

Will Price Control Legislation Satisfactorily Address the Issue of High Prescription Drug Prices?: Several States Are Waiting in the Balance for *PhRMA v. Concannon*

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Everywhere you look, the high cost of prescription drugs is making news.¹

I. INTRODUCTION

[S]eniors across the nation are searching for ways to cut their drug bills. They are buying drugs much more cheaply in foreign countries.²

A growing number of Americans who do not have a prescription drug benefit and have earnings too high to qualify for various state prescription drug programs have been rushing to Canada to fill their prescriptions.³ This phenomenon is especially true for senior citizens who qualify for Medicare but cannot afford to purchase supplemental insurance to cover the price of prescription drugs.⁴ States across the nation neighboring Canada have organized bus trips for the elderly to buy cheaper drugs in Canada; price limits imposed by the Canadian government have resulted in substantially lower prices.⁵ The National

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1. David Schwab, *The Issues Behind the Battle Over Drug Prices*, SEATTLE TIMES, June 3, 2001, at D1.

2. Marsha King, *Retirees making 'drug runs' for B.C.'s cheaper medicines*, SEATTLE TIMES, Dec. 8, 1999, at 1.

3. Maine Rx Express, *Join our Fight for Fair Prescription Drug Prices: Oh Canada*, at <http://www.rxmaine.com/home/index.cfm.html>. (last visited Jul. 29, 2002) [hereinafter *Oh Canada*].

4. King, *supra* note 2.

5. *Oh Canada*, *supra* note 3.

Council of Senior Citizens charters "Prescription Bus Trips" to Canada in response to the high cost of prescription drugs, and to make a statement about the high cost of drugs in the United States.⁶

Compelling stories illustrate the plight of those who are adversely affected by the soaring prices of prescription drugs. For example, a woman suffering from high cholesterol in Maine scrambled to pick up one of her cholesterol pills when she dropped it on the floor because she knew that money was running right out of her hands if the pill was not retrieved.⁷ Similarly, another woman was taking the prescription drug Tamoxifen for breast cancer and claimed the drug costs almost six times as much at her local pharmacy than it does in Canada.⁸

These situations illustrate why states across the United States are trying to find ways to make prescription drugs more affordable.⁹ States' efforts to provide prescription drug relief took on added importance in 2001 after Congress failed to reach a compromise on a federal program.¹⁰ However, in late August 2001, an announcement that the federal budget surplus had all but evaporated dashed hopes that a federal program will be funded.¹¹

One of the most controversial, yet most praised, solutions to exorbitant prescription drug prices comes from Maine; the first state in our nation to pass a price control law for prescription drugs.¹² The law is called the Maine Act to Establish Fairer Pricing for Prescription Drugs.¹³ The issue emerged in Maine out of concern that many citizens who were not Medicaid recipients could not afford necessary prescriptions.¹⁴ The bill that created the Act was also submitted in response to senior citizens traveling hundreds of miles to Canada to purchase prescription drugs.¹⁵ Meanwhile, the National Conference of

6. King, *supra* note 2.

7. Diana Graettinger, *Seniors Cross Border to Fill Prescriptions; Trek to Canada Protests High Drug Prices in U.S.*, BANGOR DAILY NEWS, Aug. 29, 2000, at 1.

8. *Id.*

9. See National Conference of State Legislatures, Health Care Program, 2001 Prescription Drug Discount, Bulk Purchasing, and Price-Related Legislation, at <http://www.ncsl.org/programs/health/drugdisc01.htm> (last updated June 27, 2002) [hereinafter NCSL 2001].

10. Evan Osnos, *Maine Fights Drug Costs; States Watch Suits Over Price Controls for Prescriptions*, CHI. TRIB. Sept. 2, 2001, at C1.

11. *Id.*

12. Me. Rev. Stat. Ann. tit. 22, § 2681 (2000).

13. 2000 Me. Laws 786 (S.P. 1026) (L.D. 2599).

14. *PhRMA v. Concannon*, 249 F.3d 66, 71 (1st Cir. 2001), *cert. granted*, *PhRMA v. Concannon*, 122 S.Ct. 2657 (2002).

15. Maine Rx Express, *Join our Fight for Fair Prescription Drug Prices*, at <http://www.rxmaine.com/home/index.cfm> (last visited July 29, 2002) [hereinafter Maine Rx Express]. Senior citizens are often the hardest hit by increasing prescription drug costs since they are the pharmaceutical industry's largest consumer. *Id.*

State Legislatures reported that thirty-four states have considered legislation in the past two years for discount, rebate, or price control programs that would limit prices in ways similar to new legislation adopted in Maine.¹⁶ In the year since Maine passed its law, price controls have been considered by legislators in over fourteen states.¹⁷ Maine's proposed solution is getting reactions from all over the country, but the legislation is on hold while the Act is being challenged by the pharmaceutical industry in *PhRMA v. Concannon*.¹⁸ The case is currently on appeal from the United States District Court of Maine, which held that Maine's price control law was constitutional.¹⁹ Many states await the final ruling to decide whether to adopt a prescription drug financing scheme modeled after Maine's recent legislation.

The problem is clear: Current prescription drug pricing methodologies across the nation are inadequate, and purchasing prescription drugs in Canada is not a long-term solution to the problem of escalating drug costs for the citizens of Washington State.²⁰ As a fellow northern border state with Canada, Washington should adopt similar legislation as the Maine Act in order to provide easy and affordable access to prescription drugs. Continuous tension over the last few decades between providing access to the latest efficacious treatments while controlling rising health spending makes this issue particularly important.²¹ In an effort to take responsibility for providing health care solutions, Washingtonians, and all Americans, are discovering how price controls work in Canada.²²

Section II of this Note will discuss Canada's prescription drug pricing scheme and why prescription drugs cost significantly more in the United States. Section III will discuss *PhRMA v. Concannon*,²³ including an analysis of the parties' arguments on price controls for prescription drugs. Section IV will illustrate that Washington's current role in the battle on prescription drug pricing is inadequate to provide accessible and affordable prescription drugs for its citizens. Section V concludes with the proposal that Washington adopt new legislation modeled after the Maine Act to Establish Fairer Pricing for Prescrip-

16. NCSL 2001, *supra* note 9.

17. *Id.*

18. 249 F.3d 66.

19. *Id.* at 85.

20. See *Oh Canada*, *supra* note 3.

21. J.D. Kleinke, Health Affairs: *Prescription Drug Coverage Policy*, 20(5) HEALTH AFFAIRS 43, 44 (2001).

22. E.g. Devidas Menon, *Pharmaceutical Cost Control in Canada: Does it Work?*, 20 HEALTH AFF. 92, 93 (2001).

23. *PhRMA*, 249 F.3d 66.

tion Drugs, which created the Maine Rx Program. In this manner, Washington would have a better methodology to make prescription drugs more affordable within its borders so that more citizens will have access to necessary treatments without having to travel into Canada in order to purchase less expensive prescription drugs.

II. PRESCRIPTION DRUG PRICING IN CANADA

A. *Why Are Prescription Drugs in Canada So Much Cheaper?*

Every American should get the same price that a Canadian gets for American-made drugs.²⁴

There is an overwhelming concern in the United States that prices of prescription drugs are too high.²⁵ This claim is based on the fact that Canadian drug prices are significantly lower than prices in the United States.²⁶ Moreover, politicians in the United States have proposed measures to lower the cost of American drugs to a price comparable to Canadian prices, an approach that is likely to be received favorably by American patients, consumers, and healthcare managers.²⁷

Canada has managed to keep its prescription prices low by imposing government controlled price restrictions.²⁸ Differences in prescription pricing can be attributed to the cost of research and development.²⁹ As a means for recovering this cost, manufacturers may charge different prices to different customers; "they often use measures of national income to guide them in setting their prices: higher income countries pay more."³⁰ The fact that Americans have become increasingly wealthier is a reason one would expect to see higher prices in the U.S.³¹ Further, pharmaceutical companies charge higher prices in the United States to compensate for the risk of litigation.³² Canadian

24. *Oh Canada*, *supra* note 3 (quoting Hilary Clinton, Address at Rochester, N.Y., Feb. 10, 2000).

25. John R. Graham & Michael Walker, *Commentary: Why are Drug Prices Lower in Canada?*, 6 AM. J. MAN. CARE 745, 745 (2000).

26. *Id.* In addition to brand-name drugs, less expensive generic drugs are offered in Canada that are not offered in the U.S. *Id.*

27. Graham & Walker, *supra* note 25, at 745.

28. *Oh Canada*, *supra* note 3.

29. Graham & Walker, *supra* note 25, at 746.

30. *Id.*

31. *Id.*

32. *Id.*

courts, however, do not experience the same superfluity of multibillion dollar liability suits.³³

Another heated issue currently being debated revolves around the drug industry's act of pushing new prescription medications on the American public through direct-to-consumer advertising. While this issue will be discussed later in this Note, the pharmaceutical industry spent over \$2 billion on television and magazine ads in 2000, which many consider a ploy to get consumers to ask their physicians for the latest, most expensive treatments.³⁴ This belief is supported by evidence that prescription drugs advertised to consumers are now the largest and fastest selling medicines.³⁵ Recent research documenting the trend in pharmaceutical spending revealed an escalation in the volume of prescriptions being distributed, and a shift to using newer drugs that are usually more expensive as the primary forces in the increase of prescription drug expenditures.³⁶ Consequently, many Americans are forced to look elsewhere for less expensive prescription drugs.

B. How Are Many American Citizens Purchasing Prescription Drugs in Canada?

It is no longer necessary to travel to Canada to purchase prescription medications at Canadian prices.³⁷

It is important to know how Americans purchase prescription drugs in Canada. First, they must have a prescription that is written or co-signed by a doctor licensed in Canada.³⁸ Accordingly, a number of U.S. doctors practicing medicine in border states are also licensed in Canada.³⁹ Citizens who receive prescriptions from Canadian doctors are able to have the prescription filled in a Canadian pharmacy.⁴⁰ Although each consumer is only allowed a six-month supply, it is legal to bring back or re-import prescriptions from Canada so long as they are for a patient's own use.⁴¹

33. *Id.*

34. Schwab, *supra* note 1.

35. Fred Charatan, *US [sic] Prescription Drug Sales Boosted by Advertising*, 321 BRIT. MED. J. 783 (30 Sept. 2000).

36. Health Net, *Prescription Drug Expenditures in 2000: The Upward Trend Continues*, 1 HEALTH CARE FOCUS 2 (2001).

37. RxPassport, *Services: Bulletin! A NEW System for the Seattle area!*, at 2.

38. *Oh Canada*, *supra* note 3.

39. *Id.*

40. *Id.*

41. *Id.*

Seniors have also purchased their prescriptions from Canada online.⁴² There are a handful of websites owned by Canadian pharmacies and other entrepreneurs where prescription drugs can be purchased online at a savings of 20% to 50%.⁴³ While customers from the U.S. enjoy a favorable exchange rate, ordering drugs online from Canada is illegal for U.S. citizens.⁴⁴ An exception to the rule is that citizens can import three months of prescriptions from Canada for personal use if the same medications are not available in the United States.⁴⁵ Nevertheless, online pharmacies fill prescriptions for many U.S. citizens.⁴⁶

Purchasing necessary medications in Canada, or other low-cost foreign countries, is only a temporary solution. And, not all drugs are cheaper outside the U.S. For example, generic drugs in Canada are often more expensive than generic drugs in the U.S.⁴⁷ "The Canadian Institute for Health Information reported recently that . . . spending on drugs now surpasses every other area of health care spending except hospital services", including spending on doctor's services.⁴⁸ Although drug expenditures continue to rise in Canada, price control measures have been effective.⁴⁹

C. Why Are U.S. Drug Costs So Much Higher than Canada?

The overall evidence is that U.S. prices are by far the highest in the world.⁵⁰

Prescription drug costs are rising twice as fast as inflation, and the pharmaceutical industry is the most profitable industry in the

42. *Id.*

43. *Id.*

44. *Id.*

45. *Id.*

46. *Id.*

So far U.S. authorities have been looking the other way since the Federal Drug Administration is primarily concerned with large commercial shipments and doesn't have the manpower to monitor individual shipments. While it is currently legal in Canada for pharmacies there to fill prescriptions for U.S. citizens, some authorities are looking to tighten the rules.

Id.

47. Graham & Walker, *supra* note 25, at 745.

48. Shelley Martin, *Canadians Continue to Spend More on Drugs Than Doctors*, 164 J.A.M.C. 1336 (May 2001).

49. Menon, *supra* note 22, at 99.

50. Dana A. Elfin, *Drug Cost Debate Continues: Industry Opposes Price Controls*, 11 THE BUREAU OF NAT'L AFF. 484 (May 12, 2000) quoting Alan Sager, professor at Boston University's School of Public Health.

world.⁵¹ In 1999, the cost of prescription drugs went up a record 17.4% over the previous year, and similar increases are forecasted for coming years.⁵² “Americans spent \$132 billion on prescription drugs [in 2000] - an increase of \$20.8 billion dollars (18.8%) over 1999.”⁵³

The National Institute for Healthcare Management Foundation’s 2001 study of prescription drug expenditures revealed that the overall rise in spending was attributable to three key factors: (1) utilization, (2) price, and (3) changes in the types of drugs used.⁵⁴ Statistics of the aforementioned factors have shown a 42% increase in the number of prescriptions written by doctors, while price increases and a shift toward prescribing more expensive drugs have increased spending by 58%.⁵⁵

Prescription utilization increased 53% from 1992-2000, compared to a U.S. population growth of only 10%.⁵⁶ Additionally, prescription prices reflect manufacturer price changes for existing drugs and changes to newer and more expensive drugs, increasing on an average of 6.7% a year over the last decade.⁵⁷ Availability of the newer, top-selling brand name drugs is affected by research and development activities conducted by manufacturers and the National Institute of Health.⁵⁸ Although research and development as a percentage of prescription drug sales has remained relatively stable since the 1980s,⁵⁹ research and development spending increased \$14 billion from 1988-1998.⁶⁰ These trends indicate that factors such as increasing prescription use, rising prices, and growing reliance on newer, high-priced brand name drugs have all contributed to the growth in spending for

51. Betsy Z. Russell, *State Looks at Plan to Fight Drug Prices; Under measure, States Would For Coalition to Negotiate Savings*, SPOKESMAN-REVIEW, Mar. 10, 2001, at B1.

52. *Id.*

53. Fred Charatan, *U.S. Spending on Prescription Drugs Rose by 19% in 2000*, 322 BRIT. MED. J. 1198, 1198 (2001).

54. NAT’L INST. OF HEALTH CARE MGMT., *PRESCRIPTION DRUG EXPENDITURES IN 2000: THE UPWARD TREND CONTINUES*, 11 figure 6 (May 2001), at: <http://www.nihcm.org/spending2000.pdf> (last visited July 31, 2002) [hereinafter NIHCM].

55. *Id.* at 2. The foundation reported that manufacturer price increases for existing drugs account for 22% of the overall increase in prescription spending from 1999-2000. An increase in the number of prescriptions dispensed accounted for 42% of the overall increase. Changes in the types of drugs used, with new high-priced drugs replacing old less-expensive drugs, accounting for 36% of the increase. *Id.* at 11 figure 6.

56. *Id.* at 9.

57. THE KAISER FAMILY FOUND., *PRESCRIPTION DRUG TRENDS: A CHARTBOOK*, 2 (July 2000), at <http://www.kff.org/content/2000/3019/PharmFinal.pdf>.

58. *Id.* at 49.

59. *Id.* at 57, ex. 3.22.

60. *Id.* at 56, ex. 3.21.

prescription drugs.⁶¹ Moreover, aging factors into a person's individual prescription use⁶² and plays a significant role in the national growth in average prescription utilization.⁶³

Advertising, however, is a major factor affecting prescription drug utilization and the shift to higher-priced drugs.⁶⁴ Consequently, "as the government has allowed more advertising of brand-name drugs, more citizens have sought prescriptions."⁶⁵ In 1999, for example, approximately "55 million people talked with doctors about prescription drugs they saw advertised."⁶⁶ During that year, the pharmaceutical industry spent \$13.9 billion on promotions alone.⁶⁷ Since 1995, spending for direct-to-consumer advertising for newer, higher-priced drugs has more than tripled.⁶⁸ Television advertising was 12 times greater in 1998 than in 1995, reaching \$664 million.⁶⁹ Since increased advertising prompts an increase in demand for higher priced medications, it will in turn, lead to an increase in the cost of prescription drugs.

While the growth in advertising has played a role in rising prescription drug costs,⁷⁰ there are additional contributing factors, for instance, medications as front-line therapy in treating illness.⁷¹ Increasingly, people take more drugs for health conditions that were once treated with surgery and long hospital stays.⁷² And, increased drug use raises concerns regarding the overall costs and affordability of prescription drugs nationwide.⁷³

61. NIHCM, *supra* note 54, at 11 figure 6.

62. *Id.* at 10. People between the ages of 65–74 use 4 times as many prescription drugs as those between 25–34. *Id.*

63. *Id.* (citing a study from Brandeis University indicating that between 1996 and 1999 the number of new drug users rose "fastest among 45 to 64 year olds while the number of prescriptions per person was rising fastest among people aged 65 and over.").

64. Fred Charatan, *supra* note 35.

65. Pat Thibaudeau & Alex Deccio, *Making Prescription Drugs Affordable*, SEATTLE TIMES, Feb. 25, 2000, at B5.

66. *Id.*

67. Frank Davidoff, *Editorial: The Heartbreak of Drug Pricing*, 134 (11) ANNALS OF INTERNAL MED. 1068 (5 June 2001). Spending on promotions "included about one drug "detail" salesperson for every 10 U.S. doctors, \$2 billion on direct-to-consumer advertising, and more than \$7 billion in "free" drug samples." *Id.*

68. THE KAISER FAMILY FOUND., PRESCRIPTION DRUG TRENDS, (Sept. 2000), at: <http://www.kff.org/content/2000/3057/PrescriptionDrugsFactSheetPDF.pdf> (last visited July 31, 2002).

69. *Id.*

70. *Id.*

71. Thibaudeau & Deccio, *supra* note 65.

72. Elfin, *supra* note 50, at 486.

73. THE KAISER FAMILY FOUND, *supra* note 68.

Prescription drug costs in the U.S. are the greatest driver of health care inflation nationwide, rising twice as fast as health care costs in general.⁷⁴ “The numbers are even more striking when compared to the industry’s overall profitability.”⁷⁵ For instance, in 1999 the industry achieved a profit of 18.6% on \$125 billion sales “a larger profit margin than most other sectors of the U.S. economy.”⁷⁶ Measures must be taken to control prescription drug costs. The task, therefore, “is twofold: (1) to curb the growth of state spending on prescription drugs without compromising the quality of care”, and (2) provide a method “for ways to help our older citizens find affordable prescriptions” legally.⁷⁷

III. PHRMA V. CONCANNON—MODEL LEGISLATION?

A. Summary of the Case

On May 11, 2001, the Act to Establish Fairer Pricing for Prescription Drugs established the Maine Rx Program.⁷⁸ The bill creating the statute was enacted in response to the escalating number of senior citizens traveling hundreds of miles on bus trips to buy cheaper prescription drugs in Canada.⁷⁹ With prescription drug costs rising at an average of 18-19% in the U.S.,⁸⁰ many people were forced to choose between paying for their medications or for essential items such as food, utilities and rent.⁸¹ “The problem is especially severe for senior citizens, many of whom are on fixed incomes, because Medicare does not cover the prescription costs.”⁸² The Maine Legislature was concerned that citizens who were not Medicaid recipients would not be able to afford necessary prescription drugs.⁸³

The essential problem shared by Maine and many other states is, “given the rising cost of prescription drugs, how [to] extend access to those drugs for people who don’t have private insurance but earn too

74. Thibaudeau & Deccio, *supra* note 65.

75. Davidoff, *supra* note 67, at 1068.

76. *Id.*

77. Thibaudeau & Deccio, *supra* note 65.

78. Me. Rev. Stat. Ann. tit. 22, § 2681 (2001). This “program” was established to reduce prescription drug prices for residents of Maine. *Id.*

79. Maine Rx Express, *supra* note 15.

80. NIHCM, *supra* note 54, at 2.

81. Congressman Tom Keefe, *An Investigation of Prescription Drug Price Disparity in the 5th Congressional District of Washington*, at <http://www.tomkeefe.org/html> (last visited Jul. 24, 2002).

82. *Id.*

83. *PhRMA v. Concannon*, 249 F.3d 66, 71 (1st Cir. 2001).

much to qualify for Medicaid."⁸⁴ Maine's mandatory drug rebate program was created to address this problem.⁸⁵

Under the Program, the State serves as a pharmacy benefit manager by establishing manufacturer rebates and pharmacy discounts to reduce prescription drug prices to consumers.⁸⁶ The Act authorizes the Commissioner of Maine's Department of Health Services to negotiate rebate agreements with manufacturers so that participating Maine pharmacies can offer prescription drugs at a discounted price.⁸⁷ Proceeds raised from rebate payments are deposited into a special fund used to reimburse pharmacies offering discounted prescription drugs to consumers.⁸⁸ All Maine residents who enroll in the Program are eligible to purchase prescription drugs from participating pharmacies at this discounted rate.⁸⁹

Although pharmacy involvement in the Program is voluntary, non-participating manufacturers and labelers are subject to pre-authorization restrictions on their products.⁹⁰ The State Medicaid administrator cannot authorize a drug to be dispensed that is subject to prior authorization to a Medicaid beneficiary without approval.⁹¹ Additionally, the Act provides that manufacturers who do not enter into rebate agreements with the Commissioner will have their names released to health care providers and the public.⁹² Manufacturers who fail to achieve certain price reductions by July, 2003 will also be subject to state controls.⁹³

Pharmaceutical Research & Manufacturers of America (*PhRMA*) brought suit in the United States District Court of Maine against the Commissioner of the Maine Department of Human Services and the Maine Attorney General alleging that the Act violated the dormant Commerce Clause and was preempted by the federal Medicaid Statute

84. Wayne J. Guglielmo, *Rx Price Controls: Maine Gets a Go-Ahead*, MED. ECON., July 9, 2001 at 23-24.

85. *Id.* at 23.

86. Me. Rev. Stat. Ann. tit. 22, § 2681(1) (2001).

87. *PhRMA*, 249 F.3d at 71. When negotiating the rebate, the Commissioner is to take in to account the rebate amount calculated under the Federal Medicaid Program, 42 U.S.C. § 1396r-8 (2001), and to use "best efforts" to obtain a rebate in the same amount. *PhRMA*, 249 F.3d at 71; see also Me. Rev. Stat. Ann. tit. 22, § 2681(4)(A)-(C), and § 2681(5) (2001).

88. *Id.*

89. *Id.*

90. Me. Rev. Stat. Ann. tit. 22, § 2681(7). The drugs of all noncompliant manufacturers are subject to the prior authorization requirements in the State Medicaid program. *Id.*

91. *PhRMA*, 249 F.3d at 72.

92. *Id.* at 71-72.

93. Guglielmo, *supra* note 84, at 23-24.

under the Supremacy Clause.⁹⁴ The District Court issued a preliminary injunction and found the Act unconstitutional on both grounds, holding that (1) the Act had an extraterritorial reach in that it regulated out-of-state revenues received by pharmaceutical manufacturers from out-of-state distributors, thereby violating the dormant Commerce Clause and (2) the Act was preempted by the Supremacy Clause because it conflicted with the purpose of the federal Medicaid program.⁹⁵

However, a three-judge panel sitting for the First Circuit Court of Appeals in Boston, concluded that Maine's Rx Program to establish Fairer Pricing for Prescription Drugs was constitutional.⁹⁶

B. The Circuit Court's Reasoning

To determine the validity and constitutionality of the Maine Act the 1st Circuit court conducted a four-part analysis including the issues of (1) standing, (2) preemption, (3) the dormant Commerce Clause, and (4) other preliminary injunction factors.⁹⁷ First, the court reviewed the question whether *PhRMA* had prudential standing to challenge the prior authorization provision of the Act.⁹⁸ Because the interests to be protected in this case were created by the Supremacy Clause and not by the federal Medicaid statute, the court concluded that *PhRMA* had prudential standing.⁹⁹ The Third Circuit recently opined that an entity seeking the protection of the Supremacy Clause does not need prudential standing.¹⁰⁰ In this regard, the court established that *PhRMA* could assert the rights of Medicaid recipients in this action so long as it had prudential standing grounded in the Supremacy Clause.¹⁰¹

94. *PhRMA*, 249 F.3d at 72.

95. *Id.*

96. *Id.* at 85.

97. *Id.* at 72-85.

98. *Id.* at 72-74. The Supreme Court held that to have prudential standing, a plaintiff must fall within the relevant "zone of interest," which is determined by discerning the interests "adequately" to be protected by the statutory provision and whether the plaintiff's affected interests are among them. *Nat'l Credit Union Admin. v. First Nat'l Bank & Trust Co.*, 522 U.S. 479, 492 (1998) citing *Data Processing Service Organization, Inc. v. Camp*, 397 U.S. 150, 153 (1970).

99. *PhRMA*, 249 F.3d at 73-74.

100. *Id.* at 73 (quoting *St. Thomas-St. John Hotel & Tourism Ass'n, Inc. v. Government of the U.S. Virgin Islands*, 218 F.3d 232, 241 (3d Cir. 2000)).

101. *PhRMA*, 249 F.3d at 74. When a party has standing to challenge the lawfulness of a statute, it is "entitled to assert those concomitant rights of third parties that would be 'diluted or adversely affected; should [its] constitutional challenge fail and the statute[] remain in force.'"

Second, the court considered whether the Maine Act was facially subject to implied conflict preemption under the Supremacy Clause.¹⁰² While a federal law may expressly or impliedly preempt state law under the Supremacy Clause, only implied conflict preemption was at issue in this case.¹⁰³ The court did not consider express preemption because the Medicaid statute did not contain explicit language, forbidding the Maine Act.¹⁰⁴ Implied preemption may be "field" or "conflict"; here the court addressed "conflict" preemption. To resolve the implied preemption question, the court scrutinized the state regulation to ascertain if it was consistent with the Medicaid statute by examining the structure and purpose of the statute in its entirety.¹⁰⁵ The court found no conflict between the Maine Act and Medicaid's structure and purpose because the policy of both Acts were consistent—to provide medical services to those who do not have sufficient resources to subsidize these services on their own,¹⁰⁶ while reducing Medicaid expenditures by making prescription drugs more accessible to the uninsured.¹⁰⁷

The court further noted that the letter and intent of the Medicaid statute does not prevent states from imposing prior authorization requirements, but explicitly permits it.¹⁰⁸ As such, the Maine Act incorporated the requirements of the Medicaid program by explicitly stating that prior authorization requirements would be imposed in the Medicaid program to dispense prescription drugs.¹⁰⁹ After holding

Id. (citing *Craig v. Boren*, 429 U.S. 190, 195 (1976) (quoting *Griswold v. Connecticut*, 381 U.S. 479, 481 (1965))).

102. *PhRMA*, 249 F.3d at 74 quoting U.S. Const. art. VI, cl. 2, "stating that federal law 'shall be the supreme law of the Land . . . any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.'" *Id.*

103. *PhRMA*, 249 F.3d at 74.

104. *Id.* at 74 n. 6 (quoting *Grant's Dairy-Me., LLC v. Comm'r of Me. Dep't of Agric., Food & Rural Res.*, 232 F.3d 8, 15 (1st Cir. 2000)). Express preemption applies when "a federal statute explicitly confirms Congress's intention to preempt state law and defines the extent of that preclusion." The court noted the doctrine of implied "field" preemption did not apply because Medicaid is a cooperative federalism program so Congress explicitly allows some room for State law. *PhRMA*, 249 F.3d at 74 n. 6 (citing *Gade v. Nat'l Solid Waste Mgmt. Ass'n*, 505 U.S. 88, 98 (1992)).

105. *PhRMA*, 249 F.3d at 74–79.

106. *Id.* at 78.

107. *Id.* at 75. The court reasoned that when people cannot afford to purchase necessary medication, their conditions could worsen, forcing them into poverty and right into the hands of the Medicaid program at a higher cost of treatment, which could have been prevented had earlier more affordable services been available in the beginning. *Id.*

108. *Id.* at 75 (citing 42 U.S.C. § 1396r-8(d)(1)(A)).

109. *PhRMA*, 249 F.3d at 75. The court read the language in the Act to limit its application to circumstances in which prior authorization is acceptable under Medicaid. *Id.*

that the Maine Act was not preempted by the federal Medicaid statute, the court addressed the dormant Commerce Clause question.¹¹⁰

Under the dormant Commerce Clause, states are prohibited from acting in a way that burdens the flow of interstate commerce.¹¹¹ To determine whether a statute violates the dormant Commerce Clause, at least one of several levels of analysis applies, depending on the state legislation's effect and reach.¹¹² Here, the court reviewed all three: (1) when a state statute has an extraterritorial reach it is a per se violation of the Commerce Clause;¹¹³ (2) when a state statute discriminates against interstate commerce, a strict scrutiny analysis is applied, whereby a state statute will be per se invalid unless the state can show that a legitimate local purpose will not be adequately served by any reasonable nondiscriminatory alternative;¹¹⁴ and (3) when a state statute regulates independently and only has incidental effects on interstate commerce, a lower standard of scrutiny is applied under a balancing test.¹¹⁵ Respondents contended that the Maine Act was per se violative of the Commerce Clause, while appellants asserted that the Act independently regulated an in-state matter that merely had an incidental effect on interstate commerce.¹¹⁶

The court, therefore, considered both levels of analysis.¹¹⁷ As to per se invalidity, it did not agree with the respondent that the Maine Act had an extraterritorial reach on matters outside the state.¹¹⁸ The court concluded that the Maine Act did not regulate the price of transactions outside the state either by its "express terms or inevitable effect,"¹¹⁹ and it did not impose controls on out-of-state transactions.¹²⁰

While the respondent asserted that the effect of the Act would be to regulate transactions between manufacturers and wholesalers, which are out-of-state activities, the court reasoned that an incidental negative effect on manufacturers' profits did not amount to a regulation of those profits.¹²¹ Nor did the court find that the Act interfered

110. *Id.* at 79.

111. *Id.* (citing *Okla. Tax Comm'n v. Jefferson Lines, Inc.*, 514 U.S. 175, 179–180 (1995)).

112. *PhRMA*, 249 F.3d at 79.

113. *PhRMA*, 249 F.3d at 79 (citing *Healy v. Beer Inst.*, 491 U.S. 324 (1989)).

114. *PhRMA*, 249 F.3d at 79 (citing *Or. Waste Sys., Inc. v. Dep't of Envtl. Quality of Or.*, 511 U.S. 93, 100–01 (1994)).

115. *PhRMA*, 249 F.3d at 80 (citing *Pike v. Bruce Church, Inc.*, 397 U.S. 137, 142 (1970)).

116. *PhRMA*, 249 F.3d at 80.

117. *Id.*

118. *Id.* at 82.

119. *Id.* at 81.

120. *Id.* at 81–82.

121. *Id.* at 82. The court noted that the Act did not regulate transactions between manufacturers and wholesalers, but amounts to a "best efforts" obligation on the part of the Commis-

with regulations in other states; the Act did not regulate prices, but simply negotiated rebates.¹²² The court reasoned that all activities regulated by the Act occurred in the state, which included: the purchase of prescription drugs to trigger the rebate; the negotiation of a rebate amount; and the subjection of a manufacturer's drug to prior authorization, as well as, the release of the manufacturer's name to health care providers and the public.¹²³ Thus, the regulation of these in-state transactions could not amount to an extraterritorial reach so the Act was not per se invalid under the Commerce Clause.¹²⁴

The court concurred with the State that the Act regulated evenhandedly and had only incidental effects on interstate commerce.¹²⁵ The court opined that there was a presumption in favor of the validity of the Act that would be upheld unless it imposed a burden on interstate commerce that was excessive in relation to the putative local benefits.¹²⁶ In this regard, the court undertook a lower level of scrutiny, known as the *Pike* balancing test,¹²⁷ to balance the nature of the putative local benefits promoted by the Act against the burden it placed on interstate commerce, and to determine whether the burden was "clearly excessive" as compared to the putative local benefits.¹²⁸ The court found that the enforcement of the Act could negatively impact manufacturers' profits but did not find an excessive burden on interstate commerce when compared to the local benefits.¹²⁹ It was concluded that the local benefit of providing increased access to prescription drugs outweighed the possible burden on interstate commerce of lost profits for manufacturers.¹³⁰

In its final analysis, the court gave deference to the constitutional notion of federalism, favoring a state's right to experiment with social

sioner to negotiate an initial rebate amount equal or greater than the rebate offered under Medicaid. Essentially, the Act seeks to offer a negotiated rebate agreement between a manufacturer or labeler that sells prescription drugs in the low-cost drug program in Maine. *Id.*

122. *Id.* at 82.

123. *Id.*

124. *Id.* at 82-83.

125. *Id.* at 84.

126. *Id.* at 83-84 (quoting *Pike*, 397 U.S. at 142 (1970)).

127. *PhRMA*, 249 F.3d at 83-84. Courts undertake this balancing approach when a legitimate local interest is found, making the question one of degree. The extent of the burden that will be tolerated depends on the character of the local interest involved and whether it can be advanced with a low impact on interstate transactions. *Id.*

128. *Id.*

129. *Id.* at 84. The court recognized the difficulty in foreseeing what could arise from the enforcement of the Act, which is why a *Pike* balancing test of the possible effects rather than the actual effects the Act was applied. *Id.*

130. *Id.*

and economic matters without risk to the rest of the nation.¹³¹ In essence, Maine could be viewed as a laboratory for which this new Act, if adopted, could serve as a model for similar legislation in other states.¹³²

C. The Parties' Views on the Maine Rx Program

1. The Opponents' View: A Bad Idea for Patient Welfare and Innovation

As a spokesman for the pharmaceutical industry, *PhRMA* labeled the Maine Rx Program a "bad idea" and encouraged other states not to follow the Maine Model.¹³³ Although *PhRMA's* constitutional challenge was unsuccessful, the pharmaceutical industry remains steadfast in its campaign against employing the Maine Rx Program, as well as other programs that seek to impose price controls on prescription drugs.¹³⁴

One of the industry's main concerns is that a prior authorization requirement places an administrative burden on physicians and patients by interfering with the delivery of Medicaid services.¹³⁵ It maintains that the Maine Rx Program creates a high likelihood of harm from improper medication prescriptions, which unnecessarily burdens physicians, and creates needless inconvenience for Medicaid recipients.¹³⁶ Furthermore, prior prescription drug authorization without considering safety or efficacy could lead to more prescriptions that are less safe and efficacious.¹³⁷

131. *Id.* at 85.

132. *Id.*

133. *States Should Reject the Maine Price Control Law as Bad for Patients and Bad for the Economy* at <http://www.phrma.org/press/newsreleases/2000-06-20.44.phtml> (last visited July 29, 2002) [hereinafter *Reject*].

134. *Id.*

135. *PhRMA*, 249 F.3d 66 at 76.

136. *Id.* at 77–78. *PhRMA* contends that the Maine Rx Program will harm Medicaid recipients by inhibiting access to their physician's first-choice medications. The district court agreed, and concluded that the Maine Act conflicted with the Medicaid provision setting forth a general requirement provision that a state Medicaid plan contain safeguards to assure that care and service will be provided consistently with the "best interests of the recipients." *Id.* at 77 quoting 42 U.S.C. § 1396a(a)(19). The Court of Appeals, however, did not find sufficient basis for concluding that the Maine Act facially controverts the Medicaid goal of "best interests." *Id.* at 78.

137. *Id.* at 78.

Another concern is that research and development will be negatively affected.¹³⁸ While the pharmaceutical industry is extremely profitable, it asserts that substantial profits are crucial to the industry's research and development efforts; the average cost to research and develop one new drug is \$500 million,¹³⁹ taking on average twelve to fifteen years to reach the market.¹⁴⁰ Extensive and costly research is required before the benefits of a new drug are known.¹⁴¹ Additionally, many new drug developments fail after considerable costs are incurred, including time value and fiscal support.¹⁴² For these reasons, intractable problems arise when developing price controls because methodology cannot rest on independent, predictable standards such as the costs or benefits of specific drugs.¹⁴³ The pharmaceutical industry contends that without objective standards, incentives would be created for price regulators to decrease drug costs toward marginal costs of production and delivery, which is significantly below adequate levels to reward innovative research.¹⁴⁴

Consequently, the downward biased price setting device would apply with specific force to the few successful schemes that produce innovative prescription drugs, whose prices would not be predetermined by regulatory authorities until after research and expenditures are incurred and the new drugs can be sold.¹⁴⁵ The pharmaceutical industry believes that drug manufacturers would expect price controls to reduce the potential gains from new and improved drugs, which could substantially decrease incentives to pursue innovative research.¹⁴⁶ In effect, "price control systems . . . tend to create disincentives for innovative products; they are systems that tend to shelter older medicines, and tend to disincentivize new medicines."¹⁴⁷

In essence, the pharmaceutical industry argues that price controls do not work because they result in decreased access and rationing of necessary drugs, and they slow the development of new and improved,

138. John E. Calfee, *Pharmaceutical Price Controls and Patient Welfare*, 134 ANNALS OF INTERNAL MED. 1060, 1060 (2001).

139. *Id.* at 1061. The \$500 million dollar figure takes into consideration the costs of researching a particular drug, including the drug failures that lead up to the development of that drug, as well as inflation. Elfin, *supra* note 51, at 484-85.

140. Elfin, *supra* note 50, at 484.

141. Calfee, *supra* note 138, at 1060-61.

142. *Id.* at 1061.

143. *Id.* at 1061-62.

144. *Id.* at 1062-63.

145. *Id.* at 1062.

146. *Id.* at 1062-63.

147. Elfin, *supra* note 50, at 485 (quoting Shannon Herzfeld, senior Vice President, International Affairs, at PhRMA).

cost-effective drugs.¹⁴⁸ For these reasons, the pharmaceutical industry claims that the Maine Act does not really help those that lack prescription drug coverage, but harms those waiting for new developments and treatments to help cure diseases.¹⁴⁹ Furthermore, the Act would enable state bureaucrats to decide which drugs are best for patients rather than doctors, resulting in an obstruction of the doctor-patient relationship.¹⁵⁰

According to the pharmaceutical industry, the solution to providing more accessible and affordable prescription drugs is not a patchwork of state price control proposals that attempt to slow the development of new and better prescription drugs.¹⁵¹ The solution, they believe, is found in the adoption of federal legislation that would attenuate insurance coverage to those without it.¹⁵² In other words, the pharmaceutical industry strongly supports congressional action that expands drug coverage for those with a substantial need, such as seniors and disabled citizens, by providing a choice of private-sector plans.¹⁵³ This solution would help patients who need access to currently developed drugs without harming patients who need access to drugs not yet developed.¹⁵⁴

2. The Proponents' View: A State-Based Policy Solution for Affordable Prescriptions

Without the Maine Rx Program, many needy citizens would continue to be deprived of necessary medical care due to rising prescription drug costs.¹⁵⁵ Given that affordability is crucial in providing access to prescription drugs,¹⁵⁶ proponents of the Maine Rx Program assert that "this kind of innovative, state-based policy solution is the only practical way of winning fair prescription prices for millions"¹⁵⁷ of American citizens. Affordable drugs increase accessibility, which enhances the overall health of many citizens, encourages healthy communities, and protects public health and welfare.¹⁵⁸

148. *Reject*, *supra* note 133.

149. *Id.*

150. *Id.*

151. *Id.*

152. *Id.*

153. *Id.*

154. *Id.*

155. *PhRMA v. Concannon*, 249 F.3d 66, 84 (1st Cir. 2001).

156. Me. Rev. Stat. Ann. tit. 22, § 2681(1) (2001).

157. Maine Rx Express, *supra* note 15.

158. Me. Rev. Stat. Ann. tit. 22, § 2681(1) (2001).

Furthermore, price controls will dampen the effects of price discrimination, which often escalates drug prices at the expense of those who rely on prescription drugs in order to maintain healthy lives.¹⁵⁹ Drug manufacturers' pricing strategy "victimize those Americans who are least able to afford it."¹⁶⁰

As a result of this price discrimination, larger purchasers with market power, such as Health Maintenance Organizations (HMO's) and government customers, are able to purchase their drugs at lower prices while senior citizens, who often have the greatest need and the least ability to pay, must pay the highest prices.¹⁶¹

With prescription drug costs rising, many citizens are forced to choose between paying for their drugs and for life essentials such as food, bills, and rent.¹⁶² This is especially problematic for senior citizens who are not receiving necessary drugs because Medicare does not cover the cost of prescriptions.¹⁶³ The problem is even worse for rural seniors because they are 60% less likely to get necessary drugs, and when they do receive these drugs, they are often times 25% more expensive.¹⁶⁴

As a result, many citizens are forced to cross the border into foreign countries like Canada to purchase the prescription drugs they need.¹⁶⁵ The Maine Act will ease this burden, while significantly lowering the costs in this country.

Finally, proponents of the Maine Rx Program contend that the pharmaceutical industry benefit from the implementation of price controls.¹⁶⁶ As the most profitable industry in the world, "it can easily absorb a modest slowdown in the rate of revenue growth without compromising its own vigor or the overall quality of health care."¹⁶⁷ While the industry argues that price controls would negatively impact research and development for more effective and better quality drugs, "of the nine U.S. companies that manufactured the fifty top-selling drugs, eight spent more than twice as much on advertising, marketing,

159. Congressman Bernard Sanders, *Legislation: Three Bills Push for Prescription Drug Pricing Reform*, at <http://www.Bernie.house.gov/prescriptions/index.asp> (last visited July 23, 2002).

160. *Id.*

161. *Id.*

162. *Id.*

163. *Id.*

164. *Id.*

165. Sanders, *supra* note 159.

166. See Davidoff, *supra* note 67, at 1070.

167. *Id.*

and administrative costs than they did on researching new drugs.”¹⁶⁸ The pharmaceutical industry, which evidently will not lower prescription drug costs, has plenty of financing to overwhelm the media with their advertising.¹⁶⁹

With the highest profit margin in the world, the pharmaceutical industry is clearly in the business of making money. Because the industry allocates nearly comparable amounts of its 19% profit margin to both advertising and research,¹⁷⁰ a decrease in the amount spent on advertising could be achieved without a significant loss in the drive for developing the latest and most efficacious medications.¹⁷¹ Even though profits may suffer from a decrease in aggressive advertising, the huge profit margin realized by the pharmaceutical industry leaves plenty of latitude to continue funding research and development. In other words, the reduction in revenue expected by the industry as a result of price control, could be compensated for by taking profits that are used in advertising and putting it toward research and development.

Lowering drug prices rather than increasing advertising to fix their public image may be the right move for the industry, especially because the industry lacks a positive public image.¹⁷² Additionally, a cut in drug prices might actually increase industry revenues.¹⁷³ Both Merrill Lynch and the New England Journal of Medicine have re-

168. *Prescription Drug Coverage Policy*, HEALTH AFF. 61 (Sept./Oct. 2001), at <http://130.94.25.113/readeragent.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v20n5/s8.pdf> (last visited July 31, 2002). The pharmaceutical industry runs millions of dollars in newspaper, television, and radio advertisements. In addition, the pharmaceutical industry spends more money on campaign contributions and lobbying than any other industry. During the 2000 election cycle, for example, it contributed approximately \$4.4 million to Democrats (a 66% increase over the 1998 election cycle) and approximately \$14.9 million to Republicans (a 141% increase over the 1998 election cycle). Center for Responsive Politics, at <http://www.opensecrets.org/industries/Indus.asp?ind=H4300> (last visited July 28, 2002). Total contributions to Congress were \$4.6 million. *Id.* at <http://www.opensecrets.org/industries/summary.asp?Ind=H4300&cycle=2000&recipdetail=A&sortorder=U>. (last visited July 23, 2002).

169. Congressman Bernard Sanders, *Prescription Drug Pricing Reform, Help Fight the High Cost of Prescriptions*, at <http://bernie.house.gov/prescriptions/index.asp>. (last visited July 23, 2002).

170. For example, in 1999 the industry spent approximately \$14 billion on promotion alone and about \$20 billion on the overall costs of development. Davidoff, *supra* note 67, at 1068; see also Luke Timmerman, *Demand, Marketing Drive Up Drug Price*, SEATTLE TIMES, April 28, 2002, at A26 (stating that the pharmaceutical industry is the most profitable industry in the world with a profit margin at 18.5% in 2001 with \$20.8M on R&D and \$30M on advertising).

171. Elfin, *supra* note 50.

172. Davidoff, *supra* note 67, at 1070.

173. D.Z. Jackson, *Drug Price Cuts Won't Kill Industry*, 22 BOSTON GLOBE, Sept. 22, 2000, at A27.

ported that price cuts in the proposed 40% range will be more than compensated for by increased sales volume.¹⁷⁴ In this regard, states like Washington would benefit from enacting price control legislation for its citizens.

IV. WASHINGTON'S ROLE IN THE BATTLE ON PRESCRIPTION DRUG COSTS

I compared the cost of the top ten prescription drugs in Washington State to the cost of the same drugs in Canada. What I found was outrageous—seniors would save an average of 64% by purchasing their drugs in Canada.¹⁷⁵

The word is out, and more and more Washington residents seem to be making the trip to Canada to cash in on the savings attributed to the lower costs of prescription drugs.¹⁷⁶ According to RxPassport, Washington has experienced a flow comparable to Maine of citizens traveling across the border to receive cheaper prescription drugs.¹⁷⁷

For example, Washington citizens have organized bus trips to Canada to purchase their prescriptions. Additionally, prescription drug systems in Washington State such as RxPassport help residents gain access to affordable drugs through physicians and pharmacies in Canada.¹⁷⁸ Since its inception in 2000, RxPassport has reportedly helped Americans save between 40-80% on their prescription drugs.¹⁷⁹ While the program initially required U.S. citizens to travel to Canada to have their prescriptions authorized by a Canadian physician, it has been updated under a new system called Cross Border Rx Services, making travel to Canada no longer necessary.¹⁸⁰ This system allows citizens in the Seattle area to purchase their prescriptions in the state through a licensed physician who may order prescriptions from Canada.¹⁸¹ The quality and cost of the new program is reportedly equal to

174. *Id.*

175. *Oh Canada*, *supra* note 3, (quoting Slade Gorton, former U.S. Senator of Washington State).

176. Rx Passport, *Your American Right to Affordable Medication*, <http://www.rxpassport.com/services/services.html> (paraphrasing a quote by Ross McLaughlin, KIRO 7 Eyewitness News) (last visited August 30, 2002).

177. *Id.*

178. *Id.*

179. *Id.*

180. *Id.*

181. *Id.*

the previous program, without the added inconvenience and expense of traveling to Canada.¹⁸²

Despite the benefit this system offers to Washington residents, there must be a more permanent solution to the high costs of prescription drugs. Washington needs a state-based policy solution so residents no longer need to go through channels in a foreign country to buy their necessary prescriptions.

The need for a new plan in Washington is clear considering that an estimated one in five Washington residents do not have prescription drug insurance, forcing them to pay the maximum cost for their prescriptions.¹⁸³ Furthermore, medical advances have increased utilization as well as prescription prices, compelling thousands of residents to dig deeper and deeper into their pocketbooks to pay for these life-prolonging drugs.¹⁸⁴

Prescription drugs' rising costs also put pressure on the state to increase expenditures to meet the health care needs of lower-income families.¹⁸⁵ In this regard, there are dual pressures facing the state to make prescription drugs more affordable for its neediest citizens, while trying to control the cost of providing the most vital prescription drugs.¹⁸⁶

A. What Has Washington Proposed to Combat the High Price of Prescription Drugs? Is It Enough?

One in four Washington residents have no prescription drug insurance, and, as a result, pay top dollar for their prescriptions.¹⁸⁷

Concerned about the implications of rising drug costs, the Washington Legislature has reviewed a number of proposals to determine what can be done to control cost increases. While other states offer subsidy programs for prescription drugs, Washington has been beset

182. *Id.*

183. Beth Silver, *Debate Over Drug Costs Heats Up*, THE NEWS TRIBUNE, February 14, 2001, at A1. An estimated 1.25 million people (1 in 5 Washington residents) are without prescription drug coverage, almost half of which are seniors. *Id.*; see Senator Rosa Franklin, *Senate Calls For Regional Strategy to Reduce Prescription Drug Costs*, at <http://.sdc.wa.gov/franklin.htm>.

184. *The Bottom Line on PRESCRIPTION DRUG COSTS*, at <http://www.sdc.wa.gov/Issue%20Briefs/bottomlineprescriptiondrugcosts.pdf> (last visited August 30, 2002).

185. *Id.* During the 1999-2000 state budget period, for example, about 25% of the state's general fund (about \$5 billion) went toward the purchase of health care services. Furthermore, total general fund spending on health care is expected to increase 20% during the next biennium to \$6 billion. *Id.*

186. *Id.*

187. Franklin, *supra* note 183.

by unique circumstances, such as double-digit inflation in health care and the Initiative 601 spending cap, which called for a creative solution.¹⁸⁸ First, the State proposed The Washington Pharmacy Access Program,¹⁸⁹ which would create a prescription drug insurance plan for people who are aged sixty-five and older or disabled. The program provides that enrollees would pay premiums and make subsidies available to low-income seniors. Second, the Bulk Purchasing Study¹⁹⁰ calls for researching the feasibility of consolidating the purchase and distribution of prescription drugs for certain state-funded programs. Third, there is a proposal for an Aggregate Purchasing Prescription Drug Discount Program,¹⁹¹ which directs the State to consolidate drug purchasing for all its health care and other programs, and provides citizens aged fifty-five and older with eligibility for discounts negotiated with manufacturers. Fourth, the Regional Purchasing Plan,¹⁹² which calls upon northwestern states to investigate the feasibility of managing prescription drug prices through cooperative strategies, passed both houses during the 2002 regular session and has been filed with the Secretary of State.¹⁹³ It must be noted, however, that the aggregate purchasing program and the bulk purchasing plan did not pass muster in the House.¹⁹⁴

Finally, and perhaps most importantly, Governor Gary Locke's AWARDS Discount Program attempted to provide discounts to residents aged fifty-five and older who do not have a prescription drug benefits.¹⁹⁵ For an annual fee of \$15 per individual and \$25 per family, enrollees would receive a card allowing them to purchase prescriptions at discounted prices through a prescription drug buyer's club.¹⁹⁶

188. Robert L. Jamieson Jr., *Rx for Cutting Drug Costs of Seniors*, SEATTLE POST-INTELLIGENCER, Aug. 30, 2000 at 2; see <http://seattlep-i.nwsource.com/local/drug30.shtml>.

189. Substitute Senate Bill 5030, available at: <http://www.leg.wa.gov/pub/billinfo/2001-02/Senate/5025-5049/5030-s.pdf> (last visited July 30, 2002).

190. Senate Bill 5027, available at: <http://www.leg.wa.gov/pub/billinfo/2001-02/Senate/5025-5049/5027.pdf> (last visited July 30, 2002).

191. Senate Bill 5026, available at: <http://www.leg.wa.gov/pub/billinfo/2001-02/Senate/5025-5049/5026-s.pdf> (last visited July 30, 2002).

192. Senate Joint Memorial 8001, available at: http://www.leg.wa.gov/pub/billinfo/2001-02/Senate/8000-8024/8001_pl.pdf (last visited July 30, 2002).

193. *Id.*

194. Senator Rosa Franklin, *Senate Calls For Regional Strategy to Reduce Prescription Drug Costs*, at <http://sdc.wa.gov/franklin.htm> (last visited July 30, 2002).

195. The Washington State Department of Health, *AWARDS Program Prepares to Sign Up Seniors*, at http://doh.wa.gov/Publicat/2000_News/Awards.html. (last visited Jul. 23, 2002).

196. *Id.* If enrollees go to participating pharmacies, they will get discounts ranging from 12 percent to 30 percent. If they use mail service, on the other hand, they may receive an even bigger discount ranging from 20 percent to 49 percent. *Id.*

Enrollees' purchases at participating pharmacies would be merged with the buying power of the state Uniform Medical Plan to buy drugs at significantly lower costs.¹⁹⁷ The AWARDS program was challenged by pharmacists claiming the AWARDS program was unfair and would have forced them to provide discounts that would have put them out of business.¹⁹⁸ The program was overturned in June, 2001, by Superior Court Judge Richard Strophy as beyond the authority of the Health Care Authority.¹⁹⁹

The AWARDS program had several problems.²⁰⁰ Although the AWARDS program was a good first-step, it was the "wrong prescription" for Washington because it placed the financial burden of discounts entirely on community retail pharmacies.²⁰¹ Additionally, the governor's proposed operating budget provided no fiscal support to pay for discounts offered under the program.²⁰² The program would have operated at no cost to the state.²⁰³ As a result, "community pharmacists [were] expected to provide the discounts out of their pockets."²⁰⁴ Eighty-five percent of a prescription's retail price comes from manufacturer's costs,²⁰⁵ and 3% of the price comes from the wholesaler.²⁰⁶ After additional costs of rent, salaries, insurance, taxes, etc., pharmacists would receive only a net 3.4% profit.²⁰⁷ Consequently, pharmacists could not possibly remain in business if they

197. Governor Gary Locke, *Establishing a Washington State Alliance to Reduce Prescription Drug Spending "AWARDS" Program*, Exec. Order No. 00-04, available at: http://www.governor.wa.gov/eo/eo_00-04.htm (last visited Jul. 24, 2002).

198. *Judge Says No to Drug Program*, THE SEATTLE POST-INTELLIGENCER, May 26, 2001 at 1 (citing Coalition for Affordable Prescriptions for Seniors v. State of Washington, State of Washington, No. 01-2-00525-9 (Thurston Co. Super. Ct. 2001)); see Angela Galloway, *Discount Drug Program for Seniors Ruled Illegal*, at http://seattlepi.nwsource.com/local/24836_drugs26.shtml (last visited August 12, 2002).

199. Galloway, *supra* note 198. "[T]he executive branch lacks the authority to implement the program without statutory authority. On June 22 the judge noted that state agency has authority to 'implement joint purchasing strategies' that have 'potential application to all state-purchased health services.' Because AWARDS 'does not involve state purchased health services and therefore exceeds the authority' in state law." National Conference of State Legislatures, *Health Care Program: State Pharmaceutical Assistance Programs*, at: <http://www.ncsl.org/programs/health/drugaid.htm> (last modified July 18, 2002).

200. See Senator Linda Evans Parlette, *AWARDS program is wrong prescription for Washington*, SEATTLE-POST INTELLIGENCER, Jan. 9, 2001 at 1; see <http://www.src.wa.gov/news/pr/2001/parlettege010401.htm>, at 1 (last visited August 12, 2002).

201. *Id.*

202. *Id.*

203. *Id.*

204. *Id.*

205. *Id.*

206. *Id.*

207. *Id.*

were expected to subsidize prescription drug discounts.²⁰⁸ The AWARDS program seemed to be a damaging quick fix that could have destroyed any chance of producing its intended result: providing access to affordable drugs.²⁰⁹

Other options for reducing drug prices and controlling expenditures within Washington State include a national proposal to expand Medicaid's prescription benefit to seniors, and a state-based policy solution that would impose price controls on prescription drugs so that they are offered at discounts to all citizens of the state.²¹⁰

Whatever the final solution may be, one thing remains certain: Washington State can, and must, proactively address the real problem of skyrocketing prescription drug prices.²¹¹

B. Is the Maine Program a Solution for Combating High Prescription Drug Prices in Washington State?

Although the 'Maine Rx Law' is the most comprehensive prescription drug price control bill to be signed into law . . . price control bills have been proposed . . . or enacted in 16 other states.²¹²

While the federal government takes its time in deciding how to solve the problem of escalating prescription drug costs, states are beginning to address the problem themselves.²¹³ Maine was the forerunner. Obviously, a state-adopted policy does not solve the problem for all Americans, but it is a good solution for the citizens of Washington State.

The fundamental reason why Washington should adopt price control legislation is the same for every state in America—citizens want relief from high prescription drug costs. Additionally, no other proposal in Washington State has passed without much explanation from state legislators except that they were the "wrong prescription."²¹⁴ Because Maine's price control program is different from the other proposed programs, it may finally be the right prescription.

208. *Id.*

209. *Id.*

210. *The Bottom Line on PRESCRIPTION DRUG COSTS*, at <http://www.sdc.wa.gov/Issue%20Briefs/bottomlineprescriptiondrugcosts.pdf> (last visited July 30, 2002).

211. Parlette, *supra* note 200.

212. NCSL 2001, *supra* note 9. Nineteen state legislatures considered price control bills between the years 1999 and 2001. *Id.*

213. Locke, *supra* note 197.

214. See Parlette, *supra* note 200.

First, proponents of price controls claim that it is an innovative state-based policy solution to provide fair prescription prices for millions of citizens.²¹⁵ A state solution will provide more immediate results for citizens rather than a federal solution. Citizens want relief, and they want it now. More importantly, it makes a difference where citizens buy their prescription drugs.

Second, local pharmacists are more knowledgeable about the needs of their individual patients, decreasing the risks of improper dosing and mixing of incompatible drugs.²¹⁶ Generally, community pharmacists know their customers' health history and out-of-state distributors do not.²¹⁷ Furthermore, even though a state program may not result in prescription drug prices equivalent to those available in other areas, including Canada, it will at least lower prices enough to make it less economical to travel far from home.

Third, proponents claim that price controls will dampen the effects of price discrimination, which often escalates drug prices at the expense of those who rely on prescription drugs in order to maintain healthy lives.²¹⁸

Finally, proponents contend that the pharmaceutical industry stands to benefit by the implementation of price controls.²¹⁹

Several states are aware of the clear advantages of a price control system, and they plan to adopt similar legislation to the Maine Rx Program when the dust settles from *PhRMA v. Concannon*.²²⁰ Although state-level price controls will lead to price disparities between states, any legislation on a state-by-state basis will inevitably lead to disparities. The issue of fairer pricing for prescription drugs is clearly a nationwide problem, but it is up to individual states to decide what is best for their own citizens.²²¹ The best solution in Washington State for combating the high price of prescription drugs is to adopt price control legislation modeled after the Maine Rx Program.

215. Maine Rx Express, *supra* note 15.

216. Parlette, *supra* note 200.

217. *Id.*

218. See Keefe, *supra* note 81.

219. Jackson, *supra* note 173.

220. Physicians For a Nat'l Health Prog., *Court Rules in Favor of Maine Rx Price Controls*, at: http://www.pnhp.org/Press/2001/court_rules6_4_01.htm (last visited Jul. 25, 2002).

221. *Becker v. United States Marine Co.*, 88 Wn.App. 103, 107-08, 943 P.2d 700, 703 (Div. 1 1997).

V. CONCLUSION

Now that the appeals court has wiped away the stigma of unconstitutionality, we expect the Maine approach to move like wildfire across the country.²²²

Many states have been waiting for a court decision in Maine to see what the future holds for fair-pricing legislation.²²³ National interest is high due to concerns about the lack of insurance coverage for prescriptions, particularly for the elderly, and rising spending for drugs.²²⁴ Price increases for drugs currently on the market, increased prescription utilization, and reliance on newer, more expensive drugs have all contributed to growth in spending.²²⁵ "[S]pending on prescription drugs [in the U.S.] is expected to continue to rise rapidly, reaching \$243 billion by 2008."²²⁶ Meanwhile, "drug costs in 2001 are expected to continue to increase at double-digit rates",²²⁷ rising twice as fast as inflation.²²⁸ With these increases, policy makers will likely continue to be pressured to address cost concerns.

The implications of rising drug prices are alarming. In the absence of some form of price control measure, higher cost sharing and reduced drug benefits are likely.²²⁹ Furthermore, many insurance companies that do offer coverage for some prescription drugs may reduce or eliminate that drug coverage altogether to compensate for rising costs.²³⁰ As a result, the health and well being of many Americans will be jeopardized due to inability to afford their prescription drugs. Consequently, American borders will continue to be crowded with people seeking to purchase cheaper prescriptions in other countries. These results are not only inconvenient, but also unnecessary.

222. Physicians For a Nat'l Health Prog., *supra* note 220 (citing Center for Policy Alternatives, *Alternatives* 9 (Summer 2001)).

223. *Id.*

224. THE KAISER FAMILY FOUNDATION, *supra* note 57.

225. *Id.*

226. *Id.*

227. Bernard Mehl & John Santell, *Projecting Future Drug Expenditures- 2001*, 58 AM. J. HEALTH-SYST. PHARM. 125 (Jan. 15, 2001).

228. Russell, *supra* note 51, at B1.

229. Jason S. Lee & Laura Tollen, *How Long Can you Go? The Impact of Reduced Benefits and Increased Cost Sharing*, HEALTH AFFAIRS, June 19, 2001, at P1.

230. It is alarming that 30% of Medicare beneficiaries lack any prescription drug coverage, and those without insurance coverage pay the highest price for prescriptions. This is because insurance companies possess the bargaining power to require discounts with pharmacies in their system, something uninsured individuals cannot do. See Stephen R. Smith, M.D., M.P.H., *Prescription Drug Costs*, at http://www.brown.edu/courses/Bio_Community_Health_7/review/Rx_Webpaper.html#Ref5 (last visited August 12, 2002).

During the 2000 election campaign, the prescription drug cost crisis was a major issue nationally and within Washington State.²³¹ While there have been several proposals to cut prescription drug costs, nothing has received as much attention as the Maine Rx Program. It not only provides a solution for the nation's elderly who are the primary consumers of prescription drugs, but it also assists many uninsured and indigent citizens. In this regard, the Maine Rx Program promotes the overall health and well being of citizens by affording them the opportunity to receive a health benefit.

Although Washington State has seen its fair share of prescription cost-cutting proposals, it should adopt legislation modeled after the Maine Rx Program to provide better access to more affordable prescription drugs for all citizens.

231. See, e.g. NCSL 2001, *supra* note 9.