

Prescription Drugs: Policy Options for States March 2008

1. PRICING PROVISIONS

States continue to scramble to provide access to affordable prescription drugs for all of their residents, as drug prices continue to climb and state revenues struggle in the current economic downturn. There are several basic approaches to reducing drug prices, many of which can be used in combination with each other for greater effectiveness. In addition to the rebate approach to negotiating prices, states are joining together to some states are more directly addressing drug pricing through anti-price gouging provisions, reference pricing and laws giving authority to the state or to consumers to go to court to reduce drug prices under certain circumstances.

- **Supplemental Medicaid rebates:** States that do not already have an extensive rebate negotiation/preferred drug list effort as part of their Medicaid programs can save substantially by better managing and purchasing drugs. For example, the prices paid by the state of Maine for prescription drugs in its Medicaid program average around 50% of the “Average Wholesale Price” (AWP) as a result of both the federal Medicaid rebate, rebates through the state’s supplemental rebate program, and a tiered Preferred Drug List (PDL). The state also has improved its bargaining power while maintaining this basic approach by expanding the size of its purchasing pool. (See discussion below under Purchasing Pool.)
 - *Link to presentation on Maine’s purchasing savings:*
<http://www.reducedrugprices.org/october2007portlandmeeting.asp>
- **West Virginia Reference Pricing:** Includes both price-gouging language and provisions providing for reference pricing as the basis for negotiating prices. Defines as unlawful restraint of trade or unreasonable commerce actions to fix, control or maintain the market price, rate or fee of pharmaceuticals; to allocate or divide customers or markets; or to establish, maintain or use of a monopoly to exclude competition or control, fix or maintain pharmaceutical prices. Also gives state Pharmaceutical Costs Management Council authority to establish a “reference price” based on FSS and excluding advertising & marketing costs. West Virginia just completed rulemaking on marketing cost disclosure as part of its plan to implement this provision.
- **Colorado Price gouging law:** Says emergency drug shortage may be declared to prevent practice of unfair drug pricing, defined as charging 10% more than pre-shortage price (SB 05-22, signed in April 2005). This law is fairly typical of several such laws around the country. Has limited effect (emergencies).
- **Wisconsin Best Price Law:** Wisconsin has a provision which has not been challenged, in the courts, W.S.A. 100.31, “Unfair discrimination in drug pricing.” The law requires “every seller” to “...offer drugs from the list of therapeutically equivalent drugs published by the federal food and drug administration to every purchaser in this state, with all rights and privileges offered or accorded by the seller to the most favored purchaser, including purchase prices for similar volume purchases, rebates, free merchandise, samples and similar trade concessions,” which would appear to include the excellent Medicaid or FSS price. The law provides for treble damages and injunctive relief.
 - Link to Wisconsin pricing law: <http://www.reducedrugprices.org/read.asp?news=335>

- **Copay provision.** A Maine law prohibits pharmacies and health plans from charging the copay instead of actual price when the retail price of the drug is *less* than the copay. [PL 431, 2007]
- **Maine Rx Pricing Provisions.** Maine law contains provisions (*never implemented*) providing for the setting of maximum retail prices for prescription drugs sold in the state based on whether the cost of prescription drugs provided to qualified residents under the Maine Rx Plus Program is “reasonably comparable” to the lowest cost paid for the same drugs delivered or dispensed retail. The Maine Rx price is generally the Medicaid price. This provision was enjoined by the District Court on Commerce Clause grounds and the state did not appeal this part of the case. As the state interprets the court decision, it may only enforce this provision as top pharmacies, not manufacturers.
- **District of Columbia Excessive Pricing Legislation:** Provides judicial remedy (treble damages, injunction) to “any affected party” when drug price found to be “excessive,” defined as prices in excess of 30% over other “high income” countries. Enacted September 2005, this law has been enjoined by the federal courts on preemption and patent law grounds. States interested in this approach should not limit the law to patented medicines and that the reference price should include more than prices outside of the U.S., eg, the Federal Supply Schedule (FSS). The D.C. law would also be improved by a more particularized showing of harm on a case-by-case basis before injunctive relief or damages could be imposed.

2. PRICE DISCLOSURE

- **Pharmacy prices.** Quite a few states (including Michigan, New Jersey, New York) provide for the posting of pricing information on a website. This enables consumers to compare prices among pharmacies. There can be significant differences from pharmacy to pharmacy for particular drugs. This approach does not deal with excessive drug pricing set by manufacturers, and can lead to consumers shopping at multiple pharmacies. Some question whether this is a good idea since multiple pharmacists may not catch drug interactions; moving to electronic records that can be exchanged between pharmacies would address this concern.
- **Retail price disclosure.** Maine has a provision requiring the retail price to be printed on the receipt even when the purchaser pays only a copay.
- **AWP disclosure.** Maine and Vermont have laws requiring drug companies to provide data directly to state regulators concerning AWP and other pricing criteria, backed up by sworn statements that the data is correct. This provision was sought by the AG in response to investigations and lawsuits against drug companies for Medicaid “best price” violations.
 - Link to Maine PL 603 (2005), <http://www.reducedrugprices.org/read.asp?news=111>

3. PURCHASING POOLS COMBINED WITH PREFERRED DRUG LISTS (PDL)

States can use the leverage of larger numbers of “covered lives” to negotiate for discounts in drug costs through purchasing pools that include several programs in one state (such as Medicaid, elderly assistance, state employees, workers’ compensation) or one or more programs in several states. This strategy is most effective when combined with a Preferred Drug List (PDL) to promote clinically appropriate alternatives that are the most cost effective in each individual state. Examples are the *Sovereign States Drug Consortium - SSDC (Iowa, Maine & Vermont)*, a first in the nation, state-administered Medicaid supplemental drug rebate pool which received federal approval in July 2006, and the *Northwest Prescription Drug Consortium (Oregon & Washington)* initiated in August 2006. Two other Medicaid pools have been approved by CMS besides the SSDC;¹ a 2005 survey found that 6 of 37 states surveyed reported pooling drug purchasing across several states, and 3 states pooled purchasing across several state programs.²

- Model preferred drug list bill: <http://www.reducedrugprices.org/read.asp?news=240>

4. PROMOTING GENERICS

States have a variety of policies to promote generic use, including requiring the generic to be dispensed when available unless the treating medical provider overrides, through preferred drug lists, lower co-pays, and counter detailing. Vermont’s omnibus 2007 prescription drug legislation S.115 established a generic drug sample voucher program as a way to encourage generic drug prescribing.³ Even though many states already have policies to promote generics, significantly more could be saved in the next several years because some of the most expensive and most frequently prescribed drugs have recently gone off patent, or will do so in the next several years. As a result these drugs will be available in generic versions which cost substantially less than brand name drugs (30-80% less than AWP). Although the savings will vary by program depending on the size of the rebates currently being negotiated, these savings could be realized across state government including corrections, state employee benefits, Medicaid, and programs for seniors and others

For example, some of the major drugs losing patent are Fosamax (Osteoporosis) which went generic February ’08, Risperdal (Psychosis) which goes generic in June ’08, and Prevacid (GI Disorders) which goes generic in November ’09. Other big-name and big-price drugs going off patent in the near future include Lamictal (Epilepsy, bipolar disorder) in July ’08, Topamax (Epilepsy, migraine) in September ’08, Advair (Asthma, COPD) in February ’08, Casodex (Prostate cancer), October ’08, and drugs for HIV.

States are also recognizing the need to address patent policies. Recently, 11 state governors asked the FDA to issue guidelines allowing insulin to be produced in generic form. People with diabetes in this country, as well as government and private insurers, spend a combined \$3.3 billion a year on insulin, including \$500 million spent by state Medicaid programs in 2005. Insulin prices could drop by 25% if generic versions become available.⁴

- **Cost savings:** On average, a generic drug costs about \$45 less than a brand name drug and it is estimated that for each 1% increase in generic fill rate, pharmacy spend decreases by 1%.⁵ According to the generic drug industry, Massachusetts saved more than \$150 million by changing a policy related to the way doctors can prescribe brand drugs when a generic is available, and Texas saved more than \$223 million simply by changing its prescription pads, making it easier for doctors to prescribe generics. Florida saved roughly \$30 million by eliminating special brand

¹ Maine Governor Baldacci’s press release, August 2, 2006.

² Crowley & Ashner, “State Medicaid Outpatient Prescription Drug Policies: Findings of a National Survey, 2005 Update,” (October 2005).

³ Crowley & Ashner, “State Medicaid Outpatient Prescription Drug Policies: Findings of a National Survey, 2005 Update,” (October 2005).

⁴ “States, Bridling At Insulin’s Cost, Push for Generics,” By STEPHANIE SAUL, New York Times, January 11, 2007

⁵ Ibid.

name “carve outs” in its Medicaid program.⁶ The Georgia prior authorization program for anti-ulcer medications increased the use of generics from 31% to 79% for net savings of \$20.6 million the first year.⁷

Examples of State Savings with Generics:

- Massachusetts saved more than \$150 million by requiring doctors to provide reasons when overriding the generic alternative
- Texas saved more than \$223 million by changing its prescription pads, making it easier for doctors to prescribe generics
- Florida saved roughly \$30 million by eliminating special brand name “carve outs” in its Medicaid program
- A Georgia prior authorization program for anti-ulcer medications increased the use of generics from 31% to 79% for net savings of \$20.6 million in the first year⁸
- Maine’s 2008 supplemental budget estimates savings of \$3.5 million by more aggressively managing brand name drug prescriptions and encouraging doctors to prescribe generics. This plan was put forward as an alternative to completely eliminating prescription drug coverage for poor childless adults, which would have saved about twice as much.

5. AVOIDING THE MIDDLEMAN

States negotiating rebates, whether through inter- or intra-state purchasing pools, can insure that they achieve the greatest savings by directly negotiating rather than going through a middleman vendor such as a pharmacy benefit manager. At a minimum, states should require transparency, a fiduciary relationship, and annual audits with any PBM they contract with to insure that they receive the full value of any negotiated discounts, rebates or other financial consideration.

- ***PBM Transparency and Fiduciary Duty Legislation:*** Maine’s law enacted in 2003 remains the most comprehensive; the D.C. law is very similar. The Maine law was upheld by the First Circuit U.S. Court of Appeals in a broad decision, and the U.S. Supreme Court refused to consider an appeal. The D.C. law was also upheld, based on the 1st Circuit decision. South Dakota, North Dakota, Iowa and Vermont also have PBM laws and several other states have more limited laws governing registration and payment provisions including Rhode Island and Mississippi.
 - *Cost savings:* Several recent reports have pointed to the value of transparency requirements in achieving savings for state government. A plan prepared for the Governor of Oregon by the Heinz Family Philanthropies recommended Oregon “require the greatest level of transparency possible” with PBMs as well as annual audits of the PBMs and insurance companies the state contracts with to insure that rebates are passed through.⁹ A report to the Illinois Commission on Government Forecasting and Accountability recommended the state stop using PBMs entirely, or at least require a fiduciary relationship. By directly negotiating pharmacy benefits in its state employee health plan instead of paying a PBM \$2.81 per enrollee per month to negotiate on its behalf, the report estimated savings of \$1.35 per claim or about \$10 million per year.¹⁰

In South Dakota, well over \$800,000 has been saved in state health insurance costs in a single year as the direct result of a more transparent business model required by their

⁶ Source: Generic Drug Association, accessed at:

http://www.gphaonline.org/AM/Template.cfm?Section=State_Affairs&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENT_ID=1967

⁷ Medical News Today reporting on January 2005 study in the American Journal of Managed Care, see:

<http://www.medicalnewstoday.com/medicalnews.php?newsid=18888>

⁸ GPHA; Medical News Today reporting on January 2005 study in the American Journal of Managed Care

⁹ Lewis, “The Oregon Blueprint,” at 11-12.

¹⁰ “Potential for Savings on Pharmacy Benefit Management Costs,” Illinois Commission on Government Forecasting and Accountability, prepared by Winkelman Management Consulting (April 2006) at 11-16.

law.¹¹ The University of Michigan dropped the five benefit managers it had been working with, hired a single new manager that has less control over how the drug plan is administered, and imposed strict new transparency rules, enabling UM to hold its drug spending to \$43 million in 2003, or \$8.6 million less than it would have paid under the previous plans.¹²

- PBM fact sheet: <http://www.policychoices.org/projects/PDF/FastFactsPBMs.pdf>
- PBM model bill: http://www.policychoices.org/projects/PDF/ModelPolicy_PBMs.pdf
- Link to NCSL presentations on PBMs: <http://www.reducedrugprices.org/read.asp?news=422>

6. 340(B) PRICING UNDER THE FEDERAL PUBLIC HEALTH ACT

Another policy option for increasing savings and expanding access to prescription drugs is to maximize participation in 340B pricing under the federal Public Health Act. The 340B price is 19% below the average Medicaid “best price” net or rebates, 39% below the average insurance reimbursement, and 51% less than AWP.¹³ One obvious strategy to maximize savings even in a pilot program is to target the most costly aspects of the pharmacy program. The largest individual cost drivers for a state Medicaid program include such populations or disease states as mental health patients, transplant recipients, hemophiliacs, People Living With HIV/AIDS, or other categories of patients with expensive and chronic disease states. 340B programs are ongoing in several states, including Oregon, Texas, Massachusetts, and Connecticut.¹⁴ Some examples:

- **Oregon pilot project:** One example of a program to utilize 340B pricing for high-cost Medicaid populations is an Oregon pilot project in which a State AIDS Drug Assistance Program creates an unfunded eligibility category for HIV positive Medicaid beneficiaries. Doing so will allow the Medicaid programs to, in effect, gain access to 340B pricing for those patients. This will result in an approximate 10% savings, yet the actual dollars saved will be greater due to the high morbidity and high costs of the patient population. In addition, the State will realize greater indirect savings due to an increase in prescription adherence and the resulting improvement in outcomes. This same model can be used for HIV positive prisoners to create savings for the State Corrections Department.¹⁵
- **Texas Department of Corrections:** The prison system has a contractual relationship with two hospitals that are 340B eligible providers; the prisons have been deemed outpatient clinics and the State corrections system has been able to access drugs for inmates at “dramatically reduced prices”¹⁶ about \$10 million in savings annually.
- Link to 340B presentation at NLARx meeting: <http://66.203.151.63/documents/vonOeshen.pdf>

7. ADVERTISING & MARKETING

- **Minnesota gift ban:** A law enacted in 1993 bans “gifts of value” to health care practitioners from drug manufacturers and wholesalers, excluding drug samples, items of less than \$50 in a calendar year, payments to the sponsor of a bona fide educational purposes, honoraria for a practitioner

¹¹ Email communication between Deborah Bowen, then South Dakota Insurance Commissioner, and RxPlus Pharmacies, February 2006; confirmed in telephone communication between Debra Bowen, now SD Social Services Director, and Ann Woloson of Prescription Policy Choices (August 7, 2006 email communication from Ann Woloson).

¹² Katz, David. “Drug Discount Peddlers” CFO.com 10/28/05 <http://www.cfo.com/printable/article.cfm/5079733?f=options> and Saxl, Michael. “Making PBMs Work for North Dakota” <http://www.legis.nd.gov/assembly/59-2005/docs/saxlpresentation.ppt>

¹³ Lewis, “The Oregon Blueprint” at 18.

¹⁴ Ibid.

¹⁵ Email communication to Sharon Treat from Jason Hardaway, Wellpartner, 3/22/06

¹⁶ Lewis, “The Oregon Blueprint” at 66.

who serves on the faculty at a professional or educational conference or meeting; compensation for consulting services of a practitioner in connection with a genuine research project; publications and educational materials; or salaries or other benefits paid to employees.

- Link to Minnesota Gift ban and Disclosure law:
<http://www.reducedrugprices.org/read.asp?news=334>
- **Disclosure of marketing and payments.** In addition to Minnesota, Vermont, Maine, D.C. and West Virginia each have versions of legislation requiring disclosure of marketing and advertising spending. Vermont has extensive reports on data collected on the Attorney General's Website. Legislation is still pending in Massachusetts and New York but was recently defeated in Washington.
 - These laws are reviewed for effectiveness here:
<http://www.reducedrugprices.org/documents/lurie01252008.pdf> .
 - A model bill is posted here: <http://www.reducedrugprices.org/read.asp?news=823> . Link to disclosure fact sheet:
http://www.prescriptionproject.org/tools/solutions_factsheets/files/0006.pdf
- **Drug detailer registration and regulation:** The District of Columbia passed in 2008 the first law in the nation requiring licensing of pharmaceutical drug reps ("detailers") and regulating their activities. Vermont and Nevada enacted legislation in 2007 to govern the behavior of drug industry sales representatives. Vermont's legislation also addressed misleading marketing to health care practitioners and direct to consumer advertising and established a state cause of action to enforce these standards. In Nevada, **AB 128** as amended and signed into law (Chapter 409) requires marketers of drugs, medicines and devices to adopt and comply with a code of conduct.
 - Final Nevada legislation: http://www.leg.state.nv.us/74th/Bills/AB/AB128_EN.pdf
 - D.C.'s SafeRx: <http://www.reducedrugprices.org/read.asp?news=753>
- **Prescription data confidentiality:** A first-in-Nation New Hampshire law prohibiting the use of doctors' prescription information for commercial purposes was enacted in 2006. The law prohibits the use of patient or prescriber-identified data for marketing purposes, with exceptions for aggregated data and uses defined as non-commercial such as tracking patient safety. Maine and Vermont passed similar, but less comprehensive laws in 2007. All three laws are being challenged in court on first amendment and commerce clause grounds, and we are awaiting the 1st Circuit Court of Appeals decision due out this spring.
 - Links to fact sheets:
http://www.prescriptionproject.org/tools/solutions_factsheets/files/0003.pdf
http://www.prescriptionproject.org/tools/solutions_factsheets/files/0004.pdf
 - Link to legal analysis: <http://www.reducedrugprices.org/read.asp?news=518>
- **Restricting electronic marketing activities:** In 2006 Florida enacted a law, Chapter 2006-271, restricting advertising as part of electronic prescribing software including "instant messaging, and pop-up ads, to influence or attempt to influence, through economic incentives or otherwise, the prescribing decision of a prescribing practitioner at the point of care." New Hampshire and Maine followed suit in 2007 [Maine law, PL362]
- **Misleading advertising:** In 2005, Maine passed a law adopting federal misleading advertising standards and giving its Attorney General explicit authority to go after violators Maine is the only other state to have enacted standards for misleading advertising and providing for a state cause of action for violations [22 MRSA Section 2700-A]. The law also requires posting data on clinical trials and a consumer education initiative by the state, funded with a fee paid by manufacturers. Vermont enacted similar misleading advertising legislation in 2007, and extended its reach to pharmaceutical drug representatives and other marketing activities [S.115; see also discussion of D.C.'s SafeRx and Nevada law, above]. Some other initiatives which were introduced in recent years but did not pass include:

- ➔ A Washington bill would have clarified prescription drug product liability by stating that manufacturers who advertise directly to consumers remain liable despite warning prescribers of “proper use and attendant dangers.”
- ➔ Legislation in Tennessee would have required the commissioner of Commerce and Insurance to conduct a study of the effects of prescription drug advertising in the state. A Pennsylvania Concurrent Resolution would have directed the state Health Care Cost Containment Council to conduct a study on the impact of prescription drug advertising and promotion on drug prices in Pennsylvania, including impacts on the state’s drug program for the elderly.
- ➔ A California bill would have prohibited the state from entering into a contract for a drug, including the Medi-Cal contract drug list, if the drug was promoted in California with direct-to-consumer advertising.
- ➔ New York legislation, A 1027, would have prohibited pharmaceutical manufacturers and distributors from deducting the costs of advertising drugs to consumers from their personal or corporate income taxes. West Virginia’s disclosure regulation has a link to drug pricing; the rules are intended to assist the state in negotiating drug prices that do not reflect the cost of marketing.

8. COMMUNICATING EFFECTIVENESS AND SAFETY EVIDENCE

- **Counter-detailing Programs:** Academic detailing and other programs aim to provide better information to medical providers and consumers about which drugs are the most effective and have the least adverse effects, and the costs of these drugs. Pennsylvania has operated an academic detailing program since October 2005, and in 2007 Maine (LD 8839) and Vermont (S.115) passed legislation requiring state support of academic detailing. A survey of state Medicaid programs in 2005 found that 22 states have programs to educate providers or provide “counter detailing” to promote the use of generics instead of more expensive brand name drugs, although most of these programs are not as comprehensive as the Pennsylvania program.
- **The Pennsylvania Independent Drug Information Service** (www.rxfacts.org) is the most comprehensive of the state programs. The program makes use of sophisticated “marketing” materials (“unadvertisements”), clinical information, drug information consultants, and patient education materials to help facilitate prescribing change. The academic detailers have clinical background (nursing, pharmacy). *Cost savings:* Although it is early in the implementation of Pennsylvania’s program to be able to calculate savings, a formal benefit-cost analysis of a 4-state Medicaid study involving 435 doctors showed savings of \$2 for every \$1 the program cost, based on just Medicaid paid claims data.¹⁷ The challenge in implementing this program is the need to invest money in order to save money, and figuring out how to come up with the initial financing. One option is to use funds collected in settlements in Medicaid fraud cases such as the 2004 global settlement of the Neurontin marketing case.
 - Link to report on the cost-effectiveness of prescriber education programs: <http://www.reducedrugprices.org/read.asp?news=1209>
 - Link to report on Northern New England Academic Detailing Summit: <http://www.reducedrugprices.org/read.asp?news=1100>
- **Participation in evidence-based information project:** More than a dozen states involved in the Oregon Drug Effectiveness Review Project, and New York based its PDL on the information from this project.
 - Model bill linking state purchasing pool and PDL provisions with evidence-based decision making: <http://www.reducedrugprices.org/read.asp?news=240>

¹⁷ “Economic and Policy Analysis of University-Based Drug ‘Detailing,’” by Stephen B. Soumerai and Dr. Jerry Avorn, *Medical Care*, Vol. 24, No.4, April 1986. A report on the costs effectiveness of the Pennsylvania program is forthcoming.

- **Posting clinical trials results:** Maine law requires internet posting of all clinical trials results, including adverse results. The law went into effect 10/15/05. A 2007 federal law requiring clinical trials results posting will preempt such state laws once the federal law goes into effect (in three years).

9. MEDICARE PART D

- **Wraparound coverage.** The biggest issue for states is insuring a safety net for dual eligibles and other low-income consumers. Pennsylvania, Vermont and Wisconsin are some of the leaders in providing wraparound coverage. Language in the budget pending now in New York would provide funding for appeals of Part D denials; estimates are that an investment of \$1 million funding such appeals could bring a return of \$7-8 million in savings due to shifting coverage to Part D from state SPAPs. Maine already does this, funding a supervising attorney and 3 paralegals at Legal services for the Elderly who automatically appeal any denial of a drug by a Part D plan, where that drug has been covered instead by the 100% state-funded wraparound program. The denials are generally for the most expensive drugs – costing \$100 to more than \$1,000 per prescription – and the modest investment of \$300,000 in this strategy has saved many times this figure.
- **Consumer protections:** A 2007 Maine law [PL 52], prohibits insurance marketing tactics and solicitations that use Part D solicitations as a means to market other insurance policies such as life insurance, including door to door solicitations and cold calls. Vermont passed similar legislation as part of Act 80 in 2007 and legislation is pending in California (California bill text: <http://www.reducedrugprices.org/read.asp?news=1079>)

10. FALSE CLAIMS ACTS

The Federal False Claims Act has been used in litigation against PBMs, chain drugstores and pharmaceutical manufacturers for fraudulent pricing and billing practices including drug switching, false reporting of Medicaid ‘best price’, short-filling prescriptions, failure to pay rebates, kickbacks and side deals. States involved in these federal cases, or bringing claims under similar state laws, have recovered millions of dollars.

- Model false claims act: <http://www.reducedrugprices.org/read.asp?news=115>
- **Cost savings:** One report concludes that every dollar invested by the government in investigation and prosecution of federal health care fraud returns \$15 back to the American people.¹⁸ States frequently share in these recoveries. For example, in August 2006 the drug manufacturer GlaxoSmithKline agreed to a \$70 million settlement with Arizona, California, Connecticut, Montana, Nevada and New York over allegations that the company artificially inflated average wholesale prices of prescription drugs. Thirty-four other states and the District of Columbia also will be eligible to receive part of the settlement.¹⁹ Recent changes in federal law create a financial incentive (an additional share of any recovery based on Medicaid funding formulas) for states to enact false claims laws that are as effective as the federal law. The additional recovery could be considerable. For example, in the recent Serono settlement, New York state recovered \$80 million. If New York had a qualifying False Claims Act, however, it would have gotten \$96 million -- an additional 20% over its initial recovery, or \$16 million.²⁰

11. TRADE ISSUES

¹⁸ Taxpayers Against Fraud report accessed at: <http://www.taf.org/FCA-2006report.pdf>

¹⁹ “GlaxoSmithKline Settles Civil Suits for \$70 Million,” REUTERS NEWS SERVICE, August 11, 2006; Wall Street Journal; see this and other articles excerpted and posted at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=39086

²⁰ See Taxpayers Against Fraud materials at <http://www.taf.org/cashbackstatefca.htm>

State legislators, through state trade policy commissions and the Legislative Working Group on Prescription Drugs and Trade (part of NLARx), are becoming increasingly active expressing views on trade agreements that have language that could be interpreted to limit state affordable prescription drug options. Look for states to pass resolutions objecting to trade agreements limiting imports and price regulation, and calling on Congress and the USTR to enact interpretive guidance to insure these agreements do not restrict state prescription drug programs and Medicaid.

- Link to policies and information on trade: <http://www.reducedrugprices.org/trade.asp>

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