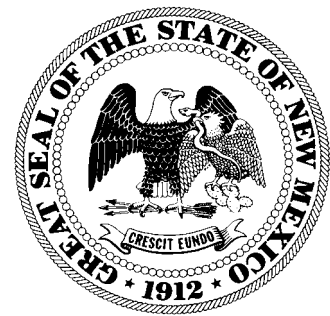




HOUSE JOINT MEMORIAL 22

A STUDY ON THE IMPACT OF THE
RISING COST OF PRESCRIPTION
DRUGS IN NEW MEXICO

Printed October 2002





HEALTH POLICY COMMISSIONERS

Scott Garrett, Chair

Barbara M. Moore, Vice Chair

Satyra Brown

Grace M. Klement

Felicia Casados

K. Babette Saenz

Donald G. Silva

Marjorie T. Slaten

For more information, please contact:

New Mexico Health Policy Commission
2055 South Pacheco Street, Suite 200
Santa Fe, NM 87505
(505) 424-3200 ext. 100

Or

Visit these websites

hpc.state.nm.us www.healthlinknm.org

Table of Contents

I.	Executive Summary	1
II.	Environmental Overview	5
	A. Prescription Drug Costs	
	B. Access	
	C. Federal Response	
	D. State Responses	
	E. Current Status of Prescription Drug Programs in New Mexico	
	Legislative Initiatives	
	Available Services to New Mexicans	
III.	Survey Methodology and Results	21
	Statewide Telephone Survey	
	Survey of Community Health Clinics	
	Survey of Maternal Child & Health Council Coordinators	
	Survey of County Indigent Fund Administrators	
	Discussion and Summary of Survey Results	29
IV.	Policy Recommendations	31
Appendices		
	Appendix A: Advisory Committee Members	39
	Appendix B: House Joint Memorial 22	43
	Appendix C: Federal Programs	47
	Appendix D: State Legislation	57
	Appendix E: Survey Questions	69
	Appendix F: Comments	73
	Appendix G. BCA Telephone Survey Report	85

I. HJM 22 Executive Summary

During the 2001 Legislative Session, Representative Patsy Trujillo-Knauer sponsored House Joint Memorial 22 (HJM 22) requesting that the New Mexico Health Policy Commission (HPC) conduct a study to examine the impact of rising prescription drug costs for New Mexico residents, and to develop recommendations for addressing those issues. The Memorial was motivated by concerns that New Mexicans were struggling with high drug prices, low health insurance coverage, and little or no drug coverage even for those able to afford health insurance. The Legislature had heard anecdotal information about the hardships New Mexicans were enduring in order to obtain their medications, and the negative health outcomes that were created when patients either went without their medications altogether, or tried to save money through various strategies, such as taking less than prescribed dosages.

HPC Response to HJM 22

The HPC responded to the Memorial in several ways.

The first step was the creation of an Advisory Committee, which identified issues that needed to be addressed and assisted the HPC to develop its statewide telephone survey.

Secondly, additional surveys were created to gain community-based and overall statewide perspectives on prescription drug access. The surveys differed for each entity or population targeted, but all asked questions specific to prescription drug access. For purposes of this study, “access” is broadly defined to include

- Health care insurance coverage (full, partial, none)
- Financial ability to pay for prescription drugs (*less than full access* – sometimes able to obtain medications or never able to obtain medications vs. *full access* – always able to obtain medication)
- Geographic elements (e.g., lack of pharmacy, transportation issues)

Please see the community-focused surveys in Appendix E, and the Burger, Carroll and Associates’ (BCA) survey questions in Appendix G.

88 community health clinics, 15 Maternal Child and Health (MCH) Councils, and 19 County Indigent Fund (CIF) administrators responded to the surveys, giving the HPC insight on access issues their residents experience. In addition, 2,627 out of 3,305 respondents from the telephone survey identified themselves or a member in their household as having a recognized need for a prescription drug during the last 12 months.

The final step the HPC took in response to HJM 22 was to conduct an environmental scan of federal, national, and other states’ initiatives, studies and reports.

Key study findings

The study’s four surveys resulted in numerous findings, which are detailed in the full report. The most significant findings, which respond directly to the concerns of the Memorial, are:

- New Mexicans have significant problems accessing the prescription drugs they need. 12% of the telephone survey respondents reported *less than full* access to prescription drugs (sometimes able to get medication or never able to get medication vs. *full access*, always able to get medication).
- As might be expected, the populations that have the most difficulties getting the prescription drugs they need are low- income persons, the uninsured, low/fixed income seniors, disabled persons, and immigrants.
- Difficulties accessing prescription drugs is not just a problem for the elderly: Respondents between 18-64 years old experience less than full access to prescription drugs due to numerous factors, including insurance coverage, ability to pay, geographic considerations.
- New Mexicans have difficulties obtaining their prescription drugs whether or not they have health insurance. (For example, 35% of respondents to the telephone survey who had less than full access said that although they did have insurance, their policies did not include prescription drug coverage.)
- New Mexicans acquire their prescription drugs in a variety of ways, and nearly all seek to reduce the cost of those drugs. Some New Mexicans use relatively low-risk cost-saving methods, such as buying through the Internet. Others try to save money by engaging in practices that may be harmful to their well-being, such as stretching their prescriptions by taking less than prescribed dosages.

Although communities and safety net providers strive to offer enough resources to assist their residents through programs such as the federally sponsored 340B Pharmaceutical Assistance Program, other discount programs, charity organizations, and a limited supply of sample prescription drugs, these resources are simply not substantial enough to meet the needs of New Mexicans.

Recommendations

In response to the findings of this study, the HPC Commissioners and the HJM 22 Advisory Committee developed the following recommendations for the Legislative Health and Human Services Sub Committee.

Health Policy Commission

Understanding that the New Mexico Legislature is attempting to harness over spending while promoting responsible spending to assure that the health of New Mexicans is not jeopardized, the Commissioners offer the following considerations in support of the efforts in other healthcare forums regarding expansion of prescription drug access to the under and un-insured.

- Expand eligibility of Medicaid pharmacy only benefits to non-Medicaid populations.

- HPC study indicates that the working poor have difficulty obtaining the drugs they may need, but are not poor enough to be eligible for Medicaid.
- Families with household members needing multiple prescription drugs for a chronic illness have difficulty making co-payments for each prescription, or have limited insurance coverage that may not pay for particular drugs.
- Provide prescription drug discounts to any Medicare beneficiary.
 - 15.6% of Medicare recipients are under the age of 65 (persons with disabilities)
 - Seniors with supplemental health coverage often experience difficulty paying for the premiums in addition to co-payments and out-of-pocket expenses regardless of their income, and because of the multiple prescriptions they must often fill.

HJM 22 Advisory Committee

- Explore feasible mechanisms to expand access to prescription drugs, such as creative subsidizing, or creating a multi-state financial pool to enhance purchasing power.
 - Pharmacy Working Group Coalition, the Northeast Legislative Association on Prescription Drug Prices, and the Northern New England Tri-State Coalition are initiatives comprised among groups of states to enhance purchasing power and save money.
- Conduct a pilot study to restructure pharmacy and pharmacist reimbursement.
 - Determining solutions so that pharmacists do not absorb much of the costs resulting from Pharmaceutical Company discounts.
 - Reduce the amount of administrative responsibilities to process the numerous types of public and private insurance discount programs.
- Enhance and expand development of free or discount programs through safety net providers, and where possible integrate retail pharmacies.
 - Revisit the 340B discount program.
- Develop education and outreach programs to promote understanding and awareness regarding drugs, their affects and other drug-related issues.
- Create a 1-800-RX hotline so that people can get information about resources and available assistance.

In addition, individuals who responded to the Community Health Clinics and County Indigent Fund Administrators surveys made informal suggestions:

- Bolster the New Mexico safety net by:

- Providing more State support for pharmacy personnel in primary care clinics and subsidies for 340B drug costs.
- Providing matching funds from the State to assist the counties with the purchase of prescription drugs for needy populations.
- Allocating direct funding from the State to the counties for the purchase and distribution of prescription drugs.

II. Environmental Overview

The HPC carried out the objectives of the Memorial by conducting extensive research, surveying community-based entities, and completing a statewide, 3,305-household telephone survey with the ongoing guidance and recommendations of an Advisory Committee. The Advisory Committee was comprised of consumers, mental health professionals, healthcare advocates, other State agencies, community health clinics, pharmacists, and retail pharmacies. See Appendix A for listing of names and their respective organizations.

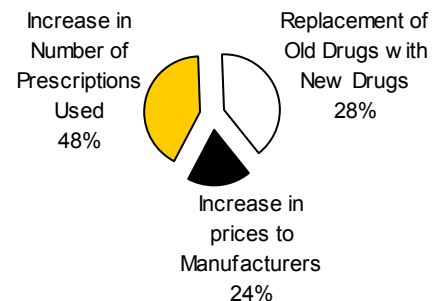
The objectives and scope of this study are to present the issues surrounding prescription drugs in New Mexico, including access (insurance coverage, financial, geographic) to prescription drugs, and how federal, state, and local policies may impact access to these drugs. This section of the report begins with an environmental scan of prescription drug cost issues on national and local levels. Federal, national, and states' concerns about prescription drugs will then be addressed, followed by an overview of New Mexico specific programs and policies. Detailed information on current New Mexico access issues as identified by consumers and healthcare providers is captured by the statewide telephone survey, and the surveys of community health clinics, Maternal, Child & Health Council coordinators, and the County Indigent Fund administrators.

A. Prescription Drug Costs

Patient access to prescription drugs would be a purely medical decision if it were not for the dramatic rise in the price of these medications. For over a decade, prescription drugs have been the fastest growing segment of national health care expenditures. Indeed, spending on prescriptions rose over 2.5 times faster than overall health care spending between 1995 and 2000 (Walker, 2002: 2). In 1999, spending for prescription drugs was \$99.6 billion, projected to reach \$116.9 billion by 2000 (Kaiser Family Foundation, Nov. 2001).

There are several explanations for this rise in cost. Studies suggest that about 48% of the increases in expenditures on prescription drugs are caused by increased utilization. The number of prescriptions dispensed in retail pharmacies has increased at an annual rate of 6% since 1992 (Kaiser Family Foundation, Nov. 2001: 8). Despite their growing cost, prescription drugs are a ever-more important component of modern medicine: "evidence suggests that more appropriate utilization of prescription drugs has the potential to lower total expenditures and improve the quality of care" (Employee

Factors of Growth in Expenditures since 1992 (Kaiser Family Foundation, Nov. 2001)



Benefit Research Institute: 1). Part of the increase in demand for prescription drugs reflects new efforts of pharmaceutical companies to market their products directly to consumers: the fastest growing sector of drug advertising was TV ads for prescription drugs, which increased by 88% between 1994 and 2000 (Kaiser Family Foundation, Nov. 2001: 9).

Another 28% of the growth in expenditures on prescription drugs can be attributed to shifts from existing medications to newer, more expensive drugs. These new drugs are also the top-sellers, and their popularity combined with higher prices helps explain the overall increase in spending. For example, only two drugs, Vioxx and Celebrex, accounted for nearly 10% of the growth in total prescription sales in 2000 (Kaiser Family Foundation, Nov. 2001: 12). The pharmaceutical companies often claim that the high cost of these new drugs is a reflection of their substantial investments in research and development (R & D): in absolute dollars, R & D spending more than tripled between 1990 and 2001. However, as a percent of sales, R & D spending has held relatively steady, rising from 14.4% in 1990 to 17.1% in 2001, and pharmaceutical companies spend more than twice as much on marketing and administration than they do on R & D (Kaiser Family Foundation, Nov. 2001: 11-13). Since 1995, the pharmaceutical industry has been the most profitable industry in the U.S., with profits over 5% higher than the second-ranking industry and “more than 5 times greater than the median for all Fortune 500 companies in 2001” (Kaiser Family Foundation, May, 2002: 46).

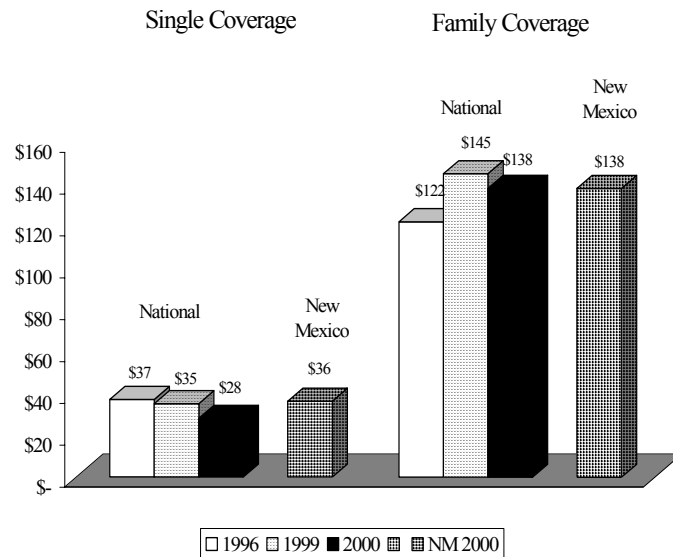
The last 24% of increase in expenditures results from manufacturer price increases. In 2000, the average price of a retail prescription was more than double the average price in 1990, and across all drugs, the average retail price of prescriptions increased “more than three times the rate of general inflation and more than twice the CPI for medical care from 1998 to 2000” (Kaiser Family Foundation, Nov. 2001: 8).

B. Access

A growing body of evidence shows that prescription drugs have the potential to both improve quality of care and lower total personal health care expenditures, yet significant barriers to access exist for an increasing number of Americans.

For most of the elderly population (65+ years), Medicare provides coverage for critical basic health services, but there are many services and costs that it does not cover. Beneficiaries are often left with high out-of-pocket expenses, according to recent estimates that Medicare does not cover 45% of beneficiaries’ health care costs. (Scanlon: 2). Many of those uncovered costs are related to prescription drugs, since Medicare does not provide outpatient prescription drug coverage. To pay for the often-substantial costs not covered by Medicare, and to seek prescription drug coverage, beneficiaries must rely on other sources – or go without: recent estimates are that at any given time, over 30% of Medicare beneficiaries lack prescription drug coverage (Walker, 2002: 1).

**Average Monthly Worker
Health Care Insurance Contribution, 1996-2000**
Source: *HPC Quick Facts 2002*



Many Medicare beneficiaries are able to secure one form or another of drug coverage. About 30% are covered under employer-sponsored retiree health plans, which are the “single largest source of supplemental coverage for Medicare beneficiaries” and cover almost 14 million people (Kaiser Family Foundation, April 2002: v). However, the number of employers offering retiree health plans is declining, due primarily to the ever-rising costs of health care and prescription drugs. Those employers who continue to offer retirement health plans are responding to higher costs by shifting more of the economic burden to consumers, requiring greater cost-sharing and raising premiums. Studies show that 53% of firms with over 200 employees have increased retirees’ share of premiums, and 32% have increased retiree cost-sharing on prescription drugs: while active workers pay on average \$30 per month, retirees of the same firm pay an average of \$50 per month (Kaiser Family Foundation, April 2002: 6). In short, there are fewer employer-sponsored retiree health plans, and those that still exist are getting more costly and are providing fewer benefits.

Medicare beneficiaries who are not covered by an employer-sponsored plan – or who cannot afford one – can turn to one of three other categories of supplemental insurance to provide prescription drug coverage. About 25% of Medicare beneficiaries have Medigap policies, which are purchased through private insurers, and cover Medicare deductibles, coinsurance and co-payments. These policies, however, are expensive, with an average annual premium of over \$1,300 in 1999. And Medigap policies that include coverage for prescription drugs are even more costly – typically an additional \$450 a year. The premiums for plans that provide drug coverage are steadily increasing – up 37% between 1999 and 2001. In addition

to higher premiums, these plans typically impose high costs -- a \$250 deductible, 50% coinsurance and coverage limited to between \$1,250 and \$3,000. No surprise, then, that more than 90% of the retirees who have Medigap policies opt for plans without drug coverage (Scanlon, 2002: 11).

Approximately 14% of Medicare beneficiaries are enrolled in Medicare+Choice plans. These plans are purchased from HMOs and other private insurers, who provide Medicare-covered services for a set amount each month. While beneficiaries who choose these plans will have less choice amongst providers, these plans generally have lower cost-sharing requirements and offer additional benefits, including prescription drug coverage. The major barrier to access for these plans is geographical: in 2002, approximately 40% of Medicare beneficiaries live in counties where there are no Medicare+Choice HMOs (Scanlon, 2002: 4).

Another 17% of Medicare beneficiaries turn to Medicaid. Under federal law, Medicare beneficiaries who have incomes under the Federal Poverty Level (FPL) are entitled to have their Medicare out-of-pocket costs paid for by Medicaid. Beneficiaries with incomes slightly above the poverty level may qualify to have some of their Medicare premiums paid by Medicaid. All state Medicaid programs provide some form of prescription drug coverage, yet a new study from the Center for Studying Health System Change (HSC) shows that “the prescription drug access problems experienced by Medicaid beneficiaries are virtually the same as the uninsured” – 26% of Medicaid beneficiaries and 29% of the uninsured population report significant difficulty accessing needed drugs (HSC News Release, April 9, 2002). Medicaid has become less effective at meeting the prescription drug needs of its beneficiaries because states have implemented a number of cost-saving policies that directly impact access to prescriptions, such as higher co-pays, restricted numbers of prescriptions per patient, rules requiring prior authorization and step-therapy protocols. The HSC study argues that any one of these changes does not, by itself reduce access, but when states implement more than one at a time the cumulative effect is reduced beneficiary access to prescription drugs (Cunningham(a): 3).

There are about 12.5% of Medicare beneficiaries who have no form of supplemental insurance at all. Their incomes are too high for Medicaid, but too low to bring a supplemental policy within reach. Among this group, those who have greater health care needs clearly face the greatest barriers to access. A 1998 study showed that this group spent significantly less money on prescriptions and filled a much smaller number of prescriptions than did their covered cohort. “The difference in expenditures and use between the two groups suggests that the lack of drug coverage may impose barriers to care” (Walker, 2002: 10). Medicare beneficiaries who lack supplemental coverage are a vulnerable population and have a disturbing pattern of sharing other characteristics: being black, or disabled, or poor, or very sick, or very old (Laschober, et al: 131).

Lack of access to prescription drugs is not just a problem for Medicare beneficiaries. Non-elderly adults (less than 65 years) generally have prescription drug coverage through their employers or through Medicaid, but about 25%, or “over 26 million lack health insurance coverage of any kind for medical care” (Cunningham(b): 2). Since they are not a part of the economy of scale generated by employer-based or government programs, the uninsured generally pay higher prices for prescription drugs. Higher prices are a significant barrier, since 64% of the uninsured are from families with incomes of less than 200% of the federal poverty level. The result? While the uninsured of all ages face many health care related challenges, in 2000, 30% of non-elderly adults without insurance cited cost as the major reason for not filling at least one needed prescription (Kaiser Family Foundation, May 2002: 76 - 78).

C. Federal Response

In response to the growing healthcare coverage concerns, the Bush Administration has proposed a total overhaul of the Medicare and Medicaid programs, both of which are facing financial crisis. At the current time, the President and Congress are locked in a struggle over the exact shape and form – and cost – of any reform of Medicare and Medicaid, including the possible addition of a prescription drug benefit. However, the Administration has proposed a set of policies that are meant to address the most critical needs immediately. One of these is the Medicare-Endorsed Prescription Drug Card program, first proposed in July, 2001, and quickly met with a law suit from the pharmacy industry, *National Association of Chain Drug Stores v. Tommy Thompson, et al.* The Administration modified its proposal, and the final rule was issued on August 30, 2002. The basic program is not a prescription drug benefit. Rather, it is a mechanism for the federal government to identify and endorse private prescription drug card programs. The Department of Health and Human Services will endorse prescription drug card programs that have at least 5 years of experience and meet certain other requirements such as: open enrollment for any Medicare beneficiary who wants to join, for free or for a one-time enrollment fee of no more than \$25; “substantial” manufacturer rebates or discounts; and broad geographic access via a national or regional retail pharmacy network. In addition, participating drug card programs must agree to join an “administrative consortium” and take part directly in administering and paying for the larger program (Federal Register, March 6, 2002: 10262). Existing programs that may qualify under the rule include those sponsored by health plans, chain drugs stores, and interest groups such as AARP. When the rule was initially announced, twenty-eight different companies applied for inclusion in the program, and HHS expects similar interest this year (Kaufman: 1).

HHS will also publicize information about these programs so that Medicare beneficiaries will be able to directly compare the benefits offered by the different cards, and knowledgeably chose between them. Participating drug card programs will have to accept marketing guidelines established by HHS, and will assume the responsibility of providing consumer information after the first year.

Some states have already established programs that may include drug card discounts; Alabama, California, Florida, Iowa, Maryland, New Hampshire, and West Virginia. Other states are in the process of implementing a program but are waiting for approval or are not fully operational yet include: Hawaii, Maine, New Mexico, Oregon, and Vermont. (See Appendix C for the complete table of State programs and eligibility criteria.) The Administration does not believe these programs are “well-suited” for the new HHS program, most notably because they do not meet the requirement of providing service over a broad national or regional area. Instead, the Administration would like to see states partner with private drug card programs by selecting one Medicare-endorsed program and giving it the additional endorsement of the state (Federal Register, March 6, 2002: 10268).

Prescription drug card programs, as they currently exist, bring challenges as well as benefits to health care consumers. Elderly and ill people have a particularly difficult time trying to compare programs or use the internet-based programs. Consumers’ ability to compare programs is hindered by the often-confusing language and terminology in the promotional materials. And the programs get their savings from a variety of sources – some negotiate discounts from pharmacies, some from manufacturers, some from enrollment fees, and some from a mix of the above. As one study notes, “the only way a consumer can determine whether or not a particular card will give them value is to obtain specific price quotes on the set of drugs they use. This may not be possible without considerable effort and time commitment” (Kaiser Family Foundation, Feb. 2002: viii).

The Administration’s proposal appears to address many of these concerns, but most existing programs would have to significantly reorganize in order to meet the criteria for Medicare endorsement. Furthermore, the suit brought against the first proposal and continuing opposition to the final rule makes clear that the pharmaceutical and pharmacy industries have some misgivings about the program that have not been allayed by the revised rule. In particular, they argue that HHS does not have the authority to make fundamental changes to Medicare – only Congress has this right. The final rule will inevitably face another legal challenge, but Bush Administration officials say they will pursue the Medicare drug card idea whether or not the courts rule against them, in the hopes that Congress will take legislative action on the idea (Kaufman: 1).

Congress has also been active in introducing legislation to address the prescription drug crisis. At the start of the August 2002 recess, there were dozens of bills pending that addressed Medicare and Medicaid reform (See appendix D), but most of these have been languishing in committee for months, most without so much as a scheduled hearing. Congress appears to have run up against the hard reality of the political and financial costs of adding drug coverage to Medicare, despite the many campaign promises for quick action: “A sober recognition has settled in Washington that little can be done to expand or improve health coverage while health care costs spiral out of control and the federal budget sinks deeper into deficit” (New York Times on the Web, May 28, 2002). In June, the House of Representatives passed a \$320 billion

Republican plan to require private insurers to offer a drug benefit to seniors. However, the Senate tried and failed four times to pass various versions of the Democratic plan, which was focused on the goal of offering uniform coverage to all seniors, regardless of coverage by private insurance. By August, the Senate had only managed to pass a bill that would move less-expensive generic drugs to the market more quickly – and the fate of this bill is uncertain, since it faces steep opposition in the House (Goldreich).

Members of both the Senate and the House have vowed to return to the issue when Congress resumes its deliberations. However, the possibility of a lame-duck Congress achieving any meaningful Medicare drug benefit is increasingly unlikely. While both Democrats and Republicans are trying to make major political hay on the failure of the other party to move drug benefit legislation, public anger over congressional inaction appears to cross partisan lines. A recent Democratic National Committee poll found that if Congress fails to take action on a Medicare drug benefit program, 22% of voters would blame the Democrats more, and 29% would blame Republicans more (Kirchoff). In short, the issue has become so blurred in the minds of voters that clear-eyed pressure on either party is lacking, and with it the necessary political motivation to pass significant legislation.

D. *State Responses*

In the meantime, the most innovative and direct action on the issue continues to be at the state level. While Congress is locked in a partisan debate within budgetary constraints, and the President struggles with the courts to determine the extent of his rule-making authority, the states are engaged in serious debate on the issue of prescription drug access. In the 2001-2002 legislative session, there were over 180 bills considered in 37 different states. The states with outstanding activity include Hawaii, where there were 17 separate prescription drug bills introduced, Maryland and Vermont, which each introduced 13 bills, and New Mexico with 11. 10 bills each were introduced in Washington and Massachusetts, and 9 in New York. This flurry of activity shows a pattern of response along or near the country's borders, across which prescription drugs can be obtained at often much-lower prices than in the US. There were only three bills introduced in Maine, but that state's plan has captured national attention and spawned a multitude of similar proposals in other states.

Maine's plan revolves around using the buying power of the state's Medicaid program to negotiate drug discounts from manufacturers for people who are not Medicaid-eligible. This requires a waiver from the federal government, which was issued by HHS in January 2001. The Maine plan also includes a method for sanctioning manufacturers who do not go along with the discounts, by requiring physicians to obtain prior approval from the state before prescribing drugs made by these companies. In response to the Maine Rx law, the Pharmaceutical Research and Manufacturers of America (PhRMA) filed a lawsuit. A federal district judge sided with the industry, and issued an injunction to stop the program, but the US First Circuit Court of Appeals lifted this injunction. The case is now pending before the US Supreme Court, and the Bush Administration has recently issued a brief in

support of Maine's position. In the meantime, 27 other states introduced legislation modeled on Maine's program during 2001, but all of these programs are on hold awaiting the outcome of *PhRMA v. Concannon*.

PhRMA has also filed suit against several other states, which have integrated preferred drug lists or formularies into their Medicaid programs. While drug formularies have been a standard part of private insurance plans for years, the notion of states throwing their weight into this arena has wide implications for prescribing practices, drug manufacturer profits, and state savings. Governor John Engler of Michigan estimates that Michigan's program will save the state over \$42 million this year alone, and estimates for the Oregon program are \$17 million for the first two years. Medicaid savings at the state level, of course, are multiplied at the federal level, which has ensured the strong support of the Bush Administration. In response, PhRMA has filed suit against the federal government for granting waivers to the states for these programs (Connolly).

Illinois's SenioRx Care program has also received national attention. HHS approved Illinois' waiver application in January 2002, and announced a new state model demonstration form, Pharmacy Plus, that is based on the Illinois model. The Illinois plan relies more heavily on an annual enrollment fee, enrollee co-payments and state subsidies than the Maine program, but both essentially utilize the same mechanism: using the buying power of the Medicaid program to secure drug discounts for people who are not otherwise eligible for Medicaid, primarily low-income Medicare beneficiaries.

There are concerns, however, that some state programs are experiencing financial difficulty that may shed light on the future of any federal drug benefit. Pennsylvania's Pharmaceutical Assistance Contact for the Elderly (PACE) is the nation's largest prescription assistance program for low-income elderly. PACE limits co-pays to \$6 a prescription, and covers approximately 225,000 people. The program has no enrollment fees or annual cap, and is funded through the state lottery. However, increased utilization has led to program costs that have begun to outstrip resources: the average number of prescriptions per person in the program is now over 3.5 per month, up from 2 per month in 1987. The cost of the program has risen on average 13% a year since 1997, due primarily to increased claims and claim amounts rather than increased enrollment. Pennsylvania would like to extend the program to cover more seniors, but is scrambling to cover existing expenses and control costs. Under consideration are a preferred drug list, higher co-payments for non-formulary drugs, and limits on the prices of generic drugs (Pear, July 13, 2002).

In all, some 32 states have programs in place or authorized that provide some sort of prescription drug coverage, mostly for low-income seniors and/or disabled persons. State initiatives fall into two major categories. Twenty-six states have subsidy programs that provide assistance with prescription expenses for seniors and other categories of residents. Six of those are new programs established in 2001. An

additional six states have discount only programs, with no state subsidy, that provide prescription drugs at a reduced cost to eligible seniors.

There are also initiatives within the states for multi-state cooperation. The governors of New Hampshire, Maine, and Vermont have formed the Northern New England Tri-State Coalition to pool their Medicaid funds and utilize their combined purchasing power to save an expected 10 to 15 percent a year on prescriptions drug expenditures. The Northeast Legislative Association on Prescription Drug Prices includes the 6 New England states, New York and Pennsylvania, and has developed legislative ideas that could lead to the creation of a regional buying pool, with an anticipated savings of nearly 40% per year. A group of southern states (LA, MD, MS, MO, NM, SC and WV) have joined together in the Pharmacy Working Group coalition to combine their purchasing power and get better prices for people covered by government insurance plans. Health policy leaders are also joining discussions in Alaska, Idaho, Montana, Nevada, Oregon, Utah, Washington and Wyoming about strategies for lowering prescription drug costs in their region (NCSL, Aug.8, 2002). In short, the states are the front line of new ideas and new efforts to slow the rising cost of prescription drugs.

See chart in Appendix D, which details each of the individual state programs, categorized as subsidy, discount, or Medicaid programs (drawn from NCSL data, available at www.ncsl.org).

E. Current Status of Prescription Drug Programs in New Mexico

Other than Medicaid, limited Medicare coverage, and programs through the New Mexico Department of Health no other formal State-administered prescription drug program is offered to serve the uninsured and underinsured in New Mexico. While numerous discount programs are available for low income New Mexicans, such resources might not be well known to the general public or are available only to populations meeting strict eligibility criteria, such as for those over 64 years old, or for those who meet Medicaid criteria.

A recent report published by the Kaiser Family Foundation found that national spending for prescription drugs grew 17.3% in 2001, varying from as low as 12.0% in Maine to a high of 25.2% in Alaska. New Mexico experienced an increase of 4.5% between 2001 and 2002 and a 9.5% increase in the average price of retail prescriptions. The same report revealed that the average price of retail prescriptions in 2001 for New Mexico was lower than the national average; \$46.41 compared to \$49.84. The percent change in total sales of retail prescriptions between 2000 and 2001 was also lower; 14.4% compared to 17.3% (State Health Facts Online).

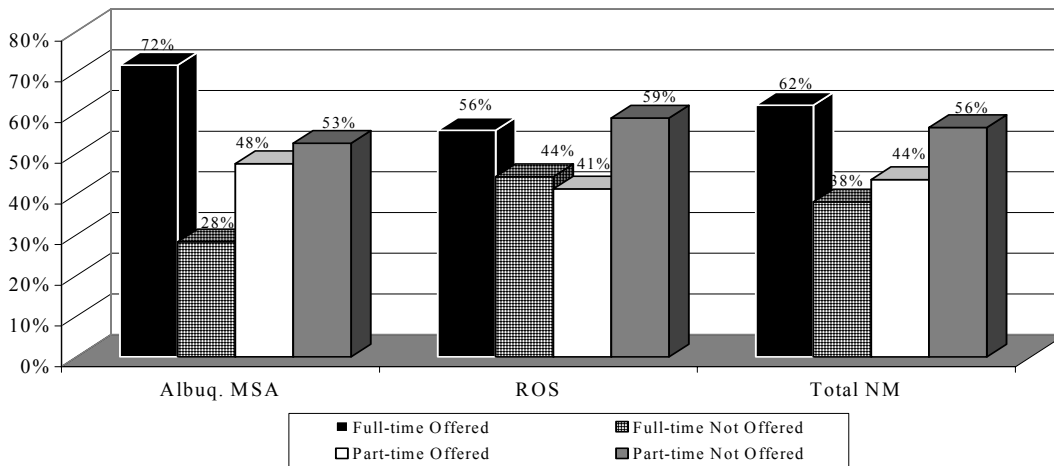
According to a NM Human Services Department contact, in New Mexico, from 1994 to 2000, the average per month amount paid for prescription drugs increased from \$88.41 to \$175.53. The average amount paid per prescription in fee-for-service (FFS) Medicaid increased from \$30.53 to \$40.70 during the same period.

Employers pay for a great portion of prescription drug coverage through the insurance policies they offer their employees. According to the Kaiser report, between 1999-2000, 35% of private sector firms with fewer than 50 employees offered health insurance to their employees, while 94% of firms with 50 employees or more offered health insurance. Insurance status for New Mexicans between 1999-2000 was –

- Employer based 46%
- Medicaid based 14%
- Medicare based 13%
- Individual -self 3%

The same report stated that 25% of New Mexicans were uninsured.

According to the HPC’s *Quick Facts 2001*, employer based insurance dropped to almost 51% compared to 56% in 1998 (44). The 2000 HPC Household Survey found that among persons who did not enroll in their employer-based insurance, nearly 19%



**Percent of Establishments Offering Health Insurance –
By Employee Status and Area (Source: *Quick Facts 2000*, p. 58)**

stated that they could not afford the coverage, while about 30% said they were covered through a family member (28). The Household Survey also found that 67% of 3,771 respondents mentioned a needed access to prescription drugs, yet 94% of those respondents said they received medications when they needed them (49; 53). How they receive their medication was not determined in the Household Survey, but based on the HPC’s recent telephone survey, it can be speculated that prescription medications were obtained through discount pharmaceutical programs, community health clinics, or other sources.

A significant portion of New Mexicans continue to struggle with poverty and the lack of any source of health care coverage. 17.7% of the New Mexico population lives in poverty, compared to the 11.5% national average (US Census Estimations 2000 – available at <http://quickfacts.census.gov>).

Legislative Initiatives

Recognizing that many constituents are facing hardships in purchasing prescription drugs, New Mexico Legislators introduced in the Regular 2002 Legislative Session at least nine Bills and Memorials in the Senate and six in the House relating to making prescription drugs more affordable and accessible to New Mexico residents. Four passed and were signed by the Governor.

New Mexico was one of sixteen states that approved legislation this year to create or amend preferred drug lists, prior authorization, supplemental drug rebates, generic substitution, prescribing and dispensing limitations, co-payments and dispensing fees. (NCSL, July 11, 2002).

The following Bills and Memorials were passed and signed by the Governor in 2002:

- Senate Bill 200/House Bill 91, Senior Prescription Drug Program
- Senate Bill 253, Pharmaceutical Supplemental Rebate Act
- House Joint Memorial 50, Reuse of Unused Unit Doses of Packaged Drugs
- Senate Joint Memorial 35, Maximize Prescription Drug Discounts.

Senate Bill 200/House Bill 91 amends the Retiree Health Care Act to provide for a senior prescription drug program. An eligible senior who must be a resident of the state, be 65 years of age, and not have any drug benefit would pay an annual enrollment fee not to exceed \$60.00. According to research done by the HPC, an estimated 68,000 to 110,000 seniors may participate in the prescription drug program, potentially generating \$4 - \$6.6 million annually for the Senior Prescription Drug Program Fund. Interest would go into the State General Fund.

Projections by the New Mexico Human Services Department show that implementing a senior prescription drug program alone would cost \$44.5 million per year (20,600 clients times \$2,160 per client). This data is based on actual Medicaid expenditures for prescribed drugs in 1999 and 2000 for SSI-Aged clients, 65+ years old with approximate income less than 73% of federal poverty level.

Senate Bill 253 enacts the Pharmaceutical Supplemental Rebate Act, which requires the development of a preferred drug list and prior authorization for drugs not on the list. Supplemental rebates or discount prices will be negotiated from the drug manufactures. The New Mexico Human Services Department, which currently manages the Medical Assistance Division's Medicaid Drug Program, is given the task of adopting rules and seeking any necessary Federal waivers to implement the Act.

House Joint Memorial 50 requests that the Human Services Department, Department of Health and Board of Pharmacy collaborate on a study of the potential for safe re-use of unused, unit dose packaged drugs, which could potentially save money for consumers and the State.

Senate Joint Memorial 35 requests the Human Services Department to lead an interagency group to study how to expand the use of the Federal 340B program and maximize prescription drug discounts.

Pharmaceutical Services Available to New Mexicans

Medicaid

Until the above-mentioned programs become well-established, Medicaid will continue to be the primary resource for prescription drug access for people meeting its eligibility requirements. Medicaid services, benefits and eligibility criteria vary from state to state. The Medicaid Program, administered by the Centers for Medicaid and Medicare Services (CMS), allows prescription drug coverage as an optional benefit, and virtually all states take advantage of this option. States have varying degrees of “prior authorization” policies and/or prescription caps for Medicaid pharmaceuticals. Prior authorization policies may include the utilization of formularies or requiring that physicians get prior approval from their Medicaid agency or a managed care organization before prescribing or dispensing drugs. New Mexico is one of 40 states and the District of Columbia that has some form of prior authorization policy. New Mexico does not place limits, or caps, on the number of prescriptions filled or refilled per month, unless the drug is a narcotic or other type of drug that needs special monitoring (NCSL, 1996). According to a Medicaid Benefits contact, New Mexico Medicaid eligibility is determined monthly, and because clients may switch from one Managed Care Organization to another, prescriptions and their re-fills are monitored to avoid abuse.

New Mexico Medicaid provides health care coverage, including pharmaceuticals, for low-income children, families, pregnant women, disabled persons, and elderly persons meeting specific eligibility criteria. The program attempts to assist as many people in need as it can by offering specialty categories in which limited targeted eligible populations can obtain specific prescription drugs, such as contraceptive drugs for family planning. The SCHIP program, tailored for children who meet at least 235% federal poverty level criteria, also qualify for health care and prescription drug services. According to recent NM HSD statistics, over 363,000 adults and children are enrolled in the State's Medicaid program through managed care or fee-for-service.

Like other states facing budgetary constraints, New Mexico's Legislators are examining Medicaid Program spending to determine where or if expansion and benefits offered by the program can be reduced or eliminated. Changing eligibility criteria and benefits may decrease the number of people who have access to necessary prescriptions.

Medicare

Medicare is the nation's largest health insurance program, covering over 39 million Americans age 65 and over, as well as those who have permanent kidney failure, and certain people with disabilities. 14% of Medicare recipients are under the age of 65

(Briesacher). Medicare does not provide pharmaceutical coverage as an outpatient service, but offers limited and restricted prescription drug coverage through optional insurance referred to as “Part B” to assist with medications and additional medical expenses not covered by Medicare. The prescription drugs that are covered include some antigens, osteoporosis injectable drugs, hemophilia clotting drugs, and oral cancer drugs. Medicare recipients generally pay extra for supplemental insurance such as Medigap. According to a NM Pharmaceutical Association report to the NM Legislature in 2001, the national average cost for monthly premiums is \$90, compared to New Mexico’s average monthly premium of \$141. In addition to premiums, New Mexicans pay co-payments, which may be costly for seniors living on a fixed income. According to recent data, the number of over 64 year old Medigap enrollees has increased 15% in the state, from 1997 to 2000 (National Association of Insurance Commissioners).

Department of Health

According to a Department of Health (DOH) contact person, public health clinics primarily work in prevention of diseases rather than in treatment of diseases. They serve limited populations who require short term, specific specialized treatment such as immunizations, treatment of sexually transmitted diseases, infectious diseases, some prenatal care, and family planning. The DOH State Pharmacy provides drugs to the public health clinics, which are dispensed to patients on a sliding fee scale or free of charge, depending on the services utilized. If a pharmaceutical drug is not available through the clinic’s drug room, patients may be given a prescription that must be filled elsewhere at the patient’s own personal expense. Other than the above-mentioned public health services, the Department of Health administers the HIV/AIDS program, which provides necessary prescription drugs to its clients.

Community Health Clinics

Community Health Clinics (CHCs) are a resource in local communities for anyone seeking medical services, regardless of the person’s ability to pay. Within the available limits of resources, they provide their patients assistance to purchase prescription drugs.

As part of the War on Poverty in the mid-1960s, the Federal Government funded CHCs to provide accessible, affordable personal health care services to low-income families. The CHC Federal grant program is authorized under Section 330 of the Health Centers Consolidation Act of 1996. CHCs are designed to provide family-oriented primary and preventative health care services for people living in medically underserved communities. According to the Bureau of Public Health Care, the Act stipulates that services should be tailored to the communities and should provide services that -

- ▶ Provide essential ancillary services such as laboratory tests, X-ray, environmental health, and pharmacy services as well as related services such as health education, transportation, translation, and prenatal services.

- ▶ Provide links to welfare, Medicaid, mental health and substance abuse treatment, WIC, and related services.
- ▶ Provide access to a full range of specialty care services.

According to the New Mexico Primary Care Association's (NMPCA) report to the New Mexico Legislature during the Regular 2002 Session, more than 79% of the state's CHCs are located in rural and frontier areas but clinics are also found in urban areas, providing primary health and dental care to low-income, under and uninsured patients. The report went on to say that the health care safety net is critical in New Mexico because –

- Of the State's relatively low per capita income and relatively high level of uninsured, and broad geographic expanse.
- CHCs delivered more than \$26.6 million in uncompensated care in 2000, serving over 234,000 residents in 93 underserved communities in 31 counties.
- CHCs provide health care to urban and rural working poor, migrant farm families, and homeless individuals.
- The number of uninsured individuals receiving health care in these centers has increased to more than 100,000 (43.8%) since 1995.
- In 2000, pharmaceuticals valued in excess of \$16.7 million were dispensed to uninsured and elderly patients at deep discounts.

New Mexico CHCs depend on State appropriations, such as Rural Primary Health Care Act (RPHCA) funding, and Federal support to supplement their patient generated revenues. CHCs may participate in the Community Health Center (CHC) Program, a Federal grant program funded under Section 330 of the Public Health Service Act. The program provides funding support to CHCs located in rural or urban areas classified as Medically Underserved Areas (MUAs). Through Section 330, CHCs are eligible for cost-based reimbursement under Medicaid and Medicare and may participate in the 340B Federal Drug Pricing program (Bureau of Primary Health Care).

340B Program

In 1992, Congress enacted Section 340B of the Public Health Service Act, which enables public hospitals, community, migrant and homeless health centers, HIV/AIDS clinics, and other safety net providers to purchase certain outpatient pharmaceuticals at discounted rates lower than the Medicaid discount. Since the program took effect, according to the 340B Coalition, "it has saved safety net providers and the taxpayers that support them hundreds of millions of dollars in outpatient drug costs." The program allows qualified health facilities to pay only 49% of regular market prices so the CHCs can continue to assist their patients to purchase needed medications. Other than the usual medication needed to treat acute illnesses, the program provides coverage for serious conditions such as HIV/AIDS, diabetes, hemophilia, asthma, and other serious life threatening diseases (Public Hospital Pharmacy Coalition).

In New Mexico, 166 facilities and clinics have been approved for the 340B program (Health Resources and Services Administration. Available at www.hrsa.gov/odpp). Eighty NMPCA member clinics offer pharmacy benefits to their patients by availability of 340B or similar pharmacy drug programs.

Other Services

Numerous discount prescription programs are available for Medicare and Medicaid eligible clients. Discount drugs may be found on the Internet and many New Mexicans travel to Mexico to purchase their medicine. The New Mexico State Agency on Aging has created a matrix of insurance programs that provide State, Federal and other prescription drug coverage for eligible New Mexicans. Several of the programs are Medicaid Extension programs. Others include services for veterans, Native Americans, and miners. This still leaves out many residents who may be the working poor, may not have access to the Internet or transportation to travel far for discounted medicine.

Assistance to receive prescription drugs may be provided at local levels via the religious community, charity organizations, and other non-profit entities. Managed Care Organizations, private physicians, or health clinics may provide their patients with discounted or sample drugs.

In summary, there are many ways to obtain prescription drugs but the results from the HPC's surveys show that all of these are still not enough. There are still many New Mexicans experiencing serious difficulties accessing prescription drugs, some who might never have entered any health care provider facility to seek any kind of healthcare.

III. Survey Methodology and Results

To acquire a comprehensive picture of prescription drug access in New Mexico, the HPC conducted four independent surveys. A statewide telephone survey was designed with the assistance and recommendations from the Advisory Committee, and was initiated by a local consulting business. Separate surveys were designed by the HPC directly for community health clinics (with the assistance of the New Mexico Primary Care Association), Maternal Child Health Councils' coordinators, and County Indigent Fund administrators to record their observations and perspectives of prescription drug access in their respective counties.

Statewide Telephone Survey

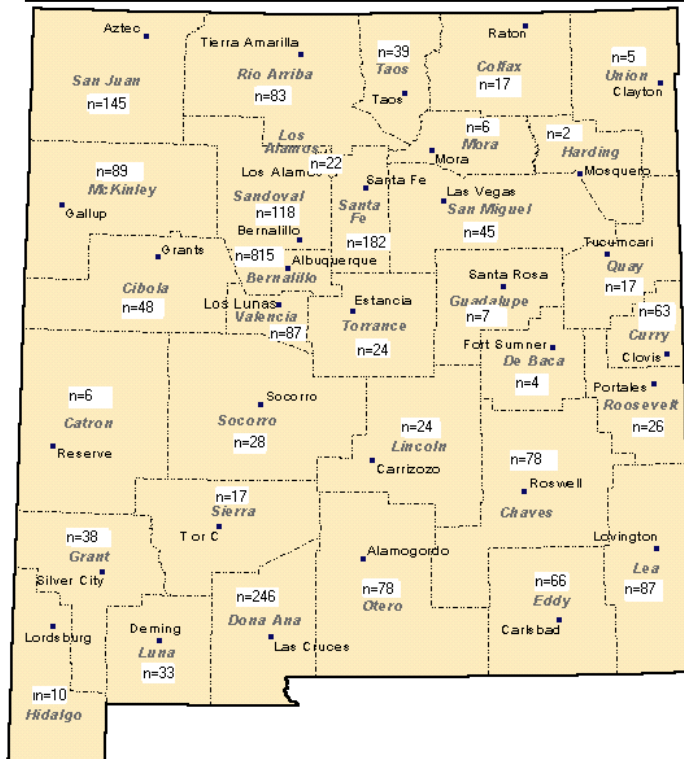
The statewide survey was designed to answer specific questions relating to access and barriers to prescription drugs in relation to demographics; the incidence and characteristics of New Mexicans depleting liquid assets such as savings or property to purchase prescription drugs; and the relationship between the severity of illness and access to prescription medication. The following is an excerpt from the full BCA telephone survey report found in Appendix G.

Telephone Survey Methodology

Burger, Carroll & Associates, Inc. (BCA), a New Mexico based business specializing in management consulting, conducted the survey, with the services of Research & Polling, a New Mexico polling firm. The ten-member Advisory Committee and the HPC staff guided the telephone interview design.

A detailed telephone survey was conducted between November 2001 and February 2002 of households with self-reported need for prescription drugs in the last 12 months. Within these households, an individual who makes decisions about prescription medications for themselves or others was identified. This individual was asked a set of questions about themselves, the household, and any additional senior or child in the household. These questions were regarding behaviors in obtaining prescriptions; ability to get needed prescriptions (access) including health care coverage and hardships encountered; health status and medical conditions; and household prescription expense information. Individuals who had less than full access to needed prescription

Number of Telephone Survey Respondents per NM Counties



medications (sometimes able to get) were asked an additional set of questions to determine why they could not obtain the needed medications, and how they dealt with not being able to obtain needed medications. See Appendix G for the questions.

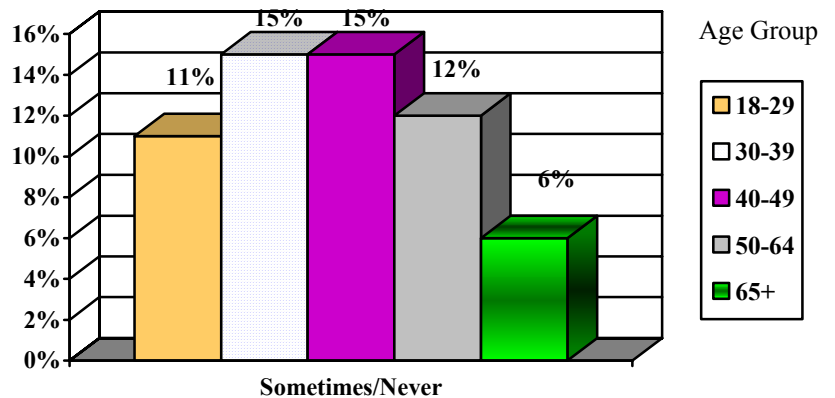
Telephone interviews were conducted during weeknights and weekends to enhance the response rate. Random digit dialing (RDD) was used to include households with and without published telephone numbers so as to enhance the likelihood of interviewing a broad spectrum of respondents in broad geographic areas. To be consistent, 2000 U.S. Census data on adults was used to assure demographic representation for the 33 counties.

A total of 3,305 households responded to the survey. Of these, 2,627 indicated a need for prescriptions for at least some members of the household within the previous 12 months. Participants from every New Mexico county are represented in the survey. Fewer Hispanics were reached than are proportionally in the population, but the full sample was weighted, or adjusted, to be fully representative of New Mexico with regard to age and race/ethnicity. Additionally, the full sample closely matches New Mexico with regard to income and county of residence.

Results of Telephone Survey (excerpts from the full BCA Survey Report)

Of 3,305 households responding to the telephone survey, 77% of the households responded that they had a “recognized need” for prescription medications during the last 12 months. A “recognized need” could be defined as someone having been prescribed medication to treat an acute (“one time” or temporary), or chronic condition (ongoing). The recognized need for prescriptions was greatest among seniors in the household, followed by adults, and then children (81%, 53% and 45%, respectively). The survey showed that seniors had the best access to the drugs they needed when they needed them, but also that they spent the most money.

**Were you able to get the needed prescription medications?
Sometimes, Never**

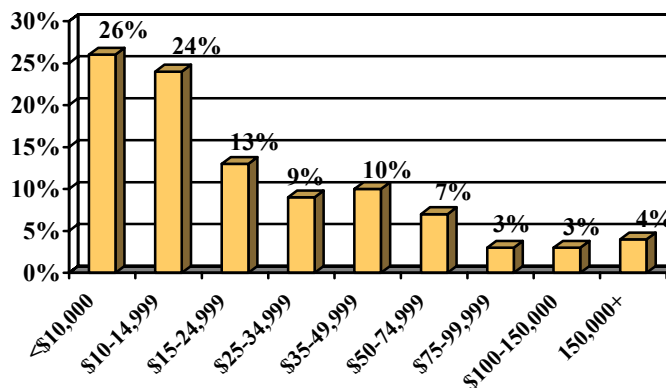


Better access for seniors in the HPC study may be related to Medicare + Choice coverage, which correlates with the Commonwealth Fund’s 2001 Survey of Health Insurance, another recent telephone study, which found that elderly Medicare beneficiaries, according to their annual income, were overall more satisfied with their insurance coverage and ability to access medical care and prescriptions than those with employer insurance or no insurance. Lower-income seniors were less likely to give high

satisfaction ratings (Davis, et al: W 312). When breaking down access by income level for seniors, the HPC found that 20% (15/75) with incomes less than \$10,000 experienced difficulties, as did 14% (19/137) with incomes less than \$15,000.

The Commonwealth Fund survey also found that Medicaid beneficiaries are generally more likely than the privately insured to be in poor health. They are more likely to have more than one chronic disease, and are three times more likely to report being in fair or poor health (Davis, et al: W 313), subsequently resulting in high out of pocket expenses for multiple prescriptions. Non-Medicare respondents with lower incomes, insufficient insurance coverage, or with no insurance at all reported less satisfaction and less ability to access the medical services and prescription drugs that they needed. The table below illustrates the HPC telephone survey results by the percentage of New Mexicans, all ages, who had less than full access to prescription drugs based on their annual income (sometimes able to or never able to obtain drugs). Example, of 331 respondents with annual incomes \$10,000 or less, 26% (86) experienced difficulties obtaining prescription drugs.

BCA Telephone Survey: What income category best describes your total household income + Were you able to get the needed prescription medications? (Sometimes, Never)



Below are statistics giving an overview of the HPC telephone survey results.

- 12% of the respondents (7.99% to 10.36% of all New Mexico households) have less than full access to needed prescriptions.
 - o 76% of those respondents were unable to pay for the medications.
 - o 87% of these same individuals did not have insurance coverage at the time or their insurance coverage did not cover the medication.
 - o 53% of individuals with less than full access had trouble getting refills.
- Individuals with full prescription coverage had the best access, while individuals with no health care coverage at all had the worst (95% vs.69% full access).
- Seniors had the best access to prescription medications of the age groups, but spent significantly more.

- Hispanics had the lowest access by race/ethnicity at 15%, as did individuals with lower household income.
- 15% of households indicated they had to obtain their prescription drugs in a community other than their own due to
 - o Lack of a local pharmacy, or
 - o Cost of prescription drugs.
- 23% of individuals had difficulty getting prescription refills.

The respondents were creative in obtaining their medications.

- 16% used the Internet to order prescription medications.
- 45% received some free drug samples from their doctors.
- 6% used prescription drug discount cards.

The BCA chart below illustrates what steps individuals took in order to purchase their medications broken out by age groups.

Hispanics and American Indians, individuals with lower household income, and younger or middle aged people were most likely to undergo these practices.

BCA Chart: Health Care Coverage & Hardships				
PR=Prime Respondent (includes Seniors) who answered the questions, Adult PR=Non Senior Prime respondent				
Percent Sometimes/Always	Child	P.R.	Adult P.R.	All Seniors
Sold Possessions	2%	13%	16%	6%
Given or Lent \$	8%	12%	13%	6%
Take Short Term Loan	2%	3%	3%	2%
Choose Between Themselves or Others	7%	9%	10%	4%

Individuals reporting the poorest health status had the worst access. Individuals reporting allergies, chronic pain, arthritis, emotional disturbances, lung, bone or autoimmune diseases, migraines or stomach problems were more likely to have access problems than individuals reporting no or other medical conditions.

Not all New Mexicans are able to pay all of their out-of-pocket expenses for prescription medications. Of the study sample, 8.82% were unable to do so (n=226). The median amount spent on prescription medication was \$200.00 per year. Of those able to pay out of pocket expenses:

- \$634.66 was the average annual out of pocket expense per household by New Mexicans with a recognized need for prescription medications.
- Age, health care coverage and the number of medical conditions increased out of pocket spending.
- Older individuals clearly spend more on prescription medications.

Groups spending more out of pocket have higher proportion of individuals with less than full access.

Survey of Community Health Clinics

This survey was created to gain a perspective on local access to prescription drugs through community health clinics (CHCs). Community health clinics may be the sole healthcare provider in smaller rural communities, and serve as a safety net in larger communities for the uninsured or otherwise low-income populations. The HPC developed a survey in collaboration with the New Mexico Primary Care Association (NMPCA), a non-profit organization that serves as an advocate for its members.

Methodology

The survey was targeted at 88 CHCs who were listed in the *New Mexico Community-Based & Rural Health Clinics Resource Directory*, a publication of the Department of Health Primary Care/Rural Health Bureau. Directors of the CHCs were contacted via telephone and were asked questions regarding pharmacy assistance programs and benefits offered to CHC patients, access and barriers to getting prescription drugs filled and refilled, and if there was a perception that some patients do not receive the medications they needed. The survey responses represented 88 CHCs statewide. See Appendix E for survey questions.

Results of Community Health Clinic Survey

According to the CHC survey, 81 clinics offer pharmacy benefits through 340B or similar pharmacy drug programs, which may allow the availability of an in-house drug room, or special discount program with local pharmacies. A drug room, unlike an in-house pharmacy, does not need the oversight of a pharmacist, and might be limited to providing only initial prescriptions to clinic patients. Seventy clinics (79%) reported that their patients face a financial burden to purchase prescriptions while 18 (20%) clinics reported that their patients do not face financial burdens when purchasing prescriptions.

The CHCs assist their patients by offering sliding fees or charge accounts, dispensing sample drugs, contracting with local pharmacies for dispensing discounted prescription medications, facilitating paperwork for Medicaid eligibility or pharmaceutical drug programs, and participating in drug manufacture programs.

Eighty-one CHCs receive 340B federal support and reimbursement by being a Federally Qualified Health Clinic (FQHC) or FQHC Look Alike. These CHCs are distributed through urban, semi urban and rural communities. Sixty-four (78%) of those clinics reported that their patients face a financial burden to purchase pharmaceuticals, particularly the underinsured, the uninsured, elderly, immigrants and disabled.

Seventy-four clinics reported that all or most all prescriptions are filled and refilled locally. Seventy-five clinics (85%) reported that the cost of drugs is rising.

Six CHCs are neither FQHCs nor FQHC Look-Alike and receive no section 330 Federal funding. All six clinics are located in rural communities, and all responded that their patients faced a financial burden to purchase their drugs.

One-on-one comments provided by the clinic administrators included:

- Cost of drugs is rising because of increased utilization as well as costs. Overall costs will double in ten years.
 - Cost of all prescription drugs is rising at a rapid rate. Antibiotics and cholesterol medications were listed as some of those drugs that are most frequently used and are increasing in cost.
- Most visits require dispensing of medication unless they are well-baby checkup or sports physical.
- Clinic usually pays 95% of costs to local pharmacist. Client pays \$5 co-pay.
- Clinic uses volunteers to staff programs to get free drugs from manufacturer and to deliver prescriptions to isolated individuals.
- Patients must travel to other towns, often to other counties or sometimes to Mexico, to purchase drugs not available through the limited drug supplies that the clinics carry.
- Medications available in in-house drug rooms are limited... Patients go out of town for re-fills.
- The uninsured, those on fixed incomes, and the elderly face the greatest need.

Survey of Maternal Child Health Council Coordinators

To attain a perspective on how community residents receive prescription drugs that they cannot get from a healthcare provider due to financial, distance, or other reasons, the HPC designed a questionnaire for Maternal Child and Health (MCH) council coordinators. MCH councils are community based. The issues they deal with are multi-faceted in nature, reflecting community interest. Because the MCH councils are familiar with the social, economic, and health needs of their communities, the HPC asked the MCHC coordinators to identify safety net systems available for their residents that have limited income to purchase pharmaceutical drugs.

Methodology

The survey was faxed to MCH council coordinators and their answers were returned via fax. The questions asked if their offices have been consulted for assistance to purchase prescription medications, what resources besides health facilities or doctors' offices were available, and the types of support given to people seeking assistance. The questionnaire also asked what groups of people in their immediate or surrounding community were least likely to get the prescription medicines that they needed. Fifteen (57%) out of 26 coordinators responded to the questionnaire. See Appendix E for the survey questions.

Results of MCH Survey

Ten of the 15 responding MCH coordinators indicated that they had been consulted for assistance to purchase prescription drugs.

Twelve coordinators responded that limited financial assistance for prescription drug purchase is available in their community through local churches and affiliated associations (e.g., St. Vincent de Paul), other charities, the County Indigent Fund, and Community Action Agency/Program (mentioned by four councils). Another type of assistance the MCH's provide is helping clients to complete Drug Program Assistance forms.

All coordinators reported that the populations least likely to get necessary medications are the uninsured, followed by the elderly. Other populations include undocumented workers, migrant workers, women who are not pregnant, disabled, mentally ill, persons on fixed incomes, and those having high-deductible insurance.

Survey of County Indigent Fund Administrators

The County Indigent Fund (CIF) is a safety net resource for healthcare providers to receive some reimbursement for the uncompensated care they provide, and to occasionally assist individuals with guidance and referrals on how to get healthcare services they might need. The HPC's informal survey was designed for the CIF administrators.

Methodology

The HPC assembled county-based prescription drug access information through informal phone interviews, a mailed questionnaire, and the 2001 Annual County Indigent Report. County administrators were asked about prescription drug components of their respective indigent programs as well as other means by which an indigent person might obtain prescription drugs. They were also asked for their informal opinion on access to prescription drugs in the county in general. Nineteen counties responded to the mailed questionnaire, while 33 County Indigent Fund administrators were interviewed informally via the telephone. See Appendix E for the mailed survey questions.

Results of CIF Survey

For the most part, the New Mexico counties recognize that there is a serious problem with the availability of prescription drugs to certain segments of the population. Based on the responses from 19 CIF administrators, six counties offer "very limited" financial assistance with prescription drug purchases, eight counties offer substantial assistance through referrals to non-profit organizations and drug manufacturers, eleven counties don't offer any referrals, and eight counties offer no financial assistance and no referrals to those who need prescription drugs.

The counties have identified the working poor, which includes immigrant populations, as needing the most assistance to purchase prescription drugs.

Conversations and CIF Survey responses reveal that New Mexico CIF administrators do have a general awareness and concern about the lack of availability of prescription drugs for low-income residents. Ten counties identified the elderly and the working poor as the populations most affected by high prescription drug costs. Of the remaining counties, six

counties cited only the elderly and 2 counties cited only the working poor as those segments of their populations affected by the high cost or availability of prescription drugs

Nine counties provided estimates on the number of their residents having access barriers:

<u>County</u>	<u>Number of People and Percent of County Population</u>	
Cibola County	2,900	10%
Dona Ana County	53,400	30%
Eddy County	19,630	40%
Lincoln County	50	<1%
Roosevelt County	6,006	33%
San Juan County	22,000	20%
Santa Fe	16,808	13%
Torrance County	4,000	15%
Union County	209	5%

Eight counties indicated that high prescription drug costs have been a topic of public discussion during county commission meetings.

Additional comments from CIF administrators were:

- Counties actively participate in making referrals to non-government sources for their residents' prescription drug needs such as churches, drug manufacturers and not-for-profit organizations.
- Most counties cannot afford the additional cost of providing or supplementing the cost of prescription drugs for their residents.
- Counties are concerned that State lawmakers may impose an un-funded mandate to the counties that requires additional expense to the counties with no assistance from the State level.

Recommendations

- That the State provide matching funds to assist the counties with the purchase of prescriptions drugs for needy populations.
- That the State allocate direct funding from the State to the counties for the purchase and distribution of prescription drugs.

Those counties that responded to the survey, with one exception, identified the social and financial impact of high prescription drug costs to their residents, and recognize the potential financial impact on their county budgets. CIF administrators, while not in a

position to initiate changes in county public policy, advocate State leadership in addressing and resolving the problems associated with high prescription drug costs.

Discussion and Summary of Survey Results

The general findings of all four HPC surveys were consistent with national research, which have found that the populations having the most difficulties obtaining prescription drugs, regardless of age, are the working poor, the uninsured, minorities, and those living in rural communities. The HPC study correlates with other studies showing that seniors are spending more for their prescription drugs. It also compares with other studies, which have found that those who have trouble buying their prescription drugs find ways to get those drugs whether it means rationing their drugs, sharing with family and friends, borrowing money, or selling possessions.

The HPC study found the following to be true for New Mexicans:

- New Mexicans have significant access problems getting the prescription drugs that they need.
- The populations with the most difficulties getting the prescription drugs they need are the low- income population, the uninsured, 18-64 year olds, low-fixed income seniors, disabled persons, and immigrants.
- New Mexicans have difficulties obtaining their prescription drugs whether or not they have health insurance.
- New Mexicans who have difficulties obtaining their prescription drugs due to the cost have acquired their medication in a variety of ways, which may have consequences for their well being.

Although respondents to the community surveys said that disabled persons and immigrants have difficulties accessing prescription drugs, the telephone survey as designed with input from the Advisory Committee, did not ask specific questions related to those populations.

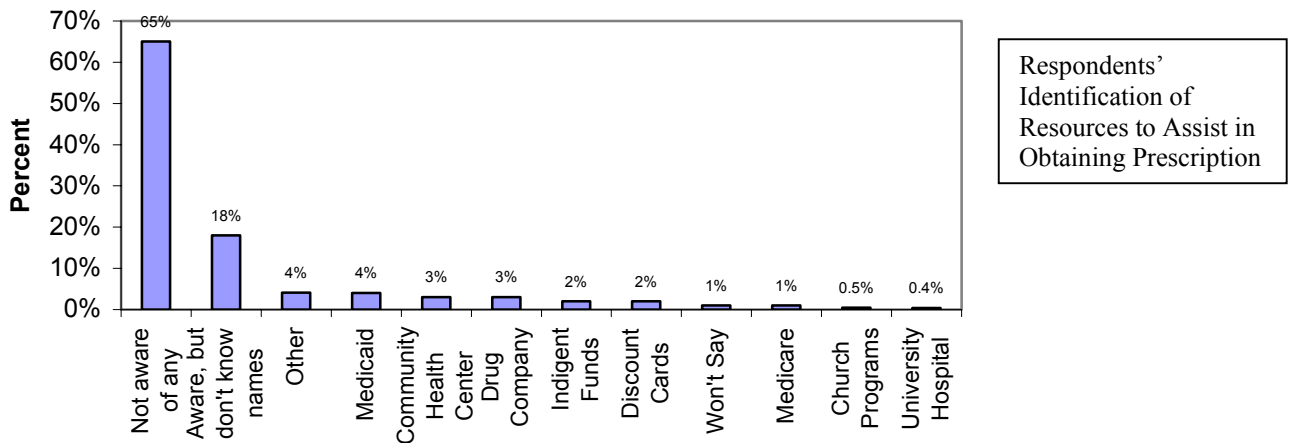
In response to the telephone survey results, the State Agency on Aging, a member of the Advisory Committee, offered its concerns that the telephone survey results are contradictory to most recent national studies and reports, which find that the elderly and the disabled experience the most difficulty accessing prescription drugs. Please see the Agency's full comments in Appendix F.

The HPC responded that the telephone survey was targeted to populations who self-identified themselves as having a recognized need during the last 12 months. The survey did not target incomes, age, ethnicity or any other demographic indicator. However, when the HPC ran a special query on seniors and access based on income, the results indicated that 20% (15/75) of seniors with incomes less than \$10,000 annually and 14% (19/137) with annual incomes less than \$15,000 had less than full access to prescription drugs. Please see the HPC response letter to the State Agency on Aging in Appendix F.

Burger, Carrol and Associates also responded to the Agency’s letter. Please see their response in Appendix F.

The surveys confirmed anecdotal evidence, which came from our Advisory Committee and others. The telephone survey confirmed the Committee’s concern that a number of New Mexicans are not taking their medication as prescribed due to financial hardships. A consultation by a pharmacist at the time of the initial prescription could warn or alert the individuals on the consequences of not taking their medication appropriately, but administrative obligations to comply with discount and other programs often inhibit having that consult. The Committee believed that educating consumers on the medications they were taking is crucial to assure optimal health benefits while recognizing that pharmacists often did not have sufficient time to provide the necessary consultation.

The surveys linked with each other on concerns that there is still a large population going without the medications they need due to a lack of financial ability or geographical



access, in spite of in house drug rooms, pharmaceutical discount programs, and State assistance through Medicaid and State grants. In particular, the elderly, those on fixed incomes, the uninsured, and immigrant populations are perceived as having the greatest need. The telephone survey found that when asked if they knew of resources that are available to help people obtain the prescription drugs that they needed, 65% of respondents were not aware of any resources.

A great number of persons who had insurance found that their insurance did not cover the cost of all their drugs, or the formularies did not include the particular drugs that they needed, or that their insurance coverage didn’t cover prescription drugs at all. As a result, community health clinics and maternal child and health councils showed that communities tend to pull together via individual, private and public business support to assist their residents to get the medications they may need. The amount of paperwork, bureaucracy, time and effort it sometimes takes to process prescription drug assistance often overwhelms the resources of those trying to help their clients, which burdens not only the consumer, but the health provider as well.

IV. Policy Recommendations

Recommendations

Recommendations

Although communities and safety net providers strive to offer enough resources to assist their residents through programs such as the federally sponsored 340B Pharmaceutical Assistance Program, other discount programs, charity organizations, and a limited supply of sample prescription drugs, these resources are simply not substantial enough to meet the needs of New Mexicans. In response to the findings of this study, the HPC Commissioners and the HJM 22 Advisory Committee developed the following recommendations for the Legislative Health and Human Services Sub Committee.

Health Policy Commission

Understanding that the New Mexico Legislature is attempting to harness over spending while promoting responsible spending to assure that the health of New Mexicans is not jeopardized, the Commissioners offer the following considerations in support of the efforts in other healthcare forums regarding expansion of prescription drug access to the under and un-insured. The Commission recognizes and supports educating New Mexicans about available resources as well as on taking their medications appropriately to avoid harmful consequences.

- Expand eligibility of Medicaid pharmacy benefits only to non-Medicaid populations.
 - HPC study indicates that the working poor have difficulty obtaining the drugs they may need, but are not poor enough to be eligible for Medicaid.
 - Families with household members needing multiple prescription drugs for a chronic illness have difficulty making co-payments for each prescription, or have limited insurance coverage that may not pay for particular drugs.
- Provide prescription drug discounts to any Medicare beneficiary.
 - 15.6% of Medicare recipients are under the age of 65 (persons with disabilities), who are often low-income and otherwise uninsured.
 - Seniors with supplemental health coverage often experience difficulty paying for the premiums in addition to co-payments and out-of-pocket expenses regardless of their income, and because of the multiple prescriptions they must often fill.

HJM 22 Advisory Committee

- Explore feasible mechanisms to expand access to prescription drugs, such as creative subsidizing, or creating a multi-state financial pool to enhance purchasing power.
 - The Northeast Legislative Association on Prescription Drug Prices, and the Northern New England Tri-State Coalition are initiatives comprised among groups of states to enhance purchasing power and save money.
- Conduct a pilot study to restructure pharmacy and pharmacist reimbursement.

- Determining solutions so that pharmacists do not absorb much of the costs resulting from Pharmaceutical Company discounts.
 - Reduce the amount of administrative responsibilities to process the numerous types of public and private insurance discount programs.
- Enhance and expand development of free or discount programs through safety net providers, and where possible integrate retail pharmacies.
 - Revisit the 340B discount program.
- Develop education and outreach programs to promote understanding and awareness regarding drugs, their affects and other drug-related issues.
- Create a 1-800-RX hotline so that people can get information about resources and available assistance.

In addition, individuals who responded to the Community Health Clinics and County Indigent Fund Administrators surveys made informal suggestions:

- Bolster the New Mexico safety net by:
 - Providing more State support for pharmacy personnel in primary care clinics and subsidies for 340B drug costs.
 - Providing matching funds from the State to assist the counties with the purchase of prescription drugs for needy populations.
 - Allocating direct funding from the State to the counties for the purchase and distribution of prescription drugs.

Works Consulted

Administration on Aging. *Older Adults and Mental Health: Issues and Opportunities*. January 2001. Available at www.aoa.gov/mh.report2001.

Briesacher, Becky, Bruce Stuart, Jlapa Doshi and Sachin Kamal-Bahl. *Medicare's Disabled Beneficiaries: The Forgotten Population in the Debate over Drug Benefits*. The Commonwealth Fund. Available at www.cmwf.org.

Bureau of Business and Economic Research. University of New Mexico. *Health Care Coverage and Access in New Mexico; An Analysis of the 1999 Health Policy Commission Statewide Household Survey of Health Care Coverage*. New Mexico Health Policy Commission. Santa Fe, New Mexico: March 2000.

Bureau of Primary Health Care web site. Community Health Center Information Page. Available at www.pbhc.hrsa.dhhs.gov.

Center for Policy Alternatives. *States Poised to Lower Prescription Drug Prices as First Circuit Court of Appeals Rules Against PhRMA*. Vol. 9, No. 3. Summer 2001. Available at: www.cfpa.org

Center for Studying Health System Change. *More Than 1 in 4 Medicaid Beneficiaries Can't Afford Prescription Drugs*. News Release. April 9, 2002. Available at www.hschange.org

Connolly, Ceci. *States Sued for Pushing Cheaper Drugs Via Medicaid*. Washington Post. 8/26/02: Page A01.

Cooksey, Judith A. *Challenges to the Pharmacist Profession from escalating Pharmaceutical Demand*. Health Affairs. Vol. 21. Number 5. September/October 2002.

Cunningham, Peter J. (a) *Affording Prescription Drugs: Not Just a Problem for the Elderly*. Center for Studying Health System Change Research Report No. 5. April 2002. Available at www.hschange.org

Cunningham, Peter J. (b) *Prescription Drug Access: Not Just a Medicare Problem*. Center for Studying Health System Change Issue Brief No. 51. April 2002. Available at www.hschange.org

Davis, Karen, Cathy Schoen, Michelle Doty, and Katie Tenney. *Medicare Versus Private Insurance: Rhetoric and Reality*. Health Affairs Web Exclusive. Oct. 9, 2002. Available at www.healthaffairs.org/WebExclusives.

Dummit, Laura A. *Medicare: Beneficiaries' Prescription Drug Coverage*. Testimony before the Subcommittee on Health and Environment, Committee on Commerce, U.S. House of Representatives. September 28, 1999. GAO. Washington, DC.

Dummit, Laura A. *Medicare – Considerations for Adding a Prescription Drug Benefit*. Testimony before the Committee on Finance, U.S. Senate. June 23, 1999. GAO. Washington, DC.

Employee Benefit Research Institute. *Prescription Drugs: Issues of Cost, Coverage, and Quality*. EBRI Issue Brief Number 208. April 1999. Available at www.ebri.org

Employee Benefit Research Institute. *Prescription Drug Costs Up Sharply – but Still Small Overall*. April 14, 1999. Available at www.ebri.org

Federal Register, May 14, 2001, Volume 66, Number 93. Pages 252625-25626. Available at: frwais.access.gpo.gov

Federal Register. *Medicare Program; Medicare-Endorsed Prescription Drug Card and Drug Discount Card Assistance Initiative; Proposed Rule*. Part II: Department of Health and Human Services. Available at: www.frwais.access.gpo.gov

Goldreich, Samuel. *Capitol Hill Analysis for September 3, 2002*. Congressional Quarterly Daily Monitor. Sept. 3, 2002.

Health Policy Alternatives, Inc. *Prescription Drug Coverage for Medicare Beneficiaries: A Side-by-Side Comparison of Selected Proposals*. For the Henry J. Kaiser Family Foundation. July 2001. Available at www.kff.org

Health Policy Alternatives, Inc. *Prescription Drug Discount Cards: Current Programs and Issues*. For the Henry J. Kaiser Family Foundation. February 2002. Available at www.kff.org

Kaiser Commission on Medicaid and the Uninsured. *A Profile of Federally Funded Centers Serving a Higher Proportion of Uninsured Patients*. For the Henry J. Kaiser Family Foundation. June 2002. Available at www.kff.org.

Kaiser Commission on Medicaid and the Uninsured. *Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey and Selected Case Study Highlights*. For the Henry J. Kaiser Family Foundation. October 2001. Available at www.kff.org

Kaiser Commission on Medicaid and the Uninsured. *The President's Fiscal Year 2003 Budget: An Overview of Health Programs*. For the Henry J. Kaiser Family Foundation. March 8, 2002. Available at www.kff.org

Kaiser Commission on Medicaid and the Uninsured. *President Bush's Budget: An Overview of Health Programs*. For the Henry J. Kaiser Family Foundation. May 2001. Available at www.kff.org

Kaiser Family Foundation. *State Health Facts Online*. Available at www.Statehealthfacts.kff.org.

Kaiser Family Foundation. *Erosion of Private Health Insurance Coverage for Retirees. Findings from the 2000 and 2001 Retiree Health and Prescription Drug Coverage Survey*. April 2002. Available at www.kff.org

Kaiser Family Foundation. *National Survey of Physicians. Part II: Doctors and Prescription Drugs*. March 2002. Available at www.kff.org

Kaiser Family Foundation. *Prescription Drug Discount Cards: Current Programs and Issues*. February 2002. Available at www.kff.org

Kaiser Family Foundation. *Prescription Drug Trends: A Chartbook Update*. November 2001. Available at www.kff.org

Kaiser Family Foundation. *Trends and Indicators in the Changing Health Care Marketplace, 2002*. Chartbook, May 2002. Available at www.kff.org

Kaiser Family Foundation. *Medicare State Profiles. State and Regional Data*. September 1999. Available at www.kff.org.

Kaufman, Marc. *Final Rule is Issued for Seniors' Drug Cards*. Washington Post. August 31, 2002.

Kennedy, Jane. *Prescription Noncompliance due to Cost Among Adults With Disabilities in the United States*. American Journal of Public Health. Vol. 92. No. 7, July 2002.

Kirchhoff, Sue. *Parties Pursue More Senior Voters*. Boston Globe. August 25, 2002, Page A01.

Laschober, Mary A., et al. *Trends in Medicare Supplemental Insurance and Prescription Drug Coverage, 1996-1999*. Health Affairs. February 27, 2002. W127-W138.

National Association of Insurance Commissioners. *Medicare Supplemental Insurance Data*. September 5, 2002. Special query for NM Health Policy Commission.

National Conference of State Legislatures. *2001-2002 State Senior Pharmaceutical Subsidy Proposals*. Updated May 15, 2002. Available at www.ncsl.org.

National Conference of State Legislatures. *2002 Prescription Drug Discount, Bulk Purchasing and Price-Related Legislation*. Updated August 8, 2002. Available at www.ncsl.org.

National Conference of State Legislatures. *Medicaid and the States*. Updated: March 28, 2002. Available at www.ncsl.org

National Conference of State Legislatures. *Medicaid Prescription Drug Laws and Strategies, 2001-2002*. Updated May 15, 2002. Available at www.ncsl.org

National Conference of State Legislatures. *Medicaid Survival Kit*. 1996. Available at www.ncsl.org.

National Conference of State Legislatures. *Other Initiatives and Multi-State Activities*. Updated May 9, 2002. Available at www.ncsl.org

National Conference of State Legislatures. *State Pharmaceutical Assistance Programs*. Updated May 15, 2002. Available at www.ncsl.org

National Rural Health Association. *Access to Healthcare for the Uninsured in Rural and Frontier America*. May 1999. Available at www.nrharural.org/dc/issuepapers

New Mexico Health Policy Commission. *Quick Facts 2002: Healthcare in New Mexico*. December 2001. Available at www.hpc.state.nm.us

New Mexico Pharmaceutical Association. *Report to the New Mexico Legislature*. September 2000.

New Mexico Primary Care Association. *New Mexico's Primary Care Safety Net: Even More Critical in Tough Economic Times*. Report to the New Mexico Legislature in response to SB22 and HB 24. 2002.

New York Times on the Web. *Paralysis in Health Care*. May 28, 2002. Available at www.nytimes.com.

Pear, Robert. *Pennsylvania Struggles to repair Model Prescription Aid Program*. New York Times on the Web. July 13, 2002. Available at www.nytimes.com

Pear, Robert. *U.S., in Court Filing, Backs Maine's Drug Discount Plan*. New York Times on the Web. June 1, 2002. Available at www.nytimes.com

Public Opinion Strategies and Peter D. Hart Research Associates. *Medicare and Prescription Drug Focus Groups: Summary Report*. For the Henry J. Kaiser Family Foundation. July 2001. Available at www.kkf.org.

Public Hospital Pharmacy Coalition web site. Available at www.phpc-rx.org

Safran, Dana G. *Prescription Drug Coverage and Seniors: How Well are States Closing the Gap?* Henry J. Kaiser Family Foundation. July 31, 2002. Available at www.Kaisernetwork.org

Scanlon, William. *Medigap: Current Policies Contain Coverage Gaps, Undermine Cost Control Incentives*. Testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives. March 14, 2002. GAO. Washington, DC.

Scanlon, William. *Prescription Drugs: Adapting Private Sector Management Methods for a Medicare Benefit*. Testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives. May 11, 2000. GAO. Washington, DC.

Schore, Jennifer, and Randall Brown. *State Variation in Medicaid Pharmacy Benefit use Among Dual-Eligible Beneficiaries*. For the Henry J. Kaiser Family Foundation. March 2002. Available at www.kff.org

Thompson, Tommy. *Integrating Prescription Drugs into Medicare*. Testimony before the Committee on Ways and Means, U.S. House of Representatives. April 17, 2002. Available at www.hhs.gov

Toner, Robin. *Maine at Front Line in Fight Over the High Cost of Drugs*. May 11, 2002. New York Times on the Web. Available at www.nytimes.com

US Census Estimations. New Mexico Information Page. Available at <http://quickfacts.census.gov>

U.S. Department of Health and Human Service, Health Resources and Services Administration. *Overview and Frequently Asked Questions: 340B Drug Pricing Program*. Accessed on May 22, 2002. Available at www.hrsa.gov

U.S. Department of Health and Human Service, Office of the Inspector General. *Medicare + Choice HMO Extra Benefits: Beneficiary Perspectives*. February 2000. Available at www.hhs.gov

U.S. Department of Health and Human Service, Office of the Inspector General. *Medicare Reimbursement of Prescription Drugs*. January 2001. Available at www.hhs.gov

U.S. Department of Health and Human Services, Office of the Inspector General. *Prescription Drug Coverage, Spending, Utilization and Prices*. April 2000. Available at www.hhs.gov

U.S. Government Accounting Office. *Medigap Insurance: Plans Are Widely Available but Have Limited Benefits and May Have High Costs*. Report to Congressional Requesters. GAO. Washington, DC: July 2001.

U.S. Government Accounting Office. *Prescription Drugs: Drug Company Programs Help Some People Who Lack Coverage*. Report to Congressional Requesters. GAO. Washington, DC: November 2000.

U.S. Government Accounting Office. *Prescription Drugs: Expanding Access to Federal Prices Could Cause Other Price Changes*. Report to Congressional Requesters. GAO. Washington, DC: August 2000.

U.S. Government Accounting Office. *Prescription Drug Benefits – Implications for Beneficiaries of Medicare HMO Use of Formularies*. Report to Congressional Requesters. GAO. Washington, DC: July 1999.

U.S. Government Accounting Office. *State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budget*. Report to Congressional Requesters. GAO. Washington, DC: September 2000.

U.S. Government Accounting Office. *VA Drug Formulary: Better Oversight is Required, but Veterans are getting Needed Drugs*. Report to the Ranking Member, Senate Committee on Veterans' Affairs. GAO. Washington, DC: January 2001.

Walker, David M. *Medicare: Financial Outlook Poses Challenges for Sustaining Program and Adding Drug Coverage*. Testimony before the Committee on Ways and Means, U.S. House of Representatives. April 17, 2002. GAO. Washington, DC.

Walker, David M. *Prescription Drugs: Increasing Medicare Beneficiary Access and Related Implications*. Testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives. February 15, 2000. GAO. Washington, DC.

Appendix A

Advisory Committee Members

HJM 22 Advisory Committee Members

Mary Beavis, AARP

Matt Borrego, University of New Mexico School of Pharmacy

Karla Finnell, New Mexico Primary Care Association & Integrated Network Services

Linda Grisham, New Mexico Division of Insurance

Representative John A. Heaton, New Mexico House of Representatives

Elaine LeVine, Psychopharmacology for Psychology

Jack Mack, State Agency on Aging

Jerry Montoya, New Mexico Board of Pharmacy

Lucille Montoya, Health Centers of Northern New Mexico

Neal Solomon, New Mexico Medical Assistance Division

Dale Tinker, New Mexico Pharmaceutical Association

Appendix B

House Joint Memorial 22

HOUSE JOINT MEMORIAL 22

45th legislature - STATE OF NEW MEXICO - first session, 2001

INTRODUCED BY
Patsy G. Trujillo

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

A JOINT MEMORIAL

REQUESTING THE NEW MEXICO HEALTH POLICY COMMISSION CONDUCT AN IN-DEPTH STUDY OF THE IMPACT ON NEW MEXICO OF THE RISING COST OF PRESCRIPTION DRUGS.

WHEREAS, prescription drug prices are high and rising at a rate twice that of the country's inflation; and

WHEREAS, as many as two hundred eighty-four thousand New Mexicans are without any health insurance coverage, and as many as five hundred thousand New Mexicans may be without any coverage for prescription drugs; and

WHEREAS, people who are uninsured pay the highest prices for prescription drugs because they cannot afford insurance, which provides access to discounted drug prices; and

WHEREAS, medicare no longer covers outpatient prescription drugs; and

WHEREAS, no in-depth studies have been conducted in New Mexico to identify precisely the number of people without insurance coverage for prescription drugs; and

WHEREAS, the relationship between ill health and lack of access to appropriate prescription drugs is generally accepted but unstudied in our state; and

WHEREAS, the impact of the rising cost of prescription drugs may have a direct impact on the health and well-being of the citizens of New Mexico; and

WHEREAS, the interim legislative health and human services committee this interim heard significant testimony from senior citizens and others that the high cost of prescription drugs causes them to forgo necessary medical care, to violate doctors' orders by taking their drugs less frequently than directed in order to stretch their prescription

dollar and to choose between prescription drugs and other basic necessities such as food, clothing or housing in order to afford their medications;

NOW, THEREFORE, BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO that the New Mexico health policy commission be requested to study the impact of the rising cost of prescription drugs in New Mexico, including a targeted survey to identify the populations affected by these prices; and

BE IT FURTHER RESOLVED that the study identify potential solutions to the problem at the state level and an analysis of the cost and impact on access they present; and

BE IT FURTHER RESOLVED that the New Mexico health policy commission present its findings and recommendations to the interim legislative health and human services committee at its September 2001 meeting; and

BE IT FURTHER RESOLVED that a copy of this memorial be sent to the New Mexico health policy commission.

- 3 -

Appendix C

2001-2002 Federal Legislation

2001-2002 Federal Legislation – US House of Representatives

H.R.68 To amend the Federal Food, Drug, and Cosmetic Act relating to the distribution chain of prescription drugs. Sponsor: Rep Emerson, Jo Ann (Introduced 1/3/2001). Latest Major Action: 2/7/01 Referred to House subcommittee.

H.R.339 Medicare Outpatient Prescription Drug Coverage Act of 2001 Sponsor: Rep Engel, Eliot L. (Introduced 1/31/2001). Latest Major Action: 3/14/2001 Referred to House subcommittee. Title: To amend title XVIII of the Social Security Act to provide for coverage of outpatient prescription drugs under part B of the Medicare Program, and for other purposes.

H.R.383 To amend the Internal Revenue Code of 1986 to allow a deduction for amounts paid for health insurance and prescription drug costs of individuals. Sponsor: Rep Stearns, Cliff (Introduced 1/31/2001). Latest Major Action: 2/9/2001 Referred to House subcommittee.

H.R.568 Equity in Fertility Coverage Act of 2001. Sponsor: Rep Andrews, Robert E. (Introduced 2/13/2001.) Latest Major Action: 3/29/2001 Referred to House subcommittee. Title: To assure equitable treatment of fertility and impotence in health care coverage under group health plans, health insurance coverage, and health plans under the Federal employees' health benefits program.

H.R.758 Breast Cancer Prescription Drug Fairness Act of 2001. Sponsor: Rep McCarthy, Carolyn (Introduced 2/27/2001). Latest Major Action: 3/14/2001 Referred to House subcommittee. Title: To provide for substantial reductions in the price of prescription drugs for Medicare beneficiaries and for women diagnosed with breast cancer.

H.R.803 Medicare Modernization and Solvency Act of 2001. Sponsor: Rep Stark, Fortney Pete (Introduced 2/28/2001). Latest Major Action: 3/14/2001 Referred to House subcommittee. Title: To amend title XVIII of the Social Security Act to make the Medicare Program more competitive and efficient, to extend the solvency of the Medicare Program, to provide for a prescription drug benefit under the Medicare Program, to improve quality of care, to make Medicare supplemental insurance (Medi-gap) more affordable, and for other purposes.

H.R.828 Senior's Health Care Choice Act of 2001. Sponsor: Rep Grucci, Felix J., Jr. (Introduced 3/1/2001). Latest Major Action: 3/14/2001 Referred to House subcommittee. Title: To amend title XVIII of the Social Security Act to expand coverage of preventive services under the Medicare Program and to provide coverage of outpatient prescription drugs under that program.

H.R.946 North American Prescription Price Equity Act of 2001. Sponsor: Rep Duncan, John J., Jr. (Introduced 3/8/2001). Latest Major Action: 3/8/2001 Referred to House committee. Title: To amend the Internal Revenue Code of 1986 to allow drug

manufacturers a credit against income tax if they certify that the price of a drug in the United States market is not greater than its price in the Canadian or Mexican market.

H.R.1063 Drug Competition Act of 2001. Sponsor: Rep Andrews, Robert E (introduced 3/15/2001). Latest Major Action: 3/22/2001 Referred to House subcommittee. Title: To enhance competition for prescription drugs by increasing the ability of the Department of Justice and Federal Trade Commission to enforce existing antitrust laws regarding brand name drugs and generic drugs.

H.R.1111 Equity in Prescription Insurance and Contraceptive Coverage Act of 2001. Sponsor: Rep Greenwood, James C. (Introduced 3/20/2001). Latest Major Action: 5/30/2001 Referred to House subcommittee. Title: To require equitable coverage of prescription contraceptive drugs and devices, and contraceptive services under health plans.

H.R.1127 Health Care Tax Deduction Act of 2001. Sponsor: Rep Stearns, Cliff (Introduced 3/20/2001). Latest Major Action: 3/27/2001 Referred to House subcommittee. Title: To amend the Internal Revenue Code of 1986 to allow a deduction for amounts paid for health insurance and prescription drug costs of individuals.

H.R.1200 American Health Security Act of 2001. Sponsor: Rep McDermott, Jim (introduced 3/22/2001). Latest Major Action: 4/16/2001 Referred to House subcommittee. Latest Status: Referred to the Subcommittee on the Civil Service and Agency Organization. Title: To provide for health care for every American and to control the cost and enhance the quality of the health care system.

H.R.1387 Drug Availability and Health Care Access Improvement Act of 2001. Sponsor: Rep Ganske, Greg (Introduced 4/4/2001). Latest Major Action: 4/25/2001 Referred to House subcommittee. Title: To amend the Social Security Act to improve access to prescription drugs for low-income Medicare beneficiaries, the Internal Revenue Code and other Acts to improve access to health care coverage for seniors, the self-employed, and children, and to amend the Federal Food, Drug, and Cosmetic Act to improve meaningful access to reasonably priced prescription drugs.

H.R.1400 Prescription Drug Fairness for Seniors Act of 2001. Sponsor: Rep Allen, Thomas H. (Introduced 4/4/2001). Latest Major Action: 4/25/2001 Referred to House subcommittee. Title: To provide for substantial reductions in the price of prescription drugs for Medicare beneficiaries.

H.R.1530 Prescription Drug Competition Act of 2001. Sponsor: Rep Waxman, Henry A. (Introduced 4/4/2001). Latest Major Action: 4/25/2001 Referred to House subcommittee. Title: To ensure the timely availability of generic drugs through enhancement of drug approval and antitrust laws enforced by the Food and Drug Administration and the Federal Trade Commission regarding brand name drugs and generic drugs.

H.R.1641 Medicaid Obesity Treatment Act of 2001. Sponsor: Rep Towns, Edolphus (Introduced 4/26/2001). Latest Major Action: 5/8/2001 Referred to House subcommittee. Title: To amend title XIX of the Social Security Act to require States that provide Medicaid prescription drug coverage to cover drugs medically necessary to treat obesity.

H.R.1862 Greater Access to Affordable Pharmaceuticals Act of 2001. Sponsor: Rep Brown, Sherrod (Introduced 5/16/2001). Related Bills: S. 812 Latest Major Action: 6/1/2001 Referred to House subcommittee. Title: To amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals.

H.R.1905 New Insurance Coverage Equity (NICE) Act of 2001. Sponsor: Rep Maloney, James H. (Introduced 5/17/2001). Latest Major Action: 6/1/2001 Referred to House subcommittee. Title: To amend title XVIII of the Social Security Act to assure access of Medicare beneficiaries to prescription drug coverage through the NICE drug benefit program.

H.R.2352 Fair Balance Prescription Drug Advertisement Act of 2001. Sponsor: Rep Stark, Pete (introduced 6/27/2001). Latest Major Action: 7/16/2001 Referred to House subcommittee. Latest Status: Referred to the Subcommittee on Health, for a period to be subsequently determined by the Chairman. Title: To amend the Internal Revenue Code of 1986 to deny any deduction for direct-to-consumer advertisements of prescription drugs that fail to provide certain information or to present information in a balanced manner, and to amend the Federal Food, Drug, and Cosmetic Act to require reports regarding such advertisements.

H.R.2497 Managed Care Bill of Rights for Consumers Act of 2001. Sponsor: Rep Velazquez, Nydia (Introduced 7/12/2001). Latest Major Action: 11/2/01 Referred to House subcommittee. Title: To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish certain requirements for managed care plans.

H.R.2513 State Prescription Drug Flexibility Act of 2001. Sponsor: Rep Allen, Thomas H. (Introduced 7/17/2001). Latest Major Action: 7/31/2001 Referred to House subcommittee. Title: To amend title XI of the Social Security Act to clarify that the Secretary of Health and Human Services has the authority to treat certain State payments made in an approved demonstration project as medical assistance under the Medicaid Program for purposes of a rebate agreement under section 1927 of the Social Security Act, and for other purposes.

H.R.2632 Medicare Rx Drug Discount and Security Act of 2001. Sponsor: Rep Foley, Mark (Introduced 7/25/2001). Related Bills: S. 1239. Latest Major Action: 8/20/01 Referred to House subcommittee. Title: To amend title XVIII of the Social Security Act to provide Medicare beneficiaries with access to affordable outpatient prescription drugs.

H.R.2641 Save Money for Prescription Drug Research Act of 2001. Sponsor: Rep Stark, Fortney Pete(introduced 7/25/2001). Latest Major Action: 7/25/2001 Referred to House committee. Latest Status: Referred to the House Committee on Ways and Means. Title: To amend the Internal Revenue Code of 1986 to deny any deduction for certain gifts and benefits provided to physicians by prescription drug manufacturers.

H.R.2660 Prescription Drug Consumer Information Act of 2001. Sponsor: Rep Hastings, Alcee L. (Introduced 7/26/2001). Latest Major Action: 8/10/01 Referred to House subcommittee. Title: To direct the Secretary of Health and Human Services to prepare and publish annually a consumer guide to prescription drug prices.

H.R.2740 Drug Access Act of 2001. Sponsor: Rep Burr, Richard (introduced 8/2/2001). Latest Major Action: 8/2/2001 Referred to House committee. Title: To amend the Federal Food, Drug, and Cosmetic Act with respect to the receipt of donated prescription drug samples by charitable health care entities.

H.R.2801 Prescription Drug Affordability Act. Sponsor: Rep Paul, Ron (Introduced 8/2/2001). Latest Major Action: 8/2/2001 Referred to House committee. Title: To amend the Internal Revenue Code of 1986 with respect to the purchase of prescription drugs by individuals who have attained retirement age, and to amend the Federal Food, Drug, and Cosmetic Act with respect to the importation of prescription drugs and the sale of such drugs through Internet sites.

H.R.3626 Medicare Drug and Service Coverage Act of 2002. Sponsor: Rep Emerson, Jo Ann (introduced 1/24/2002). Latest Major Action: 2/4/2002 Referred to House subcommittee. Latest Status: Referred to the Subcommittee on Health. Title: To amend title XVIII of the Social Security Act to provide for an outpatient prescription drug benefit under the Medicare Program.

H.R.3684 Immediate Helping Hand Prescription Drug Assistance Act of 2002. Sponsor: Rep Simmons, Rob (introduced 2/5/2002). Latest Major Action: 3/5/2002 Referred to House subcommittee. Latest Status: Referred to the Subcommittee on Health, for a period to be subsequently determined by the Chairman. Title: To amend the Social Security Act establish an outpatient prescription drug assistance program for low-income Medicare beneficiaries.

H.R.3757 Honor Thy Parents Act of 2002. Sponsor: Rep Wexler, Robert(introduced 2/13/2002). Latest Major Action: 2/13/2002 Referred to House committee. Latest Status: Referred to the House Committee on Ways and Means. Title: To freeze and repeal portions of the tax cut enacted in the Economic Growth and Tax Relief Reconciliation Act of 2001 and to apply savings therefrom to a comprehensive Medicare outpatient prescription drug benefit.

H.R.3913 Prescription Drug Benefit Equity Act of 2002. Sponsor: Rep Lowey, Nita M.(introduced 3/7/2002). Latest Major Action: 3/26/2002 Referred to House subcommittee. Latest Status: Referred to the Subcommittee on Health.

Title: To assure equitable treatment in health care coverage of prescription drugs under group health plans, health insurance coverage, Medicare and Medicaid managed care arrangements, Medigap insurance coverage, and health plans under the Federal employees' health benefits program (FEHBP).

H.R.4136 Medicare Outpatient Prescription Drug Coverage Funding Act of 2002. Sponsor: Rep Frank, Barney (introduced 4/10/2002). Latest Major Action: 4/10/2002 Referred to House committee. Latest Status: Referred to the House Committee on Ways and Means. Title: To use the estate tax revenue to finance an outpatient prescription drug program under Medicare.

H.R.4614 To permit commercial importation of prescription drugs from Canada, and for other purposes. Sponsor: Rep Sanders, Bernard(introduced 4/25/2002). Latest Major Action: 5/6/2002 Referred to House subcommittee. Latest Status: Referred to the Subcommittee on Health. Title: To permit commercial importation of prescription drugs from Canada, and for other purposes.

H.RES.26 Expressing the sense of the House of Representatives regarding the disparity between identical prescription drugs sold in the United States, Canada, and Mexico. Sponsor: Rep Baldacci, John Elias (Introduced 1/31/2001). Latest Major Action: 2/14/2001 Referred to House subcommittee

H.CON.RES.99 Whereas the United States has the most expensive health care system in the world in terms of absolute costs, per capita costs, and percentage of gross domestic product (GDP). Sponsor: Rep Conyers, John, Jr. (Introduced 4/4/2001). Latest Major Action: 4/16/2001 Referred to House subcommittee. Title: Directing Congress to enact legislation by October 2004 that provides access to comprehensive health care for all Americans.

H.CON.RES.155 Expressing the sense of Congress that comprehensive Medicare modernization is a top priority of the 107th Congress. Sponsor: Rep Greenwood, James C. (Introduced 6/7/2001). Latest Major Action: 6/18/2001 Referred to House subcommittee. Title: Expressing the sense of Congress that comprehensive Medicare modernization is a top priority of the 107th Congress.

H.CON. RES. 328 Expressing the sense of the Congress with respect to coverage of outpatient prescription drugs under the Medicare Program and with respect to providing for appropriate new budget authority... Sponsor: Rep Kilpatrick, Carolyn C.(introduced 2/13/2002). Latest Major Action: 3/5/2002 Referred to House subcommittee. Latest Status: Referred to the Subcommittee on Health, for a period to be subsequently determined by the Chairman. Title: Expressing the sense of the Congress with respect to coverage of outpatient prescription drugs under the Medicare Program and with respect to providing for appropriate new budget authority for such coverage.

2001-2002 Legislation – US Senate

S.10 Medicare Prescription Drug Coverage Act of 2001. Sponsor: Sen Daschle, Thomas A. (Introduced 1/22/2001). Latest Major Action: 1/22/2001 Referred to Senate committee. Title: A bill to amend title XVIII of the Social Security Act to provide coverage of outpatient prescription drugs under the Medicare program.

S.104 Equity in Prescription Insurance and Contraceptive Coverage Act of 2001. Sponsor: Sen Snowe, Olympia J. (Introduced 1/22/2001). Latest Major Action: 9/10/01 Hearings held. Title: A bill to require equitable coverage of prescription contraceptive drugs and devices, and contraceptive services under health plans.

S.125 Prescription Drug Fairness for Seniors Act of 2001. Sponsor: Sen Johnson, Tim (Introduced 1/22/2001). Latest Major Action: 1/22/2001 Referred to Senate committee. Title: A bill to provide substantial reductions in the price of prescription drugs for Medicare beneficiaries.

S.186 Generic Pharmaceutical Access and Choice for Consumers Act of 2001. Sponsor: Sen Johnson, Tim (Introduced 1/25/2001). Latest Major Action: 1/25/2001 Referred to Senate committee. Title: A bill to provide access and choice for use of generic drugs instead of non-generic drugs under Federal health care programs, and for other purposes.

S. 215 Medication Equity and Drug Savings Act. Sponsor: Sen Stabenow, Debbie (introduced 1/30/2001). Latest Major Action: 1/30/2001 Referred to Senate committee. Latest Status: Read twice and referred to the Committee on Health, Education, Labor, and Pensions. Title: A bill to amend the Federal Food, Drug, and Cosmetic Act to permit importation in personal baggage and by mail of certain covered products for personal use from certain foreign countries and to correct impediments in implementation of the Medicine Equity and Drug Safety Act of 2000.

S.357 Medicare Preservation and Improvement Act of 2001. Sponsor: Sen Breaux, John B. (Introduced 2/15/2001). Latest Major Action: 2/15/2001 Referred to Senate committee. Title: A bill to amend the Social Security Act to preserve and improve the Medicare program.

S.358 Medicare Prescription Drug and Modernization Act of 2001. Sponsor: Sen Breaux, John B.(Introduced 2/15/2001). Latest Major Action: 2/15/2001 Referred to Senate committee. Title: A bill to amend the Social Security Act to establish a Medicare Prescription Drug and Supplemental Benefit Program and for other purposes.

S.699 Prescription Drug Fairness for Seniors Act of 2001. Sponsor: Sen Johnson, Tim(introduced 4/4/2001). Latest Major Action: 4/4/2001 Referred to Senate committee.

Title: A bill to provide for substantial reductions in the price of prescription drugs for Medicare beneficiaries.

S.754 Drug Competition Act of 2001. Sponsor: Sen Leahy, Patrick J. (introduced 4/6/2001). Latest Major Action: 10/18/01 Senate committee/subcommittee actions. Latest status: Committee on the Judiciary. Ordered to be reported with an amendment in the nature of a substitute favorably.

Title: A bill to enhance competition for prescription drugs by increasing the ability of the Department of Justice and Federal Trade Commission to enforce existing antitrust laws regarding brand name drugs and generic drugs.

S.812 Greater Access to Affordable Pharmaceuticals Act of 2001. Sponsor: Sen Schumer, Charles E. (Introduced 5/1/2001). Related Bills: HR 1862
Latest Major Action: 5/1/2001 Referred to Senate committee. Title: A bill to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals.

S.1132 To amend the Federal Food, Drug, and Cosmetic Act relating to the distribution chain of prescription drugs. Sponsor: Sen Crapo, Michael D.(introduced 6/28/2001). Latest Major Action: 6/28/2001 Referred to Senate committee. Title: A bill to amend the Federal Food, Drug, and Cosmetic Act relating to the distribution chain of prescription drugs.

S.1135 Medicare Reform Act of 2001. Sponsor: Sen Graham, Bob (Introduced 6/28/2001). Latest Major Action: 6/28/2001 Referred to Senate committee.
Title: A bill to amend title XVIII of the Social Security Act to provide comprehensive reform of the Medicare program, including the provision of coverage of outpatient prescription drugs under such program.

S.1177 Access to Affordable Prescription Drugs Act of 2001. Sponsor: Sen Snowe, Olympia J. (Introduced 7/12/2001). Latest Major Action: 7/12/2001 Referred to Senate committee. Title: A bill to amend title XI of the Social Security Act to clarify that the Secretary of Health and Human Services has the authority to treat certain State payments made in an approved demonstration project as medical assistance under the Medicaid program for purposes of a rebate agreement under section 1927 of the Social Security Act, and for other purposes.

S.1185 Seniors Prescription Insurance Coverage Equity (SPICE) Act of 2001. Sponsor: Sen Wyden, Ron (Introduced 7/17/2001). Latest Major Action: 7/17/2001 Referred to Senate committee. Title: A bill to amend title XVIII of the Social Security Act to assure access of Medicare beneficiaries to prescription drug coverage through the SPICE drug benefit program.

S.1229 Personal Prescription Drug Import Fairness Act. Sponsor: Sen Wellstone, Paul D. (Introduced 7/24/2001). Latest Major Action: 7/24/2001 Referred to Senate

committee. Title: A bill to amend the Federal Food, Drug, and Cosmetic Act to permit individuals to import prescription drugs in limited circumstances.

S.1239 Medicare Rx Drug Discount and Security Act of 2001. Sponsor: Sen Hagel, Chuck (Introduced 7/25/2001). Related Bills: HR 2632. Latest Major Action: 7/25/2001 Referred to Senate committee. Title: A bill to amend title XVIII of the Social Security Act to provide Medicare beneficiaries with a drug discount card that ensures access to affordable outpatient prescription drugs.

S.1263 - Voluntary Medicare Prescription Drug Plan Act of 2001. Sponsor: Sen Smith, Bob (Introduced 7/27/2001). Latest Major Action: 7/27/2001 Referred to Senate committee. Title: A bill to amend title XVIII of the Social Security Act to establish a voluntary Medicare Prescription Drug Plan under which eligible Medicare beneficiaries may elect to receive coverage under the Rx Option for outpatient prescription drugs and a combined deductible.

S.1600 Rx Relief for Seniors Act. Sponsor: Sen Dayton, Mark(introduced 10/31/2001). Latest Major Action: 10/31/2001 Referred to Senate committee. Latest Status: Read twice and referred to the Committee on Finance. Title: A bill to amend the Internal Revenue Code of 1986 to allow medicare beneficiaries a refundable credit against income tax for the purchase of outpatient prescription drugs.

S.2244 Prescription Drug Price Parity for Americans Act. Sponsor: Sen Dorgan, Byron L.(introduced 4/24/2002). Latest Major Action: 4/24/2002 Referred to Senate committee. Latest Status: Read twice and referred to the Committee on Health, Education, Labor, and Pensions. Title: A bill to permit commercial importation of prescription drugs from Canada, and for other purposes.

S.RES.74 Expressing the sense of the Senate regarding consideration of legislation providing Medicare beneficiaries with outpatient prescription drug coverage. Sponsor: Sen Dayton, Mark (Introduced 4/25/2001). Latest Major Action: 4/25/2001 Referred to Senate committee. Title: A resolution expressing the sense of the Senate regarding consideration of legislation providing Medicare beneficiaries with outpatient prescription drug coverage.

Appendix D

State Programs; Subsidies, Discount, Medicaid

The chart below details each of the individual state programs, categorized as subsidy, discount, or Medicaid programs (drawn from NCSL data, available at www.ncsl.org).

STATE	TYPE OF PROGRAM AND BASIC ELIGIBILITY REQUIREMENTS	CREATION/ EFFECTIVE DATE
Alabama Alabama, continued	<p>MEDICAID: Creates a new funding stream for state Medicaid program by imposing a state privilege tax on all retail prescription sales, regardless of price.</p> <p>DISCOUNT: Authorizes the states to consolidate buying power in pharmaceutical market for price reduction aggregate or to negotiate for all state agencies, or join a multi-state pooling initiative, or all of the above. Authorizes state to negotiate rebates and discounts from pharmaceutical manufacturers. Exempts the Medicaid agency.</p>	2002 2002
Arizona	<p>SUBSIDY: Creates a pilot program for Medicare beneficiaries with annual income not more than 200% of FPL. Applicants must reside in a county that has no Medicare HMO or has an HMO that does not provide prescription drug benefits.</p> <p>DISCOUNT: Pilot program allowing doctors to use a software program to check if a patient qualifies for free pharmaceutical or discount card programs.</p>	2001; not yet operational 2001
Arkansas	<p>MEDICAID WAIVER: Prescription Drug Access Improvement Act seeks a Medicaid waiver for prescription drug coverage, with income eligibility maximum of 80% of FPL, increasing to 100% FPL after 6/30/03. Enrollment fee, limited prescriptions and co-payments.</p>	As of 8/30/02, HHS has not approved a waiver
California	<p>DISCOUNT PROGRAM: Discount Prescription Medication Program (retail discounts via pharmacies). Medicare recipients, 65, or disabled. There is no income limit.</p>	2000
Connecticut	<p>MEDICAID WAIVER: Requires the state to seek a federal Medicaid waiver to obtain federal funds to cover seniors enrolled in the state-only ConnPACE subsidy program. Eligibility would be extended to 300% of FPL.</p> <p>SUBSIDY: Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled Program (ConnPACE). Covers seniors over 65, and disabled over 18 and on SSI or SSDI. Income limitations are adjusted yearly.</p>	As of 8/30/02, HHS has not approved a waiver 1986

STATE	TYPE OF PROGRAM AND BASIC ELIGIBILITY REQUIREMENTS	CREATION/EFFECTIVE DATE
Delaware	<p>SUBSIDY: Delaware Prescription Drug Assistance Program (DPAP). Eligibility is 200% of FPL. Covers seniors over 65 and disabled who are eligible for SSDI.</p> <p>SUBSIDY: Nemours Health Clinic Pharmaceutical Assistance Program. Minimum age: 65. Income limits adjusted annually. Private initiative.</p>	2000 1981
District of Columbia	<p>SUBSIDY: DC Dept. of Health purchases drugs and DC Healthcare Alliance distributes to Alliance patients with incomes no more than 200% of FPL. Must not be eligible for any other type of coverage like Medicaid.</p>	2001
Florida	<p>SUBSIDY: Prescription Affordability Act. Auto-enrolled with opt-out. Minimum age: 65 and Dually-Eligible Medicare-Medicaid. Eligibility is 90% - 120% of FPL.</p> <p>DISCOUNT: Prescription Discount Program provides discounts for any Medicare beneficiary, with no age or income limit.</p> <p>MEDICAID: New law enacts restrictions on Medicaid program, including development of a preferred drug formulary and prior authorization of drugs not on the formulary. Also allows the state to negotiate supplemental rebates.</p> <p>SUBSIDY: Pharmaceutical Expense Assistance Program. Covers persons over 65 who are dually-eligible for Medicaid and Medicare but without prescription drug coverage. State subsidy is limited to \$80/month. \$10 co-payment.</p>	2001 2000 2001 2001
Georgia	<p>MEDICAID: By department regulation, the Department of Community Health established a preferred drug list, along with tiered cost-sharing. All generics are classified as preferred drugs. The same list applies to drug benefits for public and state university employees.</p>	2002

STATE	TYPE OF PROGRAM AND BASIC ELIGIBILITY REQUIREMENTS	CREATION/EFFECTIVE DATE
Hawaii	<p><u>MEDICAID WAIVER:</u> Medicaid Prescription Drug Expansion Program extends discounted prescription drugs to individuals at 300% FPL or less, (no age limits). Also establishes a fund to receive rebates from drug manufacturers.</p> <p><u>DISCOUNT:</u> Hawaii Rx Program empowers state to negotiate manufacturer rebates and offer discounted drugs to program participants. Manufacturers who do not negotiate with the state may find their products put on a prior approval list. All Hawaii residents eligible.</p>	<p>2002 – not operational yet</p> <p>2002 – not operational yet. Goal: 7/1/04</p>
Idaho	<p><u>MEDICAID WAIVER:</u> Directs the Department of Health and Welfare to investigate the use of waivers or existing law and rule to implement cost-effectiveness programs requiring co-payments for Medicaid prescriptions and services.</p>	2001
Illinois	<p><u>SUBSIDY:</u> Pharmaceutical Assistance Program. Minimum age: 65 Disabled: over 16. Income limits adjusted annually.</p> <p><u>MEDICAID WAIVER:</u> Illinois Senior Rx Care authorizes state to seek federal matching funds for parts of the current senior Rx program, to extend up to 250% of FPL. \$3.00 co-pay for each prescription up to \$1,750/year. Above that figure, program will pay 80% and enrollee will pay 20%.</p>	<p>1985</p> <p>HHS approved 1/28/02 – up to 200% of FPL; enrollment opened in 6/02</p>
Indiana	<p><u>SUBSIDY:</u> HoosierRx Indiana Prescription Drug Fund. Minimum age: 65. Eligibility is 144% of FPL. 50% discount/cash refunds. Updated in 2002 to provide a direct benefit at the time of sale, instead of semi-annual reimbursement in original program.</p> <p><u>MEDICAID:</u> Prohibits Medicaid and SCHIP programs from placing any brand-name anti-anxiety, anti-depressant, anti-psychotic drugs, or any drug prescribed for mental illness, on a prior authorization list.</p> <p><u>MEDICAID:</u> Medicaid cost-containment program utilizing a number of mechanisms, such as reduction of reimbursement rates for over-the-counter drugs, development of a Maximum Allowable Cost schedule for off-patent drugs, and contracts with outside vendors for management of various programs.</p>	<p>2000/2002</p> <p>2002</p> <p>2001</p>

STATE	TYPE OF PROGRAM AND BASIC ELIGIBILITY REQUIREMENTS	CREATION/EFFECTIVE DATE
Iowa	<u>DISCOUNT:</u> Iowa Priority Prescription Savings Program offers discounts to any Medicare beneficiary, with no age or income limits. Enrollment fee. Administrative initiative.	2001
Kansas	<u>SUBSIDY:</u> Senior Pharmacy Assistance Program for dually-eligible QMB or SMLB Medicare programs. Minimum age: 67 on or before 10/31/01. Income limit up to 150% of FPL. Co-payment and reimbursement limits. Excludes prescriptions for acute illness. Annual reimbursement.	2001
Kentucky	<u>MEDICAID:</u> New state rules require nominal co-payments for Medicaid recipients for a variety of services, including a maximum \$1.00 co-pay for prescription drugs.	2002
	<u>MEDICAID:</u> New Pharmacy Advisory Committee to develop outpatient drug formulary for Medicaid.	2002
Louisiana	<u>MEDICAID:</u> Generic/Therapeutic Drug Substitution. Generic drugs must be substituted for brand-name drugs for Medicaid prescriptions, unless the physician specifies that the brand name drug is “medically necessary.”	2001
Maine	<u>SUBSIDY & MEDICAID WAIVER:</u> Healthy Maine Prescription Program. Eligibility is Medicare beneficiaries, up to 300% of FPL. Enrollees of the previous Low Cost Drugs for the Elderly Program were all transferred to this program. All eligible people would be able to buy prescription drugs at the discounted Medicaid price.	Waiver granted by HCFA in 1/01, and program in operation in 6/02. Currently being challenged in court.
	<u>MEDICAID:</u> Expanded prior authorization to include 150 more prescription drugs. Executive regulation.	2001
	<u>SUBSIDY:</u> Catastrophic subsidy benefit covers enrollees who have spent more than \$1,000 for the year on prescription drugs. After that amount, state will pay 80% of prescription expenses, and individual pays 20% or \$2.00 minimum.	2000
	<u>DISCOUNT:</u> Maine Rx Program provides discount prices based on Medicaid and manufacturer rebates. All Maine residents are eligible.	Operation planned for 1/1/02, but also delayed by legal activity.

STATE	TYPE OF PROGRAM AND BASIC ELIGIBILITY REQUIREMENTS	CREATION/EFFECTIVE DATE
Maryland	<p><u>MEDICAID WAIVER:</u> Maryland Pharmacy Discount Program. No limitation by age or medical condition. Single: \$10,000/Married: \$10,850; \$4,500 max assets. The waiver portion of this program allows any Medicare beneficiary without existing drug coverage to receive discount tied to Medicaid prices. Greater subsidies will be provided to persons with less than 175% FPL. If the waiver is not approved, the program will be run by the state, and eligibility will be limited to 250% FPL.</p> <p><u>SUBSIDY:</u> CareFirst Plan. Will serve not more than 30,000 Medicare enrollees with incomes up to 300% FPL. \$1,000 annual benefit limit. Premium reduced in 2001 to \$10.</p> <p><u>SUBSIDY:</u> Health Insurance Plan subsidizes health insurance coverage, including prescription drugs, for medically uninsurable residents with pre-existing conditions by July 1, 2003. May not be eligible for Medicare, Medicaid, SCHIP or employer-sponsored group health plan.</p> <p><u>DISCOUNT:</u> Maryland MedBank Program is a clearinghouse that links residents to manufacturers' free drug programs.</p>	<p>1979 for basic program; waiver applied for in 2001. As of 8/30/02, HHS has not approved a waiver</p> <p>2001</p> <p>2002</p> <p>2001</p>
Massachusetts	<p><u>MEDICAID:</u> Generic substitution initiative requires that generic prescription drugs must be used for Medicaid prescriptions, and that brand-name alternatives receive prior authorization. Executive regulation.</p> <p><u>SUBSIDY:</u> Prescription Advantage Program. Minimum age: 65. No upper income limit. No premium or deductibles under 188% FPL. Sliding scale premium up to 500% FPL. Co-payments, deductibles and premiums for above 188% FPL adjusted annually. Sets enrollment window with surcharge for people who do not enroll within their first year of eligibility.</p>	<p>2001</p> <p>2002, replaced previous programs</p>

STATE	TYPE OF PROGRAM AND BASIC ELIGIBILITY REQUIREMENTS	CREATION/EFFECTIVE DATE
Michigan	<p>MEDICAID: Authorizes the state to seek supplemental rebates from pharmaceutical manufacturers. Also expands prior authorization, and adds two-tiered co-payments of up to \$3.00.</p> <p>SUBSIDY: Michigan Emergency Pharmaceutical Program for Seniors (MEPPS). Minimum age: 65. Income limits adjusted annually. Monthly drug expenses must be at least 10% of monthly incomes for singles.</p> <p>SUBSIDY: Elder Prescription Insurance Coverage (EPIC). Minimum age 65, with up to 200% FPL. Annual fee. For 45 day emergency coverage, can drop to 150% FPL.</p> <p>TAX CREDIT: People 65 and older, with less than 150% FPL, can claim a refundable tax credit up to \$600 for prescription drug expenses that exceed 5% of household income.</p>	<p>2001; currently being challenged in court. 1988 & 1994</p> <p>2001</p> <p>2000</p>
Minnesota	<p>MEDICAID: Authorizes a supplemental rebate program, with prior authorization required for all drugs produced by manufacturers who have not signed a supplemental rebate contract.</p> <p>SUBSIDY: Prescription Drug Program. Minimum age 65, income limits revised annually. Also limits liquid assets. Income limit 120% FPL. Note: state planned to expand eligibility to disabled persons and to raise income limit to 135% FPL, but announced that 2002 budget restrictions would not allow.</p>	<p>2002</p> <p>1999</p>
Mississippi	<p>MEDICAID: Broad Medicaid cost-containment program includes limits of the number of prescriptions per month, prior authorization, dispensing fees, and generic substitution.</p>	<p>3/6/02</p>
Missouri	<p>SUBSIDY: Missouri Senior Rx Program. Eligibility age 65 or older, with an income limit of \$17,000 single and \$23,000 married. Annual enrollment fee, deductibles, and co-payments. Annual benefit capped at \$5,000. Also raises the Medicaid eligibility for elderly, blind and disabled over 3 years to 100% FPL. Replaces and eliminates previous income tax credit.</p>	<p>2002</p>

STATE	TYPE OF PROGRAM AND BASIC ELIGIBILITY REQUIREMENTS	CREATION/EFFECTIVE DATE
Nevada	<p>SUBSIDY: Senior Rx Insurance Subsidy for Prescription Drugs. Subsidy for prescription drugs private insurance policies, using tobacco settlement funds. Eligibility requirements are minimum age 62, with household income of no more than \$21,500. Originally had two plans, Nevada Blue, with a lower premium and generic drugs; and Nevada Silver, with a higher premium and some brand name drugs. Expanded in 2001 to state subsidy up to 100% of the premium, and an increase in the maximum state payment from \$480 to \$1280 annually. Co-payments.</p>	2001
New Hampshire	<p>DISCOUNT: Prescription Drug Discount Program for Seniors. Two year pilot program provides discounts of up to 40% on generics and 15% on brand name drugs. Minimum age 65, with no income limits and no enrollment fee. Program run by private contractor, and contract ended 12/01, but the program continues to operate.</p> <p>MEDICAID WAIVER: Seeks a Medicaid waiver to allow Medicare beneficiaries to receive prescription drugs as well as medical equipment at a discounted price.</p>	<p>1999</p> <p>As of 8/02, HHS had not approved waiver</p>
New Jersey	<p>SUBSIDY: Pharmaceutical Assistance for the Aged and Disabled (PAAD). Minimum age: 65 or 21 if disabled. Income limit raised to \$35,000 in 2000. \$5.00 co-pay.</p> <p>SUBSIDY: Senior Gold Prescription Discount Program expands PAAD by covering individuals with annual income up to \$10,000 above current program income limits. The income eligibility covers the range from \$19,238 to \$29,238 for an individual and from \$23,589 to \$33,589 for a couple. Enrollees must be at least age 65 or receiving Social Security disability benefits. \$15. plus 50% co-payments.</p>	<p>1975/2000</p> <p>2001</p>
New Mexico	<p>MEDICAID: Broad Medicaid cost-containment program that requires a formulary, prior authorization, and negotiated discount prices or rebates from pharmaceutical manufacturers, to include supplemental rebates. Placement of a drug on the prior authorization list will take into consideration whether the manufacturer has reached an agreement with the state on a supplemental rebate, and whether or not that rebate is as favorable as 340B prices.</p>	2002

STATE	TYPE OF PROGRAM AND BASIC ELIGIBILITY REQUIREMENTS	CREATION/EFFECTIVE DATE
New Mexico, continued	<u>DISCOUNT</u> : Senior Prescription Drug Program. Provides a discount not to exceed the dispensing fee plus the contracted discounted price. Covers persons 65 or older, with no other prescription drug benefit. Enrollment fee not to exceed \$60/year.	2002; not yet operational
New York	<u>MEDICAID</u> : Restricts Medicaid pharmaceutical benefit to generics when available. Commissioner of Health can make exemptions. <u>SUBSIDY</u> : Elderly Pharmaceutical Insurance Coverage (EPIC). Minimum age: 65. Income limits raised in 2001 to single \$35,000, married \$50,000 – adjusted annually.	2002 1987/2001
North Carolina	<u>SUBSIDY</u> : “Carolina Cares” Senior Prescription Drug Assistance Program. Expands previous program by raising income limits to \$17,180 for singles, \$23,220 for couples. Minimum age 65. Up to 60% discount on a max of \$1,000 worth of prescriptions per year. For persons diagnosed with heart disease (CVD) or diabetes.	2001 – not yet operational
Ohio	<u>SUBSIDY</u> : Up to \$12 million of Ohio tobacco settlement funds earmarked for emergency prescription drug benefits for the elderly. Four bills, three proposing discount cards and one proposing state-negotiated manufacturer rebates, carried over from 2001 to 2002 legislative session.	No program in operation yet. Bills in committees as of 8/02.
Oklahoma	<u>MEDICAID</u> : Expands prior authorization list to include any new drugs approved by the FDA if the drug falls within existing classes.	2001

STATE	TYPE OF PROGRAM AND BASIC ELIGIBILITY REQUIREMENTS	CREATION/EFFECTIVE DATE
Oregon	<p><u>MEDICAID WAIVER:</u> Medicaid cost-containment program creates a formulary, and seeks a waiver to allow co-payments. While waiting for a waiver, the state has implemented an agency regulation establishing co-payments, with a variety of exceptions such as pregnant women, emergency services, etc.</p> <p><u>SUBSIDY:</u> Senior Prescription Drug Assistance Program. Provides a subsidy of up to 50% per prescription, using a sliding scale based on the income resources of the enrollee. Annual benefit cap of \$2,000. Minimum age 65. Income limit of 185% FPL. Max liquid assets of \$2,000. No private or public drug benefit in previous 6 months. Annual enrollment fee of up to \$50.</p> <p><u>DISCOUNT:</u> Senior Prescription Drug Assistance Program also provides discounts to seniors 65 and older. Discounts not to exceed Medicaid prescription rate. Details not yet established.</p>	<p>HHS waiver scheduled to be finalized 6/02</p> <p>2001; not yet operational . Target date: 10/02. Move up 2001; not yet operational. Target date: 10/02.</p>
Pennsylvania	<p><u>SUBSIDY:</u> Pharmaceutical Assistance for the Elderly (PACE). Minimum age: 65. Income limits adjusted annually. \$6 co-pay, no cap on annual reimbursements.</p> <p><u>SUBSIDY:</u> PACE Needs Enhancement Tier (PACENET). Minimum age: 65. Income limits adjusted annually – slightly higher than PACE program. \$500 deductible.</p>	<p>1984</p> <p>1996</p>
Rhode Island	<p><u>SUBSIDY:</u> Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE). Minimum age: 65. Income limits: Singles \$16,490-\$36,225; Married \$20,613-41,400 (01). Program has three levels of coverage based on income, ranging from 60% to 15% subsidy. Excludes income spent on medical expenses if greater than 3% of total income.</p>	<p>Created in 1985, expanded in 2000.</p>
South Carolina	<p><u>SUBSIDY:</u> SilverxCard. Seniors' Prescription Drug Program. Minimum age: 65. Income limits raised in 2002 to single \$15,505 and married \$20,895. Requires \$500/year deductible and \$10 - \$21 co-payments.</p>	<p>2001</p>

STATE	TYPE OF PROGRAM AND BASIC ELIGIBILITY REQUIREMENTS	CREATION/EFFECTIVE DATE
Texas	SUBSIDY: Prescription drug subsidy program for selected Medicare beneficiaries. Eligibility will be determined by income with the poorest beneficiaries, Medicare-Medicaid dual-eligibles, receiving priority for state aid. As more funding becomes available, the program would be expanded to include more people. Co-payments, formulary, and generic substitution.	2001; not yet operational due to budget shortfall.
Vermont	<p>MEDICAID: Directs the development of a Medicaid preferred list, with utilization review and prior authorization.</p> <p>SUBSIDY: Vermont Health Access Program (VHAP). Eligibility requirements are minimum age 65, disabled, and/or recipients of disability benefits through SS or Medicare. Income limit 150% FPL. Covers acute and maintenance drugs. Co-payment of \$1 - \$3.00.</p> <p>SUBSIDY: VSCRIPT. Eligibility requirements are minimum age 65, disabled, and/or recipients of disability benefits through SS. Income limit raised in 2000 to 225% FPL. Covers only maintenance drugs. Co-payment of \$2 - \$4.00</p> <p>DISCOUNT: Pharmacy Discount Program (PDP) - expansion of VHAP, above, to 300% of FPL. Provides retail discount only; no state subsidy. No minimum age. Open to all Medicare-covered individuals and others without coverage. Income limits reviewed annually.</p> <p>DISCOUNT: Healthy Vermonters Discount Program. No minimum age. Income eligibility: age 65+ may have income up to 400% FPL; under 65, disabled and SSDI may have income up to 300% FPL.</p>	<p>2001 – to be operational by mid-2002</p> <p>1996</p> <p>1989</p> <p>HCFA waiver approved 11/00; Federal court halted operation 6/01.</p> <p>2002. Not yet operational.</p>
Washington	MEDICAID: Medicaid cost-containment program limits number of brand name prescriptions per month, and authorizes pharmacists to review patient prescription for duplications and interactions. Executive regulation.	2001
West Virginia	<p>MEDICAID: Authorizes state to negotiate supplemental rebates with pharmaceutical manufacturers. Also authorizes development of drug formulary and drug utilization review.</p> <p>DISCOUNT: Golden Mountaineer Discount Card Program. Minimum age 60; no income limits.</p>	<p>2002</p> <p>2001</p>

STATE	TYPE OF PROGRAM AND BASIC ELIGIBILITY REQUIREMENTS	CREATION/EFFECTIVE DATE
Wisconsin	<p><u>MEDICAID WAIVER:</u> Prescription Drug Assistance for Elderly Persons. Eligibility is persons 65 or older, up to 240% FPL. There is an enrollment fee, and a deductible for those with income over 160% FPL. 2-tier co-payment and enrollment fee. Also authorizes negotiated manufacturer rebates. Seeks a waiver for federal matching funds for some portions of the program.</p>	As of 4/30/02, HHS has not approved a waiver. State-only portion of the program to start 9/02.
Wyoming	<p><u>SUBSIDY:</u> Minimum Medical Program. No minimum age. Income limit 100% FPL.</p> <p><u>SUBSIDY:</u> Prescription Drug Assistance Program. Stepped series of deductibles and co-pays for families at or below 100% FPL, families btw 100% and 150% FPL, and families btw 150% and 200% FPL. Annual enrollment fee. Program begins July 2002 and will replace Minimum Medical Program (above).</p>	1988 2002; not yet operational

APPENDIX E

Survey Questionnaires

Community Health Clinic Survey

Maternal Child and Health Survey

County Indigent Survey

Telephone Survey found in Appendix G

NM Primary Care Association
Pharmacy Survey

Name of Clinic : _____

1. How many medical delivery sites does your organization have? _____

2. How many of these sites offer a pharmacy benefit to your clients? _____

3. Type of benefit?

_____ 340B drug program or similar program administered through in house drug room

How many patients are utilizing this program? _____

_____ 340 B drug program or similar program administered via contract with retail pharmacy

How many patients are utilizing this program? _____

_____ Assistance obtaining discounted or free prescriptions from manufacturer?

_____ How many patients are utilizing this program? _____

_____ Other . Please describe.

4. Which of the following answers best describes your patients ability to get prescription drugs locally?

- a) They can get all their prescriptions locally _____
- b) They can get most of their prescriptions locally _____
- c) They can get some of their prescriptions locally _____
- d) They can get very few of their prescriptions locally _____
- e) They can get no prescription drugs locally _____

5. Which of the following answers best describes your patients ability to refill prescription drugs locally?

Maternal Child and Health Councils

1. Has your office ever been consulted for assistance to purchase prescription medications?
(please circle) YES NO Don't Know
2. Other than clinics & doctor's offices, what other means are available for people needing help to purchase necessary prescriptions? (e.g., churches, civic organizations, private donations, other services)
3. Support by the above is provided via - (please check all that apply and explain)
 transportation to out-of-town pharmacies or other
 Financial Other
4. From your experience, what groups of people in your immediate or surrounding community are least likely to get the prescription medications they need? (e.g., uninsured, elderly, disabled, etc.)

**County Indigent Fund
June 2001
Questionnaire and Comments**

County _____

1. Of those indigent residents in need of subsidized or low cost prescription medication, how would you best classify the population in general?
 - _____ Working Poor
 - _____ Elderly
 - _____ Immigrant (Documented and Undocumented)
 - Comment _____

2. Can you provide an estimate of your County's population that may be in need of subsidized or low cost prescription medication?

3. Has your County Commission and, or Indigent Board had recent discussions of the prescription drug issue in your County? _____

4. Has there been a proposal in your County to address prescription drug issues by either the County Commission or Indigent Board, or by the residents of your County?

5. If your County currently provides financial assistance for the purchase of prescription drugs, has your County considered increasing the appropriation for additional purchases? _____ By how much? _____

6. If your County does not provide payment for outpatient prescription drugs to indigent residents, has your County recently discussed allocating financial resources to provide outpatient indigent residents with prescription drugs? _____

7. If your County does provide prescription drugs to outpatient residents, how does the County inform qualified residents that this service is available? _____

8. What are your concerns and what would you see as an important issue or suggestion from the State's perspective on the prescription drug issue? _____

Appendix F

Comments

State Agency on Aging Comments
on
HJM 22

“Requesting the Health Policy Commission Conduct an In-Depth Study of the Impact on New Mexico of the Rising Cost of Prescription Drugs”

The State Agency on Aging has participated in the discussions and attended several of the meetings held by the HPC on the study mandated by HJM 22. While we recognize the cost constraints, due in part to a memorial not having an appropriation, we are concerned that the survey conducted may have been flawed because the method (strictly telephone survey) may have resulted in less than accurate data collection. The preliminary data presented to the informal committee regarding access to prescription drugs by population is contradictory to the most recent national studies and reports (see studies attached) - the generally accepted position that seniors and the disabled populations have the most difficulty accessing prescription. The difficulty in accessing prescription drugs can occur for a variety of reasons, almost all of which boil down to financial ability to pay for needed medications. The specifics include but are not limited to:

- 1) Lack of available and affordable insurance for prescription drugs
- 2) High utilization translating to higher drug expenditures per individual in the two populations
- 3) Low income that is usually tied to a Social Security benefit that is far below the wages earned by the working population.
- 4) Higher costs for same drugs this population must pay vs. an employer-based insurance population or a population eligible to Medicaid.

The survey findings indicated 93% of seniors “always had access to needed prescription drugs” and also stated:

- 1) 6% of seniors sold possessions to obtain Rx
- 2) 6% of seniors were given or lent money to obtain Rx
- 3) 2% of seniors took a short term loan to obtain Rx
- 4) 4% of seniors chose between obtaining Rx for themselves or others.

The 93% of seniors having access to Rx is much higher than what other studies report and the percentages above listed as barriers to access are smaller when compared to national studies.

Additional Data:

According to the U.S. Census, New Mexico has the highest percentage of people living in poverty and 16.9% of seniors living below poverty. Kaiser reports that the average prescription drug cost for seniors is \$1700 per year. It is estimated that 70,000 New Mexico seniors aged 65 and older lack any prescription drug coverage. In addition, many seniors enrolled in Medicare + Choice plans in the Albuquerque/Santa Fe area cap out of their plans’ Rx coverage during the benefit year and must pay full cost for prescriptions (a survey conducted early in the calendar year may have undercounted individuals who were enrolled in Medicare + Choice, and, at the time, had not capped out of their plan’s Rx coverage).

This data, national studies and reports, and the State Agency on Aging experience with constituents requesting Rx assistance suggests that the survey significantly underestimates the impact Rx costs/needs/access have on the senior population. Considering NM has no pharmacy assistance program and the highest poverty and uninsured rates, it makes no sense that we should have the best access to Rx drugs, as this survey seems to indicate.

Conducting a survey by phone presents a unique challenge for this population - the veracity of the answers given by older and disabled populations to the survey questions because of reluctance to admit that financial hardships exist. Pride and a general suspicion of anonymous callers often are impediments in gathering reliable information from an older population. The State Agency on Aging encourages seniors to beware of unsolicited calls and persons asking for personal information. Also, it has been noted by physicians who tend to seniors that it is difficult to “draw out” information about how a senior is paying for, and doing or doing without their medications.

The Agency requests that the HPC and Burger Carroll & Associates, Inc. include in the HJM 22 report our concerns regarding the senior and disabled populations’ difficulties in accessing prescription drugs.

Below are studies and articles that contradict the findings of the HJM 22 survey:

PRESCRIPTION DRUG SURVEY FINDS SENIORS SKIPPING MEDICATIONS

A recent eight state survey by The Kaiser Family Foundation, The Commonwealth Fund and Tufts- New England Medical Center found that in 2001, the high cost of prescription drugs forced **22 percent of seniors to skip doses of their medications**. It also found that nearly a quarter of seniors spent \$100 or more per month on prescription drug costs alone.

In seven out of the eight states surveyed, less than 50 percent of all seniors living below the poverty level received prescription drug coverage from Medicaid. The majority of low-income seniors said they did not enroll in assistance programs because they did not think they qualified or they never thought of applying.

Of the seniors surveyed who reside in states with relatively comprehensive prescription drug assistance programs, as compared to New Mexico, approximately 20 percent have no drug coverage.

To read this study, go to < <http://www.kff.org/content/2002/6049/>> .

Cost Prompts Low-Income, Minority Seniors To Restrict Prescription Drug Use, Survey Says

Forty-three percent of seniors who lack prescription drug coverage and who are either minorities, have annual incomes of less than \$10,000 or have high out-of-pocket prescription drug costs greater than \$100 per month say they restrict their use of prescribed medications because of cost, according to a study published in the December issue of the Journal of General Internal Medicine. The study, conducted by researchers from the University of California-San Francisco Department of Medicine, surveyed about 5,000 Americans ages 70 and older -- with and without prescription drug coverage -- who "regularly used" prescription drugs. The study found that low-income participants without prescription drug coverage were 15 times more likely to restrict their drug use than low-income respondents with drug coverage. The study also found that overall, 20.9% of minority respondents, 15.6% of people with annual incomes under \$10,000 and 13.4% of participants with out-of-pocket costs exceeding \$100 per month limited their use of medications because of cost concerns. According to a release from the public advocacy group Public Citizen, "Even one of [these] three risk factors ... made it significantly more likely" that individuals without prescription drug coverage would have to restrict their use of treatments as a result of cost. The authors of the study, led by Dr. Michael Steinman of UCSF, said that restricting prescription drug use "may have serious consequences for patients' health, resulting in increased emergency department visits, nursing home admissions, (and) use of emergency mental health services." Based on the findings, Public Citizen stated that many seniors "go without the medicines they need to maintain their health." The findings in the UCSF study are consistent with the results of a Nov. 20 Harris Poll, which found that 39% of adults with annual incomes of less than \$15,000 had not filled a prescription in the past 12 months as a result of cost (Public Citizen release, 12/4).

U.S. lowest on health care access in five-country survey

A new Commonwealth Fund study finds that one in five U.S. residents had difficulty accessing health services due to cost over the past year. The report, published in the current issue of Health Affairs (<http://www.healthaffairs.org/freecontent/v21n3/s22.htm>), was conducted by Commonwealth and Harvard School of Public Health researchers and compared health services in Australia, Canada, New Zealand, the U.K. and the U.S. Other findings include 21% of U.S. citizens had problems paying medical bills compared with 20% in New Zealand, 17% in Australia, 9% in Canada and 4% in the U.K. Among citizens who didn't fill prescriptions because of costs, there were 39% in the U.S., 22% among Canadians, 21% among Australians, 20% among New Zealanders and 7% of Britons surveyed.

GAP IN SENIORS' DRUG COVERAGE EXCEEDS EARLIER ESTIMATES

The proportion of Medicare beneficiaries who had no prescription drug coverage in the fall of 1999 is much higher than originally thought, a new study shows.

Reuters Health Information 2002

<http://www.medscape.com/viewarticle/429206?srcmp=fin-030102>

INCREASES IN DRUG SPENDING SHIFTING TOWARD MEMBERS

The percentage of elderly persons now spending over \$3000 per year for prescription drugs has more than doubled.

Drug Benefit Trends 14(1) 2002

<http://www.medscape.com/viewarticle/424382?srcmp=fin-030102>

Survey Looks at Sources of Drugs Obtained by Elderly

About 22% of seniors said that they skipped doses of prescription drugs or did not buy the medications they needed in 2001 because the cost was too high. A new survey of seniors in eight states conducted by the Kaiser Family Foundation, The Commonwealth Fund and Tufts-New England Medical Center and published online by the journal Health Affairs reveals tremendous variation in available sources of drug coverage, the depth of that coverage and the extent to which seniors -- even those with drug coverage -- are exposed to high out-of-pocket costs. Medicare beneficiaries continue to rely on a range of supplemental sources to help with their drug expenses. The survey also assesses how frequently seniors skip doses or forgo medications due to costs. The study looks at the experiences of seniors in California, Colorado, Illinois, Michigan, New York, Ohio, Pennsylvania, and Texas.

Source: Health Affairs (31 Jul 2002)

Full story: http://www.healthaffairs.org/WebExclusives/Safran_Web_Excl_073102.htm

September 19, 2002

Mr. Jack Mack
State Agency on Aging
228 E. Palace Avenue
La Villa Rivera Building
Santa Fe, New Mexico 87501

Dear Mr. Mack:

Thank you for your response to the Health Policy Commission's study for House Joint Memorial 22. As a member of the HJM 22 Advisory Committee and a healthcare partner, the HPC values and welcomes your comments.

We agree with you that the findings from the Burger, Carroll & Associates, Inc. survey may have appeared to be different from other national studies that have been done on seniors' access to prescription drugs. However, looking at the study from a wider perspective, which includes individuals of all incomes and all ages, it correlates with other studies that maintain that populations other than seniors experience equal if not more difficult hardships in trying to obtain prescription drugs.

The HJM 22 Advisory Committee and the HPC spent considerable time and effort to ensure that the telephone survey and its methodology would result in a good demographic representation of New Mexicans, particularly those with a self-recognized need obtaining prescription drugs. The telephone survey is one component of the HJM 22 report. Other sources were used; a survey of community health clinics, Maternal Child and Health councils, and County Indigent Fund administrators; and extensive research on National and Federal reports and initiatives. The compilation of all these things will result in the final findings of the report and subsequent recommendations to the Legislative Health and Human Services sub committee.

Julie Carroll, President of the BCA, submitted a letter to the HPC in response to your concerns. The letter is attached for your review.

Again, thank you for your comments and for your participation on the Advisory Committee.

Sincerely yours,

Bev Russell, Acting Director



Burger, Carroll & Associates, Inc.

Ms. Leticia Rutledge
New Mexico Health Policy Commission
2055 South Pacheco Street, Suite 200
Santa Fe, New Mexico 87504

Dear Ms. Rutledge:

BCA is in receipt of the State Agency on Aging (Agency) Comments on HJM 22 of September 10, 2002. These comments express concerns with the findings and methodology of the survey of New Mexicans conducted by Burger, Carroll & Associates, Inc (BCA) under our engagement to the New Mexico Health Policy Commission. The confusion evident in the Agency's concerns may be attributed to an emphasis in both the scientific literature and popular media of lack of access to prescription medications among *high-risk senior populations*. BCA was commissioned by the HPC to conduct a study representative of the adult New Mexico population. BCA respectfully submits the following response to the concerns expressed.

"Findings are Contradictory to Most Recent National Studies"

The Agency's statement that BCA's findings are contradictory to recent national studies is inaccurate, as detailed below.

Agency Comments

One of the studies cited¹ by the Agency was of seniors 70 years and older who regularly used prescription drugs. This group of seniors is slightly older but otherwise comparable (*i.e.*, includes individuals with a recognized need for prescription medications) with the seniors in BCA's study. The Agency states: "The study found that low income participants without prescription drug coverage were 15 times more likely to restrict their drug use than low-income respondents with drug coverage. The study also found that overall, 20.9% of minority respondents, 15.6% of people with annual incomes under \$10,000 and 13.4% of participants with out of pocket costs exceeding \$100 per month limited their use of medications because of cost concerns. Even one of [these] three risk factors...made it significantly more likely that individuals without prescription drug coverage would have to restrict their use of treatments as a result of cost."

The Agency also suggests that the study indicates "forty-three percent of seniors who lack prescription drug coverage and who are either minorities, have annual incomes of less than \$10,000 or have high out of pocket prescription drug costs, >\$100/month say they restrict their use of prescribed medications because of cost."

BCA Response

The main results of this study were that of the 4,896 seniors who regularly use prescription medications, medication restriction because of cost was reported by **7.7%** of subjects with no prescription coverage, **3%** of subjects with partial prescription coverage and **2%** of subjects with full prescription coverage. The researchers did not even specifically report the proportion of *all* seniors participating in the study

*Ms. Leticia Rutledge
Health Policy Commission
September 18, 2002
page 2*

who restricted medication use, as we did, and which would predictably be lower than for those without full prescription coverage. However, that figure could be readily calculated from the data presented in the study and is **4.66%** of the study population. This figure is the one that may be properly compared with the BCA finding cited by the Agency, and is actually *lower* than our estimate for the New Mexico senior population (6.45%) and indicates even greater access by seniors than does our study. Like the study cited, BCA's findings on the factors associated with lack of access include the level of health care and prescription medication coverage, minority ethnicity (i.e., Hispanic), and low income and high out-of-pocket prescription drug costs. BCA's estimates of lack of full access, regardless of prescription drug coverage, are 15% for Hispanics and about 25% for adults in households with an annual income below \$10,000. These findings are consistent between the studies, although our findings relate to the entire adult population, including seniors, not just to seniors without prescription drug coverage.

The forty-three percent reported as restricting use of prescribed medications because of cost, inaccurately cited by the Agency, was found among seniors without prescription drug coverage **and** who are minorities, **and** have annual incomes of less than \$10,000 **and** have high out of pocket prescription drug cost; not among seniors with no prescription drug coverage and only one of the risk factors, as stated. It is reasonable to expect that estimates of less than full access from the same high-risk population in New Mexico would be considerably higher than that of the general senior population.

Agency Comment

The Agency stated: " A recent eight state survey²ⁱⁱ "found that in 2001, the high cost of prescription drugs forced 22 percent of seniors to skip doses of their medications. It also found that nearly a quarter of seniors spent \$100 or more per month on prescription drug costs alone."

BCA Response

The study cited above was primarily of the level and sources of coverage for prescription medication for seniors, examining states with and without state funded pharmacy assistance programs. It describes the disparity in coverage as a component of an argument for a national policy solution.

The assertion that twenty-two percent of seniors skipped doses is a misstatement of the actual finding in this study. The finding was that 22% of low-income seniors (below 200% poverty level), not all seniors, had not filled a prescription. Again, BCA found access to be associated with income levels; as income goes down, access goes down. Thus, there is no contradiction with this study and our findings. BCA was required to use household income, not federal poverty levels, so that comparisons could be made with census data. Thus, we have no comparable estimates for this high-risk, low-income population. However, BCA's general findings are consistent with the general finding relating to income and access.

Agency Comment

The Agency stated: "The findings in the UCSF study are consistent with the results of a Nov 20 Harris Poll, which found that 39% of adults with annual incomes of less than \$15,000 had not filled a prescription in the past 12 months as a result of cost (Public Citizen release, 12/4)."

BCA Response

The Harris poll found that 22% of all adults had not filled at least one prescription in the past 12 months because of the cost (no confidence intervals were provided). BCA's more targeted study found that 12% of adult respondents with a recognized need for prescription medications had less than full access to needed prescription medications within the past 12 months. Additionally, the Harris Poll found that worse access among low-income individuals and individuals with disabilities; age was not reported to be associated with access. This poll's estimates, based on asking a different question to a different group of people, are slightly higher than BCA's, but not inconsistent. However, they cannot be compared with the UCSF study, which examined only seniors.

Agency Comment

The Agency stated: "Percentages above listed as barriers to access are smaller when compared to national studies".

BCA Response

Other than this general allegation, the Agency cited no specific studies demonstrating differing estimates of these "barriers to access". BCA and the project team refer to these behaviors as "hardships" born in the process of obtaining prescription medications. The estimates cited by the Agency from BCA's study include all senior respondents, regardless of level of access to prescription medications. Thus, there is no evidence presented of contradictions with national studies on these items.

Agency Comment

The Agency stated: "In seven out of the eight states surveyed, less than 50 percent of all seniors living below the poverty level received prescription drug coverage from Medicaid. The majority of low-income seniors said they did not enroll in assistance programs because they did not think they qualified or they never thought of applying." Drug coverage: "relatively comprehensive prescription drug assistance programs; approximately 20% have no drug coverage."

BCA Response

The Agency took no issue with BCA's findings regarding income levels, type of health care coverage or levels of drug coverage in New Mexico.

a) "Flawed Methodology"

Agency Comments

The Agency states: "Conducting a survey by phone presents a unique challenge for this population - the veracity of the answers given by older and disabled populations to the survey questions because of reluctance to admit that financial hardships exist. Pride and a general suspicion of anonymous callers are impediments to gathering reliable information from an older population. Noted by physicians that it is difficult to draw out information about how a senior is paying for, and doing or doing without their medications."

“Medicare + Choice plans in ABQ/SF cap out their plans' rx coverage during the benefit year and must pay full cost for prescriptions (a survey conducted early in the calendar year may have undercounted individuals enrolled in Medicare + Choice, and at the same time, had not capped out of their plan's RX coverage).”

1) BCA Response

We agree that there are challenges in conducting any kind of survey with seniors. However, some of the surveys cited by the Agency as examples of good data utilized telephone surveying themselves (*e.g.*, Harris Poll, Bowen). Most importantly, the telephone interviewers for our survey were professional interviewers. BCA engaged Research & Polling, Inc., of Albuquerque, New Mexico for conducting the actual telephone interviews. In some cases, information on seniors was obtained from a non-senior adult household member. BCA is confident that any bias in the results on seniors related to methodology are comparable to those experienced by other researchers. Seniors in our survey were asked (as were all respondents) about access to needed prescription medications for the past 12 months, not just as of the current moment. The interviews were conducted between August 2001 and February 2002.

The Agency has not presented any evidence to support the suggestion that BCA has underestimated the level of lack of access among seniors, nor that BCA has suggested that New Mexican seniors have better access than other seniors in the country. To the contrary, BCA's point estimate of access to prescriptions is higher than the comparable level of access determined from a nationally representative study cited by the Agency. We do acknowledge that the literature tends to emphasize higher levels of access problems among high risk populations and that this has led to a general misunderstanding and misstatements of the access issues faced by the general population of seniors, as was studied by BCA. The Agency's statement that "the generally accepted position that seniors and the disabled population have the most difficulty accessing prescriptions", while probably true, is unsubstantiated for seniors in any literature we have reviewed. What we did find in a review of twenty-nine articles regarding prescriptions is that to a large degree only seniors have been studied, providing little comparative data. Two studies (Mueller, 1997 and Liebowitz, 1985) examined general populations, however neither examined access or hardships. One of these studies examined the effect of cost sharing on the use of prescriptions; the other examined spending for prescriptions.

BCA agrees, and our study findings support the idea, that many seniors go without the medicines they need to maintain their health. Additionally, it is clear that some seniors endure hardships to obtain their needed medications and certainly that seniors spend more out of pocket for medications than younger adults. Our study provides, additionally, information regarding access to needed medications by those adults in the general New Mexico population who have a recognized need for prescriptions.

Please do not hesitate to contact me if I may be of further assistance with this matter.

Sincerely,

BURGER, CARROLL & ASSOCIATES, INC.

Julie M. Carroll

Julie M. Carroll, M.S., Dr.P.H.,
President

ⁱ Covinsky, K.E., L.P. Sands and M.A. Steinman. "Self-restriction of medications due to cost in seniors without prescription coverage." *Journal of General Internal Medicine*, Vol.16, No.12, 2001

ⁱⁱ Bowen, A.E., M.S. Kitchman, W. Li, J.E. Montgomery, P. Neuman, W.H. Rogers, D.G. Safran, C. Schoen, I.B. Wilson "Prescription Drug Coverage and Seniors: How Well are States Closing the Gap?", *Health Affairs*, Web article, 2002.

Appendix G
BCA Telephone Survey Report

NM Health Policy Commission Staff

Beverly Russell	Deputy Director	bevr@hpc.state.nm.us
Patrick Alarid	Management Analyst	jpalarid@hpc.state.nm.us
Michael Baca	Network & Computer System Admin.	mabaca@hpc.state.nm.us
Joanne Carlsen	Financial Specialist	jjcarlsen@hpc.state.nm.us
Camille Clifford	Computer Systems Analyst	cpclifford@hpc.state.nm.us
Susan DeGrand	Computer Systems Analyst	sldegrand@hpc.state.nm.us
Jenny Felmley	Special Projects Assistant	jfelmley@hpc.state.nm.us
Irma Montoya	Management Analyst	ivmontoya@hpc.state.nm.us
Kate Myers	Office and Administrative Support	kmyers@hpc.state.nm.us
Kim Price	Computer Systems Analyst	kprice@hpc.state.nm.us
Lori Quintana	Business Operations Specialist	lquintana@hpc.state.nm.us
Leticia Rutledge	Management Analyst	lmrutledge@hpc.state.nm.us

ACKNOWLEDGEMENTS: Report compiled and prepared by Leticia Rutledge of the HPC, with assistance from Beverly Russell, Patrick Alarid, and Jenny Felmley. The HPC would like to recognize the contributions of Shaun Meeks, who was responsible for coordination of the first year's efforts on the Memorial. The HPC would also like to thank the members of the HJM 22 Advisory Committee for their participation, and for their valuable advice and feedback on this report.

For more information, please contact:
New Mexico Health Policy Commission
2055 S. Pacheco St., Suite 200
Santa Fe, NM 87505
(505) 424-3200, Ext. 100