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Providing Prescription Drug Coverage for Low and Moderate Income Senior Citizens

June 2003

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Report Summary

Prescription drugs play an ever-increasing role in modern medicine. New medications are improving health outcomes and quality of life, replacing surgery and other invasive treatments, and quickening recovery for patients who receive these treatments. However, if patients do not comply with the prescription drug regimens because they cannot afford the medications, the drug's benefits are compromised. Elderly, low-income citizens are particularly vulnerable because they often require multiple prescriptions and because Medicare provides only a very limited prescription drug benefit.

In response to these concerns, the Legislative Budget and Finance Committee (LB&FC) directed its staff to study this issue and develop options for the Legislature to consider to provide help to low and moderate income senior citizens when purchasing prescription drugs.

Existing Prescription Drug Programs for Seniors

Pennsylvania's seniors can obtain help for their prescription drug costs through a variety of public and private programs. These programs include:

PACE/PACENET. In fiscal year 2000-01, the PACE/PACENET program provided $396.4 million in prescription drug assistance to 220,000 older, low-income Pennsylvanians. Although the number of PACE participants has declined since the peak in June 1988, the program remains one of the nation's largest, with approximately 625,000 Pennsylvania seniors being potentially eligible for either the PACE (437,000) or PACENET (189,000) program. This represents nearly one-third of the state's population over age 65. Income limits for the PACE program are $14,000 for singles and $17,200 for couples; for PACENET, income limits are $17,000 for singles and $20,200 for couples.

The PACE/PACENET program is funded through the Pharmaceutical Assistance Fund, which receives monies from several sources, including the Lottery Fund, and in recent years, Tobacco Settlement funds. According to the most recent projections, the Pharmaceutical Assistance Fund will have a balance of approximately $150 million as of June 30, 2003.

Medical Assistance. Although outpatient prescription drug coverage is optional under federal law, all states provide this benefit to families and children enrolled in their Medicaid program. In federal fiscal year 2001, Pennsylvania spent $692.7 million on prescription drugs in the Medicaid fee-for-service program, 40 percent, or $278.6 million, of which was for the elderly. Additionally, DPW's managed care plan, HealthChoices, includes pharmacy

coverage. In 2002, there were 66,000 enrollees, aged 65 and older. The program reimbursed $119 million in such HealthChoices pharmacy benefits.

To qualify for Medical Assistance, Pennsylvania's Medicaid program, seniors cannot exceed the program's income and resource limits. The MA income limit for pharmacy services for those over 65 is 100 percent of the federal poverty line, or $8,988 for singles and $12,120 for couples.

Medicare. Although the traditional Medicare program does not provide prescription drug coverage, such coverage can be purchased through Medigap policies or may be available through a Medicare+Choice option. Medigap policies are offered through private insurance companies and pay for some or all of the health care costs not covered by Medicare. Of the ten types of Medigap plans allowed, three provide at least some prescription drug coverage. Medicare beneficiaries can also enroll in a Medicare+Choice plan if available in their area. In addition to paying the monthly Medicare Part B premium, seniors enrolled in Medicare+Choice HMOs in Pennsylvania pay a monthly premium that can range from $0 to $183. Some plans charge an additional monthly premium for the option of drug coverage (ranging from $20 to $48). Nearly a half-million Pennsylvania seniors are enrolled in Medicare HMOs.

The Center for Medicare and Medicaid Services (CMS) announced in August 2002 that 33 new health plans in 23 states will begin to serve Medicare beneficiaries beginning in January 2003 for up to three years as part of a Preferred Provider Organization demonstration project to introduce more variety into the Medicare+Choice program. Three health plans, operating in 24 counties in Pennsylvania, have been approved for the demonstration: Aetna, Coventry, and UPMC. A fourth plan, Highmark, was approved May 1, 2003. The demonstration plans must offer all Medicare required benefits, but will have the flexibility to offer greater access to drug benefits and disease management services. As of April 2003, 1,787 senior Pennsylvanians were enrolled in these plans.

CMS has also developed the Medicare Endorsed Discount Drug Card Initiative, which it promotes as providing meaningful savings as well as reducing the confusion associated with multiple pharmaceutical card programs. The program allows a significant number of Medicare beneficiaries to obtain discount cards who might not qualify for a pharmaceutical manufacturer's discount card.

Veterans Administration. Prescription drugs are available through the VA program, but a VA physician must issue the prescription. As a result, many veterans schedule appointments with VA physicians solely or primarily for the purpose of filling prescriptions originally written by private physicians.

The VA staff physicians then routinely review and approve the prescriptions ordered by the private physicians. This system is particularly problematic in that veterans may need to wait up to a year to be examined by a VA doctor. Pennsylvania has a veteran population of 1,280,788, as of the 2000 census, of which 544,732 were age 65 or older. Data on the number of 65+ year olds who are enrolled was not readily available, but we estimated that approximately 125,000 veterans are enrolled in the program.

Employer-Based Benefit Programs. For many persons aged 65 and older, employer-sponsored retiree health benefits are the primary source of drug coverage, assisting more than one in three seniors with Medicare. No specific information is readily available on the number of Pennsylvania seniors covered by such programs. A recent survey conducted by the Kaiser Family Foundation of 435 large firms showed that the majority of employers offering health benefits to retirees included prescription drug coverage in their benefit package. A majority of the employers provided unlimited drug benefits, with the median copayment for a 30-day prescription of $8 for generic drugs, $15 for brand name drugs on a formulary, and $25 for brand name drugs not on a formulary.

Pharmaceutical Programs. Pharmaceutical Research and Manufacturers of America (PhRMA) member companies offer several assistance programs for those who cannot afford to purchase their prescription drugs. In 2001, PhRMA reported that more than 3.5 million patients received prescription medicines through these programs, with a wholesale value estimated at about $1.5 billion. A PhRMA representative has also noted that drug manufacturers gave $8 billion in free samples to physicians in 2001. In Pennsylvania, according to PhRMA, 100,000 persons are using Patient Assistance Programs, including approximately 13,000 seniors.

Many pharmaceutical manufacturers have also developed discount card programs designed to help low-income individuals pay for prescription drugs. Seven manufacturers (Abbott Laboratories, AstraZeneca, Aventis, Bristol-Myers, Squibb, GlaxoSmithKline, Johnson & Johnson, and Novartis) have partnered together to form "Together Rx," so that only one card is needed for the drugs covered under this program. The income limits to qualify for these discount cards vary, ranging from $18,000 to $28,000 for individuals and from $24,000 to $38,000 for couples.

Cost Savings and Revenue Enhancements Measures

States can generate funds to expand their prescription drug programs by imposing a variety of cost savings or revenue enhancement measures on pharmaceutical manufactures, pharmacies, or program enrollees. Listed below are several of the most common measures used by states.

Manufacturers

Best Price. "Best Price" is the lowest price paid to a manufacturer for a drug by any purchaser other than federal agencies and state pharmacy assistance programs. Requiring pharmaceutical manufacturers to provide the PACE/PACENET program with their best price would place the programs on par with the federal Medicaid program. The rebate currently paid by manufacturers in the Medicaid program is approximately 21 percent, compared to 16 percent for the PACE/PACENET program. Enacting a best price requirement could save the PACE/PACENET program more than $30 million annually, but would require the Legislature to amend the current PACE/PACENET law.

Formulary or Preferred Drug List. A formulary is a listing of drugs, usually by their generic names. Formularies are often used to develop a Preferred Drug List (PDL), which is a pre-approved listing of reimbursable drugs. The PACE/PACENET Advisory Committee estimated that a phased-in formulary mandate could save $10 million or more annually, depending on the formulary developed. Such action would require an amendment to the current PACE/PACENET law.

Prior Authorization. Under prior authorization, physicians must obtain approval to prescribe medications not on a Preferred Drug List. Prior authorization is used as a cost saving measure in many public and private drug reimbursement plans, including Medicaid. Instituting a prior authorization requirement would require amending the current PACE/PACENET law, but could yield potential savings of $5 million to $10 million annually.

Supplemental Rebates. In addition to Medicaid "best price" provisions, several states have developed additional, or supplemental, rebate programs. Such a strategy typically involves pharmaceutical manufactures of non-preferred drugs paying supplemental rebates to have their drugs placed on the program's Preferred Drug List. Drugs from manufacturers who agree to pay these supplemental rebates are added to the PDL and are not then subject to prior authorization. In California, $158 million in savings has been realized for supplemental rebates. South Carolina has estimated $15 million to $20 million in such savings.

Pharmacies

Approximately 2,800 licensed pharmacies in Pennsylvania participate in the PACE/PACENET program. Pharmacies receive a dispensing fee of $3.50. The most common approaches for obtaining cost savings from pharmacies include:

Federal Upper Limits. Federal Upper Limit pricing limits pharmacy reimbursement for generic prescription drugs to an amount based on the price per unit which CMS has determined to be 150 percent of the lowest price listed, typically for package sizes of 100 units, on a published compendia of cost information of medications. FUL pricing is commonly used in third party drug reimbursement plans, including Medicaid. FUL would require a change in the PACE/PACENET statute but could save the program $28 million annually, according to estimates prepared by the Department of Aging.

Reduce Ingredient Cost Reimbursement. Pharmacies are reimbursed for both a product component and for professional services. PACE/PACENET currently reimburses pharmacies at 90 percent of Average Wholesale Price, or AWP-10 percent, plus a $3.50 dispensing fee. This is higher than the industry average for commercial Pharmacy Benefit Managers, which is AWP-15 percent plus a $2.00 dispensing fee. Lowering ingredient cost reimbursement to 87 percent of AWP would save $10 million in payments to pharmacies.

Mail order. In FY 1999-00, mail-order pharmaceutical sales accounted for approximately 10.6 percent of the $128 billion U.S. prescription drug market. The PACE/PACENET program allows for in-state mail order purchasing of drugs, but only through mail order pharmacists registered as providers and only for a maximum 30-day supply. Normally, mail order prescriptions are for 90-day supplies. An estimated 90 percent of PACE/PACENET prescriptions filled are for maintenance drugs and therefore might be candidates for a mail order program. Depending on how it would be structured, a mail order/ 90-day supply provision has the potential to save between $16 million and upwards to as much as $36 million annually, according to estimates.

Performance Based Network. This strategy, common among commercial Pharmacy Benefit Mangers, would require pharmacy providers to meet quarterly performance standards. For example, PACE/PACENET could set certain percentage targets for generic drug prescriptions or for the average per claim costs. In at least 12 state prescription drug programs, pharmacists receive an incentive (a higher dispensing fee) for dispensing generic drugs rather than brand-name drugs. Implementing such performance-based incentives in PACE/PACENET would require statutory amendments, but could save between $10 million and $15 million annually.

Program Beneficiaries

Increase Copayments. If PACE increased its copayment to meet the ratio established in Act 1996-134, copayments would be in the $12-$14 range, instead of the current $6. Every dollar increase in the copay yields approximately $9 million in savings. Some states tie copayments to the cost of the prescription. Delaware's copay, for example, is $5 or 25 percent of prescription cost, whichever is greater. In other states, the copay depends on the enrollee's income. Copays in the Rhode Island program, for example, vary from 15 percent to 60 percent of prescription cost, depending on income. Depending on where the copay is established, savings of $50 million or more could be achieved annually.

Establish Multi-tiered Copayments. Another option would be to establish tiered copayments for the PACE program, such as currently exists in PACENET and in programs in many other states. Assuming $5/$12/$25 copay, the PACE/PACENET program could generate an additional $30 million annually.

Require an Annual Deductible. The PACENET program currently has a $500 per person deductible; the PACE program has no deductible. If the PACE program enacted a $250 annual deductible, it could generate $50 million annually.

Establish Maximum Annual Benefit Ceiling. Many states have an annual benefit ceiling, ranging from $600 in North Carolina to $5,000 in Nevada. The PACE and PACENET programs have no such limits. According to a PACE/PACENET Advisory Committee report, a cap of $2,500 would generate $45 million annual savings.

Limit Prescriptions. New Jersey allows no more than 12 prescriptions a month without prior authorization. In Florida, enrollees may receive an unlimited number of generic drugs, but a provider may not prescribe more than four brand name drugs per month without prior authorization. Potential savings if a Florida-type approach was enacted in Pennsylvania have been estimated at $16.5 million annually.

Establish Annual Fee. Annual fees, typically in the $20-$35 range, have been instituted in several states. A $25 annual fee for PACE/PACENET enrollees could generate $5.6 million annually.

Possible Approaches for Expanding Coverage for Low and Moderate Income Seniors in Pennsylvania

Many plans have been proposed in recent years to provide prescription drug coverage to the Commonwealth's low-income seniors. The approach described below was developed by LB&FC staff and was intended for both low and moderate income seniors. The report also contains brief summaries of four legislative proposals currently before the General Assembly, the Governor's proposal, the HOPE plan developed by Heinz, and the "Pharmacy Plus" Medicaid Waiver.

An LB&FC Staff Approach to Expand PACENET Using Common Cost Savings and Revenue Enhancement Measures.

The report outlines the approach developed by LB&FC staff to expand PACENET eligibility to 300 percent of the 2003 federal poverty level by using several of the most common cost-sharing techniques being applied in other state and third-party prescription drug programs. At 300 percent of the federal poverty level, PACENET's maximum income eligibility would increase from $17,200 to $26,940 for an individual and from $20,200 to $36,360 for a couple. At these income limits, an additional 594,896 Commonwealth seniors would qualify for the PACENET program, of which an estimated 92,536 would actually enroll in the program. Income limits for the PACE program would remain the same.

Without any changes, the net cost to add these 92,536 additional enrollees to the PACENET program is estimated to be $218 million over a two-year enrollment period and $144 million annually thereafter.[1] To cover these costs, we worked with PACE staff to identify the savings and revenues that could be generated by employing Federal Upper Limit pricing, best price, a voluntary mail order program, and increased copayments. We believe these to be the most feasible strategies for meeting the costs of an expanded program.

- Instituting a **Best Price** provision could save an additional 6 percent of the state's share of PACE and PACENET claims, or about $80.1 million over the initial two years and by $44.2 million annually thereafter.
- Employing **Federal Upper Limit** pricing results in an estimated savings of $33.6 million during the initial two-year period and $18.0 million annualized thereafter.
- Assuming a 20 percent conversion of claims to **Mail Order**, the estimated savings are about $32.6 million during the two enrollment years and $16.8 million annually thereafter, assuming a $9 copay for a 90-day supply.

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[1]Figures are adjusted for inflation at the annual rate of 7.8 percent and 6.4 percent for PACE and PACENET, respectively. The model also assumes a 5 percent and 11 percent increase in prescriptions for PACE and PACENET, respectively.

- We estimated that increasing the PACE **Copay** from $6 to $8 would generate an additional $29.7 million during the first two years and $14.8 million annually thereafter.
- The final measure we modeled was **Increasing the Mail Order Copay** to $12 for PACE for a 90-day supply and, for PACENET, to $12 for generic and $22.50 for brand name drugs. This would generate an additional $8.5 million for the first two years and $4.8 million annually thereafter.

If all the above strategies were implemented, the net cost for the expansion of the PACENET program to 300 percent of the 2003 federal poverty level would be $33.6 million for the initial two-year ramp-up period and approximately $45 million a year thereafter. The difference is because the cost savings features of the plan are assumed to be implemented immediately, whereas the increase in enrollees is assumed to occur gradually over a 24-month period.

We believe costs of $45 million a year to be manageable given: (1) the Pharmaceutical Assistance Fund is expected to have an estimated balance of approximately $150 million on June 30, 2003; (2) the Lottery Fund is anticipating additional growth as a result of Powerball and changes in its marketing approaches aimed at making its products more accessible to the public; and (3) a Medicare prescription drug benefit is likely to be established by Congress prior to July 2005, thereby taking some of the pressure off the current PACE/PACENET program. If these factors are not sufficient to offset the costs of the expanded program, consideration could be given to implementing a preferred drug list and possibly a prior authorization requirement to realize additional savings.

Other Proposals

The report also outlines several other proposals that have been advanced for expanding prescription drug coverage to Pennsylvania seniors. The proposals described include House Bill 909 (Representative Eachus); House Bill 888 (Representative Vance); Senate Bill 7 (Senator Orie); Senate Bill 720 (Senator Mellow); and the Governor's proposal of May/June 2003. The report also describes the HOPE (Heinz Plan to Overcome Prescription Drug Expenses) Plan for Pennsylvania, as presented in a May 2001 report, and outlines the advantages and disadvantages of Pennsylvania's participation in the Federal "Pharmacy Plus" Medicaid Waiver.

I. Introduction

In response to legislative concern over the rising costs of prescription drugs, the Legislative Budget and Finance Committee (LB&FC) directed its staff to conduct a study to explore options to provide expanded prescription drug coverage for Pennsylvania's low and moderate income senior citizens.

Audit Objectives

A. To identify and assess current programs to assist Pennsylvania's low and moderate income seniors in obtaining prescription drugs, including the PACE/PACENET and Medical Assistance programs.

B. To report on trends in costs to the state and federal government to deliver such programs in Pennsylvania.

C. To identify options to reduce prescription drug costs to Pennsylvania's low and moderate income seniors.

Methodology

To determine what programs are available to provide prescription drug assistance for senior citizens in Pennsylvania, we reviewed Commonwealth statutes and regulations. We also reviewed state and federal proposed legislation, the Pharmacy Plus Initiative, the multi-state consortium for reducing drug prices, and the U.S. Court of Appeals opinion on the Maine Rx Program. Additionally, we developed information based on a Medicare Demonstration Project option being considered for Pennsylvania.

To identify legislative concerns, we sent letters to each member of the House and Senate Aging Committees and the Senate Public Health and Welfare Committee to inform them of the study. We also met with legislators who expressed an interest in the study and otherwise communicated with legislative staff on pertinent topics. We also attended PACE hearings held by the House Majority Policy Committee, Sub-Committee on Prescription Drugs, in Bethlehem and York, and the Senate and House Health and Welfare Committee briefing on the Pharmacy Plus 1115 Waiver program.

To identify and assess current costs to operate a prescription drug program, including through the PACE/PACENET and Medical Assistance programs and to report on trends in costs to the Commonwealth, we met with representatives of the Department of Aging, the Department of Public Welfare, and the Department of

Revenue and its State Lottery. We also analyzed data from the Governor's Executive Budget and the *Advisory Committee Report on Containing Costs in PACE.*

To identify options to reduce prescription drug costs to low and moderate income seniors, we met with officials of AARP Pennsylvania, the Pennsylvania Association of Area Agencies on Aging, and the Pennsylvania Pharmacists Association. We reviewed prescription drug programs available through Medical Assistance, Medicare, the Department of Veterans' Affairs, and other employee plans. We also reviewed pharmaceutical discount card programs and pharmaceutical assistance programs in other states. Finally, we collaborated with Department of Aging staff to develop an expanded PACE/PACENET based on selected assumption and cost-sharing scenarios. (Please note that recent estimates may differ from those presented in Chapter V which relies largely on estimates generated in 2001 and 2002.)

Acknowledgements

We wish to thank the Departments of Aging and Public Welfare, Honorable Estelle Richman and Honorable Nora Dowd, Secretaries. Mr. Tom Snedden, Director of Pennsylvania's PACE Program, deserves our special thanks. We also appreciate the AAA Association and county AAA organizations and the many other persons and organizations involved in developing this report.

Important Note

This report was developed by Legislative Budget and Finance Committee staff. The release of this report should not be construed as an indication that the Committee or its individual members necessarily concur with the report's findings and recommendations.

Any questions or comments regarding the contents of this report should be directed to Philip R. Durgin, Executive Director, Legislative Budget and Finance Committee, P.O. Box 8737, Harrisburg, Pennsylvania 17105-8737.

II. Prescription Plans Available for Seniors in Pennsylvania

Various paid prescription plans are available to seniors in Pennsylvania, depending, in part, on income level, physical disability, veteran's status, and availability of annuitant benefits. Additionally, discount drug cards and Internet pharmacies offer other cost savings options.[1]

A. PACE/PACENET

Pennsylvania has one of the largest pharmaceutical programs for older persons in the nation. The Pharmaceutical Assistance Contract for the Elderly (PACE) program began on July 1, 1984. Its purpose as stated in Act 1996-134 is to continue a program of limited pharmaceutical assistance for qualified state residents.[2] This legislation expanded the existing PACE program eligibility requirements and also created a new program, PACENET (PACE Needs Enhancement Tier).

In 2000, Pennsylvania had a population of 12,281,000 of which 1,919,165, or 15.6 percent, were age 65 or older. Only Florida, at 17.6 percent, had a higher percentage of its state's population aged 65 or older. About 26 percent of the 1.2 million Pennsylvania households with at least one member aged 65 or older are eligible for the PACE program and 34 percent are eligible for the PACENET program.

Between 1990 and 2000, Pennsylvania's 65 and older population increased 4.9 percent, but is expected to fall 0.5 percent by 2010. Since the 1990 Census, the 65 – 74 aged population declined 9.4 percent, the 75 – 84 aged population grew 21.3 percent and the 85 + population grew 38.3 percent.

The Pennsylvania Department of Aging administers the PACE/PACENET program. Its administrative responsibilities include monitoring and evaluating operations and ensuring that the legal and regulatory mandates of the program are met. Activities in these areas include conducting audits of participating pharmacies, cardholders, and the contracting agency.[3]

The Department of Aging also instituted a Prospective Drug Utilization Review (ProDUR) as part of the PACE program in 1992. Through its on-line claims processing system, PACE provides prospective clinical review of prescriptions before the pharmacist dispenses the medication to the cardholder. The review checks for potentially dangerous drug interactions, duplicative therapies, over-utilization, and under-utilization. A Surveillance Utilization Review System (SURS) monitors

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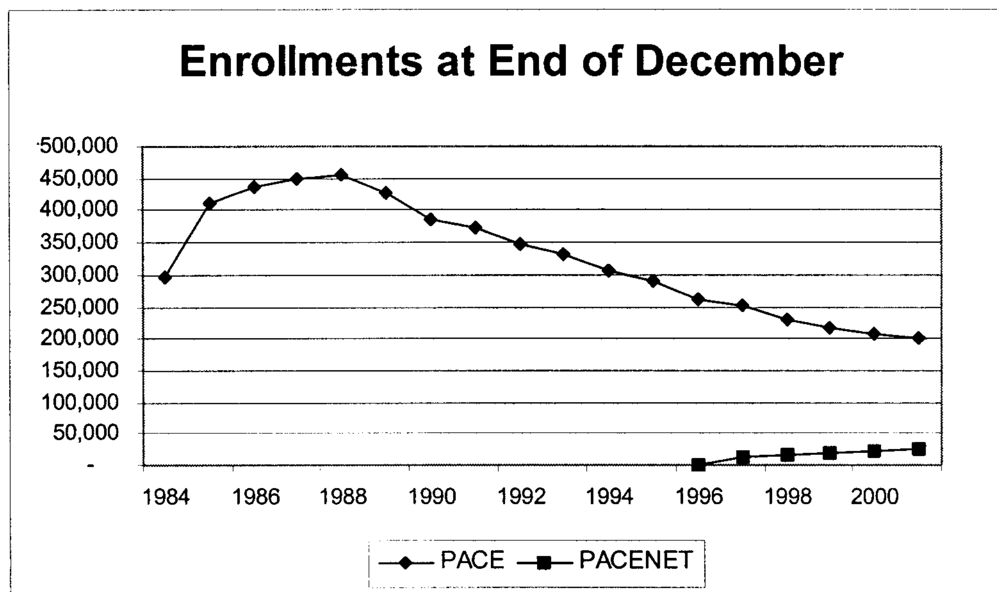
[1]See Appendix A for a glossary of selected terminology.
[2]The PACE program also serves as the fiscal agent for the General Assistance Program (Medicaid), the Special Pharmaceutical Assistance Program (both in the Department of Public Welfare), and the Chronic Renal Disease Program (Department of Health) for the collection of rebates from pharmaceutical manufacturers.
[3]The contractor, First Health Services, a healthcare management company, assists in conducting many of the day-to-day operations of the program.

medication utilization for potential fraud and abuse by cardholders, providers, and prescribers. Some of the products that receive regular review with the SURS include inhalers, barbiturates, opiates, skeletal muscle relaxants, sedatives, hypnotics, and benzodiazepines.

Eligibility Criteria

Pennsylvania residents 65 years of age and older who meet certain income eligibility requirements can participate in PACE/PACENET. To be eligible for PACE, the combined income for married applicants must not exceed $17,200 and the annual income for single applicants must not exceed $14,000 during the calendar year preceding the application. PACENET income ranges are between $17,000 and $20,200 for married couples and $14,000 to $17,000 for individuals.[4] A PACENET enrollee is responsible for an annual $500 deductible before the program begins reimbursing for prescriptions. Applicants may not be receiving prescription benefits from the Pennsylvania Medical Assistance Program (Medicaid).

Historical Enrollment Populations



As can be seen by the chart above, PACE enrollments have been declining – 32.6 percent since December 1984 (the program's first year) and 56 percent from peak enrollment in December 1988. The average annual decline in enrollment since December 1990 is 5.8 percent. As of January 2003, 436,858 seniors were eligible for PACE, and PACE enrollment was 188,854 (43.2 percent). Historically, 81 to 87 percent of PACE enrollees actually participate in the program. Persons eligible for

[4]In July 2001, Act 2001-77, the Pennsylvania Tobacco Settlement Act, increased the PACENET eligibility by $1,000 and created a limited PACE moratorium, effective January 1, 2001, until December 31, 2002, which permits certain enrollees to continue to receive PACE benefits even though their income exceeds the eligibility limits. Act 2002-149 extends this moratorium to December 31, 2003.

PACENET were 166,486, while 30,423 were enrolled (18.3 percent). (See also Appendix B.)

The PACE Advisory Committee attributes the decline in enrollment to the fixed income limits that have increased only twice (by $1,000 in 1992 and again by $1,000 in 1996), a change of less than two percent over the lifetime of the program. During this same time period, the Committee reported that Social Security payments increased 37 percent. Enrollment in the PACENET program is also less than what was anticipated. The Committee believes this is because a great majority of the seniors in this income level have access to some form of prescription drug coverage, such as health insurance from former employers, benefits from the Veterans' Administration, Medigap policies, or Medicare HMOs with drug plans. PACE officials further noted that they believe the $500 annual deductible discourages enrollments. It is also possible that confusion surrounding proposed outpatient prescription drug benefits for Medicare has affected enrollment.

Cost to Enrollee, Reimbursement to Pharmacy, Payments to Manufacturer

To receive program benefits, the cardholder presents the PACE identification card to the pharmacist or other dispensing provider when filling a prescription. The PACE cardholder is responsible for a $6.00 copayment for each prescription, an increase of two dollars over the original $4.00 copay. PACENET cardholders pay an $8.00 copayment for generic medications and a $15.00 copayment for brand name medications. A limit of a 30-day supply or 100 units, whichever is less, applies to any given claim.

The Commonwealth reimburses pharmacies for the average wholesale price of the medication (AWP) minus 10 percent, plus a $3.50 dispensing fee or their usual and customary charge, whichever is less, minus the copayment. Provider reimbursement within 21 days is guaranteed, or the Commonwealth pays interest on the unpaid balance. PACE/PACENET will not reimburse for any covered prescription drug without a rebate agreement in place between the Department of Aging and the drug manufacturer. Under the current agreement, manufacturers are to provide the Department with a quarterly rebate equal to 17 percent of the Average Manufacturers Price (AMP), less customary prompt payment deductions and adjustments made for price inflation. PACE/PACENET officials report that rebates received by the program are about 16 percent of the state's share of expenditures.

Covered Products

The program covers all prescription medications and insulin syringes unless the manufacturer does not participate in the PACE/PACENET Manufacturers' Rebate Program. Although the PACE/PACENET program may establish a restricted

formulary, it has not done so to date.[5] PACE does not cover experimental medications, medications for hair loss or wrinkles, or any medication that can be purchased without a prescription. PACE/PACENET requires generic substitution of brand multi-source products when an approved Food and Drug Administration (FDA) A-rated generic is available.[6] PACE/PACENET has a medical exception process in place and will consider a medical exception when the cardholder's physician indicates the diagnosis, medical rationale, anticipated therapeutic outcome, the expected length of exception therapy, and the last trial at alternative therapy.

Program Oversight

The Pharmaceutical Assistance Review Board consists of the Secretaries of Aging, Revenue, and Health, and five public members (one each appointed by the President pro tempore of the Senate, the Minority Leader of the Senate, the Speaker of the House, the Minority Leader of the House, and the Governor). The Board is required by statute to meet at least two times per year. It is to conduct an annual review and develop recommendations concerning any changes in the level of copayment, deductible, or in the level of fees paid to participating pharmacists. The Board may also recommend other changes in the program structure and direct the Department of Aging to discuss with the private contractor amendments to the contract. The PACE copayment and deductible schedule can be adjusted by the department annually based on financial experience and PACE projections and after consultation with the Board.

According to the PACE/PACENET Director, the Board is annually briefed on drug utilization review activities, any new criteria associated with the review process, and actual program experience. The Board acts in such a review role and monitors program performance and operations.

B. Medical Assistance

Program Overview

While coverage for outpatient prescription drugs is optional under federal law, all states provide such a benefit for families and children enrolled in their Medicaid program. Expenditures for prescription medication (outpatient, fee-for-service) more than tripled nationwide between 1990 and 1998, from $4.4 billion to $13.5 billion. In 2001, the nationwide total for Medical Assistance expenditures was $24.6 billion, and spending for pharmaceutical benefits accounted for 10.8 percent of this. Medications for elderly or disabled recipients represent just over 80 percent of Medicaid spending on prescription drugs.

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[5] A restricted formulary is a list of drugs that are excluded from reimbursements. A formulary, which lists drugs that are reimbursable, is not permitted under present statute.
[6] The FDA considers an A-rated drug product to be therapeutically equivalent to other pharmaceutically equivalent products. These drugs are regarded as bioequivalents to the brand-name product.

The Department of Public Welfare's Office of Medical Assistance administers Pennsylvania's Medical Assistance (MA) program. The MA program purchases health care for approximately 1.7 million Pennsylvania residents and in FY 2002-03 received about 62 percent of DPW's budget. Medical Assistance purchases services through contracts with managed care organizations, including pharmaceuticals, and under an indemnity, or traditional, fee-for-service system. The MA program provides payment for medically necessary pharmaceutical services furnished directly to eligible recipients by pharmacies enrolled as program providers.

Eligibility Criteria

Medicaid eligibility is determined using income, resources, and household size in comparison to established limits. Age and disability are also factors in determining which income limits apply. In Pennsylvania, the Office of Income Maintenance's local county assistance offices determine eligibility for Medical Assistance.

Anyone receiving the following benefits is automatically eligible for Medicaid without filing a separate application:

- Temporary Assistance for Needy Families (TANF)
- Supplemental Security Income (SSI)
- General Assistance (GA)
- Refugee Cash Assistance
- State Blind Pension
- State Subsidized Adoption
- Title IV-E Foster Care

Table 1 shows the current income and resource limits used for eligibility determination for those individuals who are age 65 or older, blind or disabled (identified for Medicaid purposes as SSI-related).

Table 1

Medical Assistance, Blind or Disabled,
Income Eligibility Criteria
(65 and older)

		Annual	
		Resource Limits[a]	Income Limits[b]
Categorically Needy	1 Person	$2,000	$ 8,988
(Non-Money Payment (NMP))	2 Persons	3,000	12,120
Medically Needy Only[c]	1 Person	$2,400	$ 5,100
Medically Needy Only[c]	2 Persons	3,200	5,300

[a]Resources include cash, checking accounts, savings accounts and certificates, Christmas and vacation clubs, stocks and bonds, some trust funds, life insurance, vehicles, revocable burial trusts, and non-resident property.

[b]Income includes wages (certain deductions are allowed), interest, dividends, Social Security, Veterans' Benefits, pensions, spouse's income (if living with him/her). Please note that DPW calculates income on a monthly basis which has been annualized here.

[c]Medically Needy adults are not eligible for pharmacy benefits (other than family planning drugs) unless they are nursing home residents.

Source: Developed by LB&FC staff from information provided by the Pennsylvania Department of Public Welfare.

Cost to Enrollee, Payments to Manufacturer, Reimbursement to Pharmacy

The pharmaceutical copay in Pennsylvania for all MA categories except General Assistance is $1.00.[7] General Assistance recipients have a $2.00 copay when obtaining prescription drugs, which are limited to six prescriptions/refills per month. Specific drugs for high blood pressure, cancer, diabetes, epilepsy, heart disease, psychosis, anti-Parkinson agents, AIDS-specific agents, and anti-glaucoma agents are exempt from the required copays.

Payments to providers may not exceed the lesser of the pharmacy's usual and customary charge or the estimated acquisition cost (EAC) determined by the state. Most states base the EAC on the average wholesale price (AWP), reduced by a fixed percentage to reflect discounts available to certain retailers. In addition to the cost of the drugs, states are allowed to pay pharmacists a reasonable dispensing fee to cover pharmacy overhead and profit. For most multiple-source drugs, the Centers for Medicare and Medicaid Services (CMS) has created a "federal upper limit" standard. The federal upper limit, also called the federal maximum allowable cost (MAC), for multi-source drugs is 150 percent of the least costly drug considered to have an equivalent therapeutic benefit included in a published drug price compendium.

Pennsylvania reimburses pharmacies the average wholesale price less 10 percent plus a $4.00 dispensing fee for brand name drugs (AWP – 10% + $4.00) and the state maximum allowable cost (the federal upper limit) plus a $4.00 dispensing fee for generics (state MAC + $4.00). Payment is limited to quantities consistent with the medical needs of the patient not to exceed a 34-day supply or 100 units, whichever is greater. Prescriptions may be refilled as long as the total authorization does not exceed a six months' or a five refill supply, whichever comes first.

In addition to reimbursement limits, federal law requires that pharmaceutical manufacturers enter into rebate agreements with the federal government in order for their products to be eligible for outpatient drug coverage by Medicaid programs. In general, the rebate law (Omnibus Budget Reconciliation Act of 1990, or OBRA 90) requires brand name manufacturers to return to Medicaid programs the greater of 15.1 percent of the average manufacturer's price (AMP) or the difference between the AMP price and the manufacturer's best price for "innovator drug products" (new drugs protected by patent) and 11 percent for non-innovator drug products (generics). For 2000, it was estimated that the rebate and reimbursement standards resulted in typical price reductions of 18 to 20 percent across all pharmaceuticals.

Covered Products

States providing MA pharmaceutical benefits may use restrictive formularies, but must make available all non-formulary drugs of any drug manufacturer that signs a rebate agreement with CMS when the drug is determined to be medically necessary through an exception process such as prior authorization. States

[7]General Assistance is a category of cash assistance that provides money for persons who do not meet the requirements for TANF (Temporary Assistance for Needy Families). TANF payments are funded by federal and state dollars. Most GA recipients are individuals or couples with no dependent children, who have temporary or permanent disabilities that prevent their employment. GA is state funded.

can also develop programs for prior authorization and drug utilization review to manage the drug benefit. In Pennsylvania, DPW requires prior authorization for certain drugs and for certain recipients, specifically:

- Brand Medically Necessary, Multi-Source Brand Name Drugs.[8]
- H_2 antagonist drugs unless the prescription is for the initial 90 days at the acute dosage level or the daily dosage does not exceed the maintenance level for treating gastric or duodenal ulcers.
- Concurrent use of two H_2 antagonist drugs at the same time.
- A change from one H_2 antagonist drug to another during the initial 90 days.
- Drugs for the treatment of erectile dysfunction.
- Drugs for GA recipients who require more than six prescriptions in a calendar month.
- Sustained/controlled release oxycodone/Oxycontin® when dosing exceeds certain levels.
- COX-2 drugs when dosing exceeds certain levels.

Medical Assistance Prescription Drug Expenditures

In FFY 2001 Pennsylvania reported spending $692.7 million on Medicaid fee-for-service prescription drugs. Forty percent, or $278.6 million, was for the elderly. From FY 1998-99 through FY 2001-02, Pennsylvania's share of drug expenditures for recipients age 65 and older averaged 46.1 percent or $118.8 million. The average number of eligible recipients was 185,814, and participating recipients numbered 111,708. (See Table 2.)

Table 2

Medical Assistance Drug Expenditures for Recipients Age 65 and Above*
(Fee-For-Service Only)

State Fiscal Year	Approved Claims	Amount Reimbursed	Participating Recipients[a]	Federal Share of Amount Reimbursed	State Share of Amount Reimbursed
1998-99	6,901,868	$240,547,419	123,374	$128,761,111	$111,786,308
1999-00	6,421,348	230,044,608	107,176	123,386,424	106,658,183
2000-01	6,796,311	264,976,591	108,765	141,779,603	123,196,988
2001-02	6,848,159	292,190,275	107,517	158,805,594	133,384,682

*Reliable data on managed care drug expenditures is not available from DPW. Such expenditures are significant given that nearly 60,000 persons over 65 were enrolled in DPW's Health Choices Medicaid managed care plans.

[a]Participating recipients had one or more drug claims during the year. Numbers are decreasing because participants are moving to managed care.

Source: Developed by LB&FC staff from data provided by the Department of Public Welfare.

[8]The Department will not pay for multi-source brand name drugs that have therapeutically equivalent generic substitutes available without prior authorization. Lists of brand name products requiring prior authorization are issued periodically by the Department and distributed to providers. A prescriber must provide valid medical justification that the brand name drug must be dispensed and note "Brand Necessary" or "Brand Medically Necessary" along with the 10-digit prior authorization number obtained from the Department on the prescription.

HealthChoices. DPW's HealthChoices Program contracts with managed care plans to provide care to MA recipients and consists of both physical health plans and behavioral health plans. In the counties where HealthChoices is operational, it is a mandatory managed care program that replaces the traditional fee-for-services (FFS) system. At a minimum, all HealthChoices plans must cover all Medicaid FFS services. All pharmaceuticals, whether prescribed for a physical health or behavioral health diagnosis, are covered by a physical health managed care organization.

HealthChoices was initially implemented in the five county greater Philadelphia area (Bucks, Chester, Delaware, Montgomery, and Philadelphia counties) in February 1997. HealthChoices Southeast enrollment for the fourth quarter of 2002 was 473,691. The second phase of implementation took place January 1999 in Southwest PA, a ten-county area surrounding and including Pittsburgh, made up of Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington, and Westmoreland counties. HealthChoices Southwest's enrollment for the fourth quarter of 2002 was 267,048. The Lehigh/Capital HealthChoices Zone, consisting of Adams, Berks, Cumberland, Dauphin, Lancaster, Lebanon, Lehigh, Northampton, Perry, and York was put into operation in October 2001 and as of the fourth quarter 2002, had an enrollment of 186,555.

Implementation of HealthChoices in the Northeast Zone (Carbon, Lackawanna, Luzerne, Monroe, Pike, Schuylkill, Susquehanna, Wayne, and Wyoming counties) was scheduled to begin July 2003, but has been delayed pending final passage of the Commonwealth's budget for 2003-04. Expansion into twelve Northwest counties and four additional Southwest counties is also being delayed pending further review.[9]

Total HealthChoices enrollment as of the fourth quarter of 2002 was 927,294. Approximately seven percent, or 66,159, of these enrollees are aged 65 or older. Of this subpopulation, only categorically needy adults have pharmacy benefit coverage (see note to Table 1 on page 7). DPW reports that for calendar year 2002, Pennsylvania's Medicaid program reimbursed $305 million in fee-for-service pharmacy benefits and $119 million HealthChoices pharmacy benefits for enrollees aged 65 or older.

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[9]Voluntary managed care plans, other than HealthChoices, currently operate in 25 other Pennsylvania counties with a total MA enrollment of 81,204. DPW does not maintain a breakout for enrollees aged 65 or older in these plans.

C. Prescription Drug Benefits Available Through Medicare and the Department of Veterans Affairs

Medicare and Medigap

Although traditional Medicare does not provide prescription drug coverage, such coverage is available through Medigap policies.[10] A Medigap policy is a type of health coverage offered by private insurance companies that pays for some or all of the health care costs not covered by Medicare. Insurers selling Medigap policies must offer one or more of ten standardized plans. Three of these plans include some prescription drug coverage, including a $250 deductible. The plans then pay 50 percent of covered charges up to a maximum plan payment of either $1,250 or $3,000.

Medicare + Choice. Medicare currently provides alternatives to fee-for-service health care through its Medicare+Choice (M+C) program. Introduced in 1997, Congress intended to give people with Medicare the opportunity to choose from a variety of private health plan options. The options anticipated were coordinated care plans (CCPs), such as preferred provider organizations (PPOs) and health maintenance organizations (HMOs), including those with point-of-service options; unrestricted private fee-for-service plans,[11] provider-sponsored organizations (PSOs); and medical saving accounts.

Medicare Managed Care. According to the Centers for Medicare and Medicaid Services (CMS), Medicare beneficiaries may enroll in an M+C plan as an alternative to traditional, fee-for-service Medicare, if one is available in their area. An M+C plan is a private plan that has contracted with CMS to provide the Medicare benefit package. M+C supplemental benefits often include some outpatient prescription drug coverage at a much lower premium than enrollees would have to pay for an equivalent Medigap plan.

Participation by plans in the M+C program is, however, declining. In 2001, 65 M+C HMOs chose not to renew their contracts, and 53 reduced their service areas. The number of Medicare enrollees with access to M+C plans with drug coverage fell from 65 percent in 1999 to 50 percent in 2002. As of April 2003, 495,262 Pennsylvania seniors were enrolled in Medicare HMOs. In 2002, CMS estimated that enrollees in M+C plans with unlimited brand and generic drug coverage would

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[10]Medicare does cover a limited number of outpatient prescription drugs. Specifically: some antigens, osteoporosis drugs, drugs for beneficiaries in end-stage renal disease requiring either dialysis or transplant for anemia, hemophilia clotting factors, most injectable drugs administered by a licensed medical practitioner, immunosuppressive drugs for transplant patients, oral cancer drugs, oral anti-nausea drugs if taking oral cancer drugs. Also covers some drugs used in infusion pumps and nebulizers if considered reasonable and necessary. Copay is 20 percent of the Medicare-approved amount for covered drugs.

[11]A Private Fee-for-Service Plan is an allowed option under Medicare + Choice in which Medicare pays a set amount of money every month to a private company to provide health coverage to people with Medicare on a pay-per-visit arrangement. In Pennsylvania, there is only one such plan, and it does not offer outpatient prescription drug benefits at a discount.

be less than one half of one percent, enrollees with unlimited generic drug coverage with brand name drugs subject to a cap would be about 19 percent, enrollees with combined limits on brand name and generic drugs would represent 44 percent of the M+C population, 26 percent of enrollees would be in plans offering unlimited generic only coverage, 8 percent in plans that limit generic coverage (a range of $200 to $1,000), and 2 percent with unlimited drug coverage but with coinsurance of 70 percent or 85 percent.[12]

In addition to paying the monthly Medicare Part B premium ($58.70 in 2003), seniors enrolled in M+C HMOs in Pennsylvania also pay a monthly premium that can range from $0 to $183. Some plans charge an additional monthly premium for the option of drug coverage (ranging from $20 to $69). Not all plans offer prescription drug coverage, but of those that do, all require a copay (either a flat amount or a percentage of the prescription's cost). Most copays are tiered for generic, preferred brand, and brand name drugs, and many differentiate between formulary and non-formulary drugs. Several plans also place a benefit limit on drug coverage and calculate this limit either quarterly, semi-annually, or annually. While some plans do not place a limit on generic drugs, annual limits for the majority of plans ranged from $500 to $1,500.

Medicare PPO Initiative.[13] CMS announced in August 2002 that 33 new health plans in 23 states will begin to serve Medicare beneficiaries beginning in January 2003 for up to three years as part of a demonstration project using the Preferred Provider Organization (PPO) model. This project is to introduce more variety into the Medicare+Choice program so that Medicare beneficiaries have broader choices and more options available. Three health plans in Pennsylvania have been approved for the demonstration: Aetna, Coventry, and UPMC. Coverage will be in 24 counties: Allegheny, Armstrong, Beaver, Bedford, Blair, Bucks, Butler, Cambria, Crawford, Fayette, Greene, Huntingdon, Indiana, Lawrence, Lehigh, Mercer, Monroe, Montgomery, Northampton, Schuylkill, Somerset, Venango, Washington, Westmoreland. A fourth plan was approved May 1, 2003.

The demonstration plans will be considered Medicare+Choice plans and must offer Medicare required benefits, but will have the flexibility to offer greater access to drug benefits and disease management services. Many Medicare beneficiaries are expected to choose the PPO option as a way to obtain prescription drug coverage. However, of the 11 million Medicare beneficiaries nationwide that will have a PPO available, only about one-half million do not already have access to some type of coordinated care plan. Almost all of the PPO demonstration plans charge

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[12]According to the Pennsylvania Health Care Cost Containment Council, one in four Medicare beneficiaries in Pennsylvania is enrolled in a managed care plan.

[13]All PPOs or PPO-like models share one common characteristic–a network of health care providers who have agreed to provide care to patients subject to contractually established payment levels. Some interventions, for example, disease management counseling, health education, and such benefits as prescription drugs, may be conditional upon use of providers in the network.

premiums ranging from $32 to $184 per month, and all but one plan offer some coverage for outpatient prescription drugs. As of March of 2003, approximately 1.4 million individuals in Pennsylvania were at liberty to select one of the Medicare PPO demonstration plans and by April, plan administrators had reported 1,787 enrollees.

Medicare Endorsed Discount Drug Card Initiative. CMS noted that approximately 70 percent of all physician office visits for individuals 65 years of age or older involve the physicians prescribing new or continued medications, or supplying or administering a prescription drug to the patient. Further, data indicate that the number of new drug prescriptions, renewals, or drug administrations per 100 physician office visits for patients 65 years of age or older has grown from roughly 150 in 1985 to nearly 200 in 1999. Despite the increasing use of prescription drugs in medical treatment, over 9 million Medicare beneficiaries are believed to be without drug coverage. The objectives and sponsor role of the Medicare Endorsed Drug Discount Card initiative are presented in Exhibit 1.

Even if Medicare beneficiaries are aware of prescription drug discount cards, CMS believes that they frequently do not have enough information to make a meaningful choice among the available cards. CMS reports that it will endorse prescription drug discount card programs that meet defined requirements and will permit successful applicants to market and label their programs as "Medicare-endorsed." There is support for this initiative as an interim approach to enactment of a Medicare prescription drug benefit. CMS estimates that 9.7 million Medicare beneficiaries will enroll in Medicare-endorsed drug card programs by 2004.

CMS believes that those most likely to benefit from the initiative will be the approximately 9 million Medicare beneficiaries without prescription drug coverage. Also, because many Medigap plans do not actively negotiate discounts for enrollees, it is thought that Medicare beneficiaries with standardized Medigap drug coverage will benefit from a discount card program, particularly if they spend above the benefit cap. CMS estimates that about 2 million beneficiaries have drug coverage through a Medigap policy and that 95 percent of these will enroll in a Medicare-endorsed card program. Drug discount card sponsors will also be able to accept groups of enrollees from insurance groups, such as Medicare+Choice plan members, and beneficiaries with employer-sponsored retiree health insurance.

In its final rule, CMS stated that some impediments to participation by beneficiaries in the manufacturer cards include lack of uniformity in eligibility requirements, complexity of demonstrating eligibility, and the perceived stigma associated with low-income initiatives. CMS believes that the enrollment exclusivity of the Medicare Endorsed Discount Drug Card Initiative will provide meaningful savings and limit beneficiary confusion associated with multiple card programs. Further, there are a significant number of beneficiaries who do not qualify for manufacturer card programs who could benefit under this initiative.

Exhibit 1

Medicare Endorsed Drug Discount Card

Objectives:

- To educate Medicare beneficiaries about private market methods available for securing discounts from manufacturers and other competitive sources on the purchase of prescription drugs.
- To provide a mechanism for Medicare beneficiaries to gain access to the effective tools widely used by pharmacy benefit managers or insurers and pharmacies to obtain higher quality pharmaceutical care, for example, monitoring for drug interactions and allergies.
- To publicize information (including drug-specific prices, formularies, and pharmacy networks) to facilitate easy consumer comparisojhyns that will allow Medicare beneficiaries to choose the best card for them.
- To promote participation of Medicare beneficiaries in effective prescription drug assistance programs. Increasing the leverage and ability of these programs to negotiate manufacturer rebates or discounts and to provide other valuable pharmacy services.
- To endorse qualified private sector prescription drug discount card programs (either for profit or nonprofit) based on structure and experience; customer service; pharmacy network adequacy; ability to offer brand name and/or generic manufacturer rebates or discounts (passing through a substantial portion to beneficiaries, either directly or indirectly through pharmacies); available pharmacy discounts; and permit endorsed entities to market their programs as Medicare-endorsed.
- To assist Medicare beneficiaries in obtaining a low (in Year One, $25 maximum) or no-cost opportunity to enroll in a Medicare-endorsed prescription drug discount card program.

Each Medicare-endorsed drug card program sponsor is to:

- Obtain manufacturer rebates or discounts on brand name and/or generic drugs, and provide a substantial portion of the manufacturer rebates or discounts to beneficiaries, either directly or indirectly through pharmacies, in order to reduce the price beneficiaries pay for prescription drugs or enhance the pharmacy services they receive.
- Enroll all Medicare beneficiaries who wish to participate and limit enrollment in its Medicare-endorsed discount card program(s) to Medicare beneficiaries only. They will also ensure that beneficiaries enroll in only one Medicare-endorsed prescription drug discount card program at a time, to facilitate obtaining rebates or discounts from drug manufacturers on their behalf.
- Provide stable access to discounts on at least one brand name or generic prescription drug in each of the therapeutic drug classes, groups, and sub-groups representing prescription drugs commonly needed by Medicare beneficiaries.
- Offer a broad national or regional contracted retail pharmacy network.
- Charge a small one-time enrollment fee (of no more than $25 per beneficiary in Year One) or no fee.
- Provide customer service to beneficiaries, including enrollment assistance, toll-free customer service help, and education about the card program services. Provide access to other prescription drug services offered by the program for no additional fee, including drug-drug interaction monitoring, and allergy alerts.

Source: 42 CFR Part 403 - Medicare Program; Medicare-Endorsed Prescription Drug Card Assistance Initiative; Final Rule; September 4, 2002.

A PACE/PACENET official told us that he believed this initiative to be a stopgap measure until Congress enacts an outpatient prescription drug plan for Medicare beneficiaries. However, on January 29, 2003, the Federal District Court for the District of Columbia enjoined CMS from proceeding with the Medicare-Endorsed Prescription Drug Card Assistance Initiative stating that the administration lacked congressional authority to create the program. The court had imposed an injunction on a similar plan in 2001. CMS has subsequently withdrawn its solicitation and will not accept applications in response to the solicitation. As of March 2003, CMS was evaluating the court's decision and its options.

Bush Administration Proposed Prescription Drug Benefit for Medicare. In March 2003, the Bush Administration put forth a proposed prescription drug benefit for Medicare as part of a proposed overall reform of the Medicare system. Under the proposal, all seniors, for a small enrollment fee (waived for low-income seniors), would be provided with a drug discount card estimated to achieve savings of 10-25 percent on the cost of prescription drugs through pooling the buying power of Medicare participants. Low-income Medicare beneficiaries would get prescription drug coverage without paying additional premiums and receive a $600 annual subsidy that can be added to their discount card or paid to Medicare + Choice health plans that provide prescription drug coverage.

The proposal provides three options:

- *Traditional Medicare:* Current Medicare beneficiaries will receive a drug discount card and coverage to protect them against high out-of-pocket prescription drug expenses at no additional premium. Part B premiums will not be affected.
- *Enhanced Medicare:* It will give seniors the same choice of plans available to federal employees and members of Congress through the Federal Employees Health Benefit Plan.[14] The plans will offer prescription drug benefits and protection against high out-of-pocket drug costs and will have a monthly premium and an annual deductible similar to the Part B premium under traditional Medicare. Participants will be able to choose any doctor or hospital they want.
- *Medicare Advantage:* Seniors will have the option of enrolling in low-cost, high-coverage managed care plans that offer a subsidized drug benefit.

The plan is a broad, general plan so that the Administration can work with Congress to come up with specifics, according to Administration officials.

U.S. Congressional Initiative. In early June 2003, the U.S. Senate Finance Committee announced a bipartisan agreement on prescription drugs and improving Medicare. The proposal provides that seniors may access prescription drug coverage on a voluntary basis as part of the Medicare's traditional fee-for-service benefit package, or as part of new, coordinated Medicare Advantage plans. It includes:

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[14]The government currently pays up to 75 percent of FEHBP enrollees' premiums.

Medicare Advantage

- Medicare Advantage would rely on preferred provider organizations (PPOs) and other coordinated care plans to offer integrated benefits more typical of the health benefits those in the workforce enjoy today.
- Medicare county-based coordinated care plans (today's Medicare+Choice plans) would be stabilized in a more competitive system as an option in Medicare Advantage.
- Medicare Advantage plans would offer integrated benefit packages for medical care and prescription drugs. Coverage for medical care and prescription drugs would include reasonable cost-sharing and protection against high out-of-pocket costs.
- Medicare Advantage plans would be encouraged to offer disease management services, chronic care and quality improvement programs.
- Participating PPO plans would submit bids on a national or regional basis. Plans would be available in single-state or multi-state regions designed by the Secretary. Plans would share risk for delivery of the benefit with the federal government.
- Medicare Advantage plans would operate under a more competitive system to maximize value for both seniors and taxpayers, and make it easier for plans to pass savings on to seniors in the form of lower premiums, lower cost-sharing, and improved benefits. The new program would encourage seniors to be price-conscious in choosing their Medicare Advantage plan.
- Seniors could start enrolling in Medicare Advantage in 2006.

Traditional Fee-For-Service Medicare

- Seniors choosing to remain in traditional fee-for-service Medicare would be offered affordable prescription drug coverage on a voluntary basis. Private plans would compete to offer drug coverage at an affordable price.
- The value of the drug benefit would be equal relative to the new Medicare Advantage drug benefit. For a monthly premium, prescription drug coverage would include reasonable cost-sharing and protection against high out-of-pocket costs.
- Seniors could continue to receive additional prescription coverage from supplemental sources, such as former employers and state pharmacy assistance programs. Seniors could continue to purchase many of the same Medigap policies as they do today.
- Plans would offer drug coverage beginning in 2006.

Low-Income Seniors

- For seniors eligible for both Medicaid and Medicare, medical and drug coverage would continue through Medicaid. The federal government would provide assistance to states to meet these individuals' needs.
- The Medicare program would provide drug cost assistance to other low-income seniors on a sliding scale relative to their income.
- This low-income assistance would begin in 2006.

Medicare-Endorsed Prescription Drug Discount Card

- For a nominal, one-time enrollment fee, seniors would have access to a prescription drug discount card.
- In order to receive Medicare's endorsement, card sponsors would be required to publish discounted prices, provide reliable, easy-to-compare information, and use quality-enhancement tools such as prevention of drug interactions. Sponsors would be required to provide both retail and mail-order options.
- Because of group-purchasing power, plans would be able to negotiate 10 to 25 percent discounts for their members.
- For low-income seniors, the enrollment fee would be waived. Medicare would provide an annual subsidy of $600 on these seniors' cards, enabling them to purchase their prescription with direct financial assistance. Minimal cost-sharing would be required.
- The discount card program would begin in 2004 and end in 2006.

Beneficiary Access to Care Provisions

- Major provisions of Grassley Amendment to Jobs and Growth Bill included to stabilize and to secure rural health care. New spending offset by existing program changes, not reserve fund resources.

Medicare Appeals, Regulatory and Contracting Improvements

- Regulatory relief, paperwork reduction, provider education improvements included to make Medicare a better business partner for providers. Beneficiary appeals improvements included to make Medicare a more responsive insurer for patients. Streamlined and competitive contracting system implemented to improve Medicare administration.

Creation of Center for Medicare Choices

- A new Center for Medicare Choices, outside of CMS but inside HHS, would be authorized to oversee all of the competitive options (prescription drug plans, PPOs, and discount cards).

The Department of Veterans Affairs

The federal Veterans' Health Care Eligibility Reform Act of 1996 provided for the creation of a Medical Benefits Package. Among the services covered are prescription drugs, over-the-counter drugs, and medical and surgical supplies. To qualify for pharmacy benefits, the patient must be enrolled in and receiving health care from the VA health care system. There is a copay for each 30-day or less supply of medication provided on an outpatient basis for the treatment of a nonservice-connected condition. For calendar year 2002, the copayment was $7 ($2 prior to that). By law, the VA must charge veterans a copayment for their outpatient medications.[15]

For calendar year 2002, the statutorily mandated annual cap on medication copayments was $840. Veterans who exceed the annual cap continue to receive medications without making further copayments. When a VA physician prescribes a drug, a veteran may fill the prescription at a VA pharmacy or through a VA mail order program. Medicare generally does not cover VA services, so a veteran may have to pay for the physician visit to access the drug benefit. However, visits are free for the indigent and for veterans with service-related conditions.

The VA maintains a formulary, and any products listed on the VA National Formulary must be available at all VA facilities. A Pharmaceutical Benefits Manager (PBM) is responsible for facilitating and coordinating the VA National Formulary process. As of October 2001, more than six million veterans were enrolled in the VA health care system nationwide. Pennsylvania has nine medical centers, 4 outpatient clinics, and one community-based outpatient clinic and a veteran population of 1,280,788,[16] of which 544,732, or 42.5 percent, were age 65 or older. Data on the number of 65+ year olds who are enrolled was not readily available. As of 2001, 289,588 veterans were enrolled in the program. Applying the above 42.5 percent yields an estimated 123,000 enrolled veterans. This, however, is likely low in that seniors tend to need prescription drugs more frequently than younger persons.

The VA prescription drug program, however, has problems, especially with regard to access and availability issues. For example, the Harrisburg *Patriot-News* reported in November 2002 that veterans were waiting as long as one year to be examined by a VA doctor and that some Pennsylvania veterans were traveling to Martinsburg, WV where they can see a VA doctor within a month.

The VA's Inspector General reviewed the problem and found that 90 percent of the veterans waiting to see a doctor need only prescriptions at the $7 copay. The IG, in a December 2000 report, recommended that the VA seek legislative change to permit the filling of private prescriptions (those written by family doctors) for

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[15]Copayment is waived for service-connected veterans rated with a greater than 50 percent disability and also for veterans with a low income (annual income is lower than the VA pension level).
[16]Census 2000, Department of Veterans Affairs.

enrolled veterans in priority group 7.[17] According to the audit report, a majority of priority group 7 veterans included in the review had access to private non-VA health care and/or that their use of VA was solely or primarily for the purpose of filling prescriptions originally written by private physicians. The auditors found that these veterans are scheduled for exams by VA staff physicians who then routinely review and approve the orders of the private physicians. Prescriptions are filled if they are on the VA formulary.[18]

In February 2003, the Bush Administration proposed $63.6 billion in funding for the VA for 2004, of which $30.2 billion are discretionary funds to be used primarily for health care. This is a 7.4 percent increase over the expected funding for 2003 and the largest percentage increase for any department in the Bush budget proposal. The proposal includes provisions for increasing the copays for enrolled veterans in lower priority, while eliminating the copays for veterans in higher priority groups with incomes less than $16,000.

D. Pharmaceutical Company Assistance Programs

Prescription Drug Assistance Programs

Pharmaceutical Research and Manufacturers of America (PhRMA) member companies offer several assistance programs for those who need prescription drugs but cannot afford to purchase them. Its 2002 Directory of Patient Assistance Programs lists 55 companies, the products offered, and the necessary contact information. The application process and eligibility vary for each company, but afterwards the drugs are available at no charge to the patient. In 2001, PhRMA reported that more than 3.5 million patients received prescription medicines through these programs, up from the 1.1 million that benefited in 1997. Almost 10 million prescriptions, with a wholesale value estimated at about $1.5 billion, were filled through these programs in 2001. A PhRMA representative has also noted that $8 billion in free samples were given to physicians by drug manufacturers in 2001. Data for Pennsylvania seniors taking advantage of such programs suggests that approximately 13,000 seniors are likely enrolled in Patient Assistance Programs.

Discount Cards

Individuals without prescription drug coverage may purchase discount cards from groups such as AARP that enable them to receive a percentage discount for prescriptions purchased in participating pharmacies. Several manufacturers also operate programs to make certain drugs available at a discount to uninsured people

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[17]Once enrolled and eligibility verified, veterans are placed in one of eight priority groups. The highest priority is given to Group 1 consisting of veterans with service-connected disabilities rated at 50 percent or more. Group 7 are those veterans that are not being treated for service connected disabilities and have incomes above the limits needed to qualify for entirely free care.

[18]The auditors also found that the exams frequently duplicate tests and exams that have already been performed by the patient's private physician and are conducted to allow the VA physician to support filling the prescription that the patient has brought in. These redundant evaluations impact on the delivery of services to other enrolled veterans: IG staff projected that this issue alone costs the VA over $1 billion annually in resources that could be better used in the delivery of health care services to veterans.

meeting specified eligibility criteria. According to CMS, since January 2002, a number of manufacturers have announced discount programs designed to help low-income individuals access prescription drugs. Lilly, Pfizer, and Novartis announced programs that feature a flat "copay" for each monthly supply of a particular drug. Seven manufacturers (Abbott Laboratories, AstraZeneca, Aventis, Bristol-Myers, Squibb, GlaxoSmithKline, Johnson & Johnson, and Novartis) have partnered together to form "Together Rx," which offers discounted prices to eligible persons. Individuals enrolling in these programs are able to purchase prescription drugs offered under the program at discounted prices at retail pharmacies.

The income limits of the manufacturer cards vary, ranging from $18,000 to $28,000 for individuals and from $24,000 to $38,000 for couples. With these income criteria, many Medicare beneficiaries without drug coverage could be eligible for one or more of the manufacturers' programs. Nationally, "Together Rx" had enrolled about 300,000 individuals as of October 2002, the Pfizer copay card enrolled 250,000 individuals as of December 2002, the Eli Lilly copay card enrolled 100,000 through October 2002, the GlaxoSmithKline Orange card had 100,000 enrollees by October 2002, and the Novartis copay card had enrolled 15,000 as of April 2002. CMS expects that some individuals have enrolled in more than one manufacturer's program. (See Exhibit 2.)

E. Employer Based Annuitant Programs

Private Employers

For many persons aged 65 and older, employer-sponsored retiree health benefits are the primary source of drug coverage, assisting more than one in three seniors with Medicare. No specific information is readily available on the number of Pennsylvania seniors covered by such programs. The Kaiser Family Foundation conducted a survey of 435 large firms that currently offer health benefits to retirees. The firms participating in this survey (private-sector with 1,000 or more employees) represent 36 percent of all Fortune 100 companies and 28 percent of Fortune 500 companies. They also account for more than half of the companies with the largest retiree health liability in 2001. The majority were multi-state employers that represent a broad range of manufacturing and non-manufacturing industries. The survey was conducted on-line between July 2, 2002, and September 9, 2002.

The survey showed that the majority of employers offering health benefits to retirees included prescription drug coverage in the benefit package. A majority of the employers provided unlimited drug benefits, and most of the plans offered both retail and mail order coverage. The median copayment for a 30-day script at retail pharmacies for generic drugs was $8, for brand name drugs on a formulary it was $15; and for brand name drugs not on a formulary, $25. The median copayments or 90-day mail order copayment were $10, $25, and $35 respectively. The most

Exhibit 2

Pharmaceutical Manufacturers' Prescription Drug Discount Cards

	Eligibility Requirements (All require applicants to be Medicare recipients and have no other prescription drug coverage.)	Discount or Copayment (Cards have no application or annual fees.)	Products Covered	Reported Enrollment[a]
GlaxoSmithKline **Orange Card**	Income below $30,000 (single) or $40,000 (couple)	25% of wholesale list price Estimate savings at 30 - 40% off retail list price [Cost to cardholder = maximum charge established by card administrator less GSK discount plus dispensing fee]	Drugs manufactured by: GlaxoSmithKline	Oct-2002 100,000
Novartis **CareCard**	U. S. Resident Income below 300% FPL : $26,000 (single) or $35,000 (couple)[b]	Either pay $12/month (per prescription) or 25% of wholesale list price Estimate savings at 30 - 40% off retail list price	Drugs manufactured by: Novartis	Apr-2002 15,000
Pfizer **Share Card**	Individual gross income below $18,000 or joint gross income below $24,000	Flat $15 for up to 30-day supply	Drugs manufactured by: Pfizer	Dec-2002 250,000
Eli Lilly **LillyAnswers Card**	U. S. Resident Individual gross income below $18,000 or joint gross income below $24,000	Flat $12 for up to 30-day supply	Drugs manufactured by: Eli Lilly	Oct-2002 100,000
Together Rx **Together Rx Card**	Annual income below $28,000 (single) or $38,000 (couple)[b]	Varies - each company sets own level of savings Minimum is 15% off list price to wholesalers Estimate savings at 20 - 40% off retail list price for over 150 medications	Drugs manufactured by: Abbott Laboratories AstraZeneca Aventis Pharmaceuticals Bristol-Myers Squibb GlaxoSmithKline Johnson & Johnson (Janssen Pharmaceutical and Ortho-McNeil Pharmaceutical) Novartis	Oct-2002 300,000

[a]Individuals may be enrolled in more than one program.

[b]Alaska and Hawaii have higher income levels.

Source: Developed by LB&FC staff from information provided by each pharmaceutical manufacturer.

common coinsurance amount was 20 percent for both retail and mail order prescriptions of all types.

Cost saving measures were introduced during the surveyed year for many of the firms. Almost half of the respondents stated they had increased the copay/coinsurance amounts, and half of these went to a 3-tiered copay structure. Just over one-third of the respondents said they had instituted a prior authorization requirement. Perhaps the most interesting statistic, however, was that less than one percent of the firms surveyed indicated that they had eliminated prescription drug coverage. Over the next three years the firms surveyed expect they will increase copay/coinsurance amounts, shift to coinsurance to provide incentive for generic use, over half are likely to go to a 3-tiered cost sharing structure, and over half believe they will require mail order for maintenance medications. For additional selected results from the survey, see Exhibit 3.

The Pennsylvania Employees Benefit Trust Fund

The Pennsylvania Employees Benefit Trust Fund (PEBTF) administers health care benefits to approximately 85,000 eligible Commonwealth ofPennsylvania employees and their dependents as well as to 52,000 retirees and their dependents. Active members (state employees) pay the greater of $6 or 15 percent, with a maximum of $25, for up to a 30-day prescription. Copayments for prescriptions from 31 to 100 days are $9 through mail order or Rite Aid. There is a mandatory generic reimbursement – if a brand name drug is obtained when a generic equivalent is available, the member is responsible for the difference between the price of the brand name drug and the generic in addition to the copayment. Certain medications require prior authorizations by the Pharmacy Benefits Manager – NPA/Express Scripts. There is no deductible. In 2002, PEBTF prescription drug costs for its active members averaged $9.8 million a month, or $117.6 million annually.

There is a $7 copay for a 30 day prescription for retirees. For ongoing chronic conditions, maintenance prescriptions (from 30 days to 100 days) are available with a $15 copay from mail order or Rite Aid. If a brand name drug is selected when a generic equivalent is available, the cardholder is responsible for paying the difference in price in addition to the copay. Certain medications require prior authorization by the PBM – NPA/Express Scripts. There is no deductible. Annuitants may elect to receive their prescription drug benefit through a Medicare HMO. In this case, there is a maximum $6 copay for a 30-day prescription. Some HMOs may also offer a 100 day supply at a higher copay. State retirees and dependents are eligible to receive an annual incentive of up to $500 for enrolling and remaining in a Medicare HMO. The Retired Employee Health Plan (REHP) estimates that it will spend $126 million for the Retirees' Prescription Drug Plan in 2002, an increase of more than 38 percent over three years.

Exhibit 3

Selected Results from Kaiser/Hewitt 2002 Retiree Health Survey

- The majority of employers that offer retiree health benefits (96 percent) provide coverage for prescription drugs.
- Majority of surveyed employers (89 percent) provide unlimited drug benefits.
- Among the seventeen (17) percent of plans with a separate prescription drug deductible, the most common deductible is $50.
- Among the 15 percent of plans with a separate annual out-of-pocket maximum, the most common out-of-pocket limit is $1,000.
- A majority (93 percent) of the plans offer both retail and mail order coverage.
- Sixty-six (66) percent of the employers contract directly with a PBM.
- Sixty-one percent of surveyed employers require a fixed-dollar copayment whose median values range from $8 for generics to $15 for brand-name drugs on formulary/preferred list to $25 for brand-name drugs not on formulary/preferred list.
- Twenty-six percent require a percentage coinsurance – typically 20 percent.
- Typically for purchases at retail pharmacies, retiree cost-sharing is for a 30-day supply or a lesser amount, as prescribed.
- Median copayments for mail order range from $10 per prescription for generics to $25 for brand-name drugs on formulary/preferred list to $35 for brand-name drugs not on formulary/preferred list.
- Coinsurance for mail-order, as for retail purchases, tend to be 20 percent for all types of prescriptions filled.

The surveyed employers have implemented several measures to control rising drug costs during the past two years, including plan design changes that increase cost-sharing for retirees as well as strategies to manage utilization of prescription drugs.

- Forty-nine percent have increased drug copayments or coinsurance, with roughly half of these imposing 3-tiered copayments.
- Thirty-seven percent have put in prior authorization requirements, 18 percent have imposed rules related to (formulary interventions by PBMs) and 15 percent have implemented closed or partially-closed formularies.
- Thirteen percent have implemented step-therapy provisions.
- Eleven percent have replaced dollar copayments for drugs with coinsurance.
- Ten percent now require mandatory mail-order refills for maintenance drugs.
- Less than one percent of all employers surveyed have eliminated prescription drug coverage.

The report also notes that a number of prescription drug benefit design changes are likely over the next three years. Less than 4 percent of all surveyed employers said that they were very or somewhat likely to eliminate prescription drug coverage in the next three years.

- Eighty-five percent said they were very or somewhat likely to increase retiree copayments or coinsurance for prescription drugs.
- Forty-two percent said they were very or somewhat likely to shift from fixed copayments to coinsurance for prescription drugs. Coinsurance exposes retirees to higher out-of-pocket spending as the cost of drugs rise and provide a strong incentive for retirees to select generic drugs where available.
- Fifty-three percent said they are very or somewhat likely to impose 3-tiered cost-sharing for retirees (22 percent are looking at 4-tiered cost-sharing).
- More than one-third (37 percent) said they are very or somewhat likely to impose specific deductibles for pharmaceuticals within the next three years.
- Fifty-four percent are very or somewhat likely to require mail order for maintenance drugs, 47 percent are very or somewhat likely to impose prior authorization requirements, and 42 percent are very or somewhat likely to use closed or partially closed formularies in the next three years.

Source: Developed by LB&FC staff from _The Current State of Retiree Health Benefits_, The Henry J. Kaiser Family Foundation and Hewitt Associates, December 2002.

The Public School Employees' Retirement System

For 2002, the Public School Employees' Retirement System (PSERS) redesigned its Health Options Program to reduce costs and improve operational efficiencies. The High Option Indemnity Plan's prescription drug benefit now consists of a $250 deductible, a 50/50 coinsurance after the deductible has been met whether retail or mail order, no annual limit on generic drugs or for a limited number of "critical care" brand name drugs (there is also a $75 maximum copay on critical care drugs), and a $3,000 limit for brand name drugs, except those on the critical care list. The prescription drug coverage benefit was eliminated for the Standard Option Indemnity Plan. For those annuitants that selected the managed care option, the prescription drug benefit generally conforms with that of the High Option Indemnity Plan.

F. Obtaining Prescription Drugs Through Mail Order and Canada

Mail Order Pharmacies

Many pharmacies offer to dispense prescription drugs via mail order. All offer discounted drug prices, the amount of discount varies by pharmacy, and several require either monthly or annual fees. Mail order pharmacies include:

- Advanta 65 Health Services – No fee. Discount depends on item.
- APP Pharmacy – No fee. Discount depends on Rx.
- DrugPlace.com – Shipping and handling fees apply. Discounts on generics only and discount depends upon manufacturer's current price.
- Drugspot.com - $5.95 monthly fee. 15 percent off brand name drugs and 50 percent off generics.
- Express Script – Discount depends upon quantity and manufacturer's current price.
- Liberty Health Supply – Discount depends on Rx.
- Mature Rx – No fee. Discount depends on Rx.
- Postal Prescription Services – Discounts on 30, 60, and 90-day supplies. $10 annual fee. 10 percent discount.
- Rx Power – Basic plan: $41/family annual fee. Comprehensive Plan: $65/family annual fee. 15 – 60 percent discount. Shipping and handling fees apply.
- Rx Universe/PSG – 3 month supply limit. $20/individual or $35/family annual fee. 12 – 15 percent discount and shipping/handling fees apply.
- United States Pharmaceutical Group, Inc. – No fee. Up to 21 percent discount depending on Rx.
- Costco.com – Basic membership $45/family, executive plan $100/family. Free standard delivery. 20 – 50 percent discount.
- Drugstore.com – Discount depends on Rx.
- Eckerd.com – Discount depends on Rx. Free shipping and handling.
- Familymeds.com – Discount depends on Rx.
- Prescriptionbymail.com – Free shipping and handling.
- Rxnorth.com – Shipping and handling fees apply.

The National Council on Aging has recently developed a web site (www.BenefitsCheckUp.org) to help seniors find out which prescription drug assistance program can help them save money. There is a brief on-line questionnaire to fill out. The answers to the questionnaire are analyzed and a personalized report is prepared that lists all programs the respondent may be eligible for, along with detailed instructions on how to enroll in each one. Included in this analysis (as of January 2003) are 30 state-funded programs, each state's Medicaid program, and 116 pharmaceutical-sponsored patient assistance programs.

Price Comparisons at Retail Pharmacies

Prices vary at retail locations and over time – it is beneficial to shop around, according to a November 2002 study conducted by AARP in Pennsylvania. In 2001, the average price of a retail prescription in Pennsylvania was $50.45, or 1.2 percent above the national average. Prices vary by store and by type of store where the medication is purchased. Often, the mega-discount stores and clubs have lower prices than either independent or chain pharmacies. Many independent pharmacies report slightly lower than average prices relative to chain stores.

Purchasing Prescription Drugs From Canada

For several years, seniors living near the U.S. – Canada border have traveled to Canada to fill their prescription medicine needs.[19] Senior citizen groups arrange bus trips to Canada to allow participants to bring their prescriptions and take advantage of the lower drug prices. Government price controls on prescription drugs are credited with keeping retail prices in Canada below those in the U.S. Savings of up to 50 percent have been reported.

For citizens unable or unwilling to drive to Canada themselves, there are other options. For instance, there is a doctor licensed in both the U.S. and Canada at the Mall of America in Minnesota who will write prescriptions for patients that can be faxed to a pharmacy in Canada and the medications are then mailed directly to the patient's home. Florida has at least one storefront operation that acts as a conduit to Canadian Internet pharmacies to assist local residents obtain the lower-priced medications. These include:

- Pharmacy-online.com – Operated by drugstore in Calgary, Alberta. Discount depends on Rx.
- Canadadrugs.com – More than 2,300 Rx available from Manitoba Pharmacy Association. Discount depends on the Rx.
- Canadapharmacy.com – Discount depends on Rx.
- Canadameds.com – $18 shipping and handling fee per Rx package or $10 per non-Rx package.

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[19]Under the Federal Food, Drug and Cosmetic Act, the interstate shipment of any prescription drug that lacks FDA approval is illegal. As a matter of enforcement discretion, the FDA permits individuals and their physicians to bring into the United States small quantities of drugs for patient's treatment of a serious condition for which effective treatment may not be available domestically.

- Canadamedusa.com – US-based online service that is affiliated with a Canadian pharmacy. Offers 30 – 50 percent discounts.
- Canadarx.net – Specializes in chronic and acute medications and HIV/AIDS treatment. Limit 3-month supply. $9.99 shipping and handling fee per item. Discount depends on Rx.
- Thecanadiandrugstore.com – Generic Rx only. Discount depends on Rx.

Estimates put the number of U.S. consumers receiving drugs from Canada between one and two million. This has not gone unnoticed by U.S. drug manufacturers. Citing concerns for patient safety because they believe the origin and authenticity of the product cannot be guaranteed, GlaxoSmithKline sent letters to Canadian pharmacies in late January 2003 asking them to provide proof that the GSK products they purchase were not being exported out of Canada or face being cut off from future deliveries. However, within days, GSK modified this position when it recognized that such a decision could compromise the health of patients in Canada. GSK is currently working with wholesalers to determine how much product they need for Canadian patients while it continues to work to stop the export of its Canadian-approved medications through Internet pharmacies.

III. Prescription Drug Programs for Low-Income Seniors in Other States and Related Cost Containment Strategies

In 2001, approximately 3 billion retail prescriptions were filled nationwide at a cost of over $154 billion dollars. The average retail price for a prescription drug in 2001 was $50 dollars.[1] Table 3 presents information for the 12 states with the highest number of prescriptions filled in 2001. Pennsylvania ranked fifth in total number of prescriptions filled at a cost of approximately $50 per prescription.

Table 3

Data on Retail Prescriptions Sold in 2001 for 12 States*

State	Number of Prescriptions Filled	Amount of Prescription Sales	Average Price of Prescriptions
California	280,552,000	$13,639,236,000	$49
Texas	215,353,000	10,948,867,000	51
New York	210,086,000	12,277,703,000	58
Florida	191,283,000	10,317,644,000	54
Pennsylvania	**154,490,000**	**7,794,319,000**	**50**
Ohio	133,508,000	6,141,078,000	46
Illinois	131,313,000	6,481,792,000	49
Michigan	123,183,000	6,194,373,000	50
N. Carolina	99,317,000	4,792,013,000	48
Tennessee	96,400,000	4,378,661,000	45
Georgia	92,391,000	4,159,176,000	45
New Jersey	91,111,000	5,391,570,000	59

*Prescriptions represent all products dispensed in retail pharmacies, including new prescriptions and refills. Does not include medicines purchased without a prescription (i.e., over the counter items). Data does not represent sales to senior citizens exclusively.

Source: *2001 State Health Facts Online,* The Henry J. Kaiser Family Foundation.

Nationwide, the average price of retail prescription drugs rose 9.7 percent between 2000 and 2001. The average price of retail prescriptions in Pennsylvania rose 9.4 percent. States contiguous to Pennsylvania experienced similar increases.

The journal *Health Affairs* reported in their January/February 2003 issue that, "prescription drug spending, which made up $140.6 billion of total health-care spending, continued to grow faster than all other areas." They reported a 15.7 percent growth rate in 2001 based on data compiled by the Centers for Medicare and Medicaid Services. While high, this was actually a decrease from 2000, when prescription drug spending rose 16.4 percent from the previous year.

[1] *2001 State Health Facts Online,* The Henry J. Kaiser Family Foundation.

State-Funded Prescription Drug Programs

Over half the states have initiated a pharmacy assistance program to help their elderly residents pay for prescription drugs. The National Conference of State Legislatures (NCSL) in January 2003 reported on these programs from their survey of state pharmaceutical assistance programs. A review of NCSL data shows that:

- 33 states have established or authorized a program to provide pharmaceutical coverage or assistance. Such programs are geared to helping low-income seniors, as well as the disabled in some instances, who do not qualify for Medicaid.[2]
- 26 of these state programs were in operation as of January 2003, of which 22[3] provide for a direct subsidy using state funds, while 4 offer a pharmaceutical discount for eligible seniors.[4]

Even as states establish such programs, they continue to try to make them more efficient to better respond to the twin challenges of higher demand and higher costs for prescription drugs. In 2002 alone, more than 200 legislative bills were filed nationwide that would affect changes in senior pharmacy assistance programs, including establishing buying clubs, increasing manufacturer rebates, joining interagency bulk purchasing programs, price controls through the use of preferred drug lists (PDLs) or formularies, closer regulation of pharmaceutical transactions, expanding the use of commercial discount cards and requiring more product information to be provided.

Each state prescription drug program establishes its own application and eligibility requirements. In general, states manage program costs through coverage restrictions such as maximum income eligibility, dollar caps on benefits, deductibles, copayments, and limits on the drugs covered.

By setting income eligibility requirements rather than defining eligibility as a percent of poverty or tying income eligibility to Social Security cost-of-living adjustments (COLA), Pennsylvania has been able to limit enrollment and control costs. Since the eligibility maximum declines in constant dollars each year unless raised by the legislature, PACE/PACENET enrollment has declined by approximately 3 percent every six months since 1991. This approach has come under criticism by advocates for the elderly who feel it is unjust that older adults lose their PACE/PACENET benefit solely because their Social Security COLA puts them

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[2]An indication of how these programs have proliferated is seen by the fact that the GAO found as recently as 1999 that only 14 states were operating independent, state-funded and administered programs that provide the elderly with prescription drug assistance.

[3]For a characterization of the 22 direct subsidy programs, please see Appendix C.

[4]Three of the four states (California, Iowa, New Hampshire and West Virginia) that operate a discount program provide a special discount card that the enrollee presents when filling a prescription. The remaining state requires that enrollees show their Medicare card to receive the discount. In each program, the beneficiary pays for the prescription out-of-pocket, not the state, but the price paid is discounted. None of the programs have an income eligibility requirement.

above existing income eligibility limits. The elderly cannot choose to refuse the COLA even if the PACE/PACENET benefit is more valuable.[5]

To help address this problem, many states set qualifying income levels as a specific percent over the federal poverty level (FPL).[6] The FPL is a standard used to establish financial eligibility for many federal programs. New Jersey originally had a flat dollar eligibility amount, but the legislature in 1995 voted to adjust income limits for the COLA increases. State residents 65 and older qualify for pharmaceutical assistance if their income is no more than 200 percent over FPL, or if disabled, over age 18, and their income does not exceed 222 percent of FPL. Although the expectation was that the number of enrollments would increase, in fact enrollment declined. New Jersey program administrators attribute the decline to fewer applications being received as more people delay retirement and because of increased income for older individuals. In Florida, residents age 65 and over with income at or below 120 percent of FPL are eligible to participate in the state pharmaceutical program. Every January, allowable income levels increase for these programs if the official FPL adjusts upward. Pennsylvania's current income limits for PACE/PACENET are equivalent to 156 percent of the FPL for singles and 142 percent for a couple.

Unlike Pennsylvania, many states manage program costs through coverage restrictions such as dollar caps on benefits, deductibles, limits on the types of drugs covered and preferred drug lists. A few programs also charge an annual enrollment fee. (See Chapter V.)

As in Pennsylvania, other state programs require copays for each prescription filled. However, copays in some states are higher than Pennsylvania's or require a higher copay if family income is above a specific amount. In a few states, the copay is established as a specific percent of the cost of each prescription.

All state programs obtain rebates from drug manufacturers to offset part of their expenditures. The rebates are often calculated using terms similar to the Medicaid rebate agreement established by the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990). The rebates, which in many states are mandated by law, are generally provided by manufacturers in exchange for coverage of their products and for not subjecting coverage to prior authorization requirements. As with Medicaid, some state programs receive additional rebates if the price of a drug increases more

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[5]In response to these concerns, the legislature authorized PACE/PACENET to allow all persons enrolled as of December 31, 2000, to remain eligible or be retroactively reinstated if the maximum income limit is exceeded due solely to the COLA increase. Originally set to expire on December 31, 2002, the Governor, in December 2002 signed legislation that temporarily continues letting enrollees participate in PACE/PACENET even if their income has increased above the eligibility limits.

[6]Poverty guidelines established by the U.S. Department of Health and Human Services for 2003 are $8,980 for a family unit of one and $12,120 for a family unit of two, as published in the *Federal Register*, Vol. 68, No. 26, February 7, 2003, pp. 6456-6458.

than the consumer price index, a measure of general inflation. In Pennsylvania, rebates as a percentage of net drug expenditures were 16 percent in 2001.

Additional State Strategies to Control Spending

In July 2002, the National Academy for State Health Policy published a report on initiatives states had taken to control prescription drug spending, including PACE/PACENET type programs, Medicaid, and others. The strategies focus on four groups whose choices affect cost, i.e., consumers, prescribers, pharmacists and manufacturers.[7] Pennsylvania was recognized for two strategies, administering a state-subsidized pharmacy assistance program and for exploring the possibility of joining together with other states to purchase prescription drugs. Exhibit __ presents information from that report. Among other findings, the report noted that:

- 22 states use a formulary or preferred drug list to contain costs.
- 22 states use a pharmacy benefit management company.
- 16 states have tried to contain costs by negotiating supplemental rebates for Medicaid programs.
- 10 states provide counter-detailing information to prescribers, such as information about alternatives to more expensive therapies.[8]
- 17 states promote cost sharing by encouraging use of less expensive or generic drugs by charging consumers higher amounts for brand drugs or for drugs that are not on a preferred drug list.
- 15 states have the authority to establish limits on the number of prescriptions physicians may prescribe for a patient without prior authorization from the state purchasing agency.
- 15 states have reduced pharmacy costs by reducing the allowable dispensing fee or rewarding pharmacists for directing plan participants to less expensive generic drugs.

Increasing Manufacturer Rebates

Issues have arisen in light of states' attempts to control costs, particularly Medicaid costs. In 2002, Florida's Medicaid law was upheld against challengers' claims that the law used an illegal formulary to obtain manufacturer's supplemental rebates. The program is expected to save the state $214 million the first year.

Maine has also faced challenges to its efforts at controlling costs. In particular, Maine's requirement that manufacturers who do not agree to its rebate agreement be subjected to prior authorization was objected to for illegally using the prior authorization process and for unconstitutionally interfering with interstate

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[7]*Affording Prescription Drugs: State Initiatives to Contain Costs and Improve Access,* National Academy for State Health Policy, July 3, 2002. According to the author, the report will be updated by the end of 2003.
[8]Sales representatives from pharmaceutical manufacturers often visit prescribers and "detail" to them the benefits of their product. Some states have begun to engage in counter-detailing activities to ensure that prescribers are aware of the full range of products available to them and the associated risks/benefits/costs.

Exhibit 4

Strategies Implemented or Considered by States to Contain Costs and Increase Access*

(As of July 2002)

State	PBM	Joint Purchasing[a]	Disease Management	Cost-Sharing	Counter-Detailing	Formulary/ PDL	Prescription Limits	Pharmacist Reimbursement	Manufacturer Reimbursement[b]
Alabama			✓			✓			
Alaska									
Arizona									
Arkansas		✓					✓		
California						✓			✓
Colorado									
Connecticut		✓					✓		
Delaware									
District of Col.									
Florida	✓		✓		✓	✓	✓		✓
Georgia	✓	✓		✓		✓	✓	✓	✓
Hawaii									
Idaho	✓	✓		✓	✓		✓		✓
Illinois	✓					✓		✓	✓
Indiana									
Iowa	✓	✓	✓	✓		✓		✓	
Kansas				✓	✓	✓		✓	
Kentucky									
Louisiana	✓	✓	✓	✓		✓			
Maine	✓	✓	✓	✓		✓			
Maryland									
Massachusetts		✓				✓			
Michigan	✓	✓			✓	✓			✓
Minnesota	✓					✓		✓	✓
Mississippi	✓	✓	✓	✓	✓	✓	✓	✓	✓
Missouri		✓							
Montana	✓	✓	✓	✓		✓	✓	✓	✓
Nebraska	✓		✓	✓					
Nevada			✓				✓	✓	✓

Exhibit 4 (Continued)

State	PBM	Joint Purchasing[a]	Disease Management	Cost-Sharing	Counter-Detailing	Formulary/ PDL	Prescription Limits	Pharmacist Reimbursement	Manufacturer Reimbursement[b]
New Hampshire	✓	✓							
New Jersey	✓						✓		
New Mexico		✓				✓		✓	✓
New York	✓	✓	✓	✓	✓		✓		✓
North Carolina	✓			✓			✓	✓	
North Dakota									
Ohio									
Oklahoma			✓	✓		✓	✓		
Oregon	✓		✓	✓	✓	✓	✓	✓	✓
Pennsylvania		✓							
Rhode Island		✓							
South Dakota									
South Carolina	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tennessee									
Texas		✓							
Utah	✓	✓	✓	✓		✓	✓	✓	✓
Vermont	✓	✓	✓	✓		✓			
Virginia									
Washington		✓							
West Virginia	✓	✓	✓			✓			✓
Wisconsin			✓		✓			✓	
Wyoming	✓		✓	✓	✓	✓		✓	

*A check mark (✓) indicates that one or more purchasing agencies in the state use the strategy to contain costs. However, in some states a particular strategy to contain costs remained unimplemented as of April 2002.

[a]In many states, including Pennsylvania, some members of the state legislature want the state to consider participating in a joint purchasing agreement. As of May 2003, Pennsylvania has not entered into a joint purchasing arrangement with another state.

[b]Since every state gets the standard Medicaid federally negotiated rebates, only states that negotiate supplemental rebates are checked.

Source: Data compiled by the National Academy for State Health Policy from literature reviews and an e-mail survey of Medicaid and employee purchasing agencies in all 50 states and the District of Columbia conducted in May 2002. A total of 23 agencies in 20 states provided additional information. Pennsylvania was not one of the 20 states that provided additional information. Not every state initiative is identified, nor does the exhibit identify all strategies that individual states have implemented.

commerce. These arguments were rejected by the Court of Appeals, and the U.S. Supreme Court upheld this decision. In December 2002, the U.S. Court of Appeals for the District of Columbia Circuit halted Maine's Healthy Maine Program (HMP), which also sought additional drug company rebates, because portions of it had not received necessary approval from the federal government. For additional information regarding these court challenges to state proposals, see Section V.B, Option 5 of this report.

Multi-State Joint Purchasing Initiative

In recent years, some states have begun exploring the possibility of jointly purchasing prescription drugs. The chief goal is to negotiate a lower price for drugs, but states also hope to reduce billing and utilization review costs as well as other administrative expenses.[9]

One such effort is being conducted through the National Legislative Association on Prescription Drug Prices. Initially formed in 1998, the group consists of lawmakers from Connecticut, Hawaii, Maine, Massachusetts, New Hampshire, New York, Pennsylvania, Rhode Island, Vermont, and the District of Columbia. The Association explores ways to reduce drug prices through the use of market-based approaches, including pooling the states' buying power to negotiate better prices from the pharmaceutical companies.

In July 2002, the Association endorsed the concept of a multi-state purchasing coalition with a joint contract for pharmacy benefit managers. By early 2003, the Association announced that it was organizing a joint nonprofit operation to manage prescription plans. By managing their drug benefit programs themselves, states hope to be able to save at least some of the costs of private benefit managers. Although Pennsylvania currently does not have a benefit manager for its publicly funded paid prescription programs, certain initiatives have been introduced. In his FY 2003-04 budget address to the General Assembly, the Governor indicated that his Administration is evaluating the use of a statewide pharmacy benefits manager to consolidate pharmaceutical drug purchasing, which could generate $200 million in savings.

Additionally, in the 2001-02 legislative session, House Bill 1 proposed to create a pharmacy benefits manager program to be administered by the Secretary of Administration. The Secretary would have been required to enter into a three-year contract with four pharmacy benefits managers to administer pharmacy services for participants statewide. The managers would have performed prospective, concurrent and retrospective drug utilization reviews and provided education for both

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[9]The March 2002 issue of NCSL's magazine, *State Legislatures*, noted that a survey of legislative health officials showed that 32 states predicted that purchasing pools for prescriptions were likely to be considered in the near future.

providers and participants. This process was to ensure maximum savings for the Commonwealth and participants without reducing the quality of currently provided prescription drug benefits. Each manager would have developed, updated and managed a drug formulary; negotiated drug rebates with manufacturers; provided for generic substitutions; and provided for fraud and abuse audits, among other responsibilities.

In a separate initiative, in February 2003, Michigan and Vermont announced they would implement the nation's first multi-state purchasing arrangement for drugs paid under their respective Medicaid programs. [10] Under the plan, the two states have authorized their private pharmacy benefits administrator to negotiate with manufacturers on behalf of the multi-state arrangement in an effort to obtain greater discounts, known as supplemental rebates. Such supplemental rebates are in addition to the standard rebates that manufacturers must pay states to participate in the Medicaid program. Each state will still have the flexibility and choice to determine which drugs to include on their individual PDL to best meet the needs of its citizens. They have invited other states to explore what they are doing and possibly consider joining. With a larger pool of Medicaid prescription recipients from additional states, supplemental rebates might be increased even further for participating states.

[10]Wisconsin and South Carolina subsequently announced that they would join Michigan and Vermont in the multi-state purchasing partnership to buy prescription drugs in bulk for their states' low-income Medicaid recipients.

IV. Lottery Fund and Pharmaceutical Assistance Fund Balances and Forecasts

The PACE and PACENET programs are funded through the Pharmaceutical Assistance Fund (PAF), which receives transfers from both the Lottery Fund and the Tobacco Settlement Fund. The projected balance for PAF for June 30, 2003, is approximately $150 million.[1] The long-term health of PAF is less certain because the Lottery Fund is projected to have a $128 million deficit by FY 2007-08. The Lottery's new Powerball game is exceeding revenue estimates, however, and, together with other changes, may improve the Lottery Fund's performance.

Lottery Fund Balance and Forecasts

Pennsylvania's State Lottery Fund, created by Act 1971-91, is used to operate the state lottery and for programs to support older Pennsylvanians. Fund monies are used to pay prizes,[2] to provide commissions to local lottery agents, and to pay the administrative expenses incurred by the Department of Revenue in operating the state lottery. Monies remaining after paying lottery prizes and operating expenses are used to fund programs benefiting older Pennsylvanians including free mass transit and reduced fare shared-ride programs; property tax and rent rebates; PENNCARE, which provides a variety of community-based and in-home services; and the Pharmaceutical Assistance Contract for the Elderly (PACE) program to partially rebate prescription drug costs.

The Lottery Fund receives monies from lottery ticket sales, interest earned on securities and deposits, unclaimed prize monies, and federal grants. The Lottery Fund balance at June 30, 2002, was $213.1 million but is projected to have a deficit balance of $127.9 million by June 30, 2008. See Table 4. Because the FY 2003-04 budget does not yet recognize certain planned PACE program cost reductions or enhanced lottery revenues, some officials believe that the June 30, 2008, deficit could be much less.

[1]Based on a surplus of $133.7 million on May 9, 2003, we project an approximate $150 million surplus by June 30, 2003. PACE/PACENET officials also calculate that the surplus could be at this level.
[2]By statute, at least 40 percent of the revenues derived from lottery sales must be paid out in prizes.

Table 4

Lottery Fund Balance
($000)

Fiscal Year	Ending Balance		Fiscal Year	Ending Balance	
1998-99	$112,828	Actual	2003-04	216,535	Budget
1999-00	200,965	Actual	2004-05	253,297	Estimated
2000-01	175,716	Actual	2005-06	170,674	Estimated
2001-02	213,102	Actual	2006-07	16,302	Estimated
2002-03[a]	181,569	Available	2007-08	(127,911)	Estimated

[a]Commonwealth began participating in multi-state Powerball game.

Source: Developed by LB&FC staff from Governor's Executive Budget, FY 2000-01 through FY 2003-04.

Previously, the Lottery Fund was projected to have a $179.4 million deficit by FY 2005-06. Current projections, however, are for significantly higher lottery revenue. For example, funds available projected for FY 2003-04 were $1.42 billion and are now expected to be $1.48 billion. With the introduction of Powerball in FY 2002-03 and an increased advertising budget, lottery revenue grew at 11 percent, as of November 2002. Midday drawings are expected to increase sales in FY 2002-03, which was not factored into the prior budget estimates.

Department of Revenue officials also plan to take other steps toward increasing revenue. One method of increasing revenue is by placing vending machines in high volume, low margin convenience stores whereby a player can obtain a ticket without purchasing it from an employee, thus eliminating store concerns about use of employee time. Associated with this proposal is $3 million dollars for player-activated terminal costs.

According to Department of Revenue officials, most of the elderly programs funded by the Lottery Fund have fixed statutory requirements and formulas, making it difficult to reduce their funding without a statutory change. For example, although Instant Ticket game sales continue to grow significantly and represent 34 percent of sales in FY 2000-01, by law, at least 30 percent of the lottery ticket sales must be dedicated to senior programs. But Instant Ticket sales have high payouts compared to other games, so the Lottery Fund does not realize 30 cents on each dollar of ticket sales.

As shown in Table 5, in FY 2000-01, Lottery-funded program expenditures were 84 percent of net ticket revenues and are estimated to be 92 percent by FY 2007-08. PACE/PACENET expenditures presently represent about 45 percent of

Table 5

Lottery Fund
Net Ticket Revenues and Program Expenditures
($000)

	FY 2000-01 Actual	FY 2001-02 Actual	FY 2002-03 Available	FY 2003-04 Budget	FY 2004-05 Estimated	FY 2005-06 Estimated	FY 2006-07 Estimated	FY 2007-08 Estimated
Net Ticket Revenues[a]	$858,531	$989,631	$1,103,812	$1,188,053	$1,232,528	$1,242,194	$1,251,462	$1,260,958
Program Expenditures:								
PACE/PACENET	290,000	359,000	395,000	370,000	393,000	517,000	591,000	682,000
PENNCARE	192,579	202,704	204,976	206,587	207,841	207,841	207,841	207,841
Property Tax/Rent Assistance for Older Pennsylvanians	123,388	119,713	122,180	120,375	119,900	119,425	118,950	118,500
Older Pennsylvanians Shared Rides and Free Transit	114,380	118,999	137,122	137,122	139,864	142,662	145,515	148,425
Total Program Expenditures	$720,347	$800,416	$859,278	$834,084	$860,605	$986,928	$1,063,306	$1,156,766
Program Expenditures as % of Ticket Revenue	83.9%	80.9%	77.8%	70.2%	69.8%	79.5%	85.0%	91.7%

[a]Ticket sales less commissions and field paid prizes.

Source: Developed by LB&FC staff from Governor's Executive Budget, FY 2003-04.

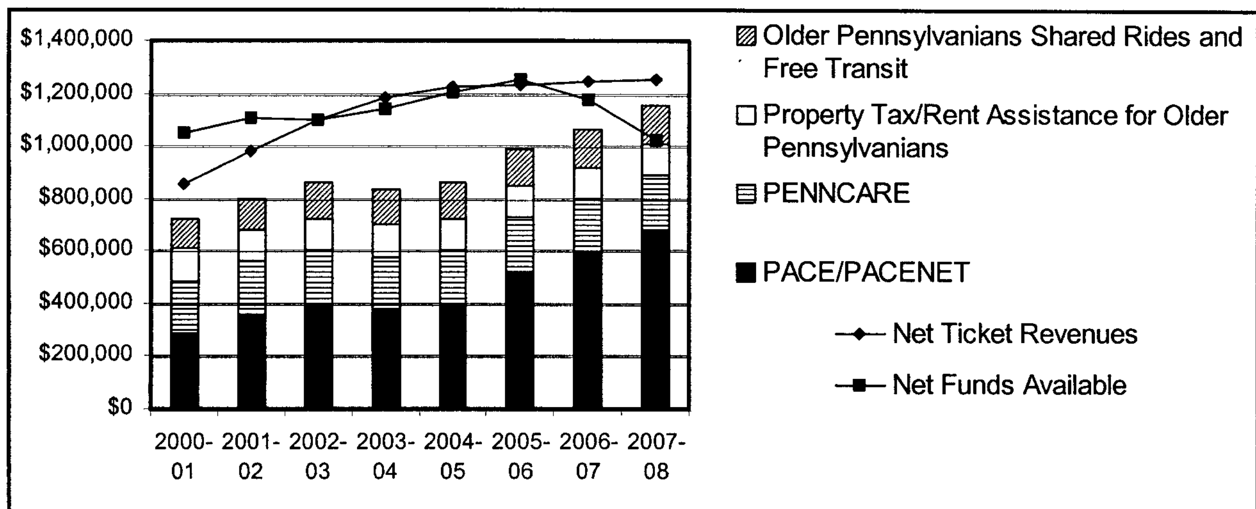
the senior programs funded by lottery revenue and are estimated to be nearly 60 percent by FY 2007-08, when a deficit is projected.[3]

Exhibit 5 below compares net ticket sales, program expenditures, and net funds available. Net funds available[4] in FY 2000-01 were $1.1 billion and are estimated to be $1.0 billion in FY 2007-08. The previous Administration estimated that the Lottery Fund would not be able to fund all senior programs beginning in FY 2005-06 when a deficit was expected.

Exhibit 5

Net Ticket Sales/Program Expenditures/Net Funds Available

($000)



Source: Developed by LB&FC staff from Governor's Executive Budget, FY 2003-04.

Pharmaceutical Assistance Fund Balance

PACE and PACENET programs are funded out of the Pharmaceutical Assistance Fund. This fund receives revenues from both the Lottery Fund and the Tobacco Settlement Fund. Funds not expended in the fiscal year in which they are appropriated are available for use in the following fiscal year. Although the FY 2003-04 budget calls for a $25 million decrease in Lottery Fund transfers, PACE officials indicate that the Pharmaceutical Assistance Fund has sufficient cash reserves to cover this decrease. (See Table 6.)

[3]According to the November 2001 *Advisory Committee Report on Containing Costs in PACE*, projections from the Governor's Budget Office indicated the need to reduce PACE/PACENET expenditures nearly $70 million per year to preserve solvency in the Lottery Fund for an additional year until FY 2004-05, assuming that recommended measures are in effect by July 2002. These recommendations are not in effect.

[4]Funds available reduced by lottery advertising, on-line and instant vendor commissions, Auditor General costs, payment of prize money, Treasury replacement checks, and beginning in FY 2003-04, player activated terminal costs.

Table 6

Pharmaceutical Assistance Fund
Statement of Cash Receipts and Disbursements
($ Thousands)

	FY 1999-00 (Actual)	FY 2000-01 (Actual)	FY 2001-02 (Actual)	FY 2002-03 (Available)	FY 2003-04 Estimated	Percent Change
Cash Balance, Beginning.....	$55,490	$58,623	$45,334	$97,661	$92,071	65.9%
Receipts:						
Transfer from Lottery Fund.	$260,000	$290,000	$359,000	$395,000	$370,000	42.3%
Transfer from Tobacco Settlement Fund[a]			27,601	34,682	34,427	
Interest on Securities..........	1,595	1,916	1,777	1,000	1,000	(37.3)
Chronic Renal Disease.......	5,185	5,522	6,571	7,684	7,691	48.3
Special Pharm. Services	24,323	19,627	27,222	33,678	38,276	57.4%
Total Receipts....................	291,103	317,065	422,171	472,044	451,394	55.1%
Total Funds Available...........	$346,593	$375,688	$467,505	$569,705	$543,465	56.8%
Disbursements:						
Treasury	$0	$0	$0	$5	$5	
Aging[b]................................	263,512	302,210	338,584	436,267	437,212	65.9%
Health[c]...............................	5,108	5,748	6,701	7,684	7,691	50.6%
Public Welfare[c]..................	19,350	22,396	24,559	33,678	38,276	97.8%
Total Disbursements	287,970	330,354	369,844	477,634	483,184	67.8%
Cash Balance, Ending..........	$ 58,623	$ 45,334	$ 97,661	$ 92,071[d]	$ 60,281	2.8%

[a]The PACE/PACENET Director indicated that the program anticipates continuing to receive Tobacco Settlement Funds. PACE/PACENET received $60 million for FY 2001-02 and FY 2002-03 and spent $15 million.
[b]Includes cost of contracted services.
[c]Expenditures from restricted revenue accounts in the Department of Aging.
[d]More recent projections place the June 30, 2003, at approximately $150 million.

Source: Governor's Executive Budget, FY 2000-01 through FY 2002-03.

Since the initiation of the PACE program in FY 1984-85 through FY 2000-01, the Commonwealth paid $3.7 billion[5] in claims for PACE and $53.6 million for PACENET claims (since its start in FY 1996-97). See Appendix D for details. Although its disbursements have increased 68 percent while Lottery Fund transfers have increased only 42 percent, the Fund balance has remained stable due largely to Tobacco Settlement Fund payments of $97 million from FY 2001-02 through FY 2003-04. (See Table 6.)

[5] Expenditures through December 31, 2001, total $4 billion.

Officials are hopeful that the PACE/PACENET program will remain viable for four reasons: (1) its estimated balance of approximately $150 million by June 30, 2003; (2) enhanced Lottery Fund revenue, especially from the new Powerball game and enhanced marketing strategies; (3) potential changes currently under consideration in PACE, such as increased copay and use of federal upper limits and best pricing with an expanded eligibility; and (4) federal augmentations,[6] especially resulting from a Medicare demonstration project.

PACE/PACENET Expenditures and Recoveries

PACE/PACENET net expenditures have increased 48.5 percent, from $227.3 million in CY 1998 to $337.5 million in CY 2001. (See Table 7.) Claim payments, representing nearly all the expenditures, were $396.4 million in CY 2001. Claim expenditures increased 52 percent due to drug price increases, increased utilization, and newer, more expensive products. Other expenditures include Department of Aging administration, a $10 million First Health Services contract, and refunds of overpayments. Increasing program costs are attributable to:

- enrollees using more medication as they age;
- new complementary drug therapies;
- advertising;
- increased price of medications introduced to the market prior to 1997; and
- introduction of substantially more expensive drug therapies since 1997.

Recoveries increased 60.5 percent, from $43.6 million in CY 1998 to $69.9 million CY 2001. Most of the recoveries are manufacturer rebates ($61.3 million in CY 2001) and third party reimbursements ($7.8 million in CY 2001). Manufacturer rebates have increased 44.1 percent from CY 1998 to CY 2001 due to higher product costs and increased utilization. Third party reimbursements increased significantly because the Commonwealth considered lawsuits against major health maintenance organizations (HMOs) in order to recover monies being held since 1995. Settlements have been reached with all the major HMOs.

Appendix E provides data by county on enrolled/participating cardholders and Commonwealth expenditures.

[6]If Congress passes a Medicare drug benefit (perhaps implemented by late 2005 or 2006), additional federal augmentations would be realized.

Table 7

PACE and PACENET Expenditures and Recoveries

	CY 1998	CY 1999	CY 2000	CY 2001	% of Gross Expenses (CY 2001)
Expenditures:					
Claims:					
Expenditures	$260,684,999	$288,628,097	$332,113,752	$378,322,011	
Adjustments[a]	0	5,734,432	14,654,873	18,036,473	
Gross Claims	$260,684,999	$294,362,529	$346,768,625	$396,358,484	97.27%
First Health Svcs Contract:					
Operations	$ 8,808,313	$ 8,427,840	$ 9,069,109	$ 9,628,930	
Miscellaneous[b]	93,316	106,060	3,657	398,430	
Special Claims	6,245	4,623	3,798	5,744	
Gross Contract	$ 8,907,874	$ 8,538,523	$ 9,076,564	$ 10,033,104	2.46%
Dept. of Aging Admin:					
Personnel	$ 538,761	$ 556,995	$ 550,313	$ 531,201	
Operations	122,895	131,875	123,938	112,363	
Fixed Assets	4,000	0	0	0	
Gross PDA Admin	$ 665,656	$ 688,870	$ 674,251	$ 643,564	0.16%
Miscellaneous:					
Comptroller[c]	$ 610,000	$ 220,000	$ 0	$ 0	
Medical Advisor	13,282	14,237	10,889	16,727	
Refund of Overpayments[d]	1,544	46,643	760,615	414,551	
Attorney General Fees	1,649	0	0	0	
Gross Miscellaneous	$ 626,475	$ 280,880	$ 771,504	$ 431,278	0.11%
Gross Expenditures	$270,885,004	$303,870,802	$357,290,944	$407,466,430	100.00%

	CY 1998	CY 1999	CY 2000	CY 2001	% of Gross Reduced (CY 2001)
Recoveries:					
Manufacturer Rebates	$ 42,543,316	$ 48,401,444	$ 53,958,307	$ 61,312,999	
Income Verification and Revenue Match	411,823	531,630	536,192	690,876	
Attny. General Collections	132,226	111,376	86,274	88,759	
Third Party Reimbursements	487,678	3,391,410	10,270,282	7,808,736	
Miscellaneous	(70)	0	0	22,463	
Total Recoveries	$ 43,574,973	$ 52,435,860	$ 64,851,055	$ 69,923,833	17.16%
Net Expenditures	$227,310,031	$251,434,942	$292,439,889	$337,542,597	

[a]Adjustments include claims paid from prior fiscal years.

[b]Extra contractual expenditures related to program activities not in the scope of the original contract, as well as providing the contractor with 10 percent of all third party liability recoveries in excess of $1 million in any one calendar year.

[c]Beginning CY 2000, comptroller expenses were appropriated out of the General Fund rather than PACE.

[d]Significantly increased due to pharmaceutical manufacturers more carefully post auditing their rebate remittances and seeking funds for overpayments.

Source: Developed by LB&FC staff from PACE Annual Reports, 1998-2001.

V. Cost Saving and Revenue Enhancing Measures Used in Commercial Plans and Other States

This chapter presents brief presentations of various cost saving and revenue enhancing options that have been used in other states and in third-party commercial prescription drug plans. Specifically:

- Section A discusses seven cost sharing options related to enrollees.
- Section B includes five cost sharing options for drug manufacturers.
- Section C analyzes five cost sharing options primarily affecting pharmacies.

A. Options for Cost Sharing Measures by Enrollees

Option 1: Increase Copayments (dollars)

Description: Increase PACE copay to meet the ratio established in Act 1996-134 (originally set forth in Act 1983-63)[1] for the program. According to the PACE/PACENET Director, the copay would be in the $12-$14 range, instead of the current $6.

Where and How Used: Copays in Connecticut and Nevada range from $12-$15 and $10-$25, respectively, depending on income; Delaware's is $5 or 25 percent of prescription cost, whichever is greater; New York's copay ranges from $3 for prescriptions under $15 to $20 for those over $55.

Potential Implementation Issues for PA: Higher cost of copay may discourage enrollment, although AARP indicates that a small increase in copay is reasonable.

Estimated Cost Savings: Every dollar increase in the current six-dollar program copay could yield savings of $9 million to the program, according to the PACE/PACENET Advisory Committee report.

Option 2: Increase Copayments (Percent)

Description: Increase PACE copayment based on the percentage change of ingredient cost as established in Act 1996-134 (originally set forth in Act 1983-63). The enrollee would pay approximately 30 percent on each

[1]According to the act, the copayment may increase or decrease on an annual basis by the average percentage change of ingredient costs for all prescription drugs plus a differential to raise the copayment to the next highest 25-cent increment. The Department is prohibited from approving adjustments to the copayment on more than an annual basis.

prescription. According to the PACE/PACENET Advisory Committee Report, the average program enrollee contributes only 15 percent of the costs, half of the 30 percent average at the beginning of the program in 1984. According to a Prescription Benefits Manager (PBM), most private sector plans have a 25-35 percent copay.

Where and How Used: Delaware's copay is $5 or 25 percent of prescription cost, whichever is greater; Maryland seniors with incomes below 116 percent of FPL receive 100 percent benefit while those with incomes between 116 percent and 175 percent of FPL pay 65 percent of prescription cost; Michigan's copay is tied to income, but it may not exceed 20 percent of cost; Missouri's copay is 40 percent of drug cost; Rhode Island's plan pays from 15 percent to 60 percent of prescription cost, depending on income; until the deductible is met, South Carolina enrollees receive a 10 percent discount on prescription drugs; Kansas enrollees receive reimbursement for a maximum of 70 percent of drug costs. Maine and Indiana participants can save up to 25 percent and 50 percent, respectively, on each prescription.

Potential Implementation Issues for PA: Higher cost may discourage enrollment. Adding a cap to the coinsurance obligation may help ensure that necessary, but expensive, medications remain obtainable.

Estimated Cost Savings: According to the PACE/PACENET Advisory Committee report, this measure has the potential to save the Commonwealth more than $50 million annually.

Option 3: Establish Multi-tiered Copayments

Description: Establish PACE copayments that increase with the cost of medications, as is currently done with PACENET.[2] Generics would have the lowest copay; preferred brand drugs the next highest copay; and non-preferred brands the highest copay.

Where and How Used: Florida has tiered copay, $2/$5/$15 (generic/preferred drug list/other brand names); copays (generic/brand name) for Illinois, South Carolina, Vermont, Wisconsin and Wyoming are $1/$4, $10/$21, $3/$6, $5/$15, and $10/$25, respectively; Massachusetts' copay is $5/$12/50 percent for lower incomes and $10/$25/50 percent for higher income groups; Michigan requires a $15 copay in addition to monthly out-of-pocket share if brand name drug is prescribed when a generic is available.

[2]Copayments for PACENET are currently $8 for generic drugs and $15 for brand name drugs. SB 47 would set a tiered copay schedule related to income. Singles with incomes from $14,000-$36,000 and married persons with combined incomes from $17,200-$39,200 would pay from $8-$16 for generics and from $15-$23 for brand names.

Potential Implementation Issues for PA: It would require at least a change in regulations and places the burden on pharmacists to ensure correct collection of copay amount.

Estimated Cost Savings: Assuming $5/$12/$25 copay, approximate Commonwealth savings could be $30 million annually, according to the PACE/PACENET Advisory Committee Report.

Option 4: Require an Annual Deductible

Description: Establish an annual deductible for all PACE/PACENET participants. To ease the burden, it could be collected semi-annually or monthly. PACENET currently has a $500 per person deductible. SB 47 would set a PACENET deductible ranging from zero to $600, based on levels of income. Single incomes range from $14,000-$36,000; combined incomes for married persons range from $17,200-$39,200.

Where and How Used: The following states have an annual deductible: Massachusetts, $0-$500 sliding scale; Missouri, $250 or $500, based on income; New York, ranges from $530 to $1,715, based on income and marital status; Rhode Island, no coinsurance requirements after $1,500 paid by first tier enrollees; South Carolina and Wisconsin, $500; Wyoming, $100-$1,000 per family, based on income. In Minnesota, the enrollee pays the first $35 each month.

Potential Implementation Issues for PA: Higher cost may discourage enrollment. AARP favors a monthly deductible over the current PACENET up-front $500 deductible. It would require a change in statute.

Estimated Cost Savings: The higher the annual deductible, the larger the savings to the PACE/PACENET program. We calculated that an average $250 annual deductible could save the PACE program $50 million.

Option 5: Establish Maximum Annual Benefit Ceiling

Description: Establish a maximum annual payout per PACE/PACENET enrollee. Another proposal, sometimes called the "hole in the donut," would cover expenses up to a specified amount, but leave a gap in coverage between the benefit limit and the level of drug expenditures required to qualify for catastrophic protection.

Where and How Used: The following states have an annual benefit ceiling: Delaware, Kansas, North Carolina, $2,500, $1,200, and $600, respectively, per individual; Missouri and Nevada, $5,000; Illinois, after $1,750 maximum

state pays 80 percent; Indiana, $500-$1,000 cap based on family income. Florida has a monthly spending cap of $160 per individual.

Potential Implementation Issues for PA: A benefit ceiling may discourage enrollment or cause hardship. Enrollees may discontinue medications as they approach the cap, only to resume therapy in the new year. It requires a change in statute.

Estimated Cost Savings: Has the potential to save the Commonwealth $20 million to $45 million annually, depending on the cap level. According to the PACE/PACENET Advisory Committee Report, a cap of $2,500 could result in $44.9 million annual savings.

Option 6: Limit Number of Prescriptions

Description: Establish limits on the number of prescriptions, especially brand name prescriptions, which may be filled or refilled within a certain time period.

Where and How Used: New Jersey allows no more than 12 prescriptions a month without prior authorization. In Florida, a provider may not prescribe more than four brand name drugs per month without prior authorization. The enrollee may receive an unlimited number of generic drugs.

Potential Implementation Issues for PA: Some studies have shown that limiting the number of times enrollees can obtain prescribed medication can lead to higher overall costs because participants may need more hospitalization or nursing home care. However, caps on high drug utilizing patients may help reduce risks of harmful drug interactions, as well as identifying possible fraud or abuse. It would require a change in statute.

Estimated Cost Savings: Florida saved $70 million from September 2000 to January 2002. Based on 2001 PACE/PACENET data, potential savings can be 4.2 percent or $16.5 million, according to the Pennsylvania Association of Chain Drug stores.

Option 7: Establish Annual Fee

Description: Establish an annual fee for all PACE/PACENET participants.

Where and How Used: The following states have an annual fee: Connecticut and Michigan, $25; Missouri, $25 or $35, based on income; New York, annual fee in quarterly installments of $8-$230/individual or $8-$300/for each member of a couple; Wyoming, $20.

Potential Implementation Issues for PA: It would require a change in statute. According to a PACE/PACENET official, an annual fee is a barrier to enrollment. When Connecticut removed its fee, enrollment increased.

Estimated Cost Savings: We calculated that a $25 annual fee for PACE/PACENET enrollees could save the program $5.6 million.

B. Options for Cost Sharing Measures by Manufacturers

Option 1: "Best Price" Rebate for Branded Products

Description: For purposes of Medicaid calculations, "Best Price" is the lowest price paid for a medication by any purchaser other than federal agencies and state pharmacy assistance programs. Best Price enhances the federally required rebate from manufacturers by also recovering the difference between what was claimed at the time of payment and the best average manufacturer price made available across the country. This option essentially would place the PACE/PACENET program on par with the federal Medicaid program with respect to drug pricing. Using best price, the rebate currently paid by manufacturers in the Medicaid program is approximately 21 percent.[3]

This option would impact manufacturers of brand multi-source medications much more than companies with single-source medications. As the only source for a particular medication, the single source manufacturer would have complete control over setting a "best price," while the "best price" for a multi-source medication would be established by competition among the various manufacturers.

Where and How Used: "Best Price" is currently used nationwide for state Medicaid programs. Delaware now requires manufacturer rebates to be consistent with Medicaid rebates. Maine's Rx legislation calls upon the state, acting as a PBM, to enter into negotiations with manufacturers using best efforts to obtain rebates for the program equal to or greater than those of the state's Medicaid program. Those drugs not covered by a rebate agreement would be subject to prior authorization. PhRMA has challenged this legislation and arguments were heard by the U.S. Supreme Court in February 2003. HB 444, under consideration in the 2001-2002 legislative session, created a Pennsylvania Rx program which included provisions similar to those in the Maine program.

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[3]As set forth in the national rebate agreement, the Medicaid rebate for branded products is the greater of either 15.1 percent of the AMP or the difference between the AMP and the best price, with an additional adjustment made for inflation. Best price is inclusive of cash discounts, free goods, volume discounts, and any rebates other than this one.

Potential Implementation Issues for PA: This option would require the Legislature to amend the current PACE/PACENET law.

Estimated Cost Savings: The PACE/PACENET Advisory Committee believes by requiring participating manufacturers to pay best price (i.e., the same level of rebates they pay the Medicaid program), PACE/PACENET rebate revenues could increase by $31 million annually.

Option 2: Change Rebate Basis from Average Manufacturers Price (AMP) to Average Wholesale Price (AWP)

Description: The current PACE/PACENET manufacturer rebate formula consists of a combination flat amount and an additional indexed amount, all of which is based upon the average manufacturer price (AMP). This option would change the rebate basis from the AMP to the average wholesale price (AWP) set by the manufacturer. This results in cost savings because, unlike most products, the AWP is generally higher than AMP.

Average wholesale price is used by pharmacies as a cost basis for pricing medications and as such, drives PACE/PACENET inflation. Pharmacies pass increases in the wholesale prices for both existing and newer products on to consumers.

Where and How Used: Standard industry practice bases pharmacy reimbursements on average wholesale price, but manufacturer rebates have not been based on AWP for either commercial or publicly funded programs.

Potential Implementation Issues for PA: This option would require the Legislature to amend the current PACE/PACENET law.

Estimated Cost Savings: The PACE/PACENET Advisory Committee expects that this option will yield 8 to 10 percent (or $21 million) annually in savings and also provide protection against inflation since the AWP is the basis for reimbursement to providers.

Option 3: Formulary or Preferred Drug List:

Description: A formulary, or Preferred Drug List (PDL), is a pre-approved listing of reimbursable drugs, typically by their generic names. It is usually constructed to include a sufficient range of medicines to enable physicians or dentists to prescribe medically appropriate treatment for all common illnesses. Therapeutic substitution or interchange is often permitted. Prescribers would be required to choose medically appropriate treatments from a pre-defined list of medicines. A formulary may also be used to list drugs for which a third party or program will not pay.

A PDL typically does not limit the kinds of drugs, but requires use of the most cost-effective drug. Access to expensive medications would be restricted by encouraging or requiring the use of less expensive therapeutic alternatives based on therapeutic equivalence.

Where and How Used: Under federal law, state Medicaid programs are allowed to move away from "open formulary programs" and develop PDLs using their prior authorization authority. They are also permitted to negotiate additional discounts above the standard Centers for Medicaid and Medicare Services (CMS) rebate level, known as supplemental rebates (see option 5 below), with drug manufacturers interested in protecting or expanding their market share.

PDLs are used extensively by Medicaid managed care organizations, which currently cover a majority of Medicaid recipients in 11 states including Tennessee, New Jersey, Arizona, Michigan, Maryland, Pennsylvania, and Virginia. Under these PDL programs, all FDA-approved drugs remain available; however, non-preferred drugs require medical justification through a prior authorization process.

Michigan, Florida, California, Hawaii, Illinois, Indiana, Louisiana, Massachusetts, Minnesota, Mississippi, New Mexico, Ohio, Oregon, South Carolina, Vermont, and West Virginia have or are planning to implement preferred drug lists, according to the Center for Policy Alternatives. New Jersey was to propose a PDL in February 2003 as part of its budget plan.

Potential Implementation Issues for PA: If a formulary or PDL is to be constructed, the Legislature will need to amend current PACE/PACENET law. Formularies are often constructed using both clinical efficacy and unit cost data to determine the most appropriate drugs to include within each therapeutic category. House Bill 888 includes a type of PDL within the section dealing with the Pharmacy Best Practices and Cost Control Program. SB 1036, under consideration in the 2001-2002 legislative session, also would have established a PDL.

Estimated Cost Savings: Cost savings generated by a formulary would depend on which medications are included on and excluded from the list. Assuming an open formulary (where the program designates preferred products but allows coverage for both formulary and nonformulary medications) and tiered copayments, the PACE/PACENET Advisory Committee estimates that a phased-in formulary could save $10 million annually in the first few years. Additional savings would depend on the aggressiveness of prior authorization enforcement and/or how restrictive a formulary is compiled.

Option 4: Prior Authorization

Description: This option would require physicians to obtain prior approval to prescribe newer medications that have been deemed to not offer significant therapeutic value over their predecessors, or in the case of a formulary, approval for medications not on the preferred list. This method is used in virtually all third party drug reimbursement plans, including Medicaid.

Where and How Used: Physicians encounter prior authorization processes in many managed care plans. It is already in use for certain Medicaid drugs in Pennsylvania (see Section II B.) Within Pennsylvania state government, PEBTF's pharmacy benefits manager maintains a prior authorization list for both its active and its retired members. States using prior authorization include:

- Kentucky – 2002 enacted Medicaid prior authorization list.
- North Carolina – 2002 enacted Medicaid prior authorization passed in state budget.
- West Virginia – Enacted Medicaid prior authorization.
- Connecticut – 2002, announced in regulation that it would implement prior authorization.
- Colorado – 2002, legislation for Medicaid prior authorization passed Senate committee and died as the session ended.

Potential Implementation Issues for PA: This option would require the Legislature to amend the current PACE/PACENET law. In states that have implemented prior authorization programs, opposition has come from physicians whose prescriptions may now require prior authorization and from pharmaceutical manufacturers that produce products that may be subject to prior authorization.

Estimated Cost Savings: The PACE/PACENET Advisory Committee anticipates potential savings of $5 million to $10 million in first year, depending on which medications are targeted. Initially, program costs associated with conducting prior authorization reviews will be high, but should decrease as the patient and provider education initiatives have their desired effect and the number of prior authorization requests declines.

Option 5: State Supplemental Rebates

Description: Pennsylvania's Medicaid program receives a rebate equal to about 21 percent of gross product payout because of the "best price" feature of the federal rebate requirement. Some states have instituted additional, or supplemental, rebate agreements with manufacturers. (Under PACE/ PACENET, manufacturers return over $55 million a year to the program in

the form of product rebates, an amount equal to only 16 percent of the gross products payouts.)

Supplemental rebates require the use of a Preferred Drug List (PDL). PDLs are what really drive supplemental rebates. To establish such a measure, negotiations are conducted with manufacturers of non-preferred drugs to ask them to provide a supplemental rebate in an amount necessary to make their drug's cost equal to the price of the reference drug in the appropriate therapeutic class. Manufacturers who agree to pay these additional rebates are added to the final PDL and are not subject to prior authorization. Those that do not are subject to prior authorization, which can result in a dramatic loss in market share for that company's products.

Where and How Used: With approval from CMS, Michigan and Florida have begun requiring manufacturers to provide supplemental rebates as part of their Medicaid programs. Litigation related to supplemental rebates includes:

- In Michigan, six large manufacturers (Eli Lilly, Johnson & Johnson, Merck, Pfizer, Pharmacia, and Wyeth-Ayerst Laboratories) initially refused to participate in discussions with the state about supplemental rebates, arguing that quality of care would be diminished by reductions in beneficiary access to prescription drugs. After several delays – owing in part to litigation by PhRMA challenging the program–the state implemented its PDL in February 2002. Several months after implementation, a number of these manufacturers reconsidered the decision not to participate and agreed to pay supplemental rebates to the state.[4]
- In September 2002, the U.S. Court of Appeals for the Eleventh Circuit upheld Florida's Medicaid law that creates a list of preferred drugs, requires manufacturers to offer a supplemental rebate to get on the list, and creates a prior authorization program for prescription drugs not on the preferred list. Challengers claimed that it violates federal Medicaid law that permits a drug to be excluded from state Medicaid formularies only after the state has concluded that the drug has no significant, clinically meaningful therapeutic advantage over other drugs in the formulary. The court found, while the Florida law steered doctors and patients toward certain preferred drugs, it did not prevent access to nonpreferred drugs. Florida's changes to the Medicaid program are expected to save $214 million the first year.

- In May 2001, the U.S. Court of Appeals for the First Circuit upheld the state of Maine's Rx Program (based on but not directly related to Maine's Medicaid program), lifting a district court injunction. The Maine Rx Program requires negotiated rebate agreements with pharmaceutical manufacturers to give those rebates to retail pharmacists to allow them to

[4]According to interviews conducted by The Kaiser Commission on Medicaid and the Uninsured.

charge uninsured consumers lower prices. Products of non-compliant manufacturers would be subjected to prior authorization requirements.

PhRMA brought suit, alleging the Maine Rx Program's use of the prior authorization provisions of the Medicaid law as an incentive or punishment in obtaining rebates is inappropriate and that the program violates the U.S. Constitution's Commerce Clause by regulating business transactions that occur between the manufacturer and the distributor outside of Maine. The Court of Appeals held that as long as the state implements prior authorization in accordance with federal rules, the motivation behind it is not of concern. The court also concluded that the fact that the Maine program might negatively affect manufacturers' profits does not necessarily mean the program is regulating those profits. The court acknowledged this issue might need to be revisited once the act took effect. In May 2003, the U.S. Supreme Court upheld the Court of Appeals decision.

- In December 2002, the U.S. Court of Appeals for the District of Columbia Circuit halted Maine's Healthy Maine Program (HMP). This program, an 1115 demonstration project that provides drug discounts to people who are otherwise ineligible for Medicaid, includes eligibility up to 300 percent of federal poverty guidelines. Four additional states – Hawaii, Maryland, New Hampshire and Vermont – have sought approval for a similar state coverage expansion. On January 19, 2001, HHS granted a waiver to give about 225,000 Maine residents who lack drug coverage the right to buy prescriptions at Medicaid prices. The waiver allows those without insurance but with incomes up to 300 percent of FPL to purchase drugs at a discount of about 25 percent. Guidelines are expected to cover about 70 percent of those who would have seen similar price reductions under the Maine Rx Program. Funding for the program's prescription drug discount program was to come from special rebates paid by drug companies.

  While technically not a Medicaid supplement rebate program per se, Maine's HMP uses the Medicaid manufacturer-rebate mechanism and collects rebates from manufacturers quarterly, depositing the rebates into a revolving fund. Providers charge HMP beneficiaries prices for prescriptions that equal the Medicaid price for a prescription, minus a fixed percentage subsidy of 18 percent. Beneficiaries receive a 14-percent reduction off the available prescription price, calculated by reducing the manufacturer's rebate of 18 percent by the four percent Maine estimates it would cost on a per-prescription basis to administer the HMP.

  The Court of Appeals, shortly after the implementation of the Maine program, held a similar Vermont program to be impermissible under the federal Medicaid act because there was no net expenditure of funds for Medicaid purposes in an amount determined independently of the amount of the rebates. In response, Maine revised its program to contribute 2 percent of the annual costs of the prescription drug program. The Court of Appeals then halted the Maine program because this revision had not

been submitted for approval by the Secretary of Health and Human Services as required by law.

In other states:

- Louisiana enacted supplemental rebates in 2001 and implemented them in 2002.
- Minnesota, Mississippi, New Mexico, and Vermont all enacted supplemental rebates in 2002.
- Illinois established supplemental rebates by regulation in 2001 and implemented them in 2002.
- Indiana issued an RFP in 2002 for a PBM to operate a supplemental rebates program.
- Ohio announced in regulation in 2002 that it would seek supplemental rebates.
- Arizona's legislation for supplemental rebates lost on the Senate floor in a tie vote in 2002.
- Maryland's legislation for supplemental rebates passed the Senate and 2nd reader on the House floor in 2002, but died as the session ended.

Potential Implementation Issues for PA: This option would require the Legislature to amend the current PACE/PACENET law. PACE/PACENET staff would need to negotiate with manufacturers whose medications have been identified as being priced higher than the reference drug in each therapeutic class of a preferred drug list. A Senior Director for Health First Services advises states to avoid accepting "in-kind" offers in lieu of PDL participation during these negotiations.

Estimated Cost Savings: There is no information on specific cost savings for Pennsylvania from supplemental rebates. However, in California, Medi-Cal received $158 million in supplemental rebates in FY 1999-2000. In Michigan, average supplemental rebates range from 22 – 29 percent and overall savings from their preferred drug list, prior authorization and supplemental rebates is reported to be $850,000 a week. Florida's Office of Program Policy Analysis and Government Accountability (OPPAGA) estimates that Florida could save an additional $64.2 million in FY 2003-04 by restricting supplemental rebates to only cash rebates. This would be in addition to the $500 million saved over the past two years from a combination of its PDL and related initiatives (including supplemental rebates). In his Executive Budget address for FY 2003-04, the South Carolina Governor states that implementation of supplemental rebates could save the state's Medicaid program $15 million to $20 million.

C. Options for Cost Sharing Measures by Pharmacies

Approximately 2,800 licensed pharmacies in Pennsylvania participate in the PACE/PACENET program. In 2000, they filled 9.5 million prescriptions for over 240,000 older state residents. The PACE/PACENET program represents a major part of pharmacies' public payer line of business. According to the Pennsylvania Pharmacists Association (PPA), over the past five years, pharmacist personnel and administrative costs have increased 40 percent. They also note that the current PACE/PACENET dispensing fee of $3.50 has not increased since the program began.[5]

Option 1: Federal Upper Limits

Description: Unlike many commercial plans, the PACE/PACENET program does not cap the amount it pays for multi-source generic medications, a practice referred to as Maximum Allowable Cost (MAC). MAC is based on federal upper limit (FUL) pricing. The FUL option limits pharmacy reimbursement for generic prescription drugs to an amount based on the price per unit which CMS has determined to be 150 percent of the lowest price listed on a published compendia of cost information of medications.

Where and How Used: Commercial drug reimbursement plans and Medicaid impose FUL pricing. According to the Department of Public Welfare, MAC is used in virtually all third party drug reimbursement plans, as well as Medicaid.

Potential Implementation Issues for PA: The PACE Advisory Committee has recommended adopting a federal upper limits maximum allowable cost policy for generic products. According to the Pennsylvania Pharmacists Association, the adoption of FUL would not increase clinical quality, lead to better services, or protect patient safety any better than what is presently in place. Pharmacies would be adversely affected, however, because of the lost income. The profits pharmacies earn on selling generic medications makes up for the lack of profits in selling brand medications.

Estimated Cost Savings: The institution of a MAC, based on the current Medicaid "federal upper limits" model, could save $28 million annually according to estimates prepared by the Department of Aging. An increase of

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[5]Compared to the PACE/PACENET dispensing fee of $3.50, most basic fees for senior paid prescription programs range between $2.55 and $4.88 per prescription. See Appendix F. Act 1996-53 mandated the Departments of Aging and Public Welfare to perform an in-depth pharmacy service study. The purpose of the study was to determine the cost of filling prescriptions and providing other pharmacy services. To comply with this requirement, in 1998 the Departments contracted to have a pharmacy service study undertaken. The PricewaterhouseCoopers (PwC) November 1998 report found that pharmacies' profits for dispensing PACE/PACENET prescriptions in 1997 was $0.84 per claim, or 3.1 percent of acquisition cost. PPA believes that there must be an updated study to determine what current costs are for pharmacies to provide services and still allow a reasonable profit. They note that the actual cost to fill a prescription ranges from $7.50 to $9.00.

$0.50 in current dispensing fees was included in the above estimate to help offset the lower reimbursement pharmacies would receive under the FUL option.

Option 2: Reduce Ingredient Cost Reimbursement

Description: Compensation for pharmacy services includes reimbursement for a product component and payment for professional services.[6] According to the Advisory Committee report, the current ingredient cost reimbursement is ninety percent of Average Wholesale Price, or AWP-10 percent, plus a $3.50 dispensing fee. This is higher than what most commercial third-party prescription drug plans allow for reimbursing pharmacists. The report notes that the industry average for reimbursement in the commercial sector using private Pharmacy Benefit Managers (PBMs) is AWP-15 percent plus a $2.00 dispensing fee.[7]

Where and How Used: The PPA believes that pharmacies would prefer that the dispensing fee be increased or remain at $3.50 but indicated that AWP-15 is an option that they may have to accept. They noted that there are differences in costs for generic medications versus brand medications and that there is more need for steeper discounts on brand medications than for generic medications. (See also Appendix F for other states' ingredient cost reimbursement.)

Potential Implementation Issues for PA: This initiative would impact both chain and independent pharmacies. Cash paying customers might be affected if pharmacies raised costs to offset reduced PACE/PACENET reimbursements. The PPA acknowledges that at the retail level, AWP-15 percent to AWP-17 percent is a reasonable estimate of pharmacies' actual acquisition cost for brand medications.

Estimated Cost Savings: Lowering ingredient cost reimbursement to 87 percent of AWP would save $10 million, according to estimates prepared by the Department of Aging.

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[6]Reimbursement related to product component typically should include the acquisition, distribution and warehousing costs related to the product. Reimbursement related to professional services generally include a payment for fixed and variable costs related to dispensing medications and counseling patients on the appropriate use of their drugs.

[7]In August 2001, the Department of Health and Human Services, Office of Inspector General reported that nationwide, "the invoice price for brand name drugs was estimated to be 21.8 percent below AWP for purchases during 1999." They predicted that state Medicaid programs could realize an estimated savings of $1.08 billion if states increased the discount of AWP by 11.5 percent on the top 200 reimbursed brand name drugs.

Option 3: Enrollee Mail Service/90 Day Supply Incentives

Description: The Advisory Committee report recommends offering mail order access for a 90-day supply of maintenance drugs to enrollees for the same copay as a 30-day supply. A state sole source administrator is one option for a mail order program; a discounted 90 day supply provider could also be included in such a program. Such mail-order pharmacies achieve their savings due to large volumes of business and the ability to achieve economies of scale by:

- Focusing on selected medications, especially maintenance drugs.
- The use of highly automated order and record-keeping systems.
- Obtaining volume discounts from pharmaceutical manufacturers.
- Providing three to six month supplies of medications at reduced copayment charges.

Where and How Used: In 2001, mail-order pharmaceutical sales accounted for approximately 12 percent of the $175 billion U.S. prescription drug market. Only chain drug stores, which accounted for 37 percent of sales, and independent pharmacies, which accounted for 17 percent of sales, sold more prescription drugs. [8] According to an Advisory Committee workpaper, this type of incentive is practiced universally among commercial third-party plans with substantial copays. The Veterans Administration (VA) also uses mail order pharmacies.

The PEBTF (state retirement system) reports that out of 2,352,087 prescription drug claims submitted for reimbursement, only 93,977 (4 percent) were through mail order. State retirees can have a 100-day prescription filled at a local pharmacy for the same price as mail order, which may explain the low use of mail order. An additional 333,149 claims, 14 percent of all claims, were submitted for retail maintenance drugs, which are the more heavily discounted 100-day supply of drugs at the same rates as mail order. We found no states with prescription drug programs that mandate mail order drugs for their PACE/PACENET type program.

Potential Implementation Issues for PA: This initiative would probably have the greatest negative impact on small pharmacies that risk losing both dispensing fees and the profits they might realize on other purchases the customer may make while in the store obtaining the prescription. Additionally, according to the PPA, mail order distribution of prescription drugs also does not allow for the face-to-face counseling that pharmacists can provide their

[8] *Prescription Drug Expenditures in 2001: Another Year of Escalating Costs,* The National Institute for Health Care Management Research and Educational Foundation. May 2002. By comparison, the University of Arkansas for Medical Sciences, College of Pharmacy reported in October 2000 that mail order pharmaceutical sales represent approximately 11% of the $128 billion U.S. prescription drug market.

customers when they come into a pharmacy to fill a prescription. Other potential limitations are that:

- Generic drugs utilization rates may be lower for mail order pharmaceuticals than for drugs dispensed through retail pharmacies. Information provided by the PPA showed that mail order brand/generic utilization rates were 72/28 percent while retail pharmacy brand/generic utilization rates were 59/41 percent respectively.
- The use of mail order pharmacies may actually increase plan sponsor costs because the sponsor loses the second and third months' copay.
- Drug waste would likely increase because a 90-day supply of drugs is dispensed but may not ultimately be used because of side effects, therapeutic failure, or the death of the beneficiary.
- The American Society of Consultant Pharmacists in March 2003 estimated that about one out of every five emergency room visits are caused by medication-related problems (MRPs). Among the elderly, at least 16 percent of hospital admissions are due to MRPs. The use of mail order, in their opinion, would only exacerbate this problem. Additionally, the PPA referenced a federal HHS study that points to the vulnerability of the 60 plus population and the need to attend to patient safety, ". . . people must carefully follow their doctor's directions and stick to a drug-taking plan." Of more than 400 preventable drug-related injuries, 89 occurred when older people in outpatient clinics mishandled their own prescriptions."

The existing Pennsylvania PACE/PACENET program allows for in-state mail order purchasing of drugs, but only through mail order pharmacists registered as providers and only for a maximum 30-day supply. It does not have a statewide mail order pharmacy. Very few enrollees use the mail order option (less than 1 percent), according to the 2001 PACE Annual Report. The Director of PACE notes that the incentives for all parties are negligible.

Estimated Cost Savings: It is estimated that 90 percent of PACE/PACENET prescriptions filled are for maintenance drugs and might, therefore, be candidates for a mail order program. Depending on any mandates or enrollee incentives, this proposal has the potential to save between $18 and $36 million annually, according to estimates. The PPA points out, however, that due to changes in medications and health status, seniors often do not use the full 90-day supply, but the PACE program would have paid for these drugs. They believe, therefore, that the cost savings estimates are too high. Additionally, the PPA pointed out that a pharmacy would be at a severe price disadvantage when competing for customers because it must purchase its stock at a higher cost than mail order businesses have to pay. This is because the drug industry places retail pharmacies in a different trade class than mail order companies, which are almost always administered by a PBM. The PBM receives a lower price for products and can, therefore, charge less.

Option 4: Performance Based Network

Description: Require PACE/PACENET pharmacy providers to meet quarterly performance standards. For example, providers could be required to meet quarterly generic dispensing percentages and specific average per claim costs.

Where and How Used: One form of a performance based network is where the managing PBM agrees to direct enrollees to specific pharmacies if they agree to meet performance guidelines and accept lower reimbursement rates. In a second form of performance-based reimbursement, the National Academy for State Health Policy in July 2002 found that at least 12 states had pharmacist reimbursement programs. Under such programs, pharmacists are provided a higher dispensing fee for generic drugs than for name brand drugs.

Potential Implementation Issues for PA: This option would require statutory amendments. Performance based networks are pertinent to prescription reimbursement plans that contract with a PBM to administer the program.

Estimated Cost Savings: Savings would vary. Depending on mandates and provider incentives, the quarterly dispensing standard proposal might save between $10 million and $15 million annually, according to an Advisory Committee workpaper.

Option 5: Discounts Through Medicaid Pharmacies

Description: This option could apply to all senior drug purchases at certain pharmacies independent of payer, including seniors paying cost with their own funds. For example, California and Florida laws require retail pharmacies that serve as Medicaid providers to provide a discount to individuals enrolled in Medicare. The beneficiaries do not become part of Medicaid, but the retail suppliers must choose to comply with the discount program or withdraw as Medicaid providers. In September 2001, the federal government approved this provider "enrollment criteria" in Florida's Medicaid state plan.

Where and How Used: In California, pharmacies may not charge Medicare beneficiaries more than the amount Medicaid would pay, plus a 15 cent fee to cover electronic transmission costs. The state maintains a database that pharmacists can access to find the Medicaid payment rate. There are no service costs to the state because participants pay for the cost of the drug. In Florida, Medicaid participating pharmacies cannot charge Medicare beneficiaries more than the average wholesale price minus 9 percent, plus a $4.50

dispensing fee. To obtain the discount seniors simply present their Medicare card to the pharmacist.

Potential Implementation Issues for PA: This option would require legislative change.

Estimated Cost Savings: Lower prescription drug prices for Medicare-eligible seniors could take pressure off the PACENET, and, possibly, the PACE program.

VI. Proposed Plans to Expand Prescription Drug Coverage for Pennsylvania's Senior Citizens

A. Cost Saving and Revenue Enhancing Measures That Could Be Used to Expand PACENET Eligibility

In this section of the report, we outline an approach to expand PACENET eligibility to 300 percent of the 2003 federal poverty level by using several of the most common cost-sharing techniques being applied in other state and third-party prescription drug programs. At 300 percent of the federal poverty level, PACENET's maximum income eligibility would increase from $17,200 to $26,940 for an individual and from $20,200 to $36,360 for a couple. The cost savings and revenue enhancing measures we modeled were: federal upper limit pricing, best price, a voluntary mail order/90-day supply program, and increasing the PACE copayment.

We collaborated with PACE program staff in developing the estimates used in this analysis. The model, and therefore our analysis, adjusts for drug price inflation and utilization[1]. The model also assumes a two-year "ramp-up" period to reflect a gradual phasing in of new enrollees. We did not independently analyze or audit the software program used by PACE/PACENET staff to develop the estimates presented below. We were informed, however, that the PACE program has been using and updating this modeling program for several years and that they use the same program and assumptions for virtually all of the scenarios they are asked to model.

Increased Eligibility With No Other Program Changes

Increasing the eligibility limit of PACENET to 300 percent of the federal poverty level will qualify an additional 594,896 Commonwealth seniors for the program. We assumed the new PACENET population would enroll in the program at 85 percent of the program's historical enrollment penetration rate of 18.3 percent.[2] This equates to 92,536 additional enrollees, a substantial increase over the 36,093 enrolled as of 2001.[3] The model assumes that these new enrollees will submit claims at the same rate as the current population, that the average state share per claim will follow the current trend, and that the state will continue to realize 16 percent in manufacturer rebates. Based on these assumptions, the net cost to add these 92,536 additional enrollees to the PACENET program is estimated to be $218.2 million over a two year enrollment period and $143.5 million annualized thereafter.

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[1]Figures are adjusted for inflation at the annual rate of 7.8 percent and 6.4 percent for PACE and PACENET, respectively. The model also assumes a 5 percent and 11 percent increase in prescriptions for PACE and PACENET, respectively.

[2]Based on discussions with PACENET staff, we did not use 100 percent because the higher income eligibility would likely yield additional persons with private pay prescription programs and/or additional ability to self pay.

[3]A smaller increase to 250 percent of the federal poverty level would qualify 519,430 additional Pennsylvania seniors with 80,797 expected enrollees (based on 85 percent of the 18.3 percent penetration rate).

Cost Saving Options Considered in the Model

The options modeled below to offset the costs associated with such a PACENET expansion would impact each of the program's major stakeholders. Best price increases the rebates that pharmaceutical manufacturers are required to pay the program; federal upper limit pricing and mail order primarily affect retail pharmacies; and increased copayments would shift more of the cost of each prescription to enrollees.

Best Price. Best price is the lowest price paid to a pharmaceutical manufacturer for a brand medication by any purchaser other than the federal government and state pharmacy assistance programs. As of 2003, the Best Price provision in the Medicaid program resulted in an approximate 21 percent rebate. Because the PACE/PACENET program already requires pharmaceutical manufacturer rebates of approximately 16 percent, the PACE/PACENET program is already capturing a significant portion of these savings. The model assumes that a Best Price provision could save an additional 6 percent of the state's share of PACE and PACENET claims, or about $80.1 million over the initial two years, followed by $44.2 million on an annual basis.

FUL Pricing. The second cost savings strategy we used is Federal Upper Limit (FUL) pricing. This option would limit the amount the PACE/PACENET program reimburses pharmacies for generic prescription drugs to 150 percent of the lowest price listed in any of the published compendia of cost information of medications as determined by CMS. The model used in this analysis assumes that 50 percent of PACE and PACENET claims would be subject to the FUL limit. This resulted in an estimated two-year cost savings of $33.7 million and $18.0 million in annualized savings thereafter.

Mail Order/90-Day Supply. The third cost savings strategy we modeled was a voluntary mail order pharmacy program that would allow cardholders to obtain a 90-day supply of prescriptions through a statewide mail order administrator or a 90-day supply provider. We assumed that, for both PACE and PACENET, the copay for a 90-day prescription would be $9, the dispensing fee paid to the mail order pharmacy would be $6, and that the provider reimbursement formula would be changed from Average Wholesale Price–10 percent (AWP-10 percent) to Average Wholesale Price–20 percent (AWP–20 percent) for brand name drugs and Average Wholesale Price–50 percent (AWP–50 percent) for generics. Assuming a 20 percent conversion of claims to mail order, the estimated savings are about $32.6 million during the two enrollment years and about $16.8 million annually.

Increase PACE Copay. The PACE copayment was last increased in July 1991, when it was raised from $4 to $6. We estimated that increasing the PACE copay to $8 would generate an additional $29.7 million during the first two years and $14.8 million annually thereafter.

The final measure we examined was increasing the suggested mail order co-pay for a 90-day prescription from $9 (as discussed above) to $12 for PACE and, for PACENET, to $12 for generic and $22.50 for brand name drugs. This would generate an additional $8.5 million for the first two years and $4.8 million annually thereafter.

Net Cost of Expansion. If all the above strategies were implemented, the net cost for the expansion of the PACENET program to 300 percent of the 2003 federal poverty level would be $33.6 for the two-year ramp-up period and approximately $44.8 million a year thereafter. The difference is because the cost savings features of the plan are assumed to be implemented immediately, whereas the increase in enrolled beneficiaries are assumed to occur gradually over the implementation period.

As shown in Table 8, our plan would require approximately $44.8 million a year (adjusted for drug inflation) in new funds beginning in the third year of the program (FY 2005-06).[4] We believe this to be a manageable cost given: (1) the PACE Fund is expected to have an estimated balance of approximately $150 million by June 30, 2003; (2) the Lottery Fund is anticipating additional growth as a result of Powerball and changes in its marketing approaches aimed at making its products more accessible to the public; and (3) a Medicare prescription drug benefit is likely to be established by Congress prior to July 2005, thereby providing an offset to current PACE/PACENET costs from federal funds. If these factors are not sufficient to offset the costs of the expanded program, consideration could be given to implementing a preferred drug list and possibly a prior authorization requirement to realize additional savings.

B. Federal Medicare Demonstration Project

CMS reports that historically a small portion of Medicare beneficiaries have accounted for a major proportion of the program's expenses. Many of these beneficiaries are chronically ill with common diagnoses creating expenditures for repeated hospitalizations. Health care for chronically ill persons, in the fee-for-service setting, has been fragmented and poorly coordinated. The patients' issues in this area center around a single disease or condition and fall into fundamental problems with their behavior, access to appropriate prescription drugs, or the disease-specific care they receive. The fact that Medicare generally does not cover prescription drugs compounds the problem.[5] CMS states that appropriate, effective pharmaceuticals are a key part of a comprehensive treatment program and effective disease management must include access to appropriate medications.

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[4]Appendix G provides additional information on the methodology used and additional back-up data used in our calculations.

[5]Medicare beneficiaries wanting drug benefits have to purchase supplemental insurance, or join a Medicare+Choice plan if they are not already covered under an employer-sponsored retirement plan or a publicly-funded program, such as Medicaid or the Department of Veterans Affairs.

Table 8

Expansion of PACENET Eligibility to 300 Percent Federal Poverty Level*

	Two-Year Ramp Up		Annualized Estimates	
	Savings	Cost	**Savings**	Cost
Expected State Share for Expansion		**$218,184,694**		**$143,528,953**
Estimated Cost Savings by Option **(see assumptions below)**				
1. Best Price				
Total Savings from Best Price	$80,059,317		$44,204,056	
Net Cost of Expansion After Adding Best Price		138,125,378		99,324,898
2. Federal Upper Limit Pricing				
Total Savings From FUL Pricing	33,654,504		18,034,294	
Net Cost of Expansion After FUL Pricing and Best Price		104,470,874		81,290,603
3. Mail Order/90-day Supply Program				
Total Savings from Mail Order	32,646,657		16,820,816	
Net Cost of Expansion After Mail Order/90-day Supply and FUL Pricing and Best Price		71,824,217		64,469,788
4. Increase Mail Order/90-day Supply Copays (Tiered $22.50 Brand/ $12.00 Generic)				
Savings Over the $9 Copay Option	8,547,155		4,845,462	
Net Cost After Increased Mail Order Copay		63,277,062		59,624,325
5. Increase PACE Copay to $8.00				
Savings from Increased PACE Copay	29,685,491		14,810,234	
Net Cost of Expansion After All Cost Savings		**$ 33,591,570**		**$ 44,814,092**

Assumptions:

- PACENET enrollment rate is 18.3 percent of eligibles, FUL pricing on generics is 50 percent of claims, Best Price savings at 6 percent of state share.
- Mail Order/90-day Supply Program – 20 percent of claims converted, 90-day supply, $9 Copay, $6 Dispensing Fee, Reimbursement for Brand Name Drugs at AWP-20 percent and AWP-50 percent for Generic Drugs.

Important Note: Care should be taken when reviewing this analysis which provides only a rough estimate of costs. Additionally, this analysis was developed by LB&FC staff in consultation with PACE staff. LB&FC did not audit PACE data directly or audit the PACE model itself. Should any of the assumptions made when developing the model be faulty, the results could be quite different.

*Figures are adjusted for inflation at the annual rate of 7.8 percent and 6.4 percent for PACE and PACENET, respectively. The model also assumes a 5 percent and 11 percent increase in prescriptions for PACE and PACENET, respectively.

Source: Developed by LB&FC staff from information provided by the Department of Aging.

Section 121 of the Medicare, Medicaid, and State Child Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA) directs the Secretary of Health and Human Services (HHS) to conduct a demonstration project for the Medicare fee-for-service population to demonstrate the impact on costs and health outcomes of applying disease management services, supplemented with coverage for prescription drugs, to specific Medicare beneficiaries with diagnosed, advanced-stage congestive heart failure, diabetes, or coronary heart disease. The project anticipates savings from more efficient provision and utilization of Medicare-covered services and the prevention of avoidable, costly medical complications. The Secretary charged the Centers for Medicare and Medicaid Services with this task.

Key Project Characteristics

The demonstration project may include up to three organizations, cover up to 30,000 individuals, and last for three years. This demonstration uses disease management interventions to (1) improve the quality of services furnished to specific beneficiaries, (2) introduce full prescription drug coverage to encourage compliance with medical instructions and requirements, and (3) manage expenditures under Parts A and B of the Medicare program. CMS is interested in testing models that are aimed at beneficiaries who have one or more chronic conditions that are related to high costs to the Medicare program, namely congestive heart failure, diabetes, or coronary heart disease.[6]

Specific demonstration projects must incorporate the following disease management features:

- Patient identification, assessment, and enrollment.
- Patient instruction and empowerment regarding self-care.
- Implementation of an appropriate treatment plan based on clinical guidelines.
- Monitoring, feedback, and communication concerning the patient's condition.
- Arranging for and/or providing needed services, including prescription drugs and preventive services.

Each proposal must explain how it will identify eligible Medicare beneficiaries and describe its disease management intervention services, showing that the project is able to serve chronically ill Medicare populations as defined by their targeting protocols. The proposals must also demonstrate that they have the infrastructure to carry out the demonstration. Preference is given to proposals in which the intervention protocols are not proprietary in nature.

The projects must be able to explain how their program will be effective in improving health status, propose an overall payment methodology and project budget that are appropriate for their proposed disease management delivery model

[6]This demonstration project differs significantly from its predecessors in that the legislation stipulates that the demonstration must cover all prescription drugs, even those drugs not related to the beneficiary's targeted condition.

and the reducing aggregate Medicare program expenditures, and demonstrate that total payment under the demonstration will be less than what Medicare payment for the demonstration's enrollees would have been absent the demonstration. (Primary interest is in testing the effectiveness of an all-inclusive rate payment.) The projects must establish a system to compensate Medicare in the event actual payments for Medicare services (including all disease management payment costs and prescription drugs) exceed the estimate of what Medicare would have paid absent the demonstration.

Pennsylvania's Initiative and Application for the Demonstration Project[7]

PACE data and Medicare Parts A & B have been linked through compatible systems since 1997. As a result, it is possible to estimate how much money Pennsylvania saves Medicare through its PACE/PACENET program. For example, the savings in 1997 to Medicare were calculated to be $73 million. PACE/PACENET officials believe that the Commonwealth could demonstrate savings to Medicare of $100-$150 million per year for up to five years (the 3 year demonstration period plus a 2 year extension) through use of PACE/PACENET. Pennsylvania would then get this amount in a grant from CMS to put back into the PACE/PACENET program. The additional money would allow PACE/PACENET to expand eligibility, which, in turn, could save Medicare even more.

Pennsylvania is actively pursuing the project and met with CMS staff in November 2002 and again in February 2003. The Governor has met with HHS Secretary Thompson to discuss the project. According to PACE/PACENET officials, as of the end of April 2003, CMS researchers and actuaries had reviewed approximately half of the 2,500 pages of information Pennsylvania has provided. When this review is complete, Commonwealth representatives will meet with the CMS research staff to answer questions and to reach agreement on the goals of the project and how savings to Medicare will be documented and measured. According to PACE/PACENET officials, staff at CMS have indicated that it could take six months to three years to get the project up and running. We were told that the demonstration project, if approved, could conceivably be operational by July 2004.

C. 2003 Legislative and Administration Proposals and Initiatives

Several bills are currently under consideration in the 2003-2004 legislative session of Pennsylvania's General Assembly that would affect eligibility requirements and other areas of the PACE and PACENET programs if enacted. Additionally, in late May 2003, the Governor set forth a proposed approach to expand PACE/PACENET eligibility and implement cost sharing measures. Below is a

[7]On February 6, 2003, House Resolution 46 was introduced calling on the Department of Aging to file an application with CMS to secure the Medicare Demonstration Project and to use the moneys provided through Medicare savings to enhance and expand pharmaceutical coverage for low-income seniors without jeopardizing the viability of the PACE and PACENET programs.

summary of selected legislative proposals as well as the Administration's proposed approach.[8]

1. House Bill 909

Representative Eachus introduced House Bill 909 on March 18, 2003. The bill was referred to the House Aging and Older Adult Services Committee. The bill proposes to amend the State Lottery Law in the following ways:

- Changes the definition of "maximum annual income" from $14,000 for singles to $15,000, and from $17,200 for married persons to $18,200.
- Adds a provision to the drug utilization review system to direct the Department to develop a therapeutic interchange program based on national medical standards that establish therapeutically equivalent drugs that produce identical levels of clinical effectiveness and outcomes.
- Increases the dispensing fee of at least $3.50 to $4.00.
- Directs the Department to reimburse, in the case of brand name products for which there is no generic, for the least expensive brand name generic therapeutically equivalent drug based on the most current listing of federal upper payment limits established under the Medicaid program, plus a dispensing fee.
- Changes income eligibility under PACE/PACENET to the following:

    - In the first year following the effective date of the act, for a single $15,000 to $19,500, and for married persons not more than $26,300.
    - In the second year after the effective date, for a single $15,000 to $19,900, and for married persons $18,200 to $26,900.
    - In the third year after the effective date, for a single $15,000 to $20,400 and for married persons $18,200 to $27,500.
    - In the fourth year after the effective date, for a single $15,000 to $20,800, and for married persons $18,200 to $28,100.
    - In the fifth year after the effective date and each year thereafter for a single $15,000 to $21,300, and for married persons $18,200 to $28,700.
    - The Governor may, based on Lottery Fund revenue and after consulting with the Board, increase the eligibility limits above those previously stated.

- Changes the deductible to a quarterly $100 deductible.
- Adds a section relating to "best price" to determine the cost of covered prescription drugs so that it matches the limits established under the Medicaid program as provided in federal regulations.
- Amends provisions relating to rebate agreements in that manufacturers with a rebate agreement must report quarterly the average manufacturer price; for single-source drugs and innovator multiple-source drugs, the manufacturer's best price for covered prescription drugs for the quarter and the best price in effect on January 1, 2003; and for new drugs, the best price in effect during the first month of marketing the new drug.
- Amends provisions relating to the amount of the rebate in that beginning with the April 2003 quarter and thereafter, the rebate is to be the greater of either the

[8]Please see Appendix H for additional selected pending legislation in the 2003-04 session.

difference between the average manufacturer price and 85 percent of that price after deducting customary prompt payment discounts for the quarter or the difference between the average manufacturer price for a drug and the best price. Beginning with the quarter after April 1, 2003, and ending before January 1, 2004, the latter rebate may not exceed 25 percent of the average manufacturer price. For quarters after December 31, 2003, and ending before January 1, 2005, the rebate may not exceed 50 percent of the average manufacturer price.

- Requires the Department to explore, review and pursue, whenever possible, any and all funding sources that may be available from the federal government. If federal monies become available to operate pharmaceutical assistance program for the elderly, these funds must be used before other funding sources.

As of late May 2003, the bill remained in the House Aging and Older Adult Services Committee.

2. House Bill 888[9]

House Bill 888, introduced by Representative Vance, removes the PACE and PACENET programs from the State Lottery Act and reestablishes them in a separate Pharmaceutical Reform Act. This bill was introduced on March 13, 2003. The bill establishes in statute a system of copayments for the PACE/PACENET Program, including a procedure for having the upper limit for payments for multiple-source drugs for which a specific limit has been established to be inapplicable upon physician certification that a specific brand is medically necessary for a patient. Under this bill, the Department of Aging would be encouraged to use a mail service program for maintenance drugs for eligible claimants. The claimants would have the option, however, to opt out of the mail order program.

The bill proposes to expand eligibility for the PACE/PACENET program to $17,000 to $20,000 for a single person and to $20,001 to $23,200 for married persons. Along with the income eligibility limit change, the bill removes the current $500 required deductible and inserts a $50 deductible per month payment per enrollee. House Bill 888 also establishes an accountability mechanism for both the PACE and PACENET programs. An annual independent audit would be required with an annual report from the auditor to appropriate House and Senate committees.

House Bill 888 also proposes to establish a Pharmacy Best Practices and Cost Control program designed to reduce the cost of providing prescription drugs, while maintaining high quality in prescription drug therapies. This program would include a preferred list of covered prescription drugs which identifies preferred choices within selected therapeutic classes for particular diseases and conditions, including generic alternatives; utilization review procedures; a supplemental rebate program or any other strategy designed to negotiate with pharmaceutical

[9]As of the week of mid-June 2003, HB 888 was expected to undergo amendment and serve as the vehicle for the bipartisan proposal set forth as number 5 on page 68.

manufacturers to lower the cost of prescription drugs for the department's Medicaid program; and an education program designed to provide information and education on the therapeutic and cost-effective utilization of prescription drugs to physicians, pharmacists and other health care professionals authorized to prescribe and dispense prescription drugs.

House Bill 888 also would create a Pharmaceutical Assistance Clearinghouse to help patients dealing with patient assistance programs.

As of late May 2003, the bill remained in the House Health and Human Services Committee.

3. Senate Bill 7

Senate Bill 7 was introduced by Senator Orie on May 5, 2003, with bipartisan supporting sponsorship. This proposal modifies the PACE reimbursement formula for generic drugs, requiring the Department to adopt federal upper limits, while keeping the AWP-10% for brand drugs. PACENET income eligibility limits would be raised to $17,000 for singles and $23,200 for married persons and would require a $480 deductible that may be met through $40 per month of expenditures. After December 31, 2003, this bill would require a "best price" rebate to be calculated based on the difference between average manufacturer's price and best price, as defined in the federal Medicaid Act. The bill would also revise the formula for calculating the price inflation discount to be provided to the Department.

Senate Bill 7 was referred to the Aging and Youth Committee on May 5 and received first consideration before the General Assembly on May 13, 2003.

4. Senate Bill 720

Senator Mellow introduced Senate Bill 720 on May 9, 2003. This bill seeks several changes to the PACE/PACENET program:

- Changes the definition of maximum annual income under the PACE program to be 170 percent of the federal poverty level and for the PACENET program to not less than 170 percent nor more than 250 percent of federal poverty level.
- Caps the reimbursement amount for generic drugs at federal upper limits.
- Modifies PACE's current mail order system requirements by requiring enrolled mail order providers to include a consumer incentive option for voluntary mail order.
- The PACENET deductible would be changed to $40 per person per month.
- A "best price" rebate would be calculated based on the difference between the average manufacturer's price and the best price as defined under the federal Medicaid Act.
- The bill would also revise the formula for calculating the price inflation discount to be provided to the Department.

Senate Bill 720 was referred to the Aging and Youth Committee on May 5 and received first consideration before the General Assembly on May 13, 2003.

5. Governor's Initiative for Expansion and Cost Containment of the PACE/PACENET Program

On May 29, 2003, the Governor presented a bipartisan plan for expanding enrollment in the PACE/PACENET program by 100,000 older Pennsylvanians, as well as for putting into operation certain cost control measures. All four caucuses in the General Assembly endorsed the plan. Key features of the bipartisan proposal are as follows:[10]

- Increase the maximum annual income limits for PACE from $14,000 to $14,500 for individuals and from $17,200 to $17,700 for couples.
- Increase the maximum annual income limits for PACENET from $17,000 to $22,500 for individuals and from $20,200 to $30,500 for couples.
- Give the Governor administrative authority to adjust the maximum annual income limits based on certified Lottery Fund revenues, without further change in the law.
- Change the PACENET deductible to $40 per person per month, which shall be cumulative and applicable to subsequent months, not to exceed $480 annually.
- Exempt the first $10,000 of total death benefits payments from the definition of "income."
- Increase the PACE co-payment from $6.00 to $8.00 per prescription.
- Limit the amount that the Commonwealth would reimburse pharmacies for each class of medications to the amount that Medicaid pays for that class, based on the most current listing of federal upper payment limits, plus a dispensing fee of $4.00.
- Adopt a "Medicaid best price" rebate requirement for manufacturers, determined by the lowest price offered by manufacturers to their best customers, as defined under the federal Medicaid Act. Allow for the differentiation of rebates for generic and brand drugs, based on the Medicaid rebate percentage requirements.
- Adopt a therapeutic interchange policy to allow the substitution of less expensive, therapeutically equivalent medications where available, based upon appropriate clinical guidelines.
- Adopt a voluntary mail order purchasing policy to allow the purchase of a 90-day supply of maintenance medications by mail at a co-pay rate equal to a 60-day supply. Retail pharmacists would also receive a $6.00 dispensing fee for filling mail order prescription orders.

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[10]SOURCE: The key features of the bipartisan plan presented here are as of late May 2003 as provided by the Department of Aging. Please note that, as of mid-June 2003, negotiations and revisions to the plan were underway.

D. The "HOPE" Plan (Heinz Plan to Overcome Prescription Drug Expenses) for Pennsylvania

The Heinz Family Philanthropies presented a prescription drug plan for Pennsylvania in a report released in May 2001. The HOPE plan outlines a prescription drug program for all seniors – age 65 and older – in Pennsylvania, regardless of income. Dual-eligible seniors (i.e., those below the income and resource limits of Medicaid) would not be eligible for HOPE, but would have to access prescription drug coverage through Medicaid. Veterans and their spouses would be encouraged to take advantage of the Veterans' Administration's drug benefit. The report recommended that the Commonwealth introduce the HOPE plan incrementally. It was suggested that the program use the administration and enrollment processes that have been refined over the years by the PACE/PACENET program. Exhibit 6 provides a side-by-side comparison of the principle features of PACE/PACENET and the HOPE plan.

Eligibility

Under the HOPE plan, all PACE/PACENET enrollees as of December 31, 2002, would remain in the program with an increase in copay to $10 and all other requirements maintained. After this date, all eligible PACE/PACENET participants would be enrolled in the HOPE plan. The same would hold true for PACE/PACENET enrollees. Beginning January 1, 2003, all persons 65 and older, including all individuals that would have been eligible for PACE and PACENET in 2003, would be eligible for the HOPE plan. PACE/PACENET participants would continue to receive PACE/PACENET benefits as long as they qualify under the income requirements.

Cost Sharing

The HOPE plan for Pennsylvania has both a front-end deductible and a monthly contribution tied to income. The plan is means-tested to ensure that, as a person's income rises, so does his or her personal financial responsibility. Each person in a married couple will pay a separate premium and deductible. For example, in the first year of the plan, a senior with an income under $14,000 would have neither a deductible nor a monthly contribution; for a senior with an income greater than $14,000 but less than $17,200, there would be no annual deductible, but a monthly contribution of $35 ($420 annually) would be required; a senior with an income of $17,200 - $19,999 would have a monthly contribution of $87 ($1,044 annually) and a $150 annual deductible; and a senior with an income of more than $30,000 would face a $500 deductible as well as a $121 monthly premium ($1,464 annually).

Exhibit 6

Summary Comparison of PACE/PACENET and the HOPE Plan for Pennsylvania

	PACE/PACENET	The HOPE Plan
Eligibility: PA Resident for at least 90 days	Age 65 or older & income limits PACE: • Individual <$14,000 • Married couple <$17,200 PACENET: • Individual $14,000-$16,000 • Married couple $17,200-$19,200	Age 65 or older • No income limits – income determines level of cost sharing
Funding:	State lottery	State lottery and enrollee contributions
Drug Formulary:	Drug formulary based on pharmaceutical manufacturer rebate agreement	Incentive drug formulary with legislated pharmaceutical manufacturer rebates
Deductible:	PACE: None PACENET: $500 annually	Income-based, between $150 and $500 annually
Contribution:	None	$0 – $121 monthly
Copayments:	PACE: • $6 all drugs • mandatory generic PACENET: • $8 generic / $15 brand name • mandatory generic	Retail Network: • $10 generic • $25 preferred drug • the greater of $50 or 50% for non-preferred • mandatory generic • annually indexed to drug trend Mail order: • Twice the retail network copay
Annual out-of-pocket limits:	None	Income-based limits of $1,000, $2,000, $3,000, & $4,000

Source: The Heinz Plan to Overcome Prescription Drug Expenses (HOPE), May 2001.

The plan would have a catastrophic cap that is tied to income, with a goal of ensuring that seniors do not spend themselves into poverty. Because seniors would spend a proportionate share of their disposable income, seniors with lower incomes will have a smaller out-of-pocket limit to meet.

Incentive Formulary

The HOPE plan uses an incentive formulary. The formulary, customized for a senior population, would be developed by a Pharmacy and Therapeutics Committee with participation from the Commonwealth. Individuals would have a copayment of $10 for generic drugs, $25 for preferred drugs (non-generic drugs on the formulary list), and the greater of $50 or 50 percent of the retail price for non-preferred drugs (drugs not on the formulary list). If an individual or physician elects a brand name drug when an approved generic drug is available, the individual would pay the price difference as well as the generic copay. In subsequent years, deductibles, copays, and out-of-pocket limits would be tied to the actual drug trend experienced under the program. The costs of non-preferred drugs or the brand/generic differentials would not apply to the out-of-pocket limit. The report also recommended that the PACE/PACENET copay, like the HOPE copay, increase annually according to actual drug trends.

Retail Pharmacy Network and Mail Order

The HOPE plan is modeled using a performance-based network of pharmacies that are contracted at a lower reimbursement rate than the current PACE/PACENET reimbursement. There is no prescription drug benefit from the plan if the drug is obtained from a non-network pharmacy. The plan makes provision for maintenance and life-sustaining drugs to be purchased through a mail order program using an exclusive provider. Individuals would be able to obtain the lesser of a 90-day supply or 300 units – three times the supply available through the retail pharmacy network – for twice the copay.

Financial Projections

The HOPE plan report contains financial projections based upon several assumptions: the grandfathering of the enrollees of the current PACE/PACENET program, but increasing the copay to $10 in 2003; implementing the HOPE plan for PACE/PACENET enrollees and all other eligible seniors in Pennsylvania; an anticipated 18 percent annual cost increase to the PACE/PACENET program; and a decline in PACE/PACENET enrollments of 3.6 percent in 2004 and 3.4 percent in 2005.

At the end of 2000, the PACE/PACENET program cost approximately $295.3 million. The report estimates that by 2003, PACE/PACENET costs will be $429.1 million and $557.2 million by 2005. Costs for the recommended HOPE plan for

2003 are projected to be $435.7 million, or $6.6 million more than for the existing PACE/PACENET programs, but it is estimated that the HOPE plan would cover an additional 200,000 seniors. As a result, the HOPE plan cost per enrollee is about half that of the PACE/PACENET cost per enrollee.

The HOPE plan recommended that the General Assembly continue to use the legislated PACE/PACENET Pharmaceutical Manufacturer Rebate Agreement, but modify the legislation to allow pharmacy management strategies such as formulary, step therapy, prior authorization, and aggressive utilization programs. Also, legislation would be needed to allow the flexibility to establish more aggressive reimbursement formulas through discounts of the average wholesale price, reduced dispensing fees, and maximum allowable cost (MAC), pricing in addition to using an exclusive mail order provider.

The Legislature was asked to explore the fiscal impact of providing a tax credit to all employers that offer to fund, in whole or in part, retiree prescription drug programs through the HOPE plan. The plan also recommended a graduated tax credit for all seniors paying contributions and that the Commonwealth use a Prescription Benefits Manager (PBM) to negotiate the best prices for discounted networks to enhance prescription drug management.

The plan also recommends a Governor's Prescription Drug Review Commission be created consisting of 16 members including the Senate President pro tempore, the Speaker of the House, and the Governor who would serve as co-chairs. The overall purpose of the Commission would be to provide proactive operational and financial oversight in an effort to determine how well the program is operating and whether changes may be necessary. The report suggested that the plan undergo sunset review after four years.

Reactions and Response

Officials with AARP Pennsylvania told us they had not done a formal analysis of the Pennsylvania HOPE plan, but had looked closely at a similar HOPE plan that had been developed for Massachusetts. This examination had raised serious concerns in their minds about the level of deductibles and the copay percentages that were recommended by the plan.

PACE/PACENET officials questioned whether the HOPE plan could, in fact, provide prescription drug coverage to all Pennsylvania seniors and suggested that passage of all the necessary legislative changes would be difficult to achieve.

E. Participation in Federal "Pharmacy Plus" Medicaid Waiver

In January 2002, the Department of Health and Human Services announced that a new type of Medicaid 1115 demonstration project, Pharmacy Plus, had been approved for Illinois and would be available to other states.[11] See Appendix I for approved and pending states' data. States apply to the Centers for Medicare and Medicaid Services (CMS) for the project and to waive certain regulations. Under the waiver, states will be able to use Medicaid (MA) funds to expand coverage for prescription drugs to seniors and disabled individuals with incomes up to 200 percent of federal poverty level, which is currently $8,980 for individuals and $12,120 for couples. The concept behind the waiver is that if more receive needed prescription drugs, in the long run it will generate Medicaid savings due to reduced home health services and nursing home costs.

Those states with their own subsidy program for income-eligible seniors, such as PACE/PACENET, may be able to obtain federal matching funds for many of those who are currently enrolled. Adopting the waiver program, with its higher income eligibility, could make an additional 55,000 people eligible for PACE/PACENET.

Financial Feasibility of the Commonwealth's Participation in the Pharmacy Plus Medicaid Waiver

Under the 1115 Pharmacy Plus waiver, the Commonwealth and the federal government share the cost (approximately 50 percent-50 percent) of the current PACE/PACENET program, thus reducing the Lottery Fund burden. It requires Pennsylvania to accept a five-year cap on the amount of federal funds it will draw down for all Medicaid expenses for the elderly and disabled including nursing facility, pharmacy, and health care benefit services. "Budget neutrality"[12] is to be achieved by changes to the PACE/PACENET program and through savings generated by reduced use of other MA services, such as nursing facilities and home care services. Departments of Public Welfare (DPW) and Aging officials indicate that Pennsylvania would need to build in a reserve in the event that costs are greater than estimated and make it clear that the Commonwealth can withdraw from the waiver or change the nature of their program if the need arises. Since PACE/PACENET enrollees use four times as many drugs as the non-PACE/

[11]The Illinois demonstration project covers the full cost of prescriptions up to a total of $1,750, and pays for 80 percent of prescription drug costs over that amount. It charges a minimum $5 annual enrollment fee, or a $25 annual enrollment fee for those with income greater than the poverty level. According to CMS, the federal government has approved the waiver for Illinois, Florida, Maryland, Wisconsin, and South Carolina. Seven applications are pending: Arkansas, Connecticut, Indiana, Maine, Massachusetts, New Jersey, and Rhode Island.
[12]Budget neutrality requires that the demonstration program use no more federal dollars than would have been spent without the waiver over the five-year duration of the waiver. The Commonwealth must maintain (or increase) the level of state funding for the demonstration program as would have been provided without the demonstration program.

PACENET population, it is important for the state to make sure that cost estimates are as accurate as possible.

In April 2002, a Senate resolution requiring Pennsylvania to apply for the waiver within 30 days failed. The Governor then directed the Departments of Public Welfare and Aging to determine whether the Commonwealth should participate in the Pharmacy Plus waiver project. DPW commissioned an actuarial study to look into the viability of budget neutrality and whether the waiver would benefit Pennsylvania to a greater degree than what is currently possible under PACE/PACENET.[13] The report was completed in October 2002.

The report lists three increasingly stringent cost sharing options and five increasingly stringent benefit management scenarios for the PACE/PACENET program as shown below.

Cost Share	Dual Copayment	Coinsurance	3-Tier Copayment
PACE:	$5 generic/$12 brand	20 percent generic and brand with $50 maximum/Rx	$8 generic/$15 preferred brand/$35 non-preferred brand
PACENET:	$500 deductible $8 generic/$15 brand	$500 deductible 20 percent generic and brand with $50 maximum/Rx	$500 deductible with copayments as above

Benefit management scenarios for PACE/PACENET:

Scenario 1: Federal rebate; provider reimbursement; mail service.
Scenario 2: Federal rebate; provider reimbursement; mail service; enhanced utilization review.
Scenario 3: Federal rebate; provider reimbursement; mail service; enhanced utilization review; preferred drug list/no plan design changes.
Scenario 4: Federal rebate; provider reimbursement; mail service; enhanced utilization review; preferred drug list/with plan design changes.
Scenario 5: Federal rebate; provider reimbursement; mail service; enhanced utilization review; closed formulary.

By using these strategies or the option to remain with the current program, the actuary estimated the savings needed for budget neutrality under the different strategies that Pennsylvania must demonstrate over the five-year period. Stated below are the report conclusions:

[13]Mercer Government Human Services Consulting.

Elderly only in the PACE/PACENET program over five-year waiver period

Savings or budget neutrality can occur with a tiered copay of $8 generic/$15 preferred brand/$35 non-preferred brand for PACE and PACENET, while keeping the current $500 deductible for PACENET. In addition, it will require the use of the federal rebate, lower provider reimbursement, mail service, enhanced utilization review, use of preferred drug lists and plan design changes (scenario 4). Such requirements are estimated to produce cost savings of $228.4 million over the five-year demonstration period. Additional savings would also result from replacing the preferred drug list and plan design changes with a closed formulary (scenario 5). With this measure, total savings would equal $264.9 million. Maintaining the current design without these adjustments and simply introducing a tiered copay would result in excess costs of $291.8 million over the five-year period.

Elderly plus the disabled in the PACE/PACENET program over five-year waiver period

By including the disabled in the PACE/PACENET program, budget neutrality can occur under all options (current design, dual copay, 20 percent coinsurance, tiered copay) at scenario 4 and 5 levels as described above. The savings range from $1.9 million (current design, scenario 4) to $630.7 million (tiered copay, scenario 5) over the five-year demonstration period. Budget neutrality can also occur under dual copay or 20 percent co-insurance under scenarios 2 and 3. Maintaining the current design would result in excess cost of $623.6 million over the five-year period.

The report concluded that budget neutrality will be difficult because the Commonwealth currently has a generous pharmacy program which has already generated Medicaid savings, so achieving additional savings is difficult. And if MA costs rise sharply beyond those projected in the waiver, it could place the General Fund at significant risk.

Additionally, the waiver would require amending both the PACE/PACENET and Lottery statutes to ensure the Commonwealth has an adequate infrastructure to meet Medicaid program requirements, including: (1) quality assurance monitoring and reporting, including monthly, quarterly, annual and final reports; (2) an actuarially designed budget neutrality framework; (3) fiscal monitoring to insure budget neutrality with rigorous reporting schedule; and (4) an evaluation design and report.

In October 2002, DPW officials and the Department of Aging provided an update on Pennsylvania's effort to secure federal waivers under the Pharmacy Plus program to a joint hearing of the Senate Public Health and Welfare and the Aging and Youth Committees and the House Health and Human Services Committee. Legislators urged the administration to continue reviewing the program. They

indicated that they will continue to work with the Department in considering other opportunities for easing drug costs for seniors, including working with New York and New Jersey, which have programs similar to PACE/PACENET, to develop strategies for encouraging the federal government to modify Pharmacy Plus participation rules.

As of March 2003, Pennsylvania was not actively pursuing the federal Pharmacy Plus program, according to Department of Public Welfare officials.

VII. Appendices

APPENDIX A

Glossary of Selected Terms

Actual Acquisition Cost (AAC): The net cost at which the pharmacy acquires a drug. It varies with the size of container purchased (e.g., 10 bottles of 100 tablets typically cost more than one bottle of 1,000 tablets) and the source of purchase (manufacturer or wholesaler).

Average Manufacturer Price (AMP): The price at which the manufacturer sells drugs to purchasers. For sales to wholesalers, AMP represents the Wholesaler Acquisition Cost (WAC) after all discounts; for sales directly to pharmacies, AMP represents the net "direct" price after discounts.

Average Wholesale Price (AWP): A national average of list prices charged by wholesalers to pharmacies. With few exceptions, the AWP is the manufacturer's suggested list price for a wholesaler to charge a pharmacy for a drug. It typically is higher than the pharmacy's actual acquisition cost (in 1997, the Office of Inspector General, Department of Health and Human Services, reported that pharmacies paid 18.3 percent less than AWP for brand name drugs and 42.5 percent less than AWP for generic drugs).

Best Price: For purposes of Medicaid rebate calculations, the lowest price paid for a medication by any purchaser other than federal agencies (such as the VA) and state pharmacy assistance programs.

Brand Name Drug: Generally, a drug product that is covered by a patent and thus is manufactured and sold exclusively by one firm. Cross licensing occasionally occurs, allowing an additional firm(s) to market the drug. After the patent expires, multiple firms can produce the drug product, but the brand name remains with the original manufacturer's product.

Chain Pharmacy: A corporate organization with multiple pharmacy store outlets under common ownership. Traditional chain pharmacies (such as Walgreens, Eckerd, Rite Aid, CVS) have approximately 50 percent of their sales as prescriptions and the remaining mix of sales in other merchandise. Mass merchandiser chain pharmacies (such as Wal-Mart, KMart, ShopKo) and food store chain pharmacies (such as Kroger, Albertsons) have a small proportion (5–10 percent) of their total sales for prescriptions.

Coinsurance: A cost-sharing requirement under a health insurance policy that requires the patient to pay a percentage of costs for covered services/prescriptions (e.g., 20 percent of the prescription price).

Cost of Sales: Within manufacturing industries, the cost of raw materials and production costs for manufacturing finished goods for sale. Cost of sales typically does not include the manufacturer's expenses involved in selling, distribution, research, or general administration. A parallel within wholesaling or retailing industries would be the cost of goods sold.

Direct Pay Insured Prescription: A prescription covered under a service benefit drug coverage insurance plan (i.e., a private or public insured prescription program). Service benefit plans provide direct payment to the pharmacy for the prescription; consumers are required to pay only a copayment or coinsurance when obtaining each prescription.

Dispensing Fee: An amount added to the prescription ingredient cost by a pharmacy to determine a prescription price. The dispensing fee represents the charge for the professional services provided by the pharmacist when dispensing a prescription (including overhead expenses and profit). Most direct pay insured prescription programs use dispensing fees to establish pharmacy payment for prescriptions.

Drug Wholesaler: A firm involved in the logistics function (assembling, sorting, and redistributing) in the channel of distribution for pharmaceuticals. They purchase goods from manufacturers and redistribute them to pharmacies based on the needs and orders of the pharmacies.

Estimated Acquisition Cost (EAC): An estimate of the price, generally, and currently, paid by providers for a medication marketed or sold by a particular manufacturer or labeler in a package size most frequently purchased by providers.

Federal Upper Limits (FUL): Listing of multiple source medications (generic medications) meeting the criteria set forth in 42 CFR 447.332 and §1927(e) of the Social Security Act, as amended by OBRA 1993, limiting pharmacy reimbursement to an amount based on the price per unit which the Centers for Medicaid and Medicare Services has determined to be 150 percent of the lowest price listed (in package sizes of 100 units, unless otherwise noted) in any of the published compendia of cost information of medications.

Appendix A (Continued)

Formulary: A listing of drug products that may be dispensed or reimbursed (positive formulary) or that may not be dispensed or reimbursed (negative formulary). A government body, third-party insurer or health plan, or an institution may compile a formulary. Some institutions or health plans develop closed (i.e., restricted) formularies where only those drug products listed can be dispensed in that institution or reimbursed by the health plan. Other formularies may have no restrictions (open formulary) or may have certain restrictions such as higher patient cost-sharing requirements for off-formulary drugs.

Generic Drug: A drug product that is no longer covered by patent protection and thus may be produced and/or distributed by many firms.

Indemnity Prescription Coverage: An insurance plan where the insured pays for the covered prescription and then is reimbursed or indemnified by the plan. Often these plans first require the insured to pay a deductible and then the insurer covers a percent (e.g., 80 percent) of the cost of prescriptions used by the insured. The insured pays the full retail price ("usual and customary" charge) when obtaining the prescription. Only a small proportion of consumers (5–10 percent) has this kind of insurance for prescriptions; most insured consumers have service benefit coverage for prescriptions.

Independent Pharmacy: An independent entrepreneur or small chain (less than 10 units under one ownership) pharmacy, often viewed as the traditional "corner drug store." These pharmacies range from prescription-dominated clinic and apothecary pharmacies to pharmacies with the traditional mix of prescriptions, over-the-counter drugs, sundries, and general merchandise. For most independent pharmacies, prescriptions are the dominant share of total store sales (typically, 70 percent to 80 percent of sales or more).

Ingredient Cost: The cost of the drug product that is dispensed in a prescription. This can refer to the actual acquisition cost (AAC) or cost of goods sold for a pharmacy, or to the amount that an insurer would use in determining payment to a pharmacy for the drug dispensed in a covered prescription.

Generic Pharmaceutical Manufacturer: A firm that produces and markets generic prescription and/or nonprescription drug products. Some generic firms both manufacture and distribute drug products while others only repackage or distribute products manufactured for them by contract manufacturing firms (sometimes even a major pharmaceutical firm). Although all drug products must have FDA approval for sale, independent clinical trials are not required for generic drugs; the innovator's evidence of safety and effectiveness are accepted. Generic firms must show that their products are bioequivalent, often through laboratory studies and assurances. Since generic firms often produce identical drugs, they generally compete on price to establish or gain market share.

Mail Order Pharmacy: A pharmacy that dispenses prescriptions to consumers who contact the pharmacy by mailing or faxing their prescription orders and then the prescription is mailed to the consumer. This can be an advantage for homebound patients or other patients without ready access to traditional community pharmacies. Unlike traditional pharmacies, the pharmacies can serve more than the local market where the pharmacy is located. Additionally, mail-order distributors can purchase drugs in larger volumes than retail entities and thus can offer significantly reduced costs for medications. Since there typically is at least a short delay between ordering and receiving prescriptions, these pharmacies generally serve patients on long-term drug therapies and those without immediate drug needs. The average size of prescriptions (number of capsules or tablets) dispensed in mail order pharmacies is larger than in local community pharmacies. Consequently, although mail order pharmacies represent less than 5 percent of all prescriptions dispensed, they comprise approximately 13 percent of total retail prescription sales.

Major Pharmaceutical Manufacturer: Manufacturers that identify and develop new prescription and/or non-prescription drugs through their research efforts. Typically these firms are large manufacturing companies. Sometimes they are referred to as "innovator" pharmaceutical firms, "brand name" pharmaceutical manufacturers, "research-based" pharmaceutical manufacturers, or generally as the "pharmaceutical industry." These firms invest in new product research and development and support their products with extensive promotional efforts. Their trade associations include Pharmaceutical Research and Manufacturers of America (PhRMA), the National Pharmaceutical Council (NPC), and the Consumer Health-Care Products Association (CHPA; formerly the NonPrescription Drug Manufacturers' Association, NDMA). Some major pharmaceutical manufacturers also have generic manufacturing divisions or generic pharmaceutical manufacturer subsidiaries.

Appendix A (Continued)

Maximum Allowable Cost (MAC): A fixed maximum reimbursed for selected medications, usually used in classes where generic products have been approved. Federal Upper Limits (see above) represents a form of MAC pricing policy.

Multi-Source or Multiple Source Drugs: A medication for which there are two or more products rated by the FDA as being not only bioequivalent, but also therapeutically equivalent. Generally, multi-source and generic drugs are synonymous terms.

Over-the-Counter (OTC) Drug: A non-prescription drug.

Patent/Patent Life: A patent provides exclusivity in marketing a product. The patent life is the time during which a patent is in force and the product's manufacturer has exclusive marketing rights. The length of a patent for a drug is 20 years, which is longer than for other products. The effective patent life for a drug may actually be shorter than 20 years depending on the time between discovery and market launch that is needed for safety and efficacy testing, clinical trials, and FDA approval for marketing.

Pharmaceutical Manufacturer: A firm that produces drug products as finished goods for human or animal use. They generally are divided into two broad categories of firms, major pharmaceutical manufacturers and generic pharmaceutical manufacturers.

Pharmacy Benefit Manager (PBM): An organization that provides administrative services in processing and analyzing prescription claims for pharmacy benefit and coverage programs. Their services can include contracting with a network of pharmacies; establishing payment levels for provider pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; and operating disease management programs. Many PBMs also operate mail order pharmacies or have arrangements to include prescription availability through mail order pharmacies.

Preferred Drug: A drug is designated "preferred" if the manufacturer agrees to make the drug available to a private insurer, health plan, or public program at a reduced price compared to other drugs that are considered therapeutic alternates. Health plan enrollees may pay lower cost-sharing amounts for preferred drugs, and pharmacists may be encouraged to dispense the preferred drug through higher reimbursement amounts (dispensing fees).

Preferred Drug List (PDL): A list of preferred drugs.

Prior Authorization: The process of obtaining prior approval from a private or public third-party prescription insurer as to the appropriateness and coverage of a service or medication.

Publicly Insured Prescription: A prescription covered under a federal, state, or local publicly funded health program. Medicaid prescriptions dominate this category. Federal programs include prescriptions covered by the Department of Defense and Veterans Administration health care programs. Medicare has limited drug coverage provisions for outpatient drugs, primarily for drugs that are not self-administered (e.g., home infusion) and for recipients enrolled in managed care programs. Some state and local public welfare programs also exist.

Rebate: An amount that the manufacturer of a drug pays to an insurer or health plan for each unit of drug dispensed. Rebate arrangements exist between manufacturers and Medicaid agencies, HMOs, and other insurers or drug plans, and generally bypass the pharmacy. Rebates are referred to as "after market" arrangements because they do not affect the prices paid at the time of service, but are implemented later, ultimately reducing the payer's expenditures or program costs. The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) requires pharmaceutical firms to give a rebate to the Centers for Medicare and Medicaid Services (CMS) for distribution to the states for all drugs covered under state Medicaid drug programs. Within the private insurance market, rebates often are associated with preferred drugs, and the rebate or level of rebate is contingent upon achieving market share goals.

Appendix A (Continued)

Retail Prescription Price: The price charged by a pharmacy for prescriptions and related services provided. For cash (self-pay), uninsured patrons (and usually for those with indemnity insurance), it also is referred to as the "usual and customary" charge, and is determined by the pricing policies of the pharmacy. For insured patients, it is the third-party payment or reimbursement amount determined by the insurance plan's payment formula and agreed to in the contract with the pharmacy. Third-party payment usually is established as an amount for the prescription ingredient (cost of drug dispensed) plus a professional dispensing fee (to cover dispensing and professional service costs of the pharmacist).

Service Benefit: Insurance coverage where payment for services is made directly to the provider pharmacy via a claims process. The provider payment will be at a level or formula specified in the provider's contract, less any cost-sharing amounts required to be paid by the patient. Most consumers with prescription drug coverage are covered by service benefit plans.

Third-Party Insurer: An entity (a public or private program, health plan, or insurer) that pays or reimburses the patient or pharmacy for all or part of the cost of services provided.

Third-Party Payment: Payment or reimbursement amounts established by third-party drug programs for prescriptions and services dispensed to beneficiaries. Payment formulas typically specify an amount for the prescription ingredients to which is added a dispensing fee (e.g., estimated acquisition cost (EAC) or maximum allowable cost (MAC) plus a dispensing fee) for calculating the total prescription price or payment from the third-party program.

Third-Party Prescription: A prescription covered under a public or private insurance drug program structured as a service benefit (the provider pharmacy submits a claim for services rendered and payment is made directly to the pharmacy, less any applicable copayment or coinsurance paid by the patient).

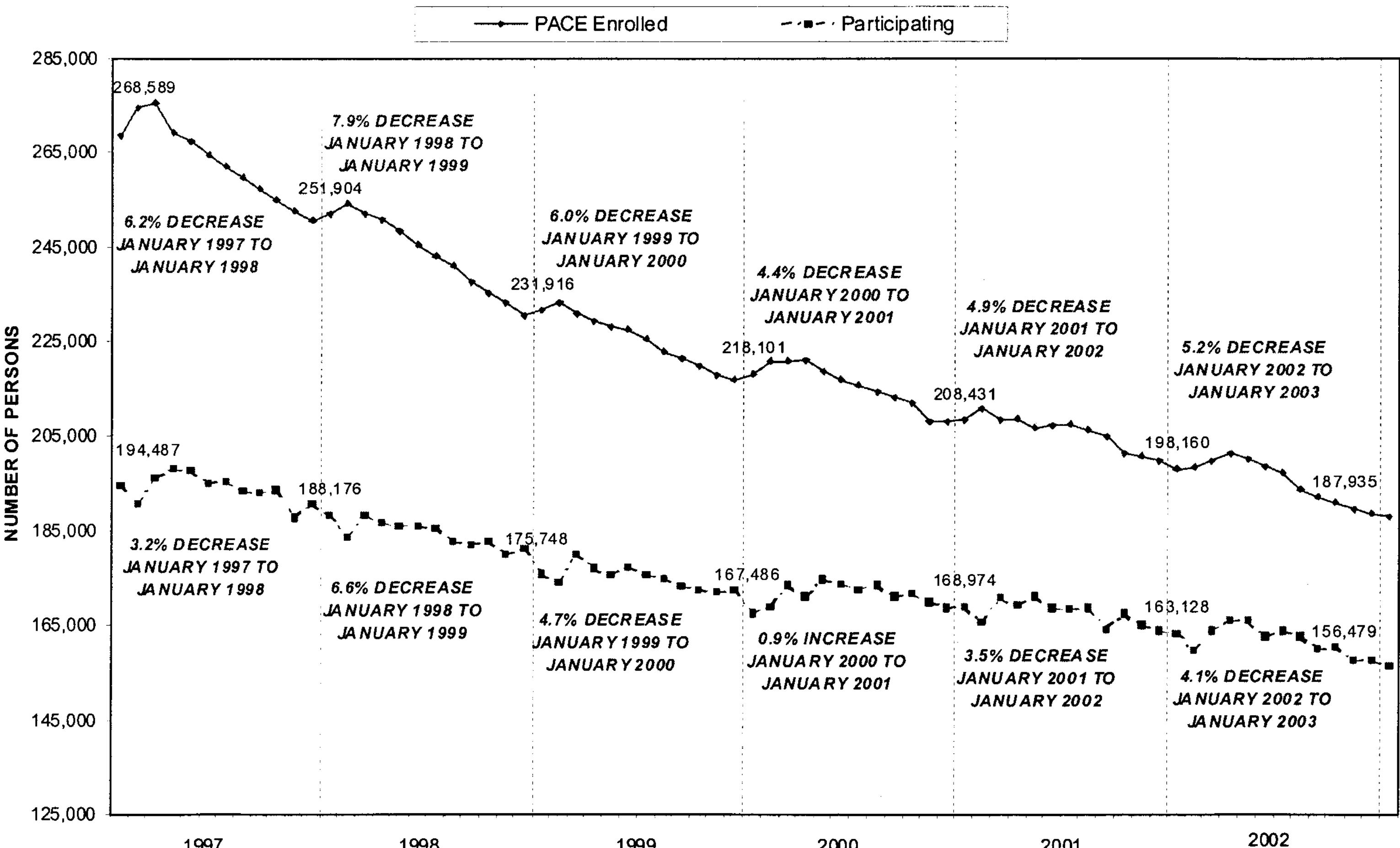
Usual and Customary (U&C) Charge: The amount a pharmacy or other provider charges self-pay (cash) patients. Some insurance programs dictate that a pharmacy's claim may not exceed its "usual and customary" charge for the prescription dispensed.

Wholesale Acquisition Cost (WAC): The price paid by the wholesaler for drugs purchased from the wholesaler's suppliers (manufacturers). On financial statements, the total of these amounts equals the wholesaler's cost of goods sold. Publicly disclosed or listed WAC amounts may not reflect all available discounts.

Sources: The Henry J. Kaiser Family Foundation, *Prescription Drug Trends: A Chartbook Update,* November 2001, and the PACE/PACENET Advisory Committee report, November 2001.

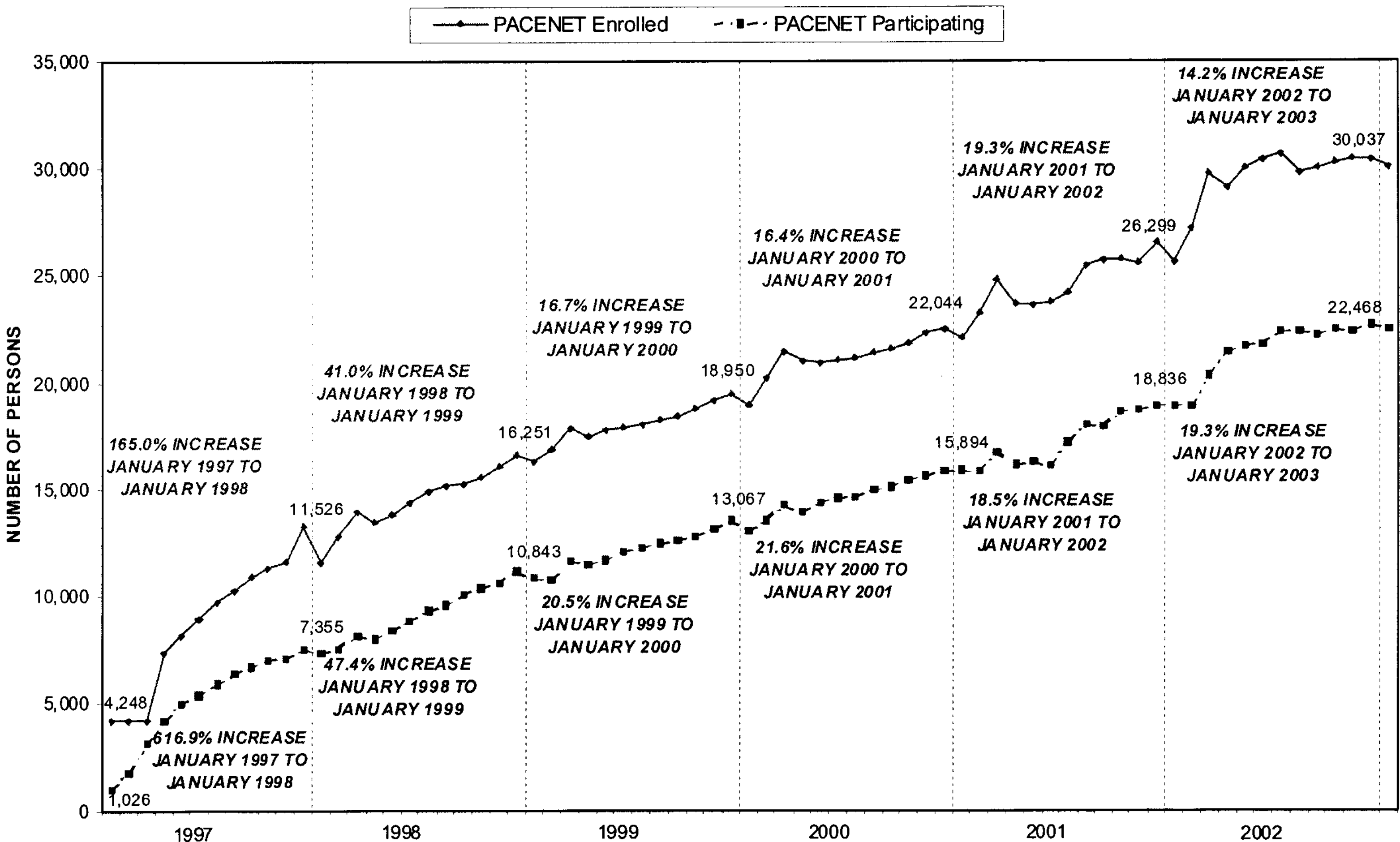
APPENDIX B

FIGURE 2.5A
PACE TOTAL ENROLLED AND PARTICIPATING CARDHOLDERS BY MONTH
JANUARY 1997 - JANUARY 2003



SOURCE: END-OF-MONTH PACE ENROLLED TAKEN FROM MR-0-01A REPORT, PARTICIPATING TAKEN FROM CLAIMS HISTORY BASED ON DATE OF SERVICE.

Appendix B (Continued)



SOURCE: END-OF-MONTH PACE ENROLLED TAKEN FROM MR-0-01A REPORT, PARTICIPATING TAKEN FROM CLAIMS HISTORY BASED ON DATE OF SERVICE.

APPENDIX C

Characteristics of Existing State Pharmaceutical Assistance Programs*

(As of January 1, 2003)

State	Who Qualifies	Income Restrictions and Other Cost Sharing Requirements	Program Description and Significant Cost Containment Strategies
Connecticut	Residents age 65 and older, as well as the disabled, age 18 and over.	Annual income must fall below $20,300/individual, $27,500/couple. Copay of $12 to $15 depending on income. There is a $25 annual enrollment fee.	Special discount card to obtain a 30-day supply of 120 capsules/tablets of most drugs at participating pharmacies. No annual cap on the number of prescriptions. Generics must be substituted for brand-name drugs, unless the physician indicates otherwise. Must reapply annually.
Delaware	Residents age 65 and older, as well as disabled who qualify for SSDI.	Income below 200% of the federal poverty level (FPL) or total prescription costs must exceed 40% of income. Copay of $5 or 25% of the cost of the prescription, whichever is greater.	Annual spending cap of $2,500 per individual. Manufacturer rebates must be consistent with Medicaid rebate amounts.
Florida	Residents age 65 and older.	Annual income must be between 88% and 120% of FPL. Copay of $2 for generics, $5 for drugs on Florida's Medicaid preferred drug list and $15 for other brand names.	Monthly spending cap of $160 per individual. No enrollment fee. Program incorporates a Preferred Drug List (PDL). In the state's Medicaid Program, manufacturers that agree to provide supplemental rebates are guaranteed consideration for inclusion on the PDL. Private company manages the PDL. Providers may not prescribe more than four-brand name drugs without prior authorization.
Illinois	Residents age 65 and older, as well as the disabled age 16 or older.	Income at or below 200% of the FPL. Copay of $1 for generic drugs and $4 for brand name drugs. If brand name drug is requested when a generic is available, copay is $1 plus the difference between the generic and the brand name drug	Full cost of prescriptions paid for up to an annual maximum of $1,750. State pays 80% of cost once maximum is reached. No enrollment fee. Eligible state residents with existing health coverage, which includes pharmaceutical benefits, may choose to receive $25 rebate each month instead of participating in the program.
Indiana	Residents age 65 and older.	Monthly income not to exceed $997 for singles and $1,344 for couples.	Program participants are eligible to receive 50% off the cost of a prescription. $500 to $1,000 tiered annual benefit cap based upon family income. Couple each receives their own individual cap.
Kansas	Residents age 67 and older.	Participants must submit a pharmacy printout of all prescriptions purchased within defined months in order to receive reimbursement.	Annual benefit cap of $1,200 per individual. Reimbursement not to exceed 70% of out-of-pocket prescription drug costs.
Maine	Residents age 62 and older, as well as disabled adults.	Annual income must fall below 185% of FPL for your household size. If participant spends 40% or more of their household income on prescription drugs, the income limits are 25% higher.	The Low Cost Drug Program saves participants up to 80% on each generic prescription. Participants pay 20% or $2, whichever is more. Prior authorization required for some prescriptions before they can be filled. A second program saves 25% off the price of retail drugs and is available to any resident under a prescribed monthly income cap.

Appendix C (Continued)

State	Who Qualifies	Income Restrictions and Other Cost Sharing Requirements	Program Description and Significant Cost Containment Strategies
Maryland	Residents age 65 and older.	Seniors with income at or below 116% of FPL (Group I) and seniors with incomes between 116% and 175% of FPL (Group II).	Members in Group I will receive the full Medicaid pharmacy benefit. Members in Group II will pay 65% of the prescription drug costs, with the program paying the other 35%. All medications for both groups will be discounted.
Massachusetts	Residents age 65 and older, as well as disabled adults with restricted income.	No upper income limit. Premiums, deductibles and copay are set according to a graduated scale. $0 to $82 sliding scale monthly premium. $0 to $500 sliding scale annual deductible. Tiered copay of $5/$12/50% for lower income groups or $10/$25/50% for higher income groups.	No annual cap on the number of prescriptions. Each enrollee has a pre-determined annual out-of-pocket (deductible and copay) spending limit- $2,000/individual, $3,000/couple or 10% gross annual household income, whichever is less. Once these levels are attained the plan will pay all remaining drug costs until the end of the plan year. Enrollees must still pay any monthly premium. Tiered copayments are based upon a preferred and nonpreferred drug formulary.
Michigan	Residents age 65 and older.	Annual income must fall below 200% of FPL. Annual fee of $25. Copay tied to household income. However, no copay for a single drug may exceed 20% of the total cost.	Preferred drug list similar to the state Medicaid program and prior authorization. If a brand name drug is prescribed and dispensed when a generic equivalent is available, a $15 copay, in addition to the monthly out-of-pocket share, will be charged. There are no caps on the number of prescriptions or the total costs of those prescriptions.
Minnesota	Residents age 65 and older, as well as disabled adults.	Income at or below 120% of FPL. Liquid assets of individual/$10,000, couple/$18,000 or less.	Program pays for drugs after the enrollee pays the first $35 each month. Under its Medicaid Program, the state contracts with a Pharmacy Benefit Management company to undertake drug utilization reviews. Mandatory generic substitution unless the prescribing physician indicates the prescription is to be dispensed as written.
Missouri	Residents age 65 and older.	$250 deductible and $25 annual enrollment fee for $12,000/individual, $17,000/couple. $500 deductible and $35 annual enrollment fee for $12,001-$17,000/individual, $17,001-$23,000/ couple. Copay of 40% of the cost of each prescription.	PDL that manufacturers must participate in if they want their drugs included in the plan. Benefit cap of $5,000/enrollee/year. Negotiated rebates from manufacturers of 15% below AWP. Brand drugs are not covered if a generic is available and the enrollee's physician has indicated that getting the generic is fine.
Nevada	Residents age 62 and older.	Household income of $21,500 or less. Copay $10/generic $25/brand-name drugs. No application fee and once enrolled eligibility is reconfirmed annually.	Plan provides seniors with insurance coverage for prescriptions. State pays the full prescription insurance premium and annual $100 deductible. Benefit cap of $5,000 annually. Plan will not enroll more participants than it can finance based upon available funds.
New Jersey	Residents age 65 and older, as well as disabled adults.	Income no more than 200% over FPL if age 65 or older, or income no more than 222% over FPL if disabled. Income levels tied to SSA COLA. Copay is $5 for generics.	Drug Utilization Review program. In Medicaid Program, no more than 12 prescriptions a month without prior authorization. Prior authorization required if drug prescribed is different than those listed on PDL.

Appendix C (Continued)

State	Who Qualifies	Income Restrictions and Other Cost Sharing Requirements	Program Description and Significant Cost Containment Strategies
New York	Residents age 65 and older.	Annual income $35,000/individual, $50,000/couple. Enrollees who have met their annual deductible pay copays for all covered prescriptions. These vary based upon the cost of the prescription, from $3 for prescriptions under $15 to $20 for prescriptions over $55.	Enrollees with moderate incomes pay low quarterly fees, and participate in the Fee Plan. In this plan participants pay an annual fee in quarterly installments of $8-$230/individual, $8-$300/for each member of a couple. Enrollees with higher incomes meet an annual deductible, and participate in the Deductible Plan. In this plan participants pay the full cost of their prescriptions until they meet an annual deductible, that varies based upon income from $530-$1,230/individual, $650-$1,715/ for each member of a couple.
North Carolina	Residents age 65 and older.	Income no more than 200% over FPL. Copay of $6.	Enrollees receive a 60% discount on prescriptions. Annual benefit cap of $600 per enrollee. Program covers prescriptions used to treat cardiovascular disease, diabetes mellitus, and chronic obstructive pulmonary disease.
Pennsylvania	Residents age 65 and older.	Annual income $14,000/individual, $17,200/couple. Copay of $6.	Manufacturers must participate in the rebate program to have their drugs included in the plan. Generic drugs required to be dispensed unless physician indicates that the brand drug must be dispensed. Drug Utilization Review part of program.
Rhode Island	Residents age 65 and older.	Three tiers for cost sharing. Plan pays 60% of the prescription for $15,932/ individual, $19,916/couple; 30% of the prescription for $19,999/single, $25,000/couple; 15% of the prescription for $30,000/single, $40,000/ couple.	Condition specific coverage limitations. For first tier, there are no participant co-insurance requirements after $1,500 out-of-pocket has been paid. For higher two tiers, there is no out-of-pocket annual limit.
South Carolina	Residents age 65 and older.	Income no more than 200% over FPL. Enrollees with incomes of 175-200% of FPL must meet a $500 deductible. After meeting the deductible, and for seniors with incomes below 175% of FPL, enrollees responsible for copays of $10/generics, $21/brand name drugs.	Formulary applies to brand name drugs. Until the deductible is met, members receive a 10% discount on prescriptions.
Vermont	Residents age 65 and older, as well as disabled adults.	Up to 150% of FPL. No enrollment fee. Copay of $3/generic, $6/brand name. $50 cap per calendar quarter on copay, then cost is $0 for the rest of the quarter.	Plan covers acute care and maintenance drugs. Two other programs help pay for maintenance drugs for residents over age 65, as well as disabled adults, with incomes above 150% of FPL.

Appendix C (Continued)

State	Who Qualifies	Income Restrictions and Other Cost Sharing Requirements	Program Description and Significant Cost Containment Strategies
Wisconsin	Residents age 65 and older.	$20 annual enrollment fee per person. Up to 240% FPL. $500 deductible for those with income over 160% FPL. Two-tier copay of $5/generics, $15/brand name drugs.	Pay discounted price for drugs until the $500 deductible is met. Prior authorization for certain drugs. Maximum allowable cost list for prescription drugs.
Wyoming	No restrictions.	Annual enrollment fee of $20. Up to 200% of FPL. $1,000 deductible for families between 150%-200% FPL for first three months of participation. After which the deductible drops to $300 and beneficiaries are charged copay of $10/ generics, $25/brand name drugs. For enrollees between 100%-150% FPL, the deductible drops to $100 after three months, with same copays. Families at or below 100% FPL have no deductible but are responsible for copay.	Will only provide funding with available funds, after which new enrollees may be denied acceptance into the program.

*Some states have filed Medicaid 1115 Research and Demonstration waiver applications with the Center for Medicaid State Operations, which, if approved, will change their eligibility criteria.

Source: National Conference of State Legislatures (NCSL), American Association of Retired Persons (AARP), and information obtained from individual states.

APPENDIX D

PACE and PACENET Claims and Expenditures

(FY 1984-85 Through FY 2000-01)

	PACE			PACENET		
FY	Processed Claims	Expenditures	Avg. State Share/Processed Claim[a]	Processed Claims	Expenditures	Average State Share/Processed Claim[b]
1984-85	5,576,859	$ 57,293,787	$10.27			
1985-86	9,339,004	111,984,527	11.99			
1986-87	10,494,888	141,547,262	13.49			
1987-88	10,956,570	164,707,174	15.03			
1988-89	11,992,415	202,973,816	16.93			
1989-90	11,253,792	217,449,036	19.32			
1990-91	10,805,841	230,107,813	21.29			
1991-92	9,890,202	230,901,320	23.35			
1992-93	9,127,238	224,856,830	24.64			
1993-94	9,070,993	230,179,979	25.38			
1994-95	8,950,355	233,431,535	26.08			
1995-96	9,338,256	252,768,365	27.07			
1996-97	8,857,776	236,309,904	26.68	75,187	$ 586,373	$ 7.80
1997-98	9,043,391	248,657,629	27.50	322,060	5,541,508	17.21
1998-99	8,724,842	273,475,871	31.34	489,386	10,147,944	20.74
1999-00	8,910,657	314,628,799	35.31	649,415	15,810,717	24.35
2000-01	9,075,465	347,948,266	38.34	802,908	21,520,028	26.80
Total	161,408,544	$3,719,221,913	$23.04	2,338,956	$53,606,570	$22.92
% Change	62.73%	507.31%	273.19%	149.30%	288.34%	55.77%

[a]The state share is the amount paid by PACE for each claim. As of November 1996, it is calculated by taking the lesser of the Average Wholesale Price (AWP) minus 10 percent plus a $3.50 dispensing fee or the usual and customary charge and then subtracting the $6 copayment. Through June 1991, the calculation was the lesser of the AWP plus a $2.75 dispensing fee or the usual and customary charge and then subtract the $4 copayment ($6 copayment starting July 1991).
[b]The state share is the amount paid for each claim in the PACENET copayment phase. It is calculated by taking the lesser of the AWP minus 10 percent plus a $3.50 dispensing fee or the usual and customary charge and then subtracting a copayment of either $8 for generic or $15 for brand products.

Source: Developed by LB&FC staff from PACE Annual Report, 2001.

APPENDIX E

Cardholders and State Expenditures, by County*

(CY 2001)

County	# of PACE Enrolled Cardholders	# of PACENET Enrolled Cardholders	Total Enrolled[a]	% of Total	# of Participating Cardholders	State Share
Adams	1,517	323	1,760	0.7%	1,600	$ 2,802,746
Allegheny	23,924	3,158	26,111	10.0	22,782	38,368,969
Armstrong	1,485	186	1,615	0.6	1,437	2,592,864
Beaver	3,641	463	3,976	1.5	3,492	6,003,351
Bedford	1,522	199	1,664	0.6	1,473	2,761,901
Berks	6,254	1,320	7,232	2.8	6,436	10,152,181
Blair	3,609	576	4,047	1.5	3,564	6,459,879
Bradford	1,651	275	1,851	0.7	1,640	2,682,531
Bucks	5,517	974	6,264	2.4	5,518	10,116,171
Butler	2,600	347	2,843	1.1	2,492	4,597,521
Cambria	3,848	419	4,145	1.6	3,679	6,058,765
Cameron	145	24	162	0.1	144	219,977
Carbon	2,009	334	2,243	0.9	1,971	3,313,062
Centre	1,616	288	1,835	0.7	1,658	2,664,968
Chester	3,056	479	3,432	1.3	2,983	4,996,431
Clarion	948	186	1,100	0.4	984	1,770,450
Clearfield	2,454	380	2,740	1.0	2,431	4,316,050
Clinton	1,154	242	1,337	0.5	1,195	1,926,559
Columbia	2,224	383	2,500	1.0	2,249	3,572,283
Crawford	2,115	377	2,393	0.9	2,143	3,568,217
Cumberland	2,690	526	3,086	1.2	2,730	4,976,098
Dauphin	3,075	519	3,462	1.3	3,056	5,038,734
Delaware	6,947	1,045	7,771	3.0	6,844	11,155,519
Elk	850	180	987	0.4	896	1,599,992
Erie	5,336	924	6,019	2.3	5,335	9,003,764
Fayette	4,053	485	4,412	1.7	3,900	6,914,646
Forest	187	30	209	0.1	176	339,258
Franklin	1,986	411	2,312	0.9	2,061	3,712,536
Fulton	325	54	366	0.1	335	581,224
Greene	808	98	882	0.3	777	1,335,377
Huntingdon	1,115	197	1,261	0.5	1,113	1,853,729
Indiana	1,653	215	1,803	0.7	1,585	2,955,332
Jefferson	1,451	304	1,664	0.6	1,507	2,606,319
Juniata	519	108	607	0.2	539	1,046,338
Lackawanna	8,772	1,274	9,729	3.7	8,746	15,011,261
Lancaster	5,748	1,238	6,699	2.6	5,944	10,146,463
Lawrence	2,856	414	3,169	1.2	2,774	4,326,029
Lebanon	1,960	391	2,257	0.9	2,008	3,494,225

Appendix E (Continued)

County	# of PACE Enrolled Cardholders	# of PACENET Enrolled Cardholders	Total Enrolled[a]	% of Total	# of Participating Cardholders	State Share
Lehigh	4,691	889	5,366	2.0%	4,764	$ 8,005,896
Luzerne	14,953	2,008	16,453	6.3	14,604	25,036,679
Lycoming	2,932	543	3,332	1.3	2,979	5,170,885
McKean	1,106	180	1,252	0.5	1,124	1,992,021
Mercer	2,739	430	3,051	1.2	2,702	4,614,153
Mifflin	1,482	276	1,694	0.6	1,534	2,872,504
Monroe	1,907	415	2,220	0.8	1,952	3,320,132
Montgomery	7,082	1,331	8,099	3.1	7,141	12,096,957
Montour	363	47	401	0.2	357	567,872
Northampton	5,328	1,014	6,088	2.3	5,382	9,025,508
Northumberland	4,433	641	4,918	1.9	4,395	7,918,273
Perry	805	140	917	0.4	815	1,556,286
Philadelphia	27,827	2,951	30,090	11.5	25,956	41,522,522
Pike	486	82	556	0.2	477	918,434
Potter	537	84	597	0.2	519	837,324
Schuylkill	7,480	1,026	8,233	3.1	7,256	11,967,186
Snyder	866	146	970	0.4	876	1,726,601
Somerset	2,350	271	2,547	1.0	2,273	4,036,088
Sullivan	216	48	252	0.1	216	331,751
Susquehanna	1,132	183	1,266	0.5	1,115	1,608,051
Tioga	1,068	207	1,222	0.5	1,082	1,925,099
Union	686	162	811	0.3	721	1,222,958
Venango	1,199	226	1,364	0.5	1,200	2,134,219
Warren	791	174	920	0.4	819	1,319,944
Washington	4,165	477	4,503	1.7	3,974	6,779,590
Wayne	1,451	233	1,622	0.6	1,435	2,291,571
Westmoreland	8,352	1,162	9,192	3.5	8,026	13,749,258
Wyoming	766	104	851	0.3	768	1,363,361
York	6,093	1,297	7,064	2.7	6,312	10,623,439
Total	234,906	36,093	261,796	100.0%	230,971	$391,576,282

*Data includes original, paid claims by date of service.

[a]Unduplicated count of cardholders, some of whom may have been enrolled in both programs during the year.

Source: Developed by LB&FC staff from PACE Annual Report, 2001.

APPENDIX F

Comparison of Pennsylvania's Pharmacy Dispensing Fee and Ingredient Cost With Other State Sponsored Prescription Drug Assistance Programs

State	Dispensing Fee Pharmacies May Charge to Fill a Generic Prescription	Price That Pharmacies May Bill the State to Recapture Ingredient Cost
Connecticut................	$3.60	AWP-12.00%
Delaware	3.65	AWP-14.00%
Florida........................	4.23	AWP-13.00%
Illinois.........................	2.55	AWP-14.00%
Indiana.......................	4.90	AWP-20.00%
Maine.........................	3.35	AWP-10.00%
Maryland....................	4.69	AWP-10.00%
Michigan	3.77	AWP-15.10%
Minnesota..................	3.65	AWP-14.00%
Missouri	4.09	AWP-10.40%
New Jersey................	4.00	AWP-10.00%
New York...................	4.50	AWP-10.00%
Pennsylvania	**3.50**	**AWP-10.00%**
Rhode Island	2.75	AWP-13.00%
South Carolina...........	4.05	AWP-10.00%
Vermont.....................	4.50	AWP-11.90%
Wisconsin	4.88	AWP-6.25%
Average	$3.92	AWP-11.98%

Source: PACE program survey of other states pharmaceutical assistance programs, May 2003.

APPENDIX G

LB&FC Cost Savings Methodology and Calculations

Methodology

A. Calculate the cost of expanded PACENET.

1. PACE staff determined eligible population using U.S. census data. The number of new enrollees is the eligible population multiplied by the PACENET penetration rate. Thirty-five percent of total is enrolled for the first six months of the ramp up period, 70 percent after a year and a half, and 85 percent after two years.
2. PACE staff provided number of claims per enrollee and average state share per claim. Number of claims = PACENET enrollees for the period multiplied by the number of claims per enrollee. Estimated state share = number of claims multiplied by average state share per claim.
3. A manufacturer's 16 percent rebate of the state share is subtracted for the estimated net cost of the expanded PACENET prior to cost savings.

B. Calculate the cost of the existing PACE and PACENET programs.

1. PACE staff projected number of claims for PACE and PACENET during the ramp up period. Multiplying the number of claims by the average state share per claim yields the state share for the existing PACE and PACENET populations.

C. Determine the cost savings for each cost savings option.

1. Cost savings from FUL determined by PACE staff. 50 percent of claims affected by this option.
2. Cost savings from Best Price also determined by PACE staff.
3. Cost savings per claim converted to mail order determined in this manner:
   a. PACE staff used the state share per claim for brand and for generic drugs calculated from previous year, added in the copay and subtracted the dispensing fee. This is the estimated ingredient cost, i.e., the Average Wholesale Price – 10%, the cost that the Commonwealth reimburses providers. Dividing by 0.90 = the AWP.
   b. Mail order assumes reimbursement at AWP-20% for brand name drugs and AWP-50% for generics. Making these adjustments takes you to the ingredient cost per claim for each.
   c. Next assumption: 20% of the claims will convert to mail order. Claims filed in the previous year multiplied by 0.2 is the number of converted claims.
   d. Next assumption: mail order claims will be for 90-day (3 month) supply. Only one third of the converted claims will have mail order copay, divide converted claims by 3.
   e. Ingredient cost of a mail order claim is 3 times the ingredient cost per claim from step C2. Three times ingredient cost, less new dispensing fee, plus new copay is state share of mail order claim.
   f. Multiply the state share for a mail order claim by the number of converted claims with a copay for cost to the state for mail order claims. Using the original AWP and multiplying it by 20% of the original number of claims gives you a cost if nothing is changed for those claims. The difference between these two values is the savings realized from mail order.
   g. Add the savings for brand name drugs and generic drugs together, divide by the number of converted claims to get the savings per converted claim to use in the overall savings calculation for the expansion

D. Subtract C from A and B to get the net cost to the program of expanding PACENET to 300% of 2003 FPL with the three initial cost savings options.

E. We modified the mail order cost savings option with increased copay amounts based on three times the monthly copay then dividing the product by 2. Example: 3x$8 = $24 / 2 = $12 (PACE and generic PACENET); 3x$15 = $45 / 2 = $22.50 (PACENET brand name drugs).

1. Using calculation in C, substitute the higher copay amounts for new cost savings per converted claim.
2. Subtract the previous mail order cost savings from new calculation to determine the additional cost savings from mail order.

F. Calculate the cost savings impact of increasing the PACE copay.

1. Multiply number of unconverted claims by dollar increase in copay.

G. Subtract E and F from D to get the net cost to the program for all cost savings discussed.

Appendix G (Continued)

Additional Data and Calculation: PACENET Expansion to 300 percent with FUL, BP, MO, and $12 / $22.50 Tiered Mail Copay

Additional PACENET	Jul 03 – Jan 04	Jan 04 – Jun 04	Jul 04 – Jun 05	2 Year Total
Total Eligibles	594,896			
Enrollment Rate: 18.3%	108,866			
Ramp up	35%	70%	85%	
Enrollees (85 percent of Enrollment Rate)	38,103	76,206	92,536	
Claims per month times number of months	16.8	16.8	37.5	
Average State Share per Claim	$46.28	$46.28	$49.24	
Number of claims (enrollees x Claims/month):	640,132	1,280,263	3,470,102	
Estimated State Share	$29,625,294	$59,250,588	$170,867,801	$259,743,684
Rebates @16%	(4,740,047)	(9,480,094)	(27,338,848)	(41,558,989)
Estimated Net Cost	$24,885,247	$49,770,494	$143,528,953	$218,184,694
Best Price @6% of state share	(1,777,518)	(3,555,035)	(10,252,068)	(15,584,621)
FUL @ $2.51 per claim (50%)	(803,365)	(1,606,731)	(4,354,977)	(6,765,073)
Mail Order @$5.62/claim (20%)[1]	(719,785)	(1,439,569)	(3,901,893)	(6,061,247)
Total Savings	$ (3,300,667)	$ (6,601,335)	$ (18,508,939)	$(28,410,941)
Estimated Cost After New PACENET Savings	$21,584,580	$43,169,159	$125,020,015	$189,773,753

Estimated Savings From existing PACE[2]

	Jul 03 - Jan 04	Jan 04 - Jun 04	Jul 04 - Jun 05	2 Year Total
PACE Claims	4,648,518	4,648,518	9,256,396	18,553,432
PACE State Share	$225,917,975	$225,917,975	$484,942,586	$936,778,536
Best Price @ 6% of state share	$(13,555,078)	$(13,555,078)	$(29,096,555)	$ (56,206,712)
FUL @ $2.51 per claim (50%)	(5,833,890)	(5,833,890)	(11,616,777)	(23,284,557)
Mail Order @ $8.60/claim (20%)[1]	(7,993,155)	(7,993,155)	(15,916,428)	(31,902,737)
Total Savings	$(27,382,123)	$(27,382,123)	$(56,629,760)	$(111,394,007)

Estimated Savings From existing PACENET[2]

	Jul 03 - Jan 04	Jan 04 - Jun 04	Jul 04 - Jun 05	2 Year Total
PACENET Claims	614,476	614,476	1,643,458	2,872,409
PACENET State Share	$28,437,926	$28,437,926	$80,923,872	$137,799,724
Best Price @6% of state share	$ (1,706,276)	(1,706,276)	(4,855,432)	(8,267,983)
FUL @ $2.51 per claim (50%)	(771,167)	(771,167)	(2,062,540)	(3,604,873)
Mail Order @$5.62/claim (20%)[1]	(690,936)	(690,936)	(1,847,957)	(3,229,828)
Total Savings	$ (3,168,378)	$ (3,168,378)	$ (8,765,929)	$ (15,102,685)
TOTAL SAVINGS FROM PACE/PACENET	$(30,550,501)	$(30,550,501)	$(65,395,689)	$(126,496,692)
Estimated Net Cost With All Savings Other Than Increase PACE Copay	$ (8,965,922)	$ 12,618,658	$ 59,624,325	$ 63,277,062

[1]Mail order provider reimbursement: AWP-20% for Brand, AWP-50% for Generic
Copay @ $12 / $22.50 and dispensing fee @ $6
Assume 20% of claims convert to mail order.

[2]Aging staff develops program measures on a fiscal year basis. To determine the model's values for each six-month period of the first ramp up year, the measures were halved and, therefore, the calculations produced identical results.

Appendix G (Continued)

<u>Additional Calculation</u>: Mail Order Savings

Change Mail Order Copay to $12

PACE	Brand[3]	Generic	
Jul - Dec 2002 State Share per Claim	$63.58	$22.69	
Plus Cardholder Copay	6.00	6.00	
Less Dispensing Fee	3.50	3.50	
Est. Ingredient Cost or AWP-10%	$66.08	$25.19	
Estimated Average Wholesale Price	$73.42	$27.99	
	AWP – 20%	**AWP - 50%**	
Ingredient Cost per Claim	$58.74	$13.99	
Jul - Dec 2002 Claims	2,553,142	2,137,419	
Number of Claims w/20% Conversion	510,628	427,484	938,112
Number of Claims w/Mail Order Copay[4]	170,209	142,495	
New Mail Order Copay	$12.00	$12.00	
New Mail Order Dispensing Fee	$6.00	$6.00	
Estimated State Share for 90-day Claim	$170.21	$35.98	
Estimated State Share for 90-day Claim	$28,972,125	$5,126,696	
Estimated State Share for 30-day Claim	$32,465,983	$9,698,285	
Estimated savings - 6 months	$ 3,493,859	$4,571,589	$8,065,448
Savings per converted claim			$8.60

Change Mail Order Copay to a Tiered $12 / $22.50

PACENET	Brand[3]	Generic	
Jul - Dec 2002 State Share per Claim	$61.65	$23.51	
Plus Cardholder Copay	15.00	8.00	
Less Dispensing Fee	3.50	3.50	
Est. Ingredient Cost or AWP-10%	$73.15	$28.01	
Estimated Average Wholesale Price	$81.27	$31.12	
	AWP – 20%	**AWP - 50%**	
Ingredient Cost per Claim	$65.02	$15.56	
Jul - Dec 2002 Claims	260,369	210,300	
Number of Claims w/20% Conversion	52,074	42,060	94,134
Number of Claims w/Mail Order Copay[3]	17,358	14,020	
New Mail Order Copay	$22.50	$12.00	
New Mail Order Dispensing Fee	$6.00	$6.00	
Estimated State Share for 90-day Claim	$178.55	$40.68	
Estimated State Share for 90-day Claim	$3,099,318	$570,396	
Estimated State Share for 30-day Claim	3,210,090	988,858	
Estimated savings - 6 months	$ 110,773	$418,463	$529,235
Savings per converted claim			$5.62

[3]Brand includes brand multi-source.

[4]One third of converted claims. 90 days = 3 months or three claims

Source: Developed by LB&FC staff.

APPENDIX H

Selected Pending Legislation – 2003-04 Session

(As of May 14, 2003)

Senate Bill 7: Defines best price; provides for reimbursements; for rebate amounts and for an excessive pharmaceutical price inflation discount.

Senate Bill 21: Amends the State lottery law defining income for pharmaceutical assistance to exclude certain veteran disabilities payments.

Senate Bill 23: Provides for a single pharmacy benefits manager to administer outpatient pharmacy services provided through the medical assistance program.

Senate Bill 47: Changes income eligibility and deductibles for PACENET in that it establishes seven levels of income and seven deductibles depending on that income.

Senate Bill 64: Amends the State Lottery law to change the maximum income limits for PACE in accordance with changes in the Consumer Price Index for all urban consumers.

Senate Bill 94: Establishes a Pharmaceutical Assistance Clearinghouse.

Senate Bill 138: Directs DPW to file an application for the Commonwealth to participate in the Federal Pharmacy Plus Program.

Senate Bill 300: Amends the State Lottery Law, eliminates PACENET, provides for rebate amounts and for excessive pharmaceutical price inflation discount; provides for a single pharmacy benefits manager; provides for rebate agreements governing reimbursement by certain public plans.

Senate Bill 418: Provides for the amount of the rebate.

Senate Bill 419: Amends the HCCC Act to provide for the definitions of pharmaceutical marketer and pharmaceutical manufacturing company; provides for an annual expense report and for disclosure by pharmaceutical marketers.

Senate Bill 420: Requires pharmaceutical manufacturing companies and marketers to report the cost of marketing prescription drugs in the Commonwealth to the Health Care Cost Containment Council.

Senate Bill 434: Provides for annual income limits for PACE and PACENET; provides for best price pharmaceuticals; establishes the Prescription Drug Access Clearinghouse Authority; provides for the Medicare Managed Care Fair Share Programs; establishes the Medicare Participation Fund.

Senate Bill 720: Changes the income eligibility for PACE and PACENET to 170 percent of FPL; provides for a mail order pharmacy; provides for discounts and rebates.

Senate Bill 726: Regulates pharmacy benefits managers through the Insurance Department; establishes the PBM Licensing Fund.

House Resolution 5: Directs the appointment of a select committee to investigate prescription drug pricing, marketing, and distribution in Pennsylvania.

House Resolution 46: Requests the Department of Aging to file an application with the Centers for Medicare and Medicaid Services to secure a Medicare Demonstration Project to provide additional monies through Medicare savings to the pharmaceutical assistance programs to expand and enhance pharmaceutical coverage for low-income seniors while protecting the validity of the PACE and PACENET programs.

Appendix H (Continued)

House Resolution 155: Directs the Governor to request GlaxoSmithKline to end their efforts to keep Pennsylvanians from being able to purchase mail order prescription drugs from retailers in Canada.

House Resolution 227: Requests the Departments of Aging and Public Welfare to investigate the possibility of interstate prescription drug purchasing agreements or pooling arrangements.

House Bill 73: Requires health insurance providers that furnish coverage for prescription drugs to extend coverage to off-label use of drugs.

House Bill 227: Establishes a Pharmaceutical Manufacturers Patient Assistance Program in the Department of Health.

House Bill 251: Authorizes pharmaceutical service expansion for certain medical assistance recipients.

House Bill 269: Provides for pharmaceutical assistance eligibility.

House Bill 362: Provides for pharmaceutical discount card minimum standards and for a report by the State Board of Pharmacy.

House Bill 393: Defines income for pharmaceutical assistance eligibility. Also House Bill 569.

House Bill 571: Defines income for PACE and PACENET to exclude a portion of interest and dividends earned.

House Bill 621: Provides for consumer guides for pharmaceutical assistance programs.

House Bill 770: Provides for prescription drug redistribution within health care facilities.

House Bill 784: Provides for a uniform prescription drug beneficiary ID card; provides for prohibitions relating to discounts from pharmacies.

House Bill 888: Provides for pharmaceutical assistance for the elderly; for pharmaceutical purchasing; for limited prescription drug redistribution within certain health care facilities; and for a pharmaceutical practices and cost control program.

House Bill 909: Amends the State Lottery Law to provide for a drug utilization review system; for PACE; for generic drugs, for a restricted formulary; for PACENET; for terms of the rebate agreement; for the amount of the rebate; for disposition of funds; and for an annual report to the General Assembly.

House Bill 953: Establishes the securing Health Care Assistance for Retired Employees and a trust fund; program involves providing prescription drug coverage for certain retired workers.

House Bill 973: Prohibits pharmaceutical price gouging and profiteering.

House Bill 1067: Regulates pharmacy benefit managers.

House Bill 1181: Defines income for PACE/PACENET eligibility.

House Bill 1225: Provides for the Pharmacy Best Practices and cost control program.

Source: Developed by LB&FC staff from a review of proposed legislation.

APPENDIX I

States Considering Undertaking Pharmacy Plus Plans

State	Status	Eligibility/Benefit[a]	Est. Enrollees
Arkansas	Filed	85-100 percent FPL	5,800
Connecticut	Filed	200 percent FPL	N/A
Florida	Approved	120 percent FPL $160/month maximum	68,000
Illinois	Approved	200 percent FPL Full cost up to $1,750 annual maximum with state paying 80 percent of cost over maximum $5-$25 enrollment fee	368,000
Indiana.......................	Filed	135 percent FPL	30,000
Maine.........................	Filed	N/A	N/A
Maryland....................	Approved	175 percent FPL State pays 35 percent Asset test	90,000
Massachusetts	Filed	188 percent FPL	N/A
New Jersey................	Filed	200 percent FPL	N/A
Rhode Island	Filed	200 percent FPL	30,000
South Carolina	Approved	200 percent FPL $500 annual maximum	26,000
Wisconsin..................	Approved	200 percent FPL $500 annual maximum Co-pay up to $15/prescription	177,000

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[a]Federal poverty level is currently $8,980 for individuals and $12,120 for couples.

Source: Developed by LB&FC staff from NCSL and CMS data.

APPENDIX J

Department of Aging's Response to This Report

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF AGING
555 Walnut Street, 5th Floor
HARRISBURG, PENNSYLVANIA
17101-1919

SECRETARY OF AGING (717) 783-1550

June 11, 2003

Honorable Robert M. Tomlinson, Chair
Legislative Budget and Finance Committee
Room 400, Finance Building
Harrisburg, PA 17105-8737

Dear Senator Tomlinson:

Thank you for providing an advance draft of the Legislative Budget and Finance Committee report, entitled, *Prescription Drug Programs for Low and Moderate Income Senior Citizens,* to the Department for review. I would first like to commend the Committee and its staff on the quality of the report, which gives thoughtful consideration to the various options for increasing prescription drug coverage to older adults. The report also provides policy makers with key background information important to understanding the existing state and national landscape of providing prescription assistance, and evaluating the pros and cons of alternatives for change.

Secondly, I strongly concur with the LB&FC staff recommendation to expand eligibility in Pennsylvania's PACE and PACENET programs, in an environment where several other states are cutting back or freezing enrollment in pharmacy subsidy programs. Though PACE is still one of the largest and most generous state prescription drug programs in the country, we must enact changes to expand coverage. There are simply too many older Pennsylvanians who lack coverage, and cannot afford the high cost of medications.

As noted in the report, Governor Rendell has worked with leaders in the General Assembly to form a bi-partisan consensus plan to expand enrollment by 100,000 additional older Pennsylvanians. I am encouraged that LB&FC staff envision a way to expand eligibility to income levels even higher than those contained in the consensus plan. We hope it is possible to achieve such levels of eligibility in the coming months.

Finally, I want to confirm that the Department's suggested corrections and additions have been incorporated into the report. I look forward to discussing the report with the Committee.

Sincerely,

Nora A. Dowd
Secretary

cc: Philip R. Durgin, Executive Director
Dave Myers, Office of the Governor