SB 306

AARP Alaska

Honorable Gene Therriault, Chair
Senate State Affairs Committee
Alaska Capitol, Room 121
Juneau, AK 99801-1182

March 18, 2002

RE: SB 306 (Davis) - SUPPORT

Dear Chair Therriault:

On behalf of the 112,000 members of AARP in Alaska, we urge you and your colleagues on the Senate State Affairs Committee to support SB 306, authored by Senator Bettye Davis of your Committee.

AARP's top legislative priority is to have Congress include prescription drug coverage under Medicare.

At the same time, we support all efforts by state legislators to make prescription drugs affordable and available. Our primary intent, in Washington D.C., as well as in Juneau, is to use all viable approaches to bring relief to those in need.

SB 306 will offer Alaska an opportunity to study, evaluate, and make recommendations on how to deal with this issue. SB 306 will establish a Prescription Drug Assistance Task Force that will enable us to learn from other states as well as to identify the most critical needs of older Alaskans.

AARP research as already told us:

- The average annual growth rate for Medicaid spending on prescription drugs in Alaska rose 23.4% from 1996-1998 compared to a 12.6% increase nationwide.
- About 1/3 of Medicare recipients have good prescription drug coverage from their former employer or from their own personal insurance; about 1/3 have some coverage but it is limited and will run out before the year's end; another 1/3 have no coverage and must pay for all prescriptions out-of-pocket. Obviously, this is the group most at risk.

AARP recommends you and your Committee colleagues vote "AYE" when SB 306 appears before your Committee.

Alaska State Office | 3601 "C" Street, Suite 1420 | Anchorage, AK 99503 | Phone: 907-341-2277 | Fax: 907-341-2270 | www.aarp.org

Should you have any questions about our position, please feel free to contact Marie Darlin (907.586.3637), Coordinator of the AARP Capitol City Task Force; Patrick Luby (907.762.3314), AARP Legislative Representative; or me (907.245.5259).

Thank you for your consideration.

Sincerely,

Marguerite Stetson

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cc: Vice Chair, Senator Randy Phillips
Senator Rick Halford
Senator Ben Stevens
Senator Bettye Davis
Marie Darlin
Pat Luby

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 306
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Administration

Title: Establishment of Prescription Drug Assistance Task Force
BRU: Central Administrative Services
Component: Protection,Community Services Administration
Sponsor: Senator Davis
Requester: State Affairs
Component No.: 2083

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services						
Travel	9.6	0.0	0.0	0.0	0.0	0.0
Contractual	10.0	0.0	0.0	0.0	0.0	0.0
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**19.6**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	19.6	0.0	0.0	0.0	0.0	0.0
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**19.6**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2002) cost: 0.0
Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill establishes a task force to investigate and review various issues related to the lack of prescription drug availability to low and moderate income senior citizens and make appropriate recommendations to the Governor and Legislature. This fiscal note assumes that members from state agencies assigned to the task force will cover the cost of their participation. This fiscal note covers the transportation, lodging and per diem for the four private sector members appointed to the task force. It assumes three required meetings and per diem for subsequent teleconference meetings. Contractual costs include advertising for public notice, teleconferencing costs, postage and printing and rent.

Prepared by: Steven P. Ashman, Director
Phone 907-269-3674
Division: Senior Services
Date/Time 3/20/02 1:46 PM
Approved by: Jim Duncan, Commissioner
Date 3/20/2002
Agency: Department of Administration

(Revised 9/2001 OMB)

Fiscal Note - DOA

FISCAL NOTE

STATE OF ALASKA **BILL NO.** SB 306
2002 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

TRAVEL	
Three Anchorage Meetings	
Three Private Sector Task Force Members	
Travel/Lodging/Per Diem	$ 9,000
Private Sector Task Force Member	
Per Diem	300
Three Telephonic Meetings	
Per Diem	300
Total Travel	$ 9,600
CONTRACTUAL	
Public Notice of Meetings	$ 5,000
Teleconferencing costs	2,500
Printing and Postage	1,000
Conference Room Rental	1,500
Total Contractural	$10,000
Total Budget	$19,600

Medicaid's Take on Pills

With health care expenses running out of control, several states are taming at least a piece of their fastest-growing cost.

Medicaid has re-emerged as a budget buster, forcing many states to work on reining in costs in the area where they are running up fastest: prescription drugs. At least 21 states went into this year's legislative sessions with an eye on prescription drug laws that target rising costs.

Several states have already started down that road. The early results suggest that there are significant savings to be had, especially by setting limits on the use of various name-brand drugs. At the same time, drug manufacturers and some physicians claim the approach takes a toll on the health of needy populations.

Maine, which cut $15 million from its Medicaid budget—50 percent more than expected—got those savings by steering doctors toward prescribing generics and lower-cost alternatives to expensive name-brand drugs. Doctors can still prescribe the name brands but must call a state-sponsored hotline to get permission first.

This prior authorization has had a dramatic effect. In 2000, Maine spent $8 million on prescriptions for Prilosec, the so-called "purple pill" that helps people who suffer from chronic heartburn. Last year, Maine spent only $1.8 million on Prilosec as doctors switched Medicaid patients over to an equivalent but cheaper alternative. The alternative cost the state $7 million, but it was able to fill close to twice as many prescriptions.

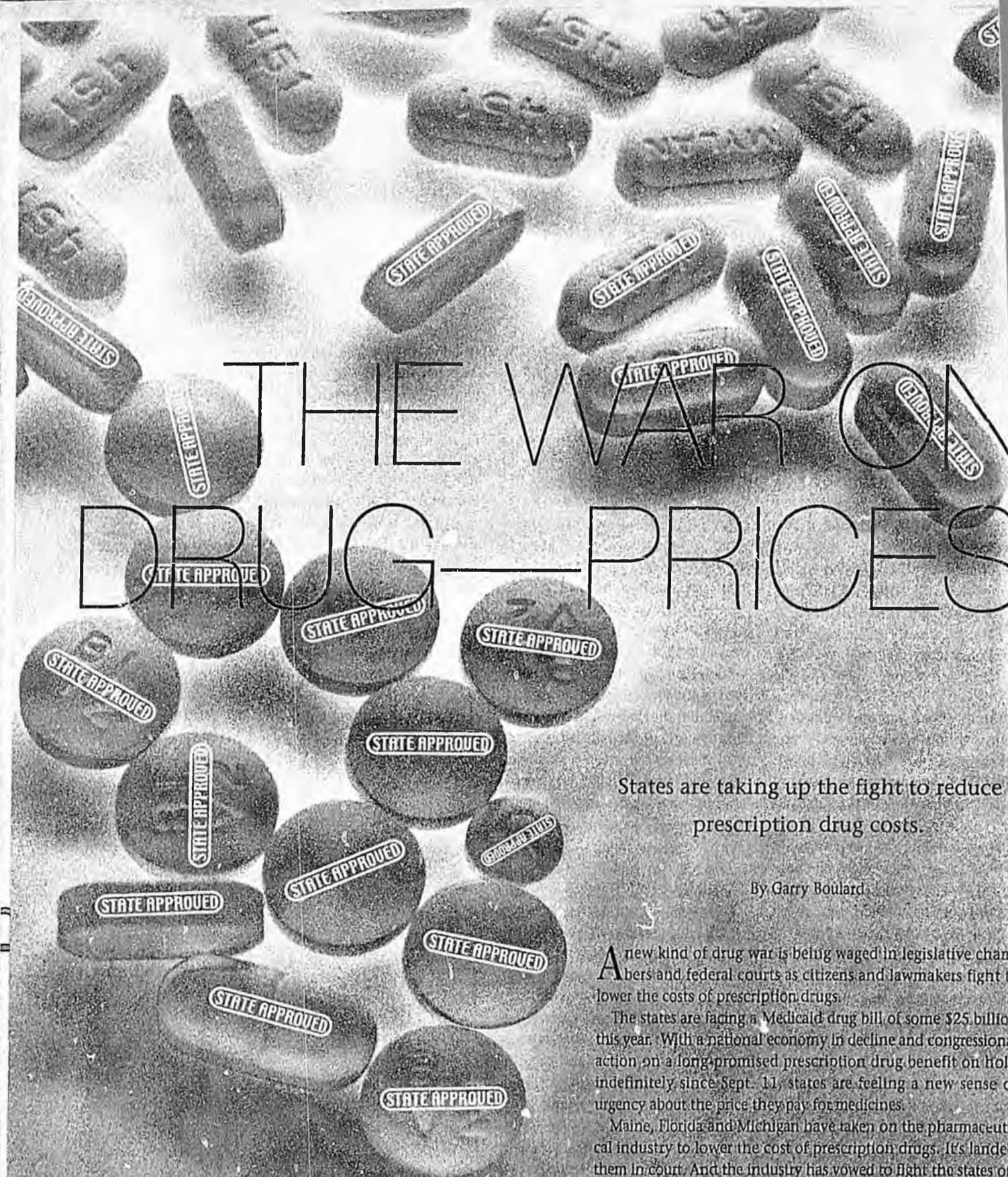
Florida, a much bigger state with a larger population of seniors, lowered its drug budget by nearly $250 million last year. With the cost of prescription drugs growing at a rate of 30 percent a year, Florida first tackled the problem in 2000 by limiting most Medicaid enrollees to four name-brand prescriptions a month, for a savings of $120 million. Then, last year, the state came up with a preferred drug list—with an unusual twist. In order to get their products on the preferred list, drug makers must either offer steep discounts or pay for health programs aimed at containing other Medicaid costs. Pfizer and Bristol-Myers Squibb signed on and guaranteed Florida a combined $49 million in savings by paying for disease prevention and management programs.

Yet PhRMA, the group that represents the major drug companies, is suing to stop the Florida program. It is also taking Michigan to court over its preferred list, which aims to extract even deeper discounts from drug makers. According to PhRMA, limiting access to drugs not only violates federal law but is bad health policy. "Pharmaceuticals save money if they are used properly and given as primary medicine," says Jan Faiks, PhRMA's assistant general counsel.

Some doctors aren't happy with preferred lists, either. While the states have tried to make the process for authorizing non-listed drugs simple, doctors are still stuck making phone calls, typing e-mails and sending faxes to get prescriptions approved. Plus, many doctors don't like having the state tell them what is and isn't good medicine. "Not all patients do as well on the cheaper drugs," says Gordon Smith, executive vice president of the Maine Medical Association. "Most of them do, but we sacrifice a few who get injured along the way."

Kevin Concannon, Maine's health commissioner, argues that it is possible to get patients the drugs they need at a reasonable cost. The proof? Maine bought 700,000 more prescriptions in 2001 than in 2000, even as the cost dropped from $56 per prescription to $53. "What we're doing is reversing some of the effects of all the advertising drug makers do on cable TV," says Concannon, who has been sued for other steps Maine has taken on prescription drugs. "The more states take an active role in this, the higher the likelihood that the prescription drug manufacturers will want to sue for peace."

—Christopher Swope



THE WAR ON DRUG PRICES

States are taking up the fight to reduce prescription drug costs.

By Garry Boulard

A new kind of drug war is being waged in legislative chambers and federal courts as citizens and lawmakers fight to lower the costs of prescription drugs.

The states are facing a Medicaid drug bill of some $25 billion this year. With a national economy in decline and congressional action on a long-promised prescription drug benefit on hold indefinitely since Sept. 11, states are feeling a new sense of urgency about the price they pay for medicines.

Maine, Florida and Michigan have taken on the pharmaceutical industry to lower the cost of prescription drugs. It's landed them in court. And the industry has vowed to fight the states on every front. It could be a long, costly and difficult fight. More states are poised to tackle the problem of rising prescription drug costs under the Medicaid program, and a battle of economic and

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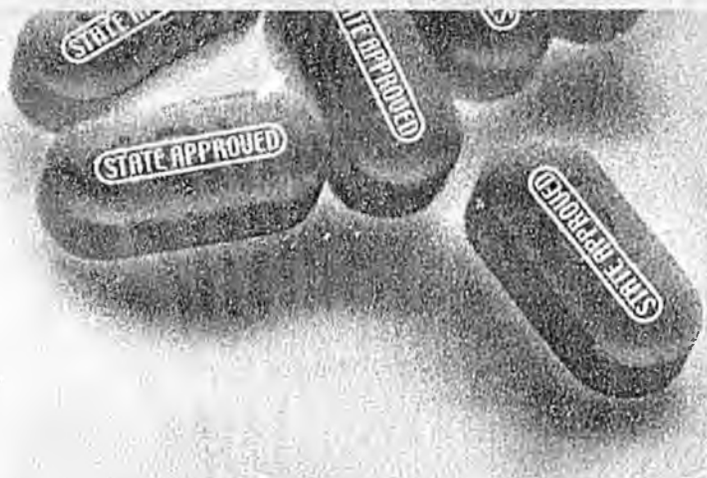
Garry Boulard, a frequent contributor to State Legislatures, *is a free-lance writer in New Orleans.*



historic significance is looming.

There are those who want to put a cap on costs. There are those who argue that the profits from drugs are ploughed back into research for even better and safer drugs. There are many nuances and sides to this issue.

"This is going to be a confrontation that the pharmaceutical industry did not see coming," observes Diane Rowland, executive director of the Kaiser Commission on Medicaid and the Uninsured. "And it is fully prepared to go to court to stop any action from the states that it views as unfair."

The first shots in the battle were fired in Maine—followed shortly by similar actions in Florida and Michigan—after lawmakers passed several bills addressing rising prescription costs, the most important of which is the "Healthy Maine" program that potentially extends Medicaid discounts on prescription drugs to more than 225,000 low- and moderate-income residents.

The "Healthy Maine" program also requires drug makers to grant Medicaid-type rebates on medicines purchased by Maine residents who have incomes less than three times the federal poverty level. While observers taking note of Maine's long history of progressive politics may have seen the "Healthy Maine" legislation as simply part of that tradition, what happened next in Florida was not as easily foreseen.

Facing spiraling drug costs that helped create a $650 million shortfall in the state's $9.7 billion Medicaid budget, lawmakers passed legislation creating a list of some 1,300 prescription drugs that will get preferential treatment from the state.

The list determines which drugs are included in the more than $1.6 billion pharmaceutical purchases Florida makes every year for its poor and disabled.

"We did it from the standpoint of being fiscally responsible," says Burt Saunders, chairman of the Senate Committee on Health, Aging and Long-term Care in Florida. "Our Medicaid budget was mushrooming and the pharmacy component of it was the largest part. It suddenly occurred to us that the pharmacy budget through Medicaid had the capacity to literally eat our overall Medicaid budget, so we thought we should do something about it," he says.

Officials say the new law could save up to $214 million a year, which is nearly 15 percent of what the state spends on Medicaid drugs.

Michigan, too, has entered the fray, developing in early December a list of lower-priced drugs that will receive preferential treatment through the state's department of community health, which administers Michigan's Medicaid program.

In response to such state actions, the pharmaceutical industry, as represented by the Pharmaceutical Research and Manufacturers Association of America—otherwise known as PhRMA—filed a series of petitions in federal court seeking to overturn state actions they claim are overreaching and could prove detrimental in the long run to the health of Medicaid patients.

PhRMA also contends that the Maine, Florida and Michigan legislation intrudes upon the relationship between physician and patient by making it either impossible or very difficult for doctors to prescribe certain drugs for patients if those drugs are expensive or not on one or the state's preferred lists.

PhRMA argues that the Maine legislation violates federal Medicaid law, which requires that federal and state governments pay for Medicaid benefits, noting that under the "Healthy Maine" program the discounts are funded entirely by the drug makers.

In response to Florida, PhRMA says the state is in violation of federal Medicaid law, partly because its list excludes drugs based only on the manufacturer's refusal to pay supplemental rebates and not because there is anything medically lacking in the drugs.

And the Michigan program, adds PhRMA, violates the separation-of-power provisions of the state's constitution because the provision did not go through the legislature, and lawmakers "were not given the opportunity to veto the policy before it took effect."

"Essentially we're fighting our battles on a series of fronts simultaneously," says Bruce Lott, director of state media for PhRMA. "Our goal is to not only defeat the actions that have taken place in Florida, Maine and Michigan, but also to discourage other states from following their lead."

Ironically the battle between the states and the nation's pharmaceutical industry began on a simple note when Maine applied for a waiver in federal Medicaid rules.

"Medicaid is a state and federal health program, but the federal government sets the rules," notes Kevin Concannon, Maine's commissioner of the Department of Human Services. "We said we would like to be able to enroll people in the Medicaid program just for the prescription drug benefits that Medicaid provides." The waiver, Maine stipulated, would apply only to those in the state who do not currently have prescription drug coverage and whose incomes are at 300 percent of the federal poverty levels or below.

Early last year, the feds approved Maine's waiver, and the state began its new "Healthy Maine" program in June. By early January, more than 108,000 people had enrolled (about 41,000 of whom have relied on a state subsidy not tied to

"READ TWO DRUG ADS AND CALL ME IN THE MORNING"

With pressure to try and curb the increased costs of prescription medicine, lawmakers are taking a closer look at the implications of pricey advertisements for state-funded programs.

At an estimated annual cost of $2.5 billion, pharmaceutical advertising on television and in the popular press has indeed made drug companies and their brand products household names.

A new analysis provided by the managed care industry reports that from 1999 to 2000, prescriptions written for the top 50 most heavily advertised drugs rose 24.6 percent, compared with 4.3 percent for all other drugs combined. Drug manufacturing is a $122 billion industry, so a small increase in market share can reflect a multimillion dollar boost for any particular company.

Legislative lawyers point out that it is nearly impossible for individual states to control national advertisements, now regulated by the Food and Drug Administration. But this has not prevented some states from seeking solutions.

Twelve states considered bills regarding direct-to-consumer advertising in 2001, and at least one—West Virginia—enacted a law that gives the director of the West Virginia Public Employees Insurance Agency, Tom Susman, discretion to use "innovative strategies" such as requiring prescription drug manufacturers to show how much they're spending on advertising and what that adds to drug costs.

However, Susman believes that West Virginia will probably train a team of pharmacists to meet with and educate doctors about the fiscal effect of prescribing higher priced and advertised drugs. "The pharmaceutical industry [representatives] don't talk about costs," Susman said. "We go in and educate [doctors] about less expensive and therapeutic equivalent drugs, and then they can make decisions to use less costly generics." Susman added that physicians who participate in Medicaid have an incentive to prescribe less costly drugs, "With only so much money to go around and using less expensive drugs, we have more money to put into paying the West Virginia physicians."

Several states—such as Florida, Michigan, Oregon and Vermont—are creating drug lists for Medicaid patients that emphasize cheaper generic products over the popular advertised pharmaceuticals.

For information: www.ncsl.org/programs/health/rxads.htm

—Karmen Hanson, NCSL

Medicaid).

"I have never seen a program at that rate of uptake," says Concannon, who previously served as the director of Oregon's health and human services department.

DRUG PRICES GREATEST INCREASE

Overall spending on health care increased to more than $1.3 trillion in 2000, according to a January report from the federal Health and Human Services Department.

The biggest increase by far came from prescription drug costs. According to the Centers for Medicare and Medicaid Services, prescription drugs in 1999, the last year for which statistics are available, accounted for 9.4 percent of personal health care spending.

But it was the increase in that spending that was most alarming: 16 percent over the year before. The Centers also predict that spending on prescription drugs will increase by an average of at least 12 percent every year for the next decade.

PhRMA's Lott disputes that the rise in prices for prescription drugs is dramatic—"not for every drug, at least," he says, or that the profits enjoyed by the pharmaceutical industry are in anyway extraordinary. "I think this is something that has been rather overstated," he says, "particularly when you take into consideration the fact that research, which is ongoing, costs so much."

But some groups, such as Families USA, a nonprofit consumer advocacy organization based in Washington, D.C., charge that most of the expenses borne by the pharmaceutical industry are because of advertising, not research.

Studying the net profits and expenses of the nation's nine largest pharmaceuticals, Families USA issued a report last summer claiming drug companies are spending "more than twice as much on marketing, advertising and administration as they do on research and development."

However the pharmaceutical industry chooses to spend its money, contends John Leuhrs, national coordinator of health affairs and long-term care with the American Association of Retired Persons (AARP) in Washington, the fact that its products continue to cost more is "a national disaster just waiting to happen."

"And to our relief, it seems to be the states who are trying to do something about it, trying to, at least, get more tools in their hands that they can use to control prescription drug prices."

Altogether some 30 states have enacted legislation that includes subsidy programs, bulk purchasing, expanded rebates from manufacturers, as well as discount formulas for both seniors and children.

And pharmaceutical industry officials are girding for more sweeping legislation similar to Maine's and Florida's in up to a dozen other states this year.

"I think the reason that you are seeing more activity of this sort coming out of the various states—instead of Washington where most battles of this sort are usually fought out—is a simple one," says Concannon in Maine. "The pharmaceutical industry does not have as much influence in the state capitals as they do in Washington."

But it is not for lack of trying.

Lott of PhRMA says his group is not concerned with protecting the industry's profits as much as it is with the question of accessibility.

What troubles them, he says, is that the Florida, Michigan and Maine plans "in the long run, limit access for Medicaid patients. We very much think this is a serious mistake, a bad thing."

Lott contends that state efforts to categorize favored drugs with a formulary "just interfere with the doctor-patient relationship and the ability of the doctor to prescribe the medicines he thinks are most important without going through a lot of bureaucratic red tape."

TAKING THE STATES TO COURT

And while PhRMA's foes in the states may find reason to argue with Lott's position, few can deny the persistence of the group as a litigant. So far, it has filed legal challenges against the prescription drug price control measures in Maine, Florida and Michigan.

PhRMA has asked the 1st Circuit Court of Appeals in Washington, D.C., to review an earlier three-judge panel decision approving Maine's prescription drug price control law. The group also filed suit

MULTI-STATE EFFORTS SEEK BETTER RX PRICES

If we buy 10 million instead of one million, can we get a much better price?" This age-old practical business question is at the core of several growing movements by states to obtain the best deals for costly pharmaceuticals.

While lawsuits challenging price control and prior authorization strategies are grabbing headlines in several locales, efforts to use bulk-purchasing and multistate purchasing coalitions have spread rapidly, but more quietly, in the past 12 months. Traditionally in most states, each agency or department paid separately for medical services, including prescription drugs. Each state runs independent Medicaid programs, and the current 26 states with senior subsidy programs have had no connection across state lines.

But that is changing. Rather than go it alone, a growing number of states have begun banding together in the hope of strengthening their bargaining clout. Participating states expect to not only save on drug prices, but also on billing and utilization review costs and other administrative expenses. Three formal regional groups and one exploratory association have formed as of January.

- The earliest legislator meetings in Montpelier and Boston evolved into the Northeast Legislative Association on Prescription Drug Prices (Connecticut, Maine, Massachusetts, New Hampshire, New York, Pennsylvania, Rhode Island and Vermont). Members last July endorsed the concept of a joint purchasing coalition with a joint contract for pharmacy benefit management.

"At first I said we will need legislation from all eight states to act," says Cheryl Rivers, who resigned from the Vermont Senate to serve as the association's executive director. "Now, I'm not convinced that's necessary if we work together and in cooperation with the executive branch." Meanwhile, their meetings serve as a clearinghouse for reports on new pharmaceutical legislation and programs. Legislators from additional states are welcomed regularly.

- A separate initiative, the Northern New England Tri-State Coalition, united Medicaid and agency leaders in Maine, New Hampshire and Vermont. They have agreed on a single pharmacy benefits manager, First Health Services Corp of Virginia, and intend to launch some services early in 2002.
- The Pharmacy Working Group began in the Southeast last March. The initial meeting in Georgia included 15 states. By November seven states (Louisiana, Maryland, Mississippi, Missouri, New Mexico, South Carolina and West Virginia) were seeking a multistate bid to serve an estimated 1.4 million public employees and their families. The seven states pay out an estimated $853 million for employee pharmaceutical claims. In developing specifications for the multistate bid, the group concentrated on how to increase rebates from drug companies and how to reduce the traditionally hefty fees charged by benefit management companies.
- Western officials representing Idaho, Montana, Nevada, Oregon, Utah, Washington and Wyoming have had discussions. Both chambers in Idaho and the Washington Senate passed resolutions in 2001 favoring joint pharmaceutical purchasing. Senator Charles Scott of Wyoming said there also is "considerable interest" in a strategy being developed in Oregon and British Columbia, which calls for reference drug pricing (the least costly of equally effective drugs becomes a state's payment standard).
- A few states intend to save by combining buys within their borders. A 2001 Texas law creates the Interagency Council on Pharmaceuticals Bulk Purchasing, including the departments of health and mental health, state employees, retirees, teachers, the prison system, and "any other agency that purchases pharmaceuticals." For the first time, the law also requires manufacturer and wholesaler price reporting. John Keel, the Legislature's budget board director, estimated two-year savings of $13,200,000. Georgia just started a similar plan for combining in-state purchasing. Massachusetts legislators hope to implement a 1999 law that would include agencies plus the Medicare population and anyone uninsured or underinsured.
- A national survey of legislative health leaders, conducted by NCSL's Health Policy Tracking Service, showed 32 states predicted that purchasing pools for prescriptions are likely to be considered in 2002.

Senator Peter Shumlin, chair of the Northeast Association, noted his group seeks a free-market approach with bipartisan support. "We are simply coming together to get a fair price. We don't want our citizens to have to use their passports to get access to a fair price for prescription drugs."

—Richard Cauchi, NCSL

in response to Florida's effort, arguing that the law "limits Medicaid patients' access to drugs that are not on the formulary by requiring doctors to obtain special permission from the state each time they want to prescribe those drugs for a Medicaid patient."

But in early January, U.S. District Judge William Stafford in Tallahassee rejected PhRMA's petition, prompting the organization to prepare arguments for an appeal to the 11th Circuit Court of Appeals.

At the same time, an Ingham County Circuit judge in Michigan blocked that state's efforts to curb drug prices, arguing, among other points, that because the plan never got the approval of the full Legislature, the state administration had overstepped its authority.

But that tentative PhRMA victory was overturned on Jan. 17, when the Michigan Court of Appeals reversed County Circuit Judge Lawrence Glazer's earlier ruling, allowing the Michigan program to become effective on Feb. 1. Despite PhRMA's energetic opposition, those who favor doing something about the rising costs of prescription drugs under Medicaid think it is not realistic to expect the pharmaceutical industry to fight multiple battles if more states do indeed follow the example of Florida, Maine and Michigan. And even Ott admits that his organization can only do so much. "We've never before been involved with this many lawsuits all at once."

But even if the industry—as expected—continues its many-faceted opposition, proponents say that should not deter states from trying to lower costs anyway.

"No one said it is going to be an easy thing to do," says Michael Saxl, speaker of the Maine House and prominent supporter of the Healthy Maine program. "You have to be willing to try a lot of different things. You have to be willing to take risks and believe in what you are doing."

Jon B. Rawlson, vice president for government affairs with PharMerica in Tampa, which provides pharmacy services to nursing home patients, is similarly optimistic. "I really do think that this is some-

CALIFORNIA PLAN ENCOURAGES RESEARCH FOR AIDS/HIV VACCINE

California Senator John Vasconcellos is a man on a mission. His goal: Create a powerful financial incentive that will encourage corporate investment in a vaccine that protects against AIDS and the human immunodeficiency virus (HIV), the agent that causes the disease.

Last year, Vasconcellos—who's serving his second term in the Senate after 30 years in the Assembly—shepherded through a bill that requires all health maintenance organizations doing business in the state, including CalPERS, a public employee health plan with 1.1 million members, to purchase an AIDS vaccine as soon as it is available and fully approved by the federal Food and Drug Administration. The law, which took effect Jan. 1, is intended to guarantee buyers for a vaccine in California, which is the largest single state health insurance market, and spur venture capital firms to invest more intensely in the development effort.

Many people in the field of AIDS medicine and research feel the financial incentives for drug manufacturers today are weighted "much more toward palliative than preventive interventions," said Vasconcellos, a Democrat from San Jose. With more than 50 million people already infected with HIV or dead of AIDS worldwide and millions more lives at stake, "we are looking to inject more balance" into the R&D equation, he explained.

The inspiration for the legislation, Vasconcellos said, was an old friend, Marcus Conant, a physician who in 1981 documented the first cases of Kaposi's sarcoma—a rare skin cancer that manifests in HIV infection. Conant later helped develop San Francisco General Hospital's AIDS Program and what's now known as the San Francisco AIDS Foundation. His Conant Foundation, an education and treatment organization founded in 1990, has also led to establishment of the International AIDS Vaccine Initiative; with a gift of $25 million from the Bill and Melinda Gates Foundation, the initiative is pressing for development of an effective vaccine.

The two men met in the early 1980s, when the AIDS epidemic was emerging. Then Speaker (now San Francisco Mayor) Willie Brown had asked Vasconcellos to begin devising legislation to address a problem taking its immediate toll on the state's sizeable gay male community. Because of his experience in treating the disease the doctor was a logical source to mine. Conant is a key character in *And the Band Played On*, Randy Shilts' influential 1987 book on early government and medical responses to AIDS. In the course of their talks, Vasconcellos and Conant discovered they share a birthday and since have met for dinner twice a year to catch up on the issues and swap ideas.

One of the first concrete proposals to come out of their talks was a Vasconcellos-sponsored law, enacted in 1986. It provided financial incentives for AIDS-related research and modified liability laws in order, as he put it, "to give developers some leeway" in their work by offering them greater protection from litigation.

But the years have passed, and "there's still nothing to stop this disease, nothing to slow it down," Conant said in an interview. Globally, according to the Joint United Nations Programme on HIV/AIDS, an estimated 21.8 million people have died of AIDS since the epidemic began. Today, 36.1 million people are living with HIV/AIDS. In the United States, the cumulative number of deaths due to AIDS stands at just over 448,000. In early January, the Centers for Disease Control and Prevention reported some troubling news: New AIDS cases in the United States rose by 8 percent last year from 38,864 in 2000 to 42,008 "after seven years of steady decline."

While some drug companies are taking the search for a vaccine seriously, "the issue is what kind of an investment is really necessary," Conant said. As a physician who has seen the toll of AIDS firsthand, he believes "we need an all-out push to develop a vaccine." All the new law does, he continued, is to assure potential developers that if they succeed "the money to pay for it will be there."

Bruce Lott, director of state media relations with Pharmaceutical Research and Manufacturers of America (PhRMA), rejected the implicit premise: Companies are devoting more time and money to treatment because they can make much greater profits on drugs that people must take day in, day out, over their lifetimes than on one that prevents the disease in the first place. R&D teams are investing in the search for "preventatives, treatments and cures and will continue to do so," he said.

A PhRMA survey of new medicines in development in 2001 found a total of 14 HIV/AIDS vaccines in the pipeline. Developers include the National Cancer Institute and 10 private sector firms, from giants like GlaxoSmithKline and Merck to lesser knowns like CEL-SCI and Therion Biologics. Still, Lott said, the outcome that Vasconcellos seeks—assuring that patients have access to a vaccine by making coverage of it mandatory—is "very positive."

In addition to Conant's contribution, Vasconcellos credits his Republican colleague, Senator Jim Battin, with building bipartisan support for the bill. (It passed by votes of 30-6 in the Senate and 56-17 in the Assembly.) When first introduced, the legislation applied only to CalPERS. Battin recognized that it could save the state upwards of $20 million a year in the cost of drugs for AIDS patients and amended it to apply to commercial plans, as well. By Vasconcellos' calculations, the state will pay less than $1,000 per dose for the vaccine. By way of contrast, the Office of AIDS in the state Department of Health Services puts the cost of one patient's supply of drugs at $10,000 to $20,000 a year. And the way the law is constructed, he said, "you don't spend any money until you've got the savings in the bank."

Now, the senator is launching a campaign designed to get the other 49 states to follow California's lead. In a letter mailed in January to the leadership of both parties as well as the chairs and vice chairs of health committees in both chambers, Vasconsellos and Battin invited their counterparts to join in an effort to develop "a coordinated, guaranteed market truly conducive to stimulating the investment of needed dollars for research and development of a vaccine." As Vasconcellos put it: "We want to build a national movement" that may eventually stop AIDS in its tracks.

—Linda Demkovich, NCSL

For more information on the California law or Vasconcellos' national campaign, go to http://www.senate.ca.gov or call Oanh Ho at (916) 445-9740.

FLORIDA AND PFIZER FORGE A DEAL

Pfizer's products remain on Florida's list of preferred drugs because of a deal cut last spring by the world's largest drug company's chairman and CEO Henry McKinnell and Governor Jeb Bush.

Lengthy discussions took place as state lawmakers were deciding which drugs should be on Florida's preferred list. The deal that McKinnell and Governor Bush finally agreed upon was both simple and revolutionary: In exchange for being allowed to keep all of its drugs on the list, Pfizer agreed to take over the day-to-day supervision of up to 12,000 chronically ill patients currently in the state's Medicaid program.

Through what the company calls "technology-based disease management," some 60 specially trained nurses will work with Medicaid patients and help them develop better diets and exercise programs while also promoting a drug education program designed to eliminate medications that are duplicative or cancel each other out.

Pfizer promised Florida that it could save the state up to $33 million in health care costs, much of it through fewer emergency room visits.

"A key public health priority must be to deliver modern medicines to those most in need in a cost-effective manner," McKinnell announced after the agreement with Bush was inked last summer, adding that the Pfizer/Florida approach exemplifies a "creative and innovative private/public partnership program."

Princeton University health care economist Uwe Reinhardt called it "as innovative as anything I've seen a drug company do." He added that Pfizer's promise to reduce costs for Florida through disease management "puts its reputation on the line" by making the company accountable for the results.

By remaining on the preferred list, the company stands to reap tens of millions in profits—certainly more, even Florida state officials admit—than the $33 million Pfizer promises it will save Florida over the next two years.

Governor Bush has said he is willing to work with any drug company that can present an innovative proposal. So far, Bristol-Myers Squibb has stepped up to the plate, agreeing in September to provide disease management for acutely ill Hispanic and African American patients in five Florida counties, including Miami-Dade.

As with Pfizer, Florida will keep all of Bristol-Myers' 54 drugs on the state's preferred list. Bristol-Myers, meanwhile, promised to save the state $16 million in Medicaid costs by the summer of 2003.

Although health care officials say the savings from disease management remains untested, both Pfizer and Bristol-Myers have agreed that if their programs fail to achieve the savings promised, they will pay cash to Florida to make up the difference.

Pfizer recently crafted another plan that has generated goodwill for the company. In January, the company said it would offer drugs to low-income elderly people for a flat fee of $15 a month for each prescription, a fraction of the average retail price of $65. This will help some 7 million people nationwide with gross incomes under $18,000 a year and couples with incomes below $24,000. The company says the measure is intended as a stopgap until Congress adopts broader Medicare reform. Medicare does not cover the cost of prescription drugs outside hospitals.

GlaxoSmithKline and Novartis AG also have discount programs for low-income elderly people.

—Garry Boulard

thing the states can tackle," says Rawlson, who has been tracking both enacted as well as proposed legislation. "But they have to do it in a way that is inclusive, bringing in the pharmaceutical industry to work out a solution, rather than approaching it as some sort of a battle or confrontation."

He says that PharMerica was brought into the Florida debate early by providing the state with data on not only which drugs the nursing home patients most commonly use, but also the drugs that clinical pharmacists—who, he says, "are always looking for the most therapeutical equivalent drug that is also lower-priced"—recommend.

"The Florida approach was one of trying to get as much information first as possible," continues Rawlson. "The fact that they also allow for a physician to override the preferred list if he or she feels a higher-priced drug is necessary, really impressed us."

Connecticut Senator Catherine Cook, whose eastern district is populated by a number of pharmaceutical companies including Pfizer, also worries that an "anti-pharmaceutical industry" atmosphere may be developing at the state level, making it difficult for the drug companies to get a fair hearing.

"Are drugs taking a bigger percentage of our health dollar now than twenty years ago?" asks Cook. "The answer is yes. But that's the good news, a sign of how many new drugs have been developed to help us live with the chronic diseases that used to kill us."

She predicts that if the states do not include the concerns of the drug companies in their approaches to lowering drug prices, "they may very well fail."

"It's illegal for any state to do a formulary under Medicaid. Washington has made that clear," says Cook. "But I don't have a problem with a preferred list, as long as doctors can override anything on that list."

"That is what Florida has done," she continues, "and I think if the other states follow that, they'll be in good shape." Cook similarly warns that not in every case are the lower cost generic drugs preferable to the higher cost name brands.

"It could come down to a brand name drug produced by the latest technology that has fewer side effects and better targets the medical problem in question versus a generic drug that was developed 17 years ago and doesn't," she remarks.

With so many nuanced concerns in the debate over Medicaid prescription drugs and how to cope with their rising prices, legislators may wonder why they should want to even tackle the issue in the first place.

Maine Speaker Saxl warns that any even-handed approach is necessarily going to be difficult. "It is an enormously complex issue, the kind of issue that, when you first begin to look into it, is extremely overwhelming."

But, Saxl adds, such challenges should not deter lawmakers from trying. "By the end of the day, we need to make certain that people get the access to health care that they need. And that can only come with affordable prescription drugs."

AARP Alaska

Honorable Gene Therriault, Chair
Senate State Affairs Committee
Alaska Capitol, Room 121
Juneau, AK 99801-1182

March 18, 2002 RE: SB 306 (Davis) - SUPPORT

Dear Chair Therriault:

On behalf of the 112,000 members of AARP in Alaska, we urge you and your colleagues on the Senate State Affairs Committee to support SB 306, authored by Senator Bettye Davis of your Committee.

AARP's top legislative priority is to have Congress include prescription drug coverage under Medicare.

At the same time, we support all efforts by state legislators to make prescription drugs affordable and available. Our primary intent, in Washington D.C., as well as in Juneau, is to use all viable approaches to bring relief to those in need.

SB 306 will offer Alaska an opportunity to study, evaluate, and make recommendations on how to deal with this issue. SB 306 will establish a Prescription Drug Assistance Task Force that will enable us to learn from other states as well as to identify the most critical needs of older Alaskans.

AARP research as already told us:

- The average annual growth rate for Medicaid spending on prescription drugs in Alaska rose 23.4% from 1996-1998 compared to a 12.6% increase nationwide.
- About 1/3 of Medicare recipients have good prescription drug coverage from their former employer or from their own personal insurance; about 1/3 have some coverage but it is limited and will run out before the year's end; another 1/3 have no coverage and must pay for all prescriptions out-of-pocket. Obviously, this is the group most at risk.

AARP recommends you and your Committee colleagues vote "AYE" when SB 306 appears before your Committee.

Alaska State Office | 3601 "C" Street, Suite 1420 | Anchorage, AK 99503 | Phone: 907-341-2277 | Fax: 907-341-2270 | www.aarp.org

Letters of Support

Should you have any questions about our position, please feel free to contact Marie Darlin (907.586.3637), Coordinator of the AARP Capitol City Task Force; Patrick Luby (907.762.3314), AARP Legislative Representative; or me (907.245.5259).

Thank you for your consideration.

Sincerely,

Marguerite Stetson

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cc: Vice Chair, Senator Randy Phillips
Senator Rick Halford
Senator Ben Stevens
Senator Bettye Davis
Marie Darlin
Pat Luby

CENTER FOR POLICY ALTERNATIVES

March 18, 2002

Alaska Senate Committee on Health, Education and Human Services
Alaska Senate Committee on Finance
State Capital
Juneau, AK 99801-1182

Dear Committee Members:

I am writing to strongly urge you to create a Taskforce to address the need to lower the cost of prescription drugs for all Alaskans without prescription drug insurance. The Center for Policy Alternatives has worked with more than twenty states to help develop model legislation that addresses this critical problem and we hope Alaska will join other states - including New Mexico, West Virginia, and Minnesota - that have taken action in 2002 to address this health crisis.

One in four Americans—70 million—do not have insurance covering prescription drugs. Medicare does not cover outpatient prescriptions, and older Americans desperately need these medicines. Because they have more medical concerns, seniors—representing only 12 percent of the population—consume one-third of all prescription drugs. More than 10 million children are also among the uninsured.

Drug manufacturers sell the exact same pharmaceuticals to different purchasers at widely varying prices. On average, uninsured Americans pay about twice as much as the federal government pays for the same drugs. Uninsured families are charged far more for prescriptions than their insured neighbors, even in the same pharmacy. Similarly, state Medicaid programs pay a price, fixed by federal law, which is 20 to 40 percent higher than the federal government pays. Drug manufacturers still make a healthy profit on the lowest prices they charge the federal government.

Unconscionably high prices for Cipro illustrate the unfairness of the current drug pricing system. A single 500 mg tablet of the antibiotic Cipro, used to fight anthrax and other dangerous bacteria, costs an uninsured American almost $5 per pill—$300 for a bottle of 60 pills. But under the federal government's "340B" program, public health facilities buy the same drug for about 43¢ per pill—only $25.80 for a bottle of 60. The manufacturer, Bayer, makes a good profit because each pill only costs 10-20¢ to manufacture.

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Through free market negotiations, states can substantially lower drug prices for both the uninsured and for the state Medicaid program. In 2000, Maine enacted legislation that directs the state to use its bulk purchasing power to negotiate steep drug discounts for the uninsured. In 2001, Florida joined California as the only states to negotiate supplemental drug rebates for their Medicaid programs, saving both states hundreds of millions of dollars per year.

The Fair Market Drug Pricing Act (available on www.stateaction.org) combines the California-Florida approach with the Maine model. The Act:

- Directs the state Secretary of Health (or similar cabinet Secretary) to negotiate voluntary drug discounts or rebates from prescription drug manufacturers and labelers.

- Gives the Secretary the leverage to negotiate with drug companies much the same way HMOs and health insurance companies negotiate—allowing the Secretary to place on the state Medicaid "prior authorization" list the products of any drug company that refuses to offer a substantial discount that is at least as favorable as the "340B" price.

- Directs the Secretary to set up and administer an Rx Card program, passing negotiated discounts to the people who need them—uninsured seniors on Medicare and residents under 300 percent of the poverty level.

- Empowers the Secretary to combine drug pricing negotiations for Medicaid, the Rx Card program, and any other state health programs, to maximize the Secretary's market clout.

The Fair Market Drug Pricing Act is based on a market approach to pharmaceutical prices—states engage in voluntary negotiations with drug companies. If the companies don't want to participate, they don't have to negotiate. This model doesn't cost taxpayers a dime. On the contrary, it will save the state tens or hundreds of millions of dollars per year, depending on the size of the state's Medicaid budget. Although the drug industry objects to these types of proposals, the Fair Market Drug Pricing Act is constitutional and complies with federal law. Both the Maine and Florida laws have survived the industry's legal challenges. In fact, the model Act is specifically designed to avoid the legal objections raised by the drug industry to date.

The Center for Policy Alternatives congratulates Senator Bettye Davis and the State of Alaska for addressing this important issue.

Sincerely yours,

Bernie Horn
Policy Director

Alaska State Legislature

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Senator Bettye Davis

Senate Bill SB 306

" An Act establishing the Prescription Drug Assistance Task Force; and providing for an effective date."

Sponsor Statement

The NCSL reports spending on outpatient drugs rose 18.8% from 1999 to 2000. In the last decade the average number of prescription per seniors per year has expanded from 19.6 to 28.6. Since 1992 the average cost of prescription drugs for seniors has gone up more than 48%.

In response to this trend, at least 40 states have considered enacting pharmaceutical assistance legislation, 31 states have actually instituted some form of program and 44 states are currently considering drug subsidy legislation.

According to the AARP, the annual growth rate for Medicaid spending on medications rose 23.4% in Alaska from 1996 to 1998 and a third of Alaska's seniors have no prescription drug coverage and must pay drug costs out-of-pocket.

SB 306 creates a Task Force to study prescription drug assistance programs currently in existence or under consideration around the country on both the state and national level. It will also review current and new Medicaid prescription drug initiatives for using drug rebates, discounts or pooling of discounts with other states with the intent of crafting a plan to help Senior Alaskan's meet the increasing burden of rising pharmaceutical costs.

The taskforce will be composed of seven members drawn from both the public and private sectors including a member recommended directly by senior organizations. The taskforce will report its findings and submit recommendations to the 23rd Legislature at the beginning of next session.

The report and recommendations will serve as a guide for crafting a comprehensive Senior Citizen Prescription Drug Assistance program that is both cost effective and meets the needs of Alaska's seniors.

State Pharmaceutical Assistance Programs, December 17, 2001

State	Program Name Year Began	Annual # of Recipients	Funding Source	Eligibility (Age & Maximum Income)	Drugs Covered / Restrictions	Deductible / Co-payment (Per Prescription)	Annual Budget; Annual Average Cost per Recipient
Arizona	Prescription Medication Coverage Pilot Program 2001 (two-year pilot)	To be determined	Tobacco Tax Medically Needy Account	Minimum Age: 65 Income: Between 100% and 200% of the FPL Must be a resident of Arizona county that does not have a Medicare HMO or Medicare HMO that does not provide Rx coverage	To be determined	100% and 149%: Deductible of at least $500 out of pocket for Rx to be eligible 150% and 200%: Deductible of at least $1,000 out of pocket for Rx The state can lower the deductible required for eligibility up to $300 in the second fiscal year, if less than 75% of the appropriation from the previous year has not been spent. Annual enrollment yet to be determined	SFY01-02: $3.9 million SFY02-03: $4.1 million An additional $400,000 annually for administration
California	Drug Discount Program for Medicare Beneficiaries February 1, 2000	1.3 million eligible	Beneficiaries pay for prescription drugs; State General Revenue covers fees for processing pharmacy price inquiries.	Medicare recipients, 65 or disabled without insurance coverage for prescription drugs; no income limit.	All prescription drugs are covered except compounded drugs.	Retail pharmacies charge beneficiaries an amount not to exceed the MediCal reimbursement rate. No deductible or co-pay. Beneficiary pays discounted drug price plus 15 cents to cover pharmacy transaction fee.	$1.7 million; N/A

State	Program Name Year Began	Annual # of Recipients	Funding Source	Eligibility (Age & Maximum Income)	Drugs Covered / Restrictions	Deductible / Co-payment (Per Prescription)	Annual Budget; Annual Average Cost per Recipient
Connecticut	Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled Program (ConnPACE) 1986	33,850	State General Revenue	Minimum age: 65 Disabled: over age 18 receiving SSI or SSDP Single: $15,100 Married: $18,100	All prescription drugs including insulin, syringes. No anti-histamines, contraceptives, experimental, weight loss, cosmetic or smoking cessation products	No deductible Co-pay is $12 per prescription Annual enrollment fee is $25	Total state expenditures of $38 million (reduced by participant fees collected & manufacturer rebates received). Rebates of $11 million deposited into the general fund as revenue. $1,123 average cost per recipient.
Delaware (I)	Delaware Prescription Drug Assistance Program (DPAP) 2000	1,200	State General Revenue Tobacco Settlement	Minimum age: 65 Disabled: eligible for SSDI Single: $16,700 Married: $22,500	Covers most drugs that are manufactured by companies that agree to pay the State a rebate for the right to participate in the program	No deductible Co-pay is $5 or 25% of the cost of each prescription, whichever is greater	Budget is $5 million in drug costs and not more than $600,000/yr in administrative costs; program will pay up to $2,500 per person, per state fiscal year
Delaware (II)	Nemours Health Clinic Pharmaceutical Assistance Program 1981	10,000	Nemours Foundation	Minimum age: 65 Single: $12,500 Married: $17,125	All prescription drugs and insulin syringes	No deductible Co-pay is 20% of retail prescription cost + $5 dispensing fee; maximum yearly benefit is $500 at Nemours discounted price	$5.4 million; $411.78

State	Program Name Year Began	Annual # of Recipients	Funding Source	Eligibility (Age & Maximum Income)	Drugs Covered / Restrictions	Deductible / Co-payment (Per Prescription)	Annual Budget; Annual Average Cost per Recipient
Florida	Prescription Affordability Act for Seniors 2000	N/A	General Revenue Fund	-Florida residents 65+ -Income between 90-120% of poverty level -Eligible for both Medicare and Medicaid -Not enrolled in a Medicare HMO -Request to be enrolled	Monthly benefits limited to $80 per participant, including a discount for any Medicare beneficiary who is a Florida resident when purchasing a prescription drug at a Medicaid participating pharmacy	Participants are required to make a 10% co-insurance payment for each prescription purchased through this program	$30 million per year worth of benefits, $250,000 to administer it

State	Program Name Year Began	Annual # of Recipients	Funding Source	Eligibility (Age & Maximum Income)	Drugs Covered / Restrictions	Deductible / Co-payment (Per Prescription)	Annual Budget; Annual Average Cost per Recipient
Illinois	Pharmaceutical Assistance Program (PAP) 1985	49,186	General Revenue and Tobacco Settlement Funds	Minimum age: 65 Disabled: eligible Single: $16,000 Married: $16,000 As of 1/01: Single: $21,218 Two Person Household: $28,480 Three or More Person Household: $35,740	Coverage limited to: (1) drugs for the treatment of heart disease, diabetes, and arthritis; and (2) insulin, syringes, and needles As of 1/01, drug coverage will be expanded to: Alzheimer's disease, Parkinson's disease, lung disease, smoking related illness and glaucoma. As of 7/1/01, drug coverage will be expanded to osteoporosis.	For the year 2000, the deductible is $15 per month for individuals if income less than 100% of FPL; $25 for individuals if income is over 100% FPL. As of 1/01, there is no deductible. However, for individuals with income less than 100% of FPL, there will be no deductible until the program has paid $2,000 in the state fiscal year. After $2,000, they are responsible for 20% of the cost of the drug. As of 1/01, for those with income above 100% of FPL, they will pay a $3 copay per prescription. For individuals with income above 100% of FPL, once the state has paid $2,000 in the state fiscal year, the individuals then pay the $3 copay plus 20% of the cost of the drug.	$34.8 million; $707.84 The annual budget was increased by $35 million to fund the first 6 months of the program beginning 1/01.

State	Program Name Year Began	Annual # of Recipients	Funding Source	Eligibility (Age & Maximum Income)	Drugs Covered / Restrictions	Deductible / Co-payment (Per Prescription)	Annual Budget; Annual Average Cost per Recipient
Indiana	HoosierRx 2000	Estimated at 40,000	Tobacco Settlement Funds	Minimum age: 65 Family income less than 135% of Federal Poverty Guidelines (FPG) No current prescription drug insurance For individual monthly income: $940 or less - 50% refund up to $500 per year $835 or less – 50% refund up to $750 per year $695 or less – 50% refund up to $1,000 per year For couple monthly income: $1,266 or less – 50% refund up to $500 per year $1,125 or less – 50% refund up to $750 per year $938 or less - 50% refund up to $1,000 per year	All prescription legend drugs, which are covered by the State Medicaid Program are also covered under the HoosierRx Program, including insulin. Individuals mail application and if eligible, the state will mail refund certificates to beneficiary. Once determined eligible, beneficiaries ask pharmacist to print out all prescriptions filled for a specified quarter.	Refunds will cover up to half of those seniors' prescription costs in each quarter, up to $1,000 a year according to the following schedule: To receive a refund for prescriptions bought October through December 2000, submit refund certificate and pharmacy printouts January through March 2001. For prescriptions bought January through March 2001, submit refund April through June 2001. For prescriptions bought April through June 2001, submit refund July through September 2001. For prescriptions bought July through September 2001, submit refund October through December 2001	$20 million

State	Program Name Year Began	Annual # of Recipients	Funding Source	Eligibility (Age & Maximum Income)	Drugs Covered / Restrictions	Deductible / Co-payment (Per Prescription)	Annual Budget; Annual Average Cost per Recipient
Iowa	Iowa Prescription Drug Purchasing Co-op FY2001 (Beneficiaries pay a annual fee to join a co-op that would take advantage of volume discounts.)	N/A	Beneficiaries pay for prescription drugs; U.S. Department of Health and Human Services, Health Care Financing Administration Demonstration Project Grant provides funds for start-up administration and marketing of the program.	All individuals who are eligible for Medicare are also eligible to join the co-op.	All prescription drugs are covered	Beneficiaries would pay an annual fee to join the co-op, which is not yet determined. Iowa would either directly or through a private contractor negotiate volume-purchasing discounts with drug manufacturers. Co-op members would be eligible for these discounts when purchasing their medications.	$1 million grant from the Health Care Financing Administration
Kansas	Senior Pharmacy Assistance Program 2000	N/A	Senior Services Trust Fund	Minimum age: 67 Income: 150% of poverty level Must not qualify for other drug-related programs	Covers up to $1200 per year for those who are eligible. Only covers maintenance drugs for specific diseases	Requires a copayment of not more than 30 percent of the cost of each prescription	N/A

State	Program Name Year Began	Annual # of Recipients	Funding Source	Eligibility (Age & Maximum Income)	Drugs Covered / Restrictions	Deductible / Co-payment (Per Prescription)	Annual Budget; Annual Average Cost per Recipient
Maine (I)	Low Cost Drugs for the Elderly Program 1975 (Beneficiaries incorporated into 1115 Medicaid waiver, Healthy Maine Prescriptions Program)	46,000	State General Revenue	Minimum age: 62 Disabled: age 19 or over Single: $15,244 Married: $20,461	Covers both prescription and non-prescription drugs produced by manufacturers who enter into rebate agreement	No deductible Co-pay is $2 or 20% of the medication's price (the price as allowed by the Dept. of Human Services), whichever is greater and if individual is using generic drugs, or drugs to treat major conditions of seniors, i.e. heart disease, diabetes, etc.	$22 million; $154.55
Maine (II)	Healthy Maine Prescriptions Program June 2001 (Incorporates Low Cost Drugs for the Elderly Program beneficiaries)	225,000 eligible As of August 2001, 61,000 enrolled.	1115 Medicaid Waiver	No age restrictions. All Maine residents with incomes up to 300% of the FPL: Single: $25,000 Married: $33,750	All prescription drugs under Medicaid	Annual administrative fee of $25	
Maine (III)	Maine Rx 2001	Estimated at 125,000	Other Special Revenue	No age restrictions. All Maine residents without 3rd party drug coverage	All prescription drugs with manufacturer rebate agreements	Combines discounts at participating pharmacies with negotiated rebates from manufacturers to at least partially reimburse the pharmacies and to cover administrative costs	
Maryland (I)	Maryland Pharmacy Assistance Program 1979	35,901	State General Revenue	No age restrictions Single: $10,000 and asset limit of $3,750 Married: $10,850 and asset limit of $4,500	Chronic maintenance drugs; anti-infective drugs, insulin	No deductible Co-pay is $5	FFY00: $45.1 million for program benefits; $581,334 for administrative.

State	Program Name Year Began	Annual # of Recipients	Funding Source	Eligibility (Age & Maximum Income)	Drugs Covered / Restrictions	Deductible / Co-payment (Per Prescription)	Annual Budget; Annual Average Cost per Recipient
Maryland (II)	Short-Term Prescription Drug Subsidy Plan July 2001 to July 2003	Maximum of 30,000	37.5% of the total value of the differential provided to carriers that offer Substantial, Available, and Affordable Coverage (SAAC)	Minimum age: 65 Medicare beneficiaries at or below 300% of the FPL: Single: $25,770 Married: $34,830	Medicare+Choice prescription drug formulary	Monthly premium is $10 Co-pay is $10 for generics, $20 brand-name, and $35 non-preferred brand-name Annual benefit limit is $1,000	$22 million
Maryland (IIIa)	Maryland Pharmacy Discount Program (as part of the Medicaid program-contingent upon HCFA approval of 1115 waiver)	Estimated participation is 105,000 Potential eligible is 210,000	Tier I: No cost (administrative costs covered by enrollees) Tier II: State General Revenue and federal Medicaid matching funds	Minimum age: 65 All Medicare beneficiaries including disabled who qualify for Medicare No other drug coverage Under Tier II, greater subsidies will be provided to enrollees under 175% of FPL Single: $15,033 Married: $20,318	All prescription drugs under Medicaid	Tier I: Enrollees purchase prescriptions covered by Medicaid for 82% of Medicaid price at pharmacy. Pharmacies required to charge Medicaid price plus $1 dispensing fee Tier II: For enrollees with income at or below 175%, State will cover 25% of prescription drug cost after Medicaid price	$8 million in State General Revenue funds $8 million in federal matching funds

State	Program Name Year Began	Annual # of Recipients	Funding Source	Eligibility (Age & Maximum Income)	Drugs Covered / Restrictions	Deductible / Co-payment (Per Prescription)	Annual Budget; Annual Average Cost per Recipient
Maryland (IIIb)	Maryland Pharmacy Discount Program (as part of the Maryland Pharmacy Assistance Program-contingent upon HCFA denial of 1115 waiver)	Estimated participation is 105,000 Potential eligible is 210,000	Tier I: No cost (administrative costs covered by enrollees) Tier II: State General Revenue	Minimum age: 65 All Medicare beneficiaries including disabled who qualify for Medicare No other drug coverage Income: At or below 250% of FPL Single: $21,475 Married: $29,025 Under Tier II, greater subsidies will be provided to enrollees under 175% of FPL Single: $15,033 Married: $20,318	All prescription drugs covered under the Maryland Pharmacy Assistance Program (MPAP)	Tier I: Enrollees purchase prescriptions covered by Medicaid for 85% of MPAP price at pharmacy Pharmacies required to charge Medicaid price plus $1 dispensing fee Tier II: For enrollees with income at or below 175%, State will cover 25% of prescription drug cost after Medicaid price	$8 million
Maryland (IV)	Maryland Medbank Program July 2001 to July 2003 MD Health Care Foundation is required to contract with local government or other nonprofit entities for operation of 5 regional sites throughout State		Foundation releases funds to the contracting entities based on need and justification contained in quarterly financial reports	Any individual who meets the criteria established by the pharmaceutical manufacturer's patient assistance program	Contracting entities are authorized to use program funds to purchase interim supplies of drugs for individuals who have applied for a manufacturer's program, but have not yet received the drug		FY02: maximum of $2.5 million FY03: maximum of $3 million
Massachusetts (I)	The Pharmacy Program 1996	43,000	Cigarette tax revenues and state appropriation	Minimum age: 65 Disabled: eligible Single: $15,492 Married: $20,769	All drugs covered by the state Medicaid program; also insulin and syringes	No deductible Co-pay is $3 for generic version; $10 for brand name drugs and certain medical supplies	$72 million; $750.00
Massachusetts (II)	The Pharmacy Program Plus (In effect 1/00 – 12/31/00)	N/A		Minimum age: 65 Disabled: must work less than 40 hours/week Single: $41,220 Married: $55,320	All prescription drugs in all therapeutic classes, including insulin and syringes (except those excluded from MassHealth)	No deductible Co-pay is $3 for generic drugs, insulin, and syringes; $10 for brand name drugs	

State	Program Name Year Began	Annual # of Recipients	Funding Source	Eligibility (Age & Maximum Income)	Drugs Covered / Restrictions	Deductible / Co-payment (Per Prescription)	Annual Budget; Annual Average Cost per Recipient
Massachusetts (III)	The Prescription Advantage Program (In effect 4/01 and will replace Massachusetts I and II programs)	N/A	Tobacco Settlement Funds	Minimum age: 65 Disabled: certain individuals – singles with annual income below $16,152 and married couples with annual income below $21,828 and either do not work or work less than 40 hours per month Income: no upper income limit for individuals over age 65	All prescription drugs	No deductible or premiums if income is below 188% of FPL ($15,698) Above 188% of FPL, premiums and annual deductibles will be based on a sliding income scale with maximum monthly premium of $82 Co-pay for all members will be based on a sliding income scale Maximum out of pocket for co-pays and deductibles is	For SFY2000, (program will only be operating for 3 months): $32.2 million
Michigan (I)*	Michigan Emergency Pharmaceutical Program for Seniors (MEPPS) 1988 Program ends September 20, 2001 To be absorbed by the EPIC program	13,000	General Revenue	Minimum age: 65 Income less than 150% of federal poverty level. Monthly drug expenses of at least 10% of monthly income for singles.	All drugs covered under the state Medicaid program	No deductible Voluntary copayment of $0.25	$6 million (1998); Average of $436 per participant over the maximum coverage of three months.
Michigan (II)	Prescription Drug Credit Program 1988/1989 Program ends December 31, 2001	About 31,000 in 1998	General Revenue	Minimum age: 65 Income less than 150% of the federal poverty level.	N/A	Tax credit of up to $600 for prescriptions exceeding 5% of household income.	$14-$15 million

State	Program Name Year Began	Annual # of Recipients	Funding Source	Eligibility (Age & Maximum Income)	Drugs Covered / Restrictions	Deductible / Co-payment (Per Prescription)	Annual Budget; Annual Average Cost per Recipient
Michigan (III)	Elder Prescription Insurance Coverage (EPIC) Program October 1, 2001 EPIC will replace MEPPS and the Credit Program.	Potential eligibles are estimated to be up to 225,000	General Revenue	Minimum age: 65 Income less than or equal to 200% of the federal poverty level. No deductions in calculating income allowed. Participants must not be receiving Medicaid benefits or have other prescription drug insurance, except for Medicare, Medicare supplemental insurance or other federal senior prescription drug insurance. Must not be a resident of an institution.	Drug coverage will be similar to the Medicaid program – insulin and syringes will be included	Annual administrative fee of $25. Copayments cannot exceed 20% of the cost of the prescription drug with a maximum monthly copayment amount calculated according to income. Copay is $15 for non-DAW brand-name drugs when generics substitution is available. Dispensing fee equal to that of Medicaid program.	Budget is projected at approximately $50 million for the first year of the program.
Minnesota	Senior Citizen Drug Program 1999	11,600 estimated for 2000	General Revenue	Minimum age: 65 Single: $4,000 Married: $6,000	Medicaid formulary as well as antacids, insulin products, vitamins, smoking cessation, and lice medication	Deductible is $35 per month No co-pay	$29.0 million; $106 in 1999, $115 in 2000 (estimated)
Missouri	Pharmaceutical Tax Credit 2000 Repealed and replaced with Missouri Senior Rx Program	510,000	State General Revenue	Minimum age: 65 Individual, adjusted gross income under $25,000.		Maximum tax credit of $200 if income is $15,000 or less. Above $15,000, tax credit amount reduced by $2 for every $100 increase in income up to $25,000. Incomes over $25,000 are not eligible to receive the tax credit.	$52.4 million

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Missouri (II)	Missouri Senior Rx Program July 1, 2002	Tier 1: Eligible: 288,000 Est. Participants: 57,000 Tier 2: Eligible: 95,000 Est. Participants: 20,000	State General Revenue and Tobacco Settlement Funds	Minimum age: Tier 1 Single: $12,000 Married: $17,000 Tier 2 Single: $17,000 Married: $23,000	All prescription drugs	Tier 1: Enrollment fee of $25; Deductible not less than $250 Tier 2: Enrollment fee of $35; Deductible not less than $500 For both Tiers, once deductible met, enrollee pays at least 40% of drug's cost and state pays remaining. Annual cap of $5,000 for both Tiers.	
Nevada	Senior Rx Subsidy for Prescription Drugs January 2001	Estimated 10,000	Tobacco Settlement Funds	Minimum age: 62 Family: $21,500 Nevada residency for minimum of one year. Must not be eligible for Medicaid benefits.	Basic: prescriptions on a managed formulary Enhanced: preferred prescription list	Maximum subsidy of $480/year. Sliding scale paying a percent of premium or $480, whichever is less. Income scale: Up to $12,700- 90% of premium $12,701-$14,800 - 80% $14,801-$17,000 - 50% $17,001-$19,100 - 25% $19,101-$21,500 - 10%	$4.6 million
Nevada (II)	Senior Rx Subsidy for Prescription Drugs July 1, 2001 Updates and replaces January 2001 Senior Rx program	Estimated 5,800	Tobacco Settlement Funds	Minimum age: 62 Family: $21,500 Nevada residency for minimum of one year. Must not be eligible for Medicaid benefits.	All drugs on the preferred prescription list	$100 deductible and annual premium paid by the state Co-pay is $10 for generics; $25 for brand name	$6.5 million State will pay annual premium of $1,280 per senior to insurance companies.

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New Hampshire	Senior Prescription Drug Discount Pilot Program 2000- Two year pilot	Estimated 12,000	No State funds. Contractor providing administrative funds.	Minimum age: 65 No income requirements.	All prescription drugs, except for intravenous or experimental drugs.	Percent discounts depending on brand of medication.	N/A
New Jersey (I)	PAAD – Pharmaceutical Assistance for the Aged and Disabled 1975	FY01: 163,943 aged and 24,728 disabled	State General Revenue and Casino Revenue	Minimum age: 65 Disabled: eligible for SS benefits Single: $19,238 Married: $23,589	All prescription drugs	No deductible; Co-pay is $5	FY01: $313 million; $1,653
New Jersey (II)	Senior Gold Program 2001	Estimated at 100,000	Tobacco Settlement Funds	Minimum age: 65 Disabled: eligible for SS benefits Single: $29,238 Married: $33,589	All prescription drugs	Single: $15 copayment plus half the remaining cost of the prescription until they have spent $2,000. After spending $2,000, there is only a copay of $15. Married: $15 copayment plus half the remaining cost of the prescription until they have spent $3,000. After spending $3,000, there is only a copay of $15.	$50 million

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New York	EPIC – Elderly Pharmaceutical Insurance Coverage 1987	215,600	Tobacco Funds	Minimum age: 65	Most prescription drugs are covered as well as insulin and insulin supplies. The manufacturer must participate in EPIC's Manufacturer Rebate Program. No experimental drugs.		$144.5 million budget beginning April 2000;
New York	EPIC Fee Plan	111,600		Single: $0-$18,500 Married: $0-$24,400		Annual fee $8-$280 – no deductible Limit on annual copayments of $300-$1,088	Sliding fee scale based on income and marital status. Co-pay based on cost of Rx Up to $8 ($3) $8.01-$13 ($5) $13.01-$23 ($7) $23.01-$33 ($10) $33.01 and up ($23)
	EPIC Deductible Plan	5,350		Single: $10,800 -18,500 Married: $14,400 - 24,400		Deductible is $468-$638, no fee. Limit on annual copayments $633-$863.	

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New York (II)	EPIC January 2001	215,000	Tobacco Funds and State General Revenue	Minimum age: 65 Single: $35,000 Married: $50,000 Not eligible if receiving Medicaid	Most prescription drugs are covered as well as insulin and insulin supplies. The manufacturer must participate in EPIC's Manufacturer Rebate Program. No experimental drugs.	With changes on January 1, 2001, copayments and annual fees are reduced by 20%	$180 million added beginning January 1, 2001 Total budget for all EPIC plans from April 2000 to March 2001 was $238.2 million. Expected budget for all EPIC plans from April 2001 to March 2002 is $396.4 million for program benefits and $11 million for administration.
New York (II)	EPIC Fee Plan	142,000		Single: $20,000 Married: $26,000		Annual fee $8-$300, no deductible. Limit on annual co-payments $291-$1,160 Co-pay based on cost of RX Up to $15 ($3) $15.01-$35 ($7) $35.01-$55 ($15) Over $55 ($20) Sliding fee scale based on income and marital status.	

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New York (II)	EPIC Deductible Plan	73,000		Single: $20,001-35,000 Married: $26,001-$50,000		Deductible $530-$1,715. Limit on annual copayment of $1,050 - $2,000	
North Carolina (I)	Prescription Drug Assistance Program 2000	N/A	State General Revenue	Minimum age: 65 Single: $12,360 150% of poverty level	Only drugs pertaining to cardiovascular disease (CVD) and diabetes. No Medicaid coverage.	No deductible Co-pay is $6	$500,000 budget; $1,000/person projected for CVD and $629/person projected for diabetes

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North Carolina (II)	Prescription Drug Assistance Plan for Seniors Spring 2002 (replaces Prescription Drug Assistance Program)	100,000	Tobacco Settlement Funds from state's Health and Wellness Trust Fund	Minimum age: 65 Income: Up to 200% of FPL Single: $17,180 Married: $23,220 Must be uninsured and not eligible for Medicaid	Coverage limited to drugs for treatment of cardiovascular disease, diabetes mellitus, and chronic obstructive pulmonary disease (COPD) Also funding disease management and pharmaceutical manufacturers donating prescription drugs to beneficiaries	Maximum subsidy of 60% per prescription: annual benefit cap of $600 which is 60% of first $1,000 in drug costs.	$35 million for first year of program, with $32 million to provide prescription drugs and $3 million for education and counseling for seniors $600 per person
Oregon**	Senior Prescription Drug Assistance Program 2001	Estimated at 110,000	Cigarette Tax Revenue	Minimum age: 65 Income: Up to 185% of FPL Single: $15,891 Married: $21,478 Maximum assets of $2,000	All prescription drugs available under the Oregon Health Plan	Annual benefit cap of $2,000 Maximum subsidy of 50% per prescription	

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Pennsylvania (I)	PACE – Pharmaceutical Assistance Contract for the Elderly 1984	211,711 (as of March 2001)	State Lottery	Minimum age: 65 Single: $14,000 Married: $17,200	Most prescriptions are covered, as well as insulin, syringes, and needles. Does not cover experimental drugs, medications for baldness or wrinkles, or non-prescription drugs.	No deductible Co-pay is $6	SFY02 estimates: $359 million - (before rebate) for both PACE and PACENET; $1,450 (net per PACE enrollee after rebate); $1,000 (net per PACENET enrollee after rebate.) PACE and PACENET contract administration estimated costs for 2002 - $9.5 million
Pennsylvania (II)	PACENET – PACE Needs Enhancement Tier 1996	23,000 (as of March 2001)	State Lottery	Minimum age: 65 Single: $17,000 Married: $20,200	Most prescriptions are covered, as well as insulin, syringes, and needles. Does not cover experimental drugs, medications for baldness or wrinkles, or non-prescription drugs.	Deductible is $500 annually Co-pay is $8 ($15 for brand name medication)	

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Rhode Island	RIPAE – Rhode Island Pharmaceutical Assistance for the Elderly 1985	33,000	State Revenue and Manufacturer Rebates	Minimum age: 65 Single: $16,490 Married: $20,613 Excludes income spent on medication if greater than 3% of total income (the program's reach has been expanded to cover services for seniors with incomes up to $41,400)	Medication for high blood pressure, heart disease, high cholesterol, circulatory insufficiency, asthma or chronic respiratory disease, diabetes, cancer, Parkinson's disease, glaucoma, Alzheimer's disease, urinary incontinence, depression, arthritis, anti-effectives, drugs for the treatment of influenza A and B available at a sliding rate based on income for state and consumer co-payments for prescriptions under the state pharmaceutical assistance to elderly program.	No deductible Co-pay percentage is determined using a formula based on income. RIPAE members pay either a 40%, 70% or 85% of the discounted RIPAE price for covered prescription drugs. Co-pays for Singles: $0-$16,490 – 40% $16,490-$20,700 – 70% $20,700-$36,225 – 85% Co-pays for Married: $0-$20,613 – 40% $20,613-$25,875 – 70% $25,875-$41,400 – 85%	$10 million; $537.30 per active RIPAE member (member filling prescriptions during benefit year).

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South Carolina	SilverRxCard October 2000	34,000	Tobacco Settlement Funds	Minimum Age: 65 Resident of SC for 6 months ineligible for Medicaid no current prescription benefits from insurance or other sources not over 175% FPL	Non-experimental, non OTC drugs, and some other drugs such as those for baldness are excluded. Only includes FDA-approved drugs	There is a $500 calendar year deductible. While meeting this deductible, SilverRxCard members receive a 10% discount on prescriptions. After meeting the deductible, generic drugs are $10 for a 30-day supply and brand-name drugs are $21 for a 30-day supply. Generics are mandatory when available.	SFY00: $20 million
Texas	Health and Human Services Commission must develop and implement a program by January 2002	To be determined	State Revenue	Medicare dual-eligibles and others; upper income eligibility limit to be determined by Commission	To be determined	To be determined	SFY02: $128.8 million
Vermont (I)	VHAP – Vermont Health Access Program (pharmacy component) 1996	8,058 (Average monthly SFY 2000: 7/1/99-6/30/00)	Medicaid (1115 Demonstration Project)	Aged: Minimum age 65 Disabled: Recipients of disability benefits through OASDI or Medicare through 150% FPL Single: $12,528 Married: $16,884	Covers all drugs in Medicaid; no experimental or non-prescription drugs. Maintenance only for individuals between 150% and 175% of federal poverty level.	No deductible. Co-pay is $1 for prescriptions costing $1 to $29.99 and $2 for prescriptions costing $30 or more.	$13 million net of rebate (estimated SFY 2001); $1,489 SFY 2001
Vermont (II)	VScript (incorporated into VHAP) 1999	2,171 (Average monthly SFY 2000: 7/1/99-6/30/00)	Medicaid (1115 Demonstration Project)	Aged: Minimum age 65 Disabled: Recipients of disability benefits through OASDI or Medicare through 175% FPL Single: $14,616 Married: $19,692	Covers maintenance drugs only, such as anti-hypertensives	No deductible. Co-pay is $1 for prescriptions costing $1 to $29.99 and $2 for prescriptions costing $30 or more.	$3.6 million net of rebate (estimated SFY 2001); $1,489 SFY 2001

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Vermont (III)	VScript Expanded (state-only VScript) January 2000	1,901 (Average monthly 7/1/00-12/31/00)	State funds	Aged: Minimum age 65 Disabled: Recipients of disability benefits through OASDI or Medicare through 225% FPL Single: $18,792 Married: $25,320		No deductible. Co-pay is 50% of prescription cost.	$1.1 million net of rebate (estimated SFY 2001); $295.64 7/1/00-12/31/99
Vermont (IV)	Pharmacy Discount Program (PDP) 2001 (Suspended June 2001)	1,104 January 2001 Projected year end, 2001: 14,327 Medicare covered beneficiaries an additional 6,266 individuals	Medicaid (1115 Demonstration Project)	Any Medicare-covered individual with income above 150% of the FPL without drug coverage. This includes those eligible for VScript (up to 225% of the FPL) who currently receive a benefit for maintenance drugs. All individuals with income up to 300% of the FPL who do not have a benefit program that includes drug coverage. Single: $25,056 Married: $33,756	All prescription drugs	Benefit is drugs at the Medicaid rate including cost of dispensing less anticipated rebate of 17.5%. Annual enrollment fee of $24 paid as $3 for each of the first eight prescriptions costing $20 or more in a calendar year.	$659,187 before rebate (estimated SFY 2001); $9.86 1/01

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Washington**	A Washington Alliance to Reduce Prescription-Drug Spending (AWARDS) 2001 (Senior citizens pay a nominal fee to join a co-op that would take advantage of volume discounts.) May 2001, AWARDS program suspended because the state agency did not have the authority to implement it without legislative approval.	N/A	Beneficiaries pay for prescription drugs	Minimum age: 55 All individuals over age 55 are eligible for AWARDS. Individual purchases at participating pharmacies, will be merged with the buying power of the state Uniform Medical Plan to buy drugs at substantially lower costs.	All prescription drugs	Annual fee of $15 per individual and $25 per family. AWARDS members can expect to pay from 12 to 30 percent less than retail prices for prescription drugs. If members order from a mail service, they can expect discounts from 20 to 49 percent. Discounts will vary, depending on an individual's drug profile and current use of generic drugs.	No cost to the state
West Virginia	Senior Prescription Assistance Network (SPAN) II 2000 (replaced with Golden Mountaineer Program)	Estimated 100,000 Actual 4,000	N/A	Minimum age: 65 Income: At or below 300% of FPL Single: $25,050 Married: $33,750	All prescription drugs	No premiums or deductibles	N/A
West Virginia (II)	Golden Mountaineer Discount Card Program September 2001 (for pharmacy component) (replaces SPAN II program)		N/A	Minimum age: 60 No income requirements	All prescription drugs	N/A	N/A

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Wisconsin	SeniorCare 2001	Estimated 260,000 eligible	State General Revenue	Minimum age: 65 Income: At or below 240% of FPL Single; $20,616 Married: $27,864	All prescription drugs	$500 deductible, waived for those with income less than 160% Co-pay is $5 for generic drugs; $15 for brand name	FY02: $2 million FY03: $49.9 million (9/1/02) Annualized Cost $78 million Reduce the average annual per beneficiary prescription bill of $1,600 by $970
Wyoming	Minimum Medical Program (MMP) 1988	539/month	State General Revenue	No age restrictions. Income: $8,240; 100% of federal poverty level with no more than $1,000 in resources	All prescription drugs and oxygen services.	No deductible Co-pay is $25 per prescription for a maximum of $75 per month per recipient. Three prescriptions per month and oxygen services.	$1.162 million; $1,041/month

*Michigan also has the State Medical Program that provides limited medical assistance, including prescription drugs, to certain financially needy and/or disabled persons who do not quality for Medicaid.

**Information for Oregon and Washington was not verified by state officials.

Information for the table was collected from interviews with state officials, the National Conference of State Legislatures, the National Pharmaceutical Council, and AARP.