STRENGTHENING NEW YORK'S EPIC PROGRAM: OPTIONS FOR IMPROVING DRUG COVERAGE FOR MEDICARE BENEFICIARIES

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FIELD REPORT

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EXECUTIVE SUMMARY

New York State's Elderly Pharmaceutical Insurance Coverage (EPIC) program is one of the largest and most comprehensive state pharmacy assistance programs in the nation for low-income seniors. In the absence of a Medicare prescription drug benefit, programs such as EPIC provide an essential, if partial, mechanism to fill the void for many low-income Medicare beneficiaries. This report tracks the evolution of the EPIC program, provides an overview of its design and operation, and recommends policy options to improve efficiency and to address more fully the needs of New York Medicare beneficiaries.

Program Design and Experience

EPIC was established in 1986 and by 2002 had more than 260,000 enrollees, making it the largest state pharmacy program in the nation. It also is one of the more generous. Through direct subsidies and manufacturer rebates, the program pays about three-quarters of all enrollee drug costs. EPIC contains a number of design features that make it unique among state programs and, in some ways, a model for other prescription drug programs, including Medicare. It also has some less successful features that provide important lessons for others.

Some of EPIC's successful design features include:

- **Generous program eligibility for seniors.** EPIC is available to seniors meeting specific income criteria who do not have Medicaid or private drug insurance that covers 80 percent or more of the costs of prescriptions. Unlike many other state programs, no asset test is required to join, and EPIC will supplement coverage from other insurance by paying for drugs that private plans will not cover or supplementing cost-sharing. About one-fifth of enrollees report that they have some private coverage.

  The program has two distinct plans: 1) the fee plan, targeted to low- and moderate-income seniors, which provides unlimited drug coverage for those who pay an income-related annual fee and make a copayment for each prescription; and 2) the deductible plan, targeted to seniors with moderate incomes, which provides unlimited coverage with copayments and an annual income-related deductible.

- **Streamlined enrollment.** Eligible seniors may enroll in EPIC at any point during the year by filling out a simple two-page application form. The only documentation required is proof of age.

- **Out-of-pocket protection.** EPIC has no limit on the amount of benefits provided (about one-quarter of the other state pharmacy programs place a cap on benefits) and provides enrollees a maximum cap on copayments ranging from 6 to 8 percent of annual income, depending on marital status. However, its premium and cost-sharing requirements are greater than in a number of other states.

- **Therapeutic drug monitoring.** EPIC includes both prospective and retrospective therapeutic drug monitoring to guard against drug interactions, adverse reactions, overutilization, and therapeutic duplications. Developed by an advisory group including pharmacologists and pharmacists with expertise in the health care needs of the elderly, the monitoring program notifies pharmacists of potential medication problems before they fill requested prescriptions. In 2000–01, more than 135,000 prescriptions were not filled because of concerns about adverse events.

- **Rebate requirements similar to Medicaid.** In line with the Medicaid program, EPIC requires a rebate of 11 percent of the average manufacture price (AMP) for generics and a rebate of the greater of 15.1 percent of AMP per unit or the difference between the AMP and best price per unit for brand-name drugs. EPIC's reimbursement policies were initially weaker than those in Medicaid, but they have been tightened over the years and have allowed EPIC to expand enrollment and to defray costs for seniors.

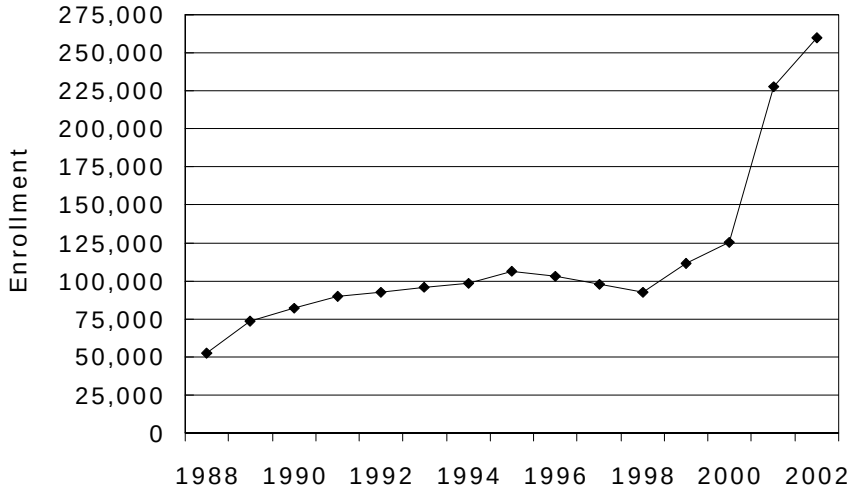
Less successful program features include:

- **Excludes beneficiaries with disabilities.** Some 14 percent of Medicare beneficiaries in New York qualify for Medicare on the basis of disability. Several thousand New York Medicare beneficiaries with disabilities, mostly individuals who are HIV positive, must purchase expensive Medigap insurance because it is the only way they can obtain prescription drug coverage.

- **Complicated structure with incentives for adverse selection.** During the first 10 years of operation, high program fees, combined with the complicated benefit structure and limited outreach activities, resulted in relatively slow growth in enrollment. Many seniors felt it was only worthwhile to join if they had substantial and predictable drug costs, resulting in a narrow pool of enrollees with low incomes and multiple chronic conditions. By 1995, enrollment had begun to drop off. Starting in 1998, the legislature enacted a number of changes—lowering fees, simplifying program structure, expanding income eligibility levels, reducing

the number of copayment levels, and adding cost-of-living adjustments to eligibility levels—that significantly reversed that trend. Between 1998 and 2002, enrollment tripled (Figure ES-1). Nevertheless, the benefit structure is still complicated—there are 15 different income and fee or deductible categories for single seniors and 21 categories for married seniors—and it is still difficult for seniors to determine whether it is worthwhile to join.

Figure ES-1. EPIC Enrollment, 1988–2002



Source: EPIC Annual Report to the Governor and Legislature: October 1999–September 2002.

- **Limited outreach.** Because of limited education and outreach activities, one-third of persons who are eligible but not enrolled in the program have never heard of it.

Policy Options for Strengthening and Expanding EPIC

In today's climate of tight budgets and cutbacks, policymakers generally focus on potential savings rather than expansions of public programs. Some of the following policy options could save dollars, while others would require additional spending and could be implemented when the budget picture improves.

1. Expand EPIC to cover the Medicare disabled population.

A number of state drug programs cover the under-65 Medicare disabled population. While there are far fewer disabled Medicare beneficiaries than there are seniors, their medical needs—including the need for prescription drugs—may be greater, and their access to necessary medical services is often even more limited.

2. Continue to expand the existing pool of individuals eligible for EPIC by increasing the state subsidy and simplifying the eligibility and program structure.

Drug coverage is especially vulnerable to adverse selection, because beneficiaries at risk for high-cost drug utilization are far more likely to enroll in such plans than are lower-risk beneficiaries. There are a number of policy approaches to help ensure that the pool of enrollees includes a manageable balance of low- and high-risk individuals. To help stabilize program financing and benefit a greater number of seniors, New York could dismantle the complex structure of premiums, coinsurance, and deductibles now built into EPIC.

3. Strengthen the rebate program.

Expanding the size of the insured pool under EPIC might enable New York to obtain better prices for prescription drugs by giving the state greater leverage with which to negotiate rebates or discounts from industry. At one point, in addition to the rebates described above, EPIC required rebates on both brand-name and generic drugs that have price increases greater than the consumer price index. An amendment eliminated this provision for generic drugs in January 2002. Restoring it could save state dollars.

4. Improve outreach and coordination efforts.

The state should provide the EPIC program with sufficient administrative funds to carry out comprehensive outreach activities on a regular basis. In addition, EPIC could coordinate its outreach and administrative activities with other state or joint state and federal programs that target similar populations.

5. Continue to explore state purchasing pools.

New York should continue to explore options for intrastate, multi-agency, or multi-state purchasing pools that would result in the ability to negotiate better prices on drugs purchased from manufacturers, not only for the EPIC program, but for all state programs involved in buying prescription drugs.

STRENGTHENING NEW YORK'S EPIC PROGRAM: OPTIONS FOR IMPROVING DRUG COVERAGE FOR MEDICARE BENEFICIARIES

INTRODUCTION

There are 2.7 million Medicare beneficiaries in New York State. In a ratio similar to the rest of the nation, 86 percent are over the age of 65 and 14 percent qualify for the program on the basis of disability.[1] Although the Medicare program provides health insurance coverage to nearly all the U.S. elderly as well as support to some individuals with disabilities, it does not cover all health care costs. On average, the Medicare program pays for about half of beneficiaries' medical expenses.[2] Arguably, the most glaring gap in the Medicare benefit package is the lack of coverage for outpatient prescription drugs. Recent trends in both the cost and utilization of prescription drugs have brought this issue to the forefront of policy discussions around reforming the Medicare benefit package.

The growing seriousness of the problem of paying for prescription drugs for Medicare beneficiaries, and the growing awareness of this problem, have led to calls for federal legislation as well as action on the part of many states. Absent a federal prescription drug benefit, about half of all states have implemented their own pharmacy assistance program. This report focuses on one of the largest of those state programs, New York's Elderly Pharmaceutical Insurance Coverage (EPIC) program. Established in 1986 and implemented the next year, EPIC is one of the original state drug assistance programs. It has grown in recent years to have one of the largest enrollments of all state drug assistance programs.

In 1999, before the large growth in EPIC enrollment, approximately 17 percent of all Medicare beneficiaries in New York were without any drug coverage. Since that time, EPIC has grown, but some other sources of coverage, such as Medicare risk HMOs, have declined. To gain a better understanding of the market in which EPIC operated, see Appendix C, which contains a detailed description of prescription drug coverage for Medicare beneficiaries in New York.

This report describes the evolution of the EPIC program and provides an overview of a number of key aspects related to its design and operation. Information was gathered from a number of different sources, including interviews with EPIC program officials, data from the national Medicare Current Beneficiary Survey (MCBS) and the New York State Department of Insurance, EPIC program statistics, and a survey of low-income Medicare beneficiaries in eight states, including New York. Based on these

findings, the report suggests policy options for modifying the EPIC program. In the absence of national legislation, programs such as EPIC provide an essential, if partial, mechanism to fill the void for many low-income beneficiaries for whom prescription medications can literally mean the difference between life and death.

The New York State Legislature established EPIC to assist low- and moderate-income senior citizens in meeting their prescription drug costs. Since October 1, 1987, state residents ages 65 and older who satisfy the income eligibility criteria have been able to participate in EPIC. Beginning in 2001, eligibility expansions to the program contributed to a dramatic growth in enrollment—from 125,099 seniors in September 2000 to about 260,000 in early 2002. EPIC enrollment represented about 9 percent of the New York Medicare population (both elderly and disabled) and 11 percent of the 65-and-older population by early 2002.*

The EPIC program provides prescription drug coverage (including coverage of insulin and insulin syringes) to qualifying seniors living in New York who either pay an annual fee or meet an annual deductible, and then pay a copayment for each prescription purchased at any participating pharmacy in New York (Table 1). Single seniors with income up to $20,000 are eligible for the annual fee plan, and those with income between $20,000 and $35,000 are eligible for the annual deductible plan (income eligibility levels for married seniors are $26,000 and $50,000, respectively, for the fee and deductible plans). Annual fees, similar to a premium, range from $8 to $300 a year, depending on income and marital status. Those in the deductible plan must meet a deductible that ranges from $530 to $1,715, depending on income and marital status, before they have access to the discount copayments. A four-tier copayment schedule ranges from $3 to $20, depending on the cost of the drug. Seniors may join the program at any time during the year, and can use EPIC to supplement other private insurance that is inadequate or less comprehensive than EPIC. Medicaid beneficiaries are not eligible for EPIC.

* Please note that these figures cannot be directly compared with the Medicare Current Beneficiary Survey data in Table 2 on page 4, since those data categorize individuals by their primary source of insurance only. The figures noted here are all EPIC enrollees, many of whom also have other insurance and use EPIC as a secondary source of insurance.

Table 1. New York EPIC Program Design, 2002

Program Feature	Fee Program	Deductible Program
Annual Income Eligibility Requirements		
Single Person	$0–$20,000	$20,001–$35,000
Married Couple	$0–$26,000	$35,001–$50,000
Annual Fee		
Single Person	$8–$230	N/A
Married Couple	$8–$300	N/A
Annual Deductible		
Single Person	N/A	$530–$1,230
Married Couple	N/A	$650–$1,715
Copayments per Prescription	$3, $7, $15, or $20	$3, $7, $15, or $20 (after meeting deductible)
New York State Residency Requirement	Yes	
Coordination with Other Coverage	Seniors can still enroll in EPIC if they have private insurance that is not as generous as EPIC, or when they reach a benefit cap; EPIC is the payer of last resort; Medicaid enrollees not eligible	
Drugs Covered	All FDA-approved prescription drugs plus insulin and insulin syringes; both generic and brand-name drugs*	
Formulary	Open	
Pharmacy Network	Open (nearly 4,000 pharmacies participate in EPIC, including chain, independent, institution, and mail order)	
Benefit Limits	Unlimited benefits (prescriptions can be written for the greater of a 30-day supply or 100 doses)	
Annual Maximum Out-of-Pocket on Copayments	Yes (after which EPIC covers full cost of prescription) Single: 7% of income Married: 9% of income	

* For drugs to be covered by EPIC, the drug manufacturer must participate in their rebate program. Currently, there are more than 300 participating manufactures, including almost all manufacturers of drugs used by EPIC enrollees.

Note: In 2002, federal poverty guidelines were $8,860 for singles in the contiguous United States and Washington, D.C. ($11,080 and $10,200 for Alaska and Hawaii, respectively) and $11,940 for couples in the contiguous United States and Washington, D.C. ($14,930 and $13,740 for Alaska and Hawaii, respectively).

THE NEW YORK EPIC PROGRAM

Current Program Eligibility: Fee and Deductible Plans

EPIC was originally structured with two distinct options for prescription drug coverage: comprehensive coverage and catastrophic coverage. Comprehensive coverage was intended for seniors at the lower end of the income scale and required enrollees to pay an annual fee or premium. Catastrophic coverage was intended for seniors with somewhat higher incomes, and enrollees could choose between an annual fee model or a high-deductible model. Beginning in 1998, in an effort to simplify the marketing efforts aimed at seniors, the two plan options were renamed the fee plan and the deductible plan. Unlike the Medicaid program, the EPIC program does not require an asset test for either the fee or deductible plan—eligibility is based solely on age (65 years or older), income, and the lack of equivalent or better insurance coverage for prescription drugs. The income eligibility levels were significantly expanded through legislation enacted in 2000, becoming effective in January 2001 (Table 2).

Table 2. Basic Eligibility Features and Enrollment Comparison, EPIC and Medicaid, 2002

Eligibility Standards	PUBLIC PROGRAMS PROVIDING DRUG COVERAGE FOR SENIORS IN NEW YORK	
	EPIC, 2002	**NY Medicaid, 2002**
Annual Income Eligibility Requirements		
Single Person	Up to $20,000 for fee program $20,000–$35,000 for deductible program	Up to $7,608
Elderly Couple	Up to $26,000 for fee program $26,000–$50,000 for deductible program	Up to $11,100
Asset Test	No	Yes Maximum of $3,800 for single Maximum of $5,550 for married
Has Other Prescription Drug Coverage	Yes, but only if limited	No
Total Enrollment, 65+*	228,057	456,868
Fee Program	192,936 (85%)	
Deductible Program	35,121 (15%)	

* EPIC enrollment as of 9/30/01, Medicaid enrollment for seniors (both SSI and Medically Needy) as of fiscal year 2000.

Note: Medicaid eligibility requirements do not include income/resource disregards.

Source: New York State Department of Health.

Fee Plan

Targeted to low- and moderate-income seniors, the fee plan provides unlimited drug coverage for seniors who pay an income-related annual fee and make a copayment for each prescription purchased. As of January 1, 2001, the fee plan is available to single seniors with incomes of up to $20,000 per year and to married seniors with combined incomes of no more than $26,000. In the context of the 2002 federal poverty guidelines, these eligibility levels range from below poverty to 226 percent of poverty for a single individual and 293 percent of poverty for a married couple.[†] Enrollees must pay an annual fee of between $8 and $300 (depending on income and marital status) and then make a copayment of between $3 and $20 (depending on the cost of their drugs) when they purchase their prescriptions at the pharmacy. Annual fees can be paid in quarterly installments. There are 15 different income and corresponding fee categories for single seniors, 21 for married seniors, and four copayment categories.

Deductible Plan

Targeted to seniors with somewhat higher incomes, the deductible plan provides unlimited coverage with copayments for each prescription purchased, but only after enrollees meet an income-related annual deductible. The deductible plan, which more closely resembles what is commonly called catastrophic coverage, is only available to elderly New Yorkers with moderate incomes (between $20,001 and $35,000 for single seniors and between $26,001 and $50,000 for married seniors). These income eligibility levels range from approximately 230 percent of poverty to 430 percent of poverty. Enrollees are required to first meet an annual deductible of between $530 and $1,715 (depending on income and marital status; if married, both individuals must meet a separate deductible), and then pay copayments of between $3 and $20. There are 15 different income and corresponding deductible categories for single seniors and 24 for married seniors. Although there is no fee to join this plan, enrollees must first spend a significant amount on drugs before they are eligible to receive benefits through EPIC (See Appendix B).

Trends in Enrollment in EPIC

EPIC's complicated program structure and high cost-sharing have been the two most important barriers to enrollment in the program. The program's planners assumed that the program design would result in enrollment from a mix of two different groups of seniors: the comprehensive plan would attract low-income seniors with close to average drug costs (but costs that were a struggle for them to manage), and the catastrophic plan would attract more moderate-income seniors with substantial drug costs. Legislators and state

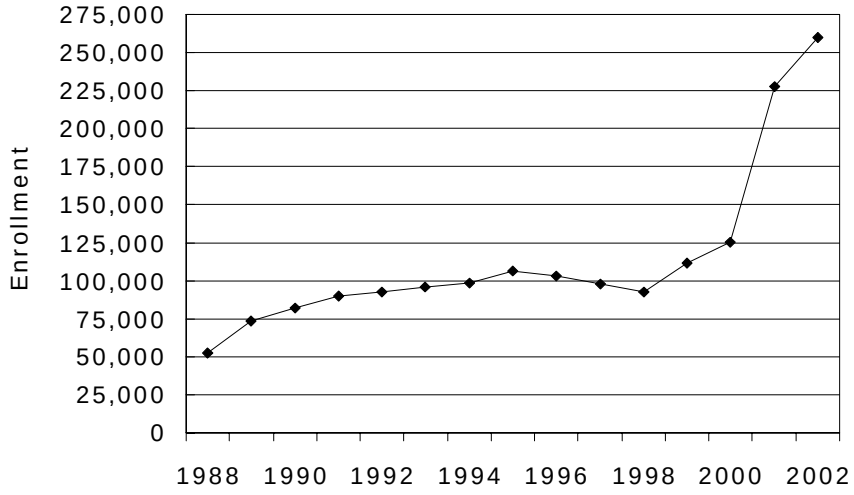
[†] In 2002, federal poverty guidelines were $8,860 for singles in the contiguous United States and Washington, D.C. ($11,080 and $10,200 for Alaska and Hawaii, respectively) and $11,940 for couples in the contiguous United States and Washington, D.C. ($14,930 and $13,740 for Alaska and Hawaii, respectively).

officials believed that the initial design was a compromise between the desire to cover as many seniors in need of assistance as possible and the desire to limit costs to the state. However, a few lessons were learned relatively quickly. First, the design of the program was too complex. Seniors simply could not understand the program structure, and found it very difficult to determine if they would save money by joining. Without that assurance, many decided not to enroll. Second, both because of the complicated structure and the costs associated with EPIC coverage, many seniors felt it was only worthwhile to join if they had very high and predictable drug costs. Program evaluations and empirical evidence showed that the design of the program resulted in the EPIC population consisting primarily of a relatively narrow subgroup of low-income seniors with multiple chronic illnesses and very high drug costs. In fact, enrollment projections were revised downward in the early 1990s to take into consideration income, other insurance coverage, and drug costs in excess of $600. For example, in 1995, based on those factors, the state estimated that there were approximately 140,000 seniors (down from their original estimates in the late 1980s of 475,000) who met the income eligibility requirements and who might be inclined to find the plan a useful investment.[3] Until significant eligibility expansions were implemented in 2001, EPIC enrollment never even approached those state estimates.

In general, seniors indicated they found the structure of the program confusing, particularly the extensive number of premium and deductible categories. The confusion of potential applicants was exacerbated by a five-tier copayment schedule that was difficult to understand and made savings assessments even more difficult to conduct. Many seniors felt enrollment in EPIC was only worthwhile for individuals who had very high medication costs.

As shown in Figure 1, enrollment grew slowly between 1988 and 1995, but a significant drop in enrollment occurred between 1995 (107,700) and 1998 (92,000). Even fewer people were choosing to apply, and more people were canceling their coverage. Apart from the complexity of the program fees, the level of the annual fees also was a significant deterrent to participation. In 1997, a large number of applicants to the fee plan (about 20 percent) decided not to enroll after they received their first bill. Furthermore, the number of cancellations due to non-payment of a bill increased between the 1995–96 and 1996–97 program years from 16,737 (15 percent) to 21,165 (19.6 percent). Among seniors who cancelled their coverage, many who participated in follow-up surveys administered by EPIC indicated that they could neither afford the premiums nor did they expect to save money by continuing their participation.

Figure 1. EPIC Enrollment, 1988–2002



Source: EPIC Annual Report to the Governor and Legislature: October 1999–September 2002.

Beginning in 1998, a number of legislative changes were implemented and an intensified outreach program was initiated that reversed the decline in enrollment in EPIC. Enrollments rose even more rapidly following a second round of expansive program changes in 2000. These factors, combined with the rapid increase in the cost of drugs and significant changes in the private insurance market (i.e., reduction in benefits or withdrawals from the market by Medicare HMOs), have driven enrollment up significantly. There were approximately 260,000 enrollees in early 2002, and enrollment is expected to continue to grow.

The program changes included:

- lowering the fees charged to enrollees;
- simplifying the structure of the program so that there were fewer fee and deductible categories;
- expanding the income eligibility levels to allow higher-income seniors to enroll, and
- reducing the number of copayment levels from five to four.

However, when the income eligibility levels were again expanded in 2001, so too were the *number* of income and deductible categories.

Another reason for declining enrollment was that the eligibility levels and corresponding fees had not been regularly adjusted to reflect increases in the cost-of-living. Based solely on these minimal increases in their Social Security payments, enrollees were becoming ineligible for the program. Legislation in 1998 gave the EPIC program's governing panel the authority to increase income limits for eligibility to reflect cost-of-living adjustments in Social Security income, although this provision is not automatic (Table 3). Cost-of-living adjustments can be made "when the State budget contains sufficient appropriations for such an adjustment."[4]

Table 3. EPIC Income Eligibility Changes, 1987–2001

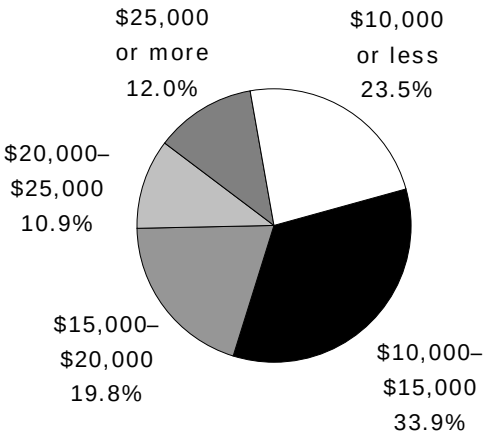
	MAXIMUM INCOME ELIGIBILITY LEVELS FOR EPIC			
	Comprehensive/Fee Program		Catastrophic/Deductible Program	
Year	Single	Married	Single	Married
1987	$ 9,000	$12,000	$15,000	$20,000
1994	10,500	14,000	17,500	23,000
1997	10,800	14,400	18,000	23,700
1998	10,800	14,400	18,500	24,400
2001	20,000	26,000	35,000	50,000

Source: New York State Department of Health.

Current Demographics, Utilization, and Drug Costs

The most recent administrative data available show that about one-quarter (24 percent) of EPIC enrollees have an annual income of $10,000 or less and another third (34 percent) have income between $10,000 and $15,000 (Figure 2). More than two-thirds are over the age of 75. Nearly 80 percent are women. As of September 2001, nearly one-quarter (24 percent) of the enrollees live in one of the five counties that make up New York City, and another 15 percent live in Nassau and Suffolk Counties.[5,6]

Figure 2. Income Distribution of EPIC Enrollees, 2001



Enrollees = 228,000 as of 9/30/01

Source: Unpublished data from the New York State Department of Health.

According to program statistics, the medication utilization rates of all EPIC enrollees exceeded those of the general elderly population, and more than 20 percent of program participants had exceptionally high annual prescription drugs costs of more than $3,000. Twelve percent had drug costs greater than $4,000, accounting for 37 percent of expenditures.

During the 2000–2001 program year, on average, an EPIC enrollee purchased 36 prescriptions at a cost of $2,283 per person.[7] This is significantly more than the average Medicare beneficiary with drug insurance, who purchases 24 prescriptions per year.[8] EPIC enrollees purchased 6.1 million prescriptions at a total cost of $390 million in program year 2000–2001.[9] Twenty-six percent of those costs ($101 million) were borne by elderly program enrollees, either in the form of annual fees, copayments, or deductibles; 62 percent ($242 million) were paid by the state; and the remaining 12 percent ($47 million) were covered by manufacturers' rebates. Significantly, as drug costs have risen dramatically in recent years, the share of total drug costs paid by EPIC enrollees has been reduced. In 1996–97, payments by EPIC enrollees covered 40 percent of the costs of the prescriptions purchased.

EPIC Benefit Design

Caps on Out-of-Pocket Copayments

New York's EPIC program is unique among state drug assistance programs in that it includes an out-of-pocket cap on copayments. That is, once an EPIC enrollee has spent a specified amount of money on copayments for prescription drugs in a given year, the EPIC program provides the drugs for the remainder of the year at no cost to the enrollee. The out-of-pocket cap varies depending on income and marital status, and can be adjusted on an annual basis, based on changes in the consumer price index or changes in the aggregate average cost of drugs purchased by the EPIC program, whichever cost increases are greater. Currently, seniors' out-of-pocket copayment expenses range from a maximum of 6 to 8 percent of their annual income, depending on marital status.

Prescription Drug Coverage from Other Sources

New York State seniors are not eligible for EPIC if they are enrolled in the Medicaid program or if they have other insurance coverage for prescription drugs that is either equal to or better than the coverage provided by EPIC. However, equivalent or better coverage is now defined by EPIC as insurance that covers 80 percent or more of the cost of the prescription. This provision of the EPIC law has become more important to seniors in recent years as private insurance plans, particularly Medicare HMOs, have reduced their coverage of prescription drugs either by increasing costs to consumers or by capping the amount of drug costs they will cover in a year. In fact, according to EPIC program officials, there are very few private plans that are now considered "better" than EPIC. Thus, many seniors can use EPIC to supplement their other coverage either by enrolling in EPIC once their other insurance reaches its limit, using EPIC to cover certain drugs their private plan will not cover, or simply supplementing the cost-sharing requirements of the other plans.[10]

The EPIC program has experienced an increase in the percent of enrollees with other private coverage, from 11 percent of enrollees in September 2000 to 21 percent by the beginning of 2002. (This information is reported voluntarily by enrollees, and is most likely underreported.) On average, seniors who have private insurance with benefit caps are reaching those caps after about five months, making the EPIC program an important safety net for the remainder of the year.[11]

For enrollees who have other sources of insurance, EPIC, by law, is the payer of last resort, and pharmacies are required to bill the private insurer first. The EPIC program will become more effective in collecting from other sources of insurance, since legislation enacted in January 2002 requires all New York State insurance plans to participate in a

"benefit recovery program" with EPIC. EPIC will be able to match its enrollees against the private insurance plan enrollees in order to determine if and how much the EPIC program should be reimbursed for payments EPIC made that should have been covered by the private insurance plan.

Drugs Covered and Use of Formularies

The EPIC program has an open formulary that covers all FDA-approved drugs, insulin, and insulin syringes. EPIC allows prescriptions to be written for up to a 30-day supply or 100 doses, whichever is greater (exceptions to these limits may be allowed under certain conditions). Both generic and brand-name drugs are covered, and the use of generics is not mandatory. However, New York State has a mandatory substitution law that requires a generic be dispensed when a multisource drug is prescribed, unless the physician indicates that a specific brand-name is required. In addition, since the four-tier copayment schedule requires higher copayments for higher-cost drugs, there is a financial incentive built in to use a lower-cost generic.

EPIC Program Operations

As already noted, the EPIC program has evolved considerably over its 15-year history, with the most extensive changes to the program occurring in the last two years, first as part of the 2000–01 New York State budget, and, most recently, as part of omnibus legislation signed into law on January 25, 2002. The changes made in the program over the last 15 years fall into a number of areas, some of which have already been discussed: expanding income eligibility levels and simplifying the eligibility, fee, and cost-sharing structures of the program. Other operational improvements include: taking advantage of data systems to improve safety and prevent adverse health effects and inappropriate utilization of medications; more effectively utilizing the purchasing power of the program to control costs to the state through a manufacturer rebate program; and improving the coordination of benefits with private insurance plans.

Program Administration

The EPIC program is administered by a committee, the Elderly Pharmaceutical Insurance Coverage Panel, composed of the following members: the commissioners of the Departments of Health and Education, the superintendent of Insurance, the directors of the State Office for the Aging and the Division of the Budget, and the deputy commissioner of the Office of Medicaid Management in the Department of Health. The commissioner of health and the director of the Office for the Aging co-chair the panel. In addition, there is an advisory committee to the panel that includes representatives of consumers, pharmacists, drug manufacturers, and pharmaceutical wholesalers. Currently,

the EPIC program is organizationally located within the Office of Medicaid Management in the Department of Health. In earlier years it was part of the Office of Continuing Care, a separate division within the Department of Health, because of concerns about the stigma associated with the Medicaid program and potential differences in programmatic philosophies.

The EPIC program does not utilize a pharmacy benefit manager in the same way most private insurance plans do, but instead contracts with a fiscal agent to perform the major operational functions required to run the program. The current contractor, First Health, has a five-year contract that was due to end in October 2002, but has been extended for one year because of the extensive amount of program changes, the rapid enrollment growth over the past several months, and a desire to maintain as much continuity as possible. First Health's responsibilities include processing enrollments for seniors and pharmacies, claims processing, pharmacy reimbursement, systems development and maintenance, outreach, and customer service. All decisions and policies about drug coverage, rebate agreements, reimbursement, and therapeutic drug monitoring are made by the EPIC program, not by First Health.

EPIC Enrollment Process

Seniors ages 65 and older can enroll in EPIC at any point during the year by filling out a relatively simple, two-page application form. The information required includes basic demographic data, whether applicants have any other insurance that covers drugs, whether they are enrolled in Medicaid, and their total annual income for the last calendar year. They must include proof of age with their application, but are not required to mail in proof of income. Instead, applicants are asked to sign an agreement attesting that the information they provide is accurate and are informed that they may be asked to verify their income through documentation.

Education and outreach are important steps toward ensuring that Medicare beneficiaries have the opportunity to enroll in EPIC. The EPIC program has received some criticism in the past regarding its limited outreach activities. One survey conducted in January 2001 in New York City found that, of all the respondents who were eligible but not enrolled in EPIC, one-third had never heard of the program.[12] In addition, a recent study that examined the prescription drug coverage, use, and spending of seniors in eight states, including four with pharmacy assistance programs (Illinois, Michigan, New York, and Pennsylvania), found that there is a widespread ignorance of the existence of the program. In the New York sample, 42 percent of respondents reported they had not heard of EPIC. This compares poorly with Pennsylvania, for example, where only 16 percent of respondents had not heard of their pharmacy assistance program.[13]

Therapeutic Drug Monitoring

The EPIC program includes both prospective and retrospective therapeutic drug monitoring programs to help ensure that medications are being used appropriately. The programs guard against drug interactions, adverse reactions, overutilization, and therapeutic duplications. The retrospective review program was implemented in 1991 and the prospective program in 1992. Both were developed and are monitored by EPIC's Technical Advisory Group, which includes pharmacologists and pharmacists with particular expertise in the health care needs of the elderly population. The prospective review system notifies pharmacists of potential medication problems at the point when a prescription is being filled. If the computer system in the pharmacy indicates that the drug should be denied, the pharmacist can check with the senior or his or her provider, and has the option to override the denial if the prescription is appropriate. In 2000–01, more than 231,000 prescriptions were suspended at the point-of-service. After review by a pharmacist, about 59 percent (135,453) of these prescriptions were not filled because of concerns about adverse events.

The retrospective utilization review system monitors all prescriptions purchased by seniors in EPIC to screen for selected combinations of medications and overutilization that may cause serious health complications. Informational letters and clinical profiles for selected cases are then sent to the affected seniors. Although the total number of cases reviewed is small, EPIC consistently has received positive feedback from health care providers for this system, and has found a significant change in therapy for 30 percent of the cases reviewed.[14]

Rebate Agreements and Reimbursement Strategies

When EPIC was enacted, it did not include a requirement for manufacturers to provide rebate payments to the program. Gradually over the last decade, EPIC's legislation has been amended to first include, and later strengthen, a requirement for rebate payments from pharmaceutical manufacturers in exchange for coverage of their drug products. The changes have resulted in significant program savings, which have allowed EPIC to expand enrollment and to defray costs for seniors.

The first requirement for a rebate agreement was enacted in 1991 and modified in 1996, 2000, and, most recently, January 2002. The rebate requirement was initially based on the basic rebate requirement in the Medicaid program, though the rebates required were generally smaller than those in the Medicaid program. Since April 2002, EPIC has been aligned with the federal Medicaid statute that requires a rebate of 11 percent of the Average Manufacture Price (AMP) per unit for generic drugs, and a rebate of the greater

of 15.1 percent of AMP per unit, or the difference between the AMP and the best price per unit, for brand-name drugs.

Medicaid law also requires an additional rebate for brand-name drugs with price increases exceeding growth in the consumer price index (CPI). The base year for these calculations in the Medicaid law is 1990, and this base is fixed. In October 2000, a similar requirement was added to the EPIC program, but went further than Medicaid by requiring these additional rebates on both brand-name and generic drugs. On the other hand, the EPIC law was weaker than the Medicaid law in that it set the base quarter beginning October 1, 1998, and required it to be updated every two years.

However, amendments passed in January 2002 again modified EPIC and placed tighter controls on manufacturers' price increases by eliminating the "rolling base" requirement. These recent changes also eliminated the requirement that additional rebates be paid on generic drugs that have price increases greater than CPI. Thus, the EPIC rebate requirement now fully conforms to the Medicaid rebate requirements.

Additional changes effective in April 2002 also brought reimbursement for pharmacies more in line with federal Medicaid policies, and are expected to result in savings to the state. Previously, pharmacies were reimbursed differently depending on whether they were independent or part of a chain in which the total prescription volume was at least 100,000 prescriptions. The amount of reimbursement for independent pharmacies was as much as the Average Wholesale Price (AWP); for chain pharmacies it was AWP minus 5 percent. In addition, pharmacies were paid a dispensing fee of $2.75 per prescription, rising to $3.00 if they provided a series of special services to EPIC enrollees (24-hour emergency prescription service, 24-hour emergency free delivery service, maintenance of patient drug profiles, and patient counseling). Under the new regulations, differential payments for independent pharmacies have been eliminated, as have the differences in the dispensing fee for pharmacies providing special services. All pharmacies are paid the Federal Upper Limit for generics, plus a dispensing fee of $4.50, and the AWP minus 10 percent for brand-name drugs, plus a dispensing fee of $3.50.

Comparisons with Other State Low-Income Drug Assistance Programs

As of January 2002, 31 states have passed some form of legislation or authorized the establishment of drug assistance programs for low-income Medicare beneficiaries.[15] Over the past several years, legislative activity in this area has been a top priority among states. In 1998, there were only 12 such programs in existence. States have been "all over the map" in terms of their approaches to assisting Medicare beneficiaries with prescription drug costs, although at this point the vast majority of them do so through direct subsidy

programs such as EPIC. Eligibility levels, drugs covered, use of formularies, cost-sharing features, and other aspects vary greatly.

Because the programs vary so significantly, it is difficult to make direct comparisons among the states. That being said, New York's EPIC program currently has one of the most generous eligibility levels (measured as a percentage of poverty).‡ After the recent income eligibility expansions, enrollment in the program rose to more than 260,000 by early 2002, making EPIC the program that covers the largest number of individuals of all the states. New Jersey and Pennsylvania also serve a large number of enrollees, and until very recently had higher enrollments than New York. However, it is important to be cautious when comparing enrollment levels among states or gauging enrollment as a percent of Medicare beneficiaries in a state. These measures do not take into account the extent of existing private or Medicaid prescription drug coverage among the Medicare population, nor do they take into account the comprehensiveness of the state drug benefit (Table 4).

Table 4. Enrollment in Selected State Direct Benefit Programs, as a Percentage of Medicare Enrollment, 2001

State	Year 2001 Enrollment	Number of Medicare Beneficiaries in State, 2001	Enrollment as Percent of Medicare Beneficiaries in State
Connecticut	33,850	516,359	6.6%
Delaware	13,577	113,967	11.9%
Massachusetts	72,866	961,409	7.6%
Michigan★	46,000	1,207,120	3.8%
Minnesota★	4,500	586,147	0.8%
New Jersey	188,000	1,207,663	15.6%
New York★	257,000	2,350,681	10.9%
Pennsylvania★	234,711	1,856,457	12.6%
Rhode Island★	33,000	147,082	22.4%
Vermont	14,563	90,049	16.2%

★ These state programs cover seniors only. Medicare enrollment listed for these states includes the elderly only.

Source: National Conference of State Legislatures' website: State Senior Pharmaceutical Assistance Programs, http://www.ncsl.org/programs/health/drugaid.htm. State Medicare enrollment data are from Centers for Medicare and Medicaid Services website: Medicare County Enrollment as of July 1, 2001, updated 3/2002, http://www.cms.hhs.gov/statistics/enrollment/county2001/default.asp.

‡ There are several good resources that summarize in chart form the eligibility requirements and benefits of each state program. For example, see National Conference of State Legislatures website: http://www.ncsl.org/programs/health/drugaid.htm.

New York has no annual benefit cap (approximately one-quarter of all the state programs have such caps), and provides additional protection to enrollees by including a maximum cap on out-of-pocket costs, after which EPIC will pay the full costs of purchased prescriptions. Many states do not have that kind of catastrophic protection, and those that have it do not go as far as New York does to cover the full costs of drugs purchased over the cap. Some states have chosen to cover only certain drugs, or drugs purchased to treat certain health conditions. New York's EPIC program has neither of those limitations. Compared with many other states, it has a sophisticated therapeutic drug monitoring program that provides an important safety mechanism for seniors.

However, as emphasized throughout this discussion, the EPIC program has a relatively complex eligibility, fee, deductible, and copayment structure that have been barriers to enrollment. Moreover, the premium and cost-sharing requirements are greater than a number of other states. In fact, data from the eight-state survey of Medicare beneficiaries showed cost to be a significant factor in whether someone was enrolled in EPIC. When asked why they were not enrolled in their state's pharmaceutical assistance program, 10 percent of New York respondents with income between 100 and 200 percent of poverty cited cost, compared with only 2 percent of Pennsylvania respondents.[16]

Finally, New York is one of about half the states with pharmaceutical assistance programs that do not cover the Medicare disabled population, although legislation to cover this population has been introduced for many years in the New York State Legislature.

POLICY OPTIONS TARGETED AT STRENGTHENING AND EXPANDING EPIC

Comparing EPIC with other state programs highlights some of the major issues surrounding the future of the program. These issues revolve around the dilemma of adverse selection in programs that cover only prescription drugs, the policy trade-offs states make, and the political context surrounding these drug program policies.

New York was not the first state to implement a program to help Medicare beneficiaries with prescription drug costs, but it was one of earliest to do so, and it is now serving one of the largest populations. State policymakers and administrators have learned some important lessons and over time have made adjustments to strengthen the program and make it more efficient and cost-effective. Yet, there are constant balancing efforts between making the program as comprehensive as possible, meeting the significant prescription drug needs of many New York Medicare beneficiaries, and containing costs to the state. This last section outlines policy options aimed at strengthening and expanding the current program.

Expand EPIC to Cover the Medicare Disabled Population

The EPIC population could be expanded by making Medicare beneficiaries with disabilities eligible for the program. A number of state drug programs cover the under-65 Medicare disabled population, including Connecticut, Delaware, Illinois, Maine, Massachusetts, New Jersey, Vermont, and others. Over the years, legislative proposals have been introduced to expand EPIC to the disabled, but none has yet been passed by the legislature.

The problems of persons with disabilities are especially severe. While there are far fewer disabled Medicare beneficiaries than seniors, their medical needs—including the need for prescription drugs—may be greater, and their access to necessary medical services is often even more limited. Especially in New York State, where a comparatively high proportion of persons with disabilities qualify because of HIV infection, disabled Medicare beneficiaries who do not qualify for Medicaid or the AIDS Drug Assistance Program (ADAP) funding may find themselves in especially dire straits.

Thus, in New York State, there is a particularly anomalous situation in which several thousand Medicare beneficiaries continue in individual Blue Cross Blue Shield insurance plans, at considerable cost to themselves and Blue Cross Blue Shield, because that is the only way they can maintain prescription drug coverage. Most of these beneficiaries are HIV-positive individuals who can no longer work because of their medical conditions, but who still have too many assets to qualify for Medicaid or ADAP. In addition, nationally, the single largest category for Social Security Disability Insurance awards is for mental illnesses, which can often be significantly improved and managed through pharmaceutical therapies.

Including the Medicare disabled population in the EPIC program may also help to prevent some persons with disabilities from spending down to full Medicaid eligibility. Although this would vary depending on the individual's health, employment, and insurance status, it is likely that assistance through the EPIC program could prevent a further decline in income and health status for a significant number of individuals with disabilities.

Continue to Expand the Existing Pool of Individuals Eligible for EPIC by Increasing the State Subsidy and Simplifying the Eligibility and Program Structure

The experience of individual Blue Cross plans, Medigap, Medicare HMOs, and other state plans, as well as with EPIC itself, reflects the basic and in some ways insoluble dilemma in the design of prescription drug insurance: drug coverage is especially vulnerable to adverse selection. In other words, beneficiaries especially at risk for high-cost drug utilization know who they are, and are far more likely to enroll in such plans than

are lower-risk beneficiaries. The more policymakers attempt to limit their financial exposure to this problem by developing intricate systems of premiums, copayments, deductibles, and total coverage limits, the more Medicare beneficiaries—who are extremely price-sensitive because their incomes are limited and generally fixed—continue to "antiselect" against the plan. That is, only those who really need the coverage buy it, as its perceived value for infrequent users of prescription drugs is reduced.

This clearly occurred in the early years of EPIC and through the mid- and late 1990s, when the program found itself primarily serving a narrower than expected subgroup of low-income seniors with very high drug costs. Although this is an important and vulnerable group of seniors, it leaves large numbers of individuals at risk for prescription drug costs that can be extremely hard to manage.

This problem of risk selection for prescription drug insurance can create a "death spiral": each year, as premiums go higher and higher, only more and more high-risk individuals find it economically rational to enroll. The costs they generate drive the following year's premiums even higher, until the market collapses entirely. The case with EPIC is somewhat different, in that premiums and cost-sharing have not necessarily been raised substantially, but instead were initially too high to attract a balanced pool of high- and low-cost users. Regardless, the beneficiary costs and the design complexity of the program still result in the state spending a greater proportion of dollars on a shrinking pool of high-cost users.

In general, the kind of adverse risk selection that produces a death spiral can be prevented by finding ways to ensure that the pool of enrollees includes a manageable balance between high- and low-cost users, thus stabilizing the financing of the program as well as benefiting greater numbers of seniors who need assistance. There are a number of different policy approaches that can be used to achieve this. First, premiums should be low enough, and benefits sufficiently generous, so that enrollment is attractive even for relatively low-risk individuals. In the EPIC program, this could be accomplished by raising the portion of the premium that is subsidized. This might attract enough low-cost enrollees to reduce the amount spent per enrollee. In fact, New York State took a step in this direction in 2001 when, partially by utilizing tobacco settlement funds, it expanded EPIC's income eligibility levels and lowered fees and cost-sharing.

However, the state could go further by dismantling the complex structure of premiums, coinsurance, and deductibles now built into EPIC. Further reducing the number of income and corresponding fee categories, raising the income eligibility level to

at least 300 percent of poverty, and reducing the number of copayment categories could go a long way toward expanding the pool of enrollees. Legislative proposals along these lines have been introduced on numerous occasions, but either have not been passed or have not been fully implemented.

Further Strengthen the Rebate Program

Expanding the size of the insured pool under EPIC also might give the state more options in addressing another major problem with prescription drug insurance, that of obtaining the most reasonable prices. Pricing of prescription drugs is an extremely complex and dynamic phenomenon. Most large purchasers in both the public and private sectors pay substantially lower prices than do uninsured retail customers, either because they negotiate lower prices directly from the pharmaceutical companies or their distributors or because they operate some sort of rebate system, as EPIC now does. The more enrollees in the EPIC program, the more bargaining leverage the state should have to negotiate rebates or discounts—and the more politically controversial such discounts will be. The highly negotiated and rapidly changing environment of drug pricing and discounting also makes it difficult for policymakers to estimate accurately how much an expansion of benefits and/or the number of beneficiaries would actually cost, which can in itself become a barrier to policy change.

The latest amendments to the EPIC program have addressed issues regarding the manufacturer rebate program, making some strides in leveraging better rebates that will result in savings for the state. EPIC law now requires manufacturer rebates—both basic rebates and additional rebates for price increases greater than increases in the consumer price index—in line with the Medicaid program. However, as noted above, at one point EPIC went further than the Medicaid program in one area, requiring additional rebates on both brand-name and generic drugs. Although this provision was eliminated in the most recent legislation, signed in January 2002, it could be restored to save even additional state dollars, which could then be used to expand the program to other populations and defray some overall costs to the state.

Improve Outreach and Coordination Efforts

When the EPIC program expanded and intensified their outreach efforts in 1998, the response was a significant increase in enrollment. EPIC should have sufficient administrative funds to carry out such activities on a regular basis. In addition, it could take advantage of administrative coordination opportunities with other state or joint state and federal programs that target similar populations. Specifically, EPIC could initiate a program that would regularly match its enrollment files to those of the Medicaid program

to identify people who are enrolled in the Medicare buy-in programs but not in EPIC, and then provide them with information on how to apply to EPIC.

Earmark Any Additional Federal Dollars for Drug Coverage for Medicare Beneficiaries for the EPIC Program

The governor and the New York State Legislature should position the EPIC program to take advantage of any new federal dollars that may become available to states to cover prescription drug costs for Medicare beneficiaries.

Continue to Explore State Purchasing Pools

Finally, the state of New York should continue to explore options for intrastate, multi-agency, or multi-state purchasing pools that would result in the ability to negotiate better prices on drugs purchased from manufacturers, not only for the EPIC program, but for all state programs involved in buying prescription drugs (e.g., Medicaid, ADAP, and state employee programs). Essentially, to help control prescription drug costs, states are investigating and experimenting with purchasing alliances to negotiate pharmaceutical prices, discounts, and rebates with manufacturers. Many states have already begun crafting and implementing these types of programs, which are strongly opposed by the pharmaceutical manufacturer industry, and the verdict is still out on many of the legal and constitutional challenges they face.

CONCLUSION

For 15 years the EPIC program has attempted to meet an important need for a vulnerable population. Although there has been much debate, seemingly endless research, and a good deal of rhetoric on the national level to address the problem of the lack of a drug benefit in the Medicare program, comprehensive federal legislation providing Medicare beneficiaries with a plan for covering their prescription drug costs is still under discussion as of this writing. Plans currently being considered leave gaps in coverage for low-income beneficiaries. These realities—combined with the realities of frail, elderly, disabled, and low-income Medicare beneficiaries being forced to choose between buying groceries or buying drugs, or skipping doses to make a prescription last longer—make it critical that the EPIC program remain a viable option for residents of New York State. Although providing prescription drug benefits is challenging and certainly complex, New York has a number of different opportunities to exhibit leadership in this area.

APPENDIX A. ESTIMATES OF DRUG COVERAGE IN NEW YORK: THE MEDICARE CURRENT BENEFICIARY SURVEY

This report presents estimates of rates of drug coverage for Medicare beneficiaries living in New York, based on data from the Medicare Current Beneficiary Survey (MCBS). The MCBS is a continuous, multipurpose survey of a representative national sample of the Medicare population, conducted by the Office of Strategic Planning of the Centers for Medicare and Medicaid Services through a contract with Westat. The MCBS covers the entire Medicare population, and follows people over time, whether they are living in the community or in an institution.

The MCBS is the most comprehensive source of data on the Medicare population. However, because of limitations in its sampling methodology, caution must be applied to state-level analyses of its data, such as those presented in this paper. The MCBS is designed to be representative of the Medicare population as a whole, and is not specifically designed to be used for state-level analyses.

Sampling begins by limiting the pool to 107 geographic primary sampling units (PSUs), consisting of groups of counties chosen to represent the nation. Within PSUs, the sample is further restricted to addresses within certain geographic sub-areas corresponding to postal zip codes. Beneficiaries residing in these areas are then selected by systematic random sampling within age strata. Sampling rates vary by age (0–44, 45–64, 65–69, 70–74, 75–79, 80–84, and 85 or over) in order to over-represent those under 65 years of age and those 85 years of age or over by a factor of about 1.5. The sample size is limited based on available budget appropriations, and includes approximately 12,000 beneficiaries.

The data is weighted in two ways. The first is a set of general purpose weights that reflect the probabilities of selection for the sample, adjusted for under-coverage and non-response. The weights have also been post-stratified for age, sex, region, metropolitan residence, and year of entry into the sample. The second part of the estimation program is a set of replicate weights (using balanced repeated half samples) that are appropriate to calculate variances for data elements collected in a sample with a complex cluster design such as that of MCBS.

Therefore, analyses conducted on smaller subgroups, such as states, may not be representative of those subgroups. However, with those caveats in mind, a case can be made that the New York MCBS sample is reasonably representative of the New York Medicare population. First, based on selected demographics, the MCBS New York population is similar to other data sources (Table A-1). Second, the MCBS draws its

sample from 30 New York counties, representing about half of all the counties in New York. The number of Medicare beneficiaries living in these 30 counties represents approximately 80 percent of all New York Medicare beneficiaries (Table A-1).

Table A-1. Selected Demographic Comparison for New York: MCBS vs. Other Data Sources

	MCBS, 1999	Other Data Source
Total Medicare Beneficiaries	2,640,612	2,694,015[a]
Gender		
Female	58%	58%[b]
Male	42%	42%[b]
Age		
0-64	14%	14%[c]
65-74	43%	44%[c]
75-84	32%	30%[c]
85+	11%	12%[c]

[a] Enrollment as of July 1, 1999, updated 3/2000. CMS Website.

[b] Henry J. Kaiser Family Foundation, 1999, State Health Facts Online.

[c] Henry J. Kaiser Family Foundation, 1998, Medicare State Profiles.

Table A-2. Counties Included in New York MCBS Sample

County	Medicare Beneficiaries in County
Albany	**45,195**
Allegany	7,888
Bronx	**145,145**
Broome	**38,140**
Cattaraugus	14,541
Cayuga	12,701
Chautauqua	25,821
Chemung	16,581
Chenango	8,823
Clinton	**10,703**
Columbia	11,084
Cortland	**6,955**
Delaware	9,158
Dutchess	**39,721**
Erie	168,739
Essex	7,269
Franklin	**7,714**
Fulton	**9,255**
Genesee	9,791
Greene	8,567
Hamilton	1,248
Herkimer	11,886
Jefferson	15,149
Kings	**291,465**
Lewis	**4,012**
Livingston	8,725
Madison	**10,055**
Monroe	**107,977**
Montgomery	**11,480**
Nassau	**219,926**
New York	**209,874**
Niagara	39,463
Oneida	**45,090**
Onandaga	**71,885**
Ontario	14,939
Orange	**41,060**

County	Medicare Beneficiaries in County
Orleans	6,159
Oswego	**17,331**
Otsego	10,631
Putnam	**10,200**
Queens	**282,485**
Rensselaer	**23,641**
Richmond	**57,651**
Rockland	**38,885**
St. Lawrence	18,018
Saratoga	**25,919**
Schenectady	**29,040**
Schoharie	5,224
Schuyler	2,944
Seneca	5,468
Steuben	17,142
Suffolk	**193,418**
Sullivan	12,642
Tioga	**7,337**
Tompkins	10,344
Ulster	26,867
Warren	11,017
Washington	9,520
Wayne	**14,801**
Westchester	**138,356**
Wyoming	6,100
Yates	4,467
Unknown	383
Total NY Medicare Beneficiaries	2,694,015
Total NY Medicare Beneficiaries in Sampled Counties	2,154,716
Percent of NY Medicare Beneficiaries in Sampled Counties	80%

Note: Bolded counties are counties from which the MCBS sample was drawn (30).

APPENDIX B. FEES, DEDUCTIBLES, AND COPAYMENTS FOR SINGLE AND MARRIED EPIC ENROLLEES, BY INCOME

EPIC Fee Plan
2002

Annual Income	Single Seniors Age 65 and Older	Married Seniors Age 65 and Older
	Annual Fee	Annual Fee Per Person
Up to $6,000	$8	$8
$6,001-$7,000	$16	$12
$7,001-$8,000	$22	$16
$8,001-$9,000	$28	$20
$9,001-$10,000	$36	$24
$10,001-$11,000	$40	$28
$11,001-$12,000	$46	$32
$12,001-$13,000	$54	$36
$13,001-$14,000	$60	$40
$14,001-$15,000	$80	$40
$15,001-$16,000	$110	$84
$16,001-$17,000	$140	$106
$17,001-$18,000	$170	$126
$18,001-$19,000	$200	$150
$19,001-$20,000	$230	$172
$20,001-$21,000	Not Eligible, See Deductible	$194
$21,001-$22,000	Not Eligible, See Deductible	$216
$22,001-$23,000	Not Eligible, See Deductible	$238
$23,001-$24,000	Not Eligible, See Deductible	$260
$24,001-$25,000	Not Eligible, See Deductible	$275
$25,001-$26,000	Not Eligible, See Deductible	$300
Over $26,000	Not Eligible, See Deductible	Not Eligible, See Deductible

EPIC Co-payment Schedule
Per Prescription, 2002

Prescriptions Costing…	Enrollees Pay…
Up to $15	$3
$15.01 to $35	$7
$35.01 to $55	$15
Over $55	$20

EPIC Deductible Plan
2002

Annual Income	Single Seniors Age 65 and Older	Married Seniors Age 65 and Older
	Annual Deductible	Annual Deductible Per Person
Under $20,000	See Fee Plan	See Fee Plan
$20,001-$21,000	$530	See Fee Plan
$21,001-$22,000	$550	See Fee Plan
$22,001-$23,000	$580	See Fee Plan
$23,001-$24,000	$720	See Fee Plan
$24,001-$25,000	$750	See Fee Plan
$25,001-$26,000	$780	See Fee Plan
$26,001-$27,000	$810	$650
$27,001-$28,000	$840	$675
$28,001-$29,000	$870	$700
$29,001-$30,000	$900	$725
$30,001-$31,000	$930	$900
$31,001-$32,000	$960	$930
$32,001-$33,000	$1,160	$960
$33,001-$34,000	$1,190	$990
$34,001-$35,000	$1,230	$1,020
$35,001-$36,000	Not Eligible	$1,050
$36,001-$37,000	Not Eligible	$1,080
$37,001-$38,000	Not Eligible	$1,110
$38,001-$39,000	Not Eligible	$1,140
$39,001-$40,000	Not Eligible	$1,170
$40,001-$41,000	Not Eligible	$1,200
$41,001-$42,000	Not Eligible	$1,230
$42,001-$43,000	Not Eligible	$1,260
$43,001-$44,000	Not Eligible	$1,290
$44,001-$45,000	Not Eligible	$1,320
$45,001-$46,000	Not Eligible	$1,575
$46,001-$47,000	Not Eligible	$1,610
$47,001-$48,000	Not Eligible	$1,645
$48,001-$49,000	Not Eligible	$1,680
$49,001-$50,000	Not Eligible	$1,715
Over $50,000	Not Eligible	Not Eligible

APPENDIX C. PRESCRIPTION DRUG COVERAGE: SOURCES AND COVERAGE RATES

Much of the current debate over adding prescription drug coverage to Medicare was catalyzed by new analyses documenting trends in the sources of prescription drug coverage for Medicare beneficiaries, the gaps in coverage, and the extent of protection, or lack of protection, provided by those sources. Just as federal policymakers need to take into account the extent of the need for drug coverage in debating a Medicare drug benefit, states also must consider both existing rates of private coverage among their Medicare population and the extent of protection that coverage provides as they design drug assistance programs for low-income Medicare beneficiaries. In order to provide a context for the discussion of New York's EPIC Program, estimates of rates of drug coverage in New York and details about what has been happening to that coverage in recent years are presented below.

Estimates of Prescription Drug Coverage for Medicare Beneficiaries in New York

Medicare beneficiaries, in New York and elsewhere, may have access to insurance coverage for prescription drugs (1) through group supplemental insurance provided as a retiree benefit by former employers; (2) through individually purchased Medicare supplemental policies, called Medigap; (3) as part of their benefit package when they enroll in a Medicare-certified health maintenance organization (HMO); (4) through Medicaid; and/or (5) through other public programs such as the Veterans Administration or Department of Defense coverage of military retirees, and state-funded programs such as EPIC.

Because of limitations in data sources and survey methodology, it is difficult to get precise state-level estimates on all sources of prescription drug coverage for Medicare beneficiaries. However, estimates from the Medicare Current Beneficiary Survey show that rates of drug coverage for Medicare beneficiaries in New York are most likely slightly higher than the nation as a whole. These estimates are reasonable, given the existence of EPIC, a relatively expansive Medicaid program, a large federal and state government workforce, and a strong labor union presence that makes retiree health insurance coverage more prevalent than in some other states.[§]

As shown in Table A-3, 73 percent of all Medicare beneficiaries had at least some coverage for prescription drugs at some point during 1998, while 83 percent of beneficiaries had coverage in New York in 1999. In general, New Yorkers are more likely

[§] Note: See Appendix A for discussion on reliability of New York Medicare Current Beneficiary Survey drug coverage estimates.

than Medicare beneficiaries nationally to have prescription drug coverage. New Yorkers are significantly more likely than the average Medicare beneficiary to have coverage through a former employer, and are also more likely to have coverage for prescription drugs through Medicaid. In 1999, New Yorkers were about on par with the national averages for both Medigap and HMO drug coverage. They are currently experiencing similar reductions in drug coverage through those sources, along with most Medicare beneficiaries throughout the country.

Table A-3. Distribution of Medicare Beneficiaries Living in the Community, by Type of Supplemental Insurance and Drug Coverage Status, United States, 1998, and New York, 1999

Source of Supplemental Coverage	Percent of Total US Beneficiaries with Drug Coverage, 1998[a]	Percent of Total NY Beneficiaries with Drug Coverage, 1999[a]
All beneficiaries	100%	100%
All beneficiaries, all sources of coverage	73	83
Medicare risk HMO	15	14
Medicaid	12	15
Employer-sponsored	33	39
Individually purchased only (Medigap)	10	11
All other[b]	3	3
No coverage—fee-for-service only	27	17

[a] Most recent data available from the Medicare Current Beneficiary Survey (MCBS). Data are based on the non-institutionalized population (both elderly and persons with disabilities), which was enrolled in Medicare at some point during the year. Each person has been assigned to one supplementary insurance category, but they may or may not obtain their drug insurance from that source. See Appendix A for discussion on reliability of MCBS for estimates of drug coverage rates in New York.

[b] Other category includes other public programs such as Veterans Affairs, Department of Defense, state pharmacy assistance programs (in New York, EPIC), and non-risk HMOs.

Source: J. Poisal and L. Murray, "Growing Differences Between Medicare Beneficiaries With and Without Drug Coverage," *Health Affairs* (March/April 2001): 74–85; and unpublished data from the 1999 Medicare Current Beneficiary Survey.

Private Sources of Prescription Drug Coverage in New York

Medicare Managed Care Plans

Medicare beneficiaries may obtain drug coverage through enrollment in a managed care plan (Medicare+Choice). Since outpatient prescription drugs are not a covered Medicare benefit, risk-based Medicare managed care plans are not obligated to provide drug benefits. However, plans can choose to provide these benefits to their Medicare members through a variety of means.

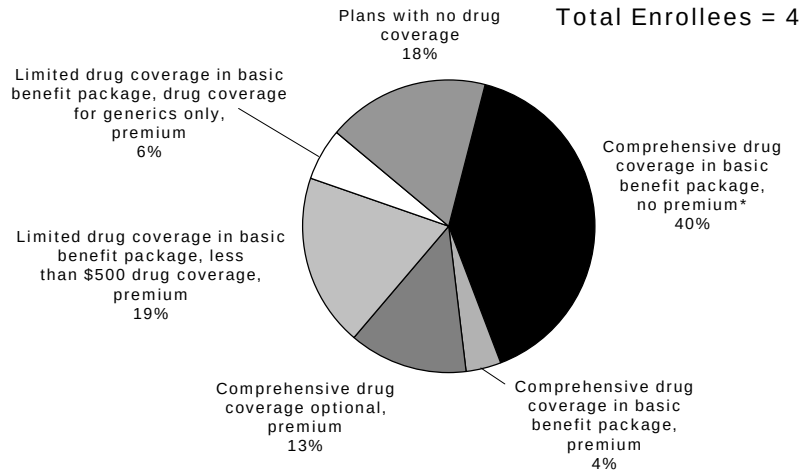
Medicare pays managed care plans based on its local fee-for-service expenditures, and Medicare's costs in New York City are the highest in the country. As a result, New York's managed care plans receive Medicare's highest per-enrollee rates. Medicare managed care emerged as a major source of drug coverage to seniors in New York in the mid-1990s, particularly in New York City and its suburbs. Medicare managed care covered only 5 percent of New York City Medicare enrollees in 1993 but almost one of five by 1999, with most enrollees receiving prescription drug coverage.[17]

In 1997, the Balanced Budget Act changed the payment levels to Medicare HMOs. As a result of these changes and other market factors, many plans cut back on drug coverage or began to charge substantial premiums for this coverage. Plans in the New York City suburbs faced significant payment reductions; several plans pulled out of Nassau, Suffolk, and Westchester Counties, affecting more than 180,000 enrollees in 1998–2001. All of the plans that stayed in Long Island or the northern suburbs of New York City had begun to charge a substantial premium for drug coverage by 2001.

In 2002, there were 14 Medicare+Choice HMO contracts operating in New York State. Eleven of these plans offered some form of drug coverage to enrollees, and all required copayments for each prescription filled. Based on 2001 enrollment data, there were approximately 420,144 Medicare beneficiaries in New York enrolled in Medicare HMOs. As of November 2001, approximately 18 percent (74,384) were enrolled in plans with no options for drug coverage. Forty percent (168,376) were enrolled in HMOs that offered prescription drug coverage in their basic benefit package for no additional premium. The remaining enrollees were in plans that offered some level of coverage for a separate premium, or through a flexible benefits package (Figure A-1).[18]

Almost all enrollees with drug coverage outside of New York City pay a premium ranging from $100 to $200 a month. Increasingly common are the preferred or required use of plan-approved prescription drugs from a formulary and the use of generic drugs. By 2001, all Medicare managed care plans throughout the state had imposed some sort of limits on drug coverage by one of three methods: dollar caps on all drug coverage by the year or the quarter, dollar limits on non-formulary brand-name drugs paired with unlimited coverage for generic and formulary drugs, or coverage of only formulary and generic drugs. Such restrictions are almost always more restrictive outside of New York City: for example, benefit limits range from $750 to $1,000 in New York City, but range from $250 to $500 in the suburbs and upstate. The Health Insurance Plan (HIP) of New York and Oxford, two large plans, offer coverage of brand-name prescriptions only to their New York City enrollees. Three plans—HIP, Empire, and the much smaller Wellcare—charge premiums outside of the city but not within it.

Figure A-1. Distribution of Enrollment in Medicare HMOs, by Type of Drug Coverage Offered, New York, 2001



* Note: Available only in NYC and Nassau County.

Source: Unpublished data from the Centers for Medicare and Medicaid Services and Medicare Compare, 2002.

Medigap

Federal legislation passed in 1990 and implemented in 1992 standardized new Medigap plans, so that there are 10 standardized Medicare supplemental policies (referred to as plans A through J), only three of which include a prescription drug benefit. This Medigap drug coverage is limited: Plans H and I require beneficiaries to meet a $250 deductible and then cover only 50 percent of the cost of prescription drugs up to a maximum annual benefit of $1,250; Plan J has the same requirements, but has a maximum annual benefit of $3,000.

The extent of drug coverage in policies issued before 1992 is difficult to determine. Estimates of the percent of policies with drug coverage vary widely, and information on the comprehensiveness of that coverage is almost nonexistent. The New York State Insurance Department reported 188,500 pre-standardization Medicare supplemental policies in force in 1998, but the department cannot determine what proportion of these pre-standardized policies includes drug coverage.[19] However, there is some evidence that many of these policies may at least include minimal drug coverage.[20] Based on the most recent available data from the New York State Insurance Department, in 1998 there were 65,900 standardized policies in force that included drug coverage. Thus, if you make the generous assumption that the pre-standardized policies include some drug coverage, the total number of people with drug coverage through Medigap in 1998 was 254,400. Although more recent data that break out the number of policies

within each plan were unavailable, since 1998 there has been a 15 percent reduction in the total number of Medicare supplemental policies in force in New York (Table A-4).[21]

Table A-4. Standardized and Pre-Standardization Medigap Policies in Force as of January 1, New York State, 1996–1998 (one person insured per policy)

Plan	1996	1997	1998
A–G	407,900	380,600	351,400
H*	48,300	46,000	42,800
I*	21,000	20,000	19,200
J*	4,800	4,300	3,900
Total Standardized	482,000	450,900	417,300
Total Pre-Standard**	250,900	223,400	188,500
Total Policies	732,900	674,300	605,800

* Includes drug coverage.
** May include some drug coverage.
Source: New York State Department of Insurance, 1999.

Unlike most other states, New York has in place a number of insurance regulations that provide important protections for consumers in this market. For example, state law requires continuous open enrollment for Medigap plans, mandating any insurer writing Medigap policies to accept new applicants at any time throughout the year. In addition, insurers may not deny the issuance of a policy or make any premium rate distinctions on the basis of health status, claims experience, or medical condition. Moreover, although federal law only requires insurers to sell policies to Medicare beneficiaries age 65 and older, New York also guarantees access to beneficiaries who are eligible for Medicare because they are disabled (under age 65). However, despite this policy, the vast majority of Medigap policyholders in New York are over the age of 65: in 1998, fewer than 3 percent were under age 65.[22]

In New York, the choice of insurers among plans offering prescription drug benefits is more limited than the choices available for the seven other Medigap plans. In 2002, seven insurers offered a policy under Plan H, only two under Plan I, and no insurer currently offers Plan J—with the most generous prescription drug coverage—to individuals in New York. Nearly all of these insurers run only closed products, renewing coverage for current policyholders but not issuing any new coverage. A recent study showed that, in 1999, there were only two insurers offering open products (that is, currently selling new policies) under Plan I.[23] This clearly indicates that, before even

considering the affordability of Medigap policies, there is significantly limited access to prescription drug coverage through Medigap policies for new enrollees.

Nationally, the monthly premium costs for Medigap plans with prescription drug coverage are high, and tend to be much higher than those for other Medigap plans. Some analyses have shown that insurance carriers are setting premium rates to account for the presence of adverse selection (the tendency of those with high expected drug costs to enroll for that coverage), and most likely also to account for the rising cost of prescription drugs.[24] New York appears to be consistent with national trends: in 2002, the average monthly premiums for Plans H and I were approximately $208 and $212, respectively. (No insurer offered Plan J in 2002.) The average premium for plans without prescription drug coverage ranged from $93 for Plan A to $169 for Plan F. Plans E and H offer comparable benefits with the exception of drug coverage, but consumers pay, on average, 50 percent more for the plan with drug coverage: Plan E has an annual premium of $1,657, compared with $2,493 for Plan H. Therefore, on average, enrollees in Plan H are paying $836 more in premiums for a benefit that covers only $1,250 worth of drugs; subtracting the additional premiums leaves enrollees with a $414 benefit. With the additional premiums plus the $250 deductible, an enrollee has to spend at least $1,086 before he or she begins to receive any drug coverage (at a 50 percent cost-sharing rate).

The premiums for plans offering prescription drug benefits also have been rising more quickly than the premiums for other Medigap plans. For example, between 1998 and 2002, the average annual rate of growth for premiums for Plan A–E policies was 7 percent, compared with 10 percent for Plan H policies.[25]

Employer-Sponsored Retiree Coverage

New York Medicare beneficiaries are more likely to have prescription drug coverage than the average Medicare beneficiary because they are much more likely to have retiree coverage. Medicare Current Beneficiary Survey data from 1999 show that 39 percent of Medicare beneficiaries in New York have prescription drug coverage through employer-sponsored retiree plans. Yet, the prevalence of retiree health coverage across the nation and in New York has been gradually eroding over the past 10 years: the percentage of large firms offering retiree health insurance for Medicare-eligible retirees dropped from nearly 40 percent in 1993 to 23 percent in 2001.[26] Because firms reducing retiree benefits tend, for moral or legal reasons, to do so prospectively, affecting future retirees first, there is a considerable lag in the impact of such changes. However, it is safe to predict continuing reductions in coverage from employer decisions that have already been made. In addition, there has been an increase in efforts to shift more of the costs of health benefits to retirees (through increased cost-sharing, capping benefits, or other methods).[27]

Public Sources of Prescription Drug Coverage in New York**

Medicaid

One of the differences in rates of drug coverage in New York, compared with many other states, is the comparatively expansive coverage of the elderly under Medicaid. In general, if you are age 65 and older and poor, there are several ways you can become eligible for the full array of Medicaid benefits. Federal law requires Medicaid programs to cover elderly persons receiving Federal Supplemental Security Income (SSI).†† In 2001, the Federal SSI eligibility limits were 74 percent of the federal poverty level for individuals and 82 percent of poverty for couples (in determining SSI eligibility, some income is disregarded). Many states also provide "state supplemental payments" (SSP) to people receiving SSI, and also to those with income too high to qualify for SSI. At their discretion, states may also provide Medicaid coverage to people who receive SSP. New York is one of about 25 states that extend Medicaid coverage to those receiving SSP, effectively raising the eligibility level for Medicaid to about 86 percent of poverty.

Some seniors may also become eligible for Medicaid through "medically needy" programs. Such individuals have incomes that would ordinarily disqualify them for SSI/SSP/Medicaid, but have medical expenses that are so large that their income net of medical expenses falls below the Medicaid eligibility level. Thirty-five states and the District of Columbia offer medically needy programs that allow people to spend down to Medicaid coverage. New York has always had a far more expansive medically needy program than most other states: the state's financial threshold for eligibility based on medical need is about the same as the financial threshold for Medicaid eligibility based on receipt of cash assistance (SSI). This is more generous than all but two states. New York's program also has an added advantage for low-income seniors, who can opt to pay the state the amount they would need to spend down each month, rather than submitting proof of medical expenses, in order to qualify for Medicaid. Thus, New York's generous medically needy eligibility criteria, coupled with the high cost of medical products and services in

** Other sources of public insurance for prescription drug coverage, in addition to Medicaid, include the AIDS Drug Assistance Program (ADAP), Veterans Administration, and Department of Defense. Those sources of coverage are not addressed here, except to note that more than 54,000 persons living with AIDS reside in New York, representing about 18 percent of all AIDS patients in the United States. A portion of these individuals receive assistance with their drug costs through ADAP, funded by the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. ADAP provides prescription medications to low-income HIV-positive individuals who have limited or no private insurance coverage or Medicaid. In 2001, ADAP served 22,000 clients in New York. Eighty percent of these beneficiaries had annual incomes below $20,000 and 73 percent lived in New York City. The AIDS Institute of the State Department of Health does not formally track data concerning Medicare eligibility. However, it estimates that 10 percent of ADAP beneficiaries are also Medicare-eligible (primarily beneficiaries who qualify for Medicare on the basis of disability).

†† There are some exceptions to the Federal SSI law: 11 state Medicaid programs are able to use more restrictive income or resource standards than SSI, and are referred to as "209(b) states."

New York, allow more people to spend-down faster and to qualify for Medicaid. Nationally, in 1997, among all elderly and younger persons with disabilities receiving Medicaid through a medically needy program, 31 percent were residents of New York.[28] About 53 percent of elderly Medicaid beneficiaries qualify for Medicaid on the basis of SSI/SSP, and 46 percent through the medically needy program.[29]

For a single elderly individual in 2002, the income limit for Medicaid eligibility (SSI-related) in New York was $7,584 a year ($632 per month); for a couple, it was $11,052 ($921 per month) (Table A-5).[‡‡] Medically needy income eligibility levels are very similar: $7,608 a year ($634 per month) for an individual living alone, and $11,100 ($925 per month) for a married couple. Unlike the EPIC program, eligibility also involves an asset test. Thus, a single elderly woman with an annual income of $15,000 (about the national average for all Medicare beneficiaries) and limited assets could qualify for Medicaid if her monthly prescription drug expenses (or other health care expenses) exceeded $618 ($15,000 – $7,584 = $7,416). The extent to which Medicaid fills the health insurance gap for New York's Medicare beneficiaries is, in essence, a reflection of how poor many elderly New Yorkers really are (Table A-5).

In 1999, Medicare Current Beneficiary Survey estimates show that about 15 percent of the total New York Medicare population, compared with 12 percent of the national Medicare population, also had Medicaid coverage for at least part of the year, including Medicaid's relatively comprehensive coverage of outpatient prescription drugs.[30] For many of these beneficiaries, Medicaid coverage, while comprehensive, is truly "catastrophic," not only in the sense that it involves whatever stigma is involved in applying for a "welfare program," but, more important, in the sense that the coverage only occurs once prescription drug or other medical expenses have left the beneficiary destitute.

[‡‡] Note: some income may be disregarded.

Table A-5. Federal SSI, New York Medicaid, and EPIC Income and Asset Eligibility Comparison, 2002

	MONTHLY INCOME GUIDELINES FOR SENIORS				
	Federal SSI	**New York Medicaid: Federal SSI and SSP**	**New York Medicaid: Medically Needy**	**EPIC Fee Plan**	**EPIC Deductible Plan**
Single Individual	$545	$632	$634	up to $1,667	$1,667–$2,917
Married Couple	$817	$921	$925	up to $2,167	$2,167–$4,167
	RESOURCE/ASSET LEVELS FOR SENIORS				
	Federal SSI	**New York Medicaid: Federal SSI and SSP**	**New York Medicaid: Medically Needy**	**EPIC Fee Plan**	**EPIC Deductible Plan**
Single Individual	$2,000	$2,000	$3,800	N/A	N/A
Married Couple	$3,000	$3,000	$5,500	N/A	N/A

Note: These figures do not include income and resource disregards.

Source: New York State Department of Health and U.S. Social Security Administration.

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