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STATE PHARMACY PROGRAMS

Assistance Designed to Target Coverage and Stretch Budgets

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Contents

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Health, Education, and
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The Honorable Thomas J. Bliley, Jr.
Chairman, Committee on Commerce
House of Representatives

The Honorable Michael Bilirakis
Chairman, Subcommittee on Health
and Environment
Committee on Commerce
House of Representatives

The Medicare program, with few exceptions, does not pay for outpatient prescription drugs, which have become an increasingly important part of health care. Over two-thirds of Medicare beneficiaries had some other source of outpatient prescription drug coverage in 1996,[1] but for some of these beneficiaries, insurance pays only a fraction of their drug costs. The other one-third of Medicare beneficiaries must pay for their prescription medications entirely out of pocket because they do not have access to coverage, cannot afford to purchase coverage, or choose not to purchase coverage. Medicare beneficiaries, in particular, may be vulnerable to high prescription drug costs because of their disproportionate use of prescription medication. To fill the insurance gaps for some low-income elderly residents, several states have enacted independent, state-funded programs to provide prescription drug coverage.

Over the past year, extending prescription drug coverage to Medicare beneficiaries has been the topic of several congressional hearings and the objective of many legislative proposals.[2] At the same time, a number of states have implemented, considered implementing, or altered existing drug assistance programs for the elderly and others with low incomes. Examining the design and administration of these state programs provides useful information about how states provide drug benefits to targeted

[1]J.A. Poisal and G.S. Chulis, "Medicare Beneficiaries and Drug Coverage," *Health Affairs* (Mar./Apr. 2000), p. 250.

[2]On June 28, 2000, the House of Representatives passed H.R. 4680, which would provide subsidies for Medicare beneficiaries to purchase private insurance plans to cover prescription drugs.

populations. You asked us to examine state-administered pharmaceutical assistance programs and to describe (1) the characteristics of state programs designed to provide prescription drug access to eligible populations and (2) the administrative and policy issues that states have encountered in operating drug assistance programs.

To respond to these questions, we examined state programs that provide prescription drug benefits. We obtained information on the policies, design features, and operations of each from interviews with state program officials. We also reviewed relevant laws, regulations, and program literature and interviewed senior citizen advocates in some states. We conducted our study from November 1999 to August 2000 in accordance with generally accepted government auditing standards; however, we did not independently verify all data obtained from state program administrators. App. I provides a more detailed discussion of our study methodology.

Results in Brief

In 1999, 14 states were operating independent, state-funded and administered programs that provided more than 760,000 elderly and other low-income persons with access to prescription drugs.[3] Most programs are funded with the state's general revenues, but some receive earmarked funds. All state pharmacy programs provide benefits for low-income elderly state residents, but specific eligibility rules differ. The programs vary in the number of people enrolled and their size relative to the number of Medicare beneficiaries in the state. States attempt to provide access to drugs and manage program costs through coverage restrictions such as dollar caps on benefits, deductibles, copayments, and limits on the types of drugs covered. Among state programs, copayments and coinsurance are more common than benefit caps and deductibles, but the amount of cost sharing varies widely across programs. All state programs obtain rebates from drug manufacturers to offset part of their expenditures; most state programs receive manufacturers' rebates that are calculated on terms similar to rebates under the Medicaid program.

To provide a pharmacy assistance benefit to a low-income and largely elderly population, while remaining within the program budget, states have taken a variety of approaches to administering their programs. These

[3]Three states—New York, Pennsylvania, and Vermont—had more than one pharmacy program, bringing the total number of operational programs to 18.

include developing adequate systems to administer benefits and coordinating payment with and recovering payment from other insurers. States have also attempted to encourage enrollment by mitigating the perceived stigma attached to assistance programs, which could inhibit enrollment, and by providing information to eligible persons so that they are aware of the program and know how to apply. Three program administrators said that drug assistance programs were intentionally administered apart from Medicaid programs to avoid the perceived stigma attached to Medicaid. However, several states administer aspects of their programs through and employ the policies of the agency administering Medicaid. Administering programs using Medicaid systems allows states to avoid duplicating program functions, such as eligibility determination and claims processing and adjudication. Nevertheless, some states have encountered administrative challenges in developing adequate eligibility determination and claims processing systems and in recovering payments from insurers when program enrollees have other drug coverage.

Background

Medicare is the primary source of health care coverage for most U.S. residents who are 65 or older, yet, with few exceptions, it does not cover outpatient prescription drugs. Most Medicare beneficiaries with prescription drug benefits receive coverage from employer-sponsored retirement plans, Medicare managed care plans, Medicare supplemental policies (Medigap), or Medicaid.[4] The protection such coverage provides varies across insurance type and can be expensive. Standard Medigap plans that cover prescription drugs have a $250 deductible, [5] require 50 percent coinsurance, and have limits of $1250 or $3000 on annual covered drug expenses. Recent evidence shows that premiums are rising for employer-sponsored plans, Medicare managed care plans, and Medigap policies. In addition, some employer-sponsored health plans and Medicare managed care plans are imposing greater cost-sharing requirements and more restrictive coverage limits for drugs under their plans.

Medicaid is a health insurance entitlement program funded jointly by federal and state governments for certain low-income populations, including about 12 percent of Medicare beneficiaries. Medicare

[4]Poisal and Chulis, "Medicare Beneficiaries and Drug Coverage," p. 252.

[5]A deductible is the amount a program enrollee must pay before the program pays some amount for covered services.

beneficiaries who qualify for full Medicaid benefits receive prescription drug coverage through their state's Medicaid program. Some Medicare beneficiaries qualify for limited Medicaid assistance with Medicare premiums and cost sharing. States are not required to provide prescription drug coverage to Medicare beneficiaries who qualify for limited Medicaid benefits.

State Programs Differ, but Eligibility, Benefit Design, and Manufacturer Rebates Influence Program Spending in All States

In 1999, 14 states were operating state-funded pharmacy assistance programs that provided more than 760,000 enrollees—mostly low-income seniors and persons with disabilities in some states—with financial assistance to purchase prescription drugs. Several other states have also recently passed legislation to add such programs. Sources of program funding and budget levels vary across states. Most states have chosen to concentrate their limited budgets by targeting drug programs to low-income seniors and persons with disabilities who do not qualify for Medicaid drug coverage, although eligibility rules vary across states. All states received manufacturer rebates on drugs to defray their programs' spending. Programs also extend their budgets by requiring recipients to contribute to the purchase price of their prescriptions; however, the amount of cost sharing varies across programs.

Pharmacy Assistance Programs Began in 1975; Additional States Have Added Programs

The first state pharmacy assistance programs were enacted in Maine and New Jersey in 1975 to provide prescription drug coverage to low-income[6] Medicare beneficiaries (see table 1). In the 1980s, eight more states—Connecticut, Illinois, Michigan, New York, Pennsylvania, Rhode Island, Vermont, and Wyoming—added prescription drug benefit programs. Eleven states enacted programs from 1996 to 2000. In 1999 alone, seven state legislatures expanded or added programs. New state programs in Florida, Indiana, Kansas, Michigan, Nevada, and South Carolina are not yet fully operational. Most programs were operational within 1 year after enactment. As of June 2000, four states have two or more programs that share some features but differ as to eligibility criteria, covered drugs, or cost-sharing requirements.

[6]"Low-income" is often defined as an individual or family income below some percentage of the federal poverty level (FPL), a standard that is used to establish financial eligibility for some federal programs. Some state drug assistance programs use FPL guidelines, and other states use different methods to define program eligibility. The 1999 FPL for an individual in the 48 contiguous states and District of Columbia was $8,240.

Table 1: State Pharmacy Assistance Programs, Years Enacted and Operational

State	Program	Year enacted	Year operational
New Jersey	Pharmaceutical Assistance to the Aged and Disabled (PAAD)	1975	1975
Maine	Maine Low-Cost Drug Card Program for the Elderly or Disabled	1975	1975
Maryland	Maryland Pharmacy Assistance Program	1978	1979
Pennsylvania	Pharmaceutical Assistance Contract for the Elderly (PACE)	1983	1984
Connecticut	Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled Program (ConnPACE)	1985	1986
Illinois	Circuit Breaker Pharmaceutical Assistance Program	1985	1985
Rhode Island	Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE)	1985	1985
New York	Elderly Pharmaceutical Insurance Coverage Program (EPIC)	1986	1987
Michigan	Michigan Emergency Pharmaceutical Program for Seniors (MEPPS)[a]	1988	1990
Wyoming	Minimum Medical Program	1988	Operational, but year not provided by program official
Vermont	VScript	1989	1989
Massachusetts	Senior Pharmacy Program	1996	1997
Pennsylvania	Pharmaceutical Assistance Contract for the Elderly, Needs-Enhancement Tier (PACENET)	1996	1996
Vermont	Vermont Health Access Program (VHAP Pharmacy)	1996	1996
Minnesota	Senior Drug Program	1997	1999
California	California Drug Discount Program[b]	1999	2000
Delaware	Delaware Prescription Assistance Program (DPAP)	1999	2000
Massachusetts	Pharmacy Program Plus[c]	1999	2000
Michigan	Elder Prescription Insurance Coverage (EPIC)	1999	Not yet operational
Nevada	Senior citizen subsidy for prescription drug private insurance policies[d]	1999	Not yet operational
North Carolina	Prescription Drug Assistance Program	1999	2000
Vermont	VScript Expanded	1999	2000
Florida	Pharmaceutical Expense Assistance Program	2000	Not yet operational
Indiana	Indiana Prescription Drug Fund	2000	Not yet operational
Kansas	Senior Pharmacy Assistance Program	2000	Not yet operational
South Carolina	Seniors' Prescription Drug Program	2000	Not yet operational

[a]According to Michigan officials, the EPIC program will replace MEPPS.

[b]The California program, which became operational February 1, 2000, allows Medicare beneficiaries in California to purchase drugs at pharmacies for the same price paid by the California Medicaid (Medi-Cal) program. A pharmacy must participate in this program as a condition of participation in the Medi-

Cal program. Because this program does not provide drug coverage, but rather allows Medicare beneficiaries to purchase drugs at Medicaid prices, it is not discussed further in this report.

[c]The Massachusetts Pharmacy Program Plus, authorized for only 1 year, is intended to cover residents who are 65 or older or disabled, with incomes not more than 500 percent of the federal poverty level, who spent at least 10 percent of their gross monthly income on prescription drugs in 3 of the 6 months prior to application, and who are projected to have prescription drug expenses exceeding 5 percent of their gross monthly income as long as they are eligible under the program.

[d]Nevada will provide a subsidy up to $480 per year to Medicare beneficiaries to purchase insurance for prescription drugs.

Sources: State programs, National Conference of State Legislatures, and http://www.ncsl.org/programs/health/drugaid.htm (downloaded 06/23/00).

Eligibility Limits and Benefit Design Target Program Assistance

States use age, income, and other criteria to target and control the size of their drug assistance programs (see table 2). All but three programs required enrollees who are not disabled to be at least 65.[7] Almost two-thirds of the programs had eligibility criteria that allow some people with disabilities to be eligible for assistance.[8] In 1999, the income limits varied from 100 percent of the federal poverty level (FPL) to 225 percent. In addition to income restrictions, Michigan required an enrollee's monthly prescription drug expenditures to exceed 8 percent of their monthly income if the person is married or 10 percent if the person is single or widowed. Recognizing that strict income limits may exclude some individuals who need assistance, the Maine and Delaware programs make exceptions to their income limits for people with drug expenditures exceeding 40 percent of their income. Three states also had asset limits. All states restricted eligibility to state residents but had variable minimum residency requirements. Most states allowed people with other drug coverage to enroll in the program, but specific rules varied.

[7]Programs in Maryland and Wyoming had no minimum age requirements. Maine requires participants to be at least age 62.

[8]The definition of "disabled," for the purpose of program eligibility, varied across states, as did age requirements for people with disabilities. For example, in Illinois, a resident with a disability must be older than 16 to be eligible for the state's pharmacy program, while in Maine, a resident with a disability must be at least 19 years old. A few states defined persons receiving or eligible for Social Security disability insurance benefits as disabled for the purposes of their pharmacy programs, while other states used state-developed criteria.

Table 2: Eligibility Requirements for State Pharmacy Assistance Programs, 1999

State	Individual income limit (percentage of 1999 FPL)[a]	Married or household income limit	Age requirement	Coverage for persons with disabilities[b]	Enrollment	Enrollment as a share of Medicare beneficiaries in state (percentage)
Connecticut	$14,500 (176)	$17,500	65	Yes	29,969	6
Delaware[c]	$16,480 (200)	$22,120	65	Yes	N/A	N/A
Illinois[d]	$16,000 (194)	$16,000	65	Yes	49,186	3
Maine	$15,244[e] (185)	$20,461[e]	62	Yes	25,000	12
Maryland	$9,400 (114)	$10,200	None	Yes	33,185	5
Massachusetts[f]	$12,360 (150)	N/A	65	Yes	27,492	3
Michigan	$12,360 (150)	$16,596	65	No	12,968	.9
Minnesota	$9,660 (117)	$13,020	65	No	1,200[g]	.2
New Jersey	$18,151 (220)	$22,256	65	Yes	195,005	16
New York—Fee and Deductible Plans[h]	$18,500 (225)	$24,400	65	No	113,000	4
Pennsylvania—PACE	$14,000 (170)	$17,200	65	No	217,103[i]	10
Pennsylvania—PACENET	$16,000 (194)	$19,200	65	No	18,655[i]	.9
Rhode Island[j]	$15,538 (189)	$19,449	65	No	29,776	18
Vermont—VHAP	$12,360 (150)	$16,590	65	Yes	7,303	8
Vermont—VScript	$14,420 (175)	$19,355	65	Yes	2,125	2
Vermont—VScript Expanded[k]	$18,540 (225)	$24,885	65	Yes	N/A	N/A
Wyoming	$8,240 (100)	$11,060	None	Yes	491[l]	.8

Notes: N/A=Not available.

Medicare beneficiary counts were as of 1998, the latest year for which state-level data were available.

[a]Seven states define income eligibility levels as a percentage of FPL. One state program allows for adjustment of income thresholds based on changes in the cost of living. Four states adjust income based on the Social Security cost-of-living adjustment.Two states do not index income requirements for inflation.

[b]Age eligibility requirements for persons with disabilities vary across states.

[c]The Delaware program was not operational until January 2000; therefore, enrollment is not included, and eligibility requirements are for 2000.

[d]During the fiscal year 2001 state appropriations process, Illinois expanded eligibility to individuals with annual incomes up to $21,218; this change is effective in 2001.

[e]The listed income limits for Maine were effective in September 1999.

[f]During the fiscal year 2001 state appropriations process, Massachusetts enacted a new catastrophic program with no upper income limit and sliding scale payments for those over 188 percent of FPL; this program is effective in 2001.

[g]The Minnesota program averaged 1200 enrollees per month in 1999.

[h]During the fiscal year 2001 state appropriations process, NewYork expanded eligibility to individuals with annual incomes up to $35,000; this change is effective in 2001.

[i]The enrollment figures for PACE and PACENET are for the last day of the last reporting quarter of 1999.

[j]During the fiscal year 2001 state appropriations process, Rhode Island expanded eligibility to individuals with annual incomes up to $34,999. The program will pay 60 percent of drug costs for those with incomes up to $15,932; 30 percent of drug costs for those with incomes up to $19,999, and 15 percent of drug costs for those with incomes up to $34,999; these changes are effective in 2001.

[k]The VScript Expanded program was not operational until January 2000; therefore, enrollment is not included, and eligibility requirements are for 2000.

[l]The Wyoming program averaged 491 enrollees per month in 1999.

Sources: State programs, National Conference of State Legislatures, http://www.ncsl.org/programs/health/drugaid.htm (downloaded 01/26/2000 and 04/04/2000), http://aspe.hhs.gov/poverty/99fedreg.htm (downloaded 06/27/00), and http://www.hcfa.gov /stats/en798all.htm (downloaded 06/27/00).

Just as states varied in their eligibility criteria, the size of state programs also varied. The New Jersey, New York, and Pennsylvania programs enrolled the most people overall and accounted for 71 percent of all assistance program enrollees in 1999. However, the Rhode Island program enrolled the largest percentage of Medicare beneficiaries in the state.

To ensure that enrollees do not lose coverage as their incomes increase because of cost-of-living adjustments to Social Security income, most states have some mechanism to increase the qualifying income threshold each year. Four states raise their income requirements based on the annual Social Security cost-of-living adjustment. Seven states set qualifying income levels as a percentage of the federal poverty level.[9] The lack of cost-of-living adjustments in income thresholds in two states could result in fewer eligible people each year. For example, the income thresholds for Pennsylvania's PACE and PACENET have become lower in real dollars each year, which, according to a program official, has made some people lose their eligibility as their Social Security income increased. The income levels for these programs were last adjusted by the state legislature in 1996.

The eligibility requirements of some programs have been modified over time to allow more people to qualify. For example, Maine recently changed its income threshold from 131 percent to 185 percent of FPL. The Massachusetts program began with an income threshold of 133 percent of FPL. The threshold was changed to 150 percent and is currently at 188 percent of FPL. Pennsylvania and Vermont added an additional coverage

[9]The federal poverty level is updated annually using the increase in the Consumer Price Index for All Urban Consumers.

tier to allow individuals with higher incomes to qualify for programs that require higher cost sharing. Vermont also established limits on the types of drugs that are covered. Programs in Connecticut and Massachusetts changed their eligibility rules to extend coverage to people with disabilities after the programs were enacted.

In addition to targeting coverage to individuals who meet income requirements, some states restrict coverage to specific types of drugs, such as maintenance drugs or drugs to treat specific conditions (see table 3). State programs generally do not use formularies to limit coverage to particular products within a therapeutic class,[10] a practice that is common in private insurance. Several program officials told us that formularies are not an appealing benefit design feature for their programs because formularies can restrict access to specific products and can be difficult to administer.

[10]Formularies are lists of prescription drugs, grouped by therapeutic class, that a health plan or insurer prefers and may encourage physicians to prescribe and beneficiaries to use. A particular product may be included on the formulary because of its medical value or because a favorable price was negotiated with the manufacturer.

Table 3: Drug Coverage Rules for State Pharmacy Assistance Programs, 1999

All prescription drugs	Drugs for specific conditions[a]	Maintenance drugs only
Connecticut[b]	Illinois	Maryland
Delaware[c]	Maine (basic)	Vermont (VScript)
Maine (supplemental)	Rhode Island	
Massachusetts		
Michigan[d]		
Minnesota		
New Jersey		
New York		
Pennsylvania		
Vermont (VHAP)		
Wyoming		

Notes: Except for Illinois and Michigan, states generally do not cover drugs for which they do not get manufacturer rebates.

[a]Conditions are defined by the states.

[b]Connecticut recently eliminated coverage for antihistamines, decongestants, and smoking cessation products.

[c]Information for the Delaware program is for 2000.

[d]Michigan limits coverage to 3 months per year.

Source: State programs.

Cost Sharing Structured to Balance Program Spending and Beneficiary Access

Beneficiary cost-sharing requirements vary among programs (see table 4). Like private insurance plans, state programs commonly require program participants to share in the cost of the prescription at the pharmacy through copayments or coinsurance. However, unlike many private plans, state pharmacy assistance programs rarely use deductibles; most state programs provide first-dollar coverage to program enrollees. Annual limits are also less common among state programs. A few states have reduced enrollment fees, but over time, some have increased the copayments and coinsurance that enrollees pay each time they purchase drugs.

Table 4: Cost-Sharing Requirements for State Pharmacy Assistance Programs, 1999

State	Annual fee	Deductible	Copayments	Coinsurance
Connecticut	$25	None	$12	None
Delaware[a]	None	None	$5[b]	25%[b]
Illinois	$40 or $80	$15 or $25/mo.	None	20%[c]
Maine	None	None	$2[d]	20%[d]
Maryland	None	None	$5	None
Massachusetts	$15	None	$3/$10[e]	None
Michigan	None	None	$0.25	None
Minnesota	None	$35/mo.	None	None
New Jersey	None	None	$5	None
New York (Fee Plan)	$8-$280[f]	None	$3-$23[g]	None
New York (Deductible Plan)	None	$468-$638[f]	$3-$23[g]	None
Pennsylvania (PACE)	None	None	$6	None
Pennsylvania (PACENET)	None	$500	$8/$15[e]	None
Rhode Island	None	None	None	40%
Vermont (VHAP)	None	None	$1-$2[h]	None
Vermont (VScript)[i]	None	None	$1-$2[h]	None
Vermont (VScript Expanded)[i]	None	None	None	50%
Wyoming	None	None	$25	None

[a]Information for the Delaware program is for 2000.

[b]Program enrollee pays the greater of the $5 copayment or 25 percent coinsurance.

[c]After the program enrollee meets the monthly deductible, the program covers all costs up to $800 annually. After that, the individual pays 20 percent of each prescription's retail cost, and the state pays 80 percent.

[d]Program enrollee pays the greater of the $2 copayment or 20 percent coinsurance.

[e]The first amount is for generic drugs; the second is for brand name drugs.

[f]The amount of the fee or deductible is determined on a sliding scale based on income.

[g]The plan has five levels of copayments, which require enrollees to pay a higher amount for higher priced drugs.

[h]Program enrollee pays $1 if the prescription costs less than $30 and $2 if the prescription costs $30 or more.

[i]Information for the VScript and VScript Expanded program is for 2000.

Source: State programs.

With one exception, the programs impose copayments or coinsurance that require enrollees to share in the drug's cost each time they purchase a

prescription. In addition to lowering public outlays, copayments and coinsurance can influence enrollees to use less expensive drugs. To encourage program beneficiaries to choose less expensive products, the Maine program changed its cost-sharing policy from a flat copayment to a coinsurance amount equal to 20 percent of the drug's price. A Maine program official estimated that the program realized a 10 percent savings after switching from copayments to coinsurance. Three programs imposed coinsurance that required enrollees to pay a fixed percentage of the cost of a drug, giving enrollees a stronger incentive to use less expensive drugs than a fixed dollar amount would have. Six programs varied the amount through a tiered copayment structure with higher amounts for more expensive drugs or for brand name products. Two programs required enrollees to pay the greater of a coinsurance or a flat copayment. Six programs used a flat copayment structure, which required enrollees to pay the same amount for each prescription, regardless of cost.

Some states have altered the prescription copayment amounts that program enrollees are required to pay. Connecticut, Maryland, and Wyoming have increased their copayments since the programs' enactment. Wyoming raised its copayment from $1 to $25 per prescription in 1997. In 1992, the Illinois program eliminated the copayment and replaced its $800 annual benefit cap with a 20 percent coinsurance that takes effect once the program pays $800 in benefits for an enrollee in a year.

A few programs impose annual enrollment fees, but because such fees, like premiums, require an enrollee to pay up front to access the assistance programs, some program officials believe that such fees impose a barrier to program enrollment. A Minnesota official said that enrollment fees in Minnesota were viewed as restricting participation in the program. As a result, the original $120 enrollment fee was eliminated and the monthly deductible was increased by $10. In New York, the impetus behind imposing annual enrollment fees when the program began was concern over potentially high enrollment. However, New York has subsequently lowered its fees to provide easier access to program coverage. The Connecticut program administrator said the state raised its annual fee from a one-time $15 fee to a $25 annual payment, which resulted in enrollment dropping by half.

Annual benefit limits and deductibles, which are common in private health insurance plans, are not used often in state programs, perhaps because these programs are designed to provide coverage to needy populations. Only Massachusetts and Delaware place an absolute limit on the total amount of drug costs the program will cover annually for an individual.[11] Although they do not have dollar caps, Wyoming will cover a maximum of three prescriptions per month, and Michigan permits people to receive assistance for only 3 months out of the year. Only four programs have deductibles. New York's deductible plan and Pennsylvania's PACENET program have annual deductibles, and the Illinois and Minnesota programs have monthly deductibles.

Most Programs Are Funded by the State's General Revenues and Benefit From Manufacturers' Rebates

Two-thirds of state pharmacy assistance programs derived some or all of their funding from legislative appropriations from general revenues, while nine programs were funded at least in part by other dedicated revenue sources (see table 5). Vermont is the only state that receives partial federal funding for its programs. According to a Vermont official, partial funding for enrollees up to 175 percent of the federal poverty level came from the federal government through the state's Medicaid waiver.[12] Most state pharmacy programs operate on budgets appropriated by the states. One program reported having a waiting list for assistance, but most program officials said that program budgets had been adequate to cover program spending. One program official noted that in the few years that the program has underestimated program spending, the legislature has provided supplemental funding. Drug expenditures made up well over 90 percent of the total expenditures for most states' drug assistance programs.

[11]The annual limit for the Delaware program is $2,500 per person. The annual limit for Massachusetts is $1,250 per person. In Illinois, before reaching $800 in annual spending, the enrollees must pay a monthly deductible. Once an enrollee reaches $800 in spending for the year, the individual must pay the monthly deductible plus 20 percent of the cost of any prescription.

[12]The Section 1115 Medicaid waiver program allows states to restructure their Medicaid programs and implement new approaches to administering benefits.

Table 5: Funding Sources for State Pharmacy Assistance Programs

State	Funding Source
Connecticut	General revenue
Delaware	Tobacco settlement
Illinois	General revenue
Maine	General revenue
Maryland	General revenue
Massachusetts	General revenue and cigarette tax
Michigan	Construction tax
New Jersey	General revenue and casino revenue
New York (Fee and Deductible plans)	General revenue
Pennsylvania (PACE and PACENET)	Lottery
Rhode Island	General revenue
Vermont (VHAP and VScript)	Cigarette tax and federal funding
Vermont (VScript Expanded)	Cigarette tax
Wyoming	General revenue

Source: State programs.

State programs, like Medicaid, offset drug spending through manufacturers' rebates. Most state programs receive manufacturers' rebates that are calculated using terms similar to the Medicaid rebate agreement established by the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990).[13] The rebates, which in many states are mandated by statelegislatures, are generally provided by manufacturers in exchange for coverage of their products and for not subjecting coverage to prior authorization requirements. Like Medicaid, some state programs receive additional rebates if the price of a drug increased more than the consumer

[13]All states offer prescription drug coverage through their Medicaid programs and receive manufacturers' rebates on drugs paid for by the program. OBRA 1990 required pharmaceutical manufacturers to enter into rebate agreements with the Secretary of the Department of Health and Human Services in exchange for state Medicaid programs covering all products of manufacturers that have entered into rebate agreements. OBRA 1990 allows states to exclude certain classes of drugs from coverage. In addition, states may place some drugs on a 24-hour prior-authorization list to allow program officials to review and approve or deny a request for certain products.

price index, a measure of general inflation.[14] However, six states said they did not get this additional rebate amount. The Illinois and Michigan programs contract with pharmacy benefit management (PBM) companies to obtain rebates from manufacturers. According to the PBM representative for the Illinois program, the state receives 100 percent of the manufacturer rebates on products with rebate agreements. A Michigan program official reported that they receive 80 percent and that the PBM retains 20 percent of the total rebate amount on products with rebate agreements.

States reported receiving rebates that ranged from 2 percent of the states' net drug spending in Illinois and Michigan to 45 percent in Rhode Island (see table 6). At least a portion of this variability can be attributed to variations in cost sharing across states. For example, Connecticut requires program participants to pay $12 per prescription, while the New Jersey program requires participants to pay $5 per prescription. If both states received the same rebate proportion before cost sharing is subtracted from total drug spending, that proportion would be a lower proportion of net spending in New Jersey than in Connecticut after cost sharing is considered. The amount states are reimbursing pharmacies for drugs is another factor that affects the share of net drug spending as a portion of rebates. State programs generally pay pharmacies for drugs at the same rates as the Medicaid program and also pay a dispensing fee similar to that paid by Medicaid. As a result, states with lower payment rates would have rebates that were a higher percentage of net drug spending.

[14]For example, if the average manufacturer's price of a drug increased by 6.3 percent and the consumer price index increased 2.3 percent, then the manufacturer must pay the program an additional rebate that equals the product of the difference between the drug price increase and the consumer price index, or 4 percent of the average manufacturer's price in this case, and the total number of units dispensed to program participants in that rebate period.

Table 6: Expenditures and Rebates for State Pharmacy Assistance Programs, 1999

State	State drug expenditures (excludes rebates and program enrollee cost sharing)	Rebates	Rebates as a percentage of net drug expenditures
Connecticut	$23,774,345	$8,068,948	34
Delaware[a]	N/A	N/A	N/A
Illinois	$34,815,790	$667,980	2
Maine	$5,373,028	$709,688	13
Maryland	$32,100,000	$5,200,000	16
Massachusetts	$8,900,000	$2,600,000	29
Michigan	$5,297,925	$92,125	2
Minnesota	$1,400,000	$175,000[b]	13
New Jersey	$285,000,000	$37,000,000	13
New York[c]	$105,500,000	$27,680,918	26
Pennsylvania—PACE and PACENET	$257,721,453	$48,401,444	19
Rhode Island	$4,090,908	$1,824,332	45
Vermont—VHAP	N/A	$1,580,000	N/A
Vermont—VScript and VScript Expanded[d]	N/A	$240,000	N/A
Wyoming	$576,527	N/A	N/A

Notes: N/A=Not available from state program.

Drug expenditures were reported by states. Rebates and any copayments and coinsurance paid by the program enrollee have been subtracted.

[a]The Delaware program was not operational until January 2000, so expenditures and rebates are not included in the table.

[b]Minnesota only submitted invoices for rebates for drugs purchased through the program from July through December 1999. The net drug expenditures reflect the program's net drug expenditures from January through December 1999.

[c]Data for New York are for 1998; data for 1999 were not available.

[d]The VScript Expanded program was not operational until January 2000, so expenditures and rebates are not included in the table.

Source: State programs.

Targeting Benefits and Operating Programs Raise Administrative Issues

To ensure that the intended recipients get drug benefits and to maximize the effect of limited program resources, state pharmacy assistance programs establish and execute a number of administrative policies. Some states attempt to encourage program participation by mitigating the perceived stigma associated with the programs and by creating awareness of the programs through outreach. Some states link eligibility for and administration of their pharmacy assistance programs to other state assistance programs for seniors, such as rent or property tax assistance. Several other states have used the systems of their Medicaid programs to carry out some or all of the administrative functions of their pharmacy assistance programs. They have thus avoided developing entirely new systems and duplicating program functions, such as determining eligibility and processing and paying claims. Nevertheless, some states have encountered administrative challenges related to developing adequate systems and recovering payments from insurers when program enrollees have other drug coverage.

Programs Undertake Efforts to Facilitate Program Acceptance and Awareness

Many program administrators said they cannot precisely determine the extent to which eligible persons are enrolled. They could, however, identify factors that may contribute to eligible persons failing to enroll, including the perceived stigma associated with programs for people with low incomes and a lack of awareness of the program. The program officials who did not believe that perceived stigma deterred participation represented programs administered separately from Medicaid. One program official whose state program is administered through Medicaid said that perceived stigma may deter enrollment, especially among the elderly. Program administrators in some states said that their legislature created drug assistance programs that are administered separately from Medicaid to avoid any association with such perceived stigma. An official in one state said that the drug assistance program is regarded favorably by the public because it is distinct from the Medicaid program.

Eligible people may also fail to enroll in programs because they are unaware of them or their eligibility for program benefits. To encourage participation, many states perform outreach and provide program information to potentially eligible people. For example, some states share information about programs and encourage program participation through print, radio, or television advertisements. Programs also reported making applications and program brochures available at a variety of locations such as area agencies on aging and senior centers. Some programs provided

brochures to physicians and pharmacists to distribute to their patients, sent information and applications along with tax booklets, or provided brochures to legislators to distribute to constituents. Information and applications for some programs were also available on the states' Web sites. One state sends applications to state residents identified through state tax returns as having incomes meeting qualifying criteria. Three administrators said their programs target outreach to Medicare beneficiaries eligible for limited Medicaid benefits. However, evidence shows that many people who are eligible do not receive such benefits.

Several States Link Program Administration to Medicaid or Other Assistance Programs; Others Are Separate

States vary in their reliance on existing programs and systems in administering their pharmacy assistance programs (see table 7). In some states, the programs are small relative to Medicaid programs and are administered, at least in part, through the state agency that administers Medicaid. In others, they are administered separately from Medicaid, sometimes by an agency that also administers other programs for the elderly such as rent or property tax relief or public transportation subsidies. Officials at the three state programs with the largest budgets and greatest number of enrollees—New Jersey, New York, and Pennsylvania—said that their senior pharmacy assistance programs were intentionally distinct from the Medicaid program and administered separately. Regardless of which agency administers the program, many use contractors to execute program functions such as eligibility determination and claims processing.

Table 7: Administrative Information on State Pharmacy Assistance Programs

State	Department administering drug assistance program	Same department that administers Medicaid?	Same eligibility determination system as Medicaid?	Same claims adjudication system as Medicaid?
Connecticut	Department of Social Services	Yes	Yes	Yes
Delaware	Department of Health and Social Services	Yes	Yes	Yes
Illinois	Department of Revenue	No	No	No
Maine	Department of Human Services	Yes	No (Department of Revenue determines eligibility)	No, but use same contractor as Medicaid
Maryland	Department of Health and Mental Hygiene	Yes	No	Yes
Massachusetts	Executive Office of Elder Affairs and Division of Medical Assistance	Yes, in part[a]	No (Executive Office of Elder Affairs determines eligibility)	Yes
Michigan	Office of Services to the Aging	No	No	No
Minnesota	Department of Human Services	Yes	Yes	Yes
New Jersey	Department of Health and Senior Services	No	No	Yes
New York	Department of Health	Same department, separate administration	No	No
Pennsylvania	Department of Aging	No	No	No
Rhode Island	Department of Elderly Affairs	No	No	No
Vermont	Department of Social Welfare, Office of Vermont Health Access	Same department, different office	Yes	Yes
Wyoming	Department of Health	Yes	Yes	Yes

[a]The Division of Medical Assistance administers the Medicaid program in Massachusetts.

Source: State programs.

Eligibility determinations are one major administrative task that the programs perform. To apply for the programs, most states have a mail-in application. Only Michigan and Rhode Island said they require an in-person application interview. Most programs require enrollees to reapply yearly, and many of them automatically send applications to current enrollees. Program participants in Michigan and Wyoming, however, must reapply

monthly. Only Rhode Island's enrollees do not have to reapply once they are initially enrolled in the program.

States request a variety of information from program applicants and some require supporting documentation. Several programs verify information provided on applications through other state programs, such as the state department of revenue and Medicaid. Five states used the same eligibility determination system for their assistance program that is used for the Medicaid program. Nine states used an eligibility determination system for the state program that was different from the one Medicaid used. In some states, the agency uses a contractor to determine eligibility; in others, eligibility is determined within the administering state agency.

Most programs use a contractor to process claims for their drug assistance programs, and over half of the programs hired the same contractor to process claims that the state Medicaid program used. Two states that did not use a contractor for claims processing—Massachusetts and Minnesota—used the same in-house systems that processed their Medicaid claims to process drug assistance program claims. However, officials in two states said that their drug assistance programs chose not to use the state's Medicaid claims processing systems because the systems were inadequate for their administrative needs. A few program administrators said that developing and coordinating automated systems were challenging aspects of program operation. A Connecticut program official told us that the most difficult aspect of implementing the program was setting up systems for claims processing and eligibility determination. Similarly, a Rhode Island program official said that linking relevant computer systems was the most difficult part of implementing the pharmacy program. Because the Rhode Island Department of Elderly Affairs determined eligibility and a contractor processed claims, the two systems had to be linked with one another and with participating pharmacies so that pharmacies would know who was eligible and what drugs were covered. Program officials in Maryland and Massachusetts said that adding on to their existing Medicaid claims processing system made the program easier to administer. However, two program officials said changing their Medicaid information systems to permit claims processing for both the Medicaid and the pharmacy benefit programs was difficult.

Recovering and Coordinating Payments Proves Challenging for Some Programs

Recognizing that some people in need of assistance may have other limited drug coverage, all but three states permit people with other prescription drug coverage to enroll in their programs.[15] According to one program administrator, coordinating benefits and recovering payment is important because the state program is increasingly being used to supplement coverage that has become inadequate due to the combination of high drug costs and benefit design features in private insurance such as caps, deductibles, high copayments, limited formularies, and coverage of generic drugs only. Some administrators said that in trying to avoid making payments when a person has other drug coverage, they have encountered the additional difficulty of recovering payments from third-party payers. For example, the authorizing legislation for the Pennsylvania PACE programs designates the state pharmacy program as the payer of last resort in cases where a program enrollee has other drug coverage. According to a Pennsylvania official, that program recently settled a long dispute with several Medicare managed care plans regarding the recovery of drug payments that the PACE program made on behalf of individuals with drug coverage through their Medicare managed care plan. According to the PACE program official, the program is in the process of implementing a system, with the cooperation of the Medicare managed care plans, that will block PACE payment of drug claims at the point-of-sale when the person has Medicare managed care plan coverage for the drug.

The New York program has attempted to develop cooperative relationships with other insurers so that EPIC can be reimbursed for any benefits it pays when program enrollees have other coverage. While one insurer has performed an enrollment match with EPIC to identify dually enrolled seniors, EPIC has not been able to achieve an agreement to recover the benefits it has paid. Another insurer, according to a program official, has refused to enter into a formal agreement to implement a jointly defined policy to coordinate payment. In contrast, the Rhode Island pharmacy program was able to reduce program spending because of coordination with other payers. According to a Rhode Island official, records of the program were matched with Medicare managed care plan records to

[15]States excluded people from coverage if they received full Medicaid benefits. Several programs performed a match with Medicaid files to determine whether an applicant was receiving Medicaid benefits. Some programs tried to identify and notify applicants who might be eligible for Medicaid, but some program administrators said they could not definitively determine Medicaid eligibility because they did not collect all the information necessary to make that determination.

ensure that program participants use any other plan coverage they might have before using the state program's coverage.

Conclusions

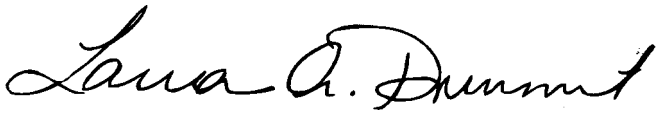
State drug programs provide important assistance with the purchase of prescription drugs to a small number of elderly low-income and other qualified individuals—more than 760,000 in 1999. Perhaps because some of these programs operate on budgets that are small relative to Medicaid, several states have added to or borrowed from their Medicaid programs to administer their drug programs for low-income seniors. Other states—including New Jersey, New York, and Pennsylvania, which together cover almost three-quarters of all state pharmacy assistance program enrollees—administer their programs separately from state Medicaid programs. It is unknown whether states' decisions to administer their programs independently or through Medicaid or other state programs would be affected if more states added programs or existing programs expanded. The effect of adding more or larger state programs on states' abilities to defray spending with manufacturers' rebates also remains unknown.

External Review

We obtained comments on the draft report from a senior policy specialist on state pharmacy assistance programs at the National Conference of State Legislatures. The reviewer provided technical comments, which we incorporated where appropriate.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of this letter. At that point, we will send copies to interested congressional committees; Members; the Honorable Donna E. Shalala, Secretary of Health and Human Services; the Honorable Nancy-Ann Min DeParle, Administrator of the Health Care Financing Administration; and other interested parties. If you or your staffs have any questions about this report, please call me at (202) 512-7114 or John Hansen at (202) 512-7105.

Major contributors to this report are Lara Carreon, Kathryn Linehan, Myrna Pérez, and Tricia Spellman.



Laura A. Dummit
Associate Director, Health Financing
and Public Health Issues

Scope and Methodology

To identify the states with prescription drug assistance programs, we used two published sources of information about state programs. For more recently enacted programs, we reviewed information from the National Conference of State Legislatures (NCSL) and interviewed a NCSL researcher who tracks state pharmacy assistance program legislation. Information on state pharmacy assistance programs, including their benefit structure, funding, and administrative characteristics, was obtained from program literature and published research. Additionally, we reviewed some annual program reports and relevant state laws and regulations that apply to the programs. Program administrators or other program staff were interviewed about their assistance programs.To verify data and collect missing information, we followed up with the program administrators. A reviewer at the National Conference of State Legislatures provided technical and other comments on this report, which we incorporated where appropriate.

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