REPORT OF THE
JOINT COMMISSION STUDYING

PRESCRIPTION DRUG ASSISTANCE

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 32

COMMONWEALTH OF VIRGINIA
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I. AUTHORITY FOR STUDY

The 2001 Session of the General Assembly passed House Joint Resolution No. 810 (Appendix A) creating a joint commission to develop ways and means to provide prescription drug assistance to needy senior citizens and to coordinate state and federal programs providing such assistance. In conducting its study, the commission was requested to examine (i) the best ways to provide prescription drug assistance to those elderly Virginians who cannot afford to purchase such assistance on their own; (ii) the current scope of coverage, or lack thereof, in major programs including Medicare and Medicaid; (iii) proposed federal legislation and the most efficient manner in which the Commonwealth may coordinate its programs with future federal programs to provide prescription drug assistance; and (iv) such other matters as are relevant to the Commission's objectives.

After much deliberation by the commission and in consideration of the status of the state budget, the commission requested to be continued for an additional year. House Joint Resolution No. 90 of the 2002 Session continued the study and added additional responsibilities, including consideration of (i) the feasibility of strengthening the Commonwealth's pharmacy purchasing ability for state programs; (ii) using the savings generated to create and fund a pharmacy benefits program for low-income and uninsured elderly persons; and (iii) pursuing cooperative arrangements with other states to pool pharmacy purchases.

II. COMMISSION RECOMMENDATIONS

First Year Recommendations

During the first year of the study, the commission concentrated on reviewing and evaluating all other working prescription assistance programs as well as proposed federal legislation for the Medicare program. With the state facing an anticipated $1 billion shortfall in revenues and a recognized need to adopt a plan that would offer a composite solution that would utilize a variety of approaches in order to maximize the number of persons that the State could help, the commission made four recommendations to the General Assembly:

- In order to assist those with the least resources, the commission recommended that the eligibility level for Medicaid for the elderly and disabled be raised from 80 percent to 100 percent of the federal poverty level. A bill was introduced to amend the state plan for medical assistance services since the federal plan already allows states to include persons up to 100 percent of poverty. The bill was left in House Appropriations.

- Expand the Pharmacy Connect program to all area agencies on aging, including providing software and other materials for training, to maximize the use of the compassionate drug programs offered by various pharmaceutical companies that provide free drugs to eligible populations. The estimated cost would be approximately $200,000 for each Area Agency on Aging (AAA) for personal and nonpersonal expenses and would be in addition to the current program in operation in Mountain Empire Older Citizens ($371,000). Total cost = $4.8 million in additional funding. The budget amendment failed.
- Amend the provision adopted in the 2001 Session of the General Assembly that provides for the Virginia Department of Health to set up a hotline to advertise and facilitate the use of the free drug programs and also provide information about the various discount cards currently being offered by some pharmaceutical companies for eligible populations. The legislation passed but was amended to include a delayed effective date contingent upon appropriations becoming available. The original program has the same contingency clause.
- Extend the study for an additional year. This resolution, House Joint Resolution No. 90, passed.

Second Year Recommendations

As the State anticipated an additional $1.5 billion shortfall in revenues in 2002-2003, the commission and staff worked to create a plan that, while not a comprehensive prescription assistance plan as originally envisioned, would serve to promote and enhance the utilization of existing programs and opportunities.

The program would likely consist of three elements:

- **Identification** of those persons who may be eligible for either Medicaid or for the free or discounted pharmaceutical card programs. This could be accomplished by identifying a core state agency likely to have such qualifying information that could then be shared with a designated state entity or grant program as well as utilizing community resources that might have direct contact with eligible persons and could act as a conduit of information.
- **Implementation** of a public/private partnership to fund an office that will develop a statewide system to enroll eligible seniors in the various drug benefit programs available in the state. Given the advantage that the Commonwealth has by virtue of having a pharmacy school in Richmond, consideration would also be given to the development of a pharmaceutical warehouse program that would provide easier access to the compassionate drug programs and facilitate dispensing of such drugs.
- **Expansion** of the program would hinge on the regular **evaluation** of the program by a designated agency/secretariat that has the responsibility for developing the program.

Most of these proposals were incorporated into House Bill 2225 (Delegate Cline)/Senate Bill 1341 (Potts) in the 2003 Session of the General Assembly (Appendix B). The legislation also directed the Joint Commission on Health Care to continue to examine the potential and feasibility of creating a state prescription drug assistance program.

House Joint Resolution No. 90 (2002), directed the commission to consider the feasibility of expanding the Commonwealth's pharmacy-purchasing ability for state programs through, for example, bulk purchasing, accessing volume discounting, or cooperative arrangements with other states to pool pharmacy purchases, and to consider using any savings generated to fund the prescription assistance program for seniors. The commission discussed many of these opportunities during the first year of its work and felt that many of the options needed further evaluation before making any recommendations. However, because the Governor's office and the Secretary of Health and Human Resources were also directed by budget language to examine and make recommendations on these proposals, the commission did not make any recommendations. The commission did provide input and received updates on the ongoing studies by these other entities.

III. SUBCOMMITTEE WORK

In Virginia in 2001, the Medicare-eligible population numbered about 930,000, with about 400,000 of those without any form of prescription assistance plan to help with the medical costs. Approximately 530,000 Virginians have some form of prescription coverage, either through Medigap policies, managed care coverage, employer-sponsored coverage, or Medicaid, but many of these policies cover only a fraction of the costs. (See the following table). Over 1 million Virginians do not have health insurance and more than half of those have incomes less than 200 percent of the federal poverty level (FPL)(approximately $18,000 for an individual). A majority (67%) of these people work ful time. Individuals whose income is above 200% of the federal poverty level represent an increasing number of the uninsured population (50% in 2000 compared to 34% in 1996). More than 162,000 persons in Virginia who are eligible for Medicare have income below 200% FPL and do not have prescription drug coverage.

Pharmaceutical Statistics[1]

- Prescription drug spending was an estimated 8.5% of total health spending in the U.S. in 2000 compared to 5.4% in 1990.
- Spending on retail outpatient prescription drugs is rising - just how much depends on to whom you talk. An analysis by Scott-Levin in "Prescription Drug Expenditures in 2000" estimates a rise of 18% from 1999 to 2000, from $111.1 billion to $131.9 billion (not including inpatient use); the Health Care Financing Administration (HCFA), now the Center for Medicare and Medicaid Services (CMS,) projected a total of $116.9 billion for 2000; a third study by IMS Health of CT cited $145.1 billion.
- The U.S. has 53,000 pharmacies with 128,000 pharmacists and in 2000 they filled approximately 3.15 billion individual prescriptions. This converts into an estimate of 10.4 prescriptions per person in 2000, up from 9.9 in 1999.

[1] *Pharmaceuticals*, National Conference of State Legislatures, updated June 14, 2002.

- The average per capita spending in the U.S. on prescription drugs was $346 in 1998.
- Total pharmaceutical spending in the U.S. was expected to exceed $141.8 billion in 2001and increase to approximately $160 billion in 2002.
- Costs increased at an estimated 16.4 percent in 2001.
- Some state-funded programs have experienced a 30% percent increase for a single year.

VIRGINIA

Insurance Coverage and Income Distribution for State Medicare Eligible Population, 2001

Towers Perrin prepared for PhRMA, Aug. 2001

Beneficiaries in 000s	INCOME DISTRIBUTION[1]									
COVERAGE TYPE	All Incomes (Norm)[2]	< 50% FPL[3]	50-100% FPL	100-150% FPL	150-200% FPL	200-250% FPL	250-300% FPL	300-350% FPL	350-400% FPL	400%+ FPL
Total[3]	929.3	13.6	68.2	127.9	117.9	99.8	94.2	95.6	92.3	219.8
Medicare Only[4]	153.9	1.8	15.7	35.0	28.0	18.4	17.4	11.5	11.5	9.2
Medigap With[5,6]	134.2	0.0	3.4	18.4	22.0	15.1	14.2	18.1	18.0	21.4
Medigap Without[7]	203.0	0.0	5.1	32.8	34.9	20.7	20.5	30.5	30.5	27.7
Total Medigap[8]	337.3	0.0	8.5	51.2	56.9	36.8	34.7	48.6	48.6	49.1
Managed Care With[9]	11.8	0.0	0.5	1.1	0.6	1.5	1.5	1.2	1.2	4.4
Managed Care Without[10]	7.9	0.0	0.3	0.7	0.9	0.8	0.8	0.8	0.8	2.9
Total Managed Care	19.6	0.0	0.8	1.9	1.5	2.4	2.2	2.1	2.0	7.3
Employer With[11]	314.8	0.0	6.5	18.2	15.9	36.4	31.2	4.8	40.8	145.0
Employer Without[12]	35.0	0.0	1.6	3.7	2.5	5.4	5.8	3.8	3.8	12.5
Total Employer[13]	349.8	0.0	8.2	21.9	18.4	40.1	37.8	40.6	40.6	157.5
Medicaid[14]	68.8	11.8	34.2	13.9	9.0	1.0	1.0	0.0	0.0	0.0

State Assistance[15,16]	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Total With	530	11.8	44.6	51.6	47.5	54.0	51.0	46.1	46.1	170.8
Total Without	400	1.8	22.7	72.3	65.8	44.7	42.2	46.6	46.6	46.3
Total	926	13.6	67.4	123.9	113.3	98.7	93.2	92.8	92.7	217.1

Percent With	57.0%	86.7%	66.3%	41.6%	41.9%	54.7%	54.7%	49.7%	49.7%	78.7%
Percent Without	43.0%	13.3%	33.7%	58.4%	58.1%	45.3%	45.3%	50.3%	50.3%	21.3%

Sources and Notes:

1. Current Population Survey-March Supplement, U.S. Census Bureau, 1998-2000. Based on average over last three years. Towers Perrin Analysis.
2. 'All Incomes' categories normalized based on 'Adjusted Total'.
3. Market Penetration File, Health Care Financing Administration, Jun 2001. Towers Perrin Analysis.
4. 14% of state Medicare beneficiaries. Assumes regional percentage is similar to state percentage. Medicare State Profiles, Kaiser Family Foundation, Sep 1999.
5. 29% of state 'Total Medigap'. Assumes national level is similar to state level. Towers Perrin Analysis.
6. Note: Includes Medigap enrollees who also have employer insurance.
7. 71% of state 'Total Medigap'. Assumes national level is similar to state level. Towers Perrin Analysis.
8. 31% of state Medicare beneficiaries. Assumes regional percentage is similar to state percentage. Medicare State Profiles, Kaiser Family Foundation, Sep 1999.
9. Market Penetration File, Health Care Financing Administration, Jun 2001. Medicare & You Regional Books, Jan 2001. Towers Perrin Analysis.
10. Market Penetration File, Health Care Financing Administration, Jun 2001. Medicare & You Regional Books, Jan 2001. Towers Perrin Analysis. Includes beneficiaries in plans that did not provide drug coverage data.
11. 90% of state 'Total Employer'. Assumes national level is similar to state level. Towers Perrin Analysis.
12. 10% of state 'Total Employer'. Assumes national level is similar to state level. Towers Perrin Analysis.
13. Statistics of U.S. Business, U.S. Census Bureau, 1998. Unemployment Statistics, Bureau of Labor Statistics, 1998. ECS Survey of Employee Benefits, Watson Wyatt, 1998/99. Towers Perrin Analysis.
14. Number of dual eligibles minus number of buy-ins. Kaiser State Health Facts Online, Kaiser Family Foundation, 2001. Medicaid drug coverage only available to individuals eligible for full Medicaid benefits.
15. State Senior Pharmaceutical Assistance Programs, National Conference of State Legislatures, Jul 2001. Http://www.ncsl.org/programs/health/drugaid.htm.
16. Limited to programs that provide state subsidy for purchase of prescription drugs.

Because of their age and accompanying physical frailties, **Medicare** beneficiaries are more vulnerable to high prescription costs because of their disproportionate use of prescription medications. Medicare is the traditional medical coverage program for senior citizens but does not provide coverage for prescription drugs. For persons without any prescription coverage, one catastrophic illness can wipe out life savings. Many of these persons make daily decisions about choosing food, shelter and utilities, or medication. A survey in Virginia found that one in six persons said that they spend more than $100 a month out of pocket on prescription drugs, and, in 1999, more than one-third of adults ages 50-64 without health insurance or prescription drug coverage let a prescription go unfilled because they simply could not afford it.

These facts, unfortunately, are contrary to what many believe is just common sense and has been proven by medical science - many illnesses, most of which are very costly when they occur in the elderly population, can be prevented or alleviated by prescription drugs. Even something as simple as aspirin therapy and anticoagulents, at the cost of a few dollars a month, can prevent or lessen the severity of strokes, at a cost that exceeds $100,000 on the average for hospitalization and rehabilitation or long-term care.

Expenditures for prescriptions have been shown to result in improved outcomes and reduced medical expenses for other services such as emergency room visits, hospital and nursing facility admissions, and physician visits.[2]

Medicaid is a health insurance entitlement program funded jointly by federal and state governments for certain low-income populations, including about 12 percent of Medicare beneficiaries nationwide. In Virginia, the state share of the program is about 49 percent with a 51 percent match by the federal government. Most of these participants receive prescription drug assistance but the program is limited to those eligible persons whose income is 80 percent of the federal poverty level or less. (The FPL, is now $8,860 for an individual and $11,940 for a family of two; for 2001, it was $8,590 for an individual. Two states, Hawaii and Alaska, have higher FPLs.)

Officials at the federal and state levels are searching for ways to expand or supplement the Medicare program by providing access to prescription drugs. Health Maintenance Organizations (HMOS), which generally provide prescription drugs in-house, have generally withdrawn from the Medicare market in Virginia. Only about 12% of Medicare recipients nationwide remain in HMOs. A recent announcement by the Center for Medicare and Medicaid Services (CMS) (formerly HCFA) stated that a pilot program under Medicare would offer a new option that would be a managed care plan that offers prescription coverage but is more flexible than HMOs in that patients have more choice in their providers. This is a Preferred Provider Organization (PPO), similar to current programs in which about 50% of those persons under the age of 65 are currently enrolled. A total of 33 health plans have signed up and committed to provide services for at least three years in 23 states. CMS estimates that about 11 million persons would be eligible. Unfortunately, the only company to do business in Virginia serves only a portion of the far Southwest, so many Virginians are ineligible.

White House Initiatives on Medicare

President Bush and the White House have issued a number of policy briefs on the problems with and restructuring of Medicare. Recognizing that the population of this country is aging, which means less people will be contributing to the Medicare program through income withholding, and that science and technology is making possible longer, healthier lives, Medicare is just not keeping up. According to the White House, 77 million Americans who will be eligible for Medicare in 2030 may be out of luck because Medicare's fund for hospital insurance will face cash flow deficits beginning in 2016 and funds for other benefits will require a doubling of beneficiary premiums and Medicare's claims on general revenues over the next 10 years.[3]

As a result, the White House has issued a framework for improving Medicare including:

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[2] *Pharmaceutical Expenditures in the Commonwealth of Virginia*, A Report to the Governor and the Chairmen of the Senate Finance and House Appropriations Committees, October 2000.

[3] *Medicare Executive Summary*, The White House, July 2001.

- All seniors should have the option of a subsidized prescription drug benefit.
- Modernized Medicare should provide better benefits coverage for preventive care and serious illnesses.
- Today's beneficiaries and those approaching retirement should have the option of keeping the traditional plan with no changes.
- Medicare should provide better health insurance options, like those available to federal employees.
- Medicare legislation should strengthen the program's long-term financial security.
- The management of the government Medicare plan should be strengthened so it can provide better care for seniors.
- Medicare's regulations and administrative procedures should be updated and streamlined, while the instances of fraud and abuse should be reduced.
- Medicare should encourage high-quality health care for all seniors.

Medicare coverage is seriously behind the times and medicine has changed dramatically. Orignally, Medicare was meant to cover hospitalization and other major costs, but much care today is provided in doctor's offices and through the use of prescription medicines. Even then, Medicare is slow to adapt to allow new treatments and preventive medicine that provide alternatives to major surgery.

The President and Republican leaders proposed major legislation in 2002 that would provide a prescription drug plan for seniors and, as of Wednesday, June 19, 2002 placed it on a fast track in the House of Representatives. DHHS analysis of the bill stated that the GOP plan would give seniors a 60-85 percent savings per prescription and cut out-of-pocket costs by as much as 70 percent.[4]

Republican Plan:
- All but low income seniors would be required to pay a monthly premium of $35 and meet a $250 yearly deductible.
- The government would pay 80 % of the costs on the first $1,000 in drugs and 50 % on the next $1,000.
- Patients would be responsible for drug costs over $1,000 until they have spent $4,500 out of pocket when additional government help would start.
- Cost=$310 billion over 10 years (Bush had proposed $190 billion for drugs).
- An amendment was offered to reduce from $4,500 to $3,800 the out-of-pocket spending requirement.

Democratic Plan:
- Lower premiums, deductibles, and co-payments.
- Cost = $800 billion in House, $500 billion in Senate.

[4] *GOP Begins Push for Prescription Plan*, Richmond Times Dispatch, Associated Press, June 19, 2002.

State Prescription Assistance Plans

Although the federal government made some preliminary commitments toward instituting a Medicare prescription program or providing funds to enable states to initiate their own program, the events of 2001 preempted such efforts and the White House and Congress continue to be unable to reach an agreement about a comprehensive program. Many states have long been addressing this issue, with additional states weighing in each year. The approaches run the gamut of solutions, including:

- Establishing programs with income limits, many of which have increased to include middle-class consumers;
- Requiring minimum age limits with limited coverage to others with certain disabilities;
- Creating programs tailored to those persons with certain conditions;
- Funding for programs from a variety of sources including cigarette taxes, casino revenues, lottery proceeds, and special trusts such as the tobacco settlement;
- Requiring cost-sharing, such as co-payments, a deductible, a monthly fee, or maximum yearly benefits;
- Basing the program on the requirement that if pharmaceutical companies do Medicaid business in the state they must provide the same prices to other individuals in the assistance program;
- Establishing multi-state purchasing pool programs in order to negotiate drug discounts enjoyed by HMOs and other organizations; and
- Imposing price controls.

A more complete description of most state programs, including eligibility, cost, and funding sources, can be found in Appendix C.

In the 2001 Session of the General Assembly, a number of bills were offered to set up a prescription assistance program for the elderly. A lack of consensus about the best way to approach such a program and how best to establish a dedicated source of funding led to the formation of this study commission. Initially, most bills revolved around the use of the tobacco settlement funds to fund such a program, but initial cost estimates indicated that such a program would run approximately $150-200 million. All of those bills died.

However, a number of states did appropriate their tobacco settlement funds toward state senior pharmaceutical assistance programs in 1999-2000:

- Delaware - $7.5 million
- Illinois - $35 million
- Indiana - $20 million
- Maine - $10 million for expanded coverage
- Massachusetts - $10 million (original program used tobacco tax revenue)
- Michigan - $33 million
- Nevada - 15% of total available revenue
- New Jersey - $29 million in FY 2000, $38 million in FY 2001

- New York - $55.7 million for FY 2001 for expansion to reduce the costs of drugs and expand the program
- North Carolina - $35 million for FY 2002 for expansion from 2,000 up to 100,000 in 2002
- Ohio - up to $12 million earmarked for future emergency elderly prescription drug benefit

Other state plans are funded through general funds, lottery or casino profits, expansion of Medicaid, and other sources. Deleware has the only privately funded program through the DuPont Company.

The Virginia Experience

According to a recent study, Virginia spent approximately $223 million, or 2.2 percent of its total general fund budget, on prescription drugs in FY 2000, which translates into an 86 percent increase from FY 1996. Total funds spent on pharmaceuticals in FY 2000 were approximately $441 million.[5] Higher expenditures in programs across the country result from increased utilization, especially by the elderly, higher prices for drugs, faster development of drugs that in turn results in more patents that protect drug prices, changes in treatment practices, and increases in direct-to-consumer advertising. Direct-to-consumer advertising increased spending by 38.5 percent in just one year from 1998 to 1999,[6] and today generally exceeds the amount spent for research and development (R&D) of new drugs.[7] However, the availability of these programs obviously does not begin to address the issue of prescription coverage for those citizens who do not meet income or eligibility standards required for these programs.

The Commission received testimony from a number of state and national organizations, including the National Conference of State Legislatures, the American Legislative Exchange Council, Pharmacy Research and Manufacturers of America (PhRMA), the Galen Institute, the Heinz Family Philanthrophies, AARP, formerly known as the American Association of Retired Persons , the Virginia Health Care Foundation, the National Association of Chain Drug Stores, the Pharmacists Association, the administration, and numerous other individuals and groups with an interest in this issue. Although the Commission decided that the development of any prescription drug plan was not feasible due to the severe fiscal restraints and cutbacks occurring in the state, they did review a number of plans that they felt might meet the needs of the Commonwealth. Prior to implementing any plan, the design would require the preliminary decision on a number of policy issues. The Commission did agree that the following issues must be resolved prior to actually developing any plan for prescription assistance.

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[5] Op cit, *Pharmaceutical Expenditures in the Commonwealth.* This is the total for the Departments of Medical Assistance Services, Mental Health, Mental Retardation and Substance Abuse Services, Health, Corrections, Juvenile Justice, and Human Resource Management.

[6] Ibid.

[7] *Off the Charts: Pay, Profits and Spending by Drug Companies*, Families USA Publication No. 01-104, Families USA Foundation, 2001

Guiding Principles for Any Prescription Drug Plan for the Elderly and Disabled

- The program should be means-tested.
- Participants should be required to contribute a co-payment of some type, either a flat rate or a tiered-rate to accommodate the differences between generic, name brand and preferred drugs. If a generic is not available, there should be no penalty.
- Programs should utilize and adequately reimburse for pharmacist services such as dispensing fees and counseling services.
- Any pharmacy should be able to participate in such a program to allow use of community pharmacies when other distribution systems are available.
- The program should establish a medication therapy management program, including programs for disease management, case management, education and counseling, special pharmaceutical packaging, and medication compliance.
- The program should utilize an electronic pharmacy benefit card to expedite claims and debit procedures.
- Any program should utilize current state programs and databases, such as social services, to implement benefits.
- The program should be limited to persons aged 65 or older, are not Medicaid eligible, and who have no pharmacy benefit plan and whose income does not exceed (100%, 125%, 150%, 175%, 200%) of the federal poverty level.
- Any plan should include a separate provision for catastrophic coverage that includes premiums and co-pays.
- Pharmacies, pharmaceutical manufacturers, and patients should contribute to cost containment proportionally to their contribution to overall prescription drug expenditures. Programs should establish similar utilization incentives established by private programs such as manufacturer rebates and weigh the benefits of administering a program-wide formulary.
- Any program being considered should examine the potential of using either a single or multiple pharmacy benefit managers (PBMs) in such a fashion so as not to be detrimental to community pharmacies. (States should also consider other opportunities to secure discounts below Medicaid "best price" since the OBRA 1990 exempted state drug assistance program prices from the Medicaid best price formula. States have the potential to get deep discounts comparable to some of the federal programs that already enjoy some of the lowest prices. However, states would have to prove a large volume market and possibly use a formulary to command such discounts and it is not clear whether outsourcing to PBMs would qualify.)[8]

[8] William H. von Oehsen, III, *Pharmaceutical Discounts Under Federal Law: State Program Opportunities*, Public Health Institute, May, 2001, pp. 21-23.

IV. RECOMMENDATIONS

After hearing the testimony, the Commission evaluated a number of options and made the following recommendations.

OPTION: REQUIRE THE STATE PLAN FOR MEDICAL ASSISTANCE SERVICES TO INCLUDE A PROVISION FOR PAYMENT OF MEDICAL ASSISTANCE SERVICES FOR AGED AND DISABLED INDIVIDUALS WITH INCOMES UP TO 100 PERCENT OF THE FEDERAL POVERTY LEVEL.

In 1988, the Medicare Catastrophic Coverage Act created a new group of mandatory categorically needy called Qualified Medicare Beneficiaries (QMBs). The income level for this group was set at 100 percent of the federal poverty level (FPL). However, Medicaid coverage was limited to payment of Medicare premiums, co-insurance and deductibles on Medicare covered services. Pharmacy, non-emergency transportation, and other services not covered by Medicare were not included. Thus, this new coverage group did not benefit aged, blind and disabled recipients who were not Medicare eligible or who needed services not covered by Medicare.

Also in 1988, Congress created an optional categorically needy group, which permitted states to grant full Medicaid benefits to aged and disabled individuals whose income was at some percentage of poverty up to 100 percent of FPL. Since the income requirements for QMBs and this group of elderly and disabled poor is the same, most individuals who would qualify under this proposal are already eligible for Medicaid as QMBs. The Department of Medical Assistance Services (DMAS) maintains that enacting this option would mean that individuals with incomes at or below 100 percent of the FPL, who are eligible for Medicaid only as QMBs, would become eligible for all Medicaid-covered services. In addition, those individuals who have recently been determined to be disabled and are awaiting Medicare eligibility (once an individual is determined to be disabled there is a two-year waiting period prior to becoming eligible for Medicare) would also become eligible for Medicaid.

Currently, Medicaid eligibility criterion for non-institutionalized aged, blind and disabled individuals is 80 percent FPL.

Reimbursement - No limit on prescriptions or refills; use formulary.

Eligibility threshold - 100 percent of FPL or below.

Cost-sharing - $1 co-payment.

Funding Source - Cost to implement 100% FPL for aged and disabled.

2001-2002	$28,570,125	GF
2001-2001	$30,675,375	NGF
2002-2003	$29,651,925	GF
2002-2003	$31,580,816	NGF

There is approximately a 51% federal and 49% state split.

DMAS estimated that there would be 10,567 disabled QMB-only average monthly enrollees in FY 2002 and 11,016 in FY 2003. For the aged population, the projections are 14,631 average monthly enrollees in FY 2002 and 15,253 in FY 2003. This legislation would result in these individuals being eligible for all services covered under the Medicaid state plan. The primary fiscal impact results from covering pharmacy and non-emergency transportation services. DMAS believed that the upgrade will cost approximately $2,351 per average monthly enrollee for the disabled population and $1,897 for the aged population. The estimated cost of providing additional coverage to this population is approximately $52.6 million in FY 2002 and $54.8 million in FY 2003. There would be additional costs for the reimbursement to the contractor for processing the claims, which have a 75 percent federal matching rate.

As the study progressed, new figures were made available that outlined the fiscal impact of raising the eligibility for Medicaid services to something higher than is currently used:

Department of Medical Assistance Services	*82% FPL*	*85% FPL*	*90% FPL*	*95% FPL*	*100% FPL*
FY 2003-Total	$4,622,695	$11,556,737	$23,113,474	$34,670,210	$46,226,947
GF	$2,346,480	$ 5,866,200	$11,732,399	$17,598,599	$23,464,798
FY 2004-Total	$7,680,785	$19,201,963	$38,403,925	$57,605,888	$76,807,851
GF	$3,881,101	$ 9,702,752	$19,405,504	$29,108,255	$38,811,007
Estimated recipients	2,279	5,698	11,396	17,094	22,792

These are the most recent figures from the Department of Medical Assistance Services to raise the percentage of the federal poverty level for qualification for Medicaid. This applies only to the aged and disabled.

COMMISSION RECOMMENDATION: The Commission recommended that the eligibility for Medicaid be raised to 100 percent of the FPL. A bill was introduced in the 2002 General Assembly but it died in the Appropriations Committee.

- **OPTION: PURSUE THE MEDICAID 1115 OPTION (#1) OFFERED BY THE CENTER FOR MEDICARE AND MEDICAID SERVICES.**

In 200 and early 2001, the Health Care Financing Administration (HCFA), now the Center for Medicare and Medicaid Services (MS), approved two programs to waive certain federal requirements applicable to state Medicaid plans in order to extend the states' Medicaid prescription drug benefit to resident who would otherwise be ineligible for Medicaid benefits. The requests were approved under section 1115 of the Social Security Act that permits HCFA to waive any federal Medicaid requirement for "any experimental, pilot, or demonstration project which, in the judgement of the Secretary of HHS, is likely to assist in promoting the objectives" of Medicaid. This waiver is commonly used to expand eligibility for individuals, but these plans are unique in that they limit benefits only to drugs and not other Medicaid-covered services and items. Unique, too, is the funding mechanism in that it does not use federal or state funds but rather patient co-payments and the manufacturers rebates required under OBRA 1990. Federal Medicaid law requiring only nominal co-payments by the patient would also be waived.

Observers indicate that although this legislation in Vermont has already withstood legal challenge (at the time of this study) by the pharmaceutical industry, future litigation is anticipated. The industry argues that because the state Medicaid agency makes no payments to pharmacies under the program, the section 1115 waiver violates the federal Medicaid statute by not complying with the federal/state cost sharing requirements. Theoretically, it is envisioned that every state in the union could replicate this model as a way to give individuals lacking prescription drug coverage instant access to Medicaid rebate prices. Experts also agree that the scrutiny being given the waivers at the present time will most likely reduce the potential for any program to be struck down as unconstitutional or inconsistent with federal law.[9]

COMMISSION RECOMMENDATION: No action due to pending litigation.

- **OPTION: PURSUE THE MEDICAID 1115 OPTION (#2) OFFERED BY THE CENTER FOR MEDICARE AND MEDICAID SERVICES.**

Much interest has developed, both on the state and federal level, in the new Illinois SenioRx Care plan. This plan was developed as a Medicaid 1115 demonstration project to help cover "virtually all drugs for most of the seniors who currently participate in the state subsidy program." The expansion will give an estimated 368,000 low-and-moderate-income seniors prescription drug coverage through Medicaid beginning in July of 2002. The existing state-only program covers individuals with income up to $21,218 and couples up to $28,480. The new program will cover individuals and couples earning up to 200 percent of the FPL ($17,720/$23,880). Each enrollee pays a three dollar co-payment for each prescription up to $1,750 per year in prescription costs. Above that figure, the program will pay 80 percent of the cost and the enrollee will be responsible for 20 percent. There is an annual enrollment

[9] *Pharmaceutical Discounts Under Federal Law: State Program Opportunities*, William H. van Oehsen, III Public Health Institute, May 2001.

fee five dollars but no co-payment for households with income under the FPL. Those with greater incomes pay a $25 enrollment fee.

Secretary of HHS Tommy Thompson announced a model state demonstration application form called "Pharmacy Plus" to allow states to immediately expand Medicaid coverage for prescription drugs to Medicare beneficiaries and other individuals with family incomes up to 200 percent FPL and provide a streamlined application process that is available electronically. While this sounds enticing for states, there are certain caveats to be considered. According to an analysis performed by the Kaiser Commission on Medicaid and the Uninsured,[10] to pay for this new program, Illinois has relinquished it's claim on the guarantee that the federal government will match the amount the state spends on its elderly Medicaid population. This program has a "cap" on the amount the federal government will spend over the next five years that is based on the amount the state anticipated it would need to cover Medicaid recipients in the absence of this project. This is anticipated to divert money from those seniors who are kept well enough not to need full Medicaid coverage and to use those savings to make up the difference in the matching funds. Medicaid demonstrations are required to be "budget neutral," meaning that the state agrees that it will spend no more on the new program than it otherwise would have spent on the same population without the demonstration project. (Illinois currently covers those whose income is 85 percent of the FPL but is scheduled to increase that to 100 percent of the FPL during this fiscal year.) If the state runs out of money, they will have to (i) cut spending on Medicaid beneficiaries, (ii) cut back the prescription program, or (iii) ante up state funds.

COMMISSION RECOMMENDATION: No action.

- **OPTION: EXPAND THE PHARMACY CONNECT (TPC) PROGRAM BY ASSIGNING ONE POSITION IN EACH OF THE ADDITIONAL AREA AGENCIES ON AGING (24) THROUGHOUT THE COMMONWEALTH AND PROVIDING TPC SOFTWARE TO ACCESS AVAILABLE PATIENT ASSISTANCE PROGRAMS OFFERED BY PHARMACEUTICAL COMPANIES.**

The Pharmacy Connect (TPC) Program, developed by the Virginia Health Care Foundation, serves as a viable and integral part of the healthcare system in the Commonwealth by assisting persons who are unable to afford their prescription drugs to acces the free drug programs offered by 99 pharmaceutical companies. Typically, these persons must not have any other prescription drug coverage and eligibility generally goes up to 100 to 125 percent of the FPL. The software developed enables the user to access all of the programs and expedites the application process. TPC determines eligibility, searches for generic equivalents, prints out completed forms, tracks the status of applicants and provides a variety of reports. Generally, this program is now used by community health centers, free clinics, hospitals, and some health departments. In 2001, 52,453 patients received free medications (this number may be duplicative since some patients receive more than one medication. There is no age limit for eligibility.

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[10] *The Financing of Illinois' Prescription Drug Demonstration Pro*ject, Kaiser Commission on Medicaid and the Uninsured, April 2002.

TPC has been expanded on the local level in the Mountain Empire Older Citizens' (MEOC) prescription drug assistance program. This program received $371,000 each year for the 2001-2002 biennium, which they used to hire 18 staff persons to work in the field to implement TPC programs. The Southwest Pharmacy Connect Program (SWPC) helped an estimated 5,127 persons in 2001. An estimated total of 27,246 persons received assistance through TPC in 2001, with approximately 54% of those being age 56 or older (14,810).

	1990 Census		2000 Census
Agency on Aging	65+ Below Poverty	Percent of 65+ Population Below Poverty	Estimated 65+ Below Poverty
Mountain Empire	3,048	30.5%	4,268
Appalachian	2,974	26.0%	4,268
District Three	5,930	29.3%	9,224
New River Valley	2,599	18.8%	3,574
LOA - Roanoke	4,490	14.1%	5,988
Valley Program	4,180	17.3%	6,260
Shenandoah	2,872	16.8%	4,229
Alexandria	967	10.4%	1,205
Arlington	1,083	6.2%	1,096
Fairfax	2,241	4.3%	3,494
Loudoun County	434	9.6%	918
Prince William	501	7.1%	1,119
Rappahannock-Rapidan	1,623	14.3%	2,459
Jefferson Area Board	2,903	19.6%	4,788
Central Virginia	4,442	19.8%	6,557
Southern	7,043	26.1%	10,498
Lake Country	3,854	43.0%	6,379
Piedmont Senior Resources	3,165	33.6%	4,985
Capital	8,449	12.2%	11,634
Rappahannock	1,622	14.2%	2,827
Chesapeake Bay	3,127	18.8%	4,501
Crater District	3,126	19.6%	4,337
Senior Services Of Southeastern	12,107	16.2%	17,527
Peninsula	3,757	11.7%	5,784
Eastern Shore	2,033	33.8%	3,101
Totals	**88,570**	**16.4%**	**131,020**

COMMISSION RECOMMENDATION: Expand The Pharmacy Connect (TPC) Program. To expand TPC statewide would require $4.8 million in additional funding. This would be in addition to the $371,000 for MEOC, Inc. and would provide funding of $200,000 for the other 24 agencies on aging. These dollars would allow each agency to operate a minimum starting program. The budget amendment died.

- **OPTION: ADOPT THE GALEN INSTITUTE PLAN FOR PRESCRIPTION ASSISTANCE**

The Galen Institute offered a proposal to the commission that would have created a Prescription Drug Security (PDS) Card consisting of two parts.

Part I would be the basic drug assistance card where low-income beneficiaries would receive a PDS card that would provide $50 a month, or $600 per year, toward the cost of their first-dollar drug expenditures. (They presented data that showed that the average expenditure of this group is less than $600 per year.) The card would work like a debit card and unspent funds would carry over in their account for the next year, acting as somewhat of a medical savings account. Participants would select a benefit administrator that manages that account and negotiates for discounts. Multiple administrators may offer slightly different programs for choice by participants. There would be no cost sharing in Part I and applies to all Medicare beneficiaries. The cost is approximately $51.9 million.

Part II provides high-end protective coverage. Once a senior reaches $2,000 in annual drug expenses, the PDS card participant would get help with the majority of his drug expenses, but still be required to pay a premium and a 20 percent co-payment. After the senior has $6,000 in annual drug expenses, he would automatically be enrolled in the state-run risk pool.

As an alternative, a sliding scale option could be used. Instead of having the drug coverage trigger at fixed levels, like $2,000 and $6,000, the program could have the coverage trigger when a senior has spent a certain percentage of his income on prescription drugs. After a senior has drug expenditures in a year that exceed five percent of annual income, for example, the catastrophic coverage could be available. For a senior with a $12,000 annual income, that would mean his total annual out-of-pocket spending would be $600. But as a person's income rises, so does the trigger amount. Someone with a $120,000 annual income would have to spend $6,000 before he would be eligible.

Commission Recommendation: No action.

- **OPTION: PURSUE A WORKING RELATIONSHIP WITH THE HEINZ FAMILY PHILANTHROPHIES AND DEVELOP A "HOPE PLAN FOR VIRGINIA."**

The Heinz Family Philanthrophies worked with the Commission and provided them with information about forming a working relationship with the Philanthrophies to develop a prescription assistance program, similar to other efforts ongoing in a number of states. Based on only preliminary information, the Heinz group offered a potential plan outline.

Each HOPE Plan is based on three principles;

1. Affordability - any program should be affordable to the state and the individual and should be means-tested. As someone's income increases, so should his financial responsibility.
2. Choice - Most HOPE strategies accommodate access to pharmaceuticals through an incentive formulary using tiered cost sharing based on the type of drug. Generics should be mandatory, but seniors should have a choice to select a more expensive drug. Patients should not be penalized if generics are not available. The issue of "choice" should be carefully managed.
3. Fiscal reality - Fiscal realism must take into account what you as a state can or cannot afford.

Any possible HOPE plan must begin incrementally and could include the following:

- Initially, any plan should focus on those people age 65 or older, who are eligible for Medicare, with incomes at or below 200 percent of the FPL. (Single persons with incomes up to $17,180 and married couples with incomes up to $23,220.)
- Participation should be voluntary.
- Seniors should pay premiums and deductibles.
- Drugs should be divided into a three-tiered incentive formulary in which generics would be mandatory.
- Program benefits are limited to $2,000 per year.
- Establishment of a Prescription Drug Review Commission to monitor the program.
- Program established must include a sunset provision after three years to keep monitoring vigilant.
- Any program should examine the level of savings that might be achieved through aggregating the contract administration and negotiations through one state agency.
- There must be comprehensive marketing and outreach.
- Enrollment must be limited to a specific period of time, such as six months, to reduce the risk of adverse selection.

Cost estimate - The program would be incremental and could cost approximately $36-40 million for the first year for 91,000 persons.

Commission Recommendation: No Action.

- **OPTION: AMEND THE PROVISION ADOPTED IN THE 2001 SESSION OF THE GENERAL ASSEMBLY THAT PROVIDES FOR THE VIRGINIA DEPARTMENT OF HEALTH TO SET UP A HOTLINE TO ADVERTISE AND FACILITATE THE USE OF THE FREE DRUG PROGRAMS AND ALSO PROVIDE INFORMATIONABOUT THE VARIOUS DISCOUNT CARDS CURRENTLY BEING OFFERED BY SOME PHARMACEUTICAL COMPANIES FOR ELIGIBLE POPULATIONS.**

Commission recommendation: Introduce bill to include the discount drug programs on the hotline to be developed by the Department of Health. The legislation passed but was

amended to include a delayed effective date contingent upon appropriations be made available. The original program has the same contingency clause.

- **OPTION: EXTEND THE STUDY FOR AN ADDITIONAL YEAR.**

Commission Recommendation: Adopt House Joint Resolution No. 90 - passed.

- **OPTION: SET A GOAL AND ADOPT A PLAN TO MAKE THE AVAILABILITY OF DISCOUNT OR FREE PHARMACEUTICAL PROGRAMS KNOWN TO THE PUBLIC AND ASSIST ALL ELIGIBLE PERSONS WITH EASY ACCESS AND ENROLLMENT IN SUCH PROGRAMS.**

Using the proposal offered by the pharmaceutical companies, "The Virginia Senior's Rx Horizon Plan," staff and members of the Commission developed the following strategy consisting three elements:

Identify

Identifying those persons who may be eligible for either Medicaid or for the free or discounted pharmaceutical card programs.

- The Commonwealth would need to identify an agency or program likely to have the information on those persons who might qualify for any of the programs and have the ability to notify those persons of that status. This would not necessarily imply that that particular agency would have any further responsibilities in implementing the program. For example, one state that does have a prescription drug program utilizes its department of taxation, which flags any return, or form indicating that a tax return is not necessary, that shows a person or couple to meet the income eligibility requirements for the pharmaceutical programs - generally those with incomes up to 80 percent of the FPL qualify for Medicaid and those with incomes between that level and up to $25,000 to $30,000 for a couple may qualify for either the free or discount drug programs. Another approach would be to flag those families whose children are eligible for the Family Access to Medical Insurance Security Plan, as well as food stamp and Supplemental Security Income recipients. This information would then be transferred to a designated state entity or grant program to notify those persons that they may be eligible and provide them with a contact telephone number or address where they can receive more information.
- Utilize pharmacies, doctor's offices, government programs like the local departments of health and the area agencies on aging, community groups, religious leaders, senior groups, and other available local resources that have direct contact with potential eligible seniors to make them aware of the programs and provide them with information.

Implement

- Create a public/private partnership between the Commonwealth, the General Assembly (led by those members sitting on this Commission), and the pharmaceutical companies and other interested parties to fund an office, possibly through the Virginia Center for

Aging, that will develop a system to enroll eligible seniors in the various drug benefit programs available in the State. This would involve enrollment information being gathered via a toll-free number and/or a website utilizing an enhanced version of the The Pharmacy Connection software that provides an automatic rollover into the discount card program if eligibility income is too high for the free pharmaceutical programs. This program would develop a system of local enablers who would have direct contact with the applicant and would provide training in the filing process. Also, consideration could be given to using state and grant dollars from pharmaceutical companies, to create and fund a program, that utilizes the principles of the pharmaceutical warehouse program in South Carolina, which would develop a system of information and access to the free drug program and actually dispense those medications. Location of such a warehouse program in the Richmond area could be accomplished by virtue of the availability of space in the downtown area and the advantage of having a pharmacy school at the MCV-VCU campus whose students may be available for community service. The success of such a program would hinge on a good-faith commitment by all parties.

- Develop an informational brochure that explains the prescription benefits programs available in the Commonwealth and simple information about who qualifies along with contact numbers and addresses to get more information. Provide these to local governmental agencies, local pharmacies, grocery stores, doctors and other health care professionals, community groups, religious leaders, panhellenic groups at colleges and other organizations that have public service as a commitment, and senior groups, especially AARP, for distribution. In addition, these same people could provide assistance at regular sign-up days designated in communities to help applicants fill out the form correctly. The brochure should also list the specific information necessary for the applicant to bring to fill out an application form.
- Make the information and general application form for the discount card programs available via the Internet through an on-line professional association membership source to make it more accessible to professionals. This information could also contain a toll-free telephone number for access.
- Application forms need to be as simple as possible, legible, and user-friendly.
- With the development of a public/private partnership, as offered by the pharmaceutical companies, create a statewide effort to designate sign-up days in various communities across the Commonwealth to assist in signing up eligible Virginians for the various discount cards so that they can access drugs from all pharmaceutical plans in operation. Pharmaceutical companies, with sponsorship by various professional and state groups, will underwrite the plan's launch promotion and administration. Suggested tactics include developing the plan of launch, designation of "action groups" responsible for the implementation of local efforts, developing a video news release that targets all television stations, writing and distributing a media advisory and press release as well as public service announcements, and developing and distributing media kits to targeted media statewide.
- Develop a plan to provide assistance to communities where they can develop and pool funds to implement a Pharmacy Connection program, perhaps in tandem with providing information on and assistance with qualifying for discount card programs, that will allow the program to hire the requisite staff, which is essential to the success of the program. An enhancement of the current Pharmacy Connection program to "kick over" to the

discount card program when income is too high may be considered to streamline the program and not lose clients in the gap.

- Establish "health-care" days, perhaps at the local health departments, when designated staff and representatives from the various pharmaceutical companies are available to assist potentially eligible persons to access information and sign up for the various pharmaceutical programs. In addition, regular sign-up should be accessible through the local area agencies on aging. These sign-up days might be held twice a year, perhaps in June after the possibility of inclement weather ends and in October/November during the flu vaccination season. Local volunteers could be used to assist persons to complete the enrollment. In addition, assistance in enrollment would be available on a continuing basis at all local area agencies on aging.
- Utilize the "community collaboration" programs being developed by the Department of Social Services as an opportunity to inform local authorities about the existence of the various programs and provide them with some training in how to get eligible seniors signed up.
- Set a goal, as suggested by the pharmaceutical plan, to have every eligible person signed up for the discount and benefits pharmaceutical programs within one year. Prompt receipt of the discount card by the approved recipient must be a necessary element of any plan to make it work.
- *Horizon* proposes that the Secretary of Health and Human Resources make monthly reports on the progress of the program, culminating in a year-end media event, in tandem with representatives from involved parties, to review the progress of the plan.

Evaluate and Expand

- Have the designated agency/person/secretariat that has responsibility for developing the program prepare an annual report to the Secretary and the General Assembly outlining the available programs, enrollment efforts, and cost effectiveness of the program.
- Continue to evaluate the potential for the development and funding of a state-sponsored prescription drug benefit program, if one has not been established by Congress.
- Develop a tracking system to evaluate the various elements of the program, such as timeliness of card receipt, difficulty in using the card, frequency of changes in program requirements and benefits and potential difficulties in program usage.

Commission Recommendation: Approve. Most of these proposals were incorporated into HB 2225 (Cline), which is identical to SB 1341 (Potts). A copy of the bill language is found in Appendix B.

Prescription Assistance Programs in Virginia

Program	Contact Information	Eligibility	Benefit
Pfizer Share Card*	1-800-717-6005 to speak to a customer service representative who will pre-screen you before sending you an application form. www.pfizerforliving.com	Annual income below $18,000 for an individual or $24,000 for a couple.	Pay only $15 for each 30-day supply of any drug made by Pfizer at participating pharmacies.
Lilly Answers Card*	1-877-795-4559 to receive application form. www.lillyanswers.com	Annual income below $18,000 for an individual or $24,000 for a couple.	Pay only $12 for each 30-day supply of a covered drug made by Lilly at participating pharmacies.
GlaxoSmithKline Orange Card*	1-888-ORANGE6 (672-6436) to receive an application form. http//us.gsk.com/card/index.htm	Annual income below $30,000 for an individual or $40,000 for a couple.	Receive a 30% to 40% discount on drugs made by GlaxoSmithKline at participating pharmacies.
Novartis Care Card*	Novartis is now issuing Together Rx Cards (see next for information)	NA	NA
Together Rx Card* Multiple drug companies offer savings through this program.	1-800-865-7211 to receive an application form. www.together-rx.com	Annual income below $28,000 for individuals and $38,000 for couples.	Receive a 30% to 40% discount on more than 150 drugs at participating pharmacies.
Veterans Administration Prescription Assistance	1-800-827-1000 for information and assistance. www.va.gov/elig	Must meet VA eligibility guidelines. Co-pay may be required.	Prescription & other drugs, available under the VA national formulary.

Program	Contact Information	Eligibility	Benefit
Pharmaceutical Research and Manufacturers of America (PhRMA)'s Helpingpatients.org website	At http://www.helpingpatients.org, PhRMA has created an online database that helps patients without prescription drug coverage access user-friendly information about more than 1,400 medicines that are offered free through patient assistance programs sponsored by the pharmaceutical industry. PhRMA previously published a Patient Assistance Directory that contained information on each assistance program. The Directory is no longer published.	People who need help in obtaining medicines can visit the website, fill out an online form and receive a list of programs for which they may qualify.	If a patient qualifies for a program, the drug manufacturer will provide the drugs directly to the physician, who can then give them to the patient.
Pharmacy Connect Program of Southwest Virginia (regional) (operated by the Mountain Empire Older Citizens Agency on Aging in Southwest Virginia)	Call MEOC at 1-800-252-6362 for information. Pharmacy Connect provides assistance to citizens in applying to the drug companies that participate in the PhRMA Prescription Drug Patient Assistance Program. meoc@meoc.org or their website at http://meco.org	Serves the citizens of Less, Scott, Wise, Buchanan, Dickenson, Russell, and Tazewell Counties as well as the City of Norton There is no age limit for eligibility.	Same as above.
American Association of Retired Persons' (AARP)'s Member Rx Choice Program	To join by phone, call 1-800-439-4457 To join online, go to: https://www.aarppharmacy.com/mc/mc_enrollmentform.asp To join by mail, print a copy of the application form(available in .pdf format at): http://www.aarppharmacy.com/mc/memrx_enroll_form_bkwt.pdf Once it is completed, mail it to: Member Rx Choice P. O. Box 40019	Persons enrolling in Member Rx Choice must be members of AARP, which requires that the person be 50 years of age or older, and pay an annual membership fee of $12.50	AARP members pay an annual fee of $19.95 per year and receive discounts on more than 5,000 medications at pharmacies nationwide. Home delivery of medications via mail is also available if prescriptions are ordered from the

	Roanoke, VA 24022-9921		AARP Mail Order Pharmacy.
Medication Assistance Program for Mount Rogers Planning District, operated by the District Three Governmental Cooperative (of which District Three Senior Services is a part. (regional)	Call 1-800-541-0933 for information and assistance or e-mail them at: districtthree@smyth.net	Participation is based on individual of total family income. Individuals must not have any other prescription drug coverage. Prescriptions are limited to medications available through the Pharmacy Connect Program.	Benefits vary according to the prescription drug assistance program to which the application is made.
Pharmacy Access Program (operated by the Appalachian Agency for Senior Citizens (AASC)) in Southwest Virginia (regional)	Call AASC at 1-800-656-2272 for information and assistance, or e-mail at: aasc@aasc.org You can visit their website at: http://www.aasc.org/ Pharmacy Access provides assistance to citizens in applying to the drug companies that have prescription assistance programs. The agency may also refer individuals to the following facility: Tri-County Free Clinic 2331 West Front Street Richlands, VA 24641 Phone: (276) 963-8505	Serves persons age 60 or older who live in Buchanan, Dickenson, Russell and Tazewell Counties. Individuals who are under 60 years of age are referred to the Pharmacy Connect program.	Benefits vary according to the prescription drug assistance program to which the application is made.
Pharmacy Central Program, operated by the Prince William Area Agency on Aging (PWAAA) & Northern Virginia Family Services (NVFS). (regional)	Call (703 792-7662 for information and assistance. You can also contact PWAAA by e-mail at: dvantiem@pwcgov.org or visit their website at: http://www.pwcgov.org The Pharmacy Central Program is based on the Pharmacy Connect software produced by the Virginia Health Care Foundation (www.vhcf.org). Many pharmaceutical companies have patient assistance programs that assist eligible individuals in obtaining free or low-cost prescription medications. The Pharmacy Connect software includes:	Serves persons age 60 or older who live in Prince William County and the cities of Manassas and Manassas Park	Benefits vary according to the prescription drug assistance program to which the application is made.

	-information about the programs -each pharmaceutical company's eligibility requirements; and -the application forms for each program		

* These cards are available at no charge, but only to Medicare recipients who do not already have a pharmacy benefit through private insurance or the Virginia Medicaid program.

If you have questions about your health care coverage, call your local Area Agency on Aging and ask to speak with a VICAP health insurance counselor. To learn the number of your local Area Agency on Aging, call the Virginia Department for the Aging, toll free, at 1-800-552-3402.
Updated 3-03
Virginia Department for the Aging

APPENDICES

Appendix A

House Joint Resolution No. 810, 2001

House Joint Resolution No. 90, 2002

GENERAL ASSEMBLY OF VIRGINIA -- 2001 SESSION

HOUSE JOINT RESOLUTION NO. 810

Establishing a Joint Commission on Prescription Drug Assistance to develop ways and means to provide prescription drug assistance to needy senior citizens and to coordinate state and federal programs providing such assistance.

Agreed to by the House of Delegates, February 24, 2001
Agreed to by the Senate, February 24, 2001

WHEREAS, rapid scientific advances in biochemistry, molecular biology, cell biology, immunology, genetics, and information technology are transforming drug discovery and development; and

WHEREAS, effective pharmaceuticals improve the quality of life for Virginia's elderly citizens and help contain the health care costs associated with aging; and

WHEREAS, improved access to pharmaceuticals for needy elderly citizens, while also continuing the flow of new, more effective, life-saving and life-enhancing prescription drugs, are noteworthy goals; and

WHEREAS, many elderly Virginians cannot afford necessary prescription drug coverage, Medicare does not provide coverage for prescription drugs, and Medicaid does not cover the cost of prescription drugs for the neediest elderly Virginians; and

WHEREAS, both major-party presidential candidates in the campaign of 2000 promised to provide prescription drug assistance to needy elderly citizens, as did most candidates for Congress from both parties, making it highly likely that the new United States Congress and new administration will take action on prescription drugs in the upcoming year; and

WHEREAS, the Commonwealth must be prepared to coordinate its state effort to provide prescription drug assistance with the proposed federal effort to avoid duplication, waste of human and fiscal resources, and the need to change state programs that are established before the implementation of possible new federal programs; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Prescription Drug Assistance be established to develop ways and means to provide prescription drug assistance to needy senior citizens and to coordinate state and federal programs providing such assistance. The Commission shall consist of 8 members, which shall include 6 legislative members and 2 nonlegislative members to be appointed as follows: 4 members of the House of Delegates to be appointed by the Speaker of the House in accordance with the principles of proportional representation contained in the Rules of the House of Delegates; 2 members of the Senate to be appointed by the Senate Committee on Privileges and Elections; 1 citizen member at-large to be appointed by the Speaker of the House; and 1 citizen member at-large to be appointed by the Senate Committee on Privileges and Elections.

The Commission shall examine (i) the best ways to provide prescription drug assistance to those elderly Virginians who cannot afford to purchase such assistance on their own; (ii) the current scope of coverage, or lack thereof, in major programs including Medicare and Medicaid; (iii) proposed federal legislation and the most efficient manner in which the Commonwealth may coordinate its programs with future federal programs to provide prescription drug assistance; and (iv) such other matters as are relevant to the Commission's objectives.

The direct costs of this study shall not exceed $9,750.

The Division of Legislative Services shall provide staff support for the study. All agencies of the Commonwealth shall provide assistance to the Commission for this study, upon request.

The Commission shall complete its work in time to submit its written findings and recommendations by November 30, 2001, to the Governor and the 2002 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

2002 SESSION

ENROLLED

HOUSE JOINT RESOLUTION NO. 90

Continuing the Joint Commission on Prescription Drug Assistance.

Agreed to by the House of Delegates, February 12, 2002
Agreed to by the Senate, March 5, 2002

WHEREAS, House Joint Resolution No. 810 (2001) established a joint commission to study and develop ways and means to provide prescription drug assistance to needy senior citizens and to coordinate state and federal programs providing such assistance; and

WHEREAS, during the course of the study the joint commission examined the approaches being used by at least 29 other states that have established or authorized some type of program to provide pharmaceutical coverage or assistance, primarily to low-income elderly or persons with disabilities who do not qualify for Medicaid; and

WHEREAS, state and federal programs that provide prescription drug assistance to senior citizens are of great importance to the individuals that fall into low-income categories because it is estimated that health care expenditures accounted for 32 percent of income for older persons in the lowest fifth of the income distribution scale and prescription drug costs accounted for 40 percent of out-of-pocket payments for health care goods and services; and

WHEREAS, the federal Medicare system, as originally designed and implemented in 1965, did not provide outpatient pharmacy benefits because many of the drugs now used to treat chronic diseases and diseases related to aging did not exist, and most treatment at the time emphasized surgery and hospitalization; and

WHEREAS, the federal Medicare program continues to lack an outpatient pharmacy benefit, despite general agreement that prescription drugs are critical to maintaining good health and raising the quality of life for millions of older Americans while avoiding higher health care costs, such as hospitalization; and

WHEREAS, according to the U.S. Congressional Budget Office, roughly half of the population age 65 and older have little or no prescription drug coverage; and

WHEREAS, a recent report on Medicare prescription drug coverage indicated that nearly half of Medicare beneficiaries have annual incomes less than $15,000, and nearly one-third have annual incomes less than $10,000; and

WHEREAS, although enrollment across the country has increased over the past year, still only about three percent of Medicare beneficiaries are covered by such programs; and

WHEREAS, in Virginia, the Medicare-eligible population is approximately 930,000, of which about 400,000 persons are without any form of prescription assistance from Medigap, employer-sponsored, or other type of prescription assistance plan, and many of these plans cover only a fraction of the cost; and

WHEREAS, because of their age and accompanying physical ailments, Medicare beneficiaries are more vulnerable to high prescription costs because of their disproportionate use of prescription medication; and

WHEREAS, Medicaid is a health insurance entitlement program funded jointly by federal and state government for certain low-income populations, including approximately 12 percent of Medicare beneficiaries nationwide; and

WHEREAS, participants in the Medicaid program receive prescription drug assistance but the program in Virginia is limited to those eligible persons whose income is 80 percent of the federal poverty level or less; and

WHEREAS, Virginia, in FY 2000, spent approximately $223 million, 2.2 percent of its total general fund budget, on prescription drugs, accounting for an 86 percent increase over what was spent in 1996 for persons receiving services from the Departments of Medical Assistance Services, Mental Health, Mental Retardation and Substance Abuse Services, Health, Corrections, Juvenile Justice, and Human Resource Management; and

WHEREAS, although the federal government has made preliminary commitments towards instituting a Medicare prescription program or providing funding to the states to enable them to initiate their own programs, a court recently issued an injunction halting the proposed federal program

and funding has been preempted for any programs currently as a consequence of the terrorist attacks of September 2001; and

WHEREAS, the joint commission, after analyzing a number of approaches, planned to issue interim recommendations to address the needs of persons in the lowest income range to help them meet the high cost of prescription drugs, but believed that it was premature for several reasons to offer a final recommendation for a comprehensive prescription drug plan; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Prescription Drug Assistance be continued. The Commission shall be composed of 8 members, which shall include 6 legislative members and 2 nonlegislative members as follows: 4 members of the House of Delegates to be appointed by the Speaker of the House in accordance with the principles of proportional representation contained in the Rules of the House of Delegates; 2 members of the Senate to be appointed by the Senate Committee on Privileges and Elections; 1 citizen at-large to be appointed by the Speaker of the House; and 1 citizen at-large to be appointed by the Senate Committee on Privileges and Elections.

In its deliberations, the joint subcommittee shall consider (i) the feasibility of strengthening the Commonwealth's pharmacy purchasing ability for state programs, (ii) using the savings generated to create and fund a pharmacy benefits program for low-income and uninsured elderly persons, such as lowering the cost of existing pharmacy benefit programs for which state general funds are expended by consolidating pharmacy purchases, and (iii) pursuing cooperative arrangements with other states to pool pharmacy purchases.

The Division of Legislative Services shall continue to provide staff support for the study.

All agencies of the Commonwealth shall provide assistance to the Joint Commission, upon request.

The direct costs of this study shall not exceed $10,200.

The Joint Commission shall complete its work by November 30, 2002, and shall submit its written findings and recommendations to the Governor and the 2003 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Implementation of this resolution is subject to subsequent approval and certification by the Joint Rules Committee. The Committee may withhold expenditures or delay the period for the conduct of the study.

Appendix B

House Bill No. 2225, 2003

CHAPTER 661

An Act to amend the Code of Virginia by adding in Article 6 of Chapter 2 of Title 2.2 a section numbered 2.2-214.1 and by adding in Article 3 of Chapter 1 of Title 32.1 a section numbered 32.1-23.1, relating to the Healthy Lives Prescription Fund.

[H 2225]

Approved March 19, 2003

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 6 of Chapter 2 of Title 2.2 a section numbered 2.2-214.1 and by adding in Article 3 of Chapter 1 of Title 32.1 a section numbered 32.1-23.1 as follows:

§ 2.2-214.1. Healthy Lives Prescription Fund; nonreverting; purposes; report.

A. There is hereby created in the Department of the Treasury a special nonreverting fund that shall be known as the Healthy Lives Prescription Fund.

B. The Fund shall be established on the books of the Comptroller. The Fund shall consist of such moneys appropriated by the General Assembly and any funds available from the federal government, donations, grants, and in-kind contributions made to the Fund for the purposes stated herein. Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund.

C. Moneys in the Fund shall be available to develop and implement programs that will enhance current prescription drug programs for citizens of the Commonwealth who are without insurance or ability to pay for prescription drugs and to develop innovative programs to make such prescription drugs more available.

D. The Secretary shall provide an annual report on the status of the Fund and efforts to meet the goals of the Fund.

§ 32.1-23.1. Alternative delivery of certain information.

A. The Commissioner shall create links from the Virginia Department of Health's website to the Virginia Department for the Aging's website and its affiliated sites pertaining to pharmaceutical assistance programs and pharmaceutical discount purchasing cards. The Commissioner of the Department for the Aging shall cooperate with the Commissioner of Health by ensuring that such information is available on the Department for the Aging's website.

B. The Commissioner shall ensure that all clinical sites administered by local health departments are provided with adequate information concerning the services of the Virginia Department for the Aging, including, but not limited to, its toll-free telephone

number and its website information on pharmaceutical assistance programs and pharmaceutical discount purchasing cards.

C. The Commissioner of Health and the Commissioner of the Department for the Aging shall coordinate the dissemination of information to the public regarding any pharmaceutical discount purchasing card programs while maintaining a neutral posture regarding such programs.

D. The Commissioner shall establish a toll-free telephone number, to be administered by the Virginia Department of Health, which shall provide recorded information concerning services available from the Department for the Aging, the Virginia Area Agencies on Aging, and other appropriate organizations for senior citizens.

2. That the Joint Commission on Health Care or any successor in interest thereof shall prepare a plan to establish the Healthy Lives Prescription Assistance Program to provide prescription drug benefits for low-income senior citizens and persons with disabilities, which shall include consideration of the resources of both the public and private sectors. The Joint Commission on Health Care shall prepare the plan in cooperation with the Secretary of Health and Human Resources, the Virginia Health Care Foundation, pharmaceutical manufacturers, health care provider organizations, advocacy groups, and other interested parties. In preparing the plan, the Joint Commission on Health Care shall review and incorporate, to the maximum extent possible, the conclusions of the Joint Commission on Prescription Drug Assistance, established pursuant to HJR 810 of 2001 and continued pursuant to HJR 90 of 2002. The plan shall coordinate state, federal and private programs providing such assistance, including any programs the federal government may implement. The Joint Commission on Health Care shall report its recommended plan to the Governor, the Chairmen of the House Committee on Appropriations, the Senate Committee on Finance, the House Committee on Health, Welfare and Institutions, and the Senate Committee on Education and Health by October 15, 2003.

Legislative Information System

Appendix C

Existing State Senior Prescription Assistance Programs

Existing State Senior Prescription Assistance Programs					
State	**Reimbursement**	**Eligibility Threshold**	**Cost-Sharing**	**Funding Source**	**2001 Changes**
Arizona (pilot program)	Covers 50% of the cost of medication, after deductibles.	$17,180 (200% FPL) Must reside in a county without HMO prescription drug coverage available.	100 to 150 FPL : $500 ded. 150 to 200 FPL: $1,000 ded. If less than 75% of appropriated moneys are spent, ded. may be reduced by not more than $300.	Moneys appropriated from the Tobacco Tax Medically Needy Account.	New. Not yet operational.
Arkansas (Prescription Drug Access Improvement Act)	Covers 2 prescriptions per month.	Age 65. Income: 80% FPL ($6872), increasing to 100% FPL after 6/30/03).	$25 annual enrolment fee. $10 for generic drugs/$20 for brands	Federal/State Medicaid funds	New. Not yet operational. Federal Medicaid waiver required.
California (Discount Prescription Medication Program)	Discount Program: Covers Medi-Cal price for prescription drugs, plus a dispensing fee to be set by the Department of Health Services. Expires 1/1/2003.	Medicare recipients, 65 or disabled. No income limits.		Not known.	
Connecticut (Pharmaceutical Assistance Contract to the Elderly and Disabled Program – ConnPACE)	AWP - 12% + $4.10	Age 65 or adult disabled on SSDP Single: $15,100 Married: $18,100	$12 co-payment.	General Fund.	Eligibility levels increased by $400.
Delaware #1 (Delaware Prescription Drug Assistance Program (DPAP))	AWP - 12% + $3.65	Age 65 Single: $16,488 (200% FPL) Married: $22,128 (200% FPL) Disabled: Eligible for SSDI.	25% co-payment with $2,500 expenditure cap.	Private foundation, tobacco settlement, general fund.	
Delaware #2 (Nemours Health Clinic Pharmaceutical Assistance Program)		Single: $12,500 Married: $17,125	20% co-payment.	Private initiative.	
District of Columbia		$17,180 (200% FPL) Not eligible for any other coverage, including Medicaid.		Publicly funded, but run by private, non-profit group, DC Healthcare Alliance.	New.
Florida (Prescription Expense Assistance Program)	AWP - 13.2% + ($3.15 - $4.23)	Age 65 $10,200 (90 % to 120% FPL) Dually eligible.	10% co-payment with $80/month expenditure cap.	General Fund.	
Illinois (Pharmaceutical Assistance Program)	AWP - 20%/11% + 5.10/$4.00	Single: $21,218 (300% FPL) Married: $28,480 (300% FPL)	$5 co-payment if single and income is less than $8,350 or married with total income less than $11,250; $25 co-payment plus $3 additional fee if income or total income exceeds $8,350. After enrollee reaches $2,000 in reimbursements, co-pay increases to 20 percent.	General Fund and $35 million from tobacco settlement	

State	Reimbursement	Eligibility Threshold	Cost-Sharing	Funding Source	2001 Changes
Indiana (Hoosier Rx)	Usual and customary. Enrollees receive 50% cash subsidies for their prescription purchases.	Single: $11,280 (200% FPL) Married: $15,192 (200% FPL) Disabled: Over 16	Enrollees pay cash and are reimbursed by the state 50% of reimbursement costs up to a maximum of $500 to $1,000 per year, dependent on income.	$20 million from tobacco settlement.	
Iowa (Prescription Drug Purchasing Cooperative)		Age 65. Regulations on eligibility not yet finalized.	Membership fee: $25 to $50.		**New. Not yet operational. Goal 10/01/01**
Kansas (Senior Pharmacy Assistance Program)	AWP - 10% + $3.90	Age: 67 Single: $12,525 (150% of FPL) Married: 16,875 (150% of FPL)	30% co-payment with $1,200 expenditure cap, plus dispensing fee established by Secretary.	General Fund.	
Maine 1 (Maine Rx Program)	AWP – 6% + $3.00 (min.)	No minimum age. (All Maine residents with an Rx Enrollment Card.)		Manufacturer rebates.	
Maine 2 (Healthy Maine Prescription Program)		300% of FPL (Family: $51,150.)	Co-pay of 75% (25% discount).	Manufacturer rebates.	**New**
Maine 3 (Low Cost Drugs for the Elderly Program)	AWP - 10% + $3.35. MFN reimbursement.	$15,244/$20,460 (185% of FPL), but if 40% of income goes to drugs: Single: $19,185 Married: $25,575 Disabled: Age 55	Co-pay of $2/20%, whichever is greater.	General Fund.	**Enrollees transferred to Health Maine Program (above) on 6/1/01. Program ended.**
Maryland 1 (Maryland Pharmacy Assistance Program)	WAC + 10%/AWP - 10% + $4.21	Single: $10,000 Married: $10,850. $4500 maximum assets test also applies. No limitation by age or medical condition	Co-pay of $5 per prescription.	General Fund.	
Maryland 2 (Maryland Pharmacy Discount Program)	Tier I: MPAP Price (AWP-10% + $4.21) + $1 Tier II: MPAP Price + $1	Medicare eligible. Tier I: Single: $21,475 (250% FPL) Married: $29,025 (250% FPL) Tier II: Single: $15,033 (175% FPL) Married: $20,318 (175% FPL)	85% co-pay (15% discount). 75% co-pay (25% discount). With approval of Medicaid waiver, 65% co-pay (35% discount)	Manufacturer rebates. Manufacturer rebates + General Fund.	New. Effective 7/1/01.
Maryland 3 (Short Term Prescription Drug Subsidy Program)	(AWP-10% + $4.21)	Medicare+Choice Eligible. Single: $25,770 (300% FPL) Married: $34,830 (300% FPL) Participation capped at 30,000 enrollees.	Monthly premium of $10. Co-payments of $10 generic/$20 brand/$35 nonpreferred. $1,000 annual benefit cap.	Refund of insurer discount on hospital fees for providing low-income insurance programs.	**Reduced monthly premium. Altered co-payment structure. Increased cap on enrollment.**

State	Reimbursement	Eligibility Threshold	Cost-Sharing	Funding Source	2001 Changes
Massachusetts 1 (The Pharmacy Program)	WAC + 10% + $3.00. MFN reimbursement.	Single: $15,708 Married: $21,156	Co-pays of $3 (generic)/$10 (brand) and expenditure cap of $1,250.	Cigarette tax revenues and state appropriations.	Increased cap on expenditures by $250.
Massachusetts 2 (Prescription Advantage Program)	Catastrophic expenses:costs of all prescription drugs for an enrollee whose out-of-pocket expenditures on prescription drugs exceeds the lesser of (a) 10 per cent of such enrollee's gross annual household income; or (b) $2,000 in out-of-pocket expenditures made by an enrollee for co-payments and deductibles.	No upper income limit. Disabled: $15,698. Does not work more than 40 hours per month.	No premium or deductibles under 188% FPL ($15,698). Department to establish program of monthly premiums ($15 to $82) and deductibles ($100 to $500), based on a sliding scale.	General Fund.	**New.**
Massachusetts (Aggregate Purchasing Law)	State agency to coordinate combined purchasing for Senior Pharmacy Assistance enrollees, Medicaid, state workers, uninsured, and underinsured.				Not yet in operation. Delayed by executive action.
Michigan 1 (EPIC (2000)	AWP - 13.5% (ind)/15.1% (chain) + $3.77	Single: $17,180 (200% FPL) Married: $23,220 (200% FPL) and enrollees in the MEPPS program which it replaces. No minimum age.	Co-pays increase as income increases. No premium below 100% FPL.	Tobacco settlement.	**New. Takes effect 10/1/2001.**
Michigan 2 (MEPPS (Will be replaced by EPIC in 2001)	Lower of AWP - 12% + $3.65 or usual and customary.	Age 65. Single: $12,885 Married: $17,415	$0.25 co-pay with each prescription	Sales tax on construction materials.	**Expires 9/30/01, to be replaced by EPIC.**
Michigan 3 (Prescription Drug Tax Credit Program)	Tax credit for consumer of $600 for prescriptions over 5% of household income.	Age 65 Single: $12,885 (150% FPL) Family: $17,415 885 (150% FPL)			
Minnesota 1 (Senior Citizen Drug Program)	Lower of AWP - 5% + $3.65 or usual and customary.	$10,260/$13,740. $10,000 assets test also applies.	Deductible of $35 per month. Co-pay = $3/Rx.	General Revenues.	Increase in eligibility levels.
Minnesota 2 (Senior Drug Discount Program)		200% FPL. Enrolled in Medicare Part A & B. No other drug coverage.	Enrollment Fee: $5	Manufacturer Rebates	

State	Reimbursement	Eligibility Threshold	Cost-Sharing	Funding Source	2001 Changes
Missouri (Pharmaceutical Tax Credit)	$200 tax rebate up to $15,000. Credit reduced $2 for each additional $100 of income.	Age 65.		General Fund.	**New**
Nevada 1(Senior Rx)	Rate negotiated by administering insurance company and pharmacies.	Minimum age 62. Family: $21,500.	Subsidizes entire cost of insurance, including premiums and deductibles. $10 maximum generic co-pay; $25 maximum preferred brand co-pay.	Tobacco settlement, general funds.	Increases degree of subsidization.
Nevada 2 (Senior Option Program)	Maximum annual drug subsidy of $5,000. Effective 1/1/2003 or earlier on declaration if fewer than 3,500 participants in Senior Rx or if moneys to subsidize Senior Rx insufficient.	Family: $21,500.	Application fee not exceeding $25. Co-pay of $10/$25. Annual deductible not exceeding $100.	Tobacco settlement, general funds.	**New**
New Hampshire (Prescription Drug Discount Program for Seniors)	Pilot program. 40% discount on generic drugs/15% discount on brands.	Age 65. No income limit.	No fees.	General Fund.	
New Jersey 1 (Pharmaceutical Assistance for the Aged and Disabled)	AWP - 10% + ($3.73-$4.07)	Age 65. Single: $19,238 Family: $23,589 Disabled: age 21	$5 co-pay per prescription.	State General Fund and Casino Revenue Fund.	**Expanded eligibility.**
New Jersey 2 (Senior Gold Prescription Discount Program)		Age 65. Single: $19,238 to $29,238 Family: $23,589 to $33,589 (not more than $10,000 above PAAD income eligibility)	$15 plus 50% of the remaining amount of the reasonable cost for the prescription drug, or the reasonable cost for the prescription drug, whichever is less. Maximum: $2,000 for a single person and $3,000 for a married couple.	Tobacco settlement funds.	New
New York (EPIC)	Lower of AWP - 5% + $3.00 or usual and customary.	Age 65. Single: $35,000 Married: $50,0000	Co-pays of $3 to $20, depending on the cost of the prescription ($15 to $55). Moderate income ($20,000 single/$26,000 married) pay fees of $8 to $230 for a single, $8 to $300 for married. High-income ($35,000/$50,000) pay deductibles of $530/$1230 and $650/$1715.	State General Fund.	**Income limits increased, co-payments for prescriptions lowered, quarterly fees reduced for low- and moderate-income seniors. New deductible plan added for higher income seniors.**

State	Reimbursement	Eligibility Threshold	Cost-Sharing	Funding Source	2001 Changes
North Carolina (Prescription Drug Assistance Program)	AWP - 10% + $5.60	Age 65. Single: $12,360 (150% FPL). Demonstration program covers heart disease and diabetes. No Medicaid Coverage	Co-pay of $6 per Rx.	Tobacco settlement.	**Enrollment temporarily closed 3/1/01 due to budgetary limitations.**
Oregon (Senior Prescription Drug Assistance Program)	MA Price + MA dispensing fee, up to $2,000 annually.	Age 65. Single: $15,891 (185% FPL) Married: $21,478 (185% FPL) Less than $2,000 in resources, excluding primary residence and car. Applicant not covered (public or private) in preceding 6 months.	$50 enrollment fee. "Critical access pharmacies" may charge beneficiaries $2 co-pay.	State cigarette tax revenues over $175 million annually.	**New. Effective July 1, 2001. Not yet in operation.**
Pennsylvania 1 (Pharmaceutical Assistance for the Elderly - PACE)	AWP - 10% + $3.50	Age 65. Single: $14,000 Married: $17,200	$6 co-pay per Rx.	State Lottery.	
Pennsylvania 2 (PACENET)		Age 65. Single: $16,000 Married: $19,200	$500 deductible. $8 co-pay for generic. $15 co-pay + 70% AWP for brand.		
Rhode Island (RIPAE – Rhode Island Pharmaceutical Assistance for the Elderly)	AWP - 13% + $2.50 Three-tiered system. Program pays 60% of the medication bills for individuals with incomes as low as $16,590, 30% of bills for those in the middle tier, and 15% of the bills for individuals up to $36,225. Married individuals also tiered.	Single: $16,590 to $36,225 Married $20,613 to $41,400 Excludes income spent on medications if greater than 3 percent of total income.	Three levels of co-pay, dependent on income, 40%, 70%, and 85% (in order of increased income).	State Revenues and Manufacturer Rebates.	**Expanded eligibility (increased eligibility levels).**
South Carolina (SilveRxCard – Seniors' Prescription Drug Program)	Rate negotiated between PBM and pharmacies.	Priority is given to single seniors with $12,525 annual income and married couples with a combined income of $16,875, although eligibility goes up to $19,678 (175% of FPL).	Discounts are available for initial purchases up to an annual deductible, after which SILVERxCARD covers all prescription costs above the participant's co-payment amount (amount unknown).	Tobacco settlement.	
Texas 1 (State Prescription Drug Program)	AWP – 15%/WAC + 12% + $5.27 + 2%	Dually eligible. Upper income limits to be determined by commission.	Requires co-pay (amount to be determined).	General funds.	**New. Not yet operational. Effective 1/1/2002.**
Texas 2 (Interagency Council on Bulk Purchasing)	State agency to coordinate combined purchasing public employees and all other state public health				**New. Not yet operational.**

State	Reimbursement	Eligibility Threshold	Cost-Sharing	Funding Source	2001 Changes
	programs. Council to develop procurement rules.				
Vermont 1 (VSCRIPT)	Lower of AWP - 10% + $4.25 or usual and customary	Age 65. Single: $18,540 (225% FPL) Married: $24,885 (225% FPL) Disabled: SSI benefits	50% co-pay with each prescription.	Cigarette tax revenue and state funds.	
Vermont 2 (Vermont Health Access Program)	Lower of AWP - 10% + $4.25 or usual and customary	Single: $12,360 (150% FPL) Married: $16,590 150% FPL) Disabled: Recipients of SSI or Medicare disability benefits.	$1.00/$2.00 co-pay, depending on the cost of the prescription.	General funds.	
Vermont 3 (Pharmacy Discount Program)	AWP – 11.9% + $4.25, minus manufacturer rebates	Any Medicare-eligible individual. Others: Single: $25,056 (300% FPL) Married: $33,756 (300% FPL)	70% co-pay. $25 annual enrollment fee. $3 co-pay for first eight prescriptions each year.	Manufacturer rebates.	**New. Suspended 6/8/01 after federal circuit court found rebate-funding illegal.**
Washington (AWARDS)	Retail discounts of 12% to 49%.	Age 55. No income eligibility limit.	Annual enrollment fee: Single: $15 Married: $25	General funds.	**New. Implemented by executive order on 1/1/2001. Suspended after state court struck down 5/25/01.**
West Virginia 1 (SPAN II)	Retail discounts.	Age 65. No income eligibility requirement.	No enrollment fee.	General funds.	**New. Implemented by executive order. Income eligibility requirement eliminated 4/1/01.**
West Virginia 2 Act authorizes request for Medicaid waiver.	Authorizes "substantial discounts".	Age 65. 200% FPL.			**Enacted 5/15/2001.**
Wisconsin	MA + 5% (AWP – 6.25%)	240% FPL (Single: $20,600; Married: $26,900)	Annual Enrollment fee: $20 Deductible (>160% FPL): $500 Co-pay: $5/$15	General Funds	September 1, 2002.

Last modified August 17, 2001.

Appendix D

A summary of the court opinion in *PhRMA v. Tommy Thompson (HHS) and Kevin Concannon (State of Maine)*

A summary of the court opinion in *PhRMA v. Tommy Thompson (HHS) and Kevin Concannon (State of Maine)*
issued February 26, 2002
by
Donna Folkemer, NCSL Staff

The United States District Court of the District of Columbia upheld the legality of Maine's prescription drug discount program. Pharmaceutical Research and Manufacturers of America (PhRMA) had challenged the Healthy Maine Prescription (HMP) program, arguing that it violated Section 1115 Medicaid demonstration program standards.

HMP, in operation since June 1, 2001, is authorized through a Section 1115 Medicaid demonstration waiver approved by the federal government on January 18, 2001. The program provides discounts on prescription drugs to persons with incomes of up to 300% of the poverty level who are not eligible for Medicaid. The price beneficiaries pay for a prescription is equal to the Medicaid payment rate for a prescription less 14%. Maine requires pharmaceutical manufacturers to pay rebates for drugs prescribed under HMP in accordance with the Medicaid rebate schedule. The state disburses the rebate funds to retail pharmacies to cover the cost of the subsidy and program administration. (Pharmacists receive a fixed subsidy totaling 18%.) Since July 2001, Maine has paid pharmacists an additional two percent - or about $1 per prescription - in state-only (unmatched) funds.

PhRMA asked for a summary judgment invalidating HMP and enjoining the Secretary of the Department of Health and Human Services from approving any other programs that include any of the features of HMP. They argued that Maine's program unlawfully required rebates from drug manufacturers even though it made no state payments under the state's Medicaid plan, failed to provide medical assistance in accordance with legal requirements, and required beneficiary co-payments exceeding nominal limits. The arguments made in this case mirrored those considered by the United States Circuit Court of the District of Columbia when it struck down Vermont's pharmacy discount plan on June 8, 2001. (*PhRMA v. Thompson*, 01-5029.) In the Vermont case, the Circuit Court said that payments made to pharmacies were not "state payments" because they were funded entirely by manufacturer rebates.

In the February 26, 2002 ruling, the District Court found that Maine's two-percent payment fits the meaning of state payment. The Circuit Court's decision on Vermont had defined payments as "state or federal funds appropriated for Medicaid expenditures." The District Court said that "since Maine's two-percent payments are in addition to and separate from the 18-percent subsidy provided by the manufacturer rebates, the court also concludes that Maine's HMP funds are not from fully reimbursed manufacturer rebates."

PhRMA's filing argued that Maine's state-only expenditures should not have been approved as "payments" because they were not made under the state Medicaid plan. On this matter, the court ruled that deference should be given to the Secretary of DHHS and his demonstration project authority. The opinion said "Medicaid treats payments made in demonstration projects as though they were expenditures under the State plan 'to the extent. .

.prescribed by the Secretary' ". On the issue of co-payments, the District Court ruled that PhRMA does not have standing to challenge because none of its members are affected by these rules.

If PhRMA appeals this decision, the appeal will be heard by the United States Circuit Court of Appeals, the same court that ruled on the Vermont program in 2001.

The decision is at http://www.dcd.uscourts.gov/01-1453.pdf [31 pages].

Appendix E

American Legislative Exchange Council "Principles Regarding Prescription Drug Benefits"

American Legislative Exchange Council
"Principles Regarding Prescription Drug Benefits"

The federal government is considering the addition of a prescription drug benefit to the Medicare program to address growing concerns about access to and affordability of prescription drugs. In addition, given the present absence of federal action, many states are crafting or have already created benefit programs for their citizenry. Numerous proposals have been offered with regard to these proposed benefits, many of which directly contradict the Jeffersonian principles of limited government, individual choice, and free markets upon which our nation was founded. Alarmingly, many of these proposals provide a new entitlement for a class of our citizenry. The Health and Human Services Task Force of the American Legislative Exchange Council is committed to the implementation of a prescription drug benefit that does not violate Jeffersonian principles. To that end, and to serve as a foundation for its work, the Task Force has adopted a model set of Principles Regarding Prescription Drug Benefits. These principles include, but are not limited to:

Flexibility. The Task Force supports a benefit that affords the states the greatest degree of flexibility in implementation. While the Task Force would prefer to have a prescription drug benefit funded using block grants, its principles apply to both a federally-implemented and a state-implemented benefit. The Task Force rejects any unfunded mandates imposed by the federal government and will oppose any movement by the federal government to shirk its financial responsibility with regard to overall Medicare reform. In addition, any federal legislation must contain the necessary provisions to permit states to continue operation of their existing plans without penalizing proactive states through maintenance of effort provisions.

A Targeted Benefit. A very small number of seniors, only 4% in 1999, spent more than $2,000 per year on out-of-pocket prescription drug expenses. Seniors with the highest expenses and the lowest incomes are those to whom a prescription drug benefit must be targeted. If a drug benefit is enacted to extend to the entire Medicare population, or the entire citizenry, it will result in the creation of another broad entitlement. The creation of such an entitlement in our nation's social policy is irresponsible and will foster unintended consequences by distorting markets, putting extraordinary burdens on taxpayers to fund this entitlement, and ultimately injecting damaging government controls. What is needed is a sense of ownership in meeting a need rather than a sense of entitlement.

Free-market supremacy. A key to the success of any health care reform, including the addition of a prescription drug benefit, is the ability of the private sector to meet the needs of the population. The federal and state governments should seek innovative partnerships with the private sector to provide prescription drugs for its citizens. Though a drug benefit will utilize public funding, the private sector is best able to deliver this benefit, as it may negotiate appropriate discounts and keep overall spending in check.

Individual Freedom and Choice. Our nation is founded upon these two bedrock principles, which are all to often ignored by policymakers, particularly in the health care arena. A prescription drug benefit must allow its beneficiaries affordable access to all necessary pharmaceuticals, whether name brands, generics, or some non-prescription over-the-counter drugs. Allowing such access protects the sanctity of the patient-provider relationship, which the Task Force acknowledges and respects.

At the same time, the Task Force recognizes the difficult choices to be made given the constraint of limited economic resources. Thus, while the Task Force supports the greatest degree of freedom possible for patients, it also recognizes that access to pharmaceuticals is not without boundaries. Accordingly, the Task Force supports allowing the states to exercise the greatest degree of freedom when it comes to making crucial decisions on issues such as formularies, cost sharing, and disease management. The Task Force further supports drug benefit plans that promote personal responsibility, encouraging beneficiaries to recognize the costs of their coverage and the consequences associated therewith.

Regardless, beneficiaries must have some level of choice with regard to a prescription drug benefit so as to encourage market-oriented behaviors. Beneficiaries must be able to choose between competing, private sector plans in order to make their own determinations, as "one size fits all" does not apply in the health care arena.

Market-Dictated Pricing. Government entitlement programs inevitably lead to price controls. When price controls are imposed on any industry, they reduce return on investment, and the ability of producers to fund new, innovative research or continued development, or increase production. The most damaging effect of price controls on pharmaceuticals is that they will discourage manufacturers from developing additional life-saving drugs because they will not be able to recoup the costs of research and development. History has proven time and again that mandated price controls do not work; in fact, one truism of public policy is that price controls on goods and services lead to shortages of those goods. It is tragically ironic that a proposal intended to expand access to medication through price controls will result in restricting patient access.

Adopted by the Health and Human Services Task Force on
August 3, 2001

Appendix F

AARP on Anti-trust Litigation, Cost Containment, and Profits

The AARP, in its June 2002 *AARP Bulletin*, has provided some initial guidance on its positions regarding access to pharmaceuticals and the cost of doing business. While this information does not directly have any impact on pharmaceutical programs, they do have an impact on customers and the availability and affordability of drugs.

- ❖ The AARP joined three lawsuits in May 2002 that charge drugmakers with violating anti-trust laws to keep low-cost generics off the market. A true generic is medically equivalent to brand-name drugs but sells for 20 to 80 percent less. The suits address issues (i) where drug companies have paid smaller companies to stop the sale of generic alternatives to the tune of $75 million; (ii) about alleged patent abuse when a company that owned a patent that was about to expire sued generic competitors for patent infringement; any such claim, valid or not, triggers a 30-month delay in FDA approval of a generic version; and (iii) regarding tamoxifen where the producer allegedly agreed to pay another company $21 million and provide the drug to them for resale if the second company agree not to produce a generic. The drug is sold by the second company over the internet for 5% less than the brand name. These lawsuits have only just begun, and details will be provided to you as they progress.
- ❖ AARP has called on Congress to include "strong and effective" cost containment measures in any Medicare prescription drug program. Prices of drugs must be contained to make the program viable for a long period of time. The basic principles of any pharmaceutical program for Medicare should (1) encourage the use of generics, (2) not encourage the abuse of drug patents, (3) not be means-tested within the Medicare program and be available to all beneficiaries, and (4) provide equal treatment for all beneficiaries across states and not be discriminated against because one state provides more funding than another.

There is concern among many consumers that pharmaceutical companies are engaging in "scare tactics" by saying that any attempts to "lower prescription drug prices would harm research, stifle innovation, and wreck hopes of cures for major diseases." While pharmaceutical manufacturers defend the high costs of many drugs to fund their research and development, opponents claim that most companies spend twice as much on marketing and administration as they do on research, that many drugs are derived from research funded by tax dollars, and that many new drugs are "me-too" drugs that offer little benefit, if any, to current drugs or are merely modifications to current drugs that generates a new patent.