STATE PHARMACY ASSISTANCE PROGRAMS: APPROACHES TO PROGRAM DESIGN

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FIELD REPORT

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EXECUTIVE SUMMARY

In the absence of a Medicare outpatient prescription drug benefit, many states have implemented pharmacy assistance programs to alleviate the burden of the high cost of prescription drugs for some portion of the Medicare population. Understanding the experience of these programs, some of which have been in existence for more than a quarter of a century, is important when considering alternative approaches for a Medicare prescription drug benefit, as well as implementing and improving programs in other states.

This report provides an overview of state pharmacy benefit programs that subsidize prescription drug coverage for low-income persons, including a historical overview of selected programs and cross-state comparisons of program design. The report is based on results from a study of state pharmacy assistance programs conducted by the Rutgers Center for State Health Policy with the sponsorship of The Commonwealth Fund. The results reported are based on a survey of all direct-benefit programs in place throughout the year 2000; information collected through qualitative case studies of programs in Maine, Massachusetts, Minnesota, Nevada, New Jersey, Pennsylvania, South Carolina, and Vermont; and reviews of the literature and program documents. The report focuses on direct-benefit programs, the most common approach taken by states.

Of the 28 states with pharmacy programs in place at the time this report was prepared, 24 had some form of subsidy program (five of which also had pursued discount programs); six states had implemented a price reduction initiative or discount program only, and two had tax credit programs. Discount programs provide marginal relief to consumers, in contrast to direct-benefit programs, many of which require only small copayments. Tax credit programs have not turned out to be a successful approach to addressing the problem of prescription drug affordability; both states with tax credit programs are in the process of phasing out these programs and replacing them with new direct-benefit programs.

Sources of Funding

In 2001, states appropriated approximately $1.5 billion for state pharmacy assistance programs. The source of funding varies by state, but most programs rely in whole or part on general funds. Programs initiated in 2000 and 2001 typically rely on tobacco settlement funds. Sources of funding have generally not kept pace with escalating net program expenditures, which have been estimated by program officials to be growing at an average annual rate of approximately 15 to 18 percent. Given the strains on state budgets, there is great interest in the possibility of Medicaid waivers that would provide pharmacy benefits

to low-income individuals not otherwise eligible for Medicaid on a federally matched basis. As of the end of 2001, Vermont was the only state to have been granted such a waiver. The approval of Illinois's waiver in January 2002, however, may open the door for additional states.

Eligibility

Most programs are means-tested, but there is considerable variation in eligibility criteria, resulting in uneven coverage for elderly and disabled persons across states.

- All states with programs cover older adults, but only half cover persons with disabilities under the age of 65.

- Income eligibility ceilings range from 80 percent to 500 percent of the federal poverty level. Massachusetts and Nevada have moved toward private insurance models that offer coverage regardless of income, using a sliding scale tied to household income to determine enrollee contributions.

- Only a few programs adjust income eligibility for those persons with catastrophic drug expenses. These programs define catastrophic costs differently, ranging from 3 percent to 40 percent of income.

- Most states do not have an asset test. The one case study state that did have such a test raised its asset limits, because the lower limits proved to be a significant barrier to enrollment.

- Many long-standing programs have incrementally increased eligibility over time, which has contributed to growing program costs. In the 1999–2001 period, the trend toward broadening eligibility criteria accelerated in part because of greater political attention to the issue, larger budget surpluses, and the availability of tobacco settlement funds. However, sustainability of such growth, unless federal funding becomes available, is uncertain.

Drugs Covered and Use of Formularies

While five programs limit coverage to drugs for certain medical conditions or to specific classes of drugs, most state programs use open formularies, following the model set by Medicaid programs. Some states, however, are exploring the possibility of increased use of more restrictive formularies and related tools widely used in the private sector, in order to encourage the use of less expensive drugs where appropriate or as leverage in securing

more favorable rebates from manufacturers. Massachusetts, for example, has employed tiered copayments to encourage enrollees to purchase less-expensive drugs.

Cost-Sharing Features

All state programs require some level of participant cost-sharing. While substantial cost-sharing can be effective in controlling costs, consumer advocates note that it can also have a chilling effect on enrollment and utilization.

- *Copayments.* Most states require participants to pay a copayment for prescription drug purchases, ranging from a nominal amount of $1 to $2 to a high of $25 per prescription. Many states set a lower copayment for generics than for name brand drugs, and some impose higher copayments for enrollees with higher incomes.

- *Fees and premiums.* The majority of programs do not charge enrollment fees, but a few states impose monthly premiums. These can limit access, particularly for low-income enrollees. For example, enrollee premiums of $34 per month for the lowest-income enrollees (less than $21,000 per year) in Nevada's prescription insurance program proved too high to attract buyers. In the three months after the state removed the premium, enrollment increased more than tenfold.

- *Deductibles.* Five states require some form of deductible, ranging from $100 to $1,230 annually. In general, deductibles have been found to be a barrier to enrollment, and some states have consequently dropped them.

- *Coinsurance.* A few states require participants to pay a percentage of the drug's cost rather than a flat copay, in an effort to sensitize patients to the actual costs of the drugs they use. Coinsurance rates vary from 10 percent in Florida to 85 percent for the highest-income participants in Rhode Island's program.

- *Sliding-scale premium subsidies, deductibles, and copayments.* A few states have used these tools in combination to help fund their programs and offset subsidy costs. Massachusetts, for example, charges no premium to the lowest-income groups but imposes sliding-scale premiums, deductibles, and copayments for higher-income persons.

Catastrophic Coverage vs. Benefit Caps

In choosing between providing catastrophic coverage to those with the highest drug costs or providing some coverage up to a cap, some states have chosen the latter, similar to the

structure of many Medicare+Choice plans. Benefit caps allow the state to calculate maximum program costs and limit adverse selection. However, capped benefits provide little relief to persons with very high drug expenses, who comprise a small, but potentially costly, proportion of enrollees. In contrast, catastrophic coverage targets benefits to the most heavily burdened, but also could attract sicker people into the program and make it difficult for states to assess program costs. Catastrophic programs also focus benefits on a narrower group, limiting their political attractiveness.

There is considerable discrepancy across states in the definition of catastrophic expenses. Where out-of-pocket cost limits exist, they average $2,000 per year; in contrast, several proposals for a Medicare drug benefit recommend limits of $4,000 to $6,000. Benefit caps range from $500 to $5,000 in states that impose them. Many officials in case study states considered benefit caps an undesirable way to control costs, since they limit the benefit for enrollees with catastrophic costs.

Program Administration and Start-Up

States have taken various approaches to the locus of program responsibility within state government, and the division of responsibilities between state staff and contractors.

- The majority of programs are operated by the state agency that administers the Medicaid program. These agencies are often selected because they have experience in eligibility determination for means-tested programs, have claims processing systems in place, and have preexisting relationships with pharmacies and manufacturers to negotiate prices and to provide payment. In choosing which agency to administer the program, states often weigh historical Medicaid program management experience against concerns about stigma associated with Medicaid that might discourage enrollment.

- Many of the case study states encountered some delays in starting up their programs, including longer-than-anticipated contracting processes in negotiating manufacturer rebates, releasing request for proposals, and identifying subcontractors for administrative tasks. Most program administrators recommended scheduling six months to a year to get new programs into operation.

Coordinating State Programs with a Medicare Benefit

Although at the time of this writing short-term prospects for a Medicare prescription drug benefit have dimmed, in the longer term options for such a benefit will continue to be evaluated and considered. As federal policymakers evaluate these options, more

consideration needs to be given to coordination with existing state programs. In that regard, state program administrators interviewed had several suggestions for how a federal benefit should be designed to support and enhance state-level programs, particularly related to the coordination of benefits with private pharmacy benefit managers.

- Some states wanted to be offered the option of functioning as a PBM for a Medicare benefit, while maintaining their current benefit structure and eligibility criteria, as long as the state program is at least as generous as the Medicare benefit.

- States wanted to be deemed payer of last resort in relation to the Medicare drug benefit—that is, in cases where coverage overlapped, the state program would pay only that portion not covered by the federal benefit.

- At minimum, state officials proposed that a Medicare benefit explicitly require all Medicare PBMs to share enrollee and cost-sharing information with the state programs to facilitate coordination of benefits.

- To maintain the same level of access for enrollees, states suggested that pharmacy networks that had been established for the state programs be maintained.

Lessons from States' Experiences

State policymakers are actively developing programs to provide adequate drug coverage in the absence of a Medicare prescription benefit. This decentralized response has resulted in almost as many different benefit models as there are states initiating programs. Ongoing revisions and amendments to pharmacy benefit programs, in some cases not even a year after the program has been implemented, suggest that developing 'best practices' in prescription drug coverage for the uninsured elderly is still a work in progress. Thus, it is important to continue monitoring states' experiences and to pay closer attention to this experience in designing a federal benefit. Federal policymakers should also anticipate that any federal benefit may require incremental revisions over time.

Given budget and resource constraints, states have had to strike a careful balance between expanding drug coverage to needy groups and controlling program costs. If a federal benefit is created, states' capacity to supplement such a benefit will be tied not only to continued availability of funds and political support, but also to the extent to which the design of a federal program facilitates coordination with state efforts. Representatives of some of the case study states were concerned that proposals for a Medicare benefit considered by Congress in 2001 did not adequately address the issues of coordination with

existing state programs. It is to be hoped that future proposals will be designed to facilitate such coordination.

In formulating national policy to address the gap left by the lack of prescription drug coverage in Medicare, it is important to understand not only the significance of existing state programs as models but also their inherent limitations in scope from a national perspective. Just three states account for almost three-quarters of state pharmacy assistance expenditures and more than half of enrollment nationwide. Their combined enrollment of approximately 1.2 million represents only about 3 percent of Medicare enrollment nationally. Moreover, the nonelderly disabled are often excluded.

While these programs are of great importance to their participants, it would be a mistake to think that they provide a national drug safety net or that their existence mitigates the need for federal action. Given the magnitude of the problem, they represent an incomplete and uneven response, one that is mainly reliant on state dollars without federal matching. In such a system, protection depends on where one lives. In the absence of federal financing, this system is unlikely to evolve into a true national safety net. Nevertheless, as we discuss in this report, they have developed an important body of experience that needs to be taken into consideration in the development of broader solutions to the problem of prescription drug affordability.

STATE PHARMACY ASSISTANCE PROGRAMS: APPROACHES TO PROGRAM DESIGN

INTRODUCTION

Many states have implemented pharmacy assistance programs to alleviate the burden of the high cost of prescription drugs for some portion of the Medicare population. These state-funded programs, some of which have been in existence for over a quarter of a century, have experience that could prove valuable to federal policymakers designing a Medicare benefit or those in states considering implementing or expanding state-based programs. In particular, the experience of states could be beneficial for:

- weighing critical choices in program design (including coverage, participant cost-sharing, and eligibility);
- evaluating the operational challenges of implementing a pharmacy benefit program; and
- appraising choices for benefit administration including use of state agencies, insurers, or pharmacy benefit managers (PBMs).

In addition, the experience of states must be understood in order to design an effective approach to coordination of benefits between Medicare and state programs. Finally, documenting the approaches taken by states can be useful for other states considering new programs or operating programs with different designs.

To these ends, this report provides an overview of state pharmacy benefit programs that subsidize pharmacy coverage for low-income persons. After a brief overview of study methods, the report begins with a general review of various options that states have considered and implemented, distinguishing among price reduction strategies, tax credits, and direct-subsidy programs, and highlighting the pros and cons of these approaches. The remainder of the report focuses specifically on those states that have chosen to subsidize the costs of prescriptions directly for some portion of the population. For these direct-benefit programs, the report provides a summary of the historical evolution of case study programs and cross-state comparisons of program design. The report identifies the diverse funding sources; eligibility criteria; benefit structures; consumer cost-sharing; administrative structures; and cost-containment strategies employed by states, and discusses perceptions of program administrators and stakeholders on the impact of these features on

program cost and enrollment. We conclude with a presentation of important issues for coordination of benefits with a Medicare program, and a summary of key findings.

STUDY METHODS

Findings are based on the results of a survey of all direct-benefit programs in place throughout the year 2000; information collected through qualitative case studies of selected states; and reviews of the literature and program documents. The survey was conducted by the Rutgers Center for State Health Policy in the fall of 2000 and was sent to all states that had a direct-benefit program in place throughout the year 2000 (N=19 programs in 15 states). Survey questions were based on key programmatic design features of interest to policymakers and built upon prior surveys conducted by the AARP Public Policy Institute, the National Conference of State Legislatures (NCSL), the National Governors' Association , and the National Pharmaceutical Council. After telephone follow-up, we received surveys from 14 out of 15 states (18 out of the 19 programs), resulting in a response rate of 93 percent. Completion rates for individual survey questions varied significantly. While states were able to provide much descriptive information on their programs, few supplied estimates of persons eligible, demographics of their enrollees, or the proportion of enrollees actively using the benefit.

To supplement the surveys and to more fully capture how various programs operate in practice and have evolved over time, we selected eight states with direct-benefit programs for in-depth qualitative case studies. Two of these case studies were conducted for a parallel study funded by the AARP Public Policy Institute, which focuses on how states have addressed prescription affordability. The remaining case study states were selected based on five criteria including representation of a diversity of program models, a balance between well-established and newer programs, relevance to Medicare proposals being discussed, program size, and regional distribution.

The case study states were Massachusetts, Minnesota, Nevada, Pennsylvania, South Carolina, and Vermont, in addition to Maine and New Jersey, which had been part of the AARP study.[1] Case study data included semi-structured interviews with key informants and review of program documents from each state. The interview protocol focused on the impetus for the program or recent expansions, other options considered, design decisions and how they were arrived at, start-up and implementation issues, and perceived impact. Respondents for key informant interviews varied somewhat by state but generally included program administrators (21), other officials in Medicaid bureaus or related state

[1] California's Medicare Discount Program was selected as part of the AARP analysis of different approaches taken by states. Since this report focuses on direct-benefit programs, California is excluded from this analysis.

agencies involved in outreach or administration (6), representatives of PBMs or claims processors (3), legislators or legislative staff (7), pharmacist trade group representatives (13), and consumer representatives (13). State documents included enrollment forms, outreach materials, annual reports, requests for proposals, contracts with suppliers, and program websites.

A TAXONOMY OF STATE APPROACHES TO ADDRESSING DRUG COSTS

As of July 2001, 28 states had passed legislation to address prescription drug affordability and 3 more had created programs authorized by the executive branch.[2] However, not all of these initiatives provide comprehensive drug coverage.

State pharmaceutical policies can be classified into three general forms—price reduction strategies, changes to tax policy such as tax credits for pharmacy costs, and direct subsidies by the state to cover the drug costs of some portion of the population. These categories can be further subdivided into various approaches. For example, state subsidy programs include both direct-benefit programs and state-sponsored private or public stand-alone insurance programs.[3] In implementing each of these approaches, states have used a variety of program designs (see Table 1) and several states have pursued more than one approach.

Price Reduction

Price reduction strategies, such as discount programs or pooled purchasing, are aimed at reducing the cost of prescription drugs for program participants at the point of purchase. Since cash-paying customers have no intermediary to negotiate prices for them, they generally pay higher prices for prescription drugs than those charged to large insurers, managed care organizations, or publicly funded insurance programs. Price reduction strategies are intended to compensate for this inequality in the market by providing marginal savings or price relief to uninsured older persons (or, in some cases, all uninsured persons in the state). This relief is offered by extending discounts available to larger covered groups (such as those receiving Medicaid) to cash-paying customers, or through pooled purchasing across programs to negotiate discounts. The resulting discounts are supported either through rebates from manufacturers, reduction of pharmacists' profit

[2] National Conference of State Legislatures, *State Senior Pharmaceutical Assistance Programs,* http://www.ncsl.org/programs/health/drugaid.htm. July 27, 2001

[3] A recent AARP Public Policy Institute report identifies five distinct policies including direct-benefit programs, state-sponsored private or public stand-alone insurance programs, price-reduction programs, buying pools, and tax-credit programs. For the purposes of this report, we combine direct-benefit and insurance approaches as direct subsidy programs, and buying pools and discount programs as price-reduction strategies.

Table 1. State Interventions for Addressing Prescription Drug Affordability (as of 2001)

INTERVENTION	STATE
Direct-Benefit/Subsidy Programs (24 states)	
Direct-benefit: CMS waiver to provide full Medicaid drug coverage to individuals above Medicaid eligibility levels through state/federal funding	*Arkansas,* Vermont
Direct-benefit: State-funded programs	*Arizona,* Connecticut, Delaware, Florida, Illinois, Indiana, *Kansas,* Maine, Maryland, Massachusetts (Pharmacy and Pharmacy Plus), Michigan, Minnesota, New Jersey, New York, North Carolina, *Oregon,* Pennsylvania, Rhode Island, South Carolina, *Texas,* Vermont, Wyoming
Insurance-based	Massachusetts (Prescription Advantage), Nevada
Private initiative—no state funds	Delaware (Nemours)
Price Reduction Strategies (10 states)	
Extend Medicaid pharmacy discount	California, Florida
CMS waiver to extend Medicaid pharmacy discount and rebate to uninsured	Maine, *Vermont, Maryland*
Contract with PBM to provide discounts	New Hampshire
Pooling of beneficiaries to negotiate discounts for state programs and individuals	*Iowa, Massachusetts, Washington,* West Virginia
State negotiated prices with price controls	*Maine*
Tax Credits (2 states)	
Tax credit on the purchase of prescription drugs	Michigan, Missouri (both being phased out)

Notes: Programs in *italics* were not yet operational as of July 2001. Discount programs in Vermont, Maine, and Washington were on hold at the time of writing due to lawsuits.

Sources: Rutgers Center for State Health Policy Survey of State Pharmaceutical Assistance Programs, December 2000; and the National Conference of State Legislatures' website: *State Senior Pharmaceutical Assistance Programs,* http://www.ncsl.org/programs/health/drugaid.htm. July 27, 2001.

margins on cash-paying customers, or both. While the discounted price lowers the cost of drugs marginally, consumers still pay full discounted prices. This contrasts with direct-benefit programs, which typically pay for a large proportion of the negotiated discounted price for the consumer. Thus, consumer savings are typically much lower in discount programs than in direct-benefit programs.

Price reduction programs set discounted prices in a variety of ways, and range considerably, both in the savings they offer and the legal challenges they face. Perhaps the

most publicized price reduction initiative on behalf of the uninsured was taken by the state of Maine. In 2000, Maine enacted a program for all uninsured residents of the state in which the state acts as a PBM to negotiate rebates with manufacturers that are passed on to the consumer through discounted prices at the point of purchase. The law goes further than those in other states that have created discount programs by seeking to obtain a rate comparable to the federal supply schedule,[4] and reserves the right to impose price controls if these lower rates are not achieved by 2003. As an alternate strategy to its Maine Rx program, Maine also applied for and was granted a Medicaid 1115 waiver to extend the Medicaid discount and rebate to all uninsured residents earning up to 300 percent of the federal poverty income level.

In contrast, other states such as Iowa, New Hampshire, West Virginia, and Washington have sought to establish, in effect, state prescription drug buyers' clubs through a variety of means. New Hampshire contracts with a PBM to implement the program, while Iowa has proposed establishing a prescription drug co-op to provide drug discounts for older adults for an annual fee of $15 to $30. The state has acquired a $1 million federal grant to support this demonstration project.

Some states have attempted to maximize discounts available for state-subsidized programs and the uninsured by pooling the number of lives covered in negotiating rebate and discount rates. Washington's bulk-buying program combines buying power on behalf of the state's Medicaid enrollees with that of the uninsured population aged 55 or older. West Virginia's program authorizes the state's Public Employees Insurance Program to use its PBM to negotiate reduced drug prices for Medicare beneficiaries with incomes below 300 percent of poverty.

Rather than creating a separate pool for the uninsured, California and Florida require pharmacies to extend the Medicaid discount to all Medicare beneficiaries as a condition of participation in the Medicaid program. Vermont, Maine, and Maryland went one step further and submitted a Medicaid 1115 waiver to the Centers for Medicare and Medicaid Services (CMS) to create programs to extend both the Medicaid price and manufacturer rebate to eligible residents. Many of these discount and pooled-purchasing programs have faced legal challenges by the Pharmaceutical Research and Manufacturers Association (PhRMA) or by pharmacy trade groups such as the National Association of Chain Drug Stores on a number of legal and procedural grounds.

[4] The federal supply schedule is the list of drug prices that the federal government has negotiated for federal programs such as the Veterans Administration.

Results of these lawsuits have been mixed and, as of September 2001, many were still under review. At the time of February 2002, the Maine Rx discount program was on hold pending a decision by the U.S. Supreme Court to hear an appeal by PhRMA to the Circuit Court's reversal of a lower court's injunction of the program. In a legal challenge by PhRMA to Vermont's prescription drug discount waiver program, the U.S. Court of Appeals for the District of Columbia Circuit ruled that CMS should not have approved the program because it did not result in any overall savings to Medicaid, while Medicaid rebates and discounts had been created by Congress for that purpose. Maine's similar Healthy Maine Prescription Program was also challenged but was not enjoined and had enrolled 108,000 people as of January 2002. In Washington, where the program was created by executive order rather than legislative action, the courts upheld a challenge by state pharmacist groups, which argued that the governor did not have statutory authority to create the program.[5] In Florida, the Chain Drug Store Association filed suit against the state's discount program, charging that the state needed to file a State Plan Amendment (SPA) to HCFA to amend its Medicaid condition of participation to include non-Medicaid beneficiaries. In response, the state temporarily suspended the program, and submitted an SPA to CMS, which was approved.[6]

Discount programs are often politically popular because they apply to a broad group of persons (i.e., they are not typically means-tested), put few administrative demands on states, and have little or no cost to the state. Nonetheless, the savings to consumers attributable to these programs have not been empirically evaluated, and in some states do not appear to be as great as consumers hoped, resulting in some negative publicity.[7] When the California discount program was initiated, some consumers were disappointed because they had anticipated greater savings than they experienced. Florida's discount program was strongly criticized on similar grounds after it was initiated. Given the competitive pharmacy market in the state, many pharmacies were already providing sizable senior discounts that were comparable or in some cases better than the discount offered by the state. In all of these programs, consumers still bear the majority of the costs of drugs, which for low-income persons may be unaffordable even with a discount. Several interview respondents from states that have pursued these initiatives acknowledged that discount programs are not a solution to the problem, but they do provide temporary relief for consumers as a gap-filler pending a more comprehensive Medicare benefit.

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[5] R. Cook, "Judge Rules Against Governor's Drug Discount Program," *The Associated Press State & Local Wire,* May 26, 2001.

[6] R. Pear, "U.S. Backs Florida Plan to Cut Drug Costs," *New York Times,* September 19, 2001.

[7] D. Lade, "State-Ordered Drug Discounts for Seniors Are Worthless at Most Pharmacies," *South Florida Sun-Sentinel,* January 1, 2001.

Tax Credits

Another strategy, used by only two states thus far (Missouri and Michigan), has been to create tax credits for prescription drug expenditures. While easier to administer than a direct benefit, these strategies appear to have provided only minimal relief to consumers who have difficulty paying at the point-of-purchase, since the benefit comes at the end of the year. The tax credits offered have been relatively low, and considerably limit the relief available to persons with high prescription drug costs. The Missouri program has provided a full credit of $200 for people over 65 earning less than $15,000. The credit is graduated up to an income ceiling of $25,000. Michigan's program has provided a higher refund of $600 for prescription costs exceeding 5 percent of household income. Both states were, at the time of writing, in the process of phasing these programs out and replacing them with new direct-benefit programs. The Michigan tax credit and the state's direct-benefit program were to be replaced by a new direct-benefit program targeted at elderly residents with incomes below 200 percent of poverty, to be financed out of existing funds for these programs and additional funds from the tobacco settlement. Missouri was also slated to replace its tax credit program with a direct-benefit program, due to unexpected cost overruns. According to news reports, the tax credit refund program cost the state four times more than what was budgeted because more residents sought the credit than the state anticipated.[8]

Direct-Benefit Programs

The majority of states with pharmaceutical programs have opted to make a more substantial commitment to addressing prescription drug affordability by directly covering some of the costs of drugs for program participants. These direct-benefit programs provide coverage for outpatient drugs through either a state-administered program or state-subsidized private insurance. In contrast to discount programs, direct-benefit programs typically cover the bulk of the cost of drugs at the point-of-purchase, with consumers paying varying levels of premiums, deductibles or copayments, depending on the benefit design set by the state. Approximately half of the programs have been in place for more than 10 years and have considerable experience (see Table 2). The remainder of this report focuses on the state direct-benefit programs. While we make use of information on all direct-benefit programs from our state survey, we focus particularly on the programs in the eight case study states.

[8] T. Ganey, "State's Tax Credit on Drugs for Elderly Cost Four Times Amount Expected," *St. Louis Post-Dispatch,* January 30, 2001.

Table 2. State Direct-Benefit/Subsidy Programs and Date of Implementation

STATE	PROGRAM NAME	IMPLEMENTED
Arizona	Prescription Medication Coverage Pilot Program	Enacted May 2001; not yet implemented
Arkansas	Prescription Drug Access Improvement Act	Enacted April 2001; not yet implemented
Connecticut	Connecticut Pharmaceutical Contract to the Elderly and Disabled (ConnPACE)	April 1985
Delaware	Nemours Health Clinic Pharmacy Assistance Program (private initiative) Delaware Prescription Drug Assistance Program (DPAP)	September 1981 January 2000
Florida	Pharmaceutical Expense Assistance Program	January 2001
Illinois	Pharmaceutical Assistance Program (PAP)	July 1985
Indiana	Indiana Prescription Drug Fund: "HoosierRx"	September 2000
Kansas	Senior Pharmacy Assistance Program	Enacted May 2000; not yet implemented
Maine	Low-Cost Drugs for the Elderly or Disabled	1975
Maryland	Maryland Pharmacy Assistance Program Short-Term Prescription Drug Subsidy Plan	January 1979 June 2001
Massachusetts	Pharmacy Program Pharmacy Program Plus Prescription Advantage	February 1997 January 2000 April 2001
Michigan	Michigan Emergency Pharmaceutical Program for Seniors (MEPPS) Elder Prescription Insurance Coverage (EPIC)	1988 Enacted June 2000; not yet implemented
Minnesota	Prescription Drug Program (PDP)	January 1999
Nevada	Senior Rx Insurance	January 2001
New Jersey	Pharmaceutical Assistance for the Aged and Disabled (PAAD) Senior Gold Prescription Discount Program	March 1976 June 2001
New York	Elderly Pharmaceutical Insurance Coverage (EPIC)	October 1987
North Carolina	Prescription Drug Assistance Program	July 2000
Oregon	Senior Prescription Drug Assistance Program	Enacted July 2001; not yet implemented
Pennsylvania	Pharmaceutical Assistance Contract for the Elderly (PACE) Pharmaceutical Assistance Contract for the Elderly Needs Enhancement Tier (PACENET)	July 1984 November 1996
Rhode Island	Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE)	October 1985
South Carolina	SilverCard Program	January 2001
Texas	State Prescription Drug Program	Enacted June 2001; not yet implemented
Vermont	Vermont Health Access Program (VHAP) VScript VScript Expanded	January 1996 1989 January 2000
Wyoming	Minimum Medical Program (MMP)	1988

Source: Rutgers Center for State Health Policy Survey of State Pharmaceutical Assistance Programs, December 2000; and the National Conference of State Legislatures' website: *State Senior Pharmaceutical Assistance Programs,* http://www.ncsl.org/programs/health/drugaid.htm. July 27, 2001

OVERVIEW OF PHARMACY PROGRAMS IN CASE STUDY STATES

Prior to providing cross-state comparisons on particular design features, this section provides a brief overview and description of the case study states, tracking their historical evolution and indicating why these state's experiences may be particularly instructive in designing a Medicare benefit or for other states.

Maine

Maine's state-funded Low Cost Drugs for the Elderly (DEL) program is one of the longest standing, established in 1975. For most of its history, DEL was targeted to people marginally above Medicaid eligibility limits, and provided limited drug coverage for four conditions. More recently, using tobacco settlement funds, it has expanded significantly, covering many more drugs, extending eligibility to the disabled, and offering a catastrophic coverage component. Maine has also taken the lead on developing mechanisms to lower the price of drugs for other uninsured persons in the state. These include the Medicaid waiver and Maine Rx program mentioned above. Maine has also worked to lower drug costs through strategies such as prior authorization in its Medicaid program and a multistate bulk-purchasing effort (with Vermont and New Hampshire) for its Medicaid and DEL programs.

Massachusetts

Massachusetts has modified its pharmacy assistance program three times in the past four years. Its most recent Prescription Advantage plan was implemented in 2001. Like Nevada's program, it is based on an insurance model, but in Massachusetts the state assumes the insurance risk. In the Prescription Advantage plan, participants pay a monthly premium, annual deductible, and tiered copayments based on a PBM's "preferred" and "nonpreferred" drug formulary. The plan is open to all elderly residents, regardless of income, and to low-income people with disabilities. The state subsidizes premiums on a graduated basis for enrollees with incomes less than 500 percent of poverty, a higher income level than subsidies in Nevada. Under this model, the state hopes to reduce the state cost per beneficiary by enrolling a number of higher-income beneficiaries, who will contribute significant cost-sharing and, in some cases, pay more in premiums than they receive in benefits.

Minnesota

Minnesota's Prescription Drug Program (PDP) is more limited in scope than those in many of the other case study states. In PDP, eligibility is restricted to those eligible for the federal Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) programs, and like these programs has an asset test for eligibility. It is

also one of only a few that originally had an enrollment fee and a monthly deductible. Due to lower-than-expected enrollment, the two-year-old program has undergone a number of design changes.

Nevada

Nevada is the only state to attempt a public-private partnership in administering a pharmacy assistance program in which the insurer, rather than the state, assumes the insurance risk of providing a prescription drug benefit. In this respect, it has design similarities to federal proposals that would rely in part on subsidized, free-standing pharmacy insurance coverage, as provided for in legislation passed by the House of Representatives and in Senate proposals (Breaux-Frist II).[9] Nevada's early experiences may provide insight into issues that might arise with the implementation of such models. In 2000, the state issued a request to insurers for competitive proposals to issue a drug-only insurance product in the state, which the state would promote and subsidize on a sliding scale for low-income older adults. After initial failure to receive proposals from licensed insurers for the program, the state eventually selected a two-product proposal that included a lower-cost basic plan with more limited access to certain drugs, and a higher-cost plan that offered more extensive drug coverage. Both products incorporated higher premiums than the state had targeted in its requests for proposals, and both included other consumer cost-sharing features, such as a deductible and tiered copays. Each included an annual cap of $5,000, limiting coverage for catastrophic costs. The state's subsidy for low-income persons, which was capped at a maximum of $480 annually, proved to be insufficient to attract buyers. In its first six months, the program suffered from serious under-enrollment. In response, in June 2001, the state revamped the program. Rather than the sliding-scale state premium subsidy in the original design, the state assumed the full cost of the premium and deductible for all low-income enrollees. In addition, the state eliminated the basic plan, expanded the drugs covered in the enhanced plan, and reduced the copay tiers to $10 for generic and $25 for brand-name drugs. These changes significantly increased the state's costs per enrollee, leading the state to cap enrollment to 3,500 persons. Early results (based on three months' experience) indicate that the increased state subsidy successfully increased program enrollment.

New Jersey

New Jersey's Pharmaceutical Assistance to the Aged and Disabled (PAAD) program is one of the most comprehensive direct-benefit programs in the country, covering most drugs with consumers paying a nominal copayment. Established in 1975 using state general funds and later expanded through casino revenue funds, PAAD has broad political support

[9] J. Breaux and B Frist, The Medicare Prescription Drug and Modernization Act of 2001, S. 358.

in the state and has a long history of incremental expansions, despite rising program costs. In June 2001, New Jersey created a new program using tobacco settlement funds. This program, called Senior Gold, is targeted to moderate-income older and disabled persons who do not qualify for the PAAD program. Rather than offering the same first-dollar coverage as PAAD, the Senior Gold program imposes 50 percent coinsurance and a $15 copayment, on the premise that persons with higher incomes should contribute toward a greater portion of the cost.

Pennsylvania

Pennsylvania's Pharmaceutical Assistance Contract for the Elderly (PACE) and PACE Needs Enhancement Tier (PACENET) programs enroll more beneficiaries than any other direct-benefit state. Modeled after New Jersey's PAAD program, the PACE program, initiated in 1985, provides first dollar coverage to low-income older adult residents, with a nominal copayment for all drugs that is slightly higher than New Jersey's. The popularity of PACE, along with concerns that many people with only slightly higher incomes were still struggling to meet high drug costs, led to the later development of the PACENET program in 1996. PACENET targets persons with incomes slightly above PACE ceilings. By including a $500 deductible, the state designed the program to help those moderate-income seniors with higher than average costs. Once participants meet the deductible, they are eligible for a benefit comparable to those available to PACE enrollees, with slightly higher copayments. The state is also a leader in supporting extensive research on drug utilization by enrollees and has developed a drug utilization review program that serves as a model for preventing medication error.[10]

South Carolina

South Carolina's SilverCard senior pharmacy program, passed in June 2000 and implemented in January 2001, is the first substantial pharmacy program for older adults to be initiated in a southern state and is unique in a number of ways. In addition to being the only direct-benefit program to be administered through the same state agency that administers the state employee benefits program, SilverCard subcontracts most of the administration of the benefit—including eligibility determination and outreach—to a PBM. Following a private insurance model, the state utilized a unique defined contribution approach to structuring SilverCard's benefit program. Rather than defining the benefit in advance, the legislation enabling the program was very flexible, dedicating $20 million from the tobacco settlement toward the program and outlining general eligibility criteria but without setting plan design or patient liability. The state then held an

[10] Drug utilization review is the process of reviewing claims either retrospectively or prospectively through an on-line point-of-sale system for therapeutic contraindication, duplicate prescriptions, early refill, etc., both to reduce inappropriate use and to contain program costs.

open enrollment period for people to apply for the program, allowing policymakers to 'back into' plan design after participant numbers and administrative fees were known. Based on the monies available and the number of applicants, the final benefit design was a model similar to the PACENET program, including a $500 deductible and differential copayments for generic and brand drugs. Thus, South Carolina's program requires significant cost-sharing from low-income beneficiaries.

Vermont

Until 2002, Vermont was the only state to have implemented a federal-state solution to providing prescription drugs to low-income Medicare beneficiaries.[11] Initially, in 1989, the state had created a state-funded program to help low-income seniors and disabled persons pay for maintenance drugs. In contrast to programs in other states at that time, this VScript program was one of the first to impose fairly substantial coinsurance requirements (50%) on low-income enrollees. Six years later, the state sought federal matching funds for a portion of this population, through its Medicaid 1115 waiver (whose principal goal was to shift the state's Medicaid population into managed care). The waiver for the Vermont Health Access Plan (VHAP) included, among other things, prescription drug coverage for elderly and disabled Medicare beneficiaries with incomes below 100 percent of poverty. Over time, the state has amended the waiver to expand eligibility to all of those originally covered under VScript, allowing for coverage of more drugs at much lower cost to enrollees. Using state funds previously dedicated to VScript, in 1996 Vermont was able to expand coverage for maintenance drugs with 50 percent coinsurance to older adults and disabled persons with higher incomes, through its VScript Expanded program. Like Maine, Vermont has also sought other avenues for lowering the cost of drugs in the state, including another waiver to extend the Medicaid discount and rebate to all Medicare beneficiaries and low-income uninsured persons in the state and to implement cross-state bulk-purchasing initiatives.

CROSS-STATE COMPARISONS OF DIRECT-BENEFIT PROGRAMS

Sources of Funding

As is the case at the federal level, the level of funding that states are able to allocate for pharmacy programs drives decisions about eligibility limits and benefit design. In 2001, states budgeted approximately $1.5 billion for state pharmacy assistance programs, covering approximately 1.2 million enrollees (see Table 3). However, the level of funding differs significantly across states, ranging from a low of $600,000 in Wyoming to a high of

[11] In January 2002, Illinois was granted a similar waiver from CMS to extend Medicaid-funded prescription drug benefits to elderly residents with incomes under 200 percent of poverty. The program was scheduled to begin on June 1, 2002.

Table 3. Direct-Benefit Pharmacy Assistance Programs— Funding Source, Appropriation Amount, Enrollment, and Percent of All Medicare Beneficiaries in the State for FY 2001 (sorted by appropriation amount and income eligibility)

STATE (PROGRAM)	FUNDING SOURCE	APPROPRIATION AMOUNT	ENROLLMENT	% OF MEDICARE BENEFICIARIES[1]
New York	General revenue and HCRA funds (tobacco tax and Hospital Reform Act)	$396,400,000	234,916	10.1%
Pennsylvania	Lottery fund and general revenue	$368,700,000	234,711	12.5%
New Jersey†	Casino revenue fund, general revenue, and tobacco settlement	$345,224,000	188,000	15.8%
Massachusetts	Cigarette tax and tobacco settlement	$69,200,000	60,900	6.4%
Illinois	General revenue and tobacco settlement	$69,000,000	145,089	8.9%
Michigan	Sales tax on construction materials and tobacco settlement	$56,000,000	46,000	3.9%
Maryland†	General revenue	$37,300,000	34,000	5.4%
Connecticut	General revenue	$28,276,961	33,850	6.6%
South Carolina	Tobacco settlement	$20,000,000	34,000	7.6%
Indiana	Tobacco settlement	$20,000,000	10,000	1.4%
Vermont	VHAP and VScript: State cigarette tax and federal Medicaid matching funds. VScript Expanded: State cigarette tax	$17,920,433	13,755	15.9%
Maine	General revenue and tobacco settlement	$17,000,000	41,000	19.5%
Florida	General revenue	$15,250,000	20,500	0.8%
Minnesota	General revenue	$14,342,000	4,500	0.8%
Rhode Island	General revenue	$8,100,000	33,000	22.3%
Delaware (DPAP)	Tobacco settlement	$5,569,418	3,577	3.3%
Delaware (Nemours)★★†	Private foundation	$5,400,000	26,000	27.5%
Nevada	Tobacco settlement	$4,600,000	4,165	2.1%
Arizona★	Tobacco tax	$3,900,000	Not Available	
Kansas★	Not Available	$1,200,000	800	0.2%
North Carolina	General revenue	$1,000,000	2,076	0.2%
Wyoming†	General revenue	$600,000	550	0.9%
Arkansas★	Medicaid waiver	Not Available	Not Available	
Oregon★	State cigarette tax	Not Available	Not Available	
Texas★	General revenue	Not Available	Not Available	
TOTAL		$1,504,982,812	1,171,389	3.0%

Note: In order to match enrollment data to appropriation year, enrollment numbers for 2001 were taken from NCSL's webpage, and do not necessarily correspond to enrollment data for other time periods discussed elsewhere in the text.

[1] Percentage of Medicare Beneficiaries does not include disabled enrollees for states where disabled persons are not eligible for the pharmacy assistance program.

★ New programs with appropriations for FY 2002. ★★ Delaware (Nemours) shown separately because it is privately funded, not state-sponsored. † Enrollment numbers are from 2000.

Sources: Rutgers Center for State Health Policy Survey of State Pharmaceutical Assistance Programs, December 2000; National Pharmaceutical Council. *Pharmaceutical Benefits Under State Medical Assistance Programs,* 2000; and the NCSL website: *State Senior Pharmaceutical Assistance Programs,* http://www.ncsl.org/programs/health/drugaid.htm. January 7, 2002.

$396 million in New York. Enrollment also varies considerably by state, both overall and relative to the funds appropriated. Three states—New York, Pennsylvania, and New Jersey—account for nearly three-quarters of state pharmacy assistance spending and more than half of enrollment nationwide (see Table 3). These states, whose programs have been in place for some time, have relatively high median incomes and relatively high proportions of the population above age 65, along with strong political leadership in providing programs for the elderly. They also have a fairly strong pharmaceutical industry presence.

The sources of funding for state pharmacy programs vary by state, but most rely in whole or in part on general funds. A few states have earmarked categorical funding to support these programs, including lottery funds (Pennsylvania), casino revenue funds (New Jersey), cigarette taxes (Vermont, Arizona), sales tax on construction materials (Michigan), and taxes on health care providers (New York). New Jersey and Pennsylvania, two states with the largest programs, rely heavily on categorical funds. For example, Pennsylvania's PACE drug benefit program is funded entirely by lottery revenues.[12]

Availability of Tobacco Settlement Funds

Programs initiated or expanded in 2000 and 2001 have typically relied on tobacco settlement funds. Among case study states, Nevada and South Carolina started new programs using their tobacco settlement funds. Massachusetts used tobacco settlement funds to underwrite its new Prescription Advantage plan for all elderly persons and low-income persons with disabilities, discontinuing its earlier state-funded programs designed to cover low- and middle-income elderly and disabled persons. New Jersey, Pennsylvania, and Maine all used tobacco settlement funds to expand prescription drug coverage for moderate-income persons or those just slightly above income limits. While Pennsylvania used tobacco funds to extend PACENET eligibility by $1,000, the bulk of the funds were used to provide a moratorium for people who had become ineligible for PACE due to their cost-of-living increases in benefits such as Social Security; we discuss this issue in greater detail below.

Shift Toward Categorical Funding

In the case studies, we found that several states have reassessed funding over time or have sought sources of support other than general funds to sustain and expand programs.

[12] Administrative expenses for PACE/PACENET for most of the program's history have also been funded by lottery funds. However, for a two-year period they were funded by general funds, due to a decision by the state to transfer all administrative expenses for lottery-funded programs to the general fund to make more dollars available for a property tax rent rebate program. Since this program generated less demand than anticipated, PA is in the process of moving PACE administration back to lottery funding.

Several policymakers in states with long-standing programs felt that the key to program success was finding a permanent source of funding other than general funds. According to state officials, most categorical funding sources provide more flexibility than general funds since budgetary changes may be made administratively rather than through changes in statute. New Jersey's PAAD program, which started out as a fairly small program for those just above Medicaid eligibility, was originally funded out of general revenues. When the state legalized casino gambling in the early 1980s, it formed a casino revenue fund to finance new programs for older adults and persons with disabilities. As a result, the state expanded PAAD income eligibility and also extended the benefit to persons with disabilities. While the state continues to rely on general funds for all persons eligible under the original program requirements, most of the program is funded by casino revenues.

Federal Matching Funds Through Medicaid Waivers

As noted above, Vermont's VScript program was initiated in 1989 and was originally supported solely by state funds to cover the costs of maintenance drugs for individuals with incomes up to 150 percent of the federal poverty income level. In 1995, when the state applied for a Medicaid Section 1115 waiver for the VHAP to expand eligibility for women and children, it also expanded eligibility for prescription drug coverage for Medicare beneficiaries below 100 percent of poverty.[13] Medicaid Section 1115 demonstration waivers allow states to extend Medicaid eligibility to individuals not normally eligible for Medicaid benefits. These waivers allow states substantial freedom and innovation, but also require federal budget neutrality. Under "budget neutrality," states must successfully make the case to CMS that during the waiver period, the federal government can be projected to spend no more than it would have had the waiver not been granted, based on projections from a base year.[14] To maintain budget neutrality while expanding eligibility, Vermont proposed to move its Medicaid population into managed care. The state also imposed a 24-cent tobacco tax, to be used toward supporting both the VHAP and the VHAP Prescription program expansions.

By seeking Medicaid eligibility for its lowest-income older adult population, the state was able to reduce the program's reliance on state general funds and obtain federal matching, reimbursing it for two-thirds of its expenditures. In its first few years, given lower-than-anticipated expenditures under its waiver, the state submitted waiver amendments to expand eligibility in its VHAP Prescription program first to 125 percent of the federal poverty income level and later to 150 percent of poverty. More recently, the

[13] Note that the Vermont Health Access Program 1115 waiver requested originally in 1995 and amended in 1999, is distinct from the PDP waiver approved in 2000, but overturned by the courts. PDP was to extend the Medicaid discount and rebate to all Medicare beneficiaries, at no cost to the state.

[14] Vermont Joint Fiscal Office, *Financial Aspects of Vermont's Medicaid Waiver,* September 18, 2000.

state extended this waiver to include VScript participants between 150 percent and 175 percent of poverty while expanding the income requirements for the state funded VScript Expanded program to 225 percent of poverty.

Vermont was the only state, until recently, to use the 1115 waiver to fund prescription drug coverage for a population not normally eligible for Medicaid,[15] although other states have submitted proposals for similar waivers that are pending CMS approval. Most program officials in other states indicated that they were skeptical about the likelihood of CMS approving similar waivers in other states. Vermont's waiver was approved prior to recent increases in drug spending and was also tied to the state's Medicaid transition from fee-for-service to managed care, which most other states have already implemented. Notwithstanding uncertainty about federal approval, however, the widespread concern about prescription drug affordability and the limited availability of state dollars has led a number of state legislatures to mandate their state's executive branch to seek similar waivers. The recent approval of a similar waiver program in Illinois may suggest that the Medicaid waiver strategy may be a viable approach to minimizing state expenditures.

In its first years, Vermont was judged to be maintaining budget neutrality under the waiver, but more recently the costs of this program have been rising faster than expected. The waiver program has been extended and is due to expire in 2003. At the time of the case study, program officials were fairly confident that the program would be extended again, although cost neutrality is an ongoing concern as costs of prescription drugs continue to rise.

Keeping Pace with Costs

In states with long-standing pharmacy assistance programs, the sources of funding have typically not kept pace with the escalating costs of prescription drug programs. These costs are fueled by expanded eligibility, increased utilization, and increased drug prices. In New Jersey, the budget for PAAD has increased dramatically since the program was first created in 1975. The funding in the original bill was set at $2.5 million out of general funds; it currently exceeds $320 million ($230 million from casino revenues and $90 million from general funds). Not surprisingly, PAAD is consuming a larger and larger share of casino revenue funds. While the program originally accounted for only 30 percent of casino revenues, it now accounts for 65 percent of those revenues.

[15] As indicated above, Maine and Vermont have been awarded 1115 waivers to extend the Medicaid discount and rebate to those not normally eligible for Medicaid which lowers the price to the consumer but does not offer the full Medicaid coverage. In addition, in January 2002, a similar waiver was granted to Illinois for a program scheduled to begin on June 1, 2002, extending the Medicaid prescription drug benefit to elderly residents with incomes under 200 percent of poverty.

State pharmacy programs have used a number of mechanisms to stem growing costs, including modifying benefit design features. However, despite these efforts, net program expenditures in state pharmacy assistance programs reported in case studies and surveys grew on average at an annual rate of approximately 15 to 18 percent. Maintaining funds to keep pace with growing expenditures continues to be a substantial problem for states.

Eligibility

Proposals for a Medicare prescription drug benefit have generally been designed to offer at least some level of pharmaceutical benefits to *all* Medicare beneficiaries. Thus, they differ from most state pharmacy assistance programs, which specifically target coverage to subgroups of the Medicare population, most commonly low-income persons over 65 without prescription drug coverage from other sources. However, even universal Medicare benefit proposals would offer different levels of financial assistance for people at different income levels. Thus, states' experiences in setting and expanding eligibility may be instructive for federal policymakers.

Coverage of Older Adults and Persons with Disabilities

Most states use age 65 as the criterion for eligibility based on age, although a few use age 62, and two (Maryland and Wyoming) are open to all residents regardless of age who meet the other program eligibility criteria. In 2001, approximately half of the state pharmacy programs covered persons with disabilities under the age of 65 (see Table 4). In some cases, persons with disabilities were not initially covered but were added over time. Informants in case study states that do not include disabled persons explained that their programs were designed in response to identified needs in the older adult population. In some states, informants also indicated that limitations in program funding have constrained their ability to extend the benefit to people with disabilities. For example, in Minnesota, which recently enacted legislation to bring persons with disabilities into the pharmacy benefit program in 2002, program administrators said this was only possible because of an increased appropriation.[16] The original PDP was only appropriated $4 million at the outset. Informants in some states also felt that most people with disabilities already have access to drug coverage through Medicaid programs.

[16] Due to inadequate funding, in December 2001 it was announced that Minnesota's expansion to the disabled would be postponed.

Table 4. Program Eligibility Levels and Benefits for 2001

STATE (PROGRAM)	ELIGIBILITY			COST-SHARING
	INCOME (%FPL)	AGE	DISABLED	
Arizona	200%	65	Yes	50% coinsurance. Deductible and enrollment fee to be determined.
Arkansas	80%	65	No	$10 or $20 copay and $25 annual fee. Limit of 2 prescriptions a month.
Connecticut	180%	65	Yes	$12 copay and $25 annual fee.
Delaware (Nemours)	150%	65	No	20% coinsurance plus $5 dispensing fee. $2,000 annual benefit cap.
Delaware (DPAP)	200%	65	Yes	Greater of $5 or 25% coinsurance and $2,500 annual cap.
Florida	120%	65	No	10% coinsurance and $80 monthly benefit cap.
Illinois	254%	65	Yes	$0 or $5 copay and $5 or $25 annual fee.
Indiana	135%	65	No	50% coinsurance with $500 to $1,000 tiered annual benefit cap.
Kansas	150%	67	No	30% coinsurance and $1,200 annual benefit cap.
Maine	185%	56	Yes	Greater of $2 or 20% coinsurance or the Medicaid discount rate for drugs for nonspecified conditions.
Maryland (MPAP)	120%	No restrictions		$5 copay.
Maryland (STPDS)	300%	65	No	$10 or $35 copay, $10 monthly premium, and $1,000 annual benefit cap.
Massachusetts[1]	No limit	65	Yes	$0 to $82 sliding-scale monthly premium, $0 to $500 sliding-scale annual deductible, and tiered copay of $5/$12/50% for lower income groups or $10/$25/50% for higher income groups.
Michigan	200%	65	No	$25 annual fee. Copay tied to income.
Minnesota	120%	65	No	$35 monthly deductible.
Nevada	257%	62	No	$10 or $25 copay and $5,000 annual benefit cap.
New Jersey (PAAD)	230%	65	Yes	$5 copay.
New Jersey (Senior Gold)	350%	65	Yes	$15 copay plus 50% of the remaining cost of the drug.
New York	419%	65	No	Tiered $3 to $20 copay and either a sliding-scale $8 to $300 annual fee or $530 to $1,715 annual deductible.
North Carolina	150%	65	No	$6 copay.
Oregon	185%	65	No	50% or more coinsurance and $2,000 annual benefit cap.
Pennsylvania (PACE)	168%	65	No	$6 copay.
Pennsylvania (PACENET)	192%	65	No	$500 deductible and $8 or $15 copay.
Rhode Island	419%	65	No	Tiered 40%, 70% or 85% coinsurance.
South Carolina	175%	65	No	$500 deductible and $10 or $21 copay.
Texas[2]	NA	65	Yes	Not Available.
Vermont (VHAP)	150%	65	Yes	$1 or $2 copay.
Vermont (VScript)	175%	65	Yes	$1 or $2 copay.
Vermont (VScript Expanded)	225%	65	Yes	50% coinsurance.
Wyoming	100%	No restrictions		$25 copay.

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

[1] Massachusetts' Prescription Advantage plan has no upper income limit for persons over the age of 65. Premiums and deductibles are subsidized on a sliding scale for enrollees with incomes below 500 percent of the federal poverty level. Disabled persons are eligible only if they have incomes below 188 percent of poverty.

[2] Income eligibility, drugs, covered and consumer cost-sharing will be determined by the Texas Health and Human Services Commission.

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

The decision to include people with disabilities has been difficult for states, as average pharmaceutical expenditures are higher for this population.[17] In Minnesota, some respondents expressed concern that once persons with disabilities are included, it may be more difficult to expand income eligibility for older adults. In New Jersey, the average monthly cost per disabled participant in PAAD FY 2000 was approximately $267, compared with $127 for elderly enrollees. New Jersey program officials indicated that higher drug costs for disabled enrollees reflect a combination of higher drug use in this population and higher prices for the drugs their conditions require. In PAAD, the average number of prescriptions filled by enrollees with disabilities in FY 2000 was approximately 44 annually, compared with 32 prescriptions for older adult enrollees. Cost per claim in FY 2000 was $72.90 for enrollees with disabilities and $48.25 for older adults. Based on New Jersey's experience, Pennsylvania estimated that adding people with disabilities would cost PACE another $150 million annually. However, persons with disabilities have protested their exclusion from pharmacy programs in some states

Income Eligibility Ceilings

Income eligibility ceilings vary considerably across states. In 2001, the average eligibility ceiling was approximately 208 percent of poverty (see Table 4), with ceilings ranging from 80 percent to 500 percent of poverty. The average represents a significant increase over the prior year (187% of poverty) due to several large expansions that were passed in 2000–01. While income-testing eligibility for subsidized benefits, Massachusetts and Nevada also offer all older residents, regardless of income, the opportunity to buy-in to their drug insurance programs with no state subsidy.

Decisions about eligibility ceilings represent a compromise between cost and coverage, and there is no clear standard for what constitutes the appropriate ceiling. With a few exceptions, case study states had little information on existing prescription drug insurance within different income categories to estimate eligibility for new benefits or assess need at different income levels. Some respondents indicated that enacted eligibility levels were often derived from political compromise between two proposals rather than being based on known numbers of persons uninsured in these income categories. However, within the case study states, most states define income eligibility by calculating how many people can be covered with the funds available, using Current Population Survey income data, national estimates of prescription drug coverage, and estimates of expected costs per participant based on Medicaid experience, or prior state pharmacy assistance program experience.

[17] The White House National Economic Council/Domestic Policy Council, *Disability, Medicare, and Prescription Drugs,* July 31, 2000.

In contrast, South Carolina used a unique approach to establish income eligibility levels. The bill passed by the legislature was intentionally vague in setting specific income eligibility. Instead, the legislature only required that eligibility not exceed 175 percent of poverty. Before determining eligibility and benefits, the state held an open enrollment period. Only after open enrollment ended and the state had received 33,000 eligible applicants under the higher income limit rule[18] did they decide that they could afford income eligibility at 175 percent of poverty.[19]

Other states have chosen to set eligibility ceilings to correspond with those in other existing low-income programs in the state. Nevada set eligibility for pharmacy premium subsidies to match those set for the property tax rebate program, while Minnesota uses the income limits for the QMB and the SLMB programs. One perceived benefit of this approach noted by program administrators was that it provided a better estimate of potential enrollees, based on enrollment figures in these existing programs. But this approach may underestimate program take-up if the existing low-income benefit programs are under-enrolled. Thus, extending a drug benefit that is either more widely advertised or offers a more desirable benefit to consumers than existing programs may result in greater take-up than existing program enrollment might suggest.

Recently, a few states have moved toward offering coverage to all persons over 65 regardless of income, using a sliding scale tied to household income to determine enrollee contributions. For example, Massachusetts offers its Prescription Advantage plan to those over age 65 in the state regardless of income, as well as to disabled persons with income below 188 percent of poverty. Similarly, Nevada created a private insurance drug benefit that is available to all adults over 62 in the state. While both programs offer all residents the ability to purchase the benefit, subsidy or premium assistance by the state is available only to lower income persons.

Tying Income Eligibility to Federal Poverty Levels

The decision to tie income eligibility to the federal poverty income level rather than to a flat-dollar amount can have cost implications. In the case study states, Pennsylvania has maintained a flat-dollar amount for income eligibility for PACE rather than defining eligibility as a percent of poverty or tying income eligibility to Social Security cost-of-living adjustments (COLA). By not tying income eligibility to the COLA, the state has

[18] The state received a total of 45,000 applications.

[19] Note that the state allows people who subsequently meet the eligibility requirements after the open enrollment period has ended (e.g., turn 65 or income falls below eligibility ceilings) to enroll over the course of the year. While the state factored an estimate of new enrollees into its plan, if the number of new enrollees is greater than expected, the state may have to close enrollment or budget additional funds for cost overruns.

controlled its enrollment figures, since the eligibility ceiling declines in constant dollars each year unless it is raised by the Legislature. PACE enrollment has declined by approximately 3 percent every 6 months since 1991.

State officials noted that not adjusting income eligibility for inflation has been an important tool in controlling program costs. However, this approach also engenders considerable criticism by advocacy groups that see older adults lose their PACE benefit solely because their Social Security COLA puts them above the income eligibility limits over time. Older adults cannot choose to reject the COLA even if they perceive their PACE benefits to be more valuable, and approximately 18,000 enrollees disqualify from PACE annually.

In response to some of these concerns, in 2001 the Pennsylvania legislature expanded PACENET eligibility by $1,000 and amended the statute, authorizing PACE to allow all persons enrolled in PACE as of December 31, 2000 to remain eligible or be retroactively reinstated if the maximum income limit is exceeded due solely to COLA increase. This COLA waiver is temporary, and is due to expire on December 31, 2002. While this change temporarily protects current enrollees, the legislature did not change PACE's eligibility requirements prospectively to adjust income ceilings automatically by the COLA for new enrollees.

Like Pennsylvania, New Jersey originally had a flat dollar eligibility amount, but after several amendments by the legislature to increase PAAD income eligibility levels, the legislature voted in 1995 to tie the income limits to the COLA. Somewhat surprisingly, despite concerns by PAAD program administrators that tying income eligibility to the COLA would increase enrollment and program costs, enrollment has actually declined since the COLA was imposed. The program administrator attributed this to a decline in new enrollees, reflecting trends toward delayed retirement and higher incomes for older individuals.

Factoring Catastrophic Costs into Income Eligibility Determination

While low-income persons are certainly at great risk of not being able to afford prescription drugs, moderate-income persons with high out-of-pocket drug expenses are also at considerable risk. Though initially most state programs did not target this group, newer programs and expansions of existing programs have often focused on meeting the needs of these individuals.

Few state pharmacy programs specifically target persons with catastrophic costs through their eligibility criteria. Those programs that do factor catastrophic costs into income eligibility generally adjust income levels for those persons whose out-of-pocket drug costs exceed some portion of their income; this is the practice in Maine, Delaware, Nevada, and Rhode Island, although the specifics vary. For example, Maine increases income eligibility limits by 25 percent in cases where an eligible resident spends more than 40 percent of household income on prescription drugs. In contrast, Rhode Island applicants can deduct from their income medical and pharmaceutical expenses in excess of 3 percent of their annual income for the purposes of eligibility determination.

Other Eligibility Criteria—Residency, Uninsured Status, and Asset Tests

In addition to income eligibility, all states have residency requirements, although the length of residency required varies. Many states also limit eligibility to persons who have no self-reported existing prescription drug coverage through Medicaid, Medicare+Choice, Medigap, or other private insurance, although some allow people to enroll after they have exhausted their other benefits. Minnesota goes one step further to discourage displacement of private coverage by requiring that applicants not be insured for prescription drugs for the preceding four months. In contrast, other states, such as New Jersey, exclude persons with equal or superior prescription coverage but allow people with less generous benefits to enroll in the program. The state pays, then recovers from the other plan the portion of a beneficiary's drug costs for which there is third-party coverage.

Most states do not have an asset test for eligibility. Of the four that do, two included them because program eligibility had been tied to the eligibility for the QMB/SLMB program. Minnesota program administrators reported that setting the asset test at $4,000 for singles and $6,000 for couples proved to be a significant barrier to enrollment. In annual hearings on the program, administrators found that possession of a certificate of deposit for burial expenses disqualified an applicant under Medicaid rules. Although potential applicants may have qualified by rearranging their burial funds, they were generally unable to do so. To compensate for this administrative barrier, the state chose to raise the asset limits to $10,000 for singles and $18,000 for couples, which administrators believe has contributed to subsequent higher enrollment.

Program directors in states without asset tests expressed concern that such a test would create a significant access barrier, since many people are reluctant to provide this information. They also felt that such a test would be cumbersome to administer. Respondents in New Jersey noted that imposing an asset test on a program that lacks one can be extremely politically unpopular. In an effort to control rising program costs, then-

Governor Christine Todd Whitman tried to impose a rather generous asset test of $50,000, but a backlash among older New Jersey residents led to the proposal's defeat in the legislature.

Eligibility Trends over Time

Many long-standing programs have incrementally increased eligibility over time, which has contributed to growing program costs. Within the past two years, the trend toward broadening eligibility criteria has accelerated due in part to greater political attention to the issue, larger budget surpluses resulting from a strong economy, and the availability of tobacco settlement funds.

In case study states with long-standing programs, program administrators generally expressed caution about the impact of eligibility expansions. They advised states initiating new programs to set eligibility limits low and to gather more information on enrollment and cost trends before overcommitting. For example, when Pennsylvania designed its PACE program in 1984, it based income eligibility on levels in neighboring New Jersey's PAAD program at that time. Enrollment was felt to be unduly slow, resulting in considerable political pressure to increase eligibility. In response, the legislature raised income ceilings by 33 percent. The rate of growth increased sharply as did program costs. Based on their experience, Pennsylvania program administrators advise that it is worth investing time and resources during program design to attain more accurate estimates of eligible persons and potential enrollment.

In contrast, advocates for the elderly caution that keeping eligibility too low will potentially discourage participation by the very group the state seeks to serve. Minnesota is cited as a case in point: the eligibility ceiling is set only slightly above Medicaid, and participation has been low even after program amendments to reduce access barriers. As of December 2000, 5,560 of an estimated 19,000 income eligible persons—8,000 of whom were estimated to meet the asset test and would enroll—were enrolled in Minnesota's PDP program.

Drugs Covered and Use of Formularies

A formulary, or list of covered drugs, is 'open' if it covers most drugs in any therapeutic class, and 'closed' if it restricts coverage to one or a few drugs in a therapeutic class. Most of the state pharmacy programs use open formularies, following the model set by Medicaid programs, which cover all prescription drugs for which the state is able to negotiate rebates

from manufacturers.[20] Generally, states are able to negotiate rebates with most of the major manufacturers for their pharmacy assistance programs, and so cover most FDA-approved prescription drugs utilized by the elderly. Most also cover insulin and insulin products including needles and syringes. However, many programs have exclusions for certain 'lifestyle' drugs and, with a few exceptions, most exclude over-the-counter drugs.

Five state programs limit coverage to drugs for certain medical conditions (Rhode Island, Illinois and Maine[21]) or only maintenance drugs for chronic conditions (Vermont and Maryland). Consumer pressure to expand these programs can be great due to perceived inequities in treatment of those people with conditions not covered by the program. In general, most of these disease-specific or maintenance drug pharmacy programs have expanded the number of qualifying conditions over time. For example, Maine's DEL program has expanded from initially covering drugs for only four conditions in 1975, to currently covering brand-name drugs for 13 conditions, generic drugs for all conditions, and all drugs for all conditions once a participant has reached $1,000 in out of pocket expenses.

While most states generally follow the Medicaid model for drug coverage, a few of the newer programs (Massachusetts, Nevada, and South Carolina) leave formulary decisions at least in part to private insurers or PBMs with which the state contracts. The insurer or PBM negotiates prices with manufacturers, often using a closed formulary. Manufacturers who want to get their drugs on the PBM's closed formulary will negotiate with the PBM for better pricing and/or rebates. This is especially true if the manufacturer's drug has a competitor in the same therapeutic class. Opponents of this approach argue that closed formularies restrict enrollees' access to drugs. To address access concerns, PBMs also utilize managed formularies that cover a broader range of drugs, but employ tiered copays, charging consumers higher copays for higher-priced, nonpreferred drugs.

[20] Based on Medicaid rules defined in the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), in order for a manufacturer's drug to be included in the Medicaid formulary, manufacturers must agree to pay the Medicaid mandated rebate of average manufacturer price (AMP) minus 15.1 percent or the "best price," whichever is less (the rebate is AMP—11 percent for generic drugs). Due to the size of Medicaid programs and the potential volume of sales, most manufacturers sign rebate agreements for Medicaid and very few drugs are excluded from coverage. In exchange for the manufacturer's rebate participation, OBRA 1990 restricts Medicaid programs from employing variable copayments to favor one type of drug over another.

[21] Since Maine's DEL program was folded into the Healthy Maine Prescription Program, DEL participants have access to the Medicaid price discount on all drugs, but the larger benefit is only available for all generics and brand-names for specific conditions.

Of the three case study states using a PBM or insurer, only Nevada opted initially to use a closed formulary. However, even in the short time that Nevada's program has been in place, the state has modified its program, favoring a less restrictive formulary. Nevada's insurance-based program originally had two benefit options. Nevada Blue was less expensive to purchase but had a more restricted formulary, while Nevada Silver covered more drugs but had a higher premium and higher copayments for nonpreferred drugs. Only a few months after the program began, in response to extremely low enrollment, the state significantly revamped the program, eliminating the product with the closed formulary, expanding the drugs covered in the Nevada Silver plan based on physician input, and lowering consumer copayments for nonpreferred brand-name drugs to be comparable to preferred drugs if a doctor confirms medical necessity.

Similarly, in Massachusetts, proponents of the insurance model originally recommended using a closed formulary in order to increase the state's negotiating power with manufacturers. Instead, the state devised a more open formulary that covered some drugs at a lower "preferred" copay while making other drugs available at a higher "nonpreferred" copay. Program officials said that having a closed formulary that denied access conflicted with the purpose of state-sponsored programs. Nonetheless, Massachusetts respondents indicated that limiting the formulary has been discussed as an option to control costs, and the state reserves the right to modify the PBM formulary in the future. In contrast, since Nevada pursued a private insurance model subsidized by the state, Nevada program officials originally chose to leave the benefit design and formulary decisions with the private insurer and its PBM subcontractor. State administrators noted that having a PBM develop the formulary kept politics from influencing the program design, and allows for a separate, independent process to develop and modify the formulary. They felt that if this were a state-run program, members would be calling their legislators and demanding that the drugs they need be included on the formulary. However, consumer groups and physicians in the state expressed concern that formulary decisions were being made on cost issues, rather than clinical criteria. In fact, when the state revamped its insurance product mid-year, it did expand the list of drugs on the formulary based on physician input. Consumers and physicians have argued for the state to form a more formal Pharmacy and Therapeutics Committee made up of physicians and pharmacists outside of the plan, which would review clinical data to develop the plan's formulary.

Cost-Sharing Features

Federal proposals for a prescription drug benefit face complex trade-offs between breadth (the number of beneficiaries eligible for various tiers of benefits) and depth (the extent of

financial protection available to a given individual). How states have chosen to address these choices, particularly in their expansions to cover more moderate-income persons, is instructive in evaluating federal proposals.

A critical feature of benefit design is the structure of participant cost-sharing. All state programs require some level of participant cost-sharing in the form of copayments (a fixed amount paid for each prescription), coinsurance (payment by the beneficiary of a percentage of the prescription's cost), premiums/fees (monthly or annual payments to participate in the program), and/or deductibles (a set amount of out-of-pocket expenses to be incurred before receiving any benefit). However, the cost-sharing requirements vary considerably by state. Many of the long-standing programs require nominal copays for the lowest-income enrollees, but have applied more cost-sharing features in program expansions to persons with somewhat higher incomes. These cost-sharing features can have a large effect on program costs. While substantial cost-sharing can be effective in controlling costs, consumer advocates note that it can also have a chilling effect on enrollment and utilization.

Fees

The majority of programs do not charge annual enrollment fees. Those that do (in New York, Connecticut, Illinois, Minnesota, and Massachusetts) have generally scaled them back over time, finding them to be a significant barrier to enrollment. In Minnesota, the PDP was initially designed to have an enrollment fee of $120 annually plus a $25 monthly deductible. According to most persons interviewed in the state, this fee presented a significant barrier to enrollment. Of 8,000 persons estimated to be eligible for the program, only 1,260 enrolled in the first six months. The imposition of the fee also prevented the state from automatically enrolling all of its QMB/SLMB enrollees into the program. In July 1999, six months after the program was implemented, the state dropped the fee and instead raised the monthly deductible to $35, essentially annualizing the cost of the fee over the course of the year. In the six months following this change, enrollment in the program more than doubled. However, this increase was largely due to the state auto-enrolling all of its QMB/SLMB enrollees into the PDP program once the fee was eliminated.

Premiums

Most states do not impose premiums, except for insurance-based programs. Monthly premiums can also create access barriers, as shown by Nevada's experience. In its original two-product design, the monthly premiums set by the insurer were $74 for Nevada Blue, and $98 for Nevada Silver. In contrast, the state's tiered premium subsidies ranged from

$40 for the lowest income enrollees (those earning below $12,700) to $10 for those earning between $19,100 and $21,500, leaving the consumer to pay at least half or more of the premium. Anyone choosing to enroll who earned more than $21,500 had to pay the full premium.

In the first six months, only 250 of the 14,000 estimated older adults eligible had signed up for the program, even though more than 1,300 had applied and were deemed eligible for some level of subsidy. Program officials indicated that once applicants were told the exact amount of the subsidy and the amount of the insurance premium, they decided that the benefit, even with the state subsidy, was too expensive. As indicated above, in response to the low enrollment, the governor and the co-chair of the Task Force for a Healthy Nevada came up with a compromise plan that dropped the requirement that low-income enrollees pay a portion of the premium to enroll in the program. Under the new program, which began in July 2001, the state subsidizes the full amount of the premium and the deductible for all enrollees with incomes below $21,500. Thus, cost-sharing for these enrollees is limited to copays at the point of use. These changes increased the state's cost per enrollee, by more than $800 per enrollee per year. While these changes were only implemented in July 2001, program enrollment rose tenfold, from 250 to 2,906, in the newly revised program's first three months.

Massachusetts has a tiered premium structure for its Prescription Advantage plan. Like Nevada's current program, enrollees in the lowest income bracket (below 188% of poverty) pay no monthly premiums. For those in higher income brackets, premiums are paid on a sliding scale, ranging up to $82 a month (single individual) or $66 a month (married individual) for those making more than 500 percent of poverty. At the time of this writing, the plan was still too new to provide clear data on enrollment patterns, but program administrators did report that about 25 percent of initial enrollees were paying some amount of premiums as of August 2001. This proportion may be as low as it is partly because the state first pushed to get people from its two existing pharmacy programs to enroll in Prescription Advantage, since those programs were ending. The state was planning to initiate a more aggressive enrollment campaign targeted at those in the upper income (and higher premium) ranges in the fall of 2001. Enrollment of these individuals was seen as important in order to bring premium funds into the plan and lower the average cost-per-participant.

In addition to reducing program costs, state policymakers incorporated a premium-based approach in order to make the plan more like an insurance model that people would

buy into and pay premiums as a precaution against potential high drug expenditures, even if they didn't necessarily expect their savings to exceed their premiums in a given year.

Deductibles

Five states require some form of deductible, ranging from $100 to $1,230 annually. These states vary in the amount of the deductible and the way in which it is applied. In some cases, such as in Massachusetts, tiered deductibles are imposed that increase with income, while in others (Pennsylvania PACENET, South Carolina) a flat deductible applies to all enrollees.

The imposition of deductibles is often criticized by consumer groups as restricting access, particularly when applied to the lowest income groups. South Carolina, for example, has a flat $500 deductible for all enrollees, regardless of income. When the program began, there was some consumer dissatisfaction when people started using the card and were not yet getting a benefit. However, several respondents noted that once enrollees met the deductible and had access to the full benefit they were much more satisfied.

Similarly, when Pennsylvania created its PACENET expansion targeted toward moderate-income older adults, the state also imposed a $500 deductible, even though there is no deductible for the PACE program. Policymakers felt that there needed to be a deductible since the target group had higher incomes and the benefit was intended to alleviate the burden for people with excessively high drug costs. Pennsylvania chose a $500 deductible since this was the average out-of-pocket expense incurred by older Americans according to data from the AARP and the National Association of Chain Drug Stores at the time.

According to consumer advocates, some enrollees in PACENET and South Carolina's program were confused about what having a deductible means, and thought that they had to pay a $500 fee to join the program. A consumer representative in South Carolina noted that there were "a lot of myths and rumors floating around" about the program, and that a simpler program design would have yielded less confusion.

Programs with annual deductibles require participants to spend the full deductible before they receive a benefit, and this may be unaffordable for some low-income participants. To compensate for this, Minnesota has a monthly rather than an annual deductible. This may cost the state more since an enrollee who does not have enough annual drug expenditures to meet an annual deductible may have enough expenses in any

given month to meet the monthly deductible and require expenditures by the state. However, from the consumer's point of view, a monthly deductible provides access to benefits sooner than does an annual deductible.

In general, deductibles have been found to be a barrier to enrollment, and some states, such as Nevada, have subsequently dropped them as a result. But the choice to impose a deductible is tied to decisions about the target group the state seeks to serve. Respondents in several states noted that some policymakers want to impose a deductible based on the principle that only those persons with high costs need help from the government. This is particularly true for programs that are targeted to higher income groups. Other respondents stated that having a deductible lessened the possibility of induced demand—that is, increased drug use induced by the presence of insurance coverage.

Copayments

All case study states except Minnesota required participants to pay a copay out of pocket for prescription drug purchases. The amount of copays vary (see Table 4) but range from a nominal $1 to $2 to a high of $25 per prescription. Many states (Maine, Massachusetts, Nevada, Pennsylvania-PACENET, South Carolina, Vermont) have a lower copay for generics than for name brand drugs, although a few—like New Jersey's PAAD program—have a flat copay for all drugs.

In some states (Illinois, Massachusetts, Pennsylvania), copays are larger for higher-income participants than for low-income participants. In Pennsylvania, this difference in copays and the inclusion of a deductible for higher-income participants was considered a trade-off for expanding the PACE program to higher-income individuals, serving to control costs of the expansion and to limit induced demand. Program officials in Massachusetts also noted that lower copays for low-income enrollees help ensure access to the plan for lower-income people.

In addition to requiring different copays for generics and brand-name drugs, as mentioned above, a few states also impose lower copays for "preferred" than for nonpreferred drugs. This allows states to steer patients to less costly alternative drugs or drugs for which the program receives better rebates. In the case of Massachusetts, the decision to include drugs on the preferred list is also based on utilization by the population covered by the program. As noted earlier, the state chose to use a tiered copay structure rather than a closed formulary in order to allow access to more prescription drugs while encouraging participants to use drugs on the preferred list.

Coinsurance

A few states require participants to pay a percentage of the drug's cost rather than a flat copay. This sensitizes patients to the actual costs of the drugs they use and may influence them to use a generic substitute or persuade their doctor to prescribe a less costly drug. Coinsurance rates vary from 10 percent in Florida to 85 percent for the highest income participants in Rhode Island's program.

Requiring participants to pay a coinsurance rate rather than a flat copay can substantially reduce state drug expenses, but also significantly increase participants' out-of-pocket expenses. For example, in Vermont's VScript Expanded program, participants pay 50 percent coinsurance on drugs purchased through the program while participants in the state's VScript program are responsible for a $1 copay for generics and a $2 copay for brand-name drugs. Thus, a $100 name-brand drug purchased through VScript Expanded costs the state (and the consumer) $50, while under the VScript program the same drug would cost the state $98 while only requiring the consumer to spend $2. According to state officials, both programs recoup about 18 percent of a drug's cost through rebates, so the net cost to the state would be $32 in the VScript Expanded program ($50 minus $18) and $80 in the VScript program—a substantial difference.

Several programs that employ coinsurance requirements target them to higher-income participants. Both Vermont and New Jersey operate a program for higher-income residents that requires coinsurance and a program for lower-income residents that requires only flat copays. New Jersey's Senior Gold requires participants to pay both a $15 copay and 50 percent of the remaining cost of the drug, even further reducing costs to the state.

A few states (Delaware and Maine) have a system in which the beneficiary pays either a flat copay or a percentage of the cost of a drug, whichever is higher. Critics of these models contend that they are very confusing to consumers and make it difficult for consumers to calculate the potential savings since they do not necessarily know the price of their drugs.

Catastrophic Coverage

The catastrophic coverage provisions of most Medicare proposals offer reduced costs to persons after spending $4,000 to $6,000 out of pocket on prescription drugs. While many states have no catastrophic component, the few states that offer a catastrophic cap on out-of-pocket expenses set much lower limits than these federal proposals.

In most cases, deductibles, premiums, and copays/coinsurance all count as costs toward the catastrophic cap. In Maine, for example, participants in the DEL program have coverage for all drugs for certain medical conditions and for generics for other conditions, but they get only a discount on other name-brand drugs until they spend $1,000 out of pocket. At that point, all drugs for all medical conditions can be purchased for a $2 copay or 20 percent coinsurance, whichever is greater. Some advocates feel that the $1,000 limit is too high for low-income participants to have to spend before receiving a full benefit, but they also agreed that catastrophic coverage helped those who have the greatest costs and, hence, the most need. At the time of this case study, which was only two months after the new catastrophic coverage had been initiated, program officials acknowledged that very few people had yet qualified for this benefit.

Nonetheless, other states have higher catastrophic caps. In New Jersey's Senior Gold program, once a participant has spent $2,000, he or she then is required to pay only the $15 copayment and not the added 50 percent coinsurance. Similarly, in Massachusetts's Prescription Advantage program, there is a catastrophic cap on out-of-pocket expenses over $2,000 or 10 percent of a person's gross annual income, whichever is less. Again, since the plan only began in April 2001, at the time of this writing it is too soon to assess the number of people who will qualify for this component of the benefit.

Programs that have deductibles also consider this to constitute a type of catastrophic coverage, in that participants have to have drug expenses that are greater than the deductible to get assistance. After the deductible is met, these programs typically provide unlimited coverage.

Benefit Caps

In contrast to the idea of catastrophic coverage, most Medicare+Choice and all Medigap plans with drug coverage have an annual cap or maximum amount that the plans will cover for prescription drugs. Once the cap is reached, consumers essentially have no further coverage and are responsible for all drug expenses. Several state pharmacy assistance programs also have benefit caps (Delaware, Florida, Indiana, Kansas, Maryland, Oregon, and Nevada). Nevada, for example, has a $5,000 cap on benefits for participants. A consumer representative in Nevada felt that compared with the average caps imposed by Medicare +Choice plans or Medigap plans that range from $1,000 to $3,000, the state's benefit cap was relatively generous.

However, many state programs explicitly avoid benefit caps. When the South Carolina program was being designed, the governor and program administrators took the

position that if the program needed to reduce costs, it would be better to raise the deductible than impose a benefit cap, since the cap would limit the benefit for enrollees with catastrophic costs who need it the most.

Program Administration

The majority of state pharmacy assistance programs are administered by the state agency that administers the Medicaid program. Some states house the program in their Department of Health or Aging and one program is operated out of a state Office of Insurance Services. In choosing which agency to administer the programs, states often weigh historical Medicaid program management experience against concerns about stigma associated with the Medicaid program.

Considerations of programmatic experience often lead to the choice of the Medicaid agency to administer the benefit because these agencies have experience in eligibility determination for means-tested programs with much larger enrollment, have developed electronic claims processing and point-of-sale data systems, and have preexisting relationships with pharmacies and manufacturers to negotiate prices and to provide payment. On the other hand, advocates, program administrators, and legislators are often concerned about 'welfare stigma' that may exist within the elderly population toward the Medicaid program.

Several respondents also said that Medicaid programs tend to be rigid, whereas programs administered outside of Medicaid can be more flexible. In South Carolina, the decision was made to house the SilverCard program in the state's Office of Insurance Services. This department had experience contracting with insurance providers and PBMs. Administrators also felt that administering the program through this department helped it to have an image that was more like an insurance benefit and less like a Medicaid-type entitlement.

Private Insurance Model vs. State-Sponsored Program

Nevada's model is different from other states' in that the state does not assume the risk for covering a portion of the population for drug coverage.[22] Instead, the state issued a request for proposal (RFP) to the health insurance industry for a prescription drug-only benefit that would be available for all older adults in the state, with state-funded tiered premium subsidies for the lowest-income older adults. Officials interviewed in the case study said that the state chose this approach because the governor wanted to encourage a market-

[22] Massachusetts Prescription Advantage plan is a private insurance model with public support. However, in contrast to Nevada, the state assumes the risk.

based strategy. State officials were also concerned that the state lacked adequate information system capacity within its existing structure to administer a large drug benefit. As a result, Nevada opted for a benefit that is almost entirely administered privately. However, even in this model, the state bears the responsibility for eligibility determination for the state premium subsidy, and outreach and marketing of the program.

As indicated above, Nevada's initial experience with a private insurance model was problematic. The prescription drug program was supposed to start in October 2000, but was delayed until January 2001 due to poor response to the RFP for an insurer willing to offer a drug-only benefit.[23] In fact, only one insurer responded to the state's original RFP and it was ineligible because it was not licensed to sell insurance in the state. Case study respondents reported that the poor response was due to misunderstandings by insurers that the state subsidy (capped at $480 per participant) was the premium that the state required. In fact, the RFP left considerable latitude to the insurers—leaving the design of the benefit fairly open-ended. The state sought to select the best benefit package proposed from the bids received. After issuing a revised RFP, the state received five bids and the Department of Human Resources awarded the contract to Fidelity Security Life Insurance/Professional Risk and Assessment Management Insurance Services. As part of the contract, Pharmaceutical Care Network provides pharmacy benefit management services for the program.

The premiums set by the insurer proved to be too high to attract purchasers, even with the sliding-scale state subsidy. As a result, the state had to step in to change the benefit, both increasing its subsidy to cover the full premium and deductible for all low-income older adults, and also changing the benefit design to offer only one product with a less restrictive formulary and lower copays. In addition, the continuation of the private insurance approach was conditioned on whether, under this new model, the state can attract 3,500 enrollees. If not, a state-run program was to take its place in 2003. The revised program reportedly reached the 3,500 enrollment mark in October 2001, four months after the changes went into effect.[24] Under the revised program, Nevada pays approximately $1,200 per participant per year in premium and deductible subsidies (not including additional funds allocated for outreach), which is slightly higher than the average per participant costs in state-run pharmacy programs.

[23] Associated Press, "Governor's Prescription Plan on Hold," *Associated Press Newswires,* June 5, 2000.
[24] C. Ryan, "Senior Prescription Plan Makes Up for Lost Time," *Las Vegas Sun,* October 5, 2001.

Subcontracting with Pharmacy Benefit Managers

To a large extent, where the program is housed also determines what administrative tasks are contracted out to other entities. Programs housed in Medicaid agencies tend to use their existing systems for administration of pharmacy benefits. Those located outside of Medicaid either contract out certain administrative tasks or set up their own systems to handle them.

All case study states subcontracted out claims processing to a private entity such as Electronic Data Systems or FirstHealth. Programs that are linked with Medicaid usually use the same claims processor as the Medicaid program. Typically, the claims processor will also collect rebates from manufacturers based on the drugs utilized by program participants, but states vary in whether the PBM or state staff negotiate the rebates. This entity may also administer drug utilization review.

In addition to using PBMs through private insurers as in Nevada, state-run programs may also contract out the entire benefit administration to the PBM. South Carolina opted to take this approach in administering its Silver Card program, awarding the contract to Consultec, a PBM that is responsible for eligibility determination, enrollment, pharmacy contracting, claims processing, drug utilization review, outreach, and participant communications. In general, program officials reported positively about their experiences outsourcing these administrative tasks, but noted that PBMs have little experience with eligibility determination and thus this was an area where the program encountered the most delays. Recognizing the difficulty that PBMs have with these functions, Massachusetts subcontracted its eligibility determination/customer service to another state entity.

Administrative Start-Up Issues

Many of the case study states encountered some delays in starting up their programs. The reasons for delays varied but generally involved longer-than-anticipated contracting processes in negotiating manufacturer rebates, releasing RFPs, and identifying subcontractors for administrative tasks. While a few programs were able to get their programs up and running in three to four months, most felt that allotting more time at the outset could have alleviated some early problems. Based on their experience, most program administrators recommended scheduling six months to a year to get new programs into operation.[25]

[25] Note that, in contrast, the Healthy Maine Prescription Program, which extended existing Medicaid rebates rather than negotiating new ones, was able to start one month earlier than anticipated.

The presence in the states of existing systems for pharmacy claims payment through their Medicaid programs does not necessarily eliminate the "learning curve" in implementing new pharmacy benefits. For example, although Minnesota integrated its new program into the state Medicaid administration in order to take advantage of existing administrative structures, administrators reported a number of difficulties getting the program up and running. Eligibility and claims systems required significant modifications to accommodate the new program, and the state had to get manufacturers to sign separate rebate agreements for the program, even though the program was to use the Medicaid rebate formula.

In contrast, South Carolina was able to start enrolling people in the state's SilverCard program four months after the enabling legislation was passed. Program administrators had been preparing to implement the program before the legislation was passed, but the main reason cited by respondents for the rapid start-up was the ability of the administering agency to quickly release an RFP and evaluate responses. Staff of the state Office of Insurance Services, which administers the program, had significant experience in writing and evaluating RFPs due to their role in administering the state employees' benefit program. The state contracted out many of the program's administrative tasks to a PBM, avoiding the need to set up their own eligibility systems or rebate contracts. However, as noted above, the PBM did not have any experience with enrollment or application processing, so there were some problems with those tasks at first.

In Nevada, the legislation called for the program to be contracted out through an insurance provider. According to program administrators, the limited initial response was due to a requirement in the RFP that the insurer be licensed in the state to administer a prescription drug-only benefit. The one insurer that responded to the first RFP was not licensed in the state. The state reworked the RFP and relaxed the licensing requirements so that responding insurers only had to be licensed in the state by the contract date. The revised RFP received five responses and a proposal was accepted. Nevada encountered further delays because the legislation had set up a Task Force for the Fund for a Healthy Nevada that had to release the funds for the program. While the administration wanted the task force to release the funds at the time that the RFP was released, the task force insisted on waiting to see the program design submitted by the insurer before releasing the funds. Eventually, the task force released the funds for the program, but there was concern on behalf of some members that the level of consumer cost-sharing was too expensive.

LOOKING TO THE FUTURE: COORDINATING STATE PROGRAMS WITH A MEDICARE DRUG BENEFIT

At the time of this writing, short-term prospects for a Medicare prescription drug benefit had dimmed. However, in the longer term, options for such a benefit will continue to be evaluated and considered. As federal policymakers evaluate these options, consideration needs to be given to coordination with existing state programs through exceptions or exclusions that would facilitate allowing older adults who have been receiving benefits in those states to maintain their coverage. In that regard, state program administrators interviewed had several suggestions for how a federal benefit should be designed to support and enhance state-level programs.

State officials interviewed in all of the case study states were unanimous in their insistence that any Medicare benefit not have a maintenance-of-effort clause for the state programs that would require them to continue their current level of spending on their drug programs. States do not want to be penalized for taking the lead on providing prescription drug coverage for some Medicare beneficiaries in lieu of a federal Medicare benefit. However, while a number of the newer state programs have clauses in their legislation that would end the programs when a Medicare drug benefit is enacted, most of the case study states plan to supplement the Medicare benefit in some way. These states would like to take some of their current funding and "wrap around" the Medicare benefit.

If the Medicare benefit is less generous than the state's current program, which was the case for most of the proposals on the table in 2001, the state may want to supplement the Medicare benefit by paying the premiums, deductibles, or coinsurance for the state's current enrollees. Some case study respondents also reported a desire to be able to supplement any restrictive formulary that a Medicare plan may have in order to continue drug access for their beneficiaries. The states may also want to use their funds to expand the level of eligibility for their programs so that the state could wrap around the Medicare benefits of a larger population, or expand their programs to include nonelderly and nondisabled populations. One administrator also noted that it was important that any contribution that a state makes to supplement a beneficiary's Medicare benefit should not be counted as income toward consideration of federal subsidies for that person.

Regardless of how a state may want its program to "wrap around" the Medicare benefit, several states have concerns about how the process of coordinating benefits would work with Medicare. Some of this concern is based on the states' experiences with trying to coordinate with Medicare for the limited number of outpatient prescription drugs that Medicare currently covers. While a few states have simply excluded these drugs from their

formulary, thus blocking the claim and making the pharmacy submit a separate claim to Medicare, others have tried to coordinate the benefits but have faced some procedural hurdles.

In mid-2001 several states with comprehensive prescription drug programs discussed these issues and issued a list of "talking points" that they felt should be taken into consideration in any Medicare prescription drug legislation. These points were sent to President George W. Bush by New Jersey's acting governor in July 2001. They asked that states have the option to function as a PBM for the Medicare benefit, while maintaining their current benefit structure and eligibility criteria, as long as the state program is at least as generous as the Medicare benefit. They also emphasized their opposition to any maintenance of effort requirements for states.

There was concern that some state program enrollees might not sign up for the Medicare benefit, especially if it had significant up-front costs. Therefore, the states asked that the Medicare legislation include provisions to allow the states to enroll their state pharmacy assistance program beneficiaries automatically into the voluntary Medicare program, with the state's paying premiums or other up-front charges. They asked as well that the state programs be designated as the payer of last resort in relation to the Medicare drug benefit (i.e., in cases where coverage overlapped, the state program would pay only that portion not covered by the federal benefit).

The states were particularly concerned about coordination of benefits between a Medicare-based program, if operated by private PBMs, and state-operated programs. The talking points called for adding state pharmacy assistance programs to the list of entities with which the federal program must coordinate, and requiring that any PBM used by the federal program coordinate with the state programs. They also called for CMS to share enrollment data for the Medicare drug benefit with the states to facilitate the coordination of benefits between the state programs and the Medicare benefit. Finally, based on state experiences with prior authorization, they called for requiring PBMs administering a federal benefit to dispense a 72-hour supply of medication for any prescription that is subject to prior authorization under the plan. This is currently the policy in the Medicaid program.

LESSONS FROM STATES' EXPERIENCES

As is clear from this report, state policymakers are scrambling to develop solutions to provide adequate drug coverage in the absence of a Medicare drug benefit. This decentralized response has resulted in almost as many different benefit models as there are states initiating programs. The continued revisions and amendments to pharmacy benefit

programs, in some cases not even a year after the program has been implemented, suggest that identifying 'best practices' in prescription drug coverage for the uninsured elderly is still a work in progress. Based on the experiences of the states, federal policymakers should anticipate that a Medicare benefit may require incremental revisions over time and should probably build continued review and consumer input into the program's design.

State Programs Are Not a National Safety Net

It is also clear that these state programs are far from constituting a national drug safety net. Their combined enrollment of approximately 1.2 million represents only about 3 percent of Medicare enrollment nationally, compared with the nearly 14 percent that are dually eligible and covered by Medicaid. In addition, the nonelderly disabled are often excluded. States have committed much energy, concern, and often substantial resources to their efforts to address the gap left by the absence of Medicare prescription drug coverage. These programs are of great importance to their participants. From a national perspective, however, given the magnitude of the problem, they represent an incomplete and uneven response, mainly reliant on state dollars without federal matching, and resting on somewhat fragile financial foundations. In such a system, protection depends on where one lives. In the absence of federal financing, this system is unlikely to evolve into a true national safety net.

Only half the states have developed some type of pharmacy assistance program. Even in states that have taken some steps to address drug affordability, not all programs are equal. Discount programs provide marginal relief to consumers, in contrast to direct-benefit programs, many of which only require small copayments. Tax credit programs have largely failed as a mechanism for providing relief to consumers in purchasing drugs; both states with tax credit programs are in the process of phasing these programs out and replacing them with new direct-benefit programs. Even direct-benefit programs vary significantly in the generosity of their benefits, with only a handful of states providing a comprehensive benefit that provides significant relief to both older adults and the disabled.

Escalating Costs Put Pressure on Continued State Commitment

Direct-benefit programs are costly, and sources of funding have typically not kept pace with escalating costs. Several policymakers in states with long-standing programs noted that the key to program success is finding a permanent source of funding other than general funds. But even these programs have struggled as pharmacy costs have consumed a larger portion of these categorical funds. While some states have turned to tobacco settlement funds to help pay for program expansions, sustainability of such growth, unless federal funding becomes available, is uncertain. For example, some states have recently

issued or considered issuing tobacco settlement fund bonds, which have the effect of relinquishing the right to future tobacco settlement revenues in order to meet current revenue needs.

Given their strained budgets, there is great interest among states in the possibility of Medicaid waivers for pharmacy benefits to low-income individuals not otherwise eligible for Medicaid on a federally matched basis. Until recently, Vermont was the only state to obtain a waiver for a drug-only program of this nature. However, the recent approval of Illinois's waiver for a similar program may suggest this is a viable option that other states may seek to pursue.

"Depth vs. Breadth" Trade-Offs in Program Design

The experience of the state programs highlights the difficult trade-offs that must be faced in the design of pharmacy assistance programs when attempting to prioritize the use of limited funds, which are similar to dilemmas that have faced designers of federal proposals. In choosing between a limited benefit to a broad group of people or a comprehensive benefit to a limited group, the states have generally chosen the latter. With limited resources available, they have most often opted to focus primarily on low-income persons with the greatest need. Several states have undertaken program expansions to include moderate-income persons, but even these are in some cases targeted to assist persons with above-average or catastrophic drug expenses.

Given the decision to means-test, a critical question both for states and for federal policymakers remains whether it is a higher priority to offer relief to those with catastrophic costs or to provide first-dollar coverage for a fairly broad population of low-income elderly and disabled individuals. In examining how states have approached this issue, one sees that benefit structures differ considerably based on how states see their role and who they are seeking to protect.

For example, some states have opted to stretch their funds by imposing benefit caps, which limit the state's burden and allow for better estimates of program costs. In contrast, respondents from other states have argued that benefit caps cut off help to precisely those heavily burdened persons who need the most assistance. For states that do address the needs of those with catastrophic drug expenses, there is considerable discrepancy in what is defined as 'catastrophic' expenses. Although only briefly discussed in this report, there are also operational challenges involved with both measuring and accounting for out-of-pocket costs in catastrophic programs, especially in deciding whether costs incurred prior to enrollment should be factored in to catastrophic cost determinations.

Impact of Cost-Sharing on Enrollment

In seeking to reach as many people as possible with limited dollars, states have experimented with a variety of mechanisms to share costs with the consumer. These experiences highlight the challenges that would be faced on a larger scale by a Medicare-based program. Cost-sharing can help to contain program costs both directly and indirectly (by serving as a constraint on utilization). However, depending on how it is structured, it can also create barriers to appropriate utilization or to program participation. Where front-end premiums or fees are substantial, enrollment is likely to be adversely affected, particularly for lower-income people, and enrollment may take place disproportionately from individuals with higher expected pharmacy costs, an adverse selection problem that can cause cost per participant to exceed projections.

Although there have not been systematic studies of willingness to pay or elasticity of demand for these programs, the states' experience does suggest that the more responsibility that is shifted to consumers, the lower the enrollment. Early experience in Minnesota and Nevada demonstrates that enrollment fees and high premiums tend to discourage enrollment of people in the lowest income groups, who cannot afford large up-front costs. Nevada's experience illustrates some of the difficulties in implementing "true insurance" models for pharmacy-only coverage, in which the insurer bears financial risk and beneficiaries are expected to pay for a high share of the actuarial cost of the benefit. In addition to its initial difficulties finding insurers that were willing to submit a bid for a drug-only benefit, Nevada also had extremely low enrollment in its first few months. This forced the state to increase its subsidy significantly; the state shifted from covering only a portion of the premium for the very lowest income groups to covering all of the premiums and deductibles for all low-income persons. The resulting cost was three times more per person than the state had originally allotted. In addition, while both Nevada and Massachusetts continue to hope that higher-income persons will choose to purchase these drug-only benefits, take-up by nonsubsidized groups has been low thus far. Massachusetts representatives, however, believe the jury is still out on the potential participation of these groups.

Coordination with a Medicare Pharmacy Benefit

Finally, the study highlighted the importance of building explicit procedures for coordination of benefits with state programs into proposed Medicare prescription drug benefits. Representatives in some of the states recommended that under such a benefit, states be given the option of becoming a Medicare PBM for their current enrollees or, at minimum, requiring all Medicare PBMs to share enrollee, formulary, and cost-sharing information with the states to facilitate coordination of benefits. As a result of some of

these coordination concerns, many states that have adopted interim prescription drug coverage in the past year have built in a sunset feature to reassess the program after passage of a Medicare benefit.

In general, in defining a federal Medicare benefit, case study results suggest the need for more consideration to coordination with existing state programs that have significantly assisted low-income persons in making prescription drugs affordable, and currently enroll more than 1.2 million Medicare beneficiaries. Given budget and resource constraints, states have had to strike a careful balance between expanding drug coverage to needy groups and controlling program costs. States have clearly filled an important coverage gap, in lieu of a Medicare benefit. If a federal benefit is created, states' capacity to supplement such a benefit will be tied not only to continued availability of funds and political support, but also to the extent to which the design of a federal program facilitates coordination with state efforts.

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#538 *A Medicare Prescription Drug Benefit: Focusing on Coverage and Cost* (April 2002). Juliette Cubanski and Janet Kline. This issue brief, prepared for the 2002 Commonwealth Fund/Harvard University Bipartisan Congressional Health Policy Conference, discusses the significant policy challenge of designing an effective and politically viable Medicare prescription drug benefit.

#505 *Drug Coverage for Medicare Beneficiaries: Why Protection May Be in Jeopardy* (January 2002). Becky Briesacher, Bruce Stuart, and Dennis Shea. In this issue brief, the authors evaluate trends in prescription drug coverage for Medicare beneficiaries during the 1990s as a way to project their future coverage, costs, and needs. Based on data from 1993 to 1998, the projections indicate that beneficiary drug coverage likely peaked in 1998 or shortly thereafter, and has been in decline ever since.

#474 *One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems* (September 2001). Marilyn Moon and Matthew Storeygard, The Urban Institute. The authors argue that any major change to the Medicare program—such as requiring coinsurance for home health care—must take into account the steep costs seriously ill beneficiaries already pay for health services.

#463 *Strengthening Medicare: Modernizing Beneficiary Cost-Sharing* (May 2001). Karen Davis. In invited testimony before a House Ways and Means Health Subcommittee hearing, the Fund's president cautioned that any effort to reform Medicare's benefit package must take into account the circumstances of all beneficiaries, including those who are older, low-income, and chronically ill.

#461 *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures* (May 2001). Stephanie Maxwell, Marilyn Moon, and Matthew Storeygard, The Urban Institute. This report presents four possible options for modernizing Medicare that would reverse spiraling costs for beneficiaries and reduce or eliminate the need for private supplemental insurance.

#498 *Dynamics in Drug Coverage of Medicare Beneficiaries: Finders, Losers, Switchers* (March/April 2001). Bruce Stuart, Dennis Shea, and Becky Briesacher. *Health Affairs,* vol. 20, no. 2. The authors analyze the sources and stability of prescription coverage maintained by Medicare beneficiaries in 1995 and 1996. The results show that fewer than half of all beneficiaries had continuous drug coverage over this period, while nearly a third gained, lost, or had spells without coverage.

#436 *Designing a Medicare Drug Benefit: Whose Needs Will Be Met?* (December 2000). Bruce Stuart, Becky Briesacher, and Dennis Shea. Many current proposals for providing a prescription drug benefit under Medicare would cover only beneficiaries with incomes at the federal poverty level or slightly above. In this issue brief, the authors propose a broader definition of need that includes beneficiaries without continuous and stable coverage, those with high expenditures, and those with multiple chronic conditions. Under this expanded definition, nearly 90 percent of beneficiaries would be eligible for coverage.

#382 *Drug Coverage and Drug Purchases by Medicare Beneficiaries with Hypertension* (March/April 2000). Jan Blustein. *Health Affairs,* vol. 19, no 2. This article shows that Medicare beneficiaries age 65 and older with high blood pressure are less likely to purchase hypertension medication if they are without drug coverage.

#365 *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter* (January 2000). Bruce Stuart, Dennis Shea, and Becky Briesacher. This issue brief reports that prescription drug coverage of Medicare beneficiaries is more fragile than previously reported, that continuity of this coverage makes a significant difference in beneficiaries' use of prescription medicine, and that health status affects drug coverage for beneficiaries primarily through their burden of chronic illness.