





## Background

Pharmaceutical drugs (medications) are now a component of almost all-medical treatment. The increase in the diversity of illness treatable with medication and the increase in cost to develop new treatments have resulted in medications being an increasing percentage of every health bill.

Multiple incomplete medication safety nets exist. Medicaid and charity clinics provide pharmaceuticals to the most impoverished. Gaps in Medicaid coverage occur when people move, exit prison, or have difficulty with appointments or paperwork. Federally Qualified Health Centers (FQHC) and certain public health jurisdictions have access to the federal 340(b) discounted pricing programs, which are able to obtain medications at 50% of an average wholesale price. In addition, Washington State passed **RCW 41.05.500** last year to provide pharmaceuticals at a reduced cost through group buying for people over 50 years old and less than 300% of federal poverty. The federal government recently passed legislation to create a medication discount card for seniors as a part of Medicare.

Whether and how far the recent state and federal legislation will go to create access to affordable medications is unclear at best.

### **The problem is that people in greatest need cannot consistently access affordable medications**

The frustration in being able to obtain affordable medications has been echoed over all demographic groups. The elderly demanded a pharmaceutical benefit as a part of Medicare. Privately insured consumers complain about increased co-pays and some are willing to go to Canada to obtain less costly medications.

People who are low income, uninsured and/or have chronic conditions are most severely impacted by lack of access to affordable medications. The Access Project<sup>1</sup> in 2003, which looked at ~ 7000 uninsured in 18 states, found that 56% of respondents prescribed medications reported that they needed help paying for the medication. In addition, 13% (in some regions 30%) of respondents reported obtaining none or only some of their medication due to cost.

Specific examples of barriers to affordable medications include:

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<sup>1</sup> Paying for Healthcare When You Are Uninsured, Jan 2003, The Access Project, Heller School for Social Policy and Management, Boston, Mass

Samples: Pharmaceutical companies (through their representatives) distribute many medication samples to physicians in an ad hoc and uncoordinated way as starter medications. Pharmacies by law usually cannot distribute these samples. The use of samples (free medications) could be better leveraged for people without other resources. (Clinic and community projects that do this find it takes substantial effort.)

Prescription Assistance: Each pharmaceutical company has a unique process and requirement (e.g., forms, criteria and eligible medications) for providing free or reduced medicines that usually requires reapplication for each medicine every three months. These medicines are usually best suited for patients with stable long term prescriptions. This complexity places a time and personnel burden on physician offices and clinics. Current software tools can be helpful but significant manpower and expense is still required.

Low Volume Purchasing: Low volume purchasing among multiple purchasers contributes to the high rate of pharmaceutical inflation.

Access Reduced Medications: To access reduced cost medications, patients go through repeated, multiple enrollment and verification processes at different locations. This is a waste of precious resources.

Loss of Medical Coverage: Patients lose state benefits and health coverage when imprisoned. Many require multiple pharmaceuticals including expensive mental health pharmaceuticals. Without pharmaceuticals many exhibit costly behavior. Reestablishing benefits is complex and takes at least three months. This loss results in increased ER use, large county expense and recidivism. Additional problem for these patients is the need to distribute meds in monitored small supplies:

The effects of not being able to obtain medication include increased medical severity, prolongation of illness, increased ultimate cost, unnecessary Emergency Department use, and poor outcomes including death.

### **Possible solutions to solve the problems**

1. **Pharmaceutical Assistance:** Standardizing the application process for the pharmaceutical companies' pharmaceutical assistance plans would be extremely helpful. A number of states have a state based charitable organization that has negotiated successfully with a group of pharmaceutical companies in that state to provide in that state a full spectrum of pharmaceuticals to the low income uninsured without having to apply for each medicine individually. For example, foundations in Kentucky, Georgia and Arkansas are able to provide free medicine to Non-Medicaid patients under 100% of FPL. Recently, Health Indiana was able to negotiate a similar plan for patients under 150% FPL.

***Goal - Implement a state wide pharmaceutical assistance program with 7-10 major pharmaceutical companies to provide pharmaceuticals to uninsured under 150% FPL similar to other states.***

Because Medicaid in this state covers most people to at least 100% of FPL this program should cover to 150%. This could be started as pilot project to work out the issues and then expanded. American Project Access Network is currently working with the corporate offices of several pharmaceutical companies to make state pharmaceutical assistance programs their new national model. The reception has been favorable as the pharmaceutical companies are looking for a new model with the introduction of the Medicare discount card.

### Convene pharmaceutical representatives from same companies.

Favorable reasons for company participation

- Company has simplicity of dealing with one organization.
- Freedom from antitrust by cooperating with others including government for charity
- Broader formulary (companies like more accessibility to their meds.)

Related decisions with options:

1) State or national entity

- American Project Access Network- unified national model
- New state foundation
- Current foundation

2) Startup

- American Project Access Network-? Unified national model
- New state foundation
- Current foundation

3) Certifying agent

- Community projects such as Project Access.
  - Little extra cost as these are currently certifying
  - Non-Medicaid uninsured and have an incentive to enroll patients on Medicaid or Basic Health. These projects frequently have formularies and Therapeutics Committees.
- State
  - State does many types of certification but this could be viewed as an increased cost to state in times of budget deficits and potential bureaucracy. The Commonwealth Fund in Sept 2003 indicated “These findings suggest that programs (Pharmacy Assistance Programs)... at the state level, may have difficulty achieving high levels of participation among low income populations.” Furthermore, pharmaceutical companies might view the state as having an interest in shifting pharmaceutical costs from the state to the companies.

4) Pharmaceutical tracking and delivery

- Foundations in states such as Kentucky have adopted two different approaches. The first is to contract with a commercial company. Some have then learned the steps and paperwork and taken it in house into the foundation to potentially save money.

Both require funding that the foundations obtain from special events, etc. Another possibility would be to try to get the states to fund. In general, pharmaceutical companies have not wanted to fund another company such as Medco.

#### 5) Pharmacists

- There may need to be small co-pay to the pharmacist (\$5.00) for processing, which includes checking formulary. For patients on multiple medicines a few dollars per prescription per month will limit accessibility.
- 2. **340(b) Programs:** These currently provide the least expensive pharmaceuticals particularly for higher priced non-generics. Federally Qualified Health Clinics (FQHC) are able to obtain 340B pricing for all of their patients. Under current law these patients must have a chart and use the medicine associated with that clinic's treatment. (The 340b medicines are associated with the entity, ie the FQHC, and not the patient.) Thus, a wide variety of other clinics, charitable physicians, community programs, etc are unable to obtain similar low pricing for their equally needy patients. A number of opportunities exist:
  - a. Under new rules, a number of rural hospitals now qualify (however these hospitals may not obtain covered outpatient drugs through a group purchasing organization or arrangement) for 340B under disproportionate share

*Action – Identify these hospitals in the state and develop networking models and systems where any resident in their catchments could purchase medication at the hospital. The hospital would need to generate sufficient revenue to cover the cost of the medication and the pharmacy cost.*

- b. Federally push for expansion of 340b to Community based charitable health coalitions (like Project Access) for the uninsured (who provide increase access to patients of FQHC)

*Action – Push current bill with suitable revisions H.R. 4161 was introduced on April 2 and referred to the House Committee on Energy and Commerce. The bill is titled the "340B Program Revision and Expansion Act of 2004." Rep. Bobby Rush of Illinois sponsored the bill.*

- c. Texas waiver Pending – Would allow use of 340b pricing for any patient who has a FQHC chart in last 3 years.

*Action – Follow outcome, if Texas is successful use similar model*

- d. Use 340b pricing in poly pharmacy patients. Requires case management by FQHC. For non-FQHC patients, this model works best with patients taking multiple medicines such as complex medical or mental health. This is the model used by the Coordinated Care Network in Pittsburg.

*Action – Set up a case management model to qualify. Establish pharmacy and distribution system.*

- e. The ultimate goal is to purchase through 340(b) programs and obtain group discounts for any low income uninsured patient regardless of the site of care. This may be possible through interpretation of current law (Texas waiver attempt) or through small incremental additions to current law.

- 3. Samples:** Create a system to better use and distribute sample medications. This could include allowing under state law pharmacies associated with charitable activities to repackage and distribute sample medications. Allow samples to be used to start (preload) pharmacies delivering medicines in prescription assistance programs locally based on best practices according to size, to facilitate statewide replication.

*Action – Study current pharmacies allowed to repackaging and replicating.*

- 4. County Pharmaceutical Coverage:** Numbers 1 - 3 above should help reduce county pharmaceutical expenses.

*Action – Enlist county support in legislature. Use county savings to further expand case management model*

- 5. More Group Purchasing:** Include enrollees in Project Access and other community access programs (see 5 below) in the state's new purchasing pool for pharmaceutical discounts similar to those currently over 50 and low income who are allowed access. No active plan or enrollment yet.

*Action: Work with state policy makers to ensure state develops a viable purchasing process where other people –particularly low-income people – can purchase more affordable medications.*

- 6. Medicare Card:** Link the new Medicare discount cards in an efficient manner to community programs.

- 7. Community Pilots:** Identify and support a few community pilots that have a good chance of testing how far we can get by putting together multiple methods for providing discounted and free pharmaceuticals. Good candidates include: "..."

- Twin Harbors Pharm-Assist Network (THPAN), initially active in Grays Harbor and Pacific Counties, is developing a large-scale prescription assistance program (see solution 2 above), investigating ways to broaden the impact of 340 (b) programs (see solution 3), and planning pilots of Automated Dispensing Devices to improve access to prescription drugs in remote rural areas. THPAN is implementing a generalized model for using volunteers for pharmacy assistance, with strong coordination and software support; this part of the work already involves partnerships with the State Insurance Commissioner's SHIBA (Statewide Health Insurance Benefits Advisor) program for training and supervision of pharmacy assistance volunteers, and with Area Agencies on Aging and other community organizations to coordinate referral and provide sites for the volunteers.
- Western Washington Rural Health Care Collaborative Network is investigating better use of 340 (b) programs and is collaborating with THPAN on both this effort and the development of tele-health technical networks that will open the door to tele-pharmacy as well as many other services.