How 14 States Have Designed Pharmacy Assistance Programs

by John Hansen

This chapter overviews programs in 14 states which were providing prescription drug benefits for 760,000 elderly and other low-income people in 1999. Most states have income limits ranging from 100% to 225% of the Federal Poverty Level. Two-thirds of the programs are funded with state general revenues, but nine receive funds from such sources as a cigarette tax, construction tax, tobacco settlement, and the lottery. Beneficiary cost-sharing varies among the states with copayments and coinsurance more common than benefit caps and deductibles. Nine of the 14 states administer their programs through the agency administering Medicaid. However, the three largest programs are intentionally administered separately to avoid any perceived stigma of programs for low income people.

Prescription drugs have become an increasingly important part of health care, especially for older adults. Yet, the federal Medicare program, with few exceptions, does not pay for outpatient prescription drugs.

More than two-thirds of Medicare beneficiaries had some other source of prescription drug coverage in 1996, but for many, insurance pays only a fraction of their drug costs. The other one-third of Medicare participants must pay for all prescription drugs entirely out of pocket. Some seniors have prescription drug coverage through Medigap, an optional supplemental policy. Only 3 of the 10 standard plans cover prescription drugs and they typically requires a $250 deductible, 50% coinsurance, and have annual limits of $1,250 or $3,000 on drug expenditures.

Medicare beneficiaries are often vulnerable to high prescription drug costs because they need more prescription drugs, compared with other segments of the population.

To fill insurance gaps for some low-income older adults, several states have enacted independent, state-funded programs to provide prescription drug coverage. A number of states have also implemented, considered implementing, or changed existing drug assistance programs for older adults and other low-income residents. Looking at the design and implementation of these state programs provides useful information about how states provide drug benefits to certain populations.

This study, conducted from November 1999 to August 2000, looked at state programs that provide prescription drug benefits. It provides information on policies, design features, and operations of each. The report is based on relevant laws, regulations, program information, and, in some states, interviews of senior citizen advocates.

Which States Were Involved in the Study?

In 1999, 14 states operated independent, state-funded and administered programs that provided more than 760,000 elderly and other low-income people with prescription drug access. Three states—New York, Pennsylvania, and Vermont—had more than one pharmacy program, bringing the total number of programs to 18.

The first programs for low-income Medicare beneficiaries to get prescription drug coverage began in Maine and New Jersey in 1975. Maryland's program began in 1979. In the 1980s, eight more states—Connecticut, Illinois, Michigan, New York, Pennsylvania, Rhode Island, Vermont, and Wyoming—added prescription drug programs. Eleven states enacted programs between 1996 and 2000 including Delaware, Massachusetts, and Minnesota. In 1999 alone, seven states expanded or added programs. New state programs in Florida, Indiana, Kansas, Michigan, Nevada, and South Carolina were not fully operational at the time of this report. Most programs began within a year of enactment.

How Have States Established Eligibility?

States use age, income, and other criteria to target and control the size of their drug assistance programs (See Table 1). Most states target their limited budgets to low-income seniors and people with disabilities who do not qualify for Medicaid drug coverage. Eligibility rules, however, vary across states. For instance, programs in Maryland and Wyoming have no minimum age requirements, whereas Maine requires participants to be at least 62. All but three programs required participants who are not disabled to be at least 65.

The income limits for prescription drug programs in 1999 ranged from 100% of the Federal Poverty Level to 225%.

Most have income requirements, often tied to the Federal Poverty Level (FPL) which is used to determine eligibility for many federal programs. The 1999 Federal Poverty Level for an individual was $8,240. The income limits for prescription drug programs in 1999 ranged from 100% of FPL to 225%. However, Illinois recently expanded eligibility to individuals with annual incomes up to $21,218, and Massachusetts recently enacted a new catastrophic program with no upper income limit and sliding scale payments for those above 188% of FPL. Rhode Island recently expanded eligibility to individuals with incomes up to $34,999. That program will pay 60% of drug costs for those with incomes up to $15,932; 30% for those with incomes up to $19,999; and 15% for those with incomes up to $34,999.

Most states have some mechanism to increase the qualifying income each year. Four states raise income requirements based on the annual Social Security cost-of-living adjustment. Seven states set qualifying income levels as a percentage of the FPL. Two states have no cost-of-living adjustment. For example, the income thresholds for Pennsylvania's PACE and PACENET were fixed by state statute in 1996 and cannot be changed without legislative action. According to Director Tom Snedden, this was a deliberate action by the legislature to contain costs. The income threshold in PACE and PACENET have become lower in real dollars each year, which has made some people lose eligibility as their Social Security income increased.

Table 1. Eligibility Requirements for State Pharmacy Assistance Programs, 1999

State	Individual income limit (percentage of 1999 FPL)	Married or household income limit	Age requirement	Coverage for persons with disabilities	Enrollment	Enrollment as a share of Medicare beneficiaries in state (percentage)
Connecticut	$14,500 (176)	$17,500	65	Yes	29,969	6
Delaware	$16,480 (200)	$22,120	65	Yes	N/A	N/A
Illinois	$16,000 (194)	$16,000	65	Yes	49,186	3
Maine	$15,244 (185)	$20,461	62	Yes	25,000	12
Maryland	$9,400 (114)	$10,200	None	Yes	33,185	5
Massachusetts	$12,360 (150)	N/A	65	Yes	27,492	3
Michigan	$12,360 (150)	$16,596	65	No	12,968	0.9
Minnesota	$9,660 (117)	$13,020	65	No	1,200	0.2
New Jersey	$18,151 (220)	$22,256	65	Yes	195,005	16
New York - Fee and Deductible Plans	$18,500 (225)	$24,400	65	No	113,000	4
Pennsylvania-PACE	$14,000 (170)	$17,200	65	No	217,103	10
Pennsylvania-PACENET	$16,000 (194)	$19,200	65	No	18,655	0.9
Rhode Island	$15,538 (189)	$19,449	65	No	29,766	18
Vermont-VHAP	$12,360 (150)	$16,590	65	Yes	7,303	8
Vermont- VScript	$14,420 (175)	$19,355	65	Yes	2,125	2
Vermont-VScript Expanded	$18,540 (225)	$24,885	65	Yes	N/A	N/A
Wyoming	$8,240 (100)	$11,060	None	Yes	491	0.8

Notes: N/A = Not available. FPL = Federal Poverty Level.
Sources: State programs, National Conference of State legislatures, http://www.ncsl.org/programs/health/drugaid.htm (downloaded 01/26/2000 and 04/04/2000), http://aspe.hhs.gov/poverty/99fedreg.htm (downloaded 06/27/2000), and http://www.hcfa.gov/stats/en798all.htm (downloaded 06/27/2000).

Some states make exceptions to income limits if drug expenses exceed 40% of income.

In addition to income, Michigan requires an enrollee's monthly prescription drug expenses to be above 8% of their monthly income if the person is married, or 10% if the person is single or widowed. Recognizing that strict income limits might exclude some people who need assistance, Maine and Delaware make exceptions for people with drug expenses above 40% of their income. Three states also have asset limits. All states restrict eligibility to state residents, although residency requirements differ. Most states allow people with other drug coverage to enroll, but specific rules vary.

Almost two-thirds of programs had eligibility criteria that allow some people with disabilities to be eligible for assistance. The definition of "disabled," for the purpose of program eligibility, varies across states. For example, in Illinois, a resident with a disability must be older than 16, while in Maine, a resident with a disability must be at least 19 years old. A few states defined people receiving or eligible for Social Security disability insurance as disabled, whereas other states used state-developed criteria.

How Large Were the State Programs?

Just as eligibility criteria varied, the size of state programs also varied. The Rhode Island program enrolled the largest percentage of state Medicare beneficiaries. However, programs in New Jersey, New York, and Pennsylvania had the most people enrolled, accounting for 71% of all enrollees in 1999. According to Director Tom Snedden, Pennsylvania's PACE and PACENET programs cost about $1 million per day in 2000 with annual expenditures of about $1400 per person.

Some states have modified their programs over time. Maine changed its income threshold from 131% to 185% of the federal poverty level (FPL). The Massachusetts program began with an income threshold of 133% of the FPL, which has since been increased to 188%. Pennsylvania and Vermont added coverage for people with higher incomes, and Connecticut and Massachusetts extended coverage to people with disabilities. Vermont has established limits on the types of drugs that are covered.

Did States Restrict the Type of Drugs Covered?

In addition to targeting coverage to meet income requirements, some states restrict coverage to specific types of drugs, such as maintenance drugs or drugs to treat specific conditions (See Table 2). For instance, states generally do not cover drugs for which they do not get manufacturer rebates, although Illinois and Michigan are exceptions. Connecticut recently eliminated coverage for antihistamines, decongestants, and smoking cessation products. Michigan limits prescription coverage to three months per year.

Table 2. Drug Coverage Rules for State Pharmacy Assistance Programs, 1999

All prescription drugs	Drugs for specific conditions	Maintenance drugs only
Connecticut[a]	Illinois	Maryland
Delaware	Maine (basic)	Vermont (VScript)
Maine (supplemental)	Rhode Island	
Massachusetts		
Michigan[b]		
Minnesota		
New Jersey		
New York		
Pennsylvania		
Vermont (VHAP)		
Wyoming		

Notes: Except for Illinios and Michigan, states generally do not cover drugs for which they do not get manufacturer rebates.
[a] Connecticut recently eliminated coverage for antihistamines, decongestants, and smoking cessation products.
[b]Michigan limits coverage to three months per year.
Source: State programs

Unlike private insurers, state programs generally do not use formularies to limit coverage to particular products within a therapeutic class. Formularies are lists of prescription drugs, grouped by therapeutic class, that a health plan or insurer prefers and may encourage physicians to prescribe. A particular product may be included on the formulary because of its medical value or because a favorable price was negotiated with the manufacturer. Several program officials said formularies are not an appealing benefit design structure for their programs because they can restrict access to specific products and can be difficult to administer.

According to Director Tom Snedden, Pennsylvania does not cover certain high-cost drugs for which a less expensive alternative is available. The state hires a panel of national experts to advise them on which high-cost drugs can be excluded from coverage.

Did States Require Program Participants to Share in the Cost?

Beneficiary cost-sharing requirements vary among programs (See Table 3). With one exception, the programs impose copayments or coinsurance that require enrollees to share in the drug's cost each time they fill a prescription. In addition to lowering public costs, copayments and coinsurance can influence enrollees to use less expensive drugs. Among these state programs, copayments and coinsurance are more common than benefit caps and deductibles, but the amount of cost sharing varies widely across programs.

Three programs impose coinsurance that require enrollees to pay a fixed percentage of the cost of a drug, giving enrollees a stronger incentive to use less expensive drugs. Six programs used a flat copayment structure that required enrollees to pay the same amount for each prescription, regardless of cost. Six programs used a tiered copayment structure with higher amounts for more expensive drugs or brand name products than generics. Two programs required enrollees to pay the greater of a coinsurance or a flat copayment.

Changing from a flat copayment to a 20% coinsurance cut program costs by 10%.

To encourage program beneficiaries to choose less expensive products, the Maine program changed its cost-sharing policy from a flat copayment to a coinsurance amount equal to 20% of the drug's price. A Maine program official estimated that this change cut program costs by 10%.

Connecticut, Maryland, and Wyoming have increased their copayments since the programs' enactment. Wyoming raised its copay from $1 to $25 per prescription in 1997. In 1992, Illinois eliminated the copay and replaced its $800 annual benefit cap with a 20% coinsurance that takes effect once the program pays $800 in benefits during the year.

A few programs have annual enrollment fees, but some program officials believe that these fees impose a barrier to program enrollment because they require payment up front. A Minnesota official said enrollment fees in that state were viewed as restricting participation in the program. As a result, the original $120 enrollment fee was eliminated and the monthly deductible was increased by $10. In New York, an enrollment fee was designed to avoid high enrollment. However, the state has since lowered its fees to provide easier access to program coverage. The Connecticut program administrator said the state raised its annual one-time fee from $15 to $25, resulting in enrollment dropping by half.

Annual benefit limits and deductibles, which are common in private health insurance, are not often used in state programs because these programs serve needy and low income populations. Only Massachusetts and Delaware place a limit on the total amount of drug costs the program will cover annually. In Delaware, the annual limit is $2,500 per person; in Massachusetts, the limit is $1,250 per person. In Illinois, before reaching $800, enrollees pay a monthly deductible. After reaching $800 in spending for the year, a person must still pay the monthly deductible plus 20% of the prescription's cost. Wyoming covers a maximum of three prescriptions per month, and Michigan allows assistance to enrollees for only three months out of the year. Only four programs have deductibles. New York and Pennsylvania's PACENET have annual deductibles, and Illinois and Michigan have monthly deductibles.

Table 3. Cost-Sharing Requirements for State Pharmacy Assistance Programs, 1999

State	Annual fee	Deductible	Copayments	Coinsurance
Connecticut	$25	None	$12	None
Delaware[a]	None	None	$5[b]	25%[b]
Illinois	$40 or $80	$15 or $25/mo.	None	20%[c]
Maine	None	None	$2[d]	20%[d]
Maryland	None	None	$5	None
Massachusetts	$15	None	$3/$10[e]	None
Michigan	None	None	$0.25	None
Minnesota	None	$35/mo.	None	None
New Jersey	None	None	$5	None
New York (Fee Plan)	$8-$280[f]	None	$3-23[g]	None
New York (Deductible Plan)	None	$468-638[f]	$3-23[g]	None
Pennsylvania (PACE)	None	None	$6	None
Pennsylvania (PACENET)	None	$500	$8/$15[e]	None
Rhode Island	None	None	None	40%
Vermont (VHAP)	None	None	$1-$2[h]	None
Vermont (VScript)	None	None	$1-$2[h]	None
Vermont (VScript Expanded)	None	None	None	50%
Wyoming	None	None	$25	None

[a]Information for the Delaware program is for 2000.
[b]Program enrollee pays the greater of the $5 copayment or 25% coinsurance.
[c]After the program enrollee meets the monthly deductible, the program covers all costs up to $800 annually. After that, the individual pays 20% of each prescription's retail cost, and the state pays 80%.
[d]Program enrollee pays the greater of the $2 copayment or 20% coinsurance.
[e]The first amount is for generic drugs; the second is for brand name drugs.
[f]The amount of the fee or deductible is determined on a sliding scale based on income.
[g]The plan has five levels of copayments, which require enrollees to pay a higher amount for higher priced drugs.
[h]Program enrollee pays $1 if the prescription costs less than $30 and $2 if the prescription costs $30 or more.
Source: State programs.

How Were the Programs Funded?

Two-thirds of state pharmacy assistance programs received some or all of their funding from the state's general revenues, while nine programs were funded at least in part by other revenue sources, such as a cigarette tax, a construction tax, a tobacco settlement, and, in Pennsylvania, the lottery (See Table 4). Vermont is the only state that receives partial federal funding for enrollees up to 175% of the Federal Poverty Level through the state's Medicaid waiver.

Table 4. Funding Sources for State Pharmacy Assistance Programs

State	Funding Source
Connecticut	General revenue
Delaware	Tobacco settlement
Illinois	General revenue
Maine	General revenue
Maryland	General revenue
Massachusetts	General revenue and cigarette tax
Michigan	Construction tax
New Jersey	General revenue and casino revenue
New York (Fee and Deductible Plans)	General revenue
Pennsylvania (PACE and PACENET)	Lottery
Rhode Island	General revenue
Vermont (VHAP and VScript)	Cigarette tax and federal funding
Vermont (VScript Expanded)	Cigarette tax
Wyoming	General revenue

Source: State programs

Did States Get Manufacturer Rebates?

State programs, like Medicaid, offset drug spending through manufacturer rebates. Most state programs receive rebates that are calculated using terms similar to the Medicaid rebate agreement established by the Omnibus Budget Reconciliation Act of 1990 (OBRA, 1990). The rebates, often mandated by state legislatures, are usually provided by manufacturers in exchange for coverage of their products and for not subjecting coverage to prior authorization requirements.

Like Medicaid, some state programs receive additional rebates if the price of a drug increased more than the consumer price index, which is a measure of inflation. For example, if the average manufacturer price increased 6.3% and the consumer price index rose 2.3%, the manufacturer would pay the 4% difference between the two increases.

However, six states said they did not get this additional rebate amount. The Illinois and Michigan programs contract with pharmacy benefit management (PBM) companies to get rebates from manufacturers. Illinois receives 100% of the manufacturer rebates on products with rebate agreements. Michigan receives 80%, while the PBM retains 20% of the rebate.

How Were the Programs Administered?

Nine of the 14 states administer aspects of their programs through the agency administering Medicaid as shown in Table 5. Programs using Medicaid systems can avoid duplicating program functions, such as determining eligibility and processing claims. Five states administer the program through a different department than the one that administers Medicaid. Program administrators of the three state programs with the largest budgets and the greatest number of participants said that drug assistance programs were intentionally administered apart from Medicaid programs to avoid any perceived stigma attached to Medicaid.

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Table 5. Administrative Information on State Pharmacy Assistance Programs

State	Department administering drug assistance program	Same department that administers Medicaid?	Same eligibility determination system as Medicaid?	Same claims adjudication system as Medicaid?
Connecticut	Department of Social Services	Yes	Yes	Yes
Delaware	Department of Health and Social Services	Yes	Yes	Yes
Illinois	Department of Revenue	No	No	No
Maine	Department of Human Services	Yes	No (Dept of Revenue determines eligibility)	No, but uses same contractor as Medicaid
Maryland	Department of Health and Mental Hygiene	Yes	No	Yes
Massachusetts	Executive Office of Elder Affairs and Division of Medical Assistance	Yes, in part[a]	No (Executive Office of Elder Affairs determines eligibility)	Yes
Michigan	Office of Services to the Aging	No	No	No
Minnesota	Department of Human Services	Yes	Yes	Yes
New Jersey	Department of Health and Senior Services	No	No	Yes
New York	Department of Health	Same department, separate administration	No	No
Pennsylvania	Department of Aging	No	No	No
Rhode Island	Department of Elderly Affairs	No	No	No
Vermont	Department of Social Welfare, Office of Vermont Health Access	Same department, different office	Yes	Yes
Wyoming	Department of Health	Yes	Yes	Yes

[a]The Division of Medical Assistance administers the Medicaid program in Massachusetts.
Source: State programs.

Many program administrators say they cannot determine the extent to which eligible people are enrolled. They can, however, identify factors that may affect whether eligible people enroll, including a perceived stigma associated with programs for low-income people and a lack of awareness of the program. Some state administrators said their legislatures intentionally separated drug assistance programs from Medicaid to avoid perceived stigma.

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One official whose program is administered through Medicaid said that stigma may affect enrollment, especially among seniors. Some states try to both increase program awareness and decrease perceived stigma through outreach.

Eligibility determinations are one major administrative task that the programs perform. Five states used the same eligibility system for their assistance program that is used for the Medicaid program. Nine states used an eligibility system that was different from the one used for Medicaid. In some states, the agency uses a contractor to determine eligibility; in others, eligibility is determined within the administering state agency.

To apply, most states have a mail-in application. Only Michigan and Rhode Island require an in-person application interview. Most programs require yearly reapplication, and many automatically send applications to current enrollees. However, participants in Michigan and Wyoming must reapply monthly. Only Rhode Island's participants do not have to reapply once they are enrolled.

A few program administrators said developing and coordinating automated systems were challenging aspects of program operation. According to a Connecticut official, setting up systems for claims processing and eligibility determination was difficult. A Rhode Island official said linking relevant computer systems was the most difficult aspect of the program. Because two different systems determined eligibility and processed claims, the two systems had to be linked with one another and with participating pharmacies so pharmacies would know who was eligible and what drugs were covered.

Because some people in need of assistance may have other limited drug coverage, all but three states permit people with other prescription drug coverage to enroll in their programs. States excluded people from coverage if they received full Medicaid benefits. Several programs performed a match with Medicaid files to determine whether an applicant was receiving Medicaid benefits.

Some administrators said they have encountered added difficulty recovering payments from third-party payers when a person has other drug coverage. For example, when a participant has other drug coverage, Pennsylvania's PACE programs designate the state pharmacy program as the payer of last resort. A Pennsylvania official said the program recently settled a long dispute with several Medicare managed care plans regarding recovery of drug payments that the PACE program made on behalf of individuals with drug coverage through their Medicare managed care plan. According to the PACE official, the program is now cooperating with the Medicare managed care plans to implement a system that will automatically block PACE payments when the person has Medicare managed care coverage.

Conclusion

Copayments and coinsurance are more common than benefit caps and deductibles.

This report features the 14 states that were providing access to prescription drugs for 760,000 elderly and other low income persons in 1999. Most programs are funded with the state's general revenue, but some receive earmarked funds. The amount of consumer cost-sharing varies across states. In general, copayments and coinsurance are more common than benefit caps and deductibles. All states obtain manufacturer rebates similar to the terms of Medicaid rebates. Nine of the 14 states administer their programs through the agency administering Medicaid. However, the three largest programs are intentionally administered separately to avoid any perceived stigma of programs for low income people, particularly among seniors. States have encountered administrative challenges in determining eligibility, processing claims, and recovering payments from insurers when program participants have other coverage.

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