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## The Citizens Health Prescription: Coping with Rising Drug Costs

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## The Citizens Health Prescription

## Coping with Rising Drug Costs

*Shannon Cadres*

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*Prescription drug prices have climbed to unaffordable levels in recent years, creating a serious public policy problem for lawmakers at both the state and federal levels. The U.S. Medicare program only covers the costs of inpatient prescription drugs, and only seventy-five percent of beneficiaries are receiving coverage through some other means. But because of the tremendous power of the pharmaceutical industry on Capitol Hill, lawmakers in Washington have been unable to agree upon a workable solution. As a result, many states are experimenting with different strategies to provide some relief.*

*Massachusetts has attempted to solve the problem through the Prescription Advantage Program, a first-in-the-nation insurance model that is open to all seniors in the state. While few would disagree that the program is an effective, inexpensive option for seniors to access sufficient prescription drug coverage, many have argued that the state needs to do more to reduce its overall drug costs. After spending two years lobbying the state to implement one cost-lowering option — a bulk-purchasing strategy to lower the state's drug spending, former Congressman Joseph P. Kennedy II set out to run his own privately run drug discount program, Citizens Health.*

*This study finds that there are lessons to be learned from both Citizens Health and the state's program, Prescription Advantage. While Prescription Advantage can serve as a model for a government-sponsored prescription drug plan for seniors, Citizen Health can provide insight into how to reach other segments of the population who can't afford the drugs they need.*

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People have to make terrible choices about whether they're going to take the drugs their doctor gave them, put food on the table, or turn the heat up. It's a very serious problem.<sup>1</sup>

—Joseph P. Kennedy II

**T**he United States has some of the most important ground-breaking pharmaceutical research in the world. Since the beginning of the twentieth century, great strides made in the development of new prescription drugs and treatments have wiped out diseases and greatly enhanced the quality of life for Americans, particularly its senior citizens. As a result, Americans are living longer and healthier lives.

But there is a downside to the important progress that has been made in this area of healthcare in the United States. Since there are now more prescription drugs on the market, many of which are more effective than older remedies, demand for them has increased significantly, driving up both cost and use. Consequently, the United States has the highest prescription drug prices in the world.<sup>2</sup> In the year 2000,

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pharmaceutical spending in the United States topped \$132 billion, an increase of 19 percent over 1999.<sup>3</sup>

The repercussions of these staggering drug costs are being felt by many. Having watched the costs of their employee benefits packages balloon over the past decade, employers have been forced either to scale back the health coverage they can offer their employees or to require greater employee contributions. Employers have also been forced to cut back dramatically the benefits they offer to their retirees. The results of these cutbacks have been dramatic. The number of Americans who have health insurance covering prescription drug costs is dropping by roughly one million each year.<sup>4</sup>

Perhaps the most vulnerable are the nation's senior citizens who are heavily represented in the 38 percent of Americans of any age who have no prescription drug coverage. Not only are their former employers cutting back on the health benefits that they offer to retirees, but HMOs that have long offered Medicare-plus benefits that have included prescription drug coverage are scaling back or abandoning drug benefits altogether.<sup>5</sup> The result is that seniors are taking risks by sharing drugs, skipping doses, or not taking their prescriptions at all.<sup>6</sup>

Because of the extent of the prescription drug crisis, and the ability of senior citizens to get their voices heard on the issue, lawmakers at both national and state levels have been under tremendous pressure to come up with a solution to the problem. The federal Medicare program, which was established nearly forty years ago as a healthcare plan for senior citizens, only covers drugs received in the hospital. With prescription drugs playing such an important role in healthcare today, lawmakers are looking at ways to expand Medicare to include drug coverage. Efforts to do that have grown only more and more complicated and expensive, as drug costs have continued to rise.

The longer it takes the federal government to solve the Medicare/prescription drug dilemma, the greater the pressure on state governments to solve the problem now or soon. State governments, which are already struggling to deal with rising drug costs in the administration of their Medicaid<sup>7</sup> programs, are now being called on to ease the burden for Medicare beneficiaries and the uninsured.

The Commonwealth of Massachusetts has been relatively progressive in this policy area. Since the late 1990s, the state has offered pharmacy benefits for lower-income seniors and the disabled of all ages. At the urging of former Congressman Joseph P. Kennedy II, Massachusetts was one of the first states to consider a bulk-purchasing initiative that would bring down the costs of drugs by aggregating purchases. In 2001, Massachusetts launched a first-in-the-nation prescription drug insurance program for all of the state's senior citizens, regardless of income.

The path of prescription drug progress in Massachusetts has not been a smooth one though. While Joseph Kennedy was successful in getting the state to *pass* a prescription drug bulk-purchasing law, he was not successful in getting lawmakers to *implement* it. Opposition from powerful special interest groups in the state and the ease with which they supported the "lesser of two evils" insurance model proposed by Teresa Heinz, ultimately killed the prospects of Kennedy's initiative. Determined to use his bulk-purchasing plan to help low-income elders to obtain drugs affordably, he ultimately sidestepped the government to launch Citizens Health. The program has become a new arm of his nonprofit Citizens Energy Corporation, which has provided heating oil at a discount to low-income elders and working families for more than twenty years.

This case study will explore the prescription drug crisis, on both a national and state level. It will provide insight into the Massachusetts approach to solving this problem for seniors, as well as Kennedy's efforts to encourage the state to implement a bulk-

purchasing strategy. Finally, it will look at the creation of Citizens Health; how the plan is designed, how it compares with other discount programs, and what lessons it offers for policymakers who are considering similar approaches to solving this crisis for their constituents.

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### **Rising Prescription Drug Costs: A National Crisis**

The Citizens Health program is one private solution to an issue that, for many states, has become a very public problem. The need for Citizens Health or a state-sponsored prescription drug program is determined by policy decisions made at the federal level. Since the prescription drug industry is one that crosses not only state, but international borders, the bulk of the prescription drug debate takes place in Washington. The major figures in that debate are members of Congress, lobbyists for the drug industry, Veterans Affairs officials, and advocates for seniors and the poor. At the center of the prescription drug discussion is the nation's Medicare program, and the question of how or if it can be expanded to cover prescription drug costs for seniors.

#### ***Medicare: What Does It Cover?***

The Medicare program was established in 1965 to provide national health insurance for the elderly and disabled. The program consists of two parts. Part A, which is financed by a 2.9 percent payroll tax paid by employers and employees, covers the cost of most inpatient hospital costs. Part B, which is financed by premiums and deductibles, is Medicare's supplemental insurance program that covers the costs of outpatient services and physicians. National data show that most Part A recipients are also enrolled in Part B.<sup>8</sup> Indeed, the Medicare card has both parts imprinted upon it, and one becomes eligible at age sixty-five.

When Medicare was established, few would have predicted that the program's costs would balloon to the levels that they have reached today. The rising costs of healthcare — medical inflation — roughly 10 percent per year, prompts fewer employers to offer benefits to retirees. Medicare membership has increased substantially. While 19.2 million individuals received Medicare benefits in 1967, 40 million elderly and disabled people are enrolled in the program today.<sup>9</sup>

Though Medicare covers the costs of inpatient prescription drugs, outpatient drugs are excluded from the plan. Considering that most of the nation's elderly population uses prescription drugs, with half of them taking five or more medications a day,<sup>10</sup> the prescription drug gap in Medicare coverage can be large and costly. Beneficiaries are forced to fill the gap by paying for drugs in one of four ways: paying for enrollment in a Medicare HMO, paying for Medigap insurance benefits, qualifying for Medicaid benefits, or paying out-of-pocket.<sup>11</sup> Medicare HMOs and Medigap plans are often too costly, and Medicaid requirements too stringent. As a result, more than one-fourth of all Medicare recipients have no prescription drug benefits,<sup>12</sup> and are faced with the most costly option of paying for drugs out-of-pocket.

In 1965, when prescription drugs were a relatively small part of overall healthcare costs not typically covered by private insurance plans, it went virtually unnoticed that Medicare did not cover outpatient drugs.<sup>13</sup> Today, however, the lack of a prescription drug benefit is perceived to be a critical missing piece in Medicare.<sup>14</sup> A pharmaceutical industry source in Massachusetts remarks:

Pharmaceuticals are about 10 percent of healthcare spending, but they are probably about 70 percent of the cure. We're doing most of the curing, and in the future, that's probably going to be more the case. To have a Medicare program not cover what is the real future of healthcare is absurd.<sup>15</sup>

The problem has grown as drug costs have continued to rise dramatically in the past decade, forcing private insurance plans to scale back coverage. In a report prepared for President Clinton in 2000, the U.S. Department of Health and Human Services found that most sources of drug coverage for both the Medicare and non-Medicare population are unstable. Even more disturbing, the report finds that individuals without drug coverage and those who pay cash at the retail pharmacy pay a higher price than the total price paid on behalf of those with drug coverage.<sup>16</sup>

### ***The Expanding Pharmaceutical Industry***

Last year, a survey was done, and the pharmaceutical industry came out as the most hated industry in the United States — over the tobacco companies, which seems just obscene. Drugs do save your life.

— Martha Morkan, Citizens Health<sup>17</sup>

The escalation of prescription drug costs was not an overnight occurrence. In fact, in 1974, author Victor Fuchs indicated that he saw the early stages of a prescription drug crisis simmering. In his book, *Who Shall Live*, Fuchs wrote that the drug industry, on the surface, appeared consumer-friendly because it was not as highly concentrated as some of the nation's other industries, such as auto manufacturers and the steel industry.<sup>18</sup> Fuchs pointed out that the drug firms' highly specialized output, even in 1974, was troubling. "Major product categories like antihistamines, anti-infectives, tranquilizers, cardiovascular preparations, gastrointestinal preparations cannot compete with one another for sales the way that Chryslers compete with Chevrolets."<sup>19</sup> As a result, it was easy for drug firms to fix prices, and the lack of competition across product types allowed the drug industry to maintain a higher profit margin than other kinds of firms.<sup>20</sup>

At the time Fuchs was writing, critics were calling for more regulation in the drug industry, but the drug firms argued that price limits would impede research. In a criticism that mirrors those that are mounted against the drug industry today, Fuchs wrote that while drug costs had remained relatively stable, only a small portion of drug costs actually went toward the materials and research to produce them.<sup>21</sup> Another disturbing trend was the industry's inconsistent pricing: the prices charged by drug firms to pharmacies ran 500 percent higher than the prices charged to hospitals. The discrepancy was due to the hospitals' greater leverage in negotiating prices and their ability to test drugs for quality and safety.<sup>22</sup>

In the last two decades, many of Fuchs's warnings about the rise in prescription drug costs and the effects of Medicare's failure to provide drug coverage to its beneficiaries have been realized at levels that even Fuchs likely never imagined. As more and more lifesaving drugs and therapies are developed, overall pharmaceutical costs are skyrocketing, placing the possibility of a Medicare prescription drug benefit even further out of reach. The drug industry source remarks, "It's a Catch-22, that we're producing all of these new drugs, and they're not covered. So people have to pay cash, and can't afford to get them, which is a genuine public policy dilemma that ought to be solved."<sup>23</sup>

The drug industry argues that there are legitimate reasons for the rising costs. Pharmaceutical companies say that today's costs are the result of private sector

laboratories being chiefly responsible for the development of breakthrough drugs.<sup>24</sup> The drug industry says it has produced effective drugs, and the high prices are simply reflective of high value. Price controls or any other limiting drug-cost policies, they argue, would serve only to reverse the progress the industry has made in its research. The industry contends that high prices in America are also a way of offsetting the losses suffered in countries where price controls are in effect.<sup>25</sup> The same Massachusetts drug industry source points out that Europe used to be the “hub of the pharmaceutical industry.” Price controls in those countries and in Canada have hindered research there, leaving Americans to foot the bill.<sup>26</sup> “Americans are paying for the [research and development], and the Canadians are freeloading off of us,” said the source. Despite these industry claims, the pharmaceutical industry realizes an average 18.6 percent return on revenues, while most other industries’ profit margins range from 0.5 to 12.1 percent.<sup>27</sup>

Even given the inflated profit margins enjoyed by drug firms, lawmakers have been reluctant to rein in the industry. Government watchdog groups contend that this reluctance is because of the power and the money wielded by the drug industry lobby. Since 1993, the drug industry has made over \$33.4 million in campaign donations. Lobbyists contribute to both Democrats and Republicans, with roughly 73 percent of the industry’s campaign money going to Republicans.<sup>28</sup> Drug firms have hired 297 lobbyists, which equals one lobbyist for every two members of Congress. The drug industry argues, however, that these lobbying efforts have little impact on public policy decisions. “When politicians see a good issue, they run with it,” said the drug industry source. “They don’t say ‘who are my contributors,’ they say, ‘who are the voters and where should I go with them.’”<sup>29</sup>

While drug firms try to justify rising prescription drug costs by citing the importance of ongoing research, critics question the basis of that claim, arguing that most drug research is publicly funded.<sup>30</sup> Studies prove that research funded by the public sector is responsible for the most medically significant advances that have led to new treatments of disease. Fifteen of the twenty-one drugs considered to have the highest therapeutic value developed between 1965 and 1992 and most cancer and AIDS drugs were developed as a result of taxpayer-funded research.<sup>31</sup> Industry critics say that the government develops the initial drug technology, transfers it to private corporations for drug development, and then loses all control of pricing. To rectify this problem, Representative Bernard Sanders of Vermont has sponsored legislation that would restore “reasonable pricing” clauses on government-funded research.<sup>32</sup> The drug industry charges that these claims are simply attempts to discredit its research. “They really want to discredit our industry,” says the drug industry source. “They have to discredit our research because there are people who do great things in our labs—and they’re voters.”<sup>33</sup> The source acknowledges that the government does fund “great research,” he says that it is also very basic and inexpensive research.<sup>34</sup>

While policymakers and scholars may differ about how to rectify the problem of rising prescription drug costs, there seems to be some general consensus on why drugs have become so costly. Most studies show that the rise in prescription drug costs is owing more to an increased demand for prescription drugs, than increased costs of the drugs.<sup>35</sup>

What’s rising is the number of drugs out there, and the number of people taking them. Utilization is growing greatly, and that’s what’s driving the cost, not the actual price. That’s why in some respects, a lot of the attempts to simply force down the price aren’t going to do anything about the basic problem; that is, more and more people are relying

on prescription drugs. People who may have taken one prescription ten years ago are now taking three or four.<sup>36</sup>

Since 1990, U.S. spending on prescription drugs has more than doubled. As more and more insurance plans expanded prescription drug coverage in the 1990s, the demand for prescription drugs increased, and the number of prescriptions written per patient rose significantly. Prescription drug use has also shifted toward newer, more costly brand-name products, a trend that some attribute to the permissive regulations of direct-to-consumer advertising.<sup>37</sup>

### ***The Effects on Seniors***

While the repercussions of high drug costs are felt throughout the American population, the group that has been hardest hit is senior citizens. The nation's elderly now spend more on medicine than on doctors' bills,<sup>38</sup> and they are less likely than the rest of the population to have prescription drug coverage. Studies show that only about half of Medicare beneficiaries have drug coverage, and most sources of coverage are insecure.<sup>39</sup> Beneficiaries who have drug coverage through Medicare+Choice plans are facing increased cost sharing as insurers lower the caps on annual drug expenses and shrink drug benefits. The high cost of drugs has also forced employers to lessen the benefits offered to their retirees.<sup>40</sup>

The result is that the nation's elderly are struggling to find ways to pay for the drugs they need, or, in some cases, forgoing their drug treatments altogether. In his testimony before Congress in February 2000, Dr. Alan Sager, Professor of Health Services at the Boston University School of Public Health, reported that 17 percent of Americans and 42 percent of uninsured Americans have reported not filling prescriptions for financial reasons.<sup>41</sup>

Senior citizens in particular have grown increasingly creative in their efforts to seek out discounted prices on the drugs they need. A growing number of seniors are hopping on buses and trekking across the U.S. border to Canada, where price controls keep drug prices at more affordable levels. Seniors who go to Canada are able to buy the drugs they need at prices that are 30 to 70 percent less than in the United States.<sup>42</sup> But the drugs that are available in Canada are limited, says the drug industry source who points out that he's seen seniors hop off the bus in Maine to buy their chemotherapy pills because they simply aren't available yet in Canada.<sup>43</sup> It took one breakthrough Alzheimer's drug four years after it went on sale in the United States to become available in Canada. "If you have Alzheimer's, you don't have that long," the source said.<sup>44</sup>

For those seniors who don't take the bus rides, many are finding the Internet to be a valuable tool for finding lower drug prices in Canada. In August 2001, the *Boston Globe* told the story of Isaac BenEzra, seventy-five, who has traveled to various senior citizen centers across Western Massachusetts and taught hundreds of seniors how to place their drug orders with Canadian Internet pharmacies. BenEzra has also reached out to doctors, persuading them to write prescriptions for their patients and fax them directly to CanadaRX.<sup>45</sup> While buying online can help seniors save money on drugs, the practice is not entirely safe, or legal. While there is little the government can do to enforce them, there are laws on the books that prohibit buying drugs from sites outside the United States. The FDA warns that seniors are putting themselves at risk when they buy drugs online, and could wind up receiving drugs that are contaminated or counterfeit.<sup>46</sup> Other industry experts point out that when seniors purchase drugs on their own they are putting themselves in danger.

With many seniors today visiting a number of different physicians to treat different conditions, there is often no single pharmacist or doctor to gauge dosages or potential drug interactions. Martha Morkan, Director of Marketing and Community Outreach for Citizens Health, points out, “One hundred thousand seniors die every year because of poly-pharmacy, and it’s because they don’t have one single place that tracks the drugs they’re taking.”<sup>47</sup>

### ***Potential Solutions***

While many scholars contend that the federal government could ease the burden of rising drug costs for seniors by simply expanding Medicare to include prescription drugs,<sup>48</sup> the cost of such a program, with drug costs at their current levels, makes it extremely difficult for lawmakers to create a cost-effective plan to do so. In fact, simply expanding Medicare to include a drug benefit would only serve to boost the demand for drugs at their current prices.<sup>49</sup> In order to keep a Medicare drug benefit affordable, the government would need to find a way to regulate the costs of drugs.

Many argue that the federal government, which is able to purchase drugs at discounted rates for veterans, the military, and Medicaid programs, could buy prescription drugs at the same rates for Medicare recipients.<sup>50</sup> Such a plan could have a significant impact on private insurers, however, as drug companies would look for ways to make up for the reduction in profits they would incur if the government expanded their bulk-purchasing efforts. In addition, a sweeping government bulk-purchasing plan would be perceived by the drug industry as a huge step toward government price controls, something one industry source says “would be the death of the industry.”<sup>51</sup> Still, other nations are using price controls to keep drug costs down for their citizens, and the United States may look to them for models for reform. The pharmaceutical industry, however, remains steadfast in its argument that such a measure would drastically harm research, a weighty claim that will require the government to proceed cautiously.<sup>52</sup>

Careful U.S. action is vital to protecting and promoting research. Unlike other nations, and unlike some U.S. states, the United States government cannot simply cut drug prices without regard for the cuts’ effects on research. Because we buy so great a share (and an increasing share) of the world’s brand name drugs, the world’s drug makers rely on the U.S. market for a disproportionate share of their profits and the dollars they require to finance research.<sup>53</sup>

### ***Divided Along Party Lines***

While many policymakers, both Republican and Democrat, are unified in their opposition to price controls, the two parties do differ, at least at the national level, on how the government might enable the nation’s elderly to get their prescription drugs affordably. Most Democrats prefer an expansion of the Medicare program to include prescription drug coverage. Most Republicans, though, believe Medicare should give subsidies to private health plans to provide drug coverage.<sup>54</sup> Contrast between the Democratic and Republican approaches was brought sharply into focus during the 2000 campaign for President. While on the campaign trail, George Bush and Al Gore each pushed a dramatically different plan for making drugs affordable for seniors.<sup>55</sup> Gore proposed spending \$253 billion over ten years to expand Medicare to include a prescription drug benefit. Bush’s plan, which carried a smaller price tag of \$158 billion over ten years, offered a smaller prescription drug subsidy than Gore’s, but allowed seniors to seek drug coverage from private plans. While critics have



argued that the private market is too unstable for seniors to rely on it for affordable drug coverage, Bush argued that private insurers would be forced to compete by offering a variety of plans for seniors to choose from.<sup>56</sup> The Bush plan ignored the fact that Medicare beneficiaries who are already trying to fill the current prescription drug gap by enrolling in additional plans are either finding their coverage inadequate or unaffordable.<sup>57</sup>

Healthcare experts appear to be watching closely to see what President Bush's next move will be on the prescription drug issue. In recent months, Bush has pushed a plan that would promote the use of drug discount cards by Medicare beneficiaries, a plan that the President says will result in savings as high as 40 percent on prescription drug purchases. Certain insurers and companies that manage drug benefits would ultimately pay for the plan. They would sign up to offer discount cards in exchange for gaining experience and information about drug use among senior citizens. Democrats have argued, however, that the plan would not provide significant savings for seniors; they accuse Bush of using the discount card strategy to avoid the addition of drug costs to Medicare benefits.<sup>58</sup>

In January 2002, President Bush proposed spending \$190 billion over the next ten years to improve Medicare coverage and provide prescription drug coverage to senior citizens. The plan, which also includes an increase in Medicare payments to health maintenance organizations to keep HMOs from exiting Medicare, calls for the federal government to pay for 90 percent of prescription drug costs while the states pay for the remaining 10 percent. The plan would also allow states to run programs that would provide Medicaid coverage solely for prescription drugs. Lawmakers from both parties challenged Bush's plan, claiming that the total price tag would have to increase by at least 50 percent to cover the costs. Bush's plan also focuses on providing drug benefits solely for low-income seniors, while most lawmakers are pushing for drug coverage for all Medicare beneficiaries.<sup>59</sup>

### ***The States Respond***

While the debate over how to implement a Medicare prescription drug benefit has stalled on Capitol Hill, states have been pressed to implement programs that will fill the prescription drug coverage gap. While national leaders may have been able to turn a deaf ear to the calls from senior advocates and delay action on the prescription drug issue, state and local leaders, who are closer and often held more accountable to their constituencies, have not. While all state governments have been forced to pay for prescription drugs on a broad scale through Medicaid programs, many have taken their coverage a step further by adding pharmacy programs to address the needs of those who do not qualify for Medicaid but still cannot afford to pay for prescription drugs.<sup>60</sup> This is a segment of the population that the federal government simply has not been able to reach yet.

According to the National Conference of State Legislatures, twenty-eight states have passed some form of pharmaceutical assistance law, while three states are addressing the issue through executive agency initiatives.<sup>61</sup> While states are using a variety of approaches to meet the prescription drug needs of their constituents, most are committing state funds to cover at least a portion of the costs of residents who meet specific criteria. Some states are experimenting with various forms of price controls and bulk-purchasing while others are working to extend Medicaid drug prices to more seniors.<sup>62</sup> Some states are offering cost-sharing programs that require enrollees to help cover costs through co-payments, annual fees, or monthly

thresholds, and a handful of states are experimenting with drug discount cards. While most states are developing programs to help only low-income individuals, others, including Massachusetts, are boldly aiming to assist all seniors who are uninsured.<sup>63</sup>

Their distance from the direct influence of the drug industry has allowed states to be more ambitious in the plans they develop. As Professor Alan Sager points out, “States can act to cut drug prices without worrying about the consequences for research. The federal government cannot do so.”<sup>64</sup> Even states that offer the most comprehensive coverage, acknowledge that state programs are simply “stopgap” measures that will hold the line only until the federal government passes a prescription drug benefit.<sup>65</sup>

New England, in particular, has been a hotbed for prescription drug policy. The state of Maine has been the most aggressive in its efforts to reduce prescription drug costs for residents. The “Maine Rx” program — which aims to provide reduced drug costs for residents who are at or below 300 percent of Federal Poverty Level (FPL) and have no prescription drug coverage — offers reduced drug prices by negotiating rebates from manufacturers. (FPL for single persons is \$8,590; for a family of 2 it is \$11,610; for a family of 3 it is \$14,510; and for a family of 4 it is \$17,650.) Though the implementation of this program has been stymied by lawsuits from the drug industry, the courts have upheld the legality of the program and policymakers are optimistic that the plan will yield significant savings for the uninsured.<sup>66</sup> In 2001, Maine joined New Hampshire and Vermont to form a tri-state buying pool, which aims to cut state drug costs by aggregating the Medicaid drug purchases of the three states.<sup>67</sup> Senior advocates are praising the states for their innovation in tackling the prescription drug issue.

It will be really interesting to see which approaches end up being the most beneficial. In every state right now, their efforts are laudable, because they are thinking of different ways to take on this one issue. We’re happy to see states are trying to take on this issue.<sup>68</sup>

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## **Solving the Problem at the State Level: The Massachusetts Strategy**

### ***Early Attempts***

In the last decade, the Commonwealth of Massachusetts has been relatively progressive in its approach to making drugs affordable for seniors and the disabled. As prescription drug costs have continued to rise, the Commonwealth has responded by implementing laws and programs that have grown incrementally more and more aggressive over the years. In 1994 the Commonwealth enacted the Medicare Supplemental Insurance law. The law required that all health insurers that offered Medigap<sup>69</sup> products offer at least one plan that included unlimited prescription drug coverage. In addition to increasing coverage for needy seniors, the law was designed to “level the playing field” for all insurers that were sharing in the Medicare Supplemental Market, so that no single insurer would be forced to bear the brunt of high-cost enrollees. By 1998, approximately 61,000 Medicare beneficiaries in Massachusetts were enrolled in Medicare HMO-plus plans.<sup>70</sup>

Despite this law, there was still a segment of the senior population that was falling through the cracks where prescription drug coverage was concerned, and that was the Medicare population that couldn’t afford to pay the premiums associated with

Medicare-plus plans.<sup>71</sup> To assist these individuals, the Legislature in 1996 created the Senior Pharmacy program. Termed the “Montigny/McDonough Act” after the bill’s sponsors, Senator Mark Montigny and Representative John McDonough, the bill increased the tobacco tax to subsidize a drug program for low-income seniors. It was the first totally state-subsidized program in Massachusetts, which made it very much on the cutting-edge for that time.<sup>72</sup>

To start, the program provided up to \$500 annually in prescription drug coverage for seniors who were 133 percent of FPL. As drug costs continued to rise, the program was expanded to reach more people and offer more coverage. In fiscal year 1998, annual coverage was boosted to \$750 annually for seniors who were 150 percent of FPL, and in fiscal year 1999, annual coverage was increased to \$1,250 for seniors who were 188 percent of FPL. As a result, enrollment in the Senior Pharmacy Program nearly doubled from 18,500 in 1997 to 33,200 in 1999.<sup>73</sup>

### ***Prescription Drug Costs Hit the Commonwealth Hard in 1999***

A change in federal law in 1997 had enormous implications for the need for comprehensive prescription drug coverage in Massachusetts. “Medicare + Choice” Medicare reform provisions in the Balanced Budget Act of 1997 prohibited the Commonwealth from requiring Medicare HMOs to provide the unlimited drug benefit option.<sup>74</sup> As a result, on January 1, 1999, Medicare HMOs in Massachusetts drastically reduced their drug benefits, replacing unlimited benefits with caps on annual coverage ranging from \$300 to \$800 per year.

That created an environment where...people no longer had unlimited options for coverage for drugs. What that created was an aggressive ramp up or an aggressive benefit for the pharmacy program that was in place at the time. That really defined, at least for the state, the problem.<sup>75</sup>

It quickly became clear to Massachusetts lawmakers that the existing Pharmacy Program would have to be expanded, and quickly. In June 1999, Senate President Tom Birmingham proposed that the state double its funding for the Pharmacy Program, in turn raising the yearly cap on an individual’s benefits from \$750 to \$1,250 annually. The program would also be expanded to include a Senior Pharmacy Plus plan, which would allow seniors up to 500 percent of FPL to receive unlimited coverage for catastrophic drug costs.<sup>76</sup> The plan was implemented, and in fiscal year 2000, enrollment spiked to 67,000 in the Senior Pharmacy Program plus an additional 8,190 individuals who were enrolled in the Senior Pharmacy Plus Program.<sup>77</sup>

With more and more seniors seeking refuge from skyrocketing prescription drug costs under the umbrella of the state Pharmacy Program, lawmakers found themselves searching for new and innovative strategies through which they could provide some relief. Their search ultimately led them to consider two very different approaches for crafting a cost-effective solution to what had become a very political, and highly charged, public policy problem.

### ***The Battle of the Two Plans: Joe Kennedy vs. Teresa Heinz***

After spending twelve years in Congress, Representative Joseph P. Kennedy II knew that Congress was not ready to address the issue of rising prescription drug costs when he returned to Massachusetts in 1998. This notion prompted him to launch a comprehensive study of how to deal with the problem at the state level. Building on his experience in running Citizens Energy, which provides heating oil to low-income individuals by purchasing it in bulk, he began to explore the feasibility of a bulk-

purchasing plan for prescription drugs. The savings generated by buying drugs in bulk, Kennedy figured, could be passed along to the people of Massachusetts who were unable, at that time, to obtain drugs affordably.<sup>78</sup>

The Commonwealth of Massachusetts was already purchasing drugs on the behalf of a number of groups including the Pharmacy Program members, state employees, Medicaid beneficiaries, prisoners, and public hospitals. What Kennedy couldn't reconcile was, why were all of these purchases made separately?

Thousands of people in Massachusetts have their drugs purchased by the Commonwealth on their behalf, but there's no single entity that buys drugs for all of those people. Joe said, "If you put all those people together, you can really leverage some lower prices. And if you take that lower price and you extend it to anybody who doesn't have insurance, you can really make a huge difference in those people's lives."<sup>79</sup>

Kennedy took this concept of bulk-purchasing to Massachusetts lawmakers and encouraged them to establish it as state law. Senator Mark Montigny, Chairman of the Senate Ways and Means Committee, was particularly supportive of the idea and worked with Kennedy to mold the concept into a policy initiative. During the FY2000 budget discussions, Montigny and Kennedy drafted a prescription drug bulk-purchasing program for the state. The bill (an outside budget rider) called on the Administration to release a Request for Proposal (RFP) for a contract to aggregate the drug purchases of Medicaid, the Group Insurance Commission,<sup>80</sup> the Department of Elder Affairs, and the Department of Public Health. The proposal became law in November 1999, as Section 271, chapter 127, of the Acts of 1999 (see Appendix B). The Executive Office of Administration & Finance was allotted sixty days to research the proposal and draft the RFP for the contract to administer the program. Despite several assurances from the Administration that the project was being studied, the RFP was never drafted.<sup>81</sup>

### ***Teresa Heinz Pushes the HOPE Plan***

While Joe Kennedy was lobbying state leaders to implement his bulk-purchasing program, another very powerful name in politics had gotten their ear as well. In 2000, Teresa Heinz, the wife of Massachusetts U.S. Senator John Kerry, was encouraging the state's policymakers to adopt a prescription drug program crafted by the Heinz Family Philanthropies, a private foundation that she chairs. The Heinz Plan to Overcome Prescription Drug Expenses, or the HOPE plan, laid the groundwork for a state-run insurance program that would be offered to all 860,000 senior citizens (age sixty-five and over) in Massachusetts, as well as low-income disabled individuals.<sup>82</sup> Heinz unveiled the plan to the public on April 5, 2000, announcing that she was pursuing the initiative in honor of her late husband, Senator John Heinz. Heinz, who pushed for prescription drug coverage for seniors while serving in the U.S. Senate, died in 1987.<sup>83</sup>

The HOPE plan was billed as "budget-neutral," requiring the state to maintain funding at the present levels committed to the Senior Pharmacy and Pharmacy Plus programs.<sup>84</sup> This feature was one of the plan's four guiding principles:

- Comprehensive drug coverage
- Responsible access to all prescription drugs
- Affordability
- Budget neutrality for the Commonwealth<sup>85</sup>

The HOPE plan was built on an insurance model, requiring members to pay annual deductibles, premiums, and drug co-payments. It differed from a traditional insurance plan for low-income members in that the state would subsidize deductibles and premiums. Rates for higher-income members would be set according to their income categories. The plan aimed to provide members with access to all prescription drugs “through a balanced cost share and incentive formulary.” It would require the state to contract with a Pharmacy Benefits Manager (PBM) that would provide administrative and management services at reduced costs.<sup>86</sup> It also included an annual cap of \$3,000 on out-of-pocket spending to protect members from incurring catastrophic drug costs, which, policymakers say, may have been one of the plan’s most attractive features:

It was originally designed, if you look at the original HOPE program, as a catastrophic plan. It was really for people who had high costs, astronomical costs, to buy a product that would protect them from these really expensive drug costs.<sup>87</sup>

Similar to a private insurance plan, HOPE’s success would be contingent upon the mix of individuals who enrolled in the program. If implemented, then low-income seniors, who were previously receiving drug coverage under the state’s Pharmacy Program, would not be required to pay premiums and deductibles. Their costs would be offset by seniors at higher income levels, who would pay monthly premiums and annual deductibles. Premium and deductible rates would be set according to individual income levels. The Heinz Family Philanthropies pointed out that attracting the right mix of low-risk and high-risk members would require the state to advertise the program, so that middle-class and higher income seniors would be encouraged to buy coverage.<sup>88</sup>

The Massachusetts Legislature took a good hard look at the Heinz plan, and ultimately decided that it was an initiative worth pursuing. It was imperative, though, that policymakers proceed cautiously. No state had launched an insurance program like the HOPE plan, so there were no examples for Massachusetts lawmakers to follow as they drafted the legislation that would eventually make the HOPE plan law. “This was revolutionary,” said a Prescription Advantage administrator.<sup>89</sup>

The HOPE plan was generally well received by senior advocates and the media, including the *Boston Globe*, which wrote in an editorial, “Elders would no longer have to fear the prospect of drug bills without limit if they contracted a chronic disease.”<sup>90</sup> Opposition to the plan included some major players in the pharmaceutical industry, who wouldn’t support the plan because it was going to be run by a PBM, which meant that some drugs would be restricted or cost more than others.<sup>91</sup> For the business community, the plan raised other concerns. Jon Hurst of the Massachusetts Retailers Association spoke out in a letter to the editor of the *Boston Globe*, expressing concern over another of the plan’s aspects, which was the promotion of mail-order drug services for members. Hurst warned that “this proposal will damage not only community pharmacies but also the health and convenience of elderly consumers.”<sup>92</sup>

The final product that came out of legislative committee was far from an exact replica of the HOPE plan that Heinz had proposed. “[It passed] with what I think would be minor changes, but they think they are major,” Tom Dehner of Senator Montigny’s office recalls.<sup>93</sup> One of the key changes involved protecting those enrolled in the existing Senior Pharmacy Program. Senior advocacy groups and many lawmakers were concerned that the Heinz proposal would actually be more costly for those seniors. “The Senate, and advocates like the Massachusetts Senior Action

Council, fought hard to protect low-income seniors from increased costs, in the form of co-payments, premiums [and the like],” Dehner says. Senator Montigny, in particular, fought to make sure that all of those who were enrolled in the Senior Pharmacy Program would be included in the new plan at a very low cost.<sup>94</sup> The other major change to the Heinz proposal in terms of coverage was a lower cap on annual out-of-pocket expenses. While the HOPE plan had recommended a cap of \$3,000 on annual expenses,<sup>95</sup> the final version of the plan that came out of the Legislature set the cap at \$2,000.<sup>96</sup> Changes intact, Governor Cellucci signed the plan into law in July 2000.<sup>97</sup> It was eventually named Prescription Advantage. The statute called for the program to be implemented in concert with Section 271.<sup>98</sup>

### ***Section 271 Under Fire***

The arrival of the Heinz proposal changed the entire landscape of the prescription drug debate in Massachusetts, and it galvanized what had become mounting opposition to Section 271. From the moment it passed as an outside section of the budget in November 1999, Section 271 faced strong opposition from three groups that have powerful voices on Beacon Hill: patients’ advocacy groups, pharmaceutical companies, and the biotechnology industry.

The criticism from the pharmaceutical industry stemmed from the idea that aggregating the drug purchases of so many different groups would require the state to contract with a PBM. In order for the PBM to negotiate the promised discounts, the state would likely have to restrict access to a large number of important drugs. A drug industry source recalls:

Under the Section 271 law, their goal was to put all of these people under one PBM, and what they were talking about was savings of 30 to 40 percent. . . . I know the business, we’re the manufacturers, we deal with it every day. In order to achieve a 30 or 40 percent discount, you’d have to exclude large numbers of drugs that were available. Otherwise, manufacturers would have no incentive to give you that price. . . . They trade a price reduction for a certain market share, that’s the way it works.<sup>99</sup>

This scenario sent shockwaves throughout the pharmaceutical and biotechnology industries in Massachusetts. Representatives from both industries began lobbying Beacon Hill heavily to drop the Section 271 proposal. Both groups painted bleak pictures of what the prescription drug situation would look like if Section 271 were implemented, and patient advocacy groups became concerned that their constituents would lose access to the drugs that they need.

In letters to Governor Cellucci and state legislators, patient advocates sharply criticized Section 271, charging that its implementation would restrict access to important drugs. In December 1999, members of the Washington-based Kidney Cancer Association held a press conference at the State House to express their fear that the implementation of Section 271 would restrict access to many FDA-approved drugs, substituting less expensive drugs in their place.<sup>100</sup>

The biotechnology industry, a powerful lobby on Beacon Hill,<sup>101</sup> also flooded the Cellucci Administration with letters opposing Section 271. They argued that the initiative was a step toward “price controls,” which if implemented would ultimately obstruct research and development efforts. The pharmaceutical industry funded a study that highlighted a number of issues for the Secretary of Administration and Finance to consider before implementing Section 271. The report, prepared at the request of the Pharmaceutical Research and Manufacturers of America, raised concerns about administrative costs, the scope of coverage, and methods of drug

distribution under 271.<sup>102</sup> The study warned the Administration to be mindful of the potential impacts that Section 271 would have on pharmacies and HMOs in the Commonwealth. It also raised the point that the Commonwealth, if it were to assume the role of purchaser and distributor of drugs, could open itself up to potential lawsuits in the cases of labeling errors and delivering or filling the prescriptions for much-needed drugs.<sup>103</sup> Also, since Section 271 would extend drug coverage to both the uninsured and the “underinsured,” the study points out that the Administration would have to define exactly who the “underinsured” were.<sup>104</sup> The PhRMA study, like the biotechnology industry, raised the issue of how the state would maintain the quality of prescription drug benefits through contracting with a PBM.<sup>105</sup>

The PBM restrictions were not the only aspects of Section 271 that provoked criticism. Members of the business community expressed concern that Section 271 would result in cost increases for private insurers, forcing Massachusetts employers to cut benefits. Jon Hurst of the Massachusetts Retailers Association, as he did with the Prescription Advantage Program, expressed concerns that the plan would contract with mail-order pharmacies, which could harm relationships between pharmacists and consumers and ultimately result in lower quality healthcare. The Massachusetts Taxpayers Foundation charged, “Enacting this proposal could result in the loss of federal Medicaid rebates and could increase costs by promoting adverse selection.” Critics of 271 were well-organized and relentless in their efforts to thwart the implementation of this plan.

### ***Criticism Directed at Kennedy***

Despite the mounting opposition to Section 271, Joe Kennedy was steadfast in his efforts to persuade lawmakers to implement the bulk-purchasing plan. At a public forum in March of 2000, Kennedy expressed his frustration with the Administration’s failure to implement Section 271, and singled out drug-makers as the primary reason. “We could solve this problem overnight,” Kennedy said, “but the problem is there are interests in our state and our country that make money selling drugs at high prices.” Senator Montigny, who had joined Kennedy in prodding state lawmakers to implement the initiative, was also growing frustrated because the bulk-purchasing program was being ignored.<sup>106</sup>

The plan’s critics continued to press on, with some charging that Section 271 was passed quietly and was not subject to public hearings:

The way the legislation was passed was not the way legislation should be passed. It was slipped into the budget and it was signed. There were not hearings on it. There was not a great deal of process to closely examine what the issues were. [Had there been,] people would have understood the practical difficulties of implementing something like that and the dangers of implementing something like that.<sup>107</sup>

Kennedy and Montigny did hold a public forum on the issue, after the initiative had passed, in March 2000. During that forum, Kennedy laid out two options for the state:

- The state could expand its current contract with Express Scripts,<sup>108</sup> to aggregate drug buying for the state.
- The state could procure a contract for aggregate buying at a lower cost by putting it out to bid.

Trevor Hughes of the *Statehouse News Service* wrote about the forum: “While the forum was intended to gather public input on the plan, after about an hour, only Kennedy and Montigny had spoken.”<sup>109</sup>

Some of the criticism surrounding Section 271 was directed at Kennedy personally. Several published reports suggested that Kennedy was pushing the plan because his nonprofit company, Citizen’s Energy, could ultimately bid on the contract to administer the program. In his letter to Governor Cellucci, Jon Hurst wrote:

This language appeared out of nowhere — it did not exist in either the House or the Senate passed budgets, nor did it exist as a stand-alone bill. Thus no hearings, floor debate, or public scrutiny whatsoever has occurred on this proposal. Reportedly a proposal of former congressman Joe Kennedy of Citizens Energy, this section makes the Commonwealth (through a nonprofit entity like Citizens Energy) a socialized purchaser of prescription drugs for an undetermined number of residents of the state.

The idea that Kennedy was pushing the plan because he had an interest in winning the contract was also mentioned in a *Boston Globe* editorial that called on the Cellucci Administration to implement the plan: “Kennedy acknowledges that Citizens Energy would earn a fee from this work that might total \$1 million.”<sup>110</sup>

Kennedy’s battle with the Administration grew even more complicated when the Group Insurance Commission (GIC) signed a new contract with Express Scripts, making the implementation of Section 271 even more difficult.<sup>111</sup> Unless the state threw out the new GIC contract, 60,000 state employees, retirees, and their families would now have to be excluded from Section 271 if it were implemented.<sup>112</sup> But if it scrapped the contract, the state risked facing a \$10 million lawsuit. Despite these potential consequences, in a story that landed on the front page of the *Boston Herald*, Kennedy called on the state to scrap the \$375 million prescription drug contract. He argued that excluding GIC members would dramatically reduce the impact of Section 271 because the number of people for whom the state would buy drugs would be far smaller, thus reducing the state’s ability to negotiate discounts. Kennedy’s critics responded by alleging that Kennedy only wanted the initiative to be implemented so he could get the business for himself. The *Herald* cited unnamed sources who accused Kennedy of lobbying for the program in such a way that would position Citizens Energy to win the job of marketing the bulk-purchasing plan to poor seniors. Kennedy staunchly denied that criticism:

You have to be able to go out and create relationships and identify the poor and [other people] who would be eligible, Kennedy told the *Herald*. It’s perfectly fine with me if the state wants to open [those services] up [to bidders]. I’m not suggesting in any way that Citizens should get a no-bid contract.<sup>113</sup>

Facing unfaltering opposition from Governor Cellucci’s Secretary of Administration and Finance Peter Forman,<sup>114</sup> Kennedy finally “threw in the towel” on pushing the Administration to adopt his plan but vowed he would not give up on the idea for good: “Now we’ll just move on, do it another way. All we wanted to do was to save millions of dollars in drug costs for the poor.”<sup>115</sup>

### ***Prescription Advantage Provides an Alternative***

Further exacerbating Kennedy’s efforts for action on Section 271 was the ease with which Teresa Heinz’s HOPE program was embraced by the Cellucci Administration and the Legislature. After the HOPE plan was signed into law in July 2000, she was successful in persuading Governor Cellucci to delay the implementation of Section



271 while the Heinz Family Philanthropies researched the potential impact of both programs being implemented simultaneously. Heinz argued that she wanted to determine whether the implementation of Kennedy's plan would increase adverse selection<sup>116</sup> in the HOPE plan, prompting Cellucci to agree to put Section 271 on hold.<sup>117</sup> Joe Kennedy did not blame Heinz for stymieing his plan, but lashed out at the pharmaceutical industry instead. Brian O'Connor, spokesman for Citizens Energy charged:

Here in Massachusetts, [pharmaceutical companies] have lobbied successfully to postpone implementation of the drug price-discount law, which would secure for ordinary people the kind of price cuts now available to only the biggest customers. Further delays will only serve to allow the pharmaceutical companies to continue getting away with charging the greatest number of people the highest possible prices for the longest possible time.<sup>118</sup>

The HOPE plan provided lawmakers with an easy alternative to Section 271. While 271 sparked letters of protest from powerful sources like the biotechnology industry, patient advocates groups, and business associations, the HOPE plan, particularly after the Legislature tinkered with it, did not come with as much baggage. "Patients liked it, seniors groups came out in favor of it, patient advocate groups liked it, so the politics were cleaner and easier, I think, in getting the Heinz plan passed."<sup>119</sup>

While pharmaceutical companies were not entirely supportive of the plan because of concerns over the limitations of the Prescription Advantage formulary, the biotechnology industry embraced the plan enthusiastically. Its support became particularly overt once the industry's lobbyists were successful in persuading legislators to assure that the industry's drugs would be fully covered under the plan.<sup>120</sup> The industry's support was also likely rooted in the idea that it had more to lose if a price control initiative like Section 271 were pursued, because the drugs the biotechnology industry makes are extremely expensive.<sup>121</sup> "The industry succeeded in stripping a provision that would have kept high-cost 'non-preferred' drugs, such as those biotech companies are now bringing to market, from counting toward the cap on out-of-pocket expenses."<sup>122</sup> Testifying before the Committee on Health Care in April of 2001, Janice T. Bourque, CEO and president of the Massachusetts Biotechnology Council, congratulated lawmakers on their efforts to implement Prescription Advantage:

In creating the [Prescription] Advantage plan, Massachusetts government has done what the government does best. It has looked out for the interests of one segment of the community – seniors and others with prescription drug needs – without damaging the interests of another segment of the community, the companies that research, develop, and manufacture these same prescription drugs.<sup>123</sup>

A policy analyst in Senator Montigny's office says he was not surprised by the level of support that drug-makers had thrown behind the Heinz plan: "They understood that the way to deflect attention from 271 was to say it would lead to price controls, and to support Prescription Advantage. Someone is getting this \$100 million [appropriation for Prescription Advantage], they're not stupid."<sup>124</sup>

### ***Implementing Prescription Advantage***

On March 14, 2001, only eight months after Prescription Advantage was signed into law, Lillian Glickman, the Massachusetts Secretary of Elder Affairs, laid out the

guidelines for the administration of the program. Eligibility was open to citizens over the age of sixty-five, members of the existing Pharmacy Program, and disabled individuals under sixty-five whose household incomes were less than 188 percent of FPL.<sup>125</sup> The program was not open to citizens eligible for Medicaid. In Glickman's "Emergency Regulations for The Prescription Drug Insurance Plan," she laid out the following guidelines:

- All enrollees will pay co-payments. Enrollees below 200% of FPL pay lower co-payments. All enrollees pay lower co-payments for mail-order maintenance drugs.
- For the plan year beginning April 1, 2001, the full premium will be \$82 per month. Enrollees at or below 188% of FPL will be eligible to have their premiums paid by the Commonwealth. Enrollees above 188% will be eligible to have the Commonwealth pay for some of their premium based on gross annual household income.
- Deductibles will range between \$100 and \$500 per year during the first year. Enrollees below 188% of FPL will have their deductibles paid by the Commonwealth.
- Once an enrollee meets the annual deductible amount, the enrollee will make co-payments and Prescription Advantage will cover the remaining cost. Maximum out of pocket expenses for co-payments and deductibles (excluding premiums) will be the lesser of \$2,000 or 10% of gross annual household income.
- Premiums, deductibles, and co-payments will be reviewed and adjusted annually.
- Prescription Advantage will have a formulary (a list of drugs paid for by the plan). No prescription drug can be excluded from the formulary unless there is a therapeutic equivalent on the formulary.<sup>126</sup>

Billed as the "First in the nation state-backed insurance plan for prescription drugs,"<sup>127</sup> Prescription Advantage opened for business on April 1, 2001.

Prescription Advantage partnered with four other entities to administer the program. Advance PCS was hired to serve as the plan's PBM. The University of Massachusetts was awarded the contract to manage enrollment and customer service for the program. William M. Mercer, Incorporated, which helped design the original HOPE framework, was hired to serve as a consultant for the program. Shandwick International won the contract to do outreach and marketing.<sup>128</sup>

The program's marketing efforts came under fire from lawmakers and senior advocates in the final months leading up to the launch of Prescription Advantage. In March, Glickman was facing criticism from both lawmakers and senior advocates who felt that her office was not doing enough outreach to attract members to the program. By the end of March, just days before the program was due to launch, only fourteen thousand individuals had enrolled in the plan, all of whom were absorbed into the program as a result of their previous membership in the state Pharmacy Program.<sup>129</sup> The launch of a mass media campaign to promote the program was delayed until May 1 — one month after the program's start date, which concerned some legislators and groups like the Massachusetts Senior Action Council, because the plan's success was contingent upon its ability to attract higher income,

healthy members. Because of the plan's slow start, Michael Widmer, of the Massachusetts Taxpayers Foundation, warned that the plan's costs would likely far exceed what had been projected for the year.<sup>130</sup>

Despite the marketing setback, enrollment in the state's Pharmacy and Pharmacy Plus programs was halted mid-March 2001, and Prescription Advantage began on April 1, 2001. For the Executive Office of Elder Affairs, the first priority was to move all of the members in the Pharmacy programs into Prescription Advantage.<sup>131</sup> Senior advocacy groups and local councils on aging notified Pharmacy and Pharmacy Plus members of Prescription Advantage through education and outreach efforts.<sup>132</sup> Members were also notified through the mail.<sup>133</sup> Within the first five months, the state was able to successfully move about 90 percent of Pharmacy Program members into Prescription Advantage.<sup>134</sup> For the remaining 10 percent, a major problem cited was higher costs, as co-payments under the new program were higher than they were under the Pharmacy Program.<sup>135</sup> In addition, some of the members' income levels required them to pay premiums, which did not exist in the old plan. The required premiums and deductibles varied according to eight different income categories, with one being the lowest (members at or below 188 percent FPL) and eight being the highest (household income of \$58,057+). "People really had to look into this program to see how they would fit, based on their income," a Prescription Advantage administrator says.<sup>136</sup>

### ***Is Prescription Advantage Meeting its Goals?***

Because of the requirement that low-income elders from the Pharmacy Program be moved seamlessly into Prescription Advantage, after one year in existence approximately 80 percent of the program's membership resided in the Category one income group. Though these early statistics may have some policymakers worried that only high-cost elders will join the plan, Prescription Advantage administrators were optimistic that the mix of members would change once they moved into the next phase of their marketing plan in the spring of 2002.<sup>137</sup> "The strategy going forward, starting March 1, [2002,] is to attract premium payers. We have to do this aggressively," a Prescription Advantage administrator said.

One of the interesting things that I noted was: during the transition, after October, when we looked at our numbers, the new people that were in the plan, the people that had never been in the Pharmacy Plus or Pharmacy Program, the new people that had joined were about 60 percent category one, and 40 percent were all premium payers. Which told me, at least as an administrator, that, boy, this would have been at least 50 percent non-risk. It would have been closer to an insurance model, where the [premium payers] would be offsetting the costs of [category one members].<sup>138</sup>

While some policymakers feared the Prescription Advantage program would simply become too expensive for the state to afford,<sup>139</sup> administrators say the program has not become the budget buster that many feared it would. "We were projected to spend about \$99 million in fiscal year 2002. I am projecting we'll spend \$80 million," said a Prescription Advantage administrator.<sup>140</sup> Furthermore, while the plan was projected to carry a \$200 million price tag by fiscal year 2003, the program administrator says he expects the total cost to be about \$100 million. He credits the low cost to the three-tier formulary, which consists of generic, select brand name, and additional brand name drugs. The administrator also touts a 24 percent discount on the average wholesale price (AWP) of drugs secured through the

PBM as a key to savings. “Given the fact that you have such a large pool of members in category one who are only paying co-pays, it is significant that our expenditure is so much lower than what was expected. It’s major news,” the Prescription Advantage administrator said.<sup>141</sup>

A year after the launch of Prescription Advantage, 70,000 Massachusetts seniors had enrolled in the program, and senior advocates appeared to be pleased with its performance, at least so far. Jessica Costantino, of AARP Massachusetts, reports that the program is good for seniors because it is affordable; voluntary, it protects seniors from catastrophic drug costs; and is available to everyone. “That’s what’s critical,” Costantino said, “making sure that it is available to everyone.”<sup>142</sup>

For Betty Schmidt, a category one Prescription Advantage member, and Vice President of the Cambridge Chapter of the Massachusetts Senior Action Council, Prescription Advantage has been a savior. Schmidt, a 75-year-old retired waitress, says her Blue Care 65 HMO only covers up to \$600 per year in drug costs or \$150 per quarter. That drug coverage does not go far enough to cover Schmidt’s \$171 monthly cost for her Lipitor prescription (a drug that controls cholesterol). With Prescription Advantage, Schmidt says she only has to pay a \$12 copayment each month for her Lipitor, as well as another \$5 copayment for her Synthroid, a generic thyroid drug.<sup>143</sup>

“If you have to have it — and the doctor told me I’d be taking it for the rest of my life — If you have to have it, and I didn’t have the Advantage, I’d have to pay it,” Schmidt said. “I’d probably have to give up going to the movie, or give up everything to rack up that \$171.”<sup>144</sup>

### ***Renewed Calls for Section 271***

While there seems to be a general consensus that Prescription Advantage has been successful in enabling thousands of seniors to access drugs affordably, Section 271, or similar bulk-purchasing initiatives, have not been ruled out. After Joe Kennedy scaled back his efforts to convince the Commonwealth that Section 271 should be implemented, Senator Montigny continued the fight in the Legislature. The Senate has repeatedly inserted bulk-purchasing initiatives in the FY 2001 and 2002 state budgets as a way to contain the costs of the Prescription Advantage Program, and the House has accepted the plans.<sup>145</sup> Shortly after the Prescription Advantage program was implemented, Montigny warned Acting Governor Jane Swift and House Speaker Tom Finneran that the Prescription Advantage plan would “fail” if it were not integrated with a drug discount-focused initiative.<sup>146</sup> Swift and Finneran were reportedly skeptical of the idea, however, and Montigny was no longer receiving a great deal of support from his colleagues in the Legislature. “There was some discussion among the members about implementing bulk-purchasing, but for the most part, it seemed like Mark Montigny was standing out there in the wilderness,” a Montigny aide said.<sup>147</sup>

While Prescription Advantage was providing drug coverage for seniors, Section 271, if implemented, would have provided drug coverage for the uninsured. “It was a new way of controlling prescription drug costs,” Montigny’s aide said. The initiative could have controlled costs, and provided discounts to the uninsured through a mechanism like a drug discount card.<sup>148</sup> One study, however, sponsored by the biotechnology industry,<sup>149</sup> charged that such a plan would hurt the state’s Prescription Advantage program. The study challenged the premise that Section 271 would actually achieve the promised discounts of 25 percent, and claimed that a Section

271 discount card would only draw participants from the Prescription Advantage Program.<sup>150</sup> The study predicted that Prescription Advantage could lose up to 100,000 participants to a Section 271 discount plan, costing the program between \$5 and \$40 million in lost enrollments. The population most likely to be drawn to Section 271 would be the higher-income individuals that Prescription Advantage was relying on to remain affordable for the state.<sup>151</sup> If this impact were realized, the state, in turn, would be forced to hike its subsidy in order to compensate for the losses.<sup>152</sup> Montigny and Kennedy refuted the findings of the report, pointing out that the study was funded by the drug industry. In a letter to the editor of the *Boston Globe*, the pair wrote:

We believe that an integrated approach will allow a bulk-purchasing discount program and Prescription Advantage to complement one another, with bulk-purchasing strengthening our ambitious new insurance plan.<sup>153</sup>

While Montigny has continued to push the state to aggregate drug purchases, plans for a program aimed to protect the uninsured have been put on hold for now. In the meantime, along with many others, Montigny is watching Joe Kennedy's nonprofit Citizens Health program to see how successful it is in making drugs affordable.<sup>154</sup>

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### **Bypassing the Government: Kennedy Launches Citizens Health**

#### *History of Citizens Energy Corporation*

Joe Kennedy's strategy for making drugs affordable for seniors and the uninsured is a natural extension of his nonprofit Citizens Energy Corporation. A self-described "nonprofit corporation that addresses social concerns through charitable programs and successful commercial enterprises," Citizens Energy has long served individuals who are in need of basic services. Its mission statement is two-fold:

- Develop new forms of commercial arrangements that improve the quality of life for working families and the elderly
- Design and manage programs to make energy, healthcare, and other of life's necessities more affordable and available<sup>155</sup>

Joe Kennedy founded Citizens Energy in 1979. Having graduated from the University of Massachusetts just a few years before, Kennedy and a few friends reportedly conceived the idea in "the cramped basement" of his Boston home.<sup>156</sup> The program's original purpose was to provide needy families with heating oil during the oil crisis of the late 1970s.<sup>157</sup> To get the program underway, Kennedy was able to use personal contacts and the clout of his family name to successfully negotiate oil prices with the Venezuelan government. Kennedy was able to persuade the Venezuelan government to sell oil to Citizens at prices that were below the open market price. Sources close to the oil industry say the deal was a strong indicator of the power of the Kennedy family, since no one else was able to negotiate such low oil prices during that time period.<sup>158</sup>

Kennedy's oil purchase and his method for redistributing it to the needy was very simple. "He went out, purchased a tanker full of oil, processed it, and used the proceeds to give the rest of it away to people of low income," Martha Morkan of

Citizens Health said.<sup>159</sup> Kennedy entered into agreements with petroleum-producing countries, “negotiated finance, shipping and refining deals and sold off the refined petroleum products.”<sup>160</sup> Through storage agreements with major terminal operators and contracts with hundreds of oil retailers, Kennedy was able to provide heating oil to the poor at discounts up to 40 percent. When Kennedy’s first tanker full of heating oil from Venezuela arrived in Boston Harbor, it did so with great fanfare, generating much publicity for the new nonprofit corporation.<sup>161</sup> The oil was distributed not only to poor elders, but to working families in the Boston area.<sup>162</sup>

Under the leadership of Joseph Kennedy, and eventually his brother, Michael Kennedy<sup>163</sup> while Joe served in Congress for twelve years, Citizens Energy expanded dramatically as it discovered new ways to meet very basic needs for low-income individuals. In addition to expanding fuel assistance to thousands of families in Massachusetts, Citizens was also very active in both nonprofit and for-profit initiatives such as oil exploration, pharmaceutical distribution, and gas and electricity trading.<sup>164</sup> Known for its commitment to re-investing in social programs in the nations Citizens does business with,<sup>165</sup> Citizens touts accomplishments including: the introduction of hybrid seeds to Nigerian farms to increase farm outputs and raise nutrition levels; channeling loans to poor people in Ecuador, Colombia, and South Africa, enabling them to start their own businesses; the introduction of biomass technology in Costa Rica, bringing electricity to rural communities; the introduction of solar energy to hospitals in Jamaica and Venezuela; and the creation of Angola’s first private university, the Catholic University of Angola.<sup>166</sup> Locally, Citizens launched a number of other public service initiatives including conservation programs, public health initiatives, and healthcare for the homeless programs.<sup>167</sup>

The Citizens program that may have best positioned Kennedy for the eventual launch of Citizens Health was the mail-order prescription drug program that was the direct result of a valuable partnership between Citizens Energy and the Medco Corporation. In the early 1980s, Joe Kennedy realized that rising drug costs were becoming a problem for low-income people. “What he found was that the cost of the middle-man was really inflating the price of drugs,” Morkan says.<sup>168</sup> Citizens partnered with Medco containment services, a pharmacy benefit manager that offered drugs to businesses at low prices, in part, by using mail-order services. The result was a mail-service pharmacy called Citizens Medco, based on Kennedy’s idea that he could save people money on their drug costs by taking the pharmacist out of the equation.<sup>169</sup> In the Citizens Medco partnership, Citizens primarily served as the marketing arm for Medco, recruiting clients for the company including many national unions, the Nynex company, and Blue Cross Blue Shield of Massachusetts.<sup>170</sup> The joint venture proved to be very profitable for Citizens, but it was also very effective in saving people 40 percent off the costs of their drugs. To serve the needy, Citizens pitched the mail-service program to church plans, employee contracts, and other organizations that would reach working families.<sup>171</sup>

The Citizens Medco program was, in large part, overseen and developed by Michael Kennedy, while Joe Kennedy served in Congress from 1986 through 1998. While working on Capitol Hill, Kennedy immersed himself in issues that would directly address social needs, looking for novel private sector approaches that would help communities to achieve economic growth and prosperity.<sup>172</sup> Among other initiatives, Kennedy pushed legislation that included fair-lending reforms that would help working people buy homes and start businesses, created affordable housing units by using tax credits to encourage private investment in public housing, and preserved and expanded federal research and development accounts that stimulate

new jobs and business growth.<sup>173</sup> These initiatives helped Kennedy to develop an agenda in Washington that proved to be consistent with the values on which he had built Citizens Energy.

When Joe Kennedy returned to manage Citizens Energy full time in 1998 after his brother was killed in a tragic ski accident, his experience in Washington told him that prescription drug costs were becoming a huge problem for low- to moderate-income individuals. It also became apparent that the mail service that he had helped implement fifteen years earlier just wasn't solving it.<sup>174</sup>

### ***Citizens Health is Launched in Fall 2001***

After two years of haggling with state lawmakers to implement his bulk-purchasing initiative, Kennedy remained committed to "doing it another way."<sup>175</sup> "It was clear that the state just didn't want to move forward," Joe Kennedy told the *Boston Globe*. "The state had an opportunity to save itself tens of millions of dollars a year. You can bring a horse to water, but you can't make him drink."<sup>176</sup> Perhaps the years of wrangling with state leaders provided even more motivation for launching the bulk-purchasing plan as a nonprofit initiative. "We were frustrated," Martha Morkan says. "He had stepped out there into the issue, and he felt like he had to do something."<sup>177</sup>

Though the premise for the Citizens Health program had been well developed for the push for Section 271, the Citizens Energy staff had a lot of work to do to make the idea operational. New staff were hired to concentrate on the new project; thus it took more than a year to get off the ground. In the summer of 2000, Citizens put out a request for information (RFI) for a PBM. Though Citizens received a lot of responses, Express Scripts was awarded the contract because of its standing as the largest PBM in the country and its proposal to offer to Citizens some money to help pay for the development of the new program.<sup>178</sup> While Express Scripts was largely responsible for recruiting the network of pharmacies for participation in Citizens Health, Kennedy himself was responsible for forming important partnerships with two pharmaceutical manufacturers: GlaxoSmithKline and Bristol-Myers Squibb. The two companies agreed to provide deeper discounts to Citizens Health members who purchased prescription drugs that they manufacture.<sup>179</sup>

The key to getting Citizens Health off the ground resided in its marketing and community outreach efforts. Citizens developed a "two-prong approach" to create awareness of the new program — a "community-based outreach supported by a mass marketing campaign."<sup>180</sup> The strategy relied heavily on the proven qualities of Citizens Energy Corporation:

- trust and credibility with working families and seniors;
- the influence and name recognition of Congressman Joseph P. Kennedy II as an advocate for vulnerable populations; and
- a highly targeted distribution network of community-based organizations.<sup>181</sup>

Community outreach efforts, and efforts to form partnerships with pharmaceutical companies were complicated because Citizens Health, prior to its launch, did not have an existing base of potential members. Unlike the state, which, had it implemented a Section 271 discount card, already would have had its pool of members in place if it headed to the bargaining table, Citizens Health didn't have that base. To bring pharmaceutical companies on board so that the program could offer deeper

discounts on some brand-name drugs, Citizens had to win the trust of those companies by promising that the discount would be worth their while because Citizens was going, one day, to have a lot of members, which would, in turn, increase the companies' market share. Citizens faced a similar challenge when it tried to partner with community organizations: "We went to the community organizations and said, 'if you get on board with us, then we're going to have more leverage with the pharmaceutical manufacturers and the pharmacy benefit managers,'" Morkan says.<sup>182</sup> Ultimately, Citizens realized, it would just have to launch the program, recognizing that as more people signed up, the discounts would grow.<sup>183</sup>

Though Citizens Energy designed Citizens Health so that it might eventually be applicable nationwide, its leaders felt that it was best to start small so that the corporation could experiment, on a much smaller scale, with community outreach strategies, marketing, and customer service. The plan was initially launched, then, to serve individuals in Massachusetts, Connecticut, and Rhode Island.<sup>184</sup> The target population, Morkan says, was Medicare beneficiaries who didn't have drug coverage and hadn't figured out some other way to get drug coverage. In Massachusetts, that would mean the segment of the population not enrolled in Prescription Advantage. The discount card would cost participants \$12 annually for an individual membership and \$28 annually for a family membership. The plan would offer discounts that would average about 40 percent,<sup>185</sup> with deeper discounts realized on GlaxoSmith-Kline and Bristol-Myers Squibb manufactured drugs. Cardholders could get their discounts at about a thousand pharmacies in the three states.

Citizens Health was due to launch in September 2001, and according to one *Boston Herald* columnist, it was going to be unveiled to the public during the week of September 11.<sup>186</sup> Due to the tragic events surrounding the terrorist attacks on the World Trade Center and the Pentagon that day, the launch was delayed until later that month. Kennedy kicked off the program with various press events scattered throughout the three states where the program was being offered.<sup>187</sup> In general, state lawmakers offered their support to Kennedy's program. Senator Richard Moore, chair of the Legislature's Health Care Committee, praised the program as "another important option for many people across the state."<sup>188</sup> Senator Montigny, Kennedy's Section 271 ally, was not caught off guard by the launch of Citizens Health. "He was not surprised," Tom Dehner said. "They did not spring it on us."<sup>189</sup> By October 2001, Citizens Health was up and running, aiming to make drugs affordable for people in Connecticut, Massachusetts, and Rhode Island.

### ***Program Mechanics***

*Eligibility.* Unlike Prescription Advantage, which is designed to help senior citizens and the low-income disabled population, there are no restrictions on who can enroll in the Citizens Health program. While the plan was designed to help the "gap" population who are not eligible for Medicaid but still cannot afford health insurance, anyone can apply to enroll in Citizens Health.<sup>190</sup> In fact, Citizens Health does not require applicants to disclose their income level on the application for the program. Morkan says that the decision was made to exclude that requirement because Citizens didn't want people who were filling out the applications to think that the program would only be available to them if they fell into a certain income category.<sup>191</sup>

*Enrollment.* Participants can enroll in Citizens Health by applying for membership online on the Citizens website, through the mail, or over the telephone. Online enrollment, which offers secure credit-card processing, is the quickest and easiest



method if Internet access is available. The mail option may take a bit longer, but it allows members to pay the enrollment fee via credit card, personal check, or money order.<sup>192</sup> Telephone enrollments are also a quick way to apply for membership, if the participant can pay the enrollment fee via credit card.

In addition to relying on public-service announcements and billboards that publicize the Citizens Health hotline (1-800-JOE-K-4RX), Citizens relies heavily on its partnerships with community-based organizations to facilitate enrollment.<sup>193</sup> To enhance these partnerships, Citizens remains in constant contact with its community partners by sending them weekly emails, brochures, and other literature to get their attention. “In most cases, what people have told us is that they see us as another tool in their toolbox,” Morkan says, pointing out that Citizens Health has made life easier for social workers in these agencies who previously may have had to tell people who may not be eligible for Medicaid but can’t afford insurance that there was nothing they can do to help them. “We have had great success with those people who say ‘thank God there’s something that I can offer them.’”<sup>194</sup>

*Achieving Discounts.* In order to purchase drugs at the discounted rates that Citizens Health has negotiated, cardholders must purchase their drugs at one of the approximately one thousand pharmacies in Connecticut, Massachusetts, and Rhode Island that have signed on with the plan. National chains that have participating outlets in any of the three states will also honor the discount at their locations in other states.<sup>195</sup> The Citizens pharmacy network includes a number of major retailers including Brooks Pharmacy, Stop & Shop, Shaws, Star, Costco, Target, and several independent pharmacies.<sup>196</sup>

The discounts that Express Scripts has negotiated with the Citizens pharmacy network are applicable to all drug purchases. Discounts are realized immediately at the point of purchase, enabling members to save approximately 35 to 50 percent off the price of generic drugs and 12 to 25 percent off the price of brand name drugs.<sup>197</sup> Citizens Health members may also reap “EXTRA Savings” on a list of approximately sixty drugs manufactured by GlaxoSmithKline, Bristol-Myers Squibb, and Eli Lilly<sup>198</sup> owing to the direct negotiating that Joe Kennedy has done with those companies. Members may also increase their discounts by using the Citizens Health mail-order service, a service that Morkan says is not heavily used. The call center, which is administered by Express Scripts, encourages members to use the mail service because the extra savings on brand name drugs are significant, but, for reasons that program administrators have not identified, people are hesitant to use it.<sup>199</sup>

*Medical Information & Education.* In addition to the drug discounts that Citizens offers its members, the company also touts its commitment to educating its members about the drugs they buy as well as its ability to track drug purchases to ensure that patients are using their drugs safely. Membership in Citizens Health provides participants with access to a 24-hour toll-free call-line through which they can ask pharmacists specific questions about the drugs they are taking or other related medical conditions.<sup>200</sup> In addition, Citizens Health also functions as a manager of pharmaceutical purchases, effectively tracking the drugs that its members purchase, flagging potential drug interactions even if the patient makes purchases at multiple pharmacies. This particular feature is especially important for seniors who may be visiting a number of doctors who are prescribing a number of different drugs. “If you’re taking six drugs, there’s a 100 percent chance that there are going to be interactions,”

Morkan says. By entering a member's drug purchases into one central computer, a pharmacist would be prompted to ask questions or provide the proper advice to a patient who may experience the effects of a potential drug interaction.<sup>201</sup>

### ***Negotiating Discounts***

The success of Citizens Health is largely determined by its ability to negotiate discounted drug prices for its members. While Express Scripts has been successful in achieving discounts with the pharmacies that have signed on to the program, Citizens has found that it can be more effective in extracting discounts from drug manufacturers by negotiating with them directly. Joe Kennedy and his staff were successful in getting GlaxoSmithKline and Bristol-Myers Squibb to offer deeper discounts before the program was launched.<sup>202</sup> Morkan says the Citizens pitch was: "This is a population that doesn't purchase prescription drugs because they don't have insurance, and we could actually increase their market share, if these people could afford their drugs."<sup>203</sup> During the planning phase, it was difficult to attract more manufacturers to participate in the program because Citizens did not have an existing customer base yet. Once the plan got underway in October, Morkan says, "other drug companies started calling us back, saying 'let's talk about this.'"<sup>204</sup> Eli Lilly has since formed a partnership with Citizens, and many others are looking at joining the program as well.

In its ongoing talks with various pharmaceutical manufacturers, Citizens is finding that it may have to change the way in which it offers discounts to its members in order to get more companies to participate. What Citizens has learned is that the pharmaceutical companies are willing to negotiate deeper discounts if they can be targeted specifically to lower income individuals — members who are under 300 percent of FPL, and promising even deeper discounts to members who are under 200 percent of FPL.<sup>205</sup> "We got far to a certain point, [getting] three companies to sign on for giving discounts to everybody — but they are willing to give greater discounts to the poor," Pat Norton, Director of Business Development for Citizens Health, said.<sup>206</sup> While Citizens Health has, in large part, ignored the income levels of its participants, inviting everyone to join, they will begin tracking income so that the program will be able to offer more relief to people with low incomes. While everyone will still be eligible to join the program, members who are low income will have access to greater discounts. In fact, Citizens said GlaxoSmithKline and Eli Lilly would be offering extra discounts for low-income seniors by May 2002.<sup>207</sup>

### ***Partnerships with Pharmaceutical Companies***

This is an opportunity to provide some leadership in the industry and reinforce the message it is important for a Medicare reform bill to pass that has a prescription drug benefit included.<sup>208</sup>

—Nancy Pekarek, spokesperson for GlaxoSmithKline

Despite their strong opposition to bulk-purchasing initiatives proposed at the government level, pharmaceutical companies are forming partnerships with Citizens Health, and providing drugs to its members at discounted rates. Why the change of heart? Although Citizens Health has enabled them, to some extent, to increase their market share, the main reason why they have likely agreed to work with Citizens Health is, Morkan says, because "they're beginning to recognize that that they need to start being a part of the solution" to the problem, which is that many Americans cannot afford drugs. If pharmaceutical companies are voluntarily providing some

relief for those individuals, then maybe the government won't hit them with price controls.<sup>209</sup> The drug industry source agrees:

I think the companies will do a lot of things to forestall that from happening, whether it's more philanthropy, support of government programs, or a variety of creative things to deal with the genuine problem, but without going so far to destroy the industry or weaken it irreparably.<sup>210</sup>

### ***Grassroots Outreach***

While Express Scripts' success in signing on a number of pharmacies to the Citizens Health plan has been key to its ability to get underway, more important, Morkan says, are the partnerships that Citizens has formed with several independent pharmacies. "The population that we're trying to serve, and the way that we're trying to serve them, [through] grassroots outreach, is really best-served through independent pharmacies." Independent pharmacies, Morkan says, which typically form more personal relationships with their customers, are more likely to be able to offer the card to someone who may need it. "They recognize the people they serve who don't have insurance."<sup>211</sup>

In addition to forming relationships with the pharmacies, Citizens continues to knock on the doors of various community groups who may help them identify individuals who could benefit significantly from enrollment in the Citizens Health program. Citizens Health has developed relationships with senior centers, community health centers, and councils on aging throughout the three states that it currently serves. Morkan says that the outreach can be slow and tedious, as her staff members essentially go door-to-door to community meetings and events, but it is crucial to reaching the people whom Citizens Health is trying to help. "The majority of people don't look for services, they're not out there looking for help. Finding a way to get to them is our struggle right now, from a cost-effective perspective."<sup>212</sup>

The ironic aspect of Citizens Health's outreach efforts in Massachusetts is that they often result in the recruitment of members for the Prescription Advantage program. "We're not out there telling people what they should do," Morkan says. "We're giving you options, and that's what this is about."<sup>213</sup> As part of that education process, Morkan says her outreach staff will tell people that insurance is better if people can afford it. In Massachusetts, that mantra will often drive people toward Prescription Advantage. Since Citizens Health has targeted its outreach to low-income elders, that education process has actually raised concerns for Prescription Advantage administrators, according to Morkan:

The state had some real concerns that we were going to increase their numbers once we started doing our outreach. We know that we have. When we find lower income people, we say to them "you're crazy to buy our card, because the state will give you this benefit for next to nothing."... But from the state's perspective, they're not looking for that group anymore, they're looking for healthier, higher income people, and those are the people who are more likely to buy a discount card.<sup>214</sup>

### ***Citizens Health Report Card***

Approximately six months after the launch of Citizens Health, administrators were pleased with the extent to which they had helped people get drugs affordably. As of March 2002, fifteen thousand people had enrolled in the program. "That's a good strong number for what we've been doing for six months, for the discounts we've been able to offer so far," Morkan says. "Once we can offer some deeper discounts,

that will change dramatically.” She says that Citizens had not made any enrollment projections with which they can compare outcomes, but Morkan says that Joe Kennedy is aiming to enroll one hundred thousand members in the program.<sup>215</sup> In terms of discounts being realized by members, though they vary by individual drug needs, discounts are averaging 40 percent for members, which is what the program had advertised when it launched.<sup>216</sup>

The rollout of Citizens Health has helped the program’s administrators to better define both who their target audience is and what may be the best way to reach them. In Massachusetts, for example, the Citizens Health population has turned out to be moderate- to middle-income seniors, and uninsured individuals under age sixty-five who are not in Medicaid.<sup>217</sup> Morkan says their original outreach strategy, which was heavily reliant on relationships with community health centers, may not be the best way to reach that population. “We’ve got to figure out where’s the best place for us to be, where we can reach people. We thought it was going to be community health centers and CAP agencies that were the place to go, but we’ve learned they’re a little too low-income for us.” The majority of the population served by community health centers is either signed up with Medicaid or other free care programs.<sup>218</sup>

One strategy that Citizens is exploring to reach out to the under 65 population is forming relationships with corporations. Morkan says Citizens has been talking with corporations in the services, retail, and manufacturing industries, which employ a number of part-time workers who may not qualify for health insurance benefits. In some cases, even if employees do qualify, the health benefits offered by these companies are so expensive that workers would have to contribute their entire part-time paychecks to enroll in them. To tap into this market, Citizens has been talking to various employers about either buying Citizens cards for their employees or allowing Citizens to advertise the card on the company premises via posters, handouts, and applications.<sup>219</sup>

### ***How Citizens Compares with Other Discount Plans***

Citizens Health is certainly not the first discount drug plan to hit the market. PBMs, insurance companies, retail stores, associations, and nonprofit organizations have long offered similar programs. Recently, some states and even drug manufacturers have jumped on the discount card bandwagon.<sup>220</sup> AARP has offered a discount card for its members for ten years.<sup>221</sup>

Citizens Health says it scores very well on five criteria identified in a February 2002 report on discount drug plans released by the Kaiser Family Foundation for measuring a program’s value: number/type of medications available, convenience and accessibility, mail-order services, professional pharmacist consulting, and discounts realized by members.<sup>222</sup> In terms of the number/type of medications available, Morkan points out that all drugs are discounted under the Citizens Health plan, both generic and brand name. Morkan would also give Citizens a relatively high mark for convenience and accessibility because of its relationship with approximately one thousand retail locations. Until the plan successfully convinces large chains including CVS, Rite Aid, and Walgreens to sign on to the program, Morkan says, there is clearly room for improvement in this area. Citizens does offer mail service, and Express Scripts pushes it at the call center when it is apparent that a customer could achieve greater savings by going that route, but few people tend to use it. The exact opposite is true, however, for Citizens’ professional pharmacist consulting option. Morkan says the Citizens Health 24-hour toll-free hotline is

heavily used. “I’m guessing it’s because this is a population that — especially the under 65 — doesn’t have primary care physicians, and they are using the pharmacist more as their physician,” Morkan says.<sup>223</sup>

Kaiser’s last criteria — “discounts realized by members” is the area where Citizens feels it most stands out from the pack. While it is not unusual for a discount card program to cover all drugs, Citizens may be the only plan out there that’s actually negotiating deeper savings for consumers. “It sent lots of waves through the industry when Joe started doing that.” In addition, if other plans do get rebates from specific manufacturers (as they likely are, Morkan says), they are not necessarily passing them on in full to consumers, Morkan says.<sup>224</sup> All of what Citizens Health terms “prebates,” or the discounts that Citizens negotiates, are passed along in their entirety to consumers. Unlike some plans, Morkan says, Citizens does not steer customers to certain drugs so that Citizens will get greater discounts from the manufacturers. Citizens Health is now offering more than sixty drugs that everyone, no matter what income level, can receive extra savings on. The discount is calculated right at the register, so consumers only see the lower price. “We’re gaining on this extra savings thing, and the others don’t seem to be looking to change at all,” Morkan says.<sup>225</sup>

Citizens Health points out that it is just getting started, too, in terms of the discounts that it is offering to members. “What we have right now, and it’s probably the best thing out there, it is middle class,” Pat Norton says.<sup>226</sup> As Citizens continues to explore opportunities where manufacturers are willing to negotiate deeper discounts for lower-income members, their card will be even better. “Once we get these other pieces of it, we’re by far the best card. Right now, we’re competitive,” Norton says. “This is what we call an incremental product development.”<sup>227</sup> Martha Morkan agrees: “Once we can operationalize deeper discounts for [members] under 65, that will just totally change who we are, and what we are in this market.”<sup>228</sup>

### ***Weighing in on Citizens Health***

While few would argue that any initiative that aims to save money on drugs for the poor is an unworthy undertaking, many healthcare experts point out that the savings it achieves for people are essentially a drop in the bucket in terms of what is needed to make a difference for people who are looking for a way to access drugs affordably. “Making drugs cheaper doesn’t go far enough,” says Dr. Stephen Soumerai, director of drug policy research at Harvard Medical School. “It doesn’t reduce out-of-pocket expenses . . . enough to make drugs cheap enough to ensure access for lower-income people.”<sup>229</sup> Doctor Alan Sager of the Boston University School of Public Health echoes Soumerai’s sentiment: “The cards are not a big benefit. They’re like trying to stop the tank of skyrocketing drug spending with a peashooter.”<sup>230</sup>

In Senator Montigny’s office, staffers are supportive of Kennedy’s initiative, but agree that it is limited in terms of the kind of impact it can have. “The discounts aren’t big enough, even Joe Kennedy doesn’t have enough power,” Tom Dehner says.<sup>231</sup> At Prescription Advantage, where many calls from confused consumers were misdirected when Citizens Health first rolled out its discount plan, a key administrator pointed out that the discounts were limited. For example, he said, if a patient takes the drug Zocor, a \$95 drug per month for high cholesterol, he’s still going to pay \$65 to \$75 for it with a Citizens discount.

One of the things we heard after three months of the card’s rollout . . . people felt misinformed, or very deceived, because what they thought was going to be a major discount

at the pharmacy, wasn't. That's the problem with marketing this type of card. They're not going to get you huge discounts.<sup>232</sup>

The administrators at Citizens Health fully acknowledge the limitations of a discount card, and in their outreach efforts will recommend that individuals seek out insurance coverage if they have high drug use. Citizens' goal has been to give people who don't have insurance a means of lowering their drug costs and, as the program moves forward, its administrators say they will remain committed to seeking deeper discounts for members. As Martha Morkan points out — there's a great deal at stake for Citizens if it fails to do so:

People's Prescription Plan or Merck-Medco can go out there with their discount cards . . . people have an expectation that's really low. They control their expectation because it is a for-profit discount card. But, when Joe Kennedy goes out there, and it's a nonprofit discount card, and Joe's face is on everything, and the phone number is JOE-K-4RX, it's a very personal thing.<sup>233</sup>

### ***Outlook for the Future***

Citizens Health is focused on seeking out ways to negotiate deeper discounts and making drugs affordable for the people it serves in Massachusetts, Connecticut, and Rhode Island. It is no secret, however, that in its current form, Citizens Health is essentially a pilot initiative for a program that Kennedy plans to expand on a national level.<sup>234</sup> For that reason, the lessons that administrators are learning about the population that Citizens can best serve, and the strategies it should employ to do outreach for the program, are extremely valuable as Kennedy prepares for a national rollout. In fact, Citizens is eyeing September 2002 as a target date for taking their program national.<sup>235</sup>

Right now, in March of 2002, while administrators are testing the model,<sup>236</sup> Morkan is closely evaluating the strategies they use for community outreach, and is trying to better define the population Citizens serves. In addition to broadening its outreach to corporations that may sell the card or at least educate their uninsured employees about the card, Citizens Health is also experimenting with selling prepaid Citizens Health cards to pharmacies and convenience stores. The concept is similar to that of the prepaid calling card. The customer can pay the \$12 enrollment fee right at the register, and then call in and activate the card via a unique pin number.<sup>237</sup>

In terms of product development, Citizens is continuing its efforts to negotiate discounts with manufacturers, and is seeking out even deeper discounts for low-income individuals. In addition, Citizens Health is broadening its discount plan to include vision care. The optical departments at Target, Sears, and Pearle Vision locations will be among the retailers that will allow members to access discounted prices with their Citizens Health cards. "This is big, because it is different than drugs," Morkan says.<sup>238</sup>

### ***A Government Model?***

It is no coincidence that President Bush is currently pushing a Medicare-sponsored drug discount plan that is fundamentally built on the premise underlying Section 271, and now, Citizens Health. A few years ago, when Joe Kennedy was encouraging Massachusetts leaders to adopt his bulk-purchasing initiative, he was also sending letters to the governors of the forty-nine other states in the United States, encouraging them to do the same thing. At that time, George W. Bush was Governor of Texas and now-Health & Human Services Secretary Tommy Thompson was

Governor of Wisconsin. “Some of the actions that the Bush administration is taking now with Medicare Rx are direct results of the conversations that Joe had with them when they were governors,” Morkan says. The Bush administration continues to consult Citizens Health on this particular issue, as he continues to push for a Medicare discount plan.<sup>239</sup>

The drug industry source raises the point that Kennedy may have moved forward with Citizens Health because he was interested in positioning himself for a role in the proposed Medicare drug program. Many of the bills circulating on Capitol Hill call for the Medicare benefit to be administered region-by-region, making Kennedy a perfect candidate for managing the benefit for the New England region:

If Congress does pass a Medicare prescription drug benefit, it will be companies like Express Scripts that may be running it. He could be a person that would help run the Medicare benefit, with millions and millions of seniors, which would be an enormous financial opportunity.<sup>240</sup>

While Martha Morkan says that the experience of building Citizens Health could definitely make the nonprofit an ideal candidate to play the role of “aggregator” for purchasing the drugs for a Medicare benefit, she is skeptical that the result would be the same. “The thing that I can’t get my arms around is the fact that the industry won’t play with [the government] the same way, *can’t* play with them the same way,” Morkan says.<sup>241</sup> When the industry negotiates with Citizens Health, she points out, they know they’re not facing the power of the government.

We don’t have price controls in our back pocket, and the government does. It would have been like pulling teeth to get them to come to the table if we were the government. The fact that we weren’t, but that we had the credibility of Joe Kennedy, that’s what got them to the table.<sup>242</sup>

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## Analysis of the Findings

### ***Drugs Cost Too Much, Even for the Government***

At the crux of the prescription drug crisis and the government’s challenge in unraveling it lies the reality that prescription drug costs are climbing to levels that are unaffordable, not only for the uninsured, but for HMOs, Medicare-plus plans, state Medicaid programs, and even the federal government. In the private sector, insurance coverage is slipping as prescription drug costs grow to levels that insurance companies simply can’t absorb without hiking the costs of their benefit plans. As a result, employers are forced to cut back on the benefits they provide to their existing employees and their retirees, and in many cases even drop prescription coverage altogether from the plans that they offer. The fallout from this chain of events is that more and more people are looking to the federal and state government to protect them from the lack of drug coverage and the rising prices, either through subsidies or by developing and implementing a strategy that would lower actual costs. For seniors and their advocates, the most obvious solution would be the addition of a prescription drug benefit to Medicare. But Congress and the Bush administration have yet to construct a plan that would make such an option affordable. While lawmakers on Capitol Hill continue to drag their feet on this issue, states are doing the right thing by implementing programs that will relieve some of the burden facing their seniors, but for the most part, these plans are only stopgap measures.

### ***Prescription Advantage Provides the Coverage that Medicare Should***

In Massachusetts, the implementation of the Prescription Advantage program is revolutionary. It is a plan that aims to provide prescription drug coverage not only for low-income elders, but for senior citizens who have higher incomes, who, depending on their healthcare needs, may also be vulnerable to skyrocketing drug costs. It frees seniors from the anxiety surrounding the possibility that suddenly they could be struck with a catastrophic illness that would bring drug costs that they simply could not afford to bear. Most important, it is an insurance model, not an entitlement program that — despite warnings from senior advocates, government watchdog groups, and fiscal conservatives — has remained affordable for the state in its first year of operation. From a fiscal perspective, the outlook may grow more positive as the program continues to step up its efforts to recruit healthier, higher-income seniors who will pay more into the program, further offsetting the costs of the low-income elders who now constitute 80 percent of the membership.

Even the key administrator interviewed for this case study admits, however, that if Medicare ever implements a prescription drug benefit, the need for Prescription Advantage would disappear. Prescription Advantage, though it has captured a small discount on drugs by offering a three-tier formulary through its PBM, has done very little in reducing the actual prices paid to drug companies. If drug prices continue to rise at double-digit rates<sup>243</sup> as they have in the past decade, Prescription Advantage will grow more and more expensive for the state, and possibly for plan members, who may be charged higher premiums and co-payments. Although there is still talk among lawmakers about aggregating the state's drug purchases, the pharmaceutical and biotechnology industries have done an excellent job of convincing lawmakers that to save money through bulk-purchasing, they would have to restrict the number of drugs that are offered. These assertions have put patient advocate groups on the alert, and they are likely ready to flood lawmakers with letters that will oppose any kind of bulk-purchasing proposal.

### ***Citizens Health: Serving a Different Population***

Joe Kennedy's Citizens Health program is doing exactly what he had set out to do through Section 271, but on a much smaller scale. He is squeezing savings out of the drug companies that are willing to negotiate with him and passing on those discounts directly to consumers enrolled in the plan. Once he can segment his membership into age and income categories, Kennedy will make drugs even more affordable for those who have the greatest need for assistance. If he succeeds in taking his plan national, and reaches his goal of 100,000 members or more, he will have a greater impact on the pharmaceutical industry, and may succeed in effectively bringing down the costs of drugs, at least to some extent, on a national scale.

Unlike Prescription Advantage, Citizens Health will still maintain a niche in the market if and when the federal government passes a Medicare prescription drug benefit. According to Martha Morkan, Citizens is finding that it can serve a much broader population than even the program's organizers originally had thought. While the most obvious population to be served had been elders because they fill the most prescriptions, clearly today's drug prices have put drugs out of reach for uninsured individuals under sixty-five as well. By not requiring members to fall into specific age or income categories, Citizens Health has attracted a wide range of individuals to its plan. Citizens has been very innovative in its strategies to seek out members by forming partnerships with corporations, and by selling cards at the registers of convenience stores, similar to pre-paid phone cards. With national data



indicating that one in four, or 70 million, Americans do not have insurance that includes prescription drug coverage,<sup>244</sup> there is certainly a large group of people, who are not elders, who likely would not be any better off if Medicare eventually includes a prescription drug benefit. For those folks, a program like Citizens Health is a practical option.

### ***Discount Card Not the Answer for Medicare***

While Citizens Health is a worthwhile program that can effectively make drugs affordable for thousands of people in Massachusetts, Connecticut, and Rhode Island, and eventually the United States, it should not serve as a model for a Medicare drug benefit. All of the individuals who were interviewed for this case study agree that Medicare beneficiaries need drug *coverage*, not a *discount*. For Betty Schmidt, who would face a monthly bill of \$171 for Lipitor if she were not enrolled in Prescription Advantage, a 40 to 50 percent discount would still put her drug bill at around \$100 a month, which is too much for a low-income senior citizen to spend. If Betty were ever struck with a catastrophic illness that were to suddenly drive her drug costs even higher, she would find herself having to make the tough decisions that Joe Kennedy often talks about, between heating oil, food on the table, or the drugs she needs to stay alive.

As this case study points out, Martha Morkan is not sure the government could even implement a discount program like Citizens Health, because drug companies would likely be more hesitant to negotiate significant discounts with the government. Right now, the companies that work with Citizens Health do so voluntarily, knowing that if they don't want to negotiate, they don't have to. Joe Kennedy, as powerful as his family name is, cannot directly penalize them for not participating. The government, though the powerful prescription drug lobby will likely persuade it not to, could slap the industry with price controls if it wanted to penalize drug companies for not coming to the bargaining table.

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### **Concluding Thoughts**

While Prescription Advantage is essentially a temporary solution for Medicare's lack of drug coverage and is doing very little to bring down drug prices, it is effectively helping seniors meet their prescription drug needs in Massachusetts. State lawmakers, however, should re-visit the idea of aggregating drug purchases — not to provide a discount card — but to lower the costs of drug purchases for Prescription Advantage, Medicaid, and state employees. By lowering its drug costs, the state could ensure that it would be able to maintain an adequate level of assistance for those who need it most. Nobody, at least not publicly, has conducted an in-depth, nonpartisan study that has specifically itemized the costs or potential savings of such a proposal. Nor has anyone provided a detailed plan for implementing a bulk-purchasing initiative for the state. If lawmakers could determine exactly how the plan would work and prove that it would yield significant savings, they would have little choice other than to endorse the measure. In the meantime, Prescription Advantage can serve as a model for policymakers on the national level, who should move forward with a comprehensive prescription drug benefit for Medicare beneficiaries. Prescription Advantage administrators would be a valuable resource for information and advice on tracking drug use, cutting costs through a three-tier formulary, and providing customer service and enrollment procedures for a potential Medicare drug benefit.

Policymakers could learn a great deal from Citizens Health in terms of customer service and outreach through a strong grassroots network. There are many lessons to be learned from Citizens Health's innovative approaches to seeking out the people who could benefit from a prescription drug assistance program, but who may not be actively looking for help. If the government could take a similar approach, it could help more people get the drugs they need, and fewer would be skipping doses or not filling prescriptions in order to avoid paying high prices. By encouraging people to keep up with their prescribed drug therapies, as their doctors have recommended, the government could prevent the increased healthcare costs that will come after an individual's condition has worsened.

Citizens Health could also provide valuable insight into negotiation strategies with prescription drug companies — which will be crucial to implementing a Medicare prescription drug benefit that the government will be able to afford. Expanding Medicare to include a prescription drug benefit simply will not go far enough. To implement an effective program that will remain viable, the government is going to have to take the pharmaceutical industry head-on. Leaders need to convince drug-makers to work with them on this issue in order to determine just how far they can go in cutting drug prices without hurting the industry's ability to conduct important research and development.

Prescription drugs, which must be subject to a very safe and thorough development process, are always going to come at a cost. The real question, then, is how that cost can be distributed fairly between the drug companies, the government, the health insurance industry, the pharmacies, and the individual. The federal government must find a way to strike that balance. If it fails to do so, drug costs will continue to climb to unimaginable levels, and a Medicare prescription drug benefit will be far too costly for the government to maintain. While programs like Citizens Health are helpful in enabling people to access drugs affordably for now, they are not the answer to the broader problem.✿

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