



State Pharmacy Assistance Programs vs. Medicare Prescription Drug Plans: How Do They Contain Rising Costs?

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This policy brief is one in a series presenting results from a recent Georgetown study of State Pharmacy Assistance Programs, their implementation, and operational experience. The study included case studies of 14 selected programs with site visits, in-depth interviews with state program leaders and stakeholders, as well as a survey of state program directors to explore their plans regarding various strategic options for responding to the Medicare drug benefit. The principal investigator for the study is Jack Hoadley. The study was funded by The Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization initiative, for which AcademyHealth serves as the national Program office.



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Introduction

This policy brief is one in a series based on a study examining the implementation and operational issues of State Pharmacy Assistance Programs (SPAPs). SPAPs exist in 22 states to provide assistance to residents to purchase prescription drugs. Most programs are aimed at the elderly who lack other prescription drug coverage and many are limited to persons with low or moderate income.

In addition to prescription drug coverage available through SPAPs, most enrollees over the age of 65 have coverage for other medical costs through Medicare. As a result, most will be eligible for prescription drug coverage under Part D in the recently passed Medicare Modernization Act (MMA). With their targeted population soon eligible for additional prescription drug coverage, SPAPs will be making major changes in program structure and design. Our earlier issue brief, *State Pharmacy Assistance Programs at a Crossroads*, examined the decisions states were considering in response to the passage of the MMA.¹ The options considered include: wrapping around the Part D benefit in order to help pay premiums or cost sharing or fill in gaps in coverage; keeping the existing SPAP structure as an alternative to Part D; or eliminating the program and helping enrollees transfer to a Medicare Part D plan.

States' decision making in response to Part D is influenced, in part, by financial constraints and the competing demands for limited state resources. The passage of MMA presents a dilemma for states. Eliminating what, in most cases, is a popular program will save the state money, but may result in a public outcry from enrollees. Keeping the existing SPAP in place as an alternative may also produce political fallout, however, especially if the state has to forgo cost savings from the federal program as a result. Wrapping around Part D may seem like a natural middle ground, but it presents its own administrative and financial burdens.

Even before the passage of MMA, financial concerns were inherent to SPAPs. Like other purchasers of prescription drugs, SPAPs have experienced rapidly rising costs. Many states have recently implemented policies to help control those costs. Most of the cost containment mechanisms in use are similar to those found in the private insurance market, although their use in SPAPs is still relatively new and varies among states.

Prescription drug plans (PDPs) formed to provide drug coverage under MMA will also face high drug costs and are likely to employ various cost containment mechanisms. In general, the MMA gives PDPs broad latitude to implement policies to minimize drug costs while still providing access to medically necessary prescription drugs.

Understanding the cost containment mechanisms most commonly used in SPAPs and how they compare to those allowed under MMA is important for federal policy makers, state program officials, beneficiaries and beneficiary advocates. In some cases, beneficiaries may need to trade one drug coverage for another as the SPAP is terminated, while in other cases states may need to work within another plan's cost containment structure in order to provide wrap around benefits. In still other cases, beneficiaries may need to choose between two programs and understanding how cost

¹ Williams, Goodell, Hoadley, O'Brien, and Kanter, *State Pharmacy Assistance Programs at a Crossroads: How Will They Respond to the Medicare Drug Benefit?* July 2005. Published on the Changes in Health Care Financing and Organization's website: www.hcfo.org/pdf/brief0705.pdf.

containment policies are used in each may be part of that choice. While this policy brief does not provide cost containment information on a state-by-state basis, it does present an overview of the mechanisms used, how common they are, and how they may affect beneficiaries' access to prescription drugs.²

Price Negotiation

The most commonly used cost containment mechanism in SPAPs is price negotiation, usually in the form of manufacturer rebates. Most programs require drug manufacturers to provide rebates in exchange for being included as a covered drug, often modeling their rebate programs after Medicaid. The rebate in Pennsylvania was recently changed from 16 percent to 21 percent of gross product payout in order to match the state's Medical Assistance program.³ Pennsylvania adjusted its rebate as part of an effort to have a uniform manufacturer rebate across all state programs that provide drug coverage. Pennsylvania estimated that this change would add \$30 million annually in new rebate revenues, which is deposited directly into the SPAP general fund.

Unlike SPAPs, there is no government agency to negotiate rebates for beneficiaries in MMA. Under Part D, the government, be it federal or state, is explicitly prohibited from negotiating prices. Price negotiation is left to individual prescription drug plans. The MMA and its implementing regulation do not put many restrictions or offer many guidelines on plans' use of price negotiation, preferring instead to take a market-based approach. The regulations do require that a portion of the discounts obtained by PDPs be passed on to beneficiaries. The size of the rebates PDPs are able to negotiate will be based on a variety of factors including: the market power of the PDP, whether or not the drug is a new or breakthrough drug, and whether or not there are alternatives or generic equivalents available.

It is impossible to predict whether the rebates negotiated by PDPs will be greater or less than those negotiated by individual SPAPs. In fact, private plans typically regard rebate amounts as proprietary information and do not reveal them. Some states have significant market power to negotiate rebates because their programs are large or they have combined the rebates with those of other state programs that provide prescription drugs. At the same time, some PDPs may be quite large and they can tie manufacturer rebates in with those of their commercial business. In addition, the prices PDPs charge must be competitive with other PDPs in order to secure enrollment and remain viable.

One thing that is clear is that for states providing a wrap around benefit, negotiating and receiving rebates will likely be more complex when coordinating benefits with one or more PDPs. Depending on how a state structures its wrap around, there may be an issue of whether or how they can claim rebates for drugs covered by both the SPAP and the PDP. For example, a state that is paying the SPAP enrollee's share of a drug that is covered by the PDP will likely be able to claim only a portion of the rebate based on how much the state actually pays. If a state pays for a drug not covered by the PDP, however, they may be entitled to the full rebate.

² Our 14 case studies were Connecticut, Delaware, Florida, Illinois, Indiana, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New York, Pennsylvania, Rhode Island, and South Carolina.

³ The Medicaid program in Pennsylvania is known as Medical Assistance.

Formularies and Preferred Drug Lists

One of the most visible differences between SPAPs and PDPs may be in their use of formularies and preferred drug lists. Some SPAPs have adopted preferred drug lists in order to obtain supplemental rebates from manufacturers. In order to be included on a state's preferred drug list, manufacturers must agree to provide supplemental rebates. Maryland recently implemented a supplemental rebate program in two of its three pharmacy assistance programs and estimated savings of \$1.6 million in one quarter.⁴ In addition to helping programs achieve additional rebates, formularies and preferred drug lists are adopted by many states to encourage the use of generic drugs, less expensive drugs, and drugs that are most suitable for a given condition or for a given population – in this case, the elderly or chronically ill. Six of the fourteen study states use a preferred drug list and two states were in the process of developing one. Most of the states that have a preferred drug list describe it as very open, indicating that most drugs are included. In fact, some state programs, such as Florida, use the same formulary as their Medicaid program. Medicaid programs that participate in the federal rebate program are required to cover all drugs (with certain exceptions) that are made by any manufacturer that participates in the rebate program. Some Medicaid programs use either prior authorization or education to implement a preferred drug list. In general, SPAPs with formularies or preferred drug lists have some type of medical exception process in place.

The Medicare law does not require plans to use a formulary, but allows it under certain conditions. The conditions include review by a Pharmacy and Therapeutics committee and the inclusion of at least two drugs in each therapeutic class. Plans are also required to provide a medical exception process for drugs not on the formulary. Evidence from the commercial market shows that formularies are an important cost containment mechanism and their use is widespread. Some evidence shows that formularies used by Medicare+Choice plans (now known as Medicare Advantage plans) are more restrictive than those used for the same plans' commercial business.⁵

In states with relatively open formularies, it would not be surprising for PDP formularies to be more restrictive than those to which SPAP enrollees have become accustomed. This has both financial and medical implications. Beneficiaries may be forced to pay higher cost sharing for a non-preferred drug or may be forced to switch medications altogether for drugs not on the PDP's formulary. States that choose to wrap around the Medicare drug benefit could cover non-formulary drugs, although it would be complicated to do so and only seven of the states we surveyed late last year indicated they are considering this option.⁶

⁴ The adoption of the supplemental rebate took place at the same time copayments were changed from a flat \$5 co-payment to \$2.50 co-payment for generics and \$7.50 co-payment for brand name drugs, so not all of the savings can be attributed to the rebate.

⁵ Draper, Debra A.; Anna E. Cook; and Marsha R. Gold, *How Do M+C Plans Manage Pharmacy Benefits? Implications for Medicare Reform*, Henry J. Kaiser Family Foundation, March 2003.

⁶ Williams, et al.

Cost Sharing

Another area in which SPAPs will likely differ from PDPs in their cost containment approach is through enrollee cost sharing. Fixed copayments are the most common cost sharing tool used in SPAPs. Ten of fourteen states require beneficiaries to pay a fixed copayment and in about half those states the cost sharing is fairly minimal. For example, in New Jersey's PAAD program, beneficiaries pay a \$5 copayment per prescription. Several states have tiered copayments, charging more for brand name drugs or drugs not on the preferred drug list. South Carolina's program charges beneficiaries \$10 for generics, \$15 for brand name drugs and \$21 for prior authorized drugs. Overall, fixed copayments in the programs studied ranged from \$2 for generic drugs in Florida's Silver Saver program to \$35 for a non-preferred brand name drug in Maryland's Senior Prescription Drug Program.

The use of deductibles in SPAPs is not common. Only five states require beneficiaries to meet a deductible prior to receiving benefits. When Maryland's Senior Prescription Drug Program was first introduced it included a deductible, but after low initial enrollment, the deductible was eliminated in favor of copayments to make the program more attractive to potential beneficiaries. When Pennsylvania first introduced PACENET, available to persons with higher income than its base program, there was a \$500 annual deductible. Due to low enrollment, the state changed to a \$40 rolling monthly deductible and saw an increase in enrollment.⁷ South Carolina has a \$500 annual deductible, which many advocates cite as a significant barrier to enrollees. Only about half of its enrollees meet the deductible in a given year. In the New York EPIC program, seniors pay an annual fee or meet an annual deductible. The deductible plan, targeted to seniors with modest incomes, requires enrollees to meet an annual deductible ranging from \$530 to \$1,715 and is equivalent to 3% of income.

Extra help with prescription drug costs will be available to beneficiaries eligible for both Medicare and Medicaid and certain other low-income beneficiaries who enroll in both Part D and a separate low-income subsidy program (see table below). For these beneficiaries, the Medicare prescription drug benefit will have minimal cost sharing in the form of set copayments with no deductible. Copayments for this population range from \$1 to \$5 per prescription with no copayments once out-of-pocket spending reaches \$3,600 (\$5,100 in drug costs).⁸ For beneficiaries with slightly higher income and assets, a \$50 annual deductible must be met along with 15% co-insurance up to the out-of-pocket limit, followed by copayments of \$2 and \$5 after the limit is reached. For these dual eligible and low-income beneficiaries, cost sharing under MMA will likely offer significant savings compared to cost sharing in SPAPs.

⁷ Some of the increase was also due to a concurrent eligibility expansion.

⁸ These thresholds will increase each year based on an inflation adjustment.

Table 1: Cost Sharing Under the MMA (2006)

Income ¹	Assets ²	Deductible	Co-insurance or Co-pay ³
On full Medicaid	Medicaid rules	\$0	\$1/\$3 \$0 above \$5,100
Below 100%	\$6,000/\$9,000	\$0	\$1/\$3 \$0 above \$5,100
101-135%	\$6,000/\$9,000	\$0	\$2/\$5 \$0 above \$5,100
136-150%	\$10,000/\$20,000	\$50	15% \$2/\$5 above \$5,100
Above 150%	N/A	\$250	25% from \$251-2,250 100% from \$2,251-5,100 5% above \$5,100

¹ As a percentage of the Federal Poverty Level

² Single/Married

³ Generic/Brand

Evidence indicates that most SPAP enrollees will not be eligible for the low-income assistance under Part D, however.⁹ In fact, fewer than 50% of SPAP enrollees were estimated to be eligible for the transitional assistance available with the Medicare drug discount cards.¹⁰ In addition, the criteria for the low-income subsidies under Part D is stricter than that for the discount cards because beneficiaries not enrolled in Medicaid must meet an asset test in addition to the income guidelines (see Table 1). A few states, such as Minnesota, have program eligibility levels such that all enrollees are likely to be eligible for the Part D low-income subsidy. Other states are adopting strategies to ensure that anyone eligible for the low-income subsidy will be enrolled for it.

Beneficiaries who do not qualify for the low-income subsidy must meet a \$250 annual deductible and then pay 25% co-insurance up to the initial coverage limit of \$2,250. Beneficiaries pay for all costs until they reach an annual out-of-pocket limit of \$3,600. This gap in coverage, sometimes called the “doughnut hole” is discussed in greater detail below. After they have incurred this out-of-pocket total (amounting to \$5,100 in total drug costs), beneficiaries are responsible for a 5% co-insurance. PDPs are not bound by the cost sharing structure outlined in the MMA. In fact, PDPs could use fixed copayments rather than co-insurance as long as the net benefit is actuarially equivalent to the standard benefit. Some PDPs also may offer supplemental coverage, for an additional premium, to eliminate the deductible or fill in gaps in coverage. In addition, states that choose to wrap around the Medicare benefit may pay the deductible or bring

⁹ Fox, Kimberly, Rutgers Center for State Health Policy, presentation to the State Coverage Initiatives National Meeting, February 4, 2005.

¹⁰ Fox, Kimberly and Crystal, Stephen, *Coordinating Medicare Prescription Drug Benefits with State Pharmacy Assistance Programs*, New York, NY, The Commonwealth Fund, publication forthcoming.

cost sharing down to levels equivalent to that now required by the SPAP. Without additional assistance from states, however, seniors who do not qualify for the low-income subsidies will likely face higher and more complex cost sharing under Part D than they currently do in their State Pharmacy Assistance Programs.

Benefit Limits

Five of the SPAPs in our study use a monthly or annual benefit limit or a limit on the number of prescriptions filled in order to contain the scope of their programs. In some states the benefit limit greatly reduces access to prescription drugs while in other states only a small number of people are affected. In Florida, beneficiaries are limited to \$160 in benefits per month (\$1,920 annually). Similarly, Maryland's Senior Prescription Drug Program has an annual limit of \$1,100. Both states report that many beneficiaries reach the benefit limit. In contrast, Nevada's annual limit is \$5,000 and the state reports that few beneficiaries have ever reached the limit.

In the Medicare prescription drug benefit all beneficiaries have catastrophic drug coverage with no more than a 5% co-insurance. The Medicare benefit does have a gap in coverage, however. For individuals not qualifying for the low-income subsidy, once the initial coverage limit of \$2,250 is reached, they are responsible for 100% of drug costs up to the catastrophic limit of \$5,100. In a survey for our earlier issue brief, of the 11 states considering some form of wrap around benefit for cost sharing, seven were considering filling in the coverage gap.¹¹

For enrollees in SPAPs with low benefit limits and high prescription drug costs the Medicare drug benefit will provide a safety net they currently lack. Although their share of the drug costs may be high, beneficiaries will have catastrophic coverage. For many other enrollees who do not qualify for the low-income subsidy and are in SPAPs without a benefit limit, the out-of-pocket spending required in MMA will be significantly higher than that of their state program. Most SPAP enrollees now have catastrophic coverage for prescription drugs at a lower cost than that which will be provided under MMA.

Generic Substitution

Nine of the fourteen SPAPs studied, including the largest programs, mandate the use of generic drugs when available. The remaining states provide incentives to use generics either through tiered cost sharing, a strict benefit limit which will stretch further if generics are used, or through co-insurance which makes most generics more affordable than brand name drugs. Many of the states that mandate generic substitution report a high compliance rate, several around 90%. In 2004, Minnesota tightened its generic substitution rules and reported substantial savings to the program. Previously pharmacists could override system edits and use brand name drugs, but now they must get prior authorization in order to override the generic substitution rule. Most states that mandate generic substitution have a medical exception process in place that allows beneficiaries to get the brand name drug when necessary for the same cost as the generic.

¹¹ Williams, et al.

The Medicare law does not mandate generic substitution but does not prohibit PDPs from using this strategy. Based on evidence in the commercial market, it is likely that most plans will require the use of generic drugs. In addition, the Medicare law requires plans to have a drug utilization management program that includes incentives to reduce costs when medically appropriate. Mandatory generic substitution could be a part of that program. If plans do require generic substitution they are required to have a medical exception process in place.

Because generic substitution is relatively common in SPAPs, its use by PDPs will not present a new cost containment approach to most beneficiaries.

Prior Authorization

Ten of the fourteen SPAPs studied had some form of prior authorization, although in several states it was fairly limited. For example, in Connecticut, prior authorization is required in three cases: if there are more than three generic drugs available; if refills are requested early; or if a drug costs more than \$500. However, several states are in the process of tightening their prior authorization rules. In New Jersey, physicians used to be able to write “medically necessary” on a prescription for a brand name drug and it would be dispensed. Now the physician must call for prior authorization and explain why the brand name drug is medically necessary. The state reported a drop in brand name drugs (where generics were available) from 9% to 7% after this change.

The Medicare law neither requires nor prohibits plans from using prior authorization. Again, based on evidence in the commercial market, it is likely that PDPs will use some form of prior authorization. Plans may target certain classes of drugs, breakthrough drugs, drugs with generic equivalents available, or drugs that are not on the preferred drug list.

Although prior authorization is common in SPAPs, it is still relatively new and limited in many cases and thus beneficiaries may face tighter rules under PDPs. With several states tightening their prior authorization requirements, however, there may be more similarities than differences between SPAPs and PDPs.

Drug Utilization Review

Most SPAPs use some form of concurrent and retrospective drug review, although the use varies from state to state. In several states, drug utilization review is focused mainly on safety issues such as drug interaction effects or possible dosage errors. Other states, such as Nevada, monitor physicians’ prescribing patterns and send out letters to physicians noting things such as drug interactions, patients who are seeing multiple physicians, and expensive prescribing patterns.

The Medicare law requires plans to have a drug utilization review program that provides incentives to reduce costs when medically appropriate. The program must assist in preventing over- and under-utilization of prescription drugs. The law gives plans broad

authority in designing a utilization management program so there will likely be a variety of approaches. Some plans may focus solely on safety while others may interchange drugs for more appropriate alternatives according to their therapeutic guidelines.

Because the use of drug utilization review varies widely among states and because it is unknown what approach individual PDPs will take, it is impossible to say how enrollees' experiences will differ between SPAPs and PDPs.

Conclusion

The State Pharmacy Assistance Programs have been active in designing effective ways to contain their costs. Several programs have taken specific steps in the past several years to obtain larger rebates, add preferred drug lists, or strengthen their requirements for generic substitution or prior authorization. Looking forward to 2006, however, the state programs and their enrollees will be seeing more fundamental changes.

The biggest differences between cost containment approaches used by SPAPs and those likely to be used by PDPs under MMA are in the areas of formularies, cost sharing, and benefit limits. While experiences will vary by state, most SPAP enrollees can expect tighter formularies in PDPs, higher cost sharing for those not qualifying for the low-income subsidies, and potential gaps in coverage that they do not currently face. States that are considering how to redesign their programs in response to the Medicare drug benefit must consider these factors while moving forward with a decision that weighs the financial, administrative, and political costs to the state along with the value to the beneficiaries.

For Further Information

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