



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

THE MAINE HOPE STRATEGY

Creating a Comprehensive and Affordable
Prescription Drug Program for All Persons
62 and Older in Maine

May 10, 2001

A project of the Heinz Family Philanthropies, PharmaCare and
The Women's Institute for a Secure Retirement

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Dedication

The **Maine HOPE Strategy** is dedicated to three tireless advocates who together recognized the importance of providing prescription drug coverage to senior citizens. Senators John Heinz (R-PA) and George Mitchell (D-ME) worked together to offer, and ultimately passed, the first Medicare prescription drug amendment. These two men fought to help ensure that all senior citizens could live a dignified retirement, free from financial ruin because of the costs of prescription drugs, catastrophic illnesses, and unnecessary placement into nursing homes. While Senator Mitchell continues this and other battles, the vision, passion and dedication of the late Senator John Heinz is a spirit that lives on in each of us who seek to design solutions to help older Americans address the rising costs of prescription drugs and help them to remain independent.

In Maine, the original pioneering work on prescription drugs was begun in 1975 by then Governor James B. Longley. It was his administration that paved the way for the creation of what is today the Low Cost Drugs for the Elderly or Disabled Program.

The same Heinz/Mitchell spirit of bipartisanship is alive in Maine today. Under the leadership of Republican Senate President Pro Tem Rick Bennett and Senate President Michael Michaud, House Speaker Michael Saxl and Republican House Leaders Joseph Bruno and William Schneider, the Maine legislative leadership has responded to the challenge of designing a prescription drug strategy to help all Maine residents aged 62 and older. Each legislative leader has spent many long hours in meetings, both in person and over the telephone with the author. Their legislative insight and expertise have been invaluable to this report's author and his consultants. Like Teresa Heinz, these legislative leaders understand, appreciate and staunchly support the notion that we cannot, indeed, we must not, ignore the needs of middle class senior citizens.

There are a number of additional unsung heroes whose time, energy, ideas, and insights were invaluable to the author, chief among them were Tarren Bragdon, Special Assistant to Senate President Pro Tem Rick Bennett and Peter Chandler, Chief of Staff to Senate President Michael Michaud. In addition, Brian Whitney, Chief of Staff to Senate President Pro Tem Rick Bennett; Rick McCarthy, Special Assistant to Senate President Michaud and Bill Brown, Legislative Aide to Speaker Saxl were very helpful. And, while not a formal member of the legislature or administration, John Grotten, the Vice President of Operations for Goold Health Systems, the agency responsible for administering the Low Cost Drugs for the Elderly or Disabled Program (DEL) was both patient and extremely helpful in addressing key substantive questions that were examined as this report was being prepared.

Letter from the Chairman

Governor Angus S. King, Jr.
Senate President, Michael Michaud
Senate President Pro Tem Richard Bennett
Speaker of the House, Rep. Michael V. Saxl
House Republican Leader, Joseph Bruno

Dear Governor King, Senator Michaud and Senator Bennett, Speaker Saxl, Mr. Bruno:

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 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, millions of senior citizens still confront that challenge each day. Nothing could be more tragic; and, in the richest nation on the earth, nothing could be more wrong.

In 1999, the Heinz Family Philanthropies prepared the first HOPE blueprint for the State of Massachusetts, Senate President Pro Tem Rick Bennett and Senate President Michael Michaud asked if we would look at Maine's Low Cost Drugs for the Elderly or Disabled Program (DEL) and determine whether, and under what circumstances, a HOPE strategy to provide prescription drug coverage for all persons aged 62 and older could be implemented in Maine, while not exceeding the budget that the state currently spends on the DEL program. In addition, and joined by Speaker Saxl, we were also asked to ensure that those persons aged 62 and older currently enrolled in the DEL program not incur any greater out of pocket costs.

The result – the Heinz Plan to Overcome Prescription Drug Expenses (HOPE) – the Maine HOPE Strategy – is contained in the report that follows.

The Maine HOPE Strategy, in part, builds on the already substantial work of, and expertise derived from, the DEL program. However, the Maine HOPE Strategy takes that good work the final step by creating a plan that, for the first time, offers affordable and comprehensive coverage to all people aged 62 and over regardless of their income. It also builds in catastrophic coverage to help protect the thousands of seniors in Maine who spend more than \$1,000 each year for prescription drug coverage.

There may be provisions contained in the Maine HOPE Strategy to which some, and even I, may take specific exception, or even disagree. But I think everyone can agree that consideration of the Maine HOPE Strategy will present the Maine legislature with a unique opportunity and a significant challenge.

Letter from the Chairman

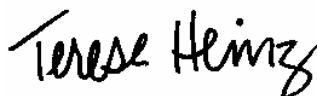
The challenge and opportunity is to redesign a statewide program in ways that will help those too often forgotten older Americans, the members of the middle class.

The Maine HOPE Strategy reflects a prodigious amount of work done by many extraordinary people who truly deserve to be applauded and thanked. Among them are: Annette Boyer, Laura Coe, Ernie Lampron, Lisa Coe, Barb Karwowski, Thomas S. Tomczyk, and Tom W. Tomczyk of William M. Mercer, Incorporated, and Brian Tiboni of Tiboni Chambers Associates, for their extensive and invaluable technical expertise; Mary Anne Marsh of GPC International for her communications expertise, and Frank Gannon, Grant Oliphant 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 and author 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.

Finally, I would like to express a very sincere and special thank you to Greg Weishar, President of PharmaCare, our funding partner in this initiative. The willingness of PharmaCare, and Greg in particular, to invest valuable resources in a project like this demonstrates how philanthropic and corporate partnerships together can achieve great things when there is a willingness to do so. Fortunately, for us, Greg Weishar is one of those rare corporate presidents who recognizes the need to design strategies to help all seniors to remain independent and to be able to access affordable prescription drugs.

Sincerely,



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 costs. Any bill presuming to protect Medicare beneficiaries against catastrophic costs is an impostor without a provision to cover prescription drugs.

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 even 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 serves the people and provides for them, at the same time, the legitimate services they cannot otherwise find for themselves. Coverage for prescription drugs was then, and remains today, one of those legitimate services. As Chairman of the Senate Special Committee on Aging, he wanted to ensure that all Americans, and particularly seniors who need help, should have access to it.

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.²

Teresa Heinz shares her late husband's concerns that far too many seniors desperately need help with the costs of their prescription drugs. Far too many of these seniors, including many who live in Maine, find that they are not eligible for existing programs such as the DEL (the Low Cost Drugs for the Elderly or Disabled Program), and are also unable to afford today's high-priced, private Medigap insurance plans with prescription drug benefits.

Mrs. Heinz, Chairman of the Heinz Family Philanthropies, sees a clear need to ensure that middle class seniors who do not qualify for Medicaid or other State-assisted programs are not forgotten or ignored. Because their situation is growing increasingly critical, she challenged us to design a plan to bring prescription drug coverage to all seniors. 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): The Maine Strategy – meets the challenge set forth by Mrs. Heinz, and represents an innovative and practical way for Maine to help senior citizens fight the nightmare of escalating prescription drug costs and 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 hundreds of thousands of middle class seniors in Maine.

II. Prescription Drug Benefits for Seniors: The Nation's Challenge

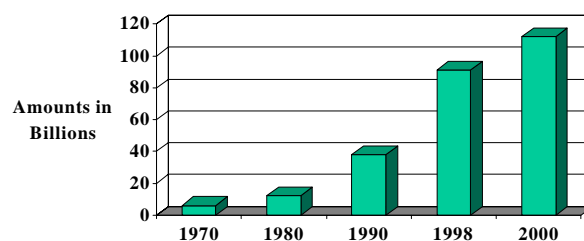
Today, many seniors are forced to choose between paying for necessities of daily life, such as food, clothing and heating, or their prescription medications. Stories of senior citizens who had to cut back sometimes on food or heating fuel to be able to afford a prescription drug have been told repeatedly.³ In addition, compliance with recommended dosages is often compromised due to limited financial resources. Since most seniors utilize pharmaceutical therapies for chronic conditions, incorrect compliance, such as missed doses or partial doses of drugs, may lead to increased medical costs and utilization. The result is a population whose health status suffers because of this gap in coverage. We believe an obligation exists to design a solution to improve the availability of prescription drug coverage for all people age 62 and over living in Maine, not just those on limited incomes.

Some in Congress have responded by saying it is time once again to expand Medicare to cover the costs of prescription drugs. However, in so doing, Congress refuses to address the underlying root causes of this and other Medicare problems. But we can no longer simply tinker on the edges of a program desperately in need of overhaul. A band-aid won't stop a wound that is hemorrhaging. The reality is that Congress is at a political stand-still and lacks the courage and conviction to address this problem at its root cause. Congress refuses to examine why the United States remains one of the few nations in the world that does not regulate the costs of prescription drugs. In the absence of a complete and overall reform of the Medicare program, we believe that each state should be given the financial resources to lead by designing supplemental programs like state-based prescription drug coverage for seniors.

National Prescription Drug Expenditures

Prescription medications are a critical component in health care treatment. In 1970, outpatient prescription drug spending totaled about \$6 billion in the United States. At that time, prescription medications were used primarily to treat patients in a hospital setting for acute conditions. By 2000, national prescription drug spending increased by 11% accounting for \$112 billion of health care spending. As illustrated in Figure 1, national spending for prescription medications since 1990 has tripled.

Figure 1
Prescription Drug Expenditures in U.S.
1970 - 2000



Source: Health Care Financing Administration Office of the Actuary

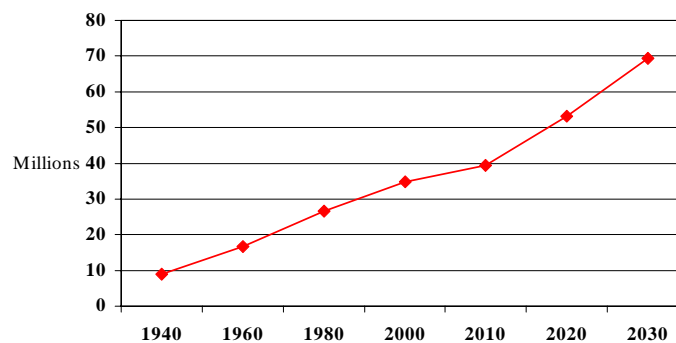
II. Prescription Drug Benefits for Seniors: The Nation's Challenge

Today, prescription medications treat a broad range of illnesses and chronic conditions such as cancer, heart disease and depression. Medications have contributed to increased life expectancy and a dramatic improvement in the quality of life.

Aging of the Population

Like the cost of prescription drugs, the age 65 and over population has been increasing and is expected to increase significantly over the next 30 years. The U. S. Bureau of Census estimated a senior population of 35 million as of July 1, 2000, and projects a senior population of 70 million as of 2030⁴ (Figure 2). The under-65 population, in contrast, is expected to increase just 18% over the same time period. The fastest growing segment of senior population are persons age 85 and older. While there were 4.0 million persons age 85 and older in 1998, it is estimated it will grow to 8.5 million by 2030.

Figure 2
Number of Persons Over Age 65
1940 - 2030



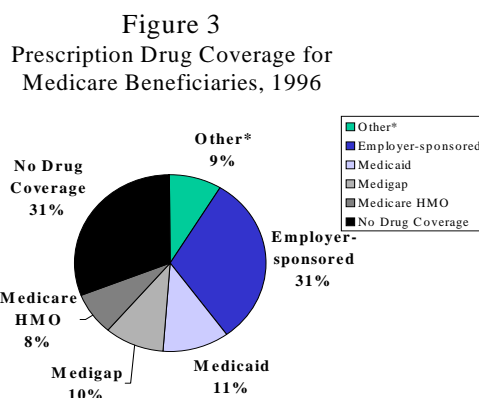
Source: The U.S. Bureau of Census

The dramatic growth in the senior population is significant because they are the largest users of prescription drugs. The typical Medicare beneficiary uses an average of 18-35 prescriptions per year, as compared with about 9-13 per year for the under-65 population.⁵ Moreover, seniors spend significantly more money out-of-pocket for prescriptions. On average, prescriptions account for 34% of the out-of-pocket health care expense burden for seniors (excluding premiums). This is more than physician visits (31%) and hospital admissions (14%).⁶ Unlike physician and hospital care, Medicare does not pay for outpatient prescription medications for seniors.

II. Prescription Drug Benefits for Seniors: The Nation's Challenge

Senior Prescription Drug Coverage

Today, the Medicare program does not cover outpatient prescription drugs. In order to obtain coverage, many seniors purchase supplemental insurance coverage. In 1996 nearly 70% of Medicare beneficiaries (26 million) had some form of drug coverage either through employer-sponsored health plans, Medicaid, Medicare HMOs or Medigap insurance plans (Figure 3).



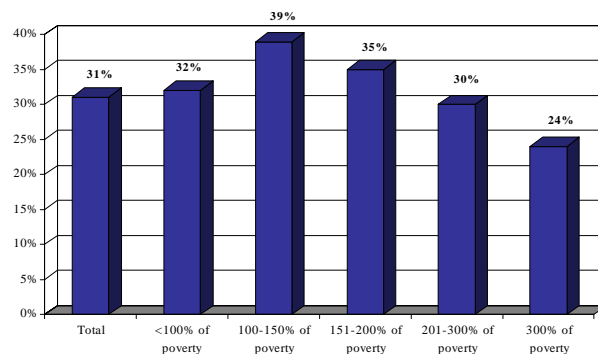
Source: Poisal, J. A. and Chulis, G. S., *Health Affairs*, March/April 2000
Note: Data are based on the noninstitutionalized population.
*Includes people who changed coverage during the year and those with Medicare and "other" coverage.

Those with drug coverage find that most of the coverage is restricted, due to the imposition of payment and benefit limits. Further, the amount of coverage is expected to decline in the future.

While two-thirds of the Medicare beneficiaries have some form of drug coverage, nearly one third (12 million) lack coverage and must pay out-of-pocket for their drug expenses. Even though there are some State programs to provide prescription drug assistance, generally these programs only provide coverage for seniors up to 150% of the Federal Poverty Level (FPL). Consequently as shown in Figure 4, there are a number of Medicare beneficiaries with incomes above 150% of the Federal Poverty Level who are not eligible for State-sponsored drug plans.

II. Prescription Drug Benefits for Seniors: The Nation's Challenge

Figure 4
Medicare Beneficiaries Without Prescription
Drug Coverage, by Poverty Level, 1996



Note: 1996 federal poverty level was \$7,740 for individuals; \$10,360 for couples.
Source: Poisal, J. A. and Chulis, G. S., *Health Affairs*, March/April 2000.

With prescription drugs being used more frequently as primary therapy, coupled with an aging population who are already high utilizers of prescription drugs, there is an immediate need to expand coverage to seniors.

The principal reform options to expand coverage to seniors are to:

- 1) offer senior prescription drug coverage by expanding the current Medicare program or,
- 2) offer a State-level solution.

With the reengineering required to bring Medicare into the 21st century, we believe that a State-level solution – **The HOPE Plan** – is the best way to develop a prescription drug program to ensure access for all seniors. It is essential that senior citizens have access to affordable coverage that will meet their needs. In addition, seniors who have limited financial resources must have access to subsidized or free coverage, depending on their financial situations.

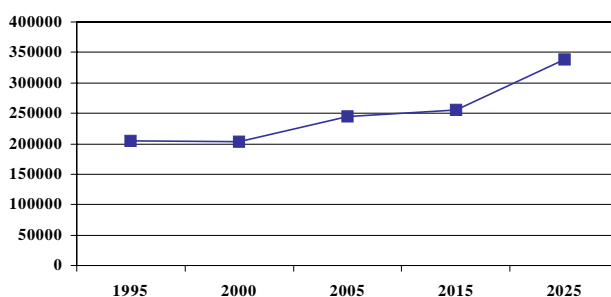
Maine stands at an important historical crossroads – one that will challenge both the political and institutional mettle of the legislature as well as that of the Office of the Governor. This report addresses many of the issues affecting the availability of senior prescription drug coverage for Maine residents. The challenge is whether the State's political structure is prepared and willing to tackle this problem. While this challenge is not new, it cannot and should not be ignored any longer.

III. Prescription Drug Benefits for Seniors: The Situation in Maine

The Aging of the Population in Maine

In Maine there are approximately 204,000 seniors age 62 and over. This population is projected to increase to 338,000 by 2025 (Figure 5).

Figure 5
Number of Persons In Maine Age 62 and Over
1995 - 2025



Source: The U.S. Bureau of Census

Maine, like several other states illustrated in the Table 1, has a senior population that exceeds 15% of its total population.⁷

TABLE 1 PEOPLE 65 AND OLDER AS A PERCENTAGE OF TOTAL STATE POPULATION	
STATE	PERCENT OF TOTAL POPULATION
Florida	18.3%
Pennsylvania	15.9%
Maine	15.7%
Rhode Island	15.6%
West Virginia	15.2%

III. Prescription Drug Benefits for Seniors: The Situation in Maine

Current Senior Prescription Drug Coverage in Maine

Maine Medicare beneficiaries fortunate enough to have prescription drug coverage are generally enrolled in one of four different types of programs:

- Employer-sponsored plans
- Medigap plans
- Medicaid
- State pharmacy assistance program: Low Cost Drugs for the Elderly or Disabled Program (DEL)

The benefit designs for these prescription drug programs vary widely, ranging from limited benefits with high deductibles and member contributions to comprehensive pharmacy coverage. Most recently Medicare HMOs have pulled out of the Maine market entirely. This leaves seniors struggling for alternatives beyond the four identified above.

Employer-sponsored Plans

During the 1990s there has been an erosion of employer-sponsored medical plans for retirees. From 1993 to 1999, as reported in the Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans, the number of large employers (employers with 500 or more employees) offering medical coverage to Medicare-eligible retirees had dropped from 40% to 28%. Further, from 1999 to 2000, this process appears to have accelerated as the percentage of large employers offering medical plans dropped to 24%, the largest one-year drop in employer-sponsored plans over the period 1993 to 2000. The corresponding numbers for 2000 for the Northeast part of the United States, which includes the State of Maine, are a little higher with 30% of large employers offering medical coverage to Medicare-eligible retirees. However, like the national data, this is a decrease from 34% from 1999. In addition, only 8% of small employers (employers with less than 500 employees) in the Northeast in 2000 offered medical coverage to Medicare-eligible retirees. Further, fewer than 8% of the employers in 2000 in the Northeast offer prescription drug coverage. This has left a number of seniors without employer-sponsored prescription drug coverage.

Medigap Plans

Medigap plans provide seniors the opportunity to purchase supplemental coverage that reimburses expenses not covered by Medicare. Only 3 of the 10 standard Medigap plans, designated as Plans H, I and J, include coverage for prescription drugs. Plans H and I pay 50% of the drug costs up to \$1,250 a year after a \$250 deductible is met. Plan J also pays 50% of the drug costs after a \$250 deductible with a maximum benefit of \$3,000 per year. Generally, only Plan H is offered in Maine to seniors who enroll within 6 months following enrollment in Medicare Part B.

III. Prescription Drug Benefits for Seniors: The Situation in Maine

Since prescription drug costs could represent as much as 50% of the overall costs of these programs, premiums for these plans (illustrated in Table 2) are relatively high since they may not fully leverage volume discounts and pharmacy management opportunities. In addition, because of the limitations placed on prescription drug coverage, seniors enrolled in these plans are likely to have a good understanding of how much they spend on prescription drugs per year, and thus enhance their ability to select among the prescription drug benefits.

TABLE 2 2001 SAMPLE OF MEDIGAP PLANS IN MAINE (MONTHLY PREMIUMS)		
VENDOR	PLAN H WITH DRUG COVERAGE	PLAN C WITHOUT DRUG COVERAGE
Banker's Life	\$458.37	\$177.53
Life Investors Insurance Company of America	\$178.00	\$126.00
Monumental Life	\$178.00	\$126.00
United Healthcare (AARP)	\$170.00	\$104.50
Average	\$246.09	\$133.51

It is estimated that Medigap rates for Plan H in 2003 will range from \$191 to \$515. The change in cost for a Medigap plan that includes drug coverage versus one that does not will range from \$63 to \$323.

Medicaid

The original Title XIX legislation that defines Medicaid coverage includes prescription drugs as an optional service. Therefore, pharmaceutical coverage is not required as part of Medicaid benefits; however, nearly all states, including Maine, have included comprehensive prescription drug coverage in their Medicaid programs.

The total Medicaid population in Maine is in the traditional fee-for-service program. In the Medicaid traditional fee-for-service program, recipients have comprehensive prescription drug coverage with a copayment ranging from \$.50 to \$3 per prescription based upon category of need and type of medication. The Medicaid fee-for-service program allows for a formulary based on manufacturer participation in the Omnibus Budget Reconciliation Act (OBRA) mandated rebate agreements. These regulations require that drugs are covered under this program if

III. Prescription Drug Benefits for Seniors: The Situation in Maine

manufactured by a pharmaceutical company that participates under the Health Care Finance Administration (HCFA) Federal Rebate Program.

State Sponsored Plan: Maine Low Cost Drugs for the Elderly or Disabled Program

In 1978, the Low Cost Drugs for the Elderly or Disabled Program (DEL), a State subsidized drug program, was implemented. The goal of the DEL program, was to provide the elderly, and disabled adults over age 55, with low cost prescriptions and non-prescription drugs for special illnesses.

Over time it became clear that this program was not doing enough and that access to prescription drug coverage was still a problem. Several changes to the DEL program have been enacted in recent years to help make prescription drug coverage more readily available to residents in Maine. As a result, the current program is structured very differently than the original design. Currently to be eligible for the program, an individual must be at least 62 years old, or 19 years old and disabled according to Social Security standards. In addition, you must have a household income of less than 185% of the Federal Poverty Level (FPL) for your household size. Currently those levels are \$15,893 a year for a household of one and \$21,479 a year for a household of two or more. If a participant spends 40% or more of their household income on prescription drugs, the income limits for eligibility are 25% higher. The household income limits change every year based on Federal Poverty Levels set by the U.S. Department of Health and Human Services.

The program consists of two parts – the Basic Program and the Supplemental Program. Under the Basic Program, the participant pays the greater of \$2 or 20% for their prescriptions. Brand drugs are only covered for a list of chronic conditions. All generic drugs are covered regardless of chronic condition. Under the Supplemental Program, the State pays \$2 per prescription for any prescriptions not covered under the basic program, and the participant pays the remainder. In addition, the plan limits out-of-pocket drug expense to \$1,000 per program year. Once the participant reaches \$1,000 of out-of-pocket drug expenses, the Supplemental plan design changes and the State becomes responsible for 80% of the drug cost and the participant pays the remaining 20%.

III. Prescription Drug Benefits for Seniors: The Situation in Maine

The chart below summarizes various changes that have occurred in the DEL program in 1999 and 2000.

August 1999:	<ul style="list-style-type: none"> ▪ Changed DEL program income levels to 185% of the FPL and lowered the disabled age criteria to age 19. ▪ Expanded DEL program to include a basic and a supplemental drug benefit. The basic benefit covers prescription drugs for chronic conditions at either a \$2 or 20% copayment. Under the supplemental program the State pays a \$2 copayment for any medically necessary prescription not covered by the basic plan, and the participant pays the remaining cost.
Spring 2000:	<ul style="list-style-type: none"> ▪ Maine enacted legislation to establish the Maine Prescription Program to reduce prescription drug prices for all uninsured and under-insured State residents, using Medicaid eligibility guidelines.
August 2000:	<ul style="list-style-type: none"> ▪ Expanded DEL program to include all generic drugs in the basic drug program covered at 80% by the State. Additionally, a \$1,000 per program year out-of-pocket maximum for drug expenses was added.

In a time when prescription drug expenditures have been sky rocketing, the DEL program has been proactively changing in an attempt to improve participant benefit levels while controlling costs. One cost controlling mechanism is the program’s use of a chronic condition list. This list has been expanded as funds were available to include coverage of additional chronic conditions. The list was last updated in 1999 to include Hyperlipidemia, Osteoporosis, Glaucoma, Parkinson’s Disease, Multiple Sclerosis, Thyroid Disease, Incontinence and ALS (Lou Gehrig’s Disease). The current DEL plan benefit structure also utilizes copayments. This cost controlling mechanism enables the cost sharing features to change as drug expenditures change.

State Sponsored Plan: Proposed Waiver

Legislation is being reviewed that would increase the eligibility under the current DEL program. The legislation, entitled Maine Prescription Drug Discount Waiver, would establish a discount program for those Maine residents between 185% to 300% of the FPL. The discount program would be structured for individuals to receive the negotiated discount plus an additional 15% off prescription drugs at the point of purchase. The legislation provides for the State to receive pharmaceutical rebates that will be used to offset any administrative expenses associated with the discount program. It also requires utilization management which will generate savings for the DEL program.

IV. The HOPE Plan: Confronting the Tough Choices

First, the HOPE Plan will provide, for the first time in Maine, a voluntary and affordable prescription drug program for all seniors – 62 and over – regardless of income.

Second, the HOPE Plan provides for responsible access to all prescription drugs through cost sharing and a value-based formulary. Individuals will pay a copayment of 20% for generic drugs, 40% for preferred drugs.

The tough choice here is how best 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. Under a value-based formulary, all categories of drugs are covered with the exception of certain “lifestyle” or cosmetic medications; however, not all medications within a given class are included on the formulary. Based on clinical and economic appropriateness, individual medications are evaluated and a determination is made relative to formulary status.

It is important to underscore that the purpose of a value-based formulary is not to deny access to pharmaceuticals. Rather, it introduces and implements an approach, that requires recipients and their physicians to decide what they need, and what they are willing and able to pay. The formulary encourages participants to become more informed participants of prescription drugs and more active decision-makers in their health care choices.

Third, the HOPE Plan mandates the use of generic drugs. 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 generic copayment.

Fourth, all current and future DEL participants remain part of the DEL program unless they decide to enroll in the new HOPE Plan.

Fifth, to ensure that the Maine HOPE Plan does not adversely impact the State’s fiscal position, we have designed the program with a front-end deductible and a monthly contribution tied to income. In other words, the HOPE Plan ensures that as a person’s income rises, so does his or her personal financial responsibility. This is done to ensure fairness and to protect seniors with lower incomes.

The tough choice here was whether or not to impose contributions and deductibles tied to income. We believe it would be a mistake not to do this. States have limited revenues with which to work and an unyielding demand for those dollars. Requiring people to pay a proportional share based on their income is not only fair, but also equitable.

Sixth, the HOPE Plan protects seniors against catastrophic costs. The tough choice here was whether to tie the catastrophic cap to income or to initiate an across-the-board cap – a single cap that would apply to everyone. Consistent with the philosophy of indexing contributions and deductibles with a participant’s income, we have recommended that the level of catastrophic cap also be tied to a person’s income.

IV. The HOPE Plan: Confronting the Tough Choices

The goal of a catastrophic cap is to ensure that seniors 62 and older do not spend themselves into poverty. Today, every senior is treated the same regardless of income. As a result, lower and middle-income seniors spend a greater share of their disposable household income than wealthier seniors. The result is often financial devastation, particularly in those households where one spouse lives independently and one resides in an institutional facility.

A catastrophic cap tied to income ensures that seniors will only spend a proportionate amount of their disposable income. Therefore, seniors with lower incomes have a smaller catastrophic cap to meet. We believe this approach builds in a greater sense of fairness to ensure that people who can afford to pay more do, and those who cannot do not. A single catastrophic cap would disadvantage lower-income and lower-middle income seniors by requiring them to spend more of their income than seniors with greater wealth.

Seventh, allow maintenance and life-sustaining drugs to be purchased through a voluntary mail order program through an exclusive provider. A maintenance drug is defined as a drug that is taken for a chronic condition, daily, and for a long 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 age 62 and older, and to protect them against catastrophic out-of-pocket expenses, we have 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 mail order program for maintenance drugs accomplishes both objectives.

Eighth, it is possible that a program such as the HOPE Plan may cause some employers who currently offer post-retirement prescription drug coverage to stop such coverage for future retirees. Our desire 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 support a trend that exists today. In order to compete in a global marketplace, employers must attract and retain the very best workers. Offering to help employers remain competitive and locate and expand in Maine is an important goal that cannot be ignored. That said, we understand that this aspect of the plan is not without controversy.

However, we are recommending that the Maine legislature examine the fiscal impact of providing a tax credit to all employers who offer to fund, in whole or in part, retiree prescription drug coverage through the HOPE Plan. Absent some form of a tax credit, we do not believe employers will participate without contractual obligations.

Ninth, for all seniors paying contributions, we are recommending that the legislature examine a tax credit program. The tax credit, while designed to help all persons who make contributions, should be graduated, that is, the more you pay the greater your tax credit. This would help attract more seniors into the program and therefore reduce adverse selection.

IV. The HOPE Plan: Confronting the Tough Choices

Tenth, 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. Seniors who do not qualify for existing programs like DEL are faced with two choices – either purchase an expensive “Medigap” plan that offers a less comprehensive prescription drug benefit or, second, go without such coverage and pay for all of their prescription drugs at full cost or through some sort of discount program. 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.

Eleventh, 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. Typically, a married couple is likely to have a higher household income than that of a single person. Currently, the DEL program includes separate income limits for singles versus married couples (single \$15,892, married couple \$21,479). We have continued this practice in setting the HOPE Plan income limits.

Twelfth, critical to the success of this plan are enrollment and outreach 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 contribution and/or an actuarially increased deductible. 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.

Thirteenth, in subsequent years of the program, deductibles, copayments, and the out-of-pocket limits will be tied to the actual drug cost trend experienced under the program. In other words, based on increases or decreases in the overall program drug cost trend the deductibles, copayments, and out-of-pocket limits 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 State of Maine – continue to remain current and do not place the plan in fiscal jeopardy.

IV. The HOPE Plan: Confronting the Tough Choices

Fourteenth, the HOPE Plan recommends the creation of a Prescription Drug Review Commission. Because this would be a legislatively-created Commission, we believe that the legislature needs to be completely involved in and focused on the difficult decisions that a plan such as this, which sets out to achieve prescription drug coverage for all seniors, will require. However, this must also be a partnership where both the Senate President and Speaker of the House understand this program first hand. To that end, the Commission should consist of members including the Senate President and the Speaker of the House who would serve as co-chairs.

Fifteenth, 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% of Medicare beneficiaries eligible for Medicaid are actually enrolled. Consequently, dually eligible seniors would not be eligible for the HOPE Plan.

If the State of Maine is committed to constructing a truly comprehensive prescription drug program for seniors, then the Legislature should instruct the appropriate individuals in State government to deliver a strategy on how to find all eligible seniors and to determine what the potential costs to the State would be if these people were enrolled in the Maine Medicaid program.

Sixteenth, to capture the success of the current DEL Program, we are recommending that the HOPE Plan build upon some of the existing strategies currently used in the DEL Program. For instance, the use of a pharmacy benefit manager, percentage copayments, a mandatory generic program, and pharmaceutical manufacturer rebate arrangements should continue to be part of the HOPE Plan.

Seventeenth, to ensure that the HOPE Plan is financially sound well into the future, the program will sunset after four years. This will require the legislature to reevaluate the HOPE Plan thoughtfully and carefully in order to ensure its fiscal integrity and the State of Maine'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 something many people do not like because it forces a legislative body to reaffirm, just a few years after a program was started, 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, a sunset provision 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 analyze trend and cost data carefully, and reevaluate its own decisions made years earlier. For a program of this magnitude we believe this will be fiscally prudent.

IV. The HOPE Plan: Confronting the Tough Choices

Eighteenth, we have not changed the retail discounts and pharmacy dispensing fees that exist under the DEL program. However, we do encourage the legislature to examine these issues carefully in order to determine whether the fees offered by, and contracted for, in a commercial market (private sector) are more appropriate, and could result in additional savings for Maine. In other words, there could be substantial savings from adopting a more aggressive reimbursement methodology.

Nineteenth, and finally, the Maine HOPE plan should be a payer of last resort. Where a senior has other coverage for prescription drugs, that program would serve as the primary payer with the HOPE Plan paying last.

V. The HOPE Plan: Executive Summary

The Heinz Family Philanthropies engaged William M. Mercer, Incorporated to assist with the design of, and to 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 designed to be available to seniors (age 62 and older) who reside in the State of Maine and do not qualify for the Low Cost Drugs for the Elderly and Disabled Program (DEL).

HOPE builds on the existing DEL program and demonstrates how an effective combination of cost sharing, pharmacy management, and volume purchasing can yield a comprehensive prescription drug program that would be affordable to seniors. Our efforts in Maine have resulted in a proposed statewide prescription drug program that is unique in one particular way: it keeps the DEL program in place for those below 185% of Federal Poverty Limit (FPL), while providing a plan that is available and affordable for all other seniors.

The HOPE Plan is focused on more than 204,000 seniors – age 62 and older– residing in Maine. In designing a senior prescription drug plan for Maine, it was important to maintain budget neutrality and minimize the disruption to existing DEL enrollees. As a result, our recommendation is to keep the existing DEL program in place and build a new program on top of it. Moreover, in utilizing the Maine Prescription Drug Discount Waiver - for eligible Maine residents with incomes under 300% of the FPL – a discount plan is provided for those individuals between 185% and 300% of the FPL. These individuals will then have the additional option to enroll in the HOPE Plan. Additionally, as in the current DEL program, seniors eligible for Maine Medicaid will retain Medicaid benefits and are not considered for the HOPE Plan. The recommendation is summarized in Table 3.

TABLE 3 SUMMARY OF RECOMMENDED OPTIONS SENIOR PRESCRIPTION DRUG COVERAGE			
Level of FPL	0-185%	185%-300%	>300%
Type of Program	DEL	Waiver Discount Plan or HOPE Plan	HOPE Plan

The HOPE Plan: Program Design

The HOPE Plan is based on four guiding principles:

- build upon the existing senior program framework within the State, inclusive of the discount waiver;
- provide for comprehensive coverage to a broader population at a reasonable expense;
- encourage responsible utilization of prescription drugs; and
- maintain affordability and budget neutrality for the State of Maine.

V. The HOPE Plan: Executive Summary

An important characteristic of the HOPE Plan is its ability to accommodate the State of Maine’s budget allocations without compromising the core advantages of the plan. The four basic core advantages of the HOPE Plan are pharmacy benefit design, pharmacy benefit management strategies, controlled enrollment, and program oversight.

Pharmacy Benefit Design

The first core advantage of the HOPE Plan is the overall pharmacy benefit design. The HOPE plan is built upon graduated contributions, deductibles and out-of-pocket thresholds tied to household income. Seniors who have higher incomes pay more for the plan. After the individual deductible is met, a copayment amount for a value-based (closed) drug formulary is charged for each prescription. The value-based drug formulary maximizes the generic substitution opportunities and promotes the use of the most cost-effective brand medications. Drugs not on the value-based formulary are paid for by the enrollee at 100% copayment. Table 4 below summarizes the combined program recommendation.

TABLE 4 MAINE COMBINED PROGRAM SUMMARY		
	DEL	The HOPE Plan
Eligibility: Maine resident for at least 90 days	Age 62 or older or age 19 or older and disabled with income below 185% of FPL	Age 62 or older and above 185% of FPL* Income determines level of cost sharing
Drug formulary	Disease-state based	Value-based (closed)
Deductible	None	Income based, ranging from \$100 to \$500
Copayment	Basic Program – Enrollee pays the greater of \$2 or 20%. Brand drugs covered for a list of chronic conditions, all generic drugs covered. Supplemental Benefit - State pays \$2 per prescription for any drug not covered under the basic program, enrollee pays the remainder	Generic drugs – State pays 80%, enrollee pays 20% Preferred brand drugs: State pays 60%, enrollee pays 40% Non-preferred brand drugs: Enrollee pays 100%
Catastrophic coverage	Enrollee pays 20% after \$1,000 out-of-pocket threshold is reached	Enrollee pays 20% after out-of-pocket threshold is reached. Threshold is \$1,000 or \$2,000 depending on income level

* Those qualifying residents with income between 185% and 300% may elect to participate in the waiver discount plan.

V. The HOPE Plan: Executive Summary

Pharmacy Benefit Management Strategies

The second advantage of HOPE is the opportunity to give the program flexibility to maximize the services of a pharmacy benefit manager (PBM) as in the private sector. A PBM provides uniform administration of the program, maximizes the State's capacity to negotiate the best prices for discounted networks and mail order, and enhances prescription drug management. The PBM selected through a competitive bidding process is required to partner with the State to reduce the costs of the pharmacy plan through a variety of mechanisms which manage prescription benefit costs and encourage cost-effective utilization of prescription drugs.

Controlled Enrollment

The third core advantage of HOPE is controlled enrollment. Those who are age 62 on or before the HOPE Plan becomes effective must be enrolled within the first six months following HOPE's enactment date. Those who attain age 62 following the enactment the HOPE Plan must enroll within six months of their sixty-second birthday. Those who elect not to enroll may permanently lose the opportunity to enroll or, at a minimum, be charged a substantial additional premium for delaying enrollment. There will need to be exceptions for those who:

- 1) are involuntarily terminated from a health plan that provided prescription coverage,
- 2) are covered under a health plan that reduces or eliminates prescription drug coverage, or
- 3) have an annual household income under the limits established by the State for a full premium subsidy.

Adverse selection is a factor in any voluntary, premium-based program such as the HOPE Plan. Adverse selection is defined as a situation in which potential enrollees are able to predict their own claim experience and decide whether to enroll in a benefit program. Although potential enrollees do not know exactly what their future prescription drugs will cost, many will make reliable assessments of whether or not their claims will be greater than their premiums and other out-of-pocket costs from copayments and deductibles. This knowledge, along with other factors, will determine whether or not they participate in the new program. If the eventual pool of enrollees contains too many people with high prescription drug expenses, the program's financial risk becomes too great. Subsequently, to reduce adverse selection, participation in the HOPE plan must be high. As a result, the HOPE Plan includes requirements for timely enrollment and substantial penalties for delayed enrollment.

Program Oversight

The fourth core advantage of HOPE is program oversight. The HOPE Plan recommends the creation of a Prescription Drug Review Commission to be involved in and focused on the difficult decisions regarding providing prescription drug coverage for all seniors. 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.

V. The HOPE Plan: Executive Summary

The HOPE Plan: Financial Summary

The initial success of the HOPE plan rests with the ability to create a design that is cost neutral to the State, while keeping disruption to existing DEL enrollees at a minimum. Therefore the HOPE plan was designed to keep the DEL program in place and build the HOPE Plan on top of it. The costs associated with the HOPE Plan are funded by income based premiums.

As a result, the new plan, a combination of DEL and HOPE, is cost-neutral to the State but provides coverage to an additional 29,000 individuals. Under the proposed HOPE Plan, it is estimated that as many as 61,400 individuals could be covered by fiscal year 2005, with 30,760 individuals in the DEL program.

TABLE 5 – DEL + THE HOPE PLAN		
FINANCIAL SUMMARY		
	Enrollment	Net Cost*
Fiscal Year 2003	57,880	\$26,630,000
Fiscal Year 2004	59,620	\$32,600,000
Fiscal Year 2005	61,409	\$39,735,000

* Net cost after the application of deductible, copayments, premiums, and coordination of benefits

VI. The HOPE Plan: Pharmacy Benefit Design

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

- income-based annual deductible and contributions;
- responsible access to prescription drugs through balanced cost sharing and a value-based formulary; and
- an annual income-based out-of-pocket threshold to protect against catastrophic costs.

Income-based Annual Deductible and Contribution

The HOPE Plan allows seniors with household incomes at or above 185% of the FPL to participate financially in the plan. However, the annual deductibles and contributions – Table 6 – are intended to be affordable for individual seniors within a given household income bracket. Individuals in the lowest income bracket – below 185% of the FPL – will remain in the DEL program. Consequently, individuals with household incomes in one of the higher income brackets will pay up to the full cost for the plan and will have a maximum annual deductible of \$500 for year 1 of the program.

Annually, deductibles are adjusted according to the actual drug trend experienced under the program.

TABLE 6 – THE HOPE PLAN ANNUAL DEDUCTIBLE AND MONTHLY PREMIUMS						
Annual Household Income (Federal Poverty Level)	Annual Deductible			Monthly Premiums		
	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
0 – 185% FPL	\$0	\$0	\$0	\$0	\$0	\$0
185% - 200% FPL	\$100	\$120	\$140	\$68	\$79	\$92
200% - 250% FPL	\$150	\$180	\$210	\$75	\$87	\$101
250% - 300% FPL	\$200	\$240	\$280	\$81	\$94	\$107
300% - 350% FPL	\$250	\$300	\$350	\$86	\$100	\$113
350% - 400% FPL	\$300	\$350	\$420	\$89	\$103	\$122
400% - 450% FPL	\$350	\$410	\$490	\$94	\$109	\$129
>450% FPL	\$500	\$590	\$700	\$99	\$115	\$131

VI. The HOPE Plan: Pharmacy Benefit Design

Responsible Access to Prescription Drugs

The HOPE Plan provides for responsible access to prescription drugs through balanced cost sharing and a value-based formulary. Once individuals meet their annual deductibles, they are required to pay a copayment which is a percent of the cost of each prescription. Under the HOPE Plan, individuals will pay 20% for generic drugs, 40% for brand drugs with a \$5 minimum and \$100 maximum payment per prescription. Individuals will be responsible for 100% of costs for drugs not covered under the program's value-based formulary.

A mandatory generic provision is also applied to the plan 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 copayment.

We recommend that the minimum and maximum payment per prescription be increased annually to the actual drug trend. In the HOPE Plan model, drug trends of 17% for year two and 16% for year three were used to calculate the cost share increases. Once the program is operational, the drug benefit trends may vary as a result of increased drug utilization, availability of more generic drugs in the market due to patent expirations, and the impact of the introduction of new pharmaceuticals.

The copayment design outlined above provides for responsible access to prescription drugs through a value-based formulary. The drug formulary is designed to enhance the quality and cost of the plan through drug mix in addition to addressing appropriate use of new pharmaceutical products and evidence-based prescribing guidelines. The financial impact to the pharmacy plan is ultimately dependent on the specific drugs selected for the drug formulary, how actively the formulary is managed, and the pharmaceutical rebate arrangement.

The HOPE value-based formulary will provide access to most therapeutic classes of medication with the exception of specific classes that are not considered medically necessary, such as cosmetic agents which would fall outside the formulary. The value-based formulary will identify specific medications within each class which have been selected based on a thorough analysis of their clinical and economic benefits. HOPE Plan participants with incomes below 300% of the FPL qualify for the discount program and would be able to receive medications not covered in the HOPE formulary at the discounted rate. We anticipate that a small amount of prescription drug expenditures would not be covered in the HOPE value-based formulary provisions.

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

VI. The HOPE Plan: Pharmacy Benefit Design

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 annual out-of-pocket thresholds, \$1,000 to \$2,000, tied to household income, as illustrated in Table 7.

Under the HOPE Plan, only the copayment for the drugs covered under the value-based formulary apply to the out-of-pocket threshold. Prescription drug costs used to meet the program deductible, costs not covered under the formulary arrangement, and brand/generic differentials do not apply to the out-of-pocket threshold. Once a person has met their individual annual threshold, 80% of prescription drug costs on the value-based formulary are covered by the HOPE Plan.

TABLE 7 – THE HOPE PLAN ANNUAL OUT-OF-POCKET THRESHOLDS			
Annual Household (Federal Poverty Level)	Annual Out-of-pocket thresholds		
	Year 1	Year 2	Year 3
< 185% FPL	\$1,000	\$1,180	\$1,390
185% - 200% FPL	\$1,000	\$1,180	\$1,390
200% - 250% FPL	\$1,000	\$1,180	\$1,390
250% - 300% FPL	\$1,000	\$1,180	\$1,390
300% - 350% FPL	\$2,000	\$2,360	\$2,780
350% - 400% FPL	\$2,000	\$2,360	\$2,780
400% - 450% FPL	\$2,000	\$2,360	\$2,780
> 450% FPL	\$2,000	\$2,360	\$2,780

Scope of Coverage

The HOPE Plan is designed to provide the type of coverage found under the private sector employers' and commercial health plans. For instance, coverage is provided for "life-sustaining" drugs and excludes drugs for which medical need is difficult to establish. Additionally, consideration is given to limiting conditions for which drugs are covered to the diagnosis approved by the FDA. Biotech drugs are carved out from coverage and could be managed under a separate program. The HOPE Plan needs the flexibility to modify or expand its scope of coverage dependent on new drugs and selected opportunities for cost effective therapies using over-the-counter medications.

VII. The HOPE Plan: Pharmacy Benefit Management

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

The State can accomplish this objective by contracting with a pharmacy benefit manager (PBM), as is common in the private sector, which specializes in providing administrative and management services in order to enhance quality of care and reduce pharmacy benefit costs. The use of a PBM provides uniform administration of the program and enhances prescription drug management. The PBM, selected through a competitive bidding process, will be required to partner with the State to identify opportunities to reduce the costs of the pharmacy plan through benefit management strategies, and to offer administrative efficiencies.

The HOPE Plan maximizes the potential of the PBM by encouraging the appropriate utilization of medications and management of costs through a variety of mechanisms:

- Designing, implementing and managing a prescription drug formulary
- Encouraging generic and therapeutic substitution where appropriate
- Conducting drug utilization reviews
- Utilizing different drug management mechanisms for selected medications

Drug Formulary and Therapeutic Substitution

A customized value-based drug formulary – an effective means of enhancing quality and managing program costs – will be developed for the HOPE Plan. The drug formulary will be customized for a senior population and developed by a traditional Pharmacy and Therapeutics Committee with participation by the State.

Additionally, the HOPE Plan formulary will be designed to provide the type of coverage found under the private sector employers’ and commercial health plans. For instance, coverage is provided for “life-sustaining” drugs and excludes drugs for which medical need is difficult to establish.

Under a value-based (closed) formulary, benefit coverage is limited to formulary medications only. Typically, the patient is required to pay the full cost of any non-formulary drug, unless the physician can establish medical necessity criteria. A value-based formulary can generate the highest level of formulary compliance and rebates.

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 intervention opportunities will be identified. The HOPE Plan will also use therapeutic substitution conversion programs to encourage the use of specified formulary drugs. Typically these programs

VII. The HOPE Plan: Pharmacy Benefit Management

involve provider interventions to switch from one medication to another therapeutically equivalent medication within the same drug class.

In addition, provider profiling of both physicians and pharmacies will be performed in order to assess levels of formulary compliance, generic substitution, and adherence to appropriate prescribing guidelines. Various approaches, including focused interventions, will be used to influence appropriate prescribing and dispensing patterns.

Formulary education, compliance and patient consultation will also be requirements of the HOPE Plan. The HOPE Plan incorporates an efficient and fair appeal process for physician-requested clinical exceptions for non-formulary drugs.

Generic Drug Incentives

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

Drug Utilization Management

The HOPE Plan provides for prospective, concurrent, and retrospective drug utilization management strategies to ensure that prescription drugs are used appropriately, safely, and effectively.

The prospective drug utilization review process will incorporate strategies such as provider and patient education programs in order to advance the understanding of new and existing therapies, as well as the benefits and costs associated with them.

Concurrent drug utilization management primarily focuses on patient safety and appropriateness of therapy. Prescriptions are reviewed “real-time” when they are dispensed as a safeguard to identify claims requiring intervention – such as inappropriate dosages or combinations of drugs. Concurrent utilization management will also allow for implementation of advanced pharmacy management tactics and prescribing guidelines in order to enhance the appropriate use of prescription drugs in the program.

Under retrospective drug utilization management, past prescription drug utilization patterns are reviewed to identify any inappropriate use or non-compliance with the pharmacy management strategies.

By providing for a timely and effective identification of problems and an appropriate level of intervention, the State can reduce unnecessary prescription drug use, assure appropriate utilization, and safeguard seniors from potentially harmful situations while promoting utilization of cost-effective medications.

VII. The HOPE Plan: Pharmacy Benefit Management

Drug Management Mechanisms

The drug management mechanisms employed by the PBM use clinical criteria to determine whether a particular prescription drug is appropriate for the specific medical condition. If the clinical criteria are not met, the drug is generally not covered. These drug management mechanisms are accomplished through the following:

Prior Authorization

Prior authorization is used 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.

Step Therapy

Step therapy requires evidence of the use of a first line medication prior to using a less cost-effective second line medication. This drug management mechanism is effective in addressing the appropriate utilization of many expensive second-line therapies such as antibiotics, nonsteroidal anti-inflammatory drugs, and ulcer medications.

Maximum Dispensing Limits

This drug management mechanism manages prescription drug costs by ensuring that the quantity of units supplied in each prescription remains consistent with clinical dosing guidelines.

Provider Interventions

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

Health Management

In the HOPE Plan, seniors will receive customized 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.

VII. The HOPE Plan: Pharmacy Benefit Management

Recovery of Funds

The HOPE Plan provides for recovery of funds through a provider audit process and 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 payor of last resort.

VIII. The HOPE Plan: Controlled Enrollment

There are over 204,000 individuals in the State of Maine age 62 or older. Approximately 77,000 currently have incomes less than 185% of the Federal Poverty Level and are eligible for the DEL program.

To project the enrollment in the HOPE Plan, four sources of enrollment were considered. These include:

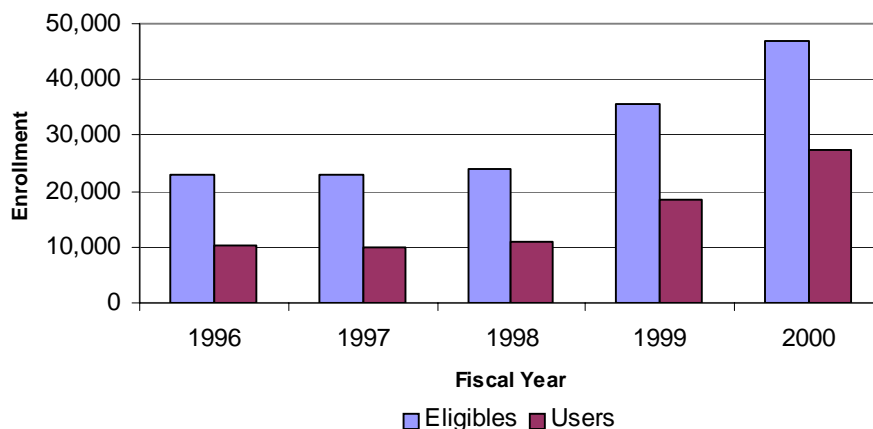
- Individuals currently enrolled in DEL with household annual incomes below 185% of the Federal Poverty Level
- Individuals currently enrolled in standardized Medicare supplement plans (Medigap)
- Individuals currently enrolled in employer sponsored plans
- Individuals who currently do not have prescription drug coverage

Seniors Eligible under DEL

Eligibility for the DEL program benefits is determined by examining resident tax returns. Once an individual is identified as meeting program requirements, an application is forwarded to their attention. Although many residents return the application and receive a benefit card, approximately 50% of cardholders actually utilize the benefit. This is primarily due to the DEL program being the payor of last resort. In this analysis, both cardholders and users are examined.

Enrollment in the DEL program has increased since fiscal year 1996. As shown in Figure 6, enrollment increased from approximately 23,000 cardholders and 10,000 users of the program in 1996 to 46,800 cardholders and 27,300 users at the end of fiscal year 2000. We have projected DEL enrollment to increase 3% per year from fiscal year 2000 through fiscal year 2005. By fiscal year 2005, the user count is projected to be about 30,760. These projections assume a continuation of the current economy and that the annual income limits will remain the same.

Figure 6
DEL Enrollment



VIII. The HOPE Plan: Controlled Enrollment

Although funds for marketing have been included in the HOPE Plan financial projections, the availability and application of these funds may not substantially impact the enrollment of individuals and families with annual household incomes under 185% of the FPL. Given the full subsidization of the premium and the fact that the DEL program has been in place for several years, an extensive marketing campaign may not be effective or necessary for this income group. However, an effective communication strategy of the HOPE Plan benefit and aggressive pharmacy management will be needed for all other income groups. This strategy will help sustain the current enrollment and encourage additional enrollment.

Seniors Who Would Become Eligible under The HOPE Plan

The enrollment of those individuals with household incomes that are higher than the permissible limits under DEL is subject to greater uncertainty. Although the DEL program provides an enrollment history for those in the lower income ranges, there is no track record on how many higher income individuals will participate in a State-sponsored pharmacy program. There are, however, a number of factors to be considered in setting reasonable projections.

While the need for prescription drugs has increased, the availability of insurance plans that provide coverage has decreased. There are no Medicare HMO plans available for Medicare beneficiaries in the State of Maine to obtain prescription drug coverage and although many residents have Medigap coverage, the majority of individuals are enrolled in Medigap plans which do not cover prescription drug costs.

A significant number of seniors, however, may have prescription drug coverage under employer-sponsored retiree health plans. It is expected that there will be some transfer of these individuals to the HOPE Plan. Recent developments have shown that many employers are reducing retiree benefits, in particular prescription drug benefits. As the cost for a prescription drug benefit increases there is the potential for employers eventually to eliminate prescription drug benefits from their employer-sponsored plans altogether.

As a result, it is assumed that three groups of seniors would be increasingly interested in participating in the recommended HOPE Plan. These include seniors currently enrolled in Medigap plans, seniors participating in employer-sponsored plans, and seniors who do not currently have prescription drug coverage. In the first year of the proposed HOPE Plan, we project that 57,880 individuals will enroll, inclusive of the 28,994 in the DEL and waiver discount programs. This represents about 24% of total eligible seniors and disabled individuals.

In the first year of the program, fiscal year 2003, the additional premium required for the above plans that have prescription coverage are expected to approach the HOPE contributions. As a result, in subsequent years it is projected that seniors will rely on the HOPE Plan to provide a sufficient level of either primary or secondary coverage - Table 8.

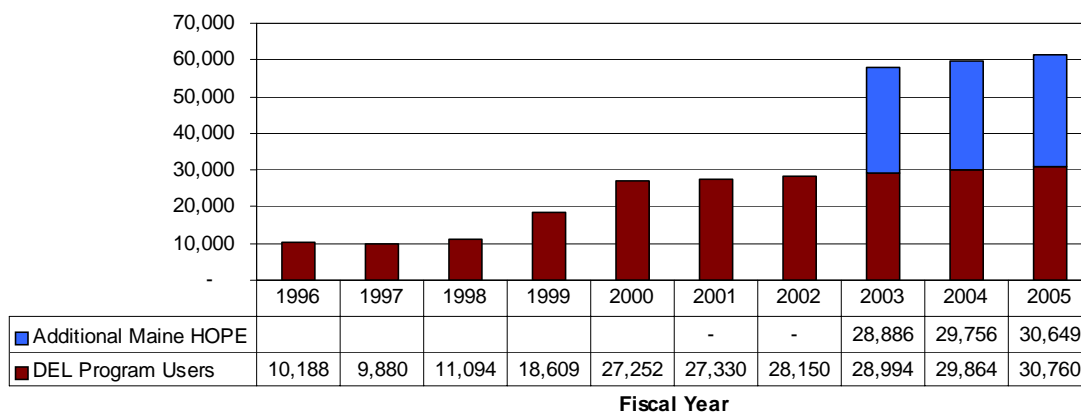
VIII. The HOPE Plan: Controlled Enrollment

TABLE 8 ENROLLMENT PROJECTIONS			
Fiscal Year	Enrollment		
	DEL & Waiver Discount Plan	HOPE Plan	Total
2003	28,994	28,886	57,880
2004	29,864	29,756	59,620
2005	30,760	30,649	61,409

Total Enrollment before and after The HOPE Plan

Figure 7 (below) illustrates observed and expected enrollment under DEL and HOPE. The numbers shown for the DEL program represent total users of the benefit. As household incomes increase due to cost of living adjustments (COLA) or other sources, individuals will not lose their options to have prescription drug coverage. They may, due to increased incomes, be subject to higher deductibles and contributions. On average there were approximately 27,252 individuals enrolled in the DEL program in fiscal year 2000. The enrollment is projected to increase to about 28,150 by fiscal year 2002. Removing the income limits, via the HOPE Plan, is projected to increase the total enrollment in Maine's sponsored pharmacy plans to 57,880 in fiscal year 2003. With effective advertising and outreach, 61,409 seniors could be enrolled by fiscal year 2005.

Figure 7
Enrollment Projections for Maine HOPE



VIII. The HOPE Plan: Controlled Enrollment

Adverse Selection

Although the State of Maine's DEL program subsidizes low-income individuals, the HOPE Plan is a premium-based model. Premium-based plans require controls to minimize the cost of adverse selection. Adverse selection occurs when individuals are allowed to postpone enrollment until their prescription drug cost exceeds the premium that they must pay for the plan. To the extent that individuals are allowed to delay enrollment, the cost per person of the plan will rapidly escalate. At some point the premiums required to cover prescription drug costs will no longer be affordable for an increasing number of those eligible. Avoiding this cost spiral necessitates enrollment rules that require enrollment once an individual attains age 62.

Those who are age 62 on or before the HOPE Plan becomes effective must be enrolled within the first six months following HOPE's enactment date. Those who attain age 62 following the enactment the HOPE Plan must enroll within six months of their sixty-second birthday. Those who elect not to enroll may permanently lose the opportunity to enroll or, at a minimum, be charged a substantial additional premium for delaying enrollment. There will need to be exceptions for those who:

- 1) are involuntarily terminated from a health plan that provided prescription coverage,
- 2) are covered under a health plan that reduces or eliminates prescription drug coverage, or
- 3) have an annual household income under the limits established by the State for a full premium subsidy.

Barring extraordinary circumstances beyond their control, enrolled individuals who discontinue the membership in the HOPE Plan should not be allowed to re-enroll.

Given the concern of employers regarding the cost impact of increasing prescription drug costs on retiree health plans, the HOPE Plan is likely to offer a viable alternative for providing retiree prescription coverage for employers. With adequate provisions to control the potential for adverse selection, the enrollment of retirees could have a beneficial impact on the HOPE Plan's costs. Since many retirees have pension plans that place them in the higher household income brackets they will be able to afford the required contributions which are needed to control plan costs.

To avoid a cost spiral, adverse selection will have to be rigorously monitored and rules governing enrollment will be required to prevent adverse selection from destroying the HOPE Plan's financial viability.

IX. The HOPE Plan: Oversight: 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 required by HOPE and any plan that sets out to achieve prescription drug coverage for all seniors. 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 should consist of members including the Senate President and the Speaker of the House who serve as co-chairs. No designees should serve in their places except in the event that they are unable to perform their duties as Speaker or President. The Senate President and the Speaker of the House would each appoint two members to the Commission.

Additional Commission members would include the Co-Chairs of the Joint Standing Committee on Health and Human Services or their designees, the Co-Chairs of the Joint Standing Committee on Banking and Insurance or their designees, the Director of the Bureau of Medical Services of the Department of Human Services, and the Commissioner of the Department of Human Services. In addition, six members would be appointed by the Governor, including a representative of a senior citizen's advocacy organization, a health care economist from a university or college within the State, 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 would serve at the pleasure of their appointing official. The Commission would only take official action, by a majority vote of those members present, when both co-chairs are in attendance.

The duties of this Prescription Drug Review Commission would consist of the following:

- a) The Commission would be responsible for the oversight of the HOPE Plan.
- b) The Commission would meet at least quarterly with the management team from the pharmacy benefit manager to:
 - 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 them;
 - 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: Oversight: Prescription Drug Review Commission

- analyze current and future information systems and pharmaceutical technology advancements to determine whether – and, if so, how – such advances will result in cost savings or otherwise affect the program; and
 - review the pharmacy benefit manager’s designated formulary for the program.
- c) The Commission would have sole responsibility for approving changes to copayments, deductibles, out-of-pocket limits, drug exclusions, and contributions in relation to pharmacy benefit trends. In the event the Commission approves changes that result in increases to copayments, deductibles or contributions, it would file a report with the Clerks of the Senate and the House explaining why.
- d) The Commission would 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: Funding

In designing a plan for the State of Maine to provide affordable coverage to seniors, it was important to be budget neutral and to minimize any disruption to existing DEL enrollees. As a result, we have designed a premium-based program (the HOPE Plan) which includes financial projections based on the premise that the existing DEL program remains intact. Subsequently, the new HOPE Plan provides for coverage for those up to 185% FPL under DEL, and a comprehensive prescription drug coverage option for all other seniors in Maine.

If legislation to establish a discount program – Maine Prescription Drug Discount Waiver – for eligible Maine residents with incomes under 300% of the FPL is passed, we assume those individuals between 185% and 300% of the FPL will choose whether they want to enroll in the HOPE Plan and/or the discount program. The discount program would be structured for individuals to receive the negotiated discount plus an additional 15% off prescription drugs at the point of purchase. As per the Maine Prescription Drug Discount Waiver, the State receives pharmaceutical rebates that will be used to offset any administrative expenses associated with the discount program. We have assumed that there would be no premium charged to enrollees in the discount programs and no additional subsidies provided by the State. Since the pharmaceutical rebates are expected to cover all administrative expenses, this alternative would not increase the cost of the current DEL program. In fact, the Maine Prescription Drug Discount Waiver, requires utilization management which will generate savings for the DEL program. As a result, according to our financial analysis, by using the discount waiver the program may expect to be \$500,000 less expensive than the current DEL program due to the addition of prior authorization and other cost containment programs.

For the period ending June 30, 2000, the DEL cost the State approximately \$13.3 million. With increases in enrollment, these costs are projected to increase to \$26.6 million by fiscal year 2003 and to \$39.7 million by fiscal year 2005. These projections are based on anticipated cost trends under the DEL program of approximately 15% - 18% per year and an increase in DEL enrollment of 3% per year from fiscal year 2001 to 2005.

Under the recommended HOPE Plan, which assumes that the current DEL plan remains in place, those enrollees over 185% of the FPL would be required to pay premiums for a comprehensive prescription drug plan. Additionally, those individuals between 185% and 300% of the FPL can choose to participate in the discount plan. These premiums, based on income levels, would offset all claim and administrative costs completely. As a result, the plan would be cost neutral to the State, costing \$26.6 million in fiscal year 2003, while providing coverage to an additional 29,000 individuals. Under the proposed HOPE Plan, it is estimated that as many as 61,400 individuals could be covered under the HOPE Plan by fiscal year 2005, with 30,760 individuals covered by the DEL program.

The design of the HOPE Plan includes annual deductibles and contributions for enrollees at or above an annual household income of 185% of the Federal Poverty Level. To test the affordability of the HOPE Plan, we compared its premium rate per month to projected Medigap premiums for Plan H (supplemental coverage including drugs). Based on an anticipated increase in Medigap premiums of 4% - 6% a year, the average 2003 premium would be around \$200 per

X. The HOPE Plan: Funding

month, or an annual cost of \$2,400. Since Medigap Plan H includes medical drug coverage, we compared it to Plan C which does not. The benefits covered under Medigap Plan C are almost identical to Plan H with the exception of prescription drugs. Estimated premium for Medigap Plan C in 2003 is \$140 per month or \$1,680 annually. Taking the difference between Plans H and C, we estimated the cost of prescription drugs under Medigap Plan H to be approximately \$60 per month or \$720 per year.

The corresponding annual premium rate for a HOPE enrollee at the highest household income category is estimated to be about \$1,188 (\$99 per month) in fiscal year 2003, or about \$468 (\$39 per month) more than the estimated Medigap premiums for prescription drug coverage. Annual premium payments would be even lower for the other income categories under the HOPE Plan when compared with the Medigap premium projections. While it could be argued that premiums for drug coverage under the Medigap plans may be lower than the HOPE Plan enrollee premium rates in fiscal year 2003, the HOPE Plan would provide more comprehensive prescription drug coverage with contributions and cost-sharing provisions that are affordable to enrollees.

Premium rates per month under the recommended HOPE plan would be as follows.

Recommended HOPE Plan			
Household Income (as % of Federal Poverty Limit)	Fiscal Year 2003	Fiscal Year 2004	Fiscal Year 2005
< 185%	\$0	\$0	\$0
185% - 200%	\$68	\$79	\$92
200% - 250%	\$75	\$87	\$101
250% - 300%	\$81	\$94	\$107
300% - 350%	\$86	\$100	\$113
350% - 400%	\$89	\$103	\$122
400% - 450%	\$94	\$109	\$129
> 450%	\$99	\$115	\$131

X. The HOPE Plan: Funding

Alternatives

While we believe that this recommended HOPE plan offers affordable, comprehensive prescription drug coverage to significantly more individuals with no additional cost to the State, we recognize the need to examine alternatives. To satisfy this need we devised three alternatives that could be added on to the current DEL program.

Alternative 1

Although the recommended HOPE plan offers affordable premiums and comprehensive coverage, the plan calls for a value-based formulary. This provision is included in the recommended HOPE plan to control the premium rates charged to individuals above 185% of the Federal Poverty Level.

If these cost containment features are undesirable, an alternative HOPE plan could be structured with the same deductibles and out-of-pocket thresholds as the recommended HOPE plan, but under an incentive formulary rather than the value-based formulary.

Under this alternative, access to all prescription drugs would be provided through a mechanism that uses lower cost sharing to influence the selection of preferred products – either generic drugs or preferred brand drugs. Once individuals meet their annual deductibles, they would be required to pay a copayment of 20% for generic drugs, 40% for preferred brand drugs and 80% for non-preferred brand drugs; with a \$5 minimum and \$100 maximum payment per prescription. The same out-of-pocket thresholds would apply and the individual would be responsible for 20% of costs for all drugs after the out-of-pocket threshold has been reached. Prescription drug costs used to meet the program deductible, non-preferred brand drugs, and brand/generic differentials would not apply to the out-of-pocket threshold. Exhibit B in the appendix of this report summarizes these benefits.

Under Alternative HOPE Plan 1, which assumes the DEL program remains as is, the plan would be cost neutral to the State, costing \$26.6 million in fiscal year 2003. Premium rates would, however, be substantially different. Premium rates per month by income level are shown in Table 11 (page 41).

Alternative 2

Alternative HOPE Plan 2 is very similar to Alternative 1. While the general benefit design and incentive formulary would be the same as Alternative 1, the number of income cohorts would be reduced from 8 to 4. The deductibles and out-of-pocket thresholds would be as follows:

X. The HOPE Plan: Funding

Annual Household (Federal Poverty Level)	Deductible	Out-of-pocket threshold
< 185% FPL	\$0	\$1,000
185% - 300% FPL	\$150	\$1,000
300% - 450% FPL	\$300	\$2,000
> 450% FPL	\$500	\$2,000

All other benefit provisions would be identical to the provisions outlined in Alternative 1. Exhibit B in the appendix of this report summarizes the benefits provided under this alternative.

Although reducing the number of income cohorts provides administrative and communication ease, there are trade-offs. Premiums, deductibles and out-of-pocket threshold must begin at a higher level than can be achieved under Alternative 1. This may harm the perception of the program and result in lower enrollment which, in turn, results in slightly higher adverse selection.

The premium rates which result under Alternative 2 are shown below in Table 11.

Alternative 3

Another alternative to the recommended HOPE Plan would be simply to provide catastrophic coverage to those individuals currently not eligible for the DEL program. Although this type of program does not provide any first dollar coverage and would be subject to significantly higher adverse selection than the other HOPE Plans outlined in this report, individuals who enroll would be protected from financial ruin resulting from catastrophically high prescription drug costs.

Under Alternative HOPE Plan 3, once individuals meet an annual deductible of \$2000, 100% of costs for all drugs would be covered. All payments made by enrollees for prescription drugs would count toward the deductible. The DEL program would remain in place under Alternative HOPE Plan 3.

Since premiums would be required for individuals with incomes over 185% of the Federal Poverty Level, Alternative HOPE Plan 3 would also be cost neutral to the State, costing \$26.6 million in fiscal year 2003. Premium rates would, however, be substantially different. Premium rates per month by income level are shown in Table 11 below.

The premium rates per month for the recommended HOPE Plan as well as the three alternatives outlined above would be as follows.

X. The HOPE Plan: Funding

TABLE 11				
Premium Rate per Month – Fiscal Year 2003				
Household Income (as % of Federal Poverty Limit)	Recommended HOPE Plan	Alternative HOPE Plan 1	Alternative HOPE Plan 2	Alternative HOPE Plan 3
< 185%	\$0	\$0	\$0	\$0
185% - 200%	\$68	\$78	\$87	\$110
200% - 250%	\$75	\$90	\$87	\$110
250% - 300%	\$81	\$93	\$87	\$110
300% - 350%	\$86	\$98	\$101	\$110
350% - 400%	\$89	\$102	\$101	\$110
400% - 450%	\$94	\$105	\$101	\$110
> 450%	\$99	\$108	\$108	\$110

It is important to note that the HOPE Plan financial estimates are based on the assumption that adequate measures will be taken to minimize the potential for adverse selection, and that a sufficient promotional effort will be embarked on to ensure the timely enrollment of eligible individuals. Additionally, aggressive pharmacy benefit management, continuation of the DEL program, and formulary management are key factors in the development of the cost estimates. As with any voluntary plan, enrollment and claim experience must be routinely and rigorously monitored. To meet financial targets, it will be necessary to manage the plan proactively and adjust the benefit design, contributions, pharmacy benefit management techniques and other aspects of the plan on an annual basis.

XI. 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. **Catastrophic Cap:** Once an individual exceeds a set dollar threshold of expenditures out of his or her pocket – a combination of deductible and copayment – specific drugs are covered at some level by the plan, unless otherwise specified. (See also Out-of-pocket threshold.)
3. **Coinsurance:** Cost sharing that requires an individual to pay a specific percentage of the charge for each prescription drug.
4. **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 his wife’s coverage might be through an employer-sponsored program. The coordination of benefits agreement states that the primary plan pays first and the secondary plan pays last.
5. **Copayment:** Cost sharing that requires an individual to pay a fixed dollar amount for each prescription drug. Under the HOPE Plan, copayment is used to identify the payment required for each prescription drug, which may be either a flat dollar amount or a percentage of the total drug cost.
6. **Deductible:** The amount that an individual pays under the plan each benefit year, in addition to the premium, before prescription drug coverage begins.
7. **Dually eligible:** Individuals who are eligible for both Medicare and Medicaid.
8. **Formulary:** A list of drugs, selected on the basis of quality and cost, developed to encourage members to use appropriate, cost effective medications. The list is used by physicians when making decisions on what medications to prescribe. The list is subject to periodic review and modification by the plan. Several formulary options exist:

Open formulary – all medications are covered with little or no cost-sharing implication to the member for selecting a non-formulary medication.

Value-based (closed) formulary – medications deemed as non-formulary are not included as a covered benefit.

XI. Glossary of Terms

Incentive or “tiered” formulary – patient cost share is less for formulary medications, and can be tiered based on the type of drug, i.e., generic, brand, and/or preferred or non-preferred. Non-formulary medications are covered but at a greater cost to members.

9. **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.
10. **Income-related contribution:** Requires individuals with higher incomes to pay a higher contribution for a benefit than individuals with lower incomes.
11. **Maintenance Drug:** A drug that is taken for a chronic condition, daily, and for a long period of time, generally longer than three to six months.
12. **Mandatory Generic:** A plan design provision that incorporates a cost differential when a generic drug is available but a brand drug is requested by either the patient and/or the physician.
13. **Medicare HMO:** A Health Maintenance Organization that agrees to accept payment from the federal government in return for providing all of the Medicare health care benefits to enrollees.
14. **Medigap Insurance:** Supplemental private insurance that is purchased by Medicare recipients to fill in the deductibles and copayments amounts not covered by Medicare.
15. **Out-of-pocket threshold:** The total dollar amount, a combination of copayment and deductible, that an individual pays of their own money. Unless otherwise specified, once the limit is reached, specific drugs are covered at 100% for the remainder of the benefit year. (See also Catastrophic Cap.)
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 in the drug formulary.
18. **Premiums:** Fees, usually paid monthly, for insurance coverage.

XII. Appendix: Assumptions

Pharmacy Cost and Administrative Expense Assumptions

The prescription drug model used to calculate the HOPE 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 to account for the fact that the program includes an open enrollment period which allows individuals to decide whether they will join the plan based on their prescription drug needs. This option to enroll or not to enroll will inevitably result in adverse selection. To moderate this situation, the length of the open enrollment period should be limited to six months.
- For the years following the initial year, individuals will be allowed to enroll within six months of reaching age 62. Contributions, where applicable, and benefits will begin on the first of the month following the date a person reaches age 62. Effective communications, financial incentives and enrollment controls will be in place to encourage timely enrollment. There are no adjustments for additional adverse selection in the last two projection years.
- The effective discount used in the modeling is 13%. The 13% discount factor is a combination of usual and customary pricing, discounted AWP and the maximum allowable cost (MAC), for generic and brand drugs. Under the current DEL program, brand discounts are contracted at 10% off AWP. Generic discounts are expected to be 38% off AWP. The weighted average of these two discounts yields an effective discount of 13%.
- Formulary rebates under the proposed and current plans were assumed to reduce the prescription drug ingredient cost by 18% for individuals with household incomes below 185% of the Federal Poverty Level. For all others, formulary rebates were assumed to be 2% - 6%. The design of the formulary with respect to the drugs selected for preferred status could significantly alter this estimated cost reduction.
- A 2% - 10% ingredient cost reduction will be achieved by applying formulary management, mail order for maintenance drugs, enhanced utilization management, prescribing guidelines and therapeutic interventions through a pharmacy benefit manager (PBM).

XII. Appendix: Assumptions

- Assuming that pharmacy benefits under an individual's other coverage are coordinated with the HOPE Plan benefits, the estimated recoveries are approximately 1% 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 other plan benefits are paid first. The 1% recovery is net of the cost of administrative and legal fees associated with recovery.
- The annual cost and utilization trend applied to arrive at fiscal year 2003 ingredient cost is about 17%. Trends for subsequent years were reduced one percent per year. These annual trends are applied to adjust the annual deductibles and out-of-pocket thresholds for fiscal years 2003 through 2005.
- The dispensing fee applied per prescription is \$3.35.
- The annual expense for pharmacy management and claim administration is \$15 per enrollee. This includes administrative expense from the PBM in addition to resources dedicated to the program from the State.
- The annual expenses for other administration functions (such as marketing, membership, income testing, billing, collections, financial reporting and auditing) is \$90 per enrollee.
- 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 State 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 HOPE.
- Monthly contributions for HOPE for fiscal year 2003 range from \$0 for those with low incomes to \$99 for those in the higher income categories. Although there is considerable uncertainty attached to projecting enrollment in any new plan, the projections appear reasonable given the premiums charged and the general lack of health plans available with comprehensive prescription drug coverage in Maine.

Exhibit A

**Recommended HOPE Plan
Exhibit A
Premiums, Deductibles and Out-of-Pocket Limits**

Annual Income Range [as % of Federal Poverty Level (FPL)]	Annual Deductible FY 2003	Annual Out-of- Pocket Limit FY 2003	Enrollment			Annual Funding Rates			Percent Contribution	Monthly Premium Payment		
			FY 2003	FY 2004	FY 2005	FY 2003	FY 2004	FY 2005		FY 2003	FY 2004	FY 2005
100%-185% FPL	\$0	\$1,000	28,994	29,864	30,760	\$862	\$998	\$1,172	0%	\$0	\$0	\$0
185-200% FPL	\$100	\$1,000	5,042	5,193	5,349	\$1,068	\$1,239	\$1,453	76%	\$68	\$79	\$92
200-250% FPL	\$150	\$1,000	3,995	4,115	4,239	\$1,051	\$1,217	\$1,423	86%	\$75	\$87	\$101
250-300% FPL	\$200	\$1,000	5,457	5,622	5,790	\$1,027	\$1,193	\$1,356	95%	\$81	\$94	\$107
300-350% FPL	\$250	\$2,000	3,632	3,742	3,853	\$1,000	\$1,162	\$1,319	103%	\$86	\$100	\$113
350-400% FPL	\$300	\$2,000	2,464	2,539	2,616	\$984	\$1,142	\$1,346	108%	\$89	\$103	\$122
400-450% FPL	\$350	\$2,000	1,615	1,664	1,714	\$968	\$1,123	\$1,324	116%	\$94	\$109	\$129
> 450% FPL	\$500	\$2,000	6,681	6,881	7,088	\$951	\$1,103	\$1,262	125%	\$99	\$115	\$131

Exhibit B

HOPE Prescription Plan for Maine

Fiscal Year 2003 (beginning July 1, 2002)

	CURRENT	PLAN SCENARIOS			
	DEL with Healthy Maine Waiver	Recommended Plan	Alternative 1	Alternative 2	Alternative 3
Plan Design	Disease-Based Formulary	Value-Based Formulary	Incentive-Based Formulary	Incentive-Based Formulary	Catastrophic Plan
Copay	20%	20%	20%	20%	N/A
Generic	20%	40%	40%	40%	N/A
Brand - Preferred	Cost over \$2	100%	80%	80%	N/A
Brand - Non-Preferred	Brand Drugs for only 13 Diseases, not including cancer & depression, & All Generics Covered	Indexed Deductible, Out-of-Pocket Limit & Premiums	Indexed Deductible, Out-of-Pocket Limit & Premiums	Indexed Deductible, Out-of-Pocket Limit & Premiums	
Additional Information		DEL Program Remains As Is	DEL Program Remains As Is	DEL Program Remains As Is	DEL Program Remains As Is
Out-of-Pocket Limit (OPL)					
100%-185% FPL	\$1,000				None
185%-200% FPL	Discount Program Only (25% off Retail)	\$1,000	\$1,000	\$1,000	\$2,000
200%-250% FPL					
250%-300% FPL					
300%-350% FPL					
350%-400% FPL	N/A	\$2,000	\$2,000	\$2,000	
400%-450% FPL					
> 450% FPL					
Enrollee Copay After OPL	20%	20%	20%	20%	0%
Premium per Enrollee per Month					
100%-185% FPL	\$0	\$0	\$0	\$0	\$0
185%-200% FPL		\$68	\$78	\$87	\$110
200%-250% FPL		\$75	\$90		
250%-300% FPL		\$81	\$93		
300%-350% FPL		\$86	\$98		
350%-400% FPL		\$89	\$102		
400%-450% FPL		\$94	\$105		
> 450% FPL		\$99	\$108	\$108	
Deductibles					
100%-185% FPL	\$0	\$0	\$0	\$0	\$0
185%-200% FPL	N/A	\$100	\$100	\$150	N/A
200%-250% FPL		\$150	\$150		
250%-300% FPL		\$200	\$200		
300%-350% FPL		\$250	\$250		
350%-400% FPL		\$300	\$300		
400%-450% FPL		\$350	\$350		
> 450% FPL		\$500	\$500	\$500	
Generic, Preferred Only Apply To OPL		N/A	YES	YES	

Endnotes

¹ Health Care Financing Administration