**REPORT OF THE**
**DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**

# Medicare Part D and Pharmacy Assistance Programs in Virginia

**TO THE GOVERNOR AND**
**THE GENERAL ASSEMBLY OF VIRGINIA**


# HOUSE DOCUMENT NO. 67

**COMMONWEALTH OF VIRGINIA**
**RICHMOND**
**2006**

# Report by the Department of Medical Assistance Services and Its Pharmacy Assistance Program Task Force

## Introduction

During the 2005 Session of the Virginia General Assembly, the legislature enacted two companion bills, House Bill 1624 and Senate Bill 841, directing the Department of Medical Assistance (DMAS) to: (i) promulgate the necessary regulations to implement the federal Medicare Part D benefit; and (ii) convene a task force to assist the Department in evaluating the Medicare Part D benefit and making recommendations for enhancing, coordinating and integrating the existing the pharmacy assistance programs for low-income Virginians and Medicare Part D. Copies of both HB 1624 and SB 841 are provided at Attachment A.

As required by the legislation, DMAS convened a task force of key public and private stakeholders (see Task Force roster in Attachment B). This report conveys the findings and recommendations of the Department as developed in conjunction with the Task Force members.

## Background on Medicare Part D

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173) was enacted into law on December 8, 2003. Chief among the Act's provisions was an amendment to the Social Security Act to create a new Part D in the Medicare program, the Voluntary Prescription Drug Benefit Program. Effective January 1, 2006, the new program established access to prescription drug insurance coverage for all individuals who are entitled to Medicare Part A or enrolled in Part B and requires an affirmative election to participate in the program. As with Part B, a monthly premium payment is required for Part D coverage.

As specified in the MMA, coverage for the new prescription drug benefit is provided through private prescription drug plans (PDPs) that offer drug-only coverage for individuals in the traditional fee-for-service Medicare program. Beneficiaries enrolled in private health plans under Part C, or Medicare Advantage (MA), may also obtain drug coverage through a PDP if the MA plan is a Medicare Advantage Private Fee-For-Service (PFFS) plan that does not offer qualified Part D drug coverage. Medical Savings Account (MSA) enrollees may also join a stand-alone PDP. Beneficiaries may also elect to receive both medical and prescription drug coverage through one entity, the Medicare Advantage Prescription Drug (MA-PD) plan. All participating insurance plans must meet financial and operational requirements established by the Centers for Medicare and Medicaid Services (CMS), the designated administrator for Part D. In 2006, there were more than 40 of the above options to choose from for Virginia's Medicare beneficiaries.

## Medicare Part D Benefits and Cost Sharing

In 2006, the standard Part D plan has a $250 deductible and 25 percent beneficiary coinsurance for the first $2,250 in drug costs. Thereafter, there is a coverage gap of $2,850 (the "donut hole") during which no benefits are paid. Enrollees must continue to pay premiums throughout this gap though they are receiving no benefit. When an individual's out of pocket drug expenditures reach that amount, catastrophic coverage begins with beneficiary co-payments of $2 for generics and $5 for brand drugs, or coinsurance of five percent, whichever is higher, for the remainder of the calendar year (see Attachment C for details on Part D cost sharing). The deductible, benefit limits, and catastrophic thresholds are indexed to rise with the growth in per capita Part D spending. All PDPs must offer a standard plan with no lesser benefit and most PDPs also offer higher option plans with enhanced coverage levels, a number of which provide some coverage during the gap, for an increased premium amount. Medicare's Part D benefit renews annually at the first of the year.

Medicare Part D cost sharing amounts from the deductible, coinsurance, co-payments and coverage gap expenditures are counted toward the individual's true out of pocket (TrOOP) costs. The Part D insurance premiums do not count toward TrOOP. The cost sharing described in the previous paragraph equals a TrOOP of $3,600 (in 2006) before catastrophic coverage begins. Only costs actually paid by the beneficiary, another person on their behalf, a bona fide charity, or by a qualified State Pharmaceutical Assistance Program (SPAP) are counted toward TrOOP. These expenses cannot be paid or reimbursed by a third-party (e.g., supplemental insurance, employer/union insurance plan). Most third-party assistance, including pharmaceutical manufacturers' patient assistance programs, does not count toward the TrOOP threshold.

## Medicare Part D Low-Income Subsidies

The MMA includes help with the cost of the drug plans for those beneficiaries with limited means, consisting of several levels of assistance with premiums, deductibles and co-payments. The Low Income Subsidy (LIS) (also referred to as "extra help" by the Social Security Administration) is available for individuals who have income up to 150% of the Federal Poverty Level (FPL) and resources no greater than $10,000 ($20,000 for a couple) in 2006. While the subsidy is substantial for those with income of less than 135% FPL, individuals with income in the 135-150% segment have more considerable cost sharing obligations (see Attachment C for LIS details). The MMA mandates that Medicare beneficiaries who are also enrolled in State Medicaid programs must receive their prescription drug benefits through Medicare not Medicaid. These "dual eligibles" are automatically deemed eligible for the full LIS and are directly enrolled into PDPs randomly by CMS from data files routinely transmitted by the States. In 2006, there were 16 PDPs that all LIS enrollees could choose from, or were auto-enrolled into, with no premium cost to the enrollee. Other plans were available at additional cost to the enrollee.

## Pharmacy Assistance Programs

For many years, pharmaceutical companies have sponsored pharmacy assistance programs (PAPs) to provide prescription medications to low-income individuals and families who cannot otherwise afford them. All of these programs have specific requirements that must be met in

order to receive assistance and they vary from one program to another. All PAPs require an application form to be completed. Generally, they require proof of financial status and often the doctor's consent. Some programs do not allow participants with health insurance, or there must be no prescription drug benefit through the health insurance. Many programs provide prescription medicines free of charge, but some require a nominal fee or a co-payment each time the drug is supplied.

## Legal Issues Regarding Medicare Part D and the PAPs

With the establishment of the Medicare Part D prescription drug benefit, most of the pharmaceutical manufacturers' PAPs discontinued Medicare beneficiaries' eligibility for their programs. This was in part the result of a special advisory bulletin issued in November 2005 by the Office of the Inspector General (OIG) at the federal Department of Health and Human Services stating that pharmaceutical companies face a heightened risk of liability under the fraud and abuse laws if they assist Part D enrollees by subsidizing Part D cost sharing amounts for enrollees to obtain the company's products. This assistance could violate anti-kickback provisions if found to be influencing a beneficiary's choice of drugs, which would include providing an economic incentive to use the PAP product over competing drugs and reducing a beneficiary's incentive to use less expensive, equally effective drugs. Such activities would negatively impact the Part D program by increasing costs to Medicare.

As mentioned, pharmaceutical companies by and large terminated coverage for Medicare beneficiaries in their PAPs due to the potential for prosecution. CMS has contended that companies need not discontinue PAP assistance for Medicare beneficiaries enrolled in a Medicare prescription drug plan. The assistance just has to be outside of the Part D coverage (i.e., the beneficiary obtains the drug without using the Part D insurance benefit). The drug cost associated with this assistance cannot apply toward the beneficiary's true out-of-pocket costs (TrOOP) or to total drug expenditures. Nor can a claim be filed with the beneficiary's Part D plan for payment of the prescription drug provided outside of the Part D benefit. As long as the PAP is "properly structured," the manufacturers' programs can provide free or reduced price drugs to Medicare Part D enrollees. Unfortunately for many PAP enrollees, the manufacturers generally have been uncomfortable with the potential legal hazards of operating an improperly structured program.

## Medicare Part D and PAP Legal Issues: Recent Developments

There has been interest and some movement on the part of pharmaceutical companies to reopen their PAPs to Medicare beneficiaries. Several companies have requested advisory opinions from the OIG to determine if the structure of their existing or redesigned program would not place them in violation of the fraud and abuse statutes. Schering-Plough was the first company to receive an OIG advisory opinion regarding how to structure their PAP to help Part D enrollees. While the OIG stated the program was acceptable outside of the Part D program, the cost of medications provided by the PAP could not apply towards TrOOP and so would not help the patient though the coverage gap. In addition, on September 18, 2006, the OIG rendered another advisory opinion to a requestor (name redacted) regarding a charitable organization's proposal to provide financially needy persons who have (diseases redacted) with grants to defray the costs of

premiums and cost sharing obligations under Part D (and various other Medicare programs). The OIG advised that it would not impose sanctions against the entity. Another OIG opinion issued on September 21, 2006, advised that OIG would not impose administrative sanctions on a pharmaceutical manufacturer's proposed PAP (name redacted) based on the facts certified in the request. On the date this was posted, Eli Lilly announced it had been granted approval of its PAP, LillyMedicareAnswers, to provide assistance entirely outside of Part D. Therefore, no payment will be made for the PAP drugs by Medicare or any PDP, nor will any of the drug costs count toward TrOOP. The aforementioned OIG opinions apply only to those specific PAPs and while they may serve as a template from which to configure their PAP design, it appears incumbent upon other manufacturers/organizations to acquire their own opinion to protect themselves if they wish to assist Part D enrollees.

In a recent update by CMS on October 6, 2006, a new response was issued for a Frequently Asked Question about whether PAPs can provide assistance with Part D drug costs to Part D enrollees outside of the Part D benefit and its effect on true out of pocket costs (TrOOP). In brief, the FAQ advises that PAP assistance provided outside the Part D program cannot count toward the beneficiaries' TrOOP, but nominal co-payments paid for PAP assistance with Part D-covered drugs can be counted. Beneficiary payments of administrative fees or premiums cannot count toward TrOOP or total drug spend balances. Enrollees would have to submit the appropriate paperwork to their plans to have co-payment amounts reflected in TrOOP. Furthermore, PAPs must not tie a cap in benefits to when catastrophic Part D coverage kicks in, but should continue PAP eligibility for the remainder of the year. It concludes with the warning that PAPs must still comply with fraud and abuse laws.

The DMAS PAP Task Force felt strongly that the PAPs should be allowed to assist low-income Part D beneficiaries with their prescription medication needs as in the past, particularly during the "donut hole" without fear of legal consequences from the OIG or CMS. Moreover, the Task Force believes that one way to facilitate broader participation by the PAPs is for the OIG to issue an advisory opinion that would apply industry-wide and provide guidance to the manufacturers on how to structure their PAPs to meet this need.

## Other Types of Pharmacy Assistance Programs

There are a variety of other types of prescription drug assistance programs, including manufacturer-sponsored card programs that offer a percentage discount off of their products, such as the GlaxoSmithKline "Orange Card" and the Pfizer "Pfriends Card." The American Association of Retired Persons' MembeRx Choice Program also has a discount card, if you have an AARP membership and pay an additional annual fee for the card. Two non-manufacturer patient assistance programs, Rx Outreach and Xubex Pharmaceutical Services, provide generic drugs for a fee to low income applicants.

Some States have established state-funded prescription assistance programs to provide financial assistance to low-income and medically needy senior citizens and individuals with disabilities who need help paying for medications. As authorized by the MMA, the payments made by the state pharmaceutical assistance programs (SPAPs) for a Part D enrollee can be counted towards an enrollee's true out-of-pocket costs. (SPAPs must first attest to CMS that their program meets certain requirements to be a qualified SPAP under MMA.) This allows the enrollee to reach the

catastrophic coverage faster. Part D prescription drug plans (PDPs) are required to work directly with the SPAPs to systematically coordinate and accept premium payments in states where the SPAP is subsidizing the premium. As of May 17, 2006, CMS lists 25 states that had 38 qualified state pharmaceutical assistance programs under the MMA.

**Pharmacy Assistance Activities in Virginia**

There are several public and private initiatives that facilitate the medication assistance process for individuals in need. Virginia has a number of local/regional pharmacy assistance programs that are operated/funded by the local government, health department, area agency on aging, or local charity. Representatives of these programs typically utilize the software developed by the Virginia Health Care Foundation, The Pharmacy Connection, to assist individuals in applying for manufacturer PAPs. The Pharmacy Connection maintains the current applications and eligibility requirements for all manufacturer PAPs so this one system can provide access and ease the application process for low income individuals who need medications from more than one company. Since it began in 1997, The Pharmacy Connection has helped over 123,371 uninsured Virginians acquire free medications worth more than $374.8 million. In the past fiscal year, this software has assisted 53,000 people by providing $101 million in free medications.

The Virginia Health Care Foundation was also a key partner in the development of the RxPartnership, a public/private partnership established with the General Assembly's Joint Commission on Health Care, the Medical Society of Virginia, and a number of other organizations. Its purpose is to increase access to free prescription medications for Virginia's uninsured, which it does by soliciting free bulk medications from manufacturers for distribution to non-profit, licensed affiliate pharmacies that the RxPartnership credentials and monitors. These pharmacies are typically operated by free clinics and community health centers. With the free medications, these health care providers are able to immediately fill prescriptions for qualifying patients and avoid the 6-12 week wait that is typical of the manufacturers' PAP. The RxPartnership provides free bulk medications to 20 free clinics and community health centers with more than 35 clinical delivery sites, which have provided these drugs to more than 8,000 patients with over 30,000 prescriptions. These medications are valued at greater than $9.2 million.

The Partnership for Prescription Assistance (PPA) of Virginia is the state chapter of a national program that provides a toll-free number and web site to help individuals in determining which of the many public and private patient assistance programs will best meet their medication needs, and then helps with the application process. Since it began in August 2005, the Partnership for Prescription Assistance of Virginia has helped match over 61,283 individuals with more than 475 public and private patient assistance programs. The Help Is Here Express bus tour operated by the PPA has been bringing help directly to communities across Virginia by providing access to the tools needed to enroll with PAPs and the assistance of a trained specialist.

## Task Force Meetings

The Pharmacy Assistance Program Task Force was convened by DMAS in order to address the legislature's interest in evaluating the Medicare Part D program and in determining how to coordinate or integrate Part D with existing pharmacy assistance programs in Virginia. DMAS invited a broad array of public and private stakeholders to participate on the Task Force; two meetings were held. In addition, information was communicated to the Task Force through a listserv. (See Attachment B for a list of the Task Force members.)

The first meeting of the Task Force included presentations on how the Part D program has impacted low-income Medicare beneficiaries and negatively influenced the availability of low or no cost prescription drugs for them through pharmaceutical manufacturers' PAPs. Representatives of organizations that facilitate the application process for individuals and health care providers to acquire manufacturers' products described the PAPs' termination of eligibility for Medicare beneficiaries and offered real life examples of how people have been affected (see Attachment D for the concerns of one such local agency). Additional presentations described the basic drug plan, the Part D implementation and its impact on Medicaid, Virginia's dual eligibles and the pharmacy community, and the legal issues currently influencing PAP decision-making.

## Areas of Concern Identified by the Task Force

During the first and second meetings, the Task Force discussed the "gaps" that now exist in prescription drug coverage since implementation of Part D and what the greatest problems are for low-income residents. In addition to concerns raised by Task Force members, public comments regarding these issues also were solicited from others in attendance at the meetings.

*Surviving the "Donut Hole:"* The most significant problem cited is the inability of many beneficiaries to pay for needed medications during the Part D coverage gap, or "donut hole." The $2,850 gap (in 2006) is a substantial portion of the total income available to elderly and disabled Medicare beneficiaries in the lower economic strata. Because of the eligibility requirements for the low income subsidy (LIS), many individual beneficiaries with modest savings accounts (> $10,000) are turned down for the subsidy though they may have income that would otherwise make them eligible for the LIS. In addition, the subsidy only applies to individuals with income below 150% of the federal poverty level and there are many people with slightly higher income who can barely afford their medications under Part D and certainly cannot if they reach the donut hole. While the manufacturers' PAPs provide help to patients with income up to 200% of poverty, most Medicare beneficiaries are not being assisted by the PAPs due to the aforementioned legal issues. For those Part D beneficiaries with high drug costs who reach the "donut hole," there are few, if any, options for meeting their prescription needs during this time period other than the PAPs.

Throughout the Task Force discussions, the group returned to this primary issue — the inability of the PAPs to assist patients who need help with their cost sharing obligations under Part D, chiefly with the "donut hole." Because the payments cannot apply toward the individual's true

out of pocket (TrOOP) costs, the result is that the beneficiary never gets out of the coverage gap. The Task Force identified this issue as the most critical problem that needs to be addressed.

*Part D Administrative Issues and LIS Determinations:* The Task Force also indicated that there continue to be problems with understanding and navigating the complexity of the Part D program and in selecting/enrolling in a Part D plan that best matches one's requirements. In addition, the LIS eligibility requirements and process for applying for LIS were cited as problem areas. There was consensus among the group that the federal administration of the low income subsidy and the Part D benefit should be revisited by the Social Security Administration, the Centers for Medicare and Medicaid Services, and Congress. Where federal agencies have the latitude to streamline and relax regulatory restrictions that impede LIS enrollment and access to Part D benefits, they should be strongly encouraged to do so. It also is recognized that some changes require Congressional action to amend current statutory provisions.

The following lists some of the specific problems/issues identified by the Task Force:

- A good deal of confusion about the overall structure and administration of the Part D program and LIS process still remains, particularly among low-income beneficiaries.

- Formulary restrictions have forced many beneficiaries to change to other drug products and it has often not worked well for the patients, particularly those with mental illness, resulting in non-compliance and in some cases, an exacerbation of the condition.

- Some PDPs have not included "all or substantially all" of the mental health drugs in their formularies, as required by CMS regulations; moreover, additional classes of drugs (e.g., cardiovascular) should be subject to the requirement that "all or substantially all" of drugs in the class be included in the formulary.

- The frequency of formulary changes in some PDPs makes it difficult for beneficiaries to select the plan that best meets their prescription needs and makes it difficult for providers to know the current list of approved medications.

- A lack of standardization in PDP administration has made it difficult for patients and providers alike when trying to navigate the system to obtain prior authorization for a medication and to appeal an adverse decision.

- LIS eligibility determinations include some sources of income (e.g., funds provided by family members) that should be disregarded; also, the dollar amounts of some necessary expenses (e.g., allowance for funeral expenses) that are disregarded, should be increased.

- Virginia's academic medical centers have experienced a resurgence in Medicare patients returning to their facilities for assistance due to the generally higher cost sharing required by Part D, especially during the coverage gap.

## Task Force Recommendations

The members of the Pharmacy Assistance Program Task Force reached consensus on several recommendations on how to correct or ameliorate problems or inadequacies relating to the Medicare Part D program, and for better integrating the PAPs with the Part D benefit structure. The Task Force recognizes that the changes included in the following recommendations are beyond the legal and regulatory authority of the Commonwealth, and must be enacted and/or adopted by the federal government. The recommendations are enumerated below.

*Recommendation #1*: The General Assembly may wish to consider adopting a memorializing resolution that would urge the appropriate federal officials (i.e., Congress, the Centers for Medicare and Medicaid Services, and the Office of the Inspector General) to make several changes to the current statutory and regulatory framework within which the Part D program is administered and the pharmaceutical manufacturers' PAPs operate. The memorializing resolution would urge:

- Congress to change the statute(s) relating to the fraud and abuse laws to ensure that the pharmacy assistance programs established by pharmaceutical manufacturers are not in violation of said laws when they assist low-income Medicare Part D beneficiaries with low cost or free medications.
- The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services to issue an industry-wide statement vs. company-specific advisory opinions to encourage the development/operation of pharmacy assistance programs established by pharmaceutical manufacturers. This OIG statement should clearly delineate the parameters by which these programs can participate with Medicare Part D program.
- Congress to change the statute(s) relating to what is allowed to count toward true out of pocket (TrOOP) costs for Medicare Part D. The costs of medications provided by the pharmacy assistance programs established by pharmaceutical manufacturers should count toward TrOOP to assist these low income beneficiaries in the coverage gap and enable them to reach the catastrophic coverage under Part D.
- Congress to change the Low Income Subsidy (LIS) requirements for the Medicare Part D program to (i) not count family financial contributions as income, (ii) increase (double) the amount of savings and funeral expenses allowed, and (iii) streamline the annual re-determination process or require less frequent re-determinations.
- Congress to change the Prescription Drug Plan (PDP) formulary requirements to expand the required coverage categories to include all cardiovascular and mental health drugs in the "all or substantially all" group. Congress should also address the frequency of when a PDP can change their formulary and only allow changes when (i) the enrollee also has the ability to change plans, (ii) a drug becomes generic, or (iii) health/safety issues arise.
- Congress to change the statute if necessary or direct federal agencies to create uniformity/consistency in prior authorization and appeals processes across all PDPs.

- The Centers for Medicare and Medicaid Services and the Social Security Administration to increase and improve their consumer education programs to enhance beneficiaries' understanding of the Part D and low-income subsidy (LIS) programs.

*Recommendation #2*: The Governor may wish to consider working with the Virginia Congressional delegation to inform them of the problems and needed improvements identified above in Recommendation #1, and urging the delegation to advocate for the changes identified by the Task Force.

*Recommendation #3*: The Governor and General Assembly may wish to consider establishing a State Pharmaceutical Assistance Program (SPAP) which would pay Part D premiums for prescription drug plans that do not have a coverage gap for Virginia Medicare beneficiaries within 135% - 200% of the federal poverty level (FPL).

**Acknowledgements**

The Department of Medical Assistance Services would like to express its deep appreciation to the members of its Pharmacy Assistance Program Task Force for their involvement and many contributions to this project.

**ATTACHMENT A**

**CHAPTER 56**

*An Act to implement the federal Medicare Part D benefit and to convene a task force on prescription drug assistance for low-income Virginians.*

[H 1624]

Approved March 20, 2005

Be it enacted by the General Assembly of Virginia:

**1.** *§ 1. Implementation of the Medicare Part D benefit.*

*A. The Board of Medical Assistance Services shall promulgate necessary regulations to implement the provisions of the Medicare Part D prescription drug benefit that becomes effective January 1, 2006.*

*B. Upon the implementation of the Medicare Part D program, the Department of Medical Assistance Services shall convene a task force of public and private stakeholders to assist the Department in evaluating the Medicare Part D benefit and to make recommendations for enhancing, coordinating, and integrating the existing pharmacy assistance programs for low-income Virginians and the Medicare Part D benefit. The Department shall report its findings and recommendations to the Governor and the General Assembly no later than November 1, 2006.*

2. That the Board of Medical Assistance Services shall promulgate regulations to implement the provisions of this act to be effective within 280 days of its enactment.

**ATTACHMENT A**

**CHAPTER 24**

*An Act to implement the federal Medicare Part D benefit and to convene a task force on prescription drug assistance for low-income Virginians.*

[S 841]

Approved March 20, 2005

Be it enacted by the General Assembly of Virginia:

**1.** *§ 1. Implementation of the Medicare Part D benefit.*

*A. The Board of Medical Assistance Services shall promulgate necessary regulations to implement the provisions of the Medicare Part D prescription drug benefit that becomes effective January 1, 2006.*

*B. Upon the implementation of the Medicare Part D program, the Department of Medical Assistance Services shall convene a task force of public and private stakeholders to assist the Department in evaluating the Medicare Part D benefit and to make recommendations for enhancing, coordinating, and integrating the existing pharmacy assistance programs for low-income Virginians and the Medicare Part D benefit. The Department shall report its findings and recommendations to the Governor and the General Assembly no later than November 1, 2006.*

2. That the Board of Medical Assistance Services shall promulgate regulations to implement the provisions of this act to be effective within 280 days of its enactment.

**ATTACHMENT B**

# Virginia Department of Medical Assistance Services
# Pharmacy Assistance Program Task Force
# Membership

| Name | Affiliation |
|---|---|
| Ms. Beth Bortz | The Medical Society of Virginia Foundation<br>Rx Partnership |
| Mr. R. Neal Graham | Virginia Primary Care Association |
| Ms. Anna Keiter | Highland Medical Center |
| Ms. Anne Leigh Kerr/<br>Mr. Richard Grossman | Troutman & Sanders<br>The Vectre Corporation |
| Dr. Manikoth G. Kurup | Board Chairman, Virginia Department of Medical Assistance Services |
| Ms. Shannon Lambert | Community Memorial Health Center - South Hill |
| Ms. Julie Locke | Anthem |
| Ms. Trudy Maske/ Ms. Janet Schaefer | Virginia Department for the Aging |
| Ms. Debbie Oswalt | Virginia Health Care Foundation |
| Dr. Rachel Selby- Penczak | Virginia Commonwealth University Health System<br>Member, Virginia Medicaid Pharmacy and Therapeutics Committee |
| Ms. Becky Snead | Virginia Pharmacists Association |
| Dr. Michele Thomas | Virginia Department of Mental Health, Mental Retardation<br>and Substance Abuse Services |

**ATTACHMENT C**

## Medicare Prescription Drug Program, Medicare Part D
**(2006)**

Under the standard prescription drug benefit, most beneficiaries in 2006:

- Pay an average monthly premium of $34
- Pay the first $250 in drug costs (deductible)
- Pay 25% of total drug costs between $250 and $2,250
- Pay 100% of the costs between $2,250 and $5,100 in total drug costs (this $2,850 gap is known as the *"donut hole"*), equivalent to $3,600 out of pocket.
- Pay the greater of $2 for generics, $5 for brand drugs, or 5% coinsurance after reaching the $3,600 out-of-pocket limit

The deductible, benefit limits, and catastrophic thresholds are indexed to rise with the growth in per capita Part D spending.

## Low Income Subsidy
**"Extra Help" To Offset Cost of Prescription Drug Benefit for Certain Beneficiaries**
**(2006)**

Group 1: Full benefit "Dual Eligibles" with income ≤100% Federal Poverty Level (FPL) ($9,800/year); no resource limits

Group 2: Persons with income ≤135% FPL ($13,230/year) and limited resources ($6,000/individual; $9,000/couple)

Group 3: Persons with income ≤150% FPL ($14,700/year) and limited resources ($10,000/individual; $20,000/couple)

| Cost Sharing Requirements | Group 1 | Group 2 | Group 3 |
|---|---|---|---|
| $34/Month Premium | $0 | $0 | Sliding scale based on income |
| $250/year Deductible | $0 | $0 | $50 |
| Coinsurance up to $3,600 (donut hole) | $1/$3 co-pay | $2/$5 co-pay | 15% coinsurance |
| 5% or $2/$5 co-pay after $3,600 out-of-pocket limit | $0 | $0 | $2/$5 co-pay |

## ATTACHMENT D

### Medicare Part D Concerns Observed by Staff of Mountain Empire Older Citizens, Inc. and The Pharmacy Connect Of Southwest Virginia Partnership

Mountain Empire Older Citizens, Inc. ( MEOC) serves as the area agency on aging for Lee, Wise, Scott Counties and the City of Norton in Virginia's westernmost jurisdictions and has served citizens in these locales since 1974. Since 2000, MEOC has operated a Virginia General Assembly funded program called Pharmacy Connect of Southwest Virginia in the seven county area comprising Planning Districts 1 and 2. Pharmacy Connect accesses the free patient assistance programs of over 100 major pharmaceutical companies to assist medically indigent adults in Lee, Wise, Scott, Tazewell, Dickenson, Buchanan and Russell counties and the City of Norton.

From July 1, 2000 to June 30, 2006, Pharmacy Connect of Southwest Virginia: processed 134,367 applications for assistance with pharmaceuticals; accessed 343,081 different prescription drugs; and accessed medications whose wholesale cost was valued at $74, 887, 875. That is nearly $75 million. I point this out because Pharmacy Connect of Southwest Virginia has made a major impact on the health of the medically indigent and low-income in our region and because our six years of experience with Pharmacy Connect of Southwest Virginia put us in a unique position to evaluate the impact of Medicare Part D on the citizens of our area.

During the past year, MEOC and its partners worked literally thousands of hours in transitioning older people and persons with disabilities from the Pharmacy Connect Program to Medicare Part D. Now, we are faced daily with many of these same persons who have now reached the "doughnut hole" and are struggling and not sure where to turn.

Following is a summary of the truth as we perceive it and as it presents itself to us every hour of every day. When Medicare Part D recipients reach the "doughnut hole", we find that it is practically impossible for them to get out of it because of the following issues:

1. Medications purchased by enrollees that are not covered by their specific plan's formulary are not counted towards the out of pocket expenses. This is a Catch 22 because these people cannot afford the monthly premiums for the more expensive plans that would cover more of their medical needs;
2. The enrollees must continue to pay their monthly premiums for Part D while in the doughnut hole even though they are without coverage during this time;
3. Enrollees in the "doughnut hole" are simply going without critically needed mediations because they cannot afford them.
4. Enrollees in the "doughnut hole" are not taking their medications correctly in order to stretch limited funds. We are seeing people who are cutting their medications in half in order to make it through the month;
5. A very small handful of Pharmacy Assistance Program of the Pharmaceutical Companies will assist people who are in the "doughnut hole", but the value of these medications does

not apply across the board to the out of pocket expenses. Recent information indicates that these few companies will evaluate each PAP applicant on a case by case basis, so not all will be found eligible;

6. Many Part D enrollees were much better off and were much better served prior to Part D if they were participating in Pharmacy Connect of Southwest Virginia. Staff spends much time explaining to Part D participants why they can no longer be served by Pharmacy Connect and the Patient Assistance Programs;
7. The cost of some common brand name medications commonly used by older citizens has increased by 8% to 12 % since the inception of Medicare Part D because this new benefit prohibits the government from negotiating prices. Thus, trying to buy these drugs while in the "doughnut hole" presents additional financial hardships to people already strapped for funds. Life has become even more difficult financially for people during this time because Medicare deductibles and premiums continue to rise as well; and
8. Staff members report serving lots of persons who need to choose a Part D plan that covers their psychotropic drugs. These plans often do not cover the other drugs needed by these enrollees and they often go without these needed prescriptions. It is doubly dangerous when these enrollees hit the "doughnut hole" and have to go without their psychotropic drugs or try to cut their meds in half for financial reasons.

Thank you for this opportunity to comment. We welcome you and your staff to visit our area and to hear firsthand the concerns of our citizens.

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