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**Prescription Drugs:  
Options for Increasing Access**

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212 SW Eighth Avenue, Topeka, KS • Lower Level Conference Room

**A DISCUSSION FEATURING**

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Kansas Health Policy Forums are a series of interactive sessions for policymakers examining a broad array of health issues. Forums present a wide range of expert views on current health policy issues followed by facilitated discussion and dialogue in a non-partisan, off-the-record, setting. Forum Briefs analyze issues, present relevant data and information and are prepared in advance of each Forum.

**Prescription Drugs: Options for Increasing Access** will present information on the range of approaches taken by states and private organizations to increase access to prescription drugs. The Forum Brief also examines key policy questions to be addressed by policymakers as they consider the need for and development of public and private options to satisfy the pharmaceutical needs of Kansans. Some of the key questions for state policymakers are:

- Who requires assistance in paying for prescription drugs?
- Who is in the greatest need and how should priorities be set?
- How should responsibility for improving access be shared between the public and private sectors?
- How well do current public and private programs work?
- Is there effective local or statewide coordination to improve access to available programs?
- Is there a portion of the population left behind after all public and private programs are considered? How best can the identified needs that still exist be met?

### **Speaker Biography**

**Samantha Ventimiglia** is a Policy Analyst in the Health Policy Studies Division at the National Governors Association Center for Best Practices in Washington, D.C. Her work at NGA includes policy analysis and providing technical assistance to states in several

areas, including Medicare, Medicaid, and pharmaceuticals. She previously worked on children's health care issues in the NGA Center for Best Practices Health Policy Studies Division while earning her master's degree in public policy. Prior to NGA, Samantha held legislative staff positions in both the U.S. Senate and the U.S. House of Representatives. She also has a bachelor's degree in psychology and political science.

### **Panelists**

**Janis DeBoer** is the Deputy Secretary/Commissioner for Programs and Policy at the Kansas Department on Aging (KDOA) in Topeka, Kansas. KDOA administers federal and state programs to assist the senior population of Kansas, including the Kansas Senior Pharmacy Assistance Program. The agency also acts as an advocate and coordinator to ensure state services meet the needs of seniors in the most effective manner.

**Rosa Molina** is the Director of the Medical Service Bureau in Wichita, Kansas. This program, supported by the Medical Society of Sedgwick County, the United Way, Via Christi Regional Medical Center, Sedgwick County and others, helps low-income people enroll in pharmaceutical industry assistance programs.

**A Pharmaceutical Industry Representative** will provide information on industry pharmaceutical assistance programs.

### **Brief Authors**

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# Prescription Drugs: *Options for Increasing Access*

Prescription drugs play an important role in the delivery of medical care in the United States, but their high cost makes them unavailable to many who need them. The rising cost of prescription drugs is driven by increases in both the unit price of drugs and the number of medicines the average person uses. The average retail price of prescription drugs more than doubled between 1990 and 2000, led by inflation and the shift to newer, more expensive medicines. The number of prescriptions filled per capita increased by 37 percent in the six years between 1992 and 1998. By 1998, the average American used ten prescriptions per year (Kreling, et al., 2001).

## **TARGETING PHARMACY ASSISTANCE**

The increasing cost of pharmaceuticals affects low-income elderly, disabled, and uninsured persons more profoundly than others in the population. Elderly and disabled people are more likely than others to have multiple health conditions requiring medications. Nationwide, people over age 65 use three and one-half times as many prescriptions as those under 65 (Thomas, et al., 2001). Although most elderly and many disabled persons are covered by Medicare, the traditional Medicare program does not offer an outpatient pharmacy benefit. Beneficiaries can purchase supplemental (Medigap) coverage or enroll in a Medicare HMO<sup>1</sup> to gain prescription drug coverage. However, nearly one-half of Medicare beneficiaries were without prescription drug coverage for a portion of 1998 (Neuman, 2001). More than a quarter of Medicare beneficiaries, 10 million people, were without prescription drug coverage for all of 1998 (Poisal, et al., 2001). Research shows that Medicare beneficiaries without coverage used fewer prescriptions on average than those with prescription drug coverage,

indicating that coverage may affect access to needed medications (Poisal, et al., 2001).

In Kansas, an estimated 245,000 persons are not covered by health insurance. A majority (65 percent) of uninsured Kansans have incomes below 200 percent of the federal poverty level (Kansas Insurance Department, 2001). Like elderly and disabled persons, these low-income, uninsured individuals often have difficulty affording prescription drugs and may be forced to choose between buying medicine and paying for other necessities.

State governments and private organizations across the country have developed programs to improve access to prescription drugs. The range of options for improving access to prescription drugs is quite wide and includes alternatives that cost state governments millions of dollars and those that have few or no direct costs to states. The box on this page lists the most frequently used types of public and private pharmacy assistance programs. In this Forum Brief, we will discuss each of them.

## **PUBLIC PHARMACY SUPPORT PROGRAMS**

At least 30 states had enacted or authorized pharmaceutical coverage or assistance programs as of November 2001. Programs are active in 24 of the 30 states (NCSL, 2001b). Eligibility criteria for these pro-

grams usually are limited by age and/or income and generally focus on elderly or disabled persons who are not eligible for Medicaid. During 2001, at least 44 states considered legislation that attempted to reduce prescription drug costs for residents (NCSL, 2001a). The table in Appendix A summarizes the major approaches states have authorized and/or implemented.

## **State Pharmacy Assistance Programs**

Kansas and twenty-five other states have created pharmacy assistance programs that use direct subsidies of state funds to allow persons to purchase prescription drugs (NCSL, 2001b). In implementing assistance programs, states encounter a variety of alternatives that allow them to tailor programs to fit their unique circumstances. Critical considerations for states when designing programs include:

- **Who will the program serve?** Potential eligibility criteria can include conditions such as age, income, insurance status, and disability.
- **What will be the costs to participating individuals?** Cost-sharing\* mechanisms such as deductibles, premiums, enrollment fees and co-insurance can affect participation and overall cost to the state.
- **What medications will be covered?** Limiting pharmacy coverage to certain drugs or drugs for certain medical conditions lowers expenditures and targets

\* Terms with an asterisk are defined in the glossary at the end of the Brief.

### **Public and Private Pharmacy Assistance Programs**

#### **Public Initiatives**

State subsidy or insurance programs  
State pharmacy discount programs  
Bulk purchasing programs

#### **Private Initiatives**

Patient assistance programs  
Discount programs  
Referral programs

<sup>1</sup> Some Medicare+ Choice health maintenance organizations offer pharmacy benefits to their enrollees.



services but serves fewer individuals.

- **How will the program be administered and how will services be delivered?** States can choose to administer assistance programs through existing state programs like Medicaid or establish new programs.
- **How will potential enrollees find out about the program and then enroll?** Potential ways to make people aware of programs and then encourage enrollment range from television/radio/print advertising to one-on-one outreach.
- **How will the state pay for the program?** States can fund programs through a variety of mechanisms including general revenues, tobacco settlement funds, taxes on cigarettes or liquor, Medicaid funds or other sources.

One way states can lower the cost of prescriptions in their pharmacy assistance programs is by using the federal Public Health Services Drug Discount Program or 340B program (Von Oehsen III, 2001). Pharmaceutical manufacturers must agree to participate in the 340B program if their drugs are covered by Medicaid. Under

**Kansas Senior Pharmacy Assistance Program at a Glance**

- Administered by the Kansas Department on Aging (KDOA)
- Serves Kansas seniors 67 years of age and older who have no prescription coverage and participate in Medicare/Medicaid dual eligible programs
- Funded at \$1.2 million for fiscal year 2002 from special revenue funds
- Reimburses up to seventy percent of out-of-pocket costs for most prescription drugs
- Annual cap of \$1,200 per enrollee
- Anticipated to benefit approximately 1,000 Kansas seniors in 2001
- Reimbursement checks expected to be issued by December 31, 2001

this agreement, the manufacturer agrees to provide discounts, based on Medicaid rebates, on drugs purchased by safety net providers (e.g. Federally Qualified Health Centers and health departments) and provided only to their clients. These providers can also negotiate additional discounts with manufacturers. States can use these providers as access points for their pharmacy assistance programs to take advantage of the discounted prices.

The table below illustrates how some

states have addressed the critical questions. Note that Illinois provides coverage for seniors and disabled persons who have incomes below 254 percent of the federal poverty level (FPL). Although the Illinois program is available to more people than other state programs listed drug coverage is provided for only eight conditions. The South Carolina program, on the other hand, covers most drugs but is available only to seniors living below 175 percent of the FPL. The program also includes sizeable deductibles and co-payments. It is clear from the table that there are a variety of eligibility, coverage, and cost-sharing alternatives from which states chose. It

is also useful to note that while some state programs are similar, no two are identical. Appropriations for these six programs range from \$1.2 million to \$45.0 million. Annual costs per person range from \$100 to \$700 (NGA, 2001).

**State Insurance Programs**

At least three states have used a public insurance approach to make prescription drugs more affordable (Gross, 2001). These state sponsored insurance programs charge enrollees a premium and provide

**Examples of Six State Prescription Drug Programs\***

State	Income Limit (%FPL) <sup>+</sup>	Eligible Age		Drugs Covered	Cost Sharing
		Seniors	Disabled		
Illinois	254%	65	16	Drugs for eight conditions	\$0 or \$3 co-payment and variable deductible based on income and utilization
Kansas	150%	67	—	Most	30% coinsurance and \$1,200 annual cap
Maryland	116%	No age restriction		Maintenance drugs*	\$5 co-payment per prescription
Minnesota	120%	65	—	Most	\$35 monthly deductible
North Carolina	200%	65	—	Drugs for three conditions	\$6 co-payment per prescription and \$600 annual cap
South Carolina	175%	65	—	Most	\$500 deductible and \$10 or \$21 co-payment

# Includes eligibility levels and benefits for 2001. Additional eligibility requirements and program conditions may exist in some states.  
 + Federal Poverty Level. In 2001, 100% of the federal poverty level represented an annual income of approximately \$11,600 for a family of two.



them prescription drug insurance coverage. Additional cost-sharing such as co-payments or co-insurance may be required by the insurance plan. Subsidies are provided to low-income enrollees to assist with premiums and other cost sharing in Nevada and Massachusetts. Programs in Nevada and Maryland use contracts with private pharmacy benefit managers or insurance companies. The Massachusetts state-administered program replaces the state's direct subsidy program.

### **State Pharmaceutical Discount and Bulk Purchasing Programs**

Instead of providing a direct state-funded subsidy, some states have used a variety of methods to lower pharmaceutical prices for residents without expending large amounts of public funds. Some states are using their Medicaid purchasing power to leverage price reductions for broader categories of consumers. At least three states have submitted and/or received Medicaid waivers from the federal government that allow them to pass on Medicaid discounts and rebates\* on pharmaceuticals to people who are not eligible for Medicaid. These waiver programs are currently embroiled in court action, thus it is too early to tell whether they are a viable option for states. Other states have joined together to form purchasing coalitions to aggregate the purchasing power of several populations and increase negotiating power with pharmaceutical companies for discounts.

Discounting and bulk purchasing strategies considered or implemented by states in 2001 included:

- Discount prices for Medicare elders and disabled people based on Medicaid rates.
- Discount prices for seniors based on prices paid by federal agencies or the lowest market rate.
- General price discounts or "fair drug pricing" programs for uninsured persons.
- Discount prices for Medicare beneficiaries through rebates negotiated with

pharmaceutical companies that choose to participate.

- State bulk purchasing of drugs to achieve greater price discounts for eligible groups.
- State "buyers clubs" or purchasing cooperatives.

### **Other Public Initiatives**

Other initiatives discussed by state legislatures during 2001 included establishing "information broker" programs in which residents are provided assistance in using the patient assistance programs provided by most drug manufacturers. Eight states have developed programs to assist citizens in accessing these programs, and six other states discussed such initiatives during their 2001 legislative sessions.

No formal system of state coordination exists in Kansas for linking people in need with patient assistance programs sponsored by the pharmaceutical industry, but the Kansas Insurance Department operates the Senior Health Insurance Counseling for Kansas (SHICK) program ([www.ksinsurance.org/shick/pdp.html](http://www.ksinsurance.org/shick/pdp.html)) that provides information and counseling on how to access programs of various drug companies.

The federal government also offers assistance to persons seeking information on discount or free medication programs through their Prescription Drug Assistance Programs section at [www.medicare.gov](http://www.medicare.gov). The information is targeted at Medicare beneficiaries, but can be used by anyone. It can be searched for appropriate programs by residence, manufacturer, or conditions/diseases and provides links to other Web resources.

Other low-cost strategies that states discussed or implemented included:

- State tax credits for pharmaceutical purchases.
- Price controls on drugs sold within the state.
- Regulation of private "discount cards" (e.g. extending consumer protections to users of the programs and standardizing identification cards).

### **States With Programs to Assist Citizens in Accessing Private Pharmacy Support Programs**

- Arkansas
- Maryland
- Missouri
- New Mexico
- Texas
- Virginia
- Wisconsin
- West Virginia

### **The Federal Perspective**

Unlike Medicare, Medicaid, the shared federal and state insurance program for the poor, has a pharmacy benefit. Medicaid provides pharmacy coverage to low-income families and some low-income elderly and disabled people. The eligibility criteria for Medicaid, however, exclude many of the elderly and working poor.

During the 2000 presidential election and the first eight months of 2001, the topic of creating a Medicare prescription drug benefit received much attention. Both the President and Congress agreed in principle that expanding Medicare drug benefits was good public policy. How best to finance and deliver benefits was still being debated when the events of September 11, 2001 changed the policy landscape. President Bush had proposed two interim steps: (1) a national discount card and (2) grants to states to finance pharmacy assistance programs for the most needy seniors until a national plan could be implemented. Implementation of the discount card program was held up by court action but received permission to proceed in November 2001. The second proposal is still under consideration at the federal level.

The U.S. General Accounting Office (GAO) reported research findings on January 3, 2002 that private pharmacy discount cards on average save patients approximately \$3.30 per prescription (or less than 10 percent) on drugs "commonly taken" by seniors (GAO, 2002). Citing the GAO study, House Democrats charged that under the Administration's discount card proposal "seniors will receive meager



savings at best.” Administration officials responded that the volume of drugs included in the President’s plan would enable the Administration to negotiate larger discounts with participating drug companies (*Washington Post*, 1/4/02).

Given the partisan wrangling in Washington, D.C. on this admittedly interim step and the current national economic situation, it is highly unlikely in the short term that Congress will add a pharmacy benefit for seniors to Medicare. Budgetary constraints in Kansas also reduce the probability of a major pharmacy assistance initiative by state government. The need, however, persists. In fact, the number of people denied access to prescription drugs might grow as pharmaceutical costs continue to increase. The fiscal restrictions on federal and state governments may require an incremental, public-private solution that targets people of greatest need. The next section considers some private approaches to the problem.

#### **PRIVATE PHARMACY SUPPORT PROGRAMS**

A number of private organizations, including pharmaceutical companies, online pharmacies, and foundations offer assistance to individuals to gain access to medicines. Assistance may come in the form of free or discounted drugs or referral programs to help people access free or discounted medications.

#### **Patient Assistance Programs**

A November 2000 report from the U.S. General Accounting Office (GAO) found that nearly all large research-based drug companies and many smaller companies offer patient assistance programs that provide drugs at little or no charge to low-income people without prescription drug coverage. According to an industry profile published by the Pharmaceutical Research and Manufacturers of America (PhRMA)<sup>2</sup>, the number of persons receiving assistance through patient-assistance programs offered by the pharmaceutical industry increased by more than 50 percent from 1997 to 2000. These programs provided \$934 million of prescription drugs to 2.4 million people in 2000. (PhRMA, 2001a).

In general, these programs are intended to be short-term, last-resort options for people who otherwise lack access to necessary medications. Most programs require health care providers to be involved in applying for and receiving drugs for their patients. Applicants are required to provide information on income, necessary medications, and insurance status; program eligibility criteria vary between companies. The report concluded that pharmaceutical companies’ patient assistance programs “may provide valuable assistance to a small share of the uninsured population that complies with program procedures and meets program requirements” (GAO, 2000). Companies also

work with hospitals, community clinics, Federally Qualified Health Centers (FQHCs), non-profit access programs and others to obtain pharmaceuticals for indigent patients (PhRMA, 2001b).

#### **Discount Programs**

Individual pharmaceutical manufacturers, mail order pharmacies, national associations and non-profit organizations have implemented their own discount pharmacy programs. Novartis AG and GlaxoSmithKline PLC discount card programs, for example, are targeted at low-income, elderly persons, and require those receiving assistance to have no other prescription drug coverage. These programs only cover a limited number of medications. Non-profit organizations, such as the American Kidney Foundation, have teamed up with online pharmacies to offer discount card programs to their members. Some online pharmacy services offer discounts on products sold online as well as providing discount cards for drugs purchased at networks of local pharmacies. Non-profit organizations have formed in some states specifically for the purpose of providing discounts for the purchase of prescription drugs. One example is the Citizens Health Corporation, which was formed in 2001 and serves residents of Connecticut, Massachusetts and Rhode Island (NCSL, 2001a).

#### **Referral/Information Programs**

National and local organizations have also created programs to help those in need to access existing pharmacy assistance programs. National programs are sponsored by a variety of organizations including foundations, medical associations, advocacy organizations and pharmaceutical companies. Access to these programs is largely through the internet although phone access is sometimes available.

A local example is the Community Service Bureau in Wichita, Kansas. This program,

#### **National Online Information/Referral Sources**

**Rx** Online applications and information on both pharmaceutical company programs and state/federal programs are available at RxHope.com, sponsored by the Pharmaceutical Research and Manufacturers of America (PhRMA).

**Rx** A directory of all patient assistance programs offered by pharmaceutical companies that are members of PhRMA is available online at [www.phrma.org](http://www.phrma.org) or by calling 800-762-4636.

**Rx** RxAssist, supported by the Robert Wood Johnson Foundation, provides health care providers with information about and online applications for pharmaceutical companies’ assistance programs at [rxassist.org](http://rxassist.org).

**Rx** NeedyMeds.com has free information on patient assistance programs and contact information for nearly 200 programs.

<sup>2</sup> PhRMA is a trade association whose membership includes most large pharmaceutical companies and many smaller biotechnology drug companies.



supported by the Medical Society of Sedgwick County, United Way, Via Christi Regional Medical Center, Sedgwick County and others, helps low-income people access pharmaceutical industry assistance programs. In 1999, the bureau enrolled 776 people who received a total of 3,378 prescription medications and saved over \$477,000 through pharmaceutical industry programs.

### **POLICY ALTERNATIVES**

While it seems evident that many Kansans who need prescription drugs may not be able to pay for them, the actual number of elderly, chronically ill, and uninsured people in Kansas who require assistance is not known. Likewise, the consequences to the state of short and long-term restricted access to pharmaceuticals are unclear. For example, does the failure to obtain maintenance drugs for chronic conditions increase uncompensated care in the state's emergency rooms or push the uninsured working poor over the line into Medicaid? As is true of many areas of health policy-making, good research is lacking on the dimensions of this issue.

As this Forum Brief indicates, however, public and private resources are available to assist those in need to purchase prescription drugs. Typically these programs are means tested and/or limited to certain groups of people, such as the elderly. The extent to which these programs are effective at serving the people in greatest need is also unknown.

Anecdotal evidence, particularly among the elderly, seems to indicate that the need for pharmaceutical assistance persists. What is less clear is whether there are currently insufficient public and private resources available to help the elderly pay for prescription drugs, or whether there are barriers that prevent full use of existing programs. Potential barriers include knowledge of the existence of programs, complexity of application procedures, and program restrictions. The Kansas Health Institute Health Policy Forum scheduled for January 30, 2002 is intended as a first step in a process that may lead

to an assessment of the need for additional or changed pharmacy assistance programs in Kansas, and if a need is identified, to the development of public and private alternatives to address the problem. Policy questions to be addressed include:

- Who requires assistance in paying for prescription drugs? For whom is the need greatest?
- How should priorities be established? Should financial criteria or medical needs play the biggest role?
- How should the responsibility for improving access be shared between the public and private sectors?
- How well does the pharmacy assistance program in the Kansas Department on Aging work? Do more qualified clients request assistance than the program can handle?
- What private pharmacy assistance programs currently exist in Kansas? What services do they provide and are they effective in meeting the needs of Kansans?
- Is there effective local or statewide coordination to improve access to public and private pharmacy assistance programs?
- Is there a portion of the population of Kansas denied full access to pharmacy services even after accounting for participation in public and private pharmacy support programs?
- How best can the identified needs that still exist be met?

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*The contents of this brief are solely the responsibility of the authors and do not necessarily represent the views of the funding organizations.*

### **Glossary of Terms**

**Cost-Sharing:** Requires a health plan beneficiary to pay some portion of the medical or pharmaceutical cost. The term includes co-payments, deductibles, annual fees, and premiums.

**Maintenance Drug:** Medications used for long periods to control chronic conditions.

**Medicaid Rebate:** Under federal law, pharmaceutical manufacturers must enter in to rebate agreements with the federal government in order for the Medicaid program to cover their products. Rebates are given to states which effectively lower the cost of the drugs for Medicaid programs.

*Source: National Governors Association Center for Best Practices, Issue Brief, State Pharmaceutical Assistance Programs, May 10, 2001.*



## REFERENCES

Gross, David, *State Pharmacy Assistance Programs 2001: An Array of Approaches*, AARP Public Policy Institute, Issue Brief Number 50, July 2001.

Kansas Insurance Department, *Finding and Filling the Gaps: Developing a Strategic Plan to Cover all Kansans*, August 2001. Prepared by Duncan, R. Paul, et. al., Department of Health Services Administration, University of Florida.

Kreling, David H., David A. Mott, Joseph B. Wiederholt, *Prescription Drug Trends: A Chartbook Update*, Henry J. Kaiser Family Foundation, November 2001.

National Conference of State Legislatures (NCSL), *2001 Prescription Drug Discount, Bulk Purchasing, and Price-Related Legislation*, November 2001a.

National Conference of State Legislatures (NCSL), *State Pharmaceutical Assistance Programs*, November 2001b.

National Governors Association, *Chart on State Pharmaceutical Assistance Programs*, December 2001.

Neuman, Patricia, *Improving Prescription Drug Coverage: Opportunities and Challenges for Reform*, Henry J. Kaiser Family Foundation, for presentation to the Committee on Finance, The United States Senate, March 22, 2001.

Pharmaceutical Research and Manufacturers of America (PhRMA), *Pharmaceutical Industry Profile 2001: A Century of Progress*, 2001a.

Pharmaceutical Research and Manufacturers of America (PhRMA), *Directory of Prescription Drug Patient Assistance Programs 2001-2002*, 2001b.

Poisal, John A. and Lauren Murray, *Growing Difference Between Medicare Beneficiaries With and Without Drug Coverage*, Health Affairs, Volume 20, Number 2, March/April 2001.

Thomas, Cindy Parks, Grant Ritter and Stanley S. Wallack, *Growth in Prescription Drug Spending Among Insured Elders*, Health Affairs, Volume 20, Number 5, September/October 2001.

U.S. General Accounting Office, *Prescription Drugs: Drug Company Programs Help Some People Who Lack Coverage*, GAO-01-137, November 2000.

U.S. General Accounting Office, *Prescription Drugs: Prices Available Through Discount Cards and From Other Sources*, GAO-02-280R, January 2002.

### Appendix A

#### Public Pharmacy Support Programs: Major State Approaches

##### Type of Program

State	Direct Subsidy or Insurance	Discounts	Bulk Purchasing	Tax Credit
Arizona	X <sup>3</sup>			
Arkansas	X <sup>3</sup>			
California		X		
Connecticut	X	X		
Delaware	X			
Florida	X	X		
Illinois	X			
Indiana	X			
Iowa			X	
Kansas	X			
Maine	X	X	X	
Maryland	X	X		
Massachusetts	X		X	
Michigan	X <sup>1</sup>			X <sup>1</sup>
Minnesota	X			
Missouri	X <sup>3</sup>			X
Nevada	X <sup>2</sup>			
New Hampshire			X	
New Jersey	X			
New York	X			
North Carolina	X			
Oregon	X <sup>3</sup>			
Pennsylvania	X			
Rhode Island	X			
South Carolina	X			
Texas	X <sup>3</sup>			
Vermont	X	X	X	
Wisconsin	X <sup>3</sup>			
West Virginia		X		
Wyoming	X			

<sup>1</sup> Tax credit and direct benefit programs will end in late 2001 and be replaced by the insurance program.

<sup>2</sup> Replaced by insurance program in July 2001.

<sup>3</sup> Program not yet operational.

Sources: National Governors Association, 2001 and National Conference of State Legislatures, 2001b.

Von Oehsen III, William H., *Pharmaceutical Discounts Under Federal Law: State Program Opportunities*, May 2001. Prepared in conjunction with Marice Ashe and Kathryn Duke, Public Health Institute, Pharmaceuticals and Indigent Care Program, Oakland, CA.