REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

HB 2225/SB 1341 (2003)
Healthy Lives Prescription Assistance Plan

Report Document No. 17

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March 15, 2005

TO: The Honorable Mark R. Warner, Governor of Virginia
and Members of the General Assembly

The 2003 General Assembly, by enacting House Bill 2225 and Senate Bill 1341, established the Healthy Lives Prescription Assistance Fund. In addition, an enactment clause required the Joint Commission to prepare a plan for the provision of drug benefits. The Joint Commission on Health Care, in consultation with a variety of stakeholders, developed a two-phased design for the Healthy Lives Prescription Plan that supports existing programs and resources.

This report on the Healthy Lives Prescription Plan is enclosed for your consideration.

Respectfully submitted,

Harvey B. Morgan
Chairman

JOINT COMMISSION ON HEALTH CARE: 2004

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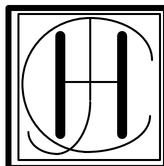

PREFACE

During the 2003 Session of the General Assembly, the enactment of House Bill 2225 and Senate Bill 1341 amended the *Code of Virginia* to establish the Healthy Lives Prescription Assistance Fund. The Fund accepts "appropriations, donations, grants, and in-kind contributions to develop and implement programs that will enhance current prescription programs for citizens of the Commonwealth who are without insurance or the ability to pay for prescription drugs and to develop innovative programs to make such prescription drugs more available." The Secretary of Health and Human Resources is required to report on the Fund on an annual basis.

HB 2225 and SB 1341 included a second enactment clause that required the Joint Commission on Health Care (JCHC) to prepare a plan "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 the private sectors." (Because the Healthy Lives Prescription Assistance Fund contains no funding at this time, JCHC in consultation with stakeholders developed a Plan that supports existing programs and resources.)

In November 2003, the Joint Commission unanimously approved a two-phased design for the Healthy Lives Prescription Plan. Phase I of the Plan discussed ways to inform and assist seniors and their families in applying for pharmaceutical discount cards. Phase II addressed additional actions that could be taken to assist seniors and uninsured Virginians in obtaining their prescription medications. During the 2005 General Assembly Session, two resolutions and three budget amendments were introduced by the Joint Commission to provide information about and funding for prescription assistance programs.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the numerous individuals who represented advocacy groups, health care providers and associations, pharmaceutical manufacturers, State agencies, medical centers, and the Office of the Secretary of Health and Human Resources for their participation and assistance in designing and implementing the Healthy Lives Prescription Plan.

Kim Snead
Executive Director

March 2005

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HEALTHY LIVES PRESCRIPTION ASSISTANCE PROGRAM
EXECUTIVE SUMMARY

Authority for Study

House Bill 2225 and Senate Bill 1341, identical bills, enacted during the 2003 General Assembly Session amended the *Code of Virginia* to establish the Healthy Lives Prescription Assistance Fund under the auspices of the Secretary of Health and Human Resources to "accept appropriations, donations, grants, and in-kind contributions to develop and implement programs that will enhance current prescription programs for citizens of the Commonwealth who are without insurance or the ability to pay for prescription drugs and to develop innovative programs to make such prescription drugs more available." In addition, HB 2225 and SB 1341 include a second enactment clause that requires the Joint Commission on Health Care to prepare a Plan "to provide prescription drug benefits for low-income senior citizens and persons with disabilities…."

To develop recommendations for the Plan, a diverse group of interested parties, representing advocacy groups, health care providers and associations, pharmaceutical manufacturers, state agencies, and the Secretary of Health and Human Resources participated in workgroup meetings during the summer of 2003. Based on recommendations from this group, JCHC on November 12, 2003 unanimously approved a two-phased design for the Healthy Lives Prescription Plan.

Phase I included such activities as informing seniors and their families regarding the existence of pharmaceutical discount cards and affiliating with opportunities that currently exist in the community to provide assistance in filling out applications.

Implementation of Phase II included the following activities:

- Monitoring the actions of Congress regarding a Medicare prescription drug benefit;
- Examining what other states are doing to assist seniors;
- Encouraging Virginia-based initiatives such as The Pharmacy Connection;
- Continuing to develop partnerships with community-based entities such as pharmacies, faith-based organizations, human service agencies, and advocacy associations; and
- Analyzing potential legislation to increase the income limits for Medicaid eligibility in Virginia.

Actions Taken by JCHC

Ten policy options were offered for consideration by the Joint Commission on Health Care. On November 15, 2004, the Commission voted in support of six of the options including:

- **Option II:** Introduce a joint resolution requesting the Virginia Department for the Aging and the Virginia Department of Health to provide information on the "wrap around" coverage currently offered by private pharmaceutical companies. This coverage is available for low-income individuals enrolled in the Medicare prescription drug discount card program who use all of their $600 transitional assistance credit.

- **Option IV:** Introduce a budget amendment (language and funding) to expand the use of The Pharmacy Connection software to other areas of the state.

- **Option V:** Introduce a joint resolution requesting the Department for the Aging, the Department of Medical Assistance Services, and the Department of Health to work with the Virginia Dental Association and the Virginia Health Care Foundation in exploring the feasibility of using the Mission of Mercy initiative as a vehicle for expanding access to and information about pharmaceutical assistance programs and Medicare prescription drug discount cards.

- **Option VIII:** Continue to address the development of the Healthy Lives Prescription Plan by including the issue on the JCHC workplan for 2005.

- **Option IX:** Introduce a budget amendment (language and funding) to increase funding for the acquisition and provision of prescription medications to Free Clinic patients.

- **Option X:** Introduce a budget amendment (language and funding) to increase funding for the Virginia Primary Care Association Indigent Pharmacy Assistance Program.

I. Authority for the Study/Organization of Report

During the 2003 General Assembly Session, the *Code of Virginia* was amended by the enactment of House Bill 2225 and Senate Bill 1341. (Appendix A) These two identical bills were designed to provide assistance for individuals who are unable to pay for their prescription medications.

The first enactment clause created the Healthy Lives Prescription Fund. The addition of *Code of Virginia* § 2.2 – 214.1, "created in the Department of the Treasury a special nonreverting fund that shall be known as the Healthy Lives Prescription Fund." The Fund will be supported by moneys appropriated by the General Assembly and other resources available from the federal government, donations, grants, and in-kind contributions. Funds are available to create and execute initiatives that will enhance current prescription drug programs as well as develop innovative programs to increase the availability of prescription medications for Virginia's citizens who do not have insurance coverage or the ability to pay for prescription drugs.

The first enactment clause also amended the *Code of Virginia* by adding § 32.1 – 23.1 which requires the Virginia Department of Health (VDH) and the Virginia Department for the Aging (VDA) to establish various mechanisms for the dissemination of information about prescription drug assistance. Information and links regarding pharmaceutical assistance programs and pharmaceutical discount purchasing cards are to be included on their respective websites. The responsibility of disseminating information to the citizenry regarding any pharmaceutical discount purchasing cards, while retaining a neutral posture, was also delegated to these two state agencies. All clinical sites administered by local health departments are to be provided with information about the services available through VDA. This information is to include VDA's toll-free telephone number and materials on their website about purchasing pharmaceutical drugs. The legislation also directed VDH to administer a toll-free number that provides recorded information about services available from VDA, Virginia's area agencies on aging, and other appropriate organizations for senior citizens.

The second enactment clause of House Bill 2225 and Senate Bill 1341 directs the Joint Commission on Health Care to create a plan to establish the Healthy Lives Prescription Assistance Program. Considering resources available in both the private and public sectors, the Healthy Lives Prescription Assistance Program should be designed to provide prescription drug benefits for low-income senior citizens and

individuals with disabilities. The plan was to coordinate federal, state, and private programs. In working with stakeholders, such as the Secretary of Health and Human Resources, the Virginia Health Care Foundation, pharmaceutical manufacturers, health care provider organizations, and advocacy organizations, the Joint Commission on Health Care was to incorporate, as much as possible, the recommendations from the Joint Commission on Prescription Drug Assistance. The Joint Commission on Prescription Drug Assistance was established, by House Joint Resolution 810 (2001) and continued by House Joint Resolution 90 (2002), to develop a plan for assisting the needy elderly with their prescription medications.

On November 12, 2003, the Joint Commission on Health Care unanimously approved a two-phased design for the Healthy Lives Prescription Plan. Phase I of the Plan includes informing seniors and their families of the existence of pharmaceutical discount cards and affiliating with opportunities that currently exist in the community to provide assistance in filling out applications. The second phase involves continued research and consultation on additional actions that the General Assembly may implement to aid senior citizens in acquiring their prescription medications.

ORGANIZATION OF THE REPORT

This report includes five separate sections. The initial section, which was just discussed, covers the authority for this study. Section II will provide greater detail on the Healthy Lives Prescription Plan, followed by overviews of Phases I and II of the Plan in Sections III and IV. Policy options available to the Joint Commission on Health Care will be covered in the final section of the report.

II. Background on the Healthy Lives Prescription Plan

The cost of health care has continued to rise in the United States. Rising prescription drug costs have been a major contributor to this phenomenon. With this increase in pharmaceutical costs over the last several years, an increasing amount of attention has focused on the issue of prescription drug coverage. These concerns have often focused on the increasing cost of medications and the lack of prescription drug coverage for the elderly.

The Kaiser Family Foundation ranked Virginia 21st among states and the District of Columbia when comparing the average price of retail prescriptions in 2002. Alaska led the states with an average price of $64.81 while Alabama had the lowest average price at $44.80. With the average price of a retail prescription in Virginia rising 9 percent from 2001 to $53.39 in 2002, the Commonwealth came in just below the national average of $54.58. Figure 1 outlines spending for retail prescription drugs, in the United States, for selected years over a span of 42 years.

Figure 1
U.S. Spending For Retail Prescription Drugs, In Dollars and Percentage Growth From Prior Year, Selected Years 1960 – 2002

Spending	1960	1980	1982	1992	1994	1999	2000	2002
Prescription drugs (billions)	$2.7	$12.0	$15.0	$48.2	$54.6	$104.4	$121.5	$162.4
Out-of-pocket	2.6	8.4	10.0	26.4	26.3	34.4	38.3	48.6
Third-party	0.1	3.7	5.0	21.8	28.3	70.1	83.2	113.8
Private health insurance	0	2.0	3.0	13.1	17.5	47.9	56.6	77.6
Medicaid	---	1.4	1.7	6.9	8.7	17.3	20.9	28.6
Other public support	0.1	0.3	0.3	1.8	2.1	4.9	5.8	7.6
Per capita (dollars)	$14	$52	$64	$186	$206	$376	$433	$569
Average annual growth from prior period	---	7.8%	11.7%	12.4%	6.4%	13.8%	16.4%	15.6%

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group

With the rising cost of pharmaceuticals, health insurance coverage that includes prescription drug coverage is critical for many people to access needed medications. The following table outlines insurance status in the Commonwealth between 2001 and

2002. Information used in the table was gathered using the Current Population Survey which is self-reported and reflects point-in-time data, therefore, estimates are generally lower than the program enrollment data provided by the federal Centers for Medicare and Medicaid Services.

Figure 2

Population Distribution in Virginia by Insurance Status
State Data 2001 – 2002, U.S. 2002

Source of Coverage	Population VA	VA %	Population US	US %
Employer	4,562,790	65%	161,727,800	57%
Individual	303,340	4%	13,365,930	5%
Medicaid	469,520	7%	33,006,620	12%
Medicare	818,370	12%	33,404,670	12%
Uninsured	868,060	12%	43,572,090	15%
Total	7,022,090	100%	285,077,110	100%

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2002 and 2003 Current Population Surveys.
Total US numbers are based on March 2003 estimates.

ACTIVITIES AND RECOMMENDATIONS OF THE JOINT COMMISSION STUDYING PRESCRIPTION DRUG ASSISTANCE

In 2001, House Joint Resolution 810 established the Joint Commission on Prescription Drug Assistance. House Joint Resolution 810 charged the Commission 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.

The passage of House Joint Resolution 90 during the 2002 Session of the General Assembly continued the work of the Joint Commission on Prescription Drug Assistance. In addition to the responsibilities outlined in the 2001 resolution, House Joint Resolution 90 directed the Joint Commission on Prescription Drug Assistance to consider in its deliberations:

(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 program for which state general funds are expended by consolidating pharmacy purchases, and (iii) pursuing cooperative arrangements with other states to pool pharmacy purchases.

In each year, the Joint Commission on Prescription Drug Assistance issued a set of recommendations. During the first year of activity, the following four recommendations and consequent actions were taken by the Joint Commission on Prescription Drug Assistance:

1) The Commission recommended that the eligibility level for Medicaid for the elderly and disabled be raised from 80 percent of the federal poverty level (FPL) to 100 percent of the federal poverty level (FPL), in order to extend Medicaid benefits, which include prescription drug coverage to the elderly and individuals with disabilities who possess minimal financial resources. House Bill 913 was introduced during the General Assembly Session in 2002, but was tabled in House Appropriations.
2) Expanding the Pharmacy Connect program to all area agencies on aging (AAA) was recommended by the Commission to maximize the use of free drugs offered by various pharmaceutical companies for eligible populations. According to the *Report of the Joint Commission Studying Prescription Drug Assistance,* the estimated cost of implementation for each area agency on aging (AAA) was approximately $200,000, including providing software and other materials for training. The total cost, taking into account the program operated by Mountain Empire Older Citizens ($371,000), was estimated at $4.8 million. The Commission introduced budget amendment Item 314.1h during the 2002 General Assembly Session to expand the Pharmacy Connect program statewide. This budget amendment which included $5 million in GF funding per year was not included in the approved budget.
3) The Commission concluded that 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 should be amended to include discount drug cards offered by pharmaceutical companies for eligible populations. Including this amendment, House Bill 560 passed in the 2002 Session but contained a delayed effective date contingent upon appropriations being made available.
4) The Commission decided that another year was needed to work on the study. Language confirming this was passed in House Joint Resolution 90.

Due to the anticipated budget shortfalls in 2002-2003, the Commission altered the direction of the plan which had originally envisioned a comprehensive prescription assistance plan. Instead they focused on promoting and enhancing the utilization of existing programs and opportunities.

The Commission agreed upon three elements that would likely be included in the program. They consisted of:

1) Identification of individuals who may be eligible for Medicaid or free or discounted pharmaceutical card programs.
2) Implementation of a public/private partnership that would create a program to enroll eligible seniors in drug benefit programs available across the state.
3) Expansion of the program which would be dependent upon the regular evaluation of the program by a designated agency responsible for developing the program.

The majority of the aforementioned elements were incorporated into House Bill 2225 and Senate Bill 1341 during the 2003 Session of the General Assembly. The passage of these bills created the Healthy Lives Prescription Fund and directed the Department of Health and the Department for the Aging to disseminate information about prescription drug assistance in a variety of methods. In addition, the Joint Commission on Health Care was charged with preparing a plan to establish the Healthy Lives Prescription Assistance Program.

DEVELOPMENT OF THE HEALTHY LIVES PRESCRPTION ASSISTANCE PROGRAM

House Bill 2225 and Senate Bill 1341, sponsored by Delegate Benjamin L. Cline and Senator H. Russell Potts, Jr., directed the Joint Commission on Health Care to:

> 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 Plan was fashioned with assistance from a variety of stakeholders including health care providers and associations, pharmaceutical manufacturers, state agencies, medical centers, and the Office of the Secretary of Health and Human Resources. Delegate Cline and the legislative assistant to Senator Potts were also active in the creation of the Healthy Lives Prescription Plan. To define the parameters of the Plan, three workgroup meetings were held during the summer of 2003.

The Plan created by the workgroup and unanimously approved by the Joint Commission on Health Care on November 12, 2003, included a two phase approach. In Phase I of the Healthy Lives Prescription Plan, seniors and their families would be informed of the existence of pharmaceutical discount cards. To aid in this process, opportunities already available in the community would be used to provide one-on-one assistance in filling out applications.

Phase II of the Plan called for several different actions involving continued research and consultation regarding additional actions the General Assembly may want to pursue to assist seniors in obtaining prescription medications. The activities outlined by the workgroup include:

- Monitoring the actions of Congress regarding the creation of a prescription drug benefit under Medicare.
- Analyzing what other states have created and implemented to assist seniors with access to needed pharmaceuticals.
- Reviewing ways that Virginia-based initiatives such as the Pharmacy Connection and Pharmacy Connect can be enhanced.
- Encouraging partnerships with community-based organizations, such as pharmacies, faith-based entities, human services agencies, and advocacy groups.
- Exploring the impact of legislation to increase the income limits for Medicaid eligibility for non-institutionalized aged, blind, and disabled individuals.

During the November 12, 2003 meeting of the Joint Commission on Health Care, members voted to submit the two phase Healthy Lives Prescription Plan to the chairmen of the House Appropriations and Senate Finance Committees as well as the House Committee on Health, Welfare, and Institutions and the Senate Committee on Education and Health. In addition, members of the JCHC voted unanimously to address the development of the Healthy Lives Prescription Plan with its inclusion on the JCHC 2004 workplan.

III. Overview of Phase I of the Healthy Lives Prescription Plan

Phase I of the Healthy Lives Prescription Plan focuses on: (1) informing seniors and their families about existing opportunities for pharmaceutical assistance, and (2) coordinating with current opportunities in the community to provide one-on-one help in completing applications for assistance.

PHARMACEUTICAL ASSISTANCE PROGRAMS

As noted in the *Report of the Joint Commission on Health Care Healthy Lives Prescription Plan* (RD 14, 2004), there are a number of ways in which seniors receive assistance in obtaining prescription medications. These forms of assistance fall into three general categories: patient assistance programs; pharmaceutical discount cards; and direct assistance by the federal, state, or local government.

Patient Assistance Programs

Patient assistance programs (PAPs) are programs created by pharmaceutical manufacturers to provide certain prescriptions at no cost to low-income "prescription-uninsured" individuals of any age. Pharmacy Connect and The Pharmacy Connection, two programs that will be discussed later, are examples of programs that facilitate patient access to PAPs. According to the Virginia Health Care Foundation (VHCF), there are approximately 126 PAPs, each with their "own forms, procedures, eligibility criteria and supply limitations." Most of the PAPs set income eligibility for free medication at 100 percent of the federal poverty guidelines; some PAPs set eligibility as high as 150 percent of the federal poverty guidelines. VHCF indicates that use of The Pharmacy Connection software has allowed $183 million (average wholesale price) of free medications to be dispensed to Virginians since 1997.

Pharmaceutical Discount Cards

Pharmaceutical discount cards were introduced several years ago to assist Medicare recipients who did not have prescription coverage. Pharmaceutical manufacturers offer the following five discount cards:

- Lilly Answers (Eli Lilly and Company)
- Novartis Care
- Orange Card (GlaxoSmithKline)

- Share Care (Pfizer)
- Together Rx (Abbott Laboratories, AstraZeneca, Aventis Pharmaceuticals, Bristol-Myers Squibb Company, GlaxoSmithKline, Johnson & Johnson, and Novartis).

The benefit provided by each card varies with some cards providing a percentage discount of the medication cost and other cards providing for a flat fee to be paid for each prescription. The applications for the discount cards are very simple and no proof of income is required to apply.

Direct Assistance from the Federal or State Government

Direct assistance with the cost of prescription medication can also be provided by the federal or state government. Until the implementation of the Medicare prescription drug benefit, the most expansive example of direct assistance has been the prescription coverage provided in the Medicaid program. Medicaid is a means-tested, entitlement program that provides health and long-term care, and is supported by federal and state funding.

In the absence of prescription drug coverage in Medicare, a large number of states established prescription assistance programs for seniors. The majority of state programs involved a direct subsidy for prescription costs or a discount card that allowed a senior to pay a discounted price for prescription medication. Four states had Medicaid waivers to provide prescription assistance.

Pharmaceutical assistance programs may change significantly, particularly when prescription drug benefits are added within the Medicare program beginning in January 2006. While prescription assistance programs that provide assistance for low-income individuals of any age may continue to operate, pharmaceutical discount cards and state programs that provide prescription drug coverage exclusively for Medicare-eligible seniors and individuals with disabilities may be changed or discontinued.

The passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) significantly changed the focus of prescription assistance for seniors from private and state-level programs to the federally-sponsored Medicare discount cards. Consequently, the focus of Phase I of the Healthy Lives Prescription Plan changed to include information about the Medicare discount cards to augment information about the discount cards sponsored by pharmaceutical manufacturers.

Secretary of Health and Human Resources

The Department for the Aging, in the Health and Human Resources Secretariat, has taken primary responsibility for educating seniors on pharmaceutical assistance programs. Their website at www.vda.virginia.gov contains information on both private and government sponsored prescription drug assistance programs.

In the community, the primary mode for educating individuals about pharmaceutical assistance programs and discount cards has been the Virginia Insurance Counseling and Assistance Program (VICAP). Located throughout the state at local area agencies on aging (AAA), VICAP counselors can help with a variety of health insurance matters, from filing for benefits to resolving billing issues. Assistance provided by VICAP counselors is confidential and is provided without charge.

The Department of Medical Assistance Services (DMAS) has also been involved in efforts to raise awareness about the new Medicare drug benefit. In five town hall meetings across the Commonwealth, DMAS staff provided an overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to senior citizens. Other educational activities included coordinating statewide training on the new Medicare program for local human resource agencies. Many of the over 800 participants were local Department of Social Services staff.

Various agencies under the Secretary of Health and Human Resources have also used activities in the community to provide information about pharmaceutical assistance programs as well as other health related programs. The Missions of Mercy program, which provides dental care to individuals in localities in need, is an example of a program that has been used as an opportunity to provide information on how to access "safety net" health care services, such as Medicaid, FAMIS, and mental health programs.

Legislation

House Bill 1202 and Senate Bill 158, enacted during the 2004 Session of the General Assembly, contained several initiatives for the dissemination of information about prescription drug assistance. House Bill 1202 contained the following key provisions while Senate Bill 158 included the first two of the following provisions:

1) The Commissioners of the Virginia Department of Health and the Department for the Aging are required to circulate information to the citizens of the Commonwealth regarding legislation passed by Congress authorizing

prescription drug coverage under Medicare and how these benefits may impact the prescription drug costs of senior citizens.

2) The Commissioners of Health and the Department for the Aging, working with the Virginia area agencies on aging and other private and nonprofit organizations, are to develop a plan for promulgating information about pharmaceutical assistance programs, as well as training senior citizen volunteers to aid individuals completing applications for pharmaceutical assistance programs and discount cards sponsored by pharmaceutical manufacturers.
3) The above mentioned Commissioners are to encourage pharmaceutical companies to include on their websites, pharmaceutical discount purchasing card application forms that are capable of being easily downloaded and printed. If it is feasible, the Department for the Aging should include direct links to these forms.
4) A report to the Governor and General Assembly on the feasibility of developing a single application form for individuals to use when applying for pharmaceutical assistance programs and pharmaceutical discount purchasing cards was due from the Commissioners of Health and the Department for the Aging by October 30, 2004.

To comply with House Bill 1202, links to the Virginia Department for the Aging website on prescription drugs have been created on the websites of the Secretary of Health and Human Resources, the Department for the Deaf and Hard of Hearing, the Department of Health, the Department of Health Professions, the Department of Medical Assistance Services, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Social Services, the Department for the Blind and Vision Impaired, the Virginia Board for People with Disabilities, and the Office of the Comprehensive Services Act. The Virginia Department for the Aging website contains information on a variety of prescription drug assistance programs available in Virginia. Specifically, the website addresses the new Medicare approved prescription drug discount cards, statewide company sponsored prescription drug programs, and regional and membership prescription drug assistance programs. Direct web links are provided for many of the programs.

A variety of information is available about the Medicare approved drug discount card programs on the website. Links and contact information to Medicare are provided. In addition, useful tools such as the "Drug Discount Card Comparison Worksheet" and the "Enrollment Tip Sheet" are included.

IV. Overview of Phase II of the Healthy Lives Prescription Plan

Phase II of the Healthy Lives Prescription Plan called for the following five activities:

1) Monitoring the actions of Congress with regard to a prescription drug benefit for Medicare beneficiaries.
2) Examining what other states have implemented to assist seniors with obtaining prescription medications.
3) Examining ways that Virginia-based initiatives such as the Pharmacy Connection and Pharmacy Connect could be enhanced.
4) Continuing to encourage partnerships with community-based entities such as pharmacies, faith-based organizations, human service agencies, and advocacy associations.
5) Considering the impact of legislation to increase the income limits for Medicaid eligibility for non-institutionalized aged, blind, and disabled individuals.

ENACTMENT OF A MEDICARE DRUG BENEFIT

Creating changes in Title XVIII of the Social Security Act, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was enacted on December 8, 2003. Several elements of the law directly affect access to prescription medications for Medicare beneficiaries, including the creation of the Medicare Prescription Drug Discount Card and Transitional Assistance Program, the Part D prescription drug benefit, and the Medicare Replacement Drug Demonstration.

The benefits under Medicare are often referred to in alphabetical terms. The following list provides a short summation of covered benefits.

- Part A, typically referred to as the hospital insurance component of fee-for-service Medicare, assists in the payment of inpatient hospital services, skilled nursing facility services, certain home health services and hospice care.
- Part B, often referred to as the medical insurance component of fee-for-service Medicare, helps pay for physician services, outpatient hospital services, certain home health services, medical equipment and supplies, and other health services and supplies.

- Part C, previously called Medicare +Choice but now renamed Medicare Advantage, allows Medicare beneficiaries to select health plans (such as health maintenance organizations, preferred provider organizations) allowing beneficiaries to go to physicians, specialists or hospitals that participate in the plan. Some of the managed care plans have offered services that were not previously available to Medicare beneficiaries such as hearing aids and outpatient prescription drugs.
- Part D, as part of the MMA of 2003, will begin offering outpatient prescription drug coverage for Medicare beneficiaries on January 1, 2006.

Description of the Medicare Prescription Drug Program

The Medicare Prescription Drug Discount Card and Transitional Assistance Program were designed to provide relief to Medicare beneficiaries by reducing their out of pocket expenditures on prescription drugs until the implementation of the full Medicare prescription drug benefit in January 2006. Thus, the Medicare prescription drug discount card and transitional assistance program will be in effect from June 2004 through December 2005. During that time period, CMS expects to enroll 7.3 million Medicare beneficiaries in the discount drug card program.

The Medicare prescription drug cards provide discounts off the regular cash price of prescription medications. Beneficiaries must select the Medicare prescription drug discount card that best suits their needs since each Medicare-approved card offers varying discounts on different drugs. Therefore, for a beneficiary to obtain maximum savings, they must know and understand the options offered under the different cards. As of July 2004, there were 41 Medicare prescription drug cards that beneficiaries could choose from in the Commonwealth.

Individuals who are entitled to benefits or enrolled under part A or enrolled under part B of Medicare are eligible for the Medicare drug discount cards. However, if they are enrolled in Medicaid and are entitled to outpatient prescription drug coverage, they are ineligible for the Medicare drug discount cards since prescription assistance would be provided through the Medicaid program. Enrollment in a Medicare card plan is voluntary.

Individuals may only enroll in one approved Medicare prescription drug discount card at a time. For initial enrollment in one of the cards, they may enroll at any time in 2004. After that time, they may change their card during a coordinated election period. For individuals enrolled in Medicare Advantage plans, their Medicare managed care plan may offer an exclusive card for plan members only. If this is the

case, managed care beneficiaries can only enroll in this discount card program. If a Medicare Part C participant's managed care plan does not offer a card, they may choose any discount card.

Estimates as to the amount of cost savings available to participants in the discount card program vary. The Henry J. Kaiser Family Foundation estimates that the cards will produce savings of 5 to 10 percent while CMS indicates that Medicare beneficiaries will see savings in the 10 to 25 percent range. Each company sponsoring a Medicare prescription drug assistance card sets an annual enrollment fee of up to $30. This fee is charged no matter when a beneficiary enrolls in the plan and is charged in both 2004 and 2005.

In Addition to the Potential Savings Available Through the Discount Cards, Low-Income Beneficiaries May also Be Eligible for Transitional Assistance. A $600 credit for the purchase of prescription drugs in 2004, as well as an additional $600 credit in 2005, may be available to individuals who are eligible for the Medicare prescription drug discount card and meet additional eligibility requirements. To receive the up to $1,200 credit over two years, an individual cannot have an income over 135 percent of the federal poverty level. This translates into an income of $12,569 for a family of one and $16,862 for a family of two in 2004, with varying amounts for subsequent years. For individuals to qualify for transitional assistance, they cannot have health insurance that offers prescription drug coverage except for Medicare Part C or Medigap plans.

When using the $600 credit, Medicare beneficiaries pay a coinsurance payment relative to their income. Beneficiaries with incomes not more than 100 percent of the federal poverty level ($9,310 for a family of one and $12,490 for a family of two in 2004) pay 5 percent coinsurance when applying the $600 credit toward the purchase of prescription drugs. Beneficiaries with incomes between 101 and 135 percent of the federal poverty level have a 10 percent coinsurance payment. (The term coinsurance refers to the amount the individual pays on the discounted price of the prescription medication when applying the $600 transitional assistance. Thus, a discounted prescription drug costing $50 would cost the beneficiary $2.50 for the 5 percent coinsurance rate and $5.00 for the 10 percent coinsurance rate.) Medicare beneficiaries who receive transitional assistance do not have to pay annual enrollment fees.

The Centers for Medicare and Medicaid Services (CMS) Set a Goal of Enrolling 7.4 Million Individuals in the Medicare Discount Drug Card Program. By July 15, 2004, nearly 4 million people had enrolled in the program. This number includes almost 1 million beneficiaries who will receive the annual $600 transitional assistance. Some advocates have called for implementing automatic enrollment of beneficiaries to ensure

that all eligible individuals have access to a card and possible transitional assistance. CMS has been reluctant to pursue this option in an attempt not to limit beneficiary choice.

The United States Department of Health and Human Services (HHS) made $4.6 million available to organize and fund community-based organizations in their efforts to educate and enroll individuals in the Medicare discount card programs. CMS has also set aside $2.4 million to target the largest metropolitan areas to assist education and enrollment of low-income Medicare beneficiaries. In addition, the federal Administration on Aging has directed $2 million to complement the previous initiatives.

To target low-income seniors, HHS, and the Access to Benefits Coalition (ABC) have committed to working together. ABC is a private-public partnership of more than 70 organizations that was formed to educate and enroll low-income Medicare beneficiaries in the new Medicare prescription drug programs and other programs for which they may qualify. Grants of up to $40,000 are being made available to local or statewide ABC coalitions to maximize outreach regarding the Medicare drug discount cards and other prescription assistance programs. Awardees were announced in September 2004.

Beneficiaries also have access to the toll-free hotline, 1-800-MEDICARE, for information on the Medicare prescription drug discount cards. Due to feedback from beneficiaries, their families, advocates, providers, and others, numerous upgrades and features have been improved and added to the Medicare website, at www.medicare.gov, to assist beneficiaries in choosing the most appropriate card. Features of the website include:

- A listing of the five cards that offer the lowest aggregate prices for an individual's drugs.
- Enrollment information and online enrollment for 36 of the cards.
- Drug pricing information that makes it possible for users to compare the prices between brand-name and generic drugs.
- Information about state pharmacy assistance programs.
- Details about drug manufacturer "wrap around" programs that offer additional discounts for beneficiaries who receive the $600 credit.
- Updated card-sponsor information.
- Easy access and viewing of all drug card sponsors in an individual's area.

A Number of Issues Have Surrounded the Provision of Public Assistance for Low-Income Medicare Beneficiaries who Qualify for the Transitional Assistance. Most of this controversy has involved the Medicaid program and the United States Department of Agriculture's (USDA) Food Stamp program. Initially, CMS indicated that the $600 credit available to transitional assistance Medicare discount card enrollees could not count toward the spend down required for Medically Needy Medicaid eligibles. However, CMS has revised its policy and states in a series of questions and answers: "Any discount received and any portion of the $600 credit which is used to pay for prescription drugs must be treated as an incurred medical expense by the beneficiary for Medicaid spend down purposes." In addition, the USDA has revised its Food Stamp policy in regards to claiming medical deductions. The revised policy as issued in a June 18, 2004 memo requires that "discounts and subsidies a household receives through the Medicare drug discount card be treated as standard medical expenses to be used in determining the household's medical expense deduction." To do otherwise, would have meant that the $600 in assistance would have counted against an individual in determining his or her Food Stamp allocation. Both of these revised policies conform to the Medicare Prescription Drug Improvement, and Modernization Act of 2003 which requires that the Medicare prescription drug cards and transitional assistance are not to be taken into account when determining an individual's eligibility or amount of benefits for another federal program.

To assist low-income Medicare discount card participants who have used their entire $600 credit, several prescription drug manufacturers are providing additional assistance to these individuals to help with out-of-pocket pharmaceutical costs once the $600 credit has been exhausted. CMS lists the following companies as having arrangements with Medicare-approved discount drug card sponsors; Abbott, AstraZeneca, Eli Lilly, Johnson & Johnson, Merck, and Novartis. The degree to which additional assistance is available varies depending upon the company. Some companies will be charging a flat fee, while others will provide the prescription drugs at no cost.

With the creation of the Medicare prescription drug discount cards, several options were made available to states who may wish to provide additional assistance to Medicare beneficiaries receiving their medications through the discount card program. For low-income beneficiaries, with incomes of not more than 135 percent of the federal poverty level ($12,569 for an individuals, $16, 862 for a married couple in 2004), and who qualify for the transitional assistance $600 credit, the state may choose to cover the coinsurance for these beneficiaries. Another option available to states is to cover the cost of enrollment fees for card participants. A state would only have to cover the yearly enrollment fee for individuals who do not qualify for transitional assistance.

Any Plans to Cover the Cost of Co-Insurance and Enrollment Fees for Certain Medicare Prescription Drug Card Enrollees Should Consider the Limited Timeframe of the Medicare Prescription Drug Card Program. Due to this limited timeframe, state assistance would only be available for the last six months of calendar year 2005. Administrative expenses incurred by state agencies operating the programs would also need to be considered. In addition, more detailed cost estimates would need to be developed, taking into account the multiple variables that could affect the cost of these programs. Federal funding is not available to assist the state in offsetting costs.

The *Medicare Replacement Drug Demonstration* was mandated under Section 641(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Under this demonstration, payment will be made by Medicare for drugs or biologicals prescribed as replacements for drugs or biologicals that are otherwise currently covered by Medicare, which includes drugs administered in the physician's office. Only drugs for treatment of such diseases as rheumatoid arthritis, multiple sclerosis, pulmonary hypertension, and cancer will be included. The demonstration, which has also been renamed "The Lottery", will not last past December 31, 2005. The 50,000 Medicare beneficiaries chosen to participate in this program will be responsible for cost sharing requirements that will mirror those under the full Medicare prescription drug benefit to be implemented January 1, 2006. Program costs are being capped at $500 million. Trailblazer Health Enterprises is serving as the contractor for this program.

This program has been designed as a demonstration project. As such, an evaluation of patient access to care and outcomes must be conducted and submitted by the Secretary of Health and Human Services to Congress by July 1, 2006. Cost-effectiveness of the demonstration program is to also be considered. An analysis of this nature should include whether there were any cost-savings to the Medicare program that can be attributed to the demonstration program. If there are any cost-savings, it is expected that they will result from reductions in the cost of physician and outpatient hospital services for the administration of drugs.

The Medicare Part D Prescription Drug Benefit Will Begin on January 1, 2006. Outpatient prescription drugs will be provided to beneficiaries through private plans. Individuals who are entitled to Part A or enrolled in Part B of Medicare may receive prescription drug coverage in the new Part D. Participation in the new benefit is voluntary.

The prescription drug benefit will be administered through private health plans. Eligible individuals who are enrolled in traditional fee-for-service Medicare may seek

coverage through a stand-alone prescription drug plan, frequently referred to as a PDP. If an individual is enrolled in a Medicare Part C Medicare Advantage plan, formerly known as Medicare+Choice, they can only obtain prescription drug coverage through those plans. However, there are two exceptions to this rule. Enrollees in a Medicare Advantage Private Fee-For-Service (PFFS) plan that does not offer qualified Part D drug coverage may also enroll in a stand-alone prescription drug plan. Also, enrollees in Medical Savings Account (MSA) plans may enroll in a stand-alone PDP.

An initial enrollment period for Medicare Part D will begin on November 15, 2005, and will extend until May 15, 2006. The enrollment period in following years will extend from November 15 to December 31. Eligible beneficiaries will be able to choose a plan from among the options available in their geographic area. If two or more risk-bearing plans are not available, including at least one PDP, Medicare will contract with a "fallback" plan to serve beneficiaries in that area. If an individual is dually eligible for Medicare and Medicaid and they fail to elect a plan during the initial enrollment period, they will have a plan assigned to them.

If an eligible individual fails to enroll in the Part D benefit at the first available opportunity, they will face a late enrollment penalty when they join. If an individual has maintained what CMS defines as "creditable" prescription drug coverage outside of Medicare, such as an employer's retiree plan, they may avoid the penalty fee. When an individual involuntarily loses the creditable coverage, a special enrollment period begins in which they may gain Part D coverage without being subject to the late enrollment penalty.

Under the standard prescription drug benefit offered with Medicare Part D in 2006, beneficiaries will:

- Pay the first **$250** in drug costs (deductible);
- Between **$250 and $2,250**, pay 25 percent of total drug costs;
- Between **$2,250 and $5,100** pay 100 percent of total drug costs (possibly up to $2,850 out-of-pocket, this is commonly referred to as the "donut hole");
- Once the catastrophic threshold for drug costs of **$5,100** is reached, the individual pays the greater of $2 for generics, $5 for brand drugs, or 5 percent coinsurance.

The maximum out-of-pocket cost before catastrophic coverage begins for an individual who does not qualify for any low-income assistance is $3,600. (Out-of-pocket costs include: $250 deductible; 25 percent of the total drug costs between $250 and $2,250 which is equal to $500; and the "donut hole" of $2,850.) The maximum out-of-pocket

cost a beneficiary may have to pay does not include the estimated average cost of Part D premiums of $35 a month.

The deductibles, benefit limits, and catastrophic thresholds are indexed to rise with the growth in per capita Part D spending. Using this methodology, the Congressional Budget Office projects that the donut hole will increase from $2,850 in 2006 to $5,066 in 2013. Plans are given the opportunity to create alternative benefit designs, provided that the alternative design is actuarially equivalent and does not increase the Part D deductible or out-of-pocket limit.

In addition to the above mentioned flexibility, plans may also vary their premiums. It is estimated that the average premium for basic drug coverage will be $35 per month. This expense is in addition to Part B premiums. Plans also have the option of offering supplemental benefits for an additional premium.

All Medicare Part D beneficiaries will receive catastrophic drug coverage regardless of income. This coverage becomes effective once a beneficiary has spent $3,600 out of pocket. There is no benefit maximum, so coverage will not be capped.

Medicare Beneficiaries with Low Incomes and Limited Assets May Be Eligible for Additional Assistance. CMS estimates that of the 43 million Medicare beneficiaries in 2006, 14.5 million low-income Medicare beneficiaries will be eligible to participate in the low-income subsidy program. Of those eligible for assistance, 11 million are estimated to enroll.

If a Part D beneficiary is eligible for full Medicaid benefits, they will receive their drug benefits through Medicare instead of Medicaid in 2006. Dual eligibles will not be responsible for premiums, deductibles or drug costs above the out-of-pocket threshold of $3,600. Below the out-of-pocket threshold, dual eligibles with incomes below 100 percent of the federal poverty level will pay $1 to $3 co-pays. Dual eligibles with income above the poverty line will pay $2 to $5 co-pays. Full benefit dual eligibles who are institutionalized will not be responsible for Medicare Part D cost-sharing.

Low-income Medicare Part D beneficiaries who are not eligible for full Medicaid benefits may be eligible for additional assistance. Beneficiaries, with incomes below 135 percent of the federal poverty level and assets below $6,000 for an individual and $9,000 for a couple, will receive a subsidy to cover the average monthly premium for basic coverage in their region and will not be responsible for a deductible. The beneficiaries will be responsible for $2 to $5 co-pays. However, there is no cost-sharing above the out-of-pocket threshold of $3,600.

Beneficiaries, with incomes below 150 percent of the federal poverty level and resources below $10,000 for an individual or $20,000 for a couple in 2006, will receive premium subsidies on a sliding scale and will have a $50 deductible. They will be responsible for a 15 percent co-payment, up to the out-of-pocket limit of $3,600. Once the out-of-pocket limit is reached, a beneficiary will be responsible for a $2 to $5 co-payment.

To assist in educating low-income Medicare beneficiaries about the full Medicare drug benefit to be implemented in 2006, the Department of Health and Human Resources, is making $125 million in grants available. Funding from these grants will be used to educate low-income Medicare beneficiaries who currently receive their prescription drugs through State Pharmaceutical Assistance Programs (SPAP) about the new Medicare prescription drug benefit. Funding is only available in fiscal years 2005 and 2006 and to states that operate pharmaceutical assistance programs.

Possible Consequences of Enacting the Medicare Prescription Drug Program

The new Medicare Part D program is expected to affect public and private programs that currently provide prescription drug coverage to some Medicare beneficiaries.

The leading source of drug coverage for Medicare beneficiaries in 2001 was from either retiree or current employer-sponsored insurance. A Bearing Point Analysis conducted for the Kaiser Family Foundation found that 24 percent of Medicare beneficiaries received supplemental insurance with drug coverage through retiree-sponsored insurance with an additional 5.2 percent receiving additional coverage, including prescription drugs, through current employer-sponsored health benefits. In 2006, employers who chose to provide prescription drug coverage comparable to Medicare Part D to Medicare beneficiary retirees and employees will receive subsidies from the federal government. With this subsidy, Medicare will cover 28 percent of the costs between $250 and $5,000 in drug expenses per beneficiary. The Congressional Budget Office estimates as a result of the new Medicare law, one in five retired beneficiaries with employer coverage will lose those drug benefits.

In the same analysis Bearing Point conducted for the Kaiser Family Foundation, they found that Medigap insurance policies provided 7 percent of outpatient prescription drug coverage for Medicare beneficiaries. Starting in 2006, insurers offering Medigap policies will not be allowed to issue new policies that include or supplement Part D coverage. If a Medicare beneficiary currently has a Medigap drug coverage policy, they will be allowed to keep that policy. However, if they chose to

enroll in Part D outside of the initial enrollment period, they may face a premium penalty. In response to these changes, Medigap will include two new policies that provide only catastrophic coverage that do not include prescription drug coverage.

According to the Henry J. Kaiser Family Foundation, Medicare Advantage plans, formerly known as Medicare +Choice plans under Part C, provided prescription drug coverage to 18 percent of non-institutionalized Medicare beneficiaries in 2001. Starting in 2006, they will be required to offer basic drug coverage, except in certain circumstances previously discussed. Medicare Advantage plans also have the option of offering additional drug benefits to beneficiaries with an additional premium.

For Individuals Eligible for Full Medicaid Benefits and Medicare Part D, Medicaid Will No Longer Be Responsible for Providing Prescription Drug Coverage. State officials originally thought that this change would result in substantial cost-savings for state budgets. However, a portion of the cost of covering prescription drugs for these individuals will be levied on the states. The Congressional Budget Office estimated that during the first five years of the program, states will pay $48 billion to the federal government to cover expenses occurred through Part D (Figure 3). This state obligation has been dubbed the "clawback."

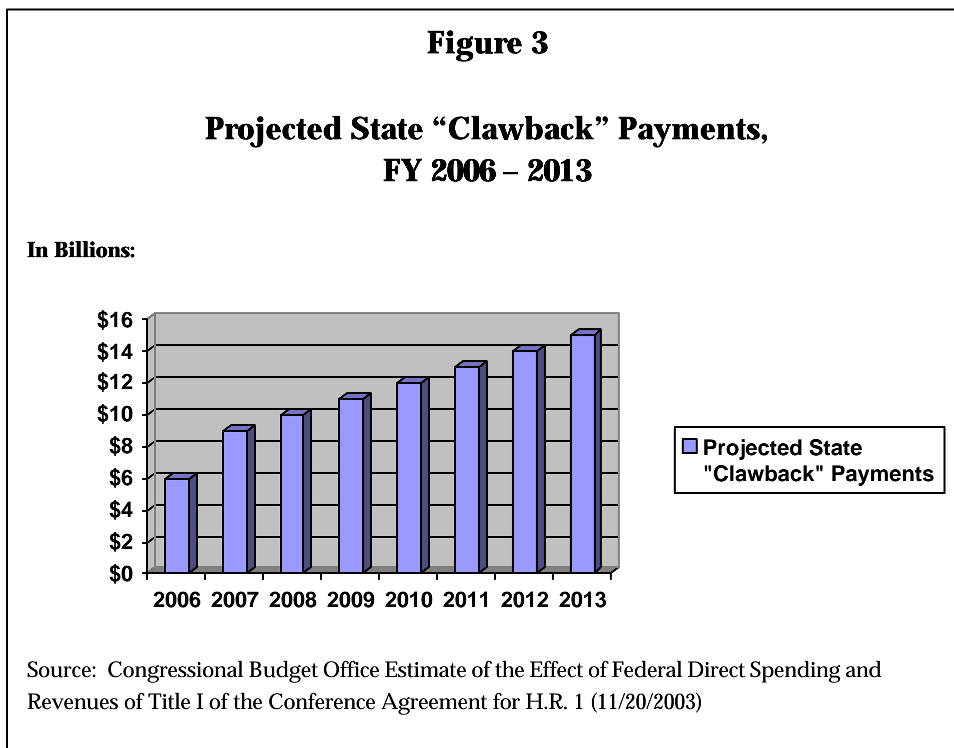

Figure 3

Projected State "Clawback" Payments, FY 2006 – 2013

Source: Congressional Budget Office Estimate of the Effect of Federal Direct Spending and Revenues of Title I of the Conference Agreement for H.R. 1 (11/20/2003)

The clawback, will begin in January 2006 when each state which offers Medicaid prescription drug coverage will be required to make a monthly payment to the federal government. Figure 4 displays the formula to be used by the federal government to determine each state's monthly payment.

Figure 4

Formula for Determining Monthly State Clawback Payments

Monthly State Payment	=	**1/12**	X	**Per Capita Expenditures (PCE)**	X	**Dual Eligibles (DE)**	X	**Phase-Down Percentage (PD%)**
				State share of per capita Medicaid expenditures on prescription drugs covered under Part D for dual eligibles during 2003, trended forward		Number of dual eligibles enrolled in a Medicare Part D plan in the month for which payment is made		Phase-down percentage for the year specified in the statute (e.g., 90% in 2006)

Source: The Kaiser Commission on Medicaid and the Uninsured

The clawback formula relies on a per capita expenditure (PCE) that is largely based on a state's Medicaid spending for prescription drugs for dual eligibles in calendar year 2003. The way the law is currently written does not permit CMS to rebase the PCE amount for 2004 or 2005. Therefore, a state that implemented prescription drug cost-savings measures after 2003 would not see these reduced costs in the clawback calculation used by CMS. Although the Medicare legislation calls for a "phased down contribution" from states, the savings to some states would be offset if the clawback payment is based on prescription drug expenditures in 2003. Virginia is one of those states since implementation of the preferred drug list occurred in January 2004.

Rough estimates of Virginia's clawback payment have been developed by the Department of Medical Assistance Services. These estimates are not considered to be accurate because the cost of certain drugs that are to be excluded from the clawback payment could not be estimated. To date, CMS has not provided the information needed to make more accurate projections.

An additional concern is the potential for the new Medicare program to increase Virginia's cost for administering the Medicaid program and addressing changes in

Medicare. The federal government is planning to assume the states' administrative costs for Medicaid over time. However, it is unclear how these administrative costs will be determined, and if they will accurately reflect actual costs.

INITIATIVES UNDERTAKEN IN OTHER STATES TO PROVIDE PRESCRIPTION ASSISTANCE

States have assisted individuals not eligible for Medicaid prescription drug coverage in a variety of methods. As of July 2004, 39 states had either established or authorized programs to provide or assist individuals in acquiring their prescription drugs. These programs have primarily targeted individuals with disabilities and the elderly who do not qualify for Medicaid.

Thirty-one states enacted legislation to provide for a direct subsidy using state funds. The breadth and scope of these programs varies widely from state to state. The programs typically target elderly low-income Medicare beneficiaries, although some programs include individuals with disabilities. The income limits cover individuals who would not typically qualify for Medicaid, however, the various states have a multitude of income standards. Reflecting this diversity in eligibility requirements, there is also a wide variance in the amount of cost-sharing required of participants. Appendix B summarizes the provision of these state-funded pharmaceutical assistance programs.

Some states have chosen to provide pharmaceutical assistance in the form of discounts to their eligible residents. There are currently 20 states that have created or authorized programs that offer a discount on prescription medications. These programs primarily target Medicare beneficiaries and frequently have a separate subsidy program. Appendix B includes a description of the various state-supported discount programs.

Another option some states have pursued is the 1115 Waiver Research and Demonstration Project. Section 1115 is a part of the Social Security Act that allows states to "waive" certain requirements of the Medicaid program. The demonstration projects are designed to test how providing a prescription drug benefit and primary care to a non-Medicaid eligible population will affect Medicaid and health outcomes of waiver participants. A key component of 1115 waivers is that they must be budget neutral. Section 1115 Research and Demonstration Projects under the Pharmacy Plus initiative can be used to extend prescription drug coverage to certain low-income individuals, including the elderly and individuals with disabilities. Some forms of assistance that the demonstration projects may take include: providing pharmaceutical

products; assisting individuals who have private pharmacy coverage with high premiums and cost sharing; or providing wrap-around pharmaceutical coverage to bring other sources of pharmacy coverage up to the desired level of coverage.

Under the Pharmacy Plus 1115 waiver projects, CMS has limited eligible waiver participants to those with incomes below 200 percent of the federal poverty level. A state may choose to cover prescription and over-the-counter medications to a range of individuals including Medicare beneficiaries who are not eligible for full Medicaid benefits. The ultimate purpose of the project is to help individuals maintain their health in order to prevent them from spending down their income and assets, therefore, becoming eligible for the full Medicaid benefit at a much greater cost to the state. Fifteen states have applied for Pharmacy Plus waivers. According to CMS, only four have been approved. Appendix C provides a description of the four approved waivers from Florida, Illinois, South Carolina, and Wisconsin.

The passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 has changed the parameters of prescription drug coverage dramatically. States that currently operate pharmacy assistance programs may coordinate their current program with the Medicare drug discount card. Medicare beneficiaries can be enrolled in the Medicare drug discount card and the state's pharmaceutical assistance program. In addition, Medicare beneficiaries who qualify for both programs can be encouraged to first use the Medicare card and the $600 subsidy if applicable. States may also choose to cover the 5 and 10 percent coinsurance and the enrollment fee for beneficiaries with incomes above 135 percent of the federal poverty level. States that currently offer pharmaceutical assistance programs may also auto-enroll their members into the Medicare prescription drug card program if they submit the information needed for CMS to determine eligibility for the Medicare drug card and the $600 transitional assistance.

State subsidy and discount card programs will be impacted further when the full Medicare prescription drug benefit goes into effect in 2006. It remains to be seen how the states will alter their current programs. Several states have statutory mandates that once a Medicare prescription drug plan is enacted, their state pharmaceutical program will terminate. However, states may elect to supplement the prescription drug benefit provided under Medicare Part D using state funds. Examples of benefits they may cover include:

- Covering drugs Medicare will not cover.
- Assistance with premiums, deductibles, and co-insurance.
- Help in covering drug expenditures incurred during the "donut hole" phase.

CMS has not been forthcoming with 1115 Pharmacy Plus waiver approvals. Of the fifteen waiver submissions, only four have been approved. The rest have either been denied, withdrawn, or are still pending after having been under review for several years. (However, the federal government will be responsible for providing prescription drug coverage in 2006 for many of the individuals who would qualify for a Pharmacy Plus waiver. Consequently, it may be beneficial for CMS to allow states to cover part of the cost of providing prescription drug benefits.) Virginia has not submitted a Pharmacy Plus waiver application to CMS.

ENHANCEMENT OF VIRGINIA'S PRESCRIPTION ASSISTANCE INITIATIVES

During the original submission of the Healthy Lives Prescription Assistance Plan to the Joint Commission on Health Care in November of 2003, several initiatives were reviewed which provided assistance to individuals seeking access to free or discounted pharmaceutical products.

The Pharmacy Connection and Pharmacy Connect

In order to increase access and availability to Patient Assistance Programs, programs created by pharmaceutical manufacturers to provide certain prescriptions at no cost to low-income individuals without prescription drug coverage, the Virginia Health Care Foundation developed The Pharmacy Connection (TPC). A software program, the TPC, is designed to assist medical practices, free clinics, and other similar organizations process applications for Patient Assistance Programs. Using this software has enabled individuals in need of prescription drugs to access over 125 patient assistance programs. At the beginning of July 2004, $183 million (average wholesale price) of free medications had been accessed through this program since its inception in 1997.

Using the The Pharmacy Connection software program, Pharmacy Connect of Southwest Virginia, serves the counties of Lee, Scott, Wise, Buchanan, Dickenson, Russell, Tazewell and the city of Norton. The LENOWISCO Health District, Stone Mountain Health Services, Inc., Clinch River Health Services, Inc., Cumberland Plateau Health District, St. Mary's Health Wagon, Virginia Health Care Foundation and the Junction Center for Independent Living form this joint, cooperative program to assist medically indigent individuals of all ages access needed medications.

From July 1, 2003 to June 30, 2004, Pharmacy Connect of Southwest Virginia helped individuals access $12,891,837 (wholesale value) worth of medications. This is a

substantial increase from the wholesale value of medications accessed from July 1, 2000 through June 31, 2001 which were valued at $5,767,722.11. The chart below provides a more detailed accounting of how Pharmacy Connect has increased access to prescription medications in its four years of operation. Additional resources have continued to be appropriated by the state legislature for the Pharmacy Connect of Southwest Virginia Program in the amount of $364,809 each year for state fiscal years, 2005 and 2006.

Figure 5

Access to Prescription Drugs Through Pharmacy Connect of Southwest Virginia

	FY 2001	FY 2002	FY 2003	FY 2004	Totals or Average
Unduplicated Persons Served	4,294	4,211	4,422	4,712	4,410 (avg)
Number of Medications Accessed	39,160	55,575	60,178	61,576	216,489
Wholesale Value of Medications	$5,767,722	$9,819,930	$11,692,212	$12,891,837	$40,171,701
State GF	$371,000	$358,000	$329,809	$329,809	$1,388,618
Dollar Value Returned	$15.55	$27.43	$35.46	$39.09	$28.93

Source: Mountain Empire Older Citizens, Inc.

Funding of $200,000 was provided for each state fiscal year of 2005 and 2006 out of the Temporary Assistance to Needy Families and Social Services Block Grant funds to the Virginia Health Care Foundation. The Virginia Health Care Foundation will serve as an intermediary in support of the Mount Rogers Medication Assistance Program. With funding from the Commonwealth beginning in fiscal year 2003, the program was able to serve 2,536 individuals, fill 14,337 prescriptions, and access $3.1 million in average wholesale value of medications. The Mount Rogers Program uses The Pharmacy Connection software and serves individuals of all ages in Bland, Carroll, Grayson, Smyth, Washington, and Wythe counties in addition to the cities of Bristol and Galax. The VHCF also received an additional $125,000 each fiscal year for 2005 and 2006 to expand The Pharmacy Connection software program to underserved areas of the state. To allow The Pharmacy Connection software to be accessed statewide would

require additional funding. In 2002, the Joint Commission on Prescription Drug Assistance recommended such an expansion and a budget amendment for $4.8 million was introduced but not included in the approved State budget.

Development of Community Partnerships

Partnerships with community-based entities such as pharmacies, faith-based organizations, human service agencies, and advocacy associations could assist in increasing access to prescription drugs.

Rx Partnership. Rx Partnership is a non-profit, public-private partnership that seeks to remove the barriers to prescription drugs by serving as a broker between pharmaceutical companies' patient assistance programs and the pharmacies that are run by community-based clinics. The program specifically targets the provision of free prescription medications for Virginia's eligible uninsured by soliciting free medications in bulk from pharmaceutical companies. Rx Partnership will arrange for the drugs to be distributed directly to non-profit, licensed affiliate pharmacies. Rx Partnership will credential and monitor these pharmacies.

For credentialed sites, the Rx Partnership will:

- Determine which community-based entities are qualified to participate in the program.
- Provide the criteria to identify and verify eligible patients.
- Provide instruction and training on receiving, dispensing, tracking, and re-ordering available free medications.
- Ensure that all participating health providers are in compliance by conducting audits and on-site reviews.

In the credentialing process, each affiliate must demonstrate that it uses a specific intake process to determine income eligibility below 200% of the federal poverty level. To assure that this process is being met, Rx Partnership will conduct periodic site reviews and require annual reporting and training sessions. The majority of the credentialed pharmacies will be operated by free clinics and community health centers.

As a public–private partnership, Rx Partnership, has received funding and support from a variety of sources. The General Assembly appropriated $75,000 a year for fiscal years 2005 and 2006. In addition, private funds have been received from foundations, corporations, trade associations and affiliate fees.

The Board of Directors for the Rx Partnership has been established and includes members of the Joint Commission on Health Care. To oversee the day to day operations of the organization, a new executive director was scheduled to begin in August of 2004. In preparation for an anticipated start date in September of 2004, the credentialing criteria were piloted in three locations, with two of the sites gaining their credentials and the third one to do so shortly. Affiliate workshops have been held and have generated numerous applications for participation. A public announcement of the initiative is expected in October 2004.

The Mission of Mercy (MOM) Program. The MOM program, sponsored by the Virginia Dental Association and the Virginia Health Care Foundation, is a community-based entity that could provide an avenue for informing individuals about prescription assistance programs. The MOM projects are conducted in underserved areas of the state where there are not enough resources or dental practitioners to meet the needs of citizens within the community. When an individual arrives, he/she registers for services and is asked to fill out and sign a health and release form. This time would be an excellent opportunity to provide information about prescription assistance programs and the Medicare discount cards and future drug benefit. Currently, information on how to access Medicaid, Family Access to Medical Insurance Security (FAMIS), primary care, mental health, and various pharmaceutical assistance programs is made available to MOM clinic attendees. By expanding the scope of the pharmaceutical outreach, individuals who do not have access to prescription drugs could be reached.

Development of "Senior Kits." Reflecting the concept of the New Parent Kits, a part of Governor Warner's Education for a Lifetime Initiative, a similar product, Senior Kits, could be developed for Virginia's seniors. New Parent Kits contain information on a wide variety of parenting issues including a guide to additional parenting resources. The Senior Kits could mirror this concept with information specifically directed to seniors including information about the Medicare discount cards and the future drug benefit.

New Parent Kits were funded through a public-private partnership. A similar approach could be taken in the creation of the Senior Kits. The inclusion of stakeholders from public and private entities would be crucial. The cost of implementing such program would depend in part on the scope and breadth of the materials provided and the outreach.

LEGISLATION TO INCREASE INCOME LIMITS FOR MEDICAID ELIGIBILITY

The current income limit for Medicaid eligibility for non-institutionalized aged, blind, and disabled individuals is 80 percent of the federal poverty level ($7,448 a year for one person). During the 2002 General Assembly Session, House Bill 913, which would have increased the income eligibility standard for Medicaid aged, blind, and disabled individuals from 80 percent to 100 percent of the federal poverty level, was introduced. House Bill 913 was continued to 2003 in the House Appropriations Committee, where it was tabled in November 2002. The 2003 Report of the Joint Commission Studying Prescription Drug Assistance recommended that the income limit for this Medicaid eligibility group be raised to 100 percent of the federal poverty level ($9,310 for an individual in 2004).

The Department of Medical Assistance Services estimates that increasing the eligibility limit from 80 to 100 percent of the federal poverty level will cost up to $84.2 million total funds in fiscal year 2006 and up to $135 million total funds in fiscal year 2007. The state general fund portion of these costs includes $41.1 million from the general fund in fiscal year 2006 and $67.5 million from the general fund in fiscal year 2007.

The aforementioned estimates are based upon the current Medicaid program. Expanding the eligibility limit to 100 percent of the federal poverty level would result in a number of Medicare beneficiaries receiving Medicaid benefits. Once the Medicare drug benefit becomes effective in 2006, individuals in this new Medicaid eligibility group who are Medicare beneficiaries would receive their prescription medications through Medicare. However, Virginia would be responsible for the "clawback" payment to the federal government. In addition, expanding the income limit for eligibility could have an unforeseen cost impact beyond the extension of pharmaceutical benefits.

IV. Policy Options

The following Policy Options were offered for consideration by the Joint Commission on Health Care. On November 15, 2004, the Commission voted to approve Options II, IV, V, VIII, IX, and X.

Option I: Take no action.
Two comments were received in opposition of Option I: Northern Virginia Access to Health Care Consortium and the Virginia Association of Area Agencies on Aging.

Option II: **Introduce a joint resolution requesting the Virginia Department for the Aging and the Virginia Department of Health to provide information on the "wrap around" coverage currently offered by private pharmaceutical companies. This coverage is available for low-income individuals enrolled in the Medicare prescription drug discount card program who use all of their $600 transitional assistance credit.**
One comment was received opposing Option II: Northern Virginia Access to Health Care Consortium.
One comment addressing specific issues with Option II was received. The Virginia Association of Area Agencies on Aging expressed concern that, "To effectively maintain information on changes in "wraparound" programs, as suggested in Option II, its success will also be directly tied to the dedication of staff to the task."

Option III: Introduce a joint resolution directing the Department of Medical Assistance Services to explore one or more of the following:

A. The option of providing supplemental drug coverage for individuals who are eligible for Medicare and Medicaid (dual eligibles) in order to pay for prescription drugs that Medicare will not cover.

B. The option of creating a state pharmaceutical assistance program to provide "wrap around" coverage of the Medicare prescription drug benefit for low-income beneficiaries.

One comment was received in opposition of Option III:
Northern Virginia Access to Health Care Consortium.
One comment was received in support of Option III:
Virginia Association of Area Agencies on Aging.
One comment was received on the potential issues associated with Option III:
Virginia Department of Medical Assistance Services (DMAS).
Excerpt of Comment by DMAS:
"There are a lot of issues which would have to be resolved if the State were to consider implementing these proposals such as whether the supplemental coverage would cover excluded drugs and/or those that are off the formulary. The State may also want to study how it would address the needs of individuals who opt out of Medicare Part D coverage…thus the main issue for DMAS at this point would be to determine whether it has the resources to conduct this study."

Option IV: **Introduce a budget amendment (language and funding) to expand the use of The Pharmacy Connection software to other areas of the state.**

Two comments were received in support Option IV:
Virginia Association of Area Agencies on Aging and the Virginia Health Care Foundation.
The Virginia Association of Area Agencies on Aging supports Option IV, "with the recognition that successful use of the Pharmacy Connection software program (or any other software program) is directly dependent upon the availability of staff to assist the Seniors to benefit."
One comment was received supporting amending Option IV:
Northern Virginia Access to Health Care Consortium.
"JCHC should amend Option IV to provide funding for regions wishing either to use software such as the Pharmacy Connection or to develop an affiliate of Rx Partnership in that region."

In a response to a JCHC-staff request, the Virginia Health Care Foundation, supplied several budget estimates for expanding The Pharmacy Connection software to other areas of the state. These estimates are based on the VHCF's experience with expanding The Pharmacy Connection software program:

- Provide for a medication assistance case worker (MAC) for each city/county that does not have TPC program at this time *($4,060,000 GF)*.
- Fund 100 additional MACs throughout Virginia *($3.5 million GF)*.
- Increase the number of MACs at an estimated cost of *$35,000 GF per MAC.*

Option V: **Introduce a joint resolution requesting the Department for the Aging, the Department of Medical Assistance Services, and the Department of Health to work with the Virginia Dental Association and the Virginia Health Care Foundation in exploring the feasibility of using the Mission of Mercy initiative as a vehicle for expanding access to and information about pharmaceutical assistance programs and Medicare prescription drug discount cards.**
One comment was received in support of Option V:
Virginia Association of Area Agencies on Aging.

Option VI: Introduce a budget amendment (language and funding) for a Senior Kits program under the Department for the Aging.
One comment was received in support of Option VI:
Virginia Association of Area Agencies on Aging.
One comment was received in support of amending Option VI:
Northern Virginia Access to Health Care Consortium.
The Northern Virginia Access to Health Care Consortium supports amending Option VI to increase the scope of the initiative to cover Virginians of all ages so that the program is "not targeted at senior citizens."

In response to a request for cost-estimate information, the Virginia Department for the Aging provided a preliminary estimate of *$100,000 GF* for the development, production and distribution of printed materials. This figure could be greatly affected depending upon the scope of the materials provided and contributions from private-sector partners.

Option VII: Introduce legislation and accompanying budget amendment to increase the Medicaid income eligibility level for non-

institutionalized aged, blind, and disabled individuals from 80 percent to 100 percent of the federal poverty level.
Two comments were received in support of Option VII:
Virginia Association of Area Agencies on Aging and the Northern Virginia Access to Health Care Consortium.

In response to a request for cost-estimates on Option VII, DMAS supplied the following information:
"Based on enrollment and expenditure patterns for the current 80 percent ABD group, DMAS estimates expenditures for the expansion from 80 percent to 100 percent of FPL would cost up to $84.2 million total funds in FY 2006 *($41.1 million GF)* and up to $135 million total funds in FY 2007 *($67.5 million GF)*."

Option VIII: **Continue to address the development of the Healthy Lives Prescription Plan by including the issue on the JCHC workplan for 2005.**
Two comments were received in support of Option VIII:
Northern Virginia Access to Health Care Consortium and the Virginia Association of Area Agencies on Aging.

Option IX: **Introduce a budget amendment (language and funding) to increase funding for the acquisition and provision of prescription medications to Free Clinic patients.**

The Free Clinics play a vital role in providing needed prescription medications to the uninsured. Medical health care professionals volunteer thousands of hours of care each year in Free Clinics. "State funds enable Free Clinics to acquire and provide medications, without which the patient care provided by medical volunteers would be rendered useless." In FY 2004, the Free Clinics provided $7.69 in medications for every $1.00 spent. The Virginia Association of Free Clinics requests than an additional $778,600 be added to the current budget appropriation of $921,400 for Free Clinics in FY 2006. These funds will be used for the acquisition and provision of prescription medications to Free Clinic patients. The amount of the requested increase is calculated by taking the percentage (57%) of expected growth in Free Clinic utilization and inflation from FY 2002 to FY 2006 and applying it to the base

appropriation in FY 2002, which was $1,084,000 (prior to the Governor's budget cuts).

Option X: **Introduce a budget amendment (language and funding) to increase funding for the Virginia Primary Care Association Indigent Pharmacy Assistance Program.**

The Virginia Primary Care Association (VPCA) and Community Health Centers provide services to many of the uninsured and impoverished in 70 communities across the state. Providing prescription medications for this vulnerable population is part of the mission of these entities. According to the VPCA, "The latest annual report released by the Virginia Primary Care Association shows that Community Health Centers participating in the VPCA Indigent Pharmaceutical Funds Program returned over $125 in medications and services for every dollar invested by the Commonwealth." This rate of return is based on the FY 2004 GF appropriation of $233,750. The VPCA requests an increase in the VPCA Indigent Pharmacy Assistance Program funding from the current level of $233,750 GF to $343,750 GF. This increase in funding would restore the 15% cut in funding implemented previously and provide a 25% increase in funding to match the percentage increase in the indigent population being served by Community Health Centers across Virginia.

APPENDIX A

VIRGINIA ACTS OF ASSEMBLY -- 2003 SESSION

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.

CHAPTER 674

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.

[S 1341]

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.

APPENDIX B

PHARMACEUTICAL ASSISTANCE PROGRAMS

Arizona: Arizona Prescription Drug Discount Program

Eligibility	
Age:	Medicare-eligible
Income:	No income requirements

Enrollment:	600,000 eligible 14,000 enrolled
Funding:	Annual Enrollment Fees

Other Enrollment Requirements
None.

Benefits
▪ Members receive a negotiated discount rate at participating pharmacies, providing savings of up to 55 percent off prescription drugs (with an average savings of 39.5 percent on generic drugs and 17 percent on brand name pharmaceuticals). ▪ Members also have the option to purchase mail-order prescription drugs.

Enrollee Costs	
Annual Enrollment Fee:	$9.95
Prescription Copayment:	None

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	No
Mandatory Generic Substitution	No
Other	

This program will continue if Congress enacts a Medicare prescription drug benefit.

California: Prescription Drug Discount Program

Eligibility	
Age:	All Medicare recipients
Income:	No income requirements

Enrollment:	Not applicable
Funding:	No funding needed

Other Enrollment Requirements
None.

Benefits
Medi-Cal participating pharmacies must offer Medicare-enrolled seniors a price no greater than the Medi-Cal negotiated price (plus a $0.15 fee) for prescription drugs. Over-the-counter drugs are not covered.

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	None

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	No
Mandatory Generic Substitution	No
Other	

If Congress enacts a Medicare prescription drug benefit, the Senate Office of Research must report that fact to the appropriate legislative committees. The committees will then evaluate whether or not there continues to be a need for the program.

Connecticut: ConnPACE

Eligibility	
Age:	65 years and older or 18 years with SSDI
Income:	≤ 226% FPL

Enrollment:	51,000 (as of 12/02)
Funding:	State General Fund

Other Enrollment Requirements
Individuals are not eligible for this program if they are: ▪ enrolled in Medicaid; ▪ have insurance that covers a portion of their prescription drug costs; ▪ or have a deductible plan that includes prescription drug coverage. Individuals are eligible for this program if they have a health insurance plan with maximum benefits or an Anthem Blue Cross Blue Shield plan that covers prescription drugs; however, ConnPACE only can be used once the benefits of other programs have been exhausted.

Benefits
ConnPACE provides direct assistance to pay the costs of prescription drugs, insulin, insulin syringes and needles at participating pharmacies. The program excludes coverage for antihistamines, contraceptives, cough preparations, diet pills, experimental drugs, multivitamin combinations, products prescribed for cosmetic purposes and smoking cessation gum. There are no annual dollar limits on the cost of prescriptions that can be purchased.

Enrollee Costs	
Annual Enrollment Fee:	$30
Prescription Copayment:	$16.25 per prescription

Cost Containment Strategies	
Preferred Drug List	Yes
Prior Authorization	▪ Required for brand name drugs when generic equivalents are available (except for non-maintenance drugs used for less than 15 days). ▪ Also required for prescriptions that cost more than $500 for a 30 day (or less) supply
Mandatory Generic Substitution	Yes
Other	Limits enrollees to a 30 day supply or 120 units (tablets or capsules), whichever is greater, for each prescription.
Notes: The ConnPACE program is preparing a preferred drug list for 3 classes of drugs, including Proton Pump Inhibitors, and two other yet to be determined classes of pharmaceuticals.	

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

Delaware: Delaware Prescription Assistance Program (DPAP)

Eligibility	
Age:	65 years and older or ≥ 18 years with SSDI
Income:	▪ < 200% FPL ▪ or individuals whose prescription drug costs take up at least 40% of their income

Enrollment:	
Funding:	Tobacco settlement funds

Other Enrollment Requirements
Individuals are not eligible for this program if: ▪ they qualify for the privately funded Nemours insurance program, ▪ they are enrolled in any other private insurance plan with prescription drug coverage. However, individuals participating in certain drug discount programs (such as AARP, Conseco, and Peoples) are eligible for DPAP. DPAP does not cover drugs or supplies for diabetics in the Medicare program.

Benefits
DPAP members receive prescription drug coverage of up to $2,500 per individual.

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	$5 or 25 percent of drug cost, whichever amount is greater.

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	Yes, required for purchase of name brand drugs.
Mandatory Generic Substitution	Yes, generic drugs are mandatory without prior authorization.
Other	

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

Florida: Medicare Prescription Drug Discount Program

Eligibility	
Age:	Medicare-eligible
Income:	No income requirements

Enrollment:	Not applicable
Funding:	

Other Enrollment Requirements
None.

Benefits
All Medicaid-participating pharmacies must offer Medicare enrollees discounted prices on prescription drugs. That discounted price is the average wholesale price for the drug, plus a $4.50 dispensing fee.

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	None

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	No
Mandatory Generic Substitution	No
Other	

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

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Florida: Silver Saver

Eligibility	
Age:	Medicare eligible
Income:	▪ 88-120% FPL ▪ No assets test

Enrollment:	68,149
Funding:	

Other Enrollment Requirements
Individuals must have exhausted benefits under Medicare, Medicaid or other health insurance.

Benefits
The Silver Saver program provides members with savings of up to 50 percent on their prescription drug costs. Savings are based on income levels, and benefits are capped at $160 per month.

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	▪ $2 for generic drugs ▪ $10 for brand name drugs on the PDL ▪ $30 for brand name drugs not on the PDL

Cost Containment Strategies	
Preferred Drug List	Yes, the same as Florida's Medicaid PDL.
Prior Authorization	Yes, for the same drugs as Medicaid.
Mandatory Generic Substitution	Yes
Other	▪ Drug utilization reviews ▪ Annual cap of $600

To be eligible for this program, one must have exhausted benefits under Medicare, Medicaid and any other insurance plans. Therefore, if Congress enacts a Medicare prescription drug benefit, the statute language could be interpreted to require that the Medicare benefit be utilized before Silver Saver.

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Illinois: SeniorCare

Eligibility	
Age:	65 years and older
Income:	< 200% FPL

Enrollment:	175,000
Funding:	▪ 50% federal funding ▪ 50% state funding

Other Enrollment Requirements
Individuals with health insurance coverage that already covers prescription drugs can choose to receive a $25 rebate check every month in lieu of a SeniorCare card.

Benefits
SeniorCare covers most prescription drugs, and some over-the-counter drugs if specifically prescribed by a physician.

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	**First Benefit Level:** ▪ (Single ≤ $8979, Couple ≤ $12,119) ▪ SeniorCare pays up to $1,750 in prescription drug costs per person per year with no charge to the individual. ▪ After that, enrollees pay 20 percent of drug costs. **Second Benefit Level:** ▪ (Single $8,980-$17,960, Couple $12,120-$24,240) ▪ Individuals pay $1 for generic drugs and $4 for brand name drugs up to $1,750. ▪ After which, enrollees pay the same copayments, plus an additional 20 percent of prescription costs.

Cost Containment Strategies	
Preferred Drug List	Yes
Prior Authorization	Yes
Mandatory Generic Substitution	No
Other	

If Congress enacts a Medicare prescription drug benefit, this program will remain in place; however, Medicare would have to be billed for medications before SeniorCare coverage could be used.

Indiana: Hoosier Rx

Eligibility	
Age:	65 years and older
Income:	▪ Single income $12,132 ▪ Couple's income $16,368

Enrollment:	14,893
Funding:	Money from the tobacco settlement fund has been set aside for this program for the next 3 years.

Other Enrollment Requirements
Individuals are not eligible for this program if they are: ▪ enrolled in Medicaid; ▪ enrolled in Medicaid with a spend-down; ▪ or have insurance that covers a portion of their prescription drug costs.

Benefits
Hoosier Rx provides participants with discounts of 50 percent off their medications up to an annual cap (which varies based on income). Once the annual cap is met, Hoosier Rx continues to provide a small discount on prescription drugs. Drugs covered are prescription legend drugs. Hoosier Rx does not cover prescription drugs and supplies not covered by Medicaid either.

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	Copay of 50%

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	No
Mandatory Generic Substitution	No
Other	Annual costs are capped at $500 for: ▪ Single income of $12,132 ▪ Couple's income of $16,368 Annual costs are capped at $750 for: ▪ Single income of $10,776 ▪ Couple's income of $14,544 Annual costs are capped at $1,000 for: ▪ Single income of $8,988 ▪ Couple's income of $12,120

If Congress enacts a Medicare prescription drug benefit, Hoosier Rx would coordinate their program with the federal program.

Kansas: Senior Pharmacy Assistance Plan

Eligibility	
Age:	65 years and older
Income:	< 150% FPL

Enrollment:	▪ 4,600 eligible (as of 9/03) ▪ No numbers on how many using the program
Funding:	State General Fund

Other Enrollment Requirements
Individuals are not eligible for this program if they: ▪ have private insurance that covers a portion of their prescription drug costs; ▪ have any local, state or federal prescription drug coverage; ▪ or have cancelled any local, state or federal prescription drug coverage within 6 months of applying for this program.

Benefits
This reimbursement program covers legend drugs and diabetic supplies not covered by Medicare, and prescription drugs that are used to treat chronic illnesses. Over-the-counter and lifestyle drugs are not covered. Covered drugs are reimbursed at a level of up to 70 percent.

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	Reimbursement program

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	No
Mandatory Generic Substitution	No
Other	Reimbursements cannot exceed 70 percent of out-of-pocket prescription drug costs, and are capped at $1,200 annually.

This program will automatically sunset if Congress enacts a Medicare prescription drug benefit.

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Maine: Low Cost Drugs for the Elderly and Disabled (DEL)

Eligibility	
Age:	62 years and older
Income:	▪ ≤ 185% FPL ▪ Or incomes up to 25% higher than the income limit with 40% or more of their income being spent on medications.

Enrollment:	36,000 (as of 12/02)
Funding:	

Other Enrollment Requirements
▪ Individuals are not eligible for this program if they have prescription drug coverage under Medicaid. ▪ Members can have other prescription drug coverage.

Benefits
▪ DEL pays for 80 percent of the cost of drugs used for treating chronic illnesses such as diabetes, heart disease, high blood pressure, chronic lung disease, Parkinson's, Glaucoma, Multiple Sclerosis, ALS and Osteoporosis. ▪ DEL also provides limited discounts for other drugs related to other illnesses and conditions. If an individual spends more than $1,000 annually on prescription drugs used to treat other ailments, DEL will pay 80 percent of the costs above that $1,000.

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	$2 or 20 percent of the drug cost, whichever is greater.

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	Yes, for specific drugs.
Mandatory Generic Substitution	No
Other	Members can only receive a 34 day supply of brand name drugs, or and up to a 90 day supply for generic prescriptions.

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

Maryland: Maryland Pharmacy Programs

Maryland Pharmacy Assistance Program (MPAP) and Maryland Pharmacy Discount Program (MPDP)

Eligibility	
Age:	Medicare-eligible
Income:	For MPAP: ▪ Single income < $10,417, with < $4,000 in assets ▪ Couple income < $12,120 with < $6,000 in assets For MPDP: ▪ < 175% FPL

Enrollment:	50,000
Funding:	State General Fund and federal funds

Other Enrollment Requirements
To be eligible for this program, one must be eligible for Medicare and have no other public or private insurance.

Benefits
This program covers all medically necessary prescription drugs that are covered by the Maryland Medical Assistance Program through one of two benefit programs: the Maryland Pharmacy Assistance Program (MPAP) or the Maryland Pharmacy Discount Program (MPDP).

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	MPAP: ▪ $2.50 for generics and certain brand name drugs. ▪ $7.50 for other brand name drugs. MPDP: ▪ Program pays 65 percent of the drug cost at the state's negotiated rate, members pay the remaining balance, plus a $1 processing fee.

Cost Containment Strategies	
Preferred Drug List	Yes, determined by the pharmacy benefit manager, Provider Synergies, and similar to Medicaid's PDL.
Prior Authorization	Yes, on non-preferred drugs.
Mandatory Generic Substitution	Yes.
Other	

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

Massachusetts: Prescription Advantage Plan

Eligibility	
Age:	▪ 65 years and older ▪ low-income individuals under 65 that are not covered by Medicaid
Income:	▪ No income requirements for those 65 and over ▪ 180% FPL for those <65

Enrollment:	85,000
Funding:	State General Fund

Other Enrollment Requirements
To be eligible for this program, one must have exhausted benefits under Medicare supplemental insurance on an annual or quarterly basis. An individual cannot have any other state-sponsored prescription drug coverage.

Benefits
The Prescription Advantage Plan provides comprehensive prescription drug coverage for all seniors age 65 and up, and certain younger low-income individuals. The Massachusetts Executive Office of Elder Affairs administers this program. Members pay premiums, deductibles, and co-payments at a graduated rate based on gross annual household income, for single incomes of between $0-$44,900 and dual incomes of between $0-$60,600. The lowest income bracket has no premiums or deductibles. The plan includes an unlimited coverage benefit called "Stop-Loss Protection," in which the maximum out-of-pocket expense for co-payments and deductibles for any enrollee will be the lesser of $2,000 or 10 percent of gross annual household income. Once the maximum is reached, the full cost of prescription drugs is covered.

Enrollee Costs	
Annual Deductibles:	Annual deductible based on income as follows: ▪ Single income of $0-16,883, no deductible; ▪ Single income of $16,884-$20,205, $25 deductible; ▪ Single income of $20,206-$26,940, $50 deductible; ▪ Single income of $26,941-$44,900, $100 deductible; ▪ Single income of ≥ $44,901, $125 deductible; ▪ Dual income of $0-$22,786, no deductible; ▪ Dual income of $22,787-$27,270, $25 deductible; ▪ Dual income of $27,271-$36,360, $50 deductible; ▪ Dual income of $36,361-$60,600, $100 deductible; ▪ Dual income of ≥ $60,601, $125 deductible.
Premiums:	Premiums based on income as follows: ▪ Single income of $0-16,883, no premium; ▪ Single income of $16,884-$20,205, $15 premium; ▪ Single income of $20,206-$26,940, $25 premium; ▪ Single income of $26,941-$44,900, $50 premium; ▪ Single income of ≥ $44,901, $100 premium; ▪ Dual income of $0-$22,786, no premium; ▪ Dual income of $22,787-$27,270, $12 premium; ▪ Dual income of $27,271-$36,360, $20 premium; ▪ Dual income of $36,361-$60,600, $40 premium;

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	▪ Dual income of ≥ $60,601, $74 premium.
Prescription Copayment:	**Level One - Generic Drugs:** ▪ $9 for up to a 30-day supply for those with single incomes of $0-$16,883 and dual incomes of $0-$22,786. ▪ $12 for up to a 30-day supply for those with single incomes > $16,883 and dual incomes > $22,786. ▪ $18 for up to a 90-day mail order supply for those with single incomes of $0-$16,883 and dual incomes of $0-$22,786. ▪ $24 for up to a 90-day mail order supply for those with single incomes > $16,883 and dual incomes > $22,786. **Level Two - Brand Name Drugs:** ▪ $23 for up to a 30-day supply for those with single incomes of $0-$16,883 and dual incomes of $0-$22,786. ▪ $30 for up to a 30-day supply for those with single incomes > $16,883 and dual incomes > $22,786. ▪ $46 for up to a 90-day mail order supply for those with single incomes of $0-$16,883 and dual incomes of $0-$22,786. ▪ $60 for up to a 90-day mail order supply for those with single incomes > $16,883 and dual incomes > $22,786. **Level Three – Additional Brand Name Drugs:** ▪ $45 for up to a 30-day supply for those with single incomes of $0-$16,883 and dual incomes of $0-$22,786. ▪ $50 for up to a 30-day supply for those with single incomes > $16,883 and dual incomes > $22,786. ▪ $80 for up to a 90-day mail order supply for those with single incomes of $0-$16,883 and dual incomes of $0-$22,786. ▪ $100 for up to a 90-day mail order supply for those with single incomes > $16,883 and dual incomes > $22,786.

Cost Containment Strategies	
Preferred Drug List	Yes, determined by PCS Health Systems, Inc. (a PBM).
Prior Authorization	Yes
Mandatory Generic Substitution	Yes
Other	Costs are capped at $2,000 per year or 10 percent of an individual's annual income, whichever is less.

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

Michigan: Elder Prescription Insurance Coverage Program

Eligibility	
Age:	65 years and older
Income:	≤ 200% FPL

Enrollment:	15,000
Funding:	State and federal funds

Other Enrollment Requirements
Individuals are not eligible for this program if they have any other type of prescription drug coverage, with the exception of Medicare and any future federal prescription drug benefit. Nor are individuals eligible if they are institutionalized.

Benefits
This program assists seniors with the cost of prescription drugs based on their income.

Enrollee Costs	
Enrollment Fees and Deductibles:	▪ $25 application processing fee. ▪ Annual deductible based on income.
Prescription Copayment:	▪ Copayments are based on total annual household income, and are not to exceed 20 percent of the cost of the drug.

Cost Containment Strategies	
Preferred Drug List	Yes, determined by the state.
Prior Authorization	Yes, for drugs not on the PDL.
Mandatory Generic Substitution	No, but if generic equivalents are available and members choose a brand name drug instead, they pay an additional $15 copayment.
Other	

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

Minnesota: Prescription Drug Program

Eligibility	
Age:	Medicare-eligible
Income:	≤ 120% FPL

Enrollment:	7,200
Funding:	State General Fund

Other Enrollment Requirements
To be eligible, individuals must: • not be eligible for full Medical Assistance (MA), but some people who have MA with a spenddown may be eligible; • not have had prescription drug coverage within four months of applying; or • be enrolled in, or apply for, a Medicare Savings Program that helps pay out-of-pocket costs related to Medicare.

Benefits
This program pays for most prescription drugs, above a $35 monthly deductible.

Enrollee Costs	
Deductible:	$35 monthly deductible
Prescription Copayment:	None

Cost Containment Strategies	
Preferred Drug List	Yes
Prior Authorization	Yes
Mandatory Generic Substitution	Yes, this requirement to be made more stringent on January 1, 2004.
Other	There is a 34-day supply limit on all prescriptions.
Note: language in the FY 2004-2005 Appropriations Act called for changes to be made in the program. Those changes have yet to be finalized, but are to be effective January 1, 2004.	

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

Missouri: Missouri Senior Rx Program

Eligibility	
Age:	65 years and older
Income:	• Single income $17,000 • Couple's income $25,000

Enrollment:	18,788
Funding:	Tobacco settlement funding

Other Enrollment Requirements
Individuals are not eligible for this program if they are: • enrolled in Medicaid; • have VA pharmacy benefits; • or have any other insurance that covers a portion of their prescription drug costs.

Benefits
This program pays 60 percent of covered drug costs above a member's deductible.

Enrollee Costs	
Annual Enrollment Fee:	Fee of $25 per person for: • Single income ≤ $12,000 • Couple's income ≤ $17,000 Fee of $35 per person for: • Single income $12,001-$17,000 • Couple's income $17,001-$23,000
Annual Deductible:	$250 Deductible for: • Single income ≤ $12,000 • Couple's income ≤ $17,000 $500 Deductible for: • Single income $12,001-$17,000 • Couple's income $17,001-$23,00

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	No
Mandatory Generic Substitution	Yes, unless otherwise specified by a physician.
Other	Annual cap on benefits at $5,000 per member.

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

Nevada: Senior Rx Insurance

Eligibility	
Age:	62 years and older
Income:	▪ Single income $22,016 ▪ Couple's income $28,660

Enrollment:	8,400
Funding:	Tobacco settlement funding

Other Enrollment Requirements
Individuals are not eligible for this program if they are receiving Medicaid benefits.

Benefits
Nevada's Senior Rx program provides seniors with insurance coverage for prescription medications. It provides up to $5,000 in benefits per year for prescription drug coverage. The Nevada Department of Human Resources surveyed pharmacies throughout the state to determine the most frequently prescribed pharmaceuticals in order to best target the insurance program and provide discounts on those medications prescribed most often.

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	▪ $10 for generic drugs. ▪ $25 for brand name drugs on the PDL. ▪ $25 for brand name drugs not on the PDL (if approved through the prior authorization process).

Cost Containment Strategies	
Preferred Drug List	Yes, determined by Pharmaceutical Care Network, Inc (a PBM).
Prior Authorization	Yes, to show the medical necessity of brand name drugs.
Mandatory Generic Substitution	No
Other	$5,000 annual cap

Nevada statute addresses the possibility that Congress will enact a Medicare prescription drug benefit, and allows for changes in the Senior Rx program if that should happen.

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New Hampshire: Senior Prescription Drug Discount Pilot Program

Eligibility	
Age:	65 years and older
Income:	No income requirements

Enrollment:	77,000
Funding:	No state or federal funding

Other Enrollment Requirements
Individuals are not eligible for this program if they have any other insurance that covers a portion of their prescription drug costs.

Benefits
Under this program, seniors receive discounts of up to 40 percent on generic drugs and 15 percent on brand name drugs.

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	None

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	No
Mandatory Generic Substitution	No
Other	

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

New Jersey: Pharmaceutical Program for the Aged and Disabled (PAAD)

Eligibility	
Age:	▪ 65 years and older ▪ or 18 years with SSDI
Income:	▪ Single income $20,437 ▪ Couple's income $25,058

Enrollment:	191,318
Funding:	State General Fund

Other Enrollment Requirements

Individuals are not eligible for this program if they are:

- enrolled in Medicaid; or
- have insurance with prescription drug coverage that is equal to, or better than, PAAD.

Individuals are eligible for this program if they have no prescription drug coverage, or if their prescription drug coverage is less comprehensive than PAAD.

Benefits

This program helps New Jersey residents pay for prescription drugs, insulin, insulin needles, certain diabetic testing supplies and syringes.

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	▪ $5 copay for generic drugs. ▪ $5 copay for brand name drugs, plus the difference in cost between the brand name and its generic equivalent.

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	Required in the following cases: ▪ to obtain a brand name version of a multi-source drug; ▪ to obtain diabetic testing supplies, nebulizers, oral cancer drugs and immunosuppressives; ▪ for specific drugs used for such treatments as weight loss or cosmetic improvements.
Mandatory Generic Substitution	Yes, the state of New Jersey has established a list of generic drugs that must be dispensed in place of brand name drugs.
Other	

The future of PAAD, should Congress enact a Medicare prescription drug benefit, cannot be determined until the structure of a Medicare plan is finalized.

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New Jersey: Senior Gold Prescription Discount Program

Eligibility	
Age:	▪ 65 years and older ▪ or 18 years with SSDI
Income:	▪ Single income $20,437-30,437 ▪ Couple's income $25,058-$35,058

Enrollment:	29,057
Funding:	State General Fund

Other Enrollment Requirements
Individuals are not eligible for this program if they have prescription drug coverage that is equal to, or better than, Senior Gold.

Benefits
The Senior Gold program pays 50 percent of members' prescription drug costs after a $15 copayment. The program pays 100 percent of prescription drug costs after an enrollee has incurred costs above $2,000 in a calendar year for a single person, and $3,000 a year for a couple. Members continue to pay the $15 copayment, after those totals have been reached.

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	$15 per prescription, plus half the cost of the prescription.

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	Yes, for brand name drugs.
Mandatory Generic Substitution	Yes
Other	

The future of Senior Gold, should Congress enact a Medicare prescription drug benefit, cannot be determined until the structure of a Medicare plan is finalized.

New Mexico: Senior Prescription Drug Program

Eligibility	
Age:	65 years and older
Income:	No income requirements

Enrollment:	1,357
Funding:	Self-funded through mail order prescription rebates

Other Enrollment Requirements
Individuals with other prescription drug coverage are eligible for this program.

Benefits
Seniors enrolled in this discount card program save approximately 13 percent off retail pharmacy brand name drugs and 50 percent off the cost of generic pharmaceuticals. If members obtain their prescriptions by mail order, they can receive up to 19 percent off brand name drugs and 55 percent off generics.

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	None

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	No
Mandatory Generic Substitution	Generics are prescribed unless otherwise specified by a physician.
Other	

This program will remain in place if Congress enacts a Medicare prescription drug benefit.

New York: Elderly Pharmaceutical Insurance Coverage (EPIC)

Eligibility	
Age:	65 years and older
Income:	▪ Single income ≤ $35,000 ▪ Couple's income ≤ $50,000

Enrollment:	320,000
Funding:	State General Fund

Other Enrollment Requirements
▪ Individuals are not eligible for this program if they are enrolled in Medicaid. ▪ Members can have other insurance with prescription drug coverage, but EPIC is the payer of last resort.

Benefits
EPIC covers almost all prescription drugs for the elderly, as well as insulin, insulin syringes and needles.

Enrollee Costs	
Annual Enrollment Fees and Deductibles:	Enrollment Fee based on income for the following income levels: ▪ Fee of $8-$230 for a single income of ≤ $20,000 ▪ Fee of $8-$300 for a dual income of ≤ $26,000 Deductible based on income for the following incomes: ▪ Deductible of $530-$1,230 for a single income of $20,001-$35,000 ▪ Deductible of $650-$1,715 for a dual income of $26,001-$50,000
Prescription Copayment:	▪ $3 copay for drugs costing up to $15 ▪ $7 copay for drugs costing $15.01-$35 ▪ $15 copay for drugs costing $35.01-$55 ▪ $20 copay for drugs costing ≥ $50

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	No
Mandatory Generic Substitution	No
Other	

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

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North Carolina: Senior Care

Eligibility	
Age:	65 years and older
Income:	▪ Single income $17,720 ▪ Couple's income $23,880

Enrollment:	24,000
Funding:	Tobacco settlement fund

Other Enrollment Requirements

Individuals are not eligible for this program if they are:
- enrolled in Medicaid;
- enrolled in Tricare (the military healthcare program for active duty uniformed service members);
- receiving VA prescription drug benefits;
- enrolled in a private healthcare plan that covers prescription drugs
- or receiving Medicare supplemental benefits.

Benefits

Senior Care pays for 60 percent of prescription drugs and insulin costs for seniors. There is an annual limit of $600 for drugs related to the treatment of cardiovascular disease, chronic obstructive pulmonary disease and/or diabetes. Covered drugs include those for the following disease states:

- Hypertension - High Blood Pressure
- Hyperlipidemia - High Cholesterol
- Angina - Chest Pain
- Arrhythmia - Irregular Heartbeat
- Diabetes Mellitus - Sugar Diabetes
- Heart Failure
- Emphysema
- Bronchitis
- Asthma

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	▪ Members pay 40 percent of drug costs for covered drugs. ▪ They also pay $6 for each 30-day prescription. ▪ Members pay 100 percent of drug costs once the $600 annual state contribution cap has been reached.

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Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	No
Mandatory Generic Substitution	Generic drugs are used unless otherwise specified by a physician.
Other	$600 cap on annual spending.

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

Ohio: Golden Buckeye Prescription Drug Discount Program

Eligibility	
Age:	▪ 60 years and older ▪ ≥ 18 years with SSDI
Income:	No income requirements

Enrollment:	678,000
Funding:	Drug discounts were agreed to by the pharmaceutical manufacturers, so no charge to the state. Privately funded and managed by MemberHealth.

Other Enrollment Requirements
No other eligibility requirements.

Benefits

This program offers cardholders direct savings on prescription drugs, and has automatic utilization review to check for potential drug interactions. The Golden Buckeye program has multiple levels of discounts based on an individual's age and income level.

- Brand name drug prices are reduced by approximately 13 percent and generic drug prices are reduced by approximately 20 percent.
- Mail order prescriptions are reduced by approximately 17 percent for brand name drugs and 40 percent for generic drugs.
- Cardholders receive an additional 10-30 percent savings on preferred drugs ordered by mail.

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	None

Cost Containment Strategies	
Preferred Drug List	Yes, determined by MemberHealth, Inc. (a PBM).
Prior Authorization	No
Mandatory Generic Substitution	No
Other	

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

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Oregon: Senior Drug Prescription Assistance Program

Eligibility	
Age:	65 years and older
Income:	≤185% FPL and < $2000 in assets

Enrollment:	About 200
Funding:	Enrollment fee

Other Enrollment Requirements
Individuals are not eligible for this program if they are: ▪ enrolled in Medicaid; ▪ or have insurance that covers a portion of their prescription drug costs.

Benefits
Members can purchase prescription drugs at Medicaid's reduced rate. This program does not cover over-the-counter medications or medical supplies and equipment.

Enrollee Costs	
Annual Enrollment Fee:	$50
Prescription Copayment:	None

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	No
Mandatory Generic Substitution	No
Other	

If Congress enacts a *subsidized* Medicare prescription drug plan, this program would go out of existence. If, however, the federal government enacts a program that only provides *discounted* drugs, seniors would still be eligible for this program.

Pennsylvania: Pharmaceutical Assistance Contract for the Elderly (PACE)

Eligibility	
Age:	65 years and older
Income:	Single Income: $14,000 Couple's Income: $17,000

Enrollment:	188,000
Funding:	State lottery

Other Enrollment Requirements
Individuals are not eligible for this program if they are: ▪ enrolled in Medicaid; or ▪ enrolled in the state Retired Employees Health Program (REHP). PACE enrollees can be members of other prescription drug coverage plans, but PACE is the payer of last resort.

Benefits
PACE provides low-income seniors with reduced rates on prescription drugs. Under this program, all generic drugs can be purchased for a $6 fee.

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	$6 copay for generics, and $6 copay plus 75% of the difference in cost for brand name drugs.

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	No
Mandatory Generic Substitution	No
Other	

This program will not automatically sunset if Congress enacts a Medicare prescription drug benefit, and unless such a plan provided equal or better coverage, PACE would likely remain in place.

Pennsylvania: PACENET

Eligibility	
Age:	65 years and older
Income:	▪ Single income $14,000-$16,000 ▪ Couple's income $17,200-$19,200

Enrollment:	32,000
Funding:	State lottery

Other Enrollment Requirements
Individuals are not eligible for this program if they are enrolled in Medicaid, but other prescription drug coverage is allowed.

Benefits
PACENET provides prescription drug coverage for low-income seniors that are not eligible for PACE.

Enrollee Costs	
Annual Deductible:	$500
Prescription Copayment:	$8 after reaching the $500 deductible

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	No
Mandatory Generic Substitution	No
Other	

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit. Unless such a plan provided equal or better coverage than PACENET, this program would likely remain in place.

Rhode Island: Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE)

Eligibility	
Age:	▪ 65 years and older ▪ 55-64 years of age with SSDI
Income:	▪ No income requirements for those 65 and older. ▪ 55-64 years old with incomes < $37,687.

Enrollment:	Approximately 38,000
Funding:	State General Fund

Other Enrollment Requirements
▪ Individuals are not eligible for this program if they are enrolled in Medicaid. ▪ Individuals must exhaust other prescription drug benefits before being eligible for this program.

Benefits
RIPAE pays for up to 60 percent of prescription drug costs for members. The amount paid is based on an individual's income as follows: ▪ with a single income of ≤ $17,155, or a dual income of ≤ $21,445, the state pays 60 percent of drug costs; ▪ with a single income between $17,156-$21,535, or a dual income between $21,445-$26,919, the state pays 30 percent of prescription drug costs; ▪ with a single income between $21,536-$37,687, or a dual income between $26,920-$43,070, the state pays 15 percent of prescription drug costs.

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	Yes, based on income.

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	No
Mandatory Generic Substitution	Yes, unless otherwise specified by a physician.
Other	

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

South Carolina: Silver Rx Card Program

Eligibility	
Age:	65 years and older
Income:	200% FPL

Enrollment:	54,000
Funding:	General State Funds

Other Enrollment Requirements
Individuals are not eligible for this program if they are: ▪ enrolled in Medicaid; or ▪ have health insurance that covers a portion of their prescription drug costs.

Benefits
Covers most prescription and over-the-counter medications (with a prescription), and medical supplies such as insulin syringes, insulin and other injectables.

Enrollee Costs	
Annual Deductible:	$500
Prescription Copayment:	Once the deductible is met: ▪ $10 copay for generic drugs ▪ $15 copay for brand name drugs ▪ $21 for prior authorization drugs

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	Yes
Mandatory Generic Substitution	Yes
Other	Covers a maximum of 4 prescription drugs per month, with exceptions for certain medical conditions.

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

Vermont: VHAP Pharmacy

Eligibility	
Age:	All uninsured adults 18 and over
Income:	▪ ≤ 150% FPL ▪ < 185% FPL for parents and caretakers

Enrollment:	8,491
Funding:	Vermont Health Access Trust Fund

Other Enrollment Requirements
Individuals are not eligible for this program if they have other health insurance that reimburses for prescription costs.

Benefits
VHAP-Pharmacy helps low-income, disabled and elderly individuals pay for prescription drugs for both short-term and long-term conditions and illnesses. Members are covered with copay, and eyeglasses and related eye exams are also covered under this program.

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	▪ $3 for generic drugs* ▪ $6 for all other prescription drugs* *The maximum aggregate copayment a beneficiary can be charged in a calendar quarter is $50. After this amount is reached, there is no copayment.

Cost Containment Strategies	
Preferred Drug List	Yes, based on Medicaid PDL.
Prior Authorization	Yes, if drug is not on the PDL.
Mandatory Generic Substitution	Yes
Other	

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

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Vermont: Healthy Vermonters

Eligibility	
Age:	All ages
Income:	▪ ≤ 300% FPL all ages ▪ ≤ 400% FPL for those 65 and older, or those on SSDI

Enrollment:	9,000
Funding	State General Fund

Other Enrollment Requirements
Individuals must use other prescription drug coverage before utilizing Healthy Vermonters.

Benefits
Beneficiaries will be able to purchase prescription drugs at the Medicaid payment rate. Upon CMS approval, an additional discount based on manufacturers' rebates and a state contribution will be extended to individuals of all ages with annual incomes at or below 300 percent of the federal poverty level, and to people over the age of 65 who are at or below 400 percent of the federal poverty level.

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	None

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	No
Mandatory Generic Substitution	Yes
Other	

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

Vermont: VSCRIPT

Eligibility	
Age:	▪ 65 years and older or ▪ >18 years with SSDI
Income:	151-175% FPL

Enrollment:	3,076
Funding:	Vermont Health Access Trust Fund

Other Enrollment Requirements
Individuals are not eligible for this program if they have other health insurance.

Benefits
This program provides pharmacy coverage of Medicaid-allowed maintenance drugs for the aged and disabled who are not eligible for Medicaid or VHAP Pharmacy. VScript helps cover the cost of drugs for long-term medical conditions and illnesses.

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	▪ $5 for generic drugs* ▪ $10 for all other prescription drugs* *The most a beneficiary pays in a calendar quarter is $100. After that, there is no copayment.

Cost Containment Strategies	
Preferred Drug List	Yes, similar to the state's Medicaid PDL.
Prior Authorization	Yes, for drugs not on the PDL.
Mandatory Generic Substitution	Yes
Other	

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

Vermont: VSCRIPT Expanded

Eligibility	
Age:	• 65 years and older • 18 years and older with SSDI
Income:	176-225% FPL

Enrollment:	3,212
Funding	Vermont Health Access Trust Fund

Other Enrollment Requirements
Individuals are not eligible for this program if they have health insurance that covers a portion of their prescription drug costs.

Benefits
This program provides prescription coverage of Medicaid-allowed maintenance drugs for the aged and disabled who are not eligible for Medicaid or VHAP Pharmacy. VScript Expanded helps cover the cost of drugs for long-term medical conditions and illnesses.

Enrollee Costs	
Annual Deductible:	$275
Prescription Copayment:	After meeting the deductible, members pay 41 percent of drug costs, up to $2,5000 in a calendar year, after which all prescription costs are covered.

Cost Containment Strategies	
Preferred Drug List	Yes, based on the state's Medicaid PDL.
Prior Authorization	Yes, for drugs not on the PDL.
Mandatory Generic Substitution	Yes
Other	

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

West Virginia: Golden Mountaineer Discount Card

Eligibility	
Age:	60 years and older
Income:	No income requirements

Enrollment:	▪ 360,000 issued ▪ 16,000-17,000 in use
Funding	State lottery pays for the distribution of the cards, and drug manufacturers provide the drug discount.

Other Enrollment Requirements
▪ Golden Mountaineer cardholders are not precluded from having other insurance plans with prescription drug coverage. ▪ Cardholders can ask their pharmacists whether the GMDC will provide a better rate than their other insurance plan, and use whichever plan provides the best rate on prescription medications.

Benefits
▪ The Golden Mountaineer card provides discounts through a network of participating pharmacies for many of the drugs commonly used by seniors. It can also be used in many retail stores for discounts on food, merchandise and services. ▪ Brand name drugs are available at the average wholesale price (about 13 percent less than retail prices). ▪ Generic drugs are available at the average wholesale price (about 60 percent less than retail prices).

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	None

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	No
Mandatory Generic Substitution	No
Other	

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

Wisconsin: SeniorCare

Eligibility	
Age:	65 years and older
Income:	Rate reduction based on income level, but everyone is eligible regardless of income.

Enrollment:	90,000
Funding	State General Fund

Other Enrollment Requirements
• Individuals enrolled in Medicaid are not eligible. • Those that have other forms of prescription drug coverage are eligible, and benefits will be coordinated. SeniorCare is, however, the payer of last resort.

Benefits
• SeniorCare covers most prescription drugs and over-the-counter insulin. • Coverage levels are based on income, but not assets.

Enrollee Costs	
Annual Enrollment Fee:	$30
Prescription Copayments & Deductibles:	Level One: • Single income ≤ $14,368 • Couple's income ≤ $19,392 • Copay $5 for generic drugs and $15 for brand name drugs. Level 2A: • Single income $14,369-$17,960 • Couple's income $19,393-$24,240 • Copay $5 for generic drugs and $25 for brand name drugs, once a $500 deductible has been met. Level 2B: • Single income $17,961-$21,552 • Couple's income $24,241-$29,088 • Copay $5 for generic drugs and $25 for brand name drugs, after an $850 deductible has been met. Level 3: • Single income ≥ $21,553 • Couple's income ≥ $29,089 • Pay retail price for prescriptions equal to the difference between $21,553 and an individual's income, and $29,089 and a combined income. Then meet an $850 deductible, after this point individuals qualify for the $5 and $25 copayments listed above.

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Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	Yes, for certain drug classes.
Mandatory Generic Substitution	Yes, unless otherwise specified by a physician.
Other	

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit. If a federal program is put in place, the state of Wisconsin would coordinate its plan accordingly.

Wyoming: Prescription Drug Assistance Program

Eligibility	
Age:	All ages
Income:	< 100% FPL

Enrollment:	1,254
Funding:	State General Fund

Other Enrollment Requirements

Individuals are not eligible for this program if they are:
- enrolled in Medicaid;
- or have insurance that covers a portion of their prescription drug costs.

Benefits

This program provides discounts on prescription drugs for anyone whose income is below 100 percent of the federal poverty level.

Enrollee Costs	
Annual Enrollment Fee:	None
Prescription Copayment:	• $10 copay for generic drugs • $25 copay for brand name drugs

Cost Containment Strategies	
Preferred Drug List	No
Prior Authorization	Yes, with a few classes of drugs, such as Proton Pump Inhibitors and Cox II Inhibitors.
Mandatory Generic Substitution	No
Other	• Limits enrollees to 3 prescriptions per month. • The program is no longer accepting new members.

This program does not automatically sunset, with the enactment of the Medicare prescription drug benefit.

APPENDIX C

Florida: Silver Senior Rx Program

Date Submitted:	06/10/02
Date Approved:	07/31/02

Federal Poverty Level:	120%
Eligible Age:	≥ 65

Background:
This program has no assets test and is for Medicare-eligible individuals only. All enrollees have a benefit limit of $160 per month, with a three-tiered copayment system of $2 for generic drugs, $10 for Medicaid Preferred Drug List (PDL) products and $30 for non-PDL products. The demonstration project required the use of current Medicaid management procedures including use of a preferred drug list, existing prior authorization requirements, drug utilization review and other current Medicaid pharmacy benefit management tools. Enrollment was capped at 68,149.

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Illinois: Prescription Drug Benefit for Illinois' Low-Income Seniors

Date Submitted:	07/31/01
Date Approved:	01/28/02

Federal Poverty Level:	200%
Eligible Age:	≥ 65

Background:

The Centers for Medicare & Medicaid Services (CMS) approved Illinois' application to provide comprehensive pharmacy benefits, with primary care coordination to low-income seniors. The demonstration was implemented by moving the majority of enrollees in Illinois' State-only pharmacy benefit program into the demonstration. This program provides enrollees with an identification card used at local pharmacies, and its benefit includes all drugs covered by Medicaid. The card must be renewed annually. Individuals with private insurance may choose to receive a monthly "rebate" check of approximately $25, instead of participating directly in the demonstration benefit. Benefits for members are listed below.

First Benefit Level (<100% FPL):

- For those with an annual single income equal to or less than $8,979 or annual dual income equal to or less than $12,119, SeniorCare pays up to $1,750 in prescription drug costs per person per year with no charge to the individual.
- After that, enrollees pay 20 percent of drug costs.

Second Benefit Level (100-200% FPL):

- Those individuals with an annual single income of between $8,980 and $17,960 or annual dual income of between $12,120 and $24,240, pay $1 for generic drugs and $4 for brand name drugs up to $1,750.
- After which, enrollees pay the same copayments, plus an additional 20 percent of prescription costs.

South Carolina: Prescription Drug Benefit for South Carolina's Low Income Seniors

Date Submitted:	01/08/02
Date Approved:	01/01/03

Federal Poverty Level:	200%
Eligible Age:	≥ 65

Background:

This demonstration is a statewide program that provides prescription drug benefits to eligible South Carolina seniors. Eligibility is based on the above income and age limits, and an individual's ability to meet existing Medicaid residency requirements, rules on citizenship and rules regarding residents or inmates of public institutions. In addition, individuals cannot have private prescription drug coverage or spend down to become eligible for this waiver program. After enrollment in this program, individuals will receive an identification card to be used for the purchase of Medicaid-covered prescription drugs. The demonstration is administered on a fee-for-service basis.

South Carolina uses the following cost-management strategies:

- prospective/retrospective Drug Utilization Review;
- participants pay no more for a drug than the Medicaid reimbursement rate during the deductible period; and after the $500 deductible is satisfied, participants pay $10 for generic drugs, $15 for brand name drugs and $21 for prior authorization drugs.

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Wisconsin: SeniorCare

Date Submitted:	03/28/02
Date Approved:	07/01/02

Federal Poverty Level:	200%
Eligible Age:	≥ 65

Background:

This demonstration is a statewide program that provides prescription drug benefits (for drugs covered under Medicaid) to Wisconsin seniors. After enrollment, individuals receive an identification card that allows them to purchase drugs at Medicaid discounted prices. SeniorCare is administered on a fee-for-service basis.

Wisconsin uses the following cost-management strategies for this program:

- pharmacy Point-of-Sale system, to enable providers to submit real-time claims for prescription drugs and to verify eligibility and medical history of members;
- prospective/retrospective Drug Utilization Review;
- Maximum Allowable Cost list for prescription drugs;
- prior authorization for certain drugs; and
- diagnosis restriction and excluded drugs.

Pharmacy benefits are as follows:

Level One:

- Single income equal to or less than $14,368
- Couple's income equal to or less than $19,392
- Copay $5 for generic drugs and $15 for brand name drugs.

Level 2A:

- Single income of between $14,369 and $17,960
- Couple's income of between $19,393 and $24,240
- Copay $5 for generic drugs and $25 for brand name drugs, once a $500 deductible has been met.

SeniorCare provides benefits to those individuals with single annual incomes of up to $21,553 and for individuals with dual annual incomes of up to $29,089. However, only those with incomes of up to 200% FPL are paid for through the federal waiver.

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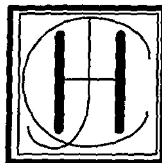

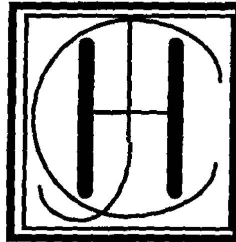

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