



# State Pharmacy Assistance Programs: A Chartbook—Updated and Revised

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## Introduction

Prior to the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) in December 2003, many states provided some level of drug coverage to low- to moderate-income elderly or disabled residents who do not qualify for Medicaid drug coverage. In 2003, state pharmacy assistance programs (SPAPs) served more than 1.5 million Medicare beneficiaries in 22 states. The new environment created by Medicare Part D represents numerous challenges and opportunities for states in deciding: 1) whether to create, maintain, or end their SPAP programs, and 2) how to coordinate their programs with the new federal benefit. Given the financial and design constraints of the Part D pharmaceutical coverage program, there continues to be an important role for additional assistance from states, whose ability and willingness to do so will continue to be influenced by federal policies and a host of other factors.

As the national dialogue over Part D legislation, regulations, and implementation progressed, the Commonwealth Fund-supported project on state pharmacy assistance at Rutgers worked with the states to identify and analyze the many complex issues involved for states in the Part D transition and provide a forum for public discussion of these issues and for exchange of information. Developed as part of this work, this chartbook documents the pre-Part D landscape of state pharmacy assistance programs. This information serves as an important baseline in assessing the evolving

role of the states going forward in the MMA era, and the impact of policy choices on that role.

In 2003, states spent a total of \$2 billion on prescription drug costs in SPAPs—a considerable investment of state funds that would be lost to beneficiaries if federal policies tend over time to “crowd-out” the state role. On the one hand, some provisions of the MMA explicitly acknowledge the role of states and seek to avoid “crowd-out” of these important programs by extending special privileges to states that opt to continue to subsidize coverage for their residents as a supplement to the Part D benefit. Under the MMA, SPAP contributions count toward the calculation of TrOOP (true out-of-pocket costs) thereby allowing them to help their beneficiaries reach the Part D catastrophic cap sooner, and making it even more important to sustain existing SPAPs and indeed to expand them to additional states. Nonetheless, other MMA policy choices constrain the states’ role.<sup>1</sup> Understanding the current coverage provided by these programs and the persons they serve, relative to the new Medicare benefit, may help to inform future decision making by federal and state policymakers.

Since the inception of Medicare Part D on January 1, 2006, many changes have taken place for SPAPs. In 2005, some states created new SPAPs to wrap around Part D (Hawaii, Kentucky, Montana, and New Hampshire), but others ceased

<sup>1</sup> See, for example, K. Fox and S. Crystal, *Coordinating Medicare Prescription Drug Benefits with Existing State Pharmacy Assistance Programs*. Prepared for The Commonwealth Fund. Rutgers Center for State Health Policy, 2005.



operation of their SPAPs (Florida, Kansas, Michigan, Minnesota, and North Carolina.)<sup>2</sup>

The remaining SPAPs have pursued varied courses of action, including providing state funds to wrap around Part D, providing emergency coverage during the initial transition period, expanding programs to cover non-Medicare eligible populations, and reducing or eliminating benefits that are now covered by Part D.<sup>3</sup> As states journey through the uncharted territory of Medicare Part D, more changes are likely to develop;<sup>4</sup> however, it is important to take into account the vital role that states have played in providing prescription drug assistance to their residents and to encourage their ongoing participation.

This chartbook updates a previous one that was released in August 2004 reporting SPAP data from 2002 and trends over time. The present report provides 2003 SPAP data on the number and types of programs, eligibility requirements, benefit design, and program administration in comparison to the new Medicare Part D benefit, as well as most recent annual enrollment, utilization, and program expenditures.

This chartbook is intended to serve as an information source about these programs and as a baseline to compare and contrast these benefits with the new Part D benefit. Unless otherwise stated, the data in the chartbook are from

surveys of SPAPs conducted in 2000, 2002, and 2003 by the Rutgers University Center for State Health Policy.

For cross-sectional charts, where 2003 state survey data was incomplete, we utilized the most recent data available and note this in the source citations. The results of CSHP's survey as well as supplemental qualitative interviews on specific SPAP issues have also been discussed in several reports published by The Commonwealth Fund or CSHP. CSHP has also written a detailed report on coordination of benefits issues and SPAP plans for coordinating with the Medicare benefit. These reports may be found at <http://www.cmwf.org> and <http://www.cshp.rutgers.edu/>.

**The chartbook is divided into five sections:**

**State Approaches to Addressing Prescription Drug Affordability.** This section provides an overview of the types of programs that states have instituted to reduce prescription drug costs for program participants. States have either provided state-funded subsidies to pay for some portion of enrollees' prescription drug costs (a "direct benefit" program), or have arranged for participants to receive a reduced price for prescriptions at participating pharmacies (a "discount" program).

As of August 2004, 41 states had authorized some type of prescription assistance program, with 20 states authorizing

<sup>2</sup> National Conference of State Legislatures' Web site: *State Pharmaceutical Assistance Programs, 2006 Edition*, <http://www.ncsl.org/programs/health/drugaid.htm>. Accessed July 27, 2006.

<sup>3</sup> National Conference of State Legislatures' Web site: *State Pharmaceutical Assistance Programs in 2006: Helping to Make Medicare Part D Easier and More Affordable*, <http://www.ncsl.org/programs/health/SPAPCoordination.htm>. Accessed July 27, 2006.

<sup>4</sup> For a recent update on SPAP wrap-around activities, see K. Fox and L. Schofield, *The Pharmacy Coverage Safety Net: Variations in State Responses to Supplement Medicare Part D* (Portland, Maine: Muskie School of Public Service, University of Southern Maine, Feb. 2006).



direct benefit programs only, eight authorizing discount programs only, and 12 authorizing both direct benefit and discount programs; however, not all of these programs were operational.<sup>5</sup> Since direct benefit programs generally have a greater impact on enrollees' out-of-pocket costs, as well as on state expenditures, we surveyed only states with direct benefit programs, and the remainder of the chartbook focuses only on these programs. These direct benefit programs, which include the Pharmacy Plus waiver states that may seek to give up their waiver authority to meet the statutory definition of an SPAP, are also most likely to be integrated with the new Medicare Part D benefit.

**Program Enrollment.** Taken together, the 22 SPAP states enrolled about 1.5 million people as of July 2003; however, 74 percent of these individuals were enrolled in just five states. There has been considerable growth in enrollment in these programs since 1999, but SPAP enrollees still accounted for only 7.3 percent of Medicare beneficiaries in states that had such programs in 2003 (the most recent year for which Medicare enrollment data were available).

Programs that are older and those that did not have caps on benefits or enrollment tended to have the highest enrollment rates; and programs with up-front fees or deductibles tended to have moderate enrollment fees.

**Program Expenditures and Utilization.** In total, states spent about \$2 billion on prescription drug claims in SPAPs in 2003. This contrasts with the estimated \$49 billion that

Medicare expects to spend on the Part D benefit in its first year of full implementation.<sup>6</sup> The five states with the most persons enrolled also accounted for 71 percent of all drug expenditures. Annual costs per enrollee averaged \$1,478 in 2003 and ranged from \$105 in North Carolina to \$2,472 in New Jersey. In recent years, expenditures have increased dramatically for many states. For states with programs established before 1999, annual drug expenditures per enrollee increased 59 percent from 1999 to 2003.

The average number of prescription claims per year per enrollee was 31.5 in FY 2003 and ranged from 5.2 in South Carolina to 45.6 in Pennsylvania. The average state cost per claim before rebates was \$50.00 in 2003 and ranged from \$16.64 in Indiana to \$78.05 in Connecticut. States with programs established before 1999 had a 45.3 percent increase in costs per claim from 1999 to 2003, but states with programs established in 1999 and thereafter had a more variable course. These different cost-saving strategies. On average, SPAPs recovered \$9.11 per filed claim through manufacturer rebates in 2003. Overall, SPAP rebates averaged 17.7 percent of total state drug expenditures. This also varied by state, partly because of the different rebate rates among states, different consumer cost-sharing requirements, and the types of drugs used by enrollees (brand-name private sector generally does not achieve better rebates than the Medicaid rate and getting supplemental rebates, beyond those negotiated by the private plans for the Part D benefit and incorporated into the drug price, may be difficult).

<sup>5</sup> National Conference of State Legislatures' Web site: *State Pharmaceutical Assistance Programs, 2003 Edition*, <http://www.ncsl.org/programs/health/drugaid.htm>. Accessed Nov. 11, 2004.

<sup>6</sup> CMS, Federal Register, vol. 70, no. 18, Jan. 28, 2005, p. 4455.



**Program Design.** While most direct benefit programs are targeted to elderly persons with low to moderate incomes, there is considerable variation in eligibility and cost-sharing requirements among programs. Of the 22 states with operational programs in 2002, all were available to persons over 65, nine extended eligibility to disabled persons under the age of 65, and two programs were open to persons of all ages/disability status who met income and other eligibility requirements of their programs. Income eligibility requirements range from 100 percent to 500 percent of the federal poverty level (FPL). This contrasts with the Medicare low-income subsidy income eligibility levels of below 135 percent of FPL for full subsidies and below 150 percent of FPL for partial subsidies. In addition Part D subsidies have an asset test, which only two states required.

Cost-sharing varies considerably but, in many SPAPs, was lower than what is required for the basic Part D benefit, and equivalent or higher than what is required for the Part D low-income subsidies. SPAP program designs range from requiring only a small copayment per prescription to having deductibles, coinsurance, premiums, or benefit caps, all of which are also included in the Part D basic benefit.

The challenge of integrating with the myriad coinsurance requirements in the Part D benefit and low-income subsidies will affect states' decisions to provide supplemental or wrap-around benefits to Part D. Additionally, all Part D plans may design their own benefit structure, adding another level of complexity to the design of the federal benefit. The administrative burden of working with multiple plans may

further discourage states from continuing their SPAP programs. For the SPAP programs that provide a more generous benefit than the federal benefit, the implication of "crowd out" would be that SPAP beneficiaries would lose their coverage and be worse off with Part D.

**Program Funding and Administration.** In total, the 22 SPAP states in the survey committed over \$2 billion to fund these programs for fiscal year 2003–2004. Fifty-five percent of SPAP funding came from categorical funding sources such as lottery and casino revenues, 22 percent came from general revenues, 9 percent came from tobacco settlement funds, 6 percent from federal matching funds in states with Pharmacy Plus or 1115 waivers, and 8 percent from other sources.

Under the MMA, the Part D benefit is administered by private entities similar to pharmacy benefit managers (PBMs). While several states contracted with PBMs to negotiate pharmacy reimbursement rates and pharmaceutical manufacturer rebate rates, most states set these in statute. Under the Part D benefit, the ability of states to control reimbursement rates and rebates as a secondary payer may be at risk. In addition, nine of 22 states have preferred drug lists (PDLs) or prior authorization programs that require doctors or pharmacists to obtain approval from the PBM or the state before dispensing drugs with less expensive therapeutic equivalents. To the degree that these states choose to wrap around a Part D benefit, this would require matching their PDL with the different formularies provided by Part D plans.



# Section 1. State Approaches to Addressing Prescription Drug Affordability



## Chart 1-1 State Interventions for Addressing Prescription Drug Affordability, 2004

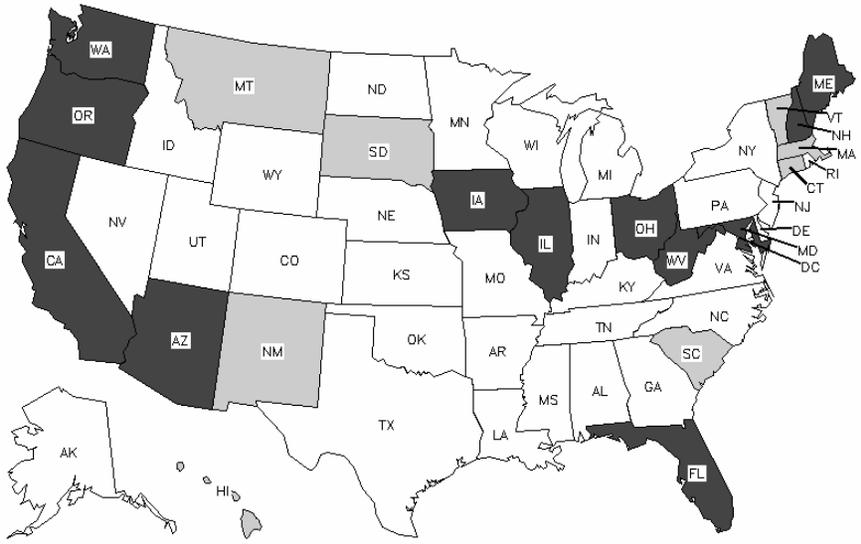
- As of August 2004, 41 states had authorized some type of program to reduce the costs of prescription drugs for a portion of their non-Medicaid eligible residents, and several states had authorized more than one type of program.<sup>1</sup> In general, states have authorized direct benefit programs that are state-funded or discount programs that provide state-negotiated discounts to members. Throughout the chartbook, unless stated otherwise, states that had more than one program are shown as having one combined program.
- Thirty-one states and Washington D.C. had enacted a direct benefit program, and programs in 23 of those states were operational. Alaska enacted a direct benefit program in March 2004 that became operational in May 2004.<sup>1</sup> Alaska's program was intended to serve as a gap filler until Medicare prescription drug benefits began in January 2006.
- Twenty states had authorized discount programs to reduce the costs of prescription drugs to consumers at little or no cost to the state.<sup>1</sup> In 2004, Arizona, Illinois, and Washington initiated new state-sponsored discount card programs and Maine Rx was reconfigured and implemented as Maine Rx Plus, after overcoming legal challenges.<sup>1</sup>
- In the 12 states with both types of programs, the direct benefit programs were targeted to persons with lower incomes and the discount programs typically had no income limits.
- Several states had authorized programs that were not yet operational in 2004, in many cases because of lack of funding.
- The remainder of the chartbook will focus only on direct benefit programs, which provide the greatest financial support for individual enrollees and are at-risk of being "crowded-out" over time by the new Medicare Part D benefit.

<sup>1</sup> National Conference of State Legislatures' Web site, *State Pharmaceutical Assistance Programs, 2004 Edition*, <http://www.ncsl.org/programs/health/drugaid.htm>. Nov. 11, 2004.

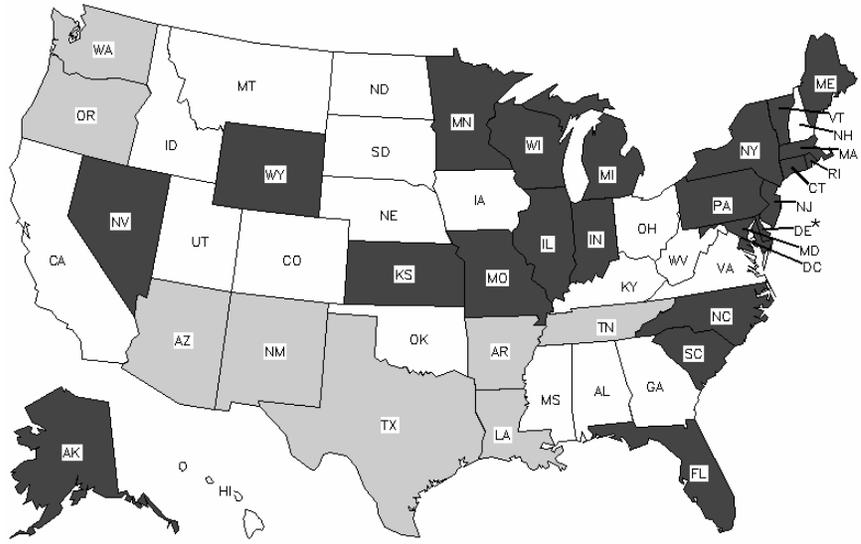


# Chart 1-1 State Interventions for Addressing Prescription Drug Affordability, 2004

**Discount Programs, 2004**



**Direct Benefit Programs, 2004**



**Operational Status**

- No program enacted or operational
- Program enacted but not operational
- Program is operational

\* The District of Columbia's direct benefit program was enacted but not operational.

Source: National Conference of State Legislatures' Web site, *State Pharmaceutical Assistance Programs, 2004 Edition*, <http://www.ncsl.org/programs/health/drugaid.htm>. Nov. 11, 2004.

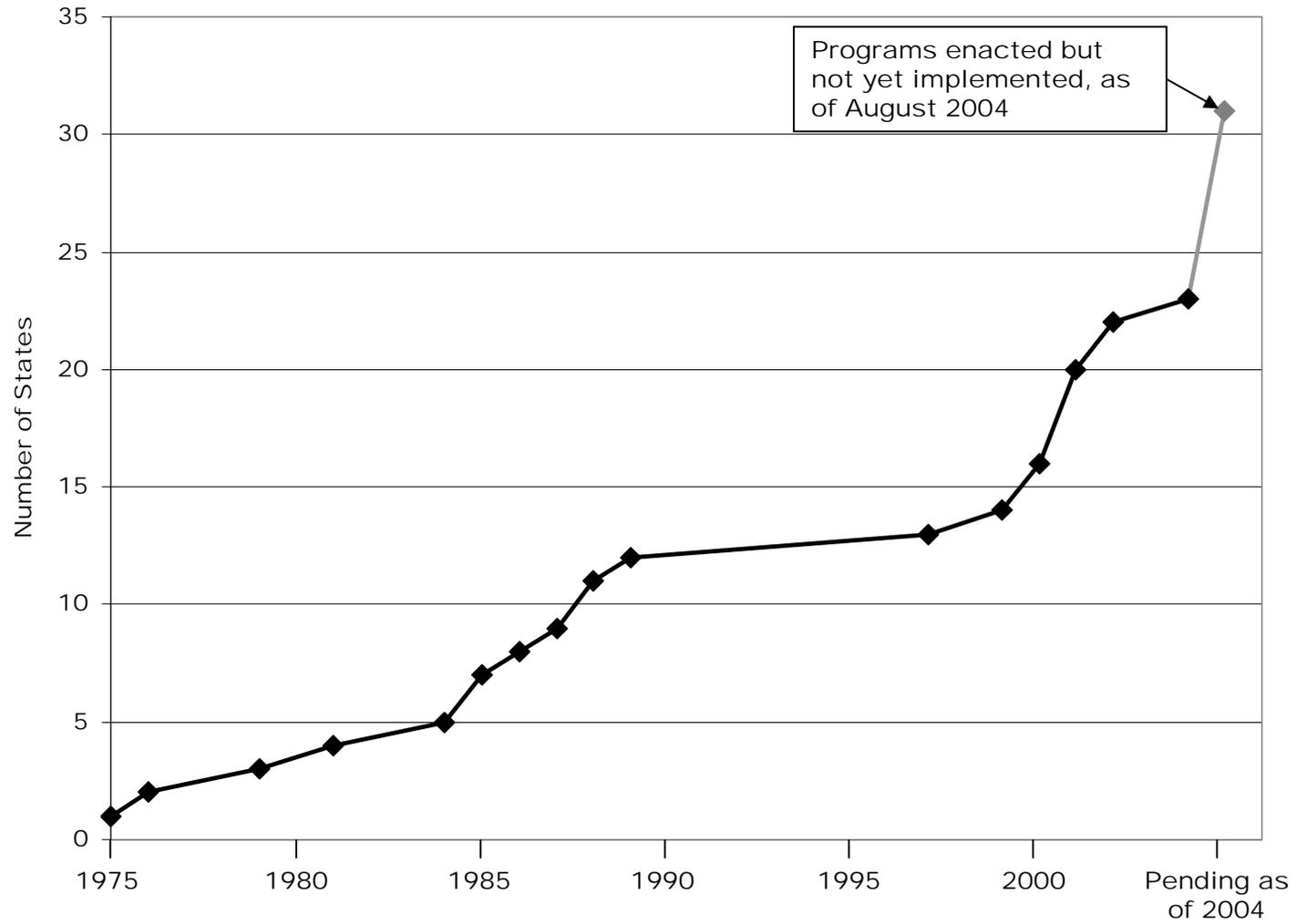


## Chart 1-2 Cumulative Number of States Implementing Direct Benefit Programs over Time

- Maine and New Jersey had the longest standing programs, initiated in 1975 and 1976, respectively.
- Since the first direct benefit SPAP was implemented in 1975, there were generally three periods of growth in the number of states with SPAPs.
- Four states implemented direct benefit programs prior to 1984, and six states implemented programs between 1984 and 1989.
- Another steep increase in the number of states with direct benefit programs began in 1997 with 10 more states implementing programs by 2004, and eight states along with Washington, D.C., had programs enacted but pending implementation as of August 2004.
- The introduction of new direct benefit programs in the mid to late 1980's and from 1997 to 2004 corresponded with the increasing national attention to the issue of prescription drug coverage under Medicare during those periods. The interest in this issue during the 1980's culminated with the passage of the Catastrophic Coverage Act of 1988, which included a plan to phase-in prescription drug coverage for Medicare beneficiaries. This Act was later repealed. The reemergence of the issue in the late 1990s has culminated in the passage of the Medicare Prescription Drug, Improvement and Modernization Act, signed into law on December 8, 2003.
- Seven states had more than one operational direct benefit program. These different programs were usually targeted to persons with different income levels, and the programs for higher income individuals had higher cost-sharing requirements than the lower income programs.



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





## Section 2. Program Enrollment



## Chart 2-1 SPAP End-of-Year Enrollment, 2003

- Taken together, the 22 SPAPs in operation as of July 2003 enrolled 1,500,293 people. Enrollment ranged from 1,151 in Wyoming to 323,592 in New York.
- In 2003, most persons were enrolled in Northeastern (63%) or Midwestern (25%) states.
- As of July 2003, three states capped the number of persons that could enroll in their SPAPs and one state capped total expenditures. Florida capped enrollment at 58,472 people. Nevada had a cap of 10,440 persons to be increased to 12,160 in FY 2005. Wyoming had placed a cap on new enrollment. Minnesota had an expenditure cap of \$8.5 million. As of July 2002, Michigan limited enrollment to current program enrollees (about 14,700 people) but allowed persons to temporarily enroll on an emergency basis (data not available for 2003).
- In six of the 11 states that also covered the disabled, the disabled generally represented on average 10% of enrollment but ranged from 1% in Rhode Island to 49% in Delaware.

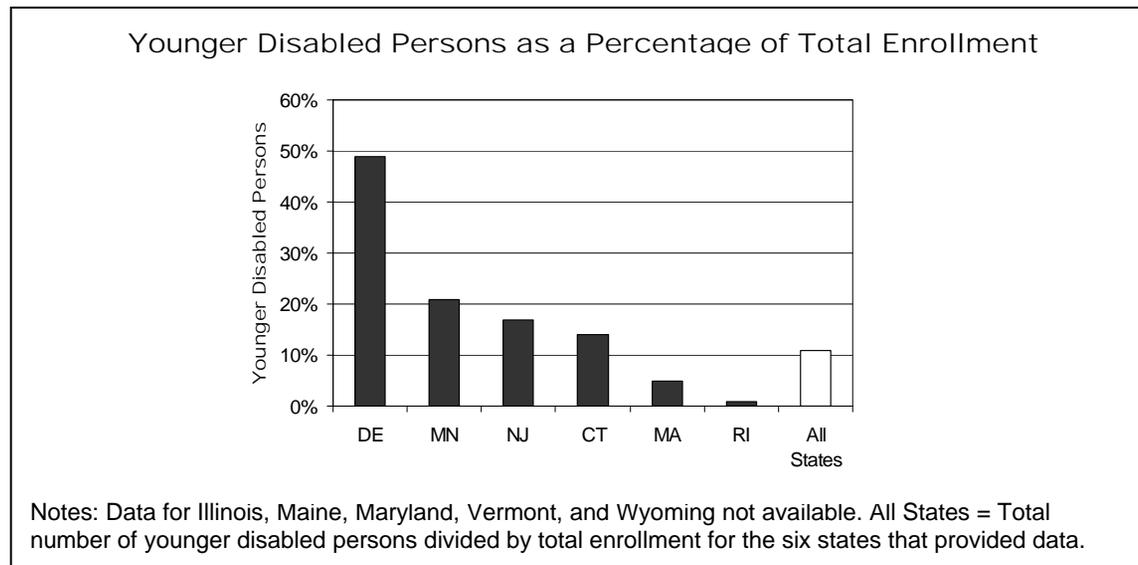
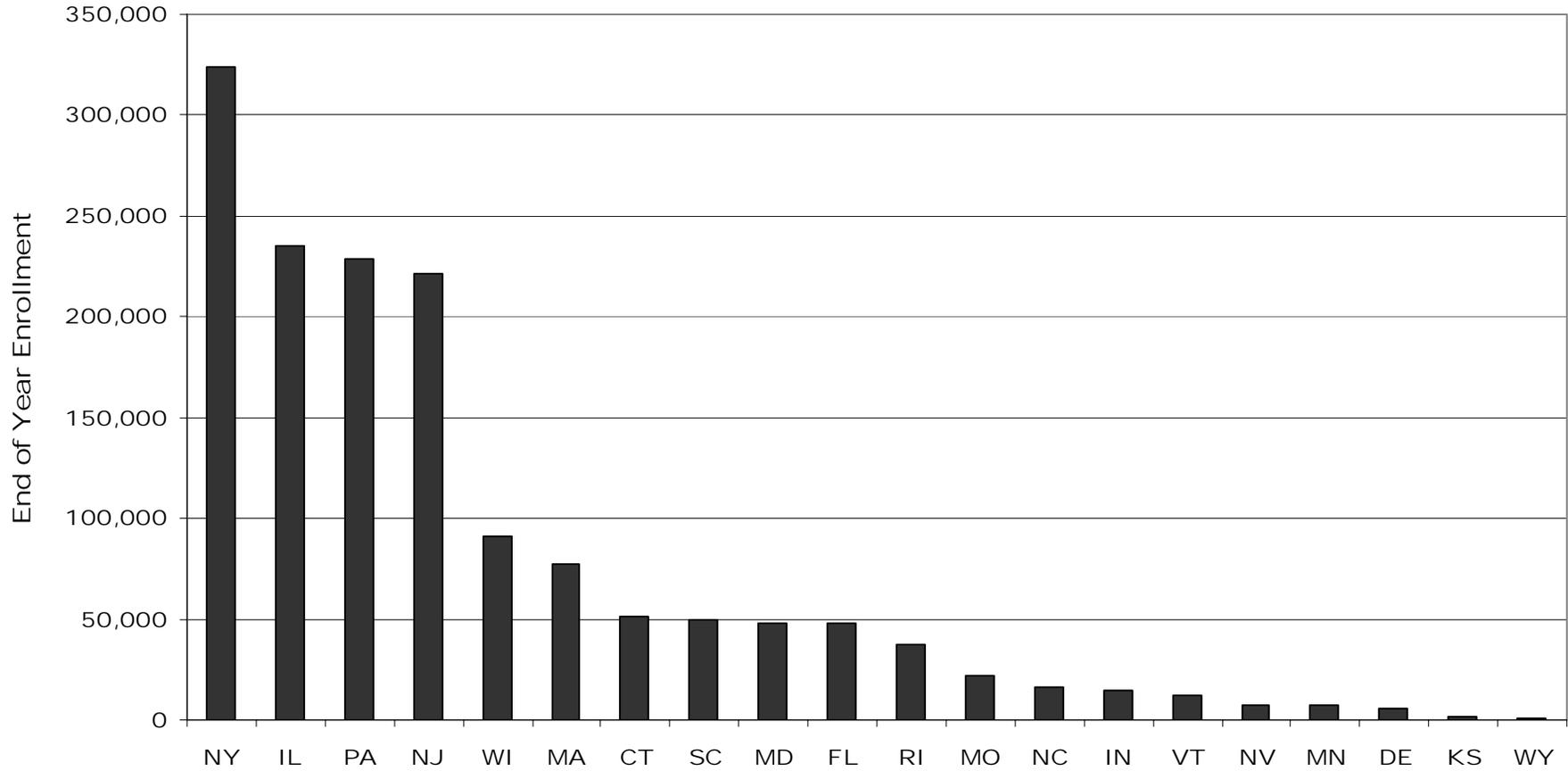


Chart 2-1  
SPAP End-of-Year Enrollment, 2003



Notes: South Carolina only included six months as a new Pharmacy Plus waiver program. Wisconsin was a new program and only includes 10 months. Delaware enrollment does not include the privately funded Nemours program. Data for Maine and Michigan not available.



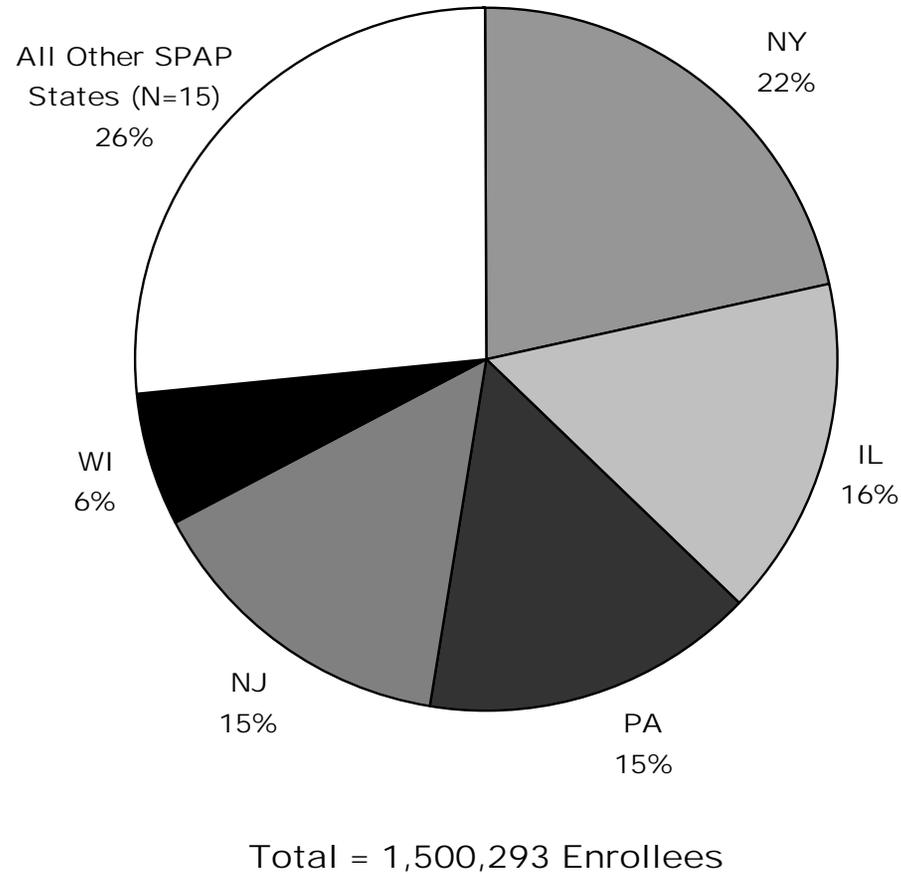
## Chart 2-2

### Proportion of SPAP Enrollees in Five States vs. All Other States with SPAPs, 2003

- About 1,100,000 individuals (74% of all enrollees) were enrolled in the five largest SPAPs in New York, Illinois, Pennsylvania, New Jersey, and Wisconsin, two of which had Pharmacy Plus waivers.
- These five states represented 21.3% of Medicare beneficiaries nationally.
- Wisconsin's SeniorCare program began in September 2002 and after only 10 months achieved the fifth-largest SPAP enrollment in the nation.



Chart 2-2  
Proportion of SPAP Enrollees in Five States vs. All Other States with SPAPs, 2003



Notes: South Carolina only includes six months. Wisconsin only includes 10 months. Delaware enrollment does not include the privately funded Nemours program. Data for Maine and Michigan not available.



## Chart 2-3 SPAP Enrollment as a Percentage of Medicare Enrollment, 2003

- While a considerable number of people were enrolled in SPAPs, these programs provided prescription drug coverage to only a small percentage of the Medicare population in the states with programs.
- On average, SPAP enrollees accounted for only about 7.3% of Medicare beneficiaries in states that had such programs in the year 2003, the most recent year for which Medicare enrollment was available. The level of enrollment in SPAPs by Medicare beneficiaries ranged from under 1% in Kansas to over 22% in Rhode Island.
- This measure may reflect differences in SPAP eligibility levels as well as the income distribution of Medicare beneficiaries in the state, the availability of other types of prescription drug coverage, the extent of program outreach in the state, and other factors.
- On average, for the six states for which we had data, disabled SPAP enrollees accounted for 9.2% of disabled Medicare beneficiaries in these states while elderly SPAP enrollees accounted for 11.2% of elderly Medicare beneficiaries.
- However, there was considerable variability across states in reaching the disabled. Rhode Island, which only extended coverage to the disabled in 2003, was reaching only 1% of Medicare disabled beneficiaries in the state compared to more than 25% of the elderly. Similarly, Massachusetts enrolled a greater proportion of elderly Medicare beneficiaries than they do of disabled beneficiaries, probably because of the stricter income requirements placed on the disabled.

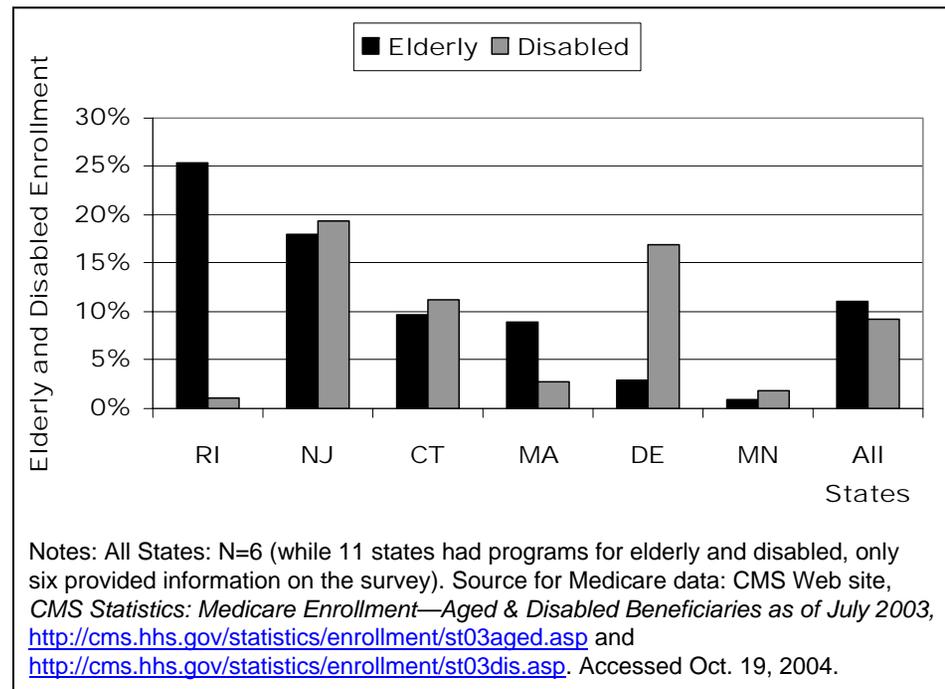
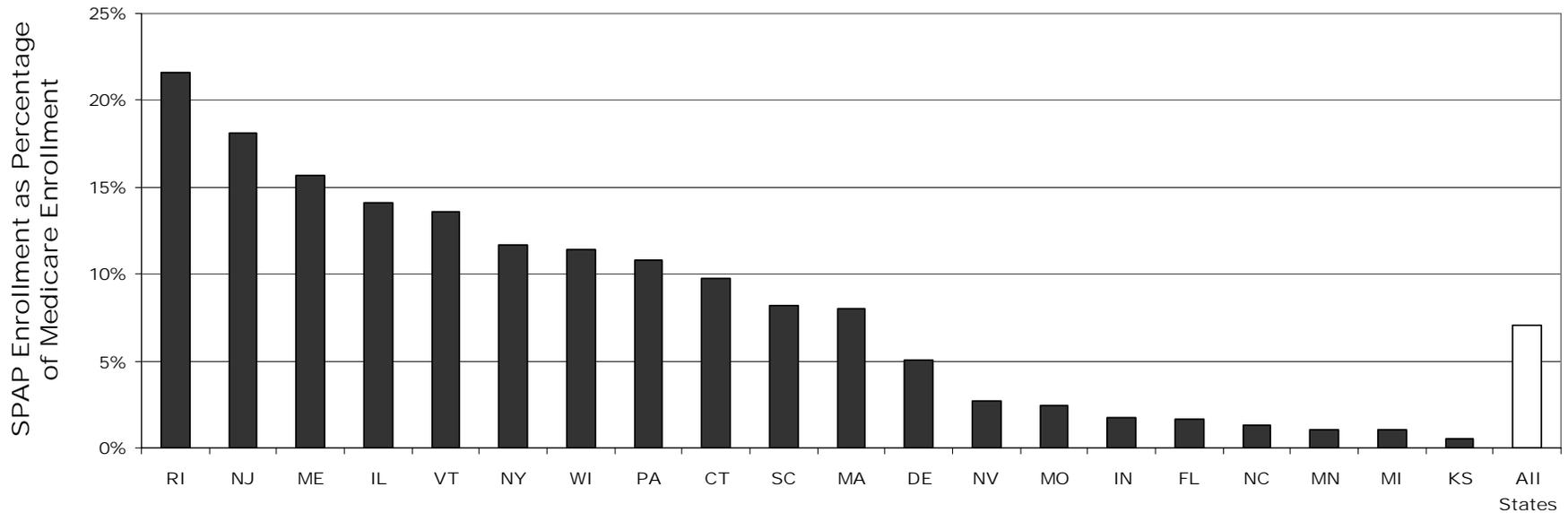


Chart 2-3  
 SPAP Enrollment as a Percentage of Medicare Enrollment, 2003



Notes: South Carolina only includes six months. Wisconsin only includes 10 months. Delaware does not include the privately funded Nemours program. Data for Maryland and Wyoming were not included in this analysis since the programs in those states do not cover only Medicare beneficiaries.

All States = Total enrollment in all programs divided by the total number of Medicare beneficiaries (N=18).

Source for Medicare enrollment data: CMS Web site, *CMS Statistics: Medicare Enrollment—All Beneficiaries as of July 2003*, <http://cms.hhs.gov/statistics/enrollment/st03all.asp>. Accessed Oct. 19, 2004.



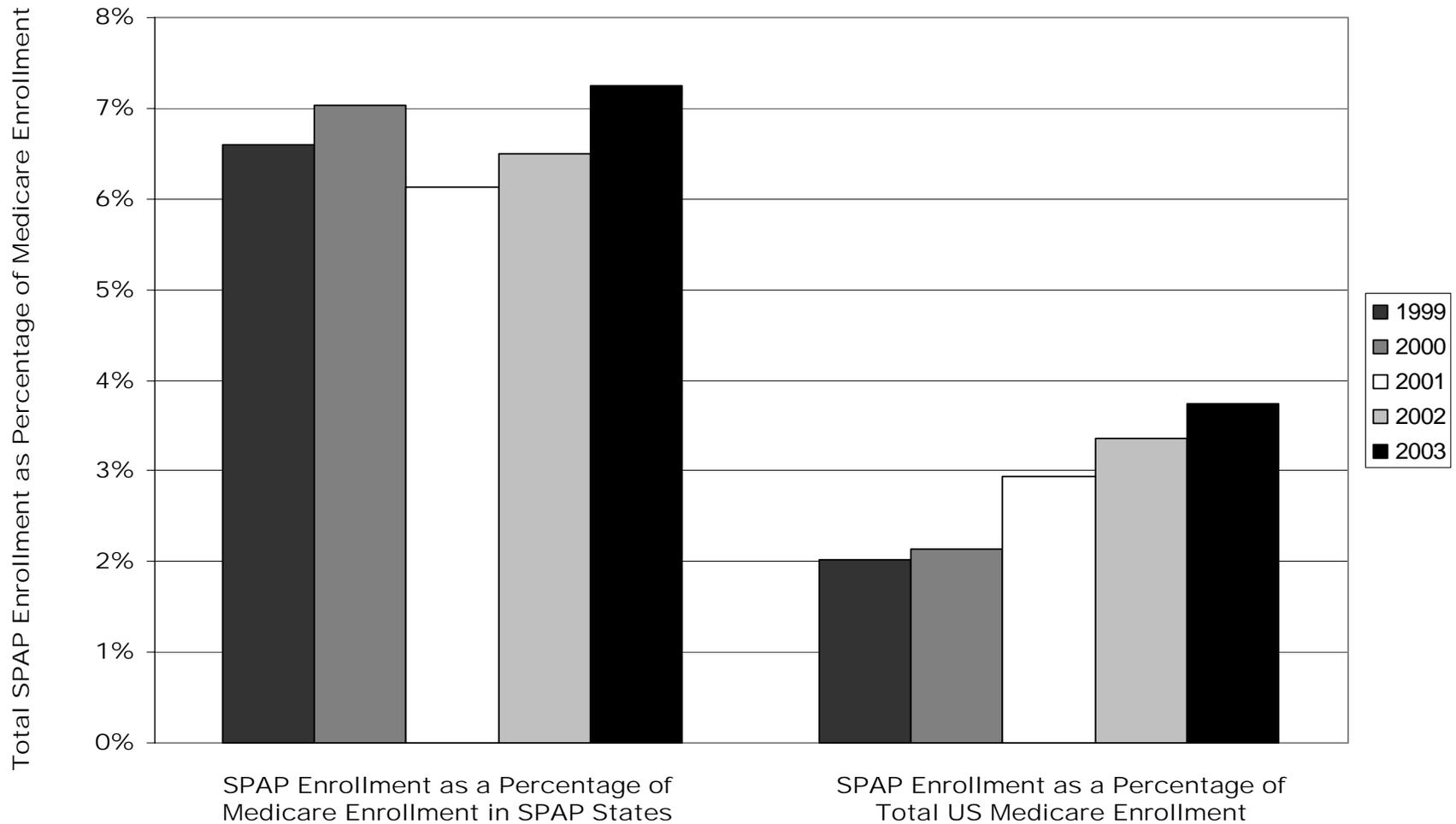
## Chart 2-4 Total SPAP Enrollment as a Percentage of Medicare Enrollment, 1999 to 2003

- Nationwide, SPAPs provided prescription drug coverage to a small—but growing—percentage of Medicare beneficiaries.
- The percentage of all Medicare beneficiaries nationwide accounted for by SPAP enrollees increased from 2% in 1999 to 3.7% in 2003. This was because of increased enrollment in existing SPAPs and the creation of new SPAPs.
- The slow growth of enrollment and lower eligibility levels of new programs established between 2000 and 2001 resulted in a lower proportion of Medicare beneficiaries in SPAP states covered by these programs in 2001 than in the previous two years. However, from 2002 to 2003, the proportion of Medicare beneficiaries in SPAP states increased, consistent with increased enrollment in the new programs and also higher income limits from 2002 to 2003 in many states (see Chart 4-4).



Chart 2-4

Total SPAP Enrollment as a Percentage of Medicare Enrollment, 1999 to 2003



Source for Medicare enrollment data: CMS Web site, *CMS Statistics: Medicare Enrollment—All Beneficiaries as of July 2003*, <http://cms.hhs.gov/statistics/enrollment/st03all.asp>. Accessed Oct. 19, 2004.





## Section 3. Program Expenditures and Utilization



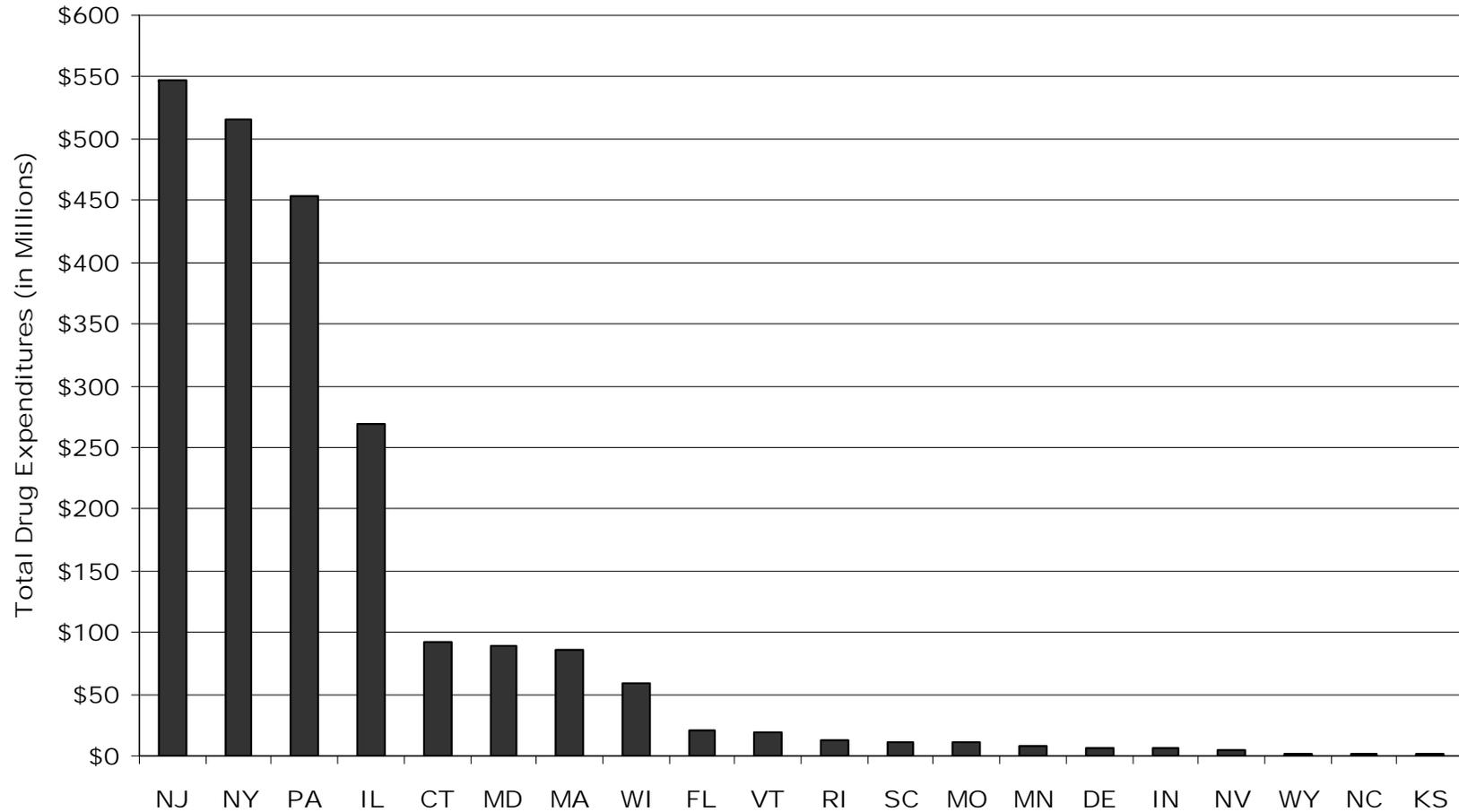
### Chart 3-1 Total Drug Expenditures by SPAPs Before Rebates, 2003

- In total, states spent about \$2 billion on prescription drug claims for SPAPs in 2003. In contrast, the Medicare prescription drug program is a much larger program (by one estimate, projected for 2006 at \$30.5 billion.)<sup>1</sup>
- State expenditures varied in relation to the generosity of the benefit, drug utilization rates, pharmacy reimbursement agreements, enrollment, and other factors.
- New Jersey, New York, Pennsylvania, and Illinois spent over two to five times as much on their SPAPs as did any other state. These four states also had the highest enrollment.
- Wisconsin, which had implemented a new program in 2002, had the fifth-highest enrollment but the eighth-highest drug expenditure, perhaps because of lower utilization at program start-up.



<sup>1</sup> R. Pear, "Federal Costs Dropping Under New Medicare Drug Plan, Administration Reports," *New York Times*, Feb. 3, 2006.

Chart 3-1  
Total Drug Expenditures by SPAPs Before Rebates, 2003



Notes: South Carolina only includes six months. Wisconsin only includes 10 months. Delaware does not include the privately funded Nemours program. Massachusetts includes ingredient cost and dispensing fee.

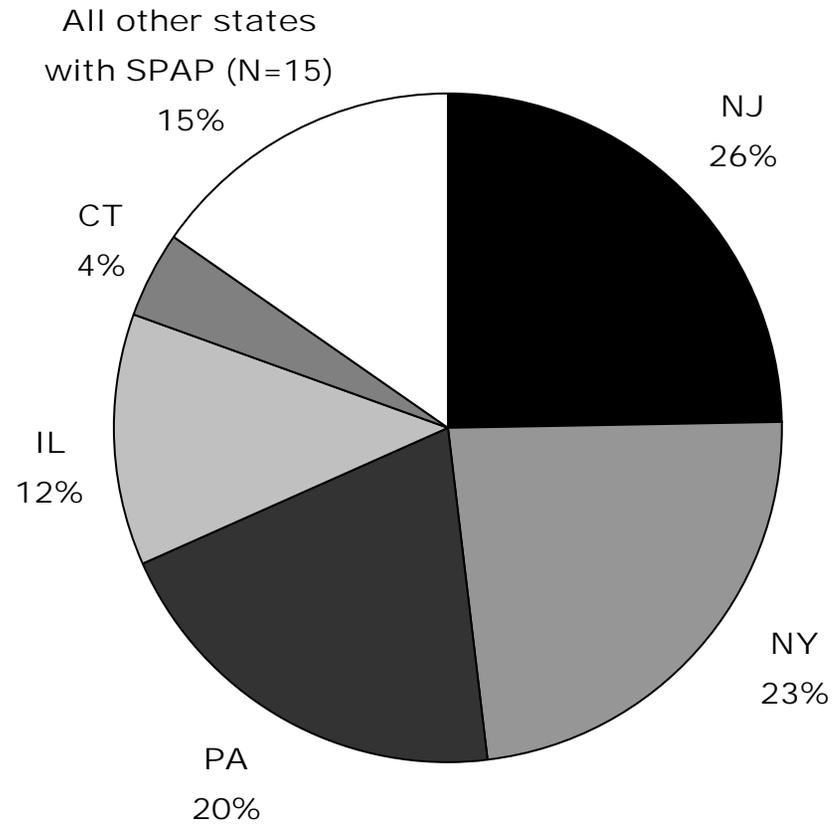


Chart 3-2  
Proportion of SPAP Drug Expenditures in Five States  
vs. All Other States with SPAPs, 2003

- New Jersey, New York, and Pennsylvania accounted for \$1.5 billion or 68% of all drug expenditures by SPAPs in 2003.
- Together with Illinois and Connecticut, these five states accounted for \$1.9 billion or 85% of total SPAP expenditures.
- These five states (New Jersey, New York, Pennsylvania, Illinois, and Connecticut) also accounted for 71% of all persons enrolled in SPAPs in 2003.



Chart 3-2  
Proportion of SPAP Drug Expenditures in Five States  
vs. All Other States with SPAPs, 2003



Total Expenditures = \$2,217,711,745

Notes: South Carolina only includes six months. Wisconsin only includes 10 months. Delaware does not include the privately funded Nemours program. Massachusetts includes ingredient cost and dispensing fee.



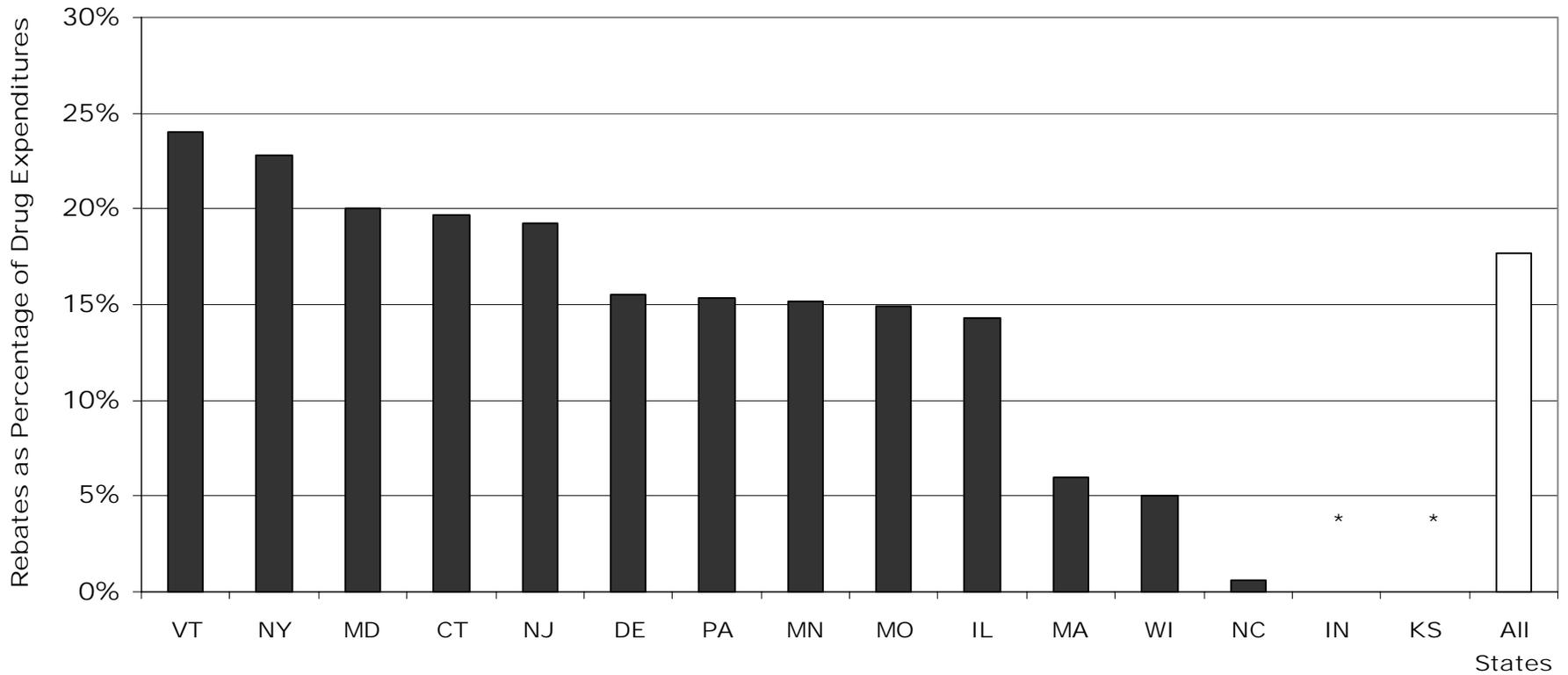
### Chart 3-3

## Rebates as a Percentage of Total Drug Expenditures, 2003

- Rebates averaged 17.7% of expenditures across states and ranged from 0% in Indiana and Kansas to 24.1% in Vermont.
- Kansas did not negotiate rebates and therefore had none to report. Indiana, which had negotiated commercial level rebates, had not yet received the rebates at the time of our survey, but expected to collect some for the fourth quarter.
- The percentage of expenditures returned through rebates is affected by the manufacturer rebate rate, the drug mix used by enrollees (brand-name drugs usually have higher rebate rates), and the amount of participant cost-sharing (since this reduces total program expenditures).
- Under Part D, Prescription Drug Plans are encouraged to negotiate rebates with drug manufacturers and may have to pass on some portion of the savings to consumers. Historically, rebates in the private sector have been less generous than those achieved through state mandates and Medicaid. States may or may not be able to negotiate their own rebates with manufacturers for use during the doughnut hole period.



Chart 3-3  
 Rebates as a Percentage of Total Drug Expenditures, 2003



Notes: Florida, Maine, Michigan, Nevada, Rhode Island, South Carolina, and Wyoming did not provide data on rebate collection. Wisconsin only includes 10 months. Delaware does not include the privately funded Nemours program. Massachusetts includes ingredient cost and dispensing fee.

\* Indiana and Kansas reported 0% rebates collected.

All States = Total rebates divided by total drug expenditures (N=15).



### Chart 3-4

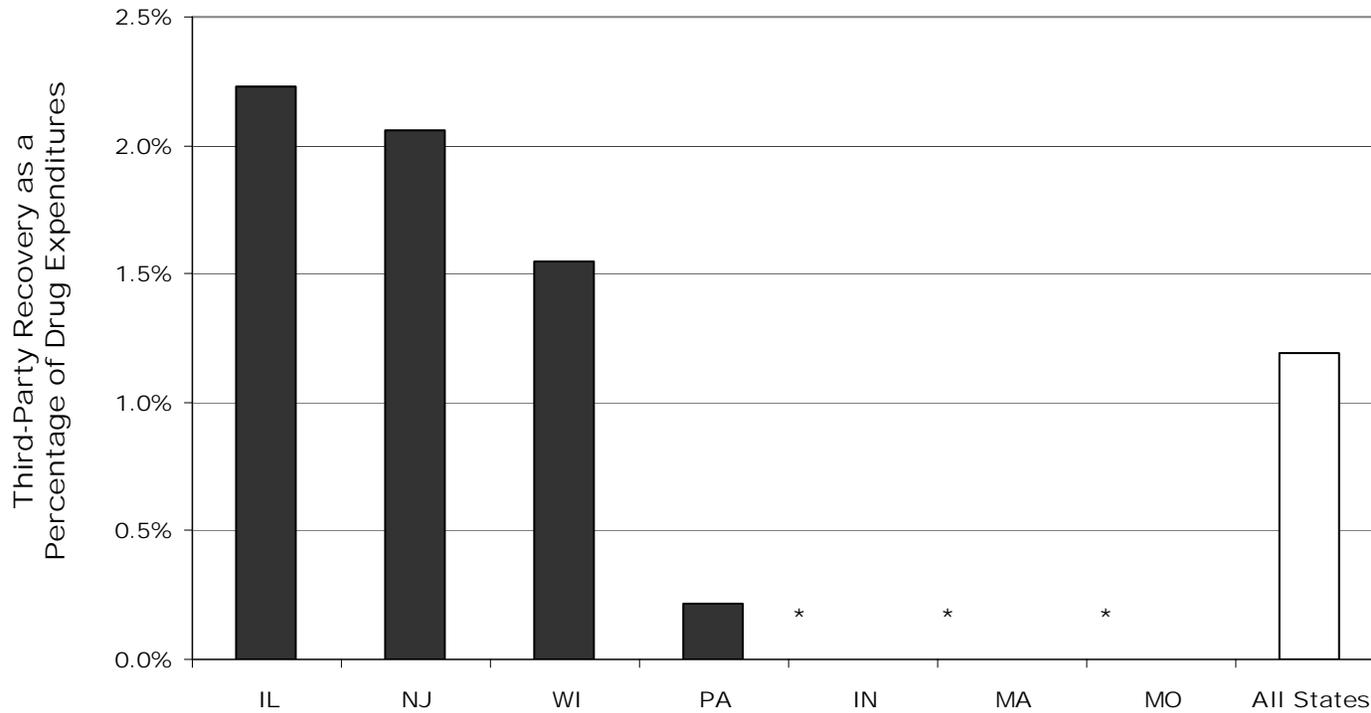
## Third-Party Recovery as a Percentage of Total Drug Expenditures, 2003

- Ten states allowed their enrollees to receive state benefits when they have other drug coverage, either as a supplement to these benefits, or once they have been exhausted. As the payer of last resort, states can recover third-party payments from Medicare or other primary drug insurers.
- Only four of the 10 states that allowed other drug coverage reported collecting any third-party recoveries in 2003.
- Third-party recovery was highest for the Circuit Breaker program in Illinois where it equaled 2.2% of total drug expenditure.
- New Jersey and Pennsylvania, which had two of the highest drug expenditures across the nation, reported third-party recovery rates of 2.0% and 1.6%, respectively.
- Indiana, Massachusetts, and Missouri reported 0% for third-party recovery.
- According to officials in states that have reported the greatest success in these cost recoveries (New Jersey, Pennsylvania, and Illinois), it required concerted effort including stronger statutory language to force insurers to provide necessary information and has resulted in relatively minimal recoveries.<sup>1</sup>
- Other states reported that collection of third-party recoveries was limited due in part to anticipated marginal return on investment given insufficient data on the availability of other drug coverage for their enrollees. Self-report on applications was universally found to be unreliable, both because many people were not necessarily aware that they had coverage and because coverage may have changed since they applied or recertified.<sup>1</sup>

<sup>1</sup> K. Fox, J. Sia, and S. Crystal, *Coordinating Medicare Prescription Drug Benefits with Existing State Pharmacy Assistance Programs: Partnership or Crowd-Out?* (New Brunswick, N.J.: Rutgers Center for State Health Policy, Mar. 2006).



Chart 3-4  
 Third-Party Recovery as a Percentage of Total Drug Expenditures, 2003



\* Indiana, Massachusetts, and Missouri reported 0% third-party recovery. Data for Connecticut, New York, and Rhode Island not available.

Notes: Wisconsin only includes 10 months. Illinois does not include SeniorCare program.

All States = Total third-party recovery divided by total drug expenditures (N=7).



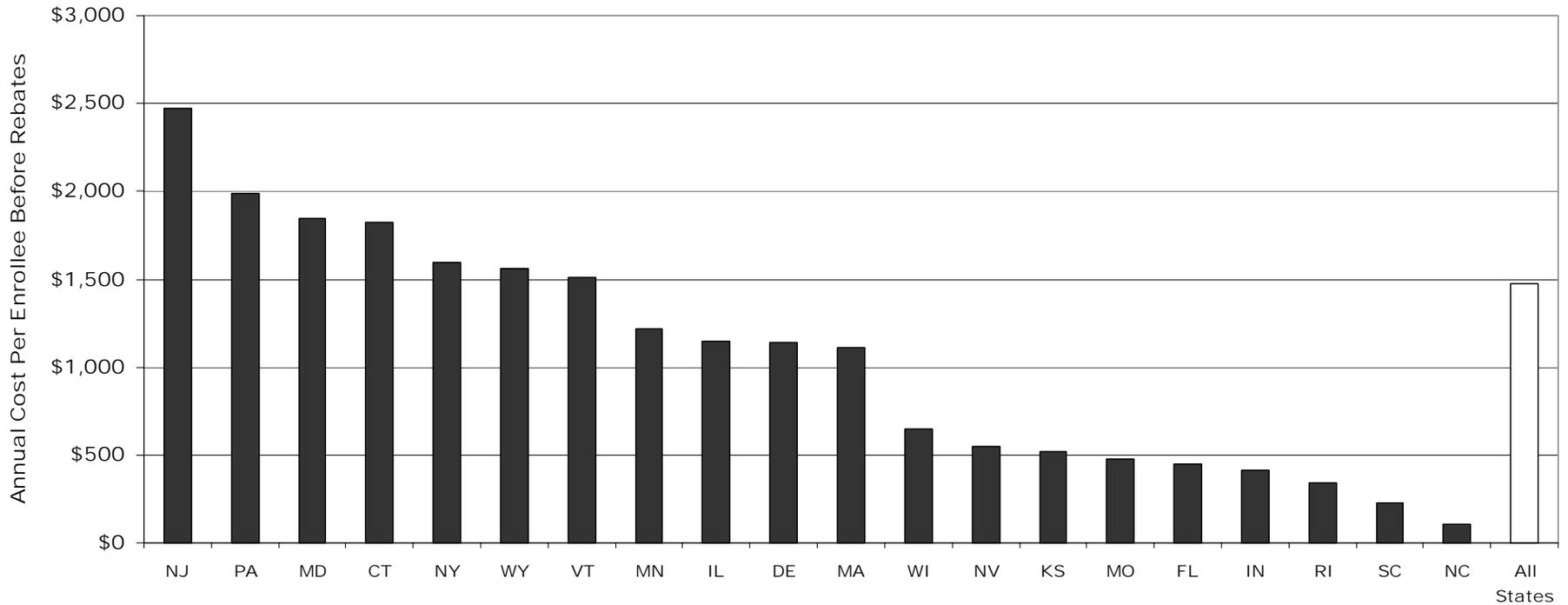
### Chart 3-5 Annual Drug Expenditures per End-of-Year Enrollee Before Rebates, 2003

- On average, SPAPs spent about \$1,478 per enrollee for prescription drugs in 2003.
- Annual costs ranged from \$105 in North Carolina to \$2,472 in New Jersey.
- Differences in costs per enrollee reflect a variety of factors including level of consumer cost-sharing, benefit caps, pharmacy pricing agreements, types of drugs covered, and regional differences in drug utilization.
- By way of rough context, although Part D per-beneficiary spending is a moving target, one early calculation projected an average CMS expenditure of \$1,138 per beneficiary receiving the basic Part D drug benefit, assuming he/she would spend on average \$2,260 per year, and an expenditure of \$4,189 for those eligible for the Part D low-income subsidies, assuming they spend on average \$4,359 per year.<sup>1</sup>



<sup>1</sup> CMS, Federal Register, vol. 70, no. 18, Jan. 28, 2005. p. 4465.

Chart 3-5  
Annual Drug Expenditures per End-of-Year Enrollee Before Rebates, 2003



Notes: Data for Maine and Michigan not available. South Carolina only includes six months. Wisconsin only includes 10 months. Massachusetts includes ingredient cost and dispensing fee.

All States = Total drug expenditures before rebates divided by total end-of-year enrollees (N=20).



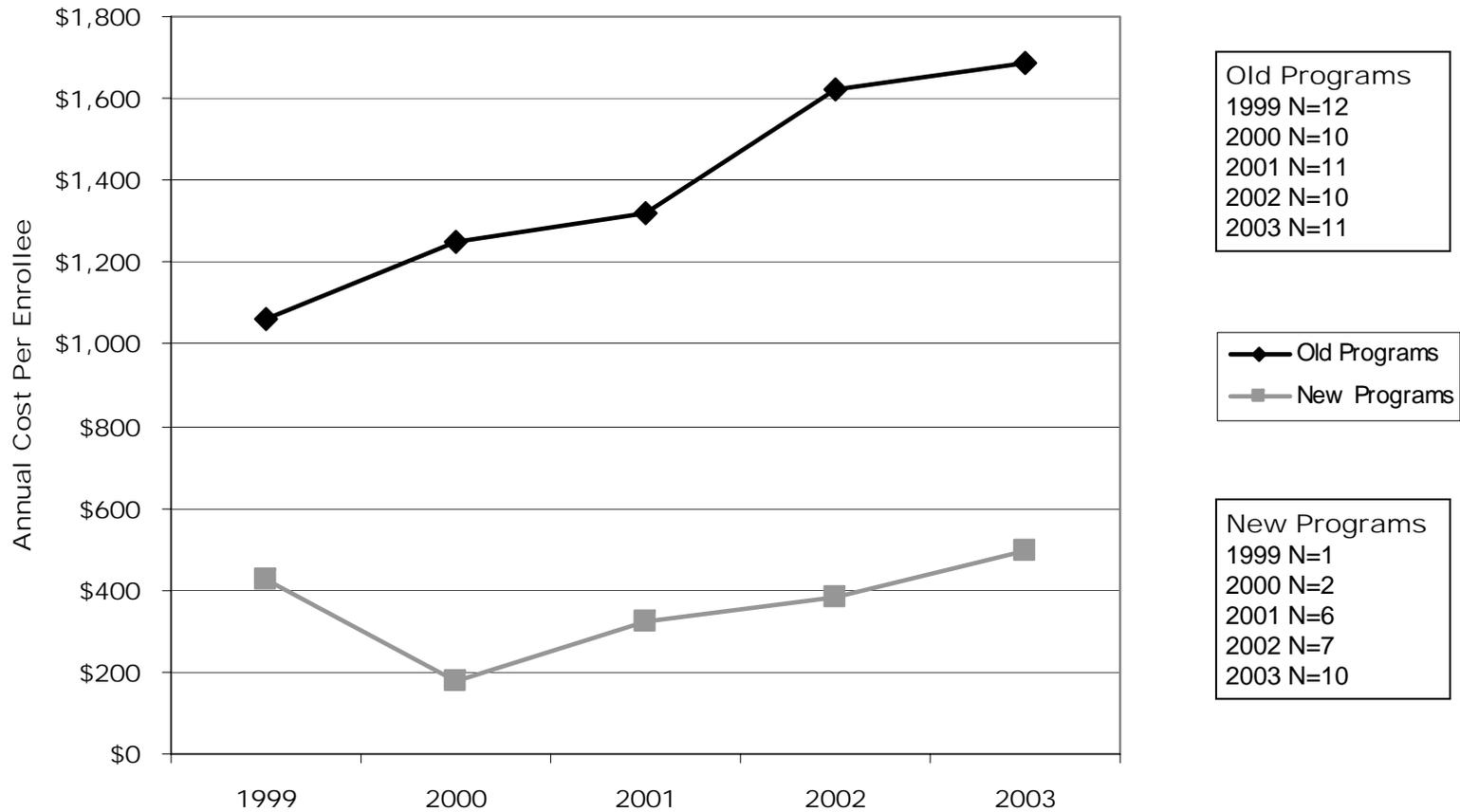
### Chart 3-6

#### Trends in Annual Drug Expenditures per End-of-Year Enrollee, 1999 to 2003

- For states with programs established before 1999 (N=12), annual drug expenditures per end-of-year enrollee increased from \$1,062 in 1999 to \$1,689 in 2003, a 59% increase.
- For states with programs established since 1999, annual drug expenditures per end-of-year enrollee decreased from \$425 in 1999 to \$180 in 2000 (reflecting creation of programs that were in the process of “ramping up” during the year or were less generous, but subsequently rose to \$495 in 2003, by which time there were 10 of these newer programs in operation.
- Drug expenditures per enrollee are affected by the level of consumer cost-sharing, program enrollment, use of the benefit by enrollees, drug utilization rates, and drug prices. Programs experiencing large increases in enrollment during a year (e.g., older programs implementing expansions, newer programs getting “ramped up”) will have lower costs per end-of-year enrollment as fewer enrollees will have used the benefit for the entire year.



Chart 3-6  
Trends in Annual Drug Expenditures per End-of-Year Enrollee, 1999 to 2003



Notes: Old programs are those established prior to 1999 (N=12), and new programs are those established since 1999 (N=10). Only programs operational for at least one full year were included in the analysis. Averages represent data from all states that reported for that year (see legends).

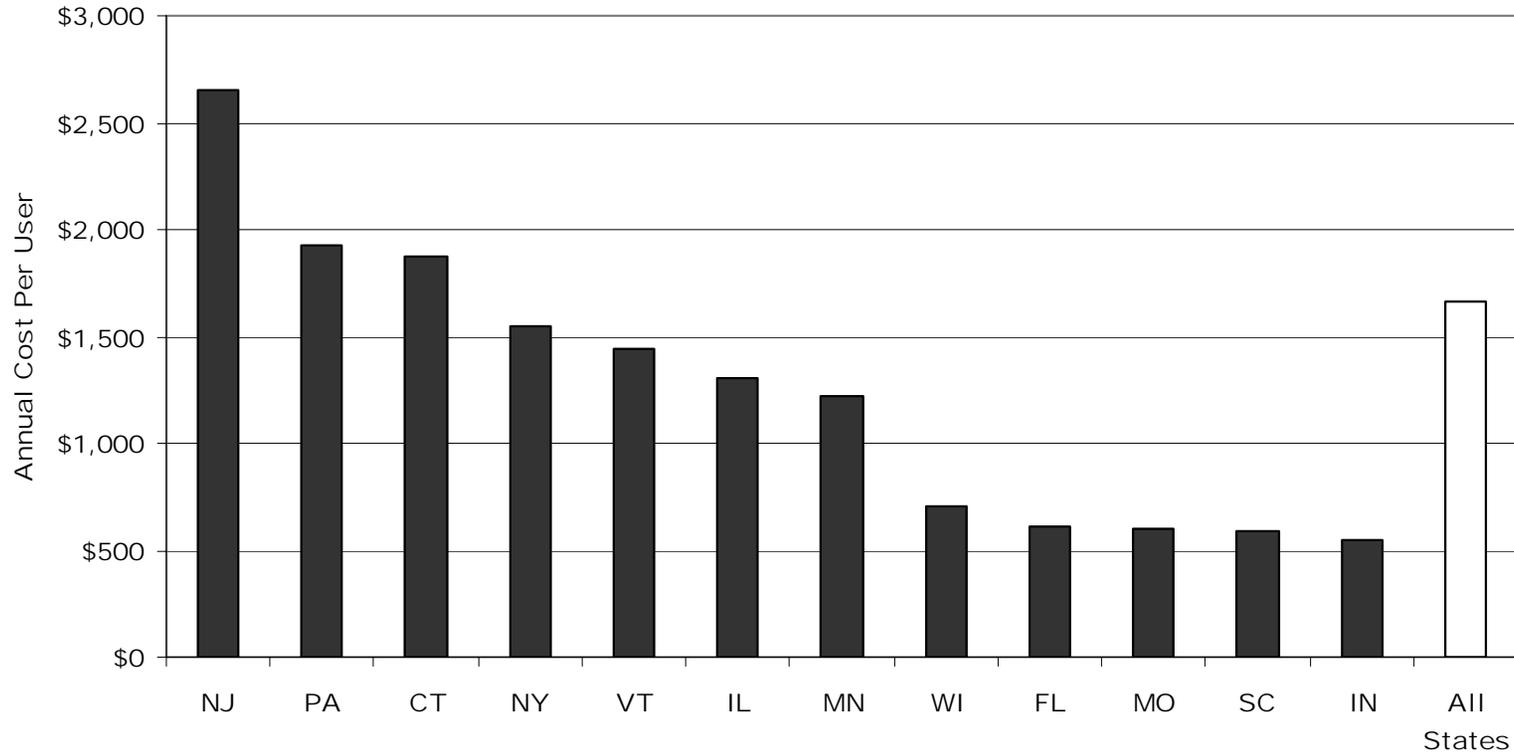


### Chart 3-7 Annual Drug Expenditures per User, 2003

- Another measure of program costs is the amount of annual state expenditures for enrollees who actually use the program benefits (i.e., file a prescription claim at any time during the year).
- Data on the number of users were only available for 12 states, but program costs per user in those states averaged \$1,668 in 2003 versus the average cost per end-of-year enrollee of \$1,557 of 2003 for those same states.
- Costs per user ranged from \$545 in Indiana to \$2,649 in New Jersey.
- Note that cost per user can be different from costs per enrollee 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.



Chart 3-7  
Annual Drug Expenditures per User, 2003



Notes: Data for Delaware, Kansas, Maine, Maryland, Massachusetts, Nevada, North Carolina, Rhode Island, and Wyoming not available. New Jersey does not include Senior Gold. Illinois does not include Circuit Breaker. Wisconsin only includes 10 months. South Carolina only includes six months. All States = Total drug expenditure divided by total number of enrollees who filled a prescription (N=12).



### Chart 3-8

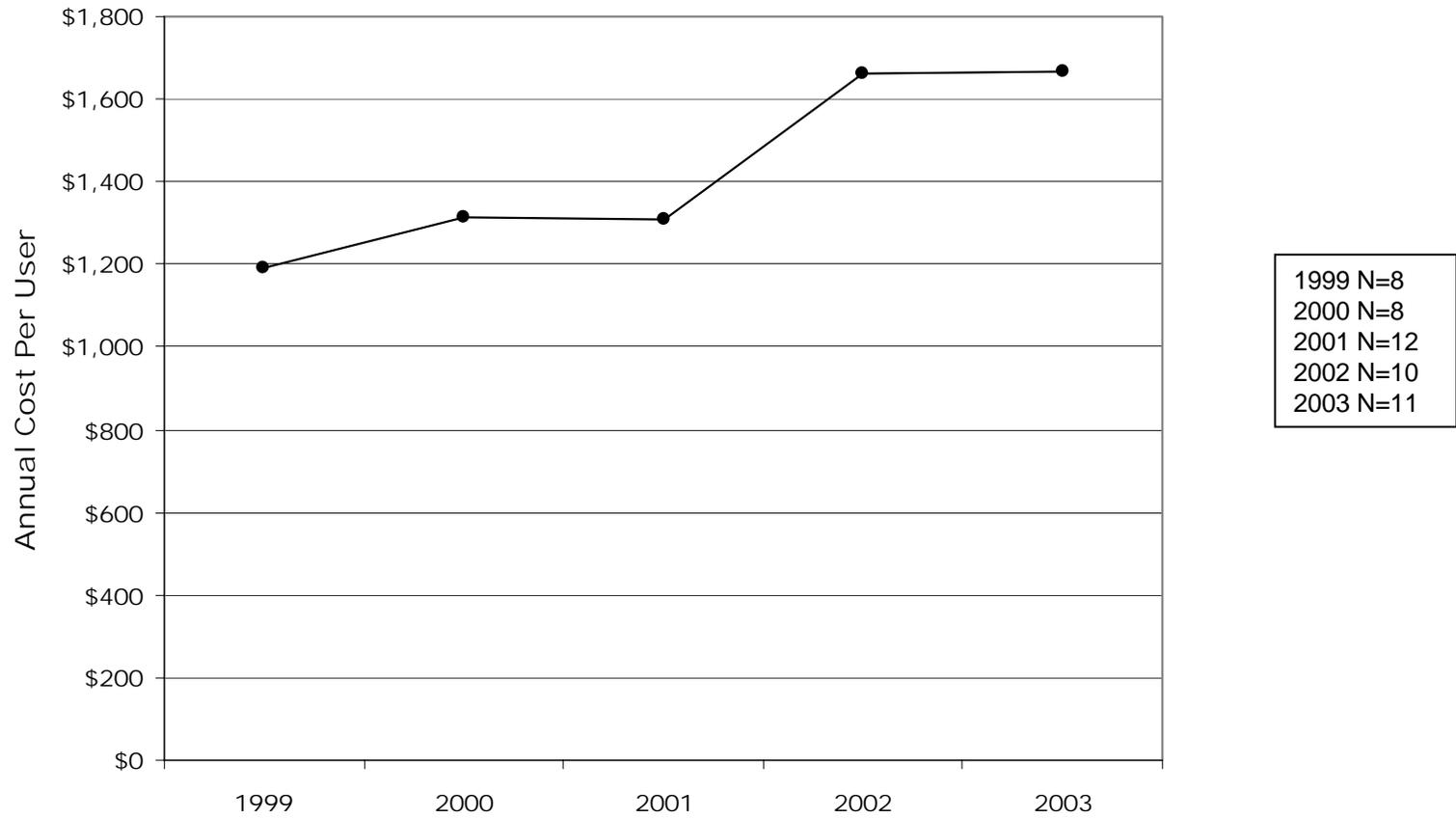
## Trend in Annual Drug Expenditures per User, 1999 to 2003

- Average expenditures per user increased from \$1,191 in 1999 to \$1,668 in 2003, a 41% increase in four years.
- Again, by way of rough context, one federal estimate projected that average Medicare expenditures per non-low-income beneficiary would be expected to increase from \$2,260 in 2006 to \$2,945 in 2010, a 30% increase in four years—and that for low-income beneficiaries, expenditures could be projected to increase from \$4,359 to \$5,684, a 30% increase in four years.<sup>1</sup>



<sup>1</sup> CMS, Federal Register, vol. 70, no. 18, Jan. 28, 2005. p. 4465.

Chart 3-8  
Trend in Annual Drug Expenditures per User, 1999 to 2003



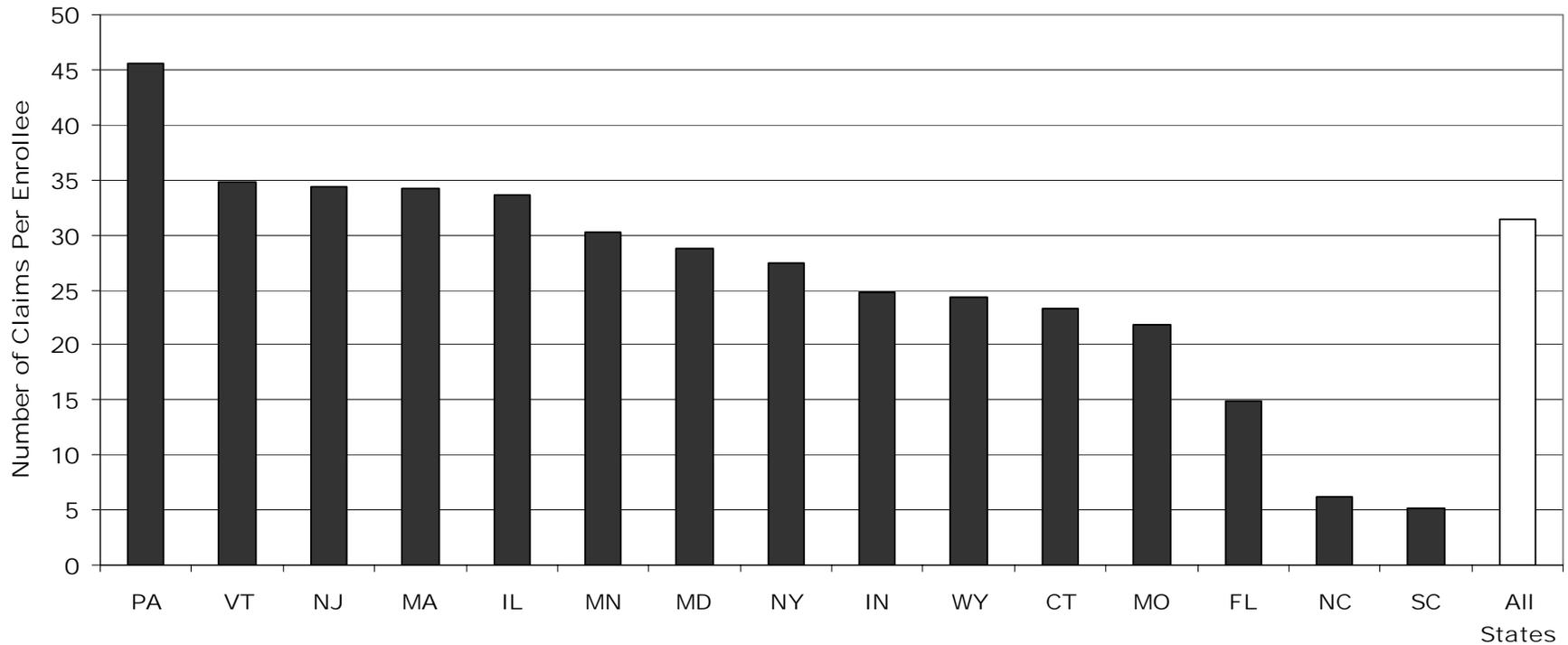
Notes: Averages represent data from all states that reported for that year (see legend).

### Chart 3-9 Number of Claims per End-of-Year Enrollee, 2003

- The average number of claims per year per enrollee was 31.5 in 2003, an increase of 6.3% from 29.5 in 1999.
- The number of claims per year per enrollee in 2003 ranged from 5.2 in South Carolina to 45.6 in Pennsylvania.
- In addition to utilization by enrollees, the number of claims per enrollee can be influenced by the number of days' supply per claim allowed by a program, the presence of deductibles, the number and type of drugs covered, and regional variations in prescription drug utilization.



Chart 3-9  
 Number of Claims per End-of-Year Enrollee, 2003



Notes: Data for Delaware, Kansas, Maine, Michigan, Nevada, Rhode Island, and Wisconsin not available. South Carolina only includes six months.  
 All States = Total number of claims divided by total end-of-year enrollees (N=15).

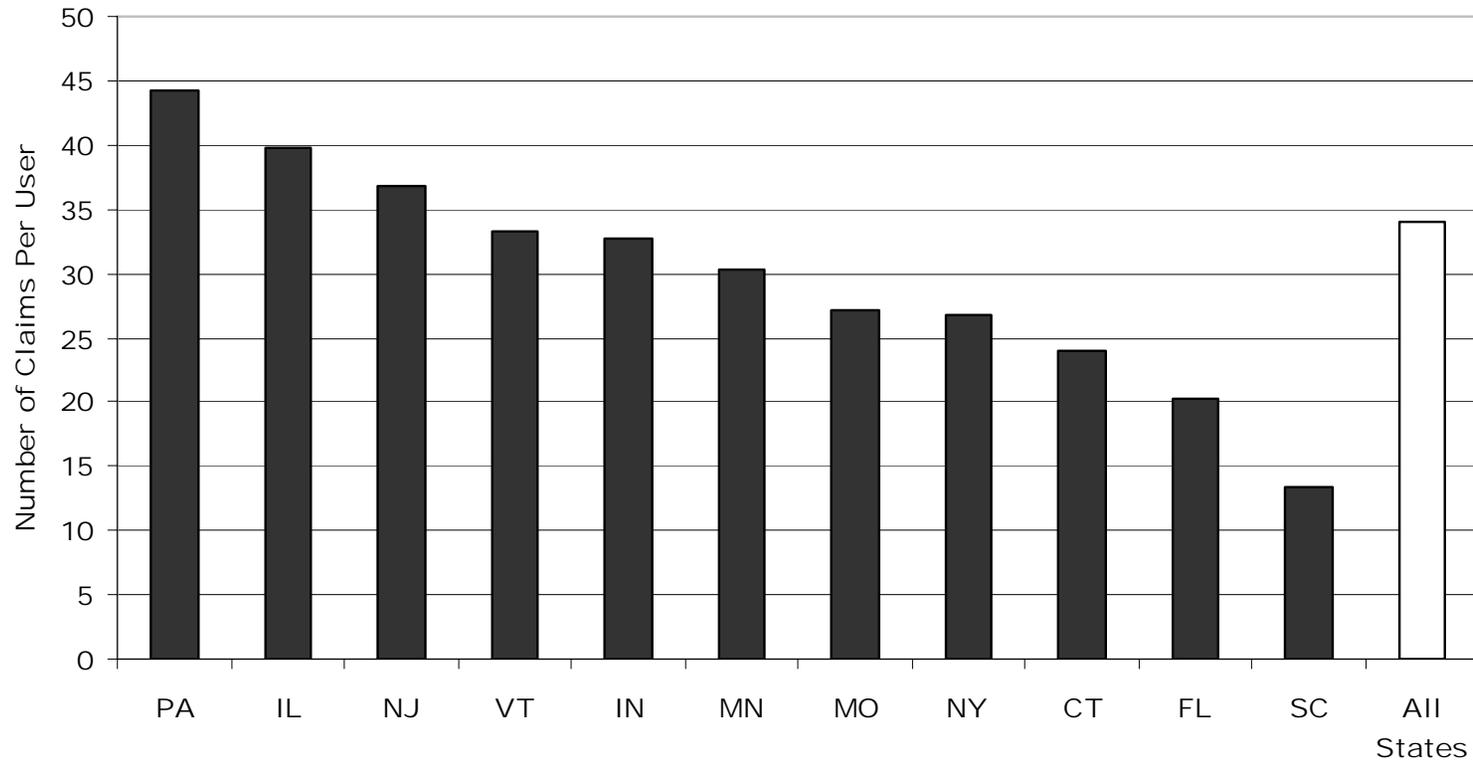


### Chart 3-10 Number of Claims per User, 2003

- In the 11 states for which claims and user data were available, the average number of claims per person filling a prescription was 33.9 in 2003, ranging from 13.3 in South Carolina (although this is based on six months of data) to 44.3 in Pennsylvania.
- In addition to utilization by enrollees, the number of claims per user can be influenced by the number of days' supply per claim allowed by a program, the presence of deductibles, the number and type of drugs covered, and regional variations in prescription drug utilization.



Chart 3-10  
 Number of Claims per User, 2003



Notes: Data for Delaware, Kansas, Massachusetts, Maryland, Maine, Michigan, North Carolina, Nevada, Rhode Island, Wisconsin, and Wyoming not available. South Carolina only includes six months.

All States = Total number of claims divided by total number of enrollees who filled a prescription (N=11).



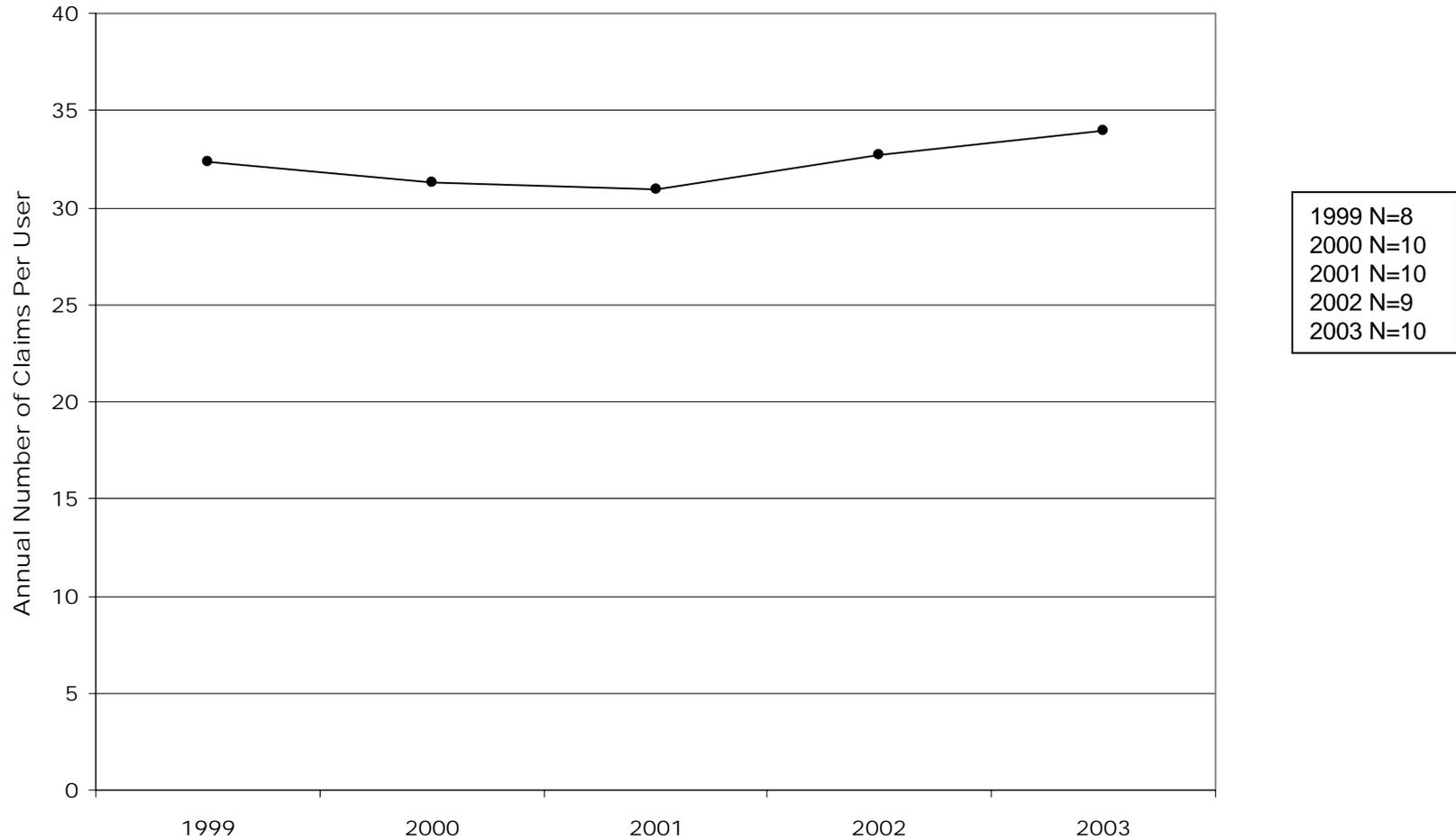
### Chart 3-11

#### Trend in Annual Number of Claims per User, 1999 to 2003

- The average annual number of claims per user rose slightly from 32.4 in 1999 to 33.9 in 2003.
- The average cost per claim rose dramatically for older programs (see Chart 3-13) whereas the average number of claims per user increased only slightly. One possible contributor to the increase in cost per claim was the increasing cost of pharmaceutical drugs. Older programs may provide more coverage of brand-name versus generic medications, also contributing to the increased cost per claim.



Chart 3-11  
Trend in Annual Number of Claims per User, 1999 to 2003



Notes: Averages represent data from all states that reported for that year (see legend).



### Chart 3-12 Average Cost per Claim, 2003

- The average state cost per claim was \$50.00 in 2003.
- Cost per claim ranged from \$16.64 in Indiana to \$78.05 in Connecticut.
- Cost per claim is affected by the level of consumer cost-sharing at the point of sale, the number of days' supply per claim allowed by a program, the drug mix utilized by beneficiaries, and the pharmacy reimbursement rate.



Chart 3-12  
Average Cost per Claim, 2003



Notes: Data for Delaware, Kansas, Maine, Michigan, Nevada, Rhode Island, and Wisconsin not available. South Carolina only includes six months. Illinois does not include Circuit Breaker. Massachusetts includes ingredient cost and dispensing fee. All States = Total drug expenditure divided by total number of claims (N=15).



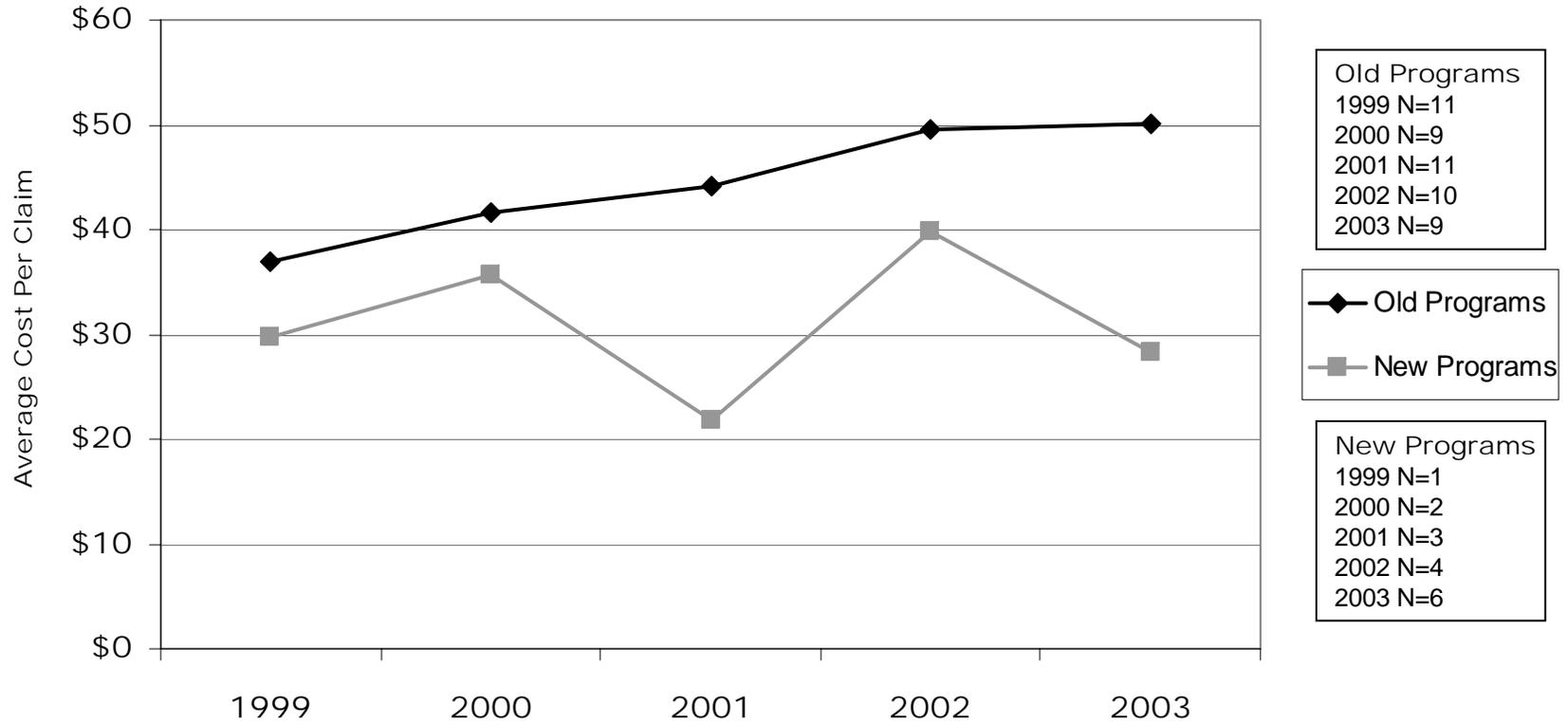
### Chart 3-13

#### Trends in Average Cost per Claim, 1999 to 2003

- For states with programs established before 1999 (N=12), costs per claim increased from \$36.96 in 1999 to \$50.00 in 2003, a 45.3% increase.
- For states with programs established since 1999 for which expenditure and claims data were available (N=7), SPAP costs per claim were more varied but the average cost per claim from 1999 to 2003 was \$31.07.
- A possible reason for the difference in level of generosity between the older and newer programs is that older programs may be less likely to employ cost-saving strategies used in the private sector, whereas newer programs can more readily incorporate these strategies into their program design.



Chart 3-13  
Trends in Average Cost per Claim, 1999 to 2003



Notes: Old programs are those established prior to 1999 (N=12), and new programs are those established since 1999 (N=7). Only programs operational for at least one full year were included in the analysis. Averages represent data from all states that reported for that year (see legends).

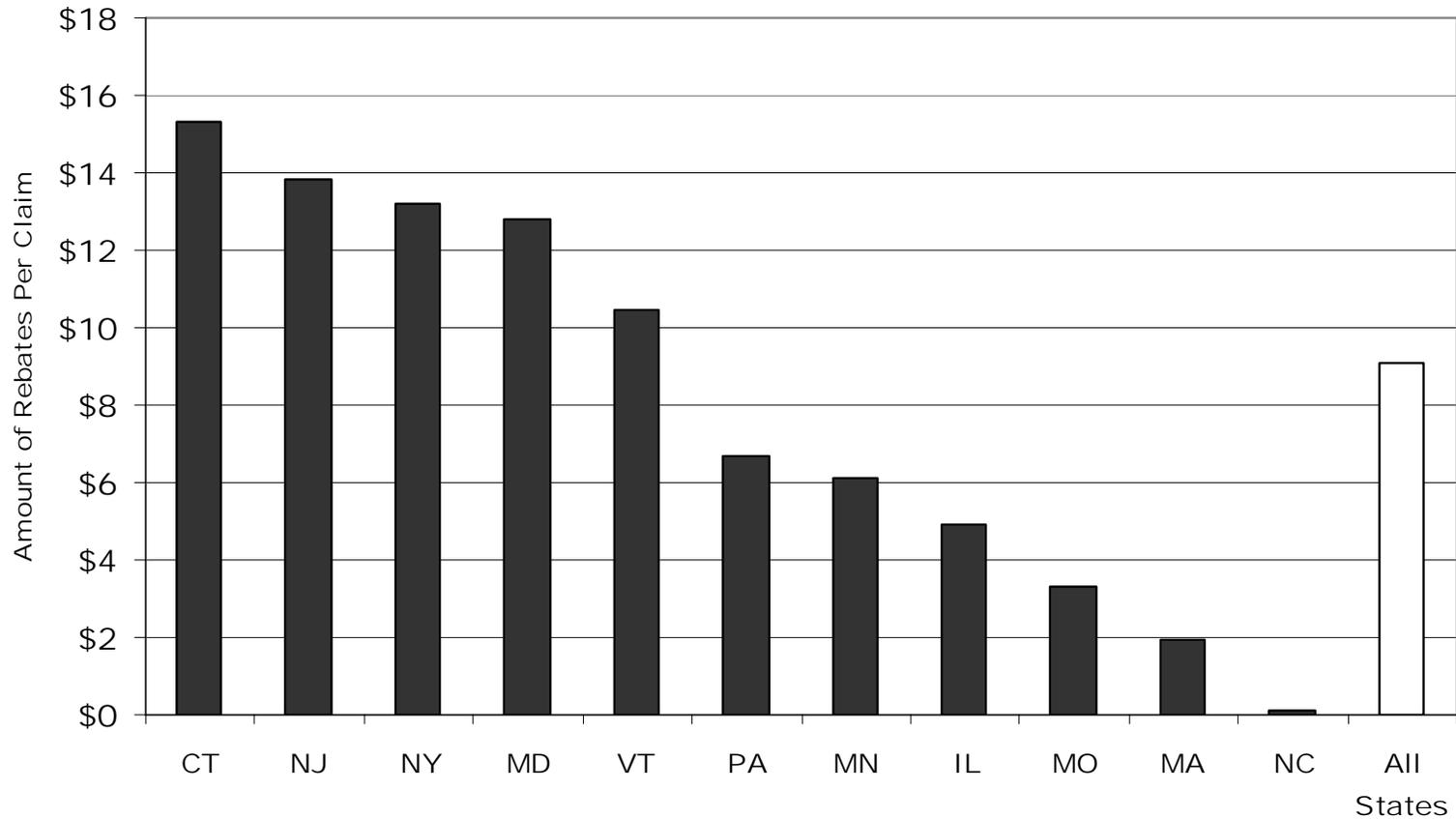


### Chart 3-14 Amount of Rebates per Claim, 2003

- On average, for the 11 states for which rebate and claims data were available, SPAPs recovered \$9.11 per filed claim through manufacturer rebates. This ranged from \$0.11 in North Carolina to \$15.34 in Connecticut.
- The amount of rebates per claim is affected by the manufacturer rebate rate, the drug mix used by enrollees (brand-name drugs usually have higher rebate rates), and the number of days' supply per claim allowed by a program.
- Massachusetts and North Carolina received the lowest amounts of rebates per claim. Massachusetts had their PBM negotiate rebates with manufacturers rather than setting the rebate amount in statute as most other states have done. This indicates that rebates that will be negotiated by PDPs will be less than those set in statutes or tied to Medicaid.



Chart 3-14  
Amount of Rebates per Claim, 2003



Notes: Data for Delaware, Florida, Indiana, Kansas, Maine, Michigan, Nevada, Rhode Island, South Carolina, Wisconsin, and Wyoming not available. Massachusetts includes ingredient cost and dispensing fee.

All States = Total amount of rebates received divided by total number of claims (N=11).





## Section 4. Program Design



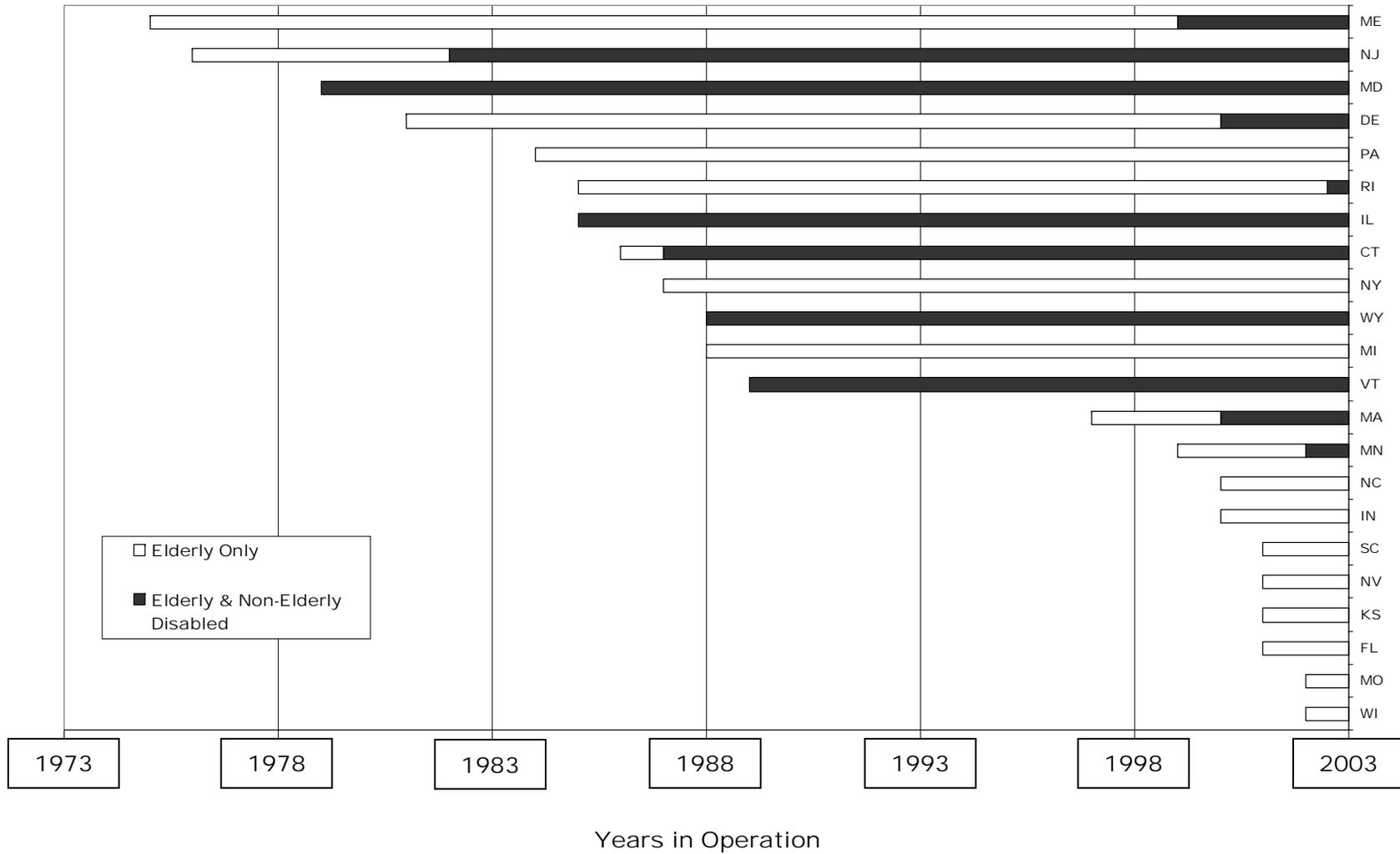
## Chart 4-1 Groups Covered over Time by State, 2003

- Out of 22 states in the survey, 11 (50%) covered both elderly persons and younger disabled persons. Maryland and Wyoming offer coverage to all persons, regardless of age or disability status, who meet the eligibility criteria for their programs. Most recently, Rhode Island recently expanded its program in 2003 to cover the SSDI population (ages 55–65).
- Four of these programs have covered disabled persons since their inception, and seven added coverage for the disabled at a later time. Massachusetts, which added coverage for younger disabled persons in 2000, has a lower income limit for younger disabled persons of 188% of FPL, compared to 500% of FPL for elderly enrollees.
- The definition of disability may vary across states; however, many states have adopted the federal definition of disability as a standard for state pharmaceutical assistance eligibility.<sup>1</sup>
- All programs implemented between 2000 and 2003 offered coverage only to the elderly.
- Age requirements for elderly participants are typically age 65 or over, but Maine and Nevada set the minimum age for eligibility at 62.

<sup>1</sup> National Conference of State Legislatures' Web site, *State Pharmaceutical Assistance Programs, 2004 Edition*, <http://www.ncsl.org/programs/health/drugaid.htm>. Nov. 11, 2004.



Chart 4-1  
Groups Covered over Time by State, 2003

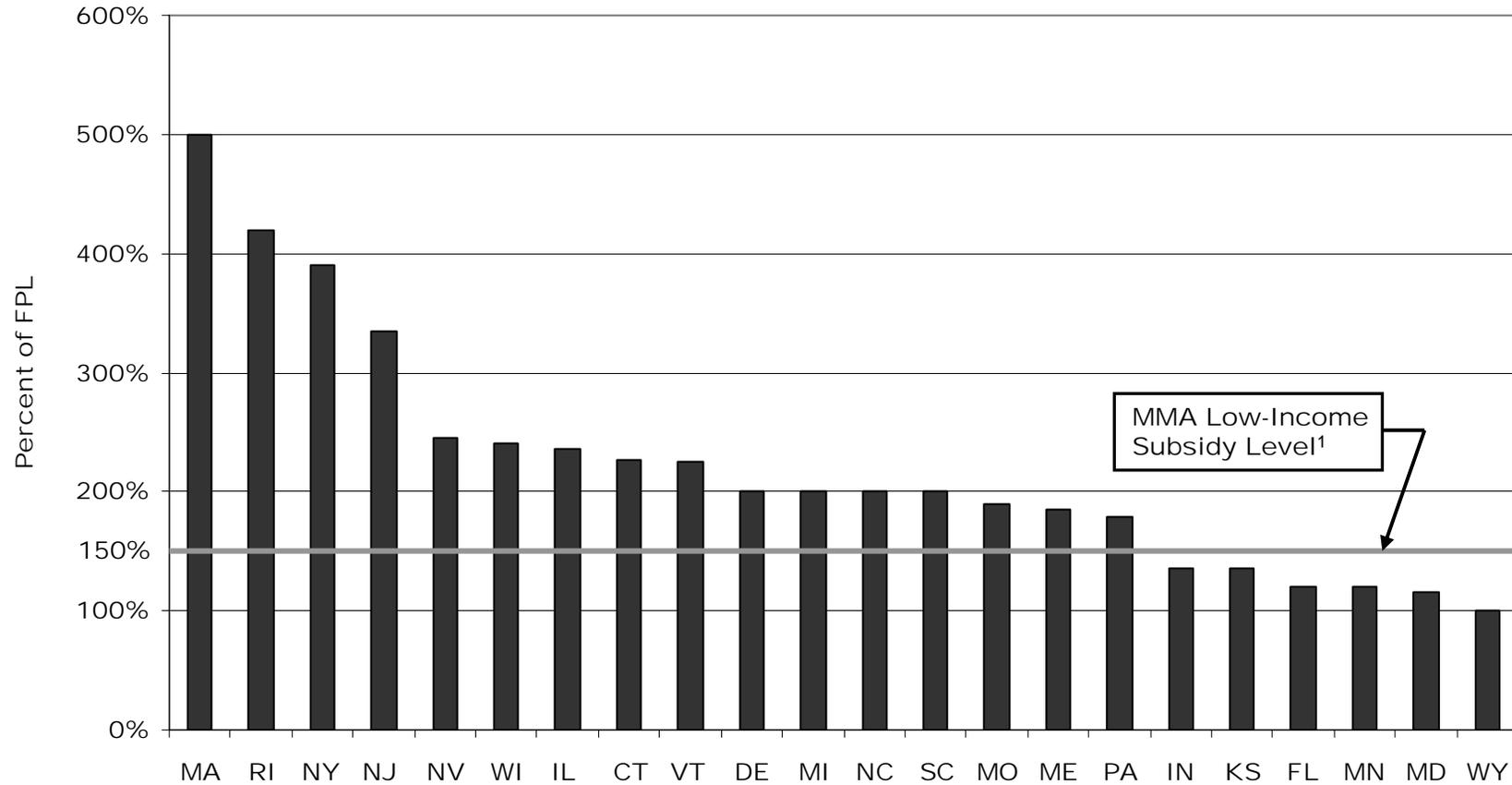


## Chart 4-2 Income Eligibility Requirements for SPAPs as a Percentage of the Federal Poverty Level, 2003

- In 2003, income thresholds for SPAPs ranged from 100% of the Federal Poverty Level (FPL) in Wyoming to 500% of FPL in Massachusetts.
- In 2003, the Federal Poverty Level was \$8,980 for individuals and \$12,120 for couples, so income eligibility in 2003 ranged from that level to \$44,900 for singles and \$60,600 for couples.
- Income eligibility levels in Massachusetts and Nevada are for individuals who are applying for state subsidies to help pay the insurance premium for the program. People with incomes above these levels can enroll in the programs at the full premium if they meet the other eligibility requirements (e.g., age, residency).
- Note that, since incomes and the cost of living vary among states, poorer states that have lower income requirements may be able to reach the same proportion of residents as do more well-off states that have higher income requirements.
- Maine sets income eligibility higher (210% of FPL) for applications who spend 40% or more of their income on prescription drugs, and Delaware has no income limits for applicants who spend 40% or more of their income on prescription drugs. In addition, Missouri disregards income spent on Medicare premiums when calculating income eligibility, effectively raising income eligibility levels from 135% of FPL to 144% of FPL.
- In contrast, income limits for the Medicare Part D benefit are 150% of FPL for the partial low-income subsidy and 135% for the full low-income subsidy and there are no adjustments to these income levels for those with excessive drug costs.



Chart 4-2  
 Income Eligibility Requirements for SPAPs  
 as a Percentage of the Federal Poverty Level, 2003



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



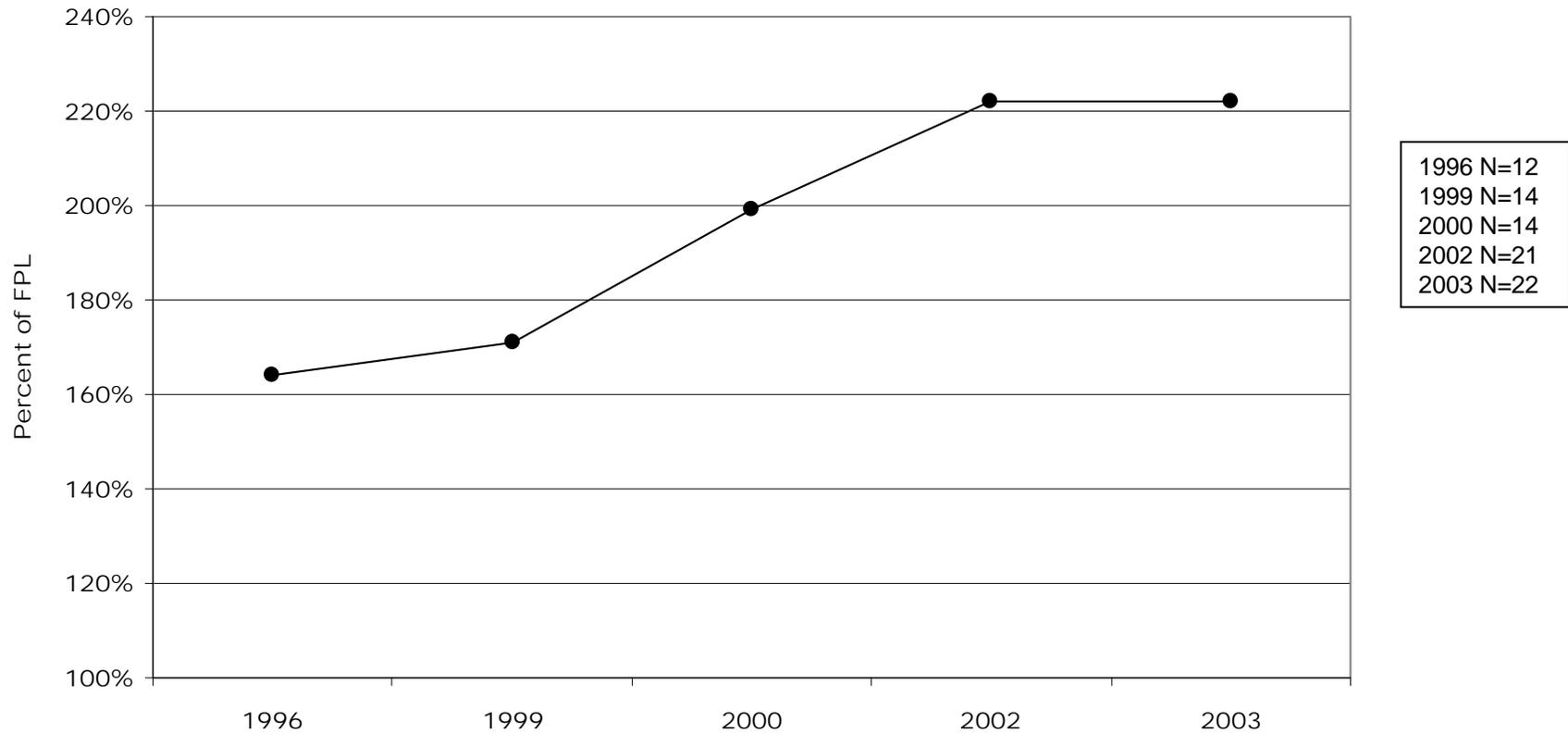
### Chart 4-3 Trend in Average SPAP Income Eligibility Levels as a Percentage of FPL

- Average income limits across all states with programs increased from 164% of FPL in 1996 to 222% of FPL in 2002 and 2003. All but two states, Pennsylvania and South Carolina, maintained their income limits between 2002 and 2003. Pennsylvania’s income limit increased from 178% to 192% of FPL. South Carolina’s income limit increased from 175% to 200% of FPL, from 2002 to 2003.
- The increases in average income eligibility levels from 1996 to 2003 were due both to the passage of legislation expanding income eligibility levels for existing programs and the creation of new programs with higher income eligibility levels.
- Most states automatically increased income limits each year in accordance with changes in the FPL. Some other states, as detailed in the table below, either used the annual increase in the Social Security Cost-of-Living Adjustment (COLA) to determine income eligibility increases, or do not automatically increase income eligibility each year. As of 2003, Nevada used the Consumer Price Index (CPI) to determine eligibility increases.
- States that do not automatically increase income limits by FPL, COLA, or CPI may face additional challenges in coordinating benefits with the Medicare Part D drug benefit, which determines income limits based on FPL.

Annual Income Adjustment	States
Social Security COLA	Connecticut, Maryland, New Jersey, Rhode Island
CPI	Nevada (as of 2003)
None	Missouri, New York, Illinois Circuit Breaker program, Pennsylvania (except that cardholders enrolled as of 12/31/00 received COLA increases through 12/31/02)
FPL	All other states



Chart 4-3  
Trend in Average SPAP Income Eligibility Levels as a Percentage of FPL



Notes: "Average SPAP income eligibility level" is the mean of states' upper limits for program eligibility and is not weighted by enrollment. Averages represent data from all states that reported that year.

Sources: New York State Department of Health (1996), *EPIC Evaluation Report to the Governor & Legislature: October 1987–September 1995*; United States General Accounting Office (2000), *State Pharmacy Assistance Programs: Assistance Designed to Target Coverage and Stretch Budgets*, GAO/HEHS-00-162; Rutgers Center for State Health Policy Survey of State Pharmacy Assistance Programs, Dec. 2000, Aug. 2002, and Sept. 2003.



## Chart 4-4 SPAP Other Eligibility Requirements

- In addition to income requirements, some SPAPs had eligibility requirements for assets, length of state residency, existing prescription drug coverage, and other requirements.
- The MMA requires an asset test for its low-income subsidy. For applicants under 135% of FPL, the asset limits are \$6,000 (single)/\$9,000 (couple) and for applicants under 150% of FPL, the asset limits are \$10,000/\$20,000.
- In contrast, Maryland and Minnesota were the only two SPAP states that had asset tests. In 2003, these were \$3,750/\$4,500 in Maryland, and \$10,000/\$18,000 in Minnesota.
- Most states allowed current residents to enroll in their programs, but some required applicants to have been state residents for up to one year.
- Most states excluded persons with any other drug coverage from eligibility. However, some states allowed persons to receive SPAP benefits after their other benefits had been exhausted (4 states) or if their other coverage is less generous than that available through the SPAP (3 states). Pennsylvania, Illinois, and Wisconsin had no such restrictions on other coverage, but beneficiaries in Illinois and Wisconsin were required to assign their other benefits to the state.
- While all SPAPs excluded persons from eligibility if they already received Medicaid prescription drug coverage, a few states (Delaware, Massachusetts, Nevada, and Wyoming) excluded persons if they were eligible for Medicaid, even if not actually enrolled in Medicaid.
- Effective January 2006, Medicaid drug coverage was replaced by the Medicare Part D benefit. Dual-eligibles were auto-enrolled into a Medicare prescription drug plan, if they had not selected a prescription drug plan by November 15, 2005, but were given the option of opting out.



Chart 4-4  
SPAP Other Eligibility Requirements

State	Asset Test	Length of State Residency	Medicaid Status	Other Prescription Drug Coverage	Other Eligibility Requirements
CT	No	6 months		Eligible after exhausting other benefits	None
DE	No	Current	Must not be eligible for Medicaid	Not eligible	Must not be eligible for Nemours Health Clinic pharmaceutical benefit
FL	No	Current		Not eligible	None
IL	No	Current	Must not be enrolled in Medicaid	Eligible if benefits are assigned to state	<b>Circuit Breaker:</b> Widows or widowers who turned 63 or 64 before the deceased claimant's death are also eligible
IN	No	90 days in the last year		Not eligible, except those with discount cards that offer no more than 20% discount	None
KS	No	Current		Not eligible	Must not have voluntarily cancelled a local, state, federal, or private prescription drug program within six months of application to the program; must not be eligible for or enrolled in any other local, state, or federal prescription program; must be a current recipient of the QMB or LMB programs administered by SRS
MA	No	Current	Must not be eligible for Medicaid	Eligible after exhausting other benefits	Persons with disabilities must meet income requirements and work no more than 40 hours per month unless they were enrolled in the previous Pharmacy or Pharmacy Plus programs. Persons with disabilities were automatically eligible for Prescription Advantage if they submitted an enrollment form prior to April 1, 2002 and were a Massachusetts resident and not eligible for Medicaid.
MD	\$3,750 single \$4,500 couple	Current		Not eligible	Must not be detained in a correctional (federal, state, local) system
ME	No	Current		Not eligible	None
MI	No	3 months		Not eligible	Must not be residing in an institution. Enrollees in the previous MEPPS and prescription tax credit programs are deemed eligible for EPIC. Regular enrollment is closed. Additional emergency enrollment requirements are: the cost of prescriptions must be at least 10% of a single person's monthly household income or 8% of a couple's monthly household income. Applicants must have unfilled prescriptions or authorized refills due within 30 days of the application date. Documentation from the attending physician must verify that the condition is an emergency. At least one unfilled prescription must meet the EPIC program definition of a medical or psychiatric emergency. The emergency coverage period is 45 days and is available up to two times a year.
MN	\$10,000 single \$18,000 couple	180 days	Eligible if applicant needs to spend-down to be eligible for Medicaid	Not eligible	Eligible if applicant had no prescription drug coverage through health insurance in the four month period prior to the application month, except for persons on PDP 3-1-2001 who have Medicare Supplement Plan to which an annual \$400 drug coverage was added. Eligible if enrolled in Medicare, QMB or SLMB Medicare supplement program.
MO	No	12 months		If other coverage is less generous, the state will coordinate benefits with other coverage	None
NC	No	Current		Not eligible	None
NJ	No	30 days	PAAD and SG: Must not be enrolled in Medicaid	<b>PAAD:</b> Must not be enrolled in a prescription drug benefit plan with equal or better coverage than PAAD. <b>Senior Gold:</b> Must not be enrolled in PAAD. Applicants with limited or partial coverage of prescription drugs are eligible.	None
NV	No	12 months	Must not be eligible for Medicaid prescription benefits	Not eligible	None
NY	No	Current		Eligible if other coverage is less generous than EPIC. Partial year coverage is available after exhausting other	None
PA	No	90 days	Must not be enrolled in Medicaid prescription coverage	Eligible	None
RI	No	Current		Eligible after exhausting other benefits	None
SC	No	6 months		Not eligible	None
VT	No	Current		Not eligible	None
WI	No	Current	Must not be enrolled in Medicaid prescription coverage	If other coverage exists, coordination of benefits applies	None
WY	No	Current	Must not be eligible for Medicaid.	Not eligible	None

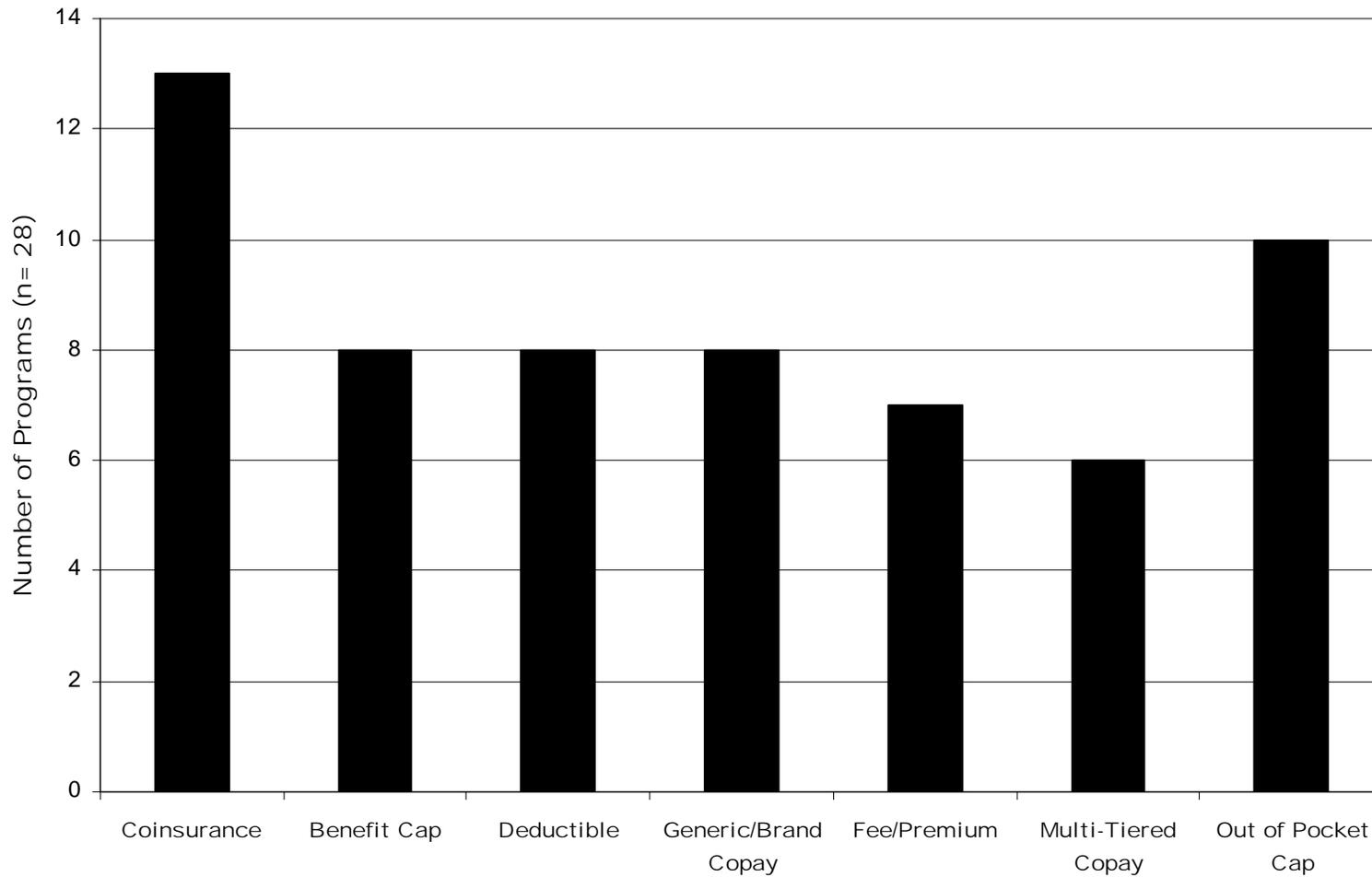
## Chart 4-5 Type of Consumer Cost-Sharing by Programs, 2003

- Under the standard Part D benefit, beneficiaries were to pay a premium projected to average about \$35 per month in 2006 along with a \$250 deductible. The coinsurance structure under the standard Part D benefit requires beneficiaries to pay 25% after the \$250 deductible to the coverage limit of \$2,250. In the “doughnut hole,” beneficiaries pay 100% above the coverage limit until they reach the out-of-pocket limit of \$3,600 (i.e., total drug spending of \$5,100). Above the out-of-pocket cap, beneficiaries were to pay \$2 for generic medications and the greater of \$5 or 5% for brand-name medication.<sup>1</sup>
- SPAP cost-sharing requirements vary by program. Chart 4-5 shows the number of programs that use each type of consumer cost-sharing, and Chart 4-6 details the cost-sharing requirements for programs in each state.
- Coinsurance (consumer cost-sharing at the point of sale based on a percentage of a drug’s cost) was the most used form of point of sale cost-sharing by SPAPs.
- Two-tiered generic and brand copayments were used by six programs, and multi-tiered copayments were used by five programs. The tiers in these programs were based either on a drug’s designation as a generic, a preferred brand, or a non-preferred brand (Florida, Massachusetts, and Nevada), or solely on a drug’s price (both New York programs).
- Seven programs had deductibles. New York and Pennsylvania imposed deductibles only on people in their programs with higher income limits.
- To some degree, the use of coinsurance and deductibles in some SPAPs ties well with the Part D benefit. However, Part D is much more complex and integrating the myriad different coinsurance requirements in Part D with SPAPs has been challenging for states supplementing or wrapping-around the Part D benefit.
- Only six programs required applicants to pay a fee or premium to join.
- Eight programs had benefit caps on the cost or number of drugs that participants can purchase.
- In contrast, 10 programs put a cap on enrollees’ out-of-pocket expenditures. After reaching this cap, enrollees paid either nothing or a small copayment for their remaining drug purchases. These caps can be either annual or monthly.

<sup>1</sup> CMS, Federal Register, vol. 70, no. 18, Jan. 28, 2005. p. 4237.



Chart 4-5  
 Type of Consumer Cost-Sharing by Programs, 2003



Note: Several states (Illinois, New Jersey, New York, Pennsylvania, and Vermont) had more than one SPAP program with different cost-sharing requirements. In total, there were 28 programs in 22 states. Totals do not add to 28 since several programs had more than one type of cost-sharing.



## Chart 4-6 Cost-Sharing Provisions by State and Program, 2003

- Annual fees/premiums ranged from \$5 for lower income participants in Illinois's Circuit Breaker program to \$300 for higher income participants in New York's fee program.
- Deductibles can be either annual, quarterly, or monthly. For a given yearly deductible, monthly deductibles allow participants to access the benefit sooner than annual deductibles. As of 2003, only Minnesota had a monthly deductible.
- Coinsurance levels ranged from 20% in Maine to 85% for the highest income group in Rhode Island. Programs often have a minimum dollar amount for the coinsurance (e.g., Delaware's coinsurance is \$5 or 25%, whichever is higher).
- Four states had a flat copayment for all prescriptions (\$16.25 in Connecticut, \$5 in Maryland and New Jersey, and \$6 in Pennsylvania's PACE program). Copayment amounts ranged from \$2 for generic drugs in Florida to \$40 or 50% of a drug's cost (whichever is higher) for non-preferred drugs in Massachusetts.
- Minnesota was the only state that did not have point-of-sale cost-sharing in the form of coinsurance or a copayment.
- Programs with benefit caps typically set a maximum dollar amount that the state will pay for beneficiaries' prescription drug purchases, although Wyoming sets a three-prescription-per-month limit regardless of cost. Most cost caps are calculated on an annual basis and range from \$500 a year for higher income participants in Indiana to \$5,000 a year for participants in Missouri and Nevada.
- In contrast to benefit caps where the beneficiary is responsible for all prescription drug costs above the cap, states with out-of-pocket caps covered all or most of beneficiaries' prescription drug costs after they have spent a certain amount out-of-pocket on copayments/coinsurance and deductibles. These can be set as a percentage of income or as a set dollar amount and can be calculated on a monthly, quarterly, or annual basis.
- The out-of-pocket cap is higher under the standard Part D benefit than those that were used by most states.
- States that choose to wrap around the Part D benefit to provide the same level of coverage for their enrollees will have to coordinate their already complicated benefit structures with an equally complex benefit for Medicare Part D.

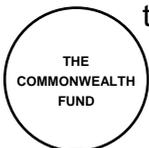


Chart 4-6  
Cost-Sharing Provisions by State and Program, 2003

State (Program)	Income Eligibility (% FPL)	Annual Fee/ Premium	Deductible	Coinsurance / Copay	Benefit Cap	Out of Pocket Cap
CT	226%	\$30		\$16.25		
DE	200%			\$5 or 25%, whichever is greater	\$2,500	
FL	120%			\$2/\$5/\$15 tiered copay	\$160 a month	
IL (Circuit Breaker)	236%	\$5 or \$25 by income		\$0 or \$3 by income up to \$2,000 in drug costs. 20% coinsurance above \$2000		
IL (Senior Care)	200%			< 100% FPL, no copay. Up to 200% FPL \$1 Generic, \$4 Brand, up to \$1,750. 20% coinsurance above \$1,750		
IN	135%			50%	\$500, \$750, or \$1,000 by income	
KS	135%			30%	\$1,200	
MA	500%	\$0 to \$99 by income	\$0 to \$125 a quarter by income	\$6/\$16/50% or \$40 to \$10/\$28/50% or \$40 by income		\$2,000 or 10% of income, whichever is lower
MD	116%			\$5		
ME	185%			\$2 or 20%, whichever is greater		\$1,000 for drugs for non-covered conditions
MI	200%	\$25		20%		Monthly co-payment maximums by income.
MN	120%		\$35 a month	None		
MO	189%	\$25 or \$35 by income	\$250 or \$500 by income	40%	\$5,000	
NC	200%			40%	\$600	
NJ (PAAD)	223%			\$5		
NJ (Senior Gold)	334%			\$15 plus 50% of the remaining cost of the drug		\$2,000 single, \$3,000 couple
NV	245%			\$10 generic, \$25 preferred brand	\$5,000	
NY (Fee)	223%	\$8 to \$300 by income		\$3 to \$20 by drug price		9% of annual income
NY (Deductible)	390%		\$530 to \$1,715 by income	\$3 to \$20 by drug price		9% of annual income
PA (PACE)	156%			\$6		
PA (PACENET)	178%		\$500 a year	\$8 generic, \$15 brand		
RI	420%			40%, 70%, or 85% by income		\$1500 for lowest income level
SC	200%		\$500 a year	\$10 generic, \$15 brand, \$21 brand name requiring prior authorization		
VT (VHAP)	150%			\$3 generic, \$6 brand		\$50 per calendar quarter
VT (VScript)	175%			\$5 generic, \$10 brand		\$100 per calendar quarter
VT (VScript Exp.)	225%		\$275 a year	41%		\$2,500 per calendar quarter
WI	240%		Income <160% FPL - no deductible; income 160%<200% FPL - \$500 deductible per person; income 200%< 240% FPL - \$850 per person; income >240% FPL - \$850 after spend down	\$5 generic, \$15 brand		
WY	100%			\$10 generic, \$25 brand	3 prescriptions per month	



## Section 5. Program Funding and Administration

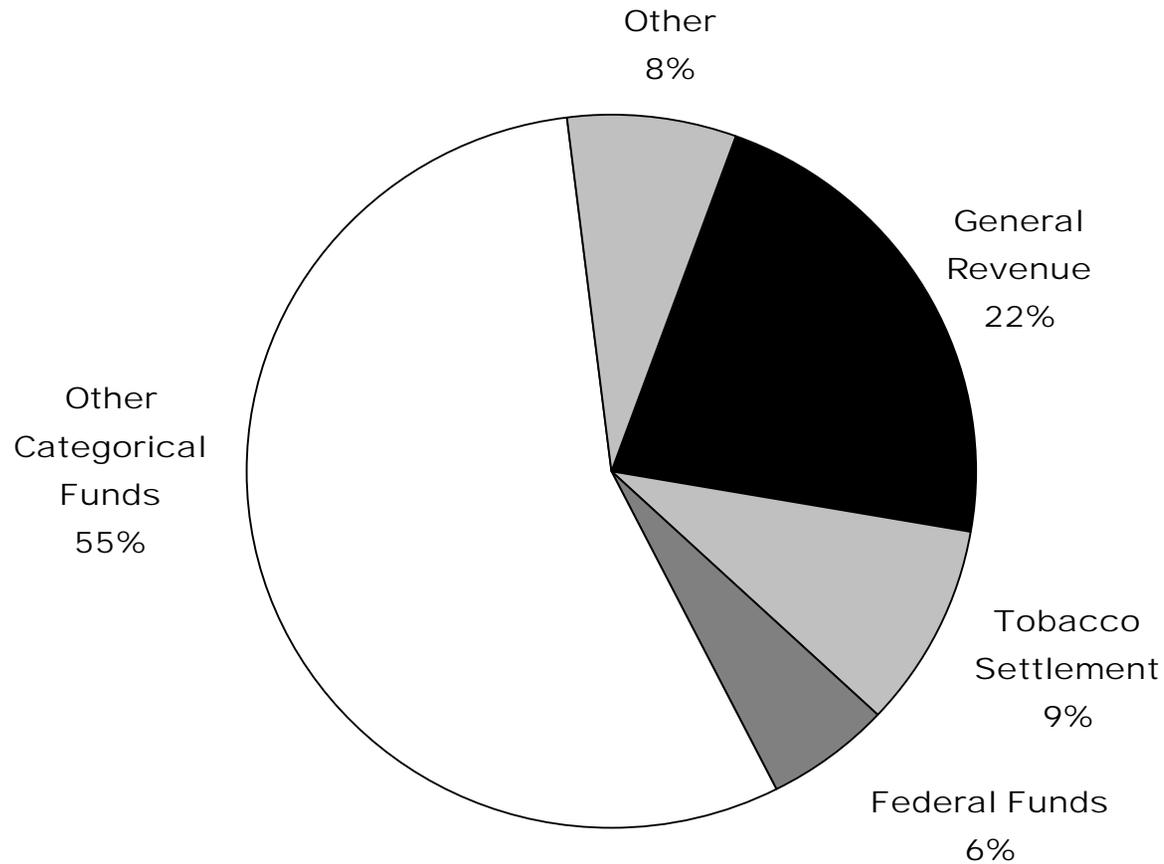


## Chart 5-1 Proportion of Total SPAP Funding by Source for FY 2004

- In total, 22 SPAP states in the survey committed over \$2.4 billion to fund these programs for FY 2004.
- About \$545 million (22%) of this funding was from state general revenues, \$230 million (9%) was from tobacco settlement revenues, and about \$1.5 billion (54%) was from other categorical funding sources (e.g., lottery fund revenues in Pennsylvania and casino fund revenues in New Jersey). Four states (Illinois, Missouri, New York, and Wisconsin) reported that manufacturer rebates and enrollment fees accounted for \$187 million (8%).
- About \$138 million (6%) of this funding was from federal matching funds for programs in Florida, Illinois, Maryland, South Carolina, Vermont, and Wisconsin that have Medicaid 1115 or Pharmacy Plus waivers. Under the MMA, these programs do not meet the definitions of an SPAP because they receive federal financial assistance and are therefore ineligible both for the SPAP transitional grant funds and for having state contributions paid on behalf of enrollees to supplement Part D cost toward the enrollees' true out-of-pocket costs.



Chart 5-1  
Proportion of Total SPAP Funding by Source for FY 2004



Total budget dollars = \$2,465,616,979

Other = Manufacturer rebates and enrollment fees for four states that provided data.

Note: Budget numbers for Maine, Maryland, Michigan, and South Carolina are based on data from FY 2003.

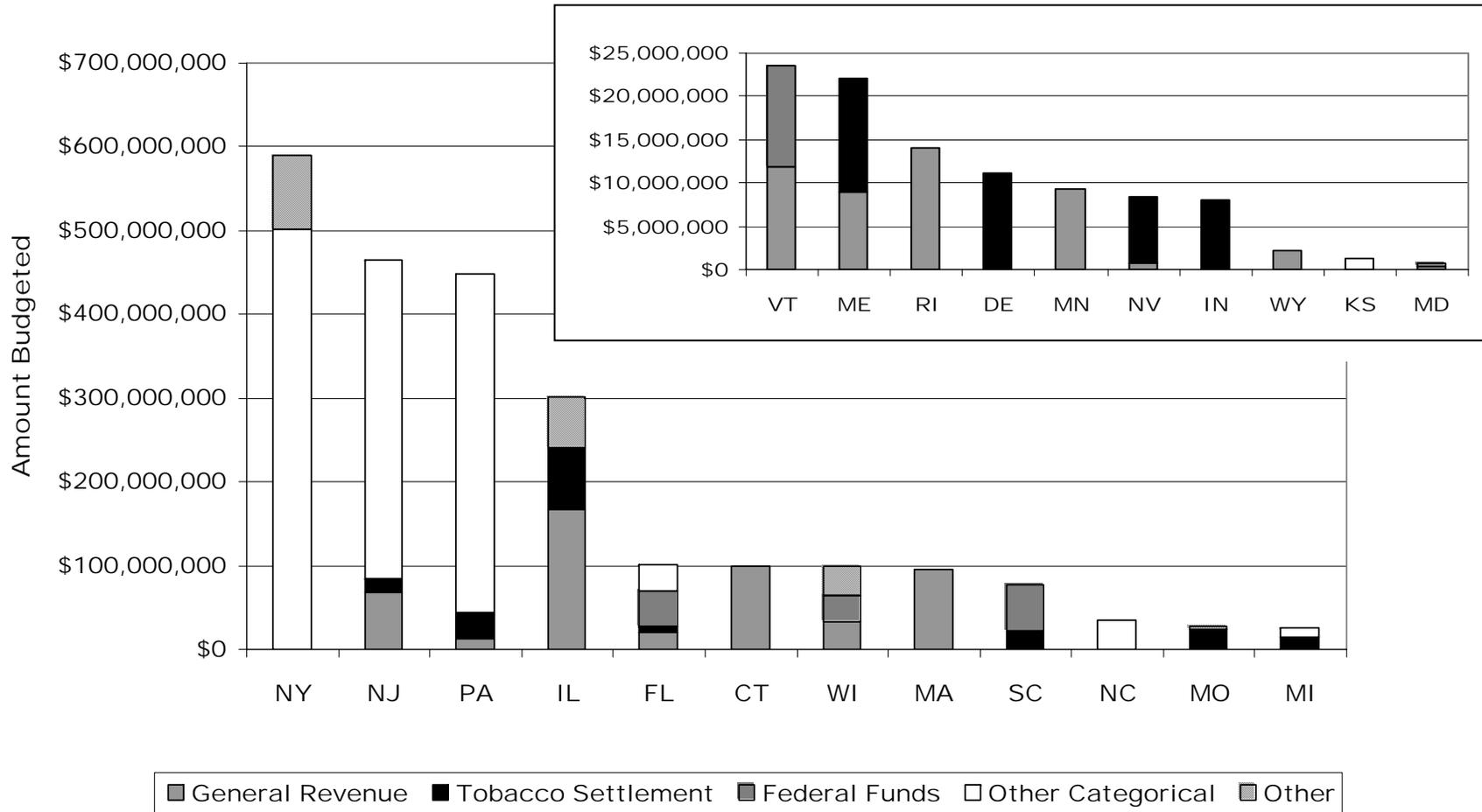


## Chart 5-2 Amount of Funds Budgeted and Sources of Funding by State for FY 2004

- Three SPAPs received the majority of their funding from general revenues, and seven programs received the majority of their funding from tobacco settlement revenues.
- Four out of nine programs introduced in 2000–2003 were funded primarily through tobacco settlement funds.
- Categorical funds accounted for most of the funding in New York, Pennsylvania, New Jersey, and Kansas.
- States with more than one program may have different budgetary changes for each program. For example, New Jersey's PAAD program experienced steady growth whereas its Senior Gold program had lower than expected enrollment and therefore lower expenditures. In the past, there were higher appropriations for Senior Gold, which lapsed back to the State's General Fund because expenditures were less than predicted.



Chart 5-2  
Amount of Funds Budgeted and Sources of Funding by State for FY 2004



Other = Manufacturer rebates and enrollment fees for four states that provided data.  
Note: Budget numbers for Maine, Maryland, Michigan, and South Carolina are from FY 2003.



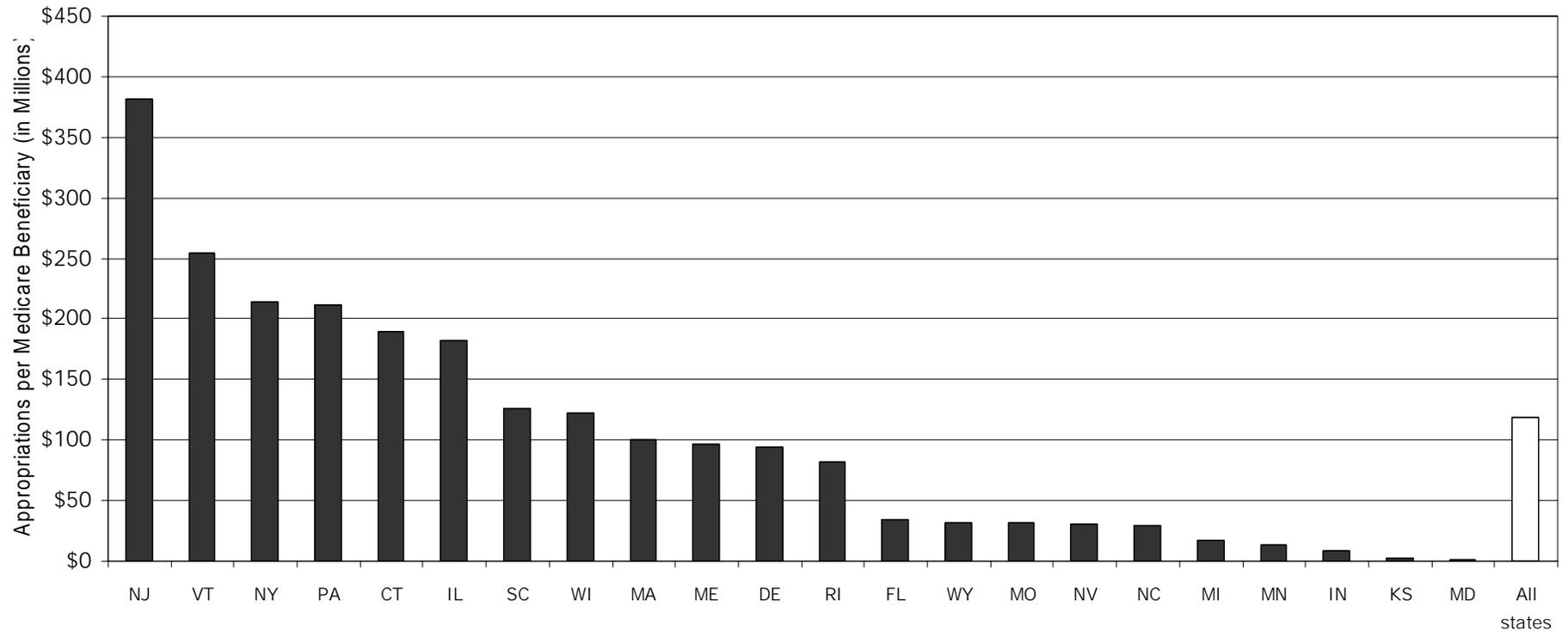
### Chart 5-3

## Program Generosity as Measured by SPAP Appropriations per Medicare Beneficiary for FY 2004

- As an indicator of program generosity, we calculated the amount of state appropriations per Medicare beneficiary in the state as a measure of state financial effort on SPAPs.
- By this measure, states with SPAPs allocated on average about \$119.19 per Medicare beneficiary in the state.
- This measure ranged from about \$0.95 in Maryland (using budget numbers from FY 2003) to \$381.41 in New Jersey.



Chart 5-3  
 Program Generosity as Measured by SPAP Appropriations  
 per Medicare Beneficiary for FY 2004



Notes: Budget numbers for Maine, Maryland, Michigan, and South Carolina are from FY 2003. The average for “All States” is the total Medicare enrollment in all programs divided by the total dollar amount spent across all programs (N=22).

Source for Medicare enrollment data: CMS Web site, *CMS Statistics: Medicare Enrollment*, <http://cms.hhs.gov/statistics/enrollment/default.asp>. Accessed Sept. 28, 2004.

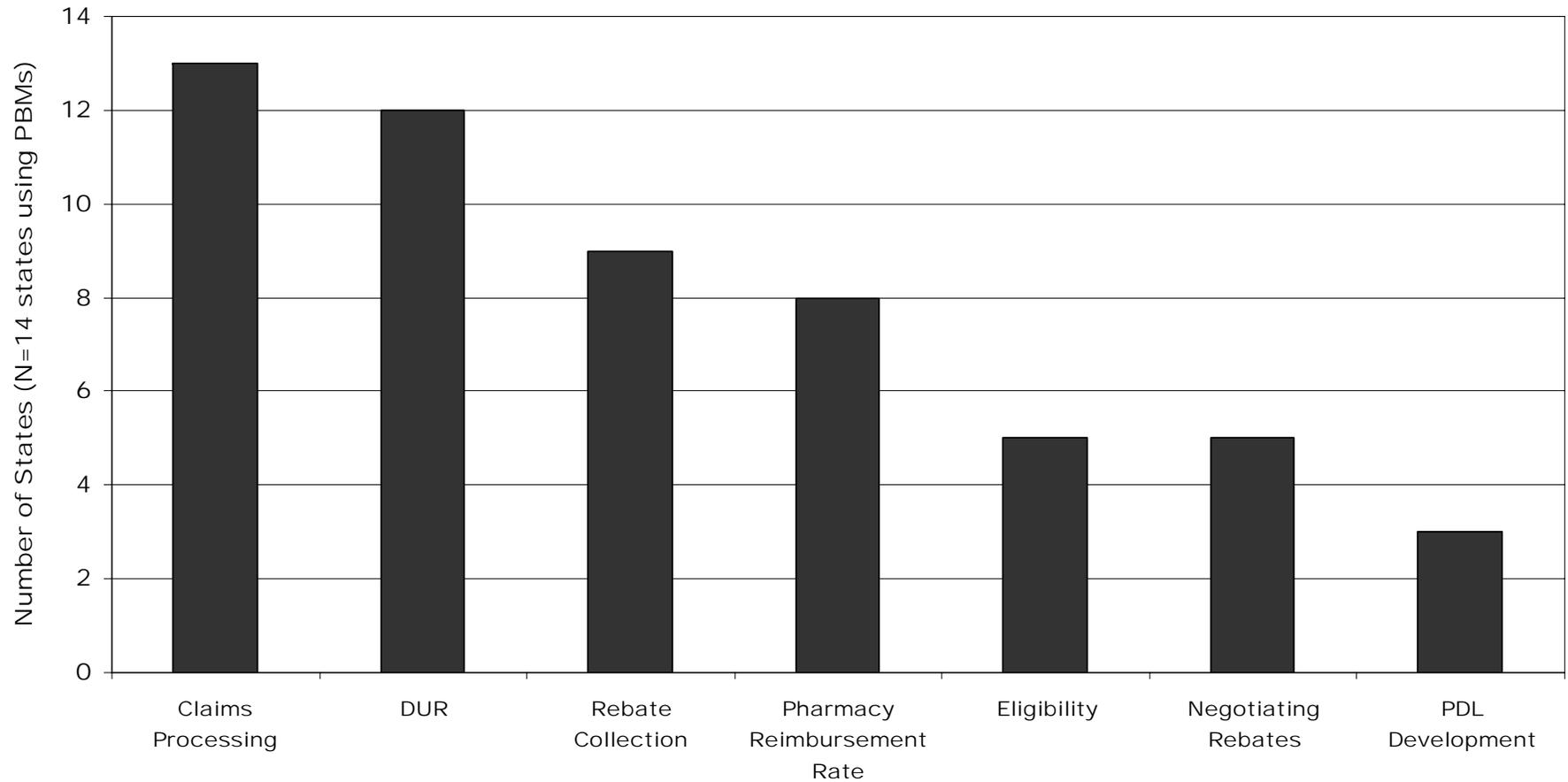


## Chart 5-4 Functions Administered by Pharmacy Benefit Managers for SPAPs, 2003

- The Medicare Part D drug benefit is administered by new private entities known as Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug (MA-PD) plans. The PDPs include Pharmacy Benefit Management (PBMs) firms and/or insurers that work closely with PBMs. As states may need to coordinate their benefits with Part D, it is important to assess states' experience with these private entities to date.
- Fourteen of the 20 SPAP states for which we have data indicated that they use a PBM to administer some of their program functions. Of those 14 states, almost all used a PBM for processing claims, 12 used a PBM for drug utilization review (DUR)—a review of prescriptions that provides pharmacists and physicians informational warnings about potentially inappropriate prescriptions, nine used a PBM to collect manufacturer's rebates, and eight used a PBM to negotiate pharmacy reimbursement rates. Only five states used a PBM for eligibility determination, five states used a PBM for negotiating manufacturer rates and three states used a PBM for PDL development.
- States that did not use PBMs to negotiate manufacturer rebates or pharmacy reimbursement rates usually have the rebate and/or reimbursement rates set in statute.
- In addition to the states that contracted with a PBM, most states used a third-party vendor to process claims.



Chart 5-4  
Functions Administered by Pharmacy Benefit Managers for SPAPs, 2003



## Chart 5-5 Pharmacy Reimbursement and Manufacturer Rebate Formulas

- Chart 5-5 shows the formulas SPAPs used to reimburse pharmacies for claims and to collect rebates from pharmaceutical manufacturers in 2003.
- While pharmacy reimbursement varied considerably across states, in general SPAP pharmacy reimbursement and dispensing fees were more generous than those typically negotiated in the private sector.
- For manufacturer rebates: AMP is the listed Average Manufacturer Price for prescription drugs, and the Medicaid base rate is AMP –15.1% for brand-name drugs and AMP –11% for generic drugs. Pharmaceutical manufacturers are also required to provide Medicaid with rebates that equal the best price given to private purchasers (but not to several federal agencies or SPAPs), and manufacturers must give Medicaid an additional rebate on a drug if the price of that drug increases more in a year than the Consumer Price Index (CPI).
- Of the 21 SPAPs, 14 had statutory requirements that manufacturer rebates must be similar to Medicaid. Nine of these states required the better of the Medicaid base rate or “best price” with the CPI adjustment; five only required the Medicaid base rate.
- Kansas, which had a unique retrospective reimbursement program, was the only state that did not set pharmacy reimbursement rates and dispensing and did not collect rebates.
- Under Part D, pharmacy reimbursement rates and manufacturers rebates are negotiated by the private PDPs and may be higher or lower than those achieved by state programs. For manufacturer rebates, PDPs are required to pass on some, but not all, of the rebates to the consumer through the drug price.
- If states elect to optimize federal funding available through the new Part D drug benefit, states will become the secondary payer to Medicare thus potentially limiting their ability to set pharmacy reimbursement rates and dispensing fees or to negotiate additional rebates from manufacturers.



Chart 5-5  
Pharmacy Reimbursement and Manufacturer Rebate Formulas

State	Pharmacy Reimbursement					Manufacturer Rebates		
	Brand Formula	Generic Formula	FUL	State MAC List	Dispensing Fee	Base rebate Formula	Medicaid Best	Medicaid CPI Adjustment
CT	AWP - 12%	AWP - 40%	N	N	\$3.30	Same as Medicaid	Y	Y
DE	16%	SMAC, FUL or U&C	Y	Y	\$3.65	Same as Medicaid	Y	Y
FL	AWP -13.25%, WAC +7%, SMAC, MAC	AWP -13.25, WAC +7%, SMAC, FMAC	Y	N	\$4.23	Greater of AMP X the base rebate % or AMP - best price	Y	Y
IL - CB	AWP - 14%	AWP - 50% (MAC)	N	Y	\$2.55	Negotiated by PBM	N	N
IL - SC <sup>1</sup>	Lesser of AWP - 14% or U&C	Lesser of AWP - 25%, FUL, SMAC, and U&C	Y	Y	\$2.25	Same as Medicaid	Y	Y
IN	AWP - 13.5% or U&C	AWP -20%, U&C, MAC or SMAC	N	Y	\$4.90	Negotiated by PBM	Y	N
KS	NA	NA	NA	NA	NA	No rebates collected	N	N
ME	AWP - 13%	AWP - 13%	N	Y	\$3.35	Same as Medicaid	Y	Y
MD	Lower of WAC + 10% or AWP - 10%	Lower of EAC, MAC or SMAC	Y	Y	\$4.21	Same as Medicaid	Y	Y
MA	Retail: AWP -14%, U&C or MAC. Mail Service: AWP - 22% or MAC	Retail: AWP -14%, U&C or MAC. Mail Service: AWP - 22% or MAC	N	Y	Retail: \$2.50, mail order: \$0	Negotiated by PBM	N	N
MI	AWP - 15.1%	AWP - 15.1%	N	Y	\$3.77	Same as Medicaid		
MN	AWP - 11.5 % U&C, FUL or SMAC, whichever is lower	AWP - 11.5 % U&C, FUL or SMAC, whichever is lower	Y	Y	\$3.65	Same as Medicaid	N	N
MO	AWP - 10.43%	AWP - 20%	N	N	\$4.09	Generic: AMP-11% Brand name: AMP - 15%	N	N
NV	Negotiated by PBM. AWP - 14%	MAC	N	Y	\$2.29	Negotiated by PBM	N	N
NJ	AWP - 10%	AWP - 10% of FUL	Y	Y	From \$3.73 to \$3.88 by volume and services	Same as Medicaid (without CPI Adjustment for NJ PAAD)	Y	Y
NY	AWP - 12%	FUL (if no FUL, AWP -12%)	Y	N	\$4.50 for generics, \$3.50 for brands	Generic: AMP - 11%. Brand name: AMP - 15.1% or AMP - best price	Y	Y
NC	AWP - 10%	AWP -10%, MAC or SMAC	Y	Y	\$4.90	Same as Medicaid	N	Y
PA <sup>2</sup>	AWP -10% or U&C, whichever is less		N	N	\$3.50	AMP - 17%	N	N
RI	AWP - 13%	MAC	Y	Y	\$2.75	Same as Medicaid	N	N
SC	AWP - 10%	AWP - 10%	N	Y	\$4.05	OBRA 90 Rebate Formula	Y	Y
VT	AWP -11.9%, FUL, MAC or U&C	AWP -11.9%, FUL, MAC or U&C	Y	Y	\$4.25	Same as Medicaid	Y	Y
WI	AWP - 12%	MAC	N	Y	\$4.88	Standard CMS URA formula	Y	Y
WY	AWP - 11%	AWP - 11%	N	Y	\$5.00	Same as Medicaid	Y	Y

AWP = Average Wholesale Price, FUL = Federal Upper Limit, (F)MAC = (Federal) Maximum Allowable Cost, SMAC = State Maximum Allowable Cost, EAC = Estimated Actual Cost, WAC = Wholesale Acquisition Cost, URA = Unit Rebate Amount, U&C = Usual and Customary Reductions.

Notes: Data for Maine and Michigan are from 2002.

<sup>1</sup> Illinois' new SeniorCare waiver program uses the same rebate formula as Medicaid.

<sup>2</sup> Pennsylvania has a slightly different formula from Medicaid for calculating the CPI adjustment.

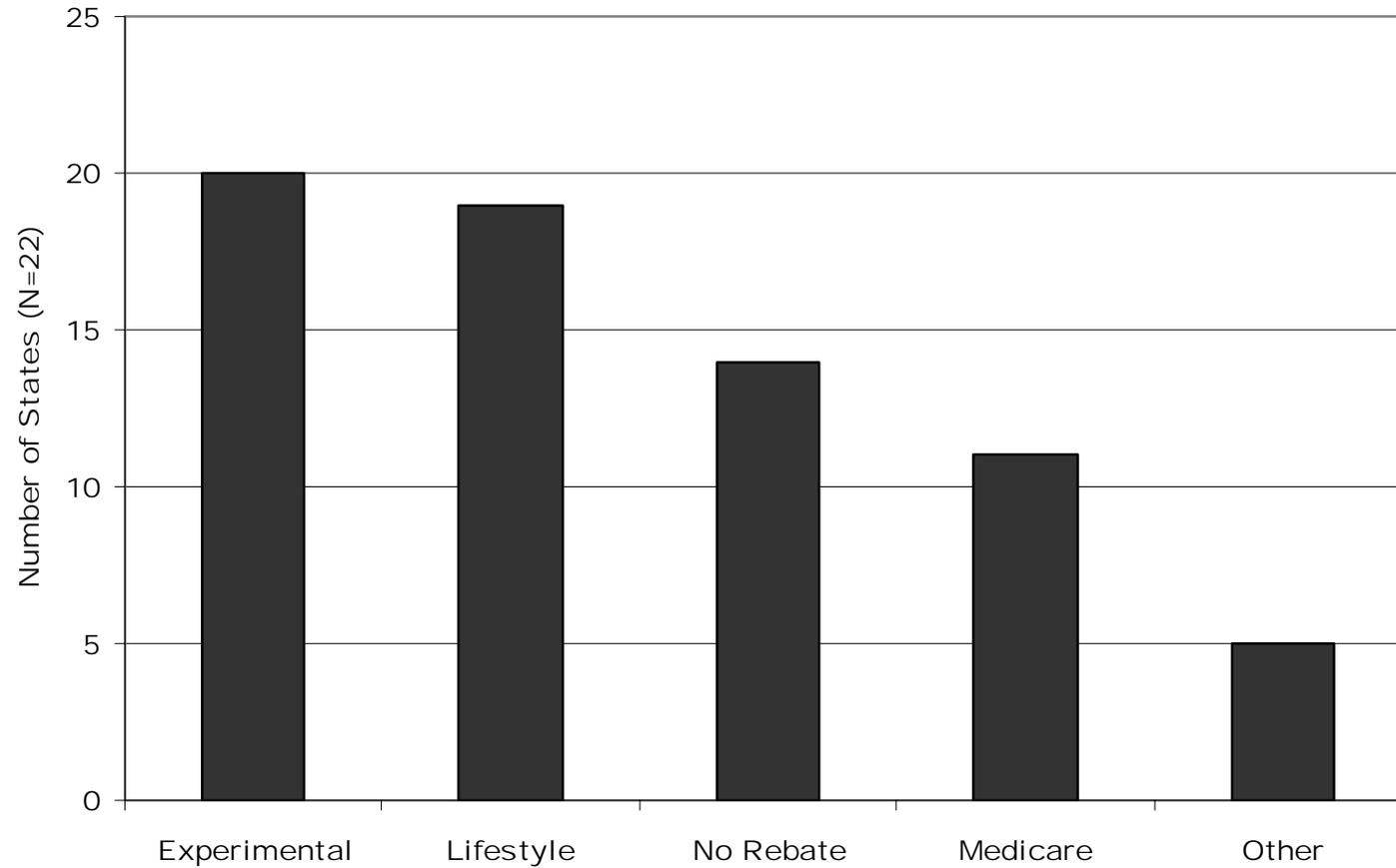


## Chart 5-6 Classes of Exclusions Used by States, 2003

- To be covered under Medicare Part D, a drug must be available by prescription, FDA-approved, and used for the medically accepted indication. Covered Part D drugs include prescription drugs, biological products, insulin and related medical supplies, and vaccines. Part D specifically excludes drugs or classes of drugs that are excluded from coverage under Medicaid, including weight-loss or gain drugs, cosmetic or hair-loss drugs, drugs used for relief of cough and colds, prescription vitamins, over-the-counter drugs, barbiturates, and benzodiazepines. Part D also excludes drugs currently covered under Medicare Part B.
- Most SPAPs also excluded some, but not all, of these drugs from coverage.
- Like Medicare, most SPAPs for which we have data excluded non-FDA-approved experimental drugs. With the exception of Indiana and Kansas, 20 out of 22 SPAPs exclude experimental drugs.
- Most states excluded lifestyle drugs, including hair-loss and impotency drugs. However, Massachusetts, New York, and South Carolina do cover some lifestyle drugs.
- Eleven states excluded outpatient drugs that are already covered by Medicare. While these exclusions were initially directed at excluding the few outpatient drugs covered under Medicare Part B that are administered by a physician, depending on the specific statutory language, this could also be interpreted to extend to Part D covered drugs in the future.
- Fourteen states also excluded drugs for which there is no manufacturer rebate agreement.
- Five states also had other exclusions. Illinois SeniorCare excluded drugs that are available from the Department of Health. Vermont's VScript Expanded program for moderate-income seniors covered only maintenance drugs. Michigan excluded injectable and oral AIDS drugs, injectable drugs, allergy serums, and DESI drugs (drug efficacy study implementation drugs, approved by the FDA solely on the basis of safety prior to 1962). Maine excluded DESI drugs (according to 2002 survey).



Chart 5-6  
Classes of Exclusions Used by States, 2003



Notes: Data for Maine from *A Guide to Prescription Drug Assistance in Maine, October 2004*. Available at <http://www.maine.gov/dhhs/beas/medbook.htm>. Accessed Dec. 6, 2004. Data for Michigan from *Elder Prescription Insurance Coverage*. Available at <http://www.miepic.com/formulary.asp>. Accessed Dec. 6, 2004.

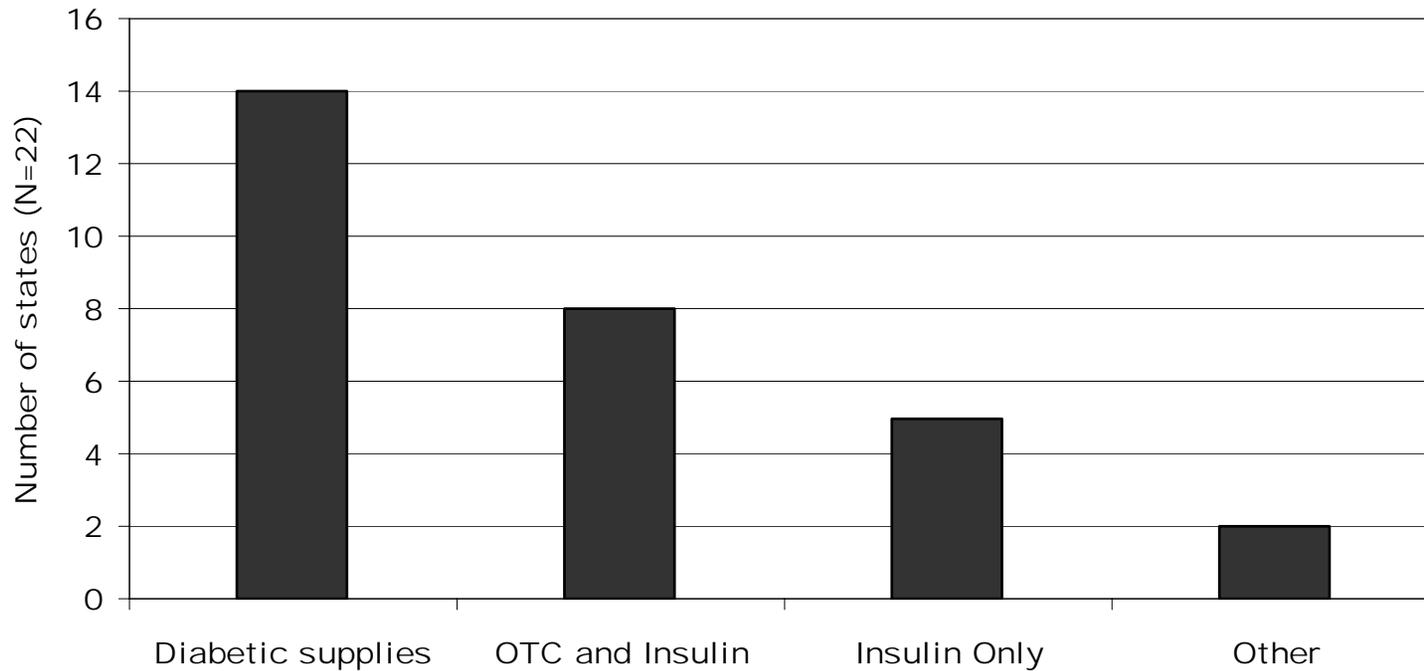


## Chart 5-7 Over-the-Counter Drugs and Medical Equipment Coverage, 2003

- Twenty-one out of 22 states covered over-the-counter drugs and/or medical equipment, and most of these (14) covered diabetic supplies including insulin needles, syringes, and diabetic testing strips, or insulin only (5), which will be covered by Medicare Part D.
- Eight states had broad coverage of over-the-counter medications some of which are not covered under Medicare Part D, including cough and cold remedies, antihistamines, analgesics, antacids, vitamins, and contraceptives.
- Two states covered other over-the-counter medications or supplies. New Jersey specifically offered coverage of needles and syringes for injectable medications used for treating multiple sclerosis. Michigan covered prescribed over-the-counter medications for approved step therapy programs.



Chart 5-7  
Over-the Counter Drugs and Medical Equipment Coverage, 2003



Notes: Totals do not add to 22 since several states have more than one type of OTC coverage. Data for Maine from *A Guide to Prescription Drug Assistance in Maine, October 2004*. Available at <http://www.maine.gov/dhhs/beas/medbook.htm>. Accessed Dec. 6, 2004. Data for Michigan from *Elder Prescription Insurance Coverage*. Available at <http://www.miepic.com/formulary.asp>. Accessed Dec. 6, 2004.



## Chart 5-8 Use of Drug Formularies by SPAPs, 2003

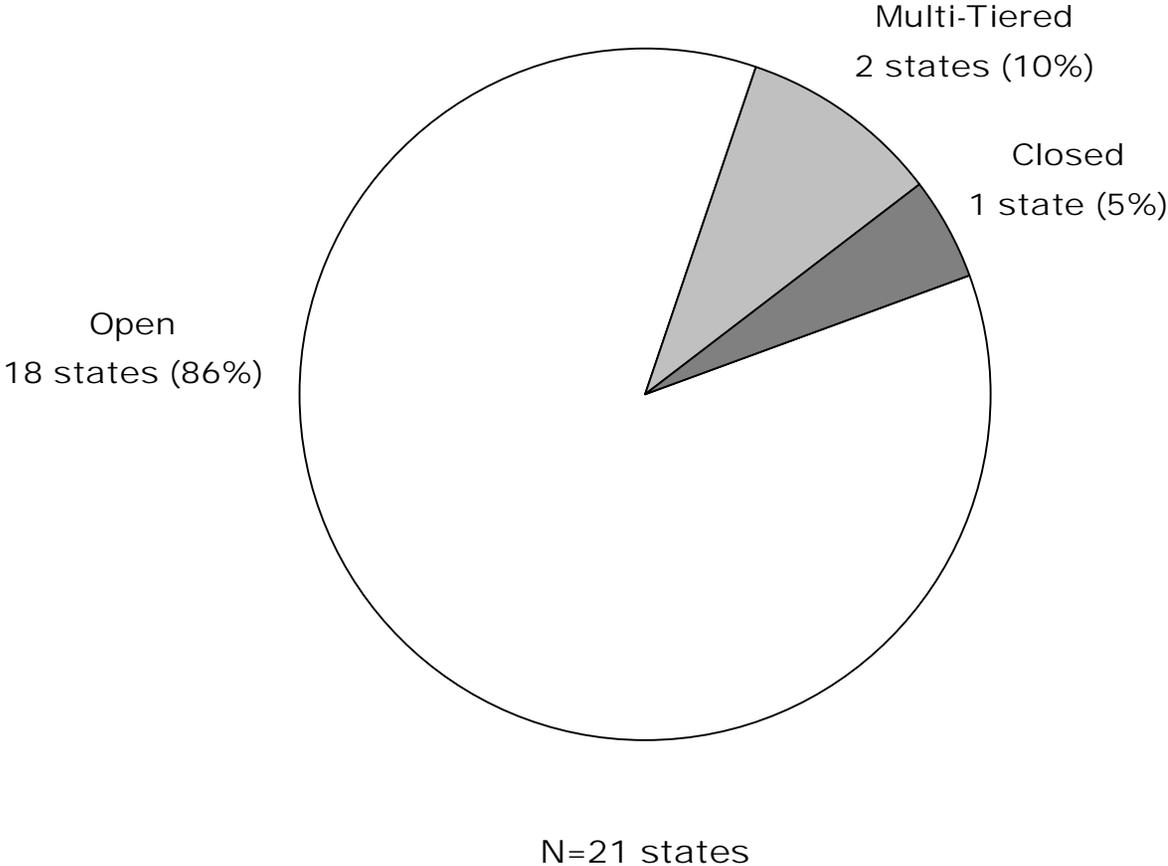
- States may use drug formularies as a cost-containment measure. Open formularies offer a broad coverage of drugs or drug classes. Closed formularies limit coverage of drugs or drug classes. Multi-tiered formularies offer financial incentives to encourage enrollees to purchase on-formulary drugs but also provide flexibility to enrollees to purchase off-formulary drugs at a higher out-of-pocket cost.
- According to 2002 survey data, 18 out of 21 (86%) states had an open formulary.<sup>1,2</sup>
- Nevada was the only state to have a closed formulary.
- Two states, Florida and Massachusetts, had a multi-tiered formulary.

<sup>1</sup> Data not available on Wisconsin's new SeniorCare program.

<sup>2</sup> Rutgers Center for State Health Policy Survey of State Pharmacy Assistance Programs, Aug. 2002.



Chart 5-8  
Use of Drug Formularies by SPAPs, 2003



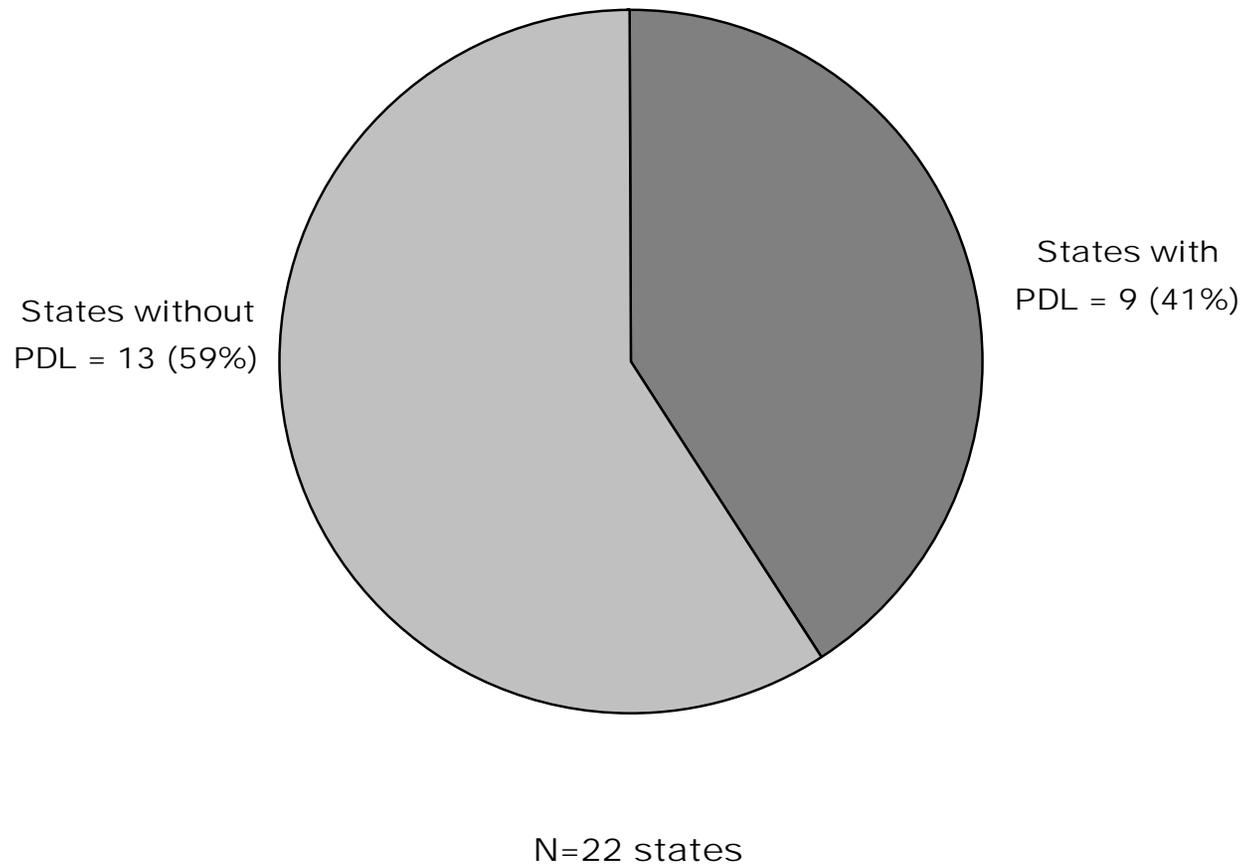
Note: Data on Wisconsin not available.

## Chart 5-9 States that Utilize a Preferred Drug List, 2003

- In addition to formularies, states can attempt to influence drug utilization through the use of preferred drug lists (PDLs). In these programs, drugs that are not on the PDL, or, in some cases, all drugs in a class, must receive prior authorization either from the state or the pharmacy benefit manager before they can be dispensed. States may also require enrollees to pay tiered copayments, in addition to obtaining prior authorization, to discourage use of non-preferred drugs.
- The number and types of drugs included on SPAP PDLs vary widely by state. In 2002 states reported that preferred drugs were selected based on a variety of criteria including the availability of therapeutic equivalents and clinically appropriate substitutions, the price of the drug, and, in some states, whether the manufacturer was willing to offer a supplemental rebate.
- Under the Medicare Part D drug benefit, private plans are allowed to use either closed or tiered formularies to contain program costs so long as they offer at least two drugs within each therapeutic category and class of covered Part D drugs as defined either by guidelines established by US Pharmacopeia or alternative classifications put forward by the PDP and approved by CMS.
- Nine states utilized a PDL—Florida, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, and Vermont.
- All of the nine states that utilized a PDL required Prior Authorization. In addition to prior authorization, Maine, Massachusetts, and Florida required consumers to pay higher copayments for drugs not included on their PDL.



Chart 5-9  
States that Utilize a Preferred Drug List, 2003



Notes: Data for Maine from *A Guide to Prescription Drug Assistance in Maine, October 2004*. Available at <http://www.maine.gov/dhhs/beas/medbook.htm>. Accessed Dec. 6, 2004. Data for Michigan from *Elder Prescription Insurance Coverage*. Available at <http://www.miepic.com/formulary.asp>. Accessed Dec. 6, 2004.

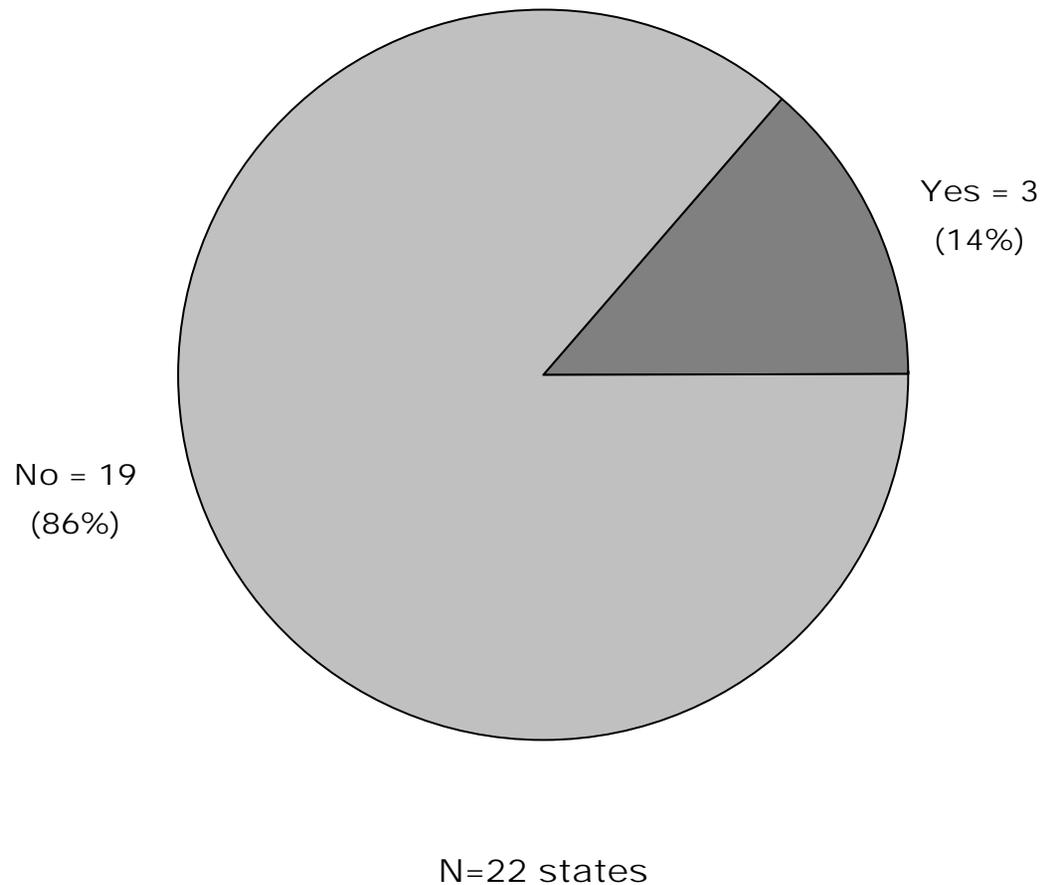


## Chart 5-10 States with Mail-Order Requirement, 2003

- Private plans administering the Medicare Part D benefit are permitted to offer a home delivery option via a mail-order pharmacy but can only offer this in addition to the retail pharmacies in a plan's network that must meet a minimum access standard. Draft Part D regulations also allowed PDPs to vary cost-sharing by preferred and non-preferred pharmacies, which may include mail-order pharmacies.
- Only Massachusetts and Nevada encouraged their participants to use mail-order by offering a lower copayment than would be available at the retail pharmacy (i.e., the copayment for a three-month mail-order supply is equal to that of a two-month supply from a pharmacy).
- In its FY 2004 Appropriation Act, the New Jersey legislature allowed the state to issue an RFP for a voluntary mail-order service, but implementation was delayed because the state focused its attention on coordinating with the Medicare interim discount card program, which includes mail-order and could conflict with the state initiative.



Chart 5-10  
States with Mail-Order Requirement, 2003



Notes: Data for Maine from *A Guide to Prescription Drug Assistance in Maine, October 2004*. Available at <http://www.maine.gov/dhhs/beas/medbook.htm>. Accessed Dec. 6, 2004. Data for Michigan from *Elder Prescription Insurance Coverage*. Available at <http://www.miepic.com/formulary.asp>. Accessed Dec. 6, 2004.

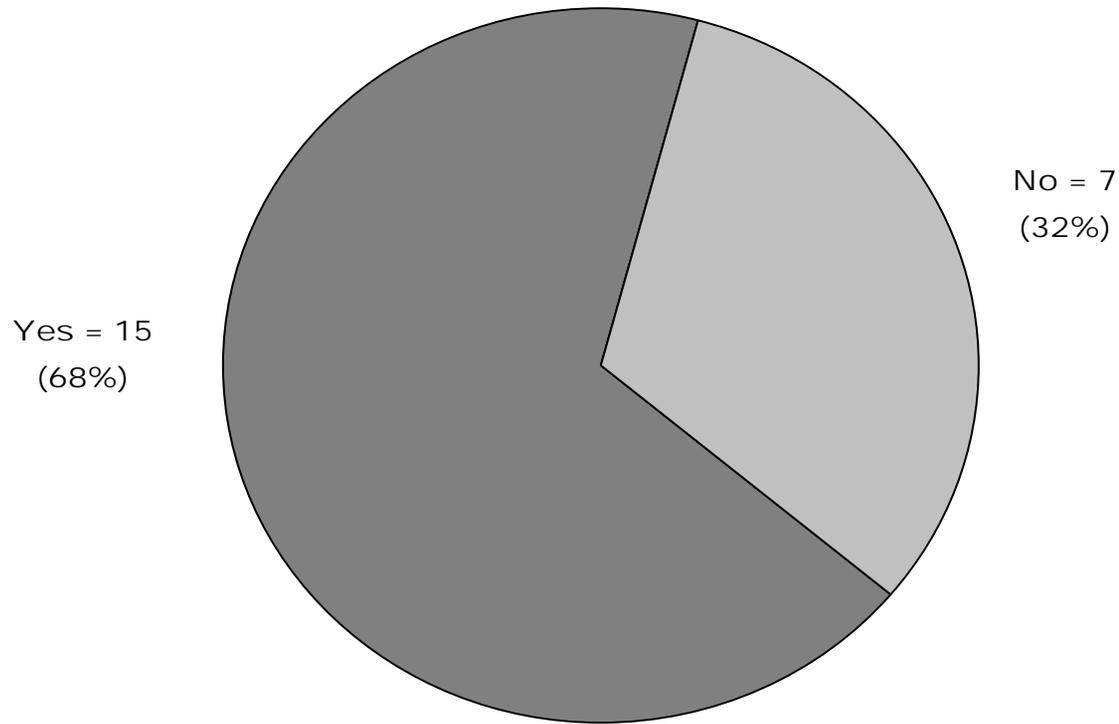


## Chart 5-11 States with Generic Substitution Requirement, 2003

- As a cost-containment measure, states may require generic substitution of a brand-name medication, if a generic alternative is available. Generic medications are typically much less expensive than brand-name medications. However, rebates collected for generic medications are lower.
- The MMA regulations encourage Prescription Drug Plans to employ generic substitution as a cost containment measure.
- Fifteen of 22 states required mandatory generic substitution.
- In five of these states, prior authorization was needed for the patient to receive the brand-name drug.
- In eight of these states, physicians could override the mandatory generic substitution by noting on the prescription that the brand is medically necessary.
- In Pennsylvania, the card holder was required to pay the copayment plus 70% of the average wholesale price of the brand-name drug.
- In Wyoming, the state paid the generic price of the drug and the enrollee was responsible for the balance.



Chart 5-11  
States with Generic Substitution Requirement, 2003



N=22 states

Notes: Data for Maine from *A Guide to Prescription Drug Assistance in Maine, October 2004*. Available at <http://www.maine.gov/dhhs/beas/medbook.htm>. Accessed Dec. 6, 2004. Data for Michigan from *Elder Prescription Insurance Coverage*. Available at <http://www.miepic.com/formulary.asp>. Accessed Dec. 6, 2004.



## Related Publications

[\*Using Clinical Evidence to Manage Pharmacy Benefits: Experiences of Six States\*](#) (March 2006). David Bergman, Jack Hoadley, Neva Kaye, Jeffrey Crowley, and Martha Hostetter. The authors of this issue brief provide an overview of how six state Medicaid agencies—in California, Florida, Kansas, Michigan, Missouri, and Washington—are managing their pharmacy benefit.

[\*Medicare's New Adventure: The Part D Drug Benefit\*](#) (March 2006). Jack Hoadley, Health Policy Institute, Georgetown University. This report considers the types of plans that initially entered the Medicare Part D market; the shape the market and the benefit are taking; the drugs initially available through the plans offering the benefit; the success in enrolling beneficiaries; whether beneficiaries will have improved access to needed drugs; and the impact on the larger marketplace for prescription drugs.

[\*Stretching State Health Care Dollars: Pooled and Evidence-Based Pharmaceutical Purchasing\*](#) (October 2004). Sharon Silow-Carroll and Tanya Alteras, Economic and Social Research Institute. According to the authors, in recent years rising pharmaceutical costs have contributed in a major way to the growth of overall health care costs generally and of Medicaid outlays in particular. As a result, many states are implementing drug-cost-containment mechanisms that put innovative approaches in place that reduce state costs so as to expand or maintain access.

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

[\*Medicare's Future: Current Picture, Trends, and Medicare Prescription Drug Improvement & Modernization Act of 2003\*](#) (updated February 2004). Barbara S. Cooper and Sabrina How, The Commonwealth Fund. This chartpack presents an array of PowerPoint slides highlighting recent research and analytical findings on Medicare, including an overview of changes brought about by the Medicare prescription drug bill.

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

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