PRESCRIPTION DRUG ISSUES: OVERVIEW REPORT

An Examination of Access to Prescription Drugs
By The Low and Moderate Income Residents
In A Tri-County Service Area
On The Connecticut and New York State Border

The Foundation for Community Health

Prepared By
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EXECUTIVE SUMMARY

Scope. This Overview Report summarizes information in two earlier Foundation for Community Health (FCH) publications: "*Assessment Of The Pharmaceutical Cost Assistance Project*" by Hanna K. Grossman and "*Prescription Drug Finances*" by David A. Grossman. The full reports can be accessed on the FCH website. http://www.fchealth.org/.

Sources. The reports were largely based on material from Federal agencies, from State agencies in Connecticut and New York and from the Commonwealth Fund and the Kaiser Family Foundation websites. The assessment of FCH's pilot effort to provide financial aid for prescription drugs to needy individuals and families was based on data measuring how the pilot program actually operated.

The People Served. The FCH Service Area is a 17-town, tri-county region on both sides of the Connecticut-New York border. It has 52,500 residents in 20,750 households. FCH has set its target population are those with three times the basic Federal Poverty Line (3FPL). For a typical household (with 2.5 persons), this meant household incomes below $45,000 in 2006. Some 7,000 households, with a total of 17,500 persons, have incomes below 3FPL.

The FCH Pilot Project. In mid-2004, FCH began a project to help low and moderate-income families buy needed pharmaceutical products. The medical conditions for which clients sought help were almost entirely chronic. These diagnoses accounted for the bulk of prescriptions: hypertension, psychiatric conditions, diabetes, elevated cholesterol, asthma and osteoporosis. See the full *"Pharmaceutical Assistance Project"* report for detailed information on how the pilot project was carried out and who it served.

The Prescription Drug Programs. The report "*Prescription Drug Finances*" examines Federal, State and private programs that help finance the cost of prescription drugs for people of low or moderate income in the FCH Service Area. These include:

1. Medicare Part D, which went into effect at the start of 2006, potentially covering everyone over the age of 65, as well as disabled people below that age. A major exception is that people who have private insurance programs that are "credible equivalents" could opt out.

2. Medicaid, a State-administered, Federally-assisted program of medical and hospital care for low income families and individuals and for residents of nursing homes and other care facilities, pays for prescription drugs for recipients.

3. State prescription drug aid programs for low and moderate income people are offered by both New York and Connecticut. Generally, these State programs are designed to help people with incomes above the Medicaid eligibility level but below 3FPL.

4. Private drug programs aid some low and moderate income people to purchase drugs. Private drug insurance, generally offered through employers, is generally not available to families with incomes below 3FPL. However, pharmaceutical drug manufacturers and distributors do offer free or reduced-cost drugs to selected groups of all income levels.

Recommendations. The two studies presented a number of actions that the authors recommend that FCH consider taking:

• **Continue Pilot Efforts.** Even with its limited resources, FCH can conduct direct service efforts to give its staff and volunteers hands-on knowledge.

• **Plan Better.** Improve data collection by making it more uniform and by relating the individual client's characteristics to the kind and amount of assistance to be provided.

• **Improve Communication.** FCH should convene officials from State agencies, together with local officials and providers (especially pharmacists), to focus on the unique problems of this rural region.

• **Clarify Options.** Many seniors and other low income people find it hard to make sensible selections among drug programs. More and better public information is urgently needed. So is hands-on assistance.

• **Strengthen Local Government.** FCH could help by increasing knowledge of the array of drug-financing options on the part of local officials and pharmacists through publications and training seminars.

• **Apply Leverage.** FCH should focus on how it can use its limited resources to leverage more help on behalf of the at risk population.

• **Close The Gaps.** In future years, it will be important to take further action to close the gaps that still remain in drug aid for the low and moderate income residents of the Foundation for Community Health's Service Area. Providing information of the type presented in this report to policy makers at the state and national levels is one way to move effectively in this direction.

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Prevention, Access, Collaboration

The mission of the Foundation for Community Health (FCH) calls for us to focus on the health needs of people living in the greater Harlem Valley in New York and the northern Litchfield Hills in Connecticut. This Service Area was the primary region served by Sharon Hospital when it was a nonprofit organization.

Prepared for the Foundation by Hanna and David Grossman, this report examines issues involving financial assistance available to low and moderate income residents of the FCH Service Area in obtaining prescription drugs. It also describes and assesses a pilot effort undertaken by FCH to provide direct financial help to Area residents for the purchase of prescription drugs.

This Overview Report is based on more detailed information presented in two earlier FCH publications:

"*Assessment Of The Pharmaceutical Cost Assistance Project*" by Hanna K. Grossman, September 2006, describes FCH's pilot project to provide financial assistance to help in the purchase of prescription drugs by needy individuals and families.

"*Prescription Drug Finances*" by David A. Grossman, November 2006, examines how the Federal, State and private programs of prescription drug assistance apply to low and moderate income households in the tri-county FCH Service Area.

Copies of both of these earlier reports are available on the FCH website. http://www.fchealth.org/ or from the Foundation's office.

John Charde, MD
Chair, Board of Directors
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ABOUT THE AUTHORS

Hanna and David Grossman live in Cornwall, CT. Both are retired. Formerly, Hanna worked as an analyst for the New York City and New York State Departments of Social Services. David was President of The Nova Institute, a nonprofit consulting organization. He is a former budget director of New York City. Their work on this research effort has been as volunteers for the Foundation for Community Health.

The authors want to express their thanks to the Foundation's Advisory Committee for this and the two prior reports: Ella Clark and Dr. Anna Timell, both FCH Board Members, and Nancy Heaton, FCH Executive Director.

SOURCES OF INFORMATION

The information in this report on Federal and State prescription drug aid programs was largely drawn from material provided on the websites of the US Department of Health and Human Services, the New York State Departments of Health and Social Services and the Connecticut Departments of Public Health and Social Services. Officials of State agencies responded to inquiries and reviewed drafts. The websites of the Commonwealth Fund and the Kaiser Family Foundation were very useful sources of relevant information about the rapidly developing Medicare Part D program, as was Stuart Guteman, Senior Program Director of the Commonwealth Fund. Ella Clark, Sharon's Social Service Agent, provided guidance on how State programs actually operate within the tri-state Service Area. The US Census was, as always, a basic reference source for data on Area population numbers and characteristics.

The portions of the report assessing the Foundation for Community Health's experiment in providing financial assistance for prescription drugs to needy individuals and families are based on data measuring how the pilot program actually operated. This data was gathered by local Social Service agents and First Selectmen in the Litchfield County towns in Connecticut and for the New York towns by the Community Action Agencies of Dutchess and Columbia Counties.

ONE: BACKGROUND TO THE REPORT

The Population "At Risk".

The FCH Service Area includes 17 Towns located in a tri-county area on both sides of the Connecticut-New York border. This FCH Service Area, as shown on the accompanying map, includes nine Towns in Litchfield County, CT, six Towns in Dutchess County and two Towns in Columbia County NY. The Service Area's population, as of the 2000 Census, consisted of 52,540 residents, members of 20,747 households. Their median household income in 1999 was $50,800.

Nearly seven percent of all Area households -- about one in every 14 – had incomes below the Federal Poverty Line in 1999. But many more families with incomes well above the poverty line also face serious problems paying for essential prescriptions. In recognition of this fact, FCH has adopted as the definition of its primary target group all households with incomes below *three* times the basic Federal Poverty Line (subsequently abbreviated as 3FPL). This is the eligibility level used in the FCH Pharmaceutical Assistance Project and also as its basic measure of who is "*at risk*" in affording essential pharmaceutical drugs. For the average Service Area household of 2.5 persons, this 3PL standard meant an annual income below $37,400 in 1999, or $44,700 in 2006. An estimated 7,000 Service Area households, containing 17,500 individuals, had incomes below 3FPL in the year 2000. This was one-third of the total Service Area population. These are the people "at risk" whose pharmaceutical drug needs this report addresses.

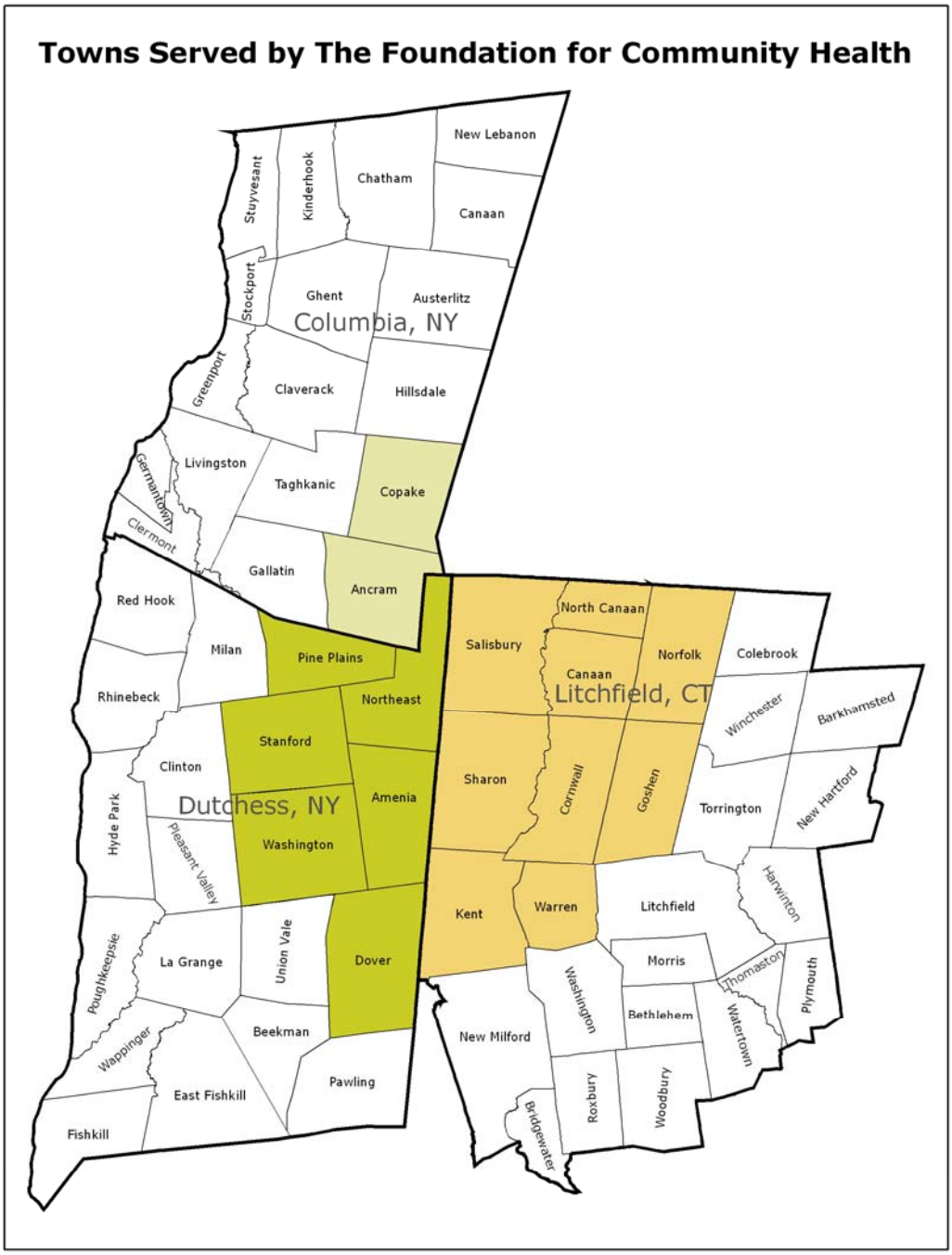
The FCH Pilot Project

In mid-2004, the Foundation for Community Health began a Pharmaceutical Assistance Project to help at least some low and moderate-income families to buy needed pharmaceutical products. A separate publication, "*Assessment Of The Pharmaceutical Cost Assistance Project*" examines the Project based on its operations in calendar 2005, based on data gathered by the local agencies that participated.

The population served by the Project was 60 percent female and 40 percent male; 57 percent of the participants were below 65 and 43 percent were older. Many of those below 65 were disabled. Few clients were regularly employed. Most were over-income and therefore ineligible for Medicaid and, to the extent that they were financially eligible for other public programs, these tended not to meet their pharmaceutical needs because of application timing issues or the cost of premiums and co-pays.

The medical conditions for which clients sought help were almost entirely chronic. The following diagnoses accounted for the bulk of prescriptions: hypertension, psychiatric conditions, diabetes, elevated cholesterol, asthma and osteoporosis. Many clients had more

Towns Served by The Foundation for Community Health



than one condition. Interested persons should see the full Pharmaceutical Assistance Project report for detailed information on how the pilot project was carried out and the characteristics of the people served.

The Prescription Drug Programs

The FCH report "*Prescription Drug Finances*" examines the Federal, State and private programs that help finance the cost of prescription drugs for people of low or moderate income in the FCH Service Area. These include:

- **Medicare Part D**
- **Medicaid**
- **NY and CT drug aid programs**
- **Private drug aid and insurance programs**

Just because they may be potentially eligible for one or more of these categories of aid does not mean that a family or individual will be able to obtain or afford the pharmaceutical products they need. Many programs, both public and private, have burdensome co-pay requirements and nearly every program has "red tape" that can result in individuals failing to obtain help. Data on participation rates suggest that many otherwise eligible people fail to get prescription drug aid.

The final section of this Summary Report cites actions that can help expand the availability of prescription drug aid for the one-third of the Service Area's residents who are clearly in need of such help. It also suggests action that FCH can take to strengthen the ties between town officials, State agencies and private organizations with respect to the provision of prescription drug aid.

TWO: MAJOR DRUG AID PROGRAMS IN THE FCH SERVICE AREA

The major Federal, State and private pharmaceutical programs available to low and moderate income residents in the FCH Service Area are described in the following sections of this report. For more detailed information on these program, see the full FCH "Prescription Drug Finances" report.

MEDICARE PART D

Part D, which first became available to Medicare recipients on January 1, 2006. represents the first time that Medicare has offered coverage for prescription drugs outside of hospital or physician office settings. But instead of the Federal Government offering the program directly, as it does with other Medicare benefits, Part D relies primarily on private providers that compete for enrollees. Under present law, the Federal Government is apparently prohibited from negotiating with providers to obtain lower prices for prescription drugs (as it does on behalf of Federal employees). This matter has been quite controversial.

All Medicare recipients over age 65 are eligible – but are not required -- to enroll in Part D. Enrollees must select one of the many different drug insurance plans offered by private health organizations. The disabled and persons with renal disease are eligible to enroll in Part D at any age. Medicaid recipients over age 65 are *required* to enroll in Part D and are assigned to a private plan by Federal officials. Anyone eligible to enroll in Part D but who already has what is termed "credible equivalent" insurance coverage for pharmaceutical products may choose not to enroll in Part D, and may continue to utilize their own coverage instead.

In the first year of Part D's operation, the "standard" benefit required enrollees to pay the first $250 of their drug costs. Then, Medicare paid 75 percent of the next $2,000 in drug costs. Coverage stops at that point – the start of the gap or "doughnut hole" – by which time the enrollee will have spent $750 out of pocket. After that, the standard benefit provided no further coverage until the enrollee's total drug spending (including the share that Medicare paid of the first $2,250) reaches $5,100. By that time, the enrollee would have spent $3,600 out of pocket. Beyond that point, Medicare pays 95 percent of the enrollee's remaining drug costs. This payment cycle begins again and is repeated every calendar year, although the exact amounts of where each stage begins are likely to be adjusted each year. The Federal Government allows private insurers to introduce variations to these standard payment provisions and they have been changed in most of the private drug plans offered to Part D enrollees. Variations range from those linking drug plans to more comprehensive health insurance plans (the Medicare Advantage option) to "bare bones" drug insurance plans that offer only restricted access to many pharmaceutical products. Also, persons who delayed signing up in Part D's first year had to pay penalties for late enrollment.

Special provision is made under Part D for subsidies for people with very low incomes – in general, those with incomes below $14,700 for an individual or $19,800 for a married couple living together. However, there is also an asset test for these special low income provisions that limits availability of the low income subsidy.

On balance, Part D is a major step forward in providing health benefits. However, it has serious shortcomings:

- First, it covers only persons over 65 and a small number of people below 65 with very serious health problems. Most working age adults and their children with low and moderate incomes and who are in serious need of help in obtaining prescription drugs are not eligible for Part D.

- Second, most people who are eligible for Part D must finance both the required co-pays and all of their drug costs during the "doughnut hole" period out of their own pockets. A Commonwealth Fund study estimated that people eligible for Part D would still have to pay nearly half of all their drug costs themselves.

- Third, for reasons that are hard to explain, Federal data indicate that between 30 and 40 percent of the people eligible for Part D in New York and Connecticut have not enrolled in the program; this excludes people who have "credible" equivalent benefits under other drug insurance programs. A Commonwealth Fund study estimated that more than a third of all Part D enrollees will fall into the "doughnut hole" and that one in every seven will exceed the $5,100 threshold and enter the catastrophic aid category.

- Fourth, for a program designed to help senior citizens, Part D is complex and hard to understand. Among other things, the number of choices available under Part D to the typical senior citizen presents a difficult problem of choice. For example, there are 51 different prescription drug plans available to eligible residents of Litchfield County, and at least as many in Dutchess and Columbia Counties. Many seniors need hard-to-find assistance to understand such a bewildering menu of choices.

Data is not currently available on enrollment in Part D or equivalent drug insurance programs below the county level. The authors estimate that, as of the year 2000, there were 8,200 people aged 65 or over in the Service Area. Together with the disabled persons that are also eligible, there were a total of about 9,650 persons eligible for drug insurance, either under Part D or an equivalent program. Of these, we estimate that there were an estimated 2,800 people aged 65 and over who had incomes below 3FPL, the population group of principal concern to the Foundation.

While it is not known how many of the 2,800 individuals who are most at risk are actually enrolled in Part D, it is still possible to estimate their total out of pocket costs, assuming that all do enroll, based on national and regional patterns and on studies by the Commonwealth Fund. On this basis, we estimate that Service Area residents may incur a

total of as much as $4.7 million of out-of-pocket costs for prescription drugs per year -- in addition to the financial assistance that Medicare Part D provides. Thus, it seems likely that there will remain a substantial need for prescription drug aid, over and beyond the benefits provided by Part D.

MEDICAID

Medicaid is a long-established Federal program that finances remedial, preventive and long-term medical care -- including much of the cost of prescription drugs -- for low income families with children and for aged, blind or disabled individuals. Starting in 2006, however, Medicaid recipients over 65 and those who were disabled were required to utilize Medicare Part D to obtain their prescription drugs.

State agencies administer the Medicaid program and generally receive 50 percent of the program's cost from the Federal Government. The remainder comes from State budgets.

Individuals may meet Medicaid eligibility requirements in a number of ways:

- **In Connecticut**, the Department of Social Services operates the Medicaid program. To be eligible, single individuals must have incomes below $9,600 a year or $12,840 for a couple; as of 2006, these figures were close to 1FPL. Children or pregnant women whose family income is less than 185% of 1FPL are also eligible.

- **In New York**, the Medicaid program is operated by the Department of Health. Single individuals must have incomes below $8,300 a year and couples must have incomes under $10,800. As in Connecticut, the income limits are higher for pregnant women and for women with children and for persons on SSI.

Data on Medicaid recipients is available by town in Connecticut but not in New York. As of 2005, there were 1,500 Medicaid recipients in the CT part of the Service Area, about one-third more than the number of persons below 1FPL. In New York State, Medicaid enrollment data is available only by counties.

STATE DRUG AID PROGRAMS

Both Connecticut and New York State offer programs designed to provide financial assistance in obtaining prescription drugs to low and moderate income families and individuals. Generally, these State programs are designed to assist individuals and families with incomes above the Medicaid eligibility level, or 1 FPL. The State programs are briefly described below, together with data on the number of enrollees in each program in Service Area towns -- where such data is available.

Connecticut Programs

ConnPACE. Connecticut's Department of Social Services (DSS) has operated a pharmaceutical assistance program known as ConnPACE since 1986 to assist low and moderate income elderly residents with their prescription drug expenses. Since the start of Medicare Part D, ConnPACE has been largely merged into that program.

HUSKY. The CT Department of Social Services provides free or low-cost health care, including drug coverage for children and teens without health insurance, under a set of programs known as HUSKY. Services for children whose families are enrolled in Medicaid are served under HUSKY A. Health services for children in higher-income families are provided under HUSKY B. A third option, HUSKY Plus, is for children who have intensive physical or behavioral health needs. HUSKY is funded by the State and Federal governments.

SAGA (State-Administered General Assistance) is the CT DSS program of medical and pharmaceutical assistance primarily to individuals unable to work for medical or other prescribed reasons. Employable individuals are not eligible for SAGA cash assistance. There are also income and asset limits for eligibility, as well as a citizenship requirement. Most Service Area towns have fewer than ten SAGA recipients. Sharon has more than 60 due to the location there of a facility for individuals recovering from addiction or alcoholism.

Based on data provided by State agencies, it appears that most of the children and youth in the CT portion of the Service Area who are likely to be eligible for HUSKY A have been enrolled. No data is available to gauge the extent to which SAGA meets the needs in the Service Area.

New York State Programs

EPIC. The Elderly Pharmaceutical Insurance Coverage program is a New York State prescription cost-sharing plan for senior citizens who need help paying for their prescriptions. It is administered by the NYS Department of Health. New York residents can join EPIC if they are 65 or older and have annual incomes under $35,000 if single or $50,000 if married. As of 2006, EPIC's upper income limits are slightly higher than the 3FPL limit of concern to the Foundation. EPIC enrollees are encouraged to join the Medicare Part D prescription drug plan. In addition, EPIC can cover drug-related costs not covered by Medicare, such as deductibles, co-payments, coinsurance, non-covered drugs, or any gap in coverage. No data is available on past EPIC enrollment below the county level. EPIC is being phased into Medicare Part D and future information is likely to come from that program.

Child Health Plus. The NYS Department of Health also offers health insurance programs that assist in the purchase of prescription drugs as well as in the financing of other health services for children and youth. Depending on family income, a child may be eligible to join either Child Health Plus A (formerly called Children's Medicaid) or Child Health Plus B. The two plans vary primarily in terms of family income. For the most part, eligibility for either plan is limited to families with income of about $25,000 for a family of 2.5 members, well above the Medicaid eligibility level in New York. Child Health Plus covers the cost of both prescription and non-prescription drugs if ordered by a physician. The program requires enrollees to pay certain premiums but there are no co-payments.

Family Health Plus is an insurance program for adults between the ages of 19 and 64 who do not have health insurance on their own or through their employer, but whose incomes are too high to qualify for Medicaid. Family Health Plus provides comprehensive health care coverage as well as prescription drugs. Health care is provided through participating managed care plans. There are a number of qualified providers in or near the Service Area, including Hudson River HealthCare which has offices in Amenia, Dover Plains and Pine Plains in the Service Area.

PRIVATE DRUG AID PROGRAMS

In addition to these Federal and State programs, residents of the Service Area can receive help in obtaining prescription drugs from a number of other sources. These include private health and drug insurance, programs offered by nonprofit associations and free or reduced-price drugs offered by pharmaceutical manufacturers and distributors.

Private Drug Insurance. In the nation as a whole, a substantial fraction of the Medicare-eligible population over 65 years of age has private health insurance derived from current or prior employment. In many cases, this insurance includes prescription drug coverage that is considered "equivalent" to that available under Medicare Part D. People with private drug coverage are encouraged by Medicare policy to continue to utilize their prior coverage, rather than Part D, with the option of enrolling in Part D if their private coverage stops. In the FCH Service Area, the largest organizations that offer "equivalent" drug coverage are the Empire and Anthem Blue Cross and Blue Shield:

- Empire Blue Cross Blue Shield serves more than five million members in the states of New York and Connecticut. Its health and drug insurance is accepted by more than 82,000 providers and 147 hospitals in the NY-CT-NJ area.

- Anthem Blue Cross Blue Shield is a subsidiary of the WellPoint Corporation. It provides many people in Connecticut with group and individual health, disability and drug insurance coverage.

Neither Empire nor Anthem was willing to provide information for this study on the number of persons in the Service Area covered by their prescription drug insurance programs.

Nonprofit Organizations. A number of nonprofit organizations have been active in seeking to help meet the pharmaceutical needs of low and moderate income families in the Service Area. For example, in addition to participation in the FCH Pharmaceutical Assistance Project, the Eastern Dutchess Rural Health Network has undertaken and stimulated other activities in the communities along Route 22 in New York. The Network utilized its own funds to participate in the FCH Project.

Drug Manufacturers And Providers. Free or reduced-cost pharmaceutical drugs have been made available to Service Area residents by pharmaceutical manufacturers and drug research organizations. Application for such assistance can be made either directly to the manufacturer or through a national organization, the Pharmaceutical Research and Manufacturers of America (PhRMA) which operates the Partnership for Pharmaceutical Assistance. Generally, assistance is limited to persons who have incomes below 2FPL. With the start of Medicare Part D at the beginning of 2006, there appears to be some indication that these free drug programs being cut back. No information is available on the extent to which free or reduced-price drug programs are currently being utilized by residents of the Study Area; however, use of free private drug assistance was cited by several of the participants in the FCH Pharmaceutical Assistance Project.

THREE: RECOMMENDATIONS

Recommendations Based On The FCH Pilot Project

The following recommendations address experience with the FCH Pharmaceutical Assistance Project. Based on that, we recommend:

- **Continue Pilot Efforts.** Even with limited resources, the Foundation can still conduct direct service efforts. The value of such efforts is that they give FCH staff and volunteers hands-on knowledge of the issues facing real people, as well as a solid basis for gathering vital statistics.

- **Plan Better.** As it continues its Pharmaceutical Assistance Project, FCH should: (1) improve data collection to relate the individual client's characteristics to the kind and amount of assistance needed; (2) collect income and insurance data more uniformly; (3) recruit eligible clients more actively; and (4) ensure that prescriptions for chronic conditions are for longer than 30 days and also rely more on generic drugs.

- **Improve Communication.** Comments from participants in the Pharmaceutical Assistance Project suggest that it would be useful for FCH to convene officials from State agencies together with regional social service agents and providers (such as pharmacists) to talk through the unique problems of this essentially rural Service Area.

Recommendations Based On The Prescription Drug Aid Review

The following recommendations are based on our examination of Federal, State and private drug aid programs and how they relate to the needs of the Service Area population "at risk". We recommend that FCH:

- **Clarify The Options.** Faced with a maze of options when they need to make a choice under Medicare Part D, senior citizens find it hard to make sensible selections – and in some cases, to make any decision at all. More and better information, either produced directly by FCH or through cooperative efforts with other organizations, is urgently needed. So is hands-on assistance whenever possible.

- **Strengthen Local Government Capacity.** Many people seeking help in obtaining pharmaceutical products turn first to their local public officials or to their pharmacists. The Foundation could play a useful role by increasing knowledge of the

array of drug-financing options on the part of local officials and pharmacists through publications and training seminars.

• **Apply Leverage.** FCH has only modest financial means compared to the magnitude of the drug needs of the Area's low and moderate income residents. FCH should focus on deciding how it can use its limited resources to leverage more help on behalf of the at risk population.

Participation In
State Policy-Making

Even since the publication of the two reports on which this Summary is based, active efforts have developed in both Connecticut and New York to try to address the health needs of the uninsured segments of their populations. For example, in Connecticut, both the Legislature and the Governor have currently developed different plans to address this goal. We believe that FCH is uniquely positioned to present the viewpoint of its rural and small town region to policy-makers in the State Capitals.

It seems clear that the needs of the Service Area, with its modest population and only a few – albeit very capable – State legislators, can have only a very modest impact on the discussions in Hartford and Albany. Nevertheless, we believe that this region's voice should also be heard with regard to critical health issues. We recommend that attention be paid to the following:

• **Close Gaps.** Despite the major move forward that took place with the creation of Medicare Part D by the Federal Government, the drug needs of substantial groups within the Service Area's at risk population – especially children, youth and working-age adults under age 65 -- are still very severe. Many of them are uninsured and unable to afford the drugs they need. Action to close these serious gaps in the health system are urgently needed.