ALASKA PRESCRIPTION DRUG TASK FORCE

RECOMMENDATIONS TO GOVERNOR TONY KNOWLES

October 1, 2002

Alaska Prescription Drug Task Force

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Introduction:

When Medicare was signed into law in 1965, little thought was given to providing a prescription drug benefit. Few prescriptions were regularly used as "preventive medicine" and those that were available were not that expensive. In today's medical world, prescription drugs are considered "smart medicine." Research has created thousands of new medications that are routinely used to avoid expensive surgery and maintain optimum health. Most employers routinely provide prescription drug coverage to their enrolled employees and dependents because it is an effective, economical tool in the health care resource box. Thirty-seven years after enactment, however, Medicare still does not provide a prescription drug benefit to Alaskans over 65 and younger persons with disabilities who are also covered under Medicare. Medicaid, on the other hand, recognizes that prescription coverage is an essential part of a health care plan.

In the absence of a federal plan, 34 states have established some type of program to provide pharmaceutical coverage or assistance to older persons or younger persons with disabilities who are not eligible for Medicaid. The programs vary in their approaches, their target population, and in the amount of assistance they provide. However, each shares a common element: it is designed to reduce the burden of prescription drug costs for a selected group in the population. In addition, some require a drug regimen review that usually results in lower costs as well as healthier residents.

The Task Force has reviewed the programs of each state, conferenced with staff experts at the National Conference of State Legislatures, solicited comments in writing and through a public hearing, and reviewed a variety of changes that might have some impact on reducing the cost of prescription drugs to Alaska's seniors. Current pharmaceutical costs were reviewed and projections are included for growth of Alaska's senior population. Baring Congress enacting a significant prescription drug program under Medicare, Alaska can expect increasing pharmaceutical costs for our older population and increasing costs to the Medicaid program. In 2001, pharmaceutical costs for all Alaskans went up over 25% and 27% for the Medicaid program. As Governor Knowles said on August 2, 2002…"we can't wait any longer--it's time to take action."

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The task force wishes to thank these individuals who gave us tremendous assistance in researching the problem and developing recommendations:

Representative Joe Hayes
Richard Benavides, Legislative Aide to Senator Bettye Davis
Angela LeBoeuf, R.Ph., incoming President of the Alaska Pharmacists Association
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We particularly appreciated the time of Richard Cauchi, Senior Policy Specialist, Health Programs, National Conference of State Legislatures in Denver, Colorado. Dick generously shared his expertise on the variety of pharmaceutical programs that states have developed.

We want to pay tribute to the outstanding report developed by Lynn Merrick, Research Attorney for the Legislative Reference Bureau for the Hawaii Legislature. Ms. Merrick's report "Take As Directed: Prescription Drug Options for Hawaii's Uninsured" was one of the finest documents we used in preparing this report. Our charge was eased considerably because of her original and comprehensive work.

Task Force Assignment # 1: Study Prescription Drug Assistance Programs That Have Been Used In Other States

Existing State Pharmaceutical Assistance Programs

State programs can basically be divided into two categories: either state-funded direct benefit programs or state-created "discount" drug programs that require little or no state funding. These include:

1. State-funded direct benefit programs:

    - Traditional pharmaceutical assistance programs
    - Subsidized prescription drug insurance coverage
    - State income tax credits

2. Programs that provide access to prescription drugs at discounted prices:

    - Ceiling prices on prescription drugs
    - Access to Medicaid prices for Medicare beneficiaries
    - Medicaid section 1115 waivers
    - Bulk purchasing (including inter- and intra-state models)
    - Buyers' clubs
    - Prescription drug discount cards

ISSUE: State funded programs are more effective in reducing pharmaceutical costs for older citizens who are most in need of assistance. These programs require a state appropriation. Discount programs are less costly to the state and may help more moderate and upper-income citizens. However, for those who cannot currently afford prescribed medications, even discounted drugs may still not be affordable.

State-funded Direct Benefit Programs

State-funded direct benefit programs use state funds to subsidize prescription drug costs for program participants who meet eligibility requirements, most frequently determined by age, income, and residency. They primarily target low-income seniors who do not qualify for Medicaid and have no private prescription drug coverage; some include disabled individuals. Historically, participants paid only a nominal amount for their prescription drugs. Recently created state programs have required participants to pay a higher portion of the cost of each prescription. Co-payment or co-insurance payments in these programs may be as much as 50% of the prescription drug cost (in contrast to earlier programs with co-payments of $5). More recent state programs are also more likely to have deductibles and/or benefit caps. Most states do not have an enrollment fee. Instead of the normal point of purchase subsidy, Indiana's HoossierRx program reimburses participants for their drug expenditures, requiring citizens to bear the burden up front and recap the state subsidy later.

While general fund revenues finance the majority of state-funded direct benefit programs, some have a dedicated funding source such as lottery or casino revenues. Since 1999, at least eleven states have established or expanded pharmaceutical assistance programs using tobacco settlement funds. States often use manufacturer rebates to keep costs low, often conditioning program coverage on rebate arrangements.

Some of the states with newer programs represent an initial effort to lower prescription drug costs and may reflect a cautious financial startup. North Carolina's new program covers only certain drugs that treat cardiovascular disease and diabetes while longer established programs usually cover all prescription drugs available under Medicaid.

State funding support to provide drugs at a lower cost

New Jersey Pharmaceutical Assistance to the Aged and Disabled

Created in 1975, New Jersey's PAAD program is one of the oldest and largest state-funded pharmaceutical assistance programs. Unlike most programs, PAAD uses casino revenues to subsidize drug costs. Participants include approximately 196,000 seniors and disabled citizens who meet income requirements and have drugs costs not fully covered by any insurance plan.

Participants present a program ID card when buying a covered drug, paying the pharmacy a $5 co-payment for each covered prescription. Participating pharmacies must display the usual price charged to others on receipts as a condition for reimbursement under the PAAD program. Generic drugs must be dispensed instead of a prescribed brand name drug unless the prescribing physician writes "Brand Medically Necessary". Manufacturer rebates are required and used to offset the cost of benefits provided; only those drugs subject to a rebate agreement are covered. PAAD pays the pharmacies the "reasonable cost" of dispensed drugs that exceed the participant's $5 co-payment (a pre-determined maximum allowable cost plus a dispensing fee). A Drug Utilization Review component monitors drug usage. Most participants need to submit a renewal application every two years. PAAD has a dedicated toll-free number to answer participants' questions.

To be eligible for PAAD, one must be at least 65 years old with an income no greater than $19,739 (single) or $24, 203 (married). Younger disabled persons are eligible at age 21.

Discount program to supplement an existing direct assistance program

New Jersey Senior Gold Prescription Discount Program

On May 15, 2001, New Jersey established the "Senior Gold Prescription Discount Program for senior and disabled residents who are ineligible for Medicaid or PAAD and who meet Senior Gold's slightly higher income requirements. Senior Gold has higher cost sharing requirements than PAAD: co-payments are $15 plus 50% of the remaining "reasonable cost" of a prescription. After unreimbursed out-of-pocket expenses exceed $2,000 for an individual or

$3,000 for married couples, participants pay only the $15 co-payment. Generic substitutes are required unless a brand name is specified in the prescription and the physician indicates “no substitutes”.

Unlike PAAD, Senior Gold’s required manufacturer rebates are based only on the State’s per-prescription cost. New Jersey reimburses participating pharmacies in an amount equal to the difference between the co-payment and the “reasonable cost” of the drug.

Acknowledging the difficulty in quantifying the number of eligible persons, New Jersey estimated that 180,000 seniors and 10,000 younger disabled would qualify for Senior Gold. Anticipating that 25% to 40% of those eligible would actually participate, state costs are expected to be between $70 million and $86 million in the first full year, including $4.1 million in administrative costs. Like many new programs, Senior Gold is financed by tobacco settlement funds.

To be eligible for Senior Gold, a citizen must be at least 65 with an income between $19,740 to $29,739 (single) and $23,204 to $34,203 (married). Disabled residents are eligible at age 21. Income parameters are adjusted each January.

Missouri Senior Rx

Beginning July 1, 2002, Missouri’s new Senior Rx program is similar to the New Jersey program, but requires participants to meet an initial deductible of $250 or $500, depending on income, after which the state will pay 60% of prescription medication costs.

Unlike New Jersey’s Senior Gold, the Missouri program does not add to a pre-existing “traditional” program and does not decrease participant cost after an out-of-pocket expense has reached a specified level. Prescription drugs not covered by a Senior Rx rebate agreement will not be reimbursable, but nonparticipation will not affect the manufacturer’s Medicaid status.

Medicaid recipients are not eligible. Pharmacies are reimbursed a dispensing fee of $4.05, plus the Average Wholesale Price (AWP) minus 20% for brand name drugs or the AWP minus 10.43% for generics.

It is estimated that 25,000 citizens will participate by December 31, 2002.

To be eligible for Missouri Senior Rx, a citizen must be at least 65 with an income less than $17,000 (single) or $23,000 (married). There is a sliding scale application fee that varies from $25 to $35.

Missouri has a state income tax and also offers a Pharmaceutical Tax Credit that 262,000 citizens utilize. The minimum age is 65 and any single older person with income at or below $15,000 can have a maximum credit of $200. The credit is reduced by $2 for every additional $100 in income.

State Funds Reimburse Out-of-Pocket Drug Costs

Kansas Senior Pharmacy Assistance Program

The Kansas Senior Pharmacy Assistance Program provides state-funded reimbursement to seniors currently receiving Qualified Medicare Beneficiary Program or Low Income Medicare Beneficiary Program benefits who meet income requirements and do not have or qualify for any private drug benefit. The annual reimbursement limit is $1,200. Legend drugs and diabetic supplies not covered by Medicare and prescription drugs that treat chronic illness are covered. There is a 30% co-payment and a maximum reimbursement of $1200 per person.

A citizen must be at least age 67 to be eligible for the Kansas program. Single older persons are eligible if they are within 150% of the poverty level ($13,296 in 2002). Married couples are eligible if their income is $17910 or below. During the first three months of the program, almost 1100 persons were receiving reimbursements.

Advantages of State-Funded Direct Benefit Programs

♦ Qualifies for Medicaid "best price" exemption for "state pharmaceutical assistance programs" to get pricing below the "commercial rates" or Medicaid rates without having to give the same discount to all Medicaid programs under the rebate program.

♦ Provides meaningful coverage to neediest population.

♦ Retail pharmacy participation ensures widespread access to participants.

♦ Can impose formulary or preferred drug list.

Disadvantages of State-Funded Direct Benefit Programs

♦ Requires significant investment of state revenues.

♦ Continued availability of meaningful rebates is in question.

Insurance Programs

Generally, insurance program participants may have to make premium payments, co-payments to the pharmacy when a prescription is dispensed, and meet a deductible before state subsidized benefits begin. Benefits and cost sharing are often scaled to participant income. Two states, Nevada and Massachusetts, introduced subsidized prescription drug insurance coverage programs for certain low-income residents in 2001, both using tobacco settlement funds. Massachussetts' Prescription Advantages covers seniors and disabled; Nevada Senior Rx covers only seniors.

Massachusetts Prescription Advantage

Prescription Advantage is described as a "state-backed prescription drug insurance plan" for seniors and disabled residents not eligible for Medicaid. On October 1, 2001, Prescription Advantage replaced the Senior Pharmacy Program, a state-funded program that previously provided drugs covered by Medicaid to seniors and certain disabled up to 188% of the federal poverty level.

Prescription Advantage has a sliding scale state subsidy up to 500% of the federal poverty level, but no income limits. Participants' monthly premiums, co-payments, and deductible are income based. The program incorporates the catastrophic cost element of the Senior Pharmacy Prescription Advantage. After a participant pays $2,000 or 10% of gross annual household income (whichever is less), the participant is responsible only for premium payments for the rest of the year. Prescription Advantage uses a formulary and a three-tier co-payment for generic drugs, select brand name drugs, and additional brand name drugs. Prescription Advantage pays after any other private drug benefits are paid.

A citizen must be at least 65 to be eligible. To be exempt from the premium, an individual must be at or below 188% of the federal poverty level, $16,657 for a single, $22,448 for a couple. Approximately 83,000 citizens participate in Prescription Advantage.

Nevada Senior Rx

Senior Rx is the only state created prescription drug assistance program in Nevada. It is a state-funded privately managed insurance benefit for residents age 62 and over with family incomes less than $21,500 and who are not eligible for Medicaid drug benefits. Early reviews were mixed. Initial enrollment was so low during the first few months of 2001 that lawmakers substantially revised the program in June 2001. Enrollee costs were reduced and the program was simplified. Senior Rx now provides up to $5,000 in annual benefits and tobacco settlement funds subsidize the $1,180 annual premium and $100 deductible costs. The program covers all drugs on a "preferred prescription" list and participants make a co-payment of $10 for generics or $25 for brand name drugs per prescription. Over 7,250 citizens are enrolled and a waiting list is now maintained.

Advantages of state subsidized insurance coverage

♦ Can use a formulary or preferred drug list to move market share and increase possibility of obtaining manufacturer discounts.

♦ Public insurance programs may qualify for Medicaid "best price" exemption.

♦ Private insurance gives state fixed costs.

Disadvantages of state subsidized insurance coverage

♦ Retiree programs might end their programs to "buy in" or terminate coverage altogether to save money.

♦ A complex insurance program would be relatively expensive to administer and difficult for consumers to understand.

♦ Income-related cost structure may create adverse selection, as those most likely to enroll will be the most expensive; requires seniors with higher incomes to knowingly pay more for the same benefit available at less cost to others.

♦ Public insurance premiums may increase because costs likely to rise.

♦ Terminating enrollees for not paying premiums may be difficult.

♦ Using a private Pharmacy Benefit Manager (PBM) may eliminate Medicaid "best price" exemption.

State Income Tax Credits

This information is provided only because two states use this method of funding.

Only Missouri and Michigan offer state income tax credits for prescription drug expenditures. This approach offers a relatively small benefit to a few individuals is outweighed by its drawbacks.

Advantages of state income tax credits

♦ Financial relief for some.

Disadvantages of state income tax credits

♦ Costs the state money not recovered through income tax.

♦ Minimal savings to participants.

♦ Because the benefit is delayed to tax filing the subsequent year and only benefits those who are actually taxed, it doesn't increase timely, affordable access for the neediest population.

State-Created Discount Drug Programs

Legislation has been enacted in Arkansas, California, Florida, Hawaii, Maine, Maryland, New Hampshire, Oklahoma, Oregon, South Dakota, Texas, Virginia, and West Virginia to lower the cost of prescription drugs for a sizable target populations by discount programs, bulk purchasing, expanded manufacturer rebates, price negotiations or price controls. Discount programs reduce the retail cash price for individuals with no drug benefits, and require little state funding. Most state discount programs are new programs without long-term documented evidence of success or failure. Their attraction is the opportunity to provide some financial relief without expending significant state funds.

Hawaii Rx

One of the newest and most comprehensive laws passed in 2002 establishes the Hawaii Rx pharmaceutical discount program for all state residents. It provides for the state to obtain manufacturers' rebates on drugs that are offered at discounted prices to program participants. Discounts are intended to be at least at the Medicaid discount level. It also provides reimbursement to participating pharmacists and establishes a commission and a special fund. The program will take effect July 1, 2004.

Creating a Ceiling Price for Prescription Drugs—Price Controls

Maine Rx

In May 2000, Maine Rx was signed into law as the first state discount program to authorize the establishment of "maximum retail price" for prescription drugs. Implementation of the program was halted by federal litigation initiated by the pharmaceutical industry. The case will be heard by the US Supreme Court.

All Maine residents would be eligible for a Maine Rx enrollment card which would discount prices based on manufacturer rebates and the Medicaid rate. All states and the pharmaceutical industry are awaiting the Supreme Court decision.

Medicaid Prices for Medicare Beneficiaries

California Discount Prescription Medication Program

In 1999, California enacted a law to allow Medicare beneficiaries to buy prescription drugs at a price "not to exceed the Medi-Cal reimbursement rate for prescription medicines" plus a fifteen cent fee for transmission charge. The program is funded by pharmacy discounts that are required as a condition of Medicaid participation. Retail pharmacists did not oppose this legislation, anticipating that the Medi-Cal rate would be an enticement for new "walk-in" customers. An estimated 3.9 million Medicare beneficiaries are eligible. The stiff burden on retail pharmacies and growing dissatisfaction resulted in S.B. 639, approved by the Governor on October 10, 2001, establishing the Golden Bear State Pharmacy Assistance Program to provide low cost drugs for any Medicare beneficiaries. Participation in

Golden Bear is voluntary for Medicare beneficiaries, pharmacies, and drug manufacturers. Participants are required to register, on a one-time basis at participating pharmacies. At registration, participants pay an administrative fee to the pharmacy that the pharmacy retains. Pharmacy prices may not exceed a specified amount, with rebates funding Department of Health reimbursements to participating pharmacies.

Florida Medicare Prescription Discount Program

Similar to California's Discount Prescription Medication Program, Florida's Medicare Prescription Discount Program, effective July 1, 2000, allows any Medicare beneficiary to purchase any prescription drugs at Medicaid participating pharmacies at discounted prices. Pharmacies are required to provide the discounted price as a condition of participating in Medicaid. Unlike California, the U.S. Department of Health and Human Services expressly approved a Florida Medicaid plan amendment to allow the state to implement new provider qualifications "requiring Medicaid participating pharmacies to give price discounts to Medicare beneficiaries similar to those required by Medicaid program."

Advantages of Providing Medicare Beneficiaries Drugs at Medicaid Rates

♦ Minimum state costs.

♦ Lower drug prices may save taxpayers money because increased drug use would reduce use of more expensive treatments, many that might be paid by Medicaid or Medicare.

♦ Pharmacy-only discount avoids constitutional challenges under commerce clause used when states limit drug manufacturer prices.

♦ State can administer pharmacy-only discount program easily.

Disadvantages of Providing Medicare Beneficiaries Drugs at Medicaid Rates

♦ Discounts may have limited value to those with great need and moderate income.

♦ Pharmacy-only discount doesn't take advantage of "best price" exemption.

♦ Pharmacy-only discount places burden on pharmacist whose profit margin is smaller since pharmacy dollars are split 70/30 between the manufacturer and the pharmacy.

Medicaid Waivers—Prescription Drug Discounts for Eligibles

Vermont's Pharmacy Discount Program was established as a Medicaid waiver demonstration program after a November 2000 request to amend its earlier section 1115, Medicaid waiver was approved. A federal court ruling on June 8, 2001, has halted this program's operation. Maine's section 1115 waiver program, Healthy Maine Prescription Program, faces a similar court action. Because federal law requires Medicaid waiver

demonstration projects to be budget neutral, programs established to provide prescription drug benefits pursuant to Medicaid waivers should not require additional state funding.

As Medicaid waiver programs, Maine and Vermont claim manufacturer rebates are required for prescription drugs sold to participants in the waiver programs who would not ordinarily qualify for Medicaid pharmacy benefits. Because drug manufacturers have filed lawsuits in federal court against both programs, the future of Medicaid waivers as a tool to expand prescription drug benefits is uncertain pending the resolution of both cases. Despite industry opposition, a number of states are poised to request Medicaid waivers if Maine and Vermont prevail in the courts.

Maryland Pharmacy Discount Program

Maryland created the Maryland Pharmacy Discount Program as part of Medicaid through section 1115 waiver. If the federal waiver is approved, any Medicare beneficiary without drug coverage will be eligible to enroll and will receive a discount on purchases tied to the Medicaid price less rebates. Persons with incomes at or below 175% of the poverty line ($15,033 single; $20,318 couple) will receive a subsidy of 35% of the costs. If the waiver is not approved, the Pharmacy Discount Program will be run as part of the existing state Pharmacy Assistance Program. In that case, eligibility will be limited to persons with annual incomes at or below 250% of poverty ($21,475 for single; $29,025 for couple). The discount will be tied to the Pharmacy Assistance Program prices less rebates. Persons with incomes at or below 175% of the Federal Poverty Level will receive a subsidy of 25% of the costs.

Arkansas Prescription Drug Access Program

In 2001, Arkansas created the Prescription Drug Access Program, a Medicaid waiver prescription drug benefit that allows only two prescriptions per month for seniors with no drug coverage and incomes at the Qualified Medicare Beneficiary (QMB) level, has an enrollment fee of $25, and requires co-payments of $10 for generics and $25 for brand name drugs. The program is not operational because waiver approval has not yet been received.

Hawaii Medicaid Prescription Drug Expansion Program

In 2002, Hawaii passed a law to offer discounted prescription drugs to qualified individuals whose income is at or below 300% of the Federal Poverty Level ($30,600 for an individual in Hawaii. The law includes a state appropriation of $1.5 million. The state would then pay $1 for every prescription written. The federal government would pay for the remaining costs. This program requires a federal waiver that is pending.

Advantages of Medicaid Waivers

♦ May qualify for Medicaid “best price exemption” as Medicaid demonstration project.

♦ No additional state or federal funds required.

Note: Federal law requires Medicaid waivers to be budget neutral.

Disadvantages of Medicaid Waivers

♦ Future uncertain because of litigation in Maine and Vermont.

♦ Unsettled issues of federal preemption because discount prices may violate Medicaid nominal co-pay requirement.

♦ Opposed by manufacturers.

♦ Requires waiver from CMS.

♦ Medicaid waivers may be unlikely to be granted, until Vermont and Maine litigation is resolved.

♦ If perceived as Medicaid entitlement, perceived stigma may limit participation.

Bulk Purchasing of Prescription Drugs

A number of states are considering bulk purchasing to lower drug costs by combining the pharmaceutical purchases for groups defined, hoping the increased volume will increase their leverage in price negotiations with drug manufacturers. There are two approaches to combined pools as a tool to lower costs: bulk purchasing within a state and bulk purchasing across a coalition of states.

Bulk Purchasing Within a State

According to a recent report from the National Governors Association on pharmaceutical purchasing pools, Georgia has pooled funds of state employees, higher education health insurance premiums, and the Georgia Medicaid and PeachCare for Kids program, and uses a bulk purchasing program. A private pharmacy benefit manager, Express Scripts Inc., will work with Georgia's Department of Community Health to administer the drug benefits for the pool population. In October 2000, services for Medicaid and PeachCare for Kids participants began.

In 2001, Texas created the Interagency Council on Pharmaceuticals Bulk Purchasing to consider bulk purchasing of prescription drugs by state agencies, including the Department of Health and Mental Health, state employees, retirees, teachers, prison systems, and any other agency that purchases pharmaceuticals using existing distribution networks.

Bulk Purchasing Across the States

Since 1999, a number of states have formed coalitions to explore lower prescription drug costs for a variety of populations that include the Northeast Legislative Association on Prescription Drug Pricing, the Northern New England Tri-State Coalition, and the Pharmacy Working Group. The Minnesota Multistate Contracting Alliance for Pharmacy, however, has been around since 1985.

Minnesota Multistate Contracting Alliance for Pharmacy

Administered by the Minnesota Department of Administration, Materials Management Division, the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP) now has nearly 3,000 participating facilities in 38 states, including Hawaii. Participating states are eligible to get pharmaceuticals and related items and supplies at reduced contract prices; contracts are administered by MMCAP staff. In promoting the benefits of membership, MMCAP's website states "Members are expected to buy pharmaceuticals from the MMCAP contract, not from any other nongovernmental contract with which they may be associated."

Pharmacy Working Group

An alliance of personnel agencies seeking to pool drug purchases for their Medicaid and state employees seven states, the Pharmacy Working Group is an interstate bulk purchasing initiative: Louisiana, Mississippi, Missouri, New Mexico, South Carolina, West Virginia, and Maryland. The total annual pharmacy claims in the seven states is nearly $853 million. West Virginia spearheads the project and recently sent out a request for proposals for a pharmacy benefit manager (PBM) for a multistate pool. Seven companies submitted bids. The PBM would process claims, collect and report data, and establish and maintain drug formularies. The group plans to pay its PBM on a fixed fee basis instead of a percentage of their drug expenditures. They also want to "put the rebates back to the states" instead of the current practice that allows PBMs to keep most of the rebate funds. The group started the program in July in West Virginia. The other states have the option to join at any time.

Northeast Legislative Association on Prescription Drug Pricing

The six New England states, plus New York and Pennsylvania, have formed a similar bulk purchasing alliance called the Northeast Legislative Association on Prescription Drug Pricing (NELA). NELA is now trying to implement a bulk purchasing plan in increments, a few drugs at a time, while trying to form a regional buying pool. Because the most dramatic expense increases are concentrated among a small number of categories of drugs and among a relatively small number of drugs, these categories will be targeted first. The incremental start will give the coalition experience in negotiating discounts by setting up a list of preferred drugs, e.g., drugs for heart conditions or allergies.

Advantages of Bulk Purchasing

- Increased volume may improve chances to negotiate higher savings.

♦ Bulk purchasing that is restricted to state pharmacy assistance programs, excluding state employees and others, may qualify for Medicaid "best price" exemption.

Note: Can include Medicaid participants and 340B programs because they have "best price" exemption (and anyone else who has 'best price' exemption).

Disadvantages of Bulk Purchasing

♦ New approach without established success.

♦ May not be considered a "state pharmaceutical assistance program" for Medicaid best price exemption, if program has state employees or others included.

♦ Anyone outside Medicaid 'best ' exemptions may harm opportunity to get good discount from manufacturer.

♦ Administrative issues may frustrate across-states efforts.

Buyers' Clubs and Prescription Discount Card Programs

Voluntary buyer's clubs and discount drug cards are essentially the same model: a pharmacy benefit manager or "third party" negotiates prices for each prescription drug. With this model, state investment may be minimal. A modest enrollment fee paid by participants may subsidize administrative program costs. Unlike most proposed state bulk purchasing arrangements, consumer participation in buyers' clubs and discount drug card programs is voluntary. Eligibility and benefits vary and most programs lack statutory authority.

Washington Awards—Retail Pharmacy Discount for Ages 55 and Older
On August 29, 2000, Governor Gary Locke of the State of Washington issued Executive Order 00-04 to establish a Washington State Alliance to Reduce Drug Spending, commonly known as AWARDS, to provide discount drug prices for residents 55 and older who lacked drug coverage. Participation was limited by income requirements. Governor Locke directed the Secretary of Washington's Department of Health and the Administrator of the Health Care Authority to implement the program no later than January 2001. Retail pharmacy discounts were to be negotiated by the Health Care Authority and the program was intended to be self-supporting, or "without cost to the state." The program was enjoined by the courts and later terminated.

Public Prescription Drug Discount Card Plans

Several states—New Hampshire, Washington, West Virginia, and Iowa—have agency-sponsored discount card programs.

Federally Funded Rebate Program for Medicare Benefits

Iowa Priority Prescription Savings Program

Iowa's Priority Prescription Savings Program (Iowa Priority) is the first program of its kind in the nation. It is a nonprofit organization created through an alliance of consumers, physicians, pharmacists and pharmaceutical companies, and funded by a $1 million federal grant from CMS. Iowa Priority is open to any Medicare beneficiary for a $20 annual membership fee that covers the program's administrative cost. Members will present a card at any Iowa pharmacy to receive a discounted price on any prescription, "actual discounts will vary by prescription." Early enthusiasm promised discounts of up to 70%; more recent estimates predicted a minimum of 10% discounts. Iowa Priority uses a pharmacy benefit manager to negotiate discounts from manufacturers, process claims, and provide other services. The program received approximately 500 to 750 phone calls a day from residents wanting information or to enroll during its first four days of operation. Initial interest was so positive that the organizations' phone system was expanded. Information is also available online or through the Iowa Department of Elder Affairs Area Agencies on Aging throughout the state. The discounts were available January 2, 2002.

West Virginia Golden Mountaineer Card—Pharmacy Discount for Ages 60 and Older

The new Golden Mountaineer Card was mailed to all West Virginia residents, aged 60 and older, in September 2001. Using the card, participants pay the lower of the pharmacy's usual and customary price or average wholesale price minus 13% for brand name drugs and maximum allowable cost minus 60% for generics. AdvancePCS, which administers the card, reimburses pharmacies for the discount and refunds them a dispensing fee. At least one pharmacist has claimed pharmacy losses of 37% of gross profits on each Golden Mountaineer prescription, attributable at least in part to PBM-related fees, while seniors' savings are only 10.4%.

Advantages of Public Prescription Drug Discount Card Plans

♦ Easy access to retail pharmacies.

♦ Simple enrollment procedures.

♦ Negotiated discounts will reduce out-of-pocket expenditures.

♦ Administration by nonprofit keeps program costs low.

Disadvantages of Public Prescription Drug Discount Card Plans

♦ Private Pharmacy Benefit Manager adds increased expense and administrative burden to pharmacies in Golden Mountaineer.

♦ Offers minimal discounts, similar prices available through Internet pharmacy.

♦ Some discount plans were implicated in fraudulent schemes, promising more than delivered.

The establishment of a state pharmaceutical assistance program presents no shortage of issues for policymakers to consider.

States and the 340B Pricing Program

The Federal 340B Drug Pricing Program provides significantly reduced price prescription drugs to more than 9,150 certified health care facilities. These clinics, centers and hospitals (collectively "entities") serve more than 100 million people in 50 states, plus commonwealths and territories.

There are currently 34 such facilities in Alaska and approximately 70 more sites that are eligible. The possibility exists for a great many more sites across the state of Alaska to become eligible.

Under Section 340B of the Public Health Service Act (42 U.S.C. 256b), drug manufacturers must enter into agreements with HHS to provide covered outpatient drugs to covered entities at discounted prices. This limits the cost to covered entities. FQHC's (Federally Qualified Health Centers) are included in the list of entities eligible to purchase covered drugs at discounted prices.

A Section 340B entity can bill no more than its actual acquisition cost plus a reasonable dispensing fee. This specifically allows for contract Pharmacies and the reasonable dispensing fee can provide financial motivation to participate.

Because of the infrastructure of Alaska and the many federally funded sites across the state the 340B may offer statewide access to reasonably priced drugs to elder and needy individuals from a local site. Ceiling price discounts average 25-40% on most drugs. There is also the ability to negotiate for further price reductions.

Several states have authorized or are considering an expanded use of FQHC's to increase access to low cost drugs. In addition the US department of Health and Human Services has announced a recent initiative to potentially expand the programs reach to a greater number of needy individuals. Approved demonstration projects allow an increased number of Pharmacies where prescriptions can be dispensed to expand and improve patient access to affordable medications.

Task Force Assignment # 2: Ascertain the potential applicability of Medicaid regulations and waivers to the needs of the elderly low to moderate income Alaskans and other Medicaid-eligible Alaskans for assistance with the costs of the prescription drugs.

Medicaid already provides prescription drug coverage to many low-income aged and disabled, as well as low-income children and their families. It currently covers Alaskans age 65 and older and adults with disabilities with incomes below approximately 110 percent of the federal poverty guidelines for Alaska. There is also an asset test. Individuals may have $2,000 in countable assets; couples may have $3,000. People's homes, personal belongings and, in most cases, at least one car, are excluded in counting assets. Recipients are required to make a co-payment of $2 per prescription. There is a requirement that generics be used when available, unless a physician provides medical justification.

Regulation: There is little potential to increase the assistance to elderly low and moderate income Alaskans through regulation changes alone. With statute changes, the state could increase the income and/or asset limits for seniors, or a medically-needed program, allowing moderate income people to spend down their income or resources on medical expenses to qualify for Medicaid. However, both of these options would result in broad-based expansion of the Medicaid program far beyond increased assistance with drug costs.

There are some ways in which regulation changes could supplement other efforts, which would require legislation. For example, the Medicaid program could implement drug regimen reviews, a preferred drug list, or higher copayments for brand-name drugs to reduce Medicaid spending on prescription drugs for those currently covered. These savings could be used in conjunction with a waiver (see below) to expand Medicaid prescription drug coverage.

Waivers: Section 1115 of the Social Security Act, allows for states to seek demonstration waivers from the Secretary of Health and Human Services to provide services or cover people not otherwise covered under federal law. These waivers are supposed to be consistent with Medicaid program purposes and be budget neutral. States seeking to use Medicaid to provide targeted assistance with prescription drug costs for seniors typically use Section 1115 waivers.

To encourage states to expand prescription drug coverage, the Secretary of Health and Human Services introduced the Pharmacy Plus initiative in January 2002. This initiative sets forth guidelines for states to apply for 1115 waivers to extend prescription drug coverage to more low-income seniors and people with disabilities who would not otherwise be eligible for Medicaid. States have flexibility to determine eligibility requirements and the extent and form of the assistance provided. CMS encourages states to consider the use of a pharmacy benefits manager (PBM) either for the expansion group or the entire Medicaid population.

Like all 1115 waivers, states must show budget neutrality. According to CMS, "[i]t is expected that States will demonstrate how their demonstration program will expand pharmacy services, produce offsetting reductions in Medicaid expenditures for acute and long term care, and incorporate private-sector tools for encouraging cost containment through cost effective utilization of pharmaceuticals."

Some of the cost can also be offset by imposing higher premiums, co-payments, and deductibles on the waiver expansion group than for existing Medicaid coverage groups. A review of the literature suggests that states that try to finance their expansion primarily through client cost-sharing are the most susceptible to legal challenge from drug manufacturers.

The state can also include cost saving measures that do not require waivers, such as implementing drug regimen reviews or a preferred drug list, as part of its overall savings strategy. But Alaska may not be able to expand as much as other states that pursue Pharmacy Plus waivers. In medically needy states, it is anticipated that some individuals not otherwise eligible for Medicaid will spend down to qualify as a result of their lack of prescription drug coverage. Alaska could anticipate no savings from this. Other states can use the waiver to integrate existing state-financed pharmacy assistance programs for seniors, providing a source of state Medicaid match not available to Alaska.

Task Force Assignment # 3: gather demographic information on the senior population in the state and its likely size and makeup over the next 10 years.

Alaska's senior population is one of the fastest growing in the nation and is the fastest growing sector of Alaska's population. According to the Alaska Department of Labor and Workforce Development[1], the number of Alaskans 65 years of age and older in 1998 is expected to more than triple from 32,726, or approximately 6% of the population to 92,356, or approximately 12 percent, in 2018. The population projections are shown below.

Year	65+ Population Estimate	Percent Change from 1998
July 98	32,726	0
July 03	40,379	23.39%
July 08	52,298	59.81%
July 13	69,555	112.54%
July 18	92,356	182.21%

The majority of this population will be centered around Anchorage and the Matanuska-Susitna Borough. These areas, together with Fairbanks, Kenai Peninsula, Juneau, and Valdez-Cordova will account for 85 percent of the senior population's expected growth.

Women make up 48.3 percent of the total Alaska population, and men the other 51.7 percent. However, this ratio reverses with age. Alaska women age 65 and over made up 53 percent of the senior population compared for 47 percent for men in 2000. As senior citizens age, this ratio changes significantly. Alaska women over the age of 85 make up 65.7 percent of the total population within this age group.

[1] This section has been prepared from census data prepared by the Alaska Department of Labor and Workforce Development and an article in Alaska Economic Trends, Seniors in Alaska, Cristina Klein, Deputy Director, Division of Senior Services, Department of Administration, December 2001.

Task Force Assignment # 4: Develop Reliable Estimates For How Much Alaska's Senior Citizens Have Been Spending And Will Probably Spend Each Year On Prescription Drugs And Their Rates Of Drug Usage Over The Past Five Years And Over The Next Five Years

Without a detailed survey of Alaska's senior citizens, an exact estimate of how much money has been spent on prescription drugs is not possible. However, members of the task force reviewed the expenditures of various health insurance providers that cover senior citizens 65 years of age or older.

The table shows the average total expenditures for prescription drugs for senior citizens 65 years of age or older. These estimates indicate that in 2002, annual prescription drug costs range from $1,446 to $2,842 per senior citizen. The average number of prescriptions per senior citizen was just about 18 prescriptions. The estimated prescription drug cost increase to a range of $2,908 to $5,716 in the year 2007.

It is important to note that the figures described above and shown below in the tables are total prescription drug expenditures for senior citizens with prescription drug insurance coverage. Accordingly, the actual out of pocket expense is the co-payment of $5 to $20 dollars each time a prescription is filled.

Again, although no reliable statistics for Alaska are available, it is commonly reported that approximately one-third of senior citizens in the United States have no prescription drug coverage. In Alaska, this would equate to approximately 11,000 senior citizens. If these senior citizens were to have out of pocket costs of 50% of those shown in the below tables, the individual costs would be about $725 to $1,000 per year. Or for the entire 11,000 senior citizens without coverage, the annual cost could be from $7.97 to 11.00 million a year for Alaska's.

Prescription Drug Cost and Utilization Estimates
Estimated Total Prescription Drug Spending Per Person

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Alaska State Retirees			1,095	1,287	1,446	1,663	1,912	2,199	2,529	2,908
CBO					2,387	2,928	3,224	3,549	3,908	4,302
Families USA	1,181	1,307	1,446	1,586	1,739	1,908	2,092	2,294	2,478	2,676
Alaska Medicaid	1,709	1,811	2,188	2,451	2,842	3,268	3,759	4,322	4,971	5,716

Notes on Estimates:

Alaska State Retirees:
40% of retirees live outside of Alaska
Spending estimates are not retail (i.e. reflect actual discounted payments)
2003-2007 estimates assume a 15% annual increase

CBO (Congressional Budget Office)
National Medicare population (includes under 65 Medicare beneficiaries)
Testimony before the Committee on Finance (US Senate) March 2002
Increased by 20% which represents the additional average retail prescription drug costs in Alaska compared with the national average (Verispan Scott Levin's Source Prescription Audit)

Families USA
National Medicare population (does not include under 65 Medicare beneficiaries)
From Cost Overdose: Growth in Drug Spending for the Elderly, 1992-2010
Increased by 20% which represents the additional average retail prescription drug costs in Alaska compared with the national average (Verispan Scott Levin's Source Prescription Audit)

Alaska Medicaid
Spending estimates are retail
2003-2007 estimates assume a 15% annual increase

Estimated Total Prescriptions Per Person

	1998	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
Alaska State Retirees			16.27	17.35	17.65	18.36	19.10	19.86	20.65	21.85
Families USA	15.90	16.49	17.10	17.76	18.44	19.14	19.88	20.64	21.11	21.59

Families USA
Adjusted by 60% based on Premera Blue Cross insured data that shows that Alaskans utilize about 60% of the number of prescriptions that a similar population in Washington utilizes.

Estimated Total Prescription Drug Spending For Alaskans 65 and Older**

2002	$78,000,000
2003	$92,000,000
2004	$110,000,000
2005	$132,000,000
2006	$157,000,000
2007	$187,000,000

**Average of above estimates (not including CBO) of total prescription spending per person times the Estimated Alaska Department of Labor 65+ population projections under # 3.

Task Force Assignment # 5: Hold Public Hearings And Use Other Means To Solicit As Much Helpful Information As Possible On This Subject From The Citizens Of The State, Including Patients, Doctors, Hospitals, Insurance Providers, Representatives Of Pharmaceutical Companies And Other Alaskans

The task force held five separate meetings, all of which were properly noticed to the public. One meeting was a public hearing that was held for several hours in the middle of the day as well as in the evening.

Information about the task force meetings appeared in print media and the public hearing was promoted to all target groups, particularly senior organizations and facilities that serve Alaska's seniors.

Input was received in writing, by testimony, by teleconference and by special solicitation by the task force members. Input was received from several states and national organizations.

Task Force Assignment # 6: Develop Recommendations For Regulations, Waiver Applications, and Legislation That This State Should Pursue In Assisting Alaskans With The Costs Of Their Prescription Drugs, And Project A Cost To The State For Each Recommendation

The task force considers it important to recognize that these recommendations do not focus solely on reducing the cost of prescription medications. It is equally important to consider improving the health status as an overall and appropriate goal. We have only to look to the experience of the Alaska Pioneer Homes to see this.

When the Pioneer Home staff pharmacists began to perform drug regimen reviews, the typical Pioneer (average age 89) was taking 14 medications. By a simple review of all medications and discussion with the resident and his/her physician, drug usage was cut by 50%. With only 7 medications, the overall health status of the residents improved and prescription drug expenses were significantly reduced.

1. Establish a direct benefit pharmaceutical program

It is the consensus of the task force that Alaska should establish a state-funded direct benefit prescription drug program for residents who meet age or disability and income requirements whose needs cannot be met by the other recommendations.

These programs, similar to programs adopted in many other states that have proven successful and have provided the greatest benefit to those most in need due to high and hard-to-control pharmaceutical costs.

The eligible population should be those over 65 and eligible for Medicare and those under 65 who receive Medicare benefits due to disability. The Legislature should determine the most appropriate income level. However, the income level should be above that for Medicaid eligibility and most states have selected a limit determined by the federal poverty level, e.g. 150% ($16,620 single, $22,395 couple) or 200% ($22,160 single, $29,860 couple) of the Federal Poverty Level.

One of the benefits of a state-funded direct benefit program would be that it qualifies for the Medicaid best price exemption and that it will help in negotiating the highest rebates.

Develop and implement formularies, preferred drug lists and/or prior authorization requirements as cost control tools, for negotiating manufacturer rebates, and for selecting the best therapeutic medication of “fail first” triaging of drug choices.

To reduce the state’s share of the cost of a direct benefit pharmaceutical program, and to promote maintenance of individual and family responsibility, consideration should be given to requiring participant co-pays on a sliding scale basis. Sliding scales will allow the state to benefit those Alaskans with the greatest financial need. Other cost control techniques may include deductibles and maximum benefit limits.

The State should also consider including some or all of its direct benefit pharmaceutical program under a Medicaid waiver. This would allow some federal funds to be used to subsidize the costs of the program, although federal cost neutrality requirements for waivers may limit the amount available.

The State should consider adding a catastrophic benefit for those with higher incomes but extremely high prescription costs.

The State should consider a variety of delivery mechanisms but should maximize the opportunity for drug regimen reviews by pharmacists. The task force believes, based on the Alaska Pioneer Home experience, any drug regimen review process will result in reduced costs and reduced inappropriate usage.

In marketing a new state-funded direct assistance program, the State should look to the experience of the Denali KidCare program as a successful model of outreach and enrollment.

2. Establish a clearinghouse/education program on prescription drugs.

The task force recommends that Alaska establish a clearinghouse for information on prescription drugs and an educational outreach program.

Some private pharmaceutical companies have, individually or in collaboration with other companies, established free or deeply discounted prescription drugs to low-income individuals. It is difficult for individuals, physicians and pharmacists to stay up to date on the variety of available programs and the changes that the marketplace continues to create in regard to existing and new programs. The task force believes that the Department of Administration, Division of Senior Services, is a logical location for such a clearinghouse. The Division already performs extensive outreach throughout the State and houses a successful Medicare/Medicaid information program that acts as a clearinghouse on these topics. Likewise, DOA staff pharmacists of the Pioneer Homes already do outreach and education to older persons as well as to physicians and community and institutional pharmacists and other health care professionals. Funding for the Pioneer Home's outreach is temporary and should be made permanent.

A clearinghouse on available prescription drug programs can be developed with or without a direct benefit program. With a minimal investment, Alaska can greatly increase the utilization of free pharmaceutical programs from private companies by older and disabled Alaskans who meet the income parameters, as well as significantly enhance the knowledge of physicians and pharmacists about appropriate therapeutic substitutions, available generic substitutes, etc.

An educational component targeted toward consumers can include information on use of generics, therapeutic substitution as well as a drug regimen review that can act to counter the effects of direct to consumer prescription drug advertising.

An educational component targeted toward prescribing physicians should include cost information on brand name drugs, availability of less expensive generics, therapeutic substitution as well as information on conducting drug regimen reviews with patients. It will help balance the information currently provided by pharmaceutical companies encouraging the use and sale of their latest product.

3. Expand the use of the 340B program.

There are currently 34 facilities in Alaska that use the 340B program. Approximately 70 more sites are eligible. Under the 340B program, drug manufacturers must enter into agreements with the United States Department of Health and Human Services to provide covered outpatient drugs to participating entities at discounted prices. Federally Qualified Health Centers (FQHC) exist throughout Alaska. If all the entities eligible actually participated in the 340B program, discounts averaging 25-40% would be offered on most drugs and could be made available to financially needy older and younger disabled Alaskans from sites near them. The task force recommends that Alaska increase the use of safety net providers and expand the 340B drug pricing availability to more citizens throughout the State. Current and future 340B entities should be encouraged to apply to HHS as demonstration projects allowing them to expand access to more affordable medications to greater numbers of local citizens.

4. Use a preferred drug list or formulary and drug regimen review in the Medicaid program.

The task force recommends that the Alaska Medicaid program develop a preferred drug list or formulary that designates less expensive but therapeutically appropriate drugs. The Alaska Pioneer Homes already uses an approved formulary. Likewise, the task force recommends that the Medicaid program develop a drug regimen review similar to the successful reviews conducted by the Alaska Pioneer Homes.

Therapeutic substitution is the practice of dispensing an alternate chemical entity from the same therapeutic class for the drug that was ordered. In institutions like the Pioneer Homes, this is worked out prospectively as much as possible. In the event that a substitute has not been agreed upon up front, the pharmacist makes recommendations for alternate available choices to the ordering physician or other prescriber. This is different from generic substitution that is the substitution of exactly the same chemical entity and bio-equivalent drug product form for one of a different brand name.

Currently Alaska Medicaid recipients have a $2 co-payment for each prescription. The task force recommends that the Medicaid program consider changing the co-payments to a reduced amount for medications that are generic or on a preferred drug list and a higher amount for medications that are brand name, e.g. $1 or $2 for preferred drugs/generics and $3 or $4 for brand name medications.

5. Seek possible funding from private sources. The task force recommends that the State seek possible funding opportunities from private foundations interested in health issues. Many foundations are willing to collaborate with state government to develop models that reduce inappropriate prescription drug usage and costs.