefully evaluate the treatment of these "high utilizers," which in extreme cases may be using 20 or more prescriptions in a six-month period.

States also could consider implementing Maximum Allowable Cost (MAC) programs, which limit payments for brand name drugs when generic copies are available. For example, a state can preclude Medicaid from paying more than 150 percent of the cost of the cheapest generic copy. This approach does not limit access to drugs and still lowers costs.

States also should act to eliminate both intentional and unintentional Medicaid fraud. Some recipients leave the program, usually because their income increases, yet they remain on the rolls. If they are covered by an employer plan,

the state Medicaid program can recover inappropriate payments from the new insurer. Reducing fraud is politically popular and saves money without reducing patients' access to needed drugs.

The best way to ensure that all decisions about which drugs will and will not be on the formulary is to require that all meetings and records are open so that the public can see why the committee decided on one drug over another and what research and testimony was used to make those decisions. Moreover, decisions should be made so that clinical and cost considerations are clearly understood. Clinically inferior drugs should not be sold to the public as superior products in order to meet cost goals.

Finally, any new drug should be available to all patients unless and until the committee decides otherwise. If the committee is going to err, it should err on the side of access and availability.

Importation and Reimportation

Explanation.

Importation refers to the practice of bringing prescription drugs into the United States, but avoiding the FDA's processes for ensuring drug safety. "Reimportation" generally refers to the drugs that are made by U.S. drug manufacturers and sold and shipped to other countries, which are then sold and shipped back (reimported) to the states. While the two terms are often used interchangeably, reimportation is actually one form of the broader practice of importation.

Issues.

It is against the law to import or reimport drugs into this country. The FDA allows U.S. citizens traveling internationally to return with a small amount (usually defined as 90-days' worth) for personal use. But that doesn't mean it's legal; for practical and political reasons the law just has not been rigidly enforced. So elected officials who encourage or help the poor, seniors or government employees buy prescription drugs from Canada or other countries are helping those Americans break the law, and may be breaking the law themselves if they facilitate those acquisitions.

The Food and Drug Administration opposes importation, saying it does not have the ability to ensure the safety of those drugs. Congress has given the secretary of the Department of Health and Human Services the authority to permit importation whenever the secretary can ensure the drugs are safe, but neither the current nor the past secretaries has reached that conclusion. Moreover, 11 former FDA commissioners have sent a letter to Congress opposing importation, considering it a threat to public health.

The safety warnings from the world's top experts at the FDA seem to have had little effect on many Americans, including some elected officials—e.g., several mayors, state legislators, governors from Illinois, Wisconsin, Iowa, Minnesota and New Hampshire and even members of Congress—who incorrectly assume that what they buy from Canada or

another country is no different from what they can buy in the U.S. (i.e., a reimported drug). Yet the Canadian government has made it very clear that it does not oversee or regulate drugs being sold to the U.S.

Moreover, when countries such as Canada buy prescription drugs from U.S. manufacturers, they agree not to reimport those drugs to the U.S. If they do allow the practice, they are in violation of their contracts.

So why don't drug companies simply refuse to sell their products to other countries at discounted prices? There are several reasons, including:

- An ethical responsibility to provide lifesaving medicines to all.
- The realization that most countries have lower per-person incomes—much lower in many cases—than the U.S.
- Recognition that selling drugs even at lower prices to low-income countries helps offset fixed operations costs.
- Threats by some countries of compulsory licensing, which would allow the country to manufacturer a generic version of a drug if the drug company refuses the price the country offers.

But isn't importation just free trade? The answer is that free trade presupposes it is legal trade; importation is illegal, just

as cross-border trade in narcotics and certain types of military technology are illegal, even though allowing the transfers would boost trade numbers. Additionally, free trade implies the free flow of goods across borders competing freely on price and quality. Drugs imported from Canada do not compete freely on price; the prices of these products are not set in the marketplace, but by government bureaucrats in the Canadian health care system.

Furthermore, expanding importation will not lead to lower prices for Americans. Canada represents 2.6 percent of the global prescription drug market, while the U.S. represents 53.4 percent, which means Canada has a very limited supply of drugs when compared to the U.S. market. Any economist knows that when demand is greater than the supply, the price will rise—regardless of the price countries initially pay drug manufacturers for their products—or wholesalers will find other sources. News stories are already emerging that in order to meet the demand, Canadian drug wholesalers are scrambling to find more drugs in what's known as the secondary market, where middlemen from all over the world buy and sell drugs.

Nevertheless, two U.S. cities have decided to import drugs from Canada for city employees and retirees, and several

states are considering a similar program, even though the FDA has adamantly opposed such actions and sent warning letters to those attempting such programs.

Thus, when a city or state employee is harmed by imported drugs, trial lawyers will have a good case that the state and local governments promoting the program acted negligently because they knowingly broke federal law and ignored all the warnings. Significant tax dollars will have to be used to defend against the suits and to pay out damages. These dollars could be better spent providing health care for those in need.

Positive Steps.

While some elected officials have gained headlines trying to import drugs, such programs will surely be a short-lived response. Shortages emerging in Canada are driving Canadian officials to restrict or eliminate reimportation, especially for large groups such as city employees.

There are a number of options available for states wanting to help low-income people gain access to affordable prescription drugs. To begin with, most states and drug manufacturers have programs to provide low-income patients with access to prescription drugs at greatly discounted prices or free. States that don't have such a program should implement one. Those that do should begin an educational campaign that

will expand awareness of what is available and how to access the programs. (See the Appendix for a list of these programs.)

Second, most of the major manufacturers have created nationwide programs for low-income seniors. For example, a qualifying senior can buy any Pfizer drug for $15 per month and any Eli Lilly drug for $12 per month. In addition, GlaxoSmithKline has a program that provides significant discounts, and several drug companies have created the TogetherRx program, which also provides significant discounts. Educating low-income seniors about the availability of these programs—perhaps by establishing a program clearing house—would be very helpful. For most states, there is no reason to reinvent the wheel by trying to create a new state-run program. Several drug manufacturers make their products available to low-income seniors for less money out of pocket than many insured patients pay. Helping seniors contact the programs and get enrolled is one of the most cost-effective ways of increasing access to affordable drugs. Of course, the recently enacted Medicare bill will soon provide discount cards and modest coverage for low-income seniors.

Purchasing Coalitions

Explanation.

Several states are forming co-ops in the hope of getting large group discounts when buying prescription drugs.

Issues.

In February 2003, Michigan, Vermont, South Carolina and Wisconsin announced that they were forming a coalition for the purpose of purchasing larger quantities of prescription drugs at lower prices for their Medicaid populations. Several states in the Northeast, plus the District of Columbia and Hawaii, are also working to create their own "bulk purchasing" pool. And 14 southern states have banded together for a similar purpose. These purchasing coalitions have not achieved significant success for a variety of complex—as well as some simple—reasons, such as the fact that the states are reluctant to cede control of the pharmacy benefits of their citizens to a hired purchasing agent.

Would such mega-co-ops be able to wring out more savings? Some pharmacy benefit managers (PBMs) already negotiate on behalf of 70 million people—much larger than the Canadian population—and so presumably get the best prices available to the private sector. And Medicaid by law always gets the best price.

There is nothing wrong in theory with states joining together in voluntary arrangements to negotiate discounts. That's just relying on economies of scale. In practice, however, they are using the arrangements to limit access to drugs, telling each drug manufacturer that unless it accepts what the co-op is willing to pay, the states will restrict the poor's access to all of the company's drugs.

Thus, what is touted as using the market to negotiate discounts is little more than an attempt to create a monopsony (i.e., a market where there is only one buyer; the flip-side of a monopoly). Indeed, if the co-op becomes large enough, it can dictate the direction of research and development and the products that are available, since the standard for which new drugs to produce would no longer be what patients need, but what the co-op will approve.

Positive Steps.

If a state wants to enhance its buying power by joining with other states, negotiations should be free of coercion. Using the threat of limiting the poor's access to certain drugs is an unethical, and probably illegal, bargaining chip.

In addition, the negotiations should be decentralized as much as possible. Investing some type of committee with the power to make decisions about which drugs will and will not be available to a population of millions of people would be an invitation for all types of interest groups to become involved, politicizing the entire process.

If a committee is formed, the best way to limit the political influences is to ensure that all records are open so that the public can see why the committee decided on one drug over another and what research and testimony was used to make those decisions.

Finally, any new drug should be available to all patients unless and until the committee decides otherwise. If the committee is going to err, it should err on the side of access and availability.

Drug Price Controls

Explanation.

Under federal law, pharmaceutical companies participating in Medicaid rebate 11 percent for generic companies and between 15 percent and 25 percent for branded companies. Some states—most prominently, Maine—are attempting to force the pharmaceutical companies to give discounts equal to the Medicaid rebates to all state residents who lack drug coverage. If companies do not agree, Maine threatens to put their products on a "prior authorization" list, which means that most patients get the drugs only if a doctor specifically requests permission from the state. A number of states are considering similar programs. After nearly four years, Maine's program has not yet been implemented due to legal challenges. It was due to be implemented early in 2004, but was put on "indefinite hold" because the upcoming Medicare discount cards may provide better benefits to many Maine residents than the Maine program.

Issues.

Maine and other states are attempting to use the federal statute authorizing special Medicaid drug pricing to justify a state requirement that pharmaceutical companies offer deep

discounts to persons not in the federal program. The Maine program also would give the state health department authority to impose statewide maximum retail price levels for prescription drugs if it deemed pharmaceutical company discounts to be unsatisfactory.

What Maine is doing is creating a system of price controls. But price controls never work in the long run. They always increase prices and decrease access, especially for low-income people. The reason is that all companies, not just those in the pharmaceutical industry, sell their products at different prices to different groups, depending on such factors as time, place and quantity. When price controls are implemented, the company does not settle on the lowest price, but somewhere between its lowest and highest prices. As a result, low-income people looking for the lowest price may pay more, while higher-income people may get the product for less. It is virtually certain that if Maine is successful in establishing price controls, the poor will face higher prices for their drugs.

Finally, imposing price controls in one area usually shifts costs to another. In this case, government-mandated price controls for Medicaid patients could impose higher costs for others, primarily those in the private sector.

Positive Steps.

Instead of quick, shortsighted and ultimately unsuccessful attempts to control prescription drug prices, states could expand disease and case management programs that promote

effective drug use to reduce other health care costs. For example, the Disease Management Association of America (www.dmaa.org) provides an online searchable database for eight of the most costly chronic medical conditions such as asthma, congestive heart failure, diabetes, coronary artery disease and depression. Therapeutic solutions for these diseases usually rely heavily on prescription drugs. States that manage these patients well will both improve health outcomes and save money.

States also can purvey information. Most states have drug assistance programs, and pharmaceutical manufacturers have numerous plans for seniors and the poor. Often, however, eligible patients do not know what is available or how to enroll. Each state can and should serve as a clearinghouse for information that connects the needy with the programs that can meet their needs. To this end, the National Council on Aging recently introduced a Web site, www.benefitscheckup.com, which acts as a clearinghouse for state, federal and manufacturer programs available to U.S. citizens. (See the Appendix at the end.)

The goal behind price controls is to control or reduce spending. But there are private sector ways of doing that. For example, using a private insurance company, Nevada offers low-income seniors a prescription drug benefit that could serve as a model for other states. To be eligible, a Nevada

resident must be at least 62 years old, make less than $21,500 a year and not qualify for Medicaid. The roughly 7,500 seniors in the program pay only $10 for a generic and $25 for a brand name drug. Although the coverage is limited to $5,000 per person per year, the state pays the entire insurance premium. With a federal waiver, a state could apply the Nevada model to its Medicaid population by contracting with a private insurer to provide the coverage.

Tort Reform

Explanation.

The United States has become the most litigious society in history. The tort system cost about $233 billion in 2002, or 2.2 percent of U.S. gross domestic product—more than double the average cost for other industrialized nations—and the cost is growing. Some efforts at reforming the tort system have been successful. Building on these reforms could produce billions in savings throughout the health care system.

Issues.

The U.S. tort system is costly and inefficient. This "litigation tax" on every American is estimated to cost about $809 each year. The country spends about $60 billion to $100 billion for "defensive medicine"—the cost of extra tests and other measures intended to discourage litigation. Ironically, about 60 cents of every litigation dollar goes to cover the costs of litigation, including attorneys' fees.

These costs do not include benefits lost to individuals and society because of the liability concerns that keep valuable products off the market. These losses are most acute in medical research and development. Companies are wary of developing vaccines, and the number of companies doing research on contraceptive devices has declined from 13 to 2 because of the fear of liability.

States that have adopted the appropriate malpractice reforms have experienced substantial savings. Laws that directly limit liability cut hospital expenditures between 5 percent and 9 percent within three to five years, with no differences in mortality and no serious complications.

A Stanford University study estimated that uniform adoption of such legal reforms would reduce health care costs by $50 billion with no serious adverse consequences to the nation's health.

Reforming state liability laws also slows the rate at which malpractice insurance premiums increase. Premium increases from 2001 to 2002 averaged 15 percent in states with punitive damage caps of less than $250,000, compared with a 44 percent increase in states without caps.

Positive Steps.

State legislators should consider capping punitive (not economic) damages. California's model of a $250,000 cap on

non-economic damages has worked very well. (For more information, see ALEC's model legislation.) For example, in 2003 Texas enacted sweeping and comprehensive tort reform that included California-style non-economic damage caps of $250,000. Medical malpractice insurance rate hikes have already been eliminated for 2004 premiums and are even declining for some doctors.

Alternatively, states could redirect punitive damages to someone or some group other than the plaintiff and the plaintiff's attorney. For example, diverted punitive damages could help to fund the state's provision of prescription drugs to low-income families or its coverage of the uninsured.

A less-comprehensive but still helpful approach would be to exempt drug manufacturers from liability when a doctor has prescribed a properly labeled FDA-approved drug. The FDA approves drugs for safety and efficacy. Manufacturers should not be subject to lawsuits if patients ignore labels or a doctor's instructions.

Direct-to-Consumer Advertising

Explanation.

In 1997 the FDA reduced the restrictions imposed on direct-to-consumer (DTC) advertising by pharmaceutical compa-

nies, which in turn led to a significant increase in drug advertising in print and broadcast media.

Issues.

Some critics claim that advertising has caused prescription drug prices to skyrocket and encouraged excessive, even unnecessary drug use. Proponents argue that the ads educate consumers about health issues and the values of the products.

What critics either fail to understand or fail to acknowledge is that advertising empowers patients and lowers prices. This is as true of prescription drugs as it is of groceries, automobiles and computers. The average monthly price of an advertised prescription drug ($78.19 in 2002) is less than the average cost of an unadvertised drug ($90.65).

Because direct-to-consumer advertising helps to raise awareness of health issues, it can lead to physician visits and diagnoses of previously undisclosed conditions. *Prevention* magazine reported in 2002 that more than 61 million Americans talked to their doctors about a medical condition they had seen advertised, and 25 million talked to their doctor for the first time about a medical condition. According to a 2003 FDA survey, 88 percent of responding physicians said patients inquiring about a drug had a disease the drug treated.

Responding to an ad for one drug also may lead patients to receive treatment for other illnesses. According to the Pharmaceutical Research and Manufacturers of America, of

1 million men who visited their doctors as a result of seeing or hearing an advertisement for Viagra, 30,000 turned out to have untreated diabetes, 140,000 had untreated high blood pressure and 50,000 had untreated heart disease.

Of course, seeing an advertisement does not mean that consumers will get the prescription that was advertised. Physicians have to write a prescription first, and research indicates that unnecessary prescriptions are quite rare. One survey showed that among consumers who saw a specific advertisement, only 13 percent received a prescription as a result.

Positive Steps.

The states' primary concern over DTC advertising is whether it is increasing utilization among populations whose prescriptions are subsidized with state money, primarily Medicaid and other public health program recipients and state employees.

If there is concern that DTC advertising encourages drug overuse or abuse, legislators could commission a study by an outside group, the health department or another state agency to see if patients are receiving appropriate care. However, the FDA recently did this for the second time nationwide and found that DTC advertising encourages patients with medical conditions to seek needed treatment, that very little abuse occurs and that most doctors are comfortable with patients' drug inquiries. These finding are important because two of the biggest problems facing Medicaid populations are awareness and compliance. By advertising, the manufacturers

actually heighten public awareness about certain illnesses that can and should be treated. And the ads implicitly serve as reminders that patients already on medications should take them.

Some state legislators have considered restricting drug advertisements in their states. But this action surely would be unenforceable because some ads are part of national programming. They also likely would be unconstitutional and doubtless would run counter to existing state laws.

Rather, what a state could do is sponsor its own ad encouraging those concerned about a medical condition see their doctor. The ad could refer the audience to a Web site or a phone number that provides information about available programs and services. The point is not to fight advertising and the media, but to use them to enhance the state's message.

Supplemental Rebates

Explanation.

Under federal law, pharmaceutical companies participating in Medicaid rebate 11 percent for generic companies and between 15 percent and 25 percent for branded companies. In exchange, Medicaid was supposed to allow broad coverage of manufacturers' products, although states can exert some restrictions to control spending. Now some states facing budget pressures are requiring or considering additional—

"supplemental"—rebates of 10 to 80 percent. Only by paying these additional rebates could firms assure their products appeared on the Medicaid formulary, the list of approved drugs for that state's Medicaid recipients.

Issues.

Pharmaceuticals account for an average of 12 cents of every dollar of Medicaid spending on health care. By a 1990 law, Medicaid already gets the lowest price offered to any private purchaser. And pharmaceutical companies already pay a rebate of almost one-sixth of the cost of providing prescription medicines to Medicaid patients. The Congressional Budget Office estimated that, under the 1990 law, collections would be $1.9 billion over five years; collections were $4.7 billion in 2001 alone.

Supplemental rebates are new taxes on drug companies under another name; legislators who have signed "no new taxes" pledges will be violating the pledges if they agree to the new charges. Further, requiring supplemental rebates effectively limits the selection of medicines available to low-income patients, which can lead to increases in total costs if patients are substituting hospital or institutional care for drug therapy. Studies show that such restrictions have led to more hospitalizations, emergency room visits and physician visits.

Finally, all supplemental rebates collected by states must be shared with the federal government at the same rate as the federal Medicaid matching grant. Thus a dollar in supplemental rebates may mean only 30 or 40 cents in additional state revenue.

Positive Steps.

Since supplemental rebates are a new tax on drug manufacturers, legislators can take a strong anti-new-tax stand by challenging those who support supplemental rebates. Federal law does not clearly authorize supplemental rebates or punitive access restrictions. Legislatures can clarify the matter by specifically prohibiting both.

States also could let competition drive drug costs down by giving Medicaid participants a defined contribution as Nevada has done for its low-income seniors who are not qualified for Medicaid. Claims costs in Nevada were only running a little more than $40 per person per month, plus overhead and administrative fees. Thus it provides a very affordable alternative while retaining access to needed medications.

Drug Assistance Programs

Comparative Chart of Pharmaceutical Manufacturers' Drug Discount Cards

Program	Prescriptions Covered	Annual Income Below (For households of 3 or > people, there may be higher income limits)	Benefit	Contact & Misc. Info.
GlaxoSmithKline Orange Card	All Drugs	$30,000/Individual $40,000/Couple	At participating pharmacies receive a 30% average savings	1-888-672-6436 Patients can participate in either the Orange Card or Together Rx for GSK medications (the Orange Card has higher income limits)
LillyAnswers *(Eli Lilly & Company)*	All drugs except controlled substances	$18,000/Individual $24,000/Household	At participating pharmacies pay $12.00/prescription for a 30 day supply	1-877-795-4559 www.lillyanswers.com
Novartis Care Card	Select Drugs	Two Income Categories A. $18,000/Individual $24,000/Couple B. $28,000/Individual $38,000/Couple	At participating pharmacies: A. Pay $12.00/mo. (per prescription) B. Receive a 25%-40% off	1-866-974-2273 www.NovartisCarePlan.com Enrollment for the Novartis savings program will be through Together Rx.
Pfizer for Living Share Card	All Drugs	$18,000/Individual $24,000/Couple	At participating pharmacies pay $15.00/ prescription for up to a 30 day supply	1-800-717-6005 www.pfizerforliving.com
Together Rx Card This one card can be used for many medications manufactured by: Abbott Laboratories, AstraZeneca, Aventis Pharmaceuticals, Bristol-Myers Squibb Company, GlaxoSmithKline, Johnson & Johnson and Novartis	Selected Drugs	$28,000/Individual* $38,000/Couple* *Alaska & Hawaii have higher income limits	At participating pharmacies receive a 20-40% savings off the regular prescription price of over 150 medications	1-800-865-7211 www.together-rx.com

All programs require that applicants be Medicare recipients and have no other prescription coverage. These drug discount cards have no enrollment or annual fees.

Other Drug Discount Cards

Program	Prescriptions Covered	Income Guidelines	Benefit	Contact & Misc. Info.
Nonprofit Warehouse	All Drugs	No Income Limits	At participating pharmacies receive up to 50% off regular retail price on generic drugs and up to 15% on brand name prescriptions	1-770-541-7777 www.nonprofitwarehouse.com

Drug Assistance Locator Programs

The federal government sponsors an agency known as the Eldercare Locator, which helps seniors age 60 and older in finding assistance programs, such as the Area Agency on Aging, in their local communities. You can reach the Eldercare Locator at 1-800-677-1118 or at www.eldercare.gov.

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www.helpingpatients.org is a free, confidential Web-based service sponsored by thePharmaceutical Research and Manufacturers of America (PhRMA) to help patients find assistance programs

Drug Assistance Programs by State

State	Population Served E -Elderly D -Disabled M -Medicare U -Uninsured	Name of Program	Contact Information
Alabama	E	SenioRx	800-AGE-LINE (800-243-5463)
Alaska	---	No Program	----
Arizona	M	Prescription Medication Coverage Pilot Program	Not yet operational
Arizona	E or D	Arizona Prescription Drug Discount Program RxAmerica	888-227-8315
Arkansas	E	Prescription Drug Access Improvement (Medicaid waiver for Rx drug coverage)	Not yet operational - Contact Dept. of Human Services
Arkansas	All low income	Arkansas Health Care Access Foundation, Inc.	1-800-950-8233 or 1-501-221-3033
California	M	Drug Discount Program for Medicare Recipients	Show your Medicare card at participating pharmacies to get drugs at Medi-Cal prices.
California	M	Golden Bear State Pharmacy Assistance Program(revision of discount program above)	Medi-Cal 916-552-9557 not yet in effect
Colorado	---	No Program	---
Connecticut	Anyone	Citizens Health (program being piloted in MA, CT & RI)	800-JOE-K-4RX (800-563-5479)
Connecticut	E or D	Connecticut Pharmaceutical Assistance Program Contract to the Elderly and the Disabled Program (ConnPACE)	CT Dept. of Social Services 860- 832-9265 or toll free in-state 800-423-5026
Delaware	E or D	Delaware Prescription Assistance Program (DPAP)	Division of Social Services 800-996-9969 x.17;302-577-4900
Delaware	E	Nemours Health Clinic Pharmaceutical Assistance Program	800-292-9538
District of Columbia	All low income	DC Healthcare Alliance	202-842-2810

Florida	M	Prescription Discount Program	Show your Medicare card at participating pharmacies to get drugs at Medicaid prices.
Florida	M	Silver Saver Program	888-419-3456
Georgia	All low income	Georgia Partnership for Caring Foundation	800-982-GPCF (4723)
Georgia	M	GeorgiaCares	800-669-8387
Hawaii	Anyone	Hawaii Rx Discount Program	Not yet operational: possible implementation 7/1/04
Idaho	---	No Program	---
Illinois	E or D	Circuit Breaker/Pharmaceutical Assistance Program (PAP)	800-624-2459
Illinois	E	Illinois Senior Care	800-356-6302
Indiana	E	Hoosier Rx	317-234-1381 or 866-267-4679
Indiana	M	Senior Health Insurance Info Program	800-452-4800
Iowa	M eligible	Iowa Priority Prescription Savings Program	866-282-5817
Kansas	E	Kansas Senior Pharmacy Assistance Program	Contact Dept. of Aging 785-296-4986 or 800-432-3535
Kentucky	All low income	Health Kentucky	800-633-8100
Louisiana	E	Louisiana SenioRx Program	225-342-3570 www.louisianaseniorx.org
Maine	All low income	Healthy Maine Prescriptions	866-796-2463 (TTY/TTD 207-622-3210)
Maine	E, D	Maine Low Cost Drugs for the Elderly & Disabled Program	866-796-2463
Maryland	All low income	Maryland Medbank Program	410-821-9262; 877-435-7755
Maryland	D, Any age, Low income	Maryland Pharmacy Assistance Program	800-226-2142
Maryland	M	Senior Short-term Prescription Drug Plan (Care First Plan)	BC/BS 800-972-4612
Massachusetts	Anyone	Citizens Health (program being piloted in MA, CT & RI)	800 -JOE -K-4RX (800 -563-5479)
Massachusetts	E, D	The Prescription Advantage Program	Exec. Office of Elderly Affairs 800-243-4636; 617-727-7750
Michigan	E	Elder Prescription Insurance Coverage	866-747-5844 (Program is currently closed except for emergency coverage)
Minnesota	E, D	Minnesota Prescription Drug Program	800-333-2433; 651-297-5418 www.dhs.state.mn.us/healthcare/asstprog/prescription drugs.htm
Mississippi	---	No Program	---
Missouri	E	MO Senior Rx Program	866-556-9316 or www.missouriseniorx.com
Montana	E	Prescription Drug Expansion Program	Not yet operational - estimated date of 2004
Nebraska	---	No Program	---
Nevada	E	Senior Rx	800-262-7726
New Hampshire	E	Senior Prescription Program (discount card)	888-580-8902

New Hampshire	All low income	NH Medication Bridge Program	800-852-3456
New Jersey	E, D	Pharmaceutical Assistance for the Aged and Disabled (PAAD)	609-588-7048; 800-792-9745
New Jersey	E	Senior Gold Program	609-588-7048; 800-792-9745
New Mexico	E	New Mexico SenioRx Program	866-244-0882
New York	E	Elderly Pharmaceuticals Insurance Coverage (EPIC) Program	800-332-3742
North Carolina	E	North Carolina Senior Care Program	866-226-1388
North Dakota	---	No Program	---
Ohio	E, D	Golden Buckeye Card Program	866-301-6446
Ohio	All low income	Rx for Ohio	877-794-6446
Ohio	Seniors over 60 and the uninsured at or below 250% of the federal poverty level	Best Rx	---
Oklahoma	---	No Program	---
Oregon	E	Senior Prescription Drug Assistance Program	800-359-9517
Pennsylvania	E	Pharmaceutical Assistance Contract for the Elderly (PACE) & PACE Needs Enhancement Tier (PACENET)	PA Dept of Aging 717-787-7313 800-225-7223
Rhode Island	Anyone	Citizens Health (program being piloted in MA, CT & RI)	800-JOE-K-4RX (800-563-5479)
Rhode Island	E	Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE)	Dept. of Elderly Affairs 401-462-3000 or 1-800-322-2880
South Carolina	E	Silver Rx Card	Silver Rx Card Hotline 877-239-5277
South Carolina	All low income	Commun-I-Care	803-933-9183
South Dakota	E	Senior Prescription Discount Card	800-257-9946
Tennessee	All low income	TennCare Rx Program	Not yet operational
Texas	M	State Prescription Drug Program	Not yet operational, postponed
Utah	---	No Program	---
Vermont	E or D	Vermont Health Access Program (VHAP) & VScript Expanded (state only VScript)	800-250-8427 or instate 800-529-4060
Vermont	All low income	Vermont Medication Bridge Program	866-887-4276
Virginia	---	No Program	---
Washington	E	Pharmacy Plus	Not yet operational
West Virginia	E	Golden Mountaineer Discount Card Program (replaces SPAN II)	877-987-3646
Wisconsin	E	Senior Care	800-657-2038
Wyoming	All low income	Prescription Drug Assistance Program	800-438-5785 or 307-777-7531

About the Authors

Merrill Matthews Jr., Ph.D., is a resident scholar with the Institute for Policy Innovation (IPI) and director of the Council for Affordable Health Insurance. He is past president of the Health Economics Roundtable for the National Association for Business Economics and health policy advisor for the American Legislative Exchange Council. Dr. Matthews served for 10 years as the medical ethicist for the University of Texas Southwestern Medical Center's Institutional Review Board for Human Experimentation.

James Frogue is director of the Health and Human Services Task Force at the American Legislative Exchange Council (ALEC). Prior to joining ALEC, Mr. Frogue served as legislative director for Rep. Kay Granger (R-TX) and as a legislative assistant for Reps. Jay Kim (R-CA) and Carlos Moorhead (R-CA). He also spent two years as the health care policy analyst at the Heritage Foundation. His areas of expertise include Medicaid, prescription drugs, the uninsured and broader health insurance market reform. He holds a Bachelor of Arts degree in International Relations and Political Science from the University of Southern California and a Master of Philosophy degree from Cambridge University in England.

Institute for Policy Innovation

1660 S. Stemmons Frwy. Suite 475

Lewisville, Texas 75607

Phone - (972) 874-5139

Fax - (972) 874-5144

www.ipi.org

American Legislative

Exchange Council

1129 20th Street N.W., Suite 500

Washington D.C. 20036

Phone - (202) 466-3800

Fax - (202) 466-3801

www.alec.org