HEINZ FAMILY PHILANTHROPIES

HEINZ PLAN TO OVERCOME PRESCRIPTION DRUG EXPENSES

Creating a Comprehensive and Affordable Prescription Drug Program for All Persons 65 and Over in Mississippi

Wednesday, October 10, 2001

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A project of the Heinz Family Philanthropies

in conjunction with PharmaCare Management Services, Johnson & Johnson, Eli Lilly & Company, GlaxoSmithKline, Merck & Co., Inc., Pfizer Inc., Pharmacia Corporation, Bayer Pharma, Aventis Pharma AG, AstraZeneca PLC, RiteAid Corporation, and Schering-Plough Corporation

Report prepared by Jeffrey R. Lewis, Executive Director
With technical support from William M. Mercer, Incorporated

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Dedication

The **H**einz Plan to **O**vercome **P**rescription drug **E**xpenses: The Mississippi Strategy (HOPE for Mississippi) is dedicated to the vision of two great men, United States Senator John Heinz and Mississippi Governor Ronnie Musgrove.

Senator Heinz was that rare Republican Senator who not only cared about the welfare of all people, but particularly women, and aged and disabled citizens. Senator Heinz recognized and believed that for senior citizens and disabled individuals to survive and avoid unnecessary placement into a hospital, or premature placement into a nursing home, they would need a national prescription drug benefit to help them remain independent. That is why he led a bipartisan effort to enact the first Medicare prescription drug plan, only to watch the Congress repeal that provision, and many others, contained in the Medicare Catastrophic Coverage Act (MCCA).

Governor Ronnie Musgrove is that exceptional Governor who has recognized that unless, and until, people 65 and older, particularly the more than 81% of the elderly in Mississippi with incomes under 200% of the federal poverty level ($17,180 for an individual, and $23,220 for a married couple) are given assistance with the skyrocketing costs of prescription drugs, far too many will be impoverished and far too many will needlessly end up in nursing homes. While recognizing that the State of Mississippi has, at best, limited resources, Governor Musgrove asked the Heinz Family Philanthropies with pharmaceutical industry support to provide the State with a blueprint on how it might provide prescription drug coverage to elderly Mississippians.

This strategy is dedicated to both men for their willingness to tackle the kinds of tough issues that many state and federal legislatures shy away from.

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Letter from the Chairman

The Honorable Ronnie Musgrove
Office of the Governor
P.O. Box 139
Jackson, MS 39205

Dear Governor Musgrove:

One of the greatest crises facing people 65 and older is the skyrocketing cost of prescription drugs. Far too many senior citizens in Mississippi have, and continue to face, the tough choice of choosing between important necessities of life, such as food and housing, and purchasing and re-filling needed prescription drugs. Being forced to make these kinds of choices at any age is difficult and, I believe, wrong.

My late husband, United States Senator John Heinz, championed the issue of prescription drug coverage for people 65 and older in Congress. As early as 1987, he was seeking legislative solutions for this already serious problem. Joined by colleagues from both sides of the aisle, John, a Republican, believed that we must help save our seniors from having to choose between filling a prescription and being able to buy food or other personal necessities. Sadly, in the United States today, hundreds of thousands of seniors still confront that challenge each day. Nothing could be more tragic and, in the richest nation on the earth, nothing could be more wrong.

A number of months ago, Governor Ronnie Musgrove asked if the Heinz Family Philanthropies, with assistance from the pharmaceutical industry, could assist the State of Mississippi by preparing a blueprint that would create an affordable prescription drug program for all people 65 and over living in Mississippi. The result –"The Heinz plan to Overcome Prescription drug Expenses: The Mississippi Strategy" (HOPE for Mississippi) – is contained in the report that follows.

HOPE for Mississippi represents the results of months of work by the foundation's Executive Director Jeffrey Lewis, our consultants from the William M. Mercer Incorporated, PharmaCare (a pharmacy benefit manager), and representatives from a number of pharmaceutical manufacturer's including Johnson & Johnson, Eli Lilly & Company, GlaxoSmithCline, Pharmacia Corporation, Bayer Pharma, Aventis Pharma AG, Schering-Plough Corporation, Pfizer Inc., Merck & Co., Inc., AstraZeneca PLC, PharmaCare Management Services, and Rite Aid Corporations.

HOPE for Mississippi creates, for the first time, affordable and comprehensive prescription drug coverage for all people 65 and older. However, to ensure that the program remains financially realistic, only people with incomes at or below 200% of poverty ($17,180 for a single person, $23,220 for a married couple) will be initially eligible. Once the program is up and running, the legislature will assess how, and in what ways, all other people 65 and older could be eligible for this program.

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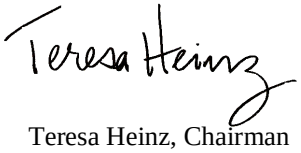
Letter from the Chairman

I think everyone can agree that HOPE for Mississippi reflects a prodigious amount of work done by many extraordinary people who truly deserve to be applauded and thanked. Among them are: Annette Boyer, Thomas Tomczyk, Lisa Coe, Laura Coe, Elizabeth Henry, and Barb Karwowski of William M. Mercer, Incorporated for their extensive and invaluable technical expertise; Irwin (Tubby) Harrison of Harrison and Goldberg for his important knowledge and focus group research; and Dr. Frank Gannon, Bobbi Munson and Brian Schuetz of the Heinz Family Philanthropies staff, for their research and editing assistance.

And a very special thank you to Jeffrey R. Lewis, the author of this report. Jeff is my chief of staff and the executive director of the Heinz Family Philanthropies. He continues to lead the effort to keep the vision of my late husband, Senator John Heinz, alive and flourishing.

Sincerely,



Teresa Heinz, Chairman
Heinz Family Philanthropies

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I. Why this Report?

Almost 14 years ago, on October 27, 1987, the United States Senate debated whether to expand the Medicaid program to include catastrophic health insurance coverage for all eligible recipients. This bipartisan effort was led by Senator John Heinz (R-PA), Senator George Mitchell (D-ME) and others, and offered an amendment to expand Medicare to include prescription drug coverage for all recipients.

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

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

> "This is an age of medical miracles, of artificial hearts, and mechanical lungs, and there is probably no greater miracle than the drugs used in combating and controlling disease. The irony is that for millions of older Americans, this miracle becomes a nightmare because of costs…any bill presuming to protect Medicare beneficiaries against catastrophic costs is an imposter without a provision to cover prescription drugs."

Even in 1987, John Heinz refused to accept that the nation which prides itself as the leader of the free world could fail to create and implement a national program to help middle class seniors from becoming bankrupt because of the costs of prescription drugs.

Today, the current and anticipated advances in medicine and biotechnology are likely to make prescription drugs more critical to the preservation and quality of life than ever before.

Senator Heinz believed that there was a need to redefine the role of government away from the notion of the all-encompassing welfare state that is all things to all people. Rather, he envisioned a government that more properly serves the people and provides for them, at the same time, the essential services they cannot otherwise, or best, find for themselves. As Chairman of the Senate Special Committee on Aging, he wanted to ensure that all Americans who need help – and particularly seniors – should have access to it. Coverage for prescription drugs was then, and remains today, one of those legitimate services.

Former Senator Tim Wirth (D-CO), a long-time personal friend of Senator Heinz, may have said it best:

> "More than anything else, John Heinz believed in the power and promise of good government. Where others were cynical, he was creative. Where others gave up, he persisted… He simply believed that there was a proper role for government, and he demanded that it be efficient, effective and compassionate."

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I. Why this Report?

Teresa Heinz shared her late husband's concerns that far too many people 65 and over desperately need help with the costs of their prescription drugs. Far too many of these seniors, including many who live in Mississippi, find that they are not eligible for state subsidized programs, and are also unable to afford today's high-priced private Medigap insurance plans with prescription drug benefits.

Against this background, Mrs. Heinz, now Chairman of the Heinz Family Philanthropies, sees a clear need to help those middle class seniors who do not qualify for Medicaid or other state assisted programs. Because their situation is growing increasingly critical, she challenged us to design a plan to bring prescription drug coverage to all persons 65 and over. Teresa Heinz, like Senator John Heinz, brings a special intensity of interest, a unique energy, and a sincere dedication to finding solutions for these kinds of problems.

The report that follows – HOPE for Mississippi – meets the challenge set forth by Mrs. Heinz, and represents an innovative and practical way for state government to help senior citizens fight the nightmare of escalating prescription drug costs, and to avoid having to choose between prescription drugs and other basic personal and household needs. Based on months of research, focus groups, and meetings with experts, we believe that HOPE for Mississippi as described and detailed in the following pages, accomplishes her goal.

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

Today, many seniors are forced to choose between paying for necessities of daily life, such as food, clothing and heating, or their prescription medications. Stories of senior citizens who had to cut back sometimes on food or heating fuel to be able to afford a prescription drug have been told repeatedly[i]. In addition, compliance with recommended dosages is often compromised due to limited financial resources. Since most of the Medicare beneficiaries utilize pharmaceutical therapies for chronic conditions, incorrect compliance, such as missed doses or partial doses of drugs, may lead to increased medical costs and utilization. The result is a population whose health status suffers because of this gap in coverage. We believe an obligation exists to design a solution to improve the availability of prescription drug coverage for all people 65 and over living in Mississippi, not just those on relatively low fixed incomes.

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

National Prescription Drug Expenditures

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

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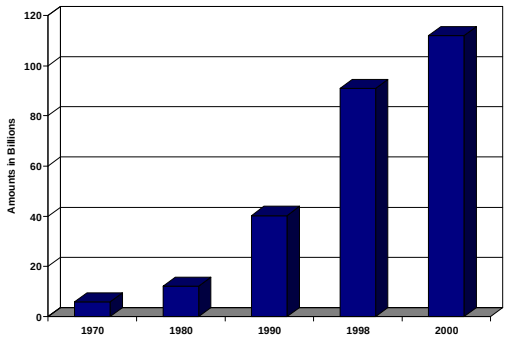
II. Prescription Drug Benefits for Seniors: The Nation's Challenge

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



Source: Health Care Financing Administration Office of the Actuary

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

Aging of the Population

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

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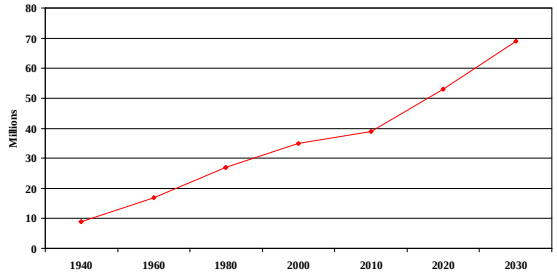
II. Prescription Drug Benefits for Seniors: The Nation's Challenge

Figure 2
Number of Persons Over Age 65
1940 - 2030



Source: The U. S. Bureau of Census

The dramatic growth in the senior population is significant because they are the greatest users of prescription drugs. In 1999, the typical Medicare beneficiary used an average of 34 prescriptions per year, as compared with about 10 to 11 per year for the under-65 population.[ii] Moreover, seniors spend a great deal more of their discretionary income for prescriptions.

Senior Prescription Drug Coverage

Today, the Medicare program does not cover outpatient prescription drugs. In order to obtain this coverage many seniors turn to other types of coverage. The four major sources for coverage are employer-sponsored health plans, Medicaid, Medicare+Choice HMO and Medigap. Figure 3 shows where Medicare beneficiaries have turned to obtain coverage that either replaces Medicare or supplements Medicare Parts A & B. Not all coverages, however, include prescription drug benefits.

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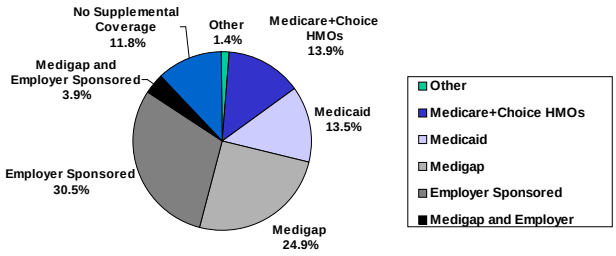
II. Prescription Drug Benefits for Seniors: The Nation's Challenge

Figure 3
Prescription Drug Coverage of Medicare Beneficiaries, 1997



Source: 1997 Medicare Current Beneficiary Survey

Employer-Sponsored Health Plans

At present, one-third of former employees are provided with employer-sponsored health plan coverage.[iii] There is strong evidence, however, that this is declining.

One in four seniors who had drug coverage through a retiree health plan between 1994 and 2000 lost that benefit. As reported in the Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans for calendar year 2000, those employers offering retiree health insurance to Medicare eligible retirees coverage dropped from 40% in 1993 to a low of 24% in 2000 (see Figure 4).[iv] Out of the 24%, 83% of employers offer retiree health coverage to Medicare eligible retirees that includes prescription drug coverage.

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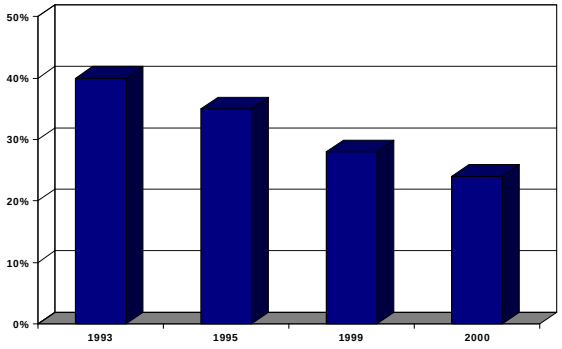
II. Prescription Drug Benefits for Seniors: The Nation's Challenge

Figure 4
Percentage of Employers Offerings
Health Care Benefits to Retirees



Source: Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans (Large employers)

One of the principal factors contributing to employer termination of retiree health insurance is the escalating cost of prescription drug coverage. Prescription drugs can account for 40% - 60% of an employer's share of Medicare eligible retiree medical plan costs even when Medicare Parts A & B are primary.

Medicaid

About 13% of Medicare beneficiaries have prescription drug coverage through the Medicaid program. Medicaid provides medical assistance to certain categories of low-income people, including the aged and the disabled, through a federal-state partnership. Although not required to do so, all states currently cover prescription drugs as part of their Medicaid programs.

Comment: Is this nationally, or is it Mississippi?

Unfortunately, Medicaid programs typically do not enroll all those who are eligible for benefits. Under-enrollment in the Medicaid program is caused by many factors, including insufficient outreach to eligible individuals. According to a 1998 Kaiser Family Foundation study, only about 40% of Medicare beneficiaries eligible for Medicaid are actually enrolled.[v]

Comment: Are we talking about Medicaid or Medicare? The paragraph discusses the under-enrollment problems of Medicaid, but then states that only 40% of MEDICARE are enrolled.

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

Medicare+Choice

Because Medicare does not provide an outpatient prescription drug benefit, many seniors have been attracted to Medicare+Choice programs – and other managed care programs including HMOs – that offers a prescription drug benefit. In 1999, 13% of Medicare beneficiaries obtained their prescription drug coverage through a Medicare+Choice HMO.[vi] This is a decrease from the 14% reported in the 1997 Medicare Current Beneficiary Survey.

The future of these benefit plans is uncertain. Many plans, faced with rapidly escalating prescription drug costs and declining reimbursement from the federal government, are reducing the prescription drug benefit, or even eliminating it entirely.

Medigap Policies

Approximately 25% of Medicare beneficiaries obtain coverage through supplemental Medigap policies that they purchase individually.[vii] Medigap policies offer supplemental coverage for expenses not paid for by Medicare, such as deductibles and copayments.

Of the ten standard Medigap policy designs, however, only three offer prescription drug coverage as part of the benefit package. The coverage offered by these three plans is limited and expensive. Two of the plans that offer prescription drug coverage (plans "H" and "I") only cover 50% of prescription drug costs to a maximum benefit of $1,250 with a $250 deductible. The maximum prescription drug benefit on the third plan (plan "J") is $3,000. The incremental cost of the pharmacy coverage in these plans ranges from $300 to $500 per year and is high relative to other coverage options. It should be noted that not all plans are available in all states because of state regulatory considerations.

Due to lack of options and the rapid decline of HMOs participating in the Medicare program, seniors enrolled in such plans have found themselves forced to purchase expensive Medigap insurance plans to ensure for prescription drug coverage.

What Lies Ahead

While two-thirds of Medicare beneficiaries have some form of drug coverage, nearly one-third lack coverage and must pay out of pocket for their drug expenses. Even though there are a few state programs to provide prescription drug assistance, these programs generally only provide coverage for seniors with incomes up to 135% of Federal Poverty Level (FPL) $11,597 for a single person and $15,674 for a married couple. Over half of all Medicare beneficiaries nationally have incomes above 150% of poverty (or $12,885 annually).

With prescription drugs, however, now used as primary therapy, coupled with an aging population that relies more heavily on such medications, there is an immediate need, and demand, for expanded coverage for seniors.

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

The primary potential reform options are to offer senior prescription drug coverage either by expanding the current Medicare program, or by offering a state-level solution. The recent proposal by the Bush Administration for a senior discount program does provide for some relief. However it is not a sustainable solution. Because of the reengineering required to bring Medicare into the 21st century, we believe that a state-level solution –**HOPE for Mississippi** – is the best way to develop a prescription program to which seniors have access. Seniors must, at a minimum, have access to affordable coverage that will meet their needs. Seniors with limited financial resources should have subsidized or free coverage, depending on their financial situation.

A Medicare prescription drug benefit is bogged down in Congress and is not likely to become law soon. Even President Bush's attempt at reform, the Prescription Drug Discount Program proposal, will take Congress several years to provide meaningful prescription drug coverage for seniors.[viii] Uninsured working families continue to find themselves forced to use hospital emergency rooms for treatment of acute and chronic health care problems. And, because of this, many end up spending time in a hospital because they have been unable to purchase needed medicines. And the high cost of such care is ultimately borne not only by individual seniors and uninsured working families, but also by their children and the nation's taxpayers.

Mississippi stands at an important historical crossroads – one that will challenge both the political and institutional courage of the Mississippi State Legislature as well as that of the Office of the Governor. This report addresses many of the issues affecting the availability of senior prescription drug coverage for Mississippi residents. The challenge is whether the Mississippi political structure is prepared and willing to tackle a problem confronting all people 65 and older. This challenge is not new. It cannot and should not be ignored any longer.

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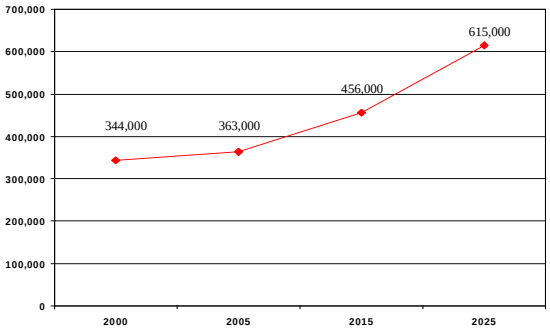
III. Prescription Drug Benefits for Seniors: The Situation in Mississippi

The Aging of the Population in Mississippi

According to the U.S. Bureau of Census, there are 344,000 seniors age 65 and over in Mississippi at the end of year 2000. This population is projected to increase to 615,000 by 2025 (Figure 5).

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



Source: The U. S. Bureau of Census

Approximately 29% of people 65 and older living in Mississippi have income at or below the federal poverty level ($8,590 for a single person and $11,610 for a married couple), as illustrated in Table 1.

Comment: What about Louisiana and Arkansas? Is the 100% of the federal poverty level?

TABLE 1
PERCENTAGE OF PERSONS 65 AND OLDER

STATE	AS COMPARED TO STATE'S TOTAL POPULATION	BELOW THE FEDERAL POVERTY LEVEL*
Alabama	13%	24%
Florida	18%	11%
Iowa	15%	11%
Mississippi	**12%**	**29%**
Pennsylvania	16%	10%
Tennessee	12%	21%
West Virginia	15%	17%

* Numbers reflect count of individuals based on household income

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

Current Senior Prescription Drug Coverage in Mississippi

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

- Employer-sponsored plans
- Medicare+Choice HMOs
- Medigap plans
- Medicaid

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

Employer-sponsored Plans

During the 1990s the trend with employer-sponsored plans was to eliminate retiree benefits for medical and prescription drug coverage. As reported in the Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans for calendar year 2000, only 24% of large employers (employers with 500 or more employees) in Mississippi provide retiree health coverage to employees who retire and are eligible for Medicare. Of the 24% who provide retiree health coverage, 83% of large employers in Mississippi provide prescription drug coverage. Most employer-sponsored plans provide limited benefits for their employees due to the expense of the benefit to the employer. This adds to the decrease availability of affordable prescription drug benefits for the 65 and over population.

Medicare+Choice HMOs

There is one Medicare+Choice HMO providing coverage to Medicare eligibles in Mississippi inclusive of prescription drug coverage. Coverage is limited only to those Medicare eligibles that reside in Southern Mississippi.

Comment: Where in Southern Mississippi?

Medicare+Choice plans in Mississippi have followed a national trend by imposing quarterly limits on prescription drugs. Prior to this, HMOs would, for example, pay for drug coverage up to $1,000 a year. However, given the dramatic increase in prescription drug costs, Medicare+Choice plans have imposed "quarterly" limits. This means, for example, that when a senior citizen spends $250, for the remainder of that quarter, the HMO will not pay for any of their prescriptions and the senior must pay 100%. The Medicare+Choice HMO product in Mississippi has a quarterly limit of $75.

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

Medigap Plans

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

Since prescription drug costs could represent as much as 50% of the overall costs of these programs, premiums for these plans (illustrated in Table 2) are relatively high since they may not fully leverage volume discounts and pharmacy management opportunities.

TABLE 2
2001 SAMPLE OF MEDIGAP PLANS IN MISSISSIPPI (MONTHLY PREMIUMS)

VENDOR	PLAN H WITH DRUG COVERAGE	PLAN C WITHOUT DRUG COVERAGE
Blue Cross Blue Shield of Mississippi	$163.13	$105.25
United Healthcare Insurance Company (AARP)	$144.00	$112.60
Average	$153.57	$108.93

Referencing the 2001 monthly premiums in Table 2, it is estimated in 2003 that Medigap premium rates for Plan H, which includes prescription drug coverage, will range from $160 to $185. The range of cost between a Medigap plan with prescription drug coverage and a Medigap plan without coverage is estimated to be $35 to $69.

Medicaid

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

Comment: Earlier, it was stated that ALL STATES provide coverage. Which is it?

There are 26,072 seniors enrolled in the Mississippi Medicaid fee-for-service program. Recipients have comprehensive prescription drug coverage with a copayment of $1 per prescription, for a 34-day supply limit or 100 units or doses, whichever is greater. Total prescriptions dispensed per month per recipient are limited to 5 or recipients may get up to 10 prescriptions with prior authorization.

Comment: I thought that Medicaid participants could receive 10 prescriptions per month without prior authorization?

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IV. Confronting the Tough Choices

In constructing HOPE for Mississippi, a decision was made early on to include various provisions to address the difficult issues of cost and utilization of prescription drugs. Costs, both for the beneficiary and the State of Mississippi, have to be carefully managed and controlled to avoid more difficult problems once a program is passed and implemented. Our goal and strategy is to ensure that we are recommending a series of options, all of which are financially sustainable now and in the future. We believe our responsibility is to the citizens of Mississippi, and to future generations of taxpayers.

First, HOPE for Mississippi will provide, for the first time, a voluntary and affordable prescription drug program for seniors – 65 and over. However, to ensure for the fiscal solvency of the program and to help those seniors most in need, only those seniors with incomes at or below 200% of the Federal Poverty Level will be eligible – $8,590 for a single person and $11,610 for a married couple.

Second, HOPE for Mississippi provides for responsible access to all prescription drugs through cost sharing and an incentive formulary. Individuals will have a copayment, which requires an individual to pay a fixed dollar amount for each prescription, of 30% for generic drugs, a chemically equivalent copy of a brand name drug, 50% for preferred drugs and 90% for non-preferred drugs. Coinsurance is used as a cost share technique to protect the program from drug inflation. Coinsurance requires an individual to pay a specific percentage of the charge for each prescription drug. Moreover, if the individual or physician elects a brand name drug when an approved generic drug is available, the individual will pay the price difference in addition to the copayment.

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

Third, HOPE for Mississippi protects seniors for the costs of prescription drugs up to $2,000. In other words, once a state has spent $2,000 for an individual in actual drug costs, coverage will cease for that calendar year and begin again on January 1 of the next calendar year.

Fourth, to ensure that this or any pharmacy plan does not adversely impact Mississippi's fiscal position for seniors, seniors covered under the plan, must financially participate in the plan. HOPE for Mississippi calls for a nominal premium payment of $10 per month for individuals with incomes at or below 200% ($8,590 for a single person and $11,610 for a married couple) of the Federal Poverty Level, and a $50 annual individual deductible. All premiums and annual deductibles are tied to trend and, therefore, will increase with inflation.

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IV. Confronting the Tough Choices

Fifth, a difficult decision involved whether to build HOPE for Mississippi incrementally, or start a full-blown program with every person age 65 and over being admitted to it. We believe that the plan must be incremental in its design, meaning that in each successive year after its inception, an increasing number of eligible persons age 65 and older would be admitted. This is done in order to build a set of fiscal benchmarks for the plan, and to ensure that the Governor and state legislators fully understand all of the costs associated with the plan, whether modifications may be required, and the fiscal implications of expanding this program to all people 65 and older.

Sixth, we have built into the plan's design the appropriate pharmacy benefit cost and utilization management strategies to help ensure its financial solvency. One pharmacy benefit management strategy not included in HOPE for Mississippi is a mandatory prescription drug mail order program for maintenance and life-sustaining drugs. Life-sustaining drugs are used in the treatment of conditions that are life threatening or impact the health status of a patient. A maintenance drug is defined under this plan as a drug that is taken for a chronic condition, consecutively, for a period of time generally longer than three to six months.

Given the value provided by pharmacists, especially in the State of Mississippi where much of the population resides in very rural areas, we believe that the consistency of one to one contact between a pharmacist and an elderly person far outweighs the limited savings achieved through a mandatory mail program. However, a voluntary mail order benefit is recommended as part of HOPE for Mississippi for members who would benefit from the convenience of this service.

Seventh, it is possible that a plan such as this may cause some employers who currently offer post-retirement prescription drug coverage to stop such coverage for future retirees. Our hope is that employers would decide to provide future retired employees with the cash benefit to purchase this coverage. In the long term, this would greatly reduce an employer's liability. More importantly, it would recognize a trend that exists today: to compete in a global market place, we must help employers attract and retain the very best workers. Offering to help employers remain competitive and stay in Mississippi is an important goal that cannot be ignored. But we understand that this aspect of the plan is not without controversy.

Eighth, we tackled the issue of "household equity: whether each person in a married couple should pay a separate premium and deductible. We concluded that they should.

Ninth, critical to the success of this plan are enrollment procedures that incorporate a variety of choices that are easy to understand – including telephone, Internet, senior center, welfare office, mail, etc. We have built into the overall budget of HOPE for Mississippi, $2 million for an aggressive, private sector marketing campaign. The use of private sector marketing expertise is critical to the design of a successful outreach program. The success of Mississippi HOPE will be predicated in large part on educating senior citizens about the program. The educational materials must be simple to understand to ensure that seniors know the what, the where, the why and the who.

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IV. Confronting the Tough Choices

We believe beneficiaries should have an initial election period during which they can accept or decline prescription drug coverage under the plan. If they decline because of existing post-employment retirement insurance that includes prescription drug coverage, they should be permitted to join HOPE for Mississippi if their employment-related plan is discontinued or becomes substantially more expensive. Delayed election would, however, result in an actuarially increased premium. Enrollment during the first year of the program must, however, remain flexible. We specifically do not want to deny access to this plan to someone who, for whatever reason, fails to meet an arbitrary cutoff. This must be balanced against the need to control adverse selection, which is the result of a greater number of individuals with higher health care utilization participating in greater numbers than those who have lower health care requirements. This creates higher costs and increased financial risk on insurance products.

Tenth, in subsequent years of the program, deductibles and the benefit limit will be tied to the actual drug trend experienced under the program. In other words, based on the drug trend – increase or decrease – the deductibles and benefit limit will be adjusted accordingly. This is included as part of HOPE for Mississippi to ensure that the costs of the plan – both for beneficiaries and the State of Mississippi – continue to remain current and not place the plan in fiscal jeopardy.

Eleventh, HOPE for Mississippi recommends the creation of a Prescription Drug Review Commission. Because this would be a legislatively-created plan, we believe that the legislature needs to be completely involved in, and focused on, the difficult decisions that plans like HOPE for Mississippi, which sets out to achieve prescription drug coverage for all seniors, will require. To that end, the Commission shall consist of sixteen members including the Governor, the Senate President and the Speaker of the House who shall serve as co-chairs. The structure and the responsibilities of the Prescription Drug Review Commission are discussed in section IX.

Comment: I'm not sure that we want this included at all!

Twelfth, in order to obtain the greatest value for the dollar spent, the State of Mississippi should explore what cost savings might accrue if all existing state programs that provide prescription drug coverage, such as Medicaid, state employees (active and retired), HOPE for Mississippi, etc., purchased their drugs collectively.

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V. HOPE for Mississippi Executive Summary

The Heinz Family Philanthropies engaged William M. Mercer, Incorporated to assist with the design of and provide financial projections for the development of the **H**einz plan to **O**vercome **P**rescription drug **E**xpenses (HOPE Mississippi). HOPE for Mississippi is a prescription drug program that will be made available to all seniors (age 65 and over) with annual household incomes at or below 200% of the Federal Poverty Level ($8,590 for a single person and $11,610 for a married couple) who reside in the State of Mississippi.

The goal was to demonstrate how an effective combination of cost sharing, pharmacy management, and volume purchasing could yield a comprehensive prescription drug program that would be affordable for senior residents. Our efforts in Mississippi have resulted in a proposed statewide prescription drug program that is focused exclusively on the 215,641 seniors – age 65 and over - residing in Mississippi with incomes at or below 200% of the Federal Poverty Level.

HOPE for Mississippi: Program Design

HOPE for Mississippi is based on three guiding principles:

- provide comprehensive coverage at a reasonable cost;
- encourage responsible access to all prescription drugs; and
- maintain affordability.

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

Pharmacy Benefit Design

The first core advantage of HOPE for Mississippi is the overall pharmacy benefit design. HOPE for Mississippi is built upon affordable contributions and deductibles. Seniors who have higher incomes pay more for the plan. After the individual deductible is met, the individual pays an out-of-pocket cost for each prescription based on an incentive-based drug formulary. The incentive-based drug formulary maximizes the generic substitution opportunities and promotes the use of the most cost-effective brand medications.

Comment: Earlier it was stated that the cost of the program was $10 per month with an annual deductable of $50. There was not mention of scalablity?

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

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V. HOPE for Mississippi Executive Summary

Pharmacy Benefit Management Strategies

The second core advantage of HOPE is the ability to give program flexibility to maximize the services of a pharmacy benefit manager (PBM) as in the private sector. A PBM is an organization that specializes in providing administrative and management services to reduce the cost of pharmacy benefits. A PBM maximizes the state's capacity to negotiate the best prices for discounted networks and mail service drugs. The PBM, selected through a competitive bidding process is required to partner with Mississippi to reduce the costs of the pharmacy plan through a variety of mechanisms which manage prescription benefit costs and encourage cost-effective utilization of prescription drugs.

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

Managed Enrollment

The third core advantage of HOPE for Mississippi is managed enrollment. HOPE for Mississippi is incremental in its design, meaning that in each successive year after its inception, an increasing number of eligible persons age 65 and older are admitted. This is purposely done to build a set of fiscal benchmarks for the plan since one of the greatest risks for HOPE is adverse selection. Adverse selection is defined as a situation in which potential enrollees are able to predict their own claim experience and decide whether to enroll in a benefit program. Although potential enrollees do not know exactly what their future prescription drugs will cost, many will make reliable assessments of whether or not their claims will be greater than their premiums and other out-of-pocket costs from copayments, deductibles, and maximums. This knowledge, along with other factors, will determine whether or not they participate in the new program. If the eventual pool of enrollees contains too many people with high prescription drug expenses, the program's financial risk becomes too great.

As a result, HOPE for Mississippi includes requirements for timely enrollment and substantial penalties for delayed enrollment.

Program Oversight

The fourth core advantage of HOPE is program oversight. HOPE for Mississippi recommends the creation of a Prescription Drug Review Commission to be involved in, and focused on, the difficult decisions required to provide prescription drug coverage for all seniors. The overall purpose of the Commission is to provide proactive operational and financial oversight in an effort to determine how well the program is operating and whether changes may be necessary.

Comment: We should look at a administrative oversight rather than legislative oversight of the program. This can be accomplished through Medicaid's advisory commission, which is already established and has legislators as non-voting members.

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V. HOPE for Mississippi Executive Summary

HOPE for Mississippi: Financial Summary

The initial success of HOPE for Mississippi will rest with the ability to design a plan that is affordable to Mississippi. In addition, the program must be designed carefully to keep program costs as low as possible. As a result, we have designed a premium-based program which provides coverage for 215,641 seniors with incomes at or below 200% of the Federal Poverty Level (FPL) ($8,590 for a single person and $11,610 for a married couple).

Under HOPE for Mississippi, projected total net costs for a three-year period based on enrollment, cost and contribution projections – is summarized in Table 3. For example, if HOPE for Mississippi was fully implemented in the year 2003, the total annual cost to Mississippi is projected to be $20.5 - $23.5 million and would cover 33,164 seniors with a comprehensive prescription drug program.

Comment: What would be the federal, state general, and special fund costs?

TABLE 3
RECOMMENDED PLAN PROJECTIONS

PROJECTED YEAR	ENROLLMENT	STATE COST
2003	33,164	$20.5 – $23.5 million
2004	34,156	$23.2 - $26.6 million
2005	35,185	$27.5 - $31.5 million

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VI. HOPE for Mississippi Pharmacy Benefit Design

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

- low annual deductible and contributions;
- responsible access to all prescription drugs through a balanced cost sharing and an incentive formulary; and
- an annual benefit limit to reduce program costs.

Low Annual Deductible and Contribution

Annual deductibles and contributions as shown in Table 4, are intended to be affordable for seniors who qualify for the program. HOPE for Mississippi requires seniors with household incomes at or below 200% of the Federal Poverty Level ($8,590 for a single person and $11,610 for a married couple) to pay an individual monthly premium for the plan. For the first year of the plan the premium is $10 per month. Individuals will also be responsible for an individual annual deductible and, once the deductible is met the individual will pay a coinsurance, based on the type of drug prescribed.

TABLE 4

ANNUAL INDIVIDUAL DEDUCTIBLE AND MONTHLY CONTRIBUTIONS

HOUSEHOLD INCOME (AS % OF FEDERAL POVERTY LIMIT)	INDIVIDUAL ANNUAL DEDUCTIBLE			MONTHLY INDIVIDUAL CONTRIBUTION		
	YEAR 1	YEAR 2	YEAR 3	YEAR 1	YEAR 2	YEAR 3
< 200%	$50	$60	$70	$10	$11.70	$13.57
> 200%	Not Eligible for Benefits during the first years of the program					

Responsible Access To All Prescription Drugs

HOPE for Mississippi provides for responsible access to all prescription drugs through balanced cost sharing and an incentive formulary. Once individuals meet their annual deductible ($50), they are required to pay the greater of a minimum copayment or a coinsurance toward the cost of each prescription.

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VI. HOPE for Mississippi Pharmacy Benefit Design

The three-tier coinsurance levels recommended for HOPE for Mississippi are displayed in Table 5. Annually, the minimum copayments, deductibles, premiums and the annual benefit limit, will be adjusted according to the actual drug trend experience under the program. In HOPE for Mississippi, pharmacy benefit trends of 17% for year two and 16% for year three were used. Once the program is operational, the benefit trends may vary as a result of increased drug cost and utilization as well as the effect of new pharmaceuticals.

TABLE 5 – HOPE FOR MISSISSIPPI
COINSURANCE AFTER ANNUAL DEDUCTIBLE

SOURCE	DAYS SUPPLY	COINSURANCE			
		GENERIC DRUGS*	PREFERRED DRUGS	NON-PREFERRED DRUGS	MINIMUM COPAYMENT
▪ Retail	Up to 30 days	30%	50%	90%	$10, indexed annually with trend
▪ Mail service	Up to 90 days	30%	50%	90%	$20, indexed annually with trend

*Mandatory generic provision applies

A mandatory generic provision, which incorporates a cost differential when a generic is available but a brand name is requested, is also applied to the three-tier plan design. Under the mandatory generic provision, if an individual or physician requests a brand name drug when an approved generic drug is available, the individual is required to pay the price difference between the brand and generic drug in addition to the copayment/coinsurance.

The three-tier design provides for responsible access to all prescription drugs through an incentive formulary. The formulary will be designed to favorably enhance the quality and cost of the plan through drug mix and rebates, in addition to addressing new pharmaceutical products and evidence based prescribing guidelines. The financial impact to the pharmacy plan is ultimately dependent on the specific drugs selected for preferred status in the drug formulary.

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VI. HOPE for Mississippi Pharmacy Benefit Design

Annual Benefit Limit to Reduce Program Costs

To keep program costs within the states budget constraints, HOPE for Mississippi recommends an annual benefit limit of $2,000. Once the state has spent $2,000 in the year for an individual, the State will no longer pay any portion of the individuals prescription drug costs for the remainder of that year. We anticipate that up to 12% of members could be effected by this annual benefit limit. Reaching the annual benefit limit is highly dependent on the proportion of generic versus preferred versus non-preferred drugs that an individual receives.

Comment: What are the costs to the state if the annual benefit is limited to $1000?

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VII. HOPE for Mississippi Pharmacy Benefit Management

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

Mississippi can accomplish this objective by contracting with a pharmacy benefit manager (PBM), which, as in the private sector, specializes in providing administrative and management services to reduce the cost of pharmacy benefits. The use of a PBM provides uniform administration of the program and enhances prescription drug management. The PBM selected through a competitive bidding process will be required to partner with Mississippi to reduce the costs of the pharmacy plan through the benefit management strategies in addition to administrative efficiencies.

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

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

Retail Pharmacy Network and Mail Service

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

Under HOPE for Mississippi, individuals will be able to obtain up to a 30-day supply for the specified coinsurance amount from the retail pharmacy network provider. There is no prescription drug benefit if the drug is obtained from a non-network pharmacy provider.

Comment: Does this mean that "mom and pop" pharmacists will not be included initially?

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

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VII. HOPE for Mississippi Pharmacy Benefit Management

Incorporating a mail service option into program design offers the opportunity to maximize the inherent advantages and quality enhancements of the mail service program such as therapeutic intervention, formulary compliance, and utilization management.

Through the mail service program, individuals will be able to obtain up to a 90-day supply. One design consideration in lieu of an exclusive provider is to offer mail service through the retail pharmacies, contracted at competitive mail service pricing.

Drug Formulary

An incentive drug formulary – an effective means to enhance quality and manage program costs – will be developed for HOPE for Mississippi. The formulary, customized for a senior population, will be developed by a traditional PBM Pharmacy and Therapeutics Committee with participation from healthcare providers and thought leaders from the State of Mississippi.

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

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

HOPE for Mississippi is designed to provide the type of coverage found under the private sector employers and commercial health plans. For instance, coverage is provided for "life-sustaining" drugs and excludes drugs for which medical need is difficult to establish, such as medications used to treat cosmetic conditions or other "lifestyle" medications.

Generic Drug Incentives and Therapeutic Intervention

HOPE for Mississippi incorporates a mandatory generic provision through the benefit design. Under mandatory generic, the recipient is required to have the generic when available. If the patient/or physician requests the brand drug, the patient pays the cost difference between brand and generic, in addition to the copayment. To augment the benefit design, provisions for generic drug communication as well as financial incentives, and profiling of providers to encourage the use of generic drugs, when they are medically appropriate, are included in HOPE for Mississippi.

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

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VII. HOPE for Mississippi Pharmacy Benefit Management

Drug Utilization Management

HOPE for Mississippi utilizes prospective, concurrent, and retrospective drug utilization management to ensure that prescription drugs are used appropriately, safely, and effectively.

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

By providing for timely and effective action at the appropriate level of intervention, Mississippi can identify and reduce unnecessary prescription drug use, assure that prescription drugs are used in proper clinical circumstances, safeguard seniors from prescription drugs that are potentially dangerous, and from prescription drugs that are more costly than necessary.

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

Drug Management Mechanisms

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

PRIOR AUTHORIZATION

Prior authorization is used for certain drugs, or classes of drugs, with a high potential for over-utilization or misuse. Prior authorization will ensure that coverage, and the use of a specific drug, are appropriate for a given individual.

STEP THERAPY

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

MAXIMUM DISPENSING LIMITS

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VII. HOPE for Mississippi Pharmacy Benefit Management

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

PROVIDER INTERVENTIONS

Through the PBM, HOPE for Mississippi will have a targeted provider – physician and pharmacist – intervention process that will identify providers who might be responsible for high costs as a result of potentially inappropriate prescriptions. The plan also provides for interventions aimed at educating and changing prescribing behaviors.

HEALTH MANAGEMENT

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

Recovery of Funds

HOPE for Mississippi provides for recovery of funds through an audit process and coordination of benefits. Coordination of Benefits applies when an individual is covered under more than one pharmacy plan, requiring the coordination of payment to eliminate duplication or double payment. Pharmacy benefits under HOPE for Mississippi will be coordinated with any other plans under which an individual might have pharmacy coverage, provided, of course, that the coverage information can be obtained. Even though HOPE for Mississippi is not an entitlement plan, it is positioned to be the payor of last resort.

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VIII. HOPE for Mississippi Managed Enrollment

There are over 344,000 seniors in Mississippi who are age 65 or older, and 215,641 of these seniors fall at 200% Federal Poverty Level or below ($8,590 for a single person and $11,610 for a married couple). To project the enrollment in HOPE for Mississippi, four sources of enrollment were considered. These include:

- Individuals currently enrolled in Medicare+Choice HMO plans
- Individuals currently enrolled in standardized Medicare supplement plans (Medigap)
- Individuals currently enrolled in employer-sponsored plans
- Individuals who currently are not enrolled in any medical plan that could provide prescription drug coverage

Seniors Who Would Become Eligible under HOPE for Mississippi

Although there is no track record on how many Mississippi seniors will participate in a state-sponsored pharmacy program, there are a number of factors that can be considered in setting reasonable projections.

While the need for prescription drugs has increased, the availability of insurance plans that provide coverage has decreased. Very few seniors in Mississippi are enrolled in a Medicare+Choice HMO plan that does not have some type of annual and/or quarterly limit on prescription drug coverage. Although many residents have Medigap coverage, the majority of these individuals are enrolled in Medigap plans that do not cover prescription drug costs.

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

As a result, it is assumed that four groups of seniors would be interested in participating in the recommended HOPE for Mississippi Plan. These include seniors currently enrolled in Medicare+Choice HMOs, seniors enrolled in Medigap plans, and seniors participating in employer-sponsored plans, along with seniors who are currently without any medical coverage beyond Medicare. In the first year of the proposed HOPE for Mississippi Plan we project that over 33,000 individuals will enroll. This represents about 15% of total eligible seniors.

After the initial offering, we anticipate that enrollment in HOPE for Mississippi will increase at the same pace at which the general population of eligible seniors increases. Table 6 displays the projected enrollment over a three-year period.

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VIII. HOPE for Mississippi Managed Enrollment

TABLE 6 ENROLLMENT PROJECTIONS FOR HOPE FOR MISSISSIPPI	
CALENDAR YEAR	**ENROLLMENT**
2003	33,164
2004	34,156
2005	35,185

Adverse Selection

Although low-income individuals are subsidized, HOPE for Mississippi is an insurance-based model. Insurance plans require controls to minimize the cost of adverse selection. Adverse selection occurs when individuals are allowed to postpone enrollment until their prescription drug cost exceeds the premium that they must pay for the plan. In the circumstance that individuals are allowed to delay enrollment, the cost per person of the plan would rapidly escalate. At some point the contributions required to cover prescription drug costs would no longer be affordable for an increasing number of those eligible. Avoiding this cost spiral necessitates immediate enrollment rules that require enrollment once an individual attains age 65.

Those who are age 65 on or before HOPE for Mississippi becomes effective must be enrolled within the first six months following HOPE's enactment date. Those who attain age 65 following the enactment of HOPE for Mississippi must enroll within six months of their sixty-fifth birthday. Those who elect not to enroll may permanently lose the opportunity to enroll or, at a minimum, be charged a substantial additional premium for delaying enrollment. There will need to be exceptions for those who:

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

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

Given the concern of employers regarding the cost impact of increasing prescription drug costs on retiree health plans, HOPE for Mississippi is likely to offer a viable alternative for providing retiree prescription coverage for employers. With adequate provisions to control the potential for adverse selection, the enrollment of retirees could have a beneficial impact on HOPE for Mississippi's costs. ~~Since many retirees have pension plans that place them in the higher~~

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household income brackets, they will be able to afford the required contributions, which are needed to control plan costs.

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

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IX. HOPE for Mississippi: Oversight: Prescription Drug Review Commission

HOPE for Mississippi recommends the creation of a Prescription Drug Review Commission to be involved in, and focused on, the difficult decisions that plans like HOPE for Mississippi, and any plan that sets out to achieve prescription drug coverage for all seniors, requires. The overall purpose of the Commission is to provide proactive operational and financial oversight in an effort to determine how well the program is operating, and whether changes may be necessary.

The Commission would consist of members including the governor, chairmen of the Senate and House Public Health and welfare Committees, who would serve as co-chairs. In addition, Commission members would include the ranking members of the public Health and Welfare Committees, the Division of Medicaid Director, the State Insurance Administrator . . .

The Governor would appoint five additional members including, a representative of a senior citizen's advocacy organization, a health care economist from a university or college within Mississippi, and a representative of the contracted pharmacy benefit manager. The Governor's appointments would include an individual who is a full-time employee of a pharmaceutical manufacturer to be named to the commission biennially. All non-governmental members of the Commission would serve at the pleasure of the Governor.

The duties of said Commission would consist of the following:

- The Commission would be responsible for the oversight of HOPE for Mississippi.

- The Commission would meet at least quarterly with the management team from the pharmacy benefit manager to:
  - Determine how well the program is operating and whether changes may be necessary
  - Assess with the pharmacy benefit manager where and why specific problems are occurring, and design and implement a strategy to resolve such problems;
  - Have the pharmacy benefit manager explain current and projected cost trends for the program and determine whether and, if so, how changes need to be made to ensure the fiscal integrity of the program;
  - Analyze current and future information systems and pharmaceutical technology advancements to determine whether and, if so, how such advances will result in cost savings or otherwise affect the program; and
  - Review the pharmacy benefit manager's designated formulary for the program.

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IX. HOPE for Mississippi: Oversight: Prescription Drug Review Commission

- The Commission would have sole responsibility for approving changes to coinsurance levels, deductibles, out-of-pocket limits, drug exclusions, and contributions in relation to pharmacy benefit trends. In the event the Commission approves changes that result in increases to copayments, deductibles, or contributions, it would file a report with the Clerks of the Senate and the House explaining why.

- The Commission would review overall plan costs, adequacy of funding and projected revenues to determine what, if any, changes need to be made to the program.

Comment: I'm not sure that we want this in the report?

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X. HOPE for Mississippi: Funding

In designing a plan for the State of Mississippi to provide affordable prescription drug coverage to seniors, it was important to keep program costs as low as possible. As a result, we have designed a contributions-based program (HOPE for Mississippi) which provides coverage for seniors with incomes up to 200% of the Federal Poverty Level (FPL) ($8,590 for a single person and $11,610 for a married couple).

The recommended plan provides a low cost plan to Mississippi seniors under 200% FPL. It works by charging seniors $10 per month and a $50 annual deductible. Beyond that, the enrollee would be responsible for paying a coinsurance on each prescription or the minimum copayment of $10, whichever is greater. Once the enrollee reaches a calendar year benefit limit of $2,000, they will be responsible for the full prescription cost.

Table 7 lists the coinsurance levels paid for each prescription that are built into the recommended plan design.

TABLE 7
RECOMMENDED PLAN DESIGN COINSURANCE LEVELS

Generic	30%
Preferred Brand	50%
Non-Preferred Brand	90%

Under the recommended HOPE for Mississippi Plan, costs are projected to be $20.5 – $23.5 million in calendar year 2003, while providing coverage to approximately 33,164 individuals. It is estimated that as many as 35,185 individuals would be enrolled by calendar year 2005. These projections are based on anticipated cost trends under HOPE for Mississippi of approximately 16% – 17% per year and an increase in enrollment of 3% per year. Table 8 displays estimated enrollment and program costs for the first three years of the program. Alternatively, if monthly premium rates were doubled ($20), this would generate an additional $3.7 to $4.3 million in revenue, reducing total plan costs for plan year to $16.8 to $19.2 million.

TABLE 8
PLAN PROJECTIONS

PROJECTED YEAR	ENROLLMENT	STATE COST
2003	33,164	$20.5 – $23.5 million
2004	34,156	$23.2 - $26.6 million
2005	35,185	$27.5 - $31.5 million

It is important to note that HOPE for Mississippi financial estimates are based on the assumption that adequate measures will be taken to minimize the potential for adverse selection and that a sufficient promotional effort will be embarked on to ensure the timely enrollment of eligible

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individuals. Additionally, aggressive pharmacy benefit and formulary management are key factors in the development of the cost estimates. As with any voluntary plan, enrollment and claim experience must be routinely and rigorously monitored. To meet financial targets, it will be necessary to manage the plan proactively and adjust the benefit design, contributions, pharmacy benefit management techniques and other aspects of the plan on an annual basis.

Alternatives

While we believe that this recommended HOPE for Mississippi Plan offers affordable, comprehensive prescription drug coverage, we recognize the need to examine alternatives. We have devised three alternatives that Mississippi could consider.

Alternative 1

Although the recommended HOPE for Mississippi Plan offers affordable contributions and comprehensive coverage, the plan does not offer coverage to higher income seniors. Under Alternative 1, all seniors would be eligible for coverage.

To keep program costs at reasonable levels, enrollment under Alternative 1 has been capped at 30,000 members for all years. The plan design under Alternative 1 is similar to the recommended plan, including the same tiered coinsurance levels and the $2,000 annual benefit limit. Table 9 displays the deductible and monthly premium amounts under this alternative.

TABLE 9
ALTERNATIVE 1

ANNUAL HOUSEHOLD (FEDERAL POVERTY LEVEL)	DEDUCTIBLE	PREMIUM PER MONTH
0 - 150%	$50	$10
150% - 250%	$50	$15
250% - 350%	$100	$20
>350%	$100	$25

Estimated program costs for Alternative 1 will be $17.7 – $20.3 million in calendar year 2003, rising to $22.3 – $25.5 million by calendar year 2005.

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X. HOPE for Mississippi: Funding

Alternative 2

Alternative 2 introduces a program with affordable contributions, and catastrophic coverage for all seniors in Mississippi. Unlike the recommended plan and the other alternatives, there is no annual benefit limit under this alternative. Table 10 displays the benefit design and monthly contributions recommended under this alternative.

TABLE 10
ALTERNATIVE 2

Annual Household (Federal Poverty Level)	Deductible	Premium per Month	Coinsurance
0 - 100%	$50	NONE	30% Generic 50% Preferred Brand 90% Non-Preferred Brand Subject to $10 retail and $20 mail service minimum copayments
100% - 150%	$100	$10	
150% - 200%	$150	$20	
200% - 250%	$200	$30	
250% - 300%	$250	$40	
300% - 350%	$300	$50	
350% - 400%	$350	$60	
>400%	$400	$70	

Alternative 2 provides comprehensive prescription drug coverage with contributions and cost-sharing provisions that are affordable for seniors. In calendar year 2003, estimated program costs for Alternative 2 are $28.6 – $32.7 million with an estimated enrollment of 37,718 seniors. By calendar year 2005, estimated costs are estimated to rise to $39.3 – $45 million with an enrollment of over 40,000 seniors.

Alternative 3

Another approach to providing prescription drug coverage to seniors would be to provide a low-income subsidy plan to seniors under 150% FPL while providing a separate discount program to all other seniors. Seniors under 150% FPL would not have any premium payments, but would be subject to a $2,000 annual benefit limit. The benefit design under this alternative is shown in Table 11.

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TABLE 11 ALTERNATIVE 3			
ANNUAL HOUSEHOLD (FEDERAL POVERTY LEVEL)	**DEDUCTIBLE**	**PREMIUM PER MONTH**	**COINSURANCE**
0 - 100%	$0	None	20% Generic 40% Preferred Brand 80% Non-Preferred Brand Subject to $5 retail and $10 mail service minimum copayments and $100 retail and $200 mail service maximum copayments
100% - 150%	$300	None	
>150%	Discount Program	$25 per year	100% of discount price

In calendar year 2003, estimated program costs for Alternative 3 are $20.5 – $23.5 million with an estimated enrollment of 28,736 seniors. By calendar year 2005, estimated program costs for Alternative 3 will rise to $27.6 – $31.6 million with an enrollment of 30,485 seniors.

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XI. Glossary of Terms

1. **Adverse Selection:** Adverse selection occurs when too many individuals with high health care utilization participate in a program in greater numbers than individuals who do not use as many health care services. The impact on an insurance product is higher costs and increased financial risk.

2. **Benefit Limit:** A dollar limit set by the plan that represents the maximum amount of a drug expenditure a plan will cover on any one participant. Once this limit is reached, the participant will pay 100% of their drug expenditures.

3. **Catastrophic Cap:** Once an individual exceeds a set dollar threshold of expenditures out of his or her pocket – a combination of deductible and copayments – specific drugs are covered at some level by the plan. (see also Out-of-pocket limit)

4. **Coinsurance:** Cost sharing that requires an individual to pay a specific percentage of the charge for each prescription drug.

5. **Coordination of benefits (COB):** Coordination of benefits applies when an individual is covered under more than one pharmacy plan. It requires that payments of benefits be coordinated to eliminate benefit duplication or prevent double payment for services. For example, a husband might have coverage from the State and his wife's coverage through an employer-sponsored program. The coordination of benefits agreement states the primary plan pays first and the secondary plan pays last.

6. **Copayment:** Cost sharing that requires an individual to pay a fixed dollar amount for each prescription drug. Under HOPE for Mississippi, copayment is used to identify the payment required for each prescription drug and may be a factor of flat dollar or percentage payments.

7. **Deductible:** The amount that an individual pays under the plan each benefit year, in addition to premium, before prescription drug coverage begins.

8. **Dually eligible:** Individuals who are eligible for both Medicare and Medicaid.

9. **Formulary:** A list of drugs, selected on the basis of quality and cost, developed to encourage members to use appropriate, cost effective medications. The list is used by physicians when making decision on what medication to prescribe. The list is subject to periodic review and modification by the plan. Several formulary options exist:

   Open formulary – all medications are covered with little or no cost-sharing implication to the member for selecting a non-formulary medication.
   Closed formulary – medications deemed as non-formulary are not included as a covered benefit.

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

10. **Generic Drug:** A drug that is a chemically equivalent copy of a brand-name drug. A generic drug is generally less expensive than the brand-name drug.

11. **Income-related contribution:** Requires individuals with higher incomes to pay more contribution for a benefit than individuals with lower incomes.

12. **Life Sustaining Medications:** Medications used in the treatment of conditions that are life threatening or impact the health status of a patient.

13. **Lifestyle Medication:** Medications that are designed to improve the quality of life, but are not considered to impact and individual's health status. These medications include cosmetic treatment such as anti-wrinkle agent, hair growth products, in addition to impotence and birth control substances.

14. **Maintenance Drug:** A drug that is taken for a chronic condition, consecutively, for a long period of time, generally longer than three to six months.

15. **Mandatory Generic:** A plan design provision that incorporates a cost differential when a generic drug is available and a brand drug is requested by either the patient and/or the physician.

16. **Maximum Allowable Cost (MAC):** Maximum reimbursement price for generic drugs and in some cases multi-source brand name drugs.

17. **Medicare+Choice HMO:** A Health Maintenance Organization that agrees to accept payment from the federal government in return for providing all of the Medicare health care benefits to enrollees.

18. **Medigap Insurance:** Supplemental private insurance that is purchased by Medicare recipients to fill in the deductibles and coinsurance amounts not covered by Medicare.

19. **Out-of-pocket limit:** The total dollar amount, a combination of copayments and deductible, that an individual pays of their own money. Once the limit is reached, specific drugs are covered at 100% for the remainder of the benefit year. (see also Catastrophic Cap)

20. **Pharmacy Benefit Manager (PBM):** An organization that specializes in providing administrative and management services to reduce the cost of pharmacy benefits.

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XI. Glossary of Terms

21. **Pharmacy & Therapeutics Committee – P & T Committee:** A group of physicians, pharmacists and other experts that recommends the safe and effective use of prescription drugs. The P& T Committee is charged with reviewing and evaluating drugs for inclusion and/or exclusion on the drug formulary.

22. **Premiums:** Fees, usually paid monthly, for insurance coverage.

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XII. Appendix: Assumptions

Pharmacy Cost and Administrative Expense Assumptions

The prescription drug model used to calculate the HOPE funding rates and financial projections applied certain key assumptions. These are:

- The base prescription drug ingredient cost in the first year of implementation includes an additional cost for adverse selection. This is to account for the fact that HOPE for Mississippi includes an open enrollment period which allows individuals to decide whether they will join, based on their prescription drug needs. This option to enroll or not, will inevitably result in adverse selection. To moderate this situation, the length of the open enrollment period should be limited to six months.
- For the two years following the initial year, individuals will be allowed to enroll within six months of reaching age 65. Contributions, where applicable, and benefits, will begin on the first of the month following the date a person reaches age 65. Effective communications, financial incentives, and enrollment controls will be in place to encourage timely enrollment. There are no adjustments for additional adverse selection in the last two projection years.
- The effective discount used in the modeling is 20%. The 20% discount factor is a combination of usual and customary pricing, discounted average wholesale price (AWP) and the maximum allowable cost (MAC), for generic and brand drugs.
- Formulary rebates under the proposed incentive-based formulary were assumed to reduce the prescription drug ingredient cost by 6%. The design of the formulary with respect to the drugs selected for preferred status could significantly alter this estimated cost reduction.
- An 5% ingredient cost reduction will be achieved by applying formulary management, mail service for maintenance drugs, enhanced utilization management, prescribing guidelines, and therapeutic interventions through a pharmacy benefit manager (PBM).
- Assuming that pharmacy benefits under an individual's other coverage are coordinated with HOPE for Mississippi benefits, the estimated recoveries are approximately 0.5% of the ingredient cost of the plan. This estimate is based on the assumption that the individual's share of the cost is the minimum share under either plan, and that other plan benefits are paid first. The 0.5% recovery is net of the cost of administrative and legal fees associated with recovery.
- The annual cost and utilization trend applied to arrive at year 2004 ingredient costs is about 17%. An annual trend of about 16% was applied to project year 2005 ingredient costs. These annual trends are applied to adjust the annual deductible for 2004 and 2005, and will be used to adjust the annual benefit limit once the program is operational.
- The dispensing fee applied per prescription is $2.50.
- The annual expense assumption for pharmacy management and claim administration is $37 per enrollee. This includes administrative expense from the PBM in addition to resources dedicated to the program from Mississippi. Annual expenses for other administration

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functions (such as membership, income testing, billing, collections, financial reporting, and auditing) is also included in this estimate.

- An annual advertising expense of $60 per enrollee has been included in the first year projection. This expense decreases to $30 per enrollee for the following years.
- The estimates for prescription drug discounts, rebates, dispensing fees, and administrative expenses applied in the projections are based on data observed from large Mercer clients and various industry studies. The staff currently employed by Mississippi could perform some of these administrative activities. To the extent that this is done, there may be a rationale for reducing the administrative cost estimates applied in the financial projections for HOPE.

Monthly contributions for HOPE for the year 2003 is $10 for those eligible for the program (i.e., those with incomes lower than 200% FPL). Although there is considerable uncertainty attached to projecting enrollment in any new plan, the projections appear reasonable given the premiums charged and the general lack of health plans with comprehensive prescription drug coverage available in Mississippi.

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HOPE Mississippi
Premiums, Deductibles and Annual Benefit Limits

Annual Income Range				Annual Deductible	Annual Benefit Limit	Enrollment			Annual Funding Rates			Percent	Monthly Premium Payment		
% of FPL*	Single		Married	2003	2003	2003	2004	2005	2003	2004	2005	Contribution	2003	2004	2005
0 - 100%	$ -	$ 8,350	$ -	$11,250	$50	$2,000	16,708	17,209	17,727	$781.60	$868.23	$998.76	15%	**$10.00**	**$11.70**	**$13.57**
100 - 150%	$ 8,351	$12,530	$11,251	$16,880	$50	$2,000	9,999	10,298	10,608	$781.60	$868.23	$998.76	15%	**$10.00**	**$11.70**	**$13.57**
150 - 200%	$12,531	$16,700	$16,881	$22,500	$50	$2,000	6,457	6,649	6,850	$781.60	$868.23	$998.76	15%	**$10.00**	**$11.70**	**$13.57**
							33,164	34,156	35,185						

*FPL = Federal Poverty Limit. Individuals will qualify for program based on household income.

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End Notes

[i] M. Davis, et al., "Prescription Drug Coverage, Utilization and Spending Among Medicare Beneficiaries," Health Affairs, Vol. 18, No. 1 (Jan. – Feb. 1999), p 237.

[ii] *Based on proprietary information collected by William M. William M. Mercer, Incorporated for over 1 million Medicare beneficiaries for calendar year 1999.*

[iii] Martin Frost, "What to Do About Medicare?," Dallas Morning News (August 3,1999), p. 7A.

[iv] William M. Mercer, Inc., Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, Report on Survey Findings (1999), p. 44.

[v] The White House, National Economic Council, op. cit., pp. 1, 6.

[vi] Subcommittee on Health, House Committee on Ways and Means, Hearing on Seniors' Access to Prescription Drug Benefits, 106th Cong., 1st Sess. (February 15, 2000), statement of David M. Walker, pp. 1, 5.

[vii] 1997 Medicare Current Beneficiary Survey

[viii] HCFA Press Office, "The President's Medicare Prescription Drug Discount Program" Medicare News; July 11, 2001.

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