

No. 762



ISSUE BRIEF

State-Based Pharmaceutical Assistance Programs: Temporary Fix or Lessons for Medicare?

Wednesday, April 25, 2001
Washington, DC

A discussion featuring

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State-Based Pharmaceutical Assistance Programs

The rallying cry for a Medicare outpatient prescription drug benefit reached a fevered crescendo in the 2000 presidential and statewide elections. Despite the furor and the consensus in Congress that something needed to happen, however, agreement on the shape of a federally mandated Medicare drug benefit failed to emerge. Early this year, President Bush announced guidelines for his Immediate Helping Hand Program—an interim Medicare prescription drug assistance program that most observers have concluded was “dead on arrival.” So the states, as they have done in the past, continue to take action. Now, however, the number of states involved has grown and their approaches to the programs have diversified. Going beyond the traditional assistance programs, states are trying their hands at group purchasing, price controls, and discount programs.

Over the past two years, more than one-half of the states have established some type of prescription drug assistance program for the elderly. While some of these state programs are more robust than others, they all seek to help meet a particularly difficult challenge—providing prescription drug coverage for Medicare beneficiaries.

The desire to establish such a benefit is not new. Ever since 1969, efforts have been under way to provide this benefit for Medicare beneficiaries. However, while interest has ebbed and flowed over the years, federal legislators have yet to enact such a provision. In the meantime, others have been trying to pick up the slack: the pharmaceutical industry through its patient assistance programs; the private marketplace through retiree health benefits, Medigap policies, and Medicare risk plans; and the states through Medicaid¹ and state pharmaceutical assistance programs.

As prescription medications have comprised an increasing portion of the expenditures for health care, federal interest in enacting a Medicare outpatient prescription drug benefit has come once again to the fore. Politically, the stakes are high; a mid-term election is just around the corner. Consensus on how best to proceed appears to be elusive, however. Most of the current federal proposals fall into four general categories: (a) a stand-alone Medicare drug benefit, (b) insurance approaches with premium support, (c) price controls, and (d) state block-grant programs. It is likely

that each one of these would affect the various state-based programs differently.

While the states keep one eye focused on Washington, D.C., they must keep the other on their own capitols and pocketbooks. States are finding it harder than ever to provide pharmaceutical assistance—the economy is slowing, Medicaid budgets, including prescription drug line items are exploding, and some Medicare health maintenance organizations that provide prescription drug coverage are pulling out of selected markets.

In a February 8, 2001, article, “Slowing Economy Forces Governors to Trim Budgets,” the *New York Times* reported that,

with a swiftness that has taken many governors by surprise, the slowing economy has sharply reduced state tax revenues in the last few weeks, forcing a growing number of states around the South and Midwest to cut their budgets for the first time in a decade. . . . Coming at the same time as a steep increase in Medicaid costs, the budget reversals mean that the days of bold new programs and tax cuts are over in many states.

What does this portend for the state pharmaceutical assistance programs? Even with reserve funds that states have accumulated, rising prescription drug costs, increasing numbers of elderly patients, and decreasing state tax revenues spell danger for these programs.

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STATE PHARMACY PROGRAMS: FACTS AND FIGURES

As of January 2001, 26 states had authorized some type of pharmaceutical assistance program. States have been creating such programs for low-income elderly or disabled persons since 1975. According to a report issued in September 2000 by the U.S. General Accounting Office (GAO), in 1999, 14 states operated 18 state-funded pharmacy assistance programs serving more than 760,000 enrollees.² While New Jersey, New York, and Pennsylvania enrolled the most people overall in their programs that year and accounted for 71 percent of all enrollees, the Rhode Island program enrolled the largest percentage of Medicare beneficiaries in the state.

Drug assistance programs span a wide range in their benefit design, eligibility requirements, funding mechanisms, and cost controls. According to the National Conference on State Legislatures (NCSL):

- Twenty-two states have enacted laws to create programs; four other programs have been created by executive branch action only.
- Twenty-four state programs are in operation³; an enacted law in Kansas and an agency program in Iowa are not yet in operation.
- Twenty states provide a direct subsidy using state funds; Missouri provides a subsidy only by a year-end tax credit.
- Five additional states (California, New Hampshire, Iowa, Washington, and West Virginia) have recently created programs that offer a discount only (no subsidy) for eligible or enrolled seniors.

In summing up last year's frenzied activity in the states, the NCSL's February 9, 2001, report, *Prescription Drug Discount, Rebate, Price Control and Bulk Purchasing Legislation, 1999-2000*, indicated that

some states have adjusted eligibility for Medicaid, with its prescription benefit, to cover additional people. A relatively new trend focuses on statewide programs aimed at achieving substantially lower pharmaceutical prices for broader categories of consumers. Generally these bills seek to use Medicaid-style rebates, other discount rates or current 'lowest available price' as a basis for a retail price, instead of providing a direct state-funded subsidy. A new law in Maine and proposals in several additional states also called for state price controls that would apply to public consumer purchases.

Table 1 (see page 4) summarizes much of the past year's nontraditional prescription assistance program activities undertaken by states.

STATE RX PROGRAM PARAMETERS

While no two state programs are alike, they all must deal with similar issues of design, administration, and funding. As states begin the very difficult task of bringing new programs to life, officials look to veteran programs for lessons learned. Although there is much to share, each state must still consider its own set of circumstances. Each state has a unique elderly (and/or disabled) population distribution (that is, percentage of low-income, percentage with retiree health benefits that covers prescription drugs) a unique set of economic considerations, a unique market environment (that is, number, if any, of Medicare risk plans), and a unique political apparatus.

The challenge for states, of course, is to provide a pharmacy assistance benefit to a targeted population while keeping within budget (which, by way of comparison, is very small relative to state Medicaid budgets). All states must consider the following as they began to build their programs⁴:

- Eligibility criteria (age and income).
- Cost-sharing/cost management arrangements.
- Program administration/delivery systems.
- Marketing and outreach.
- Funding.

Eligibility Criteria

The biggest determinants of program eligibility are age and income. Drug assistance programs typically are targeted towards the elderly (65 years of age and older) and the disabled. Income limits (which are distinguished between individual limits and married or household limits) vary, for instance, from 100 percent to well over 200 percent of the federal poverty level for a single person.⁵ In order not to exclude individuals, some states allow income limit exceptions for people with drug expenditures exceeding a certain percentage of their income. Income thresholds are generally adjusted each year to account for cost-of-living adjustments to Social Security income. For some programs, however, the Social Security cost-of-living adjustment issue has been problematic in that beneficiaries have had to leave the program.

Cost-Sharing–Cost-Management Arrangements

Plans use several methods to manage costs and utilization. The most common are copayments and

Table 1
Prescription Drug Discount, Rebate, Price Control, and Bulk Purchasing Legislation
1999–2000

Description of Policy for Prescription Drugs	States with Bills or <u>Laws</u> , 1999-2000
Medicare elders/disabled eligible for discount prices based on Medicaid rates	AZ, <u>CA</u> , CT, CO, <u>FL</u> , MA, MD, <u>ME</u> , MN, MO, NH, OH, RI, <u>VT</u> , WA, WI
Seniors eligible for discount prices based on Federal Supply Schedule	AZ, IL, PA, VT
Broader public use of federally qualified health centers (FQHCs obtain prescription drugs at discounts similar to the best Medicaid rebate rates)	CT, RI, VT
State bulk purchasing to achieve greater price discounts for all eligible groups	AZ, CA, FL, <u>MA</u> , <u>ME</u> , NH, NY, OR, RI, VT, WA
State “buyer’s clubs” (nonlegislative, via governors’ offices)	IA, ME, NH, VT, WA, WV (executive initiatives)
State coordination of pharmaceutical industry free/charity programs	<u>MA</u> , <u>NH</u>
Advertising costs disclosed to the state	PA
Price controls or state maximum prices	AZ, CA, CT, <u>ME</u> , MI, NJ, NY, OH, PA, VT

Source: National Conference of State Legislatures, Prescription Drug Discount, Rebate, Price Control and Bulk Purchasing Legislation, 1999-2000, 2; accessed February 9, 2001, at <http://www.ncsl.org/programs/health/drugdisc.htm>.

coinsurance, both a form of beneficiary cost-sharing. The level of cost-sharing, however, varies from plan to plan, and is different for brand and generic drug products. Some programs use benefit caps (usually annual caps), premium payment, and enrollment fees. Again, there is wide variation across programs. Almost all the state prescription drug assistance programs rely on manufacturer rebates (typically calculated on terms similar to Medicaid rebates) to offset costs. Other cost management methods employed by some programs include limiting the number of prescriptions per month, limiting the supply dispensed, covering drugs for certain conditions only, covering only maintenance drugs, and using mail order services. Very few states use deductibles and most programs offer first-dollar coverage.

The GAO study notes that, unlike private insurance, state-run drug assistance programs “generally do not use formularies to limit coverage to specific products within a given therapeutic class.” However, as men-

tioned above, some states do restrict coverage to particular types of drugs (that is, maintenance drugs or drugs to treat specific conditions.)

Program Administration-Delivery Systems

One particularly challenging issue facing program administrators involves encouraging program participation while increasing efficiencies, given the limited resources typically available for state assistance prescription drug programs. Just as it has plagued other assistance programs for other populations, the stigma or perceived stigma affiliated with a low-income program, has been, according to some plan administrators, a deterrent to beneficiary enrollment. According to the GAO study,

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.

The trade-off is that, in administering two separate programs—Medicaid and a distinct state assistance prescription drug program—economies of scale are lost. This is particularly troublesome where duplicative program functions, such as eligibility determination, the processing and payment of claims, and coordination of benefit payment when a beneficiary has other drug coverage, could be avoided.

On the other hand, states have been creative. Some have run the prescription drug assistance program as a separate program but have tapped in to their Medicaid administrative systems, while others have linked with different state senior assistance programs, most notably rent or property tax assistance. Many of the agency administrators report using contractors to assist with program functions, particularly in the cases of eligibility determination and claims processing.

Marketing and Outreach

In addition to the stigma problem, administrators have found potential beneficiaries to be unaware of the program. In order to create increased awareness, some plans have undertaken outreach programs, designed to bolster participation.

Funding and Budget Levels

Budget levels for the state prescription drug programs vary, but all are small, relative to state Medicaid programs. Most are funded by legislative appropriations from states' general revenues and others are funded by lottery funds, tobacco settlement funds, or cigarette taxes. In the case of Vermont and Maine, one component of the assistance program is run through a Section 1115 Medicaid waiver; essentially a vehicle for a discount program with no additional federal (or state) money involved. (See glossary at the end of the paper for a further explanation of the waiver.)

POLICY QUESTIONS

Several important policy questions for both federal policymakers and state officials to consider include the following:

- How would a federal Medicare prescription drug benefit affect a state program and the beneficiaries it serves? How are states planning for a transition, so that beneficiaries maintain access to their medica-

tions? Would it be the intent of a federal benefit to put a state program out of business?

- How would a federal Medicare prescription drug benefit affect state Medicaid expenditures? Should there be some trade-off of responsibilities if states would see significant reductions in spending?
- If the debate in Congress over a Medicare prescription drug benefit stalls or fails to result in a federal solution, is it likely that states will continue on a separate path?
- Could state-based assistance programs, if expanded, be sufficient to cover those Medicare beneficiaries without prescription drug coverage? (State programs cover approximately 800,000 elderly/disabled persons, but experts estimate that between six and nine million Medicare beneficiaries “need” coverage based on their income and health status.) What additional program expansions might be needed? How should they be structured? How should they be funded?
- When it comes to simplifying eligibility processes and improving marketing and outreach, what lessons can be drawn from states' experiences with programs for women and children?
- What is the effect of various cost-sharing arrangements on beneficiary enrollment?
- As states move beyond the more traditional state pharmaceutical assistance programs and experiment with more creative options, such as group purchasing arrangements, price controls, and discount programs (either as supplements to existing programs or as stand-alone options), how might these new strategies play out over time?
- How should these state-based programs be evaluated?
- What efforts are being (or should be) undertaken to measure increased quality of care, better outcomes, and decreased medication errors, as a result of the establishment of these programs?
- What affect will the recent reimportation legislation, (if implemented) have on state programs?

THE FORUM SESSION

Donna Folkemer, a program manager with the National Conference of State Legislatures, will open the session with an overview of state pharmaceutical assistance programs. Folkemer, who specializes in Medicaid, prescription drug, and disability issues at

NCSL, will provide an inventory of state activity, comparing and contrasting some of the older programs with new approaches. **Kevin W. Concannon**, commissioner of the Maine Department of Human Services, will follow with a description of the activities that have occurred in Maine. He will focus on the state's older pharmaceutical assistance plan, its waiver, its interaction with Medicaid, and its first-of-a-kind "Maine Rx" law, which seeks to control the price of prescription drugs.

To broaden the discussion, **Katie B. Horton, R.N., J.D.**, president of HealthPolicy R&D, will present alternative options for establishing state pharmaceutical programs, and **Joshua P. Cohen, Ph.D.**, a senior research fellow with the Tufts Center for the Study of Drug Development, will provide a marketplace scan, reviewing the impact of these programs on pharmaceutical manufacturers, chain drug stores, and pharmaceutical benefit managers. In addition, Cohen will discuss the "big picture," evaluating how well these assistance programs reduce the prescription drug coverage gap.

GLOSSARY OF TECHNICAL TERMS

Drug Formulary—A list of prescription medications that are preferred for use by a health plan and that may be dispensed through participating pharmacies to covered persons. This list is subject to periodic review and modification by the health plan. A plan that has adopted an "open or voluntary" formulary allows coverage of both formulary and nonformulary medications. A plan that has adopted a "closed, select or mandatory" formulary limits coverage to those drugs in the formulary.⁶

Medicaid Rebates—The Omnibus Budget Reconciliation Act (OBRA) of 1990 established the Medicaid rebate program. The basic formula requires that, in exchange for having their product(s) reimbursed (that is, included on the formulary), pharmaceutical manufacturers rebate to the states the greater of (a) 15.1 percent of the average manufacturer price (AMP) paid by wholesalers for brand-name drugs that Medicaid beneficiaries purchase as outpatients or (b) the manufacturer's "best price." The best price is the lowest price offered to any other customer, excluding Federal Supply Schedule prices and prices to state pharmaceutical assistance programs. Similarly, manufacturers pay a rebate equal to 11 percent of the AMP on generic and over-the-counter drugs. The January 1996 Congressional Budget Office study, "How the Medicaid Rebate on Prescription Drugs Affects Pricing in the Pharmaceutical Industry," noted that

If a brand-name drug's AMP increases faster than the inflation rate, an additional rebate is imposed so that manufacturers cannot offset the basic rebate by raising their AMP. The additional rebate is equal to the difference between the current AMP and a base-year AMP increased by the inflation rate as measured by the consumer price index.

Medicaid 1115 Waivers—Medicaid (Title XIX of the Social Security Act) contains two types of waiver authorities: program and demonstration. Program waivers give states program flexibility in two specific areas—alternative delivery and financing and home- and community-based long-term care—while demonstration waivers offer opportunities for experimentation and research.

Traditional Section 1115 waivers, while vehicles allowing for significant departure from program rules, are time-limited and subject to evaluation. An additional challenge to states considering Section 1115 waivers is the OMB regulation that they must be budget neutral. Nevertheless, states have been using Section 1115 waivers to address the growing burdens of the Medicaid populations. For example, Oregon has set priorities on services and expanded its Medicaid base, while Arizona has capitated its Medicaid population and Hawaii has pooled its Medicaid beneficiaries and uninsured residents into one managed care plan.⁷

The 1115 waiver that Vermont received⁸ for its pharmaceutical assistance program is very different from what is traditionally thought of as an 1115 waiver. It is essentially a vehicle for a discount program with no federal or state money involved. In Vermont, the waiver, which is used in tandem with other elements of Vermont's prescription drug assistance program, works as follows:

Medicare beneficiaries not eligible for Vermont's traditional subsidy program (up to 150% of poverty) or any individuals with an income below 300% of poverty and no drug coverage can sign up for the Medicaid waiver program, called the Pharmacy Discount Program. When an eligible person goes to the drug store, she pays the price Medicaid would pay for the drug minus the average Medicaid rebate amount of about 15%. (This percentage would change annually.) For example, for a drug that Medicaid pays \$100, the eligible individual would pay \$85 as her "co-pay" and the state would reimburse the pharmacist the remaining \$15 from the rebates it receives from manufacturers. The beneficiary's discount is reduced by \$3.00 for each of her first eight prescriptions to cover an enrollment fee of \$24 per person. The benefit the enrollee receives varies by drug. A fact sheet from Vermont, for example, indicates that Paxil costs \$77.89 retail and under the Vermont program, the

enrollee pays \$56.56 (the Medicaid price less the 15% rebate.) This represents, for this particular drug, a savings to the enrollee of about 27% off the retail price.⁹

The Vermont waiver compels manufacturers to pay rebates (since the program is run through Medicaid and rebates are required by law in Medicaid), it holds the prices of drugs to the Medicaid price, and the retail pharmacists are “made whole” up to the Medicaid payment level by the rebate payment they receive. Under this waiver, neither the federal government nor the state assumes any additional costs.

The Pharmaceutical Research and Manufacturers of America (PhRMA) has filed a complaint against the Health Care Financing Administration (HCFA) in the U.S. District Court, stating that HCFA’s waiver approval violates federal Medicaid law.

The Secretary of the Department of Health and Human Services [Shalala] and the state of Vermont have, in effect, made an ‘end run’ around existing federal law by creating a new ‘government’ program with no government cost, but paid for solely by private manufacturers. By doing so, the Secretary has clearly exceeded her authority.¹⁰

Analysts have called this waiver approach “very creative” and were surprised when HCFA approved this type of waiver. Word about the waiver option has gotten around fast and many states are considering this approach. Some analysts are of the opinion that this is the tip of the waiver iceberg, if it holds up in court.¹¹

Medigap Rx Plans—Beneficiaries have purchased supplemental insurance (referred to as Medigap policies) since the inception of the Medicare program as a way to protect themselves against costs not covered by the program (for example, outpatient prescription drugs). Medigap insurance is specifically designed to supplement Medicare’s benefits and is regulated by federal and state law. Until the passage of OBRA 1990, however, the Medigap market lacked standardization among the benefits sold, creating confusion among consumers. The Medigap provisions in OBRA 1990, which became effective on July 30, 1992, required all new Medigap policies to conform to one of ten standardized sets of benefits, or plans. These range from Plan A, the basic benefit package, to Plan J, which provides the greatest coverage.

Among other things, OBRA 1990 enabled beneficiaries to make informed choices about the benefits they were purchasing. One of those benefits was outpatient prescription drug benefits. Plans H, I, and J offer prescription drug benefits. The costs of these plans are

high in comparison to other plans (in part, to compensate for adverse risk selection), and the coverage is quite limited.¹²

ENDNOTES

1. Certain low-income Medicare beneficiaries (qualified Medicare beneficiaries, or QMBs), receive assistance from Medicaid for payment of Medicare cost-sharing charges, such as premiums, deductibles, and coinsurance. These beneficiaries include the elderly with incomes below the federal poverty line who are not Medicaid beneficiaries. In some states, however, QMBs could be full Medicaid beneficiaries; it depends on where the state sets its Medicaid income eligibility limits. For Medicare beneficiaries with incomes between 100 percent and 120 percent of poverty (specified low-income Medicare beneficiaries, or SLMBs), Medicaid pays only the Part B Medicare premium. Therefore, although Medicaid will pay the coinsurance charges for the limited outpatient drugs covered by Medicare (for QMBs), as well as Part B premiums for both QMBs and SLMBs, most QMB-onlys and SLMB-onlys do not have access to Medicaid’s outpatient drug benefit.
2. U.S. General Accounting Office (GAO), *State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets* (GAO/HEHS-00-162), September 2000, 4.
3. However, some of these programs (for example, Nevada’s) that were scheduled to begin on January 1, 2001, have not yet begun to provide benefits.
4. Much of this information is taken from the GAO September 2000 study and the National Conference of State Legislators’ Web site, <http://www.ncsl.org>.
5. For some discount-only programs, there are no limits.
6. National Pharmaceutical Council, *Pharmaceutical Benefits under State Medical Assistance Programs*, December 1998.
7. Karen Matherlee, “Walking a Tightrope between Research and Policy: The Medicaid and Medicare Waiver Processes,” National Health Policy Forum Issue Brief No. 632, Washington, D.C., October 29, 1993.
8. Maine also recently received a Section 1115 waiver that is similar to Vermont’s. Maine’s waiver was approved in 10 days, immediately before the administration changed. For a full description, see State of Maine, “Maine Prescription Drug Discount Waiver,” January 5, 2001; available at <http://janus.state.me.us/dhs/waiverreq.pdf>.
9. Donna Folkemer, telephone conversation with author, March 14, 2001.
10. For more detail, see Pharmaceutical Research and Manufacturers of America, “Why HCFA’s New Waiver Approval Violates the Medicaid Law”; available at <http://www.phrma.org/policy/statelevel/hcfa/>.

11. Donna Folkemer, telephone conversation with author, March 14, 2001.

12. Robin J. Strongin, "Providing Outpatient Prescription Drugs through Medicare: Can We Afford To? Can We Afford Not To?" background paper, National Health Policy Forum, Washington, D.C., March 1999.