

HEINZ FAMILY
PHILANTHROPIES

HEINZ PLAN TO
OVERCOME
PRESCRIPTION DRUG
EXPENSES

Creating a Comprehensive and Affordable
Prescription Drug Program for All Persons
65 and Over in the Commonwealth of
Pennsylvania

May 23, 2001

A project of the Heinz Family Philanthropies
Report prepared by Jeffrey R. Lewis, Executive Director
with technical support from William M. Mercer, Incorporated

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Dedication

The **H**einz Plan to **O**vercome **P**rescription drug **E**xpenses (**HOPE**) is dedicated to the vision and memory of the late United States Senator John Heinz, a tireless advocate for senior citizens, who fought to help all persons 65 and older live a dignified retirement – one free from financial devastation because of the costs of prescription drugs, catastrophic illnesses and unnecessary placement into nursing homes. The HOPE Plan keeps his vision, passion and spirit alive. It demonstrates that what Senator Heinz believed in and fought for was achievable.

Senators Hal Mowery and Tim Murphy (Chairman and Vice Chairman, respectively, of the Public Health and Welfare Committee) and House Democrat Leader Bill DeWeese have spent many, many long hours in meetings, both in person and over the telephone, with the author. Their legislative insight and expertise have been invaluable to the report's author and consultants. However, it has been their passion for and commitment to the need to ensure that all Pennsylvanians 65 and older have access to affordable prescription drugs that has been unrelenting. Like Teresa Heinz, Senators Mowery and Murphy, and House Democratic Leader DeWeese understand, appreciate and staunchly support the notion that we cannot – indeed, we must not – ignore the needs of middle class senior citizens.

The passion, dedication and vision of Teresa Heinz, House Democratic Leader Bill DeWeese and Pennsylvania State Senators Hal Mowery and Tim Murphy were invaluable to this author and his consultants. The other unsung heroes were Scott Johnson, Executive Director of the Senate Public Health and Welfare Committee, Joanne McGreevy, Executive Director of the Senate Aging and Youth Committee, and Thomas M. Snedden, Director, Pharmaceutical Assistance Contract for the Elderly. Their insights, expertise and patience were extremely valuable.

Letter from the Chairman

Governor Tom Ridge
PA Speaker of the House, Matthew J. Ryan
PA House Democratic Leader, H. William DeWeese
PA Senate President, Robert C. Jubelirer
PA Senate Democratic Leader, Robert J. Mellow

Dear Governor Ridge, Speaker Ryan, Mr. DeWeese, Senator Jubelirer and Senator Mellow:

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 the spring of 2000, I issued a challenge to my staff and our consultants to design a plan that would create an affordable prescription drug benefit for all people 65 and over living in Pennsylvania. The result – the Heinz Plan to Overcome Prescription Drug Expenses (HOPE) for Pennsylvania – is contained in the report that follows.

The HOPE Plan, in part, builds on the already substantial work of and expertise derived from the PACE and PACENET programs. However, the HOPE Plan takes that good work a final step further by creating a plan that, for the first time, offers affordable and comprehensive coverage to all people 65 and over regardless of their income. It also builds in catastrophic coverage to help protect the thousands of seniors in Pennsylvania who spend more than \$1,000 each year for prescription drug coverage.

There may be provisions contained in the HOPE Plan about which some (even I) may disagree or may take specific exception. But I think everyone can agree that consideration of the HOPE Plan will present the Pennsylvania Legislature with a unique opportunity and a significant challenge.

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 HOPE Plan reflects a prodigious amount of work done by many extraordinary people who truly deserve to be applauded and thanked. Among them are: Annette Boyer, Lisa Coe, Barb Karwowski, Ernie Lampron, 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; Irwin (Tubby) Harrison of Harrison and Goldberg for his

Letter from the Chairman

important expertise and polling and focus group research; Mary Anne Marsh of GPC International and Associates for her communications expertise, and Frank Gannon 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.

Sincerely,

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

Teresa Heinz, Chairman
Heinz Family Philanthropies

I. Why this Report?

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

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

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

This is an age of medical miracles, of artificial hearts, and mechanical lungs, and there is probably no greater miracle than the drugs used in combating and controlling disease. The irony is that for millions of older Americans, this miracle becomes a nightmare because of 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, or best, 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 people 65 and over desperately need help with the costs of their prescription drugs. Far too many of these seniors, including many who live in Pennsylvania, find that they are not eligible for PACE (Pharmaceutical Assistance Contract for the Elderly) or PACENET, and are also unable to afford today's high-priced, private Medigap insurance plans with prescription drug benefits.

Against this background, 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 persons 65 and over. Teresa Heinz, like Senator John Heinz, brings a special intensity of interest, a unique energy, and a sincere dedication to finding solutions for these kinds of problems.

The report that follows – The Heinz plan to Overcome Prescription drug Expenses (HOPE): The Pennsylvania Strategy – meets the challenge set forth by Mrs. Heinz, and represents an innovative and practical way for Pennsylvania 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 Pennsylvania.

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

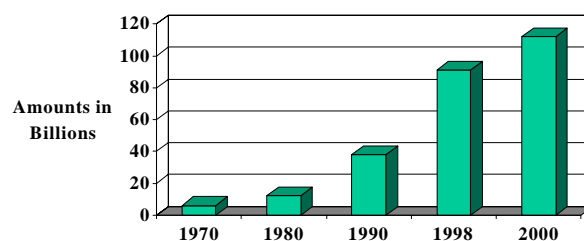
Today, many seniors are forced to choose between paying for necessities of daily life, such as food, clothing and heating, or their prescription medications. Stories of senior citizens who had to cut back sometimes on food or heating fuel to be able to afford a prescription drug have been told repeatedly.³ In addition, compliance with recommended dosages is often compromised due to limited financial resources. Since most of the Medicare beneficiaries 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 65 and over living in Pennsylvania, 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 the only nation 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

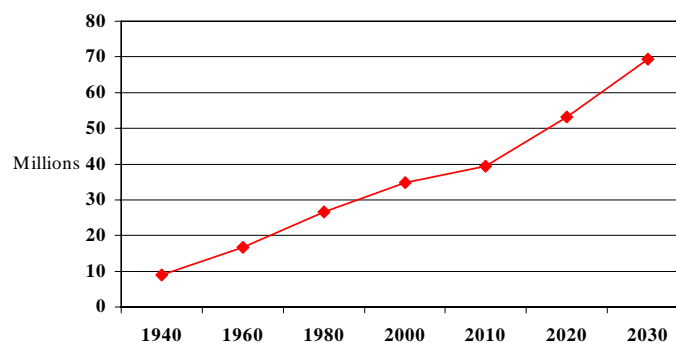
II. Prescription Drug Benefits for Seniors: The Nation's Challenge

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 is the age 85 and over sector. In 1998 there were 4.0 million persons age 85 and over, which is predicted to grow to 8.5 million by 2030, according to the Census Bureau.

Figure 2
Number of Persons Over Age 65
1940 - 2030



Source: The U.S. Bureau of Census

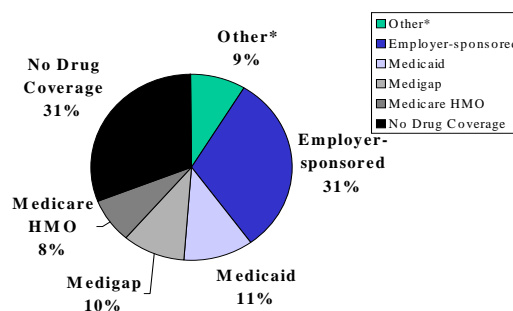
The dramatic growth in the senior population is significant because it is the largest user of prescription drugs. The typical Medicare beneficiary uses an average of 18-24 prescriptions per year, as compared with about 9-12 per year for the under-65 population.⁵ Moreover, seniors spend significantly 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).

Figure 3
Prescription Drug Coverage of
Medicare Beneficiaries, 1996



Source: Poisal, J. A. and Chulis, G. S., *Health Affairs*, March/April 2000
Note: Data are based on the noninstitutionalized population.

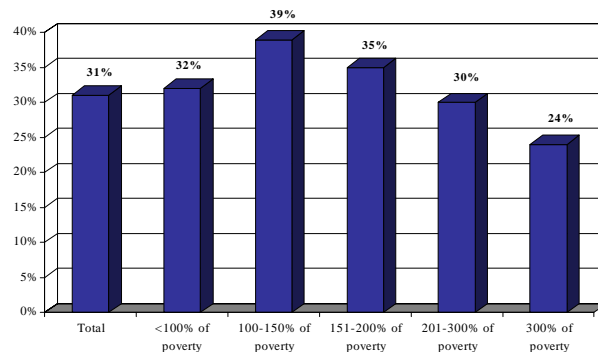
*Includes people who changed coverage during the year and those with Medicare and "other" coverage.

Those with drug coverage find that most of the coverage is restricted, due to the imposition of payment limits and benefit reductions. 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, thus, not eligible for even 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 principle 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 which seniors have access. 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.

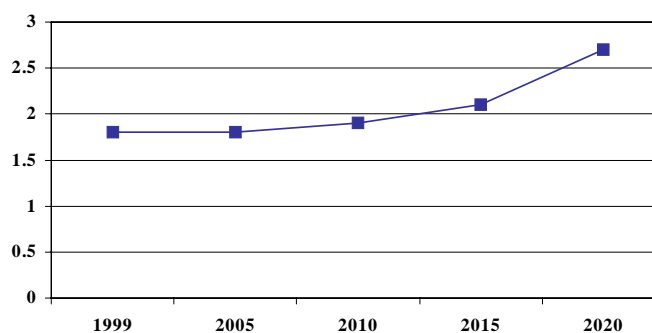
Pennsylvania stands at an important historical crossroads – one that will challenge both the political and institutional mettle of the Pennsylvania State Legislature as well as that of the Office of the Governor. This report addresses many of the issues affecting the availability of senior prescription drug coverage for Pennsylvania residents. The challenge is whether the Commonwealth's political structure is prepared and willing to tackle an overhaul of the existing PACE (Pharmaceutical Assistance Contract for the Elderly) and PACENET programs. While this challenge is not new, it cannot and should not be ignored any longer.

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

The Aging of the Population in Pennsylvania

In Pennsylvania there are 1.8 million seniors age 65 and over. This population is projected to increase to 2.0 million by 2015 (Figure 5).

Figure 5
Number of Persons in Pennsylvania Age 65 and Over
1999 - 2020



Source: The U.S. Bureau of Census

Pennsylvania, like several other states illustrated in 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%
Rhode Island	15.6%
West Virginia	15.2%
Iowa	15.1%

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

Current Senior Prescription Drug Coverage in Pennsylvania

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

- Employer-sponsored plans
- Medicare HMOs
- Medigap plans
- Medicaid
- State pharmacy assistance programs: PACE and PACENET

The benefit designs for these prescription drug programs vary widely, ranging from limited benefits with high deductibles and member contributions to comprehensive pharmacy coverage.

Employer-sponsored Plans

During the 1990s the trend with employer-sponsored plans was to eliminate retiree benefits for medical and prescription drug coverage. As reported in the 2001 Mercer National Survey of Employer-sponsored Health Plans, only 30% of large employers (employers with 500 or more employees) in Pennsylvania provide retiree health coverage to employees who retire and are eligible for Medicare. On a national basis, 28% of large employers provided retiree health coverage. This is a decrease as compared to survey results compiled in 2000 where 35% of large employers in Pennsylvania provided retiree health coverage. In 2000, on a national basis, the percentage of employers who provided retiree health coverage remained at 28%. Furthermore, less than 30% of the employer-sponsored health plans offer prescription drug coverage. In addition, for small employers (employers with less than 500 employees) in Pennsylvania, only 5% offer health coverage to Medicare-eligible seniors. Of this 5% offering health care coverage, fewer than 5% offer a prescription drug benefit, leaving a number of seniors without employer-sponsored prescription drug coverage.

An example of a Pennsylvania employer-sponsored health plan is the program offered by the Commonwealth of Pennsylvania and administered by the Pennsylvania Employees Benefit Trust Fund (PEBTF). The PEBTF provides health insurance coverage for retired employees of the Commonwealth of Pennsylvania and their dependents. For retirees and their dependents, the health insurance plan includes prescription coverage of a 30-day supply for retail drugs, both brand and generic, at a cost of a \$7 copayment.

PEBTF enrollees may also elect to have their maintenance prescriptions filled by the mail order pharmacy program or use the unique feature of purchasing their maintenance drugs at contracted retail pharmacies. Through the mail order program a 100-day supply can be purchased with a \$15 copayment for a brand or generic drug. Under both retail and mail, when a brand drug is

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

dispensed that has a generic equivalent, the enrollee pays the cost difference between the brand and generic drug in addition to the required copayment.

Medicare HMOs

Medicare HMOs were created as a result of the Balanced Budget Act of 1997. One of the most attractive features of the Medicare HMOs has been the comprehensive coverage for prescription drugs. Seniors in Pennsylvania have elected to enroll in these plans even though, in many cases, access is limited only to certain providers and the prescription drug benefit design utilizes closed formularies. The attraction to these plans has occurred due to low premiums or no premiums, low copayments for prescription drugs, and employee incentives to enroll from employer-sponsored plans. As a result, 28% of Pennsylvania Medicare beneficiaries were enrolled in a Medicare HMO as of October 2000. The most recent enrollment figures as of March 2000 shows a decline to 24%. This number is anticipated to decrease in 2001. The reduction in enrollment will occur for the following reasons: significant increases in premiums, limitations being imposed on the prescription drug benefit, and/or elimination of the prescription drug benefit, and withdrawal of these programs in selected counties in Pennsylvania.

Medicare HMOs that still offer prescription drug coverage include average copayments of \$10 and \$15 for generic and brand drugs, respectively, and \$20 and \$30 for mail order generic and brand drugs, respectively. Quarterly limits on prescription drug payments, in place of the annual limit, are now quite common and range from \$125 to \$350. These benefit changes have resulted in limited prescription drug coverage for participating senior citizens. In addition, monthly premiums for these programs now generally range from about \$90 to \$235 per month.

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 drug. 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 with a maximum benefit of \$3,000 per year. Generally, only Plan H is offered in Pennsylvania to seniors who enroll within 6 months following enrollment in Medicare Part B.

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 against the prescription drug benefits.

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

TABLE 2 2001 SAMPLE OF MEDIGAP PLANS IN PENNSYLVANIA (MONTHLY PREMIUMS)		
VENDOR	PLAN H WITH DRUG COVERAGE	PLAN C WITHOUT DRUG COVERAGE
Highmark Blue Cross/ Blue Shield	\$176.08	\$133.08
Capital Blue Cross/ Blue Shield	\$158.42	\$106.17
Independence Blue Cross/ Blue Shield	\$212.08	\$163.67
Blue Cross of Northeastern Pennsylvania/Blue Shield	\$166.67	\$129.58
Average	\$178.31	\$133.13

In 2003, it is estimated that Medigap premiums rates for Plan H, which includes drug coverage, will range from \$189 to \$197. The range of cost between a Medigap plan with drug coverage and a Medigap plan without coverage is estimated to be \$47 to \$63.

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 Pennsylvania, have included comprehensive prescription drug coverage in their Medicaid programs.

In selected locations in Pennsylvania, mandates require recipients to obtain these benefits through private or state-funded managed care organizations. Of the total Medicaid population in Pennsylvania, it is estimated that 75% - 80% is in managed Medicaid and the remainder in the traditional fee-for-service program.

In the Medicaid traditional fee-for-service program, Medicaid recipients have comprehensive prescription drug coverage with a copayment ranging from \$0 to \$2 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 Omnibus Budget Reconciliation Act (OBRA) mandated rebate agreements. These regulations require that all drugs be covered if manufactured by a pharmaceutical company which participates under the Health Care Finance Administration

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

(HCFA) Federal Rebate Program. Additionally, while formulary restrictions may be present under the Medicaid managed care plans, Medicaid recipients are able to receive nearly any outpatient prescriptions deemed medically necessary through an exception/appeal process.

State sponsored Plans: PACE and PACENET

PACE (Pharmaceutical Assistance Contract for the Elderly) was enacted in 1984, funded by revenues from the Pennsylvania State Lottery, to help seniors pay for prescription drugs. Since its inception, PACE has assisted approximately a million persons 65 and older with the costs of prescription drugs. In many cases, PACE has helped ensure that some seniors in Pennsylvania not only receive needed medications, but also helped guarantee that this population would not be prematurely or unnecessarily placed into nursing homes, or forced into hospital emergency rooms, because the prescriptions that were needed could not be obtained.

When the PACE program was established, copayments were set at \$4 per prescription, and have only increased once, in July 1991, to \$6 per prescription. In November 1996, mandatory generic substitution was enacted. Although the generic mandate provides a cost control mechanism, the \$6 copayment is inadequate for a balanced cost share for brand and generic drugs.

Despite having an impact on helping seniors pay for their prescription drugs, the number of seniors participating in the PACE program has declined over the years. In 1988, PACE served more than 477,000 seniors. As of April 2001, despite the Commonwealth's best efforts, the program only helps approximately 209,000 seniors. However, due to rising Medigap premiums and the elimination of Medicare HMOs in certain counties in the Commonwealth, the PACE program for the first time in a long time is experiencing enrollment increases.

To expand coverage to more seniors in Pennsylvania, and provide a safety net for those seniors who lost eligibility in PACE because of a slight increase in retirement income, PACENET was created. Eligibility limitations have kept PACENET from helping many eligible senior citizens. Moreover, because seniors with incomes of \$19,200 or more for married couples, and \$16,000 or more for single persons, do not qualify for PACENET, many middle class seniors are left without prescription drug coverage.

Today, of the 1.8 million people 65 and older in Pennsylvania, approximately 230,000 (as of April 2001) are enrolled in PACE and PACENET; however approximately, 910,000 are eligible for the programs. There are a number of reasons why there is a big gap between the number eligible and the number enrolled. One primary reason may be that income limits for PACE have not changed since the inception of the program.

The PACE program is funded through revenues from the Pennsylvania State Lottery. Currently, the lottery provides \$260 million⁸ in fiscal year 1999-2000, and currently the PACE program consumes about \$1 million a day of lottery funds.

IV. PACE and PACENET: What are the Tough Choices?

With the creation of PACE and PACENET, Pennsylvania has been able to provide coverage for prescription drugs to lower income senior citizens who, in most cases, would not have been able to afford such a benefit in the private insurance market. However, there is still a large group of seniors in Pennsylvania that do not qualify for PACE or PACENET. These seniors face the same daily battles as other seniors, that is, to remain independent and to avoid premature, or any, placement into a nursing home or hospital. Their ability to remain independent and free of fear that they will spend all or most of their savings (thereby placing at risk their possibility of becoming Medicaid and/or SSI-eligible), is predicated, in part, on their ability to purchase affordable prescription drugs.

To that end, the toughest choices facing the Pennsylvania Legislature and the Governor are two-fold: first, deciding whether and when the needs of middle class senior citizens will be addressed; and second, when the Legislature and the Governor will recognize that the PACE and PACENET programs are threatened by the rising costs of prescription drugs and a program redesign is required.

Why is PACE Successful?

There is one very important part of the PACE program that is, in this author's opinion, a major reason why the program has been successful: the Pennsylvania Department of Aging Executive Director, Thomas M. Snedden. He is a relentless advocate of the program and has provided a proactive vision to address the program's needs under political and legislative constraints.

As one of the oldest and most respected senior drug programs in the United States, the PACE program has benefited significantly from its years of experience providing pharmacy benefits to low-income seniors. The PACE program has evolved over the years, and several strategies have been implemented allowing PACE to benefit from technological advances as well as utilization management strategies designed to address emerging issues in the constantly-evolving pharmacy industry. Several general strategies are integral to the PACE program and continue to contribute to the success of the program.

One strategy that has been valuable to the PACE program is contracting with a Pharmacy Benefit Manager (PBM). Among services included in this arrangement are point-of-sale claims processing, clinical management services, rebate administration, and recovery program administration through coordination of benefits and audits.

The introduction of a point-of-sale claim processing system offers consistent application of the benefit design each time a claim is processed and has enhanced the efficiency and ease of processing claims at the pharmacy. This also allows the provider pharmacies to be paid for their services accurately and in a timely manner.

Secondly, while the primary focus of drug utilization review is on quality of care, aggressive utilization management programs often play a key role in managing the rising costs of providing a pharmacy benefit by influencing appropriate use of prescription medications. The PACE

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program operates both a prospective and retrospective drug utilization review (DUR) programs under the guidance of a Technical Advisory Committee comprised of health care professionals practicing in the Commonwealth of Pennsylvania. These programs are constantly enhanced in order to appropriately address inappropriate prescribing, dispensing, and utilization patterns identified in the PACE program.

Prospective drug utilization review, often referred to as concurrent drug utilization review, provides for clinical review prior to the dispensing of the prescription. The review process enhances the quality of the program by checking for potentially dangerous drug interactions, duplicative therapies, and inappropriate utilization. Within the prospective DUR program, the dispensing of a prescription that does not meet established clinical criteria is denied. Patients who can demonstrate a medical necessity for receiving a medication that was previously denied via the drug review program are offered a medical exception review process. If medical necessity is demonstrated, the denial will be overridden. This approach to prospective drug review is highly effective in influencing appropriate prescribing and utilization of medications, because it requires a review of the prescription prior to the initial dispensing.

Third, the PACE program benefits from aggressive pharmaceutical manufacturer rebate agreements comparable to rebate agreements offered to state Medicaid programs. In Pennsylvania, the PACE pharmaceutical rebate levels are legislated, and participation in rebate arrangements by pharmaceutical companies is required in order for a medication to be covered as part of the PACE benefit. These rebates have been important in lowering program costs and should continue to be part of any new program.

Fourth, another valuable component of the PACE program is the recovery administration through the Surveillance Utilization Review System (SURS), which identifies fraud and abuse among providers and participants and the PACE Coordination of Benefits program. The PACE COB program is among the most sophisticated pharmacy COB programs administered in the industry today. Pennsylvania Legislation requires that PACE be the payor of last resort. As the payor of last resort, if a member is eligible to receive pharmacy benefits through another payor, payment is “coordinated” among payors, and PACE pays only the portion of the claim not covered by the primary payor. Pennsylvania Legislation requires third parties offering benefits to seniors in the state of Pennsylvania to provide periodic eligibility files to PACE. These eligibility files are used to identify patients who may have other third party coverage. Using this eligibility information, COB is administered at the point-of-sale when possible. If a claim is identified as COB-eligible after payment of the initial claim, retrospective COB is initiated and subsequent recoveries are sought.

In addition to program management activities, several effective components of plan design have been incorporated into the PACE plan. The PACE program incorporates a mandatory generic provision that requires a member to receive the lower cost generic equivalent medication instead of the brand when a generic is available. Members who wish to receive the brand can still do so but are required to pay 70% of the average wholesale price of the brand drug in addition to the applicable copayment.

IV. PACE and PACENET: What are the Tough Choices?

Another effective plan design tool for managing utilization has been the PACE quantity limitations. Members are required to pay the applicable copayment for the lesser of a 30-day supply or 100 units of medication. This policy increases patient awareness of over-utilization of medications by requiring greater cost sharing by the members. Moreover, another effective management strategy is to exclude certain cosmetic or “lifestyle” medications. By excluding these medications, PACE can allocate more funds for coverage of medically necessary medications that will bring the greatest value to members of the PACE program.

Why Is PACE So Expensive?

Unfortunately, even with the various management strategies in place, the PACE program costs continue to increase, while enrollment decreases appear to have stabilized. Several components of the PACE law have hindered the program, preventing it from being able to implement the plans and policies necessary to keep the pharmacy benefits current and allow effective control of program costs. Modifying constraints imposed on the program could mitigate some of the cost increases.

Here are a few examples:

First, Pennsylvania law requires that the state reimburse pharmacies at a rate of 90% of the average wholesale price (AWP) plus a \$3.50 dispensing fee. This rate is significantly higher than the reimbursement rate, commonly accepted by pharmacies today, of AWP minus 12% - 14% plus dispensing fees of \$2.25-\$2.75.

Second, for generic medications that are manufactured by two or more companies, pharmacies typically accept reimbursement at a rate referred to as maximum allowable cost (MAC) plus a \$2.50 dispensing fee. MAC rates are established by various entities, such as HCFA or Pharmacy Benefit Management companies, and typically equate reimbursement of 50% - 55% of AWP costs. The use of maximum allowable cost is not an uncommon practice since it works to promote prudent purchasing practices from pharmacy providers. One opportunity to bring substantial savings to the Commonwealth is to provide the PACE program the flexibility to establish a more aggressive reimbursement formula through discounts of the AWP, reduced dispensing fees, and maximum allowable cost pricing.

Third, for maintenance drugs, most private employer prescription drug benefit plans and commercial carriers are able to achieve more aggressive pricing through the use of an exclusive mail order provider. The Pennsylvania law prohibits the state from entering into an agreement with an exclusive mail service provider.

Fourth, appropriate cost sharing strategies are an essential part of managing the pharmacy benefit. Copayments or coinsurance must be structured so those senior citizens share some of the financial impact of the health care decisions they make. This makes the patient a more informed and more engaged participant in their health care decisions. Currently the PACE

IV. PACE and PACENET: What are the Tough Choices?

copayment is legislated at a flat \$6 per prescription, and the PACENET copayments are set at \$8 for generic medications and \$15 for brand medications.

Current Pennsylvania law allows for review and adjustment of these copayments on an annual basis. However, these amounts have not been adjusted in ten years. The failure to keep copayments more closely aligned with actual drug trends means that the legislature is only delaying the inevitable.

In comparison, most private employer-based prescription drug benefit plans incorporate a 20% cost share provision and use two- and three-tiered programs designed to encourage the participant (and family members) to make an economic decision based on what is best for them and what they can, and are willing to, afford. As such, people are offered the least expensive copayment or incentive for purchasing generic prescriptions; higher copayments are placed on brand drugs.

Finally, much of the increasing expense related to providing a pharmacy benefit is associated with increased or inappropriate utilization of medications. Typically, PBMs control this component of trend through several management strategies such as formulary, prior authorization, or restructure approval systems. The use of such strategies by the PACE program is prohibited by Pennsylvania regulations. In order to maintain the flexibility to appropriately manage the pharmacy benefit, it is imperative that the Pennsylvania Legislature consider addressing some of these changes to ensure that the costs of the PACE and PACENET programs can be effectively managed.

V. The HOPE Plan: Confronting the Tough Choices

First, the HOPE Plan will provide, for the first time in Pennsylvania, a voluntary and affordable prescription drug program for all seniors – 65 and over – regardless of income.

Second, the HOPE Plan provides for responsible access to all prescription drugs through cost sharing and an incentive formulary. Individuals will pay a copayment of \$10 for generic drugs, \$25 for preferred drugs, and the greater of \$50 or 50% for non-preferred drugs.

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

It is important to underscore that an incentive formulary does not limit access to pharmaceuticals. Rather, it introduces and implements an approach which 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 consumers of prescription drugs and more active decision-makers in their health care choices.

An alternative to an incentive formulary is a closed formulary. A “closed formulary” is an effective way to control costs by allowing only drugs selected for the formulary to be covered. In other words, not all categories of drugs are covered, and within the categories that are covered the medication choices are limited. A major criticism of the closed formulary approach is that access to certain “non-formulary” medications is limited. Under such an approach, if prescribed a medication that is excluded from the formulary, the recipient would pay 100% of the cost.

Under the HOPE Plan for Pennsylvania, we have recommended the incentive formulary, but strongly encourage the legislature to examine and weigh the financial benefits of a closed formulary.

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 PACE participants enrolled in the program as of December 31, 2002, remain in the program with an increase in co-pay to \$10 with all other requirements maintained. After this date, all eligible PACE participants will be enrolled in the new HOPE Plan. The PACENET program will cease to exist after December 31, 2002. All existing PACENET participants will become part of the Pennsylvania HOPE Plan.

Beginning January 1, 2003, all persons 65 and over, including all individuals who would have been eligible for PACE and PACENET in 2003, would be eligible for the Pennsylvania HOPE Plan. As stated above, PACE will no longer exist except for those individuals who were part of the program prior to December 31, 2002.

V. The HOPE Plan: Confronting the Tough Choices

Fifth, the tough choice was whether to increase the copayment for those seniors who remain part of PACE. We answer the question affirmatively.

At the inception of the PACE program, the copayment was \$4. In 1991, the copayment was increased to \$6, and it has not been increased since that time. We are recommending that the legislature increase the PACE copayment to \$10 for those seniors remaining in the PACE program.

Moreover, we also recommend – beginning immediately – that the PACE copayment, like HOPE Plan copayments, increase annually according to the actual drug trend. For example, if the actual drug trend is 20% in 2003, the PACE copayment for 2004 would increase from \$10 to \$12.

Sixth, to ensure that the Pennsylvania HOPE Plan does not adversely impact the Commonwealth's fiscal position, we have designed the program with a front-end deductible and monthly contribution tied to income. For instance, a senior with an income of \$17,200 - \$19,999 would have a monthly contribution of \$87 and an annual \$150 deductible. For seniors with higher incomes, both the contribution and deductible would increase as income rises. In other words, the HOPE Plan is means-tested to ensure 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 contribution 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 equitable.

Seventh, 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 financial 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.

The goal of a catastrophic cap is to ensure that people 65 and over 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 income than wealthier seniors. The result is often financial devastation, particularly in those homes where one spouse lives independently and one resides in an institutional facility.

A catastrophic cap tied to income ensures that seniors will 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

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disadvantage lower-income and lower-middle income seniors by requiring them to spend more of their income than seniors with greater wealth.

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

Ninth, allow maintenance and life-sustaining drugs to be purchased through an incentive mail order program through an exclusive provider. A maintenance drug is defined as a drug that is taken for a chronic condition, for a period of time generally longer than three months.

The tough choice here is one of cost versus convenience. Because the HOPE Plan is designed to provide comprehensive prescription drug coverage for all persons 65 and over, and to protect them against catastrophic out-of-pocket expenses, we 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. An incentive mail order program for maintenance drugs accomplishes both objectives.

In the end, we are trying to accomplish two objectives. First, to provide seniors with affordable ways to purchase prescription drugs. An incentive mail program is one alternative. Under this approach, seniors are able to buy a three-month supply at two times copayment. For example, if diabetic drugs were generic, each refill would cost \$10 per month or \$30 for a three month supply. However, through the incentive mail program, the three-month supply would only cost \$20, saving \$10. For more expensive “preferred” drugs, the saving would be \$25.

While this author supports a mandatory mail order program because savings of over \$7 million could be achieved over three years, in Pennsylvania such an approach would harm and potentially destroy the retail pharmacies, particularly independent pharmacies. Retail pharmacies, chains and independents, are the lifeblood of a community. These men and women don’t just fill prescriptions, they talk with patients about their health status, the different drugs they are taking, the impact of the different drugs and whether such medications can and should be taken together. In addition, retail pharmacists are often forced into multiple roles including that of caregiver because of their commitment to each and every patient who enters their store.

Tenth, it is possible that a program such as the HOPE Plan may cause some employers who currently offer postretirement 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

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global marketplace, we must help employers attract and retain the very best workers. Offering to help employers remain competitive and locate and expand in Pennsylvania is an important goal that cannot be ignored. But we understand that this aspect of the plan is not without controversy.

However, we are recommending that the Pennsylvania 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.

Eleventh, 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 have 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.

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

Thirteenth, 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 PACE and PACENET include separate income limits for singles versus married couples. The household income limit for married couples is approximately 23% higher than for single persons. We have continued this practice in setting the HOPE Plan income limits.

Fourteenth, 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.

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

Sixteenth, the HOPE Plan recommends the creation of a Governor’s Prescription Drug Review Commission. Because this would be a legislatively-created plan, we believe that the legislature needs to be completely involved in, and focused on, the difficult decisions that 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 with the Governor where he, like the Senate President and Speaker of the House, understands this program first hand. To that end, the Commission would consist of sixteen members including the Senate President, the Speaker of the House, and the Governor who would serve as co-chairs.

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

Eighteenth, to capture the success of the current PACE Program, we are recommending that the HOPE Plan build upon some of the existing strategies currently used in PACE. For example, the HOPE Plan could benefit greatly by incorporating the program administration and enrollment processes that have been refined over the years for the current program. In addition, the continued use of a pharmacy benefit management company would enable the HOPE Plan to benefit from the experience and expertise such vendors bring, as well as enabling the HOPE Plan to implement many of the drug utilization strategies that have contributed to current program success.

Another key element that contributes significantly to the success of the HOPE Plan will be requiring pharmaceutical manufacturers to maintain the current level of manufacturer rebate agreements. Requiring a pharmaceutical manufacturer to participate at the same rebate levels as they currently do in the PACE program will significantly strengthen the financial viability of the HOPE Plan. Finally, under current legislation, the PACE program is designated as the payor of

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last resort. By maintaining this payor status and retaining the sophisticated funding recovery methodologies, the HOPE Plan will benefit considerably.

Nineteenth, because there are many veterans age 65 and older who may qualify for prescription drug coverage through the federal Department of Veterans Affairs (VA), it is important that the Commonwealth, in conjunction with the VA, implement a statewide program to help inform veterans age 65, and/or their surviving spouse, of their possible eligibility. This will help ensure that veterans (and their families) participate in the program that is in their best financial interest.

Twentieth, 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 thoughtfully and carefully to reevaluate the HOPE Plan to ensure its fiscal integrity and the Commonwealth's overall fiscal position. Moreover, including a "sunset" provision requires an act of affirmation from the legislature in order to continue the program in its current posture or to modify it for the future.

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

VI. The HOPE Plan: Executive Summary

The Heinz Family Philanthropies engaged William M. Mercer, Incorporated to assist with the design of, and provide financial projections for, the development of the **H**einz plan to **O**vercome **P**rescription drug **E**xpenses (HOPE). The HOPE Plan is a prescription drug program designed to be available to all seniors (age 65 and over) who reside in the Commonwealth of Pennsylvania.

HOPE builds on the existing framework of the PACE program but demonstrates how an effective combination of cost sharing, enhancements in pharmacy management, and volume purchasing can yield a comprehensive prescription drug program that would be affordable to seniors. Consequently, our efforts in Pennsylvania have resulted in a proposed statewide prescription drug program that is unique in one particular way: in addition to continuing to cover seniors living at or below the poverty level, the HOPE Plan would also be available and affordable to middle class seniors.

The HOPE Plan is focused exclusively on the 1.8 million seniors – age 65 and over – residing in Pennsylvania. Our recommendation is to grandfather the PACE program while increasing the copayment from \$6 to \$10 and allow the existing PACE participants to continue to receive PACE benefits as long as they qualify under the income requirements. All new participants, and the existing PACENET participants, would adopt the HOPE Plan. Additionally, as in the current program, seniors eligible for Pennsylvania Medicaid will retain Medicaid benefits and are not considered for the 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 Commonwealth;
- provide for comprehensive coverage to a broader population at a reasonable expense;
- encourage responsible access to all prescription drugs; and
- maintain affordability.

An important characteristic of the HOPE Plan is that it can be adjusted to accommodate the Commonwealth's budget allocations without compromising the core advantages of the plan. The four basic core advantages of the plan are pharmacy benefit design, pharmacy benefit management strategies, controlled enrollment, and program oversight.

Pharmacy Benefit Design

The first core advantage of HOPE is the overall pharmacy benefit design. The HOPE plan is built upon graduated contributions, deductibles, and out-of-pocket limits tied to household income. Seniors who have higher incomes pay more for the plan. After the individual deductible is met, a copayment established for an incentive-based drug formulary is charged for

VI. The HOPE Plan: Executive Summary

each prescription. The incentive-based drug formulary maximizes the generic substitution opportunities and promotes the use of the most cost-effective brand medications. As in the PACE Program, specific classes of medications that are not considered medically necessary – such as cosmetic agents or “lifestyle” medications – are not covered under the HOPE Plan. Table 4 below summarizes the recommended HOPE Plan benefit design in comparison to the current PACE and PACENET programs.

Furthermore, the HOPE Plan is modeled using a performance based network of pharmacies that are contracted at lower reimbursement rates than the current PACE reimbursement. Incentives are paid to the pharmacies to maximize the program performance in areas such as generic substitution, targeted drug interventions and formulary compliance. An incentive mail order program, contracted at aggressive reimbursement rates, is voluntary for maintenance and life-sustaining medications.

TABLE 3
PLAN COMPARISON SUMMARY

	PACE/PACENET	THE HOPE PLAN
Eligibility: PA resident for a least 90 days	Age 65 or older & income limits PACE: <ul style="list-style-type: none"> ▪ Single person below \$14,000 ▪ Married couples below \$17,200 PACENET: <ul style="list-style-type: none"> ▪ Single person \$14,000-\$16,000 ▪ Married couples \$17,200-\$19,200 	Age 65 or older <ul style="list-style-type: none"> ▪ No income limits – income determines level of cost sharing
Funding	<ul style="list-style-type: none"> ▪ State lottery 	<ul style="list-style-type: none"> ▪ State lottery and enrollee contributions
Drug formulary	<ul style="list-style-type: none"> ▪ Drug formulary based on the pharmaceutical manufacturer rebate arrangement 	<ul style="list-style-type: none"> ▪ Incentive drug formulary with legislated pharmaceutical manufacturer rebates
Deductible	PACE: None PACENET: \$500	Income-based \$150 to \$500
Monthly Contribution	None	\$0 - \$121
Copayments	PACE: <ul style="list-style-type: none"> ▪ \$6 all drugs ▪ mandatory generic PACENET: <ul style="list-style-type: none"> ▪ \$8 generic/\$15 brand ▪ mandatory generic 	Retail Network: <ul style="list-style-type: none"> ▪ \$10 generic drug ▪ \$25 preferred drug ▪ >\$50 or 50% non-preferred drug ▪ mandatory generic ▪ annually indexed to drug trend Mail order: <ul style="list-style-type: none"> ▪ 2 times the network copayment
Annual out-of-pocket limits	None	Income-based limits of \$1,000, \$2,000, \$3,000 & \$4,000

VI. The HOPE Plan: Executive Summary

Pharmacy Benefit Management Strategies

The second core advantage of HOPE is the opportunity to build upon the existing pharmacy benefit management under the PACE program and 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 Commonwealth's capacity to negotiate the best prices for discounted networks and mail order drugs, and enhances prescription drug management. The PBM selected through a competitive bidding process is required to partner with the Commonwealth 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.

In constructing the HOPE Plan, a decision was made early on to include various provisions to address the difficult issues of cost and utilization of prescription drugs and to build upon the successful strategies currently utilized in the PACE program. In addition to the benefit design, two additional strategies incorporated into the HOPE Plan include pharmaceutical rebates and provider discounts. The HOPE Plan recommends the legislature continue to use the legislated PACE Pharmaceutical Manufacturer Rebate Agreement, but modify the legislation to allow pharmacy management strategies such as formulary, step therapy, prior authorization, and aggressive utilization programs. Secondly, legislation needs to be modified to allow the flexibility to establish more aggressive reimbursement formulas through discounts of the average wholesale price, reduced dispensing fees, and maximum allowable cost pricing in addition to using an exclusive mail order provider.

Our goal and strategy is to ensure that we are creating a program that can be sustained now and in the future, and one that could easily become part of Medicare. We believe our responsibility is to the Commonwealth, its citizens, and to future generations of taxpayers. We want to address the evolving requirements of the beneficiary population, while balancing that objective with political and financial realities.

Controlled Enrollment

The third core advantage of HOPE is controlled enrollment. The HOPE Plan is incremental in its design, meaning that in each successive year after its inception, an increasing number of eligible persons age 65 and older are admitted. This is purposely done to build a set of fiscal benchmarks for the plan since one of the greatest risks for HOPE is adverse selection. 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, deductibles, and maximums. 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 must be high.

VI. The HOPE Plan: Executive Summary

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 required to provide 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 HOPE Plan: Financial Summary

The initial success of the HOPE plan will rest with the ability to design a plan that is essentially cost-neutral to the Commonwealth. In addition, it was felt that keeping disruption to existing PACE enrollees at a minimum would also be important to the success of the HOPE Plan. Therefore, our financial projections for the HOPE Plan are based on grandfathering the PACE program, and implementing HOPE for PACENET enrollees and all other eligible seniors in Pennsylvania.

The recommended HOPE Plan calls for grandfathering those enrollees in the current PACE program while increasing the copayment from \$6 to \$10 per prescription. PACENET enrollees would become part of the HOPE Plan, as would any new enrollees after January 1, 2003. As a result, it is estimated that the recommended HOPE Plan would cost \$435.7 million in 2003, or \$6.6 million more than the projected costs for PACE and PACENET. This slightly higher price tag is due primarily to the additional 200,000 seniors that would be covered under the Plan.

Table 4 summarizes anticipated program costs and enrollment associated with the HOPE Plan. Under the proposed HOPE Plan, it is estimated by 2005 that as many as 483,264 seniors could be covered at a projected cost about 3% higher than the projected costs for PACE and PACENET alone. Consequently, the HOPE Plan would serve more seniors while being a near-neutral cost alternative to PACE and PACENET.

TABLE 4 - THE HOPE PLAN FINANCIAL SUMMARY			
		ENROLLMENT	NET COST*
Seniors	Year 2003	409,548	\$435,700,000
	Year 2004	442,084	\$500,600,000
	Year 2005	483,264	\$575,900,000

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

VII. 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 all prescription drugs through balanced cost sharing and an incentive formulary; and
- an annual income-based out-of-pocket limit to protect against catastrophic costs.

Income-based Annual Deductible and Contribution

The HOPE Plan requires seniors with household incomes at or above 163% of the Federal Poverty Level (FPL) for a single person, and 148% of the FPL for a married couple, to participate financially in the plan. However, the annual deductibles and contributions – Table 5 – are intended to be affordable for individual seniors within a given household income bracket. Individuals in the lowest income bracket – below 163% of the FPL – are not subject to an annual deductible and contributions. 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. Exhibit A provides the full range of annual contributions and deductibles for single persons and married couples by annual household income ranges.

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

TABLE 5 – THE HOPE PLAN ANNUAL DEDUCTIBLE AND MONTHLY CONTRIBUTIONS									
Single Person Annual Household Income Ranges		Married Couple Annual Household Income Ranges		Annual Deductible			Monthly Contributions		
				Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
\$0	\$13,999	\$0	\$17,199	\$0	\$0	\$0	\$0	\$0	\$0
\$14,000	\$17,199	\$17,200	\$21,099	\$0	\$0	\$0	\$35	\$40	\$46
\$17,200	\$19,999	\$21,100	\$24,599	\$150	\$179	\$215	\$87	\$100	\$115
\$20,000	\$24,999	\$24,600	\$30,699	\$200	\$238	\$286	\$98	\$113	\$130
\$25,000	\$29,999	\$30,700	\$36,899	\$200	\$238	\$286	\$111	\$128	\$147
\$30,000	\$34,999	\$36,900	\$42,999	\$250	\$298	\$358	\$113	\$129	\$149
\$35,000	\$39,999	\$43,000	\$49,099	\$350	\$417	\$500	\$121	\$141	\$162
\$40,000	Plus	\$49,100	Plus	\$500	\$536	\$643	\$121	\$141	\$162

VII. The HOPE Plan: Pharmacy Benefit Design

Responsible Access to All Prescription Drugs

The HOPE Plan provides for responsible access to all prescription drugs through balanced cost sharing and an incentive formulary. Once individuals meet their annual deductibles, they are required to pay an amount referred to as a copayment toward the cost of each prescription. Under the HOPE Plan, individuals will pay a copayment of \$10 for generic drugs, \$25 for preferred drugs, and the greater of a \$50 copayment or 50% for non-preferred drugs.

A mandatory generic provision is also applied to the three-tier copayment 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.

For the existing PACE program, we are recommending that the PACE copayment increase to \$10 and then increase annually to match the drug cost trend.

The three-tier copayments recommended for the HOPE Plan are displayed in Table 6. Annually, the copayments, along with the deductibles and the out-of-pocket limits, will be adjusted according to the actual drug cost trend experienced under the program. In the HOPE Plan model, drug trends of 19% for year two and 20% 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, more generic drugs available in the market, and the impact of new pharmaceuticals.

TABLE 6 – THE HOPE PLAN					
COPAYMENTS AFTER ANNUAL DEDUCTIBLE					
	SOURCE	DAYS SUPPLY	COPAYMENT		
			GENERIC DRUGS*	PREFERRED DRUGS	NON-PREFERRED DRUGS
Year One	▪ Retail	Lesser of 30 days or 100 units	\$10	\$25	Greater of \$50 or 50%
	▪ Mail Order	Lesser of 90 days or 300 units	\$20	\$50	Greater of \$100 or 50%
Year Two	▪ Retail	As in year one	\$12	\$30	Greater of \$60 or 50%
	▪ Mail Order	As in year one	\$24	\$60	Greater of \$120 or 50%
Year Three	▪ Retail	As in year one	\$14	\$35	Greater of \$70 or 50%
	▪ Mail Order	As in year one	\$28	\$70	Greater of \$140 or 50%

*Mandatory generic provision

VII. The HOPE Plan: Pharmacy Benefit Design

The three-tier copayment design provides for responsible access to all prescription drugs through an incentive drug formulary. The drug formulary is designed favorably to enhance the quality and cost of the plan through drug mix in addition to addressing new pharmaceutical products and evidence-based prescribing guidelines. The financial impact to the pharmacy plan is ultimately dependent on the specific drugs selected for preferred status in the drug formulary, how actively the formulary is managed, and the pharmaceutical rebate arrangement. Moreover, specific classes of medications that are not considered medically necessary – such as cosmetic agents – are not covered under the HOPE Plan.

Protection Against Catastrophic Costs

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

To allow for catastrophic coverage, the HOPE Plan has annual out-of-pocket limits, \$1,000 to \$4,000 tied to household income, as illustrated in Table 7. Exhibit A provides the full range of annual premiums and deductibles for single persons and married couples by annual household income ranges.

Under the HOPE Plan, only the deductible, generic, and preferred drug copayments apply to the out-of-pocket limit. The costs of the non-preferred drugs or brand/generic differentials do not apply to the out-of-pocket limit. Once a person has met their individual annual limit, 100% of prescription drug costs for generic and preferred drugs are covered by the HOPE Plan, whereas non-preferred drugs continue to be covered at the greater of the non-preferred copayment or 50%.

TABLE 7 – THE HOPE PLAN ANNUAL OUT-OF-POCKET LIMITS						
Single Person Annual Household Income Ranges		Married Couple Annual Household Income Ranges		Annual Out-of-pocket limits		
				Year 1	Year 2	Year 3
\$0	\$17,199	\$0	\$21,099	\$1,000	\$1,190	\$1,428
\$17,200	\$19,999	\$21,100	\$24,599	\$2,000	\$2,380	\$2,856
\$20,000	\$24,999	\$24,600	\$30,699	\$2,000	\$2,380	\$2,856
\$25,000	\$29,999	\$30,700	\$36,899	\$2,000	\$2,380	\$2,856
\$30,000	\$49,999	\$36,900	\$61,399	\$3,000	\$2,380	\$2,856
\$50,000	Plus	\$61,400	Plus	\$4,000	\$4,760	\$5,712

VII. The HOPE Plan: Pharmacy Benefit Design

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 exclude for 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 have the opportunity to be managed under a separate program. The HOPE Plan needs the flexibility to modify or expand its scope of coverage dependent on the new drugs and selected opportunities for cost effective therapies using over-the-counter medications.

VIII. 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 builds upon the existing drug management process employed by the PACE Program by focusing on enhancing quality by reducing negative drug interactions, duplicate therapies, and minimizing inappropriate under and over-utilization of drugs.

The Commonwealth can accomplish this objective by continuing to contract with a pharmacy benefit manager (PBM), which, as in the private sector, specializes in providing administrative and management services to reduce the cost of pharmacy benefits. The use of a PBM provides uniform administration of the program, maximizes the Commonwealth'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 will be required to partner with the Commonwealth to reduce the costs of the pharmacy plan through the benefit management strategies in addition to 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:

- Establishing retail and mail order relationships with aggressive discounted pharmacy pricing
- Designing, implementing and managing a prescription drug formulary
- Encouraging generic and therapeutic substitution where appropriate
- Conducting drug utilization review
- Utilizing different drug management mechanisms for selected medications

Retail Pharmacy Network and Mail Service

The HOPE Plan calls for a customized, performance-based retail network of chain and/or independent pharmacies which can deliver aggressive discounted average wholesale and maximum allowable cost prices in addition to meeting technical performance and quality standards. The retail network pharmacies are required to demonstrate consistent and high levels of pharmacy program management focused on generic substitution, formulary compliance, therapeutic interventions, and drug utilization review.

Under the HOPE Plan, individuals will be able to obtain the lesser of a 30-day supply or 100 units for the specified copayments from the retail pharmacy network provider. There is no prescription drug benefit if the drug is obtained from a non-network pharmacy provider.

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

VIII. The HOPE Plan: Pharmacy Benefit Management

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

Through the mail order program, individuals will be able to obtain the lesser of a 90-day supply or 300 units – three times the daily supply available through the retail pharmacy network – for two times the copayment. One design consideration in lieu of an exclusive provider is to offer mail order through the retail pharmacies, contracted at aggressive mail order pricing.

Drug Formulary

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

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

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

Additionally, 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.

One alternative that was considered was the use of a closed drug formulary. Under a closed drug 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. Even though a closed drug formulary can generate the highest level of formulary compliance and rebates, the administration can be difficult, especially for a senior population.

It is recommended that the Hope Plan use an incentive-based formulary while retaining the pharmaceutical rebate arrangement existent under the PACE and PACENET

VIII. The HOPE Plan: Pharmacy Benefit Management

programs. This design, not modeled in the financial analysis, provides additional savings through maximum rebate potential and the ability to modify the drug mix.

Generic Drug Incentives and Therapeutic Substitution

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

The HOPE Plan also uses therapeutic substitution conversion programs to encourage the use of specified formulary drugs. Typically these programs involve provider interventions to switch from one medication to another therapeutically equivalent medication within the same drug class.

Drug Utilization Management

The HOPE Plan builds upon the existing utilization programs in PACE but enhances prospective, concurrent, and retrospective drug utilization management to ensure that prescription drugs are used appropriately, safely, and effectively.

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

Building upon the drug utilization management review process currently in place with the PACE Program, and expanding its capability, is vitally important to the quality and cost of the program. By providing for timely and effective action at the appropriate level of intervention, the Commonwealth can identify and reduce unnecessary prescription drug use, assure that prescription drugs are used in proper clinical circumstances, safeguard seniors from prescription drugs that are potentially dangerous, and from prescription drugs that are more costly than necessary.

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

VIII. 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 a specific medical condition. If the clinical criteria are not met, the drug is usually 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, are 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 pharmacist– intervention process that will identify providers who might be responsible for high costs as a result of potentially inappropriate prescriptions. The plan also provides for interventions aimed at educating and changing prescribing behaviors.

Health Management

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

Recovery of Funds

The HOPE Plan builds upon the existing PACE Program methodologies for recovery of funds through an 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, as is PACE, to be the payor of last resort.

IX. The HOPE Plan: Controlled Enrollment

There are over 1.8 million seniors in the Commonwealth of Pennsylvania who are age 65 or older. To project the enrollment in the HOPE Plan, three sources of enrollment were considered. These include:

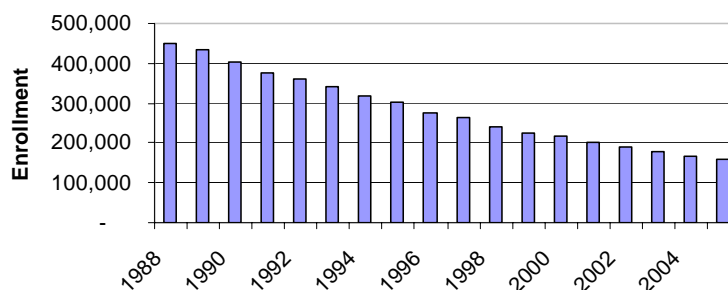
- Individuals currently enrolled in PACE
 - single individuals with annual household incomes below \$14,000 and married couples with incomes below \$17,200
- Individuals currently enrolled in PACENET
 - single individuals with annual household incomes between \$14,000 and \$16,000 and married couples with incomes between \$17,200 and \$19,200
- Individuals who have annual household incomes that are above the limits currently established for PACE and PACENET.

Seniors Eligible under PACE

PACE enrollment has continually declined since 1988. The primary reason for decline in enrollment has been PACE's annual income limits. The income limits have remained the same since 1996, while annual increases in Social Security Benefits and a favorable economy have increased household incomes. This has resulted in fewer individuals having annual household incomes under the limits.

As shown in Figure 6, the enrollment decline has been persistent through 2000. PACE enrollment declined from approximately 477,000 in 1988 to 209,208 as of April 2001. Based on past PACE experience, enrollment is projected to decline from 2003 through 2005. By the year 2005, the enrollment count is projected to be about 158,000. These projections presume a continuation of the current economy, and that the annual income limits will remain the same.

Figure 6
PACE Enrollment



IX. The HOPE Plan: Controlled Enrollment

Funds for marketing have been included in the HOPE Plan financial projections. However, given the full subsidization of the premium and the fact that PACE has been in place for over seventeen years, an extensive marketing campaign may not be effective or necessary for this income group. On the other hand, an effective communication strategy of the HOPE Plan benefit will be needed.

Seniors Eligible under PACENET

This group of seniors, according to our recommendation, will be absorbed by the new HOPE Plan design effective January 1, 2003.

Under HOPE, these individuals would be required to submit a monthly contribution which is lower than the \$500 deductible applied under the current PACENET program. Since a contribution is required, the need for an effective advertising campaign is more critical than it is for those eligible for PACE. As with any contribution product, individuals must be persuaded to purchase the benefit. Figure 7 displays the historic and projected enrollment for individuals with annual household incomes that qualify for PACENET, and that would be targeted for HOPE.

Figure 7
PACENET Enrollment

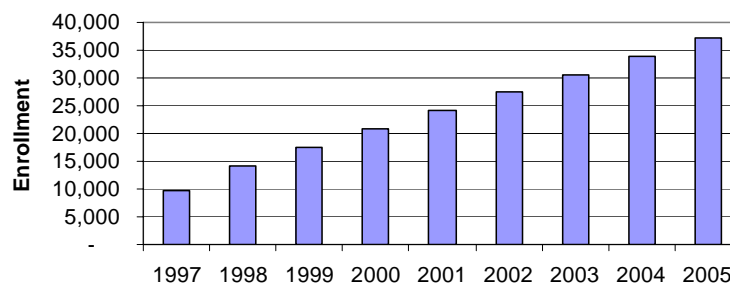


Figure 7 shows a steady increase in enrollment. This is due to the spillover from those individuals who, at one time, were eligible for PACE, but, due to annual income limits now qualify for PACENET. We expect the same trend to exist under our HOPE Plan recommendation. The expectation is that, with effective advertising, the enrollment of single individuals with annual household incomes between \$14,000 and \$16,000, and married couples with incomes between \$17,200 and \$19,200, will increase following transition to the HOPE Plan.

IX. The HOPE Plan: Controlled 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 PACE and PACENET, is subject to greater uncertainty. PACE and PACENET provide 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. For instance, some Medicare HMO plans eliminated prescription coverage in 2001. Others placed annual and/or quarterly limits on this benefit, with almost all of the Blue Cross Blue Shield Medicare HMO products across Pennsylvania having some type of annual and/or quarterly limits. On the other hand a number of seniors do have prescription drug coverage under employer-sponsored retiree health plans. That is why in the early years of the HOPE Plan, it is not expected that there will be a significant transfer of these retirees to the HOPE Plan. However, as the cost of the prescription drug benefit increases and an employer continues to search for ways to reduce their retiree benefit costs, 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 Medicare HMOs, seniors enrolled in Medigap plans, and seniors participating in employer-sponsored plans. In the first year of the proposed HOPE Plan we project that 200,000 individuals will enroll. This represents about 17% of the seniors who could utilize the services of a Medicare HMO, a Medigap Plan, or employer-sponsored plans. This is well below the number of seniors in Pennsylvania who have elected to purchase such services.

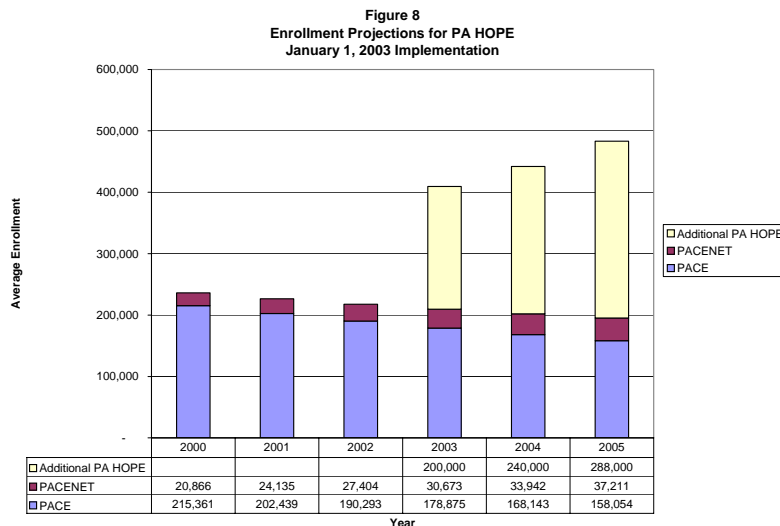
By 2003, the additional premium required for the above plans that have prescription coverage is expected to approach the HOPE contributions. As a result, in subsequent years it is projected that seniors will rely on the HOPE Plan to provide a sufficient level of either primary or secondary coverage, thus increasing enrollment at a rate of 20% a year. Table 8 displays the projected enrollment over a three year period.

IX. The HOPE Plan: Controlled Enrollment

TABLE 8	
ENROLLMENT PROJECTIONS FROM MEDICARE HMO, MEDIGAP AND EMPLOYER-SPONSORED PROGRAMS	
Calendar Year	Enrollment
2003	200,000
2004	240,000
2005	288,000

Total Enrollment before and after The HOPE Plan

Figure 8 (below) illustrates observed and expected enrollment under PACE, PACENET and HOPE. 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 236,000 seniors enrolled in PACE or PACENET in 2000. Removing the income limits, via the HOPE Plan, is projected to increase the total enrollment in Pennsylvania's sponsored pharmacy plans to 410,000 in 2003. With effective advertising and outreach, 483,000 seniors could be enrolled by 2005.



IX. The HOPE Plan: Controlled Enrollment

Adverse Selection

Although subsidized by the Commonwealth of Pennsylvania for low income individuals, the HOPE Plan is an insurance-based model. Insurance 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 65.

Those who are age 65 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 65 following the enactment of the HOPE Plan must enroll within six months of their sixty-fifth 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 Commonwealth 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's financial viability.

X. 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 that plans like the HOPE Plan, and any plan that sets out to achieve prescription drug coverage for all seniors, requires. The overall purpose of the Commission is to provide proactive operational and financial oversight in an effort to determine how well the program is operating, and whether changes may be necessary. Moreover, the Prescription Drug Review Commission's activities will be coordinated with the Technical Advisory Committee existing under the PACE program.

The Commission would consist of members including the Senate President and the Speaker of the House who would serve as co-chairs. No designees would serve in their place except in the event that one of the chairs is unable to perform his duties as Speaker or President. The Senate President and the Speaker of the House would each appoint two members to the Commission.

Additional Commission members would include the Chair and ranking member of the Senate and House Aging and Youth Committees or their designees, the Chair and ranking member of the Senate and House Public Health and Welfare Committees or their designees, the Secretary of Aging, the Director of the PACE and HOPE programs, and the Director of Medicaid.

The Governor would appoint a representative of a senior citizen's advocacy organization, a health care economist from a university or college within the Commonwealth, and a representative of the contracted pharmacy benefit manager. The Governor's appointments would 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 could only take official action when both co-chairs are in attendance and by a majority vote of those members present.

The duties of said Commission 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 such problems;
 - have the pharmacy benefit manager explain current and projected cost trends for the program and determine whether and, if so, how changes need to be made to ensure the fiscal integrity of the program;

X. 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 co-payments, 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 co-payments, 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.

XI. The HOPE Plan: Funding

The initial success of the HOPE Plan rests with the ability to design a plan that is essentially cost-neutral to the Commonwealth. Keeping disruption to existing PACE enrollees at a minimum is also important to the success of the HOPE Plan. Therefore, our financial projections for the HOPE Plan are based on grandfathering the PACE programs and implementing HOPE for PACENET enrollees and all other eligible seniors in Pennsylvania.

For the period ending December 31, 2000, PACE and PACENET cost the Commonwealth approximately \$295.3 million. These costs are projected to increase by 45% to \$429.1 million by 2003 and to \$557.2 million by 2005. These projections are based on anticipated cost trends under the PACE and PACENET program of approximately 18% per year, and a combined decline in PACE and PACENET enrollment of 3.6% in year 2004, and 3.4% in year 2005.

The recommended HOPE Plan calls for grandfathering those enrollees in the current PACE plan while increasing the copayment effective June 1, 2003 from \$6 to \$10 per prescription. PACENET enrollees, in addition to any new enrollees, would become part of the HOPE Plan after January 1, 2003. It is estimated that the recommended HOPE Plan would cost \$435.7 million in 2003 or \$6.6 million more than the projected costs for PACE and PACENET. This slightly higher price tag is due primarily to the additional seniors in Pennsylvania that would be covered under the Plan. This \$6.6 million provides coverage for an additional 200,000 seniors. Further, as Table 9 shows, costs under the recommended HOPE Plan (Column 2) are projected to be somewhat higher than projections for the current PACE and PACENET programs for 2004 and 2005. This, again, is due primarily to increases in enrollment. Under the proposed HOPE Plan, it is estimated that as many as 483,264 seniors could be covered under the HOPE Plan by 2005, at a projected cost of about 3% higher than the projected costs for PACE and PACENET. The HOPE Plan would serve more seniors while being a near cost-neutral alternative to PACE and PACENET.

XI. The HOPE Plan: Funding

TABLE 9						
COST COMPARISON						
	1 <i>Current PACE and PACENET Program</i>		2 <i>Recommended HOPE Plan</i>		3 <i>HOPE Plan – Total Replacement</i>	
Year	Average Enrollment	Annual Cost (millions)	Average Enrollment	Annual Cost (millions)	Average Enrollment	Annual Cost (millions)
PACE Enrollees						
2003	178,875	\$392.9	178,875	\$373.7	178,875	\$357.2
2004	168,143	\$439.7	168,143	\$420.1	168,143	\$387.5
2005	158,054	\$492.2	158,054	\$472.0	158,054	\$420.3
PACENET Enrollees						
2003	30,673	\$36.2	30,673	\$47.4	30,673	\$47.4
2004	33,942	\$48.7	33,942	\$60.8	33,942	\$60.8
2005	37,211	\$65.0	37,211	\$76.9	37,211	\$76.9
Additional Enrollees						
2003	–	–	200,000	\$14.5	200,000	\$14.5
2004	–	–	240,000	\$19.7	240,000	\$19.7
2005	–	–	288,000	\$27.0	288,000	\$27.0
All Enrollees						
2003	209,548	\$429.1	409,548	\$435.7	409,548	\$419.1
2004	202,085	\$488.4	442,084	\$500.6	442,084	\$468.0
2005	195,265	\$557.2	483,264	\$575.9	483,264	\$524.2

The design of the HOPE Plan includes annual deductibles and contributions for enrollees at or above an annual household income of \$14,000. To test the affordability of the HOPE Plan we compared the HOPE Plan out-of-pocket expenses (annual deductible, copayments and contributions) to projected Medigap premiums for Plan H (supplemental coverage with drug coverage), from Table 2. Based on an anticipated increase in Medigap premiums of approximately 5% a year, the average 2003 premium would be around \$208 per month, or an annual cost of \$2,496.

The corresponding annual cost to a HOPE enrollee at the highest cost-sharing category is estimate to be about \$2,344 in 2003, or about \$152 less than the Medigap premiums. Annual costs 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 Medicare HMOs may be lower than the HOPE Plan enrollee costs in 2003, these premiums are for plan designs that have more restrictive prescription drug coverage, and that are without any safety net for catastrophic drug expenses. The HOPE Plan provides comprehensive prescription drug coverage for a vast number of seniors, with contributions and cost-sharing provisions that are affordable to enrollees.

XI. The HOPE Plan: Funding

While we believe that the very small additional costs associated with the proposed HOPE Plan are a small price to pay in return for a significant increase in the number of seniors who could be enrolled, we recognize the need not to increase costs over the current programs. To satisfy this need, we devised an alternative that would replace PACE and PACENET, and would be less expensive than the proposed HOPE Plan. This alternative would offer all seniors the proposed HOPE Plan design in 2003 without grandfathering any existing PACE enrollees. As shown in Table 9 (Column 3), total program costs for 2003 are estimated to be about \$10 million less than the projected PACE and PACENET programs. This saving is achieved by implementing the HOPE design, which includes additional cost-savings features and higher copayments, compared to the PACE design. Although cost-sharing for enrollees would be somewhat higher, it is estimated that this alternative would still enroll over 400,000 seniors in Pennsylvania.

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, the ability to use existing cost savings strategies that are already part of the PACE 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 may be necessary to periodically adjust the benefit design, contributions, pharmacy benefit management techniques, and other aspects of the plan.

XII. 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 copayments – specific drugs are covered at some level by the plan. (see also Out-of-pocket limit)
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 through an employer-sponsored program. The coordination of benefits agreement states 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 and may be a factor of flat dollar or percentage payments.
6. **Deductible:** The amount that an individual pays under the plan each benefit year, in addition to 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 medication 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.

Closed formulary – medications deemed as non-formulary are not included as a covered benefit.

XII. Glossary of Terms

- Incentive or “tiered” formulary – patient cost share is less for formulary medication: and can be tiered based on the type of drug, i.e., generic, brand, and/or preferred. Non-formulary 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 more contribution for a benefit than individuals with lower incomes.
 11. **Maintenance Drug:** A drug that is taken for a chronic condition, consecutively, for a long period of time, generally longer than three to six months.
 12. **Mandatory Generic:** A plan design provision that incorporates a cost differential when a generic drug is available and 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 coinsurance amounts not covered by Medicare.
 15. **Out-of-pocket limit:** The total dollar amount, a combination of copayments and deductible, that an individual pays of their own money. 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 on the drug formulary.
 18. **Premiums:** Fees, usually paid monthly, for insurance coverage.

XIII. 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 HOPE Plan includes an open enrollment period which allows individuals to decide whether they will join, based on their prescription drug needs. This option to enroll or not, 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 two years following the initial year, individuals will be allowed to enroll within six months of reaching age 65. Contributions, where applicable, and benefits, will begin on the first of the month following the date a person reaches age 65. 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 25.4%. The 25.4% discount factor is a combination of usual and customary pricing, discounted average wholesale price (AWP) and the maximum allowable cost (MAC), for generic and brand drugs.
- Formulary rebates under the proposed incentive-based formulary were assumed to reduce the prescription drug ingredient cost by 4%. The design of the formulary with respect to the drugs selected for preferred status could significantly alter this estimated cost reduction.
- An 8% 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).
- Assuming that pharmacy benefits under an individual's other coverage are coordinated with HOPE Plan benefits, the estimated recoveries are approximately 1.4% 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 1.4% recovery is net of the cost of administrative and legal fees associated with recovery.
- The annual cost and utilization trend applied to arrive at year 2004 ingredient costs is about 19%. An annual trend of about 18.5% was applied to project year 2005 ingredient

XIII. Appendix: Assumptions

costs. These annual trends are applied to adjust the copayments and annual deductibles for 2004 and 2005, and will be used to adjust the out-of-pocket limit once the program is operational.

- A 19% trend was applied to the PACE claim costs to project 2003 claim experience. An annual trend of 19% was also applied to project claim costs for 2004 and 2005. Rebates, ingredient costs, administrative expenses, and other cost items were projected from data published in the *Annual Report to the Pennsylvania General Assembly*
- The dispensing fee applied per prescription is \$2.55.
- The annual expense for pharmacy management and claim administration is \$60 per enrollee. This includes administrative expense from the PBM in addition to resources dedicated to the program from the Commonwealth.
- The annual expenses for other administration functions (such as membership, income testing, billing, collections, financial reporting, and auditing) is \$91.11 per enrollee.
- An annual advertising expense of \$15 per enrollee has been included in the first year projection. This expense is reduced to \$5 per enrollee for the two following years.
- The estimates for prescription drug discounts, rebates, dispensing fees, and administrative expenses applied in the projections, are based on data observed from large Mercer clients and various industry studies. The staff currently employed by the Commonwealth could perform some of these administrative activities. To the extent that this is done, there may be a rationale for reducing the administrative cost estimates applied in the financial projections for HOPE.
- Monthly contributions for HOPE for the year 2003 range from \$0 for those with low incomes to \$121 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 with comprehensive prescription drug coverage available in Pennsylvania.

Exhibit A

HOPE Plan Exhibit A Premiums, Deductibles and Out-of-pocket Limits

Annual Income Range	Annual Deductible		Annual OPL	Enrollment			Annual Funding Rates			Percent Contribution	Monthly Premium Payment				
	Single	Married		2002	2003	2004	2002	2003	2004		2002	2003	2004		
\$ -	\$ 4,999	\$ -	\$ 6,100	\$ -	\$ 1,000	20,553	17,510	14,689	\$ 1,892.40	\$ 2,181.43	\$ 2,515.29	0%	\$0	\$0	\$0
\$ 5,000	\$ 8,499	\$ 6,100	\$ 10,400	\$ -	\$ 1,000	56,358	50,318	43,900	\$ 1,892.40	\$ 2,181.43	\$ 2,515.29	0%	\$0	\$0	\$0
\$ 8,500	\$ 9,999	\$ 10,400	\$ 12,300	\$ -	\$ 1,000	56,366	49,095	42,005	\$ 1,892.40	\$ 2,181.43	\$ 2,515.29	0%	\$0	\$0	\$0
\$ 10,000	\$ 12,749	\$ 12,300	\$ 15,700	\$ -	\$ 1,000	63,687	56,786	49,565	\$ 1,892.40	\$ 2,181.43	\$ 2,515.29	0%	\$0	\$0	\$0
\$ 12,750	\$ 13,999	\$ 15,700	\$ 17,200	\$ -	\$ 1,000	13,703	11,468	9,464	\$ 1,892.40	\$ 2,181.43	\$ 2,515.29	0%	\$0	\$0	\$0
\$ 14,000	\$ 17,199	\$ 17,200	\$ 21,100	\$ -	\$ 1,000	35,686	39,050	42,414	\$ 1,603.02	\$ 1,840.31	\$ 2,119.22	26%	\$35	\$40	\$46
\$ 17,200	\$ 19,999	\$ 21,100	\$ 24,600	\$ 150	\$ 2,000	17,609	20,390	23,838	\$ 1,603.02	\$ 1,840.31	\$ 2,119.22	65%	\$87	\$100	\$115
\$ 20,000	\$ 24,999	\$ 24,600	\$ 30,700	\$ 200	\$ 2,000	18,790	23,288	28,576	\$ 1,570.81	\$ 1,803.57	\$ 2,076.55	75%	\$98	\$113	\$130
\$ 25,000	\$ 29,999	\$ 30,700	\$ 36,900	\$ 200	\$ 2,000	18,790	21,808	25,540	\$ 1,570.81	\$ 1,803.57	\$ 2,076.55	85%	\$111	\$128	\$147
\$ 30,000	\$ 34,999	\$ 36,900	\$ 43,000	\$ 250	\$ 3,000	18,686	23,164	28,427	\$ 1,518.51	\$ 1,740.97	\$ 2,004.29	89%	\$113	\$129	\$149
\$ 35,000	\$ 39,999	\$ 43,000	\$ 49,100	\$ 350	\$ 3,000	15,555	17,926	20,881	\$ 1,463.35	\$ 1,675.95	\$ 1,928.21	102%	\$121	\$141	\$162
\$ 40,000	\$ 44,999	\$ 49,100	\$ 55,300	\$ 500	\$ 3,000	12,527	15,773	19,558	\$ 1,363.26	\$ 1,588.59	\$ 1,827.23	106%	\$121	\$141	\$162
\$ 45,000	\$ 49,999	\$ 55,300	\$ 61,400	\$ 500	\$ 3,000	12,542	14,310	16,542	\$ 1,363.26	\$ 1,588.59	\$ 1,827.23	106%	\$121	\$141	\$162
\$ 50,000	\$ 54,999	\$ 61,400	\$ 67,600	\$ 500	\$ 4,000	12,877	16,193	20,062	\$ 1,363.26	\$ 1,588.59	\$ 1,827.23	106%	\$121	\$141	\$162
\$ 55,000	\$ 59,999	\$ 67,600	\$ 73,700	\$ 500	\$ 4,000	9,395	10,534	12,011	\$ 1,363.26	\$ 1,588.59	\$ 1,827.23	106%	\$121	\$141	\$162
\$ 60,000	\$ 64,999	\$ 73,700	\$ 79,900	\$ 500	\$ 4,000	9,395	12,014	15,047	\$ 1,363.26	\$ 1,588.59	\$ 1,827.23	106%	\$121	\$141	\$162
\$ 65,000	\$ 69,999	\$ 79,900	\$ 86,000	\$ 500	\$ 4,000	9,296	10,415	11,868	\$ 1,363.26	\$ 1,588.59	\$ 1,827.23	106%	\$121	\$141	\$162
\$ 70,000	\$ 74,999	\$ 86,000	\$ 92,100	\$ 500	\$ 4,000	6,415	8,438	10,756	\$ 1,363.26	\$ 1,588.59	\$ 1,827.23	106%	\$121	\$141	\$162
\$ 75,000	\$ 79,999	\$ 92,100	\$ 98,300	\$ 500	\$ 4,000	6,263	6,775	7,500	\$ 1,363.26	\$ 1,588.59	\$ 1,827.23	106%	\$121	\$141	\$162
\$ 80,000	\$ 84,999	\$ 98,300	\$ 104,400	\$ 500	\$ 4,000	6,263	8,256	10,537	\$ 1,363.26	\$ 1,588.59	\$ 1,827.23	106%	\$121	\$141	\$162
\$ 85,000	\$ 89,999	\$ 104,400	\$ 110,600	\$ 500	\$ 4,000	6,263	6,775	7,500	\$ 1,363.26	\$ 1,588.59	\$ 1,827.23	106%	\$121	\$141	\$162
\$ 90,000	\$ 94,999	\$ 110,600	\$ 116,700	\$ 500	\$ 4,000	6,263	8,256	10,537	\$ 1,363.26	\$ 1,588.59	\$ 1,827.23	106%	\$121	\$141	\$162
\$ 95,000	\$ 99,999	\$ 116,700	\$ 122,900	\$ 500	\$ 4,000	6,288	6,805	7,536	\$ 1,363.26	\$ 1,588.59	\$ 1,827.23	106%	\$121	\$141	\$162
\$ 100,000	Plus	\$ 122,900	Plus	\$ 500	\$ 4,000	6,783	8,880	11,286	\$ 1,363.26	\$ 1,588.59	\$ 1,827.23	106%	\$121	\$141	\$162

Endnotes

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- 1 Health Care Financing Administration
 - 2 Joint Committee on Printing, Henry John Heinz III, Late A Senator from Pennsylvania, Memorial Addresses Delivered in Congress, 102nd Congress (1994), pp. 88-89, (floor statement by United States Senator Tim Wirth (D-Colorado) on October 23, 1991, which would have been Senator Heinz's 53rd birthday).
 - 3 M. Davis, et al., "Prescription Drug Coverage, Utilization and Spending Among Medicare Beneficiaries," Health Affairs, Vol. 18, No. 1 (Jan. – Feb. 1999), p 237.
 - 4 The U.S. Bureau of Census
 - 5 Davis, et al, Prescription Drug Coverage, Utilization and Spending Among Medicare Beneficiaries, Health Affairs (Jan/Feb 1999); Mercer experience
 - 6 MSNBC news, citing AARP study
 - 7 AARP, A Profile of Older Americans (1999)
 - 8 www.palottery.com