***February 2001***

## Options for Assisting Vulnerable Populations With Rising Costs and Declining Insurance Coverage For Prescription Drugs

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### *Introduction*

While Congress debates proposals to add a prescription-drug benefit to Medicare, many states are taking steps to better protect vulnerable residents, predominantly the elderly and disabled, from rising out-of-pocket costs and declining insurance coverage of prescription drugs. According to the National Conference of State Legislatures (NCSL), over 35 states considered legislation in 1999-2000 to address prescription-drug issues, ranging from creation or modification of pharmacy-assistance programs to creation of purchasing pools and discount-purchasing programs for seniors and persons with disabilities. In California, SB 393 (Speier) of 1999 took effect, requiring pharmacies that participate in the Medi-Cal program to charge Medicare beneficiaries no more than the Medi-Cal reimbursement rate for prescription drugs.

This issue brief describes options available to states to expand prescription drug coverage for Medicare beneficiaries and to assist these beneficiaries with the rising costs of prescription drugs.

### *The Problem: Declining Coverage and Rising Out-of-Pocket Spending for Prescription Drugs*

Although national expenditures for prescription drugs ($91 billion in 1998) comprise a small portion (9 percent) of total personal health-care expenditures, they have been one of the fastest-growing components of health-care spending in the past decade. Prescription-drug spending rose 15 percent from 1997 to 1998, compared to 5 percent for health-care expenditures overall. In the past five years, drug expenditures have grown two to four times faster than costs for most other health-care services.

Despite this rapid growth, Medicare doesn't provide coverage for prescription drugs. This means seniors and persons with disabilities must rely on supplemental coverage or pay out of pocket for their drugs. According to data compiled by the Kaiser Family Foundation, 31 percent of Medicare beneficiaries nationally had no drug coverage in 1996. Only slightly more than half had drug coverage that extended an entire year. In addition, nearly one in three insurance plans that provided supplemental coverage to Medicare beneficiaries in 2000 capped drug-benefit payments at $500 per year, far less than the out-of-pocket costs for most beneficiaries. Finally, prescription drug coverage under several types of supplemental coverage utilized by Medicare beneficiaries – including private Medigap coverage, employer-sponsored coverage, and Medicare HMOs – is declining as insurers cope with the rising costs.

Many studies show that lack of coverage for prescription drugs translates into reduced access to needed medications. According to the Kaiser Family Foundation, Medicare beneficiaries with drug coverage received an average of 21 prescriptions in 1996, compared with 16 for those without drug coverage. Total annual per-capita drug spending in 1996 by Medicare beneficiaries averaged $673. But those without drug coverage spent significantly less on drugs than those with drug coverage – $463 versus $769. Beneficiaries in poor health who lacked coverage also had substantially lower costs for drugs than those with coverage ($749 versus $1,340). At the same time, beneficiaries without drug coverage spent more per prescription in 1996 than those with coverage ($36.38 versus $28.92).

Studies also show that lower-income, older, and less-healthy beneficiaries, to whom Medicaid has traditionally been targeted, are especially vulnerable to the impact of rising drug costs. For example, according to the Kaiser Family Foundation:

- In 1996, 39 percent of beneficiaries with incomes between 100 and 150 percent of the poverty level had no drug coverage, compared with 30 percent of those with incomes from 201 to 300 percent of poverty and 24 percent of those with incomes over 300 percent of poverty.

- Among those with incomes under the poverty level, beneficiaries with drug coverage received on average 25 prescriptions in 1996, compared with 14 for those without coverage. Beneficiaries with drug coverage who listed themselves in poor health received an average of 38 prescriptions, while similar beneficiaries without drug coverage received only 27 prescriptions.

- Poor (below poverty) and near-poor (100 – 200 percent of poverty level) Medicare beneficiaries spend

disproportionately more of their incomes on out-of-pocket health-care costs (32 percent and 25 percent, respectively) than non-poor beneficiaries (15 percent) and beneficiaries overall (15 percent). These figures are driven in part by spending on prescription drugs.

### *State Options to Assist Elderly or Disabled Persons with Prescription Drug Needs*

This section summarizes recent state initiatives to increase access to prescription drugs in the following areas:

- State Prescription Drug Programs
- Discount Purchasing Programs
- Expanding Safety Net Purchasing Programs
- Increasing Enrollment in Medicaid Programs for the Elderly and Persons with Disabilities
- Subsidizing Existing Medicare HMO Coverage Arrangements
- Consumer Education About Options for Obtaining Prescription Drugs
- State Purchasing Pool Approaches
- Imposing Direct Price Controls
- New Federal Drug Assistance Program?

### *State Prescription Drug Coverage Programs*

According to NCSL, as of October 2000 some 20 states had established subsidized prescription-drug coverage programs for elderly and in some cases disabled residents who meet specified criteria. Persons enrolling in the programs meet established eligibility criteria, and pay costs that can include enrollment fees, co-payments ranging from $3 to $12 per prescription and, in some cases, deductibles. Eligibility for the programs is generally based on age, income, residency, and, in some cases, disability. Enrollees usually must have annual incomes below $14,000 to $18,000.

According to NCSL, enrollment in the programs ranges from less than 1,000 to more than 200,000, in Pennsylvania and New Jersey. Those two states, along with New York, account for two-thirds of the enrollees in the United States.

One of the oldest and largest drug-subsidy programs is Pennsylvania's Pharmaceutical Assistance Contract for the Elderly (PACE) program. Established in 1984, it provides comprehensive drug coverage to seniors with incomes below $14,000 for singles and $17,200 for married couples. Enrollees receive prescription medications from participating pharmacies for $6 per prescription. There are no deductibles and there is no maximum yearly benefit. The program is funded through the Pennsylvania lottery. The state also established a companion program called PACENET in 1986 that provides catastrophic drug coverage for seniors with incomes up to $16,000 for singles and $19,720 for couples. This program requires a $500 yearly deductible, as well as co-pays of $8 for generic drugs and $15 for brand-name drugs.

At least one state, Vermont, operates part of its prescription-drug assistance program as a Medicaid benefit. Under a Section 1115 waiver, the state provides a Medicaid-funded prescription-drug benefit to Medicare beneficiaries with incomes up to 150 percent of the poverty level. The eligibility level rises to 175 percent of poverty if maintenance drugs are needed. The state complements this with a wholly state-funded prescription-drug program for beneficiaries with incomes between 175 and 225 percent of poverty.

To obtain the waiver to operate the program and receive federal funds for it, the state had to demonstrate the cost-neutrality of the program to the federal government. It did this by including the program as part of a larger Medicaid waiver application that involved shifting enrollees (other than elderly and disabled persons) into managed care plans. The state operates a simplified enrollment program for the prescription-drug program, separate from the rest of its Medicaid program.

An advantage of drug-assistance programs is that they are generally exempt from Medicaid "best price" rules. These rules require manufacturers who participate in Medicaid to offer statutorily mandated rebates or the best price given to any purchaser in the state, with certain exceptions. The statutorily mandated rebates equal at least 11 to 15 percent of a drug-manufacturer's average price, depending on whether the drug is an innovator or generic drug.

The effect of the exemption is that drug manufacturers can extend deeper discounts on drugs offered through states' drug-assistance programs without having to offer them simultaneously to state Medicaid programs. Arguably, this gives manufacturers incentives to offer deeper discounts. However, states are limited in their ability to leverage

discounts beyond the Medicaid levels. For example, according to some experts, if states use pharmacy benefit managers (PBMs) as purchasing intermediaries, a proven technique that can in some cases result in significant discounts, the resulting prices are not exempt from Medicaid "best price" rules. In practice, according to the Government Accounting Office, most state programs receive rebates similar to the Medicaid program.

***Discount Purchasing Programs***

A number of states have taken steps to establish programs to enable seniors or others without prescription-drug coverage to purchase drugs at discounted prices.

For example, SB 393 (Speier) of 1999 (Chapter 946, Statutes of 1999) requires pharmacies that participate in the Medi-Cal program to charge Medicare beneficiaries no more than the Medi-Cal reimbursement rate for prescription drugs. Two other states, Florida and Maine, have enacted similar programs. While the Medi-Cal reimbursement level is often below the retail cost that persons without drug coverage pay, it does not reflect the rebates that the state ultimately receives on purchases for Medi-Cal beneficiaries.

States have had mixed luck allowing Medicare beneficiaries to purchase drugs at prices that reflect the Medicaid rebates. Vermont recently received a waiver so it could require manufacturers to extend Medicaid rebates to Medicare beneficiaries with incomes above 150 percent of the federal poverty level, the current Medicaid qualifying level for prescription-drug coverage. The rebates also must be extended to other individuals with incomes up to 300 percent of the poverty level who lack drug coverage. In essence, the waiver allows Medicare beneficiaries – and others without prescription-drug coverage – to be enrolled as Medicaid beneficiaries for the purpose of purchasing drugs at Medicaid post-rebate prices. There is a $24 enrollment fee for the program and a simplified enrollment process.

Maine recently received federal approval for a waiver to operate a program similar to Vermont's. New Hampshire has also announced its intent to submit a similar waiver request to allow persons with incomes up to 300 percent of the poverty level to purchase drugs at the discounted Medicaid prices.

The Pharmaceutical Research and Manufacturers of America has filed a lawsuit to stop the Vermont and Maine waiver programs on the grounds that they are not permissible under the federal Medicaid statute. State representatives expect the programs to withstand legal challenges from drug manufacturers, but final resolution is still pending.

On the other hand, Maine's controversial $R_X$ program, which seeks to provide access to discounted prices for drugs for residents lacking drug coverage based on manufacturer rebates, has been held up by a federal court. Enacted in 2000, it requires initial rebates from manufacturers at least equal to federally mandated Medicaid rebates. Subsequent rebates, beginning in October 2001, are required to be equal to or greater than any discount, rebate or price the manufacturer provides for any federal program.

The Maine law imposes civil penalties for profiteering by manufacturers, and establishes a procedure for setting maximum retail prices on all drugs sold in Maine in the event the state determines that prices under the Maine $R_X$ program are unreasonable compared to the lowest costs paid in the state. Finally, the law withholds coverage on the state's Medicaid formulary for manufacturers lacking rebate agreements and for drugs determined to be priced above maximum retail levels. In October 2000 a federal court issued an injunction prohibiting implementation of the new law, ruling it violated the interstate commerce provisions of the U.S. Constitution and was preempted by the federal Medicaid statute.

An advantage of discount purchasing programs is they generally do not require use of state funds. On the other hand, increasing access to discounted prices for prescription drugs may not provide enough relief to remove access barriers for many people. In addition, attempts to leverage discounts through economic sanctions, such as the Maine law attempts to do, may face legal barriers.

***Expanding Safety Net Purchasing Programs***

The Public Health Service Drug Discount Program, authorized under Section 340(B) of the Public Health Service Act, requires drug manufacturers participating in the Medicaid program to provide discounts or rebates for 16 specified federal health programs and to safety-net hospitals and clinics. Among the entities eligible for these discounts are certain disproportionate-share hospitals, federally qualified health centers, homeless health centers, family-planning clinics, and AIDS drug-assistance programs. Patients who receive care through the entities are eligible to purchase drugs at the discounted prices.

Federal statute establishes the Medicaid rebate price as the ceiling for drugs provided under the program, but allows lower prices to be negotiated. Since mid-2000, the program has been able to do that by contracting with a purchasing agent for the program. Through the intermediary, the program has been able to achieve discounts up to 40 percent below the mandated ceiling price on some drugs. Prices negotiated under the program are exempt from Medicaid "best price" rules.

There are a number of ways the state could make the 340(B)-discount purchasing programs more widely available to persons who lack prescription-drug coverage and are clients of 340(B)-covered programs:

- Allow the programs or entities to contract with outside pharmacies to dispense the drugs. Although federal law and guidelines allow it, the California Board of Pharmacy has interpreted California law to allow only programs or entities with in-house pharmacies to participate in the 340(B) program, thereby limiting the number of programs and entities whose patients may benefit from discount purchasing.

- Encourage other entities and programs that are not eligible to directly purchase drugs under the 340(B) program, for example certain county programs, to contract with other covered entities for care and treatment of their patients, thereby indirectly gaining access to the discounted prices.

- Provide greater information to patients about health-care programs and entities that participate in the 340(B)-discount purchasing program.

- Encourage programs or entities eligible to purchase drugs through the 340(B) program to apply for federal demonstration projects to expand access to discounted drugs for their patients. The federal Health Resources and Services Administration has indicated that it may begin authorizing demonstration projects later this year under which eligible entities will be able to contract with multiple pharmacies for dispensing of drugs and to create networks for purposes of contracting with pharmacies for drug dispensing.

Again, an advantage of these options is that they entail limited state costs. The chief disadvantage is that to benefit from the discounted prices, persons must be receiving care from entities designated under federal law – generally safety net providers – which limits accessibility to the program.

***Increasing Enrollment in Medicaid Programs for the Elderly and Persons with Disabilities***

Medi-Cal, the state's Medicaid program, offers a number of programs for elderly and disabled persons that either include prescription drugs as part of the coverage and/or assist Medicare beneficiaries with out-of-pocket costs associated with Medicare, including Part A (if applicable) and Part B premiums, deductibles, and copayments.

- **Aged, Blind and Disabled Programs**. As of January 1, 2001, elderly or disabled persons whose monthly incomes are below roughly 133 percent of the poverty level ($926 monthly for an individual and $1,247 for a couple) are eligible for full-scope Medi-Cal. For these enrollees, Medicaid acts as a secondary insurer for benefits Medicare doesn't include, such as prescription drugs and long-term care. For most, it also pays for Medicare cost-sharing amounts.

- **Medicare "Buy-In" Programs**. Medicare beneficiaries with incomes up to 175 percent of the federal poverty level are eligible for Medicare "buy-in" programs. While these programs do not provide prescription-drug coverage per se, they do provide assistance with Medicare out-of-pocket costs:

    - ***Qualified Medicare Beneficiary (QMB) Program***. Beneficiaries with incomes at or below the poverty level (roughly $707 monthly for an individual; $942 for a couple) and assets below $4,000 for an individual and $6,000 for a couple – known as qualified Medicare beneficiaries (QMBs) – are eligible to have Medicaid pay their Medicare premiums, deductibles, and co-payments.

    - ***Specified Low-Income Medicare Beneficiary (SLMB) Program***. Persons with incomes between 100 and 120 percent of the poverty level (up to $844 monthly for individuals; $1,126 for couples) are known as specified low-income Medicare beneficiaries *(SLMBs)*. They are eligible for Medicaid payment of their Medicare Part B premiums.

- ***Qualified Individual (Q1 and Q2) Programs***. States receive federal block grant payments to pay all or a portion of the Medicare Part B premiums for persons with incomes between 120 percent and 175 percent of the poverty level (up to $1,222 for individuals and $1,633 for couples). These are referred to as *qualified individuals, or Q1s and Q2s*. These programs are not entitlements and are limited to the amount of funds available.

There are a number of ways the state could expand enrollment in Medicaid programs that provide prescription-drug coverage or financial assistance to offset the costs of prescription drugs:

- **Disregard income and/or assets in determining eligibility**. Under Section 1902(r)(2) of the Social Security Act, states are allowed to set higher income and resource levels for eligibility for both full-coverage options for seniors and the disabled and the Medicare "buy-in" programs. According to Families USA, at least 12 states have liberalized income disregards for some groups of senior Medicare beneficiaries, although few, if any, appear to have expanded eligibility to above the poverty level using this mechanism. California is already pursuing this option to raise the income eligibility for the aged, blind, and disabled programs to 133 percent of the poverty level. The state could choose to disregard income up to some higher threshold, e.g. 150 or 200 percent of the poverty level and/or apply a similar disregard in QMB and SLMB programs. In addition, the state could eliminate or raise limits on assets as a means of expanding eligibility for these programs.

- **Simplify Enrollment in Existing Programs**. A variety of enrollment barriers appear to contribute to the under-utilization of Medicare buy-in programs nationally, among them lack of awareness of programs, complexity of the application process, the link to welfare programs, fear of loss of Medigap or other supplemental coverage, and apprehension about estate-recovery rules.

  According to the Kaiser Family Foundation, Medicaid provides supplemental coverage for only about half of all beneficiaries with incomes below poverty. Just 12 percent of those with incomes between 100 and 200 percent of poverty receive supplemental coverage. A 1998 Families USA report estimated that up to 3.9 million people nationally who are eligible for QMB and SLMB programs are not enrolled in them. California appears to be doing better than the national average, with roughly 80 percent of eligibles enrolled, according to Health Care Financing Administration statistics.

  While California has developed a shortened, mail-in application form for the QMB, SLMB, Q1, and Q2 programs, additional steps could be taken to simplify application for these programs, including reducing the requirements to document income and assets, and eliminating or raising asset limits. In addition, the state could adopt a combined application form for Medicare beneficiaries to use to apply for *all* Medicaid options for which they may be eligible. This would eliminate the need for beneficiaries who may be eligible for more extensive coverage under the aged, blind and disabled programs, or the medically needy program, to file supplemental applications.

  Finally, the state could modify its estate-recovery rules to disallow recovery against estates of deceased Medi-Cal beneficiaries who utilize services other than those for which recovery must be imposed under federal law. Federal rules require cost-recovery for long-term care services, hospitalization, and prescription drugs that are provided to Medi-Cal beneficiaries in the course of long-term care treatment. Limiting cost recovery to these services would exempt most services received by Medicare buy-in program enrollees and many of those used by aged, blind, and disabled beneficiaries.

- **Conduct Greater Outreach**. While California has taken strides to simplify its application process for the QMB, SLMB, and Q1 and Q2 programs, it does not conduct advertising and outreach to encourage enrollment in the programs. Several other states have developed outreach messages stressing that the QMB/SLMB programs can put needed money back in the pockets of seniors and disabled persons to pay for other essentials, such as prescription drugs, stressing that they are not government "handouts." Also effective has been use of community-based organizations in finding and screening clients for eligibility, assisting with applications, and tracking the processing of applications. As part of the administration of the Medicaid program, outreach expenditures are eligible for enhanced federal reimbursement.

There are several advantages in expanding Medicaid as a form of assistance to low-income elderly and disabled persons. The first is that the federal government pays a share (roughly 50 percent in California) of the costs of

coverage provided under these programs. In addition, for beneficiaries qualifying for full Medicaid coverage, the level of prescription-drug coverage and other services is very generous and the accessibility of services is widespread.

The chief disadvantage is the cost to the state. In addition, in the absence of enrollment simplification, outreach, revised estate-recovery requirements and other reforms, many seniors likely would not be aware of Medicaid options for which they may be eligible and could face obstacles in enrolling.

***Subsidizing Existing Medicare HMO Coverage Arrangements***

According to the California Medicare Project, over 1.5 million Medicare beneficiaries in California are enrolled in Medicare managed care plans (under what's known as the Medicare + Choice program). The advantage of these coverage arrangements is that they generally provide additional benefits beyond those covered directly by Medicare, including prescription drugs, for either no additional cost or a small monthly premium. However, in response to cost pressures, the plans have been steadily increasing the portion of costs borne by enrollees. For example, according to the project, beginning in 2001, 73 percent of plans offering coverage in California require premiums, compared to 50 percent in 2000 and 24 percent in 1999. In the area of prescription drugs, over 40 percent of the plans are increasing drug copayments in 2001, over the levels in 2000.

In order to ensure that Medicare beneficiaries do not drop out of these coverage arrangements due to increasing costs, the state could subsidize the premiums for low-income beneficiaries. As an example of this, the Governor's 2001–2002 Budget proposes to spend $20 million ($9.9 million General Fund) in 2001-2002 to fully subsidize premiums for some 64,000 Medicare HMO enrollees who are also Medi-Cal beneficiaries.

The advantage of this approach is that it creates an incentive for Medicare beneficiaries to maintain existing drug coverage. The disadvantage is that not all counties are served by Medicare HMOs (23 currently) raising geographical equity concerns; in addition, the extent of drug coverage available under these plans varies from plan to plan, also raising geographical equity issues. For example, the percentage of plans that do not offer prescription drug coverage increased to 14 percent in 2001, from 10 percent in 2000. Forty percent of plans decreased the amount of coverage they provide in 2001.

***Consumer Education About Options for Obtaining Prescription Drugs***

Many persons who lack prescription-drug coverage may, in fact, be eligible for coverage or for free or low-cost prescription drugs from a variety of sources, both public and private, including:

- Medicaid coverage options outlined above;
- Patient-assistance programs sponsored by pharmaceutical manufacturers;
- Safety-net clinics and hospitals eligible to purchase drugs through the Public Health Service Drug Discount Program;
- Programs emanating from drug-pricing lawsuits, such as the California Drug Distribution Project;
- Clinics and hospitals administered by the U.S. Veterans Administration;
- Commercial and nonprofit discount drug programs, including those administered by the American Association of Retired Persons (AARP) and by large retail chains;
- Certain Medicare supplemental-coverage plans.

Unfortunately, many seniors are confused by or unaware of the array of options facing them. As has been documented, pharmacy-assistance programs operated by pharmaceutical manufacturers require separate and, in some cases, lengthy applications. To remedy this, the state could fund a statewide ad campaign and 800 toll-free number to provide seniors and others with the information they need to find the best options and prices for prescription drugs, including subsidized coverage programs they may be eligible for.

AB 757 (Gallegos) of 2000 would have directed the state Department of Health Services to take various actions to

educate and counsel elderly persons about financial assistance for prescription drugs. These included publicizing patient-assistance programs sponsored by pharmaceutical companies and court settlements regarding free or low-cost prescription drugs for seniors who cannot afford them. This concept could be broadened to include the range of programs and options listed above.

***State Purchasing Pool Approaches***

A number of states have begun to assess the feasibility and benefits of consolidating their purchasing power, either with other states or among the various programs that purchase drugs within their borders. Their goals are to achieve deeper discounts on prescription drugs and offer uninsured residents the ability to purchase drugs through those consolidated programs.

For example, the states of Vermont, New Hampshire and Maine have formed the Northern New England Tri-State Coalition. It is determining the feasibility of aggregating the purchasing power of the three states to provide a more cost-effective means of purchasing drugs for Medicaid beneficiaries initially, with plans to later expand it to include state employees, the uninsured, and businesses that do not provide prescription drug coverage.

In California, SB 1880 (Sher) of 2000 would have required the California Public Employees' Retirement System (Cal PERS), in consultation with the state Department of Health Services, to determine the feasibility of aggregating the purchase of prescription drugs for Medi-Cal and Medicare participants, participants in the PERS health-benefits program, other individuals covered by government-subsidized programs, and uninsured and under-insured persons 65 and older.

In practice, a number of administrative issues complicate states' efforts to consolidate their purchasing power, either with other states or among the programs they operate within their borders. For example, in light of the Maine federal court ruling, in the absence of federal approval, states may be limited in the types of actions they can take to leverage greater prescription drug discounts. For example, states may not be able to restrict the access of Medicaid beneficiaries to drugs of manufacturers who don't agree to discounts.

Secondly, even if combined purchasing pools could create master formularies giving preference to drugs for which deeper discounts are provided, such formularies may run afoul of Medicaid rules requiring less restricted access to drugs for Medicaid beneficiaries. In addition, it may in practice be difficult to get agreement among disparate purchasers on the make-up of those formularies.

Finally, the various programs that purchase drugs within states do so in different ways. For example, Medicaid programs and state employee-benefit plans frequently provide services, including prescription drugs, through managed-care plans, which currently negotiate their own prices.

***Imposing Direct Price Controls***

A few states have explored the option of directly regulating prescription drug prices. As mentioned above, the Maine law passed in 2000 imposes price restrictions on pharmaceutical companies. The law establishes a commission to monitor drug prices and imposes fines up to $100,000 on drug manufacturers or distributors for profiteering. In addition, the law requires prices for drugs provided through the $R_X$ program, the state's drug assistance program, to be comparable to those provided to the lowest-paying customers in the state. The commission will decide by January 2003 whether individual companies have reached this standard. If the commission determines that prices are still too high, the law allows the state to establish price limits for all drugs sold in the state beginning in July 2003.

SB 2075 (Speier) of 2000 would have required the state Department of Health Services, in consultation with a task force created by the bill, to evaluate and report on a system for requiring manufacturers and wholesalers to sell prescription drugs at prices no higher than their prices in Canada.

State efforts to directly control prescription-drug prices face a number of legal uncertainties. In October 2000 Maine's law was put on hold by a federal court on the grounds that its pricing provisions violated federal constitutional protections for interstate commerce.

***New Federal Drug Assistance Program?***

While Congress is expected to debate comprehensive proposals to add a prescription drug benefit to Medicare, President Bush in late January proposed what he termed a "stop-gap" measure, designed to provide a limited and temporary solution to the problem of declining coverage of prescription drugs and rising costs facing the elderly and disabled.

The $48 billion, four-year program, known as the Immediate Helping Hand Program, would allocate funds to states, to be used to provide prescription drug coverage to Medicare-eligible individuals whose incomes are below 175 percent of the federal poverty level, or who have catastrophic drug expenses, and are not eligible to receive drug benefits through Medicaid or private retiree benefit plans. States would be prohibited from charging persons with incomes below 135 percent of the poverty level any premiums for participation in the program; for persons with incomes between 135–175 percent of the poverty level, 50 percent of premium costs would be subsidized. Copayments would be required to be either nominal or commensurate with one or more established benchmark plans. States would have to get federal approval of their plans in order to access the federal funding.

Under the program, states with established drug assistance programs would be allowed to use the federal funding for persons meeting the federal eligibility criteria and use state funds that they otherwise would have spent to provide drug benefits for persons with higher incomes.

Reaction to the proposal has varied and prospects for its enactment are uncertain.

### *Conclusion*

States have a number of options for expanding access to prescription drugs and/or reducing the cost of prescription drugs for vulnerable populations. Although this is not a traditional role for states, many states are moving into the void created by delays at the federal level in adopting a prescription-drug supplement to Medicare. State programs and policies are likely to evolve in this area, as states look for ways to provide meaningful relief for seniors and other vulnerable populations without creating large new expenditure programs.

*Prepared by Peter Hansel*

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***Acknowledgements***

The author would like to acknowledge the assistance of several people who reviewed and edited earlier drafts of the paper and who provided information that was utilized in the preparation of this report. In particular, the author would like to thank the following: Herb Olson, Vermont Legislative Counsel's Office; Dick Cauchi, National Conference of State Legislatures; Kathryn Duke, Director, Pharmaceuticals and Indigent Care Program; and Becky LaVally, Senate Office of Research.