

State Pharmacy Assistance Programs and
Their Implications for a Medicare Prescription Drug Benefit

Testimony Before the Senate Finance Committee

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Chairman Grassley, Senator Baucus, and Members of the Committee: Thank you for the opportunity to testify today on Medicare reform issues. I want to thank as well my colleagues at the Rutgers Center for State Health Policy on our study currently in progress for the Commonwealth Fund on state pharmacy assistance programs— Kim Fox, Tom Trail, Mina Silberberg, Susan Reinhard, and Joel Cantor. Our work is at a preliminary stage since we are currently in the early stages of state case studies for the project. During the coming months we will have much more information on the questions I was asked to address. However, we do have some basic data reported to us by states with direct benefit pharmacy assistance programs in a mail survey that we conducted between September 2000 and January 2001, and partial information from case studies in progress of several of these states that may be useful to you at this stage. We have included tables that reflect the information reported to us by the states; they are preliminary data since we are still in the process of double-checking with the states the information that they returned to us on the surveys, but they provide a good overall picture of the current landscape of state pharmacy assistance programs.

Based on the mail survey, we estimate that total enrollment in state direct benefit pharmacy assistance programs operating throughout 2000 was approximately 860,000. Although enrollment may have increased slightly in 2001 due to program startups and expansions, we estimate that fewer than 3% of Medicare beneficiaries are enrolled in state direct benefit programs. These programs are typically targeted to individuals whose incomes are low but above Medicaid eligibility levels. They are of great importance to participants, since out-of-pocket health care costs and particularly prescription drug costs represent a significant burden to individuals in these income ranges. For example, in a recent study in the *Journal of Gerontology* using data from the Medicare Current Beneficiary Survey, we estimated that health care expenditures accounted for 32% of income for older persons in the lowest fifth of the income distribution and 24% for those in the second lowest fifth. In both quintiles, prescription drug costs accounted for 40% of out-of-pocket payments for health care goods and services, a higher proportion than for higher-income people.

However, these programs are far from constituting a national drug safety net. They constitute a spotty and uneven system in which protection depends on where you live. While 14 states operated direct benefit programs throughout the year 2000, 49% of the enrollment was in just

two states, Pennsylvania and New Jersey, and 72% was in these two states plus New York and Massachusetts. In six states -- Maine, Vermont, Rhode Island and Delaware, plus Pennsylvania and New Jersey -- enrollments exceeded 10% of Medicare enrollment in the state. Many of the programs are more limited, however; for example, some cover only certain types of drugs or persons with certain conditions. Only seven of the plans covered persons with disabilities, although low-income disabled individuals who have Medicare coverage but not Medicaid may have even more difficulty than elderly beneficiaries with access to pharmaceutical treatments and potential adverse health consequences. Antipsychotic medications, for example, can be quite costly, while failure to take these medications consistently when indicated can precipitate psychiatric hospitalization. While the need is great, covering the disabled is particularly challenging for states, since those states that do so generally find that these enrollees use more prescription drugs and cost more per person to cover than do elderly enrollees.

From a national perspective, the proportion of Medicare beneficiaries enrolled in state direct benefit programs is relatively small. It probably represents a somewhat higher proportion of Medicare beneficiaries' prescription drug spending, however, since those with high drug spending are likely to enroll disproportionately in the plans. The programs are highly popular, and state legislators hear frequently from their constituents about the need to create or expand them. However, despite the fact that several states are launching new programs and several existing programs are expanding eligibility, existing programs report that they are under considerable financial pressure in the face of steadily rising pharmaceutical costs.

Eligibility, cost-sharing, and other program characteristics vary widely across states. While the elderly and in some cases the disabled are the primary focus, there are two programs (Maryland and Wyoming) that cover all residents who meet income requirements regardless of age or disability. All the programs except Nevada's are operated directly by the states, with assistance of contracted pharmacy benefit managers in a few cases. Nevada, after considerable initial difficulty in securing an interested vendor, has recently implemented a program under which state funds are used to subsidize private pharmacy insurance policies, with relatively small numbers of enrollees to date. As this program evolves, Nevada's experience will be of interest in connection with legislative options that would create stand-alone pharmacy insurance policies.

People we've interviewed in the states have been concerned about consumers whose incomes put them just over income limits, but who have great need for prescription drug coverage. A few states have dealt with this issue by allowing individuals with incomes over the limits to qualify for the program if they spend a certain percentage of their income on prescription drugs (40% in Delaware and Maine, 10% in Massachusetts, 3% in Rhode Island). In addition, states hear constantly from constituents and consumer groups about the need to increase eligibility limits in order to bring more of the near-poor into coverage.

Income eligibility ceilings range widely. Four states have eligibility limits at or below 135% of the federal poverty line, while three make some benefits available to persons at more than 400% of poverty. The majority, however, have ceilings in the range from 150% to 260% of poverty. New Jersey, for example, provides a comprehensive benefit to persons up to about 230% of the poverty line and is considering legislation to provide another tier of benefits, at a higher

copayment, to those with higher incomes. Only two states impose asset limits for eligibility, and one of those two, Minnesota, recently substantially raised its asset limit.

The more generous programs, such as those in New Jersey, Pennsylvania, and Vermont, operate on a drug benefit model similar to that of Medicaid: almost all drugs are covered for a nominal (\$6 or less) co-pay with no fees, no deductible, and no maximum benefit. Other programs have slightly less generous benefits, but still cover most prescription drugs available under Medicaid. These programs use various combinations of deductibles, coinsurance, fees, and/or benefit maximums, although the experience with programs with high up-front fees has been that this strategy substantially depresses enrollment. Generally, programs report that initially, considerable outreach and consumer education is necessary for consumers to understand the plans and to encourage those eligible to apply.

Several programs have substantial deductibles, particularly for those above the lowest eligible income tier. South Carolina and Pennsylvania's PACENET program have a \$500 annual deductible, and Minnesota has a \$35 monthly deductible. Both Massachusetts and New York offer coverage with sliding scale fees and/or deductibles based on income. In New York, enrollees pay either an annual fee ranging from \$8 to \$230 (singles) if they are in a lower income bracket, or an annual deductible ranging from \$530 to \$1,230 (singles) if they are in a higher income bracket. Massachusetts enrollees pay both a monthly fee ranging up to \$82 and an annual deductible ranging up to \$500. Both of these programs also have tiered co-pays based on the cost or type of drug, and both have annual out of pocket maximums — \$2,000 or 10% of annual income in Massachusetts and 6% of annual income (singles) in New York (8% for couples). A few active programs have annual caps on benefits: Delaware has a \$2,500 annual cap, Indiana has a \$500 to \$1,000 tiered benefit cap, Florida has an \$80 monthly benefit cap, and Michigan has had a limit of three months worth of prescriptions up to three times a year, which we understand is being modified. Nevada's new program has monthly premiums and a \$5,000 annual benefit cap.

In thinking about the challenges faced by these programs and their implications for a Medicare benefit, perhaps the most recurrent challenge cited by state officials we interviewed is the tension between ever-increasing pharmacy costs and pressures to maintain and expand program coverage driven by the high level of need. The trend in per-participant annual program costs has been sharply upwards. Programs that have made dedicated funds available to pharmacy programs and other health programs, such as lottery revenues in Pennsylvania and casino revenues in New Jersey, have seen the pharmacy programs outstripping the revenue sources and crowding out other programs or spilling over into general revenues. The stability of funding for the programs in the future is uncertain, particularly if very recent trends suggesting a deterioration of state budgetary outlooks continue. Cost containment is a constant struggle for the programs, which have pursued a variety of avenues, often in the face of opposition either from manufacturers, pharmacist organizations or consumer advocates, depending on who is impacted by a particular strategy. At the same time, there are chronic pressures to expand coverage to the groups just above the eligibility limit, wherever it is set. Although they hear loud and clear from their constituents about the magnitude of the need, states are therefore also concerned about the financial implications for state budgets of maintaining or expanding their role in pharmacy assistance.

I was asked to think about how states might respond if a universal voluntary benefit were created. This would certainly vary from state to state and would depend a lot on the type of benefit that was created and on the budget situation facing a state in a given year. These programs do have strong constituencies. If a federal benefit were less generous than the benefits in place in a state, that state would be under considerable constituent pressure to wrap around the federal benefits so as to make up the difference. Some would like to use funds freed up from pharmacy benefits to cover additional individuals beyond their present eligibility levels. However, pharmacy assistance would be competing with many other budgetary demands for these funds. States have, as you know, opposed any maintenance-of-effort requirement, arguing that this would constitute penalizing states that have taken the initiative.

If a federal benefit is less generous than some of the state programs, it would be desirable to make it as straightforward as possible for states to supplement or “wrap around” the federal benefit. State program administrators are concerned that unless provisions for this are designed into the system, coordination of benefits problems could be very difficult and could possibly become a disincentive for states to maintain their efforts. Coordination of benefits in the current system – for example, with Medicare+Choice and employer-based plans – is already a difficult problem for state pharmacy programs. While they are typically mandated to be the payer of last resort, they often are unable to recover from other payers due to lack of accurate information and the technical difficulties of coordinating benefits. To effectively coordinate benefits, program administrators say they would need direct access to enrollment and benefits information for Medicare-funded pharmacy coverage. Policy options envisioning a system of federally subsidized pharmacy-only policies, with differing formularies, co-pays, and other provisions, would appear to be particularly problematic from the coordination-of-benefits point of view, in addition to the concerns about adverse selection, consumer confusion, and administrative costs under such an approach. A defined Medicare prescription drug benefit would probably be less difficult for states to coordinate with.

There are a variety of ways in which states could be encouraged to maintain their efforts if a federal benefit is created. They could, for example, be given the option of administering a federally-funded benefit in their state, in which case supplementing the basic benefit with state funds would be straightforward. If private pharmacy-only insurance products are subsidized, these programs could be required to make enrollment and benefits information available to states operating pharmacy assistance programs. Alternatively, states could drop their existing programs and shift to a supplemental premium support role, but how this would work is uncertain and it could also involve considerable challenges of coordination.

The state pharmacy programs might also play a useful role in eligibility determination for means-tested federal prescription drug subsidies. It has been suggested, I believe in one version of the Breaux-Frist proposals, that this responsibility be assigned to state Medicaid agencies. People we interviewed from the state pharmacy assistance programs were concerned that this could be a significant barrier to participation because of the perceptions of welfare stigma that Medicaid and the Medicaid agencies carry for many older people. They were also concerned about the possibility of eligibility being restricted to individuals who meet the asset limitations of the QMB program, which are perceived as extremely restrictive and as barring many low-income

individuals who are severely burdened by pharmacy costs. Such an asset test might be strongly unpopular with beneficiaries and limit enrollment in new programs.

A final area of concern has to do with the issue of consumer confusion over complex plan requirements. Beneficiaries are often confused about even basic concepts in the state programs, such as the difference between a deductible and a premium. States are concerned that beneficiaries, already challenged by the complexity of Medicare, Medicare+Choice plans and supplementary insurance, will find it very difficult to effectively evaluate, in addition, a variety of choices for pharmacy coverage. They anticipate that this would engender considerable additional burden on already-overburdened health insurance counseling services such as those offered through area agencies on aging.

Clearly, your Committee is struggling with a most challenging and complex policy problem, in a system with many moving parts. The absence of outpatient prescription drug coverage in the traditional Medicare program is by now widely seen as a serious problem for many beneficiaries. The traditional program is still where most beneficiaries are, either by their own choice or because Medicare+Choice plans are not available in their areas. Many states have struggled, each in their own way, with the attempt to fill this gap, but have felt under considerable financial pressure in attempting to address this very expensive problem at the state level. Many of the states have, however, acquired a great deal of valuable experience which should be built on as the provision of pharmacy coverage evolves. For example, the prospective drug utilization review systems developed by Pennsylvania serve not only as a means of cost containment but also as a vehicle for important health care quality and medical error reduction purposes. Use of these systems for public health purposes, and coordination of pharmacy benefit management with other health care programs such as long-term care, are of increasing interest to states and should be encouraged.

The effort to provide both a universal voluntary benefit with some subsidy, and more significant financial protection to lower-income individuals, within limited funds is indeed a great challenge. In thinking about how to address this problem, a broad concern that grows out of our interviews with state stakeholders is the impact of existing complexity and fragmentation in the financing of health care for Medicare beneficiaries, and the desirability of attempting to minimize rather than increase it. As people in state agencies, who interact with elderly and disabled consumers on an ongoing basis, are only too well aware, many consumers find it difficult to understand the coverage choices and multiple payers involved in the existing system. In concept, policy options which would aim at creating a market for competing, subsidized private pharmacy-only policies with differing benefit structures could add to consumer choice. However, the tradeoffs might include building in increased administrative complexity and costs into the system, increased beneficiary confusion, and making it administratively more difficult for states to supplement federally supported benefits. Several of our respondents were concerned about how effectively their beneficiaries would be able to assimilate and evaluate information on new, complex choices on pharmacy coverage, and spoke to the value of considering the benefits of simplicity and comprehensibility along with those of choice in building pharmacy benefits into the system.

As we move forward with our study in the coming months, complete additional state case studies, and prepare analyses on the process of program implementation and the impact of alternative benefit designs for state pharmacy assistance programs, variation in benefit takeup, and program management strategies including drug utilization review, we will be happy to be of any further service we can be to the Committee. In conclusion, I would like to thank the Committee again for the opportunity to testify, and will be happy to address any questions.

Table 1. State Programs by Type of Program and Date of Implementation

States with Direct Benefit Programs Only (16 States)

State	Program Name	Program Type	Implemented
Connecticut	Connecticut Pharmaceutical Contract to the Elderly and Disabled (ConnPACE)	Direct benefit with \$12 co-pay and \$25 annual fee	April 1985
Delaware	Nemours Health Clinic Pharmacy Assistance Program (private initiative)	Direct benefit with \$5 co-pay, 20% coinsurance, and \$2,000 annual benefit cap	September 1981
	Delaware Prescription Drug Assistance Program (DPAP)	Direct benefit with \$5/25% co-pay/coinsurance and \$2,500 annual benefit cap	January 2000
Illinois	Pharmaceutical Assistance Program (PAP)	Direct benefit with \$0/\$5 co-pay and \$5/\$25 annual fee	July 1985
Indiana	Indiana Prescription Drug Fund: "HoosierRx"	50% coinsurance with \$500 to \$1,000 tiered annual benefit cap	September 2000
Kansas	Senior Pharmacy Assistance Program	Direct benefit with 30% coinsurance and \$1,200 annual benefit cap	Expected July 2001
Maryland	Maryland Pharmacy Assistance Program	Direct benefit with \$5 co-pay	January 1979
Massachusetts	The Pharmacy Program	Direct benefit with \$15 annual fee, \$3/\$10 co-pay, and \$1,250 annual benefit cap	July 1997
	The Pharmacy Program Plus	Direct benefit with \$3/\$10 co-pay	January 2000
	Prescription Advantage Program	Direct benefit with \$0/\$82 sliding scale monthly premium, \$0/\$500 sliding scale annual deductible and \$5/\$12/50% tiered co-pay	April 2001
Minnesota	Prescription Drug Program (PDP)	Direct benefit with \$35 monthly deductible	January 1999
Nevada	SenioRx Insurance	Insurance subsidy with \$75/\$98 monthly subsidized premiums, \$100 annual deductible, \$10/\$40 tiered co-pay, and \$5,000 annual benefit maximum	January 2001
New Jersey	Pharmaceutical Assistance for the Aged and Disabled (PAAD)	Direct benefit with \$5 co-pay	March 1976

States with Direct Benefit Programs Only (16 States) continued.

State	Program Name	Program Type	Implemented
New York	Elderly Pharmaceutical Insurance Coverage (EPIC)	Direct benefit with \$3/\$20 tiered co-pay and either \$8/\$230 sliding scale annual fee or \$530/\$1,230 annual deductible	October 1987
North Carolina	Prescription Drug Assistance Program	Direct benefit with \$6 co-pay	July 2000
Pennsylvania	Pharmaceutical Assistance Contract for the Elderly (PACE)	Direct benefit with \$6 co-pay	July 1984
	Pharmaceutical Assistance Contract for the Elderly Needs Enhancement Tier (PACENET)	Direct benefit with \$8/\$15 co-pay and \$500 annual deductible	November 1996
Rhode Island	Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE)	Direct benefit with tiered 40%/85% coinsurance	October 1985
South Carolina	Seniors' Prescription Drug Program	Direct benefit with \$10/\$21 co-pay and \$500 annual deductible	January 2001
Wyoming	Minimum Medical Program (MMP)	Direct benefit with \$25 co-pay	1988

States with Discount or Tax Credit Programs Only (6 States)

State	Program Name	Program Type	Implemented
California	Drug Discount Program for Medicare Beneficiaries	Medi-Cal reimbursement rate discount	February 2000
Iowa	State prescription drug purchasing co-operative	Discount drug purchasing co-op	Expected July 2001
Missouri	Pharmaceutical Tax Credit	\$200 tax credit	1999 tax year
New Hampshire	Senior Prescription Drug Discount Pilot Program	Pharmacy Benefit Manager discount program	January 2000
Washington	A Washington State Alliance to Reduce Prescription Drug Spending (AWARDS)	Pharmacy Benefit Manager discount program	January 2001
West Virginia	Senior Prescription Assistance Network II (SPAN II)	Public Employee Insurance Agency discount	December 2000

States with Direct Benefit Programs and Other Programs (4 States)

State	Program Name	Program Type	Implemented
Florida	Pharmaceutical Expense Assistance Program	Direct benefit with 10% coinsurance and \$80 monthly benefit cap	January 2001
	Medicare Prescription Discount Program	State-mandated discount	July 2000
Maine	Low Cost Drugs for the Elderly or Disabled	Direct benefit with \$2/20% co-pay/coinsurance	1975
	Maine Rx	State negotiated discount	Expected April 2001
	Healthy Maine Prescription Program	HCFA waiver for discount at Medicaid reimbursement rate minus average rebate	Expected 2001
Michigan	Michigan Emergency Pharmaceutical Program for Seniors (MEPPS)	Direct benefit with 25¢ co-pay and 3 month prescription limits	1988
	Prescription Drug Credit program	\$600 tax credit	1988
	Elder Prescription Insurance Coverage (EPIC)	Direct benefit — details to be determined	Expected 2001
Vermont	Vermont Health Access Program (VHAP)	Direct benefit with \$1/\$2 co-pay	January 1996
	VScript	Direct benefit with \$1/\$2 co-pay	1989
	VScript expanded	Direct benefit with 50% coinsurance	January 2000
	Pharmacy Discount Program (PDP)	HCFA waiver for discount at Medicaid reimbursement rate minus average rebate	January 2001

* Source: Rutgers Center for State Health Policy Survey of State Pharmaceutical Assistance Programs, December 2000; the Health Insurance Association of America's September 2000 report on state pharmaceutical assistance programs *State Pharmaceutical Assistance Programs Continue to Grow*. Washington, DC; and the National Conference of State Legislatures' web site: *State Senior Pharmaceutical Assistance Programs*, <http://www.ncsl.org/programs/health/drugaid.htm>.

Table 2: States with direct benefit programs, year implemented and eligibility requirements.

State	Year 2000 Income Requirements (%FPL)	Year 2001 Income Requirements (% FPL)	Elderly	Disabled
Connecticut	178%	180%	65	18
Delaware				
Nemours	152%	150%	65	—
DPAP	200%	200% ^a	65	19
Florida	—	120%	65	—
Illinois	194%	254%	65	16
Indiana	135%	135%	65	—
Kansas	—	150%	67	—
Maine	185%	185% ^b	62	19
Maryland	117%	116%	No age restrictions	
Massachusetts				
Pharmacy Program	191%	—	65	No minimum
Pharmacy Program + Prescription Advantage	500%	—	65	No minimum
Prescription Advantage	—	500% ^c	65	No minimum
Michigan	150%	150%	65	—
Minnesota	120%	120%	65	—
Nevada	—	257%	62	—
New Jersey	226%	230%	65	18
New York	225%	419%	65	—
North Carolina	150%	150%	65	—
Pennsylvania				
PACE	170%	168%	65	—
PACENET	194%	192%	65	—
Rhode Island	189%	419% ^d	65	—
South Carolina	—	175%	65	—
Vermont				
VHAP	150%	150%	65	No minimum
VScript	175%	175%	65	No minimum
VScript Expanded	225%	225%	65	No minimum
Wyoming	100%	100%	No age restrictions	

Notes: The FPL for year 2000 income was \$8,350 for single individuals. In some states, eligibility requirements are set as a percentage of poverty line; in others, we have calculated percentage of poverty line based on eligibility levels set in dollar terms.

^a Applicants in Delaware who have prescription drug expenses in excess of 40% of their income are eligible for the program regardless of their income.

^b In Maine, if an applicant spends 40% or more of his/her income on prescription drugs, the income limits are 25% higher.

^c Massachusetts' new program in effect April 2001 has no upper income limit. Premiums and deductibles are subsidized on a sliding scale for enrollees with incomes below 500% of FPL. Enrollees with incomes below 188% of FPL pay no premiums or deductibles. This program replaces the Pharmacy and Pharmacy Plus Programs.

^d When calculating income eligibility, Rhode Island's program excludes medical and pharmaceutical expenses exceeding 3% of an applicant's annual income.

* Source: Rutgers Center for State Health Policy Survey of State Pharmaceutical Assistance Programs, December 2000; and the National Conference of State Legislatures' web site: *State Senior Pharmaceutical Assistance Programs*, <http://www.ncsl.org/programs/health/drugaid.htm>.

Table 3: Enrollment as a Percentage of Medicare Enrollment in State Direct Benefit Programs Operating Throughout 2000

State	Year 2000 Enrollment	Percentage of Medicare Enrollees in State
Connecticut	30,546	6.0%
Delaware (all programs)	12,630	11.5%
Illinois	51,823	3.2%
Maine	40,277	18.6%
Maryland	41,261	6.5%
Massachusetts (all programs)	69,770	7.3%
Michigan	12,591	1.1%
Minnesota	4,833	0.8%
New Jersey	187,358	15.7%
New York	126,302	5.4%
Pennsylvania (all programs)	237,190	12.7%
Rhode Island	33,000	22.4%
Vermont (all programs)	11,175	12.9%
Wyoming	550	0.9%
Total	859,306	7.5%**

Source: Enrollment numbers come from the Rutgers Center for State Health Policy Survey of State Pharmaceutical Assistance Programs, December 2000; and the National Conference of State Legislatures' web site: *State Senior Pharmaceutical Assistance Programs*, <http://www.ncsl.org/programs/health/drugaid.htm>. State Medicare enrollment data are from the HCFA web site, *Medicare County Enrollment as of July 1, 1999: Aged and Disabled 3/2000 update*. <http://www.hcfa.gov/stats/>. Medicare enrollment figures used as denominators do not include disabled enrollees for states where disabled persons are not eligible for the pharmacy assistance program.

**Ratio of enrollment in states with programs to Medicare enrollment in those states.