ENROLLING ELIGIBLE PERSONS IN PHARMACY ASSISTANCE PROGRAMS: HOW STATES DO IT

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CONTENTS

LIST OF TABLES AND FIGURES

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EXECUTIVE SUMMARY

In the absence of a Medicare prescription drug benefit, state pharmacy assistance programs (SPAPs) provide much-needed drug coverage for eligible low-income elderly and disabled persons. Although SPAPs have reached only a limited population, the programs—having existed in some states for 25 years—have a wealth of experience that can provide insight on the design and implementation of pharmacy benefits at the state level and in Medicare.

This is the second of a series of reports based on findings from a study of SPAPs conducted by the Rutgers Center for State Health Policy. Data reported are from: 1) a survey of all direct-benefit programs (i.e., those that directly pay some or all of beneficiaries' prescription drug expenses, as opposed to just offering drug discounts) in place throughout the year 2000; 2) information collected through qualitative case studies of programs in Maine, Massachusetts, Minnesota, Nevada, New Jersey, Pennsylvania, South Carolina, and Vermont; and 3) reviews of the literature and program documents. The first report (May 2002) provided an overview of SPAPs, including histories of selected programs and cross-state comparisons of program designs.[1] This report focuses on enrollment.

Reaching the Target Population

As with other state-subsidized health insurance programs, many factors influence whether low-income elderly and disabled persons apply for and enroll in SPAPs. Eligibility requirements and benefit levels vary widely, and benefit design can have a substantial impact on enrollment. In addition, the extent to which states reach out to consumers to make them aware of the programs and the ease of the application process can greatly affect enrollment rates.

- Taken together, the 15 SPAPs in operation in the year 2000 enrolled approximately 903,000 people. A total of 551,000 enrollees (61 percent of all enrollees) were concentrated in three states, New Jersey, New York, and Pennsylvania, even though these states represented only 15.5 percent of Medicare beneficiaries nationally.

- On average, SPAP enrollees accounted for only about 7.6 percent of Medicare beneficiaries in states that had such programs in the year 2000. The proportion of Medicare beneficiaries enrolled in state pharmacy programs varied widely by state, ranging from less than 1 percent in Minnesota to more than 22 percent in Rhode Island.

[1] K. Fox, T. Trail, and S. Crystal, *State Pharmacy Assistance Programs: Alternative Approaches to Program Design* (New York: The Commonwealth Fund, May 2002).

- Since SPAPs are generally targeted to lower-income persons, a more refined marker of state pharmacy program reach is the percentage of persons eligible by income and age or disability that are enrolled. By this measure, the programs on average provided prescription drug coverage to approximately one-third of potentially eligible persons in their states in the year 2000. This measure ranged from 7 percent in Michigan to 64 percent in Pennsylvania.

- These percentages do not accurately represent the percentage of program-eligible individuals enrolled, because they do not account for other pharmacy coverage, and persons who have such coverage are not allowed to enroll in some states' pharmacy programs. Accurate state-level data on other pharmacy coverage by income level are not available. As a result, for many states the proportion of eligible individuals enrolled may be higher than the percentages shown here. Data from Pennsylvania suggest that programs that serve in the range of 50 to 60 percent of income-eligible individuals may be reaching most of those income-eligible individuals who do not have other pharmaceutical coverage.

- Well-established, older programs and those that have the fewest restrictions on enrollment—for example, those without up-front fees or premiums, or in-person eligibility interviews—tend to have the highest enrollment rates. A system of coinsurance (cost-sharing at the point of sale, based on a percentage of a prescription's cost) appears to have little negative impact on enrollment.

Table ES-1. State Pharmacy Assistance Program Enrollment and Percent of All Medicare Beneficiaries and Income-Eligible, Non-Medicaid Medicare Beneficiaries, Regardless of Insurance Coverage

State	End of Year Enrollment, 2000	Enrollment as Percentage of Medicare Beneficiaries[1]	Enrollment as Percentage of Income-Eligible, Non-Medicaid Medicare Beneficiaries[2]	Number Filling a Prescription as Percentage of Non-Medicaid Income-Eligible Medicare Beneficiaries[3]
Connecticut	30,546	5.9%	26.8%	NA
Delaware (all programs)	12,630	11.3%	37.6%	36.1%
Illinois	51,823	3.2%	15.3%	17.7%
Maine	40,277	18.6%	48.3%	29.5%
Maryland	41,261	NA	NA	NA
Massachusetts (all programs)	77,000	8.0%	33.9%	NA
Michigan	12,591	1.0%	7.1%	7.1%
Minnesota	4,833	0.8%	NA	NA
New Jersey	187,358	15.6%	53.9%	57.7%
New York	126,302	5.4%	18.7%	19.9%
Pennsylvania (all programs)	237,190	12.7%	61.8%	64.1%
Rhode Island	33,000	22.3%	62.6%	34.2%
South Carolina	32,212	7.0%	18.7%	NA
Vermont (all programs)	15,346	17.2%	45.1%	NA
Wyoming	550	NA	NA	NA
Total	**902,919**	**7.6%**	**32.4%**	**33.9%**

Note: NA = data not available. Programs in Wyoming and Maryland are open to persons of all ages, not just those enrolled in Medicare. Several states did not have data on the number of enrollees filling a prescription. The Current Population Survey (CPS) sample size in Minnesota was too small to allow for an accurate estimate of potential eligible persons (see Appendix).

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

[2] Income eligibility is defined differently by each state. 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. Note that the CPS estimates do not represent the number of eligible persons since some programs exclude persons with other drug coverage, which is not captured by CPS.

[3] Numbers in this column may be higher than those in the previous column since 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.

Source: Enrollment data are from the Rutgers Center for State Health Policy Survey of State Pharmaceutical Assistance Programs, December 2000. State Medicare enrollment data for 2000 are from the CMS website, http://cms.hhs.gov/statistics/enrollment/default.asp. Non-Medicaid income-eligible elderly/disabled estimates are based on Annual Demographic Survey component of the CPS from 2000, 2001, and 2002, at http://www.bls.census.gov/cps/cpsmain.htm.

Trends in Enrollment

- Enrollment in SPAPs increased overall between 1999 and 2000 by 7 percent. The majority of states showed some increases, but most of the growth resulted from significant eligibility or benefit expansions rather than from increased outreach efforts.

- Four states saw declines in enrollment in this period (Maryland, Michigan, New Jersey, and Pennsylvania). In Pennsylvania, enrollment has been declining annually, because the state uses fixed income limits rather than indexing eligibility to cost-of-living increases. Thus, the eligibility level in real dollars has in effect been reduced from year to year.
- Program officials in New Jersey have reported that enrollment in the state's Pharmaceutical Assistance to the Aged and Disabled (PAAD) program has increased since 2000. This is possibly due to increased outreach and publicity surrounding the state's new Senior Gold pharmacy assistance program for senior and disabled persons with annual incomes up to $10,000 above PAAD levels.

Outreach and Education Efforts

- States have utilized broad, media-based outreach strategies as well as strategies targeted to specific groups to increase awareness of their SPAPs.
- States were often able to leverage their outreach efforts by linking them to outreach for other programs for the low-income elderly and/or disabled, and some states used combined applications.
- Several SPAPs made a special effort to target hard-to-reach populations, including non-English speakers and persons who live in inner-city and rural areas. Generally, states have tried to reach these populations through nontraditional methods such as conducting outreach through local churches, hospitals, and minority advocacy groups and by going door-to-door.
- The eight states that were subjects of case studies agreed that outreach activities at the time of program initiation were necessary for these programs to reach a significant proportion of their target group. However, only two of these states allocated any funding on an ongoing annual basis for outreach.
- The effectiveness of public information efforts in increasing enrollment is difficult to measure, but most of these eight states reported that their efforts were successful in increasing program enrollment and/or awareness.

Simplifying Enrollment and Minimizing "Welfare Stigma"

States have had to balance the need for information to verify eligibility with the need to have a simple and straightforward application form.

- Long, complicated forms that require significant confidential information may be burdensome and keep eligible people from enrolling in the programs, while short forms that do not gather sufficient information may make it difficult for the state to

verify age, income, and residency requirements. Many states have moved toward shorter, simpler forms over time.

- Some states keep the application process simple by using state income tax records to verify income.
- Some states have reduced the burden of application by extending program eligibility from one year to two years and by automatically enrolling persons already enrolled in other low-income benefit programs.
- SPAPs are often housed in the state Medicaid agency. Respondents in some states noted that this could hinder enrollment because of the "welfare stigma" associated with Medicaid, but other respondents did not consider this to be a problem. There was no clear relationship between take-up benchmarks and a program's locus of administration (Medicaid or other agency).
- In programs located in the same department as Medicaid, some states had applicants submit their enrollment forms to a different office as a means of distancing the program from Medicaid.

Conclusion

- State pharmacy assistance programs have helped to address a great need among eligible low-income elderly and disabled persons, but they have only limited reach. Nevertheless, the eight case study states demonstrated a strong commitment to enrolling eligible individuals through outreach efforts and by making the application and enrollment process as easy as possible. Timely, state-level data on pharmacy coverage are needed to determine the size and distribution of the eligible population and calculate take-up rates. This need is not currently met by existing federal surveys.
- Finally, while program outreach is important, it appears that the major constraints on covering a larger proportion of the low-income elderly and disabled population are associated with program design. For example, the imposition of initial fees or premiums appears to be a hurdle to enrollment. These findings suggest that programs with such features, at the state level or as part of a Medicare prescription drug benefit, may have difficulty achieving high levels of participation among low-income populations.

ENROLLING ELIGIBLE PERSONS IN PHARMACY ASSISTANCE PROGRAMS: HOW STATES DO IT

INTRODUCTION

Over the past quarter century, many states have implemented state-sponsored pharmacy assistance programs (SPAPs) to help reduce the burden of the high cost of prescription drugs for some members of the Medicare population. States' experiences in designing and operating these programs can provide valuable guidance to other states or to federal policymakers considering a Medicare prescription drug benefit.

This report is the second in a series of reports based on findings from a study of SPAPs conducted by the Rutgers Center for State Health Policy. The data reported are based on: 1) a survey of all direct-benefit programs (i.e., those that directly pay some or all of beneficiaries' prescription drug expenses, as opposed to just offering drug discounts) in place throughout the year 2000; 2) information collected through qualitative case studies of programs in Maine, Massachusetts, Minnesota, Nevada, New Jersey, Pennsylvania, South Carolina, and Vermont; and 3) reviews of the literature and program documents. The first report (May 2002) provided an overview of SPAPs, including histories of selected programs and cross-state comparisons of program designs.[2] This second report focuses on enrollment.

As with other means-tested health insurance programs, SPAPs enrollment is affected by program design and outreach efforts of program administrators, among other factors. This report addresses the question of how successfully states encourage enrollment from the target population and from different subgroups, based on a survey of 15 state programs in place as of December 2000 and an analysis of Current Population Survey (CPS) data on income eligibility. It then describes state strategies to address three major challenges: raising awareness through education and outreach, simplifying application and eligibility determination procedures, and avoiding "welfare stigma." For this section, we performed case studies of six of the 15 states we had surveyed, as well as a case study of Nevada, which did not yet have a pharmacy program operational in December 2000 and thus was not included in the survey. Overall, we examined the pharmacy assistance programs in 16 states.

REACHING THE TARGET POPULATION: IF YOU BUILD IT, DO THEY COME?

Program take-up—that is, the percentage of estimated eligible persons who actually enroll in the program—is one measure of the success of state pharmacy programs. However, measuring actual take-up is difficult, particularly for states that have eligibility requirements

[2] Fox, Trail, Crystal, *State Pharmacy Assistance Programs,* May 2002.

that are not easily measured by existing data sources, such as the exclusion of people with existing drug coverage. Since state-specific data on the moving target of individuals having other pharmacy coverage are not available, these estimates do not exclude individuals with such coverage. Nonetheless, they provide an indication of differences in program penetration across states.

Program Eligibility Requirements and Enrollment

Most states set eligibility limits to restrict enrollment to those people the state defines as being most in need (Table 1). All states set income eligibility limits for participants who seek state subsidies. These eligibility limits vary by state, ranging from 100 percent to 500 percent of the federal poverty level (FPL). All states exclude persons who have Medicaid coverage, although some (e.g., New Jersey) permit SPAP enrollment by persons who forgo Medicaid benefits for which they are eligible. Several states also exclude persons who have prescription drug coverage through other sources, even if that coverage may be limited. Of the 16 states studied, nine excluded persons with any other prescription drug coverage and five imposed some eligibility restrictions for persons that had other coverage (i.e., they were deemed eligible only after they had exhausted their other benefits or if their other benefits were less generous than those provided by the state). Only Pennsylvania and Illinois had no restrictions on other prescription drug coverage. For those states that either excluded or restricted eligibility for persons with other coverage, these enrollment penetration numbers represent an underestimate.

Table 1. Eligibility Requirements for State Pharmacy Assistance Programs, 2001

State	Age	Disabled	Income (% FPL)	Residency	Other Insurance
CT	65	Yes	180%	6 months	Individuals with other drug coverage are not eligible until other benefits are exhausted.
DE	65	Yes	200%	Current	Not eligible if enrolled in Medicaid or Nemours Clinic, or has other drug coverage.
IL	65	Yes	254%	Current	Not eligible if enrolled in Medicaid. No restrictions on other coverage.
MA	65	Yes	No limit★	Current	Not eligible if enrolled in MassHealth or CommonHealth. Individuals with other drug coverage are not eligible until other benefits are exhausted.
MD	All ages	Yes	120%	Current	Not eligible if a Medicaid beneficiary or in a correctional facility. Must not have other drug coverage.
ME	62	Yes	185%	Current	Not eligible if enrolled in Medicaid or has other drug coverage.

State	Age	Disabled	Income (% FPL)	Residency	Other Insurance
MI	65	No	200%	3 months	Not eligible if enrolled in Medicaid or has other drug coverage.
MN	65	No	120%	180 days	Must have had no prescription drug coverage in the 4 months prior to application.
NJ	65	Yes	PAAD: 230% Senior Gold: 350%	Current	Must not be enrolled in prescription drug benefit plan with equal or better coverage. Those with limited or partial coverage are eligible.
NY	65	No	419%	Current	Seniors enrolled in a better prescription benefit plan are not eligible. Eligible after other benefits are exhausted.
NV	62	No	257%	One year	Not eligible if enrolled in Medicaid or has other drug coverage.
PA	65	No	PACE: 168% PACENET: 192%	90 days	Not eligible if enrolled in Medicaid. No restrictions on other coverage.
RI	65	No	419%	Current	Individuals with other drug coverage are not eligible until other benefits are exhausted.
SC	65	No	175%	6 months	Not eligible if has other drug coverage.
VT	65	Yes	VHAP: 150% VScript: 175% VScript Ex.: 225%	One year	Not eligible if has other drug coverage.
WY	All ages	Yes	100%	Current	Not eligible if enrolled in Medicaid or has other drug coverage.

* Massachusetts' Prescription Advantage plan has no upper income limit for persons over age 65. Premiums and deductibles are subsidized on a sliding-scale for enrollees with incomes below 500% of FPL; those with higher incomes pay unsubsidized premiums. Disabled persons are eligible only if they have incomes below 188% of FPL.

Source: Rutgers Center for State Health Policy Survey of State Pharmaceutical Assistance Programs, December 2000 and August 2002, and case studies.

Enrollment Compared with Medicare Enrollees and Income-Eligible Population

Taken together, the direct-benefit SPAPs in operation as of December 2000 enrolled approximately 903,000 people (Table 2).[3] Enrollment in these programs varied considerably due to differences in program eligibility requirements and the size of the older adult population in the states. As shown in Figure 1, the majority of enrollees were concentrated in three states: New Jersey, New York, and Pennsylvania. A total of 551,000 individuals (61 percent of all enrollees) were enrolled in these three states, which accounted for 48 percent of the Medicare beneficiaries among SPAP states in 2000. Even with the implementation of programs in additional states in 2001, these three states

[3] Fox, Trail, Crystal, *State Pharmacy Assistance Programs,* May 2002.

continue to account for the majority of enrollees in direct-benefit programs, and an even larger share of expenditures.[4]

Table 2. State Pharmacy Assistance Program Enrollment and Percent of All Medicare Beneficiaries and Income-Eligible, Non-Medicaid Medicare Beneficiaries, Regardless of Insurance Coverage

State	End of Year Enrollment, 2000	Enrollment as Percentage of Medicare Beneficiaries[1]	Enrollment as Percentage of Income-Eligible, Non-Medicaid Medicare Beneficiaries[2]	Number Filling a Prescription as Percentage of Income-Eligible Non-Medicaid Medicare Beneficiaries[3]
Connecticut	30,546	5.9%	26.8%	NA
Delaware (all programs)	12,630	11.3%	37.6%	36.1%
Illinois	51,823	3.2%	15.3%	17.7%
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Maryland	41,261	NA	NA	NA
Massachusetts (all programs)	77,000	8.0%	33.9%	NA
Michigan	12,591	1.0%	7.1%	7.1%
Minnesota	4,833	0.8%	NA	NA
New Jersey	187,358	15.6%	53.9%	57.7%
New York	126,302	5.4%	18.7%	19.9%
Pennsylvania (all programs)	237,190	12.7%	61.8%	64.1%
Rhode Island	33,000	22.3%	62.6%	34.2%
South Carolina	32,212	7.0%	18.7%	NA
Vermont (all programs)	15,346	17.2%	45.1%	NA
Wyoming	550	NA	NA	NA
Total	**902,919**	**7.6%**	**32.4%**	**33.9%**

Note: NA = data not available. Programs in Wyoming and Maryland are open to persons of all ages, not just those enrolled in Medicare. Several states did not have data on the number of enrollees filling a prescription. The Current Population Survey (CPS) sample size in Minnesota was too small to allow for an accurate estimate of potential eligible persons (see Appendix).

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

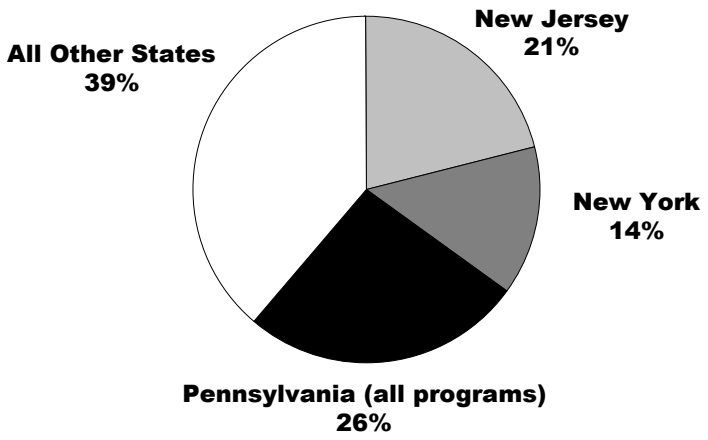
[2] Income eligibility is defined differently by each state. Estimates were calculated from three-year averages from the March supplement of the 2000, 2001, and 2002 CPS and are based on all persons meeting age, disability, and income eligibility requirements and having no Medicaid coverage. Note that the CPS estimates do not represent the number of eligible persons since some programs exclude persons with other drug coverage, which is not captured by CPS.

[3] Numbers in this column may be higher than those in the previous column since 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.

Source: Enrollment data are from the Rutgers Center for State Health Policy Survey of State Pharmaceutical Assistance Programs, December 2000. State Medicare enrollment data for 2000 are from the CMS website, http://cms.hhs.gov/statistics/enrollment/default.asp. Non-Medicaid income-eligible elderly/disabled estimates are based on Annual Demographic Survey component of the CPS from 2000, 2001, and 2002, at http://www.bls.census.gov/cps/cpsmain.htm.

[4] Fox, Trail, Crystal, *State Pharmacy Assistance Programs,* May 2002.

Figure 1. Proportion of SPAP Enrollees in New York, New Jersey, and Pennsylvania vs. All Other States



Source: Rutgers Center for State Health Policy Survey of State Pharmaceutical Assistance Programs, December 2000.

One marker of program reach is the percentage of the Medicare population enrolled in the state program. As shown in Table 2, state pharmacy program enrollees accounted overall for approximately 7.6 percent of Medicare beneficiaries in states that had such programs in the year 2000, ranging from 0.8 percent in Minnesota to more than 22 percent in Rhode Island.

Since SPAPs are generally targeted to lower-income persons, and many Medicare beneficiaries are not eligible for these programs, a more refined marker of state pharmacy program reach is the percentage of non-Medicaid persons eligible by income and age or disability who are enrolled and using the program services. Using three-year averages from the March supplement of the 2000, 2001, and 2002 Current Population Survey (CPS), we estimated the number of persons in each state who would qualify for these programs based on income and disability requirements.[5] We also excluded persons enrolled in Medicaid, since they would not be eligible for the pharmacy programs. By this measure, all 15 state pharmacy programs collectively provided prescription drug coverage for approximately 32.4 percent of non-Medicaid persons eligible by income and age or by disability in 2000. This percentage varied widely by state, with Pennsylvania and Rhode Island enrolling

[5] Disabled persons were included in the computation only in states that cover disabled individuals. Disabled persons were defined as Medicare beneficiaries below the age of 65.

more than 60 percent of this group, while Michigan's program, which had fairly narrow income eligibility in 2000, enrolled only 7 percent of this group.

As shown in Table 2, take-up benchmarks for some states often appear significantly lower when they use only the number of people taking advantage of the benefit over the course of the year (i.e., those filling a prescription under the program) to calculate the rate. In states such as Maine and Rhode Island, this difference may reflect the fact that these programs covered drugs only for certain specific conditions in 2000.

It should be noted that CPS-based estimates of the population of low-income elderly and disabled persons in these states vary in precision depending on sample sizes: estimates are less precise for less populous states. It is even more important to note that, if persons who have other prescription drug coverage could be accounted for in these estimates, the percentage of the "target population" that is enrolled would increase. For these reasons, the data shown in Table 2 should not be interpreted as "take-up" rates for these programs. However, these benchmarks provide a sense of the programs' penetration and are particularly useful for comparing enrollment and use across groups of states (e.g., those with and without enrollment fees or deductibles).

Few public data sources are available to estimate private drug coverage at the state level. The Medicare Current Beneficiary Survey (MCBS), which provides important national information on drug coverage and out-of-pocket drug expenditures, does not support state-level estimates. Even when estimates of drug coverage have been available through special state surveys, volatility and changes in the existing pharmacy coverage market, such as HMO market withdrawals, have made it difficult to accurately assess the number of people with coverage at any given time.[6]

Some states indicated that they used national estimates of drug coverage from MCBS as reported in existing literature to estimate the prevalence of prescription drug coverage in their eligible populations. However, this approach to estimating the target population of income-eligible individuals without other pharmacy coverage for a given state is imprecise, as coverage varies by income and undoubtedly differs from state to state in relation to such factors as Medicare+Choice (M+C) penetration and employer-sponsored insurance. Given these limitations, it is difficult to determine the number of individuals eligible for each state's program during a given year. Nevertheless, estimates of the population eligible by virtue of income and lack of Medicaid coverage are calculable

[6] See V. Nixon, *Access Update: Massachusetts Elderly and Prescription Drug Coverage,* C. Wacks, ed., Issue No. 1 (Boston: Massachusetts Division of Health Care Finance and Policy, March 2001).

based on data from the CPS and these estimates provide some indication of variations in program penetration.

Program officials indicated that incomplete information on eligibility has significantly reduced their capacity to accurately assess the number of people who are likely to enroll and to set realistic budget estimates. Several state program officials indicated that states should invest more funds up front to collect specific data to identify who currently does not have drug coverage, prior to setting eligibility.

Basing enrollment projections on inaccurate eligibility estimates can result in either lower than expected enrollment or higher than expected expenditures, either of which can be problematic. For example, due to a lack of data on other drug coverage, Vermont overestimated the number of persons who would enroll in its Vermont Health Access Plan (VHAP) pharmacy program. Advocates and legislators perceived low enrollment as an indicator that the state had set its income limits too low, and, in response, Vermont raised the income limits for the program from 100 percent FPL to 150 percent FPL in an effort to increase enrollment. Some officials suggested that this eligibility expansion has contributed to significant program cost increases.

Another illustration of the difficulty in projecting eligibility took place in Pennsylvania. When Pennsylvania's PACENET was passed in 1996, state officials had estimated, based on census data, that 50,000 additional people without other drug coverage would be covered; however, enrollment in the first year was far lower than this estimate. In June of 1997, a year after passage of the PACENET program, program officials engaged their actuaries at Coopers & Lybrand LLP to identify how many Pennsylvania residents were eligible for the PACE (Pharmaceutical Assistance Contract for the Elderly) and PACENET programs and how many of those eligible were participating.[7] To assess eligibility, the consultants developed estimates of eligible persons by region in the state using a variety of data sources, including 1994 and 1995 CPS information trended forward using demographic data from a private information resource company (Claritas), and state population data. The study also developed estimates of the proportion of financially eligible individuals with other drug coverage by applying assumptions about the level of drug coverage under various policies, based on a variety of data sources, including Coopers and Lybrand Employer Medical Plan statistics, Medicare enrollment statistics, and various other industry data. Based on this analysis, only 53,000 people

[7] Coopers & Lybrand LLP, *PACENET Enrollment Study December 1997 Update* (Harrisburg, Pa.: Pennsylvania Department of Aging, February 1998).

without other drug coverage would be eligible for PACENET—nearly 30 percent fewer people than originally estimated.

It should further be noted that while Table 2 presents combined enrollment estimates for four states with multiple programs, patterns of enrollment among those eligible vary from program to program within a state. This may be particularly true when there are substantial differences in cost-sharing requirements across programs targeted to different eligibility groups. For example, as indicated in the Coopers & Lybrand study of Pennsylvania programs, participation as a proportion of those eligible by income was considerably lower for Pennsylvania's PACENET program, which is targeted to moderate-income persons and imposes a $500 deductible and copayments of $8 to $15, than for its PACE program, which does not have a deductible and has a $6 copayment (Table 3).

Table 3. Estimated Participation in Pennsylvania's PACE and PACENET Programs, 1997

Program	Total Persons Age and Income Eligible	Percentage of Eligible Persons Enrolled	Percentage of Eligible Persons Without Drug Coverage	Percentage of Eligible Persons Without Drug Coverage Enrolled
PACE	630,448	39.8%	41.0%	96%
PACENET	139,444	8.2%	38.5%	21%

Source: Adapted from Coopers & Lybrand LLP, *PACENET Enrollment Study December 1997 Update* (Harrisburg, Pa.: Pennsylvania Department of Aging, February 1998).

TRENDS IN ENROLLMENT

Enrollment in state pharmacy assistance programs increased overall between 1999 and 2000 by 7 percent (Table 4). The majority of states showed some increases, but significant eligibility or benefit expansions in 2000 were responsible for much of the overall growth in enrollment. For example, in 1999 Minnesota dropped a $120 annual fee, increased asset limits, and automatically enrolled Qualified Medicare Beneficiary and Specified Low Income Medicare Beneficiary enrollees into its Prescription Drug Program (PDP), resulting in a threefold increase in enrollment. Similarly, Massachusetts created a new catastrophic program in 2000 that contributed to increased enrollment in that state.

Table 4. State Pharmacy Assistance Program Enrollment Trends from 1999 to 2000

State	1999	2000	Percent Change
Connecticut	29,969	30,546	1.9%
Delaware (all programs)	9,782	12,630	29.1%
Illinois	49,186	51,823	5.4%
Maine	38,007	40,277	6.0%
Maryland	42,385	41,261	–2.7%
Massachusetts (all programs)	33,000	77,000	133.3%
Michigan	12,968	12,591	–2.9%
Minnesota	1,215	4,833	297.8%
New Jersey	195,005	187,358	–3.9%
New York	111,786	126,302	13.0%
Pennsylvania (all programs)	244,413	237,190	–3.0%
Rhode Island	31,947	33,000	3.3%
Vermont (all programs)	13,561	15,346	13.2%
Wyoming	491	550	12.0%
Total	**813,715**	**871,780**	**7.0%**

Notes: In 2000, Massachusetts and Delaware expanded eligibility by creating new programs. Minnesota eliminated its annual fee, and increased asset limits. Vermont expanded eligibility for VScript from 175% to 225% FPL.

Source: Rutgers Center for State Health Policy Survey of State Pharmaceutical Assistance Programs, December 2000.

As shown in Table 4, four states saw declines in enrollment in this period, including New Jersey and Pennsylvania, which have large, mature programs. In Pennsylvania, enrollment has been declining annually because the state uses fixed income limits rather than indexing eligibility to cost-of-living increases. This effectively lowers eligibility in constant dollars every year unless there is a specific increase in eligibility levels. According to program officials, PACE enrollment peaked in 1988 at 480,000 and has subsequently declined by an average of 18,000 persons every year. In New Jersey, where eligibility is tied to the Social Security Cost of Living Adjustment, program officials suggested that Pharmaceutical Assistance to the Aged and Disabled (PAAD) enrollment was declining due in part to the strong economy. Since the declines seemed particularly pronounced among people ages 65 to 66, the program director suggested that people might be retiring later and therefore not meeting PAAD income eligibility requirements. However, program officials in New Jersey have reported that enrollment in the state's generous PAAD program has increased since 2000, possibly due to increased outreach and publicity surrounding the state's new Senior Gold pharmacy assistance program for senior and disabled persons with annual incomes up to $10,000 above PAAD's eligibility levels.[8]

[8] N. Parello, "New Jersey Attracts More Low-Income Seniors to Prescription Drug Plans," *The Record* (Hackensack, N.J.), December 17, 2001, p. A1.

In four of the five states in which nonelderly disabled persons were eligible for the state program, disabled persons comprised approximately 12 to 14 percent of total enrollment. The proportion was much higher in Delaware (Table 5). Given the relatively small numbers of disabled individuals included in the CPS sample in any given state, the data do not make it possible to adequately compare this figure with the percentage of nonelderly disabled persons who met the income requirements in these states. A possible explanation for the high proportion of disabled enrollees in Delaware's Prescription Assistance Program (DPAP) program is that low-income elderly persons in the state are eligible for a privately funded prescription drug program (the Nemours Health Clinic Pharmacy Assistance Program). The state program covers only those older persons whose incomes are above the eligibility limits for the Nemours program (150% FPL) and below the state program's limits (200% FPL). Disabled persons are not eligible for the Nemours program, so the DPAP program covers all non–Medicaid eligible, disabled persons with incomes below 200 percent FPL.

Table 5. Enrollment of Nonelderly Disabled Persons in Selected State Pharmacy Assistance Programs, 2000

State	Percentage of Enrollees
Connecticut	13.9%
Delaware DPAP	45.0%
Illinois*	14.3%
New Jersey	12.5%

* Number of enrollees filling a prescription.

Source: Rutgers Center for State Health Policy Survey of State Pharmaceutical Assistance Programs, December 2000.

The average age of enrollees in state pharmacy programs who reported age information was 80, but the age distribution among elderly enrollees varied considerably across state programs (Table 6).

Table 6. Distribution of Elderly Enrollees by Age Group for Enrollees Age 65+, 2000

State	Total Enrollment*	65–74	75–84	85 or Older	Average Age
Connecticut	100.0%	24.3%	46.2%	29.4%	NA
Delaware DPAP	100.0%	61.0%	30.1%	8.8%	NA
Minnesota	100.0%	48.2%	38.2%	13.7%	NA
New Jersey	100.0%	32.2%	45.2%	22.6%	79
New York	100.0%	31.6%	45.8%	22.6%	79
Pennsylvania PACE	100.0%	28.2%	47.1%	24.7%	78
Pennsylvania PACENET	100.0%	32.8%	49.0%	18.1%	78
Rhode Island	100.0%	19.3%	45.7%	34.9%	81
South Carolina	100.0%	47.6%	40.6%	11.8%	NA

Note: NA = not available from the state.

* Totals may not add to 100% due to rounding.

Source: Rutgers Center for State Health Policy Survey of State Pharmaceutical Assistance Programs, December 2000.

Comparing Enrollment with Number of Persons Using the Benefit

End-of-year enrollment figures are, for some states, higher than the number of persons actually using the benefit during the course of the year. In three programs that limit coverage to only a specific list of drugs—Maine, Maryland, and Rhode Island—the number of enrollees who actually used the benefit during the year is substantially lower than the end-of-year program enrollment. The presence on the enrollment rolls of persons who are not actually using the program's benefits complicates the interpretation of enrollment as a percentage of potentially eligible individuals. For this reason, we included in Table 2 benchmarks based both on reported year-end enrollment and on the number of persons reported to be actually using services during the year (i.e., filling a prescription), which can be either larger or smaller than end-of-year enrollment depending on turnover and use patterns. Table 7 shows the relationship between reported year-end enrollment figures from states and the number of individuals reported to be filling a prescription at any time during the year.

Table 7. End-of-Year Enrollment, Number of Persons Who Filled a Prescription at Any Time in FY2000, and Program Limits on Conditions Covered

State	Limits on Conditions Covered	Enrollment as of the End of FY2000	Number of Persons Filling a Prescription in FY2000
Delaware DPAP	None	2,130	1,629
Illinois	Eight conditions	51,823	60,183
Maine	Fourteen conditions	40,277	24,618
Maryland	Maintenance drugs only	41,261	27,261
Michigan	None	12,591	12,591
Minnesota	None	4,833	4,211
New Jersey	None	187,358	200,809
New York	None	126,302	134,507
Pennsylvania PACE	None	216,974	222,712
Pennsylvania PACENET	None	20,216	23,422
Rhode Island	Fourteen conditions	33,000	18,000

Source: Rutgers Center for State Health Policy Survey of State Pharmaceutical Assistance Programs, December 2000.

Factors Influencing Enrollment Benchmarks for SPAPs

As seen in the previous tables, enrollment in SPAPs by those persons potentially eligible varies widely across states. Many factors could influence the enrollment rates, including the age of the program, eligibility levels, consumer cost-sharing requirements, the generosity of the benefit, the perceived welfare stigma when a program is located alongside the Medicaid agency, and the amount of outreach for the program. Table 8 shows that, in general, states that require enrollment fees (referred to as premiums in some states) or deductibles have the lowest enrollment rates. As a group, the states that did not have fees or deductibles (except for Pennsylvania's PACENET) had a total enrollment rate of 56 percent, while states that did have fees or deductibles, with the exception of Michigan, had a total enrollment rate of 19 percent. This finding is substantiated by the experience of Pennsylvania's PACE and PACENET programs. As reported above, a study commissioned by the state found that the enrollment rate in the PACENET program, which has a $500 deductible, was much lower than in the PACE program, which does not have a deductible. PACENET also has somewhat higher copayment requirements than does PACE ($8 generic or $15 brand for PACENET, $6 for all drugs for PACE), but most persons interviewed in the state cited the deductible as the largest barrier to enrollment in PACENET. According to program officials, this is partly because more than half of the people eligible for PACENET do not spend more than $500 a year on prescription drugs.

Table 8. Percent of Medicare Income-Eligible, Non-Medicaid Population Using State Pharmacy Assistance Programs and Program Features for FY2000

State	Year-End Enrollment as Percentage of Income-Eligible Persons	Filling a Prescription as Percentage of Income-Eligible Persons	Maximum Income Limit for 2000 (% FPL)	In-Person Interview	Fee	Deductible	Coinsurance[1]	Limit Number of Drugs or Conditions	Administered by Medicaid	Year Implemented/ Most Recent Expansion[2]	Expenditures per Enrollee, 2000
Total: States Without Fee, Deductible or In-Person Interview in Main Program	**56.2%**	**55.6%**									
Rhode Island	62.6%	34.2%	189%				X	X		1985/1999	$212
Pennsylvania	61.8%	64.1%	194%			X (PACENET only)				1984/1996	$1,328
New Jersey	53.9%	57.7%	226%							1976/1995	$1,732
Maine[3]	48.3%	29.5%	185%				X	X	X	1975/1999	$141
Vermont	45.1%	NA	225%				X (VScript only)	X	X	1989/2000	$1,171
Delaware[4]	37.6%	36.1%	200%				X		X	1981/2000	$441
Total: States with Fee, Deductible, or In-Person Interview in Main Program	**19.4%**	**17.4%**									
Massachusetts[3]	33.9%	NA	500%		X			X		1997/2000	$270
Connecticut	26.8%	NA	178%		X				X	1985/1998	$1,279
New York	18.7%	19.9%	225%		X	X			X	1987/1998	$1,486
South Carolina	18.7%	NA	175%			X				2000	NA
Illinois	15.3%	17.7%	194%		X			X		1985/1993	$749
Michigan[3]	7.1%	7.1%	150%	X				X	X	1988	$409

NA = data not available.

[1] Coinsurance is consumer cost-sharing at the point of use sale based on a percentage of a prescription's cost. States with no "X" in this column either have copayments or have no per-prescription cost-sharing requirements.

[2] Most recent major program expansion before July 2000.

[3] Data for expenditures are from 1999.

[4] Expenditures and program features are for the state DPAP program and the private Nemours program combined.

Sources: Rutgers Center for State Health Policy Survey of State Pharmaceutical Assistance Programs, December 2000; and National Pharmaceutical Council, *Pharmaceutical Benefits Under State Medical Assistance Programs,* 2000.

The results provided no evidence that use of coinsurance (consumer cost-sharing at the point of sale, based on a percentage of a prescription's cost) had a substantial adverse effect on enrollment relative to use of either copayments or no per-prescription cost-sharing. Indeed, states that required enrollees to pay a portion of the costs of the drugs they purchased through coinsurance had some of the highest enrollment rates. In addition, well-established programs generally showed higher enrollment rates than did newer programs, especially if they had implemented recent eligibility or benefit expansions. Whether a program was administered through the same agency as Medicaid and what level of income eligibility it established did not seem to have an impact on enrollment rates for these programs. Finally, as of 2000, only one state in this analysis required an in-person interview for enrollment (Michigan). Based on only one state, no firm conclusions can be drawn about the impact of in-person eligibility interviews on enrollment. However, it should be noted that this program had the lowest enrollment rate of all states.

Program outreach was not included in Table 8 since quantitative measures of program outreach could not be obtained from states. However, respondents in several case study states noted that outreach activities can have a substantial impact on program enrollment. In addition, most case study states experienced difficulty getting people enrolled when their programs began and reported that considerable outreach is needed during this initial period.

STATE STRATEGIES FOR INCREASING ENROLLMENT

This discussion of state strategies for increasing enrollment is based on case studies of eight SPAPs, in Maine, Massachusetts, Minnesota, Nevada, New Jersey, Pennsylvania, South Carolina, and Vermont. The outreach and enrollment efforts of these programs are summarized in Table 9. Outreach activities employed by the states included program brochures, mass media advertisements and public service announcements (PSAs), mailings to potentially eligible persons, and presentations at churches, pharmacies, and Area Agencies on Aging (AAAs). Key elements of the program enrollment process include the agency that administers the process, the length and complexity of the application, the reapplication period, and the method of income verification, if any. This section addresses how states combined these elements to address three major challenges of enrollment: increasing awareness of the program, simplifying the application process, and avoiding "welfare stigma."

Table 9. Key Outreach and Enrollment Strategies of Case Study States

State	Program(s)	Outreach Activities and Outlets	Application/Enrollment Efforts
Maine	Low Cost Drugs for the Elderly or Disabled (DEL)[1]	Brochure; toll-free hotline dedicated to program questions; AAAs; public service announcements (PSAs); Web page.	Applications submitted to Department of Revenue, where income verification is performed. Shared application with tax rebate. Two-page application.
Massachusetts	Prescription Advantage[2]	Brochure; radio, newspaper, and TV advertisements; AAAs; pharmacy events; AARP mailings; churches; special outreach to non-English-speaking population; public relations consultant contracted to develop outreach; Web page.	UMass Medical School is enrollment broker. Five- to six-page application with large type. Income disclosure optional.
Minnesota	Prescription Drug Program (PDP)	Brochure; radio advertisements; TV PSAs; AAAs; churches; pharmacy bag clip-ons; coordinated outreach with Medicare savings plans; special emphasis on rural populations; Web page.	Joint application with Medicaid. Recently simplified four-page application. Applicants report assets. Option of mailing application to county social service office or applying in person.
Nevada	Senior Rx Insurance	Brochure; PSAs; mailings to those persons likely to be eligible for the program (e.g., persons enrolled in the Medicare savings plans) and to all older persons in the state; AAAs; pharmacies; Web page.	State determines eligibility and insurer processes enrollment. Original two-step application process amended to single two-part application. Two-page application form.
New Jersey	Pharmaceutical Assistance to the Aged and Disabled (PAAD); Senior Gold	Brochure; toll-free hotline dedicated to program questions; annual mailing with utility bill advertising PAAD and utility assistance; AAAs; pharmacies; Web page.	Shared three-page application with other programs. Income verification through Department of Taxation. Lowest income persons reapply every two years, others every year. Applicants notified if may be eligible for Medicaid or QMB/SLMB.
Pennsylvania	Pharmaceutical Contract for the Elderly (PACE); PACE Needs Enhancement Tier (PACENET)	Brochure; occasional TV, radio, and newsprint advertisements; AAAs; legislative district offices; pharmacies; physicians; insurance companies; Web page.	One- to two-page application plus optional medical history survey. Annual income verification through Department of Revenue.
South Carolina	SilverCard Program	Brochure; toll-free hotline dedicated to program questions; TV PSAs; news coverage; AAAs; libraries; churches; special emphasis on rural populations; Web page.	Open enrollment period. One-page application. Can apply directly over Internet. Must reapply every two years. Applicants notified if may be eligible for Medicaid.
Vermont	Vermont Health Access Program (VHAP); VScript; VScript Expanded	Brochure; TV PSAs; application included with tax forms; pharmacy bags with pharmacy program and QMB/SLMB information; AAAs; Web page.	Separate application from Medicaid. Two-page application. Application sent to Department of Taxes, but income is not verified. Health Access Eligibility Unit processes applications.

[1] DEL was consolidated into the Healthy Maine Prescription Program (HMPP) in 2001.

[2] In 2001 Prescription Advantage replaced two former state pharmacy programs: the Pharmacy Program and Pharmacy Program Plus.

Source: Rutgers Center for State Health Policy Case Studies, September 2000-August 2001

Raising Program Awareness: Outreach and Education Efforts

Outreach strategies utilized by states differed in whether they were targeted only to populations potentially eligible for the program or were broad campaigns to the wider community. The choice of what strategy or combination of strategies to employ often depended on the amount of funding available for outreach and on the demographics of the population that the state was trying to reach.

Targeted Outreach Strategies

When looking to maximize the impact of outreach dollars, states generally chose to target those likely to be eligible for the programs. They often piggybacked on other programs for the low-income elderly and/or disabled to identify persons who were eligible. Some states have even shared applications for these programs to ensure that applicants also applied for enrollment for the pharmacy programs. In Nevada and Maine, SPAP eligibility is linked to property tax rebate and rental assistance programs. Nevada also used the mailing list for its tax rebate program to disseminate information about its pharmacy program. Minnesota's Prescription Drug Program has the same income eligibility requirements as the Medicare Specified Low-Income Medicare Beneficiary (SLMB) program, and the state has disseminated information about the program to all Qualified Medicare Beneficiary (QMB) and SLMB enrollees in the state. After enrollment in the program continued to lag, the state went so far as to automatically enroll all of their QMB and SLMB enrollees into the pharmacy program.

Coordinating outreach with other means-tested programs allows states to make sure that all those receiving the outreach materials are also eligible for the program, eliminating wasted outreach to ineligible persons. However, eligible persons who are not enrolled in the other programs will not be reached by these methods. States have relied on AAAs and senior advocacy groups to distribute information about their pharmacy programs. While these organizations do not deal only with low-income populations, they are targeted to older persons and have the advantage of being seen as resources for information on programs for the elderly. Outreach through these organizations was seen by the case study states as very important in getting a significant number of eligible persons to enroll in the programs, but some respondents said that information provided through these entities would not reach certain populations. As one respondent noted, states can always reach people who go to senior centers, get meals, or are home-care clients, but it is much more difficult to reach people who do not even know about the senior centers or the state's office on aging and do not receive any other services. These persons are often members of hard-to-reach populations, such as non-English speakers and persons who live in inner-city and rural areas. Generally, states have tried to reach these populations through "nontraditional" methods. These methods have included conducting outreach

through local churches, hospitals, and minority advocacy groups and going door-to-door. Most case study states reported having their brochures and outreach materials translated into languages other than English. Massachusetts trained members of Portuguese, Chinese, and Spanish advocacy groups so that those members could be contact points for the program in their communities. AAAs also constitute an important part of these outreach efforts, and states such as South Carolina have paid AAAs to actively seek out applicants to their pharmacy program.

Pharmacies are another important venue for targeted outreach. Several states have asked pharmacies to hand out information on their SPAPs to elderly customers. Pharmacists usually do this by attaching a program brochure and application to the customer's prescription bag, or by having brochures or signs advertising the program displayed in the stores. The states saw pharmacies as an effective point of contact with persons who have a need for prescription drug coverage, particularly for persons who may not have contact with AAAs or other senior organizations. Pharmacy representatives generally felt that pharmacies were a good place to advertise programs, and some noted that the services of pharmacists could be further utilized for assistance in completion of applications. However, pharmacy organizations and some individual pharmacies or chains were less likely to support these programs when SPAP pharmacy reimbursement was perceived to be low.

Broad Outreach Strategies

Another way to reach potential applicants is through broad outreach strategies such as public service announcements (PSAs), mass media campaigns, and mass mailings. These methods have the potential to reach many people who are eligible for the programs, but are less suited to targeting specific priority subpopulations. Massachusetts and Minnesota have aired radio advertisements for their programs on foreign language stations in an effort to reach non-English speakers. In addition, program administrators in Massachusetts used a mass media campaign of radio, television, and newspaper ads to inform middle- and upper-income seniors about the state's Prescription Advantage insurance plan and to encourage them to buy into it and pay the higher premiums required of them. The state contracted with a public relations firm to create focus groups and surveys to develop the appropriate advertising framework, including television commercials. Clearly, this type of outreach program required an extensive funding commitment from the state.

Funding Dedicated Explicitly to Outreach

Often, the extent of a state's outreach campaign is largely dependent on the amount of funding dedicated to outreach activities. All respondents agreed that outreach activities

supported by adequate funding at program initiation were necessary for these programs to be able to reach a significant proportion of their target group. However, very few case study states allocated any funding on an annual basis for outreach.

Among the states studied, only Maine and Massachusetts have set aside specific funds for outreach for their pharmacy programs. Maine dedicated $100,000 of state general funds from 1998 to 2000 to expand outreach for its Low Cost Drugs for the Elderly and Disabled (DEL) program. Massachusetts emphasized the importance of outreach by setting aside $1.9 million for outreach for Prescription Advantage in the first year, enabling the state to deploy extensive education and advertising about the program.

Several states have been able to leverage federal funding for outreach from the Medicare savings programs for their state pharmacy programs. Vermont and Minnesota applied for funds from the Centers for Medicare and Medicaid Services (CMS) to increase enrollment in their Medicare savings programs and were able to get additional CMS funds to include their pharmacy benefit programs in the outreach campaigns. The amount of CMS funding received by the states ranged from $20,000 to $40,000.

Even when states did not initially dedicate funds to outreach, low program enrollment often spurred the legislature to appropriate outreach funds, or prompted the program administration to redirect funds to outreach. When faced with low enrollment during the first few months after program start-up, Nevada redirected funds to pay for outreach and the program's insurer provided funds to do an informational mailing to potentially eligible persons. Maine did little outreach for the DEL program until a task force on prescription drugs found that the state was not reaching a significant portion of people eligible for the program. At that point the legislature dedicated funds for program outreach, and the state initiated a campaign to get eligible people enrolled.

Perceived Effectiveness of Outreach

The effectiveness of outreach programs in increasing program awareness or enrollment is difficult to measure, but may be inferred from associated changes in program awareness or enrollment numbers. States reported that their outreach campaigns met with varying degrees of success in increasing program enrollment, but most reported at least some positive results, and several reported considerable enrollment increases after outreach campaigns for program expansions. However, these enrollment increases may also have been partly due to expanded eligibility and improvements in the value of the benefit. For example, in 1998 Maine expanded its outreach and education efforts on behalf of the DEL program. Enrollment nearly tripled between 1997 and 2000, from 13,671 to 40,277.

However, the increase probably reflects a concurrent increase in the types of drugs covered (in 1998 and 1999), a reduction of the age at which disabled persons could be deemed eligible for the program (from age 55 to 18 in 1997), and an increase in the income eligibility limit (in late 2000). Enrollment in the Pharmacy Program in Massachusetts also increased in conjunction with an expansion in outreach. Enrollment grew from 18,500 in 1997 when the program was established to 67,000 in 2000. The largest increase came between 1999 and 2000, when enrollment rose from 33,000 to 67,000. These enrollment increases were associated with eligibility expansions in 1998, 1999, and 2000, so the effect of outreach on enrollment increases independent of eligibility expansions cannot be directly measured. However, during this same period, a survey found that awareness of the Pharmacy Program increased from 35 percent to 55 percent of all seniors between 1998 and 2000, suggesting that the increased outreach efforts were effective.[9]

Pennsylvania was the only state that did not report an increase in program enrollment following an outreach campaign. In the late 1990s, the state spent $1 million in a media campaign promoting the PACE program, which reportedly netted no increase in program enrollment. Program officials felt that this was probably because the program had already been in place for several years and that most people who were eligible for the program, and wanted to sign up for it, were likely already enrolled. As stated earlier, the state had commissioned a study of program take-up that indicated that PACE was enrolling more than 90 percent of people thought to be eligible for the program.

Educational Outreach and Counseling

Several respondents noted that individuals did not always fully understand their benefits when they enrolled in a SPAP, particularly when the benefit design was complicated. This suggested the need for an educational component in outreach campaigns. For example, both South Carolina's program and Pennsylvania's PACENET program have a $500 deductible, and respondents from both states reported that some seniors misinterpreted the $500 deductible as an enrollment fee that they thought they had to pay in order to enroll. In addition, pharmacy representatives from several states reported that pharmacists often had to educate new enrollees about program benefits. To address this issue, states trained volunteers to explain the benefits to applicants. Some states also set up a help line dedicated to answering questions about program eligibility requirements, drug formularies, and copayments, making them especially important for programs with complicated benefit designs.

[9] Nixon, *Access Update: Massachusetts Elderly,* March 2001.

Effective Timing of Outreach Campaigns

Finally, the experiences of several states demonstrated that timing was as important as the type of outreach activities. One state conducted a mass mailing close to the date of an election, and state staff thought that their message might have been lost in the clutter of mail that people received at that time. Another developed an outreach program to distribute information and application forms with prescription orders at pharmacies, but soon after a different department changed the application form and added a new pharmacy program that was not mentioned in the packets. Respondents noted that such timing glitches could be avoided with better interdepartmental communication about upcoming program changes.

Application and Eligibility Determination Procedures: Balancing Simplicity and Accountability

In designing the application and eligibility determination process, states have had to balance the need to establish and verify eligibility with the need to have a simple and straightforward application form. Long, complicated forms that require a significant amount of confidential information may be burdensome and keep eligible people from enrolling in the programs, while short forms that do not gather sufficient information may make it difficult for the state to verify age, income, and residency requirements.

Length and Complexity of Forms

The length and complexity of enrollment forms vary greatly among states. Forms range from one to six pages, with most having a two- or three-page application. Although all states offered assistance in filling out application forms at AAAs or through the hot-line numbers, program officials still felt that the difficulty of completing applications was a potential barrier to enrollment. Many states indicated that they had shifted to shorter, simpler forms over time. However, even states with short forms have found that people may still have difficulty completing them accurately.

Reporting Requirements and Documentation

All states except Massachusetts have upper-income eligibility limits and require applicants to report their income on applications. There was some concern among respondents that people who do not want to divulge this information may forgo applying to the programs.

There is wide variation in documentation requirements for income, age, residency, and (if applicable) disability among different states. Vermont, South Carolina, and Nevada do not require documentation of any eligibility data. Vermont and South Carolina audit questionable applications and request more information and South Carolina and Nevada

perform random audits of income eligibility, comparing pharmacy application submissions against tax records. Applicants for the programs in Pennsylvania, New Jersey, Minnesota, and Massachusetts have to submit proof of income along with their applications—usually their federal income tax return for the previous year or (if no income tax return was filed) other documentation such as pay stubs or Form 1099 for Social Security income. New Jersey and Pennsylvania also require applicants to authorize the state to verify tax return information against applicants' tax records. Maine, on the other hand, has applicants mail their enrollment forms to the state revenue services department, where applicants' incomes are verified against their tax records. This sort of behind-the-scenes verification of income may help allay some of the concerns that applicants have with submitting personal documents to verify their income, and it may also reduce the perceived burden of the application process.

Reapplication Process and Open Enrollment Periods

States see the frequency of the application process as affecting retention of enrollees. Most require reapplication every year. However, some states have two-year reapplication periods either for everyone or for specific groups. South Carolina requires reapplication only on a biennial basis, partly as a matter of convenience and partly to save administrative costs. Pennsylvania and New Jersey require that higher-income enrollees reapply every year, while lower-income enrollees only have to reapply every two years, as it is less likely that their circumstances would change to make them ineligible.

Among the eight states, only South Carolina had an annual open enrollment period for applying to the program (although Massachusetts has recently instituted an open enrollment period). People can apply for the program at other times of the year if they have a qualifying event (such as their 65th birthday or a loss of income) that would make them eligible for the program. Program officials stated that the open enrollment model worked well the first year (2000), with the state receiving 68,000 applications and enrolling 31,000 applicants. In October 2001, the state had a second open enrollment period, which resulted in 5,700 additional enrollees.

Auto-Enrollment of Eligible Persons

A few states automatically enroll eligible persons in the state pharmacy program when they are enrolled in other state programs with comparable eligibility requirements. For example, Minnesota's PDP program has the same income eligibility requirements as the Medicare SLMB program, and in 2000 the state automatically enrolled QMB/SLMB enrollees into PDP after an enrollment fee was dropped from the program. Minnesota also automatically enrolls people applying for PDP into Medicaid, if they are found to be

eligible. According to one program official, this is required under state law in order to draw down federal matching funds for coverage of those persons. However, another state official interviewed felt this practice unfairly forces people into Medicaid who may not want to be in the program because of "welfare stigma" or other issues. It should be noted that Medicaid programs often provide better prescription drug benefits to enrollees than the SPAPs. For example, state Medicaid programs require little or no consumer cost-sharing and often cover more drugs than are available in the SPAPs.

The Relationship Between SPAPs and Medicaid

As of March 2002, two-thirds of state pharmacy programs were administered through the same department as the Medicaid programs, which have considerable experience in administering means-tested programs, including pharmacy benefits (Table 10). Many respondents commented that locating a senior pharmacy program in the same department as Medicaid may hinder enrollment because of the "welfare stigma" associated with Medicaid. Some respondents thought that the elderly were particularly sensitive to welfare stigma. Respondents in states that chose not to locate their SPAP in the Medicaid agency most often cited avoidance of stigma as the primary reason for choosing to place the program in an independent agency. Some states, such as Maine and Vermont, had applicants send their enrollment forms to the state's Department of Revenue/Taxation to avoid the stigma of applying to the Medicaid agency.

Table 10. Agencies Administering State Pharmacy Assistance Programs, March 2002

State	Department	Same as Medicaid?*
Arizona	Arizona Health Care Cost Containment System	Yes
Arkansas	Department of Human Services	Yes
Connecticut	Department of Social Services	Yes
Delaware (Nemours)	Nemours Foundation (private)	No
Delaware (DPAP)	Division of Social Services	Yes
Florida	Agency for Health Care Administration	Yes
Illinois[1]	Department of Revenue	No
Indiana	Family & Social Services Administration	Yes
Kansas	Department of Aging	No
Maine	Bureau of Medical Services	Yes
Maryland	Department of Health and Mental Hygiene	Yes
Massachusetts	Executive Office of Elder Affairs	No
Michigan	Department of Community Health	Yes
Minnesota	Department of Human Services	Yes
Missouri	Department of Health and Senior Services	No

State	Department	Same as Medicaid?*
Nevada	Department of Human Resources	Yes
New Jersey	Department of Health and Senior Services	No
New York	Department of Health	Yes
North Carolina	Department of Health and Human Services	Yes
Oregon	Department of Human Services	Yes
Pennsylvania	Department of Aging	No
Rhode Island	Department of Elderly Affairs	No
South Carolina	Budget & Control Board, Employee Insurance Program	No
Texas	Health and Human Services Commission	Yes
Vermont	Department of Prevention, Assistance, Transition, and Health Access	Yes
Wisconsin	Department of Health and Family Services	Yes
Wyoming	Department of Health	Yes

* Single State Agency.

[1] In January 2002, Illinois was granted a Medicaid waiver to provide Medicaid prescription drug–only coverage to most of the people eligible for their existing SPAP program. This new program will be administered through the Department of Public Aid, the same agency that administers the state Medicaid program.

Source: Rutgers Center for State Health Policy Survey of State Pharmaceutical Assistance Programs, December 2000; the National Conference of State Legislatures' website: State Pharmaceutical Assistance Programs (includes seniors, disabled, uninsured, and others), http://www.ncsl.org/programs/health/drugaid.htm/, accessed March 5, 2002.

Of the case study states, Minnesota was the only one in which the pharmacy program did not have an application and eligibility process separate from Medicaid; both programs share the same enrollment card. Many stakeholders and some program officials in Minnesota believed that the decision to merge the pharmacy programs with other means-tested programs might have hindered SPAP enrollment. However, one program official noted that, since the eligibility limits of the program are the same as for the SLMB/ Medicaid program, it made sense to use the same application form for both programs. The state would provide applicants the most comprehensive benefit available to them.

Although a Medicaid "welfare stigma" is a concern for some states, other states have not found it to be an issue that affects enrollment. Maine, for example, had over 111,000 enrollees in its Medicaid waiver discount program as of August 2002. According to a program official, enrollees have not expressed uneasiness or left the program because of its association with Medicaid. In the state-to-state comparisons shown in Table 8, there was no clear relationship between our take-up benchmarks and a program's association with a Medicaid agency.

CONCLUSION

States have employed a variety of methods to increase awareness of their SPAPs. Many states have been successful in reaching their target populations, and yet the patchwork of direct-benefit state pharmaceutical assistance programs as a whole reached only about 7.6 percent of the Medicare beneficiaries in these states in the year 2000. Thus, while SPAPs addressed a great need among the people they covered, they constituted a benefit of only limited reach, even in states that committed funds to pharmacy assistance. Nevertheless, case study states were committed to enrolling eligible individuals and put effort into outreach and making the application and enrollment process as easy as possible.

Better State-Level Data Are Needed to Support Estimation of the Eligible Population and Take-Up

While SPAPs may not account for a large proportion of Medicare beneficiaries in most states, many do seem to be reaching large proportions of the persons who actually qualify for them. It is important for states to know how many people are potentially eligible for their programs. This knowledge would help states gauge what their enrollment numbers should be and whether increased outreach is needed. However, accurate state-level data on prescription drug coverage among the elderly and disabled are not widely available and some states either exclude or restrict the eligibility of persons with other coverage. Some of these states have invested in collecting such data and found them useful in evaluating programs.

Benchmark Rates Vary Widely Among States

The data that were available for all states suggest that many of the programs were doing a good job in reaching their target populations, but rates for our benchmarks varied widely among states. Program enrollment was increasing in 10 of the 14 states surveyed, with some more than doubling in size between 1999 and 2000. Such continued growth would expand the proportion of the target population enrolled in these programs. However, it appears that the major constraints on covering a larger proportion of the low-income elderly and disabled population are associated with program design and maturity rather than education and outreach. States that required up-front costs to enroll tended to have lower enrollment rates than programs that did not have these features. This factor seemed to be more important for enrollment than did overall program generosity. In contrast, coinsurance (consumer cost-sharing at the point of sale based on a percentage of a prescription's cost) was not associated with lower enrollment rates relative to states with either copayments or no per-prescription cost-sharing. In addition, more mature programs, such as those in New Jersey and Pennsylvania, appear to have largely reached their target populations, and these states are currently struggling to afford the cost of existing benefit levels.

While Program Design Is Key, Adequately Funded, Effectively Designed Outreach Is Also Needed, Particularly at Program Start-Up

All case study states indicated the need for outreach to get eligible persons enrolled in their programs, especially when the programs were starting up. Several respondents expressed the view that states may not invest in outreach campaigns during start-up because they are concerned that the programs will be overwhelmed with applicants and outstrip their budgets. However, the experience of case study states has often been that initial program enrollment was lower than expected, frequently spurring legislatures either to appropriate funding for outreach or to expand the eligibility limits for the programs. As shown by our study, low enrollment could be avoided by appropriate outreach to the eligible population.

States' experiences have shown that outreach must have certain components, including an educational component, to make it effective. In several states, enrollees did not understand the nature of the benefit they were to receive. This problem was compounded in states that had more complex benefit designs in terms of cost-sharing or drugs covered. Several states also emphasized the need to target outreach to hard-to-reach populations, such as those who do not speak English and those who live in rural sections of the state. In addition, states found that outreach campaigns must be designed carefully to avoid timing or information errors.

States were often able to leverage their outreach efforts by linking them to outreach for other programs for low-income seniors. States with programs that cover people with higher incomes have been struggling with the best methods to reach this population, since such individuals may not be accustomed to looking to the state for assistance.

Most case study states reported that their outreach efforts were successful in increasing program enrollment and/or awareness, particularly if program take-up was low at the time. However, states emphasized that such outreach needs to be appropriately funded for it to be effective. Few case-study states devoted significant ongoing funds to outreach, but those that did were generally able to increase program enrollment.

States Have Attempted to Simplify the Application Process While Maintaining Accountability

Since most state programs have eligibility income limits, states have struggled to balance the need to collect and verify income information with their desire to keep the application process as easy and simple as possible. Several case study states have attempted to simplify their enrollment forms in order to make the process less burdensome. However, there is still a need to make applicants accountable for the information they submit, and some

states have been able to do so while minimizing the need for a complex application process by verifying income through tax records. Some states have applicants submit their tax returns for the previous year, while others verify information on the enrollment form with the state Department of Revenue or Taxation. Maine made this process even easier by having applicants submit their applications directly to the Department of Revenue.

States have also reduced the burden of application by extending program eligibility from one year to two years for enrollees and by automatically enrolling persons who are already enrolled in other low-income benefit programs.

Reducing the Impact of "Welfare Stigma"

One complication in both the outreach and application processes reported by states was the impact of welfare stigma on potential applicants' perceptions of the programs. States generally tried to distance their programs as much as possible from the Medicaid program for fear of discouraging people who did not want to sign up for a welfare program. Some states dealt with this by housing their program in another department, such as the Department of Aging. In programs located in the same department as Medicaid, states often had applicants submit their enrollment forms to a different office. In addition, respondents indicated that some people objected to being enrolled in Medicaid when they applied for the pharmacy benefit program, even if the Medicaid benefits were superior. However, some respondents pointed out that Medicaid stigma is not an issue for some people, and that the stigma attached to Medicaid varies greatly among states. In fact, there was no clear relationship between our take-up benchmarks and a program being located in the same department as Medicaid. One state official noted the state's obligation to provide applicants with the most comprehensive benefit available, and that many applicants would want to receive the best benefit for which they qualified. Still, many respondents felt that the states should provide applicants with the option to choose which programs they would be enrolled in, and that SPAPs, particularly those targeted at higher-income groups, should minimize their association with welfare-type programs.

Future Challenges and Opportunities

Since our survey was conducted in December 2000, several additional states have implemented pharmacy assistance programs. As of January 2003, the National Conference of State Legislatures reports that a total of 26 states have enacted programs to provide subsidies for prescription drugs to their elderly residents.[10] In addition, several states in our survey implemented significant expansions in eligibility levels and benefits in 2001. These

[10] National Conference of State Legislatures, *State Pharmaceutical Assistance Programs* (Washington, D.C.: NCSL, January 6, 2003). Available at http://www.ncsl.org/programs/health/drugaid.htm/.

developments should increase the number of persons enrolled in SPAPs nationwide. The creation and expansion of SPAPs also is encouraged by the recent federal approval of Medicaid Section 1115 waivers to bring enrollees in SPAPs in several states under Medicaid drug coverage.

- While the need for pharmacy assistance is an active political issue in many, if not most, states, these same states are typically under considerable budgetary pressure and struggling with health care expenditures such as the cost of Medicaid programs. Thus, significant improvements in pharmacy coverage are likely to depend on federal policy. In implementing new federally funded or federally assisted programs, the need for program outreach and the lessons learned in this area from existing state programs should be carefully considered. Traditional outreach activities focused on program awareness are only one of several factors important for access and enrollment rates. Simplifying application procedures and income verification, avoiding a "welfare" image for the program, and eligibility coordination or automatic enrollment appear to be particularly important elements of strategies to improve access. Adequate funding for public information activities and assistance with understanding program rules also are essential for such initiatives. The more extensive and complex the choices presented to consumers in such programs, the more investment in outreach and education is likely to be needed. However, states' experiences show that benefit design is a very important factor in program enrollment, and a program that requires up-front costs from enrollees may have difficulty attracting a substantial number of eligible people.

APPENDIX. STUDY METHODOLOGY

The findings of this study 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 eight states, and reviews of the literature and program documents. The survey was conducted by the 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). The 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, the National Governors Association, and the National Pharmaceutical Council. Survey questions addressed program history and administration, sources of funding, eligibility requirements, drugs covered, participant cost-sharing, program cost-containment strategies, and changes in program design over time. States also were asked to supply available data on the estimated number of eligible individuals, applications received, program enrollment, enrollee demographics (by age and race/ethnicity if available), active users, program budget, expenditures (claims and administrative costs), and revenues and net program costs for fiscal years 1999 through 2001.

Two state pharmacy program administrators reviewed the survey design to ensure that it was sufficiently comprehensive but not excessively burdensome on program officials. For eight of the 15 states, information from state websites and annual reports was gathered prior to sending the survey to program directors. Respondents were asked to confirm, correct, or add to this information where needed. After telephone follow-up, we received surveys from 14 of 15 states (18 out of the 19 programs), resulting in a response rate of 93 percent. The completion rate of individual questions varied significantly by state. While states were able to provide most descriptive information on their programs, few states supplied estimates of persons eligible, demographics of their enrollees, or the number of active users.

Estimating Program Enrollment Rates

Information for the estimates of program enrollment rates was taken from the Annual Demographic Survey component of the Current Population Survey (CPS), also known as the March Supplement. The sample for the March CPS consists of the basic CPS sample plus an additional sample of Hispanic households and includes questions on individual and household income for the previous year.[11]

[11] http://www.bls.census.gov/cps/ads/1995/ssampdes.htm/.

All states are covered in the CPS, but the states are not all allocated the same sample size. Rather, the allocation of sample size to the states is made with the aim of balancing the precision requirements of both state and national estimates. As a result, there are great disparities in sample size by state. Given the precision requirements used, it is possible to estimate the proportion of the total population in a state with a characteristic for almost all states from the CPS; however, the precision of estimates is much more problematic for population subgroups, such as the elderly. In addition, the CPS does not cover every county within each state. For example, in New Jersey, 18 out of 21 counties are represented in the survey. A study of the precision of estimates indicated that sample sizes of less than 50 individuals produced very unstable estimates, and it has been recommended that two or more years of CPS data be combined to increase state sample sizes and reduce sampling error.[12,13] In order to improve the CPS state estimates of uninsured children that are used to determine funding allocations for the State Children's Health Insurance Program, the sample for the CPS March Supplement was expanded beginning with the 2001 survey.

In the current analysis, three years of CPS data (from 2000, 2001, and 2002) were merged to obtain more households and individuals. These merged data were used to calculate the number of age and income eligible persons in each state. The 2001 March Supplement of the CPS measures income levels for 2000 and was used as the reference year for the averages. Year 2000 age, disability, and income eligibility requirements for the programs were used to estimate the number of potentially eligible persons in each state. Unweighted sample sizes of income eligible persons for states ranged from 114 to 628, with smaller sample sizes for less populous states (Connecticut, Delaware, Maine, Rhode Island, South Carolina, and Vermont). Thus, the estimates for these states should be interpreted with some caution. However, the estimates for larger individual states and for groups of states (i.e., those with and without fees or deductibles) are more precise. After combining three years of CPS data, the sample size for Minnesota was still small (50 persons), so this state was dropped from the analysis of income and age eligible persons.

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[12] L. Alecxih, J. Corea, and D. Marker, "Deriving State-Level Estimates from Three National Surveys: A Statistical Assessment and State Tabulations" (Washington, D.C.: U.S. Department of Health & Human Services/ASPE, #HHS-100-012, May 1998).

[13] It has been estimated that, compared with one-year CPS estimates, three-year averages reduce the sampling error of state insurance coverage estimates by 30 percent. State Health Access Data Assistance Center, *The Current Population Survey and State Health Insurance Coverage Estimates,* Issue Brief #1 (Minneapolis: Regents of the University of Minnesota, March 1, 2001). Available at http://www.shadac.org/resources/issuebriefs/2001/3/ib_26.asp/.

Case Studies of States with Pharmacy Assistance Programs

To supplement the surveys and more fully understand how various programs operate in practice and have evolved over time, we selected a total of eight states with direct-benefit programs for in-depth qualitative case studies. Two of these case studies were conducted in 2000 for a parallel study funded by the AARP Public Policy Institute, which focuses on how states have addressed prescription affordability (in that project, we also studied a state that operated a discount program only). The remaining case studies were conducted in 2001, and states were selected based on five criteria, including representation of a diversity of program models, balance between well-established and newer programs, relevance to Medicare proposals being discussed, program size, and regional distribution. We utilized the survey data and supplemental information collected through a literature review on programs recently implemented to select states based on these criteria. We also utilized information collected through our literature review to assess other state models for addressing drug affordability issues.

The final states selected for case studies were Massachusetts, Minnesota, Nevada, Pennsylvania, South Carolina, and Vermont, in addition to Maine and New Jersey, which were selected for the AARP study.[14] 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, program design, 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 agencies involved in outreach or administration (6), representatives of pharmacy benefits managers 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.

[14] 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.

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#648 *Whither Seniors' Pharmacare: Lessons from (and for) Canada* (May/June 2003). Steven G. Morgan, Morris L. Barer, and Jonathan D. Agnew. *Health Affairs,* vol. 22, no. 3. (*In the Literature* summary). The authors find that the tension between seniors' health needs and drug industry policies has hampered effective prescription drug regulation, and argue that political leadership and more comprehensive utilization management and competitive pricing policies are needed to create a sustainable pharmaceutical benefit program in Canada and abroad.

#646 *Reference Pricing for Drugs: Is It Compatible with U.S. Health Care?* (May/June 2003). Panos Kanavos and Uwe Reinhardt. *Health Affairs,* vol. 22, no. 3. (*In the Literature* summary). The authors explore arguments for and against reference pricing—an approach in which the insurer covers only the prices of low-cost, benchmark drugs and patients pay the difference in price for higher-cost alternatives—and discuss how this approach might work in the United States.

#628 *Medicare+Choice Plans Continue to Shift More Costs to Enrollees* (April 2003). Lori Achman and Marsha Gold, Mathematica Policy Research, Inc. The authors report that in 2003: monthly plan premiums for beneficiaries in Medicare+Choice average $37, up from $32 in 2002 and $23 in 2001; the percentage of enrollees with drug coverage is slightly down, while a larger percentage of plans provide coverage only for generics; and a higher percentage of enrollees now have copayments for hospital stays and physician visits.

#627 *State Medicaid Prescription Drug Expenditures for Medicare–Medicaid Dual Eligibles* (April 2003). Stacy Berg Dale and James M. Verdier, Mathematica Policy Research, Inc. This issue brief reports that Medicaid prescription drug coverage for approximately 6 million "dual eligibles"—low-income seniors and persons with disabilities who are covered by both Medicaid and Medicare—accounts for nearly half of all Medicaid spending on prescription drugs, including both federal and state shares of Medicaid prescription costs.

#591 *New York Seniors and Prescription Drugs: Seniors Remain at Risk Despite State Efforts—Findings from a 2001 Survey of Seniors in Eight States* (December 2002). David Sandman, Cathy Schoen, Deirdre Downey, Sabrina How, and Dana Gelb Safran. Although New York has one of the nation's largest and most effective prescription drug assistance programs for the elderly, nearly one of five seniors in the state had no coverage for medications in 2001, according to this analysis. As a result of lack of coverage or inadequate benefits, one-fifth of all New York seniors, including one-

third of those without drug coverage, reported they skipped doses of medication or did not fill a prescription because of cost concerns.

California Seniors and Prescription Drugs (November 2002). Tricia Neuman, Michelle Kitchman, Teresa McMeans, Dana Gelb Safran, Wenjun Li, and Andrea Bowen. Copies of this report (#6058) are available from The Henry J. Kaiser Family Foundation, 1450 G Street, NW, Suite 250, Washington, DC 20005, Tel: 800-656-4533, http://www.kff.org/content/2002/6058.

#544 *Stretching Federal Dollars: Policy Trade-Offs in Designing a Medicare Drug Benefit with Limited Resources* (August 2002). Marilyn Moon and Matthew Storeygard, The Urban Institute. In this policy brief, the authors suggest that a modest Medicare prescription drug benefit could be crafted that provides some coverage to all beneficiaries while protecting those with low incomes and high out-of-pocket expenses.

Prescription Drug Coverage and Seniors: How Well Are States Closing the Gap? (July 31, 2002). Dana Gelb Safran, Patricia Neuman, Cathy Schoen, Jana E. Montgomery, Wenjun Li, Ira B. Wilson, Michelle S. Kitchman, Andrea E. Bowen, and William H. Rogers. *Health Affairs* Web Exclusive. Article available online only at http://www.healthaffairs.org/WebExclusives/2105Safran.pdf.

Seniors and Prescription Drugs: Findings from a 2001 Survey of Seniors in Eight States (July 2002). Michelle Kitchman, Tricia Neuman, David Sandman, Cathy Schoen, Dana Gelb Safran, Jana Montgomery, and William Rogers. Copies of this report (#6049) are available from The Henry J. Kaiser Family Foundation, 1450 G Street, NW, Suite 250, Washington, DC 20005, Tel: 800-656-4533, http://www.kff.org.

#530 *State Pharmaceutical 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.