MINUTES OF THE
TASK FORCE FOR THE FUND FOR A HEALTHY NEVADA
October 26, 2000

A meeting of the Task Force for the Fund for a Healthy Nevada, (created as a result of Assembly Bill 474 – 1999), was called to order by Co-Chair Barbara Buckley at 1:05 p.m. on October 26, 2000, at the Grant Sawyer State Office Building, 555 East Washington Avenue, Room 4412, Las Vegas, Nevada. The meeting was teleconferenced to the Legislative Building, 401 South Carson Street, Room 3138, Carson City, Nevada. Exhibit A is the Meeting Notice and Agenda; Exhibit B contains the Attendance Rosters.

TASK FORCE MEMBERS PRESENT IN LAS VEGAS:

Assemblywoman Barbara Buckley, Presiding Co-Chair
Senator Raymond Rawson
Ms. Maureen Brower
Dr. John Ellerton
Mr. Ed Fend
Dr. Elizabeth Fildes
Mr. Ron Mestre

TASK FORCE MEMBERS PRESENT IN CARSON CITY:

Assemblywoman Vivian Freeman, Co-Chair

TASK FORCE MEMBERS EXCUSED:

Mr. Bill Welch

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Kimberly Morgan, Chief Deputy Legislative Counsel, Legal Division
Leslie Hamner, Senior Deputy Legislative Counsel, Legal Division
Charlene Adamson, Project Specialist, Legal Division
Marilyn Jayne, Secretary, Legal Division
Carol Thomsen, Secretary, Legal Division

DEPARTMENT OF HUMAN RESOURCES STAFF PRESENT:

Charlotte Crawford, Director
Jane Smedes, Management Analyst IV

Co-Chair Buckley explained that the Task Force for the Fund for a Healthy Nevada was formed to oversee the distribution of tobacco settlement monies, and noted that Nevada would receive approximately $45 million over the next 25 years from that settlement. The Task Force was charged with fulfilling the will of the Legislature to appropriate a portion of that funding for senior programs, programs to treat and prevent the use of tobacco within the State, and to establish health care programs for individuals with disabilities. Co-Chair Buckley indicated the current topic under discussion by the Task Force was reservation of the money available for the Senior Prescription Drug (Senior Rx) Program. At the September 28, 2000, meeting of the Task Force, information was not available regarding the details of the program, and the consensus of members was to wait until the details were presented prior to voting on the allocation. The suggested proposal was now available, and the Task Force had invited a representative of the Governor's Office, along with Charlotte Crawford, Director, Department of Human Resources (DHR), to provide a presentation and overview of the program.

Denice Miller of the Governor's Office stated the Governor was very proud to have recently unveiled the plan for the Senior Rx Program, which was the first of its kind in the country. She reported that response from Nevada's seniors was phenomenal, with receipt of approximately 600 calls to the toll free number, and receipt of numerous applications, even though the open enrollment period had not officially begun. Ms. Miller indicated that during the 1999 Legislature, Governor Guinn proposed use of a portion of the tobacco settlement monies for a scholarship fund for Nevada's high school seniors, and that program was now a reality. The Governor did not initially propose a plan for the remaining portion of the tobacco money. There were many legislative proposals circulating and, given the expertise and knowledge of legislators sitting on the health care committees in the Senate and Assembly, he felt a solid plan would emerge for use of the remaining money. Ms. Miller explained that when asked his opinion about how the money could be used to address health care needs in Nevada, Governor Guinn noted that in speaking with senior citizens, two issues always emerged - long-term care and the high cost of prescription drugs.

Accordingly, Ms. Miller stated, in early April 1999, the Governor offered his own plan for the second half of the tobacco money entitled, "One Half for Help." The two largest components of that plan were subsidized long-term care insurance and what came to be known as the "Senior Rx Program," which proposed subsidized prescription drug insurance for low-income seniors. Ms. Miller pointed out that ultimately, sufficient funding was not available to adopt both proposals, and the Legislature unanimously approved the Senior Rx Program. According to Ms. Miller, there were many worthy competing proposals for tobacco settlement monies, and although the Governor believed strongly in the importance of assisting needy seniors in obtaining prescription medications, he understood the importance of addressing other health care needs as well. Given the many competing proposals, the Governor was appreciative of the legislative support for his program, and recognized it as a start, one that was most needed among those seniors not eligible for Medicaid and yet not capable of purchasing private insurance without assistance. The Governor readily acknowledged that there were many health care issues within the State regarding the aged, the disabled, and children.

Ms. Miller remarked that soon after passage of the Senior Rx Program by the Nevada Legislature, prescription drugs became a national issue and the subject of intense political debate. Whether at the national or the state level, the goal was to assist those seniors who could not otherwise afford required prescription medications. In forming his approach to prescription drugs for seniors, Governor Guinn recognized the importance of helping the most needy seniors first, while also providing an option for the remaining seniors. He felt that would be a cost-effective and practical method of providing some guarantees within the State's limited resources.

Ms. Miller thanked the Task Force for its continued interest in the Senior Rx Program. She stated that the Task Force's diligence, interest, and attention to the issue caused improvement within the program. She explained that five excellent bids had been received in response to the second Request For Proposal (RFP), with the bid from the Professional Risk and Asset Management (PRAM) Insurance Services, Incorporated, which served as the managing general agent and/or underwriter for Fidelity Security Life Insurance Company, being awarded the bid. PRAM was chosen because of the choices provided by the program, the premium costs, and the outstanding drug utilization review. She emphasized that an important point regarding the Senior Rx Program was that it facilitated the creation of an insurance product which had not previously existed in Nevada, comprised of a stand-alone, comprehensive, affordable pharmaceutical plan available to all seniors. Ms. Miller further explained that any senior, regardless of income, could buy into the program. Seniors without high prescription drug costs could choose to purchase the insurance for the "peace of mind" it would provide, including a discounted price for medications, which could be significantly lower than the retail price.

According to Ms. Miller, for those low-income seniors not eligible for Medicaid, assistance would be provided in paying the insurance premium by subsidizing its cost. It was recognized that there were many seniors who could not afford such premiums, and it was hoped that as many as 12,000 seniors would be assisted. It was important to remember that all Nevada seniors would be helped by the creation and availability of the Senior Rx Program. Ms. Miller explained that the program contained two insurance options, the Senior Rx Blue option, which was the basic plan (Exhibit C), and the Senior Rx Silver option, which was the enhanced plan (Exhibit D). Both plans carried a $100 annual deductible and a $5,000 cap in annual coverage. Ms. Miller stated one of the differences between the two options was reflected in the monthly premium costs. She reiterated that any senior in Nevada could choose to purchase either plan, and any qualified, low-income senior could choose either plan and receive a premium subsidy of up to $480 per year. The best choice for any given senior would depend upon the health needs and preferences of that individual

senior.

Testifying next before the Task Force was Charlotte Crawford, Director, DHR, who noted that the Senior Rx Program contained two challenges. The first was development of a stand-alone prescription drug insurance product, which did not currently exist within the State. The second challenge was to develop a subsidy program which would apply tobacco settlement monies toward subsidizing low-income seniors in payment of the insurance premium. PRAM was awarded the bid, and won the right to endorse its insurance product as the State-endorsed Senior Rx plan, available to all seniors who wished to participate. Ms. Crawford stated that some limitation in funding existed regarding the subsidy, with approximately $4.6 million available from the tobacco monies during the first year, and approximately $6 million available during the second year. As currently written, the law limited the level of assistance to qualified low-income seniors to $480 per year, or approximately $40 per month toward the insurance premium.

Ms. Crawford reiterated that five bids had been received, and the evaluation technique used was the overall best value of the plan. She noted that PRAM presented a plan which met that criteria. There were two options under the plan, the Senior Rx Blue option (Exhibit C), which contained a managed drug formulary, and the Senior Rx Silver option (Exhibit D), which contained a preferred drug list. Ms. Crawford stated that both options included a $100 per year deductible, and a $5,000 calendar year maximum limit, which was very high for pharmacy coverage. The Senior Rx Blue option was a generic-based plan, i.e., if there was a generic equivalency available for the prescribed medication, that generic would be recommended, with a $10.00 co-pay. If there was no generic available, the co-pay would be $35 or 50 percent of the cost, whichever was greater.

According to Ms. Crawford, most formulas provided for a generic drug or a Food and Drug Administration (FDA) approved non-brand pharmaceutical product that was consistent with the medication prescribed by the physician. The second choice would be a preferred brand of medication, one that the insurer would prefer to support, probably because of an arrangement with the manufacturer. Co-Chair Buckley asked if there were no generic equivalency available, would the medication fall into the preferred brand category. Ms. Crawford replied in the affirmative, and indicated the preferred brand was covered under the plan, with the aforementioned co-pay of $35 or 50 percent of the cost of the medication, whichever was greater.

Continuing, Ms. Crawford stated that a non-preferred brand was another brand pharmaceutical product with the same general application, and was not covered in the Senior Rx Blue option. Coverage was provided in the Senior Rx Silver option, with an individual covered by the plan receiving the discount rate for the medication when purchased. The aforementioned co-pay applied to a 30-day supply of medication. A mail order option was included in the plan, which would consist of a 90-day supply of medication. The co-pay cost for mail order was $20 for generic, $70 or 50 percent for preferred medication, and non-preferred prescriptions would receive the discount rate. Ms. Crawford noted that a variety of pharmacies were also included in the plan for accessibility to medications at the discount rate.

Mr. Fend asked for clarification regarding the co-pay amounts of a 30-day supply versus a 90-day supply through the mail order option. Ms. Crawford explained that the co-pay was $10 for a 30-day supply of medication, and the co-pay for the mail order option of a 90-day supply was $20. Those co-pays applied to generic products. If a preferred brand were dispensed, the co-pay would be higher, and if a non-preferred brand were dispensed, only the discount rate would apply.

Ms. Crawford stated the monthly premium for the Senior Rx Blue option was $74.76, and the subsidy for low-income seniors (below $21,500 per year) would be figured on a sliding scale. The maximum subsidy would be $480 per year, or $40 per month, and the majority of seniors within that income range would receive the maximum subsidy, which would lower the premium cost to $34.76 per month. The Senior Rx Silver option was the enhanced plan, which provided a higher level of coverage, and included a preferred drug list. The co-pay was $10 for generic brands, $25 for preferred brands, and $40 or 40 percent, whichever was greater, for non-preferred brands. That option contained a broader coverage of preferred and non-preferred brands. The co-pay for the mail order option, a 90-day supply, was $20 for generic, $50 for preferred, and $80 or 50 percent for non-preferred, which was not covered under the Senior Rx Blue option. The premium for the Senior Rx Silver option was $98.31 before applying the subsidy of $40.00.

Ms. Crawford indicated the DHR surveyed pharmacies in Nevada to ascertain the most frequently prescribed

medications for seniors. Exhibit E, "Senior Rx, Insuring the Health of Nevada's Seniors," contained a comparison of costs between the two plans of the most frequently prescribed medications. The exhibit also contained monthly cost comparisons for seniors using different combinations of medications, and the savings realized after payment of the premium for each option. According to Ms. Crawford, the Pharmaceutical Care Network (PCN), the pharmacy benefit management company that would be dealing with the program, would review the combination and number of drugs prescribed and would recommend review when a problem was noted. The PCN would serve as the actual manager of the pharmacy component with an online, real-time, immediate consultation service available, as well as a retroactive review of medications. PCN would not, however, override a physician's latitude to prescribe. The service would be available in an advisory capacity. Ms. Crawford pointed out that the plan would not provide the same level of benefits to all seniors, noting that the benefit would depend upon the pharmacy needs of each individual.

Dr. Fildes stated she was impressed with the level of review for potential drug interactions, and asked what mechanism would be used to notify a senior regarding such a problem. Ms. Crawford replied that the pharmacist would see the interaction online when prescriptions were filled, and could communicate and/or consult with the prescribing physician. In retroactive review, the pharmacist could and would provide advisories to participating physicians. She further explained that PCN was a national organization based in Sacramento, California, which used an extensive and complex computer database.

Dr. Ellerton commented that there were 32 states that offered pharmacy programs for seniors, and Nevada's program would be the only one offering an insurance product. He was curious about the discounted price seniors would pay for drugs not included in the formulary, asking what the discounted price would be, how it would be calculated, and whether the discount would be the same in every pharmacy participating in the plan. Ms. Crawford replied that the plan was no different from other plans which contained pharmacy benefit programs. There was a different discounted rate used for various medications, i.e., preferred versus non-preferred brands, but overall, there was generally a negotiated rate for each brand of medication, including generics. She also noted the discount was different within the different pharmacies and pharmaceutical companies. The DHR had requested that seniors be provided, at the very least, the discounted rate enjoyed by the pharmacy from each pharmaceutical company. There would be no single rate, and it would depend upon negotiations by pharmacy benefit management companies.

Dr. Ellerton then asked whether seniors would know which pharmacy would provide the best possible discounted price, and whether rebates from the pharmaceutical companies would be paid to the insurance provider. Ms. Crawford once again stated Nevada's plan was an insurance product, and PRAM, as the insurer, would carry the risk and receive the rebates. The State would only subsidize premium assistance for the insurance product. Dr. Ellerton referenced the two plans, the Blue option (Exhibit C), and the Silver option (Exhibit D), asking for clarification regarding the "prior authorization" clause, which would be initiated by the physician. He noted that in general, physicians would be unfamiliar with the plan and prior authorization specifications were not included in the exhibits, which simply stated, "…some medications will require prior authorization…". He felt the medications should be delineated, along with information regarding the process for obtaining prior authorization.

Electing to respond was Ms. Miller, who commented that the insurance approach was chosen by the Governor for a number of reasons, with the primary reason being the limited availability of resources. Nevada had the fastest growing senior population in the nation, ranking 49th regarding the number of seniors over the age of 85, which was the group most in need of medical care. Ms. Miller indicated Nevada had a 10-year window of opportunity to address senior's needs. The Governor felt the pharmaceutical assistance program was needed, because of comments from seniors, and he would like the program to be fully operational as soon as possible. Ms. Miller indicated that physicians in Nevada should be aware of the program, because it had become such a national issue, and she felt physicians, hospitals, and medical providers would work with the State to provide assistance to seniors.

Ms. Crawford noted that the exhibits generally provided descriptions of the available options, and did not fully describe the plan that an individual would receive when signing up for the product. The brochures for both options, Blue and Silver, contained the statement, "Prior authorization is required for some medications, and may be initiated by your physician." Ms. Crawford stated that to the best of her knowledge, prior authorization would be initiated by the pharmacist when prescriptions were submitted. Dr. Ellerton stated that was not true, and prior authorization was

handled by the physician's office. He noted that his office staff spent approximately 2 hours a day conducting prior authorizations as required by insurers. Dr. Ellerton felt that even though prior authorization was a small point, it could blossom into a gigantic "roadblock" to the success of the program. Co-Chair Buckley asked whether a list of drugs subject to prior authorization was included in the contract documents. Ms. Crawford stated when a medication was prescribed, the pharmacist would have the insurance information available, and would call the physician's office if a prior authorization was needed; she also noted that information regarding medications that would require prior authorization could be requested. She stated prior authorization was generally initiated by the pharmacist, who would have access to the direct guidelines provided by the insurer, and would also have access to online exchanges. Ms. Crawford noted the list of medications requiring pre-authorization would be different under each plan. Like all insurance products, there were limitations on benefits, and prior authorizations would be required.

Ms. Miller stated there was every indication that the medical community would work with the State regarding the program, and most doctors would conduct prior authorizations with the knowledge that the senior would then have access to the medications needed. Dr. Ellerton emphasized that the State was underestimating the amount of anger in the physician community regarding the increasing amount of paperwork necessary to accomplish what should be part of a general national health policy, not for the benefit of insurance or pharmaceutical companies. He noted that for the existing Health Maintenance Organization (HMO) plans, there was a formulary available that listed medications covered or not covered under the plan, and those which would require prior authorization.

Dr. Ellerton requested clarification regarding the formulary, asking whether it would be possible to appeal for use of medications not included. He also asked for clarification regarding the amount deducted from the cap of $5,000 for each prescription, i.e., was the retail or discount price deducted from the cap. Ms. Crawford noted that no insurance coverage was "perfect," and certainly there would be feedback regarding the coverage. The DHR would track the medications covered relative to seniors' needs to determine whether the contract was the most effective product. She stated the current insurance product was the best overall program available, and it was just the beginning. The $5,000 cap was against the cost, however, she was unsure if the retail, wholesale, or discount cost was used. It was her understanding that the cost to the insurer would be used for deductions against the cap. Co-Chair Buckley stated, for purposes of clarification, she understood that the $5,000 cap would be reduced by the cost incurred by the insurer for each prescription, rather than the co-pay amount. Ms. Crawford replied in the affirmative, noting it would be the actual cost of the medication dispensed and paid for by the insurer.

Senator Rawson indicated there were some seniors who received two different medications for the same ailment, due mainly to changes in medication without elimination of the original prescription. He felt a utilization review should be conducted because of possible inappropriate medications the insurer would pay for. Senator Rawson interpreted the plan to indicate there would be some situations where the physician would be asked to secure the necessary prior authorization for medications, and inquired whether such authorization would be necessary for an appropriate drug that was not included in the formulary. He felt it was important that the physician community receive information regarding medications that would require prior authorization, along with details explaining how to secure that authorization. Ms. Miller agreed, and pointed out that it had only been 2 weeks since the program was unveiled, and there was much work still to be done before coverage began on January 1, 2001. She stated the open enrollment period would commence on November 1, 2000. Co-Chair Buckley inquired whether the protection stipulated in the "Patient Bill of Rights" would apply to denials of prescribed medications under the plan. As understood by Ms. Crawford, those stipulations would apply.

Mr. Fend asked whether a senior who was unable to pay the balance of the premium cost after the subsidy would be ensured continued service. As he read the contract, it indicated that a senior who was unable to pay the remaining cost of the premium would not be eligible for prescription coverage. Mr. Fend noted that some stipulation should be put into place so the extremely low-income seniors did not "fall through the cracks" in the program. Ms. Crawford remarked that was an area which had caused a great deal of concern, and explained that the plan contained a 30-day grace period before the product would be terminated. Should a senior pay his portion of the payment within that timeframe, the coverage would continue. The DHR was currently working with the counties to develop a fund that would assist those seniors who experienced difficulty in paying the remaining premium cost. Hopefully, stated Ms. Crawford, that fund would be flexible enough to be used in helping seniors experiencing difficulty with the co-pay on a particularly expensive drug. Ms. Miller added that the response from counties had been very positive to date, and it was hoped that

the 2001 Legislature would provide additional funding and/or options to ensure that all seniors would be protected.

Senator Rawson concurred that it was a start-up program, an important first step in the process, and there was a possibility that the program would be modified by action taken in Congress. He then asked whether there were any ideas of how the program might be refined, i.e., an increase in the subsidy allocation, possibly for those in the lowest categories, et cetera. Ms. Miller stated the Governor's Office had considered many options, such as raising the income cap. The current income subsidy categories were designed to track the Senior Citizen Property Tax Rebate Program, however, those subsidy categories could be accelerated. The possibility also arose of eliminating the reference to the specific subsidy amount of $480 per year, rather indicating it would be subject to legislative authorization.

Mr. Mestre also felt the program was a beginning and, based on his experience in dealing with his mother's prescription needs over the last 5 years of her life, the savings would have amounted to $4,185 per year, which he felt was close to perfect. If not for family support, many seniors either did not take their prescribed medication, or only took half doses because of the cost involved. He felt the DHR and the Governor's Office had done well in securing the insurance product.

Co-Chair Buckley stated one problem was that a senior who had no family support, and was only paying for two or three generic prescriptions, would do well under the program. However, if no generic product was available, and the senior was required to pay the higher co-pay amount, a low-income senior also paying rent or mortgage would realize very little assistance from the program. Even though there would be a 50 percent discount from the price of the medication, many seniors could not afford the price in the first place. Co-Chair Buckley indicated as the State looked to the future, that was one area which should be addressed by the Legislature. Her overall impression was that the program was a beginning, and the Governor and Legislature would need to step forward and fill some of the gaps. The program still did not provide affordable drug coverage, which was the need. Co-Chair Buckley noted it would be interesting to see what action Congress would take, because there was some support for prescription drug coverage as a Medicare benefit. If Medicare was amended to provide prescription drug coverage, the State could then assist the lower income seniors in a different way by perhaps providing support services, et cetera. The Legislature and the Governor might want to change the program based on action taken by Congress. Co-Chair Buckley emphasized she was proud of action taken by the Nevada Legislature with the tobacco settlement monies, reserving it for education, for seniors, and for the disabled.

Regarding rebates from pharmaceutical companies, Co-Chair Buckley inquired how much the State realized in rebates from the Medicaid program. Ms. Crawford indicated that the Veterans Administration, Medicaid, and Medicare were required to secure the absolutely lowest offered rate, and she could not provide a flat percentage because of the differences in medication. The rebate was negotiated and was proprietary so the DHR was unaware of what the negotiated rate was on any given contract. Co-Chair Buckley stated a study had recently been released that indicated prices of brand name prescription drugs could be significantly reduced by a new purchasing policy where the State gathered together its resources, be it Medicaid, or other prescription drug programs. She wondered whether the Task Force could entertain a Bill Draft Request (BDR) for next session, which looked at plan design improvements, in order to help more seniors and make the program more affordable. Co-Chair Buckley suggested the possibility of hearings to determine if prices could further be reduced by perhaps joining forces with neighboring states. Ms. Crawford explained that the pharmacy and mental health services budget of the DHR was a multi-million dollar expense. Should the State enter into a multi-state purchasing coalition, it still would not enjoy the same level of discount enjoyed by the Medicaid program.

Co-Chair Buckley indicated that driving prices down for seniors might be a topic for legislative review, and the Task Force could request a BDR to decrease the co-pay amounts. Ms. Miller indicated the Governor's Office would work with the Task Force in any way it could, and she felt congressional action would be welcomed, however, it was not known what or when that action might be. Congress did actually pass a prescription drug benefit for Medicare in 1988, and quickly repealed it. Ms. Miller also noted there were several forms the Medicare legislation could take, i.e., block grant to states, an insurance product, et cetera.

Co-Chair Freeman stated that unless the State had the cooperation of the medical community and pharmacists, the program would be extremely difficult to implement. She asked whether the dollars would be available to administer the program, because of the small percentage designated for that purpose. Co-Chair Freeman felt it was very important not

to promise seniors more than could be delivered, because they would come to depend upon the program. She felt the Legislature should have some clear direction from both braches of government regarding what should be done with the program. Ms. Miller indicated the Governor would like to submit an increase to the senior assistance property tax rebate in the upcoming budget.

Co-Chair Buckley moved to the public comment item on the Agenda (Exhibit A), inviting interested persons to come forward and address the Task Force. Guido Donati informed the Task Force that he was 83 years of age, and questioned why the State had selected an insurance product rather than providing direct assistance with medication costs. He explained his prescription costs were excessive, and he would be required to file for welfare assistance in 2001, as his savings had been depleted. Mr. Donati discussed his medical conditions and his experience with HMO's. He stated he paid $350 per month for insurance, and his income was $1,500 per month. According to Mr. Donati, he purchased medications in Mexico because of the lower price, and he felt the price of drugs in the United States should be reduced by the pharmaceutical companies. Mr. Donati remarked that the Senior Rx program would still present a cost to seniors, and suggested that the State directly approach the pharmaceutical companies.

Co-Chair Buckley felt the Task Force should consider submitting a BDR for a prescription drug and/or oversight committee, in order to encourage more debate and hold public hearings in order to provide additional input. The committee could consist of private seniors, physicians, pharmacists, et cetera. The Governor and the Legislature agreed that the State needed the most cost-effective and affordable program possible for seniors.

Next to address the Task Force was Ruth Mills, coordinator of the Nevada Health Care Reform Project, who commented that the Health Project was not comprised entirely of senior citizens, and also noted that many of the points she wished to make had already been discussed. However, she wanted to read her testimony in its entirety into the record, (Exhibit E).

"My name is Ruth Mills. I am coordinator of the Nevada Health Care Reform Project. Our project began in 1993 with about a dozen organizations organized by the League of Women Voters. We are a coalition of consumers, organized labor, seniors, disability groups and health care professionals. We represent more than one half million Nevadans who are part of our fifty-eight member organizations. Our mission is to assure all Nevadans comprehensive and affordable health care coverage and improve the quality of health care. We are non-partisan and have viewed attempts by both major political parties at the national level as failing to solve the problem of the high cost of prescriptive drugs. Americans of all ages can not afford the constantly escalating cost (18-20 % per year).

In reviewing the Nevada Senior Prescription Plan the Health Project would like to make a few comments:

1. We suggest the legislature appoint an oversight committee to find ways to expand the program. The disabled on Medicare need to be included as soon as possible.

2. We suggest the state consider other ways to cut prescriptive drug prices. The study by Alan Sager and Debbie Socolar entitled 'A Prescription Drug Peace Treaty: Cutting Prices to Make Prescription Drugs Affordable For All and to Protect Research: State-by-State Savings' has practical suggestions and can be found on the internet at: <http://dcc2bumc.bu.edu/lcmerr/UShealthreform.htm>.

The study states that Nevada could save $186 million if allowed to purchase at the VA rate. The leverage of a private insurer contracted by the State to negotiate favorable rates on behalf of 12,000 senior citizens is much less than the leverage that could be brought to bear representing all 557,000 Nevadans without any drug coverage, or all 1.8 million persons in Nevada who may need prescription drugs. Some states in the Northeast are exploring the opportunities to join together to jointly negotiate with drug companies on behalf of their populations.

3. It is necessary that a formulary and price list for each participating pharmacy be given to persons applying for the insurance. How can they decide if he plan will truly help them without this information.

4. The fourth tier needs to be better explained. Will all pharmacies give the same discount on drugs 'not insured'?

5. Why was University Medical Center not on the list of places to obtain drugs?

6. The Health Project has helped many people over the years. The most prevalent problem has been that the person did not know how to navigate the system. Whatever can be done to help people make the right decisions with this plan is a must. It is essential that the brochure be easy to read, the benefits be very clearly explained and the application be simple. For this plan to be helpful it must be consumer friendly.

Finally, this plan is very limited. It is designed to serve 2% of the approximately 557,000 persons without any drug coverage in Nevada. Since the Governor has embraced the principle of universality in offering the Millennium Scholarships to all college students who meet certain academic standard, he should be able to appreciate the strategic importance of applying the principle of universality to drug coverage for all Nevadans. With the fourth highest percentage of persons without drug coverage, Nevada has a critical opportunity to demonstrate what public policies at the state and federal levels are necessary to ensure affordable drug coverage for everyone."

Ms. Mills then inquired whether there were questions from Task Force members. Hearing none, Co-chair Buckley thanked Ms. Mills for her testimony.

Testifying next was Carla Sloan, State Director, American Association of Retired Persons (AARP), who indicated her testimony would lend support to questions asked by Task Force members regarding the program. She read her testimony, in its entirety, into the record, (Exhibit F).

"Good afternoon. My name is Carla Sloan. I am the State Director for AARP Nevada. AARP is the nation's leading organization for people age 50 and older. AARP serves its member's needs and interests through information and education, advocacy, and community services which are provided by a network of experienced volunteers throughout the country. Nevada is home to more than 235,000 AARP members.

AARP is pleased with the State's recognition of the need to help persons aged 62 and older obtain prescription drugs through the creation of the Nevada Senior Prescription Program. I have had the opportunity to review the materials submitted in response to the State RFP by Fidelity Security Life Insurance Company, referred to as PRAM. The material included cost comparisons utilizing individual pharmacy profiles for the Nevada Blue and Nevada Silver plans.

We are pleased with the Senior Rx Pharmacy Benefit Manager's (PBM) focus on drug benefit management. The cost comparisons included citations identifying inappropriate or duplicative drug use. Such efforts cannot only reduce drug benefit costs, but also can reduce medical errors that can adversely affect health.

AARP is concerned that even with this new program, substantial barriers remain for people to get the drugs they need. Even low cost sharing can be a barrier for lower income people getting access to prescription drugs, as noted by the studies published over the last several years in the New England Journal of Medicine. Yet the Senior Rx plans has high cost sharing for many generic drugs, and substantial cost sharing even for preferred brand medications.

We are concerned that the high cost sharing would prevent the policy from effectively helping the target population. Even if the target group is able to shoulder the co-payment requirements, the combined cost of the premium and the cost sharing makes this a very expensive program, particularly for a person with low income. It should also be noted that the cap on the premium subsidy means that instead of people at the lowest income levels getting a 90% subsidy on the premium, the subsidy they do receive is just over 50% for Nevada Blue and just over 40% for Nevada Silver.

The cost comparisons examples provided show savings, assuming that the target group already buys all the drugs

that they need. However, because of the high cost of drugs in relation to their income, many low-income people do not fill all of their prescriptions. So the savings compare to an deal, not to reality. The high cost sharing and premiums means that the target population may still not be able to pay for drugs, even by enrolling in the program.

- For example, F.M., a 75-year-old woman from Carson City, is reported to pay $327.31 per month for her drugs under the Nevada Blue plan, plus $34.76 in premiums, for a total of $362.07 per month.

If her income were $12,700, the highest income that would qualify for the full subsidy (this works out to be $1,058 per month), then she would still be spending 34% of her income each month for her prescription drugs and coverage. While her costs without Nevada Blue would be $672.42, or 64% of her income, it is unlikely that she was filling all her prescriptions at that cost. It is only slightly more likely that Nevada Blue would give her the help she needs.

- Even S.E., a 77 year old woman from North Las Vegas who would pay on $89.76 under Nevada Blue for her monthly prescriptions and premium. Perhaps she would be more likely to afford to pay for these prescriptions and the cost sharing. But she would still be paying 8 percent of her relatively low income for prescription drugs and the premium. Her savings would be $48.32 per month, or about 5 percent of her income, again assuming that she is currently financially able to fill her prescriptions.

The costs are even higher for older persons with incomes above $12,700, since they will be paying a greater share of the premium.

Drug formulary systems, the set of policies and practices to identify the most medically appropriate and cost effective drug products and therapies, are an integral feature of the Nevada Senior Prescription Program.

AARP does not oppose the use of drug formulary systems, and recognizes that well-designed prescription drug formulary systems can be an effective tool for containing drug benefit and total health care costs, and for enhancing quality of pharmaceutical therapy. However, AARP does oppose cost control measures, including those used to control prescription drug utilization, that reduce quality or deny access to appropriate care.

We urge you to assure the PRAM Senior Rx Plans include the following consumer protections:

1. The drug formulary system should provide enrollees with access to the prescription drugs that they need in as cost effective a manner as possible. To this end, PRAM should be required to show that any drug formulary system they implement:

- Is administered by a pharmacy and therapeutics (P&T) committee, or similar entity, that is comprised of practicing physicians, pharmacists, and other health care professionals
- Bases clinical decisions on the strength of scientific evidence and standards of practice, considering financial factors only after safety, efficacy, and therapeutic need have been assessed
- Contains no financial incentives - such as manufacturer rebates or payments to physicians or pharmacists - that would interfere with the delivery of high quality, medically necessary care
- Is regularly reviewed and evaluated by the P&T committee, and should reflect state of the art therapeutic treatments
- Is subject to appropriate oversight by the insurer of the P&T Committee and its decisions, and has policies that address potential conflicts of interest and disclosure by P&T committee members.

2. The insurer should permit formulary exceptions when the prescribing physician determines that medical necessity dictates that a non-formulary alternative is needed.

PRAM imposes a closed formulary for Nevada Blue, that limits coverage to a certain set of drugs, and a managed formulary for Nevada Silver, that provides broader coverage but at different cost sharing levels. Even

under a well-designed formulary, there will be circumstances where the physician determines that the 'formulary' or 'preferred' drug is not appropriate for a given patient.

For example, the formulary or preferred drug that may be appropriate for most people may not work well or may be medically inappropriate for a particular patient. Consumer access to appropriate therapies requires that plans provide for a quick and easily understood process for exceptions.

AARP also believes that medical necessity dictates that if a formulary exception is granted, then coverage must be provided under the same terms and conditions (that is, cost sharing requirements) as drugs that are on the formulary, or that are considered to be 'preferred'.

3. PRAM should not require generic substitution of a prescribed drug when the prescribing physician has deemed such substitution to be medically inappropriate. Generic substitution refers to the substitution of a prescribed drug with a drug that contains the same active ingredient(s) and is chemically identical in strength, concentration, dosage form, and route of administration to the product prescribed.

Generic versions of brand name drugs tend to be much less expensive than branded products, and typically have the same therapeutic effect on patients. Some formulary systems require the patient to obtain a generic version of a prescribed drug when the generic version is available, or, if they want the brand, to pay the entire difference in costs between the generic and brand name drugs.

However, there will be circumstances when a prescribing physician determines that generic substitution of a particular drug is inappropriate for a given patient. In these cases, the insurer should not require the patient to pay the additional cost of the brand name drug.

4. PRAM should offer an external, independent appeals process. Enrollees should have the right to appeal disputed decisions to an independent, objective third party and to receive a decision of their appeal as rapidly as the patient's condition requires.

We also have some concerns regarding implementation and oversight of the Senior Rx Plans. This is a complicated program for people to figure out if they could benefit from purchasing. Consumer-friendly education materials are needed that can help people walk through the various calculations necessary for personal cost benefit decision-making.

We also have some questions about how the Program will be administered and about the rights of Program beneficiaries. Which State agency is responsible for the program – the Insurance Commission or the Department of Human Resources? Consumers need to know who is to be held accountable for implementing and operating the program.

Will the Program operate under current rules for insurance programs or will special rules be needed? Who will answer questions such as: What happens if a premium payment is missed? Will the person be thrown off the program? What is the appeals process for consumers who believe that they have been treated unfairly? Who is responsible for outreach and education to prospective applicants? Who will make the final decision about approving an application?

Finally, under this program the Pharmacy Benefit Manager will be negotiating rebates and discounts. Where will the money go? Is the money to be kept by PRAM? Does any money revert to the state? We believe that any rebates should be shared with the State to be used to expand the program.

Thank you for this opportunity to identify the important consumer protections that AARP believes must be components of prescription drug plans."

Co-Chair Buckley thanked Ms. Sloan for her well thought out testimony, and inquired whether there were other persons wishing to present testimony.

Mike Howard indicated his concern was the cost of prescriptions, which were unbearable, and one he shared with his elderly parents. He stated when a program was evaluated, four steps should be considered: (1) Take the initiative, which the Task Force had done; (2) Evaluate the program; (3) Execution of the program; and (4) Utilization and tracking of the program.

Mr. Howard explained he had been in the pharmacy business for many years, and was well acquainted with formularies, prior authorizations, and pricing. He felt many statements had been made to the Task Force that could be challenged regarding accuracy. He voiced his support of Dr. Ellerton's statement regarding prior authorization, noting that a provider would be required to approve the prior authorization, and the pharmacists would have online access to information which could be shared with the prescribing physician. Mr. Howard stated that persons who were at the income level of approximately $12,000 per year, and who were asked to pay premiums of either $58 or $34 per month, would obviously realize a savings if there prescription costs had been over that amount.

According to Mr. Howard, in the State of Nevada, there were approximately 200,000 seniors, with approximately 10,000 seniors who would benefit from the premium subsidy. Mr. Howard felt that would only help a select few, and of the 10,000 seniors, questioned how many would qualify for the maximum $40 per month subsidy. For those who did not qualify for a subsidy amount, he questioned what the State would offer to offset prescription drug costs, asking whether PRAM would cover the benefits for those seniors who did not meet the income qualifications for subsidy eligibility. He felt there were many aspects of the plan which would require further review.

Mr. Howard informed the Task Force that he also represented one of the companies which submitted a bid under the RFP process to the State. Unfortunately, his company was not selected as the winning bid, however, he noted his company would campaign for the remaining 200,000 seniors through its programs. His company offered a lower premium, offered tier pricing, and offered lower co-payments.

According to Mr. Howard, the bid for the Pharmacy Prescription Program for Senior Rx, had to be submitted by September 8, 2000. He wanted the information on record that his company, Mature Rx Plus, submitted its original bid, which was disqualified because the company was not licensed in Nevada. After obtaining licensure in Nevada, Mature Rx Plus resubmitted its bid and was selected as one of the top five bidders. Mr. Howard referenced a memorandum from PRAM, included in Exhibit H, which read in part, "The cover memorandum indicates PRAM will apply for licensure upon approval of the bid. Please note that PRAM currently carries the following licenses in the State of California."

Mr. Howard reiterated that Mature Rx Plus was disqualified because it was not licensed at the time of the bid, and he had difficulty understanding that action when PRAM was also obviously not licensed at the time it submitted its bid. He also wanted the record to reflect that Mature Rx Plus was a division of the largest PBM in the United States, formerly Advance Paradigm, and currently Advance PCS, which managed 75-million lives. Mr. Howard pointed out that the memorandum of September 11, 2000, from PRAM also stated it would subcontract with Advance Paradigm for drug rebate administration and pharmacy audits.

The emphasis was on care for seniors and cost concerns, which would require difficult decisions. Mr. Howard felt the decision to go forth with PRAM for the Senior Rx Program was not the most cost effective decision for the seniors of the State of Nevada. He presented a list of medication comparisons, identical to that contained in Exhibit E, but which included the Mature Rx Plus costs for the same medications, noting that there were only three drugs where Mature Rx Plus had higher costs that PRAM (Exhibit I).

When maximum benefits were a consideration, it was very unusual to have a $5,000 maximum benefit on an insurance product for prescription medication costs and, in fact, the cap was usually set at $2,000. Mr. Howard questioned how that $5,000 maximum benefit would be calculated. He opined it would be based on the retail price of the medication, rather than the co-pay amount, which most plans used. He voiced concern regarding the validity of the $5,000 maximum benefit.

Mr. Fend stated it was his understanding that any person 62 years of age or older could purchase either the Blue or

Silver Senior Rx plans, and there seemed to be a misunderstanding regarding that issue. The plans were not restricted to only the low-income seniors. Co-Chair Buckley further explained that the premium would only be subsidized for those seniors who met the statutory guidelines for the subsidy program.

Senator Rawson asked Mr. Howard to further explain why his company, Mature Rx Plus, was not awarded the bid, because of the lower co-pays and the fact that the company was now licensed in Nevada. Mr. Howard replied that Mature Rx Plus was licensed in Nevada and it would offer a plan to seniors who did not qualify for the subsidy. He could not answer the question regarding the bid award, because he was not part of the evaluation team. Mr. Howard commented that on the evaluation form, in the area for financial stability, Advance PCS handled $18 billion per year in policy costs, and the State graded the company at zero out of a possible 20 points.

Co-Chair Freeman asked about the stability of Mature Rx Plus, and also of PRAM, i.e., how both companies were judged on the stock market as well managed companies. Mr. Howard stated that Advance PCS was quoted on NASDAQ, and was currently trading at $42 per share. Most analysts were projecting it as the stock to purchase. He felt the stability of Advance PCS was very good.

Ms. Miller indicated the State chose the plan which was felt to offer the best benefit relative to the premium costs to seniors. She noted the details of how PRAM was chosen over the other bidders could not be disclosed, because some vendors chose to exercise the confidentiality provision, and it would be unfair to Mature Rx Plus, PRAM, and the other vendors to enter into such a discussion.

Ms. Crawford stated the DHR greatly appreciated all five proposals received, which offered a range of benefit packages and premium rates. It was hoped that some of those companies would choose to market their product and make it available to seniors in Nevada. The insurer for the Senior Rx Program was Fidelity Security Life Insurance Company in the current contract, with PRAM designated as the administrator. The pharmaceutical benefit manager was PCN.

In summary, Ms. Miller stated that she felt two things had emerged during the hearing: (1) Information about the program should be user-friendly, including brochures that explained the program, not only for seniors, but also to the medical community. She also stated that some seniors might need assistance in deciding which plan would be best, and the company would provide that assistance. (2) The second issue that emerged was that the program was not comprehensive enough. While the program might only help a select few, those were the seniors who currently went without prescription drugs and/or went without food in order to purchase prescription drugs. Those were the seniors Governor Guinn set out to help, and in so doing, he also wanted to provide for the future, which was why the program was available to any senior in Nevada, while providing the additional subsidy assistance to 10,000 to 12,000 low-income seniors. Ms. Miller commented that there was no program available that would help everyone in Nevada, and pointed out that the Task Force was not able to fund all the requests it received, however, that did not mean it would not fund any. The Governor was aware of the need, and wanted to help those who were most needy.

Co-Chair Buckley stated that the points brought out by Ms. Sloan in her testimony, Exhibit G, should be incorporated into the plan if possible. Regarding the issue of the drug formulary, Co-Chair Buckley indicated it could be quite frustrating for a senior to think he had insurance coverage, and then have his claim denied. She asked for clarification regarding the formulary in the programs.

Ms. Crawford noted that many of the concerns voiced by Ms. Sloan were provided to the DHR prior to its evaluation of the bids, and were taken into consideration. While the program did not achieve all things mentioned by Ms. Sloan, the DHR did take many issues into consideration. The PCN formulary was designed, reviewed, and maintained by a pharmacy and therapeutics committee, which was staffed by physicians and pharmacists. Ms. Crawford was unaware whether there was a representative from Nevada on that committee. Since the Senior Rx Program was the first insurance product of its kind in Nevada, Ms. Crawford felt as additional resources were realized, more persons could be assisted. She reiterated since it was an insurance product, the DHR would share oversight with the Insurance Division. The DHR was the contractor, and performance under that contract would be monitored. All applicable Nevada law would apply to the insurer. Ms. Crawford felt that overall the formulary was found to be the most beneficial of the available options, and realized it would not cover all medications.

According to Ms. Crawford, the submitted bid was for the Silver plan, and the DHR asked the top competitors to provide a secondary plan, in order to provide a less expensive product. The Silver plan obviously provided more options for physician-prescribed, non-generic, preferred brand medications than the managed formulary included under the Blue plan. She reiterated it was not a perfect product and would not provide unlimited coverage, however, the evaluation committee felt it was the most balanced plan overall, and included the best benefit plan.

Co-Chair Buckley asked that because PRAM was an insurer, would it be required to have a Nevada-licensed physician as its medical director, as was currently required by Nevada law under the "Patients Bill of Rights." Ms. Crawford commented that the stipulation only applied to HMO's. Co-Chair Buckley felt it applied to all insurance companies who offered managed care, and with the formulary and prior authorization stipulation, the plan would fall under that category. Ms. Crawford stated she would check into that possibility. The Insurance Division licensed the company, and it would be subject to Nevada law.

Co-Chair Buckley felt the Task Force should consider a motion to reserve the funding, as required by law, and should then enter into discussion regarding possible BDR's. She also felt the Task Force should review the direction which the program should take in the future.

Dr. Ellerton stated the basic problem was that the program was an insurance product. It was supported by the pharmaceutical industry, because it served to hide what he considered to be the criminal pricing of drugs that were charged to the citizens of the United States. Dr. Ellerton indicated that the United States bore the brunt of the world's drug development costs. In Exhibit H, previously provided to the Task Force, there were several paragraphs in the letter of August 23, 2000, from PRAM, expressing the concerns of insurance companies in providing such an insurance product. The letter indicated that certain utilizations could be devastating when the definition of insurance was to spread the risk of one among a group of many, and that voluntary plans simply did not attract the good risk. The letter also stated, "Low budget, low benefit prescription drug program for seniors with restricted or limited preferred drug list with corresponding low rates only serve to complicate the matter." Dr. Ellerton noted that the letter indicated PRAM was trying to overcome those problems, but the insurance industry had provided such information to Congress, indicating that senior prescription plans included a great deal of difficulty.

According to Dr. Ellerton, the problem needed to be solved on the national level, which he felt was probably part of the problem in the development of a national consensus regarding health care. As a specific example, Dr. Ellerton indicated that in his practice, he used the drug Tamoxifen for breast cancer treatment and prevention. The price of an average 1-month supply of Tamoxifen to his patients was in the neighborhood of $120 to $140. The pharmacy benefit manager list, entitled "Covered and Non-covered Items," Exhibit J, listed the cost of a 1-month supply at $91, which would be a discount and the amount deducted from the $5,000 cap. If a patient paid cash for the same medication in Canada, including a $10 pharmacy fee, the cost would be $15 in U.S. currency. Dr. Ellerton stated that was the most outrageous and egregious example of profiteering. He questioned why the cash price at the counter was so incredibly different in Canada for branded products. He noted when generic equivalents were produced, often the price of branded products were also reduced. According to Dr. Ellerton, if the Senior Rx Program would deduct the price for medications in Canada from the $5,000 cap, seniors would realize a much greater benefit. Dr. Ellerton felt the Senior Rx Program would be an interim stopgap, and hopefully the Legislature would review the program very carefully. He concluded that the fundamental problem with the Senior Rx Program was that it was an insurance product supported by the pharmaceutical industry. In the meantime, Dr. Ellerton remarked that he would submit a motion to release the money for the program.

DR. ELLERTON MOVED TO APPROVE THE FULL ALLOCATION OF 30 PERCENT FOR THE SENIOR RX PROGRAM, LESS ANY ADMINISTRATIVE COSTS.

SENTOR RAWSON SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY VIA VOICE VOTE.

Co-Chair Buckley remarked that it seemed the appropriate time to address Item VI of the Agenda regarding BDR's, to determine whether the Task Force wanted to present any such requests. Dr. Ellerton suggested a BDR be submitted that

would create an oversight committee, which should be independent of the Task Force, and contain members such as seniors, physicians, and/or other interested persons who demonstrated the expertise needed to oversee the Senior Rx Program. Co-Chair Buckley then asked whether the pleasure of the Task Force would be to suggest some type of an advisory committee. She also suggested it should be a "lay" committee. Senator Rawson felt that perhaps it would be appropriate to have such an advisory committee report to both health care committees of the Legislature, along with the Governor, in an attempt to ascertain what recommendations it could make regarding the type of program which worked best for seniors. Co-Chair Buckley noted the input, discussion, and debate from such an oversight committee would assist in producing the best possible program. Co-Chair Buckley indicated she would accept a motion, and also stated she would review the language of the proposed BDR to ensure it contained the dictates of the Task Force, should that meet with the approval of all members. There was no disagreement from members regarding that suggestion.

DR. ELLERTON MOVED THAT THE TASK FORCE SUBMIT A BDR TO CREATE AN OVERSIGHT COMMITTEE FOR THE SENIOR RX PROGRAM, WHICH WOULD REPORT TO BOTH STANDING HEALTH CARE COMMITTEES OF THE LEGISLATURE. THE MEMBERS SHOULD CONSIST OF SENIOR CITIZENS, ALONG WITH PHYSICIANS, AND/OR PERSONS WHO DEMONSTRATED THE EXPERTISE TO OVERSEE THE PROGRAM.

DR. FILDES SECONDED THE MOTION.

THE MOTION PASSED UNINAMOUSLY VIA VOICE VOTE.

Mr. Fend noted the proposal currently before the Task Force was an insurance program, and asked whether it would operate under the auspices of the Insurance Commission. Co-Chair Buckley stated she believed the clarification was that as a contractor with the DHR, that agency would oversee the insurance provider, which was also a State licensed company, subject to all appropriate regulations. Providing further clarification was Charlotte Crawford, who stated the program was an insurance product that was provided by a licensed insurer in Nevada, and would be available to any and all seniors. The company was extending the coverage to seniors who did not meet the criteria for assistance, and would be required to pay the entire monthly premium. Ms. Crawford reiterated that the Fidelity Security Life Insurance Company provided the coverage and would be subject to all State regulations and requirements. The DHR endorsed that company's proposal as the Senior Rx Program product, declaring it as the one which would be provided the subsidy allocation for qualified seniors. Ms. Crawford stated while the DHR had initiated the development of the product, it did not hold oversight over it.

Co-Chair Buckley felt the Task Force should submit two separate BDR's, which could be considered simultaneously by the Legislature. The first would be to enhance the Senior Rx Program by allocating additional monies, thereby changing the subsidy allocation and lowering the co-payment. The second would be consideration of alternative programs, i.e., a State-run program similar to those currently operating in 14 other states, which would include a "flat" co-payment. She pointed out there should be some indication of how the current insurance program was working for the senior population by the time the Legislature convened in 2001, and it could hold hearings to evaluate different approaches. Co-Chair Buckley stated no matter whether an insurance company approach, a State-run program, or a federal Medicare program worked best, the rate for an insurance product would remain outside the control of both the Legislature and the Governor. The bottom line was to offer the most affordable program possible to seniors, and Co-Chair Buckley felt the co-payment would need to be reduced in order for that to occur. She then asked the Task Force members if they would be agreeable to the two BDR's.

Senator Rawson felt the first suggestion regarding allocation of additional monies was appropriate, because it expressed the direction in which he felt both the Task Force and the Legislature was interested in heading. He noted, however, that the second BDR, which would call for the drafting of an alternative plan, would send a message to the company providing the current insurance product that the Legislature was considering alternative programs, and he did not feel that was wise. The message might be that the insurance program was not permanent, and he questioned the effort that would be put forth by the insurance company if it felt the State was anticipating a change.

Co-Chair Buckley pointed out that the State contract with the current insurance provider was through December 31, 2001, and if the Governor and/or the Legislature felt a better program could be purchased with the funding, statutory

flexibility existed to allow the re-direction of the program. She remarked that the BDR might address the statutory parameters set by the current program, wherein the co-pay could not be altered, lowered, or changed. Should the Legislature devise a program, which might include bulk purchasing of medication, or rebates from drug companies, whereby the State could provide a better and cheaper product, Co-Chair Buckley felt that would be the direction in which the program should proceed. She reiterated that at the very least, hearings should be held by the Legislature to review all possibilities.

Dr. Ellerton asked whether there was any consideration of the disabled population in the proposed BDR's, and noted that many disabled individuals were heavy users of products and drugs, however, would not meet the age qualification for the senior subsidy program. Co-Chair Buckley felt that was an independent issue, and suggested that perhaps the Task Force could submit three BDR's, one of which could recognize the needs of persons with disabilities who were under the current Medicare system, in an attempt to provide some additional assistance. Whether or not the issue could be addressed in its entirety during the next session of the Legislature, Co-Chair Buckley felt it was worthy of a BDR, especially since other prescription drug issues would be considered. She also felt the disparity between drug prices in the different countries was bound to be an issue under discussion, and would not require a separate BDR. Co-Chair Buckley noted that all such issues would be "on the table" when the next Legislature convened. Senator Rawson felt omission of the disabled prescription drug issue was an oversight, because it was not fully realized that there would be a problem in that area. He indicated perhaps the Legislature should address that issue, and he would offer the following motion:

> SENATOR RAWSON MOVED THAT THE TASK FORCE SUBMIT THREE (3) BDR'S FOR LEGISLATIVE REVIEW: (1) THE POSSIBLE ALLOCATION OF ADDITIONAL MONIES FOR THE SENIOR RX PROGRAM, THEREBY LOWERING THE CO-PAY REQUIREMENT; (2) THE REVIEW OF ALTERNATIVE PROGRAMS; AND (3) REVIEWING THE POSSIBILITY OF INCLUDING THE DISABLED PRESCRIPTION DRUG ISSUE IN EITHER APPROACH.
>
> CO-CHAIR FREEMAN SECONDED THE MOTION.

Co-Chair Buckley felt that the recommendations presented by the AARP (Exhibit E), the Nevada Health Care Reform Project (Exhibit F), and those from Task Force members should be included in the BDR's, with affordability of the product being the number one consideration. Senator Rawson felt the motion should include the group of individuals the BDR's would address, i.e., disabled persons, needy seniors, et cetera. Co-Chair Buckley felt the Task Force should begin with needy seniors, as she felt the large-scale solution would involve the prescription drug benefit included in Medicare coverage. She did not feel it was possible to address the needs of every senior in Nevada, because of the lack of resources. Co-Chair Buckley felt that perhaps an increase in the income level of seniors eligible for the program could be submitted; she also noted that there would be numerous hearings conducted by the Legislature, which would provide opportunities for public input.

Co-Chair Freeman stated there was a State advocate currently working with the Insurance Division, and asked how that would coincide with the senior insurance product. Co-Chair Buckley felt that office could also field complaints that arose from the Senior Rx Program, as it was being provided as an insurance product.

With no further discussion forthcoming, Co-Chair Buckley called for a vote on the motion before the Task Force.

> THE MOTION CARRIED UNANIMOUSLY VIA VOICE VOTE.

Co-Chair Buckley announced that the next item for Task Force consideration was the status report regarding grants awarded by the Task Force in September 2000, and direction to the DHR staff regarding administration of those grants. Jane Smedes, Management Analyst IV, DHR, stated that since the September meeting of the Task Force, the DHR had been very busy with the grant awards, sending each recipient a letter announcing the award granted by the Task Force, and requesting second year budgets. In cases where the initial grant request was reduced by the Task Force allocation, new and/or revised budgets were requested for the first year. Ms. Smedes indicated the information was being returned in a timely manner, and the DHR was sending out contracts as the information was reviewed. The timeline was to present the contracts to the Attorney General's Office by November 6, 2000, and to the Board of Examiners meeting

planned for December 13, 2000, with a beginning date of January 1, 2001, for the grant awards. According to Ms. Smedes, those dates were contingent upon receipt of all required information from grant recipients. She stated the DHR was also working on more specific performance outcomes from each grant recipient, noting that each application included outcome measurements, however, they were not always specific. The request would be for specific performance outcomes that would, hopefully, accomplish uniformity and consistency so that similar data would be included in all quarterly reports in order to provide meaningful measurements to the Task Force. Ms. Smedes indicated a half-day workshop for tobacco grant recipients was planned for mid-November. Dr. Michael Johnson of the Gallup Organization was the planned speaker for the workshop, and the purpose would be to provide technical assistance and guidelines in data collection. In summary, Ms. Smedes stated the DHR's primary goal over the past month had been submittal of the contracts to recipients, with a secondary goal of improvement of the outcome measurements.

Dr. Fildes requested that all tobacco control grant recipients be encouraged or required to belong to local or statewide tobacco control coalitions, in order to share resources, facilitate communication, and maximize the State's investment. Ms. Smedes indicated the DHR could strongly encourage such action. Co-Chair Buckley felt that a "requirement" would have needed to be a condition listed in the RFP. However, since the Task Force was the funding authority it could review that issue when considering future grant awards, which she felt would accomplish compliance with the request.

Ms. Brower indicated it was her understanding that the DHR would collect the data regarding outcomes of the programs awarded grant funding, and then report to the Task Force. She indicated she was attempting to ascertain the oversight body. Ms. Smedes stated the outcomes would be submitted to the Director's Office of the DHR on a quarterly basis, and reports would be forwarded to the Task Force as directed. Co-Chair Buckley felt the Task Force did have oversight authority as indicated by statute.

Co-Chair Buckley announced that the Task Force had some unallocated funds available for second year requests, and suggested a meeting be scheduled in December 2000 to discuss commitment of the balance of the unexpended funding. The Task Force could also "brainstorm" with the DHR to ascertain whether the balance could be expended via the applications already submitted, or whether additional data would be required. Between now and December, Co-Chair Buckley suggested that she, Ms. Crawford, Ms. Smedes, and Ms. Morgan decide what action would be required and how the Task Force should proceed.

With no further business to come before the Task Force, Co-Chair Buckley adjourned the hearing at 3:30 p.m.

Submitted:

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Carol Thomsen, Secretary

APPROVED:

Assemblywoman Barbara Buckley
Presiding Co-Chair