PRESCRIPTION DRUG FINANCES

Financial Aid Available
For Prescription Drugs
To The "At Risk" Population In
The Foundation for Community Health's
Tri-County Service Area
In Connecticut and New York

Prepared For
The Foundation for Community Health, Inc.
By
David A. Grossman

November 2006

EXECUTIVE SUMMARY OF THE REPORT

Scope of the Report. The Foundation for Community Health is concerned with the health needs of the residents of a tri-county region on the Connecticut-New York border. The Foundation's Service Area includes 17 towns, nine of them in Litchfield County, CT, two in Columbia County, NY, and six in Dutchess County, NY. This report focuses on the programs available to help finance the prescription drugs needed by the low and moderate income residents of the Service Area.

The "At Risk" Population. The Service Area contains a total of 52,540 residents living in 20,747 households. Their median household income was $50,800 in 1999. Nearly seven percent of all Area households -- about one in every 14 -- fell below the Federal Poverty Line that year.

The Foundation for Community Health adopted a standard of three times the basic Federal Poverty Line (abbreviated in this report as "3FPL) as the eligibility level for the Pharmaceutical Assistance Project that it started in 2004. The Foundation's Advisory Committee for this study decided that 3FPL should also be used as the basic measure of the "at risk" population in the Service Area. For a typical household of 2.5 persons, this was an annual income of $37,400 or less in 1999, or about $44,700 currently. Some 7,000 Service Area households, with a total of 17,500 members, have incomes below 3FPL. The prescription drug programs examined in this report are those designed to provide aid to this group.

The Prescription Drug Programs. This report examines the array of Federal, State and private programs that help finance the cost of prescription drugs for people of low or moderate income. These include:

1. Medicare Part D, which went into effect at the start of 2006, potentially covers 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" can opt out.
Part D is a major advance in making access to drugs financially accessible to senior citizens. However, it contains limitations that still leave most people above the age of 65 responsible for a substantial portion of their drug costs. This is partly due to its co-pay requirements and also because of the much-publicized "doughnut hole" that means there is no financial aid for an individual's drug costs once they exceed $2,500 and until they are more than $5,000 in any year. Part D operates through private organizations that offer a wide variety of options – so many that many seniors have found it hard to decide which best meets their needs.

2. Medicaid is 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. It also pays for most prescription drugs for recipients. Medicaid enrollees who are over the age of 65 are required to utilize Medicare Part D. They get more

favorable co-pay and other provisions than other Part D enrollees. Enrollees under age 65 get coverage for the cost of drugs directly from Medicaid.

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. They include ConnPACE, HUSKY A and B and SAGA in Connecticut and EPIC, Child Health Plus and Family Health Plus in New York. Each of these programs has its own eligibility and financing standards.

4. Private programs aid some low and moderate income people to purchase drugs. Private drug insurance, which is generally offered through employers, is available primarily to families with incomes above 3FPL. However, pharmaceutical drug manufacturers and distributors do offer free or reduced-cost drugs to selected groups of people of all income levels.

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 and afford the pharmaceutical products they need. Many programs have co-pay requirements that can be burdensome, and each program has various forms of "red tape" that can result in individuals failing to obtain help.

Recommendations: In the course of the study, a number of actions were identified that the Foundation should consider:

• **Clarify The Options.** Faced with a maze of options, especially when faced with the need to make a choice under Medicare Part D, many senior citizens find it hard to make a sensible selection. It would be useful for the Foundation to produce a pamphlet offering a simplified explanation to help mitigate such difficulties.

• **Increase Communication.** Comments from participants in the Foundation's on-going Pharmaceutical Assistance Project suggest that it would be useful for the Foundation to convene officials from the major State drug financing agencies and local service officials and providers to talk through problems in obtaining aid and related drug policy issues.

• **Strengthen Local Government Capacity.** Many people seeking help in obtaining pharmaceutical products turn first to their local public officials. The Foundation could play a useful role by increasing knowledge about the array of drug-financing options on the part of local officials through publications, training seminars, or one-on-one consultations.

• **Focus On Using Leverage.** The Foundation has only modest financial means compared to the magnitude of the drug needs of the Area's low and moderate income residents. At best, the Foundation can hope to meet only a very small fraction of the uncovered cost of the drugs that people are unable to afford. The Foundation should focus on how it can use its resources to leverage more help on behalf of the at risk population.

• **Plan Projects Better.** Even with its limited resources, the Foundation can conduct direct service efforts. It would be most useful, however, if these efforts were carried out on the basis of a design prepared in advance to generate useful data and understanding. The Pharmaceutical Assistance Project generated a limited amount of data, but if it is to continue it should be more clearly designed to measure its results.

• **Unmet Needs Remain.** Despite the major move forward made with the initiation of Medicare Part D by the Federal Government, the drug needs of substantial groups within the Service Area's at risk population – especially those under age 65 -- are still uncovered. Many children, youth and working-age adults receive little or no such aid.

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'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.

TABLE OF CONTENTS

LIST OF MAPS, TABLES AND CHARTS

ONE: SCOPE OF THE REPORT

The Foundation for Community Health is concerned with the needs of people living in a tri-county Service Area located on the border of the states of Connecticut and New York. This Area is the same primary region that was served by Sharon Hospital when it was still a nonprofit institution. As shown on the accompanying map, the Area includes 17 towns: nine in Litchfield County, CT, two in Columbia County, NY, and six in Dutchess County, NY.

This report addresses one of the Foundation's principal priorities: improving access to pharmaceutical drugs by the Area's low and moderate income residents. The study has three parts:

- This introductory identifies the numbers and characteristics of the Area's low and moderate income residents, people who are principally "at risk" in terms of their access to drugs for their health needs.

- The next part describes the Federal, State and private programs that provide financial assistance to help the Service Area's at risk population obtain drugs and pharmaceutical products. An effort is made – subject to the limitations of data available – to estimate the extent to which these public and private assistance programs meet the essential prescription drug needs of the Service Area's residents who are most at risk.

- The final part recommends steps the Foundation should consider to improve access to pharmaceutical products by the Service Area's at risk population.

Defining The "At Risk" Population

The Federal Poverty Level (FPL) was initially set about 50 years ago, based on three times the cost of basic food needs. Since then, it has been revised only for inflation. It does not take any account of many changes in living patterns since then, including substantial increases in the relative cost of the non-food components of household budgets, nor does it give any consideration to the higher cost of housing and energy in the Northeast states. As a result, the FPL has been widely criticized as being much too low to be a realistic measure of need. Therefore, an analysis was done for this report to estimate how many households and individuals would be included if a decision were made to use a multiple of three times the basic FPL (3FPL), a measure that is more realistic in terms of defining who is likely to need financial help to afford essential pharmaceutical products.

The detailed basis of this analysis is described in Appendix A. In summary, what is shown in the Appendix is that an estimated 7,000 households in the Area, containing a total of about 17,500 individuals, have annual incomes below 3FPL. These "at risk" households include about one in every three households in the Service Area and a similar proportion of its total population.
As of 1999, when the US Census last tabulated data on household incomes, the 3FPL income level for a household of 2.5 members would have been about $37,400.

Converted to 2006 figures to take into account changes such as inflation, the current annual income limit for the average 3FPL household would be about $44,700. Here are the upper limits for three times the Federal Poverty Line in terms of annual income for families of various sizes as of 1999 and 2006:

Household Size	1999	2006
One	24,720	29,400
Two	33,180	39,600
Three	41,640	49,800
Four	50,100	60,000
Five	57,750	70,200

Given the cost of living in Northwest Connecticut and the nearby region of New York State, families with incomes below 3FPL clearly face serious difficulties in affording their essential prescription drugs as well as paying for housing, transportation and medical care.

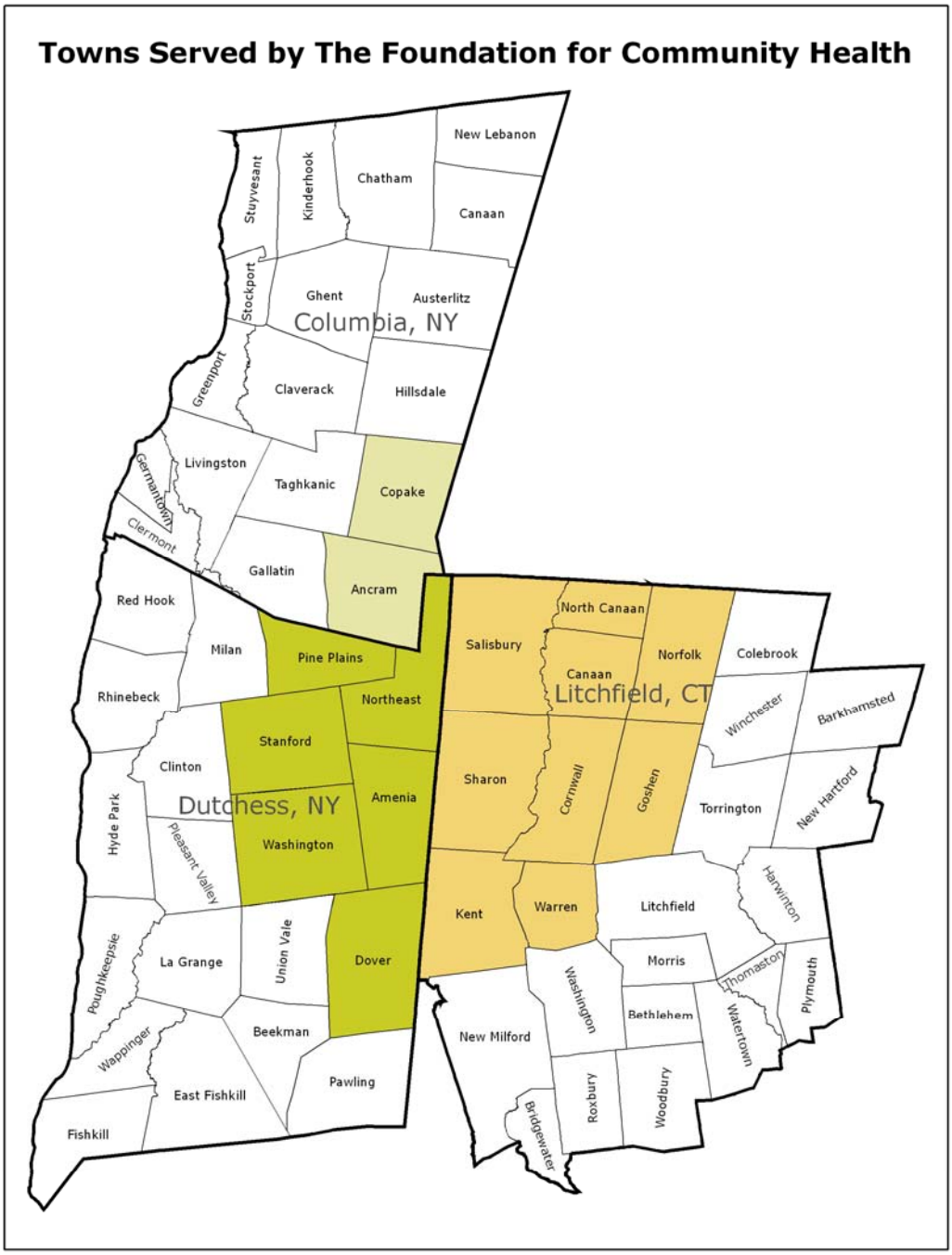
Sources and Acknowledgements

Much of the information in this report has been 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 the State agencies also responded to inquiries and reviewed drafts of portions of the report. The websites of the Commonwealth Fund and the Kaiser Family Foundation were also useful sources of information. Stuart Guteman, Senior Program Director of the Commonwealth Fund was especially helpful in providing information about the rapidly developing Medicare Part D. Ella Clark, Sharon's Social Service Agent, was always ready to provide guidance on how State programs actually operated within the tri-state Service Area. Hanna Grossman's report assessing the Foundation for Community Health's experiment in providing financial assistance for prescription drugs to needy individuals and families provided relevant current information. The US Census was, as always, a basic reference source for data on Area population numbers and characteristics.

I very much appreciate the information, advice and assistance that I have received from these agencies and individuals. I also want to express my thanks to the Foundation's Advisory Committee for this report, composed of Nancy Heaton, Executive Director, and Ella Clark and Dr. Anna Timell, Foundation Board Members.

David A. Grossman

David A. Grossman lives in Cornwall, CT. He prepared this report as a volunteer for the Foundation for Community Health. Formerly, he was President of The Nova Institute, a nonprofit consulting organization. Prior to that he was for seven years Deputy Director and then Director of the Budget for New York City.


Towns Served by The Foundation for Community Health
New Lebanon
Stuyvesant
Kinderhook
Chatham
Canaan
Stockport
Ghent
Austerlitz
Columbia, NY
Greenport
Claverack
Hillsdale
Livingston
Taghkanic
Copake
Germantown
Clermont
Gallatin
Ancram
Red Hook
Milan
Pine Plains
Rhinebeck
Northeast
Stanford
Clinton
Amenia
Dutchess, NY
Hyde Park
Pleasant Valley
Washington
Poughkeepsie
La Grange
Union Vale
Dover
Wappinger
Beekman
East Fishkill
Pawling
Fishkill
North Canaan
Salisbury
Norfolk
Colebrook
Canaan
Litchfield, CT
Winchester
Barkhamsted
Sharon
Cornwall
Goshen
Torrington
New Hartford
Kent
Warren
Litchfield
Harwinton
Morris
Thomaston
Plymouth
Washington
Bethlehem
Watertown
New Milford
Roxbury
Woodbury
Bridgewater

TWO: THE PRESCRIPTION DRUG AID PROGRAMS

A. **Overview**

A broad array of Federal, State and private programs is available to help finance the cost of needed prescription drugs that the Service Area population is unable to pay for out of its own resources. Each of these programs has its own limits on eligibility for the services it provides, as well as other limitations. Some restrict eligibility by age, others by income and yet others add their own specific definitions of who is eligible. Furthermore, the limits on some programs include restrictions on such matters as the medications that are eligible for aid, the amounts of co-payment required and the time periods during which aid is available. Together, this array of programs and limitations presents a complex and hard to understand picture to a family or individual seeking help. It is hoped that the descriptive material in this report will be of assistance to local officials and agencies in helping needy families and individuals find their way through the maze that has grown up around the various Federal and State aid programs.

This part of the report describes the principal programs of pharmaceutical aid available to residents of the Service Area and also – where data is available -- tries to measure the degree to which Area families and individuals are taking advantage of them. To begin with, it may be useful to see how the major pharmaceutical assistance programs relate to one another and to the age and income patterns of the at risk population. Chart 1 presents a simplified overview of the principal financial assistance programs available to Service Area residents:

• **Age** is shown on the horizontal axis of the chart. A major divide is shown at age 65, the point at which Medicare Part D coverage for drugs begins to be generally available. Another dividing line is shown at age 20, roughly the line between programs serving children and youth and those available to adults.

• **Income** is shown on the vertical axis of the chart. For simplicity, the only income categories shown are for households and individuals below the basic Federal Poverty Level (1FPL) and those below three times that level (3FPL). In recognition of the Foundation's focus on people with incomes below 3FPL, incomes above that level are not shown on the chart, although some programs, such as Medicare Part D and private insurance, also provide substantial amounts of help for persons with incomes above 3FPL.

CHART 1
ELIGIBILITY FOR THE MAJOR
DRUG AID PROGRAMS
IN NEW YORK AND CONNECTICUT

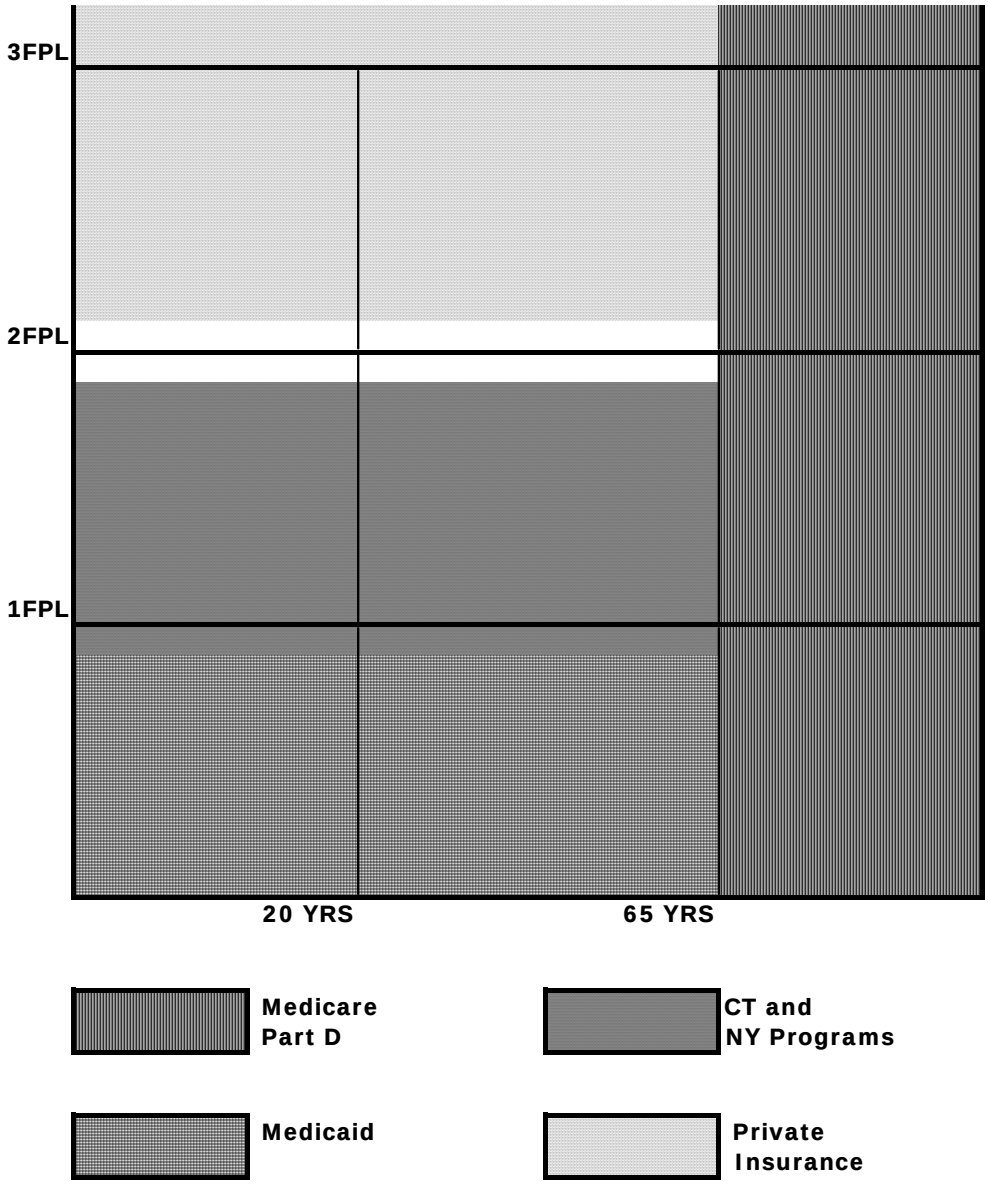


Chart 1 illustrates how the four principal forms of financial aid for drugs generally relate to one another within an overall age and income framework:

• **Medicare Part D**, in effect since the beginning of 2006, potentially covers everyone over 65. A major exception is that people who have private insurance programs that offer "credible equivalents" to Part D are allowed to opt out of coverage. As will be described more fully below, Part D's limits on coverage still leave those above 65 exposed to a substantial portion of their drug costs, partly as a result of its co-pay requirements and also because of the much-publicized "doughnut hole" when there is no coverage. Part D also provides aid to disabled people of all ages.

• **Medicaid** assistance for pharmaceutical products is available to families and individuals of low income (generally, below 1FPL) and to many who live in residential care facilities (and who have "spent down" to achieve eligibility). Medicaid enrollees over age 65 are required to utilize Medicare Part D for their pharmaceutical needs, but they receive much more favorable co-pay and other provisions than those for other Part D enrollees.

• **CT and NY State drug aid programs** are generally intended to help people whose incomes are above the Medicaid eligibility level. These programs include ConnPACE, HUSKY A and B and SAGA in Connecticut and EPIC, Child Health Plus and Family Health Plus in New York.

• **Private insurance programs** also offer aid in the purchase of drugs. The shading on this category is designed to reflect the fact that the availability of private insurance drops off sharply at lower income levels and applies primarily above 3FPL.

It is important to recognize that the potential availability of one or more of these categories of aid does not insure that a family or individual will be able to obtain or afford the pharmaceutical products they need. Each program has co-pay requirements that can be burdensome, each has various forms of "red tape" that often results in individuals failing to obtain aid, and some – especially Medicare Part D – have substantial "holes" in their coverage that are designed to reduce overall program cost to the government. In addition, it is known that some people who are eligible for State or Federal prescription drug aid do not apply for it, either because they are unaware that they are eligible or because they simply decide that the cost or the trouble to apply are just not worth it.

Chart 1 does not show some other features of the principal drug aid programs, such as the eligibility for Part D of disabled people and sufferers from renal disease, as well as the exclusion of people who have private insurance that is considered to be the equivalent of Part D. In addition, the chart shows only a rough approximation of the eligibility features of state programs, such as ConnPACE and EPIC.

The chart also does not include data on a number of other pharmaceutical aid programs, in part because most of them are available to many fewer people than are the major programs and also because some of them are hard to depict on this chart because they do not define eligibility in terms of age and/or income. These include the free or reduced charge programs offered by private drug companies, the prescription drug assistance programs of charitable organizations, foundations, and those of specialized government agencies such as the Veterans Administration.

B. Medicare Part D

The Federal Medicare Prescription Drug, Improvement, and Modernization Act became law in 2003, adding an important new drug benefit, known as Part D, to Medicare's existing outpatient and hospitalization benefits. Part D first became available to Medicare recipients on January 1, 2006. The descriptive and factual material on Part D in this section was derived largely from the websites of the US Department of Health and Human Services, the Congressional Budget Office, the Kaiser Family Foundation and the Commonwealth Fund. The estimates of how Part D affects the population of the Service Area were prepared by the author.

The Role of Private Providers. Part D 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. The general outlines of the standard drug benefit (described below) are established in the law but providers have the option of modifying it, subject to approval by Medicare, and many modify it considerably. For example, some providers make drugs available at reduced cost during the gap (or doughnut hole), although the monthly fee for such service is higher. Providers can also use cost management tools such as limiting their formularies of drugs as well as imposing prior authorization requirements like those used in some employer-based drug insurance programs. They also can alter the way that periods of coverage apply. By using such techniques, providers may be able to offer more services or lower costs as they compete for clients.

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 and may be changed by the next Congress.

Eligibility. 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 who is 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.

Payment Provisions. Under Medicare's "standard" benefit, enrollees must pay the first $250 of drug costs per year. Then, Medicare pays 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 provides no further coverage until the enrollee's total drug spending (including the share that Medicare pays of the first $2,250) reaches $5,100. By that time, the enrollee will 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. It should be noted that the exact amounts of where each stage begins are likely to be adjusted each year.

The standard payment provisions vary widely in most of the private drug plans offered to Part D enrollees. For example, many plans provide benefits from the start, without requiring the enrollee to pay the initial $250. Most plans require enrollees to pay a monthly fee and many plans require enrollees to continue paying the monthly fee even during the gap or "doughnut hole" period when they receive no benefits. Other plans provide coverage in the gap but charge higher monthly fees.

A Commonwealth Fund–supported study (*Riding the Rollercoaster: The Ups and Downs in Out-of-Pocket Spending Under the Standard Medicare Drug Benefit*, Bruce Stuart and others, *Health Affairs* July/August 2005) estimated that in the first year under the standard drug benefit, 38 percent of enrollees would probably be subject to the "doughnut hole," while 14 percent would pass the higher threshold where Part D pays almost all costs. Over three years, enrollees, on average, were estimated to incur out-of-pocket costs of 44 percent of their total drug spending. Enrollees with higher spending levels could pay as much as 67 percent of total prescription
drug costs out of pocket.

Special provision is made under Part D for subsidies for low income people – 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 prevented most of the people who applied in Part D's first six months from receiving the low income subsidy.

Uncovered Financial Needs. Under the standard benefit, each enrollee eligible for Part D whose annual drug spending is just below the $2,250 level of the doughnut hole will have to spend up to $750 out of pocket. Each enrollee who falls into the hole and just reaches the catastrophic level will have to spend $3,600 out of pocket before reaching the point where 95 percent of drug costs are covered by Medicare. Assuming that projections made in the Commonwealth Fund study cited above apply to the Service Area population, more than a third of all Part D enrollees will fall into the "doughnut hole" and one in seven will exceed the $5,100 threshold and enter the catastrophic aid category.

The Problem Of Choice. In the early stages of its implementation, Part D presented a serious challenge to potential enrollees in understanding the diverse menu of options offered by private providers. In addition, participants had to choose whether to enroll in a plan for drug coverage only and get their other Medicare benefits through the fee-for-service program, or join a Medicare Advantage plan such as an HMO that provides drugs as well as other Medicare services. Despite the efforts made by Medicare officials and providers, in the early months of Part D's operation many people reported experiencing difficulties in choosing among the many options.

The number of choices available under Part D for the typical senior citizen presents a difficult problem of choice for many eligible recipients. For example, for 2007, the Centers for Medicare and Medicaid Services (CMS) website lists 51 different prescription drug plans that are available to eligible residents of Litchfield County (see the Medicare Prescription Drug Plan Finder at www.medicare.gov). The plans rage from a bare minimum $13.40 per month Wellcare Classic plan that provides no coverage in the gap (or "doughnut hole") and has a $265 deductible required before any of the drugs

under the plan's formulary are covered. At the high end of the scale, the Humana Insurance Company offers a plan for $87.40 per month that has no deductible and includes the provision of generic drugs during the gap. The other 49 plans offer different monthly charges, different approaches to the deductible and the gap and different formularies of prescription drugs. In addition, prescription drugs are also available to Litchfield County residents under 16 Medicare Health Plans and 6 Medicare Special Needs Plans. In Dutchess County, 61 different prescription drug plans are offered, plus other more specialized plans. Medicare has done its best to make information on this diverse range of options readily available to an enrollee via the internet, including downloadable pamphlets on the prescription drug plans available in each state. Nevertheless, it seems likely that many seniors will need additional, less computerized assistance in order to be able to understand this bewildering menu of choices.

Current Enrollment In Part D. Table 2 shows data on Part D enrollment for the three counties in which Service Area communities are located, as of mid-June, 2006. No data is available for individual towns in the Service Area and therefore these county-level figures are the best available. Since the communities in the Service Area comprise only about one-tenth of the total population of the three counties, it is not clear to what extent the patterns shown in this and the following tables apply to the Service Area.

The three-county total number of Part D enrollees shown in Table 2 comes to 31,352 persons. The single largest category is that of those enrolled in "stand-alone" drug plans; these 18,824 enrollees use the fee for service program of Medicare for their physician and hospitalization benefits. A smaller number, 1,603 persons, have chosen to enroll in an HMO to receive all of their Medicare benefits. One-third of the enrollees in the tri-county region, the 10,925 Medicaid recipients, were automatically enrolled in Part D, with their drug providers chosen at random among those serving the states of NY and CT. Within the "related programs" group in Table 2, the largest category (25,542 persons) refers to the subsidies being paid to the insurance providers who offer "equivalent" insurance to Medicare recipients who choose not to enroll in Part D. This includes retirees covered by the Empire Plan in NY and Anthem in CT, as well as by other insurers. The last two categories, Federal and military retirees who are receiving equivalent coverage, are modest in size and amount to less than three percent of all persons listed as enrolled in the DHHS report.

Subtracting out the 10,925 Medicaid recipients who were automatically enrolled in Part D leaves a total of 48,615 persons who are receiving all parts of Medicare, including Part A for hospital care and Part B for physician care, as well as Part D. It is interesting to compare this number to the total number of Medicare recipients to see if enrollment in Part D or its equivalent has included all of the eligible people in the tri-county region.

Table 2

ENROLLMENT IN MEDICARE PART D AND RELATED PROGRAMS, JUNE, 2006

	Medicare Part D Enrollment			
County	Stand-Alone Prescription Drug Plans	Medicare Advantage with Prescription Drugs	Medicare-Medicaid (Automatically Enrolled)	Total, Enrolled In Medicare Part D
Litchfield	10,495	346	3,213	14,054
Columbia	1,864	331	1,619	3,814
Dutchess	6,465	926	6,093	13,484
Sub-Total	18,824	1,603	10,925	31,352

	Related Programs			
County	Medicare Retiree Drug Subsidy	Federal Employee Health Benefits	Military Retiree Benefits	Total, Persons Enrolled In Related Programs
Litchfield	7,352	503	442	8,297
Columbia	2,916	179	176	3,271
Dutchess	15,274	788	558	16,620
Sub-Total	25,542	1,470	1,176	28,188

Tri-County Total	44,366	3,073	12,101	59,540

Source: Coverage data from US Department of Health and Human Services.

Table 3 lists the number of people in the tri-county region who were enrolled in Medicare as of mid-2003 by virtue of age or disability. The table shows a total of nearly 83,000 Medicare recipients. This figure is substantially larger than the total of 48,615 persons shown in Table 2 as being covered by Part D or an equivalent program. On this basis, it appears that as of mid-2006 coverage by Part D or an equivalent program was far from having been extended to all of the potential beneficiaries in the tri-county region. Even if the assumption made about the nearly 11,000 Medicaid recipients shown in Table 2 are unwarranted, the number of missing Part D enrollees would still appear to be about 23,000. Clearly, further investigation is warranted beyond the scope of the current study to see if these apparently missing Medicare recipients have other sources of prescription drug coverage than those listed by DHHS.

Table 3

MEDICARE AGED AND DISABLED RECIPIENTS AS OF JULY 1, 2003

County	Aged	Disabled	Total	Medicare Aged as a % of Total
Litchfield	25,936	3,558	29,494	88%
Columbia	9,545	1,727	11,272	85%
Dutchess	34,676	7,407	42,083	82%
Total	70,157	12,692	82,849	85%

Source: DHHS website

Part D Coverage in The Service Area. Data is not available on enrollment in Part D or equivalent drug insurance programs below the county level. However, it is possible to estimate, at least roughly, the number of persons in the Service Area who may be eligible for Part D. Table 4 shows that, as of the year 2000, there were 8,200 people age 65+ in the Service Area. If it is assumed that they represent 85 percent of all potential Medicare recipients in the Area, and adding an additional 15 percent to account for the disabled recipients, it can be estimated that there were a total of about 9,650 Medicare eligibles in the Service Area. Presumably, all were eligible for drug insurance, either under Part D (starting in 2006) or an equivalent program.

Table 4 also shows that there were an estimated 2,800 people aged 65+ who had incomes below 3FPL, the group of principal concern to the Foundation. This group of elderly below 3FPL appears likely to include many of the Service Area population who currently lack any drug insurance, even though they appear eligible to enroll in Part D. It should also be noted that there are many people in the Service Area who have incomes below 3FPL but who may be close to age 65 and are not disabled, but who are not eligible for Part D benefits because of its strict minimum age requirements.

Table 4

ESTIMATE OF MEDICARE ELIGIBLES IN THE SERVICE AREA, 2000

County	Town	(1) Number of Persons Age 65+	(2) Estimated Number of Disabled	Total Medicare Eligibles	(2) **At Risk** (65 And Over, Below 3FPL)
Litchfield	Falls Village	154	27	181	50
	Cornwall	252	44	296	81
	Goshen	410	72	482	90
	Kent	508	89	597	133
	Norfolk	229	40	269	64
	N.Canaan	637	112	749	291
	Salisbury	859	151	1,010	319
	Sharon	622	109	731	205
	Warren	187	33	220	37
Columbia	Ancram	259	46	305	88
	Copake	599	105	704	245
Dutchess	Amenia	694	122	816	304
	Dover (2)	779	137	916	224
	North East	421	74	495	155
	Pine Plains	384	68	452	146
	Stanford	436	77	513	123
	Washington	782	138	920	246
Service Area	Total	8,212	1,445	9,657	**2,802**

Sources: Total population and persons age 65+ from US Census of 2000; estimate of persons age 65+ and also below 3 FPL derived by multiplying percent aged 65+ by number of persons in households with incomes below 3 FPL. Number of disabled persons estimated as 15 percent of total Medicare eligibles.

Uncovered Enrollee Costs. How many of the 2,800 individuals who are most at risk will actually enroll in Part D is not known. However, it is still possible to estimate their total out of pocket costs, assuming that all do enroll.

- First, they appear likely to follow roughly the pattern projected by the Commonwealth Fund study, with 48 percent spending about $500 each but not reaching the "doughnut hole"; 38 percent spending about $3,000 each because they spend most of the way through the hole; and 14 percent spending about $5,000 each because they pass into the "catastrophic" area. In all, the 2,800 enrollees would have estimated annual out of pocket spending of about $4,000,000.

- Based on national and regional patterns, there will be an additional 15 percent of Part D enrollees, or 400 persons, who will be eligible because they are disabled. If they enroll in Part D, these 400 persons together appear likely to incur another $700,000 in out of pocket costs.

This estimate indicates that at risk Service Area residents may incur a total of about $4.7 million of out-of-pocket costs for prescription drugs in addition to the financial assistance provided by Medicare. How much of such expenditures can be borne on their own by

these low income elderly and disabled persons is very difficult to know. It seems likely, however, that there will remain a substantial need for aid over and beyond the benefits provided by Part D to meet the drug needs of the at risk population in the Service Area.

C. Medicaid

Medicaid is a long-established Federal program that finances remedial, preventive and long-term medical care -- including much of the cost of needed medications -- for low income families with children, for aged, blind or disabled individuals and for others with severe financial and health needs. Medicaid is administered by State agencies that generally receive 50 percent of the program's cost from the Federal Government and the remainder from State budgets.

Until January 1, 2006, there were three principal groups who were eligible for Medicaid financing of health care and prescription drugs: (1) those who received Temporary Assistance to Needy Families (TANF) or other forms of Federally-assisted income support such as SSI; (2) aged, blind and disabled persons ineligible for SSI; and (3) persons living in residential care facilities. Starting in 2006, all Medicaid recipients over the age of 65 and the disabled were required to utilize Medicare Part D to obtain aid for drugs. These low income enrollees are not, however, subject to the "doughnut hole" stoppage of support for prescription costs nor to most of the co-pay requirements of Part D. An eligible Medicaid recipient who doesn't apply for Part D on his or her own is automatically enrolled in a randomly selected drug insurance program under Part D by the Federal Government.

Medicaid recipients below the age of 65 continue to be covered for their prescription drug needs as they were before January 1, 2006.

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

- **In Connecticut**, the Medicaid program is operated by the Department of Social Services. 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. In addition, individuals who meet all requirements except the income limits may be eligible if the amount of medical expenses they owe is greater than the amount by which their income exceeds the income standard. 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.

Table 5

MEDICAID RECIPIENTS AND RELATED POVERTY MEASURES IN THE SERVICE AREA, 2000 AND 2005

County	Town	Total Population, 2000	Persons Below 1 FPL, 2000	Medicaid Recipients, 2005	Medicaid Recipients as a % of Population Below 1 FPL (%)
Litchfield	Falls Village (1)	1,081	51	135	265%
	Cornwall	1,434	43	87	202%
	Goshen	2,697	90	131	146%
	Kent	2,858	88	215	244%
	Norfolk	1,660	67	97	145%
	N.Canaan	3,350	187	389	208%
	Salisbury	3,977	297	247	83%
	Sharon	2,968	208	168	81%
	Warren	1,254	42	33	79%
	SubTotal	21,279	1,073	1,502	140%
Columbia	Ancram	1,513	110	119	108%
	Copake	3,278	261	214	82%
Dutchess	Amenia	4,048	326	238	73%
	Dover (2)	8,565	702	521	74%
	North East	3,002	369	339	92%
	Pine Plains	2,569	233	341	146%
	Stanford	3,544	150	190	127%
	Washington	4,742	336	328	98%
	SubTotal	31,261	2,487	2,290	92%
Service Area	Total	52,540	4,633	3,792	82%

Sources: Population, 2000 and persons below 1 FPL from US Census; CT Medicaid recipients, 2005 from CT Dept. of Social Services; Data for Columbia and Dutchess from NYS/ Department of Health. NYS Medicaid data is available for towns only by zip codes. Equivalence by towns was determined as follows: Ancram (12501). Copake (12516), Amenia (12501), Dover (12522), North East (12546), Pine Plains (12567), Stanford (12581) and Washington (12545). Because of the different geographic units used by the two states, data in this table is not fully comparable.

The Connecticut data in Table 5 indicates substantial variability among towns in the relationship between the number of people receiving Medicaid and the number of persons with incomes below 1FPL. Of the nine Connecticut towns, Salisbury, Sharon and Warren had fewer Medicaid recipients in 2005 than they had people below 1FPL in 2000. The other six CT towns had Medicaid enrollment figures at least equal to the number of people below 1FPL, and in four towns, there were more than twice as many.

Information on Medicaid eligibility shown in Table 5 for New York State came from the NYS Department of Health. Medicaid data is only available in NY by zip code, and not by towns. Data on Medicaid recipients by zip code for the New York State portion of the Service Area was allocated to towns in terms of the zip codes whose areas were most similar to town boundaries. In general, towns in the New York portion of the Area had fewer Medicaid recipients than their numbers of people below 1FPL. In Amenia and Dover, the number of recipients was only three-quarters as large as the number below 1FPL. On the other hand, in Ancram, Pine Plains and Stanford, more people were on Medicaid in 2005 than the number of residents below the poverty line. This data suggests that there may be opportunities for more low income people in some of the New York towns to obtain at least the drug aid benefits of Medicaid.

D. 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

Eligibility. Connecticut's Department of Social Services (DSS) has operated a pharmaceutical assistance program known as ConnPACE since 1986. The program assists low and moderate income elderly residents and disabled adult residents with their prescription drug expenses. As of January 2006, the upper limit of eligibility for ConnPACE assistance was $22,300 for an individual or $30,100 for a married couple. These limits are above 1FPL and below 3FPL; thus, ConnPACE is designed to serve the at risk population that is of primary concern to the Foundation. Medicaid recipients are not eligible to enroll in ConnPACE.

Most ConnPACE clients (an estimated 85 percent) are over 65 years of age. The remaining 15 percent are persons with disabilities. Most are eligible for Medicare Part D. DSS has worked closely with the Federal Centers for Medicare and Medicaid Services to ensure that its enrollees apply for Part D benefits.

ConnPACE requires applicants to submit documentation of residence and income and also to pay an annual registration fee of $30 per person. Enrollees must also pay $16.25 co-pay per prescription for approved medications while ConnPACE pays the rest. To extend the range of its services, ConnPACE is designed to "wrap-around" Medicare Part D. Therefore, applicants are required to enroll in Medicare Part D if they are eligible. ConnPACE payment is then limited to drug costs beyond what Part D covers.

Enrollment. As of 2005, there were nearly 50,000 ConnPACE enrollees statewide. Table 6 shows the number of persons enrolled in the nine CT towns of the Service Area in fiscal 2005. The table also presents estimates of the potential total number of persons who may be eligible for ConnPACE assistance because of their age and income. The estimates are approximate, and do not include the non-elderly disabled who make up 15 percent of ConnPACE enrollees. Assuming that the estimates are reasonably close, it appears that actual enrollment in ConnPACE is below the potential in most Service Area towns. On average, only one in five of the people eligible for ConnPACE appears to have been enrolled in 2005. This suggests that efforts by the Foundation, in cooperation with State and local officials, to inform more eligible elderly and disabled people of the benefits available from ConnPACE could be of significant value.

Drugs Covered. ConnPACE covers all drugs that require a prescription, plus insulin and insulin syringes. There are certain exceptions such as drugs prescribed for cosmetic purposes, experimental drugs, and drugs that the Federal Food and Drug Administration has determined not to be effective.

Concerns. Even though ConnPACE offers considerable potential benefit to enrollees, its annual fee and co-pay requirements appear to present obstacles to low or moderate income people. In a number of the site reports on participants in the Foundation's Pharmaceutical Assistance Project, there are notations that Foundation funds were used to cover ConnPACE co-pays. Also, several participants cited the need for assistance in applying to enroll in ConnPACE.

Table 6

ConnPACE CLIENTS IN THE CT PORTION OF THE SERVICE AREA, 2005

County	Town	Persons Enrolled in ConnPACE	Estimated Potential ConnPACE Enrollment (2)	Actual ConnPACE Enrollees as a percent of Potential
Litchfield	Falls Village (1)	66	49	134%
	Cornwall	14	81	17%
	Goshen	23	90	26%
	Kent	38	133	29%
	Norfolk	23	65	36%
	N.Canaan	15	211	7%
	Salisbury	32	319	10%
	Sharon	27	206	13%
	Warren	7	37	19%
Sub-Total	CT Portion	245	1,153	21%

Sources: ConnPACE Annual Report, 2005 (persons enrolled in ConnPACE).
Notes:
(1) This is the most-used name for the town of Canaan.
(2) Estimate made by multiplying the percent of persons age 65+ (from Census data) times the number of persons living in households with incomes below 3 FPL (see Table 2 and accompanying text).
(3) It appears likely that DSS records have interchanged data for Canaan/Falls Village and North Canaan. The latter has three times the population of the former but DSS data shows only 15 enrollees in North Canaan.

HUSKY

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

Table 7

HUSKY A AND SAGA RECIPIENTS IN SERVICE AREA TOWNS, 2004

Town	Children and Youth below 1 FPL	HUSKY A Recipients 2004	SAGA Medical Recipients
Falls Village	51	112	3
Cornwall	43	74	1
Goshen	90	120	5
Kent	88	167	8
Norfolk	67	104	5
N. Canaan	187	244	8
Salisbury	297	167	7
Sharon	208	156	61
Warren	42	40	1
Sub-Total	1,073	1,184	99

Sources: Children and youth below 1 FPL based on 2000 Census; HUSKY A from CT Voices for Children; SAGA from CT Dept of Social Services.

SAGA

Under SAGA (State-Administered General Assistance) the CT Department of Social Services provides medical and pharmaceutical assistance to individuals who are unable to work for medical or other prescribed reasons. Also eligible are families that do not meet the blood-relationship requirements of the Temporary Family Assistance income support program. Statewide, about 29,100 clients receive SAGA medical assistance. Employable individuals are not eligible for SAGA cash assistance. There are also income and asset limits for eligibility, as well as a citizenship requirement.

Table 7 shows the number of children and youth in Area towns who were being assisted under HUSKY A and SAGA as of 2004. Based on this data, it appears that most of the children and youth in the CT portion of the Service Area who are likely to be eligible enrollees in HUSKY A have been enrolled. No comparable basis is available to gauge the extent to which SAGA enrollment meets the need in the Service Area.

NEW YORK STATE PROGRAMS

EPIC

The Elderly Pharmaceutical Insurance Coverage (EPIC) program is a New York State prescription cost-sharing plan for senior citizens who need help paying for their prescriptions. EPIC 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 3 FPL limit of concern to the Foundation.

Plan Options. EPIC offers two plans. Seniors with moderate incomes can join the Fee Plan while those with higher incomes are eligible for the Deductible Plan. Seniors receiving full Medicaid benefits are not eligible to enroll in EPIC.

- The Fee Plan covers single persons with incomes up to $20,000 and married persons with incomes up to $26,000. The fee to join this plan varies, based on annual income. Once they pay the initial fee, enrollees can purchase drugs for co-payment amounts ranging from $3 to $20, depending on the cost of the drug.

- The Deductible Plan is for single persons with incomes between $20,000 and $35,000 and married persons with incomes between $26,000 and $50,000. This plan is especially designed to help people with high drug costs. There is no fee to join the Deductible Plan. Enrollees pay the EPIC discounted price on prescription drugs by themselves until they reach their EPIC deductible level. Once the EPIC deductible has been reached, enrollees can purchase drugs for a co-payment amount ranging from $3 to $20, depending on the cost of the drug.

EPIC enrollees are encouraged to consider joining a Medicare Part D prescription drug plan. EPIC can be used to cover drug-related costs that are not covered by Medicare drug plans, such as deductibles, co-payments, coinsurance, non-covered drugs, or any gap in coverage. Medicare is considered to be the enrollee's primary coverage while EPIC is secondary. In some instances, an enrollee may pay lower EPIC co-payments by using Medicare Part D and EPIC together. EPIC enrollees with limited income and resources can receive additional assistance from Medicare to enable them to purchase medications for co-payments as low as $2 for generics and $5 for brand name drugs.

Medications Covered. Almost all prescription medicines are covered under EPIC, as well as insulin, insulin syringes and needles. Both brand name and generic drugs are included. EPIC allows only a 30-day supply of medication or 100 tablets or capsules,

whichever is greater. For EPIC enrollees with Medicare Part D or other prescription insurance, EPIC allows the quantities approved by the primary drug insurance plan on secondary claims paid by the program.

Enrollment In The Service Area. No data is available on EPIC enrollment below the county level. Data provided by the NYS Department of Health indicates that:

- As of August 2006, there were 2,100 EPIC enrollees in Columbia County, 1,540 of them in the Fee plan and 560 in the Deductible plan. Assuming that EPIC enrollees are distributed within Columbia County in the same proportion as the general population, the Columbia portion of the Service Area would have had about 158 enrollees.

- As of August 2006, there were 4,944 EPIC enrollees in Dutchess County, 3,414 in the Fee plan and 1,530 in the Deductible plan. Assuming that EPIC enrollees are distributed within Dutchess County in the same proportion as the general population, the Dutchess portion of the Service Area would have had about 444 enrollees.

The county level data suggest that EPIC may currently reach a little less than one percent of the at risk population of the Service Area, or roughly the same proportion as ConnPACE does in Connecticut. On the basis of the preceding analysis of ConnPACE figures, this suggests that there may also be considerable opportunity to expand EPIC enrollment in Service Area communities.

THE HEALTH PLUS PROGRAMS

In addition to EPIC, the NYS Department of Health offers two health insurance programs that assist in the purchase of prescription drugs as well as in the financing of other health services.

Child Health Plus. 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. To be eligible for either Child Health Plus A or B, children must be under the age of 19 and be residents of New York State. 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; this is 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 is available to single adults, couples without children, and parents with limited income who are residents of New York State. Family Health Plus provides comprehensive health care coverage as well as prescription drugs. Enrollees are not required to pay premiums to participate in Family Health Plus and there are no co-pays. Health care is provided through participating managed care plans. There are a number of qualified providers in or near the Service Area, including the Dutchess County Community Action Agency

E. Private Drug Aid Programs

In addition to the pharmaceutical assistance programs financed by the Federal and State Governments, residents of the Service Area can receive help in obtaining prescription drugs from a number of other sources in addition to their own out-of-pocket payments. These additional sources include private insurance, programs offered by nonprofit associations and free or reduced-price drugs offered by pharmaceutical manufacturers and distributors.

1. 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 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 enrolling directly in Part D, with the option of enrolling in Part D at any time their private coverage ceases.

In the 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** was founded in 1935 in New York City. It serves more than five million members in the states of New York and Connecticut, as well as elsewhere. 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. Anthem was formed in 2004 by the merger of WellPoint Health Networks, Inc. and Anthem, Inc.

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

2. 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 tri-county Service Area. In addition to its participation in the Pharmaceutical Assistance Project of the Foundation for Community Health, the Eastern Dutchess Rural Health Network has undertaken and stimulated other activities in the communities along Route 22 in New York. The Network has utilized its own funds to participate in the Foundation's Pharmaceutical Assistance Project.

3. 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. Availability of aid under this and similar private programs is subject to (a) availability of the drug the patient seeks free or at reduced cost, (b) income and other limits set by the provider and (c) proof that the applicant has no other insurance or possibility of getting the drug under a Federal or State program. Generally, assistance is limited to patients who have incomes below 2FPL. With the start of Medicare Part D at the beginning of 2006, there appear to be some indications that the number and type of free drug offers by manufacturers and other private organizations is 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. The PhRMA website notes that it has "matched more than 2.5 million patients to patient assistance programs around the country". Given the fraction of the nation's population that resides in the Study Area, this would imply that on the order of 400 to 500 people in the Area may be current or past beneficiaries of private pharmaceutical assistance programs. Use of free private drug assistance was cited by several of the participants in the Foundation's pharmaceutical assistance project.

THREE: RECOMMENDATIONS

The primary purpose of this study was to provide the Foundation with a summary of available information on the significant public and private agencies involved in providing prescription drug aid in the Service Area. In the course of the study, a number of matters emerged that could be the focus of future action by the Foundation either by itself or in cooperation with local and State officials. These are listed below.

1. Help Clarify Options. Faced with a maze of possible choices, both among the drug plans offered under Medicare Part D and also by other programs and providers, it is hardly surprising that some individuals either refuse to make any choices or make ones poorly adapted to their needs. This is more often the case for low income families and individuals. There are many qualified sources of assistance in the Service Area, such as doctors and pharmacists. It might be useful to them if the Foundation were to produce a simplified version of the contents of this report, written to inform the low and moderate income residents of the Service Area of how the various Federal, State and private programs relate to one another.

2. Increase Communication Among Advisers. Comments from participants in the Foundation's Pharmaceutical Assistance Project suggest that it would be useful for the Foundation to convene officials from the State agencies that finance prescription drug aid and selected local service providers to discuss situations where persons needing help for

their drug needs tend to “fall through the cracks”. The location of the Service Area along the boundary of two states tends to make such communication difficult but also more necessary.

3. Strengthen Local Government Capacity. Many people seeking help in obtaining pharmaceutical products turn first to their local officials. The structure of local government is quite different in the NY and CT portions of the Service Area. However, the Foundation could play a useful role by increasing the level of familiarity with the array of drug-financing options on the part of local officials. This could be done through publications, training seminars, or by one-on-one consultations. In Connecticut, where there are no county governments and almost all local government is concentrated in the town, the potential audience would be Selectmen and Social Service Agents. In New York, the government structure is more complex, with much responsibility focused in far-away (from the Service Area) county governments, and less in the towns and incorporated boroughs.

4. Focus On Using Leverage. The Foundation has only modest means compared to the magnitude of the uninsured and uncovered cost of prescription drugs needed by low and moderate income Service Area residents. Based on the analysis of Medicare Part D in this report, these uncovered needs appear likely to be in excess of $5 million a year. At best, the Foundation could hope to meet only a small fraction of the cost remaining after residents’ ability to pay out of pocket is taken into account. The Foundation’s best opportunity to increase the amount of drug aid received by Area residents would, therefore, appear to be by focusing on where it can use its resources and information to leverage more services on behalf of the at risk population.

5. Conduct Experimental Projects. Even with its limited resources, the Foundation can conduct projects that provide direct services. It would be most useful, however, if these efforts were carried out on the basis of designs prepared in advance so that they can generate useful information. The Foundation’s Pharmaceutical Assistance Project generated some suggestive insights, but if it is to continue it should be more clearly designed to produce more relevant data for future planning in addition to providing needed help to a limited number of recipients.

Unmet Needs Remain

Despite the major step forward made with the initiation of Medicare Part D by the Federal Government, the drug needs of substantial groups of families and individuals within the Service Area’s at risk population – especially people under age 65 -- are still uncovered. Medicaid, together with State programs such as EPIC and ConnPACE, provides assistance to some of these groups, but many children, youth and working-age adults receive little if any such aid.

In future years, it will be important for further action to be taken to close the gaps that still remain in drug aid for low income people. Providing information of the type presented in this report to policy makers at the state and national level may be one way to move in this direction.

APPENDIX: THE AT RISK POPULATION

A. Population And Income

This Appendix presents the population, income and poverty data that was used to estimate the number and principal characteristics of the Service Area's population "at risk" in obtaining needed drugs and other pharmaceutical products.

The first step in the analysis was to assemble the population data shown in Table A.1 from the U.S. Census of 2000 for the 17 towns in the Service Area. As of that year, the Area contained a total of 52,540 year-round residents. This included 172 institutionalized persons in the town of Dover but did not include the Area's estimated 10,000 seasonal residents. The Area's towns are small but vary considerably in size, from a low of 1,081 residents in Canaan (commonly known as Falls Village) to 8,398 in Dover.

In the year 2000, the Area population comprised a total of 20,747 households, containing an average of 2.52 persons each. Average household size ranged from 2.19 persons in Salisbury to 2.77 in Dover. Population in the 17-town Area is divided, with 31,261 on the New York side and 21,279 on the Connecticut side. Average household size is somewhat higher on the New York side, 2.61 persons per household compared to 2.43 in the Connecticut towns.

Median household income for the Area as a whole was $50,800 in 1999 (Half of all households have higher incomes than the median, half less). The median income range was wide, running from a low of $39,020 in North Canaan to a high of $64,432 in Goshen.

On average, nearly seven percent of the households in the Area, about one household in every 14, had an annual income below the Federal Poverty Line (FPL). Poverty percentages varied widely, from a low of 3% in Cornwall to 12.3% in North East. Poverty is generally higher in the NY towns, where the fraction of residents below the Federal Poverty Line is nearly twice as high as in the CT towns of the Service Area.

TABLE A.1

POPULATION , INCOME AND POVERTY DATA FOR THE SERVICE AREA COMMUNITIES, 2000

County	Town	Population	Number Of Households	Average Household Size	Percent Below 1FPL	Median Household Income ($)
Litchfield	Falls Village (1)	1,081	445	2.43	4.7	54,688
	Cornwall	1,434	615	2.33	3	54,886
	Goshen	2,697	1,066	2.53	3.3	64,432
	Kent	2,858	1,143	2.43	3.2	53,906
	Norfolk	1,660	676	2.44	4.1	58,906
	N.Canaan	3,350	1,342	2.38	5.8	39,020
	Salisbury	3,977	1,737	2.19	7.8	53,051
	Sharon	2,968	1,246	2.26	7.2	53,000
	Warren	1,254	497	2.52	3.3	62,798
Columbia	Ancram	1,513	595	2.54	7.4	45,726
	Copake	3,278	1,280	2.45	8.1	42,261
Dutchess	Amenia	4,048	1,625	2.46	8.1	39,231
	Dover (2)	8,565	3,034	2.74	8.4	50,361
	North East	3,002	1,146	2.50	12.3	42,038
	Pine Plains	2,569	988	2.60	9.2	43,125
	Stanford	3,544	1,398	2.49	4.3	54,118
	Washington	4,742	1,914	2.37	7.2	52,104
Service Area	Total	52,540	20,747	2.53	6.9	50,803

Source:US Census of 2000, DP-1 (population) and GCT-P14 (income and poverty); 2 and 3FPL and household data calculated as noted in text.
Notes:
(1) The official name of Falls Village is Canaan.
(2) Population data includes 172 instutionalized persons

B. Poverty Level Multiples

The Federal Poverty Level was initially set about 50 years ago, based on three times the cost of basic food needs. Since then, it has been revised only to take nation-wide inflation into account. It does not take any account of a number of changes since then. Also, it does not reflect the higher cost of housing and energy in the Northeast states. As a result, the FPL has been widely criticized as being too low to be a useful measure of need. Therefore, an analysis was done for this report to estimate how many households and individuals would be included if a decision were made to use a multiple of two or three times the basic FPL.

First, an estimate was made, using the detailed income data available from the census, of how many households in the tri-county FCH Service Area had incomes in 1999 (the year on which the 2000 census income data is based) that fell below *twice* the Federal Poverty Level (hence abbreviated as "2FPL"). The analysis went as follows:

1. The Basic Poverty Level. To make an estimate of what the basic FPL would have been in 1999 for a hypothetical household of 2.5 persons – roughly the average size of household in the Service Area -- it was assumed that it would have been half-way between that for a household of two and one of three persons. The two-person household income level was $11,060 and the three-person level was $13,880. Halfway between is $12,470.

2. Two Times The FPL (2FPL). Next, the basic FPL calculated for the household of 2.5 persons was doubled in order to obtain an estimate of the 2FPL ceiling. This produced a figure of $24,940, very close to the $24,999 high end of one of the brackets of income data available from the Census. Therefore, it was assumed that the number of households with incomes below $25,000 would be a reasonable approximation of the number of households with incomes below 2FPL. For the Area as a whole, the calculation resulted in an estimate that 4,422 households, or about one in every five in the Service Area, had an income below 2FPL in 1999.

Table A.2

FEDERAL POVERTY LINE (FPL) MULTIPLES, SERVICE AREA, 2000

				2FPL (Below $25,000)		3FPL (Below $35,000)	
County	Town	Population	Number Of Households	Number Of households	Percent of Households	Number of Households	Percent of Households
Litchfield	Falls Village (1)	1,081	445	89	20%	141	32%
	Cornwall	1,434	615	114	19%	184	30%
	Goshen	2,697	1,066	152	14%	236	22%
	Kent	2,858	1,143	222	19%	299	26%
	Norfolk	1,660	676	104	15%	187	28%
	N.Canaan	3,350	1,342	407	30%	613	46%
	Salisbury	3,977	1,737	437	25%	590	34%
	Sharon	2,968	1,246	231	19%	392	31%
	Warren	1,254	497	70	14%	98	20%
Columbia	Ancram	1,513	595	123	21%	206	35%
	Copake	3,278	1,280	334	26%	537	42%
Dutchess	Amenia	4,048	1,625	425	26%	710	44%
	Dover (2)	8,565	3,034	577	19%	984	32%
	North East	3,002	1,146	297	26%	443	39%
	Pine Plains	2,569	988	226	23%	390	39%
	Stanford	3,544	1,398	221	16%	401	29%
	Washington	4,742	1,914	393	21%	596	31%
Service Area	Total	52,540	20,747	4,422	21%	7,007	34%

Source:US Census of 2000, DP-1 (population) and GCT-P14 (income and poverty); 2 and 3FPL and household data calculated as noted in text.
Notes:
(1) The official name of Falls Village is Canaan.
(2) Population data includes 172 instutionalized persons

3. A More Realistic Poverty Measure (3FPL). Finally, a similar calculation was made to estimate the comparable 3FPL figure. The household income for the Area's average household of 2.5 persons was $37,410 (halfway between the two-person figure for 3FPL and the three-person figure). The closest published Census income figure is $34,999, somewhat below the estimated 3FPL figure; however, this was used as the best available approximation. As shown in Table A.2, there are an estimated 7,000 households with incomes below this estimate of 3FPL, or about one in every three Area households.

Table A.2 presents a summary of the calculations described above by town and for the Area as a whole. For both the 2FPL and 3FPL categories, the calculations indicate that 41% of lowest-income households live in the CT portion and 59% in the NY portion. This is similar to the distribution of total population between the two sub-areas.

C. Selecting the Appropriate Poverty Level

The preceding analysis provided a basis for assessing the income limitations of the Service Area's population and thus their need for financial assistance to purchase prescription drugs. Annual income is not the only relevant measure of such need, but it is a useful starting point. Factors such as the extent to which households are covered by health insurance will also influence the need for financial assistance. Above some income level, it can be assumed that households will be able to cope with the cost of drugs and other medical needs, either through insurance or their own resources.

Shown below in Table A.3 is what the three poverty multiples would mean for the Service Area (based on 2000 census data):

TABLE A.3

POVERTY MULTIPLES IN THE SERVICE AREA

Poverty Multiple	Cumulative Number of Households	Cumulative Number of People	Percent of Area Population
1FPL	1,450	3,625	7%
2FPL	4,422	11,055	21%
3FPL	7,007	17,518	33%

Source: Tables 1.1 and 1.2
Note: assumes 2.5 persons per household

The Foundation for Community Health adopted a multiple of three times this basic poverty level (3FPL) in setting eligibility for its initial pharmaceutical assistance project. After reviewing the options, the Advisory Committee for this study, composed of the Foundation's Executive Director and two Foundation Board Members, decided that 3FPL should also be used as the basic measure of the at risk population in this study of prescription drug aid programs.