



State Pharmacy Assistance Programs: A Chartbook

**Thomas Trail, Kimberley Fox, Joel Cantor,
Mina Silberberg, and Stephen Crystal**

Rutgers Center for State Health Policy

August 2004

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff.

Additional copies of this (#758) and other Commonwealth Fund publications are available online at www.cmf.org. To learn about new Fund publications when they appear, visit the Fund's website and [register to receive e-mail alerts](#).

Contents

Introduction	1
Section 1 State Approaches to Addressing Prescription Drug Affordability	5
Chart 1-1 State Interventions for Addressing Prescription Drug Affordability, 2003	7
Chart 1-2 Cumulative Number of States Implementing Direct Benefit Programs over Time	9
Section 2 Program Design	11
Chart 2-1 Groups Covered over Time by State, 2002	13
Chart 2-2 Income Eligibility Requirements for SPAPs as a Percentage of the Federal Poverty Level, 2002	15
Chart 2-3 Trends in Average SPAP Income Eligibility Levels as a Percentage of the Federal Poverty Level	17
Chart 2-4 Type of Consumer Cost-Sharing by Program, 2002	19
Chart 2-5 Cost-Sharing Provisions by State and Program, 2002	21
Section 3 Program Funding and Administration	23
Chart 3-1 Proportion of Total SPAP Funding by Source for FY 2003	25
Chart 3-2 Amount of Funds Budgeted and Sources of Funding by State for FY 2003	27
Chart 3-3 Program Generosity as Measured by SPAP Appropriations per Medicare Beneficiary, FY 2003	29
Chart 3-4 Functions Administered by Pharmacy Benefit Managers for SPAPs, 2002	31
Chart 3-5 Use of Drug Formularies by SPAPs, 2002	33
Chart 3-6 Number of Conditions Covered by States	35

Section 4 Program Enrollment	37
Chart 4-1 SPAP End-of-Year Enrollment, 2002	39
Chart 4-2 Proportion of SPAP Enrollees in Five States vs. All Other States with SPAPs, 2002	41
Chart 4-3 SPAP Enrollment as a Percentage of Medicare Enrollment, 2001	43
Chart 4-4 Total SPAP Enrollment as a Percentage of Medicare Enrollment, 1999 to 2001	45
Chart 4-5 Percentage of Income-Eligible, Non-Medicaid Population Enrolled in SPAPs, 2002	47
Chart 4-6 Percentage of Income-Eligible, Non-Medicaid Population Filling a Prescription in SPAPs, 2002	49
Section 5 Program Expenditures and Utilization	51
Chart 5-1 Total Drug Expenditures by SPAPs Before Rebates, 2002	53
Chart 5-2 Proportion of SPAP Drug Expenditures in Five States vs. All Other States with SPAPs, 2002	55
Chart 5-3 Rebates as a Percentage of Total Drug Expenditures, 2002	57
Chart 5-4 Annual State Drug Expenditures per End-of-Year Enrollee Before Rebates, 2002	59
Chart 5-5 Annual Drug Expenditures per End-of-Year Enrollee, 1999 to 2002	61
Chart 5-6 Annual SPAP Drug Expenditures per User, 2002	63
Chart 5-7 Annual SPAP Drug Expenditures per User, 1999 to 2002	65
Chart 5-8 Number of Claims per End-of-Year Enrollee, 2002	67
Chart 5-9 Annual Number of Claims per End-of-Year Enrollee, 1999 to 2002	69
Chart 5-10 Number of Claims per User, 2002	71
Chart 5-11 Annual Number of Claims per User, 1999 to 2002	73
Chart 5-12 Average SPAP Costs per Claim, 2002	75
Chart 5-13 Amount of Rebates per Claim, 2002	77
Chart 5-14 Average SPAP Costs per Claim, 1999 to 2002	79

Supplemental Charts Available at <http://www.cshp.rutgers.edu>**Program Design and Eligibility**

- Chart S-1 State Interventions for Addressing Prescription Drug Affordability, 2003
- Chart S-2 Number and Type of Programs over Time by State, 2003
- Chart S-3 Trends in Income Eligibility Levels as a Percentage of the Federal Poverty Level by State and Region
- Chart S-4 Other SPAP Eligibility Requirements

Program Enrollment and Take-up

- Chart S-5 1999 to 2002 Enrollment Trends for All SPAPs by State and Region
- Chart S-6 1999 to 2001 SPAP Enrollment Trends as a Percentage of Medicare Enrollment by State and Region
- Chart S-7 Percentage of All Medicare Income-Eligible, Non-Medicaid Population Enrolled in SPAPs and Program Features for FY 2002

Management of Program Cost and Quality

- Chart S-8 Pharmacy Reimbursement and Manufacturer Rebate Formulas
- Chart S-9 Point-of-Sale Drug Utilization Review Edits Used by SPAPs, 2002
- Chart S-10 Categories of Drugs Subject to Preferred Drug Lists / Prior Authorization in Selected SPAPs, 2003
- Chart S-11 Total SPAP Drug Expenditure Trends by State and Region, 1999 to 2002
- Chart S-12 Annual Drug Expenditures per End-of-Year Enrollee for Specific Programs by Cost-Sharing Features and Coverage, 2002
- Chart S-13 Annual SPAP Drug Expenditures per End-of-Year Enrollee by State and Region, 1999 to 2002
- Chart S-14 Annual Number of Claims per End-of-Year Enrollee by State and Region, 1999 to 2002
- Chart S-15 State Cost per Claim by Region, 1999 to 2002

Introduction

Prior to the enactment of the Medicare prescription drug benefit in December 2003, many states had implemented programs to provide prescription drug coverage to a portion of their elderly or disabled residents who did not qualify for Medicaid drug coverage. The first of these programs was established in 1975, and a majority of states now have some type of state prescription assistance program (SPAP) in place.

The Medicare Prescription Drug, Modernization and Improvement Act of 2003 includes language allowing states to “wrap around” the Medicare benefit to fill gaps in coverage and states are currently assessing whether and how they would coordinate benefits. Program benefit levels and eligibility requirements vary widely, as do the number of persons enrolled and the program costs. Coordinating the state benefits with numerous privately administered drug or Medicare Advantage plans will be complicated, especially for states with high eligibility levels and generous benefits. At the same time, coordination with Medicare would free up a significant amount of funds for states, allowing them to expand the population served by their programs or to support other state-funded programs.

This report provides current national data and trends over time for SPAPs on the number and types of programs, eligibility requirements, program design, enrollment, benefit utilization, and program expenditures. For more detailed state-specific data, please refer to a supplemental chartbook available at <http://www.cshp.rutgers.edu>. This report and the supplement provide a sense of the benefits that states

have been providing to the Medicare population over the years and how these efforts compare generally with the new Medicare drug benefit.

This chartbook is intended to serve as an information source about these programs. Unless otherwise stated, the data in the chartbook are from surveys of SPAPs conducted in 2000 and 2002 by the Rutgers University Center for State Health Policy. The results of the 2000 survey are also presented, with more detailed findings from case studies of specific state programs, in three reports published by The Commonwealth Fund.

The chartbook is divided into five sections:

Section 1. State Approaches to Addressing Prescription Drug Affordability. This section provides an overview of the types of programs that states have instituted to reduce prescription drug costs for program participants. States have either provided subsidies to pay for some portion of enrollees’ prescription drug costs (a “direct benefit” program), or have arranged for participants to receive a reduced price for prescriptions at participating pharmacies (a “discount” program). As of August 2003, 38 states had authorized some type of prescription assistance program, with 19 states authorizing direct benefit programs only, eight authorizing discount programs only, and 11 authorizing both direct benefit and discount programs; however, not all of these programs were operational.¹ Because direct benefit programs generally have a greater impact on enrollees’ out-of-pocket costs, as well as on state expenditures,

¹ National Conference of State Legislatures’ website: *State Pharmaceutical Assistance Programs, 2003 Edition*, <http://www.ncsl.org/programs/health/drugaid.htm>. Accessed August 27, 2003.

we only surveyed states with direct benefit programs, and the remainder of the chartbook focuses only on these programs.

Section 2. Program Design. Although most direct benefit programs are targeted to elderly persons with low to moderate incomes, there is considerable variation in eligibility and cost-sharing requirements among programs. Of the 21 states with operational programs in 2002, only eight extended eligibility to disabled persons under the age of 65, and two programs were open to persons of all ages/disability status who met the eligibility requirements of their programs. Income eligibility requirements ranged from 100 percent to 500 percent of the federal poverty level, and some programs had high deductibles or coinsurance, premiums, or benefit caps while others only required a small copayment per prescription.

Section 3. Program Funding and Administration. In total, the 21 SPAP states in the survey committed over \$2.1 billion to fund these programs for fiscal year 2002–2003. Fifty-seven percent of this funding came from categorical sources such as lottery fund revenues and casino fund revenues, and 19 percent came from tobacco settlement funds. Although several states indicated that they contracted with pharmacy benefit managers (PBMs), most states had pharmacy reimbursement rates and pharmaceutical manufacturer rebate rates set in statute, rather than having them negotiated by their PBMs. Also, 11 of the 21 states indicated that they had preferred drug lists or prior authorization programs that required doctors or pharmacists to get prior approval from the PBM or the state before dispensing drugs that had less-expensive therapeutic equivalents.

Section 4. Program Enrollment. Taken together, the 21 SPAP states enrolled about 1.3 million people as of July 2002; however, 73 percent of these individuals were enrolled in just five states. There has been considerable growth in enrollment in these programs since 1999, but SPAP enrollees still accounted for only 6.1 percent of Medicare beneficiaries in states that had such programs in 2001 (the most recent year for which Medicare enrollment data were available).

In order to form a more precise indicator of the proportion of eligible persons enrolled in these programs, we used the Current Population Survey (CPS) to calculate the number of persons who met program age, disability, and income criteria for each state's program who were not enrolled in Medicaid. By this measure, SPAPs on average provided prescription drug coverage to approximately 16 percent of the potentially eligible persons in their states in 2002, ranging from .4 percent in Wyoming to 42 percent in Pennsylvania. Note that these estimates do not factor in the availability of other drug coverage, which is not available in the CPS.

Section 5. Program Expenditures and Utilization. In total, states spent about \$1.8 billion on prescription drug claims for SPAPs in 2002. The five states with the most persons enrolled also accounted for 72 percent of all drug expenditures. Annual pre-rebate claims costs per enrollee averaged \$1,367 in 2002 and ranged from \$156 in Florida to \$2,031 in New Jersey. In recent years, expenditures have increased dramatically for many states. For states with programs established before 1999, annual drug expenditures per enrollee increased 53 percent from 1999 to 2002.

The average number of prescription claims per year per enrollee was 28.5 in FY 2002 and ranged from 3.4 in Indiana to 44.4 in Pennsylvania. States with programs established before 1999 had a 6.6 percent increase in claims per enrollee between 1999 and 2002, although several states that expanded the number of drugs covered under their programs or expanded eligibility had larger increases in claims per enrollee during this time.

The average state cost per claim before rebates was \$46.82 in 2002 and ranged from \$18.56 in South Carolina to \$114.83 in Indiana. States with programs established before 1999 had a 34 percent increase in costs per claim from 1999 to 2002, and states with programs established since 1999 also had a 34 percent increase over this time period.

On average, SPAPs recovered \$7.43 per filed claim through manufacturer rebates in 2002. Overall, SPAP rebates averaged 14.8 percent of total state drug expenditures. This also varied by state, partly because of the different rebate rates among states, different consumer cost-sharing requirements, and the types of drugs used by enrollees (name-brand drugs usually have higher rebate rates).

Section 1. State Approaches to Addressing Prescription Drug Affordability

Chart 1-1

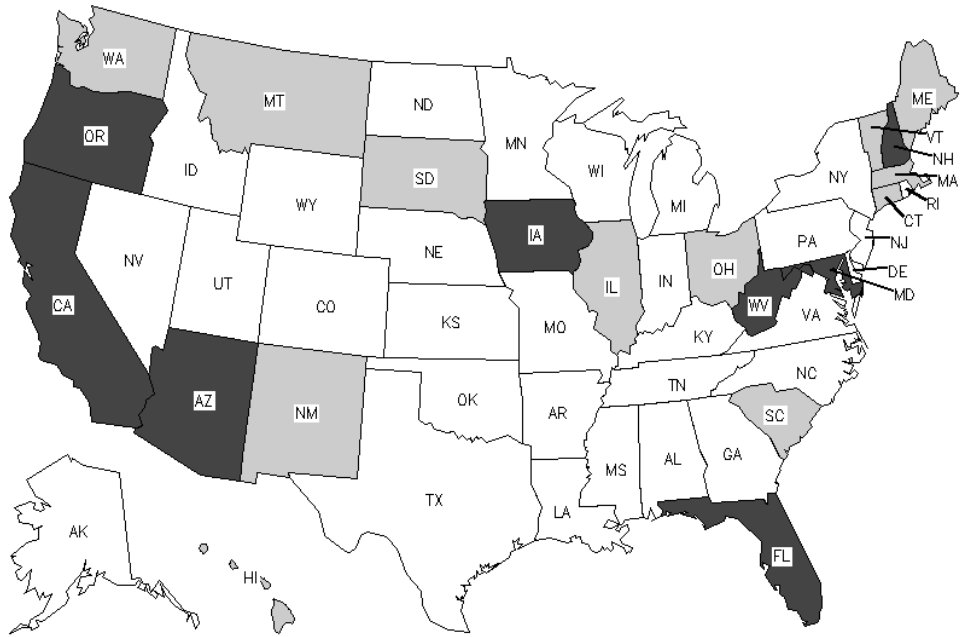
State Interventions for Addressing Prescription Drug Affordability, 2003

- As of August 2003, 38 states had authorized some type of program to reduce the costs of prescription drugs for a portion of their residents, and several states had authorized more than one type of program.¹
- Thirty states had enacted a direct benefit program, and programs in 22 of those states were operational.¹
- Twenty states had authorized discount programs to reduce the costs of prescription drugs to consumers at little or no cost to the state.¹ These programs have been legally challenged in Vermont, Maine, and Washington, and their future is uncertain.
- In light of the new interim Medicare-endorsed private discount card program, effective June 2004 with estimates of savings between 10% and 25% as well as a \$600 credit for persons earning below 135% of the Federal Poverty Level, states are currently assessing whether to maintain their discount programs. State discount programs were excluded from Medicare endorsement, only private entities qualify.
- In the 11 states with both types of programs, the direct benefit programs were targeted to persons with lower incomes and the discount programs typically had no income limits.
- All states in the Northeast had some type of SPAP in 2003. New Hampshire was the only state in the Northeast not to have a direct benefit program.
- Most states in the Midwest also had direct benefit programs.
- Several states in the South and West had operational programs, and several more had authorized programs that were not yet operational.
- The remainder of the chartbook will focus only on direct benefit programs because they have the longest history and the most financial impact both for the states and for individual enrollees.

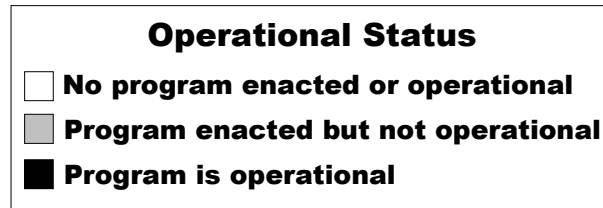
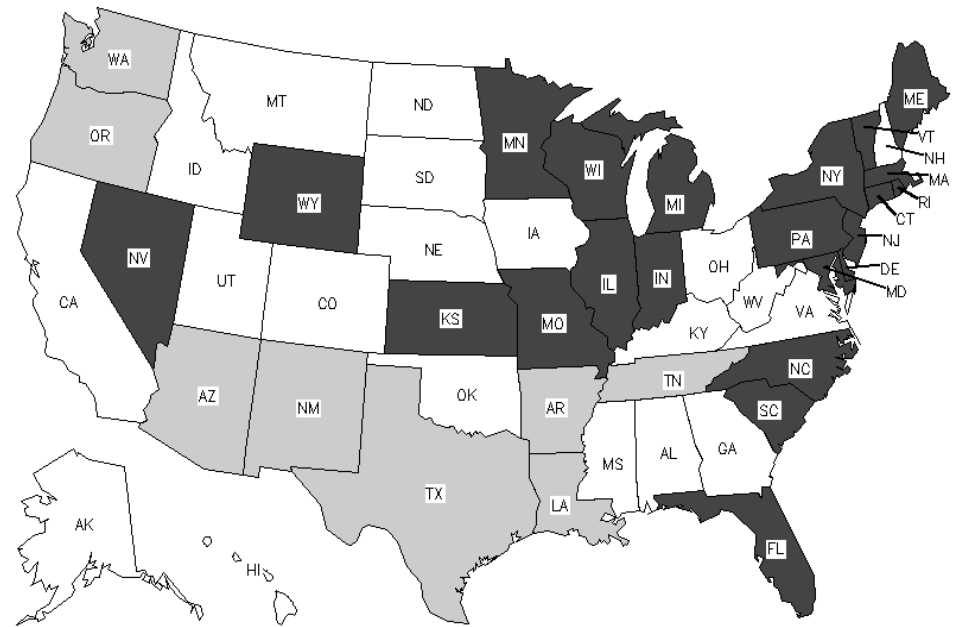
¹ National Conference of State Legislatures' website: *State Pharmaceutical Assistance Programs, 2003 Edition*, <http://www.ncsl.org/programs/health/drugaid.htm>. Accessed August 27, 2003.

Chart 1-1 State Interventions for Addressing Prescription Drug Affordability, 2003

Discount Programs, 2003



Direct Benefit Programs, 2003



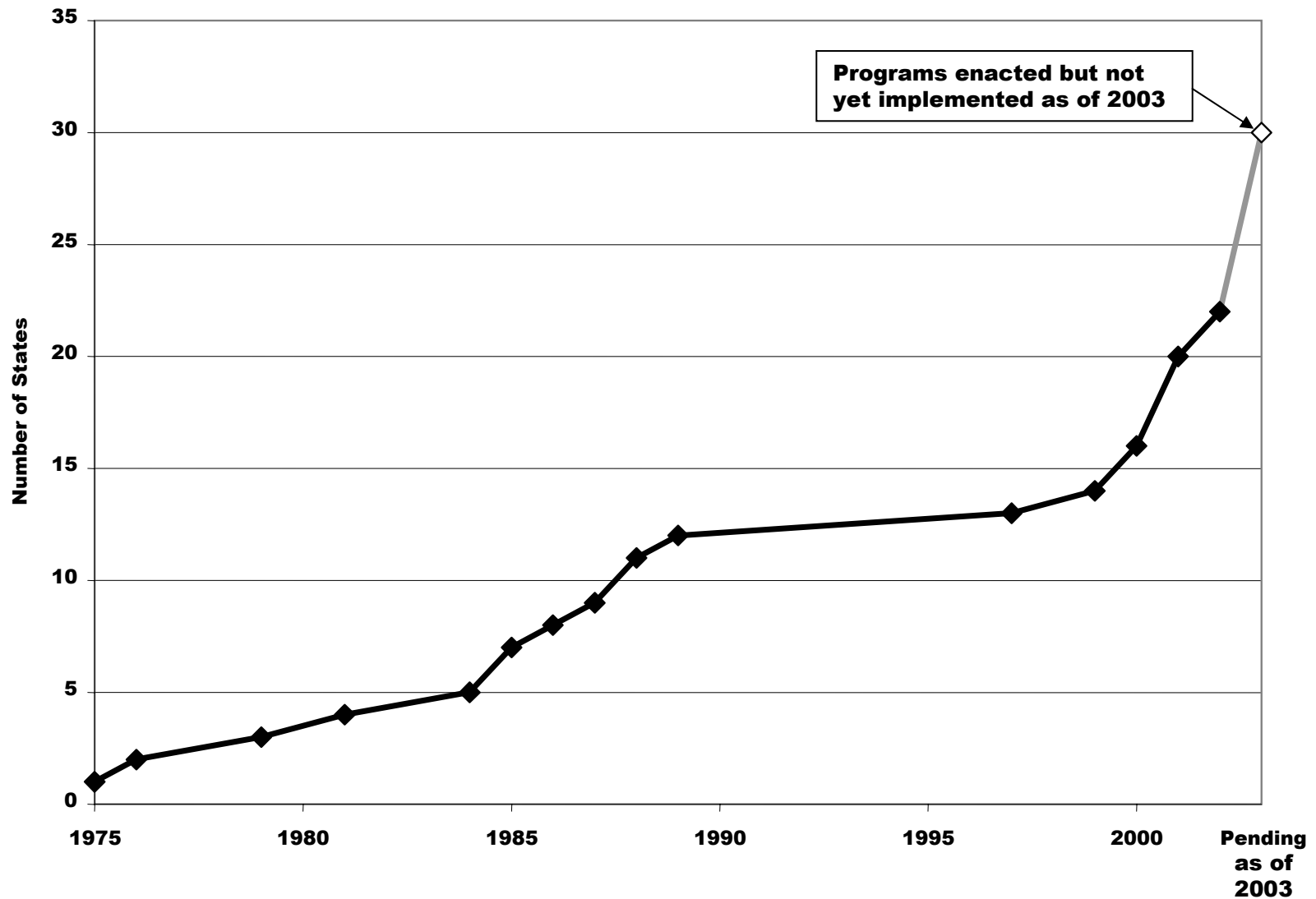
Source: National Conference of State Legislatures' website: *State Pharmaceutical Assistance Programs, 2003 Edition*, <http://www.ncsl.org/programs/health/drugaid.htm>. Accessed August 27, 2003.

Chart 1-2

Cumulative Number of States Implementing Direct Benefit Programs over Time

- Since the first direct benefit SPAP was implemented in 1975, there have been three periods of growth in the number of states with SPAPs.
- Four states implemented direct benefit programs prior to 1984 and six states implemented programs between 1984 and 1989.
- Another steep increase in the number of states with direct benefit programs began in 1997, with six more states implementing programs by 2003, and 8 states with programs enacted but pending implementation as of August 2003.
- The introduction of new direct benefit programs in the mid- to late-1980s and from 1997 to 2003 corresponded with increasing national attention on the issue of prescription drug coverage under Medicare during those periods. The interest in this issue in the 1980s culminated with the passage of the Catastrophic Coverage Act of 1988, which included a plan to phase in prescription drug coverage for Medicare beneficiaries. This Act was later repealed. The reemergence of the issue in the late 1990s led to several federal proposals for a Medicare prescription drug benefit, culminating with the enactment of the Medicare Prescription Drug, Modernization and Improvement Act of 2003.

Chart 1-2
Cumulative Number of States Implementing Direct Benefit Programs over Time



Source for number of pending programs: National Conference of State Legislatures' website: *State Pharmaceutical Assistance Programs, 2003 Edition*, <http://www.ncsl.org/programs/health/drugaid.htm>. Accessed August 27, 2003.

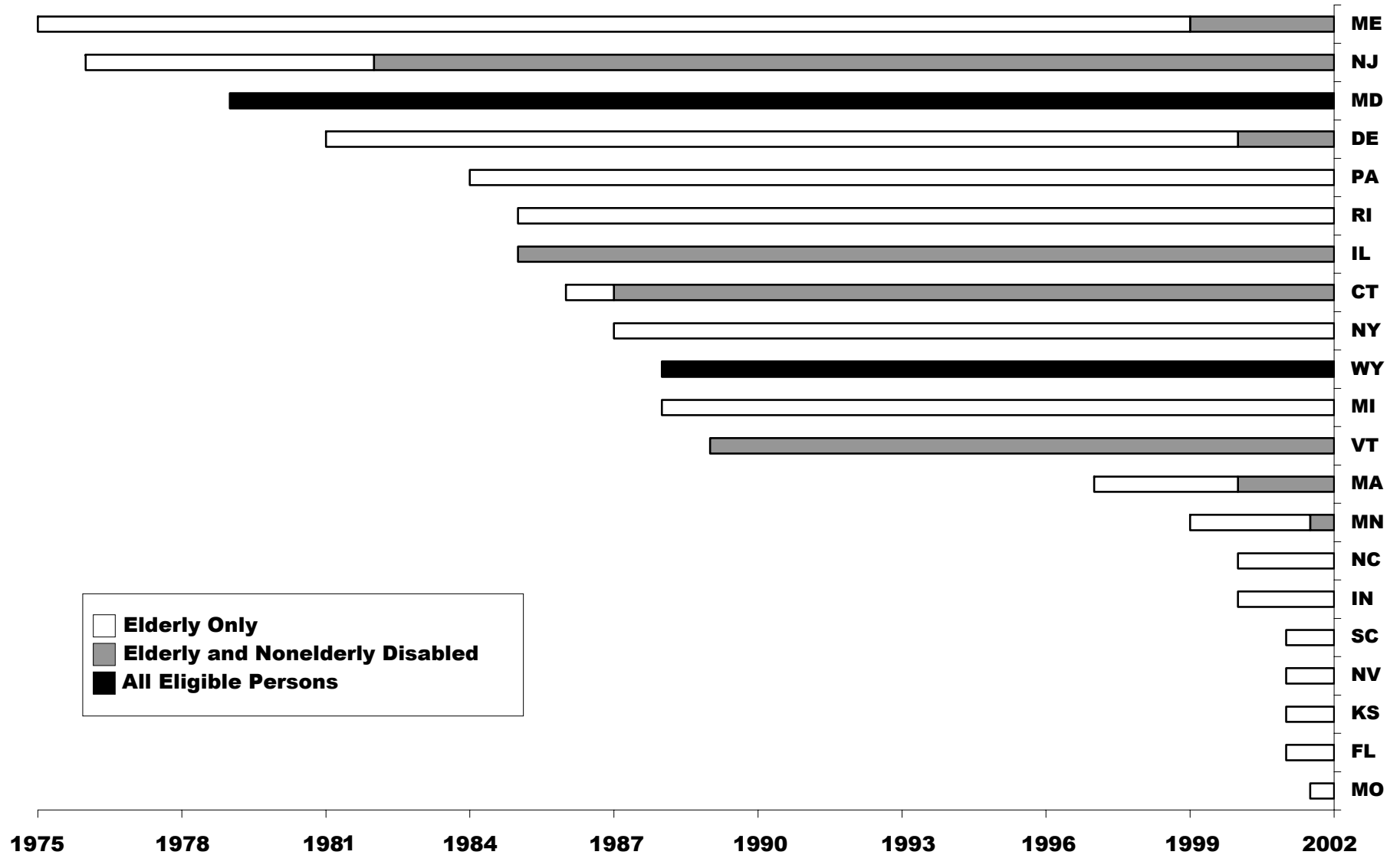
Section 2. Program Design

Chart 2-1

Groups Covered over Time by State, 2002

- Maine and New Jersey had the longest-standing programs, initiated in 1975 and 1976, respectively.
- Out of 21 states in the survey, eight (38%) covered both elderly persons and younger disabled persons.
- Two of these programs have covered disabled persons since their inception and six added coverage for the disabled at a later time.
- All programs implemented between 2000 and 2002 offered coverage only to the elderly.
- Age requirements for elderly participants were typically age 65 or over, but Maine and Nevada set the minimum age for eligibility at 62 and Kansas set the minimum age at 67.
- Maryland and Wyoming offered coverage to all persons, regardless of age or disability status, who met the eligibility criteria for their programs.
- The Medicare Prescription Drug, Modernization and Improvement Act of 2003 (MMA) voluntary Part D drug benefit will be available to all Medicare beneficiaries, including persons over 65 and the disabled.

Chart 2-1
Groups Covered over Time by State, 2002



Years in Operation

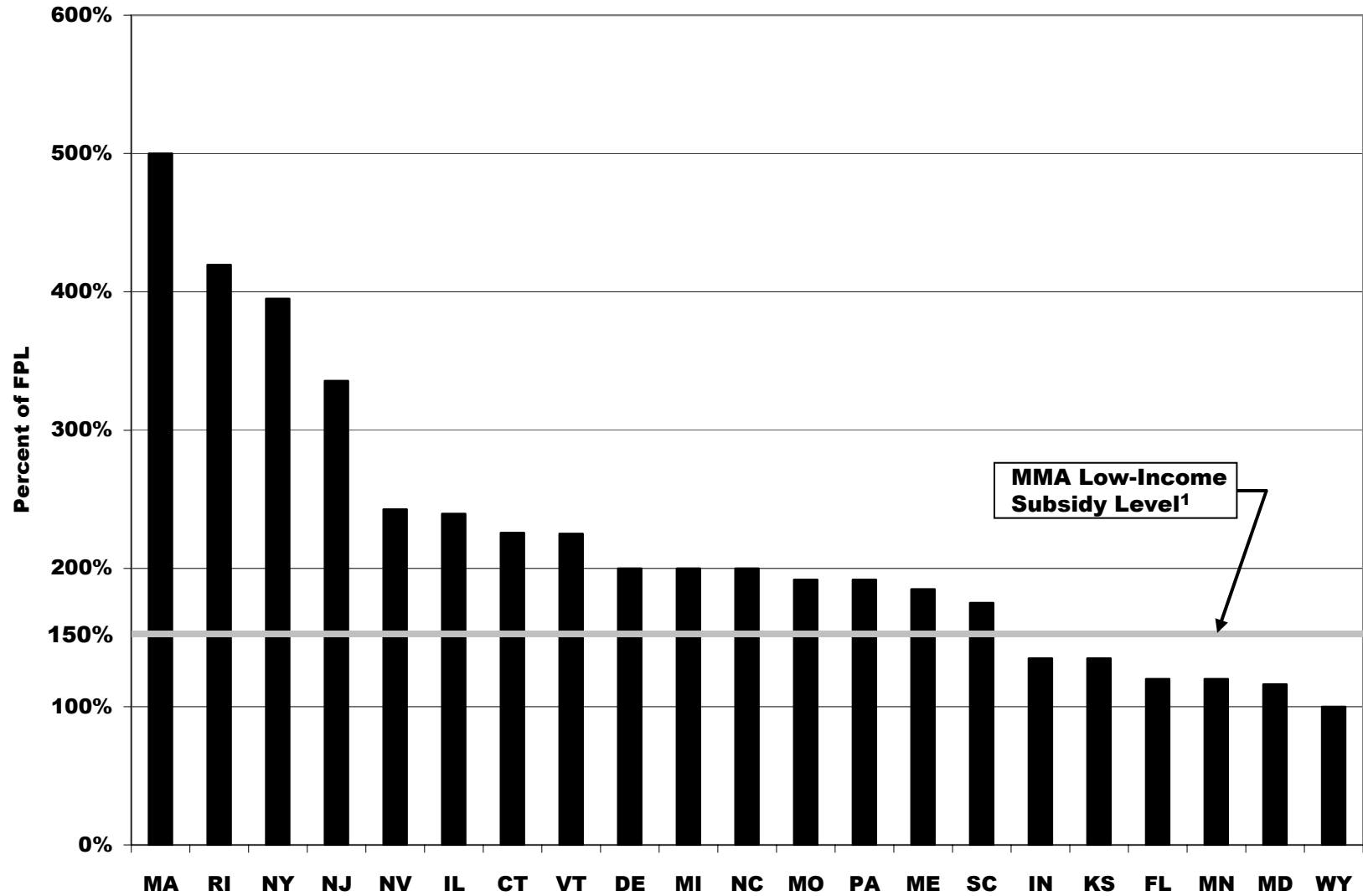
Chart 2-2

Income Eligibility Requirements for SPAPs as a Percentage of the Federal Poverty Level, 2002

- In 2002, income thresholds for SPAPs ranged from 100% of the federal poverty level (FPL) in Wyoming to 500% of the FPL in Massachusetts; however, income eligibility for younger disabled persons was set at 188% of the FPL in Massachusetts.
- In 2002, the federal poverty level was \$8,860 for individuals and \$11,940 for couples, so income eligibility in 2002 ranged from that level to \$44,300 for singles and \$59,700 for couples.
- Income eligibility levels in Massachusetts and Nevada were for individuals who were applying for state subsidies to help pay the insurance premium for the program. People with incomes above these levels could enroll in the programs at the full premium if they met the other eligibility requirements (e.g., age, residency).
- The Medicare Prescription Drug, Modernization and Improvement Act of 2003 (MMA) provides for premium subsidies and reduced cost-sharing for persons with incomes below 150% of the FPL who meet asset requirements (see chart below). Only six of the 21 states had income thresholds below 150% of the FPL, and only two states had asset tests, so most states were providing benefits to persons who will not be covered under the low-income subsidy portion of the MMA when it takes effect in January 2006.
- For detailed information on additional eligibility requirements for SPAPs, see the supplemental chartbook at <http://www.cshp.rutgers.edu>.

Program	Income Requirement	Asset Requirement	
		Single	Couple
MD	116% of FPL	\$3,750	\$4,500
MN	120% of FPL	\$10,000	\$18,000
All Other States	100%–500% of FPL (see following page)	None	None
MMA Partial Subsidy	150% of FPL	\$10,000	\$20,000
MMA Full Subsidy	135% of FPL	\$6,000	\$9,000

Chart 2-2
Income Eligibility Requirements for SPAPs as a Percentage
of the Federal Poverty Level, 2002



¹ Persons with incomes below 150% of FPL are eligible for a partial subsidy, and persons with incomes below 135% of FPL are eligible for the full subsidy.

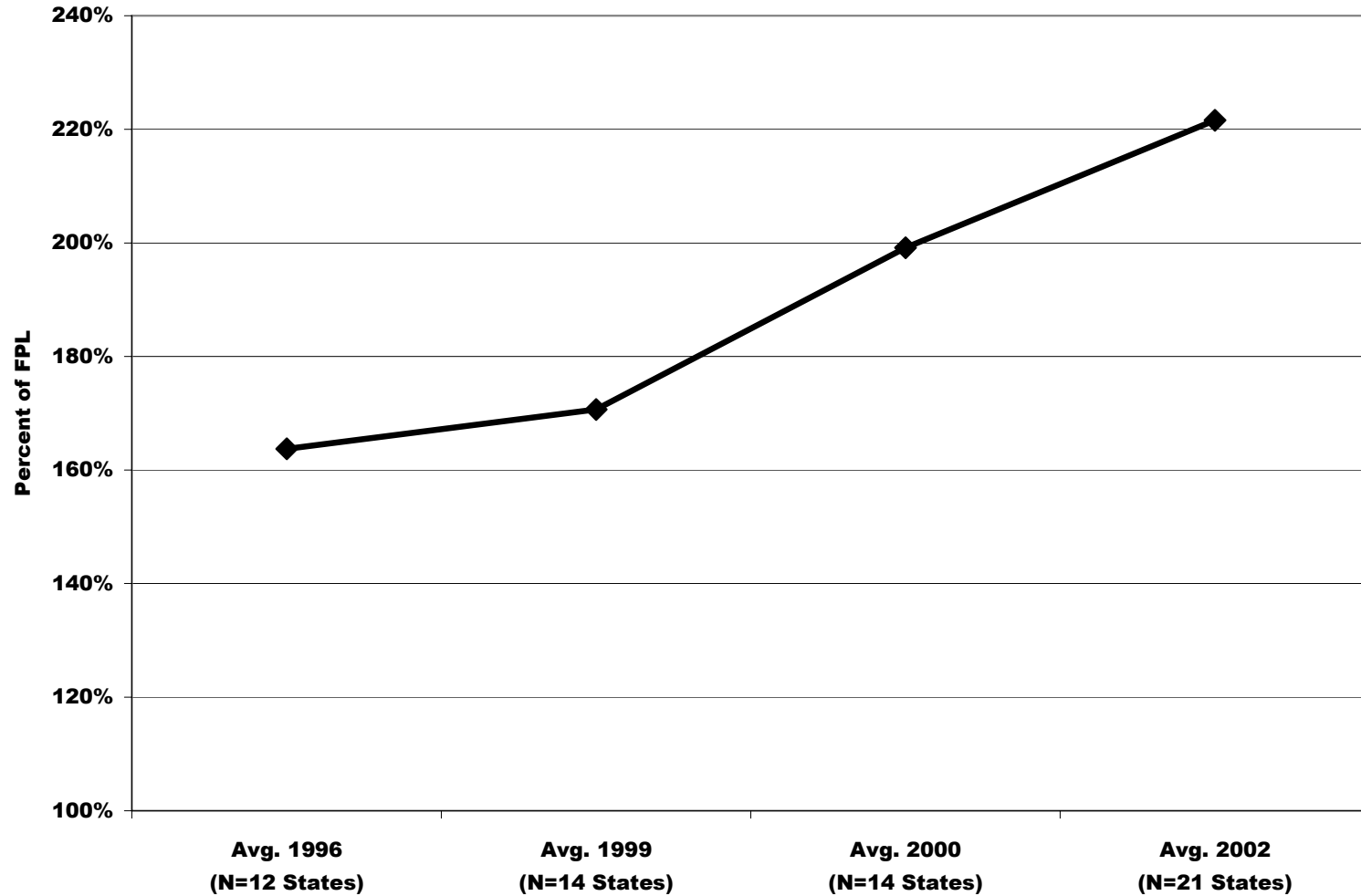
Chart 2-3

Trends in Average SPAP Income Eligibility Levels as a Percentage of the Federal Poverty Level

- Average income limits across all states with programs increased from 164% of the FPL in 1996 to 222% of the FPL in 2002.
- The increases in eligibility levels from 1996 to 2002 were due to both the passage of legislation expanding income eligibility levels for existing programs and the creation of new programs with higher income eligibility levels.
- Most states automatically increase income limits each year in accordance with changes in the FPL. Some other states, as detailed in the table below, either use the annual increase in the Social Security Cost-of-Living Adjustment (COLA) to determine income eligibility increases or do not automatically increase income eligibility each year:

State	Annual Income Adjustment
Connecticut	Social Security COLA
Illinois	None for the state funded Circuit Breaker program, increases with FPL for the SeniorCare waiver program
Maryland	Social Security COLA
Missouri	None
Nevada	None
New Jersey	Social Security COLA
New York	None
Pennsylvania	None, except that cardholders enrolled as of 12/31/00 received COLA increases through 12/31/02
Rhode Island	Social Security COLA
All Other States	Increases with the FPL

Chart 2-3
Trends in Average SPAP Income Eligibility Levels
as a Percentage of the Federal Poverty Level



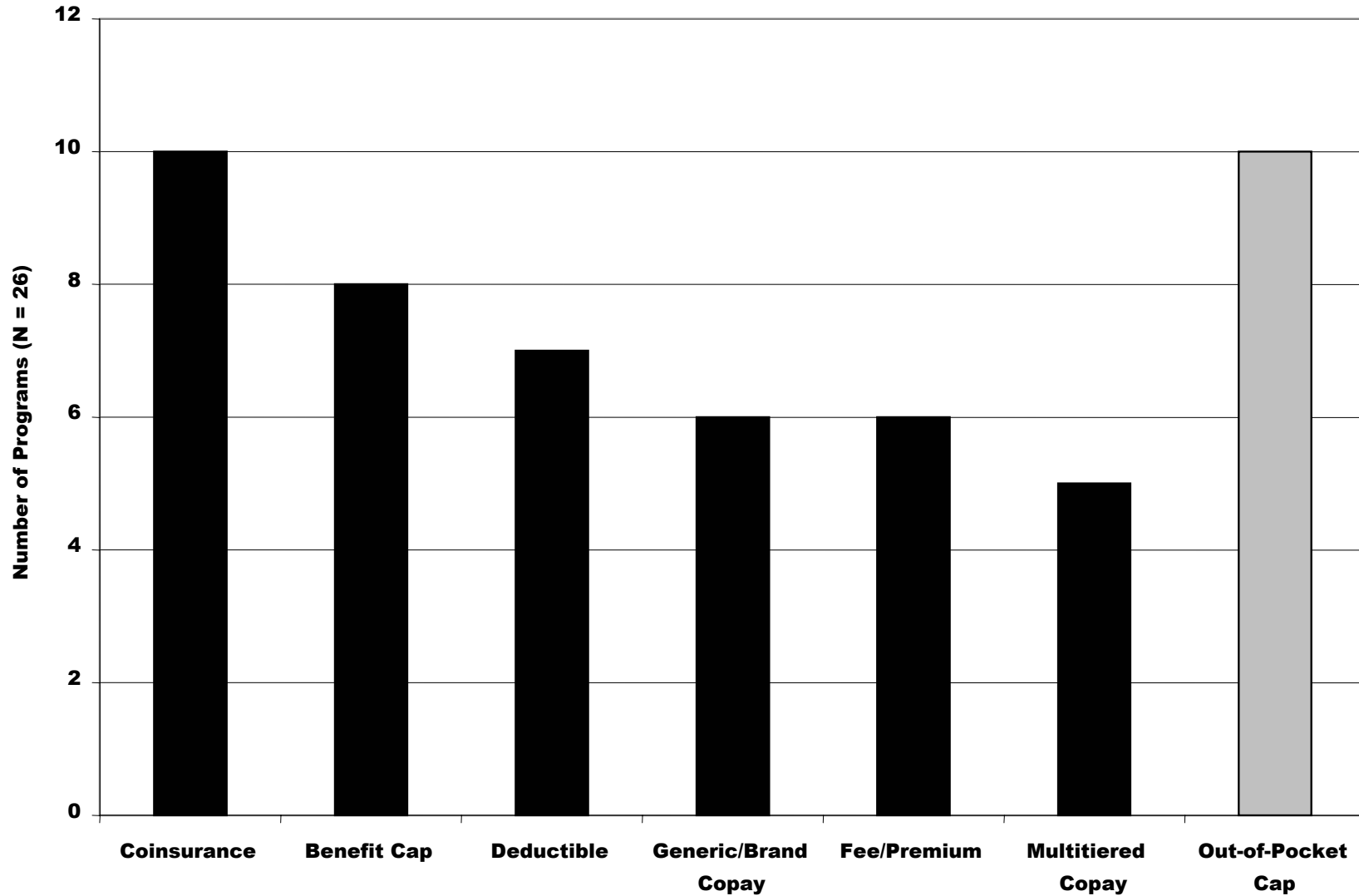
Sources: *EPIC Evaluation Report to the Governor and Legislature: October 1987–September 1995*. New York State Department of Health. United States General Accounting Office. (2000). *State Pharmacy Assistance Programs: Assistance Designed to Target Coverage and Stretch Budgets*. GAO/HEHS-00-162, Washington, D.C.: Author. Rutgers Center for State Health Policy Survey of State Pharmacy Assistance Programs, December 2000 and August 2002. “Average SPAP income eligibility level” is the mean of states’ upper limits for program eligibility and is not weighted by enrollment.

Chart 2-4

Type of Consumer Cost-Sharing by Program, 2002

- Four states had more than one operational direct benefit program. These different programs were usually targeted to persons with different income levels, and the programs for higher-income individuals had higher cost-sharing requirements than those for lower-income individuals. Chart 2-4 shows the number of programs that used each type of consumer cost-sharing, and Chart 2-5 details the cost-sharing requirements for programs in each state.
- Coinsurance (consumer cost-sharing at the point of sale based on a percentage of a drug's cost) was the most frequently used form of point-of-sale cost-sharing by SPAPs.
- Two-tiered generic and brand copayments were used by six programs, and multitiered copayments were used by five programs. The tiers in these programs were based either on a drug's designation as a generic, a preferred brand, or a nonpreferred brand (Florida, Massachusetts, and Nevada), or solely on a drug's price (both New York programs).
- Seven programs had deductibles. New York and Pennsylvania imposed deductibles only on people in programs with higher income limits.
- Only six programs required applicants to pay a fee or premium to join.
- Eight programs had benefit caps on the cost or number of drugs that participants could purchase.
- In contrast, 10 programs put a cap on enrollees' out-of-pocket expenditures. After reaching this cap, enrollees paid either nothing or a small copay for their remaining drug purchases. These caps could be either annual or monthly.
- None of the state programs had a cost-sharing provision like the one in the Medicare Prescription Drug, Modernization and Improvement Act of 2003 (MMA) commonly called the "donut hole," in which benefits are suspended when a total drug cost threshold is reached and then are reinstated when an out-of-pocket spending threshold is reached. The MMA allows for states to subsidize beneficiaries' expenditures during this gap in coverage, but it remains to be seen how this coordination of benefits will work in practice.

Chart 2-4
Type of Consumer Cost-Sharing by Program, 2002



Note: Totals do not add to 26 because several programs have more than one type of cost-sharing.

Chart 2-5

Cost-Sharing Provisions by State and Program, 2002

- Annual fees/premiums ranged from \$5 for lower-income participants in Illinois' Circuit Breaker program to \$300 for higher-income participants in New York's fee program.
- Deductibles can be either annual, quarterly, or monthly. For a given yearly deductible, monthly deductibles allow participants to access the benefit sooner than annual deductibles. As of 2002, only Minnesota had a monthly deductible. Under the MMA, there is no deductible for beneficiaries with incomes below 135% of the FPL and assets under \$6,000 for singles and \$9,000 for couples.
- Coinsurance levels ranged from 20% in Maine to 85% for the highest income group in Rhode Island. Programs often had a minimum dollar amount for coinsurance (e.g., Delaware's coinsurance was \$5 or 25%, whichever was higher).
- Four states had a flat copay for all prescriptions (\$12 in Connecticut, \$5 in Maryland and New Jersey, and \$6 in Pennsylvania's PACE program). Copay amounts ranged from \$2 for generic drugs in Florida to \$40 or 50% of a drug's cost (whichever was higher) for nonpreferred drugs in Massachusetts.
- Minnesota was the only state that did not have point-of-sale cost-sharing in the form of coinsurance or a copay.
- Programs with benefit caps typically set a maximum dollar amount that the state would pay for beneficiaries' prescription drug purchases, although Wyoming set a three-prescription-per-month limit regardless of cost. Most cost caps were calculated on an annual basis and ranged from \$500 a year for higher-income participants in Indiana to \$5,000 a year for participants in Missouri and Nevada.
- In contrast to benefit caps under which the beneficiary is responsible for all prescription drug costs above the cap, states with out-of-pocket caps cover all or most of beneficiaries' prescription drug costs after they have spent a certain amount out-of-pocket on copays/coinsurance and deductibles. These can be set as a percentage of income or as a set dollar amount and can be calculated on a monthly, quarterly, or annual basis.
- Under MMA, persons with incomes below 135% of the FPL who meet the asset requirements do not have a premium, deductible, or coinsurance, and pay a \$2 to \$5 copay. Persons with incomes below 150% of the FPL who meet the asset requirements pay a sliding-scale premium, a \$50 deductible, and 15% coinsurance. All persons with incomes under 150% of the FPL do not have the gap in coverage in the standard Part D benefit known as the "donut hole."

Chart 2-5
Cost-Sharing Provisions by State and Program, 2002

State (Program)	Income Eligibility (% FPL)	Annual Fee/Premium	Deductible	Coinsurance	Copay	Benefit Cap	Out-of-Pocket Cap
CT	226%	\$25			\$12		
DE	200%			\$5 or 25%, whichever is greater		\$2,500	
FL	120%				\$2/\$5/\$15 tiered copay	\$160 a month	
IL	239%	\$5 or \$25 by income		Copay plus 20% coinsurance after reaching \$2,000 in drug costs	\$0 or \$3 by income up to \$2,000 in drug costs		
IN	144%			50%		\$500, \$750, or \$1,000 by income	
KS	135%			30%		\$1,200	
MA	500%	\$0 to \$99 by income	\$0 to \$125 a quarter by income		\$6/\$16/50% or \$40 to \$10/\$28/50% or \$40 by income		\$2,000 or 10% of income, whichever is lower
MD	116%				\$5		
ME	185%			\$2 or 20%, whichever is greater			\$1,000 for drugs for non-covered conditions
MI	200%	\$25		20%			Monthly copayment maximums by income.
MN	120%		\$35 a month		None		
MO	192%	\$25 or \$35 by income	\$250 or \$500 by income	40%	40%	\$5,000	
NC	200%			40%		\$600	
NJ (PAAD)	223%				\$5		
NJ (Senior Gold)	336%			\$15 plus 50% of the remaining cost of the drug			\$2,000 single, \$3,000 couple
NV	243%				\$10 generic, \$25 preferred brand	\$5,000	
NY (Fee)	226%	\$8 to \$300 by income			\$3 to \$20 by drug price		9% of annual income
NY (Deductible)	395%		\$530 to \$1,715 by income		\$3 to \$20 by drug price		9% of annual income
PA (PACE)	158%				\$6		
PA (PACENET)	192%		\$500		\$8 generic, \$15 brand		
RI	419%			40%, 70%, or 85% by income			\$1,500
SC	175%		\$500		\$10 generic, \$21 brand		
VT (VHAP)	150%				\$3 generic, \$6 brand		\$50 per calendar quarter
VT (VScript)	175%				\$5 generic, \$10 brand		\$100 per calendar quarter
VT (VScript Exp.)	225%		\$275	41%			\$2,500 per calendar quarter
WY	100%				\$10 generic, \$25 brand	3 prescriptions per month	
MMA (Full Subsidy)	135%	\$0 for basic coverage	\$0		\$2 to \$5		\$3,600
MMA (Partial Subsidy)	150%	Up to an average of \$35 a month by income	\$50	15%			\$3,600
MMA (No Subsidy)	No limit	An average of \$35 a month by income and assets	\$250	25% up to \$2,250 in total drug costs, then 100% until reaching \$3,600 out-of-pocket costs, then \$5 or 5%			\$3,600

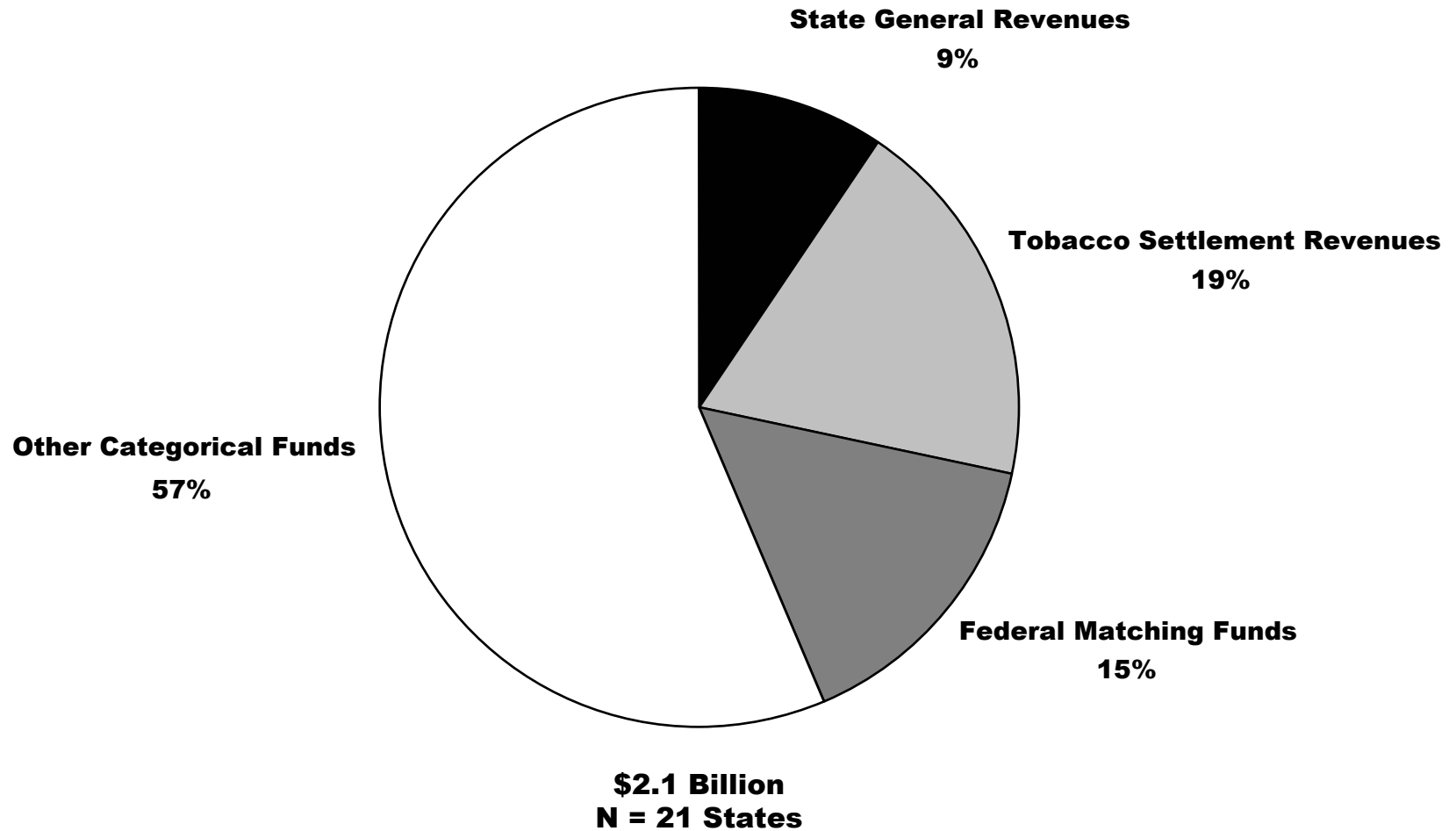
Section 3. Program Funding and Administration

Chart 3-1

Proportion of Total SPAP Funding by Source for FY 2003

- In total, the 21 SPAP states in the survey committed over \$2.1 billion to fund SPAP programs for FY 2003.
- About \$207 million (9%) of this funding was from state general revenues, \$415 million (19%) was from tobacco settlement revenues, and about \$1.2 billion (57%) was from other categorical funding sources (e.g., lottery fund revenues in Pennsylvania, casino fund revenues in New Jersey).
- About \$335 million (15%) of this funding was from actual or anticipated federal matching funds for programs funded through Medicaid 1115 or Pharmacy Plus waivers. Florida, Illinois, Maryland, South Carolina, and Vermont had received such waivers for FY 2003, and Wisconsin and Indiana have received Pharmacy Plus waivers since July 2002. New Jersey had requested but had not yet received a waiver as of the time of this writing.

Chart 3-1
Proportion of Total SPAP Funding by Source for FY 2003



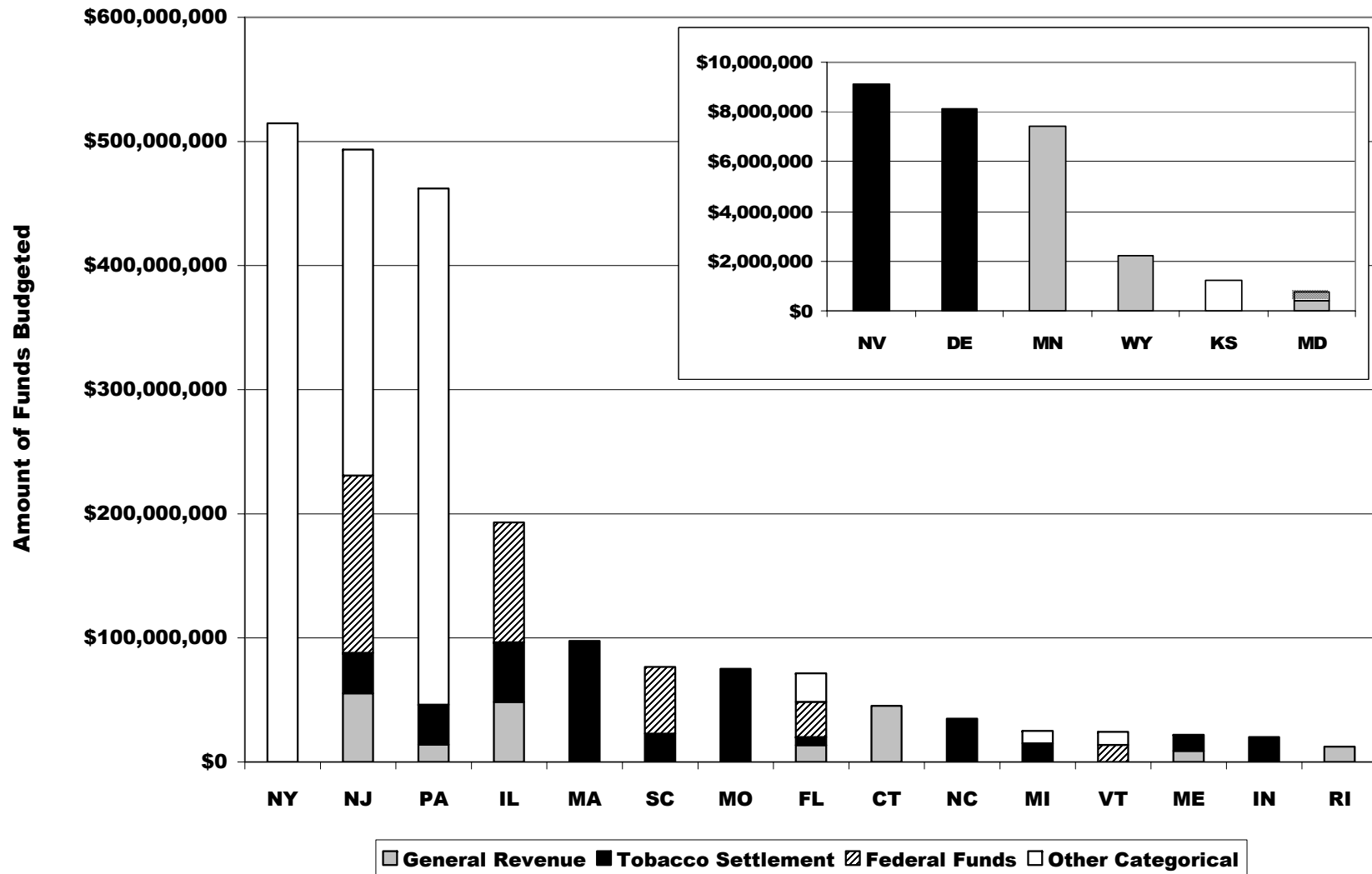
Notes: Budget numbers for Connecticut are from FY 2002; the source for budget amounts for Delaware and Maine is the National Governors Association (July 2002). *State Pharmaceutical Assistance Programs*. NGA website: <http://www.nga.org/cda/files/0702STATEPHARM.pdf>. Accessed May 2, 2003.

Chart 3-2

Amount of Funds Budgeted and Sources of Funding by State for FY 2003

- Four SPAPs received 100% of their funding from general revenues. Six SPAPs in states with only one program received 100% of their funds from tobacco settlement revenues. In addition, the Senior Gold program in New Jersey and the V-Script Expanded program in Vermont relied 100% on tobacco settlement funds.
- Categorical funds accounted for all or most of the funding in Kansas, New Jersey, New York, and Pennsylvania.

Chart 3-2
Amount of Funds Budgeted and Sources of Funding by State for FY 2003



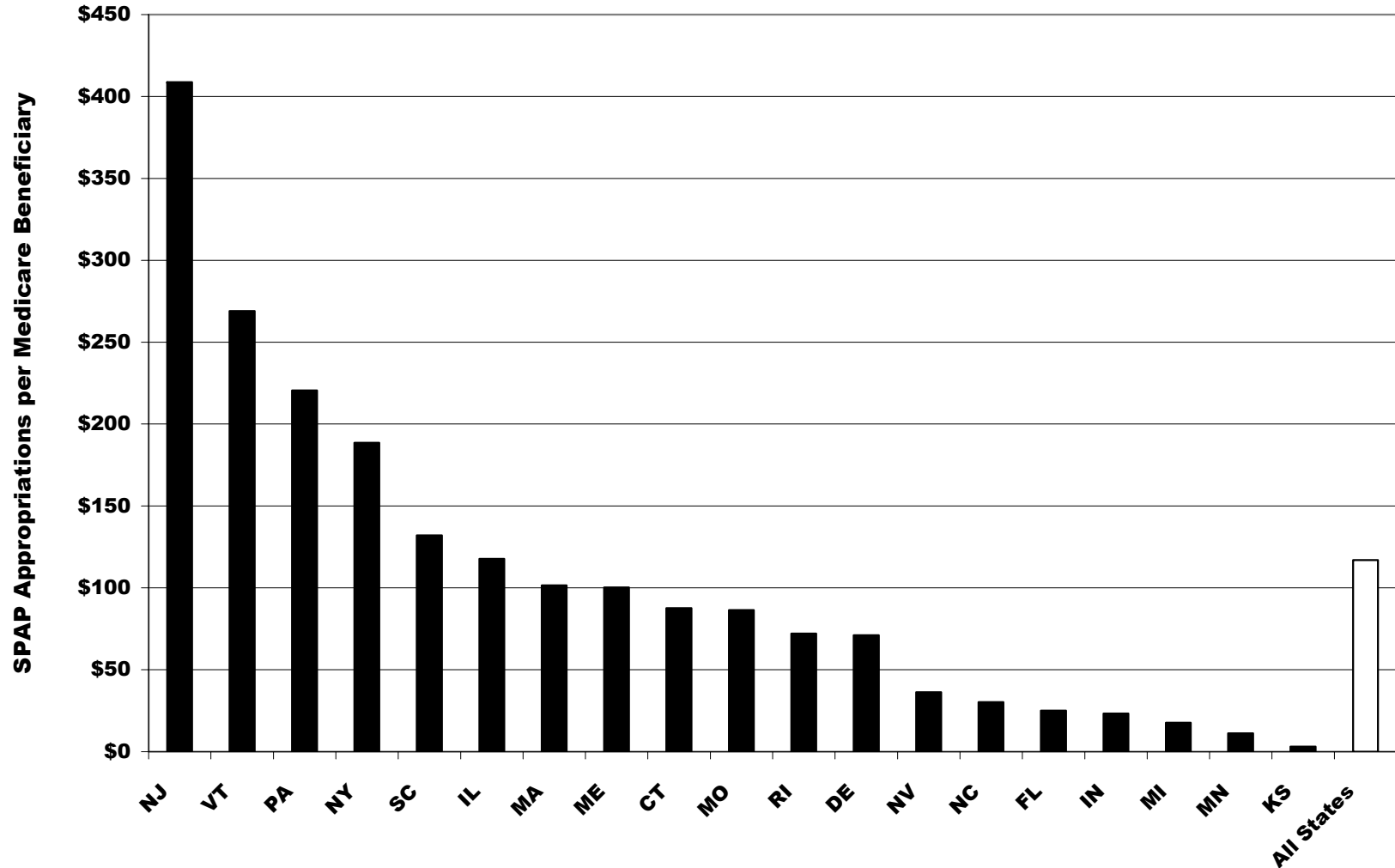
Notes: Budget numbers for Connecticut are from FY 2002; the source for budget amounts for Delaware and Maine is from the National Governors Association (July 2002). *State Pharmaceutical Assistance Programs*. NGA website: <http://www.nga.org/cda/files/0702STATEPHARM.pdf>. Accessed May 2, 2003.

Chart 3-3
Program Generosity as Measured by SPAP Appropriations
per Medicare Beneficiary, FY 2003

- As an indicator of program generosity, we calculated the amount of state appropriations per Medicare beneficiary in the state as a measure of state financial effort on SPAPs.
- By this measure, states with SPAPs allocated on average about \$117 per Medicare beneficiary in the state.¹
- This measure ranged from about \$3 in Kansas to \$408 in New Jersey.

¹ Beneficiary weighted.

**Chart 3-3
Program Generosity as Measured by SPAP Appropriations
per Medicare Beneficiary, FY 2003**



Notes: Budget numbers for Connecticut are from FY 2002. The average for “All States” is the quotient of total enrollment in all programs divided by the total number of persons estimated to be eligible for all of the programs.

Sources: The source for budget amounts for Delaware and Maine is the National Governors Association (July 2002). *State Pharmaceutical Assistance Programs*. NGA website: <http://www.nga.org/cda/files/0702STATEPHARM.pdf>. Accessed May 2, 2003. Source for Medicare enrollment data: CMS website. *CMS Statistics: Medicare Enrollment*. <http://cms.hhs.gov/statistics/enrollment/default.asp>. Accessed February 28, 2003.

Chart 3-4

Functions Administered by Pharmacy Benefit Managers for SPAPs, 2002

- Fourteen of the 20 SPAP states for which we had data indicated that they used a pharmacy benefit manager (PBM) to administer some of their program functions. Of those 14 states, 13 used a PBM for drug utilization review (DUR—a review of prescriptions that provides pharmacists and physicians with informational warnings about potentially inappropriate prescriptions), eight used a PBM to collect manufacturer's rebates, and six used a PBM for eligibility determination and formulary development. Only five states used a PBM to negotiate pharmacy reimbursement rates and four used PBMs to negotiate manufacturer rebates.
- States that did not use PBMs to negotiate manufacturer rebates or pharmacy reimbursement rates usually had the rebate and/or reimbursement rates set in statute.
- In addition to the states that contracted with a PBM, most states used a third-party vendor to process claims.
- The Medicare Prescription Drug, Modernization and Improvement Act of 2003 (MMA) provides for the prescription drug benefit to be administered by private entities such as PBMs.

Chart 3-4
Functions Administered by Pharmacy Benefit Managers for SPAPs, 2002

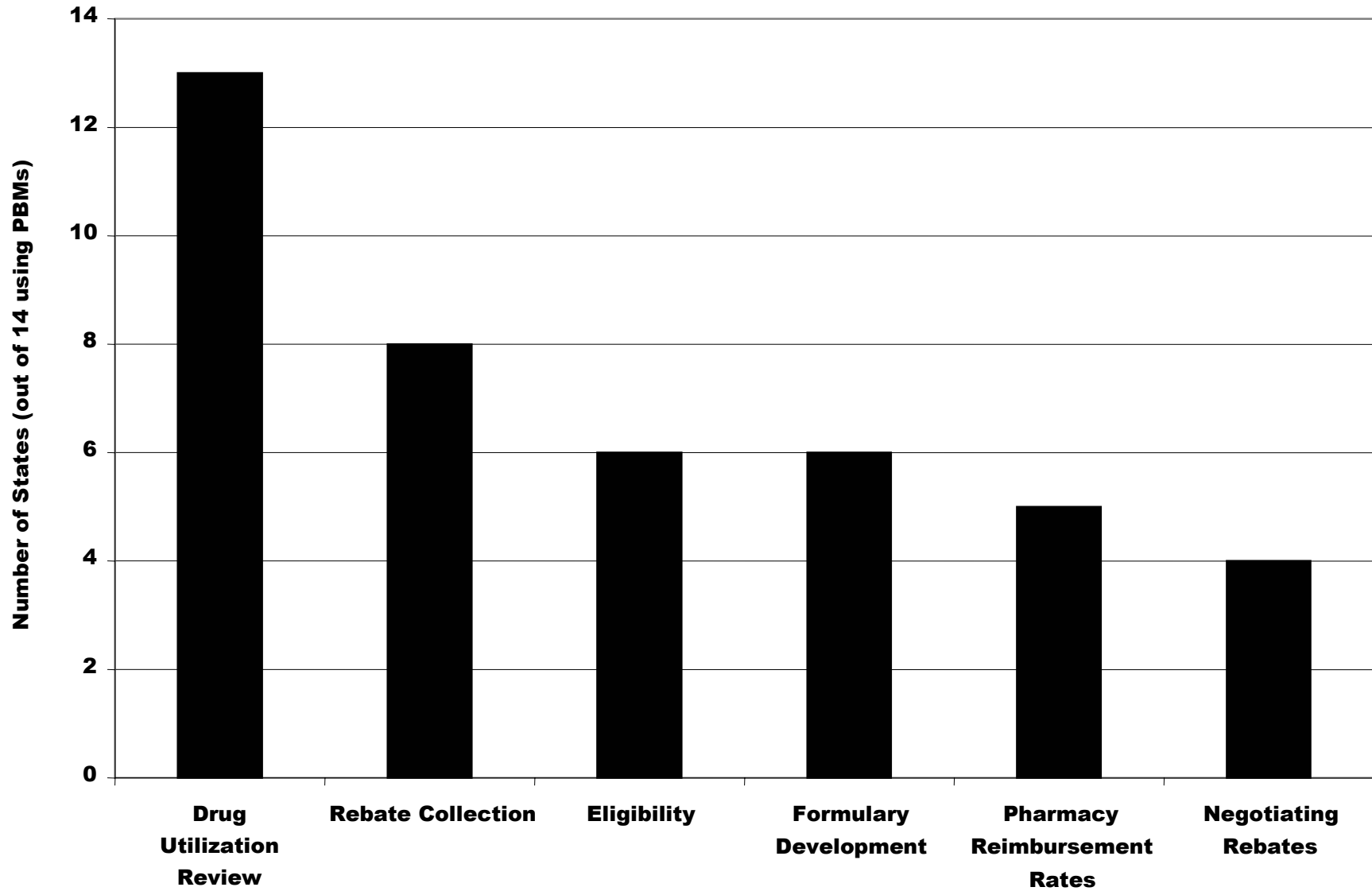


Chart 3-5

Use of Drug Formularies by SPAPs, 2002

- A drug formulary is a list of drugs that are covered by the state. These can be classified as “open” if they include most prescription drugs; “voluntary” if the state has a list of drugs that it would prefer to be used, but other drugs are still available to consumers at the same cost; “multitiered” or “incented” if the state requires different levels of cost-sharing for drugs on the formulary than for drugs not on the formulary; and “closed” if drugs that are not on the formulary are not covered by the state.
- As shown in the chart, most states indicated that they used open formularies. Only two states used multitiered formularies, although these are gaining popularity among private drug plans.¹ Only Nevada reported using a closed formulary.
- In addition to formularies and drug utilization review (DUR), states can attempt to influence drug utilization through the use of preferred drug lists (PDLs) or prior authorization programs. In these programs, drugs that are not on the PDL, or, in some cases, all drugs in a class, have to receive prior authorization either from the state or the pharmacy benefit manager before they can be dispensed. In contrast to stated reasons for DUR use, drug cost was the main factor in the decision to put drugs on PDLs.
- Under the Medicare Prescription Drug, Modernization and Improvement Act of 2003 (MMA) drug benefit, private plans are allowed to use a formulary as long as it includes drugs within each therapeutic category and class of covered Part D drugs, although not necessarily all drugs within these categories and classes will be covered.
- Of the 21 states with SPAPs, 11 had some form of PDL and/or prior authorization program (see the supplemental chartbook at <http://www.cshp.rutgers.edu> for more detailed information on some of these programs).

¹ Pharmacy Benefit Management Institute, Inc. (2001). *The Takeda and Lilly Prescription Drug Benefit Cost and Plan Design Survey Report: 2001 Edition*. Wellman Publishing, Inc., Albuquerque, NM.

Chart 3-5
Use of Drug Formularies by SPAPs, 2002

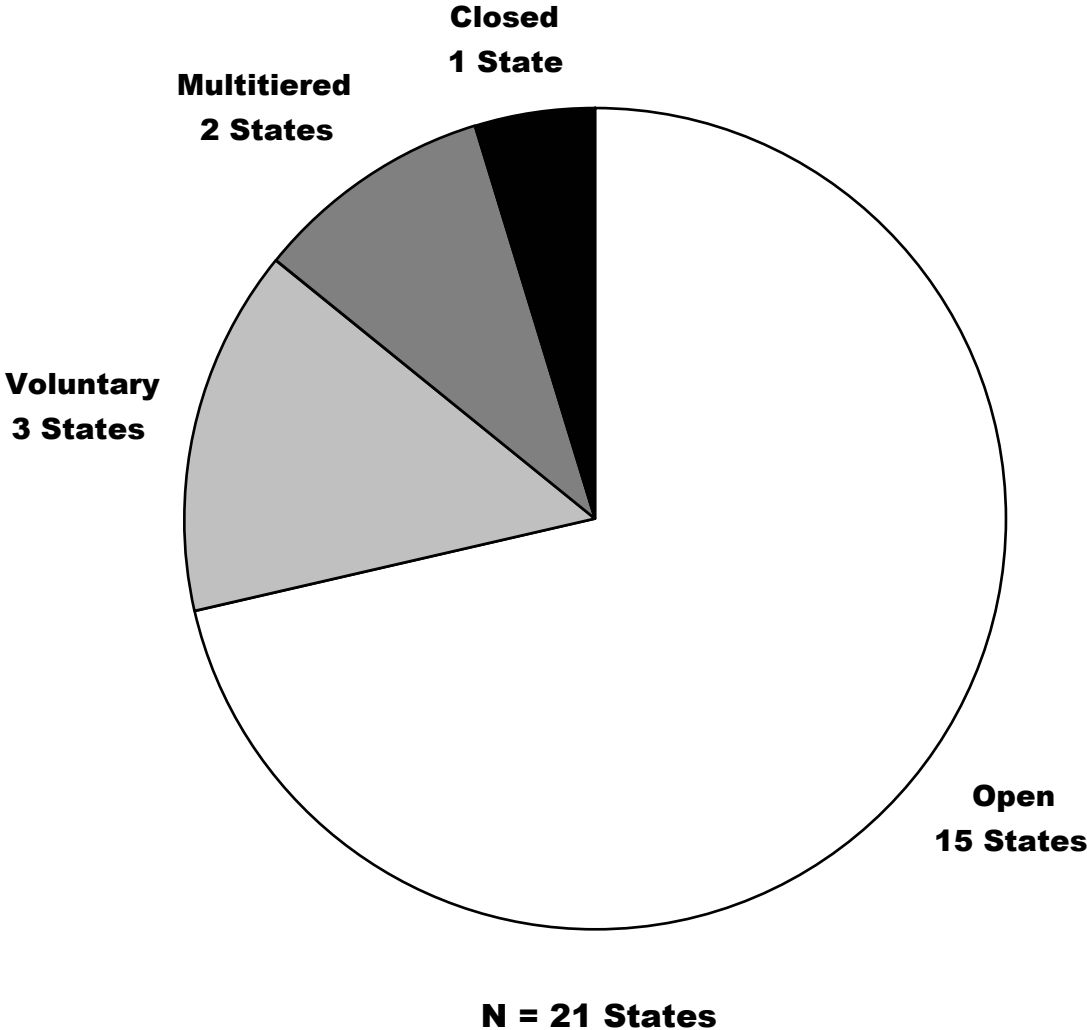
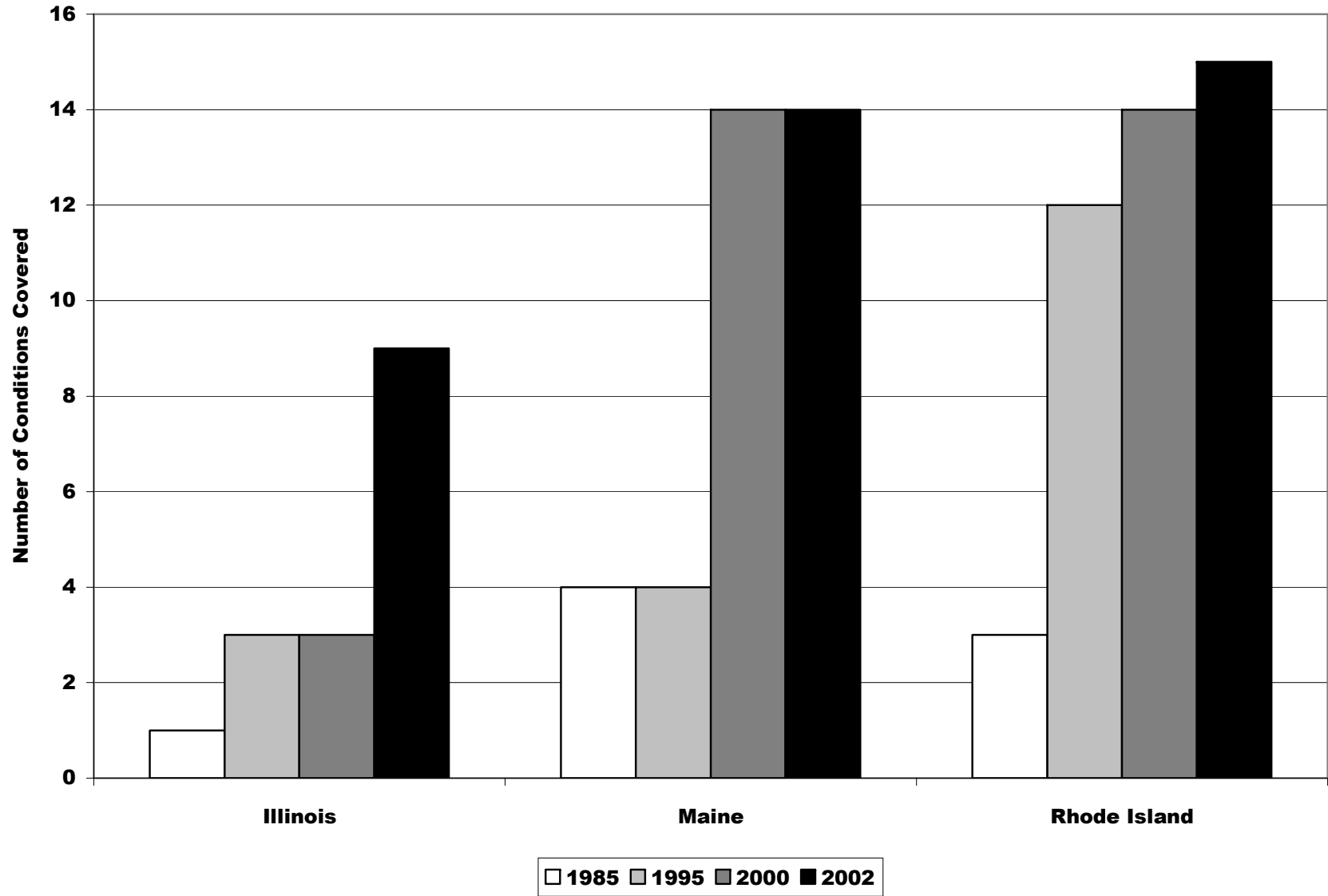


Chart 3-6

Number of Conditions Covered by States

- Maine, Rhode Island, and Illinois' Circuit Breaker program limited the medical conditions for which drugs could be purchased under their programs. The number of conditions covered by these programs increased over time as new legislation stipulated more conditions to be covered.
- The Pharmacy Plus waiver that created the Illinois SeniorCare program in 2002 provided coverage for most drugs with no limits on medical conditions for persons with incomes below 200% of the federal poverty level.
- In addition, Vermont and Maryland limited the drugs covered under their SPAPs to those used for maintenance rather than acute purposes.

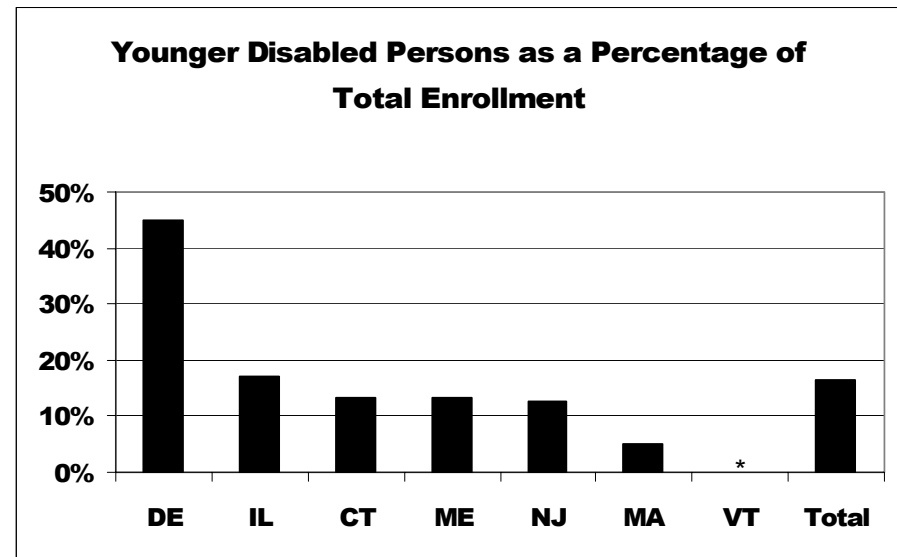
Chart 3-6
Number of Conditions Covered by States



Section 4. Program Enrollment

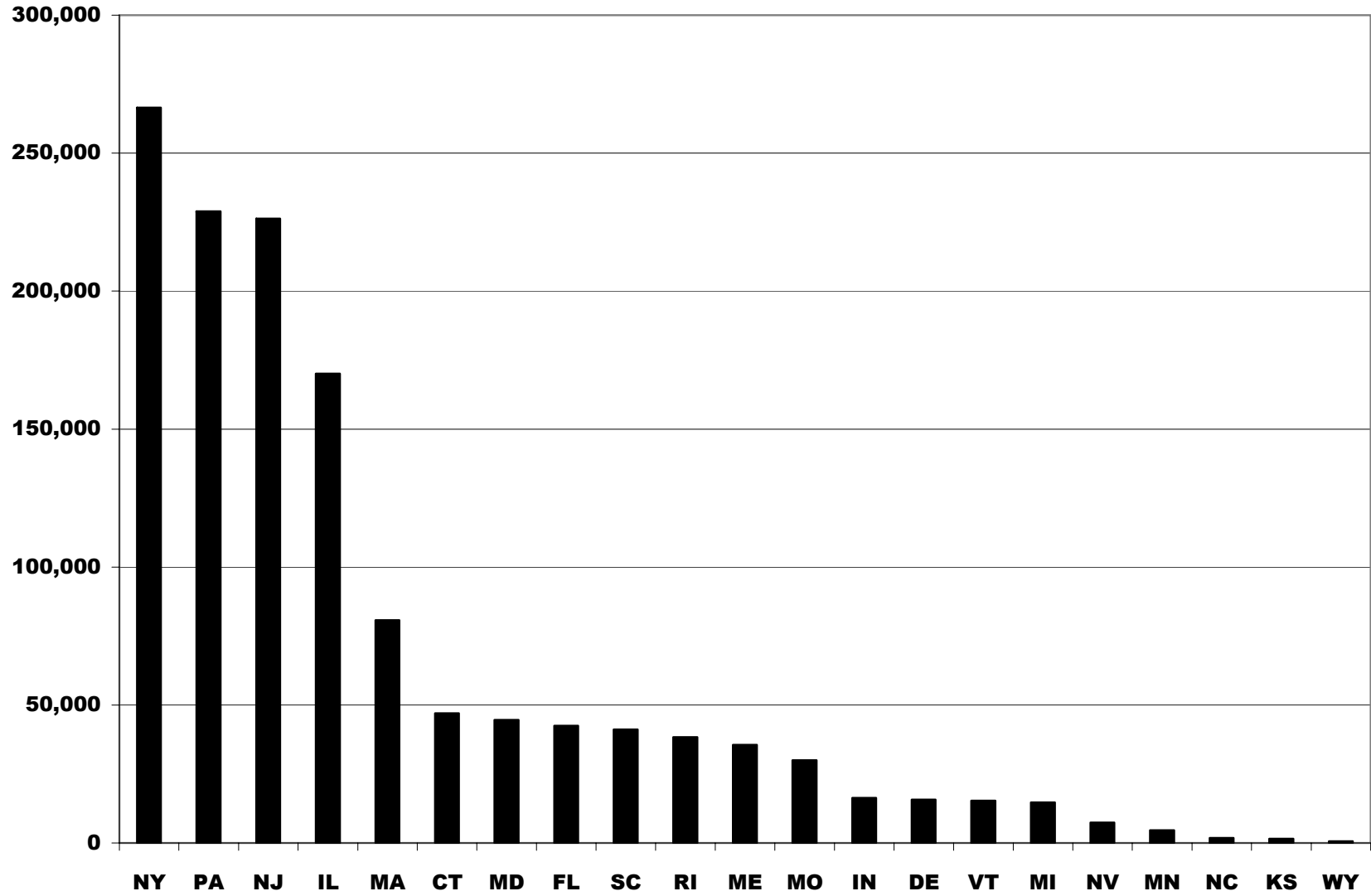
Chart 4-1 SPAP End-of-Year Enrollment, 2002

- Taken together, the 21 SPAPs in operation as of July 2002 enrolled 1,329,713 people. Enrollment ranged from 701 in Wyoming to 266,538 in New York.
- As of July 2002, only Nevada and Michigan capped the number of persons that could enroll in their SPAPs. Nevada had a cap of 7,500 persons, and 1,100 people were on a waiting list to enroll. Michigan limited enrollment to current program enrollees (about 14,700 people), but allowed persons to temporarily enroll on an emergency basis.
- Enrollment trends were variable, with most states experiencing substantial increases in enrollment in recent years, while enrollment in other states remained steady or declined slightly (see the supplemental chartbook at <http://www.cshp.rutgers.edu> for enrollment trend information for specific states).
- The inset shows the percentage of disabled persons under age 65 enrolled in SPAPs in July 2002. The percentage of disabled persons enrolled ranged from 5% in Massachusetts to 45% in Delaware.



Notes (inset): Data for Illinois are from 2001. * Vermont did not report data on enrollment of disabled persons. Data for Illinois and Maine disabled enrollment is for number of participants filling a prescription rather than end-of-year enrollment.

Chart 4-1
SPAP End-of-Year Enrollment, 2002



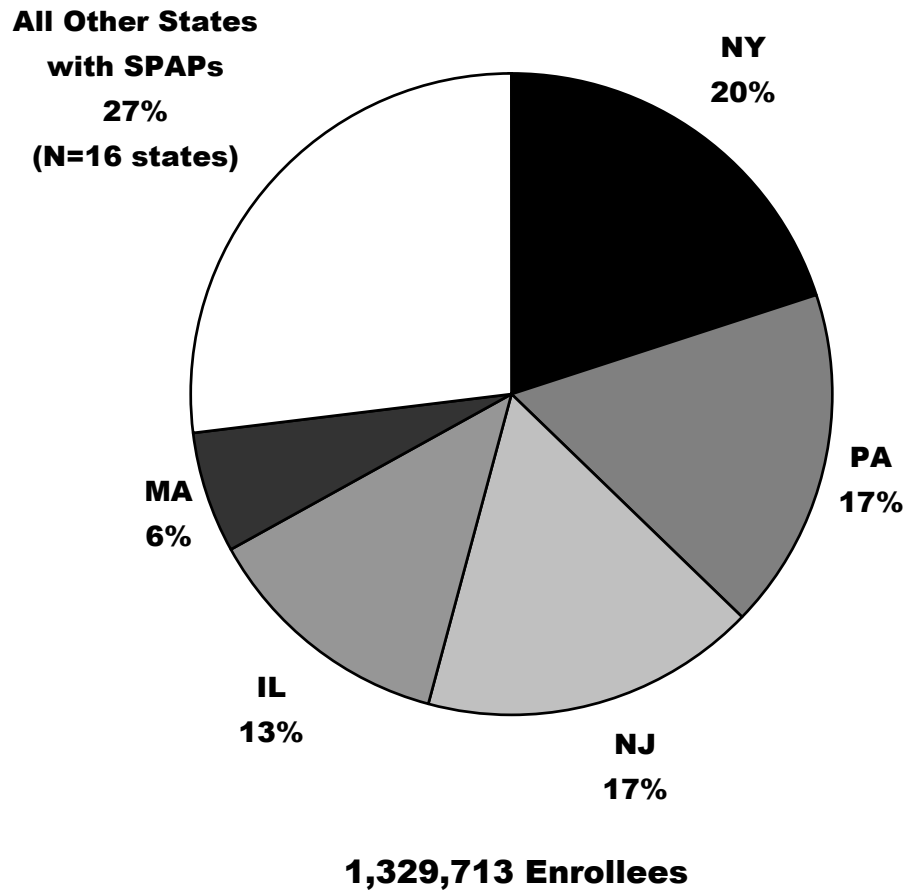
Notes: Data for Illinois and Rhode Island are from 2001. Delaware enrollment includes both the state-funded DPAP program and the privately funded Nemours program.

Chart 4-2

Proportion of SPAP Enrollees in Five States vs. All Other States with SPAPs, 2002

- About 967,000 individuals (73% of all enrollees) were enrolled in the five largest SPAPs (in New York, Pennsylvania, New Jersey, Illinois, and Massachusetts).
- These five states represented only 22.1% of Medicare beneficiaries nationally.
- About 722,000 individuals (54% of all enrollees) were enrolled in New York, Pennsylvania, and New Jersey in 2002, while these states represented only 15.4% of Medicare beneficiaries nationally.

Chart 4-2
Proportion of SPAP Enrollees in Five States vs. All Other States with SPAPs, 2002

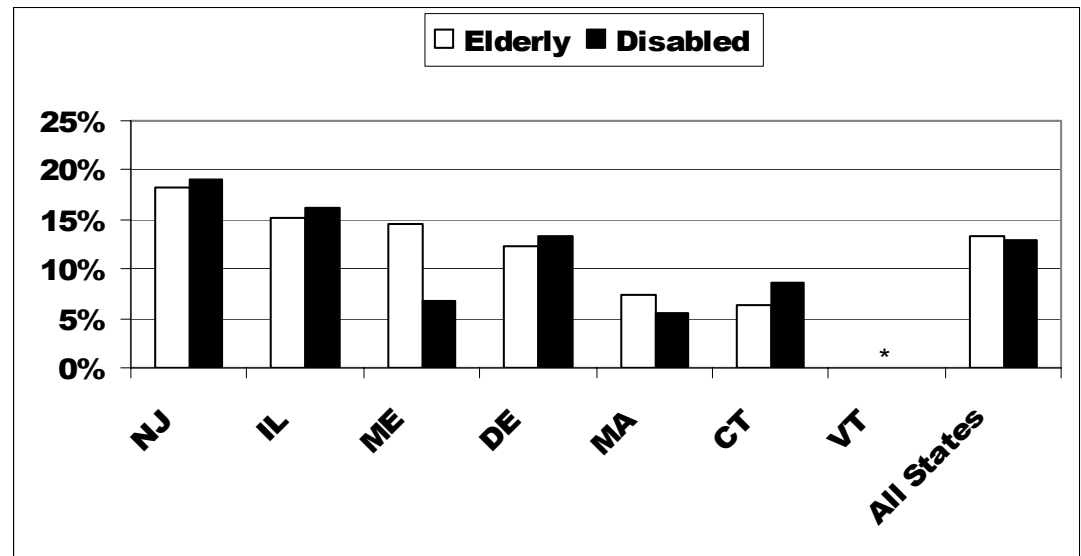


Notes: Data for Illinois and Rhode Island are from 2001. Delaware enrollment includes both the state-funded DPAP program and the privately funded Nemours program.

Chart 4-3

SPAP Enrollment as a Percentage of Medicare Enrollment, 2001

- Although a considerable number of people were enrolled in SPAPs, these programs provided prescription drug coverage to only a small percentage of the Medicare population in the states with programs.
- On average, SPAP enrollees accounted for only about 6.1% of Medicare beneficiaries¹ in states that had such programs in the year 2001, the most recent year for which Medicare enrollment was available. The level of enrollment in SPAPs by Medicare beneficiaries ranged from under 1% in North Carolina, Nevada, Kansas, Michigan, and Minnesota to over 22% in Rhode Island.
- This measure may reflect differences in SPAP eligibility levels as well as the income distribution of Medicare beneficiaries in the state, the availability of other types of prescription drug coverage, the extent of program outreach in the state, and other factors.
- As shown in the inset, most states that covered disabled as well as elderly persons enrolled a similar proportion of Medicare beneficiaries from both groups. Only Maine and Massachusetts enrolled a greater proportion of elderly Medicare beneficiaries than disabled beneficiaries; however, Massachusetts had lower income eligibility levels for disabled persons than for elderly persons (188% of the FPL versus 500% of the FPL, respectively).
- On average, for the 6 states for which we have data, disabled SPAP enrollees accounted for 12.6% of disabled Medicare beneficiaries in these states while elderly SPAP enrollees accounted for 13.8% of elderly Medicare beneficiaries.



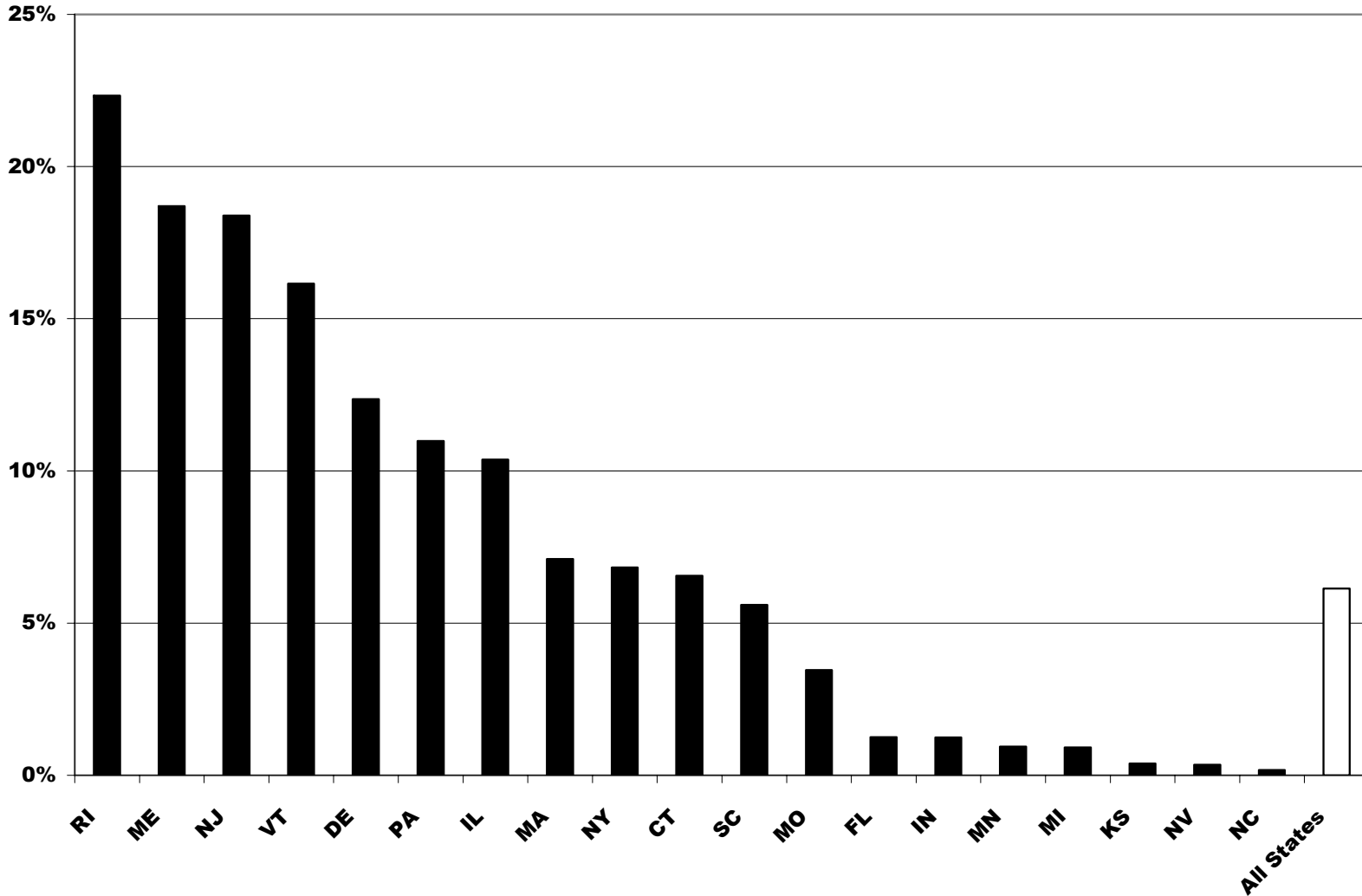
Source for Medicare enrollment data: CMS website. *CMS Statistics: Medicare Enrollment*. <http://cms.hhs.gov/statistics/enrollment/default.asp>. Accessed February 28, 2003.

* Vermont did not report data on enrollment of disabled persons.

Inset notes: Data for Illinois and Maine disabled enrollment is for the number of participants filling a prescription rather than end-of-year enrollment. The total disabled enrollment percentage does not include Vermont.

¹ Beneficiary weighted.

Chart 4-3
SPAP Enrollment as a Percentage of Medicare Enrollment, 2001



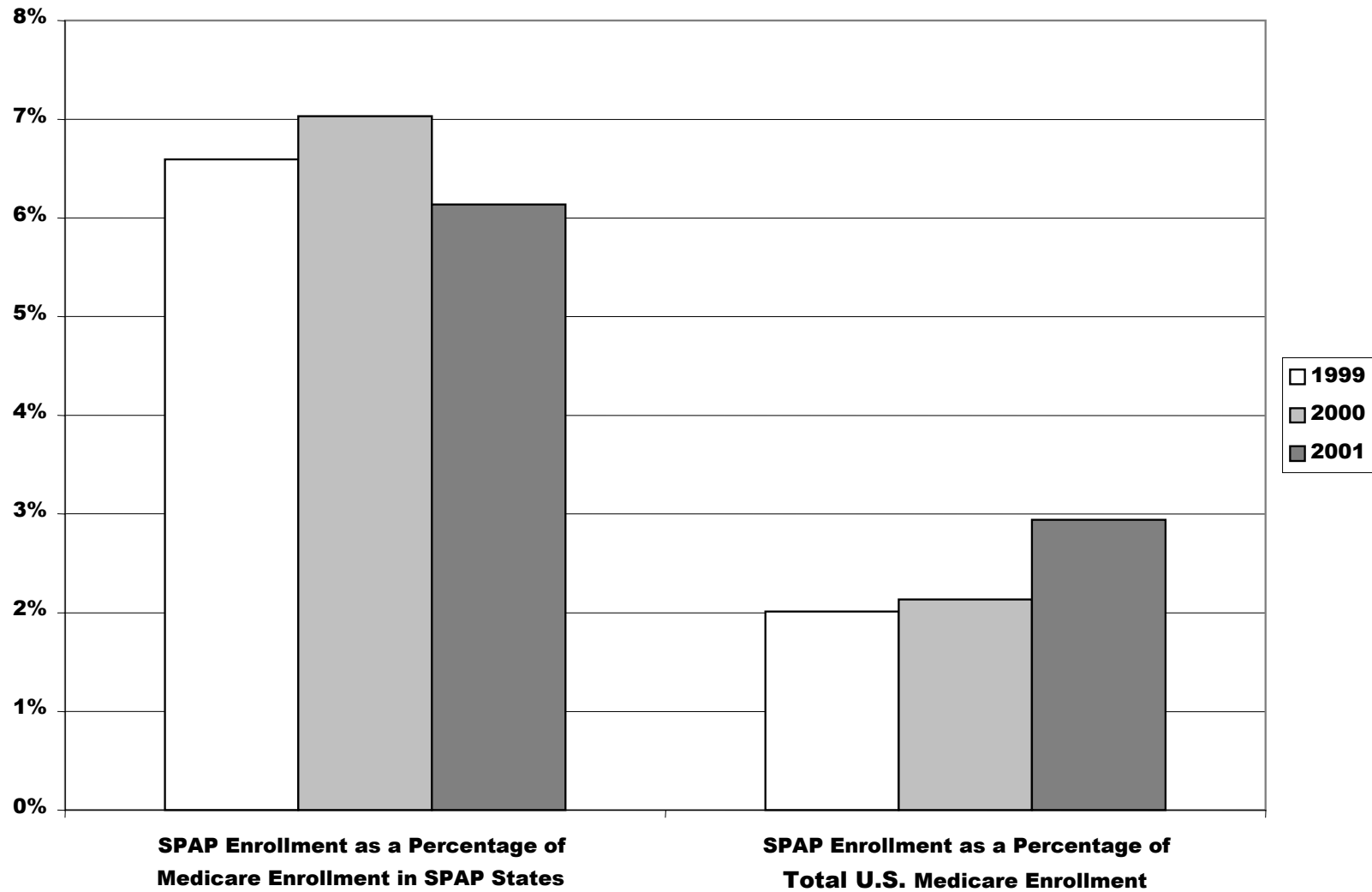
Source for Medicare enrollment data: CMS website. *CMS Statistics: Medicare Enrollment*. <http://cms.hhs.gov/statistics/enrollment/default.asp>. Accessed February 28, 2003. Notes: Delaware enrollment includes both the state-funded DPAP program and the privately funded Nemours program. Data for Kansas and Missouri are from 2002. Data for Maryland and Wyoming were not included in this analysis because the programs in those states are not limited to Medicare beneficiaries. The average for "All States" is the quotient of total enrollment in all programs divided by the total number of Medicare beneficiaries in these states.

Chart 4-4

Total SPAP Enrollment as a Percentage of Medicare Enrollment, 1999 to 2001

- Nationwide, SPAPs provided prescription drug coverage to a small — but growing — percentage of Medicare beneficiaries.
- The percentage of all Medicare beneficiaries nationwide accounted for by SPAP enrollees increased from 2% in 1999 to 3% in 2001. This was because of increased enrollment in existing SPAPs and the creation of new SPAPs (see the supplemental chartbook at <http://www.cshp.rutgers.edu> for trend information for specific states).
- However, the slow growth of enrollment and lower eligibility levels of new programs established between 2000 and 2001 resulted in a lower proportion of Medicare beneficiaries in SPAP states covered by these programs in 2001 than in the previous two years.

Chart 4-4
Total SPAP Enrollment as a Percentage of Medicare Enrollment, 1999 to 2001



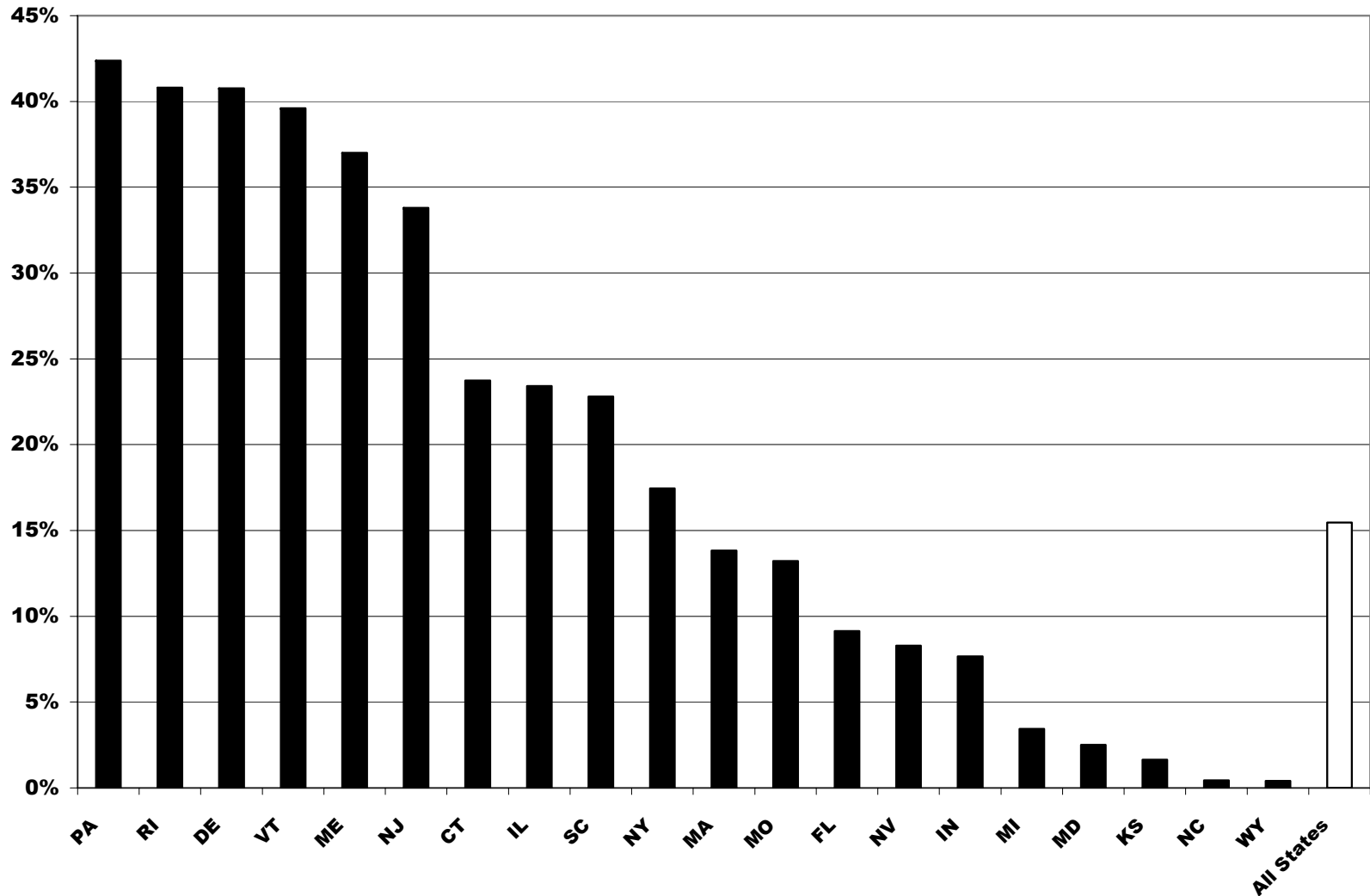
Source for Medicare enrollment data: CMS website. *CMS Statistics: Medicare Enrollment*. <http://cms.hhs.gov/statistics/enrollment/default.asp>. Accessed February 28, 2003.

Chart 4-5

Percentage of Income-Eligible, Non-Medicaid Population Enrolled in SPAPs, 2002

- Using data from the 2000, 2001, and 2002 Annual Demographic Survey portion of the Current Population Survey (CPS), we calculated the number of persons who met program age, disability, and income criteria for each state's program who were not enrolled in Medicaid. We compared this estimate with end-of-year program enrollment for 2002 to calculate a ratio of SPAP enrollment to potentially eligible persons.
- By this measure, SPAPs on average provided prescription drug coverage to approximately 16% of potentially eligible persons in their states in 2002.
- This measure varied by state, ranging from .4% in Wyoming to 42% in Pennsylvania.
- Only two states with programs implemented since 2000 had enrolled 10% or more of their eligible populations (Missouri and South Carolina).
- This estimate does not take into account other coverage for prescription drugs through retirement health benefit plans, Medicare+Choice, etc. Nineteen of the 21 states surveyed restricted eligibility for applicants with other drug coverage: 12 states did not allow applicants with any other drug coverage to enroll, and seven states only covered persons once they exhausted their other benefits or if their other coverage was not as generous as the state program.

Chart 4-5
Percentage of Income-Eligible, Non-Medicaid Population Enrolled in SPAPs, 2002



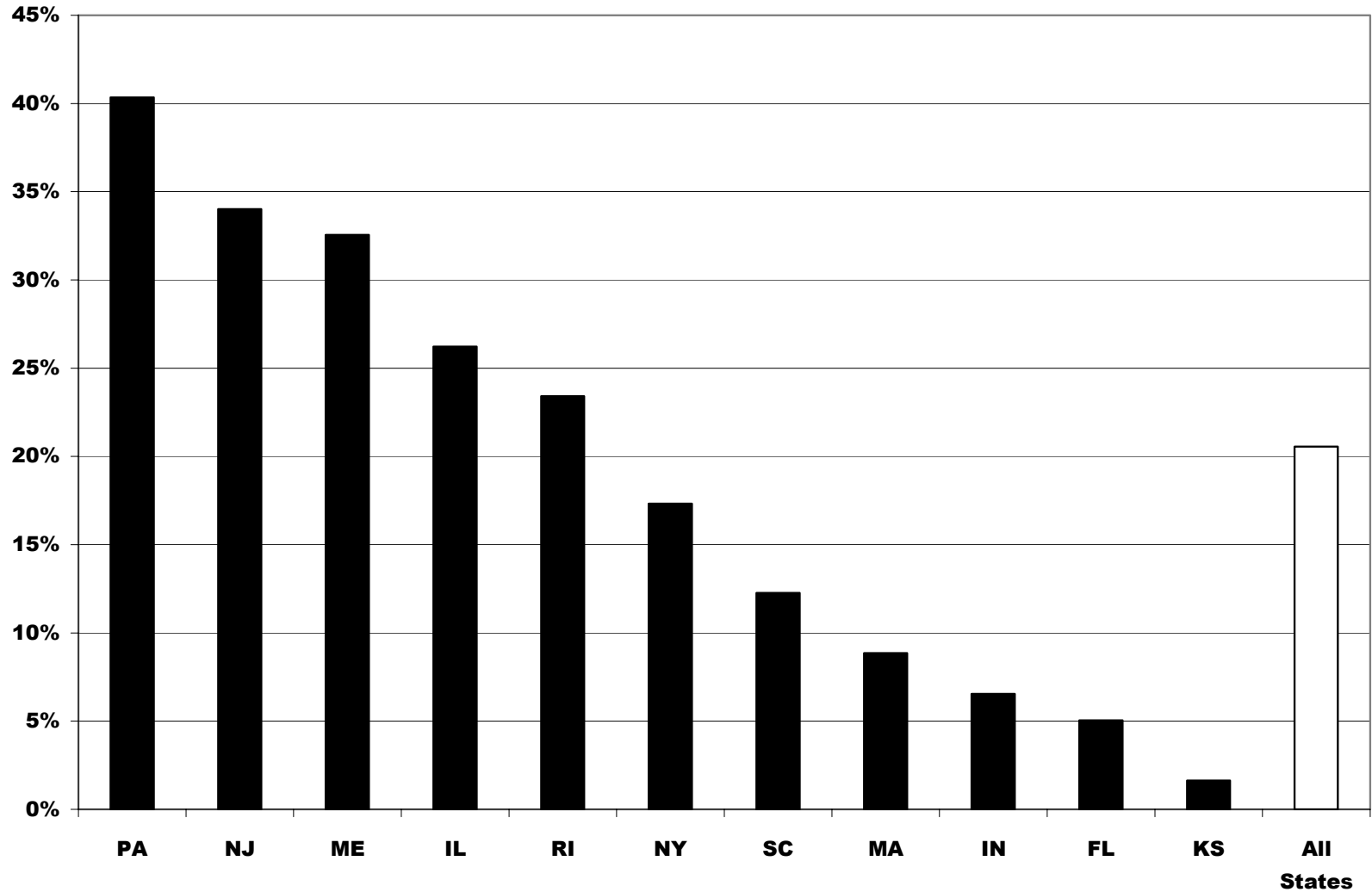
Note: Data for Illinois and Rhode Island are from 2001. Minnesota was not included in this analysis because of the small Current Population Survey (CPS) sample size in the state. Delaware enrollment includes both the state-funded DPAP program and the privately funded Nemours program. The average for “All States” is the quotient of total enrollment in all programs divided by the total number of persons estimated to be eligible for all of the programs.

Source: Estimates were calculated from three-year averages from the March supplement of the 2000, 2001, and 2002 CPS and are based on all persons meeting age, disability, and income eligibility requirements and having no Medicaid coverage. <http://www.bls.census.gov/cps/cpsmain.htm>.

Chart 4-6
Percentage of Income-Eligible, Non-Medicaid Population
Filling a Prescription in SPAPs, 2002

- As measured by the number of persons using the benefit (i.e., those filling a prescription through the program during the year), SPAPs for which we had data served about 20% of their eligible populations.
- States ranged from 1.6% in Kansas to 40.3% in Pennsylvania.
- Note that the number of program users can be greater than the end-of-year enrollment because the number of persons filling a prescription in a program can be either larger or smaller than end-of-year enrollment depending on enrollment turnover and use patterns.

Chart 4-6
Percentage of Income-Eligible, Non-Medicaid Population
Filling a Prescription in SPAPs, 2002



Note: Data for Illinois and Rhode Island are from 2001. Minnesota was not included in this analysis because of the small Current Population Survey (CPS) sample size in the state. The average for "All States" is the quotient of total number of enrollees filling a prescription in all programs divided by the total number of persons estimated to be eligible for all of the programs.

Source: Estimates were calculated from three-year averages from the March supplement of the 2000, 2001, and 2002 CPS and are based on all persons meeting age, disability, and income eligibility requirements and having no Medicaid coverage. <http://www.bls.census.gov/cps/cpsmain.htm>.

Section 5. Program Expenditures and Utilization

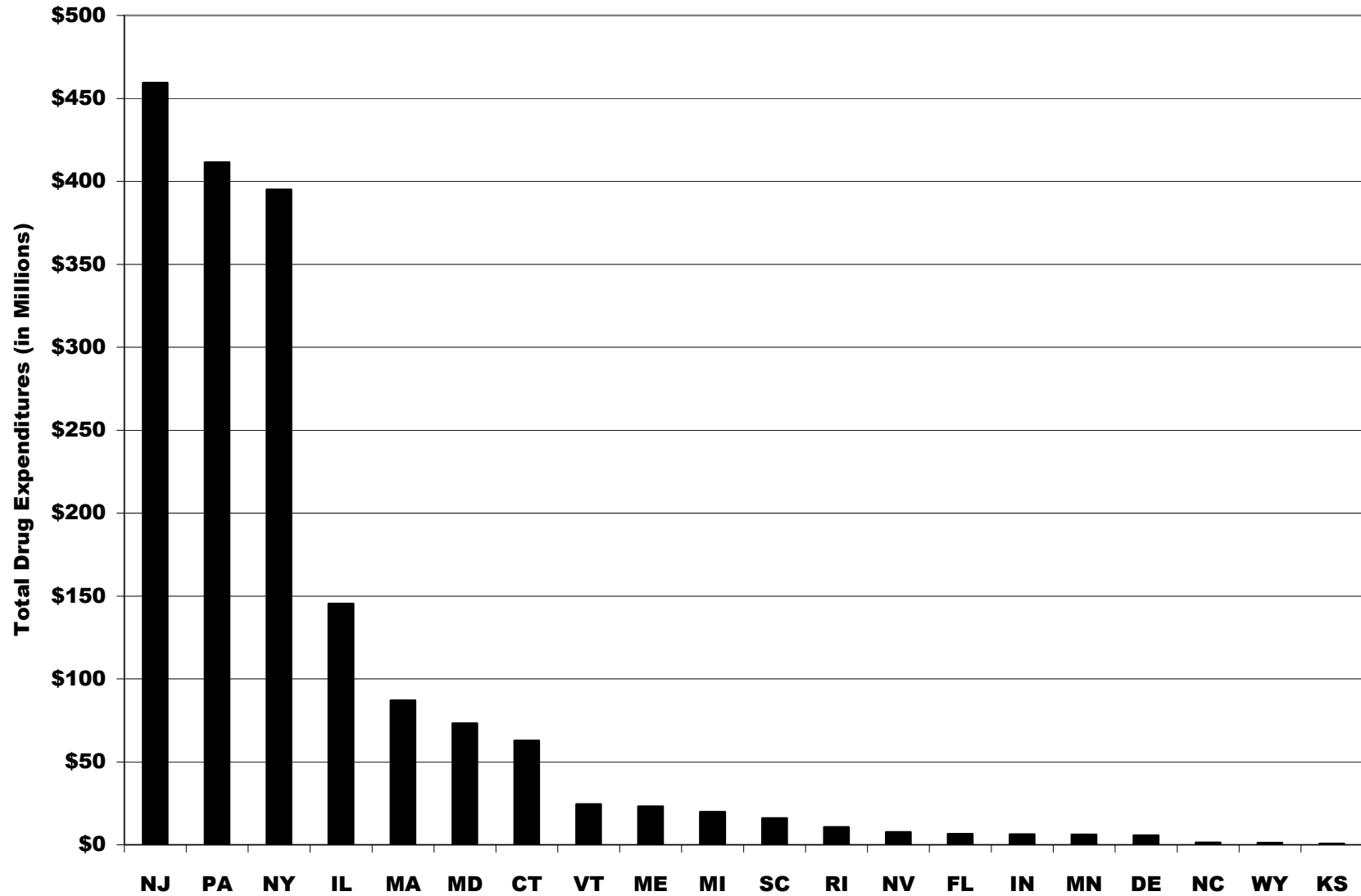
Chart 5-1

Total Drug Expenditures by SPAPs Before Rebates, 2002

- In total, states spent about \$1.8 billion on prescription drug claims under SPAPs in 2002. In contrast, according to the Congressional Budget Office, Medicare prescription drug coverage under the bills passed by Congress in 2003 would cost between \$25 and \$27 billion in FY 2006 and \$39 billion in FY 2007¹ (the first full year of implementation).
- State expenditures vary in relation to the generosity of the benefit, drug utilization rates, pharmacy reimbursement agreements, enrollment, and other factors.
- New Jersey, Pennsylvania, and New York spent over twice as much on their SPAPs as did any other state. These three states also had the highest enrollment, and New Jersey and Pennsylvania had two of the most generous programs offered by states.
- Of the 21 states surveyed, only one state did not collect rebates from manufacturers. As shown in Chart 5-3, rebates resulted in a substantial return of funds for many states.

¹ Congressional Budget Office. (July 22, 2003). *Congressional Budget Office Cost Estimate: H.R. 1 Medicare Prescription Drug and Modernization Act of 2003 As passed by the House of Representatives on June 27, 2003, and S. 1 Prescription Drug and Medicare Improvement Act of 2003 As passed by the Senate on June 27, 2003, with a modification requested by Senate conferees.* <http://www.cbo.gov>.

Chart 5-1
Total Drug Expenditures by SPAPs Before Rebates, 2002

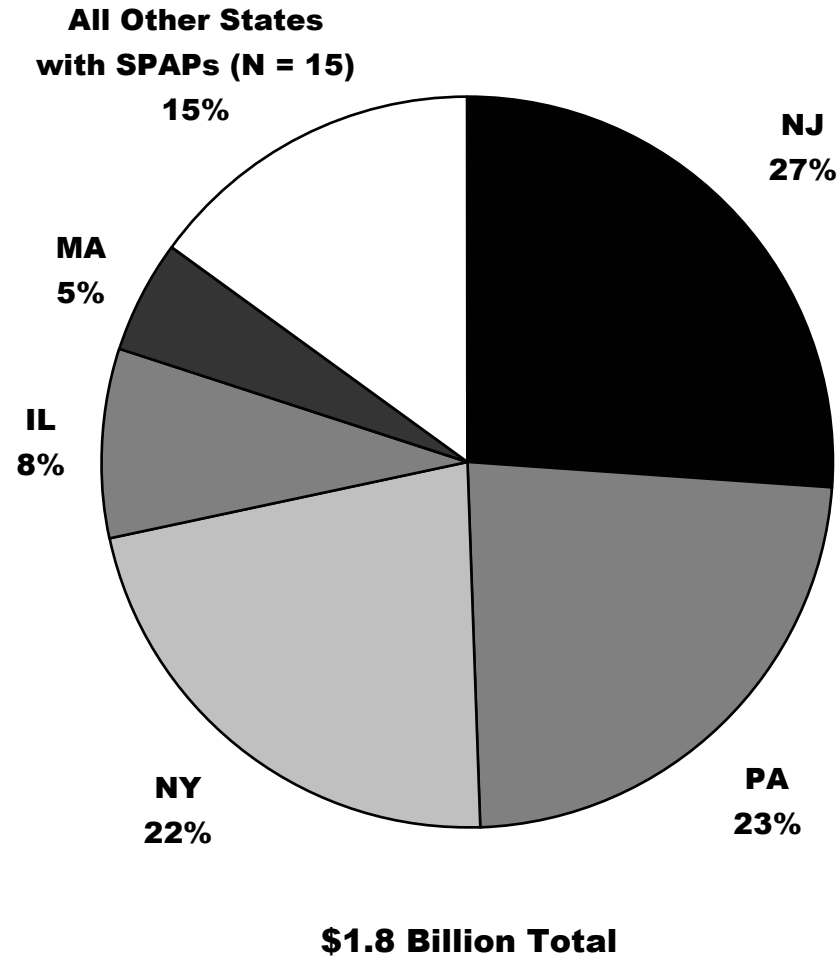


Note: Data for Illinois, Rhode Island, and South Carolina are from 2001.

Chart 5-2**Proportion of SPAP Drug Expenditures in Five States vs. All Other States with SPAPs, 2002**

- New Jersey, Pennsylvania, and New York accounted for almost \$1.3 billion or 72% of all drug expenditures by SPAPs in 2002.
- Together with Illinois and Massachusetts, these five states accounted for \$1.5 billion or 85% of total SPAP expenditures.
- These five states also accounted for most of the persons enrolled in SPAPs in 2002 (see Chart 4-2).

Chart 5-2
Proportion of SPAP Drug Expenditures in Five States vs. All Other States with SPAPs, 2002



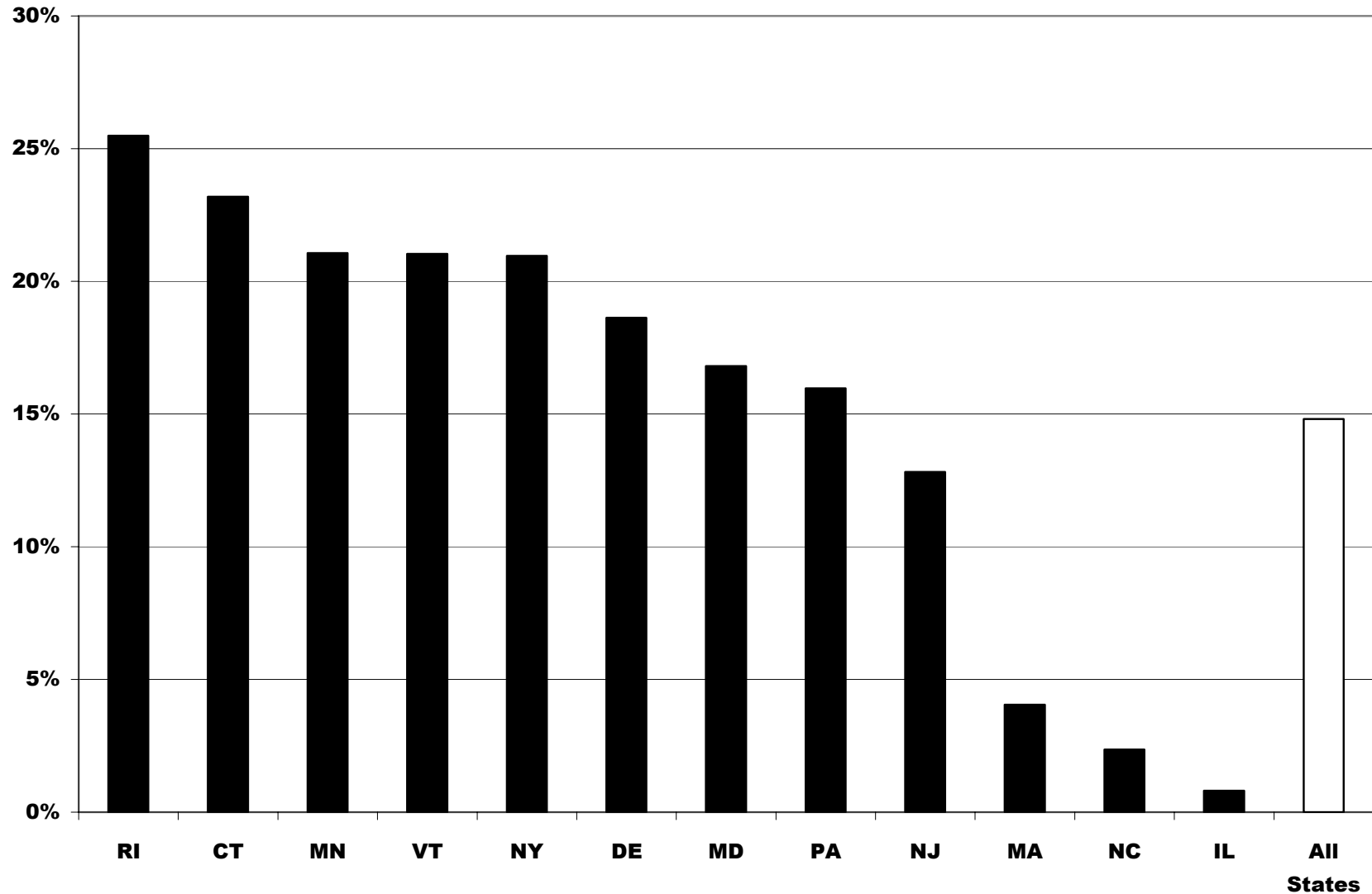
Note: Data for Illinois, Rhode Island, and South Carolina are from 2001.

Chart 5-3

Rebates as a Percentage of Total Drug Expenditures, 2002

- Rebates averaged 14.8% of expenditures across states and ranged from 0.8% in Illinois to 25.5% in Rhode Island.
- The percentage of expenditures returned through rebates is affected by the manufacturer rebate rate, the drug mix used by enrollees (name-brand drugs usually have higher rebate rates), and the amount of participant cost-sharing (because this reduces total program expenditures). Rhode Island required very high cost-sharing (40%, 70%, or 85% coinsurance), which may be why rebates accounted for a higher proportion of expenditures in that program.
- Two of the three states with the lowest percentage of expenditures returned, Illinois and Massachusetts, are also the only two states in the chart that had their pharmacy benefit manager negotiate rebates with manufacturers rather than setting the rebate amount in statute (see the supplemental chartbook at <http://www.cshp.rutgers.edu> for rebate rates for specific states).

Chart 5-3
Rebates as a Percentage of Total Drug Expenditures, 2002



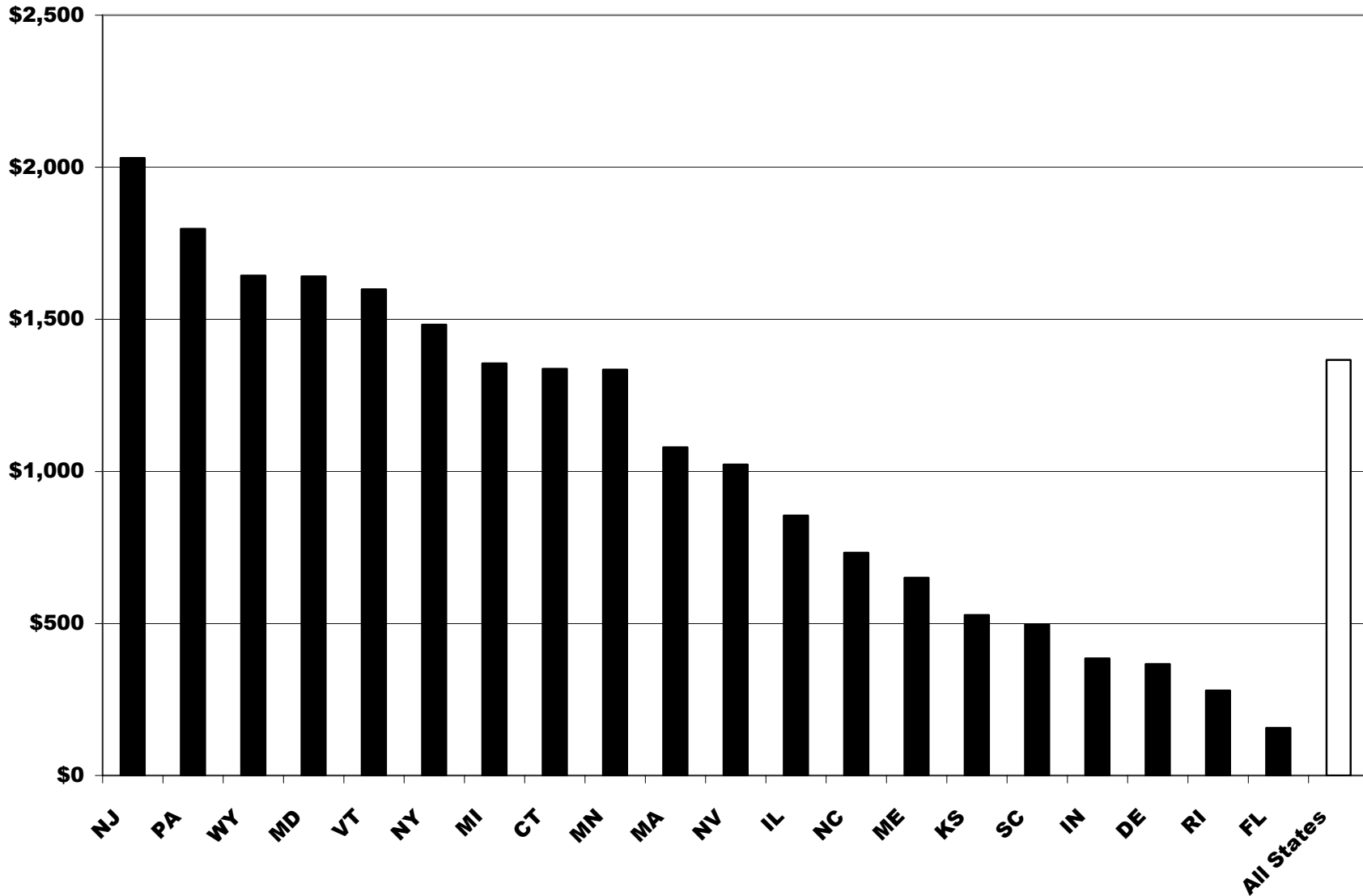
Notes: Data for Illinois and Rhode Island are from 2001. The average for “All States” is the quotient of the total amount of rebates for all programs divided by the total amount of drug expenditures for all programs.

Chart 5-4

Annual State Drug Expenditures per End-of-Year Enrollee Before Rebates, 2002

- On average, SPAPs spent about \$1,367 per enrollee for prescription drugs in 2002.
- Annual costs ranged from \$156 in Florida to \$2,031 in New Jersey.
- Differences in costs per enrollee reflect a variety of factors including level of consumer cost-sharing, benefit caps, pharmacy pricing agreements, types of drugs covered, and regional differences in drug utilization.

Chart 5-4
Annual State Drug Expenditures per End-of-Year Enrollee Before Rebates, 2002



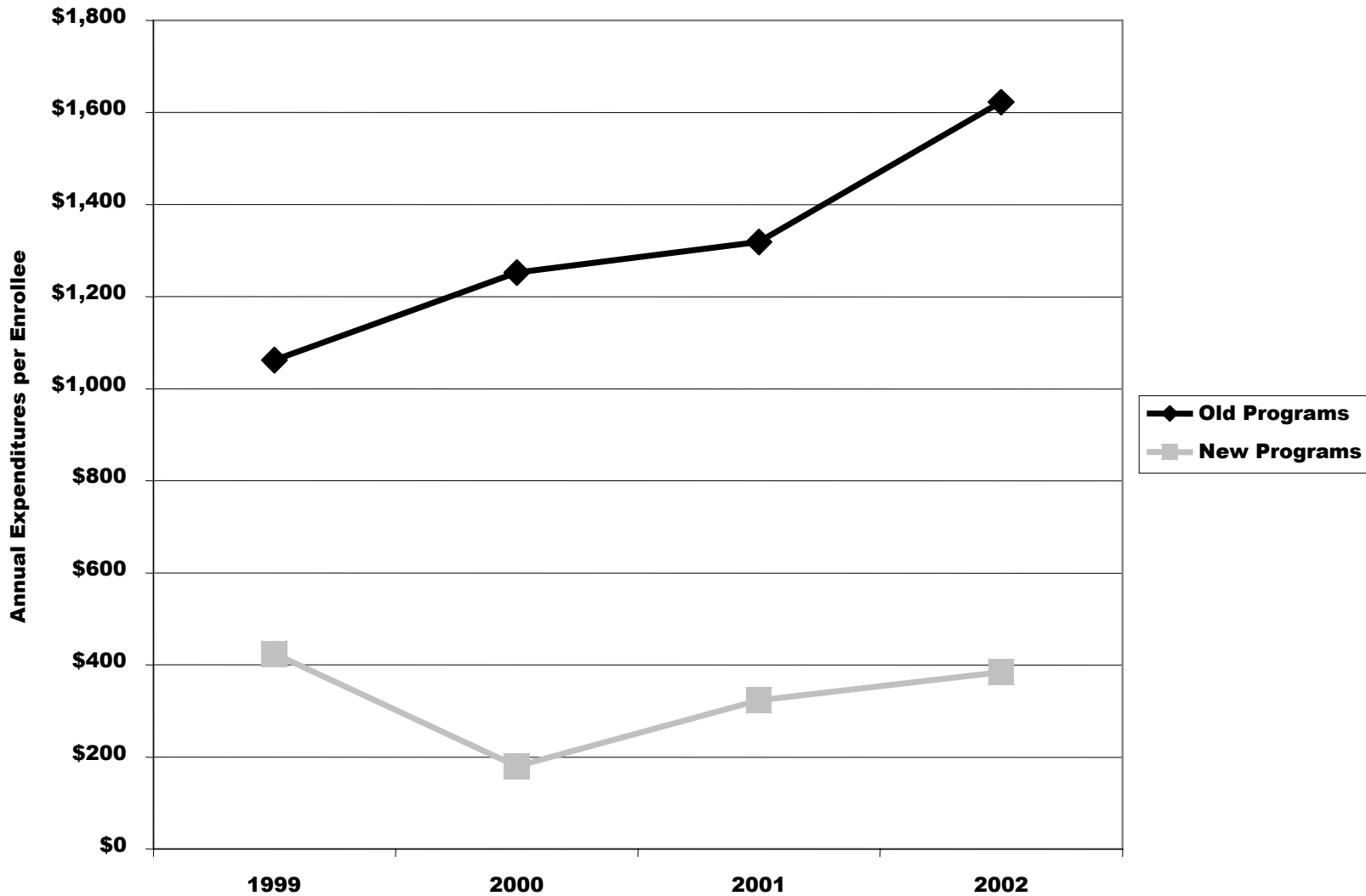
Note: Data for Illinois, Rhode Island, and South Carolina are from 2001. The average for “All States” is the quotient of the total amount of drug expenditures for all programs divided by the total number of end-of-year enrollees for all programs.

Chart 5-5

Annual Drug Expenditures per End-of-Year Enrollee, 1999 to 2002

- For states with programs established before 1999 (N = 12), annual drug expenditures per end-of-year enrollee increased from \$1,062 in 1999 to \$1,622 in 2002, a 53% increase.
- For states with programs established since 1999 (N = 8), annual drug expenditures per end-of-year enrollee decreased from \$425 in 1999 to \$385 in 2002.
- Drug expenditures per enrollee are affected by the level of consumer cost-sharing, program enrollment, use of the benefit by enrollees, drug utilization rates, and drug prices. Programs experiencing large increases in enrollment during a year (e.g., older programs implementing expansions, newer programs getting “ramped up”) will have lower costs per end-of-year enrollment because fewer enrollees will have used the benefit for the entire year.

Chart 5-5
Annual Drug Expenditures per End-of-Year Enrollee, 1999 to 2002



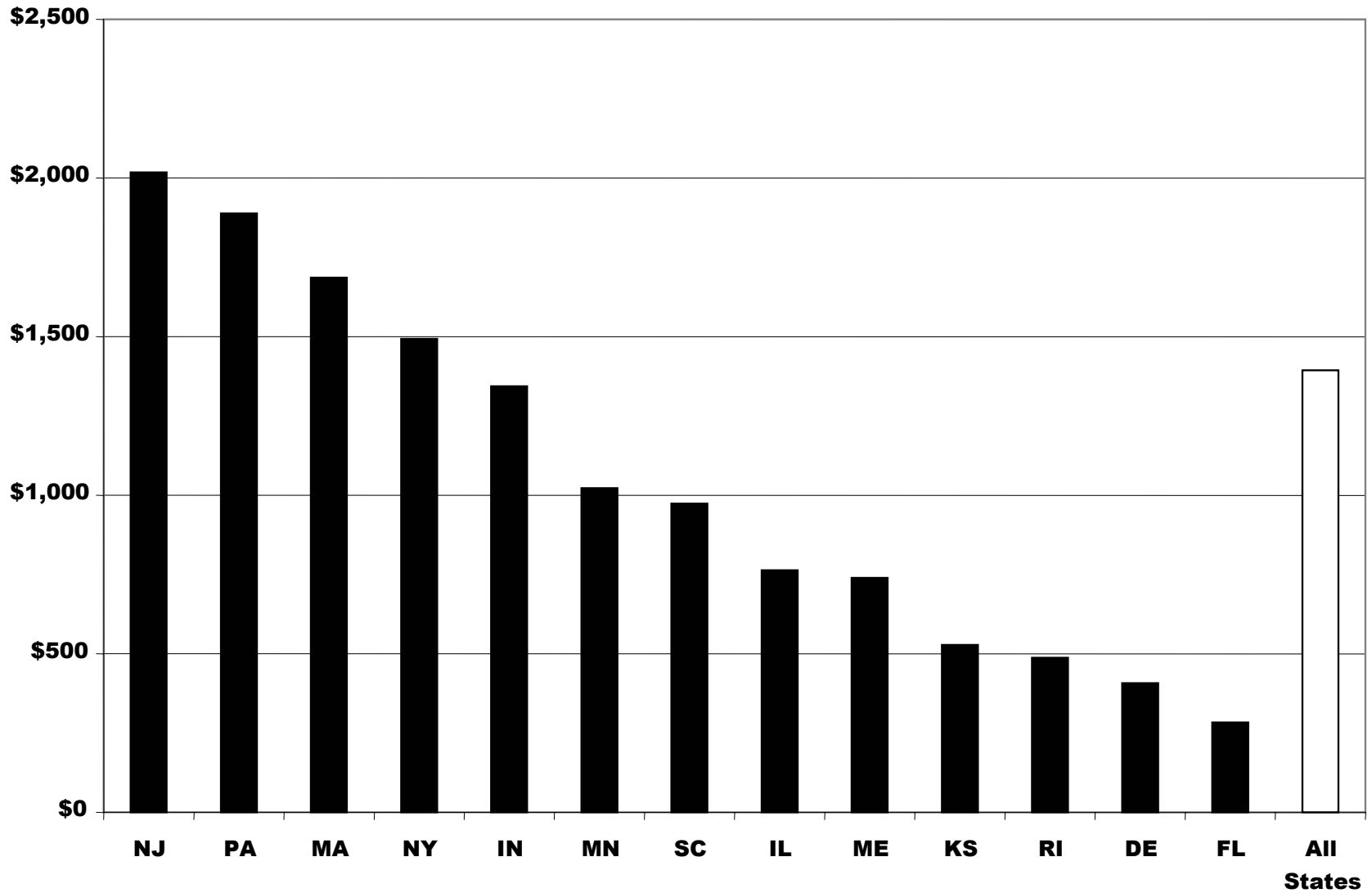
Notes: Old programs are those established prior to 1999 (N = 12), and new programs are those established since 1999 (N = 8). Only programs operational for at least one full year were included in the analysis.

Chart 5-6

Annual SPAP Drug Expenditures per User, 2002

- Another measure of program costs is the amount of annual state expenditures for enrollees who actually use the program benefits (i.e., file a prescription claim at any time during the year).
- Data on the number of users were only available for 13 states, but program costs per user in those states averaged \$1,382 in 2002, \$140 higher than the average costs per end-of-year enrollee for those same states.
- Costs per user ranged from \$283 in Florida to \$2,018 in New Jersey.
- Note that costs per user can be greater than costs per enrollee because the number of persons filling a prescription in a program can be either larger or smaller than end-of-year enrollment depending on enrollment turnover and use patterns.

Chart 5-6
Annual SPAP Drug Expenditures per User, 2002



Note: Data for Illinois, Rhode Island, and South Carolina are from 2001. The average for "All States" is the quotient of the total amount of drug expenditures for all programs divided by the total number of enrollees filling a prescription for all programs that submitted these data.

Chart 5-7

Annual SPAP Drug Expenditures per User, 1999 to 2002

- In the 13 states for which we had expenditure and user data, average expenditures per user increased from \$1,191 in 1999 to \$1,663 in 2002, a 40% increase.

Chart 5-7
Annual SPAP Drug Expenditures per User, 1999 to 2002

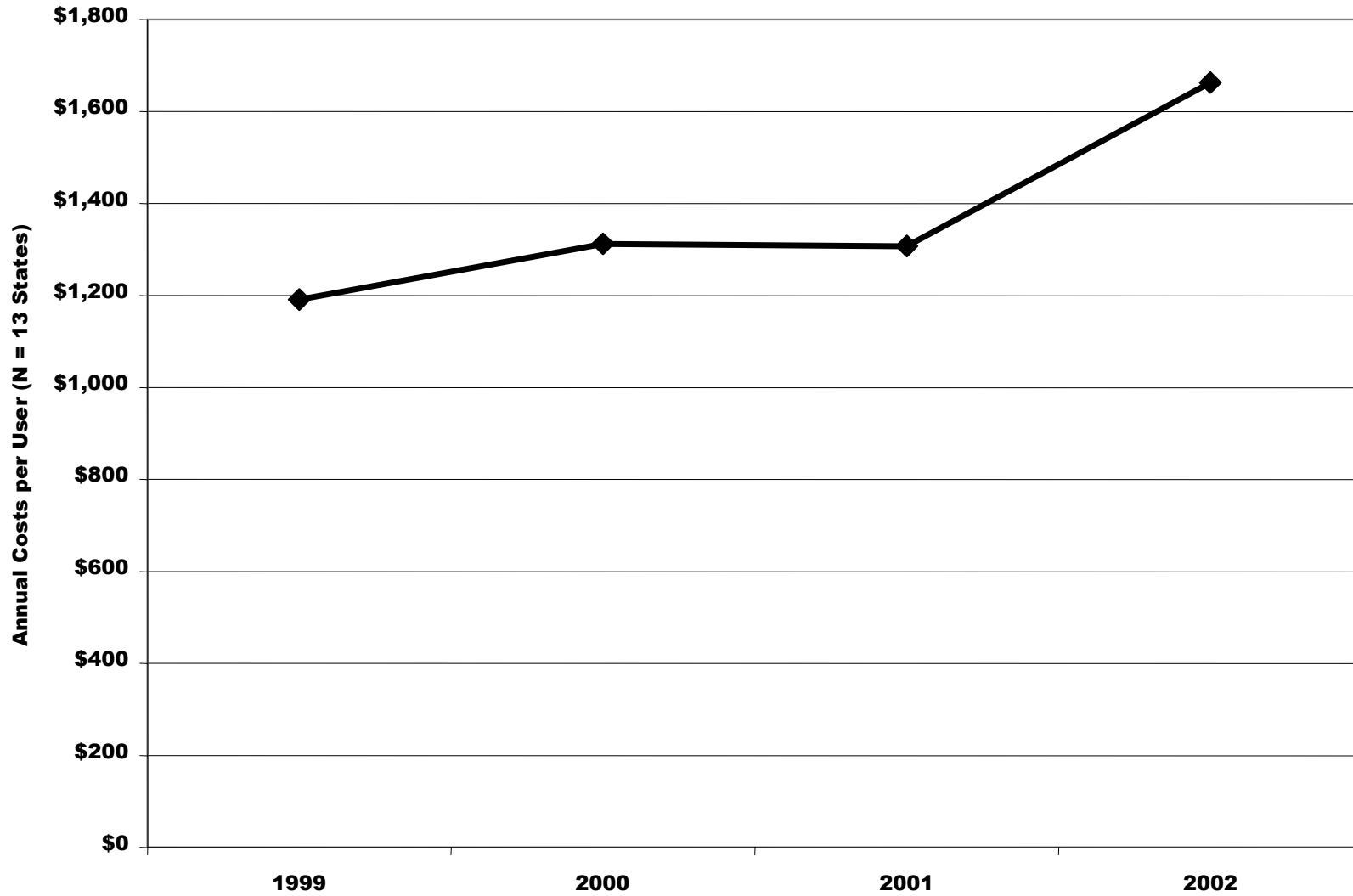
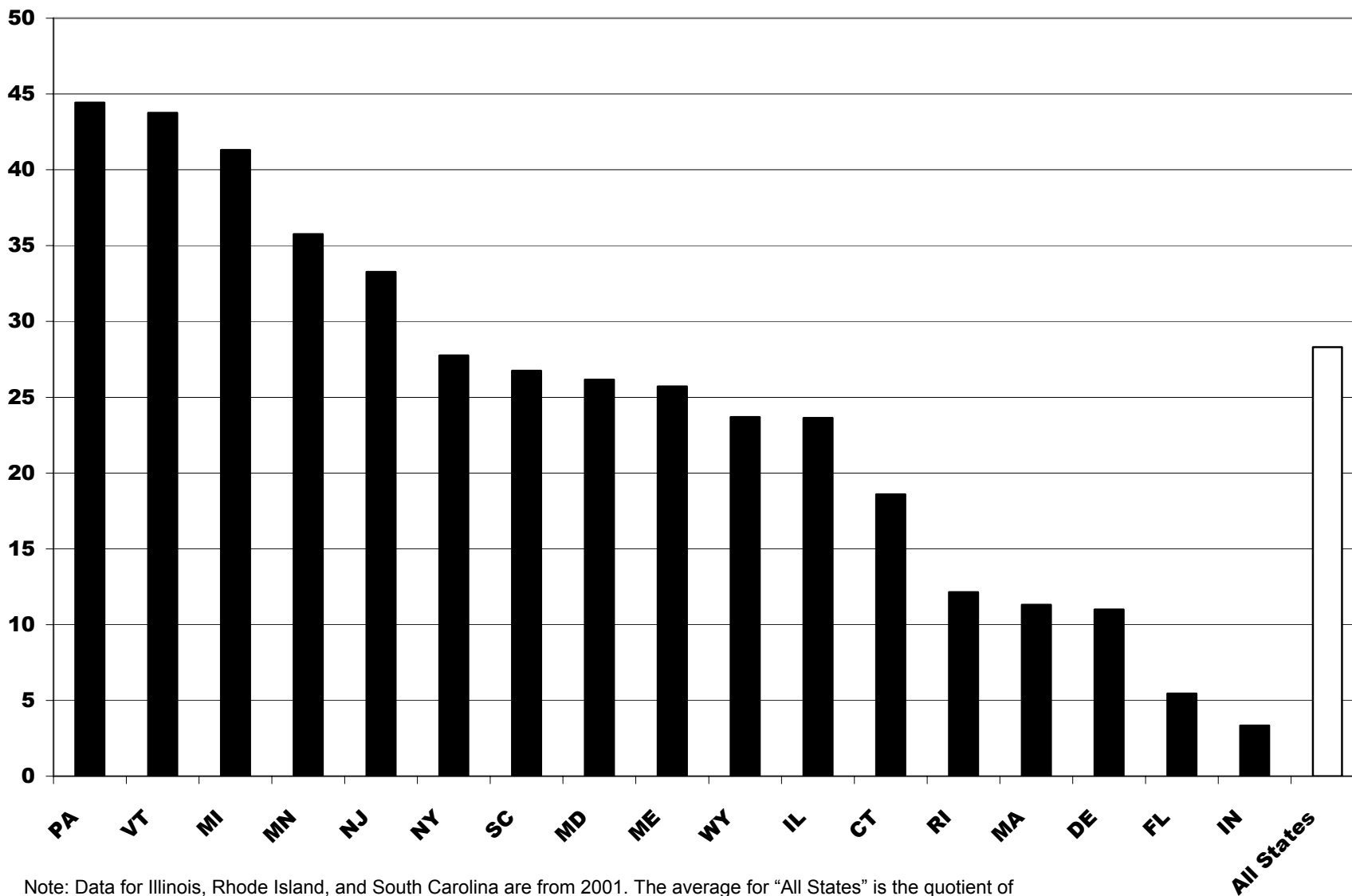


Chart 5-8

Number of Claims per End-of-Year Enrollee, 2002

- In the 17 states for which end-of-year enrollment and claims data were available, the average number of claims per year per enrollee was 28.5 in 2002 and ranged from 3.4 in Indiana to 44.4 in Pennsylvania.
- In addition to utilization by enrollees, the number of claims per enrollee can be influenced by the number of days' supply per claim allowed by a program, the presence of deductibles, the number and type of drugs covered, and regional variations in prescription drug utilization.

Chart 5-8
Number of Claims per End-of-Year Enrollee, 2002



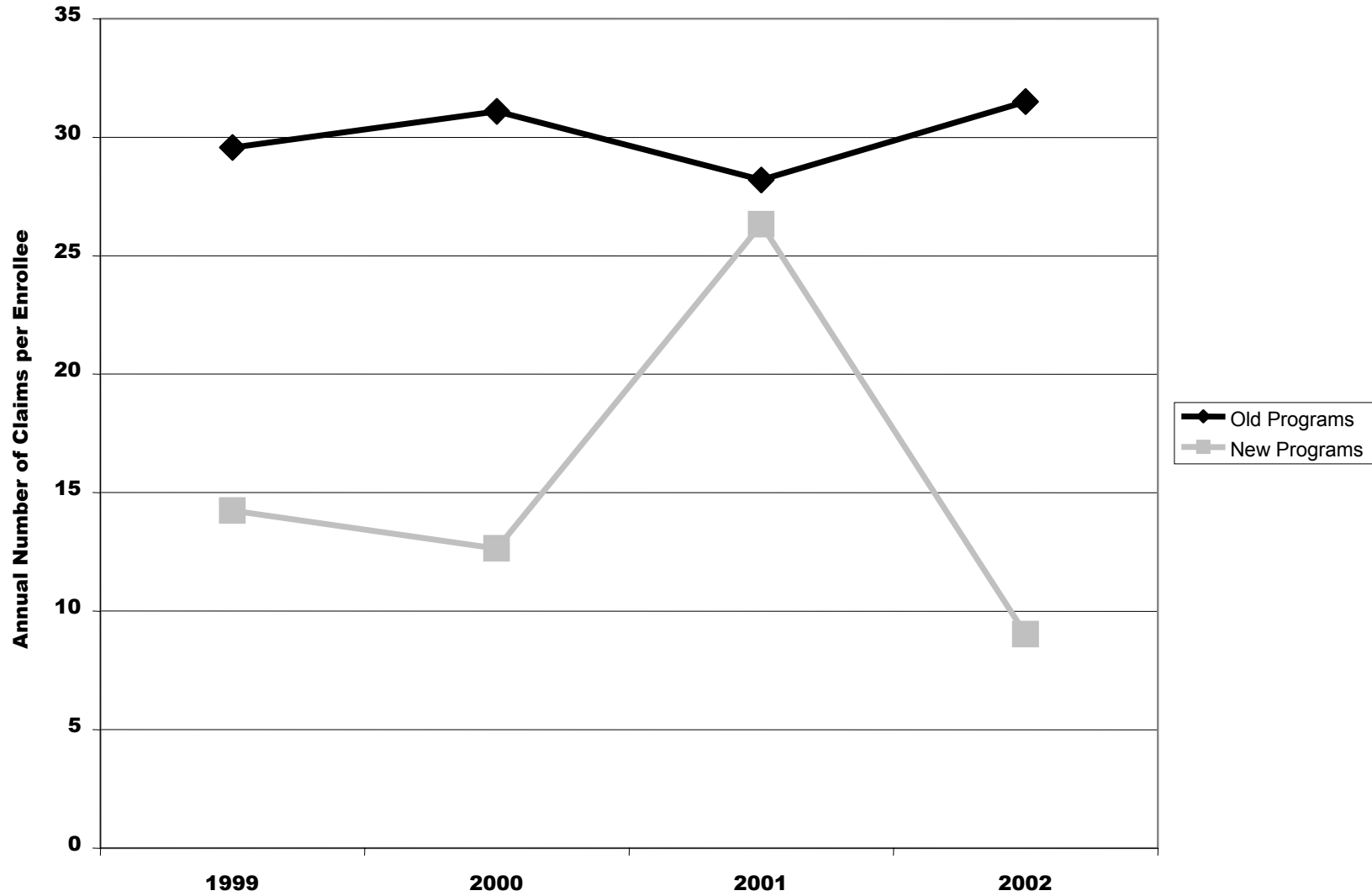
Note: Data for Illinois, Rhode Island, and South Carolina are from 2001. The average for "All States" is the quotient of the total number of claims for all programs divided by the total end-of-year enrollment for all programs.

Chart 5-9

Annual Number of Claims per End-of-Year Enrollee, 1999 to 2002

- In the 17 states for which end-of-year enrollment and claims data were available, the annual number of claims per enrollee increased from 29.5 in 1999 to 30.0 in 2002, a 1.5% increase.
- For states with programs established before 1999 (N = 12), the annual number of claims per enrollee increased from 29.6 in 1999 to 31.5 in 2002, a 6.6% increase.
- For states with programs established since 1999 for which end-of-year enrollment and claims data were available (N = 5), the annual number of claims per enrollee was much more variable, actually showing a 36.6% decrease from 14.2 in 1999 to 9.0 in 2002.
- Programs experiencing large increases in enrollment during a year (e.g., older programs implementing expansions, newer programs getting “ramped up”) will have a lower number of claims per end-of-year enrollment because fewer enrollees will have used the benefit for the entire year.

Chart 5-9
Annual Number of Claims per End-of-Year Enrollee, 1999 to 2002



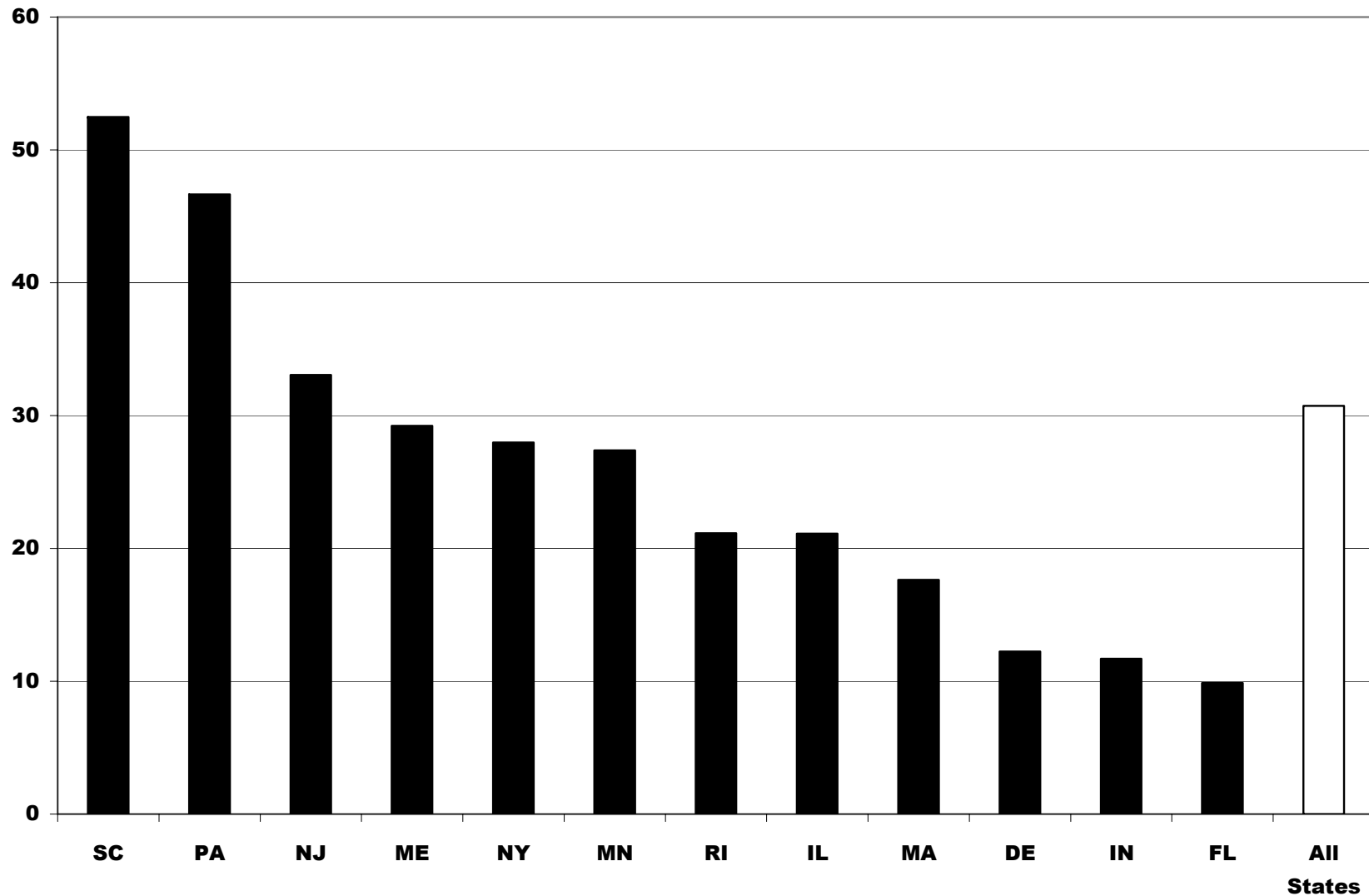
Notes: Old programs are those established prior to 1999 (N = 12), and new programs are those established since 1999 (N = 5). Only programs operational for at least one full year were included in the analysis.

Chart 5-10

Number of Claims per User, 2002

- In the 12 states for which claims and user data were available, the average number of claims per person filling a prescription was 30.7 in 2002, ranging from 9.9 in Florida to 52.5 in South Carolina.
- In addition to utilization by enrollees, the number of claims per user can be influenced by the number of days' supply per claim allowed by a program, the presence of deductibles, the number and type of drugs covered, and regional variations in prescription drug utilization.

Chart 5-10
Number of Claims per User, 2002



Note: Data for Illinois, Rhode Island, and South Carolina are from 2001. The average for "All States" is the quotient of the total number of claims for all programs divided by the total number of persons filling a prescription for all programs.

Chart 5-11

Annual Number of Claims per User, 1999 to 2002

- In the 12 states for which claims and user data were available, the average annual number of claims per user remained steady from 1999 to 2002, increasing from 32.4 to 32.7 (1.1%).

Chart 5-11
Annual Number of Claims per User, 1999 to 2002

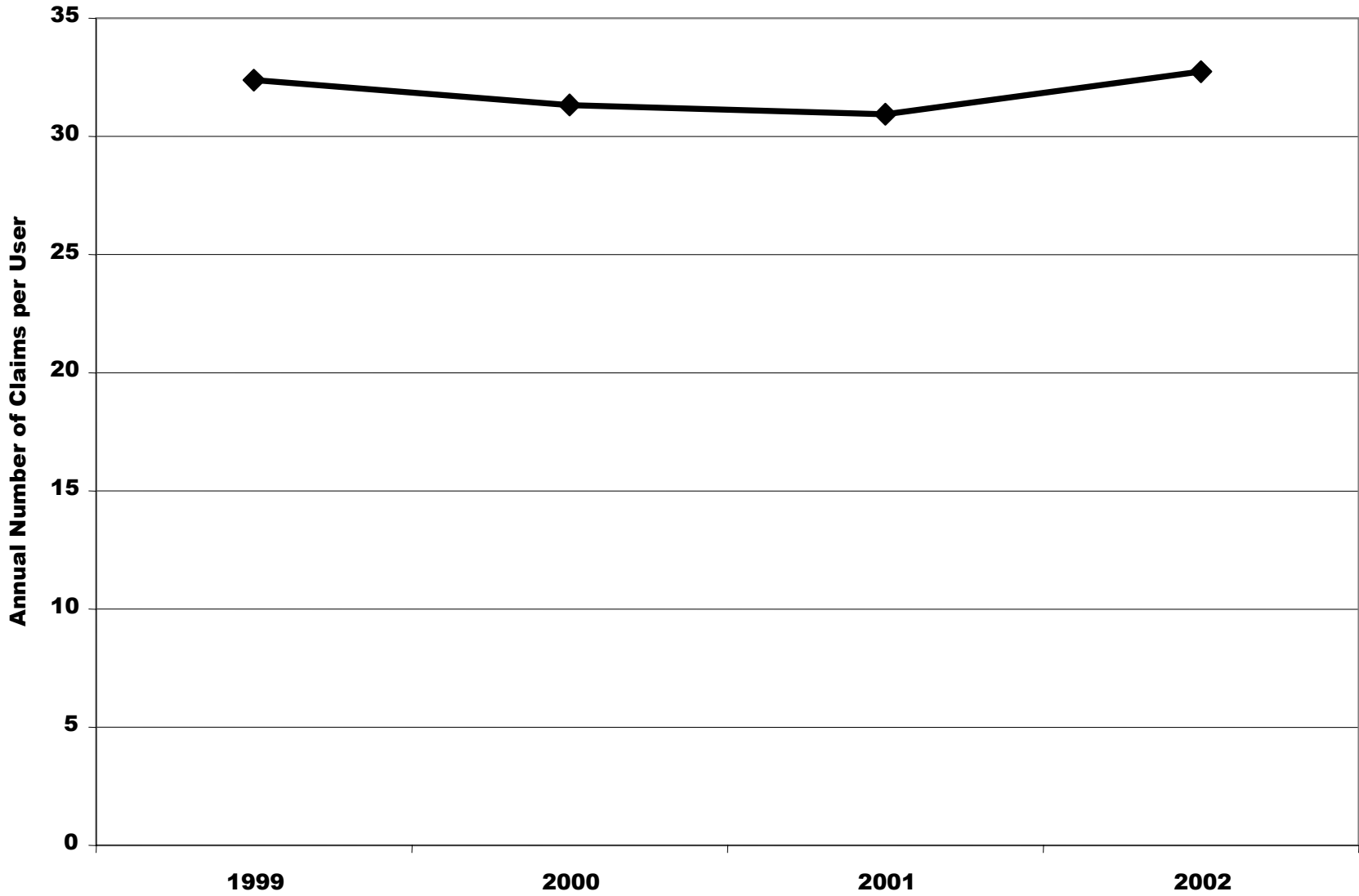
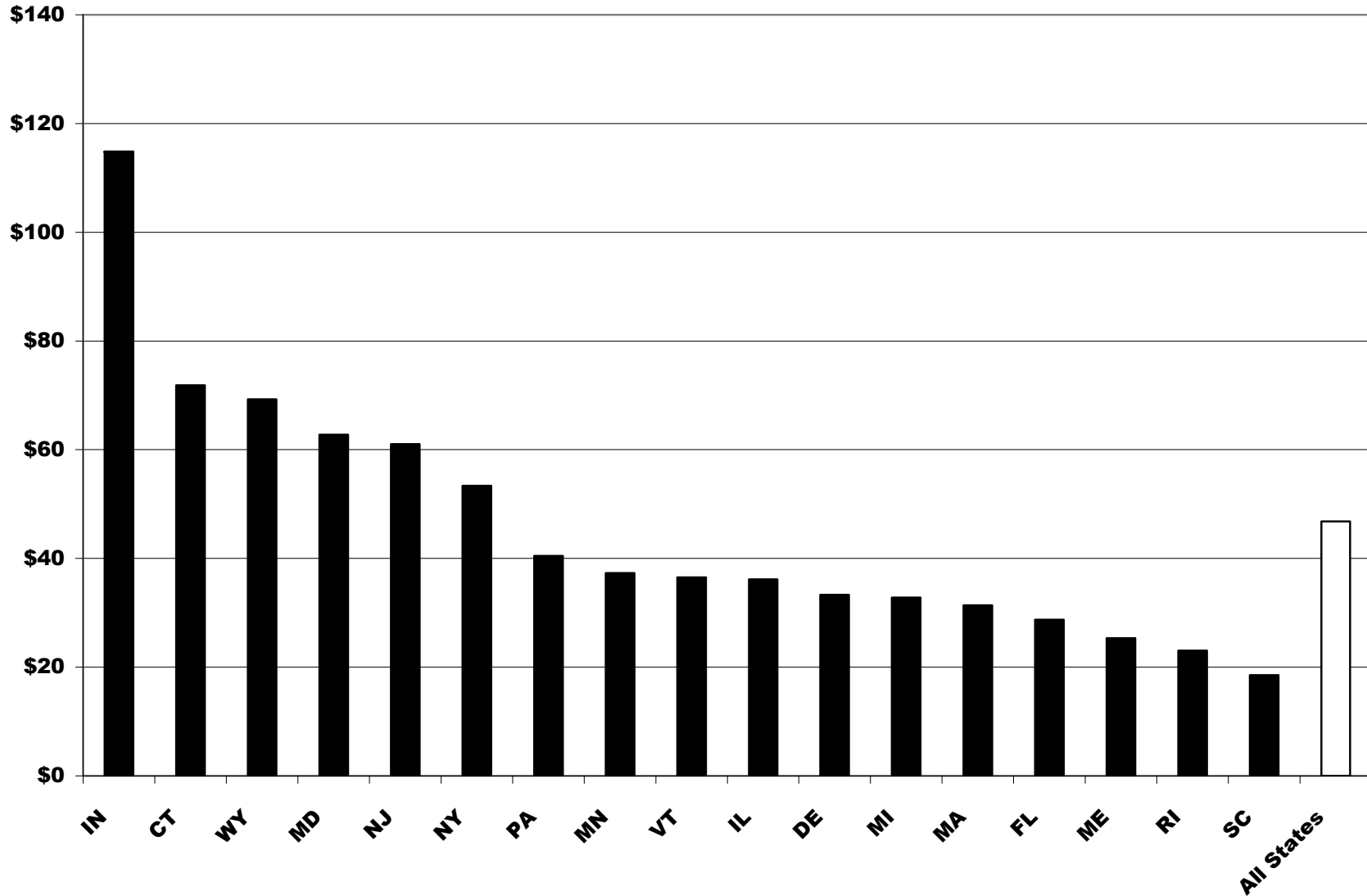


Chart 5-12

Average SPAP Costs per Claim, 2002

- The average state cost per claim was \$46.82 in 2002.
- Cost per claim ranged from \$18.56 in South Carolina to \$114.83 in Indiana.
- Most states had similar costs per claim. However, Indiana's costs per claim were much higher than those of other states in 2002. This is probably because, in 2002, Indiana's program reimbursed enrollees for prescription drugs purchased at retail prices, while other states had online claims processing programs that allowed them to reimburse pharmacies for prescription drugs at a discounted rate. Indiana has since moved to an online pharmacy reimbursement system with set pharmacy reimbursement rates.
- Costs per claim are affected by the level of consumer cost-sharing at the point of sale, the number of days' supply per claim allowed by a program, the drug mix used by beneficiaries, and the pharmacy reimbursement rate.

Chart 5-12
Average SPAP Costs per Claim, 2002



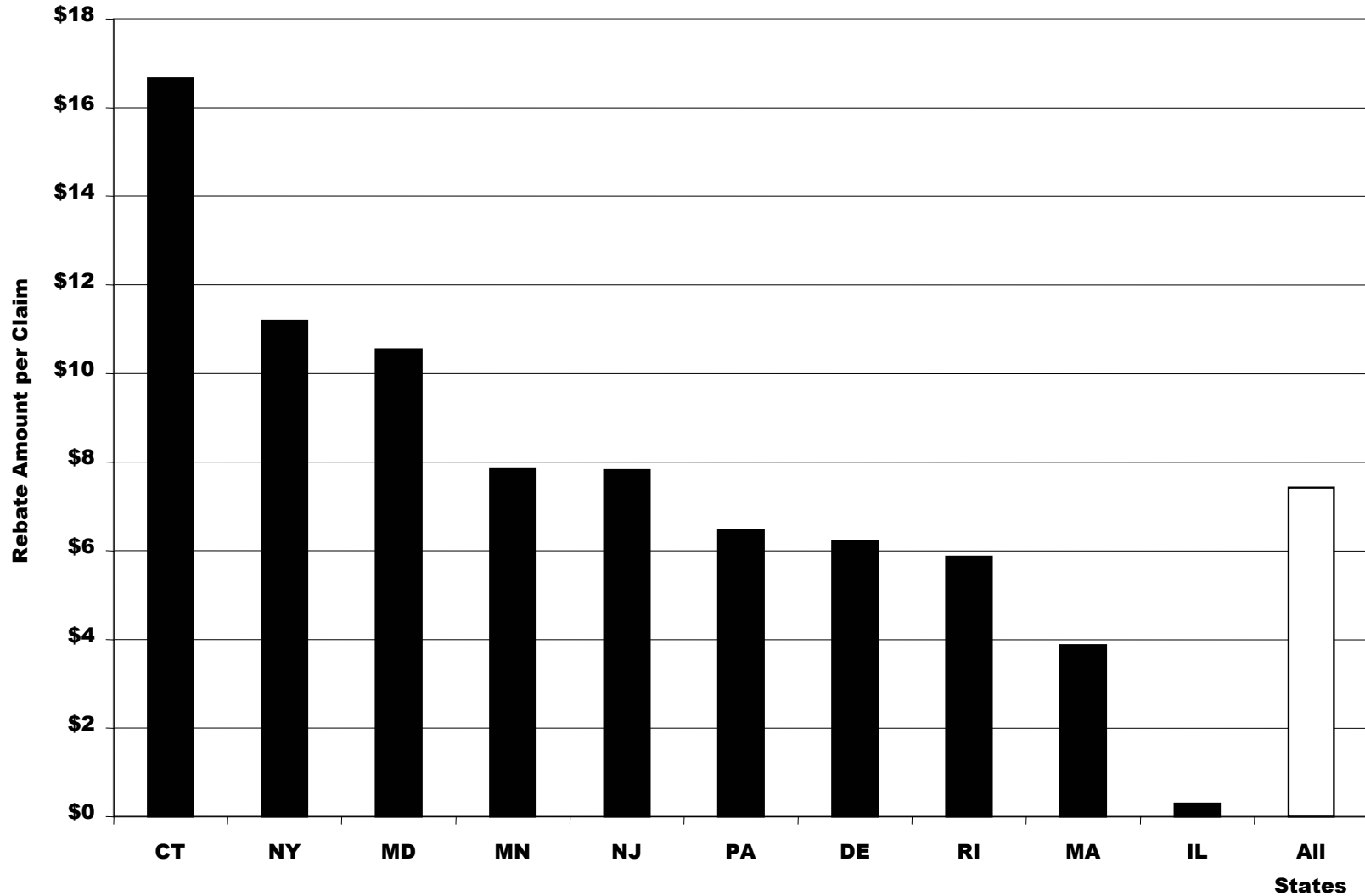
Note: Data for Illinois, Rhode Island, and South Carolina are from 2001. The average for "All States" is the quotient of the total amount of drug expenditures for all programs divided by the total number of claims for all programs.

Chart 5-13

Amount of Rebates per Claim, 2002

- On average, for the 10 states for which rebate and claims data were available, SPAPs recovered \$7.43 per filed claim through manufacturer rebates. The amount ranged from \$0.29 in Illinois to \$16.66 in Connecticut.
- The amount of rebates per claim is affected by the manufacturer rebate rate, the drug mix used by enrollees (name-brand drugs usually have higher rebate rates), and the number of days' supply per claim allowed by a program.
- The two states with the lowest amounts of rebates per claim, Illinois and Massachusetts, were also the only states in the chart that had their pharmacy benefit manager negotiate rebates with manufacturers rather than setting the rebate amount in statute.

Chart 5-13
Amount of Rebates per Claim, 2002



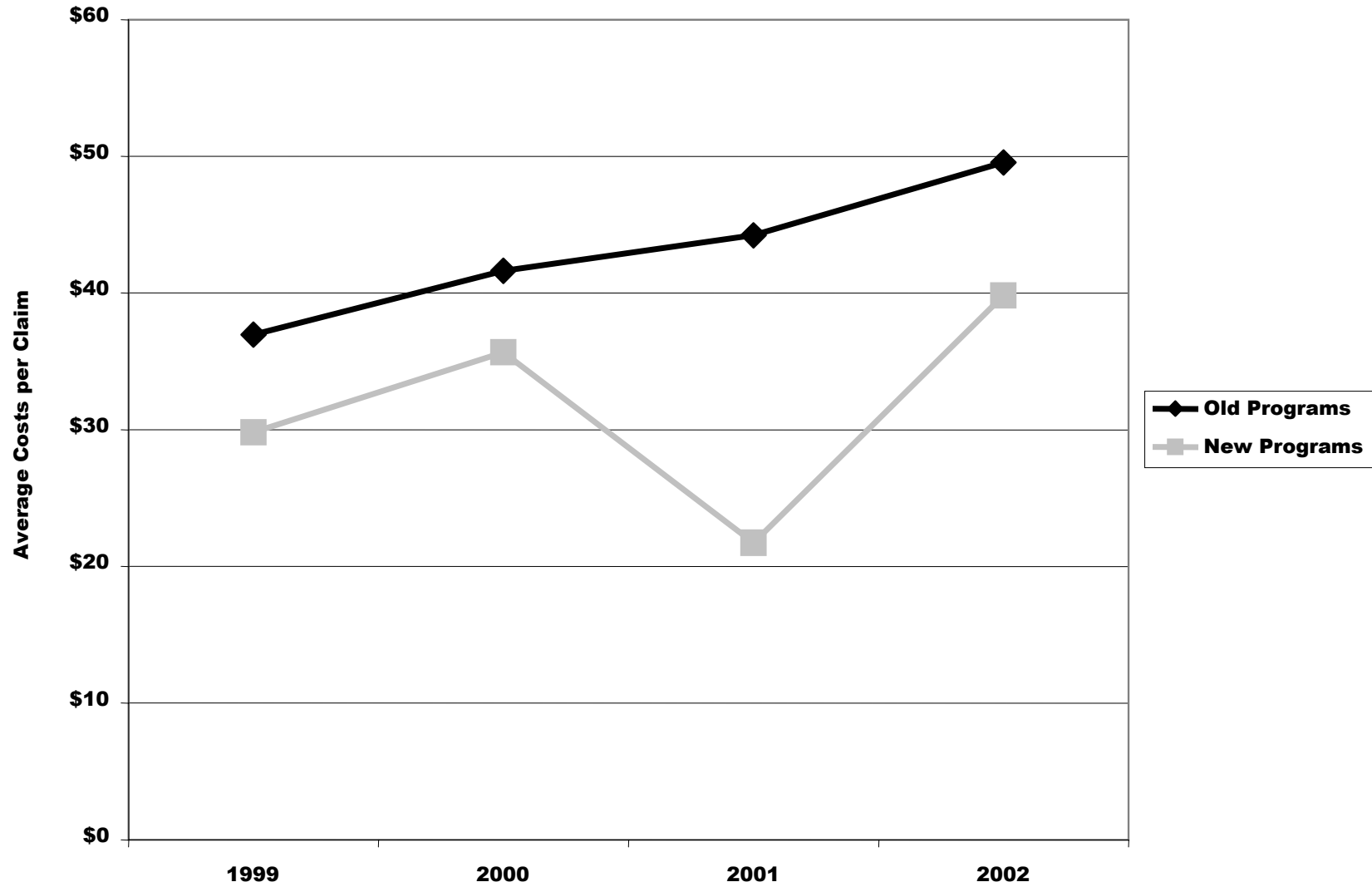
Note: Data for Illinois and Rhode Island are from 2001. The average for "All States" is the quotient of the total amount of rebates for all programs divided by the total number of claims for all programs.

Chart 5-14

Average SPAP Costs per Claim, 1999 to 2002

- For states with programs established before 1999 (N = 12), costs per claim increased from \$36.96 in 1999 to \$49.55 in 2002, a 34.1% increase.
- For states with programs established since 1999 for which expenditure and claims data were available (N = 5), SPAP costs per claim were more variable but increased from \$29.82 in 1999 to \$39.83 in 2002, a 33.6% increase.

Chart 5-14
Average SPAP Costs per Claim, 1999 to 2002



Notes: Old programs are those established prior to 1999 (N = 12), and new programs are those established since 1999 (N = 5). Only programs operational for at least one full year were included in the analysis.

Related Publications

#691 *Managing Program Costs in State Pharmacy Assistance Programs* (February 2004). Kimberley Fox, Thomas Trail, Susan Reinhard, and Stephen Crystal, Rutgers Center for State Health Policy. According to the authors, states' efforts to encourage the prescribing of generic drugs have been particularly effective in achieving cost savings. Some states, meanwhile, recover as much as a third of their program costs from manufacturer rebates based on volume of drugs purchased. Available at http://www.cmwf.org/programs/medfutur/fox_spaps_691.pdf.

#659 *Medicare's Future: Current Picture, Trends, and Medicare Prescription Drug Improvement & Modernization Act of 2003* (updated February 2004). Barbara S. Cooper and Sabrina How, The Commonwealth Fund. This chartpack presents an array of PowerPoint slides highlighting recent research and analytical findings on Medicare, including an overview of changes brought about by the Medicare prescription drug bill. Available online only at http://www.cmwf.org/programs/medfutur/medicarehtpk_debate_659.ppt.

#590 *Enrolling Eligible Persons in Pharmacy Assistance Programs: How States Do It* (September 2003). Stephen Crystal, Thomas Trail, Kimberley Fox, and Joel Cantor, Rutgers Center for State Health Policy. In this report, the authors examined 15 state pharmacy programs in operation in 2000 and determined that those with the simplest application procedures and fewest restrictions on enrollment, such as up-front fees or deductibles and in-person interviews, have the highest participation rates. Available at http://www.cmwf.org/programs/medfutur/crystal_pharmassistprogs_590.pdf.

#530 *State Pharmacy Assistance Programs: Approaches to Program Design* (May 2002). Kimberley Fox, Thomas Trail, and Stephen Crystal, Rutgers Center for State Health Policy. State pharmacy assistance programs for Medicare beneficiaries help only a small proportion of the Medicare population—just 3 percent, or 1.2 million beneficiaries out of 39 million nationwide. According to the authors, a federal program is needed to fill this gap in coverage, and it should coordinate with the 28 state programs currently in place. Available at http://www.cmwf.org/programs/medfutur/fox_statepharmacy_530.pdf.