The Institute for Health, Health Care Policy, and Aging Research

Impact of Budget Pressures on State Pharmacy Assistance Programs, FY 2003–2004

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EXECUTIVE SUMMARY

State pharmacy assistance programs have helped many low-income older and disabled adults access prescription drugs by offering them subsidized drug coverage at minimal cost. These programs served approximately 1.3 million elderly and disabled persons in 2002. In FY 2003, twenty-one states had pharmacy assistance programs that were fully operational,[1] with total expenditures estimated at $2.1 billion.

With the enactment of Medicare prescription drug legislation, states have begun a process of re-evaluating their future roles in pharmacy assistance. As the federal legislation provides for more limited coverage to low and moderate-income individuals than provided by many existing state programs, many states will be considering ways to complement or "wrap around" the federal benefits to address gaps in the federal coverage. However, in doing so, they face many financial constraints and competing needs. In this context, it becomes particularly important to examine their recent experience in funding pharmacy assistance in the face of budgetary pressures.

As states planned and enacted their budgets for the 2004 fiscal year, they confronted a particularly difficult fiscal environment. In a number of states, budget gaps raised questions about the sustainability of existing pharmacy programs or about the feasibility of program expansions that were under discussion, even though there was a widespread sense of the need for such programs. As states faced the largest deficits in decades, they were forced to reassess spending on a number of programs. To assess the impact of state budgetary pressures on SPAPs, we surveyed states with programs that were operational as of August 2002, and conducted subsequent in-depth telephone interviews with pharmacy assistance program directors, focusing on the impact of budgetary shortfalls. Of the 21 such states surveyed, eighteen participated in the telephone interviews. The surveys were completed in October 2002 and telephone interviews were conducted in March-April 2003.

The report discusses the extent to which SPAPs have faced budget cuts; how states have modified their programs in response to fiscal pressures; why these particular approaches were selected; and the potential implications of these changes for consumers. Key findings include:

- Despite the grim budget outlook for states in FY 2004, states maintained their commitment to providing drug coverage to low-income elderly residents and some programs were even expanded. At the time of our study, only Massachusetts was seriously considering eliminating its program, Prescription Advantage, and even this program was restored in the final budget. Nevertheless, the pressures experienced by these programs and the uncertain financial base of some of them suggest considerable uncertainty as to states' future role in pharmacy assistance and their ability and willingness to fill the substantial gaps in benefits provided under Medicare legislation – particularly in states where pharmacy assistance programs are less well established.

- Although many SPAPs were new and relied on state funding -- factors which could increase their vulnerability in a time of state budget crisis -- most program directors felt that the state pharmacy program was better protected from budget cuts than was the Medicaid program. Even in states that anticipated some budget cuts in FY 2004, cuts to the SPAP were anticipated to be proportionally much smaller than Medicaid cuts. In general, program directors attributed this higher level of protection to the high popularity and visibility of the SPAP programs, the well-organized constituency supporting them, and the fact that expenditures for most of the SPAPs represented a relatively small portion of the overall state budget.

- Some states reported that Medicaid Pharmacy Plus waivers would minimize the immediate fiscal pressures on their SPAPs. Six of the twenty-one states with pharmacy assistance programs had received approval for a Pharmacy Plus waiver as of November 2003 and another eight states with pharmacy assistance programs had applied and were waiting for approval, in order to expand their current programs. States believed that such waivers could reduce the burden on state general funds by qualifying the states for federal Medicaid reimbursement on behalf of some or all current SPAP enrollees. Some state officials were concerned, however, that the waivers could prove a mixed blessing, because the federally-imposed financial caps,

required as part of the waiver process, place states at increased financial risk. If Medicaid program costs exceeded cost projections over a five-year period, states could be at risk for the full expense of cost overruns for all Medicaid services for the elderly.[2]

Despite such concerns, however, the availability or potential availability of Pharmacy Plus waivers, with their ability to leverage state with federal dollars, encouraged many states to expand their role in pharmacy assistance. In the new environment created by the enactment of the Medicare prescription drug legislation, signed into law in December of 2003, such incentives to states will change, and they are likely to have fewer opportunities to leverage (as opposed to supplement) federal funds. The impact of this factor on their continued willingness to commit state funds to pharmacy assistance remains uncertain. In addition, the Medicare prescription drug legislation has created one potential disadvantage for states that have been awarded Pharmacy Plus waivers at least in the short term. While SPAP enrollees are eligible for the interim Medicare discount card as well as the $600 subsidy for low-income persons, Medicaid eligible persons, including those eligible through Pharmacy Plus waivers, are not.[3] States are currently evaluating the full impact of the Medicare legislation on both Medicaid and SPAP programs. The jury is still out on whether Pharmacy Plus waivers will result in more or less savings particularly given the 'claw-back' provisions that significantly reduce Medicaid savings resulting from the Medicare drug benefit.

- Facing escalating program costs, many SPAPs employed cost containment strategies utilized by Medicaid and the private sector to reduce spending growth. These strategies emphasized negotiating lower drug prices and controlling utilization by steering patients toward lower cost, therapeutically comparable substitutes. Many programs, for example, were following the lead of Medicaid by pursuing preferred drug lists, which allow states to negotiate higher rebates from manufacturers.

- Very few states increased consumer cost-sharing or limited eligibility or enrollment.

- New SPAP initiatives in some states went forward, although some plans to expand to people who are under age 65 and disabled were not implemented.

Overall, although several programs were significantly threatened or even underwent near-death experiences, states generally gave high priority to fiscally protecting SPAP programs in the 2002-2003 legislative session. With the exception of Massachusetts, most states did not significantly restrict previous eligibility rules. In states with large, mature programs such as Pennsylvania and New Jersey, threats to program funding that had emerged during the budget cycle were warded off; Pennsylvania, despite uncertainty about the fate and form of federal Medicare prescription drug legislation, expanded eligibility for its PACE program and its sister program, PACENET.

The high priority that states have given to their SPAP programs is testimony to the demand for pharmacy assistance for lower-income consumers. Pharmacy assistance for the elderly in particular has received high priority, while the needs of lower-income disabled individuals have not always received the same level of public attention. The need for pharmacy assistance has become highly visible on the state political scene, and states have responded with continued support for these increasing program expenditures, even in the face of fiscal pressures.

However, the longer-term outlook for these state initiatives may be more precarious, particularly in the context of new federal Medicare prescription drug legislation. At the time of our study, many SPAP states were looking to federal fiscal relief as the longer-term solution to the growing financial pressures being encountered by their programs. With new federal legislation on the books, and in the light of the financial pressures they face, the extent to which states will seek to leave the field in favor of the federal program is unclear. Coverage through most of the state programs is more generous in important ways than that provided under the federal legislation enacted in 2003, particularly for individuals who are low-income but who fall above 135% of the poverty line or have more than minimal assets. Thus, the state programs could continue to play an important role in filling gaps left by the federal program. However, the future extent of states' financial efforts in this direction remains uncertain.

[1] Wisconsin also enacted a state pharmacy program in August 2001, which was implemented in September 2002.

[2] Guyer J. *The Financing of Pharmacy Plus Waivers: Implications for Seniors on Medicaid of Global Funding Caps*. The Henry J. Kaiser Family Foundation; 2003.

[3] 42 CFR Parts 403 and 408. Medicare Program; Medicare Prescription Drug Discount Card; Interim Rule and Notice. Federal Register, Monday, December 15, 2003. P 69842.

Impact of Budget Pressures on State Pharmacy Assistance Programs, FY 2003–2004

Kimberley Fox, M.P.A., Mina Silberberg, Ph.D., Dina Belloff, M.A., Tom Trail, M.S. and Stephen Crystal, Ph.D.

Introduction

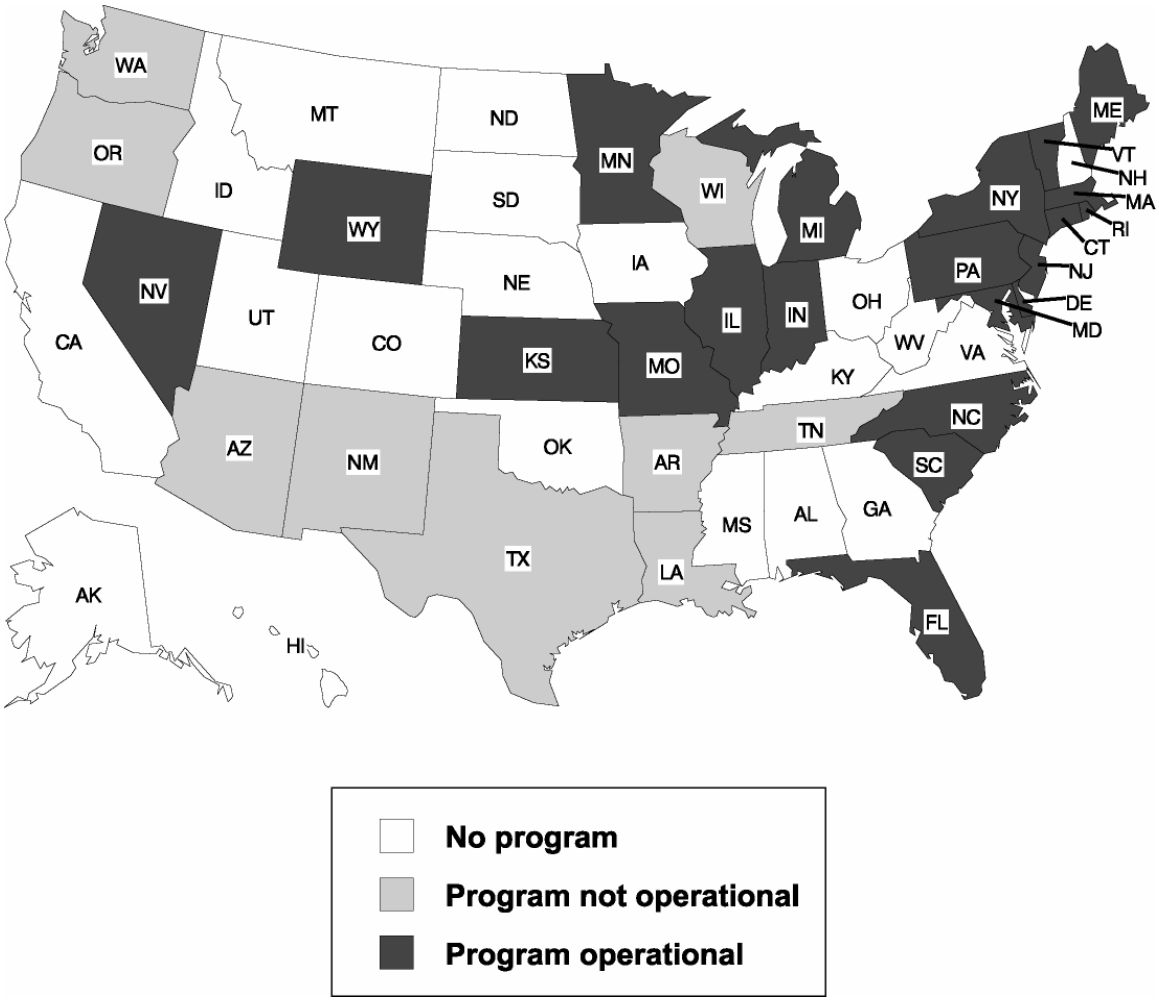
More than one-third of Medicare beneficiaries lack prescription drug coverage.[1] Those with low incomes who do not qualify for Medicaid are at particular risk. As drug costs have continued to rise, drug prices for those without insurance have become prohibitive for many low-income persons.

In response to rising drug costs and lack of drug coverage among the elderly, many states have stepped in to help low-income elderly and disabled persons access prescription drugs through state pharmacy assistance programs (SPAPs). Subsidized SPAPs provided drug coverage for over 1.3 million older and disabled persons in twenty-one states in FY 2002. Many of these programs, which are funded primarily through state general revenues or categorical funding sources such as the tobacco settlement, were initiated in the late 1990s during a time of unprecedented economic expansion.[2] Only 12 of these 21 states had programs in place prior to 1995.

However, changes in the economic climate may put the sustainability of these programs in question. States have found themselves facing the largest deficits in decades and grim forecasts of future revenues. In response, governors and state legislators have been under increasing pressure to identify ways to reduce spending. Other health programs targeted to low-income persons, such as Medicaid – and the Medicaid pharmaceutical benefit in particular -- have come under increasing scrutiny over the last several years and have been subject to significant cost controls.

To assess the impact of state budgetary crises on state pharmacy assistance programs, the Kaiser Family Foundation sponsored the present study, based on a survey and follow-up in-depth telephone interviews in 18 states in October 2002 and the spring of 2003. The survey and follow-up interviews focused on the budgetary situation in the state, and the types of cost containment approaches and/or expansions that the state had considered and implemented in Fiscal Year 2003 and were considering for Fiscal Year 2004.

Figure 1: State Pharmacy Assistance Programs, FY 2003



Source: Trail, T, Fox, K. Cantor, J., Silberberg, M., and Crystal, S. *State Pharmacy Assistance Programs: A Chart Book, 2003.* Commonwealth Fund, New York, NY, publication forthcoming

This report summarizes the impact that budgetary shortfalls and other financial pressures had on state pharmacy programs. In particular the report discusses:

- The extent to which SPAPs faced budget cuts;
- How states modified their programs in response to fiscal pressures;
- Why these particular approaches were selected;
- The potential implications of these changes for consumers.

Methods

The findings of this study are based on the results of a survey of all direct-benefit state pharmacy assistance programs fully operational in August 2002 and follow-up telephone interviews with SPAP program directors. One of a series of studies of state pharmacy assistance programs, this report is the first to focus on responses to budget pressures.[3] The survey was conducted in the fall of 2002 and was sent to all states that had a direct-benefit program that was operational as of August 2002 (N= 21 states). Survey questions addressed key programmatic design features, including sources of funding, eligibility requirements, drugs covered and participant cost-sharing; and program data, including program enrollment, utilization and expenditures (claims and administrative costs) for fiscal years 2002 through 2003. The supplemental policy questions addressed in followup telephone interviews focused specifically on the topic of the present report. We asked about a detailed list of possible program expansion and cost containment measures that states may have pursued and asked program directors to indicate which of these had been considered and implemented in FY 2003.

Responses to the survey were provided directly by SPAP program directors or their staff. Surveys were completed and returned by 20 of the 21 states contacted. For the one state that did not submit a response, we were able to gather some programmatic data from annual reports and other sources. The followup telephone interviews were conducted in March 2003 in order to secure more detailed information on policy options considered and implemented in FY 2003, and in order to assess what the state was considering for FY 2004. This timeframe was selected to ensure that what was reported as considered for FY 2004 reflected the agenda of the newly elected governors who took office in January 2003. In the interviews, we asked questions regarding the expected budget shortfalls in FY 2003 and anticipated budget cuts in FY 2004, the level of protection of SPAPs relative to Medicaid, and details of the changes that the state had implemented and planned to implement in 2004 as well as the expected impact of these changes on state expenditures and stakeholders. Reported results are based on 18 out of the 21 states in the survey whose representatives agreed to participate in the followup telephone interviews.

Background

Overview of State Pharmacy Assistance Programs

State pharmacy assistance programs subsidize some portion or all of the cost of medications for targeted low-income residents of a state.[4] While a handful of these programs have been in place since the 1970s and 80s, most were introduced or expanded in the mid- to late 1990s, when many states had budget surpluses and new revenues through the tobacco settlement. Between 1995 and 2002, the number of operating state pharmacy direct benefit programs nearly doubled, from 12 to 21.

While the number of states with pharmacy assistance programs has increased, the majority of states do not have such programs. Most enrollees live in the Mid-Atlantic and Northeastern states, with three-quarters residing in New York, Pennsylvania and New Jersey alone. Thus, even in the best economic times, state pharmacy programs have only been able to reach a small portion of the elderly and disabled who lack drug coverage in the United States. As of December 2002, SPAPs enrolled only 3% of Medicare beneficiaries nationwide and 6.2% of Medicare beneficiaries in states with SPAPs.[5]

Eligibility criteria varied considerably from state to state (see Table 1). With the exception of programs in Nevada and Massachusetts that are open to all residents, with premiums that are intended to cover full program costs in the highest-income tiers, state pharmacy programs usually target low-income elderly who do not qualify for Medicaid.

In 2002, only half of state programs extended pharmacy coverage to the disabled. Most programs were targeted to persons earning below 200-225% of the federal poverty level (FPL). A few states also provided more modest state subsidies to elderly with moderate incomes, up to 500% of the federal poverty level. Only two states – Maryland and Minnesota - imposed an asset test in addition to the income threshold. Most states excluded persons with any kind of other drug coverage from eligibility, although two did not have these restrictions and six others would extend coverage after other benefits are exhausted or if the individual's other coverage was less generous than what was covered by the SPAP.[6]

As shown in Table 1, benefits also varied widely across state pharmacy programs. The level of subsidy offered by SPAPs ranged from open-ended first-dollar coverage (in which the consumer pays only a nominal copayment per script) to programs that require consumers to pay substantial co-insurance and/or that offer a subsidy only up to a certain dollar or prescription limit. Some states had established two or more programs targeted

Table 1: SPAP Eligibility and Benefit Design Features, 2002

State (Program)	Income Eligibility (% FPL)	Under 65 disabled Eligible	Assets	Fee	Deductible	Coinsurance/Copay	Out of Pocket Cap	Benefit Cap
CT	226%	Y		$25		$12.00		
DE	200%	Y				$5 or 25%, whichever is greater		$2,500
FL	120%	N				$2/$5/$15 tiered copay		$160 a month
IL (SeniorCare)	200%	N				Copay ($1 generic, $4 brand up to $1,750 in drug costs) plus 20% coinsurance after reach $1,750 in drug costs		
IL (Circuit Breaker)	239%	Y		$5 or $25 by income		Copay ($0 or $3 by income up to $2,000 in drug costs) plus 20% coinsurance after reach $2,000 in drug costs		
IN	144%	N				50%		$500, $750, or $1,000 by income
KS	135%	N				30%		$1,200
ME	185%	Y				$2 or 20%, whichever is greater	$1,000 for drugs for non-covered conditions	
MD	116%	Y	Singles: $3750 Couples: $4500			$5.00		
MA	500%	Y		$0 to $99 by income	$0 to $125 by income	$6/$16/50% or $40 to $10/$28/50% or $40 by income	$2,000 or 10% of income, whichever is lower	
MI	200%	N		$25		20%	Monthly co-payment maximums by income.	
MN	120%	Y	Singles: $10000 Couples: $18000		$35 a month	None		
MO	192%	N		$25 or $35 by income	$250 or $500 by income	40%		$5,000
NV	243%	N				$10 generic, $25 preferred brand		$5,000
NJ (PAAD)	223%	Y				$5.00		
NJ (Senior Gold)	336%	N				$15 plus 50% of the remaining cost of the drug	$2,000 single, $3,000 couple	
NY (Fee)	226%	N		$8 to $300 by income		$3 to $20 by drug price	9% of annual income	
NY (Deductible)	395%	N			$530 to $1,715 by income	$3 to $20 by drug price	9% of annual income	
NC	200%	N				40%		$600
PA (PACE)	158%	N				$6.00		
PA (PACENET)	192%	N			$500	$8 generic, $15 brand		
RI	419%	N				40%, 70%, or 85% by income	$1,500	
SC	175%	N			$500	$10 generic, $21 brand		
VT (VHAP)	150%	Y				$3 generic, $6 brand	$50 per calendar quarter	
VT (VScript)	175%	Y				$5 generic, $10 brand	$100 per calendar quarter	
VT (VScript Exp.)	225%	Y			$275	41%	$2,500 per calendar quarter	
WY	100%	Y				$10 generic, $25 brand		3 prescriptions per month

Source: Rutgers Center for State Health Policy Survey of State Pharmacy Assistance Programs, 2002 with support from the Commonwealth Fund and the Kaiser Family Foundation.

to different income groups that provided generous subsidies for lower-income persons and more modest subsidies for moderate-income persons; this was the case in Pennsylvania, New Jersey, Illinois and Vermont. In addition to copayments and/or coinsurance, six SPAPs required annual or monthly fees, and seven required enrollees to pay a deductible. Seven states had benefit caps ranging from $500 to $5000, and one – Wyoming – limited coverage to three drugs per month. Four states – Florida, Michigan, Minnesota, and Nevada – capped the total number of persons who could be enrolled. [7]

While most states had open formularies and covered most drugs, one state had a closed formulary, and two states had multi-tiered formularies. In addition, five states limited coverage to drugs for chronic conditions or for specific illnesses.

State Budgetary Outlook in FY 2003 and FY 2004 for SPAP States

Nearly all states reported budget deficits in fiscal year 2003 and 2004.[8] In enacting their fiscal year 2003 budgets, the 50 states faced a total deficit of $50 billion. After budget enactment, another $17.5 billion was added to this deficit in FY2003, and a deficit of between $70 billion and $85 billion was estimated for FY2004. According to one source, in January 2003 the 2004 deficit was projected to account for between 14.5 and 18 percent of state total state expenditures. These budget deficits posed immediate challenges to the states and state programs, particularly those that were exclusively funded out of general funds, since all states with the exception of Vermont have balanced budget requirements.[9]

Many states with state pharmacy assistance programs were among those hard hit by deficits (Table 2). Nine of the twenty-one states expected to run deficits of at least 14% of their state budgets in fiscal year 2004, again with considerable variation across states. For example, while New York's deficit was expected to represent 29.1% of its budget, Wyoming expected no deficit at all.

Table 2: Estimated State Budget Deficits for SPAP States, Fiscal Year 2004

State	Estimated FY 2004 Deficit (Billions of Dollars)	Deficit as Percent of State Budget
CT	$1.5 b	12.9 %
DE	$0.3 b	12.2 %
FL	$2.0 b	10.1 %
IL	$3.6 b	14.8 %
IN	$0.85 b	8.8 %
KS	$0.7 b	15.7 %
ME	$0.375 b to $0.475 b	14.5 % to 18.4 %
MD	$1.2 b	11.0 %
MA	$1.4 b to $2.0 b	6.1 % to 8.8 %
MI	$1.603 b	17.5 %
MN	$2.442 b	18.7 %
MO	$1.0 b	13.1 %
NV	$0.359 b	19.0 %
NJ	$4.0 b	19.0 %
NY	$10.0 b to $12.0 b	24.3 % to 29.1 %
NC	$2.0 b	14.6 %
PA	$0.5 b to $2. 0 b	2.4 % to 9.6 %
RI	$0.175 b to $0.250 b	6.6 % to 9.4 %
SC	$0.7 b	13.6 %
VT	$.028 b	3.2 %
WY	$0 b	0 %

Source: Iris J. Lav and Nicholas Johnson (2003, January). "State Budget Deficits for Fiscal Year 2004 are Huge and Growing." Center on Budget and Policy Priorities.

While some growth in state expenditures occurred in the 1990s, current budget deficits were primarily the result of a decline in tax revenues (related to the poor state of the national economy and a 50% drop in capital gains), the growth of the service sector (states do not usually tax services), and the tax cuts of the 1990s.[10] One study found that the decline in tax revenues contributed almost nine times as much to state budget gaps in 2002 as did growth in Medicaid spending.[11] Nonetheless, controlling state expenditures is one of the more immediately available solutions for states facing a budget crisis.

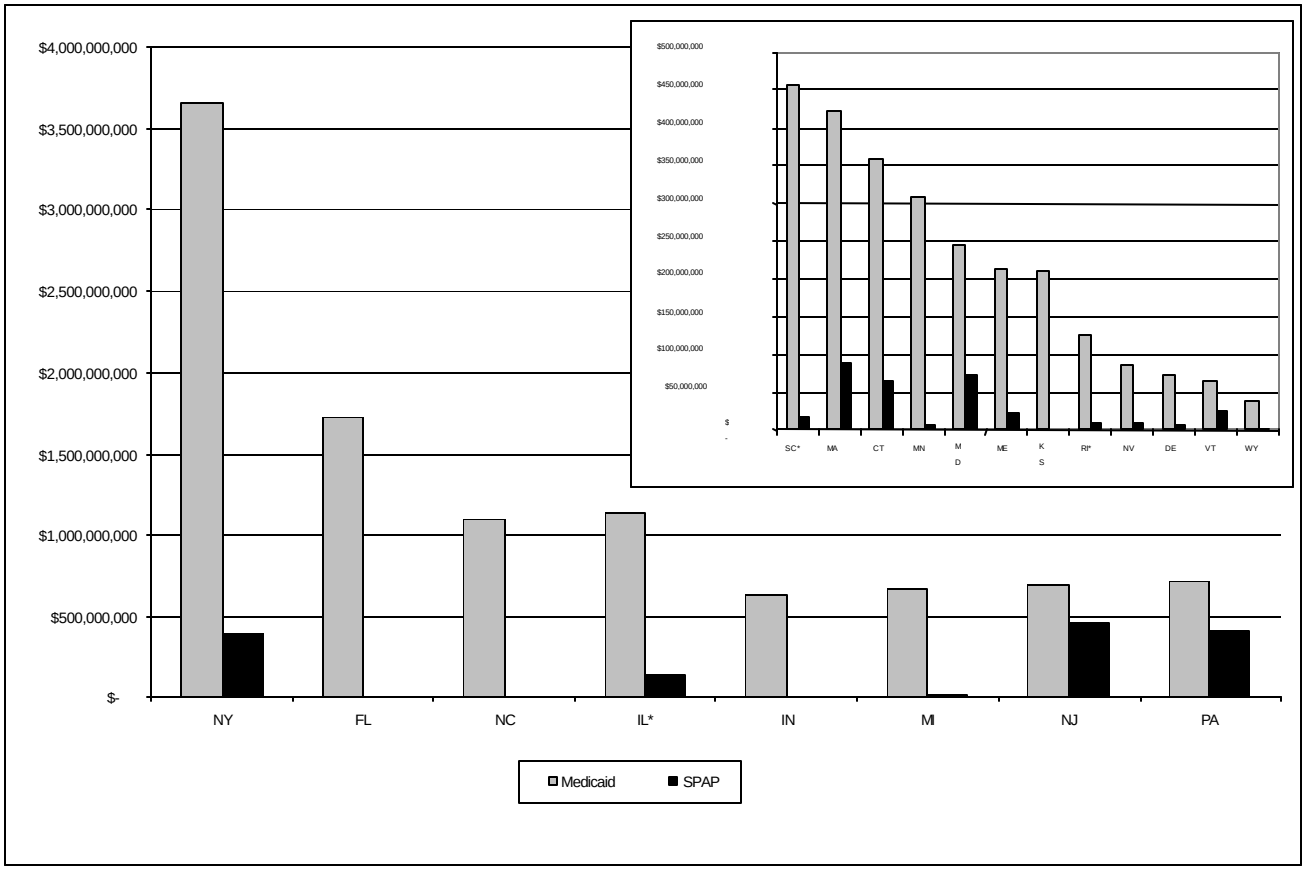
Within state budgets, health care programs comprised one of the largest segments of state expenditures, and were one of the major contributors to the growth in spending that occurred in the 1990s.[12] In states with state pharmacy assistance programs, health care spending – primarily through Medicaid -- represented from 19.9 to 44.6 percent of state expenditures in FY2001.[13] In response to increased Medicaid spending, many states sought to contain Medicaid growth. The Medicaid prescription drug benefit, which increased at an average annual rate of nearly 20 percent between 1998 and 2000, was the subject of increasing cost and utilization controls. According to a survey commissioned by the Kaiser Family Foundation, 40 out of 50 states reported plans to implement prescription drug cost controls for the Medicaid program in fiscal year 2003, as opposed to 32 states in FY 2002.[14]

Study Findings: SPAPS in the Context of Fiscal Stress

SPAP Spending and Sources of Funding

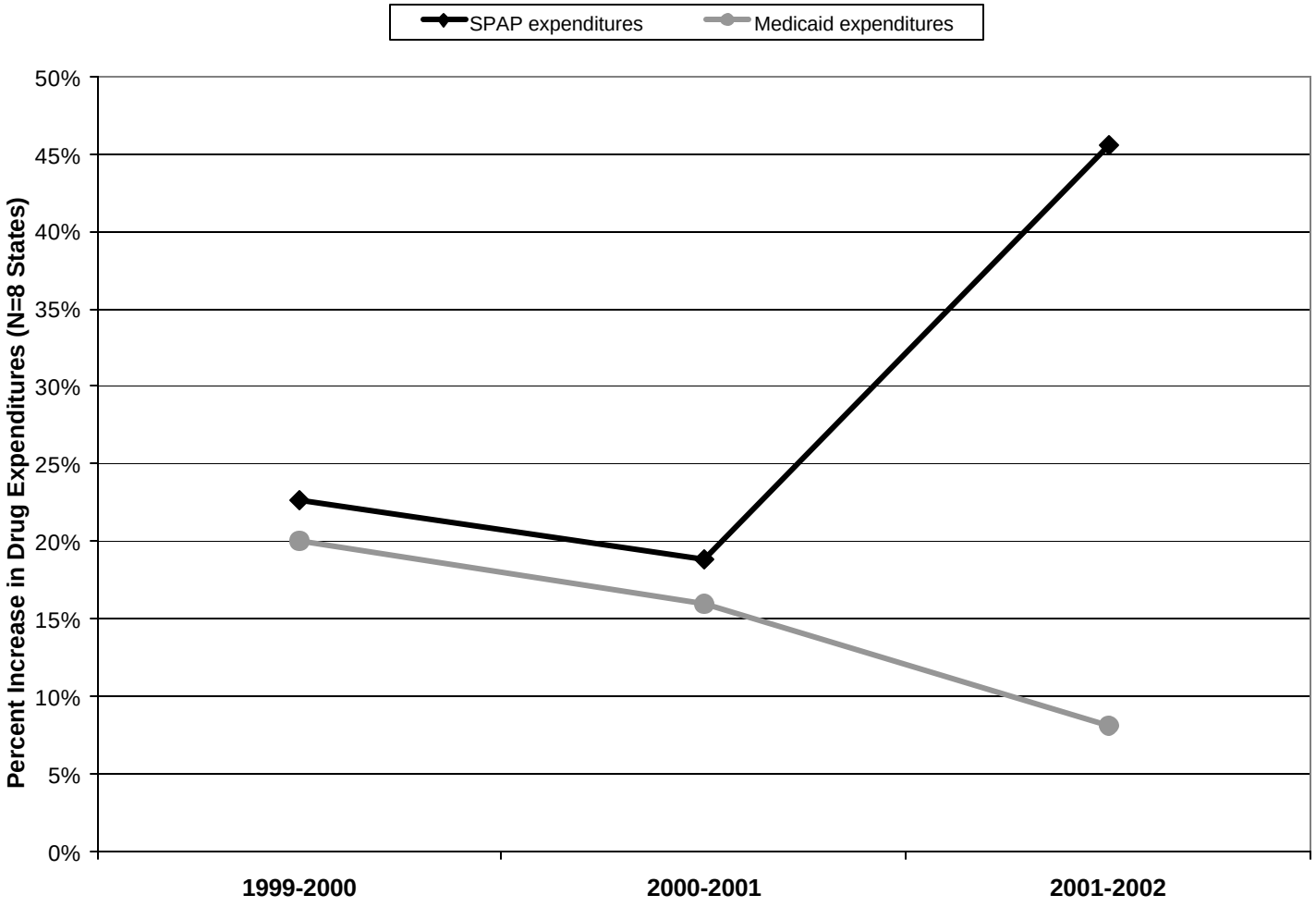
SPAPs represented a small portion of state budgets compared to Medicaid, or even to that part of Medicaid expenditures devoted to pharmacy. With the exception of four states (NJ, PA, MD, VT), SPAP expenditures amounted to less than 5 percent of Medicaid pharmacy costs (Figure 2). However, SPAP program costs were increasing at a rate far above the annual inflation rate. As shown in Figure 3, the annual rate of growth in eight states whose SPAP expenditures were available for a four-year period was significantly higher than that of pharmacy benefits in the Medicaid program. While cost containment efforts appear to have slowed the annual rate of growth in Medicaid pharmacy expenditures, the rate of growth in SPAPs increased. This higher rate of growth reflected in part program expansions that have resulted in increased enrollment, but also reflected other factors including increased use of drug therapies, use of new, more expensive drugs in SPAPs, and increases in drug prices.

Figure 2. SPAPs Versus Medicaid Pharmaceutical Expenditures, 2002



Note: SPAP Expenditure data for IL, SC and RI are from 2001.Source: Rutgers Center for State Health Policy Survey of State Pharmaceutical Assistance Programs, August 2002; CMS MSIS Statistical Reports, 1999-2001

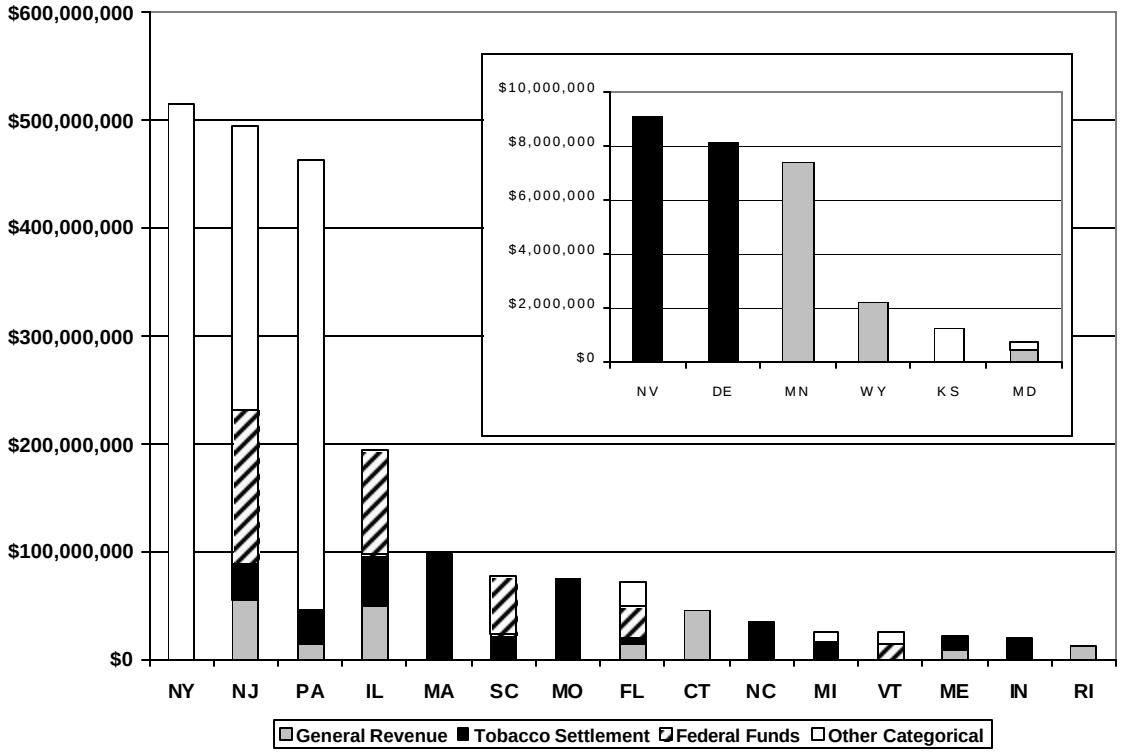
Figure 3: Annual Growth in SPAPs and Medicaid Pharmaceutical Expenditures, 1999 to 2002*



*Note: figure reflects data from states for which four years of expenditure data were available: CT, MD, MA, MN, NJ, NY, PA, and VT.
Sources: Rutgers Center for State Health Policy Survey of State Pharmacy Assistance Programs, 2000-2002 and Medicaid prescription drug expenditure data from Center for Medicare and Medicaid Services MSIS Reports 1999, 2000, 2001. accessed from http://cms.hhs.gov/medicaid/msis/msis99sr.asp on November 11,2003.

With the exception of a few states that have sought and received Medicaid waivers providing federal matching funds, most state pharmacy programs are funded entirely through state funds, making them potentially more vulnerable to state budget instability. To limit their reliance on state general revenues, many SPAPs have earmarked categorical funds in statute to pay for prescription drug programs (see Figures 3 and 4). In fact, the three states with the largest state pharmacy programs -- New York, Pennsylvania, and New Jersey -- primarily rely on categorical funds, including the lottery in Pennsylvania, casino taxes in New Jersey, and Health Care Reform Act assessments in

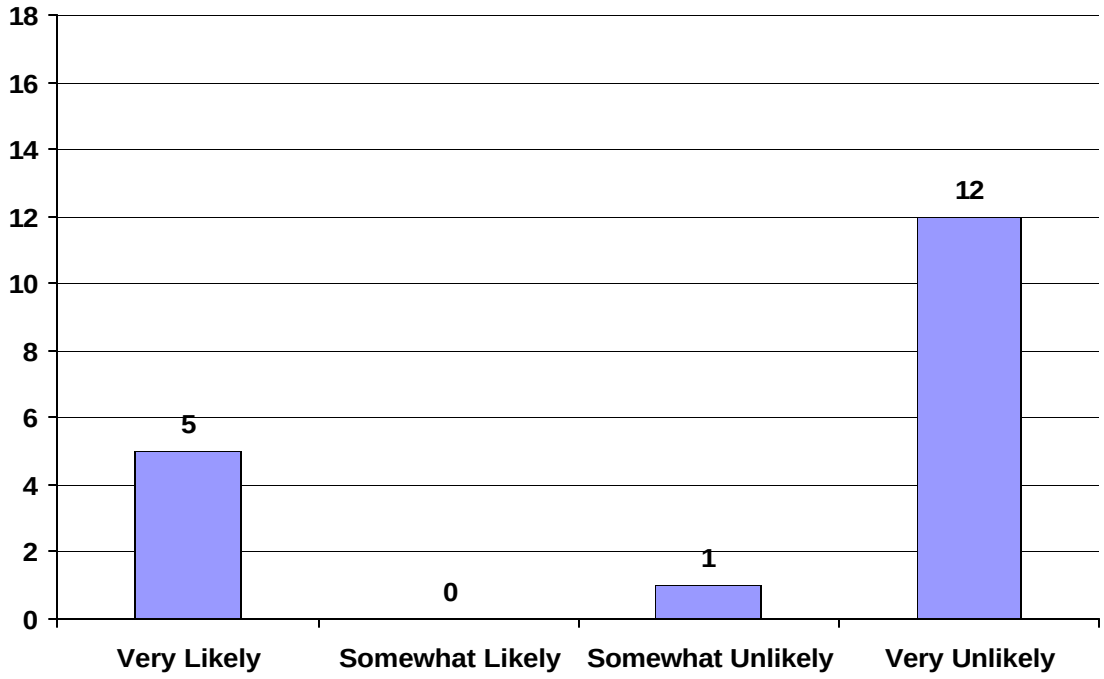
Figure 4: SPAPs' Budgets and Sources of Funding by State for FY 2003



New York. In addition, eleven programs are supported in whole or in part by tobacco settlement funds. Officials in these states indicated that having a dedicated revenue source for the program helps to protect program budgets to some extent.

Nonetheless, officials indicated that categorical revenue sources were not growing at the same pace as program costs. The burden of New Jersey's PAAD program on the state's casino revenue fund had been greater than originally anticipated (increasing from 30% of fund expenses in the early 1990s to 71% in 2003), which forced the state to seek alternate revenue sources. In Pennsylvania, state officials indicated that the PACE/PACENet programs consumed approximately 45% of the lottery funds set aside for programs for older people in the state, up from 15% when the program first started. Pennsylvania planned to increase gambling-related revenues by adding new games and expanding access, earmarking net new revenues exclusively for PACE. This restructuring of the lottery program provided the basis for the program's expansion in 2003, which was implemented despite the progress of federal Medicare prescription drug legislation.

Figure 5: Perceived Likelihood of Budget Shortfalls in SPAPs, FY 2003



Source: Survey of 18 States with operational state pharmacy programs conducted by Rutgers' Center for State Health Policy, March 2003

Not only are program costs outpacing the growth in categorical revenue sources, but coordinators for programs that rely on tobacco settlement revenues indicated that these are an unstable source of funding. Payments vary from year to year, they are contingent on continued payment by tobacco companies, and some states were considering securitizing a portion of settlement funds. In March 2003, Philip Morris was threatening to declare bankruptcy, forcing it to default on its share of the tobacco settlement. The threat was made in response to an Illinois circuit court ruling that required the company to pay an appeals bond to cover a $10.1 billion dollar judgment against the company for misleading smokers into believing that "light" cigarettes are less harmful than regular cigarettes. In study interviews, several state program directors raised the Philip Morris issue as a concern. In addition to this uncertainty about future tobacco payments, eight SPAP states were considering whether to securitize their tobacco settlement revenue. Securitization is a process by which the state sells some portion of the revenue stream of its tobacco settlement payments for a set number of

years in return for a single up-front payment.[15] The impact of securitization on future program funding is uncertain, although program officials in most states considering this strategy did not anticipate any impact on SPAP funding. The ultimate extent of securitization is also uncertain. At the time of this study, several legislatures rejected gubernatorial proposals to securitize. In fact, uncertainty over the national settlement payments related to the Philip Morris case disrupted some state budget calculations by postponing decisions to sell bonds backed by money from the tobacco settlement.

Budget Shortfalls in 2003

Despite challenging fiscal climates just described, among the 18 SPAP directors surveyed for this project, 13 said they thought it was very or somewhat unlikely that their program would have a budget shortfall for the 2003 fiscal year, while five thought it very likely that they would (Figure 5). Among the thirteen states that did not anticipate a budget shortfall, half had newly-initiated programs in which enrollment had not yet reached the anticipated target. In other cases, no shortfall was projected because the program design included caps on enrollment or benefits. However, few of these programs anticipated that they would need to impose the cap, suggesting that this year at least the programs would have been sound even without the capping provision.

Of the five states that reported that they were likely to exceed their budgets in fiscal year 2003, four attributed the shortfall to a combination of higher than predicted drug costs resulting from underestimates of utilization, and increases in enrollment resulting from recent program expansions. One state had lower than expected appropriations because the state had assumed in its budget that it would receive federal matching funds for the Pharmacy Plus waiver it had submitted. At the time of the interview, CMS had not yet approved the waiver and the state was anticipating a shortfall of $140 million for its pharmacy assistance program.

Anticipated Budget Cuts in 2004

Despite the grim budget outlook for states in FY 2004 and the instability of some categorical funding, respondents in the majority of states felt that their programs were protected from future cuts (see Figure 6). Ten states predicted that cuts were somewhat or very unlikely, while seven states reported that cuts to their program were somewhat or very likely. In particular, states with newer programs or that had recently received

Medicaid waivers did not anticipate cuts in the upcoming year. However, coordinators of some of the newer programs that had significantly underspent their appropriation in the prior year thought that the initial program appropriation might be reduced to reflect current spending levels. With a few exceptions -- despite threats of reductions during the budget cycle and the need to identify new revenues -- many of the older, larger programs were ultimately also largely protected from budget cuts. In fact, at the time of this study, Pennsylvania was proposing to expand eligibility in its program for moderate income seniors – a proposal that was passed by both houses of the state legislature in October 2003 and subsequently signed by the Governor with an effective date of January 1, 2004. This legislation increased the income limit for the state's low-income PACE program to $14,500 (from $14,000) for singles and to $17,700 (from $17,200) for married couples, and increased the income limit for the PACENET program to $23,500 (from $17,000) for individuals and to $31,500 (from $20,200) for couples.

Among the newer and less-established programs, Massachusetts' SPAP was particularly hard hit. Only two years earlier, the state had lauded the creation of its Prescription Advantage program as a landmark state-sponsored drug insurance program providing sliding scale subsidies for low and moderate-income elderly. However, mid-year in FY 2003, facing significant budget shortfalls, the state reduced the Prescription Advantage budget by $10 million, closed enrollment and increased copayments and deductibles. In FY 2004, the program was threatened with complete elimination when the Governor's proposed FY 2004 budget zeroed out appropriations for what had been a $97 million dollar program. Thus, while the program was ultimately restored in the budget, it underwent a near-death experience, and may be in a precarious position in future budget years.

Other states reported facing substantial cuts as well. Maine, which had already passed its biennial budget at the time of our interviews, approved a $1 million cut in appropriations for the state's Drugs for the Elderly (DEL) pharmacy program, representing approximately 5 percent of the program's FY 2003 budget. In addition, Maine was expecting further losses from lower-than-anticipated rebates from manufacturers, resulting from a federal court ruling that overturned the state's Medicaid waiver. Under the waiver, the state had received permission to extend the Medicaid 'best price' to all residents of the state earning less than 300% of the federal poverty level. This allowed the state not only to offer a discount card to elderly residents who were ineligible for the state's Drugs for the Elderly (DEL) program, but also to get better rebates from

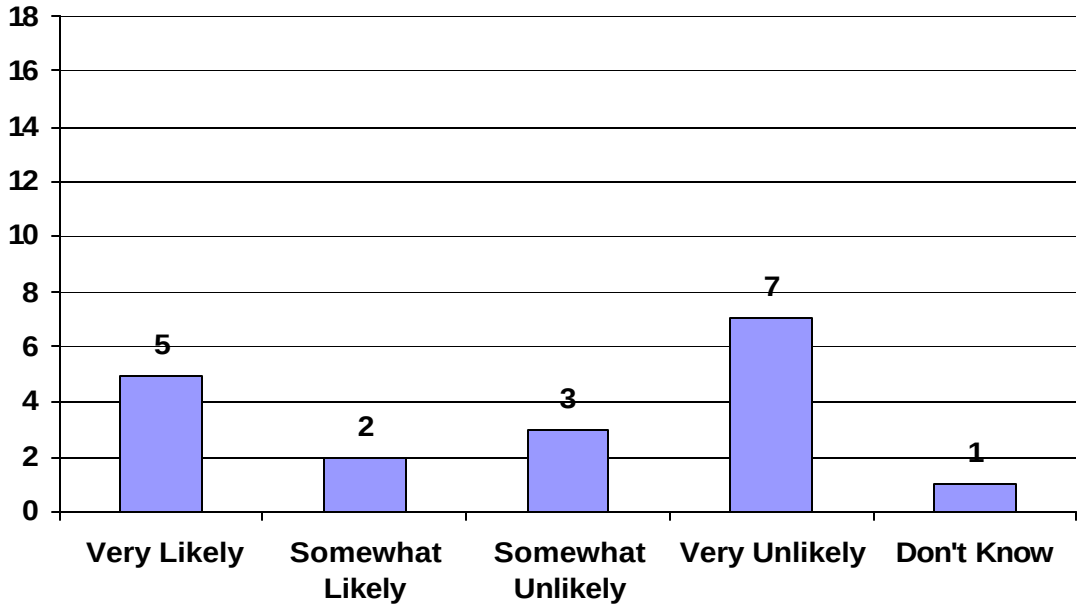
manufacturers for the DEL program itself, which previously relied on less generous voluntarily negotiated rebates. DEL's FY 2003 budget and FY 2004 budget projections had been premised on the assumption that they would be getting the more generous Medicaid rebates. However, when the courts overturned the waiver based on a legal challenge by pharmaceutical manufacturers in January 2003, the state was forced to terminate the discount card program and to renegotiate voluntary rebates for the DEL program. It was estimated that the state lost one-quarter of its rebate revenues in FY 2003 as a result of the court ruling.

Because most state budgets were still being negotiated, most of the remaining five states that anticipated some cuts in FY 2004 were unable to estimate the magnitude of the final cuts. However, several states indicated that the cuts would be achieved through administrative efficiencies, not cuts in benefits.

Perceived SPAP Budget Risk Compared to Medicaid

As shown in Figure 7, most program directors felt that the state pharmacy program was better-protected from budget cuts than was the Medicaid program. Even in states that anticipated SPAP budget cuts in FY 2004, cuts to the Medicaid program were expected to be much larger. In general, respondents attributed this higher level of protection to a more positive image for SPAPs, better name recognition and visibility, the fact that they serve a better-organized constituency, and their relatively small size as a percent of the state budget. Nearly all states indicated a strong commitment by both the

Figure 6: Perceived Likelihood of Budget Cuts to State Pharmacy Assistance Programs, FY 2004



Source: Survey of 18 States with operational state pharmacy programs conducted by Rutgers' Center for State Health Policy, March 2003

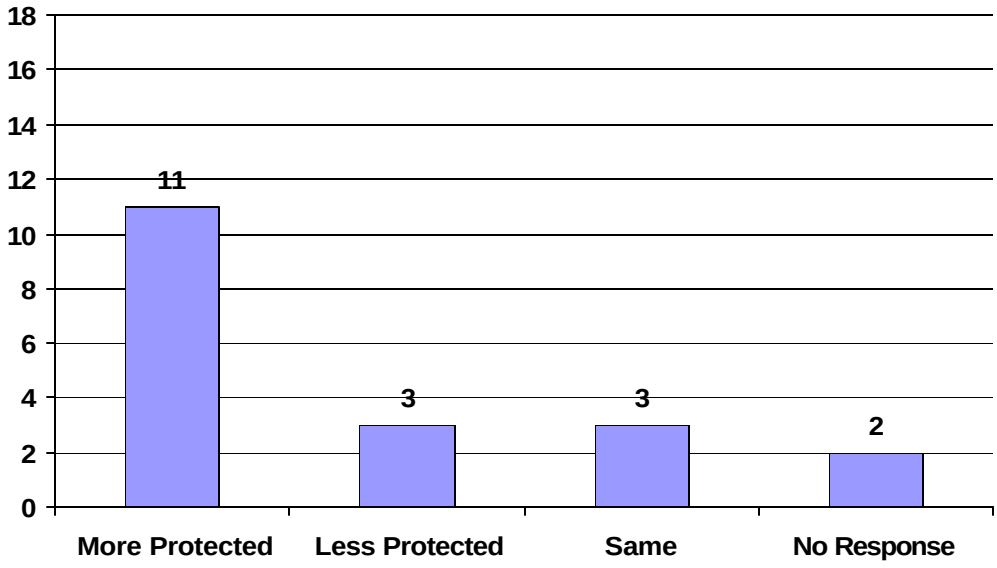
governor's office and the legislature to maintain drug coverage for the elderly, since this was a central issue in many of their election or re-election campaigns. Newer programs, in particular, felt that state policymakers were unlikely to abandon programs that had just been created -- in several cases as the governor's signature program. Most program directors noted the political influence of groups representing senior citizens. In one state, the week before our interview, senior advocacy groups had staged a rally at the State House of hundreds of seniors and some legislators, protesting the state's proposal to impose enrollment controls and increase consumer cost-sharing.

Most of the states reporting that their SPAP had the same level of protection as Medicaid either administered the SPAP out of their Medicaid agency or had received a Medicaid waiver to cover SPAP enrollees as an optional coverage group under the state's Medicaid program. These respondents suggested that both programs have costs that are growing significantly and that most cost containment strategies imposed on the Medicaid prescription benefit would automatically also be implemented in the SPAP.

Two of the three states in which the SPAP was viewed as less protected than Medicaid also had Medicaid waivers. Since benefits to optional Medicaid eligible groups are not an entitlement, respondents in these states felt that the SPAP was more easily

subject to increased cost-sharing or benefit limits than Medicaid. In the third state in which the SPAP was viewed as less protected than Medicaid, the program relies entirely on tobacco settlement funding, and the threat of Philip Morris' bankruptcy was identified as the reason for the SPAP's particular vulnerability.

Figure 7: Perceived SPAP Risk Compared to Medicaid



Source: Survey of 18 States with operational state pharmacy programs conducted by Rutgers' Center for State Health Policy, March 2003

Findings: Policies Implemented in SPAPs in FY 2003 and Considered in FY 2004

While most states did not anticipate budget cuts, nearly all SPAPs were taking some action to minimize future burden on state funds, either by seeking other sources of funding or by implementing policy changes intended to reduce program costs. This represents a shift from previous years when many SPAPs were being expanded and states had been investing significant new funds to extend the benefit to moderate-income seniors. Nonetheless, some states were still proposing expansions, albeit much smaller than in the past and primarily associated with waiver applications. With the exception of a few states with new programs that were still in start-up, most states were focused on

containing costs. The following sections address the frequency with which states have seeking new funding sources, expanding their programs, and controlling costs, as well as the specific approaches they are taking towards these ends.

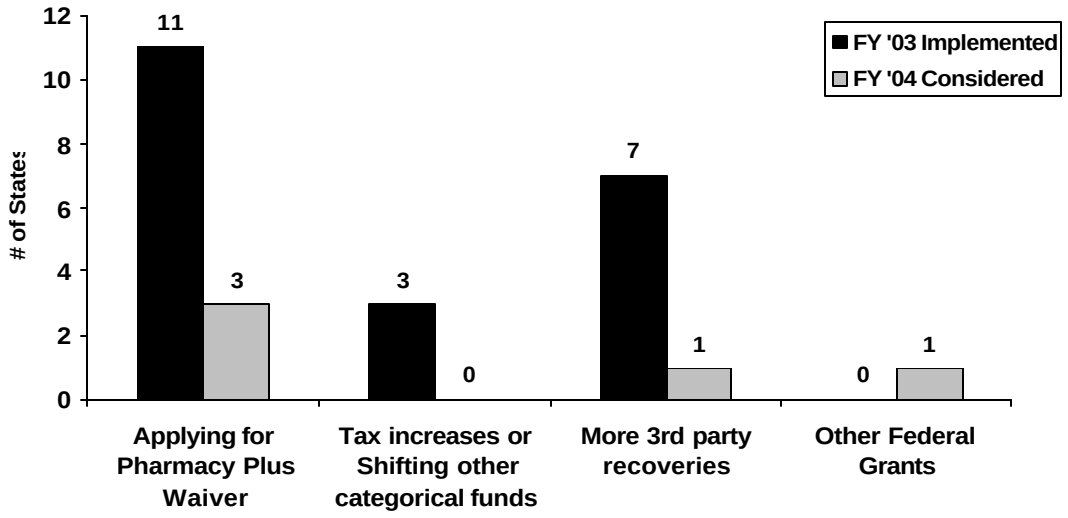
Seeking Other Source of Funding

Medicaid Waivers: Many SPAPs have been spared from budget cuts in part because of the potential for federal matching funds. The vast majority of SPAP states had considered or had submitted a Medicaid waiver to extend Medicaid prescription-only coverage to seniors who otherwise would not be eligible for Medicaid in order to secure federal matching funds for some or all of the enrollees in their existing SPAP (Figure 8). States pursued this course largely in response to the Bush Administration's introduction in early 2002 of the Pharmacy Plus waiver initiative, which simplified the process of applying for and obtaining Section 1115 waivers specifically designed for pharmacy demonstrations.[16]

Of the eleven states that reported having 'implemented' a waiver in FY 2003, four [FL, IL, SC, MD] had received approval for either a Pharmacy Plus or other 1115 waiver and were in the early stages of implementation, and another six [IN, NJ, DE, ME, NC, RI] had submitted applications and were in various stages of negotiations with CMS.[17] Vermont, which already had an 1115 waiver to expand prescription benefits, had submitted an amendment to expand a discount to higher income seniors. In FY 2004, three states were in various stages of submitting either a Pharmacy Plus or 1115 waiver [KS, NV, MA].

Several states, however, had reviewed the budget neutrality provisions and the global cap on Medicaid expenditures for the elderly required under the Pharmacy Plus waiver and concluded that it was a "bad deal for states" (in the words of two respondents) or at least too risky.[18] In order to receive a Medicaid waiver the state must prove budget neutrality, specifically demonstrating that the program will not cost the federal government any more than what it would have spent in the absence of the waiver. To ensure budget neutrality for Pharmacy Plus waivers, the Department of Health and Human Services requires states to accept a limit on the amount of federal Medicaid funds that the state will receive for all elderly Medicaid beneficiaries over the five-year waiver period. States that had decided not to submit a Pharmacy Plus waiver were concerned that, while the waivers provide short-term relief, they do so at the risk of dismantling the Medicaid entitlement in the future and putting the state at significant financial risk if

Figure 8: Other Funding Considered and Implemented in SPAPs, 2003 - 2004



Source: Survey of 18 States with operational state pharmacy programs conducted by Rutgers' Center for State Health Policy, March 2003

actual costs were to exceed projections. Most of the states that had submitted applications had demonstrated budget neutrality based on the relatively unproven assumption that extending drug coverage would prevent participants from becoming fully eligible for Medicaid through spend-down and/or would divert participants from using Medicaid long-term care services.

Two states with older programs had analyzed historical data and discovered that there was little evidence of significant migration of SPAP enrollees to the Medicaid program. While many states believed that an outpatient drug program was likely to result in significant savings to Medicare, CMS would not allow states to use Medicare savings in demonstrating budget neutrality for Medicaid waivers.

Instead of pursuing a Pharmacy Plus waiver, a few states opted to expand pharmacy coverage through amending existing Medicaid 1115 waivers. Under Medicaid 1115 waivers, states can also extend drug coverage to persons otherwise not eligible for Medicaid, but budget neutrality is calculated differently and states are not required to accept a global cap. The state of Vermont was the first to pursue this approach in 1996. Since then, Maryland has also received an 1115 waiver. Massachusetts originally applied for a Pharmacy Plus waiver, but later rescinded it and filed for an amendment to its existing 1115 waiver instead.

Tax Increases or Shifting Other Categorical Funds: In comparison to the number of states pursuing federal funds, fewer had implemented or were considering devoting more state dollars to maintain or expand SPAPs . Those states that were seeking new state dollars sought either to increase the SPAP's share of existing categorical funds or to increase taxes. Only two states (FL, PA) had increased the SPAP's share of tobacco settlement funds and one state (VT) had increased tobacco taxes in FY 2003. No states were considering these measures in FY 2004. In addition to pursuing federal matching funds through a Medicaid waiver, Florida also allocated some tobacco settlement funds to help restore its Silver Saver SPAP to its original state appropriation, which had been reduced to the program's spending level the prior year to help make up for an unexpected state deficit after September 11, 2001. Pennsylvania also shifted some tobacco settlement funds to maintain eligibility temporarily for persons whose eligibility was due to expire as a result of Social Security cost-of-living increases. Vermont was the only state to raise taxes; the tobacco tax increase benefited all programs funded by the state's Health Access Trust Fund, including the SPAP.

Third Party Recoveries: In FY 2003, to maximize revenues beyond seeking federal matching funds, nearly half the states had also either considered or implemented initiatives to improve collections for drugs that should have been covered by Medicaid, Medicare, or employer-sponsored retirement health benefits. As retirement health benefits and Medicare+Choice plans have limited their pharmacy benefits, some states that do not exclude people with other coverage have seen an increasing number of enrollees supplementing their private coverage through the state pharmacy program. To ensure payment from these other sources, states have either required pharmacists to charge the other payer first, or have developed systems to coordinate benefits with Medicare and Medicaid or private plans by matching enrollment files. While state officials estimated that enhanced recovery systems could result in some savings, recovering funds from other payers has proven to be difficult, particularly since these payers are not generally required to share enrollment and payment data with states. At the time of our interviews, none of the states that had implemented third party recovery programs in FY 2003 had seen any savings.

Other Federal Funding - Medicare Demonstration Grant: For FY 2004, officials in Pennsylvania indicated that they were pursuing the unique route of pursuing a Medicare Demonstration Grant. At the time of our interviews they had submitted a concept paper and were meeting with CMS. According to respondents, this grant option was stipulated

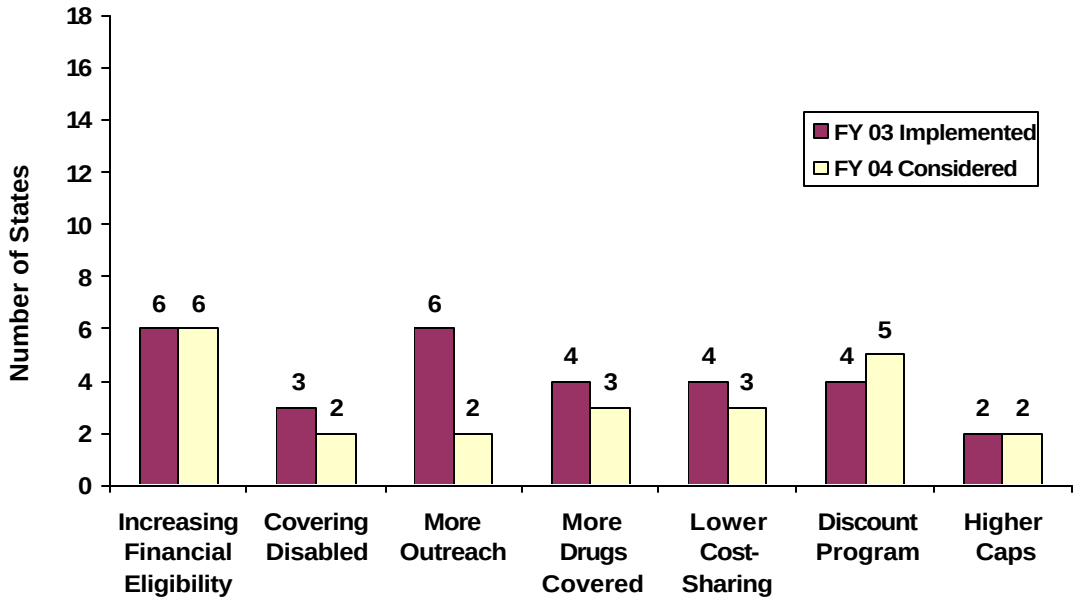
in the same statute creating the Pharmacy Plus Waiver and reimburses states for funds they can demonstrate to have saved Medicare by having a state prescription drug program. Pennsylvania's SPAP programs have the advantage of having been the subject of a great deal of research over the history of the program. Pennsylvania has used this research to provide evidence showing how diversion related to providing outpatient drug benefits has reduced utilization of other health services paid for by Medicare. While negotiations were still at a preliminary stage at the time of our study, state officials estimated that the state would be eligible for as much as $100 million per year through this grant. With the recent passage of the Medicare drug benefit, it is unclear whether this funding option is still available.

Program Expansions

Even in FY 2003, when states were already feeling the fiscal pinch, many states were still considering expanding their programs either by increasing income or asset eligibility, expanding outreach, or increasing enrollment caps. Most of these FY 2003 expansions were considered within the context of the state receiving federal matching funds through Medicaid waivers. In order to be approved for a waiver, states with existing pharmacy programs must demonstrate some benefit expansion. By FY 2004, when most states had either already exhausted the waiver option or chose not to pursue one at all, fewer expansions were being considered and even fewer were expected to be implemented. Many of the expansions being considered for FY 2004 required minimal state expenditures, such as establishing a state discount card program or increasing outreach for existing programs.

Increasing Financial Eligibility: As shown in Figure 9, the most common type of expansion proposed and implemented in FY 2003 and FY 2004 was to expand income eligibility. In FY 2003, nine states had considered and six had implemented either an increase in income eligibility or the elimination of asset test requirements. This was usually proposed in conjunction with receiving a Medicaid waiver. The two exceptions were New York and Pennsylvania; both enacted eligibility expansions without a waiver, in response to Medicare+Choice withdrawals that left many seniors in the state without

Figure 9: Program Expansions Implemented and Considered in SPAPs, 2003 -2004



Source: Survey of 18 States with operational state pharmacy programs conducted by Rutgers' Center for State Health Policy, March 2003

coverage during a gubernatorial election year. New York expanded income eligibility significantly, and Pennsylvania temporarily extended program eligibility to persons who would be income ineligible due to Social Security cost-of-living adjustments. Far fewer states were considering financial eligibility expansions for FY 2004. Of the five states that were considering some income or asset eligibility expansions, most were still waiting approval from CMS on their waiver applications from the prior year, or were proposing small expansions or modifications to their previous waivers. Pennsylvania was one of the few non-waiver states that was proposing a fairly substantial income eligibility expansion for its moderate income program, to be supported with new funds generated from expanding the state lottery.

Expanding to Disabled: In FY 2003, seven states had considered covering the disabled either for the full pharmacy benefit or for a proposed discount program. Most of these proposals were contingent on applying for or getting a waiver. These proposals were largely rejected, due to the significant anticipated costs of covering people with disabilities. Only three states actually expanded benefits to the disabled in 2003 and two of these provided only a discount, not a full drug benefit. Many fewer states were considering this option in FY 2004, and respondents in these states thought that passage was unlikely.

Increasing Outreach: Expansion of outreach, which was proposed and implemented in six states in FY 2003, was concentrated in states with new programs that were still in start-up phase or in states that had recently expanded eligibility and were eager to publicize the new benefits. Far fewer states were considering expanding outreach in FY 2004.

Expanding Drugs Covered and Raising Benefit Caps: A number of states had implemented or were considering one (or both) of two coverage expansions: increasing the number of drugs covered by the SPAP or increasing an existing benefit or enrollment cap. Most of these proposals were waiver-related. States such as Maine, Illinois, and Maryland that had previously limited coverage to certain conditions demonstrated an expansion in their waiver requests by proposing to expand the number of drugs covered. Other states, such as Florida and North Carolina, that previously had capped the benefit for SPAP enrollees, proposed to increase the cap significantly, in both cases doubling what the state previously paid. In FY 2004, since most states had exhausted the waiver option, far fewer states were considering this option. Those that were still awaiting the outcome of the previous year's waiver request.

Lowering Cost-Sharing: Changes to consumer cost-sharing to lessen consumer burden were generally not implemented by SPAP states in FY 2003 and were even less likely to be considered in FY 2004. The states that modified consumer cost-sharing in FY 2003 did not significantly reduce the cost to the consumer but just spread the costs over the course of the year rather than having an upfront fee, premium or deductible. Several of these proposals were tied either to a waiver request or to initiatives to expand coverage to higher income persons. For example, in New York, where eligibility had been expanded for moderate income persons, the state also reduced fees and copayments to enhance the benefit for low-income persons and reduce barriers to enrollment.

Instituting Discount Programs: Discount programs, which offer reduced prices to consumers at minimal to no cost to the state, have been one of the more common 'expansion' strategies that states have considered in FY 2003 and FY 2004. Seven states implemented discount programs in FY 2003 and five were considering them in FY 2004. As noted before, some of these proposals would extend the program's discounted price to disabled persons who are not eligible for the direct benefit.

Discount programs, however, have faced legal challenges. Maine and Vermont implemented discount programs that were later overturned by the courts), and this experience has constrained consideration of such programs by other states. In FY 2003,

after its program was successfully challenged, Vermont opted to extend a much less generous discount, providing only the Medicaid pharmacy price without the manufacturer rebate. In FY 2004, other states such as Florida were attempting to build on waiver programs by expanding income eligibility and extending the Medicaid discount with some state subsidy to higher income groups.

Controlling Program Costs

In addition to pursuing other sources of revenue, most SPAPs were considering or had implemented policies to control program costs in some form. The exceptions were four states that had initiated a SPAP only in the past two years and were still in the implementation phase. Nearly all of these programs had significantly underspent their FY 2003 appropriation. Thus, their directors were focused primarily on getting the program successfully up and running and maximizing enrollment, rather than on containing costs.

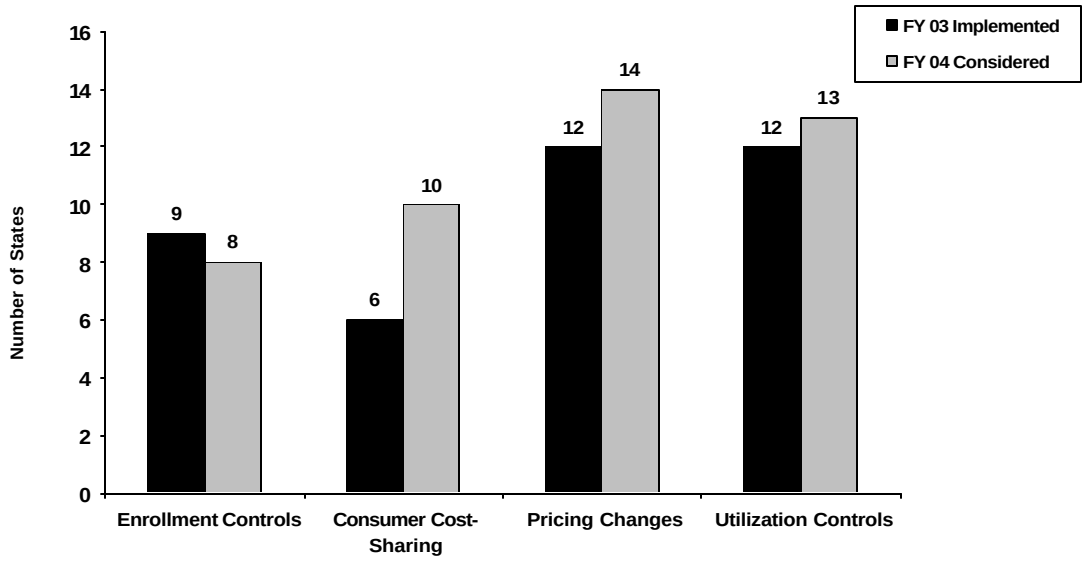
In contrast, most programs that had been in place for two or more years had experienced considerable cost growth and were taking a number of steps to control program costs. As shown in Figure 10, these efforts largely focused primarily on reducing the prices paid for drugs by the state and controlling utilization of higher cost drugs. In many states, consumers were still largely protected from these efforts to control program costs. States were much less likely to impose measures that were likely to have the greatest direct impact on consumers, such as limiting enrollment or increasing consumer cost-sharing. States that did increase cost-sharing or cap enrollment tended to be those that were pursuing Pharmacy Plus waivers, which subjected SPAP enrollees to more-rigorous cost containment strategies utilized by the Medicaid programs. In addition, many states were attempting to steer patients to lower-cost drugs through utilization controls which, depending on how they are designed, could have some impact on consumer access.

Table 3 provides greater detail on the specific strategies pursued within each of these areas, which we discuss in further detail below.

Pricing Changes

Reducing SPAP Pharmacy Payments*:* As shown in Table 3, the pricing changes made by SPAPs included reducing payments to pharmacies, getting better rebates from manufacturers, and joining with larger entities to negotiate even better prices. Following

Figure 10: Cost Containment Strategies Considered and Implemented in SPAPs, 2003 -2004



Source: Survey of 18 States with operational state pharmacy programs conducted by Rutgers' Center for State Health Policy, March 2003

the lead of Medicaid, SPAPs were seeking to get the best prices possible from both the pharmacists and the manufacturers, either by using the state's statutory authority or by employing more market-based strategies. While state efforts to lower their purchase price of drugs were targeted both to pharmacists and to manufacturers in 2003, fewer states were considering lowering payments to pharmacists in FY 2004.

Pharmacies are reimbursed by SPAPs for the ingredient costs of the prescription plus a dispensing fee. In moving to lower pharmacy payments, SPAPs have sought to lower both reimbursement rates and dispensing fees, although the former has been the more common target. There has also been a trend toward establishing state-specific Maximum Allowable Cost (MAC) lists that cap the prices to be paid for generic drugs by state programs. The greatest opposition to these policies comes from pharmacies and pharmacy associations, which argue that lowering reimbursements may drive some pharmacists out of business or lead them to exit the state pharmacy program. Despite this opposition, nine states still reduced pharmacy rates in 2003 and six were considering them in FY 2004 (Fig 9).

Negotiating or Mandating Better Manufacturer Rebates: State pharmacy programs have also become much more aggressive in seeking rebates from manufacturers. Rebates

are payments made to the state by manufacturers after the drugs have been purchased. Nearly all SPAPs require manufacturers to provide rebates as a condition of covering their drugs. But, unlike the Medicaid rebate, which is set in federal law and is uniform for all states, each state sets its own SPAP rebates either through statutory mandate or through voluntary negotiations with individual manufacturers. While some SPAPs have been able to negotiate or require the same rebates as Medicaid, many have not. Thus, many SPAPs have implemented or are considering a rebate increase.

Preferred Drug Lists:

Following the lead of Medicaid, some SPAPs were also seeking supplemental rebates from manufacturers by establishing preferred drug lists. Preferred drug lists specify drugs within therapeutic classes that the state deems preferable based on cost-efficiency and/ or clinical appropriateness. To fill prescriptions for drugs that are not on the preferred drug list, states may require enrollees to get prior authorization, pay a higher copayment, or both. States often use the preferred drug list as a negotiating tool to get supplemental rebates from manufacturers: i.e., if the manufacturer wants its drug on the preferred list, it must agree to pay the state a supplemental rebate.

PDLs are being aggressively pursued by state Medicaid programs and have faced legal challenge by the pharmaceutical industry. Thirty-one state Medicaid programs had instituted or expanded their preferred drug lists in FY 2004, up from 15 in FY 2003.[19] SPAPs were somewhat slower to pursue PDLs and particularly to use them to negotiate supplemental rebates, with only four states doing so in 2003. All four of these were states that had been granted Pharmacy Plus waivers that effectively subjected SPAP enrollees to broader Medicaid cost containment policies or states in which the SPAP is co-located in the Medicaid program. However, seven more SPAPs were considering this option in 2004, including New Jersey, which has traditionally been a pharmaceutical stronghold. PDLs have been fiercely opposed by manufacturers, who have partnered with mental health advocates in some states, arguing that restricting drug use based on costs will limit patients' access to clinically necessary treatments. In fact, several respondents indicated that the advent of PDLs had weakened manufacturer opposition to other rebate strategies, such as state efforts to obtain higher rebates for drugs whose prices increase faster than the consumer price index. PDLs are considered a far greater threat to profits, and have therefore become the main political focus of manufacturers. While only

Table 3: Number of States Implementing or Considering Specific Cost Control Strategies in FY 2003 and FY 2004 (N=18 states)

	Implemented FY 2003	Considered FY 2004
PRICING CHANGES (any)	12	14
Reducing Pharmacy Payment	9	6
Mandating Better Manufacturer Rebates	6	4
Preferred Drug Lists	4	7
Pooled Purchasing	4	2
Contracting with PBM	6	4
UTILIZATION CONTROLS (any)	12	13
Instituting or Increasing Prior Authorization	8	9
Tightening or Expanding Drug Utilization Review	6	7
Instituting Step Therapy	3	6
Stricter Generic Substitution	4	3
Limiting the # of Prescriptions	2	1
Benefit Caps	1	0
Instituting Closed Formulary	0	1
Mail Order	1	3
CONSUMER COST-SHARING (any)	6	10
Increasing Copays	2	4
Instituting 2 or 3 tier-copayments for generic/brand/ preferred	4	5
Instituting/Increasing Deductibles	2	2
Instituting/ Increasing Premiums/Fees	0	2
ENROLLMENT CONTROLS (any)	9	8
Capping Enrollment	6	3
Reducing Outreach	3	1
Delaying/canceling expansions	1	2
Lowering Income Eligibility	1	5
Increasing Application Stringency	1	1

Source: Rutgers Center for State Health Policy 2002 Supplemental Survey of State Pharmacy Assistance Programs, October 2002 and follow-up telephone interviews with program directors, March 2003
Note: Aggregate categories of pricing, utilization, consumer-cost-sharing and enrollment controls include states that pursued any of the sub-strategies. Since many states pursued more than one sub-strategy, subtotals do not match total counts.

representing the views of a few respondents, these comments suggest that the current politics of cost-containment may be developing into one of "harm-reduction" on the part of manufacturers, who realize that some cuts in state pharmacy expenses are inevitable.

Despite the threat of legal challenge, most respondents believed that their state was very likely to continue putting pressure on manufacturers for higher rebates. Similarly, while many fewer states were considering reductions in pharmacy reimbursement in 2004 than 2003, those that were pursuing such reductions indicated that they were very likely.

Pooled Purchasing and Contracting with Pharmacy Benefit Managers: Some states were also trying to increase rebates by increasing their bargaining power in negotiations with manufacturers: six had instituted or expanded use of Pharmacy Benefit Managers (PBMs) and four had joined or created pooled purchasing programs. Pooled purchasing consolidates disparate buyers, within or across states, which increases the number of covered lives being negotiated for, and thereby leverage over the manufacturers. Pooled purchasing can be designed, for example, to include the state employee health benefits program, the Medicaid program and a SPAP. They can be managed internally by the state, by a non-profit entity or by PBM. Similarly, a few states have contracted with PBMs to negotiate lower pharmacy discounts and/or rebates on behalf of a large number of privately and publicly insured individuals.

Pooled purchasing among states is most effective for states with small programs, because large programs already have significant market share. Even for small states, however, there are barriers to successful coalitions. Under the Tri-State Coalition, Maine, Vermont and New Hampshire issued a joint request for proposals for a pharmacy benefit management company to provide services across the three states. However, the states could not reach agreement on the shared functions to be performed by the PBM and thus were not utilizing it as originally envisioned. Maine decided to continue working with the claims processor it was already using, thereby effectively pulling out of the alliance. New Hampshire and Vermont contracted separately with the same PBM but used it for different functions. Vermont used the PBM to aggressively develop a preferred drug lists as a negotiating tool for seeking supplemental rebates. New Hampshire did not have the political support for a PDL and thus used the PBM for other services. Similarly, South Carolina indicated that the pooled purchasing consortium it had joined never got off the ground. Nonetheless, pooled purchasing was still being considered by many states in

2004, including states that have had limited success with them in the past. Maine continued to participate in the Northeast Legislative Coalition, which was seeking to develop a not-for-profit entity to negotiate on behalf of eight states and was open to additional opportunities to join forces. Vermont and South Carolina were both planning to join forces with Michigan to negotiate supplemental rebates for their preferred drug lists.

Utilization Management

While increases in drug prices account for some portion of the rising cost of pharmacy benefit programs, SPAPs have seen significant increases in utilization, particularly for new and more expensive drugs. As a result, in addition to controlling prices, SPAPs were equally likely to impose administrative barriers that discourage use of expensive or clinically inappropriate drugs. Most commonly, states increased the use of prior authorization (often in conjunction with establishing preferred drug lists as discussed above), or expanded drug utilization review or generic substitution programs.

Prior Authorization: Prior authorization is an administrative barrier intended to discourage physicians and patients from using particular drugs. In order to fill a prescription for a drug that requires prior authorization, the pharmacist must get approval from the state or its contractor. Some states allowed the patient to receive a 30-day supply of drugs while approval is sought. Prior authorization can be used for both quality assurance and cost-containment purposes. Cost-related prior authorization may be used in combination with a preferred drug list for rebate negotiation purposes or solely to discourage the use of brand-name drugs that have lower-cost therapeutically equivalent substitutes. In one variation of this approach, one state required that SPAP enrollees receive prior authorization for every brand name drug requested above a four-brand–per-month limit. The four-brand limit was part of the state's Medicaid pharmacy program and was extended to the SPAP as part of the state's Pharmacy Plus waiver.

States have found that imposition of prior authorization can generate considerable cost-savings in diverted utilization -- often even greater than supplemental rebates -- by changing prescribing behaviors of physicians toward lower-cost substitutes. Eight states implemented prior authorization for cost containment purposes in FY 2003, and nine were considering instituting or expanding its use in the near future.

The use of prior authorization for cost control has been controversial and generally opposed by manufacturers, pharmacists, physicians, and some consumer advocacy groups, who argue that it will restrict access to clinically necessary treatments. In particular, there has been considerable debate about whether certain categories of drugs should be excluded. States' processes for selecting which drugs require PA varied considerably. Some states focused exclusively on categories likely to produce the greatest cost savings, while others include all drug classes. In response to public pressure, three states excluded specific drug classes from prior authorization, particularly those used to treat mental illness.

Expansion of Drug Utilization Review:

Other SPAPs were moving to change utilization patterns by expanding their Drug Utilization Review (DUR) programs. DUR programs are designed to ensure that enrollees receive appropriate, medically necessary drug therapy. Before pharmacists can dispense a medication, states require them to review the patient's prescriptions for possible drug therapy problems such as incorrect dosing, drug-drug interactions, or duplicate therapy. If a problem is identified, depending on the state, the pharmacist may choose to override the warning or may be required to get prior authorization before dispensing the drug. DUR programs also retrospectively track trends in prescribing patterns and provide educational interventions to prescribers, pharmacists and patients to warn them of potential prescribing problems. Most of the states implementing or considering changes to DUR in 2003 and 2004 were attempting to strengthen their existing programs by increasing the number of warnings that cannot be overridden by pharmacists and require prior authorization.

While DUR programs can be used for cost-containment purposes, states contend that the focus is on clinically appropriate use of medications rather than on cost-containment. In fact, a few respondents had no estimates of cost savings resulting from their DUR program because, they stated, that was never the intent. DUR was not the only utilization control that was viewed by some more as a quality-assurance mechanism than as a means of cost-containment. Rhode Island encourages the use of generics through letters to consumers and providers, arguing that use of cheaper drugs increases patient compliance. New York, which is considering prior authorization combined with a preferred drug list, reported that while the initial motivation may have been cost-containment, ultimately prior authorization would be used primarily to ensure consumer

safety. If implemented, it would be part of the DUR process, and quality concerns would be considered before costs.

Mandatory Generic Substitution, Step Therapy, and Other Utilization Management: Most SPAPs have mandatory generic substitution requirements that require pharmacists to dispense the generic substitute for a brand-name drug if one exists. Several states that already have enacted such a provision have implemented or are considering strengthening this requirement by requiring prior authorization, rather than allowing physicians to override the generic substitute on the prescription by indicating 'dispense as written.' While mandatory generic substitution is intended to reduce program costs, Maine noted that its mandatory generic substitution requirement is not universally enforced, as sometimes -- given the lower rebate rate for generic drugs – use of generics is actually more expensive for the state.

Step therapy, or requiring patients to try the lower-cost therapeutic equivalent before allowing them to purchase a brand-name drug, has been implemented in SPAPs in three states, and was being considered in six states in FY 2004. Like prior authorization, step therapy is often implemented in conjunction with PDLs or mandatory generic substitution programs. Step therapy is comparable to prior authorization in that it creates an administrative barrier to purchasing drugs, but it requires a higher standard of proof that the drug is clinically necessary. States pursuing this option have done so on a fairly limited basis. For example, one state uses step therapy only for H2 antagonists or Cox II inhibitors.

Less common approaches to changing utilization patterns include promoting use of mail-order drugs (generally by encouraging their use, although Maine has actually mandated purchase of all DEL drugs through mail-order); capping the benefit amount (which one state noted not only brings down the state contribution to drug purchases, but creates an incentive for consumers to control utilization); capping the number of prescriptions that the program will cover for an individual; or instituting a closed formulary.

All of these utilization management strategies may result in substantial savings to the state; but depending on how they are designed, they also have the potential to limit consumers' access to needed drugs. Few studies have been conducted to date to measure the impact of prior authorization or other utilization management strategies on either cost or health outcomes.

Increasing Consumer Cost-Sharing

Most states had not pursued strategies to increase enrollees' out-of-pocket costs. Where such initiatives were considered or implemented, they were typically focused on establishing tiered copayments in combination with utilization controls, to provide a financial incentive to encourage enrollees to purchase cheaper drugs. Some states added or increased two-tiered copayments for generic and brand name drugs. Others established three-tier copayments for generic, preferred brands, and non-preferred brands in conjunction with the state preferred drug list. Far fewer states increased deductibles, and none instituted/increased enrollment fees. While increases in consumer cost-sharing were viewed as potentially unpopular, they were seen as preferable to eliminating the program altogether or eliminating the benefit for certain eligibility groups.

Limiting Enrollment

States can limit enrollment directly by instituting enrollment caps, limiting eligibility, or canceling plans to expand eligibility; or indirectly by reducing outreach or making it more difficult to apply for the program.

Enrollment caps: In FY 2003, a common state approach was to set enrollment caps or reserve the right to impose enrollment caps if expenditures exceeded a specified level. Many of these caps were imposed as part of state Pharmacy Plus waivers to ensure budget neutrality. However, most states had the flexibility to adjust the cap and enroll more people if projections of utilization or cost per enrollee were less than expected. Furthermore, most did not expect to reach the cap because they had used fairly generous assumptions in setting them. Some even indicated that if they hit the cap they might not enforce it, if the state could afford to serve the additional people.

Massachusetts was the only state to actually close enrollment in order to fill a $10 million dollar budget gap in 2003. The state also eliminated all outreach, increased consumer cost sharing (doubling the expenses borne by consumers), and imposed stricter income verification requirements. While these measures were strongly opposed by consumers, officials felt that they had few options available that would allow them to sustain budget cuts of this size. The alternative would have been to stop providing the benefit, as the Governor proposed for FY 2004.

Reducing Income Eligibility: For FY 2004, fewer states proposed enrollment controls than for the prior year, but five did propose to either lower income eligibility or

impose asset tests. Vermont and New Jersey were both considering implementing an asset test in 2004, with the goal of targeting limited resources to the neediest. In both cases, the asset tests were far higher than asset tests imposed in the two SPAP programs that currently have them (Minnesota and Maryland – see Table 2), and higher than those incorporated in the new federal legislation. Vermont was proposing to impose an asset test of $15,000 for singles and $22,500 for couples. New Jersey was proposing to set an asset test for the state's more generous pharmacy benefit program at $75,000 for singles and $100,000 for couples. Rather than losing coverage entirely, these individuals would move into the state's less generous SPAP targeted to moderate income elderly. The state anticipated that this would have saved nearly $17 million. However, in both Vermont and New Jersey, these proposals were expected to be rejected given fierce opposition by advocates and consumers.

Other Enrollment Controls: Less dramatic forms of enrollment controls have been tried by a handful of states, including reducing outreach, delaying or canceling an expansion, or increasing the stringency of the application process by requiring stricter income verification. In contrast to the pricing changes and utilization management initiatives proposed in FY 2004, most respondents felt that proposals to limit enrollment were unlikely to pass because cost-savings were not expected to be dramatic and such changes would alienate constituents.

Eliminating Program Funding

In FY 2003, no state had chosen to eliminate program funding altogether or to switch to a less generous program model. But two states had considered this option for FY 2004, most notably Massachusetts, as described above, whose program had no appropriation in the proposed Governor's budget. Program officials had indicated that in considering alternatives to closing the program, the state had also considered substituting a senior discount program for the current pharmacy insurance benefit. Nonetheless, in the final budget Massachusetts restored the Prescription Advantage program to its full funding amount, demonstrating the political popularity of this program.

Even after South Carolina had received a Pharmacy Plus waiver, that state was considering eliminating its SPAP along with many other optional Medicaid programs over which the state has more discretion. As in Massachusetts, however, the program was preserved.

Conclusion

In contrast to Medicaid programs, SPAPs were largely protected from program cuts for 2003 and 2004, despite some close calls. Reported reasons for this included the popularity and visibility of these programs, their small size and the relatively well-organized constituency that they serve. In addition, the availability of federal matching funds through Medicaid Pharmacy Plus waivers offered the promise of maintaining and even expanding these benefits at a lower cost to the state, even if this came with some risk of larger costs to the state over the longer term.

State budgetary crises do appear to have slowed the growth of SPAP programs. Except in Pennsylvania and in states with new waivers, most expansions implemented or considered in 2003 and 2004 were relatively modest. Even in states with newer programs, expansions were often limited to expanding outreach or simplifying applications in order to improve enrollment, or to offering pharmacy discount cards at minimal cost to the state.

At the same time, many SPAPs were under increasing pressure to reduce costs and were adopting numerous cost containment strategies. Following Medicaid's lead, more states than before were reducing the purchase price of drugs by negotiating or mandating better rebates with manufacturers and cutting payments to pharmacies. More states were also adopting preferred drug lists and requiring prior authorization for more drugs and drug classes, shaping both drug cost and utilization. Few states froze enrollment or imposed enrollment caps or increased consumers' out-of-pocket cost responsibility. Therefore, fiscal pressures had limited immediate impact on consumers. However, the impact on consumers of the more popular utilization controls is not yet known.

The issue of pharmacy assistance has become highly visible on the state political scene, and the priority that states have given to their SPAP programs, even in the face of budget constraints is testimony to the demand for pharmacy assistance by lower-income consumers. State pharmacy assistance is still quite limited however; in particular, the needs of lower-income disabled individuals have received less attention than those of the elderly. Furthermore, the longer-term outlook for these state initiatives may be more precarious than what we found in 2003. Many programs will continue to rely solely on state funds that, based on current revenue projections, are likely to be in shorter and

shorter supply. Furthermore, a number of the programs were buffered from fiscal crisis only because they were new and not yet operating at full capacity.

At the time of the study, many SPAP states were looking to federal fiscal relief as the longer-term solution to the growing financial pressures being encountered by their programs. With the enactment of Medicare prescription drug legislation, these states have begun a process of re-evaluating their future roles in pharmacy assistance. Many of them will be considering ways to provide a more adequate benefit to their residents than is provided under the federal legislation, while taking advantage of the federal funds to which their residents are entitled. As of the end of 2003, conditions under which they would be able to do so remained unclear and were likely to remain so until federal regulations were developed. For example, issues of coordination of benefits and the extent to which states would be able to provide benefits directly, were unclear.

With these uncertainties adding to the states' fiscal uncertainties, the future of the states' role in pharmacy assistance remains clouded. However, our study suggests that two important, if competing, themes are likely to characterize state responses. Clearly, there has been an increasingly high level of recognition among state policymakers of the critical importance of affordable access to prescription drugs for their elderly population, both for the poorest (e.g., those with incomes below or near the poverty line) and for a broader group of lower-income individuals. This recognition has sparked state action and motivated the maintenance of most programs. However, an equally apparent theme has been the significant financial challenges faced by states in attempting to address the need. As policy evolves in anticipation of the 2006 implementation date for the implementation of private pharmacy plans within Medicare under the new federal legislation, states will be challenged to balance these two forces. The financial pressures experienced by the SPAP programs and the uncertain fiscal base of some of them suggest considerable uncertainty as to states' future role in pharmacy assistance and their ability and willingness to fill the substantial gaps in benefits provided under Medicare legislation – particularly in states where pharmacy assistance programs are less well established.

Endnotes

[1] Laschober, MA et al, "Trends in Medicare Supplemental Insurance and Prescription Drug Coverage, 1996-1999" 27 February 2002, www.healthaffairs.org/WebExclusives/Lascholber_Web_Excl_022702.

[2] Another nine states had discount card programs operating for some portion of FY 2003. These programs involve little to no state revenues but do offer marginal savings for targeted uninsured persons.

[3] State Pharmacy Assistance Programs: State of the Art and Implications for Medicare, sponsored by the Commonwealth Fund with supplemental funding from the Kaiser Family Foundation.

[4] Some states have also created state pharmacy discount programs that provide marginal discounts on prices paid for drugs for older uninsured persons but with minimal or no state subsidy; these programs were not included in this survey since they do not involve any significant state funds.

[5] Crystal S, Trail T, Fox K, Cantor J. Enrolling Eligible Persons in Pharmacy Assistance Programs: How States Do It. New York: The Commonwealth Fund; 2003.

[6] Trail, T, Fox, K. Cantor, J., Silberberg, M., and Crystal, S. *State Pharmacy Assistance Programs: A Chart Book, 2003*. Commonwealth Fund, New York, NY, publication forthcoming.

[7] Ibid

[8] Iris J. Lav. and Nicholas Johnson. "State Budget Deficits for Fiscal Year 2004 are Huge and Growing." Center on Budget and Policy Priorities, January 23, 2003.

[9] Lav and Johnson, op cit.

[10] John Springer, "Did States Spend Their Way into the Current Fiscal Crisis?" Center on Budget and Policy Priorities, May 9, 2003.

[11] Boyd, D, The Current State Fiscal Crisis and its Aftermath. Kaiser Commission on Medicaid and the Uninsured. The Henry J. Kaiser Family Foundation, Washington, DC, September 2003.

[12] Ibid.

[13] "2000-2001 State Health Care Expenditure Report." Co-Published by the Milbank Memorial Fund, the National Association of State Budget Officers, and the Reforming States Group, April 2003.

[14] Smith, Vernon, Ellis, Eileen, Gifford, Kathy, Ramesh, Rekha, Wachino, Victoria. Medicaid Spending Growth: Results from a 2002 Survey, Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation, September 2002.

[15] NCSL Fiscal Affairs Program. *Securitization of Tobacco Settlement Revenue,* April 18, 2003, .

[16] Kaiser Commission Medicaid and the Uninsured. *The Financing of Pharmacy Plus Waivers: Implications for Seniors on Medicaid of Global Funding Caps.*

[17] In addition to the states surveyed, Connecticut and Michigan had submitted waivers to cover some portion of their existing SPAP. Arkansas, Hawaii and Wisconsin had applied to create a new pharmacy benefit for low-income elderly. Wisconsin's waiver was approved in July 2002.

[18] One other state had submitted a Pharmacy Plus waiver and rescinded their applications prior to approval. Another state rescinded its waiver after approval due to concerns about the formula for establishing the global cap.

[19] Smith V, Ramesh R, Gifford K, Ellis E, Wachino V. *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004: Results from a 50-State Survey*. Kaiser Commission on Medicaid and the Uninsured. The Henry J. Kaiser Family Foundation, Washington DC, Se