



HEINZ PLAN TO **O**VERCOME **P**RESCRIPTION DRUG **E**XPENSES

Creating a Comprehensive and Affordable
Prescription Drug Program for All Persons
65 and Over and Persons with Disabilities in
Massachusetts

April 5, 2000

A project of the Heinz Family Philanthropies
Prepared by Jeffrey R. Lewis, Executive Director

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Dedication

The **H**einz plan to **O**vercome **P**rescription drug **E**xpenses **(HOPE)** is dedicated to the vision and memory of two great men. United States Senator John Heinz, and Massachusetts seniors' advocate Manny Weiner both poured their hearts and souls into creating a prescription drug program for people 65 and older. They are gone, but the HOPE plan keeps their vision, passion and spirit alive. It demonstrates that what both men believed in, and fought for, was achievable.

Letter from the Chairman

His Excellency Paul Cellucci
State House, Room 360
Boston, MA 02133

The Honorable Thomas Birmingham
Senate President
State House, Room 332
Boston, MA 02133

The Honorable Thomas Finneran
Speaker of the House of Representatives
State House, Room 356
Boston, MA 02133

Dear Governor Cellucci, Senator Birmingham, and Speaker Finneran:

Prescription drug coverage for all older Americans was one of the most important issues that my late husband, John Heinz, championed in the United States Senate. As early as 1987, he was seeking legislative solutions for this already serious problem.

Joined by colleagues from both sides of the aisle, John, a Republican, believed that we must help save our seniors from having to choose between filling a prescription and being able to buy food or other personal necessities. Sadly, in the United States today, hundreds of thousands of seniors still confront that challenge each day. Nothing could be more tragic; and, in the richest nation on the earth, nothing could be more wrong.

At the beginning of 1999, I issued a challenge to my staff and our consultants to design a plan that would create an affordable prescription drug benefit for all people 65 and over living in Massachusetts. The result – The Heinz plan to Overcome Prescription drug Expenses (HOPE) – is contained in the report that follows.

The HOPE plan, in part, builds on the already substantial work of the Massachusetts legislature and Governor Cellucci. However, the HOPE plan takes their good work the final step by creating a plan that, for the first time, offers affordable and comprehensive coverage to middle class retirees. It also builds in catastrophic coverage to help protect the thousands of seniors in Massachusetts who spend more than \$1,000 each year for prescription drug coverage.

There may be provisions contained in the HOPE plan about which some (even I) have doubts or with which they may take specific exception. But I think everyone can agree that consideration of the HOPE plan will present the Massachusetts legislature with a unique opportunity and a significant challenge.

Letter from the Chairman

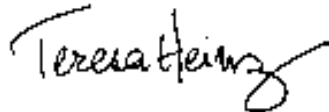
The opportunity is to be the first state in the nation to offer comprehensive prescription drug coverage for all persons 65 and over.

The challenge is to redesign the existing state Pharmacy Assistance Program in ways that will help all seniors – including those too often forgotten Americans, the members of the middle class.

From a purely practical point of view, perhaps the most important fact is that the HOPE plan uses existing state revenues already dedicated for the Pharmacy Assistance Program. Thus, the HOPE plan would provide significantly expanded coverage without requiring any new state funds.

The HOPE plan reflects a prodigious amount of work done by many extraordinary people who truly deserve to be applauded and thanked. Among them are: Annette Boyer, Ernie Lampron, and Tom Tomczyk of William M. Mercer, Incorporated for their extensive and invaluable technical expertise; Marian Wrobel and Steven Pizer of Abt Associates for their valuable economic and analytical analysis; Irwin (Tubby) Harrison of Harrison and Goldberg for his important expertise and polling and focus group research; and Frank Gannon, Frank Kurtik, Taryn Brant, Grant Oliphant, Barb Karwowski (Mercer) and Bobbi Munson for their research and editing assistance. And my particular thanks goes to Jeffrey R. Lewis, Executive Director for the Heinz Family Philanthropies, the architect of the HOPE Plan, for keeping John Heinz's spirit alive, and for working so hard to make John's vision a reality. Jeff was the Republican Staff Director for my late husband on the United States Senate Special Committee on Aging; – he now works as my chief of staff and executive director for the Heinz Family Philanthropies.

Sincerely,

A handwritten signature in black ink that reads "Teresa Heinz". The signature is written in a cursive, flowing style.

Teresa Heinz, Chairman
Heinz Family Philanthropies

I. Why this report?

On October 27, 1987, the United States Senate debated whether to expand the Medicare program to include catastrophic health insurance coverage for all eligible recipients. In a move that was ahead of his time (and, unfortunately, still ahead of our own) Senator John Heinz (R-PA) – leading a bipartisan coalition that included Senators George Mitchell, John Chafee, Tom Daschle, Ted Kennedy, Paul Simon, Don Riegle and Dave Durenberger – offered an amendment to expand Medicare to include prescription drug coverage for all recipients.¹

Senator Heinz recognized that the U.S. health care system was state-of-the-art and second to none. He understood that we had the finest equipment, the most advanced medical procedures for saving and sustaining life, superb hospitals, and highly trained physicians and other health care professionals.

But already at that early date, he recognized that the unprecedented extent of our medical advances was creating serious problems regarding fairness and access. As he told the Senate that day:

“This is an age of medical miracles, of artificial hearts, and mechanical lungs, and there is probably no greater miracle than the drugs used in combating and controlling disease. The irony is that for millions of older Americans, this miracle becomes a nightmare because of costs² ... any bill presuming to protect Medicare beneficiaries against catastrophic costs is an impostor without a provision to cover prescription drugs.”³

Even in 1987, John Heinz refused to accept that the nation which prides itself as the leader of the free world could fail to create and implement a national program to help middle class seniors from being bankrupt because of the costs of prescription drugs.

Today, the current and anticipated advances in medicine and biotechnology are likely to make prescription drugs more critical to the preservation and quality of life than ever before.

Senator Heinz believed that there was a need to redefine the role of government away from the notion of the all-encompassing welfare state that is all things to all people. Rather, he envisioned a government that more properly serves the people and provides for them, at the same time, the legitimate services they cannot otherwise, or best, find for themselves. As Chairman of the Senate Special Subcommittee on Aging, he wanted to ensure that all Americans who need help - and particularly seniors – should have access to it. Coverage for prescription drugs was then, and remains today, one of those legitimate services.

Former Senator Tim Wirth (D-Colorado), a long time personal friend of Senator Heinz, may have said it best:

I. Why this report?

“More than anything else, John Heinz believed in the power and promise of good government. Where others were cynical, he was creative. Where others gave up, he persisted. ... He simply believed that there was a proper role for government, and he demanded that it be efficient, effective and compassionate.”⁴

Teresa Heinz shared her late husband’s concerns that far too many people 65 and over desperately need help with the costs of their prescription drugs. Far too many of these seniors, including many who live in Massachusetts, find that they are not eligible for state subsidized programs, and are also unable to afford today’s high-priced private Medigap insurance plans with prescription drug benefits.

Against this background, Mrs. Heinz, now Chairman of the Heinz Family Philanthropies, sees a clear need to help those middle class seniors who do not qualify for Medicaid or other state assisted programs. Because their situation is growing increasingly critical, she challenged us to design a plan to bring prescription drug coverage to all persons 65 and over. Teresa Heinz, like Senator John Heinz, brings a special intensity of interest, a unique energy, and a sincere dedication to finding solutions for these kinds of problems.

The report that follows - The Heinz plan to Overcome Prescription drug Expenses (HOPE) – meets the challenge set forth by Mrs. Heinz, and represents an innovative and practical way for state government to help senior citizens fight the nightmare of escalating prescription drug costs, and to avoid having to choose between prescription drugs and other basic personal and household needs.

Based on months of research, focus groups, and meetings with experts, we believe that the HOPE plan, described and detailed in the following pages, accomplishes her goal. The HOPE plan will protect the truly poor seniors and, for the first time, offer financial relief to tens of thousands of middle class seniors in Massachusetts.

II. The HOPE Plan: Confronting the Tough Choices

In constructing the HOPE plan, a decision was made early on to include various provisions to address the difficult issues of cost and utilization of prescription drugs. Costs, both for the beneficiary and the Commonwealth of Massachusetts, have to be carefully managed and controlled to avoid more vexing problems once a program is passed and implemented. Our goal and strategy is to ensure that we are creating a program that can be sustained now and in the future. We believe our responsibility is to the Commonwealth, its citizens, and to future generations of taxpayers. We believe we must carefully address the evolving requirements of the beneficiary population, while balancing that objective with political and financial realities.

First, the HOPE plan will provide, for the first time in Massachusetts, a voluntary and affordable prescription drug program for all seniors –65 and over – regardless of income and for persons with disabilities with income at or below 188 percent of the federal poverty level. Upon inception, all seniors currently enrolled in the Senior Pharmacy Program and The Pharmacy Program Plus would automatically be converted to the new HOPE plan.

Second, the HOPE plan provides for responsible access to all prescription drugs through cost sharing and an incentive formulary. Individuals will pay a co-payment of \$10 for generic drugs, \$25 for preferred drugs and the greater of the preferred drug co-payment or 50 percent for non-preferred drugs. Moreover, if the individual or physician elects a brand name drug when an approved generic drug is available, the individual will pay the price difference in addition to the co-payment.

The tough choice here is the incentive formulary, which provides an effective means to manage the cost of the pharmacy plan. The use of a formulary is not a new concept but one that is misinterpreted by providers and participants as a barrier to pharmaceutical choice. Nonetheless, the formulary favorably enhances the quality and cost of the plan – through drug mix and rebates – while the benefit design allows access to all prescription drugs in a responsible manner.

Third, the HOPE plan protects seniors against catastrophic costs. The plan includes a \$3,000 annual limit on out-of-pocket expenses. In other words, once a person has spent \$3,000 a year in combined deductible and co-payments, prescription drug costs for generic and preferred drugs will be covered 100 percent by the HOPE plan, whereas the non-preferred drugs will continue to be covered at the greater of the preferred drug co-payment or 50 percent.

The tough choice here is at what level to set the catastrophic limit. Although a \$5,000 limit would have helped further reduce the overall costs of the program, we believe that such a limit would be far too high for seniors living on fixed incomes. Moreover, our effort here is to protect lower and middle income seniors, – and a combination of deductibles and co-payments equal to \$3,000 a year is already a catastrophic expense for most people. To set the limit higher is, from our perspective, poor public policy and something that could potentially penalize far too many seniors with incomes between \$12,750 and \$35,000.

II. The HOPE Plan: Confronting the Tough Choices

Fourth, to ensure that this or any pharmacy plan does not adversely impact the Commonwealth's fiscal position for seniors, we believe that all seniors with incomes at or above 150 percent of the federal poverty level must financially participate in the plan. While the HOPE plan calls for a nominal premium payment of \$24 per month and a \$100 annual deductible for seniors with household incomes ranging from \$12,750 to \$15,999, all other seniors participating would pay both a premium and deductible tied to household income. In other words, the HOPE plan is built upon a graduated premium and deductible to ensure that as a person's income rises, so does his or her personal financial responsibility.

Fifth, a difficult decision involved whether to build the HOPE plan incrementally, or start a full-blown program with every person age 65 and over being admitted to it. We believe that the HOPE plan must be incremental in its design, meaning that in each successive year after its inception, an increasing number of eligible persons age 65 and older would be admitted. This is purposely done to build a set of fiscal benchmarks for the plan. Such an approach ensures that the Commonwealth fully understands all of the costs associated with the plan and whether modifications will be required to its design. To do otherwise could place the Commonwealth and this plan in fiscal jeopardy.

Sixth, we have built into the plan's design the appropriate pharmacy benefit cost and utilization management strategies to help ensure its financial solvency. One pharmacy benefit management strategy included in the HOPE plan is a required prescription drug mail order program for maintenance and life-sustaining drugs. A maintenance drug is defined under this plan as a drug that is taken for a chronic condition, consecutively, for a period of time generally longer than three to six months.

The tough choice here is one of cost versus convenience. Because the HOPE plan is designed to provide comprehensive prescription drug coverage for all persons 65 and over, and to protect them against catastrophic out-of-pocket expenses, we looked for and included in the plan specific provisions that would help control costs while ensuring that seniors had access to needed prescription drug coverage. A required mail order program for maintenance drugs accomplishes both objectives. Seniors would not be prohibited from re-filling maintenance drug prescriptions at a local pharmacy, but the full costs of those prescriptions would be borne by the senior citizen. Thus, our approach is to build in financial incentives for people to make their decisions carefully, while always ensuring complete access.

Seventh, Massachusetts currently requires that every pharmacy be treated equally. In other words, within the Commonwealth, when contracting for prescription drug services, the state cannot limit the pharmacies at which beneficiaries purchase their drugs. This so-called "any willing provider" provision, while designed to protect independent pharmacies, limits a plan's ability to obtain the very best prices for pharmacy services. The HOPE plan would be exempt from this provision, thus enabling the Commonwealth to enter into contracts with specific pharmacies (chain and/or independent) as a means of controlling the costs of the plan.

II. The HOPE Plan: Confronting the Tough Choices

While open access to all pharmacies is a laudable goal, there is a fiduciary responsibility to ensure that the greatest value be realized for every tax dollar spent. This will not occur if the Commonwealth cannot directly negotiate the very best possible prices with chains or independent pharmacies. Because participation in the HOPE plan is voluntary, it is important both for the Commonwealth and seniors to know that they are getting the greatest value for their expenditures.

Eighth, it is possible that a plan such as this may cause some employers who currently offer post-retirement prescription drug coverage to stop such coverage for future retirees. Our hope is that employers would decide to provide future retired employees with the cash benefit to purchase this coverage. In the long term, this would greatly reduce an employer's liability. More importantly, it would recognize a trend that exists today: to compete in a global market place, we must help employers attract and retain the very best workers. Offering to help employers remain competitive and stay in Massachusetts is an important goal that cannot be ignored. But we understand that this aspect of the plan is not without controversy.

Ninth, the toughest choice of all was whether to extend this program to all seniors. We chose to do so for a variety of reasons, but primarily in order to begin a discussion of the principle that middle class seniors are not less worthy of consideration or appropriate assistance than those who are at or below the federal poverty level. The HOPE plan offers assistance to seniors with incomes up to \$35,000 annually. While the definition of income rests with the legislature, we believe that it is time for the debate on these issues to confront the needs of the middle class.

Tenth, we tackled the issue of "household equity: whether each person in a married couple should pay a separate premium and deductible. We concluded that they should.

Eleventh, critical to the success of this plan are enrollment procedures that incorporate a variety of choices that are easy to understand, – including telephone, Internet, senior center, welfare office, mail, etc. We have built into the overall budget of the HOPE plan \$2 million for an aggressive, private sector marketing campaign. The use of private sector marketing expertise is critical to the design of a successful outreach program.

We believe beneficiaries should have an initial election period during which they can accept or decline prescription drug coverage under the plan. If they decline because of existing post-employment retirement insurance that includes prescription drug coverage, they should be permitted to join the HOPE plan if their employment-related plan is discontinued or becomes substantially more expensive. Delayed election would, however, result in an actuarially increased premium. Enrollment during the first year of the program must, however, remain flexible. We specifically do not want to deny access to this plan to someone who, for whatever reason, fails to meet an arbitrary cutoff. This must be balanced against the need to control adverse selection.

II. The HOPE Plan: Confronting the Tough Choices

Twelfth, in subsequent years of the program, deductibles, co-payments and the out-of-pocket limit will be tied to the actual drug trend experienced under the program. In other words, based on the drug trend – increase or decrease – the deductibles, co-payments, and out-of-pocket limit will be adjusted accordingly. This is included as part of the HOPE plan to ensure that the costs of the plan – both for beneficiaries and the Commonwealth – continue to remain current and not place the plan in fiscal jeopardy.

Thirteenth, the HOPE plan recommends the creation of a Prescription Drug Review Commission. Because this would be a legislatively-created plan, we believe that the legislature needs to be completely involved in, and focused on, the difficult decisions that plans like the HOPE plan and any plan that sets out to achieve prescription drug coverage for all seniors will require. To that end, the Commission shall consist of sixteen members including the Senate President and the Speaker of the House who shall serve as co-chairs. The structure and the responsibilities of the Prescription Drug Review Commission are discussed in section IX.

Fourteenth, it is currently estimated that about one in eight Medicare beneficiaries have prescription drug coverage through the Medicaid program. There are, however, many more seniors eligible for Medicaid who are not enrolled because states do not aggressively seek them out. According to one report, only about 40 percent of Medicare beneficiaries eligible for Medicaid are actually enrolled. Consequently, dually eligible seniors would not be eligible for the HOPE plan.

If the Commonwealth is committed to constructing a truly comprehensive prescription drug program for the elderly and disabled, then the legislature should instruct the Commissioner of Revenue, the Director of the MassHealth program (the state's Medicaid program) and the Director of the Senior Pharmacy Program to deliver a strategy on how to find all eligible seniors and disabled persons and what the potential costs to the Commonwealth would be if these people were enrolled in the MassHealth program.

This is, by itself, an historic opportunity for the Commonwealth to decide what level of commitment it is willing to make to seniors and disabled persons living in Massachusetts.

Fifteenth, in order to obtain the greatest value for the dollar spent, the Commonwealth should explore what cost savings might accrue if all existing state programs that provide prescription drug coverage such as MassHealth(Medicaid), retired state employees, HOPE, etc. purchased their drugs collectively. Moreover, in order to help the non-profit or not-for-profit HMOs with their prescription drug costs, the Commonwealth should also explore adding these groups to the purchasing pool to help mitigate problems of adverse selection. Should savings accrue to the HMOs, the Commonwealth should examine how those savings could be used and possibly matched to help with a prescription drug program for the uninsured with an emphasis on uninsured children.

II. The HOPE Plan: Confronting the Tough Choices

Sixteenth, because the HOPE plan strives for the highest standards in continuing medical and pharmaceutical education programs, physicians and pharmacists will be required to participate in an annual internet-based accredited continuing education program – specific to a provider’s discipline – targeted to evidence-based pharmaceutical therapies.

Seventeenth, to ensure that the HOPE plan is financially sound well into the future, the program will sunset after three years. This will require the Legislature to thoughtfully and carefully reevaluate the HOPE plan to ensure its fiscal integrity and the Commonwealth’s overall fiscal position. Moreover, including a “sunset” provision requires an act of affirmation from the legislature in order to continue the program in its current posture or to modify it for the future.

A “sunset” provision is not something many people like because it starts a program and then forces a legislative body to reaffirm a few years later that it in fact made the right decision. However, given the costs involved with a program like this, we believe that the Legislature owes it to current and future generations of taxpayers not to burden them with a program that could become fiscally overwhelming. And, for the fiscally responsible, it provides an opportunity to assess where, if at all, changes need to be made to the program. More than anything else, a “sunset” provision forces a Legislature to carefully analyze trend data, cost data and reevaluate its own decisions made years earlier. For a program of this magnitude we believe it would be fiscally prudent.

Finally, one of the toughest of all the “tough choices” was the issue of whether to include the disabled population as part of the new HOPE plan. In 1999, the Massachusetts legislature added disabled persons not eligible for Medicaid to the state pharmacy assistance programs. The HOPE plan does not alter that. However, it must be said that this toughest of choices was only made with considerable reservations.

The prescription drug needs of the disabled population are extensive and the costs associated with those needs are incredibly expensive. As our report illustrates, compared with persons 65 and over, the costs for the disabled – a fraction of the population of the elderly – could place this program in fiscal jeopardy. Nevertheless, like middle class seniors, persons with severe disabilities who do not qualify for Medicaid are far too often forgotten.

To combat what we believe to be a potentially serious fiscal problem, the HOPE plan recommends that the disabled population be incrementally enrolled. To do so treats persons age 65 and over and the disabled population equally and fairly. This approach will begin to provide the Commonwealth with a greatly needed database and with the fiscal benchmarks to determine what the true prescription drug costs and utilization are for the disabled population.

Then and only then will the Massachusetts Prescription Drug Review Commission have the ability to determine how, if at all, to modify the HOPE plan in the future.

III. The HOPE Plan: Executive Summary

The Heinz Family Philanthropies engaged William M. Mercer, Incorporated to assist with the design of and provide financial projections for the development of the **H**einz plan to **O**vercome **P**rescription drug **E**xpenses (HOPE). The HOPE plan is a prescription drug program that will be made available to all seniors (age 65 and over) and disabled persons with annual household incomes at or below 188% of the federal poverty level who reside in the Commonwealth of Massachusetts.

The goal was to demonstrate how an effective combination of cost sharing, pharmacy management, and volume purchasing could yield a comprehensive prescription drug program that would be affordable for senior and income-qualified disabled residents. Consequently, our efforts in Massachusetts have resulted in a proposed statewide prescription drug program that is unique in one particular way: in addition to covering seniors living at or below the poverty level, the HOPE plan would also be available and affordable to middle class seniors.

The HOPE plan is focused exclusively on the 860,000 seniors – age 65 and over - residing in Massachusetts and those individuals who are disabled with incomes at or below 188 percent of the federal poverty level. Seniors eligible for MassHealth (Medicaid) were not considered for the HOPE plan.

The HOPE plan is based on four guiding principles:

- comprehensive drug coverage;
- responsible access to all prescription drugs;
- affordability; and
- budget neutrality for the Commonwealth.

An important characteristic of the HOPE plan is that it can be adjusted to accommodate the Commonwealth's budget allocations without compromising the core advantages of the plan.

THE HOPE PLAN: DESIGN AND MANAGEMENT

The HOPE plan has the following provisions built into the pharmacy benefit design for each individual:

- income-based annual deductible and premium contributions;
- responsible access to all prescription drugs through a balanced cost share and incentive formulary;
- an annual out-of-pocket limit to protect against catastrophic costs; and
- pharmacy benefit management through a specialized vendor.

III. The HOPE Plan: Executive Summary

Income-based Annual Deductible and Premium Contribution

The HOPE plan requires seniors with household incomes at or above 150 percent of the federal poverty level to participate financially in the plan. However, the annual premiums and deductibles are intended to be affordable for seniors and income-qualified disabled persons within a given household income bracket. The HOPE plan recommended annual deductibles and monthly premiums based on household income are provided in Table D on page 22.

In summary, individuals in the lowest household income bracket – \$0 to \$12,750 - are not subject to a premium and annual deductible contribution. Consequently, individuals with household incomes in one of the higher income brackets will pay up to the full premium for the plan and will have a maximum annual deductible of \$450. Deductibles will be adjusted annually according to the actual drug trend experienced under the program.

Responsible Access to All Prescription Drugs

The HOPE plan provides for responsible access to all prescription drugs through balanced cost sharing and an incentive formulary. Once an individual meets the annual deductible, they are required to pay an amount – referred to as a co-payment – toward the cost of each prescription.

Under the HOPE plan, an individual will pay a co-payment of \$10 for generic drugs, \$25 for preferred drugs and the greater of the preferred drug co-payment or 50 percent for non-preferred drugs. A mandatory generic provision is also applied to the three-tier co-payment design. Under the mandatory generic provision, if an individual or physician requests a brand name drug when an approved generic drug is available, the individual is required to pay the price difference between the brand and generic drug in addition to the co-payment.

The three-tier co-payments recommended for the HOPE plan are displayed in Table E on page 23. Annually, the co-payments, along with the deductibles and the out-of-pocket limit, will be adjusted according to the actual drug trend experienced under the program. In the HOPE plan model, pharmacy benefit trends of 19 percent for year two and 20 percent for year three were used. Once the program is operational, the benefit trends may vary as a result of increased drug utilization and costs and the impact of new pharmaceuticals.

The three-tier co-payment design provides for responsible access to all prescription drugs through an incentive formulary. The formulary will be designed to favorably enhance the quality and cost of the plan through drug mix and rebates, in addition to addressing new pharmaceutical products and evidence-based prescribing guidelines. The financial impact to the pharmacy plan is ultimately dependent on the specific drugs selected for preferred status on the drug formulary.

III. The HOPE Plan: Executive Summary

Catastrophic Protection

To allow for catastrophic coverage, the HOPE plan has an annual out-of-pocket limit of \$3,000. Once a person has spent \$3,000 a year in combined deductible and co-payments, prescription drug costs for generic and preferred drugs will be covered 100 percent by the HOPE plan, whereas the non-preferred drugs continue to be covered at the greater of the preferred drug co-payment or 50 percent. The costs associated with the non-preferred drugs do not apply to the \$3000 out-of-pocket limit.

Pharmacy Management Strategies

The HOPE plan is designed to manage the prescription drug needs of seniors through a balance of appropriate access and cost and utilization controls. In addition, the pharmacy plan focuses on enhancing quality by reducing negative drug interactions and minimizing the inappropriate under-utilization and over-utilization of drugs.

The Commonwealth can accomplish this objective by contracting with a pharmacy benefit manager (PBM) that specializes in providing administrative and management services to reduce the cost of pharmacy benefits. The use of a PBM provides uniform administration of the program and maximizes the Commonwealth's capacity to negotiate the best prices for discounted networks, mail order and formulary rebates. The PBM – selected through a competitive bidding process – will be required to partner with the Commonwealth to reduce the costs of the plan through the following pharmacy management strategies, in addition to administrative efficiencies.

- A customized, discounted retail network of chain and/or independent pharmacies with services provided at the pharmacy level to impact the quality of care for seniors and the disabled.
- A required prescription drug mail-order program for maintenance medications.
- An incentive formulary with targeted intervention programs that encourage the use of generics and preferred drugs to drive utilization to the most appropriate and cost-effective medications.
- Drug utilization review and education programs to advance provider and patient understanding of new and existing therapies, benefits of these therapies and associated costs.
- Quality assurance programs that educate seniors and providers about high-cost diseases, such as diabetes or heart disease, to encourage better compliance and lifestyle changes.

III. The HOPE Plan: Executive Summary

THE HOPE PLAN: FINANCIAL SUMMARY AND OVERSIGHT

Under the HOPE Plan, the Commonwealth’s total net costs for a three-year period – based on enrollment, cost and contribution projections – is summarized in Table A. For example, if the HOPE Plan was fully implemented in the year 2000, the total annual cost to the Commonwealth is projected to be \$69.4 million. This total is the sum of \$60.3 million for covering the seniors and \$9.1 million for covering the income-qualified disabled in the plan.

| TABLE A –THE HOPE PLAN | | |
|------------------------|-------------|------------|
| Financial Summary | | |
| | Enrollment* | Net Cost** |
| Seniors | Year 2000 | 127,935 |
| | Year 2001 | 145,133 |
| | Year 2002 | 162,333 |
| Disabled | Year 2000 | 4,644 |
| | Year 2001 | 5,108 |
| | Year 2002 | 5,572 |
| Total | Year 2000 | 132,579 |
| | Year 2001 | 150,241 |
| | Year 2002 | 167,905 |

* Enrollment includes seniors and disabled in the Senior Pharmacy Plan

** Net cost is after the application of deductible , co-payments, premiums and coordination of benefits

In subsequent years – based on projected drug trends of 19 percent and 20 percent, respectively – the Commonwealth’s net costs will increase due to the increases in the utilization and costs of prescription drugs and the projected enrollment.

Financial Risk

With annual pharmacy benefit trends ranging from 15 to 26 percent,⁵ there is a substantial financial risk associated with offering a pharmacy plan to seniors. Accordingly, HMOs in Massachusetts have withdrawn plans that provide unlimited pharmacy coverage. Furthermore, employers who offer retiree health insurance plans have reduced pharmacy benefits or discontinued pharmacy coverage for their employees.

III. The HOPE Plan: Executive Summary

The primary factors affecting financial risk for the HOPE plan are threefold. First, and most important, is the enrollment of individuals eligible for premium subsidies would exceed what is projected. Second is the vulnerability of adverse selection. And, third is that the actual average prescription drug cost, utilization, and administrative cost per person would exceed those projected. These factors and underestimating these averages are also risks associated with the Commonwealth's current pharmacy assistance plans.

Nonetheless, the risk of covering pharmacy benefits can be controlled to the same extent as covering other medical benefits with adequate underwriting and enrollment guidelines. Furthermore, these risks can be controlled by rigorously monitoring the pharmacy plan costs and premium revenue and, if necessary, by limiting enrollment or adjusting premium subsidies.

Pharmacy Plan Oversight

The HOPE plan recommends the creation of a Prescription Drug Review Commission to be involved in, and focused on, the difficult decisions that pharmacy plans like the HOPE plan and any plan that sets out to achieve prescription drug coverage for all seniors requires. The overall purpose of the Commission is 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 Commission shall have sole responsibility for approving changes to co-payments, deductibles, out-of-pocket limits, drug exclusions and premiums in relation to pharmacy benefit trends. The formal structure and the responsibilities of the Prescription Drug Review Commission are discussed in section IX.

In Summary, it is becoming increasingly difficult and expensive for seniors, many of whom live on fixed incomes, to meet their prescription drug expenses. In many instances the incomes of seniors are too low for them to meet their basic needs and also buy optional medical care. As prescription drugs play an ever-increasing role in overall medical care, affordable coverage coupled with the management of their appropriate use will only grow in importance. Therefore, it is critical that our society demonstrate an increasing level of commitment to assist seniors in meeting their prescription drug needs through comprehensive, affordable, and responsible prescription drug programs such as the HOPE plan.

IV. Prescription Drug Benefits for Seniors: The Situation in America Today

Background

Today, prescription drugs treat a broad range of illnesses and chronic conditions such as cancer, heart disease, and depression. Prescription drugs have contributed to increased life expectancy and to the dramatic improvement in the quality of life that characterize our country at the dawn of the new millennium.

As Table B below illustrates, between the years 1992 and 1997, spending on prescription drugs grew twice as fast as total national health spending, averaging over 11 percent growth per year, compared to 5.5 percent per year.

| TABLE B - NATIONAL HEALTH EXPENDITURES: ANNUAL PERCENTAGE GROWTH 1992-1997 | | | | | | | |
|--|-------|------|------|-------|-------|-------|-------------------|
| | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 5-Year Average |
| Total | 9.1% | 7.4% | 5.5% | 4.9% | 4.9% | 4.8% | 5.5% |
| Hospital Care | 8.2% | 5.8% | 3.9% | 3.4% | 3.9% | 2.9% | 4.0% |
| Physician Services | 8.5% | 5.7% | 3.8% | 4.6% | 3.3% | 4.4% | 4.3% |
| Nursing Home | 9.0% | 6.7% | 7.0% | 6.2% | 5.2% | 4.3% | 5.9% |
| Prescription Drugs | 10.6% | 8.7% | 9.0% | 10.6% | 13.2% | 14.1% | 11.1% |

Source: National Institute for Health Care Management Research and Educational Foundation, "Factors Affecting the Growth of Prescription Drug Expenditures, July 9, 1999, Pg. 1.

IV. Prescription Drug Benefits for Seniors: The Situation in America Today

Prescription drugs are particularly important for the senior population. While seniors make up only 12 percent of the United States population, they consume almost 35 percent of all prescription drugs.⁶ The average senior fills 18 prescriptions a year. In 1970, outpatient prescription drug spending was approximately \$5.5 billion in the United States. By 1997, it had increased to \$78.9 billion.

The already high – and constantly increasing – costs of these prescription drugs have become a serious problem for all Americans. For American seniors, most of them retired, living on fixed incomes, and lacking access to affordable, comprehensive drug coverage, the problem is acute and chronic.

Depending principally on their employment status and level of income, seniors may seek help with prescription drug costs from several sources. Among these are Medigap, Medicare+Choice plans, Medicaid, and employer-provided post-retirement health insurance coverage.

In 1999, the Domestic Policy Council of the White House’s National Economic Council reported that, as of the year 2000, the average total drug costs for Medicare beneficiaries will approach \$1,000.⁷ Over one-third (38 percent) of Medicare beneficiaries will spend more than \$1,000 on prescription drugs; and just less than 5 percent of Medicare beneficiaries will spend more than \$5,000.

Medicare itself does not cover outpatient prescription drugs. And, currently, 35 percent of fee-for-service Medicare beneficiaries lack any kind of prescription drug coverage.⁸ Many have little or no supplemental coverage for their prescription drugs.

And, while estimates suggest that 65 percent of Medicare participants have some form of drug coverage through private Medigap insurance, Medicare+Choice plans, or through post-retirement insurance from a former employer, that figure is shrinking.⁹

Medigap Policies

Approximately 3.2 million Medicare beneficiaries (13 percent) obtain prescription drug coverage through supplemental Medigap policies that they purchase individually.¹⁰ Medigap policies offer supplemental coverage for expenses not picked up by Medicare, such as deductibles and co-payments.

Of the ten standard Medigap policy designs, however, only three offer prescription drug coverage as part of the benefit package. And even the coverage offered by these three plans is limited and expensive. Two of the plans that offer prescription drug coverage (plans “H” and “I”) only cover 50 percent of prescription drug costs to a maximum benefit of \$1,250 with a \$250 deductible. The maximum prescription drug benefit on the third plan (plan “J”) is \$3,000. The incremental cost of the pharmacy coverage in these plans ranges from \$300 to \$500 per year and is high relative to other coverage options. (It should be noted that not all plans are available in all states because of state regulatory considerations.)

IV. Prescription Drug Benefits for Seniors: The Situation in America Today

Medicare+Choice

Because Medicare does not provide an outpatient prescription drug benefit, many seniors have been attracted to the Medicare+Choice program – and other managed care programs including HMOs – that offer a prescription drug benefit as an inducement to enroll. In 1999, 13 percent of Medicare beneficiaries obtained their prescription drug coverage through a Medicare+Choice HMO.¹¹

But the future of these benefits is uncertain. Many plans, faced with rapidly escalating prescription drug benefit costs and declining reimbursement from the federal government, are reducing the prescription drug benefit, or even eliminating it entirely.

For example, in the fourth quarter of 1998, 400,000 of the almost 6 million participants in Medicare+Choice plans stopped receiving prescription drug benefits. Some 50,000 of these beneficiaries lived in areas where no Medicare+Choice plans remain. Their only alternative was to use prescription drug plans supplementing traditional fee-for-service Medicare – if any of these were available or affordable. This trend progressed through 1999 and is expected to continue.

Compounding the problem is the fact that nearly three-fifths of Medicare+Choice plans still offering prescription drug benefits are reporting plans to cap present prescription drug benefits below \$1,000 this year. Since as we have seen, more than one-third of Medicare recipients (about 38 percent) are expected to spend more than \$1,000 on prescription drugs this year,¹² the problems are clear.

In the near future, the days of \$1,000 benefit caps may be viewed nostalgically. It is expected that the proportion of Medicare+Choice plans with \$500 or lower benefit caps will increase by over fifty percent.¹³

Medicaid

About one in eight Medicare beneficiaries has prescription drug coverage through the Medicaid program. Medicaid provides medical assistance to certain categories of low-income people, including the aged and the disabled, through a federal-state partnership. Although not required to do so, all states currently cover prescription drugs as part of their Medicaid programs.

Unfortunately, Medicaid programs typically do not enroll all those who are eligible for benefits. Under-enrollment in the Medicaid program is caused by many factors, including insufficient outreach to eligible individuals. According to a recent Kaiser Family Foundation study, for example, only about 40 percent of Medicare beneficiaries eligible for Medicaid are actually enrolled.¹⁴ If the whole senior population has a similar participation rate, many seniors who qualify to receive pharmacy benefits do not in fact receive them.

IV. Prescription Drug Benefits for Seniors: The Situation in America Today

Post-Retirement Health Insurance Coverage

At present, one-third of former employees are provided with post-retirement health insurance coverage by an employer.¹⁵ There is strong evidence, however, that this is declining.

One in four seniors who had drug coverage through a retiree health plan between 1994 and 1998 lost that benefit. A national survey of employer-sponsored health plans, conducted in 1999 by Mercer/Foster Higgins, found that retiree health insurance coverage dropped from 40 percent of employers in 1993 to a low of 28 percent in 1999.¹⁶

One of the principal factors contributing to employer termination of retiree health insurance is the escalating cost of prescription drug coverage.¹⁷ In 1999, prescription drugs accounted for 20 percent of retiree medical plan costs.¹⁸

V. Prescription Drug Benefits for Seniors: The Situation in Massachusetts Today

In Massachusetts, there were over 860,000 seniors age 65 and over in 1998. More than 30 percent reported that they had no coverage for prescription drugs. Currently, the Commonwealth of Massachusetts provides prescription drug assistance to poor and lower income seniors through three programs:

- **The Senior Pharmacy Program** which offers a \$1,250 annual prescription drug benefit to seniors with annual incomes below \$15,492 and to families with annual incomes below \$20,769, respectively. As of February 2000, approximately 36,000 seniors and income-qualified disabled are enrolled in the Senior Pharmacy Program.
- **The Pharmacy Program Plus** for seniors and disabled persons who incur prescription drug expenditures that exceed 10 percent of their annual incomes and who meet other specified requirements.
- **MassHealth**, the state Medicaid program, which provides comprehensive medical coverage that includes a full prescription drug benefit for seniors with incomes below the federal poverty level and assets under the prescribed limits.

All these prescription drug plans offered by the Commonwealth only assist seniors in the lowest income brackets. Of the state's senior population, 290,000 are estimated to have annual incomes below 188 percent of the federal poverty level. Even these seniors are not protected once their annual prescription drug costs exceed \$1,250 unless they qualify for the Pharmacy Program Plus or become eligible for Medicaid. Nonetheless, today, none of these plans offer protection to seniors in the middle income brackets.

In Massachusetts, the situation is similar to what is occurring at a national level. Seniors 65 and older representing 14% of the total population in the Commonwealth are particularly vulnerable to high prescription drug costs. The trends in prescription drug benefits have been increasing at a rate of 15 percent to 26 percent per year, and even greater trends are seen in programs where individuals age 65 and older are covered.

Prior to 1998, Massachusetts was the only state with a Medicare prescription drug mandate for unlimited prescription drug benefits. However, following a Federal District Court ruling upholding a federal law, Medicare HMOs have been able to reduce pharmacy benefits in order to mitigate these increases. As a result, all Massachusetts Medicare HMOs have discontinued the unlimited prescription coverage formerly available to seniors.

In Massachusetts today, the four Medicare+Choice plans available offer extremely limited prescription drug benefits. While the prescription co-payment is generally reasonable, all of these plans cap their drug benefit quarterly and annually. In other words, while a plan may offer an \$800 annual drug benefit, it generally divides that benefit into quarters – or \$200 every three months. Therefore, a senior who has filled three or four prescriptions is already likely to have exhausted the quarterly limit. He or she must then pay 100 percent of the cost for all other drugs purchased that quarter.

V. Prescription Drug Benefits for Seniors: The Situation in Massachusetts Today

Medex Gold, a supplemental Medigap policy offered by Blue Cross Blue Shield of Massachusetts, offers unlimited prescription drug coverage, however, the premiums for this coverage are beyond the means of many seniors. Effective March 1, 2000, Blue Cross Blue Shield of Massachusetts charges seniors \$314.59 per month for a Medex Gold policy.

Thus, the HOPE plan provides an option for comprehensive, affordable prescription drug coverage in Massachusetts. Table C, compares the HOPE plan to the current options available for seniors in Massachusetts today.

| TABLE C - THE HOPE PLAN Comparison To Current Programs Offering Prescription Drug Benefits in Massachusetts | | | | | |
|---|---------------------------------------|-----------------------|--|--------------------|---------------------|
| | Monthly Premium* | Deductible | Retail Co-payment | Annual Benefit Max | Out-of-Pocket Limit |
| Medex Gold (Medigap) | \$315 | \$35 Quarterly | Generic drug - \$0 Brand drug - 20% | None | None |
| Medicare + Choice HMOs | \$0 to \$50 | None | Generic drug - \$5 to \$8 Brand drug - \$15 Non-preferred - \$15 to \$75 | \$550 to \$800 | None |
| Senior Pharmacy Plan** | No monthly premium \$10 annual fee | None | Generic drug - \$3 Brand drug - \$10 | \$1,250 | Unlimited |
| Pharmacy Program Plus *** | None | 10% of income | Generic drug - \$3 Brand drug - \$10 | None | Partially Limited |
| The HOPE Plan | \$0 to \$69 | \$0 to \$450 Annually | Generic drug - \$10 Preferred drug - \$25 Non-preferred - >\$25 or 50% | None | \$3000 |

*Average premiums are for the benefit period 2000

**The Senior Pharmacy Program offers a prescription drug benefit to seniors and the disabled with annual incomes below \$15,492, and to families with annual incomes below \$20,769, respectively.

*** The Pharmacy Program Plus for seniors and disabled who incur prescription drug expenditures that exceed 10 percent of their annual income and who meet other specified requirements.

VI. The HOPE Plan: Pharmacy Benefit Design and Management

Pharmacy Benefit Design

The HOPE plan has the following provisions built into the pharmacy benefit design for each individual:

- income-based annual deductible and premium contributions;
- responsible access to all prescription drugs through a balanced cost sharing and an incentive formulary;
- an annual out-of-pocket limit to protect against catastrophic costs; and
- pharmacy management strategies through a specialized vendor.

Income-based Annual Deductible and Premium Contribution

The HOPE plan requires seniors with household incomes at or above 150 percent of the federal poverty level to participate in the plan financially. However, the annual deductibles and premiums - Table D - are intended to be affordable for seniors and income-qualified disabled persons within a given household income bracket. Individuals in the lowest income bracket - \$0 to \$12,749 - are not subject to an annual deductible and premium contribution. Consequently, individuals with household incomes in one of the higher income brackets will pay up to the full premium for the plan and will have a maximum annual deductible of \$450. Annually, deductibles will be adjusted according to the actual drug trend experienced under the program.

| TABLE D – THE HOPE PLAN | | | | | | | |
|---|----------|-------------------|--------|--------|------------------|--------|--------|
| Annual Deductibles and Monthly Premiums | | | | | | | |
| Annual Household Income Range | | Annual Deductible | | | Monthly Premiums | | |
| | | Year 1 | Year 2 | Year 3 | Year 1 | Year 2 | Year 3 |
| \$0 | \$4,999 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| \$5,000 | \$8,499 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| \$8,500 | \$9,999 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| \$10,000 | \$12,749 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| \$12,750 | \$15,999 | \$100 | \$119 | \$143 | \$24 | \$28 | \$33 |
| \$16,000 | \$16,999 | \$150 | \$179 | \$215 | \$43 | \$49 | \$58 |
| \$17,000 | \$19,999 | \$150 | \$179 | \$215 | \$50 | \$58 | \$68 |
| \$20,000 | \$24,999 | \$200 | \$238 | \$286 | \$56 | \$64 | \$76 |
| \$25,000 | \$29,999 | \$200 | \$238 | \$286 | \$63 | \$73 | \$86 |
| \$30,000 | \$34,999 | \$250 | \$298 | \$358 | \$64 | \$74 | \$87 |
| \$35,000 | \$39,999 | \$350 | \$417 | \$500 | \$69 | \$79 | \$93 |
| \$40,000 | Plus | \$450 | \$536 | \$643 | \$68 | \$78 | \$91 |

VI. The HOPE Plan: Pharmacy Benefit Design and Management

Responsible Access to All Prescription Drugs

The HOPE plan provides for responsible access to all prescription drugs through balanced cost sharing and an incentive formulary. Once individuals meet their annual deductible, they are required to pay an amount referred to as a co-payment toward the cost of each prescription. Under the HOPE plan, individuals will pay a co-payment of \$10 for generic drugs, \$25 for preferred drugs and the greater of the preferred drug co-payment or 50 percent for non-preferred drugs. A mandatory generic provision is also applied to the three-tier co-payment design. Under the mandatory generic provision, if an individual or physician requests a brand name drug when an approved generic drug is available, the individual is required to pay the price difference between the brand and generic drug in addition to the co-payment.

The three-tier co-payments recommended for the HOPE plan are displayed in Table E. Annually, the co-payments, along with the deductibles and the out-of-pocket limit, will be adjusted according to the actual drug trend experienced under the program. In the HOPE plan model, pharmacy benefit trends of 19 percent for year two and 20 percent for year three were used. Once the program is operational, the benefit trends may vary as a result of increased drug utilization and costs and the impact of new pharmaceuticals.

| TABLE E – THE HOPE PLAN | | | | | |
|-------------------------------------|--------------|---------------|----------------|-----------------|---|
| Co-Payments After Annual Deductible | | | | | |
| | Source | Days Supply | Co-payment | | |
| | | | Generic Drugs* | Preferred Drugs | Non-preferred Drugs |
| Year One | ▪ Retail | Up to 30 Days | \$10 | \$25 | The greater of the preferred drug co-payment or 50% |
| | ▪ Mail Order | Up to 90 Days | \$20 | \$50 | Same as above |
| Year Two | ▪ Retail | Up to 30 Days | \$12 | \$30 | Same as above |
| | ▪ Mail Order | Up to 90 Days | \$24 | \$60 | Same as above |
| Year Three | ▪ Retail | Up to 30 Days | \$14 | \$36 | Same as above |
| | ▪ Mail Order | Up to 90 Days | \$28 | \$72 | Same as above |

*Mandatory generic provision

VI. The HOPE Plan: Pharmacy Benefit Design and Management

The three-tier co-payment design provides for responsible access to all prescription drugs through an incentive formulary. The formulary will be designed to favorably enhance the quality and cost of the plan through drug mix and rebates, in addition to addressing new pharmaceutical products and evidence based prescribing guidelines. The financial impact to the pharmacy plan is ultimately dependent on the specific drugs selected for preferred status in the drug formulary.

Protection Against Catastrophic Costs

The physical insult of catastrophic illness – illness of great seriousness and long duration – is too often matched by the financial injury it inflicts. A long hospital stay can be followed by an extended convalescence, while the numbers and costs of prescription drugs climb week by week and month by month. Although catastrophic illness can strike at any age, it is statistically more common among seniors. They must face the particular fear of having their carefully gathered and tendered retirement incomes completely wiped out by the onset of a catastrophic condition.

To allow for catastrophic coverage, the HOPE plan has an annual out-of-pocket limit of \$3,000. Once a person has spent \$3,000 a year in combined deductible and co-payments, 100 percent of prescription drug costs for generic and preferred drugs are covered by the HOPE plan, whereas non-preferred drugs continue to be covered at the greater of the preferred drug co-payments or 50 percent. The cost of the non-preferred drugs do not apply to the \$3000 out-of-pocket limit.

Pharmacy Benefit Management Strategies

The HOPE plan is designed to manage the prescription drug needs of seniors through a balance of appropriate access and cost and utilization controls. In addition, the HOPE plan focuses on enhancing quality by reducing negative drug interactions and minimizing the inappropriate under-utilization and over-utilization of drugs.

The Commonwealth can accomplish this objective by contracting with a pharmacy benefit manager (PBM) that specializes in providing administrative and management services to reduce the cost of pharmacy benefits. The use of a PBM provides uniform administration of the program and maximizes the Commonwealth's capacity to negotiate the best prices for discounted networks, and mail order and formulary rebates. The PBM selected through a competitive bidding process will be required to partner with the Commonwealth to reduce the costs of the pharmacy plan through the following management strategies, in addition to administrative efficiencies.

VI. The HOPE Plan: Pharmacy Benefit Design and Management

- **Retail Pharmacy Network**

The HOPE plan calls for a customized retail network of chain and/or independent pharmacies which can deliver an aggressive discounted price in addition to meeting technical performance and quality standards. The retail network pharmacies will be required to demonstrate consistent and high levels of pharmacy program management focused on generic substitution, formulary compliance, therapeutic interventions, and drug utilization review.

Under the HOPE plan, individuals will be able to obtain up to a 30-day supply for the specified co-payments from the retail pharmacy network provider. There is no prescription drug benefit if the drug is obtained from a non-network pharmacy provider.

- **Required Mail Order Program**

The HOPE plan incorporates a required prescription drug mail order program for maintenance drugs. A maintenance drug is defined under this plan as a drug that is taken regularly for a chronic condition for a period of time generally longer than three to six months.

Once a prescription drug is identified as maintenance, the individual will be required to obtain the drug through the mail order program. If the individual elects to obtain the maintenance drug from a retail pharmacy network provider, he or she will be responsible for the full cost of the prescription.

The inherent advantages and quality enhancements of the mail order program: therapeutic intervention, formulary compliance, and health and utilization management will be maximized.

Through the mail order program, individuals will be able to obtain up to a 90-day supply – three times the day supply available through the retail pharmacy network – for two times the co-payment.

- **Drug Formulary**

An incentive, customized drug formulary – an effective means to enhance quality and manage program costs – will be developed for the HOPE plan. The drug formulary will be developed by a traditional Pharmacy and Therapeutics Committee coordinated by the PBM with participation from the Commonwealth.

VI. The HOPE Plan: Pharmacy Benefit Design and Management

Nationally recognized prescribing guidelines will be incorporated into the formulary management performed by the PBM. Prescriptions filled under the HOPE plan will be monitored against the prescribing guidelines and appropriate interventions identified. Providers – physicians and pharmacies – will be profiled for compliance with the formulary and the guidelines. Various tactics, including focused interventions, will be used to change provider behavior.

Formulary education, compliance and consultation will be requirements of the HOPE plan. Also, an efficient and fair appeal process will be implemented to accommodate for clinical exceptions requested by the physician.

- **Generic Drug Incentives**

The HOPE plan applies a mandatory generic provision through the benefit design. To augment the benefit design, provisions for generic drug communication as well as financial incentives and profiling of providers to encourage the use of generic drugs when they are medically appropriate is included in the HOPE plan.

- **Drug Utilization Management**

The HOPE plan incorporates prospective, concurrent, and retrospective drug utilization management to ensure that prescription drugs are used appropriately, safely and effectively.

Under concurrent drug utilization management, prescriptions are reviewed at the time of dispensing as a safeguard to catch any inappropriate dosages or combinations of drugs. Concurrent utilization management will also be used for implementing advanced pharmacy management tactics and prescribing guidelines to enhance the appropriate utilization of prescription drugs in the program. Under retrospective drug utilization management, past prescription drug utilization patterns are reviewed to identify any apparent overuse or non-compliance with the pharmacy management strategies.

The drug utilization management review process is vitally important to the quality and cost of the program. By providing for timely and effective action at the appropriate level of intervention – concurrent or retrospective – it allows the Commonwealth to identify and reduce unnecessary prescription drug use, to assure that prescription drugs are used in proper clinical circumstances, and to safeguard seniors from prescription drugs that are potentially dangerous, or prescription drugs which are more costly than necessary.

The drug utilization review process will be augmented with provider and patient education programs to advance the understanding of new and existing therapies, and the benefits of these therapies, and associated costs.

VI. The HOPE Plan: Pharmacy Benefit Design and Management

- **Prior Authorization**

In the HOPE plan, prior authorization will be required for certain drugs, or classes of drugs, with a high potential for over utilization or misuse. Prior authorization will ensure that coverage and the use of a specific drug is appropriate for a given individual.

- **Provider Interventions**

Through the PBM, the HOPE plan will have a targeted provider – physician and pharmacist – intervention process that will identify providers who might be responsible for high costs as a result of potentially inappropriate prescriptions. The plan also provides for interventions aimed at educating and changing prescribing behaviors.

- **Health Management**

In the HOPE plan, seniors and the income-qualified disabled will receive education and support to help control, alleviate, or prevent illness. The communication efforts – targeted to specific illnesses or conditions – will provide quality assurance programs that educate patients and providers on high-cost diseases, such as diabetes or heart disease, to encourage better compliance and lifestyle changes.

- **Coordination of Benefits**

Pharmacy benefits under the HOPE plan will be coordinated with any other plans under which an individual might have pharmacy coverage – provided, of course, that the coverage information can be obtained. The HOPE plan is positioned to be the payer of last resort.

VII. The HOPE Plan: Enrollment

Enrollment Projections

There are over 860,000 seniors in Massachusetts as of December 1998. Of this population, 290,000 individuals are estimated to have annual incomes below 150 percent of the federal poverty level. Some of these individuals may be dually eligible for Medicare and Medicaid benefits available under MassHealth.

As of January 2000, approximately 36,000 seniors were enrolled in the Senior Pharmacy Program (formerly the Senior Pharmacy Plan). With an effective advertising campaign, we estimate that the enrollment of seniors with annual incomes below 188 percent of the federal poverty level in the HOPE plan would be approximately 54,300, or 24 percent of the population with incomes under 188 percent of the federal poverty level.

The population of seniors who purchased Medicare HMOs or Medicare supplement plans is the primary population source for the remaining enrollment. In 1998 there were a number of plans with unlimited pharmacy coverage – plans which imposed no quarterly or annual benefit limits – available to seniors. The additional premium for plans with unlimited pharmacy benefits ranged from \$45 to \$152 per month. Of the 360,800 seniors who purchased Medicare HMOs or Medicare supplement plans in Massachusetts, 142,900 chose plans with additional pharmacy coverage. With effective advertising, the projection is that 58,000 of these seniors would enroll in the HOPE plan.

There are approximately 91,000 seniors enrolled in Medicare HMOs or Medicare supplement plans sponsored by employers. Since 92 percent of these individuals have unlimited pharmacy benefits under their current health plan, this does not appear to be a material source of enrollment in the initial years of the HOPE plan. Once the HOPE plan becomes established, employers may view this as a less expensive approach to providing retiree pharmacy benefits. There is also the potential that a significant number of employers may initially enroll seniors in the HOPE plan.

Some employers may discontinue retiree prescription drug coverage if the Commonwealth makes a comprehensive and affordable pharmacy plan available. This would, of course, represent a significant transfer of responsibility from the private sector to the Commonwealth. If properly controlled to minimize adverse selection, and if premium contributions were appropriately adjusted, this could be beneficial to the HOPE plan. Costs would be spread over a larger enrolled population. And larger enrollment should enhance the potential for negotiating greater discounts and lower administrative fees.

Enrollment projections presume that the income-qualified disabled will enroll at the same rate presumed for seniors. Even though, the disabled have a comparable, if not greater, need for prescription drugs, monthly premium will be the same as that charged to a senior with the same household income.

VII. The HOPE Plan: Enrollment

For the HOPE plan, the percent of the eligible senior population participating is expected to increase by two percent in each year after the first year. Table F displays the enrollment projected for each income category. Seniors turning age 65 and individuals who become certified as disabled would be the primary sources of enrollment increases in 2001 and 2002.

| TABLE F – THE HOPE PLAN | | | | | | | |
|----------------------------------|----------|-------------------|----------------|----------------|---------------------|--------------|--------------|
| Enrollment Projections | | | | | | | |
| Annual Household Income Range | | Senior Enrollment | | | Disabled Enrollment | | |
| | | Year 2000 | Year 2001 | Year 2002 | Year 2000 | Year 2001 | Year 2002 |
| \$0 | \$4,999 | 5,160 | 5,676 | 6,192 | 413 | 454 | 495 |
| \$5,000 | \$8,499 | 15,566 | 17,123 | 18,679 | 1,245 | 1,370 | 1,494 |
| \$8,500 | \$9,999 | 15,480 | 17,028 | 18,576 | 1,238 | 1,362 | 1,486 |
| \$10,000 | \$14,999 | 18,060 | 19,866 | 21,672 | 795 | 874 | 954 |
| \$15,000 | \$15,999 | 3,784 | 4,162 | 4,541 | 953 | 1,048 | 1,143 |
| \$16,000 | \$16,999 | 3,784 | 4,162 | 4,541 | | | |
| \$17,000 | \$19,999 | 5,790 | 6,754 | 7,719 | | | |
| \$20,000 | \$24,999 | 6,192 | 7,224 | 8,256 | | | |
| \$25,000 | \$29,999 | 6,192 | 7,224 | 8,256 | | | |
| \$30,000 | \$34,999 | 6,192 | 7,224 | 8,256 | | | |
| \$35,000 | \$39,999 | 5,160 | 6,020 | 6,880 | | | |
| \$40,000 | \$44,999 | 4,128 | 4,816 | 5,504 | | | |
| \$45,000 | \$49,999 | 4,128 | 4,816 | 5,504 | | | |
| \$50,000 | \$54,999 | 4,283 | 4,997 | 5,710 | | | |
| \$55,000 | \$59,999 | 3,096 | 3,612 | 4,128 | | | |
| \$60,000 | \$64,999 | 3,096 | 3,612 | 4,128 | | | |
| \$65,000 | \$69,999 | 3,096 | 3,612 | 4,128 | | | |
| \$70,000 | \$74,999 | 2,116 | 2,468 | 2,821 | | | |
| \$75,000 | \$79,999 | 2,064 | 2,408 | 2,752 | | | |
| \$80,000 | \$84,999 | 2,064 | 2,408 | 2,752 | | | |
| \$85,000 | \$89,999 | 2,064 | 2,408 | 2,752 | | | |
| \$90,000 | \$94,999 | 2,064 | 2,408 | 2,752 | | | |
| \$95,000 | \$99,999 | 2,064 | 2,408 | 2,752 | | | |
| \$100,000 | Plus | 2,312 | 2,697 | 3,082 | | | |
| Total Projection | | 127,935 | 145,133 | 162,333 | 4,644 | 5,108 | 5,572 |

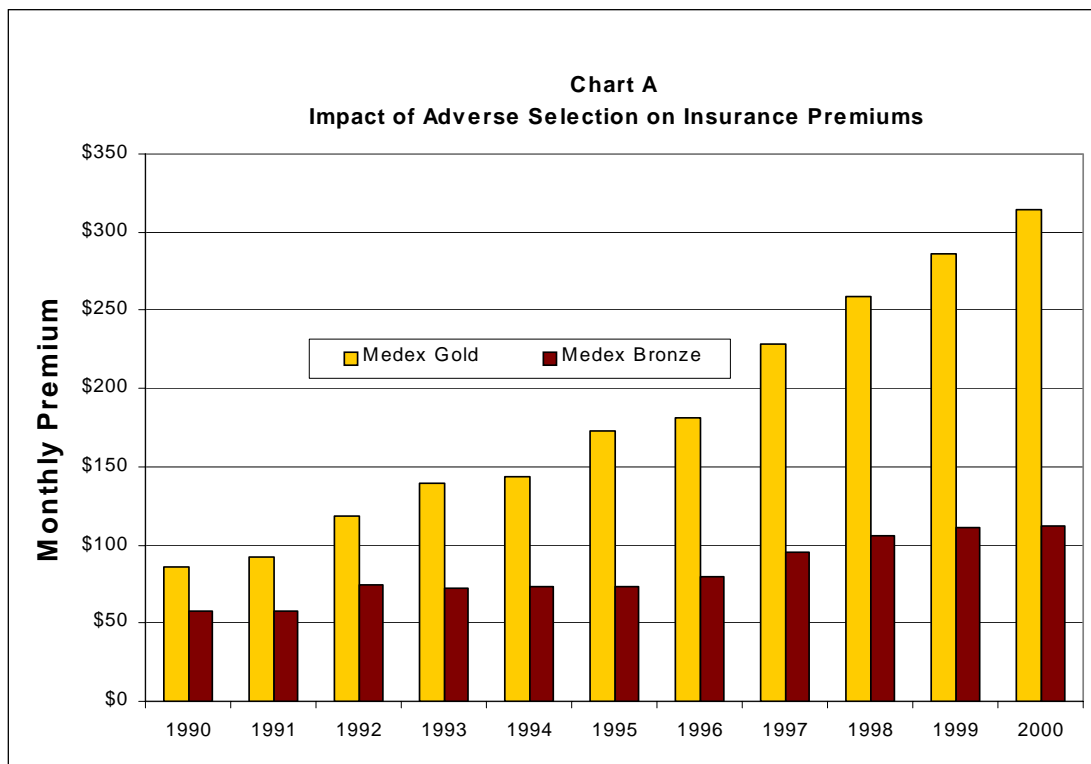
VII. The HOPE Plan: Enrollment

Adverse Selection

Adverse selection occurs when too many individuals with high health care utilization participate in a program in greater numbers than individuals who do not use as many health care services. The impact on an insurance product is higher costs and increased financial risk.

Under any pharmacy plan, adverse selection occurs when individuals delay enrollment until the cost of the prescription drugs they buy exceed the amount of the premiums paid. Carefully designed and rigorously administered enrollment rules would be necessary for the HOPE plan to control adverse selection on an ongoing basis.

The impact of adverse selection is illustrated by the comparison of monthly premiums charged by Blue Cross and Blue Shield of Massachusetts for its Medex Gold and Medex Bronze Plans. Both are Medicare supplement programs – Medigap policies – that offer supplemental coverage for expenses not picked up by Medicare, such as deductibles and co-payments. Medex Gold and Medex Bronze both provide the same benefits, except that Medex Gold covers prescription drugs. Chart A displays the large and growing premium gap between these two plans.

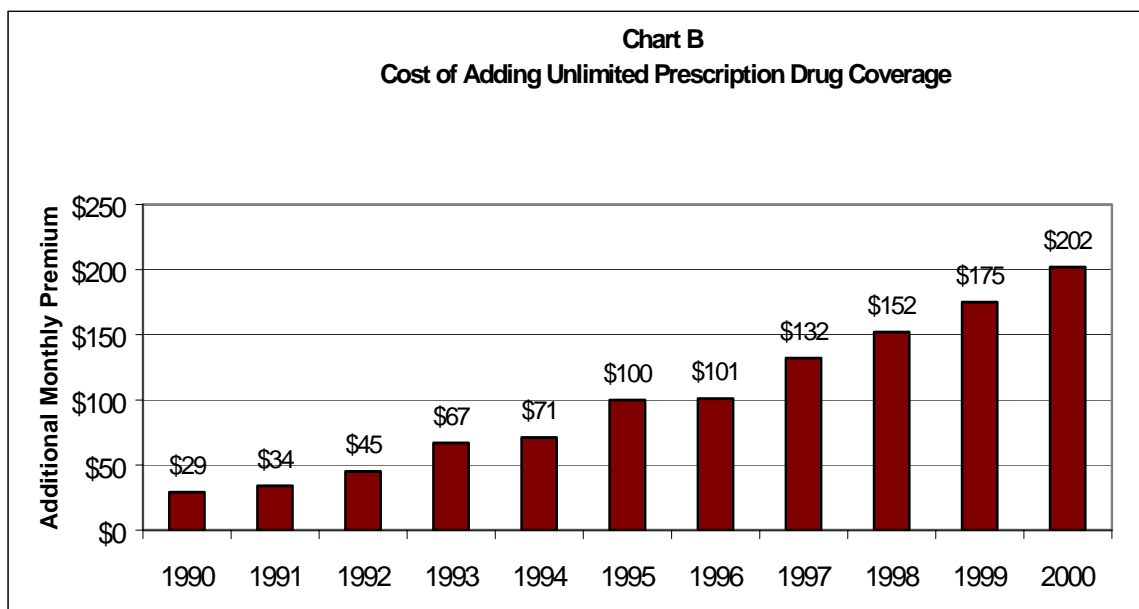


Note: Medex Gold provides pharmacy coverage, Medex Bronze does not provide pharmacy coverage.

VII. The HOPE Plan: Enrollment

The stark contrasts in monthly premiums demonstrated in Chart A make it clear why many managed care organizations have abandoned programs that offer unlimited drug coverage. Plans with the most comprehensive prescription drug benefits attract individuals with the most expensive prescription drug needs and the most expensive total medical care requirements. As a result, these plans will have the highest premiums – which individuals with the most severe medical needs will elect to pay.

Based on the premium difference between Medex Gold and Medex Bronze, Chart B displays the additional premium required to purchase an unlimited prescription drug plan. This cost difference has spiraled from \$29 to \$202 per month over the last 10 years. Adverse selection is a contributing factor, because seniors are allowed to change from Medex Bronze to Medex Gold during periodically held open enrollment opportunities.



If adverse selection occurs unabated, prescription drug costs will spiral until the premiums become no longer affordable for most individuals. Adequate protection against adverse selection, therefore, is crucial to keep premiums affordable and preserve the financial viability of the HOPE plan.

To control adverse selection, those individuals who pay premiums should enroll, and remain enrolled, upon attaining age 65. Strong financial incentives should encourage punctual enrollment and an effective and focused marketing plan would be essential to ensure maximum enrollment of those who do not have a pre-existing and substantial need for prescription drugs.

VII. The HOPE Plan: Enrollment

The HOPE plan may consider adopting the enrollment requirements applicable to Medicare Part B. Under Medicare Part B, individuals must enroll within three months of reaching age 65 in order to avoid incurring a permanent additional premium charge.

In the HOPE plan, those who delay enrollment could be charged the full premium plus a substantial surcharge that increases based on the length of the enrollment delay. A 12-month waiting period should also be applied for those who do not enroll during the prescribed period.

Adverse selection is not a concern for those with low incomes who are not required to pay a monthly premium. A delay in such enrollment does not impact the premium revenue of the HOPE plan, and does not increase the net cost to the Commonwealth. In fact, delayed enrollment of this population would actually reduce the Commonwealth's net cost.

During the first year of the HOPE plan, an open enrollment period would be necessary for individuals who are age 65 and over. This period, when individuals may enroll without a surcharge or waiting period, should be limited to three months and permitted only during the first year. During this time, a major marketing effort would be mounted to produce the projected enrollment. Consequently, given the potential for adverse selection associated with open enrollment, these open enrollment periods should be discontinued after the first year of operation.

VIII. The HOPE Plan: Funding

Based on the assumptions in the model, funding rates were calculated for each annual deductible. Exhibit A displays the funding rates for seniors and the underlying components. Exhibit A1 provides the corresponding funding rates and components for the disabled. It is important to note that all individuals in the HOPE plan would not pay the full funding rate. Exhibit B displays the actual monthly premium that would be charged based on an individual's household income bracket. Enrollees with household incomes exceeding \$35,000 will pay the full cost plus a marginal contribution to the HOPE plan.

Applying the annual funding rates to the average enrollment projected for each year produces the total annual cost of the HOPE plan. There are two sources of funds that would partially offset the total annual cost to the Commonwealth: the premium paid by the individuals and the net payment recoveries from other pharmacy plans due to coordination of benefits. There may be overlaps between the pharmacy benefits covered under the HOPE plan and those available under an individual's other pharmacy coverage. The extent of the overlap will vary based on the HOPE plan deductible and the coverage available under a particular pharmacy plan. As shown in Exhibit C, the premium contributions and net coordination of benefit recoveries are deducted from the total annual cost to arrive at the Commonwealth's net cost for 2000, 2001 and 2002.

If the HOPE plan were operable in the year 2000 with an average enrollment of approximately 132,600 the total annual cost of the plan would be \$127.0 million. Deducting the premium paid by individuals and the coordination of benefit recoveries would reduce the Commonwealth's net cost to \$69.4 million. The rising cost and utilization of prescription drugs and additional enrollment increases the Commonwealth's net cost to \$88.1 and \$113.2 for 2001 and 2002 respectively.

There are three major sources of financial risk for the HOPE plan none of them unique to the HOPE plan. First, and most serious risk, is the enrollment of individuals eligible for premium subsidies would exceed what is projected. Second, is the vulnerability of adverse selection. The third primary risk is that the actual average prescription drug cost, utilization, and administrative cost per person would exceed projected costs. These factors and underestimating these averages are also risks associated with the Commonwealth's current pharmacy assistance plans.

Nonetheless, the risk of covering pharmacy benefits can be controlled to the same extent as covering other medical benefits with adequate underwriting and enrollment guidelines. Furthermore, these risks can be controlled by rigorously monitoring plan costs and premium revenue and, if necessary, by limiting enrollment or adjusting premium subsidies.

IX. The HOPE Plan: Prescription Drug Review Commission

The HOPE plan recommends the creation of a Prescription Drug Review Commission to be involved in, and focused on, the difficult decisions that plans like the HOPE plan and any plan that sets out to achieve prescription drug coverage for all seniors requires. The overall purpose of the Commission is 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 Commission shall consist of sixteen members including the Senate President and the Speaker of the House who shall serve as co-chairs. No designees shall serve in their place except in the event that one of the chairs is unable to perform his duties as Speaker or President. The Senate President and the Speaker of the House shall each appoint two members to the Commission.

Additional Commission members shall include the Chair of the Senate Ways and Means Committee or his designee, the Chair of the House Ways and Means Committee or his designee, the co-chairs of the Joint Committee on Health Care or their designees, the Commissioner of the Division of Medical Assistance or his designee and six members to be appointed by the Governor, including a representative of a senior citizen's advocacy organization, a representative of a disability advocacy organization, a health care economist from a university or college within the commonwealth and a representative of the contracted pharmacy benefit manager. The Governor's appointments shall include an individual who is a full-time employee of a pharmaceutical manufacturer to be named to the commission biennially.

All non-governmental members of the Commission shall serve at the pleasure of their appointing official. The Commission may only take official action when both co-chairs are in attendance and by a majority vote of those members present.

The duties of said Commission shall consist of the following:

- a) The Commission shall be responsible for the oversight of the HOPE plan.
- b) The Commission shall meet at least quarterly with the management team from the pharmacy benefit manager to proactively:
 - determine how well the program is operating and whether changes may be necessary;
 - assess with the pharmacy benefit manager where and why specific problems are occurring and design and implement a strategy to resolve such problems;
 - have the pharmacy benefit manager explain current and projected cost trends for the program and determine whether and, if so, how changes need to be made to ensure the fiscal integrity of the program;

IX. The HOPE Plan: Prescription Drug Review Commission

- analyze current and future information system and pharmaceutical technology advancements to determine whether and, if so, how such advances will result in cost savings or otherwise affect the program;
 - review the pharmacy benefit manager's designated formulary for the program.
- c) The Commission shall have sole responsibility for approving changes to co-payments, deductibles, out-of-pocket limits, drug exclusions and premiums in relation to pharmacy benefit trends. In the event the Commission approves changes that result in increases to co-payments, deductibles or premiums, it shall file a report with the clerks of the Senate and the House explaining why.
- d) The Commission shall review overall plan costs, adequacy of funding and projected revenues to determine what, if any, changes need to be made to the program.

X. The HOPE Plan: Glossary of Terms

1. **Adverse Selection:** Adverse selection occurs when too many individuals with high health care utilization participate in a program in greater numbers than individuals who do not use as many health care services. The impact on an insurance product is higher costs and increased financial risk.
2. **Any Willing Provider:** A requirement that a health insurance plan must sign a contract for the delivery of health care services with any provider in the area that would like to provide services to the plan's participants.
3. **Catastrophic Cap:** Once an individual spends a specific amount of money out of his or her pocket – a combination of deductible and co-payments – specific drugs are covered 100 percent by the plan.
4. **Coinsurance:** Cost sharing that requires an individual to pay a specific percentage of the charge for each prescription drug. Under the HOPE plan, co-insurance is applied to non-preferred drugs.
5. **Coordination of benefits (COB):** Coordination of benefits applies when an individual is covered under more than one pharmacy plan. It requires that payments of benefits be coordinated to eliminate benefit duplication or prevent double payment for services. For example, a husband might have coverage from the State and the wife coverage through Medex Gold. The coordination of benefits agreement states which plan is primary 'pays first' and which is secondary and 'pays last'.
6. **Co-payment:** Cost sharing that requires an individual to pay a fixed dollar amount for each prescription drug. Under the HOPE plan, co-payment is used to identify the payment required for each prescription drug and may be a factor of flat dollar or percentage payments.
7. **Deductible:** The amount that an individual pays under the plan each benefit year, in addition to premium, before prescription drug coverage begins.
8. **Dually eligible:** Individuals who are eligible for both Medicare and Medicaid.
9. **Formulary:** A list of drugs – selected on the basis of quality and cost – used by physicians when making decisions on what medication to prescribe. The list is subject to periodic review and modification by the plan.
10. **Generic Drug:** A drug that is a chemically equivalent copy of a brand-name drug. A generic drug is generally less expensive than the brand-name drug.

X. The HOPE Plan: Glossary of Terms

11. **Income-related premium:** Requires individuals with higher incomes to pay more premium for a benefit than individuals with lower incomes.
12. **Maintenance Drug:** A drug that is taken for a chronic condition, consecutively, for a long period of time – generally longer than three to six months.
13. **Medicare+Choice:** A federal program that allows several ways for seniors to receive Medicare benefits. The options include private fee-for-service, medical savings accounts, and provider-sponsored organizations as well as several managed care choices.
14. **Medigap Insurance:** Supplemental private insurance that is purchased by Medicare recipients to fill the gaps in Medicare coverage.
15. **Out-of-pocket limit:** The total dollar amount that an individual pays out of pocket, a combination of co-payments and deductible. Once the limit is reached, specific drugs are covered at 100 percent for the remainder of the benefit year.
16. **Pharmacy Benefit Manager (PBM):** An organization that specializes in providing administrative and management services to reduce the cost of pharmacy benefits.
17. **Pharmacy & Therapeutics Committee - P & T Committee:** A group of physicians, pharmacists and other experts that recommends the safe and effective use of prescription drugs. The P& T Committee is charged with reviewing and evaluating drugs for inclusion and/or exclusion on the drug formulary.
18. **Premiums:** Fees, usually paid monthly, for insurance coverage.

XI. Appendix: Assumptions

Pharmacy Cost And Administrative Expense Assumptions

The prescription drug model used to calculate the HOPE plan's funding rates and financial projections applied certain key assumptions. These are:

- The base prescription drug ingredient cost in the first year of implementation includes an additional cost for adverse selection. This is for two reasons: first, because adverse selection is in the claim experience of the population from which all individuals would be enrolled; second, because an open enrollment period would be offered before the beginning of the plan to those who are age 65 or over. This open enrollment period will inevitably result in additional adverse selection. To moderate this situation, the length of the open enrollment period must be limited.
- For the two years following the initial year, individuals will be allowed to enroll within three months of reaching age 65 or within three months of being certified as disabled. Premium payments, where applicable, and benefits will begin on the first of the month following the date a person reaches age 65 or is certified as disabled. Effective communications and financial incentives will be in place to encourage timely enrollment. There are no adjustments for additional adverse selection in the last two projection years.
- The prescription drug ingredient cost is a 22 percent discount off the Average Wholesale Price (AWP). The 22 percent discount factors in the lower of, usual and customary pricing, the AWP discount, and the maximum allowable cost (MAC). Discounts could be greater if the "most favored nation" and "any willing provider" legislation could be repealed or restructured and exclusive or reduced access networks could be contracted.
- Formulary rebates under the proposed incentive-based formulary were assumed to reduce the prescription drug ingredient cost by 4 percent. The design of the formulary with respect to the drugs selected for preferred status, could significantly alter this estimated cost reduction.
- An 11 percent cost reduction will be achieved by applying formulary management, mail order for maintenance drugs, utilization management, prescribing guidelines, and therapeutic interventions through a pharmacy benefit manager (PBM).

XI. Appendix: Assumptions

- Assuming that pharmacy benefits under an individual's HMO plan are coordinated with the HOPE plan benefits, the estimated recoveries are approximately 1 percent of the ingredient cost of the plan. This estimate is based on the assumption that the individual's share of the cost is the minimum share under either plan, and that the HMO benefits are paid first. The 1 percent recovery is net of the cost of administrative and legal fees associated with recovery.
- The annual cost and utilization trend applied to arrive at year 2001 ingredient cost is 19 percent. An annual trend of 20 percent was applied to project year 2002 ingredient costs. These annual trends are applied to adjust the co-payments and annual deductibles for 2001 and 2002, and will be used to adjust the out-of-pocket limit once the program is operational.
- The dispensing fee applied per prescription is \$3.50.
- The annual expense for pharmacy management and claim administration is \$60 per individual. This includes administrative expense from the PBM in addition to resources dedicated to the program from the Commonwealth.
- The annual expenses for other administration functions (such as membership, income testing, billing, collections, financial reporting, and auditing) is \$91.11 per enrollee.
- An annual advertising expense of \$15 per enrollee has been included in the first year projection. This expense is reduced to \$5 per enrollee for the two following years.
- The financial estimates for including the disabled who are under age 65 presume that no additional cost burden will be placed on seniors by adding income-qualified disabled. Additionally, a disabled person would pay the same premium and be subject to the same deductible as a senior citizen whose annual income is in the same income bracket. The average prescription drug cost for a disabled person is estimated to be more than twice the average for a senior.
- The estimates for prescription drug discounts, rebates, dispensing fees, and administrative expenses applied in the projections are based on data observed from large Mercer clients and various industry studies. The staff currently employed by the Commonwealth could perform some of these administrative activities. To the extent that this is done, there may be a rationale for reducing the administrative cost estimates applied in the financial projections for the HOPE plan.

XI. Appendix: Assumptions

- Monthly premiums for the HOPE plan for the year 2000 range from zero for those with low incomes to \$69 for those in the higher income categories. These monthly premiums are lower than those charged for the unlimited pharmacy benefits that were available in 1998 under Medicare HMOs and Medex Gold. Although there is considerable uncertainty attached to projecting enrollment in any new plan, the projections appear reasonable given the premiums charged and the past purchasing decisions of the senior population.

XII. Exhibits:

Funding Rate Projections for Seniors The HOPE Plan Exhibit A

| | | Year Beginning | | Annual Household Income Range | | | | | | | |
|--|----|-----------------|---------------|-------------------------------|---------------|---------------|---------------|---------------|----------------|----------|--|
| | | January 1, 2000 | | \$0 | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | \$40,000 | |
| | | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | \$40,000 | And Over | Total | | |
| Annual Cost Per Member | | | | | | | | | | | |
| Ingrredient cost (Includes discounts and cost sharing) | \$ | 765.40 | 696.49 | 664.69 | 634.83 | 605.90 | 553.04 | 510.78 | | | |
| Dispensing fees | \$ | 120.75 | 101.50 | 101.50 | 94.50 | 94.50 | 94.50 | 87.85 | | | |
| Pharmacy management and claim processing | \$ | 60.00 | 60.00 | 60.00 | 60.00 | 60.00 | 60.00 | 60.00 | | | |
| Billing and insurance cost | \$ | 91.11 | 91.11 | 91.11 | 91.11 | 91.11 | 91.11 | 91.11 | | | |
| Other expenses | \$ | - | - | - | - | - | - | - | | | |
| Advertising cost | \$ | 15.00 | 15.00 | 15.00 | 15.00 | 15.00 | 15.00 | 15.00 | | | |
| Total cost | | 1,052.26 | 964.10 | 932.30 | 895.44 | 866.51 | 813.65 | 764.74 | | | |
| | | 87.69 | 80.34 | 77.69 | 74.62 | 72.21 | 67.80 | 63.73 | | | |
| Average enrollment | | 46,139 | 11,911 | 9,574 | 12,384 | 6,192 | 5,160 | 36,575 | 127,935 | | |
| Annual cost | | \$ 48,550,224 | \$ 11,483,395 | \$ 8,925,840 | \$ 11,089,129 | \$ 5,365,430 | \$ 4,198,434 | \$ 27,970,366 | \$ 117,582,818 | | |

| | | Year Beginning | | Annual Household Income Range | | | | | | | |
|--|----|-----------------|-----------------|-------------------------------|-----------------|---------------|---------------|---------------|----------------|----------|--|
| | | January 1, 2001 | | \$0 | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | \$40,000 | |
| | | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | \$40,000 | And Over | Total | | |
| Annual Cost Per Member | | | | | | | | | | | |
| Ingrredient cost (Includes discounts and cost sharing) | \$ | 927.93 | 846.02 | 807.87 | 772.73 | 738.25 | 677.48 | 629.43 | | | |
| Dispensing fees | \$ | 125.65 | 105.35 | 105.35 | 98.35 | 98.35 | 98.35 | 91.35 | | | |
| Pharmacy management and claim processing | \$ | 60.00 | 60.00 | 60.00 | 60.00 | 60.00 | 60.00 | 60.00 | | | |
| Billing and insurance cost | \$ | 91.11 | 91.11 | 91.11 | 91.11 | 91.11 | 91.11 | 91.11 | | | |
| Other expenses | \$ | - | - | - | - | - | - | - | | | |
| Advertising cost | \$ | 5.00 | 5.00 | 5.00 | 5.00 | 5.00 | 5.00 | 5.00 | | | |
| Total cost | | 1,209.69 | 1,107.48 | 1,069.33 | 1,027.19 | 992.71 | 931.94 | 876.89 | | | |
| | | 100.81 | 92.29 | 89.11 | 85.60 | 82.73 | 77.66 | 73.07 | | | |
| Average enrollment | | 50,753 | 13,102 | 10,916 | 14,448 | 7,224 | 6,020 | 42,670 | 145,133 | | |
| Annual cost | | \$ 61,395,397 | \$ 14,510,203 | \$ 11,672,806 | \$ 14,840,841 | \$ 7,171,337 | \$ 5,610,279 | \$ 37,416,896 | \$ 152,617,759 | | |

| | | Year Beginning | | Annual Household Income Range | | | | | | | |
|--|----|-----------------|-----------------|-------------------------------|-----------------|-----------------|-----------------|-----------------|----------------|----------|--|
| | | January 1, 2002 | | \$0 | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | \$40,000 | |
| | | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | \$40,000 | And Over | Total | | |
| Annual Cost Per Member | | | | | | | | | | | |
| Ingrredient cost (Includes discounts and cost sharing) | \$ | 1,133.57 | 1,036.57 | 991.53 | 950.15 | 909.31 | 836.61 | 778.88 | | | |
| Dispensing fees | \$ | 130.55 | 109.55 | 109.55 | 102.20 | 102.20 | 102.20 | 94.85 | | | |
| Pharmacy management and claim processing | \$ | 60.00 | 60.00 | 60.00 | 60.00 | 60.00 | 60.00 | 60.00 | | | |
| Billing and insurance cost | \$ | 91.11 | 91.11 | 91.11 | 91.11 | 91.11 | 91.11 | 91.11 | | | |
| Other expenses | \$ | - | - | - | - | - | - | - | | | |
| Advertising cost | \$ | 5.00 | 5.00 | 5.00 | 5.00 | 5.00 | 5.00 | 5.00 | | | |
| Total cost | | 1,420.23 | 1,302.23 | 1,257.19 | 1,208.46 | 1,167.62 | 1,094.92 | 1,029.84 | | | |
| | | 118.35 | 108.52 | 104.77 | 100.71 | 97.30 | 91.24 | 85.82 | | | |
| Average enrollment | | 55,367 | 14,293 | 12,260 | 16,512 | 8,256 | 6,880 | 48,765 | 162,333 | | |
| Annual cost | | \$ 78,633,874 | \$ 18,612,773 | \$ 15,413,149 | \$ 19,954,092 | \$ 9,639,871 | \$ 7,533,050 | \$ 50,220,148 | \$ 200,006,957 | | |

XII. Exhibits:

Funding Rates for Disabled Individuals The HOPE Plan Exhibit A1

| | Year Beginning | | Annual Household Income Range | | | | | | Total |
|---|--------------------|--------------------|-------------------------------|--------------------|--------------------|--------------------|--------------------|----------|--------------|
| | January 1, 2000 | | \$0 | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | |
| | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | \$40,000 | And Over | | |
| Annual Cost Per Member | | | | | | | | | |
| Ingredient cost (Includes discounts and cost sharing) | \$ 1,715.79 | \$ 1,561.32 | \$ 1,490.05 | \$ 1,423.09 | \$ 1,358.25 | \$ 1,239.75 | \$ 1,145.00 | | |
| Dispensing fees | \$ 173.95 | \$ 146.30 | \$ 146.30 | \$ 136.15 | \$ 136.15 | \$ 136.15 | \$ 126.35 | | |
| Pharmacy management and claim processing | \$ 60.00 | \$ 60.00 | \$ 60.00 | \$ 60.00 | \$ 60.00 | \$ 60.00 | \$ 60.00 | | |
| Billing and insurance cost | \$ 91.11 | \$ 91.11 | \$ 91.11 | \$ 91.11 | \$ 91.11 | \$ 91.11 | \$ 91.11 | | |
| Other expenses | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | | |
| Advertising cost | \$ 15.00 | \$ 15.00 | \$ 15.00 | \$ 15.00 | \$ 15.00 | \$ 15.00 | \$ 15.00 | | |
| Total cost | \$ 2,055.85 | \$ 1,873.73 | \$ 1,802.46 | \$ 1,725.35 | \$ 1,660.51 | \$ 1,542.01 | \$ 1,437.46 | | |
| Monthly Rates | \$ 171.32 | \$ 156.14 | \$ 150.21 | \$ 143.78 | \$ 138.38 | \$ 128.50 | \$ 119.79 | | |
| Average enrollment | 3,691 | 953 | - | - | - | - | - | | 4,644 |
| Annual cost | \$ 7,588,142 | \$ 1,785,665 | \$ - | \$ - | \$ - | \$ - | \$ - | | \$ 9,373,807 |

| | Year Beginning | | Annual Household Income Range | | | | | | Total |
|---|--------------------|--------------------|-------------------------------|--------------------|--------------------|--------------------|--------------------|----------|---------------|
| | January 1, 2001 | | \$0 | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | |
| | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | \$40,000 | And Over | | |
| Annual Cost Per Member | | | | | | | | | |
| Ingredient cost (Includes discounts and cost sharing) | \$ 2,080.14 | \$ 1,896.52 | \$ 1,811.01 | \$ 1,732.23 | \$ 1,654.93 | \$ 1,518.70 | \$ 1,411.00 | | |
| Dispensing fees | \$ 179.90 | \$ 151.55 | \$ 151.55 | \$ 141.05 | \$ 141.05 | \$ 141.05 | \$ 130.90 | | |
| Pharmacy management and claim processing | \$ 60.00 | \$ 60.00 | \$ 60.00 | \$ 60.00 | \$ 60.00 | \$ 60.00 | \$ 60.00 | | |
| Billing and insurance cost | \$ 91.11 | \$ 91.11 | \$ 91.11 | \$ 91.11 | \$ 91.11 | \$ 91.11 | \$ 91.11 | | |
| Other expenses | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | | |
| Advertising cost | \$ 5.00 | \$ 5.00 | \$ 5.00 | \$ 5.00 | \$ 5.00 | \$ 5.00 | \$ 5.00 | | |
| Total cost | \$ 2,416.15 | \$ 2,204.18 | \$ 2,118.67 | \$ 2,029.39 | \$ 1,952.09 | \$ 1,815.86 | \$ 1,698.01 | | |
| Monthly Rates | \$ 201.35 | \$ 183.68 | \$ 176.56 | \$ 169.12 | \$ 162.67 | \$ 151.32 | \$ 141.50 | | |
| Average enrollment | 4,060 | 1,048 | - | - | - | - | - | | 5,108 |
| Annual cost | \$ 9,809,569 | \$ 2,309,981 | \$ - | \$ - | \$ - | \$ - | \$ - | | \$ 12,119,550 |

| | Year Beginning | | Annual Household Income Range | | | | | | Total |
|---|--------------------|--------------------|-------------------------------|--------------------|--------------------|--------------------|--------------------|----------|---------------|
| | January 1, 2002 | | \$0 | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | |
| | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | \$40,000 | And Over | | |
| Annual Cost Per Member | | | | | | | | | |
| Ingredient cost (Includes discounts and cost sharing) | \$ 2,541.12 | \$ 2,323.67 | \$ 2,222.72 | \$ 2,129.96 | \$ 2,038.39 | \$ 1,875.43 | \$ 1,746.03 | | |
| Dispensing fees | \$ 186.90 | \$ 157.50 | \$ 157.50 | \$ 146.65 | \$ 146.65 | \$ 146.65 | \$ 94.85 | | |
| Pharmacy management and claim processing | \$ 60.00 | \$ 60.00 | \$ 60.00 | \$ 60.00 | \$ 60.00 | \$ 60.00 | \$ 60.00 | | |
| Billing and insurance cost | \$ 91.11 | \$ 91.11 | \$ 91.11 | \$ 91.11 | \$ 91.11 | \$ 91.11 | \$ 91.11 | | |
| Other expenses | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | | |
| Advertising cost | \$ 5.00 | \$ 5.00 | \$ 5.00 | \$ 5.00 | \$ 5.00 | \$ 5.00 | \$ 5.00 | | |
| Total cost | \$ 2,884.13 | \$ 2,637.28 | \$ 2,536.33 | \$ 2,432.72 | \$ 2,341.15 | \$ 2,178.19 | \$ 1,996.99 | | |
| Monthly Rates | \$ 240.34 | \$ 219.77 | \$ 211.36 | \$ 202.73 | \$ 195.10 | \$ 181.52 | \$ 166.42 | | |
| Average enrollment | 4,429 | 1,143 | - | - | - | - | - | | 5,572 |
| Annual cost | \$ 12,773,812 | \$ 3,014,411 | \$ - | \$ - | \$ - | \$ - | \$ - | | \$ 15,788,223 |

**Premium Payments and Deductibles for Seniors and Disabled
The HOPE Plan
Exhibit B**

| Annual Income Range | Annual Deductible | Enrollment | | | Annual Funding Rate for Seniors | | | Percent Contribution | Monthly Premium Payment | | |
|-----------------------|-------------------|------------|---------|---------|---------------------------------|-------------|-------------|----------------------|-------------------------|--------|--------|
| | | Year 1 | Year 2 | Year 3 | Year 1 | Year 2 | Year 3 | | Year 1 | Year 2 | Year 3 |
| \$ - \$ 4,999 | \$ - | 5,573 | 6,130 | 6,687 | \$ 1,052.26 | \$ 1,209.69 | \$ 1,420.23 | 0.00% | \$0 | \$0 | \$0 |
| \$ 5,000 \$ 8,499 | \$ - | 16,811 | 18,493 | 20,173 | \$ 1,052.26 | \$ 1,209.69 | \$ 1,420.23 | 0.00% | \$0 | \$0 | \$0 |
| \$ 8,500 \$ 9,999 | \$ - | 16,718 | 18,390 | 20,062 | \$ 1,052.26 | \$ 1,209.69 | \$ 1,420.23 | 0.00% | \$0 | \$0 | \$0 |
| \$ 10,000 \$ 12,749 | \$ - | 10,728 | 11,800 | 12,874 | \$ 1,052.26 | \$ 1,209.69 | \$ 1,420.23 | 0.00% | \$0 | \$0 | \$0 |
| \$ 12,750 \$ 15,999 | \$ 100 | 12,864 | 14,150 | 15,436 | \$ 964.10 | \$ 1,107.48 | \$ 1,302.23 | 30.00% | \$24 | \$28 | \$33 |
| \$ 16,000 \$ 16,999 | \$ 150 | 3,784 | 4,162 | 4,541 | \$ 932.30 | \$ 1,069.33 | \$ 1,257.19 | 55.00% | \$43 | \$49 | \$58 |
| \$ 17,000 \$ 19,999 | \$ 150 | 5,790 | 6,754 | 7,719 | \$ 932.30 | \$ 1,069.33 | \$ 1,257.19 | 65.00% | \$50 | \$58 | \$68 |
| \$ 20,000 \$ 24,999 | \$ 200 | 6,192 | 7,224 | 8,256 | \$ 895.44 | \$ 1,027.19 | \$ 1,208.46 | 75.00% | \$56 | \$64 | \$76 |
| \$ 25,000 \$ 29,999 | \$ 200 | 6,192 | 7,224 | 8,256 | \$ 895.44 | \$ 1,027.19 | \$ 1,208.46 | 85.00% | \$63 | \$73 | \$86 |
| \$ 30,000 \$ 34,999 | \$ 250 | 6,192 | 7,224 | 8,256 | \$ 866.51 | \$ 992.71 | \$ 1,167.62 | 89.00% | \$64 | \$74 | \$87 |
| \$ 35,000 \$ 39,999 | \$ 350 | 5,160 | 6,020 | 6,880 | \$ 813.65 | \$ 931.94 | \$ 1,094.92 | 102.00% | \$69 | \$79 | \$93 |
| \$ 40,000 \$ 44,999 | \$ 450 | 4,128 | 4,816 | 5,504 | \$ 764.74 | \$ 876.89 | \$ 1,029.84 | 106.25% | \$68 | \$78 | \$91 |
| \$ 45,000 \$ 49,999 | \$ 450 | 4,128 | 4,816 | 5,504 | \$ 764.74 | \$ 876.89 | \$ 1,029.84 | 106.25% | \$68 | \$78 | \$91 |
| \$ 50,000 \$ 54,999 | \$ 450 | 4,283 | 4,997 | 5,710 | \$ 764.74 | \$ 876.89 | \$ 1,029.84 | 106.25% | \$68 | \$78 | \$91 |
| \$ 55,000 \$ 59,999 | \$ 450 | 3,096 | 3,612 | 4,128 | \$ 764.74 | \$ 876.89 | \$ 1,029.84 | 106.25% | \$68 | \$78 | \$91 |
| \$ 60,000 \$ 64,999 | \$ 450 | 3,096 | 3,612 | 4,128 | \$ 764.74 | \$ 876.89 | \$ 1,029.84 | 106.25% | \$68 | \$78 | \$91 |
| \$ 65,000 \$ 69,999 | \$ 450 | 3,096 | 3,612 | 4,128 | \$ 764.74 | \$ 876.89 | \$ 1,029.84 | 106.25% | \$68 | \$78 | \$91 |
| \$ 70,000 \$ 74,999 | \$ 450 | 2,116 | 2,468 | 2,821 | \$ 764.74 | \$ 876.89 | \$ 1,029.84 | 106.25% | \$68 | \$78 | \$91 |
| \$ 75,000 \$ 79,999 | \$ 450 | 2,064 | 2,408 | 2,752 | \$ 764.74 | \$ 876.89 | \$ 1,029.84 | 106.25% | \$68 | \$78 | \$91 |
| \$ 80,000 \$ 84,999 | \$ 450 | 2,064 | 2,408 | 2,752 | \$ 764.74 | \$ 876.89 | \$ 1,029.84 | 106.25% | \$68 | \$78 | \$91 |
| \$ 85,000 \$ 89,999 | \$ 450 | 2,064 | 2,408 | 2,752 | \$ 764.74 | \$ 876.89 | \$ 1,029.84 | 106.25% | \$68 | \$78 | \$91 |
| \$ 90,000 \$ 94,999 | \$ 450 | 2,064 | 2,408 | 2,752 | \$ 764.74 | \$ 876.89 | \$ 1,029.84 | 106.25% | \$68 | \$78 | \$91 |
| \$ 95,000 \$ 99,999 | \$ 450 | 2,064 | 2,408 | 2,752 | \$ 764.74 | \$ 876.89 | \$ 1,029.84 | 106.25% | \$68 | \$78 | \$91 |
| \$ 100,000 \$ 104,999 | \$ 450 | 2,312 | 2,697 | 3,082 | \$ 764.74 | \$ 876.89 | \$ 1,029.84 | 106.25% | \$68 | \$78 | \$91 |
| | | 132,579 | 150,241 | 167,905 | | | | | | | |

XII. Exhibits:

Financial Projections for Seniors The HOPE Plan Exhibit C

| | Year Beginning | | Annual Household Income Range | | | | | | Total |
|---|-----------------|---------------|-------------------------------|---------------|--------------|--------------|----------------|----------------|-------|
| | January 1, 2000 | | 0 | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | |
| | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | \$40,000 | And Over | | |
| Annual Cost | | | | | | | | | |
| Ingredient cost (Includes discounts and cost sharing) | \$ 35,314,791 | \$ 8,295,892 | \$ 6,363,742 | \$ 7,861,735 | \$ 3,751,733 | \$ 2,853,686 | \$ 18,681,779 | \$ 83,123,358 | |
| Dispensing fees | \$ 5,571,284 | \$ 1,208,967 | \$ 971,761 | \$ 1,170,288 | \$ 585,144 | \$ 487,620 | \$ 3,213,114 | \$ 13,208,178 | |
| Pharmacy management and claim processing | \$ 2,768,340 | \$ 714,660 | \$ 574,440 | \$ 743,040 | \$ 371,520 | \$ 309,600 | \$ 2,194,500 | \$ 7,676,100 | |
| Billing and insurance cost | \$ 4,203,724 | \$ 1,085,211 | \$ 872,287 | \$ 1,128,306 | \$ 564,153 | \$ 470,128 | \$ 3,332,348 | \$ 11,656,157 | |
| Other expenses | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | |
| Advertising cost | \$ 692,085 | \$ 178,665 | \$ 143,610 | \$ 185,760 | \$ 92,880 | \$ 77,400 | \$ 548,625 | \$ 1,919,025 | |
| Total cost | \$ 48,550,224 | \$ 11,483,395 | \$ 8,925,840 | \$ 11,089,129 | \$ 5,365,430 | \$ 4,198,434 | \$ 27,970,366 | \$ 117,582,818 | |
| Premium revenue | \$ - | \$ 3,445,019 | \$ 5,449,014 | \$ 8,871,303 | \$ 4,775,233 | \$ 4,282,403 | \$ 29,718,515 | \$ 56,541,487 | |
| COB Recoveries | \$ 52,972 | \$ 12,444 | \$ 15,319 | \$ 29,482 | \$ 28,138 | \$ 42,805 | \$ 560,450 | \$ 741,610 | |
| Commonwealth's Net Cost | \$ 48,497,252 | \$ 8,025,932 | \$ 3,461,507 | \$ 2,188,344 | \$ 562,059 | \$ (126,774) | \$ (2,308,599) | \$ 60,299,721 | |
| Average enrollment | 46,139 | 11,911 | 9,574 | 12,384 | 6,192 | 5,160 | 36,575 | 127,935 | |

| | Year Beginning | | Annual Household Income Range | | | | | | Total |
|---|-----------------|---------------|-------------------------------|---------------|--------------|--------------|----------------|----------------|-------|
| | January 1, 2001 | | 0 | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | |
| | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | \$40,000 | And Over | | |
| Annual Cost | | | | | | | | | |
| Ingredient cost (Includes discounts and cost sharing) | \$ 47,095,231 | \$ 11,084,554 | \$ 8,818,709 | \$ 11,164,403 | \$ 5,333,118 | \$ 4,078,430 | \$ 26,857,778 | \$ 114,432,223 | |
| Dispensing fees | \$ 6,377,114 | \$ 1,380,296 | \$ 1,150,001 | \$ 1,420,961 | \$ 710,480 | \$ 592,067 | \$ 3,897,905 | \$ 15,528,824 | |
| Pharmacy management and claim processing | \$ 3,045,180 | \$ 786,120 | \$ 654,960 | \$ 866,880 | \$ 433,440 | \$ 361,200 | \$ 2,560,200 | \$ 8,707,980 | |
| Billing and insurance cost | \$ 4,624,106 | \$ 1,193,723 | \$ 994,557 | \$ 1,316,357 | \$ 658,179 | \$ 548,482 | \$ 3,887,664 | \$ 13,223,068 | |
| Other expenses | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | |
| Advertising cost | \$ 253,765 | \$ 65,510 | \$ 54,580 | \$ 72,240 | \$ 36,120 | \$ 30,100 | \$ 213,350 | \$ 725,665 | |
| Total cost | \$ 61,395,396 | \$ 14,510,203 | \$ 11,672,807 | \$ 14,840,841 | \$ 7,171,337 | \$ 5,610,279 | \$ 37,416,897 | \$ 152,617,760 | |
| Premium revenue | \$ - | \$ 4,353,061 | \$ 7,142,269 | \$ 11,872,672 | \$ 6,382,490 | \$ 5,722,484 | \$ 39,755,453 | \$ 75,228,429 | |
| Recoveries | \$ 70,642 | \$ 16,627 | \$ 21,413 | \$ 41,867 | \$ 39,998 | \$ 61,176 | \$ 805,733 | \$ 1,057,456 | |
| Commonwealth's Net Cost | \$ 61,324,754 | \$ 10,140,515 | \$ 4,509,125 | \$ 2,926,302 | \$ 748,849 | \$ (173,381) | \$ (3,144,289) | \$ 76,331,875 | |
| Average enrollment | 50,753 | 13,102 | 10,916 | 14,448 | 7,224 | 6,020 | 42,670 | 145,133 | |

| | Year Beginning | | Annual Household Income Range | | | | | | Total |
|---|-----------------|---------------|-------------------------------|---------------|--------------|--------------|----------------|----------------|-------|
| | January 1, 2002 | | 0 | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | |
| | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | \$40,000 | And Over | | |
| Annual Cost | | | | | | | | | |
| Ingredient cost (Includes discounts and cost sharing) | \$ 62,762,370 | \$ 14,815,695 | \$ 12,156,158 | \$ 15,688,877 | \$ 7,507,263 | \$ 5,755,877 | \$ 37,982,083 | \$ 156,668,323 | |
| Dispensing fees | \$ 7,228,162 | \$ 1,565,798 | \$ 1,343,083 | \$ 1,687,526 | \$ 843,763 | \$ 703,136 | \$ 4,625,360 | \$ 17,996,828 | |
| Pharmacy management and claim processing | \$ 3,322,020 | \$ 857,580 | \$ 735,600 | \$ 990,720 | \$ 495,360 | \$ 412,800 | \$ 2,925,900 | \$ 9,739,980 | |
| Billing and insurance cost | \$ 5,044,487 | \$ 1,302,235 | \$ 1,117,009 | \$ 1,504,408 | \$ 752,204 | \$ 626,837 | \$ 4,442,979 | \$ 14,790,159 | |
| Other expenses | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | |
| Advertising cost | \$ 276,835 | \$ 71,465 | \$ 61,300 | \$ 82,560 | \$ 41,280 | \$ 34,400 | \$ 243,825 | \$ 811,665 | |
| Total cost | \$ 78,633,874 | \$ 18,612,773 | \$ 15,413,150 | \$ 19,954,091 | \$ 9,639,870 | \$ 7,533,050 | \$ 50,220,147 | \$ 200,006,955 | |
| Premium revenue | \$ - | \$ 5,583,832 | \$ 9,447,657 | \$ 15,963,273 | \$ 8,579,485 | \$ 7,683,711 | \$ 53,358,905 | \$ 100,616,863 | |
| Recoveries | \$ 94,144 | \$ 22,224 | \$ 29,715 | \$ 58,833 | \$ 56,304 | \$ 86,338 | \$ 1,139,460 | \$ 1,487,018 | |
| Commonwealth's Net Cost | \$ 78,539,730 | \$ 13,006,717 | \$ 5,935,778 | \$ 3,931,985 | \$ 1,004,081 | \$ (236,999) | \$ (4,278,218) | \$ 97,903,074 | |
| Average enrollment | 55,367 | 14,293 | 12,260 | 16,512 | 8,256 | 6,880 | 48,765 | 162,333 | |

XII. Exhibits:

Financial Projections for Disabled Individuals The HOPE Plan Exhibit C1

| | Year Beginning | | Annual Household Income Range | | | | | | Total |
|---|-----------------|--------------|-------------------------------|----------|----------|----------|----------|----------|--------------|
| | January 1, 2000 | | 0 | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | |
| | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | \$40,000 | And Over | | |
| Annual Cost | | | | | | | | | |
| Ingredient cost (Includes discounts and cost sharing) | \$ 6,332,981 | \$ 1,487,938 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 7,820,919 |
| Dispensing fees | \$ 642,049 | \$ 139,424 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 781,473 |
| Pharmacy management and claim processing | \$ 221,460 | \$ 57,180 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 278,640 |
| Billing and insurance cost | \$ 336,287 | \$ 86,828 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 423,115 |
| Other expenses | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - |
| Advertising cost | \$ 55,365 | \$ 14,295 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 69,660 |
| Total cost | \$ 7,588,142 | \$ 1,785,665 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 9,373,807 |
| Premium revenue | \$ - | \$ 275,636 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 275,636 |
| COB Recoveries | \$ 9,499 | \$ 2,232 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 11,731 |
| Net cost | \$ 7,578,643 | \$ 1,507,797 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 9,086,440 |
| Average enrollment | 3,691 | 953 | - | - | - | - | - | - | 4,644 |

| | Year Beginning | | Annual Household Income Range | | | | | | Total |
|---|-----------------|--------------|-------------------------------|----------|----------|----------|----------|----------|---------------|
| | January 1, 2001 | | 0 | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | |
| | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | \$40,000 | And Over | | |
| Annual Cost | | | | | | | | | |
| Ingredient cost (Includes discounts and cost sharing) | \$ 8,445,368 | \$ 1,987,553 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 10,432,921 |
| Dispensing fees | \$ 730,394 | \$ 158,824 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 889,218 |
| Pharmacy management and claim processing | \$ 243,600 | \$ 62,880 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 306,480 |
| Billing and insurance cost | \$ 369,907 | \$ 95,483 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 465,390 |
| Other expenses | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - |
| Advertising cost | \$ 20,300 | \$ 5,240 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 25,540 |
| Total cost | \$ 9,809,569 | \$ 2,309,980 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 12,119,549 |
| Premium revenue | \$ - | \$ 348,192 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 348,192 |
| Recoveries | \$ 12,668 | \$ 2,981 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 15,649 |
| Net cost | \$ 9,796,901 | \$ 1,958,807 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 11,755,708 |
| Average enrollment | 4,060 | 1,048 | - | - | - | - | - | - | 5,108 |

| | Year Beginning | | Annual Household Income Range | | | | | | Total |
|---|-----------------|--------------|-------------------------------|----------|----------|----------|----------|----------|---------------|
| | January 1, 2002 | | 0 | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | |
| | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | \$40,000 | And Over | | |
| Annual Cost | | | | | | | | | |
| Ingredient cost (Includes discounts and cost sharing) | \$ 11,254,620 | \$ 2,655,955 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 13,910,575 |
| Dispensing fees | \$ 827,780 | \$ 180,023 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 1,007,803 |
| Pharmacy management and claim processing | \$ 265,740 | \$ 68,580 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 334,320 |
| Billing and insurance cost | \$ 403,526 | \$ 104,139 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 507,665 |
| Other expenses | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - |
| Advertising cost | \$ 22,145 | \$ 5,715 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 27,860 |
| Total cost | \$ 12,773,811 | \$ 3,014,412 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 15,788,223 |
| Premium revenue | \$ - | \$ 446,535 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 446,535 |
| Recoveries | \$ 16,882 | \$ 3,984 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 20,866 |
| Net cost | \$ 12,756,929 | \$ 2,563,893 | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 15,320,822 |
| Average enrollment | 4,429 | 1,143 | - | - | - | - | - | - | 5,572 |

XII. Exhibits:

Financial Projections for Seniors and Disabled Individuals The HOPE Plan Exhibit C2

| | Year Beginning | | Annual Household Income Range | | | | | | Total |
|---|-----------------|---------------|-------------------------------|---------------|--------------|--------------|----------------|----------------|-------|
| | January 1, 2000 | | 0 | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | |
| | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | \$40,000 | And Over | | |
| Annual Cost | | | | | | | | | |
| Ingredient cost (Includes discounts and cost sharing) | \$ 41,647,772 | \$ 9,783,830 | \$ 6,363,742 | \$ 7,861,735 | \$ 3,751,733 | \$ 2,853,686 | \$ 18,681,779 | \$ 90,944,277 | |
| Dispensing fees | \$ 6,213,333 | \$ 1,348,391 | \$ 971,761 | \$ 1,170,288 | \$ 585,144 | \$ 487,620 | \$ 3,213,114 | \$ 13,989,651 | |
| Pharmacy management and claim processing | \$ 2,989,800 | \$ 771,840 | \$ 574,440 | \$ 743,040 | \$ 371,520 | \$ 309,600 | \$ 2,194,500 | \$ 7,954,740 | |
| Billing and insurance cost | \$ 4,540,011 | \$ 1,172,039 | \$ 872,287 | \$ 1,128,306 | \$ 564,153 | \$ 470,128 | \$ 3,332,348 | \$ 12,079,272 | |
| Other expenses | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | |
| Advertising cost | \$ 747,450 | \$ 192,960 | \$ 143,610 | \$ 185,760 | \$ 92,880 | \$ 77,400 | \$ 548,625 | \$ 1,988,685 | |
| Total cost | \$ 56,138,366 | \$ 13,269,060 | \$ 8,925,840 | \$ 11,089,129 | \$ 5,365,430 | \$ 4,198,434 | \$ 27,970,366 | \$ 126,956,625 | |
| Premium revenue | \$ - | \$ 3,720,655 | \$ 5,449,014 | \$ 8,871,303 | \$ 4,775,233 | \$ 4,282,403 | \$ 29,718,515 | \$ 56,817,123 | |
| Recoveries | \$ 62,471 | \$ 14,676 | \$ 15,319 | \$ 29,482 | \$ 28,138 | \$ 42,805 | \$ 560,450 | \$ 753,341 | |
| Net cost | \$ 56,075,895 | \$ 9,533,729 | \$ 3,461,507 | \$ 2,188,344 | \$ 562,059 | \$ (126,774) | \$ (2,308,599) | \$ 69,386,161 | |
| Average enrollment | 49,830 | 12,864 | 9,574 | 12,384 | 6,192 | 5,160 | 36,575 | 132,579 | |

| | Year Beginning | | Annual Household Income Range | | | | | | Total |
|---|-----------------|---------------|-------------------------------|---------------|--------------|--------------|----------------|----------------|-------|
| | January 1, 2001 | | 0 | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | |
| | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | \$40,000 | And Over | | |
| Annual Cost | | | | | | | | | |
| Ingredient cost (Includes discounts and cost sharing) | \$ 55,540,599 | \$ 13,072,107 | \$ 8,818,709 | \$ 11,164,403 | \$ 5,333,118 | \$ 4,078,430 | \$ 26,857,778 | \$ 124,865,144 | |
| Dispensing fees | \$ 7,107,508 | \$ 1,539,120 | \$ 1,150,001 | \$ 1,420,961 | \$ 710,480 | \$ 592,067 | \$ 3,897,905 | \$ 16,418,042 | |
| Pharmacy management and claim processing | \$ 3,288,780 | \$ 849,000 | \$ 654,960 | \$ 866,880 | \$ 433,440 | \$ 361,200 | \$ 2,560,200 | \$ 9,014,460 | |
| Billing and insurance cost | \$ 4,994,013 | \$ 1,289,206 | \$ 994,557 | \$ 1,316,357 | \$ 658,179 | \$ 548,482 | \$ 3,887,664 | \$ 13,688,458 | |
| Other expenses | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | |
| Advertising cost | \$ 274,065 | \$ 70,750 | \$ 54,580 | \$ 72,240 | \$ 36,120 | \$ 30,100 | \$ 213,350 | \$ 751,205 | |
| Total cost | \$ 71,204,965 | \$ 16,820,183 | \$ 11,672,807 | \$ 14,840,841 | \$ 7,171,337 | \$ 5,610,279 | \$ 37,416,897 | \$ 164,737,309 | |
| Premium revenue | \$ - | \$ 4,701,253 | \$ 7,142,269 | \$ 11,872,672 | \$ 6,382,490 | \$ 5,722,484 | \$ 39,755,453 | \$ 75,576,621 | |
| Recoveries | \$ 83,310 | \$ 19,608 | \$ 21,413 | \$ 41,867 | \$ 39,998 | \$ 61,176 | \$ 805,733 | \$ 1,073,105 | |
| Net cost | \$ 71,121,655 | \$ 12,099,322 | \$ 4,509,125 | \$ 2,926,302 | \$ 748,849 | \$ (173,381) | \$ (3,144,289) | \$ 88,087,583 | |
| Average enrollment | 54,813 | 14,150 | 10,916 | 14,448 | 7,224 | 6,020 | 42,670 | 150,241 | |

| | Year Beginning | | Annual Household Income Range | | | | | | Total |
|---|-----------------|---------------|-------------------------------|---------------|--------------|--------------|----------------|----------------|-------|
| | January 1, 2002 | | 0 | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | |
| | \$12,250 | \$16,000 | \$20,000 | \$30,000 | \$35,000 | \$40,000 | And Over | | |
| Annual Cost | | | | | | | | | |
| Ingredient cost (Includes discounts and cost sharing) | \$ 74,016,990 | \$ 17,471,650 | \$ 12,156,158 | \$ 15,688,877 | \$ 7,507,263 | \$ 5,755,877 | \$ 37,982,083 | \$ 170,578,898 | |
| Dispensing fees | \$ 8,055,942 | \$ 1,745,821 | \$ 1,343,083 | \$ 1,687,526 | \$ 843,763 | \$ 703,136 | \$ 4,625,360 | \$ 19,004,631 | |
| Pharmacy management and claim processing | \$ 3,587,760 | \$ 926,160 | \$ 735,600 | \$ 990,720 | \$ 495,360 | \$ 412,800 | \$ 2,925,900 | \$ 10,074,300 | |
| Billing and insurance cost | \$ 5,448,013 | \$ 1,406,374 | \$ 1,117,009 | \$ 1,504,408 | \$ 752,204 | \$ 626,837 | \$ 4,442,979 | \$ 15,297,824 | |
| Other expenses | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | |
| Advertising cost | \$ 298,980 | \$ 77,180 | \$ 61,300 | \$ 82,560 | \$ 41,280 | \$ 34,400 | \$ 243,825 | \$ 839,525 | |
| Total cost | \$ 91,407,685 | \$ 21,627,185 | \$ 15,413,150 | \$ 19,954,091 | \$ 9,639,870 | \$ 7,533,050 | \$ 50,220,147 | \$ 215,795,178 | |
| Premium revenue | \$ - | \$ 6,030,367 | \$ 9,447,657 | \$ 15,963,273 | \$ 8,579,485 | \$ 7,683,711 | \$ 53,358,905 | \$ 101,063,398 | |
| Recoveries | \$ 111,026 | \$ 26,208 | \$ 29,715 | \$ 58,833 | \$ 56,304 | \$ 86,338 | \$ 1,139,460 | \$ 1,507,884 | |
| Net cost | \$ 91,296,659 | \$ 15,570,610 | \$ 5,935,778 | \$ 3,931,985 | \$ 1,004,081 | \$ (236,999) | \$ (4,278,218) | \$ 113,223,896 | |
| Average enrollment | 59,796 | 15,436 | 12,260 | 16,512 | 8,256 | 6,880 | 48,765 | 167,905 | |

Endnotes

- ¹ Congressional Record, 100th Cong., 1st Sess. (October 27, 1987), p. S29316.
- ² *ibid.*
- ³ *ibid.*, p. S29317.
- ⁴ Joint Committee on Printing, Henry John Heinz III, Late A Senator from Pennsylvania, Memorial Addresses Delivered in Congress, 102nd Congress (1994), pp. 88-89, (floor statement by United States Senator Tim Wirth (D-Colorado) on October 23, 1991, which would have been Senator Heinz's 53rd birthday).
- ⁵ Merck-Medco Managed Care, L.L.C., Managing Pharmacy Benefit Costs - A Merck-Medco Report About Drug Trend and Drug Spend and What to Do About It (1999), p. 21.
- ⁶ David Folkenflik, "High Cost of Drugs Potent in Politics," Baltimore Sun (May 30, 1999), p. 1A.
- ⁷ National Economic Council, Domestic Policy Council, Office of Domestic Policy, Disturbing Truths and Dangerous Trends: The Facts About Medicare Beneficiaries and Prescription Drug Coverage, (July 2, 1999), pp. 1, 6.
- ⁸ M. Davis, et al., "Prescription Drug Coverage, Utilization and Spending Among Medicare Beneficiaries," Health Affairs, Vol. 18, No. 1 (Jan.-Feb. 1999), p. 237.
- ⁹ Subcommittee on Health and Environment, House Committee on Commerce, Oversight Hearing, Prescription Drugs: What We Know and Don't Know About Seniors' Access to Coverage, 106th Cong., 1st Sess. (September 28, 1999), statement of Robert Reischauer.
- ¹⁰ David Gross and Normandy Brangan, Medicare Beneficiaries and Prescription Coverage: Gaps and Barriers, AARP Public Policy Institute (June 1999).
- ¹¹ Subcommittee on Health, House Committee on Ways and Means, Hearing on Seniors' Access to Prescription Drug Benefits, 106th Cong., 1st Sess. (February 15, 2000), statement of David M. Walker, pp. 1, 5.
- ¹² Subcommittee on Health and Environment, *op. cit.*
- ¹³ Subcommittee on Health and Environment, *op. cit.*, statement of Bert Seidman.
- ¹⁴ The White House, National Economic Council, *op. cit.*, pp. 1, 6.
- ¹⁵ Martin Frost, "What to Do About Medicare?," Dallas Morning News (August 3, 1999), p. 7A.
- ¹⁶ William M. Mercer, Inc., Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, Report on Survey Findings (1999), p. 44.
- ¹⁷ Health Insurance Association of America, Prescription Drugs: Costs and Coverage Trends, (September 1999).
- ¹⁸ William M. Mercer, *op. cit.*, p. 47.