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CAPITOL RESEARCH

INTERSTATE COMPACTS

Prescription Drug Abuse and the Need for Multi-State Cooperation

Prescription drug abuse continues to be recognized as the nation's fastest-growing drug problem. Data from the 2009 National Survey on Drug Use and Health indicated that nearly one-third of people age 12 and older who used drugs for the first time started by using prescription drugs for nonmedical purposes.[1]

The latest Monitoring the Future Study from the University of Michigan indicated that prescription drugs are second only to marijuana in their frequency of abuse. In Kentucky, the rate of overdoses from prescription drugs doubled among men and tripled among women between 2000 and 2009. In Florida, estimates have suggested that as many as seven people are dying daily from accidental overdoses. Deaths from prescription drug overdoses are the leading cause of accidental death in 17 states.[2]

At the center of the prescription drug epidemic are Schedule II-V pharmaceutical products (See page 2). The Office of National Drug Control Policy 2007 National Drug Control Strategy emphasizes the importance of stricter and more uniform methods of monitoring, directly and indirectly, the prescribing and sale of these controlled substances.

These drugs increasingly are being diverted for illicit purposes. In many cases, patients who have legally obtained drugs from their physicians are illegally selling or giving them to others. According to the 2009 National Survey on Drug Use and Health, approximately 70 percent of misused prescription drugs were obtained from a friend or relative, rather than more nefarious methods.[3]

The Next Step

The scope of the epidemic led the Obama administration to call for a renewed emphasis on reducing prescription drug abuse. The administration's ambitious plan, released in April 2011, aims to curb prescription drug abuse by cracking down on doctors who are overprescribing and pain clinics — known as pill mills — where prescription drugs are easy to obtain and requiring drug manufacturers to develop education programs aimed at doctors and patients. The plan also calls for every state to develop a prescription monitoring program and encourages states to begin sharing prescription drug data.[4]

According to the National Alliance for Model State Drug Laws, 40 states have operational prescription monitoring programs and another eight states have enacted enabling legislation.[5] Despite the advancement of prescription monitoring programs, much work remains. An interoperable system that permits information sharing among the various state monitoring programs is likely to be the most reliable and effective means of assuring these medicines are properly distributed.

Along those lines, two groups have developed different proposals over the last 18 months that would allow states to begin sharing prescription drug data on an interstate basis. The National Association of Boards of Pharmacy developed the NABP Prescription Monitoring Program (PMP) Interconnect. The NABP Interconnect is designed to facilitate interstate data sharing among state prescription

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What are Schedule II, III, IV and V Controlled Substances?

The U.S. Drug Enforcement Agency assigns prescription drugs to one of five controlled substances categories based on the drug's potential to be abused and to cause psychological or physical dependence. Schedule I substances have a high potential for abuse but are not currently used for accepted medical treatment in the U.S.; examples include LSD and heroin. Schedules II-V are described below. All drugs assigned to these schedules have currently accepted medical treatment uses in the U.S.

SCHEDULE II

- high potential for abuse, which may lead to severe psychological or physical dependence
- examples: Oxycontin®, Percocet®, morphine, methadone, amphetamine

SCHEDULE III

- less potential for abuse than Schedule II drugs
- abuse may lead to moderate or low physical dependence or high psychological dependence
- examples: anabolic steroids, Vicodin®, ketamine, codeine or hydrocodone combined with aspirin or Tylenol®

SCHEDULE IV

- low potential for abuse compared to Schedule III drugs
- abuse of the drug may lead to limited physical dependence or psychological dependence relative to those in Schedule III
- examples: Valium, Xanax, Darvocet®, most prescription sleeping pills or prescription diet pills

SCHEDULE V

- low potential for abuse relative to Schedule IV drugs
- abuse of the drug may lead to limited physical dependence or psychological dependence relative to those in Schedule IV
- examples: Lyrica®, Lomotil®, some non-prescription drugs such as pseudoephedrine (in some states) or cough medicines with codeine

Source: "Definition of Controlled Substances". U.S. Department of Justice, Drug Enforcement Administration. Accessed on 1/30/12. *http://www.deadiversion.usdoj.gov/schedules/*

drug monitoring programs and can be implemented through memorandums of understandings between states and the National Association of Boards of Pharmacy.[6]

The second proposal is known as the Prescription Monitoring Program Compact. Developed by The Council of State Governments' National Center for Interstate Compacts, this model functions much the same way as the Interconnect, while also providing a legal framework for enforcement and dispute resolution traditionally found in interstate compacts.

A Short-Term Solution

The Interconnect represents a significant first step in the effort to allow states to share prescription drug data across state lines in real time. To date, 13 states have signed memorandums of understanding with the Boards of Pharmacy allowing them to participate in the Interconnect. Connecticut, Indiana, Michigan, Ohio and Virginia are now participating in the system, with the other member states scheduled to begin live participation as soon as possible.[7] This represents a significant accomplishment, and for the first time, ensures that prescription drug data is being securely shared across state lines.

In order to join the Interconnect, states sign memorandums of understanding directly with the National Association of Boards of Pharmacy. Through the memorandums, each state agrees to participate in the Interconnect system and to investigate reports of prescription drug abuse within member states. At the same time, the NABP ensures that each member state's rules for accessing prescription drug data are being enforced and followed.[8]

While this method is efficient and has allowed states to participate in the Interconnect quickly and without legislative approval, the use of memorandums of understanding to facilitate interstate cooperation carries some inherent risks.

Memorandums are traditionally agreements between administrative agencies and do not require legislative approval. That allows them to be adopted and dissolved much more quickly than some of the other mechanisms of multistate cooperation. Something as common as the change of gubernatorial administration or a state administrative agency head leaving office can spell the end for such an agreement. In addition, memorandums frequently do not include the administrative system of checks and balances frequently found in interstate compacts. Without a well-developed governance structure or a clear means for resolving disputes between member states, memorandums of understanding often face significant challenges when disagreements arise between states.

A Permanent Solution

While the Interconnect represents a significant first step in the effort to ensure multistate cooperation to fight prescription drug misuse and abuse, a more permanent solution likely exists in the Prescription Monitoring Program Compact. The compact addresses issues specific to prescription drug data sharing, such as:

- Who is authorized to use prescription drug data;
- The technological requirements to ensure data is securely shared; and
- The way Commission activities will be funded.

Additionally, the compact ensures that each member state retains control and sovereignty over its existing prescription monitoring program, while also being able to share data across state lines. In these respects, the compact is very similar to the Interconnect.

But the compact mechanism also provides states a number of additional advantages. With a clearly defined governance structure, mechanisms in place to resolve disputes and a committee structure capable of allowing the compact to evolve over time, the Prescription Monitoring Program Compact has a level of sustainability that cannot be guaranteed by any other interstate prescription drug data sharing system.

Equally important, the compact allows for flexibility and necessary adjustments through the promulgation of rules and the reliance on committees to address specific issues. With a heavy reliance on technology to ensure data is shared in real time, the methods for sharing prescription drug data today are likely to change over time. To that end, any mechanism that shares prescription drug data must allow for flexibility to meet technological change.

By their very nature, interstate compacts do just that. Compacts ensure that states can act jointly to solve an immediate problem, while continuing to work cooperatively well into the future as the scope and nature of the problem change. In that respect, the Prescription Monitoring Program Compact is likely to be the most viable long-term option for states seeking a way to securely share prescription drug data.

REFERENCES

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[4]"Epidemic: Responding to America's Prescription Drug Abuse Crisis." *http://www.whitehouse.gov/sites/default/files/ondcp/issues-content/prescription-drugs/rx_abuse_plan.pdf*. Accessed on 1/26/12.

[5]National Alliance for Model State Drug Laws. "Status of State Prescription Drug Monitoring Programs." *http://www.namsdl.org/documents/StatusofStates011112.pdf*. Accessed on 1/26/12.

[6]National Association of Boards of Pharmacy. "NABP PMP InterConnect." *http://www.nabp.net/programs/pmp-interconnect/nabp-pmp-interconnect/index.php*. Accessed on 1/26/12.

[7]Ibid

[8]Ibid

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For more information on interstate compacts, visit ***http://www.csg.org/ncic/***

Status of State Prescription Drug Monitoring Programs

State	Legislation Enacted	Program Operational
Alaska	Enacted	Operational
Arizona	Enacted	Operational
Arkansas	Enacted	—
California	Enacted	Operational
Colorado	Enacted	Operational
Connecticut	Enacted	Operational
Delaware	Enacted	—
District of Columbia	—	—
Florida	Enacted	Operational
Georgia	Enacted	—
Hawaii	Enacted	Operational
Idaho	Enacted	Operational
Illinois	Enacted	Operational
Indiana	Enacted	Operational
Iowa	Enacted	Operational
Kansas	Enacted	Operational
Kentucky	Enacted	Operational
Louisiana	Enacted	Operational
Maine	Enacted	Operational
Maryland	Enacted	—
Massachusetts	Enacted	Operational
Michigan	Enacted	Operational
Minnesota	Enacted	Operational
Mississippi	Enacted	Operational
Missouri	—	—
Montana	Enacted	—
Nebraska	Enacted	—
Nevada	Enacted	Operational
New Hampshire	Pending	—
New Jersey	Enacted	Operational
New Mexico	Enacted	Operational
New York	Enacted	Operational
North Carolina	Enacted	Operational
North Dakota	Enacted	Operational
Ohio	Enacted	Operational
Oklahoma	Enacted	Operational
Oregon	Enacted	Operational
Pennsylvania	Enacted	Operational
Rhode Island	Enacted	Operational
South Carolina	Enacted	Operational
South Dakota	Enacted	—
Tennessee	Enacted	Operational
Texas	Enacted	Operational
Utah	Enacted	Operational
Vermont	Enacted	Operational
Virginia	Enacted	Operational
Washington	Enacted	Operational
West Virginia	Enacted	Operational
Wisconsin	Enacted	—
Wyoming	Enacted	Operational
TOTAL	**48 Enacted**	**40 Operational**

Source: National Alliance for Model State Drug Laws. http://www.namsdl.org/documents/StatusofStates011112.pdf. Accessed on 1/26/12.