Executive Summary

With prescription drug costs continuing to generate political debate, this report focuses on how several states across the country have designed prescription drug programs. The report reviews the evidence on the effectiveness of nine strategies states can use to control costs, and describes how several states have designed prescription drug programs.

In the first chapter, Professor Dave Kreling of the University of Wisconsin-Madison reviews the effectiveness of nine different strategies for controlling costs in prescription drug programs. For example, the potential savings of encouraging the use of generic versus brand name drugs is large even after taking into account incentives such as lower consumer cost sharing requirements or higher pharmacy dispensing fees. Drug utilization review, a process for evaluating drug use to correct problems, can improve the quality of drug use and cut costs.

By alerting consumers to differences in drug prices, cost-sharing in prescription drug programs can drive costs down. Copayments require consumers to pay a fixed dollar amount each time a prescription is filled. Moving from a two-tiered \$5/\$10 copayment structure to a three-tiered \$5/\$10/\$25 structure can lower a health plan's overall drug costs. Coinsurance, which requires a consumer to pay a percentage of the cost of each prescription, is more apt to alert consumers to differences in drug costs than copayments, provided the coinsurance rate is high enough.

Negotiating prices from pharmacies can capture volume discounts and slightly lower prescription prices. Rebates from manufacturers can result in drug cost reductions. Yet if rebates detract from the most cost-effective drug choice, they may lead to false economies. For example, a 20% rebate can reduce the cost of a brand name prescription from \$50 to \$40, but a generic drug may be available for \$17.

Formularies, a list of covered or reimbursable drugs, can save costs if high cost drugs are omitted and if the formulary is associated with tiered copayments and/or rebates. Disease management programs often pay pharmacists to educate consumers who have specific medical conditions about improving their drug use. The aim is to minimize total treatment costs, but drug costs can increase if new drugs are emphasized.

Mail-service prescriptions, which accounted for only about 6% of prescriptions in 1998, can provide additional pharmacy pricing discounts. Typically, larger quantities of medication are dispensed per prescription which requires fewer, but slightly higher, consumer copayments.

In the next chapter, John Hansen reviews the experiences of the 14 states which were providing prescription drug benefits for 760,000 elderly and other low-income people in 1999. Most states target their limited budgets to low-income seniors and people with disabilities who do not qualify for Medicaid drug coverage.

Most states have income requirements often tied to the Federal Poverty Level (FPL) with program limits ranging from 100% to 225% of FPL. The 1999 Federal Poverty Level was $8,240 for an individual. Recognizing that strict income limits might exclude some people who need assistance, Maine and Delaware make exceptions to income limits for people with drug expenses above 40% of their income. Three states also have asset limits.

Some states restrict coverage to specific types of drugs such as maintenance drugs or drugs to treat specific conditions. Unlike private insurers, state programs generally do not use formularies, lists of prescription drugs which are covered by the program. 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.

Beneficiary cost sharing varies among states. In general, copayments and coinsurance are more common than benefit caps and deductibles. Three programs use coinsurance which requires enrollees to pay a fixed percentage of the cost of a prescription, giving enrollees a stronger incentive to use less expensive drugs. Six programs use a flat copayment which requires enrollees to pay the same amount for each type of prescription. Six programs use a tiered copayment structure with higher standard copayments for more expensive or brand name drugs than for generic products. In Maine, the program changed its 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%.

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.

Two-thirds of state pharmacy assistance programs received some or all of their funding from the state's general revenues. Nine programs were funded, in part, by other revenue sources such as a cigarette tax, a construction tax, a tobacco settlement, and the lottery. Vermont is the only state that receives partial federal funding for enrollees up to 175% of the FPL through the state's Medicaid waiver. Most state programs receive manufacturer rebates similar to the terms of Medicaid rebates.

Nine states administer aspects of their programs through the agency administering Medicaid, although the three largest state programs are intentionally administered separately from Medicaid to avoid any perceived stigma of programs for low-income people. States have encountered administrative challenges in determining eligibility, processing claims, and recovering payments from insurers when program participants have other coverage.

The third chapter is a reprint of the website of the National Conference of State Legislatures. As of January 2001, twenty-six states have authorized some type of pharmaceutical assistance program. Of these, 22 states have enacted laws to create programs, and four were created by executive branch action only. Because several states have more than one program, this chapter provides profiles on 35 state subsidy programs, including the number of recipients, basic eligibility requirements, year of creation, and contact information in each state.

The briefing report concludes with a summary of Wisconsin Medicaid's pharmacy program, a listing of state and national resources, and a glossary.