

5/18/98

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SUMMARY MEDIGAP DRUG COVERAGE

Plan H:

Coverage for 50% of the cost of prescription drugs up to a maximum annual benefit of \$1,250 after the policyholder meets a \$250 per year deductible (this is called the "basic" prescription drug benefit).

Plan I:

*** Basic prescription drug coverage (see Plan H for description).

Plan J:

• Coverage for 50% of the cost of prescription drugs up to a maximum annual benefit of \$3,000 after the policyholder meets a \$250 per year deductible (this is called the "extended" drug benefit).

Additional Facts

Massachusetts and Wisconsin (non-standard States) have mandated drug coverage for all Medigap plans. We have not examined coverage in other non-standard states.

The other issue of relevance is that we think even the AARP "underwrites" the drug policies (no guaranteed issue).

Also some beneficiaries with "grand fathered" Medigap (policies in existence before standardization) may have drug benefits other than the ones described above.

What We Don't Know

Number of people in specific Medigap plans.

All We Know

NAIC has information on number of people covered by each issuer (company).

Standard Medigap Plans

Following is a list of the 10 standard plans and the benefits provided by each:

PLAN A (the basic policy) consists of these basic benefits:

- Coverage for the Part A coinsurance amount (\$190 per day in 1997) for the 61st through the 90th day of hospitalization in each Medicare benefit period.
- Coverage for the Part A coinsurance amount (\$380 per day in 1997) for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used.
- *** After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime. This benefit is paid either at the rate Medicare pays hospitals under its Prospective Payment System (PPS) or under another appropriate standard of payment for hospitals not subject to the PPS.
- *** Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells per calendar year unless replaced in accordance with federal regulations.
- *** Coverage for the coinsurance amount for Part B services (generally 20% of approved amount; 50% of approved charges for outpatient mental health services) after \$100 annual deductible is met.

PLAN B includes the basic benefit plus:

- Coverage for the Medicare Part A inpatient hospital deductible (\$760 per benefit period in 1997).

PLAN C includes the basic benefit plus:

- Coverage for the Medicare Part A deductible.
- *** Coverage for the skilled nursing facility care coinsurance amount (\$95 per day for days 21 through 100 per benefit period in 1997).
- *** Coverage for the Medicare Part B deductible (\$100 per calendar year in 1997).

*** 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.

PLAN D includes the basic benefit plus:

•Coverage for the Medicare Part A deductible.

*** Coverage for the skilled nursing facility care daily coinsurance amount.

*** 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.

*** Coverage for at home recovery. The at home recovery benefit pays up to \$1,600 per year for short-term, at home assistance with activities of daily living (bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury or surgery. There are various benefit requirements and limitations.

PLAN E includes the basic benefit plus:

•Coverage for the Medicare Part A deductible.

*** Coverage for the skilled nursing facility care daily coinsurance amount.

*** 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.

*** Coverage for preventive medical care. The preventive medical care benefit pays up to \$120 per year for such things as a physical examination, serum cholesterol screening, hearing test, diabetes screenings, and thyroid function test.

PLAN F includes the basic benefit plus:

•Coverage for the Medicare Part A deductible.

*** Coverage for the skilled nursing facility care daily coinsurance amount.

*** Coverage for the Medicare Part B deductible.

*** 80% coverage for medically necessary

*** emergency care in a foreign country, after a \$250 deductible.

*** Coverage for 100% of Medicare Part B excess charges.*

PLAN G includes the basic benefit plus:

•Coverage for the Medicare Part A deductible.

*** Coverage for the skilled nursing facility care daily coinsurance amount.

*** Coverage for 80% of Medicare Part B excess charges.*

*** 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.

*** Coverage for at home recovery (see Plan D).

PLAN H includes the basic benefit plus:

•Coverage for the Medicare Part A deductible.

*** Coverage for the skilled nursing facility care daily coinsurance amount.

*** 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.

*** Coverage for 50% of the cost of prescription drugs up to a maximum annual benefit of \$1,250 after the policyholder meets a \$250 per year deductible (this is called the "basic" prescription drug benefit).

PLAN I includes the basic benefit plus:

•Coverage for the Medicare Part A deductible.

*** Coverage for the skilled nursing facility care daily coinsurance amount.

*** Coverage for 100% of Medicare Part B excess charges.*

*** Basic prescription drug coverage (see Plan H for description).

*** 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.

*** Coverage for at home recovery (see Plan D).

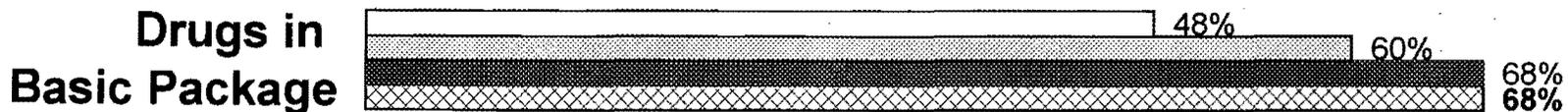
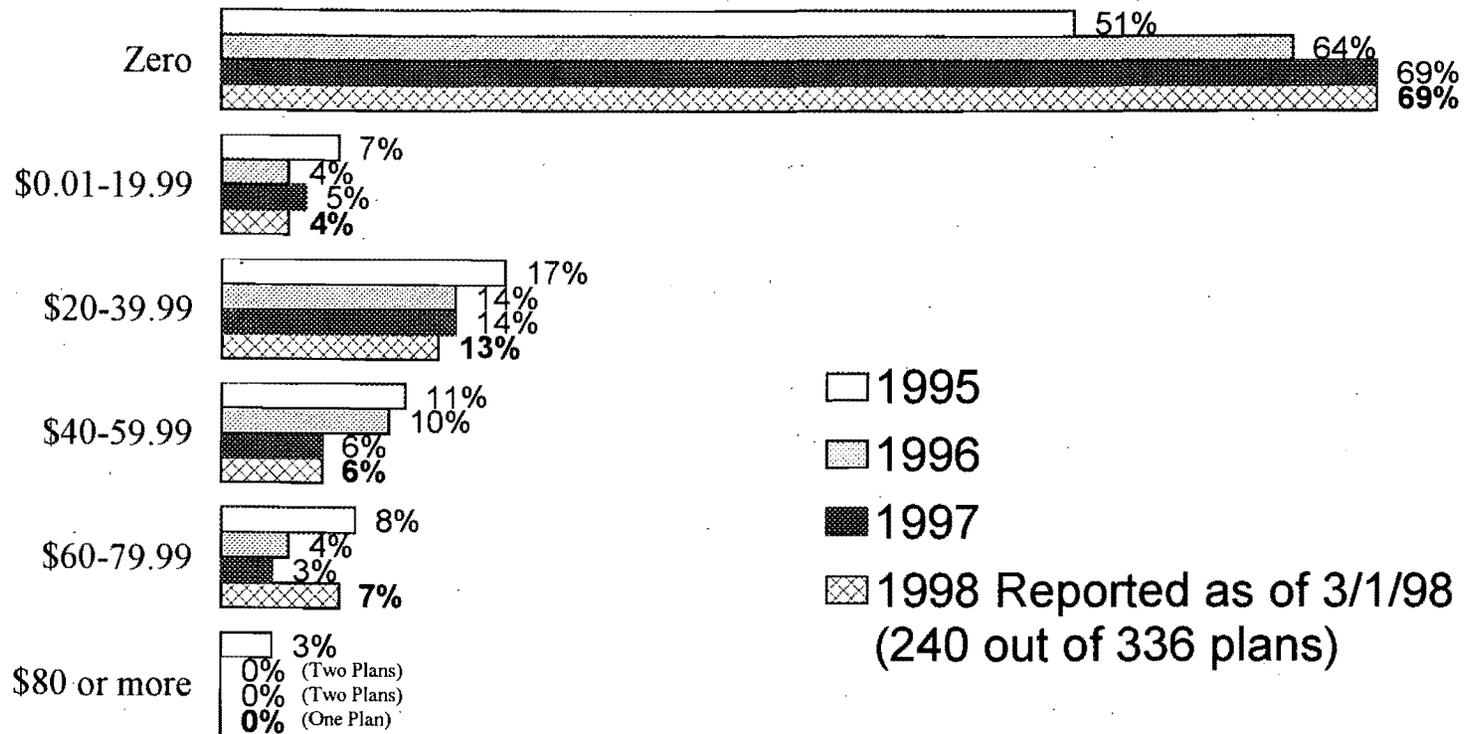
PLAN J includes the basic benefit plus:

- Coverage for the Medicare Part A deductible.
- *** Coverage for the skilled nursing facility care daily coinsurance amount.
- *** Coverage for the Medicare Part B deductible.
- *** Coverage for 100% of Medicare Part B excess charges.*
- *** 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.
- *** Coverage for preventive medical care (see Plan E).
- *** Coverage for at home recovery (see Plan D).
- Coverage for 50% of the cost of prescription drugs up to a maximum annual benefit of \$3,000 after the policyholder meets a \$250 per year deductible (this is called the "extended" drug benefit).

* Plan pays a specified percentage of the difference between Medicare's approved amount for Part B services and the actual charges (up to the amount of charge limitations set by either Medicare or state law).

Risk HMO Monthly Premium Levels, Drug Coverage: Percent of Plans by Category, October, 1995-97, March 1998

51% of plans had no basic premium in 1995, increasing to 64% in 1996 and 69% in 1997; more plans are providing prescription drugs as a basic benefit



Source: HCFA Managed Care Monthly Reports.

State Pharmaceutical Assistance Programs Overview

Overview

- There are at least eleven States that have implemented programs to provide pharmaceutical coverage for low-income elderly or persons with disabilities who do not qualify for Medicaid:

Connecticut, Delaware, Illinois, Maine, Maryland, Massachusetts, New Jersey, New York, Pennsylvania, Rhode Island, Vermont

The program vary widely in program design, cost, range of medications covered, enrollee copayments, and income eligibility limits. The attached charts summarizes the characteristics of all of these programs, except for Massachusetts. Massachusetts implemented their Senior Pharmacy Program in July, 1997, after the attached chart was published.

However, within the last year or so, we believe a few more States have implemented new programs. We have not yet been able to confirm which additional States now have low-income drug programs, although we have heard there could be as many as 7 more States with these programs.

In addition, Michigan has a tax rebate program called the Prescription Drug Credit program. To be eligible for this tax credit or rebate, seniors must be 65 years or older, have had an annual income in 1997 of less than \$11,835 if single, or less than \$15,415 if married. In addition, an individual must have spent at least 5 percent of their household income for prescription drugs in 1997. This excludes the cost of drugs paid for or reimbursed by Medicare, Medicaid, or other insurance. The maximum credit is \$600 for a single person or \$1,200 for a married couple. The actual amount of the credit will depend on the number of residents filing claims -- State law budgets a fixed amount each year, so if the credits claimed exceed that amount, all credits will be pro-rated. However, they have never exceeded the budgeted amount. The average refund mailed during 1997 was \$464.34.

Summary of the initial ten state prescription drug programs: CT, DE, IL, ME, MD, NJ, NY, PA, RI, VT

- ***Eligibility Age***
All States define elderly as age 65 or older. Four States include the under age 65 disabled. Maryland's program is not restricted to the elderly or disabled; *all ages* are eligible.
- ***Income Limits***
All are means tested, with annual income eligibility limits ranging from a low of \$9,800 for a couple (\$9,050 for a single individual) in Maryland, to a high of \$23,700 in New York (single, \$18,000).

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**PHOTOCOPY
PRESERVATION**

- ***Drugs Covered***
Six of the States cover all approved prescription drugs, with some limitations. The remaining four States cover prescription drugs for selected diseases. Four States use formularies.
- ***Co-payments and Deductibles***
All ten States use some form of co-payment -- either a flat dollar amount per prescription, or a percentage of the drug cost. Three States also require a deductible.
- ***Rebates***
Nine out of ten States uses some type of manufacturer rebate (primarily the Medicaid rebate).
- ***Funding Source***
Funding sources vary significantly, although all have co-payments and/or deductibles. Six States use funds from the State General Fund. Pennsylvania uses a lottery fund. Delaware's program is funded solely by a foundation. Vermont has set up a "Health Trust Fund," which is paid for by an increase in the tobacco tax.
- ***Number of Prescriptions***
The number of prescriptions per year per participant varies from a low of 10 (Vermont) to a high of 34 (Pennsylvania). (Maine data indicate 147 per year per participant, but this includes refills.)
- ***Program Costs***
The cost per participant in FY 1996 ranged from a low of \$96 in Vermont to a high of \$963 in New Jersey. Clearly, the cost per participant will vary depending on a number of program features.

Summary of the Massachusetts Senior Pharmacy Assistance Program

Program Name: Senior Pharmacy Assistance Program

Year Enacted: 1996 (implemented 7/1/97; revised 12/97)

Eligibility Age: 65

Eligible Income Level: 150% of poverty (up from initial 133% of poverty)

Funding Source: Tobacco tax, \$15.00 enrollment fee for admin. (deducted from the yearly benefit)

Type of Manufacturer Rebate: Medicaid

Deductible: --

Copayment: \$3 generic; \$10 brand

Maximum benefit: \$750 per enrollee per year (up from initial \$500 per enrollee per year)

Drugs Covered: Limited to certain classes of drugs such as those used to treat chronic diseases commonly found in the elderly.

Number of Enrollees: Currently, there are approximately 24,000 enrolled.

Expanded Prescription Drug Coverage

Since 1977, many states have implemented programs to provide pharmaceutical coverage for low-income elderly or persons with disabilities who do not qualify for Medicaid. Below, is a description of ten states that are currently offering expanded drug coverage--Connecticut, Delaware, Illinois, Maine, Maryland, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont. As seen below, these expanded drug coverage programs often differ in design.

The following four tables provide detail on program characteristics: program overview information and eligibility criteria; funding and reimbursement information; types of drugs covered and the existence of a formulary; and program data including number of enrollees and cost per enrollee.

Overview and Eligibility Criteria

State Name	Program Name	Year Enacted	Eligibility Age (Elderly)	Eligibility Age (Disabled)	Eligible Income Level (Single)	Eligible Income Level (Married)	Other Eligible Groups
Connecticut	ConnPACE	1986	65	18	\$13,800	\$16,600	No
Delaware	Nemour Health Clinic Pharmaceutical Assistance Program	1981	65	-	\$11,900	\$16,300	No
Illinois	Pharmaceutical Assistance Program (PAP)	1985	65	16	\$14,000	\$14,000	Widow(er) who turned 63 before deceased claimant's death
Maine	Low Cost Drugs for the Elderly Program	1975	65	55	\$10,000	\$12,400	No
Maryland	Maryland Pharmacy Assistance Program	1979	All ages	All ages	\$9,050	\$9,800	Eligibility based on income and assets
New Jersey	Pharmaceutical Assistance for the Aged and Disabled (PAAD)	1975	65	18	\$17,550	\$21,519	No
New York	Elderly Pharmaceutical Insurance Coverage (EPIC)	1987	65	-	\$18,000	\$23,700	No
Pennsylvania	PACE	1984	65	-	\$14,000	\$17,200	No
	PACENET	1996	65	-	>\$14,000 ≤\$16,000	>\$17,200 ≤\$19,200	No
Rhode Island	Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE)	1985	65	65	\$15,042	\$18,804	No
Vermont (1)	Vermont Health Access Program (VHAP)	1996	65	--	\$988 over 150% of FPL	\$1327 over 150% of FPL	Those who receive Social Security disability benefits or Medicare
Vermont (2)	VSCRIPT	1989	65	--	\$1151 over 175% of FPL	\$1548 over 175% of FPL	No

FPL = Federal Poverty Level.

SOURCE: "PHARMACEUTICAL BENEFITS UNDER STATE MEDICAL ASSISTANCE PROGRAMS: 1997"
PRODUCED BY THE NATIONAL PHARMACEUTICAL COUNCIL

NPC 1997

Expanded Prescription Drug Coverage, Con't

Funding/Reimbursement

State Name	Funding Source	Type of Manufacturer Rebates	Deductible Amount	Copayment Amount	Ingredient Cost Reimbursement	Dispensing Fee Reimbursement
Connecticut	State Budget Appropriations	Medicaid	-	\$12.00	AWP - 12%	\$4.10
Delaware	Nemour Foundation (Estate of Alfred I. Dupont)	None	None	\$5.00 or 20% of average acquisition cost + \$4.00 dispensing fee (max. yearly benefit of \$2000 based on average retail cost)	None	None
Illinois	General Fund	Not same as Medicaid; based on formulary and rebate agreements	\$180 or \$300	20% of drug cost over \$800	AWP - 10%	\$3.60
Maine	State General Fund	Medicaid	N/A	20% of drug cost	AWP - 10%	\$3.35
Maryland	General Fund	Medicaid	N/A	\$5.00	WAC + 10%	\$4.21
New Jersey	State General Fund and Casino Revenue Fund	Medicaid with no CPI	0	\$5.00	AWP - 10%	\$3.73-\$4.07
New York	General Fund, Participant Fees, Rebate Revenue	Medicaid w/o CPI penalty	\$468-\$638, depending on income	\$3-\$23 based on drug cost	AWP or AWP - 5% (based on provider volume)	\$2.75-\$3.00 based on services provided
Pennsylvania	Pennsylvania Lottery	17% AMP Brand/generic flat rate; additional rebate based on CPI annual rate of change by quarter if AMP increases exceed CPI increases	\$0	\$6.00	AWP - 10%	\$3.50
	(same)	(same)	\$500/year	\$15 brand name \$8 generic	(same)	(same)
Rhode Island	State revenues and manufacturer rebates	Medicaid	None	40% of drug cost	AWP - 13%	\$2.50 per script
Vermont (1)	Health Trust Fund plus federal match funds (60% federal, 40% state)	Medicaid	-	\$1-\$2	AWP - 10%	\$4.25
Vermont (2)	Health Trust Fund	None	-	50% of drug cost	AWP - 10%	\$4.25

AMP = Average Manufacturer Price; CPI = Consumer Price Index.

Expanded Prescription Drug Coverage, Con't

Drug Coverage

State Name	Formulary	Drug Coverage Restrictions	Drugs Covered
Connecticut	None (follows a nongate formulary)	No anti-histamines, cough preparations nor experimental, cosmetic, diet and fertility/contraceptive drugs. Also not covered are multivitamins and smoking cessation gum. 120 unit or 30 day supply limit.	All prescription medications (see restrictions).
Delaware	Yes (open)	No injectables or OTC	All prescription medications (see restrictions). Formulary is unpublished.
Illinois	Yes (open)	Generic must be dispensed if available.	Approved prescription medications used for the following conditions: cardiovascular disease, diabetes (insulin, syringes, and needles), arthritis.
Maine	No	Manufacturer must participate in rebate program.	All drugs from participating manufacturers used for the chronic treatment of diabetes, asthma, COPD, cardiac, arthritis, and anticoagulation.
Maryland	Yes	75% utilization required before prescription refill.	Specified categories of maintenance drugs used to treat chronic conditions, anti-infective drugs, and insulin syringes and needles.
New Jersey	No	No coverage of syringes, DESI drugs, diabetic-testing materials, non-rebatable drugs; Prescription supply is limited to 60 day supply or 100 count (greater amount).	All legend drugs (see restrictions).
New York	No	No DESI, non-rebatable drugs.	Approved prescription medications (see restrictions)
Pennsylvania	Yes (open)	No experimental drugs or drugs for baldness and wrinkles, OTC's, most off-label uses; mandatory generic substitution for A-rated products; DESI drugs require documentation of medical necessity	All federal legend drugs and insulin, insulin syringes and needles manufactured by companies who participate in the PACE rebate program.
	Yes (open)	(same)	(same)
Rhode Island	Yes (open)	Limited by therapeutic class.	Anti-diabetics, anticoagulants, antilipemics, oral antineoplastics, drugs for the treatment of asthma and other chronic respiratory diseases, cardiac drugs, diuretics, drugs for glaucoma, hemorrhologic agents, hypotensive agents, insulin and insulin needles/syringes, drugs for Parkinson's Disease, vasodilating agents, and prescription vitamin and mineral replacements for renal patients.
Vermont (1)	No	No experimental or OTC drugs.	Approved prescription medications.
Vermont (2)	No	30-60 day supply limit.	Approved prescription medications.

Expanded Prescription Drug Coverage, Con't

Program Enrollment/Costs

State Name	Number of Enrollees (FY 96)	Cost per Participant (FY 96)	Number of Prescriptions Per Year Per Participant	Notes
Connecticut	41,977	\$700.33	16.1	Generic substitution is mandatory.
Delaware	10,150	\$250.00	16.6	There is one central pharmacy for the entire program that distributes all drugs by courier to branch locations where citizens can pick up a 2-3 month supply. There is no need therefore for ingredient or dispensing fee reimbursement. Pharmaceutical Assistance Program is for DE residents, US citizens, people age >65 below income limits. The program receives no state or federal funds.
Illinois	60,847	\$531.57	22.2	Deductibles and co-payments are charged after the program has paid \$800 per year per recipient. Recipient pays ancillary charge for brand drugs.
Maine	22,000	\$154.55	147.0 (includes refills)	Eligible income level may be increased to \$12,500 (single) or \$15,500 (married) if legend drug expenses are greater than 40% of income. Also, if couples are age 55-62 and are attempting to qualify for coverage through disability eligibility, both individuals must be receiving disability.
Maryland	34,000	\$474.36	15.5	The following groups are ineligible for participation: people detained in a correctional (federal, state, local) system, Medicaid recipients, and non-residents. Income eligibility is defined by the number of people in a household (limit=10 people).
New Jersey	214,794	\$963.09	24.7	
New York	103,240	\$582.00 net state cost	33	Rebates do not include CPI penalty. For participants with incomes of \$5,000-\$17,500 (single) or \$5,000-\$23,000 (married), there is a quarterly, income-specific fee of \$24-\$194. For participants with incomes of \$10,500-\$17,000 (single) or \$14,000-\$23,000 (married), a deductible is paid. Fee/deductibles required to join. Copays of 40% at purchase. Enrollment declining despite 1996 COLA (3% increase for income limits).
Pennsylvania	315,720	\$855.35	34.4	In addition to the noted rebate, there is also an index rebate based on CPI if AMP exceeds CPI rate of increase from the previous year. There is extensive drug utilization review for selected therapeutic classes.
	1,522	0		
Rhode Island	16,000	\$401.80	21.9	All eligibles get \$7.37 deducted from their phone bill and 50% off of a new line installation. If income level is exceeded, state can deduct 3% and can exclude medical expenses from their income calculation. Formulary is the Medispan policy (Blue Cross).
Vermont (1)	3,378 eligibles 2,168 recipients	\$224.00	10	Health Trust Fund is paid for by an increase in the tobacco tax. People may not have prescription insurance.
Vermont (2)	3,488	\$96.00	19	Health Trust Fund is paid for by an increase in the tobacco tax. Program only covers maintenance drugs, not acute drugs.

AMP = Average Manufacturer Price; CPI = Consumer Price Index.

COMPARISON OF STATE PHARMACY PROGRAMS - TABLE F-1

	Current Number of Participants	Percent of 65+ Elderly Population	Funding Source	Average Participant	Target Population
New York	107,000 Seniors	4% ⁽¹⁾	General Fund and Enrollment Fees	Widow, age 78	Serves seniors with low to moderate income having above average drug costs and no other prescription insurance.
New Jersey	206,300 Seniors 21,700 Disabled	21% ⁽¹⁾	General Fund; Casino Revenue Fund ⁽¹⁾	Low income senior	Participation in the program qualifies elderly and disabled for other state benefits such as utility, hearing aid assistance, and motor vehicle fees reduction.
Pennsylvania	310,000 Seniors	16%	Lottery Funds ⁽¹⁾	Widow, age 79, \$9,000-\$13,000 income	Frail and elderly who meet income eligibility.
Illinois	48,000 Seniors 22,000 Disabled	6% ⁽¹⁾	General Fund ⁽¹⁾	Low income qualified senior and disabled person.	Program serves seniors 65 years or older, or persons totally disabled, 16 years or older.
Connecticut	44,314 Seniors 2,711 Disabled	11% ⁽¹⁾	General Fund and Enrollment Fees ⁽¹⁾	Low income female over 75	Program serves mostly seniors, 6 % are disabled, 66% are 75 or older and the majority have incomes between \$6,000 and \$12,000.
Maryland	11,383 Seniors 18,384 Other	5% ⁽¹⁾	General Fund ⁽¹⁾	Female with income of \$8,250	Serves 1/3 low income seniors and 2/3 low income adults and children. Elderly make up 36% in 1995, in 1992, it was 63%. Largest increase in enrollment has been in the 21-44 age group.
Maine	28,000 Seniors and Disabled	9% ⁽¹⁾	General Fund ⁽¹⁾	Low income senior	Anyone disabled or 65+ filing a Maine tax return, meeting the income eligibility limits, and receiving SS income, is eligible.
Rhode Island	23,000 Seniors	15% ⁽¹⁾	General Fund ⁽¹⁾	Widowed female 82 years old	Income eligible 65+, 68% are older than 75 years.
Vermont	4,861 Seniors 221 Disabled	5% ⁽¹⁾	General Fund ⁽¹⁾	58% are older than 75	Serves elderly and disabled, meeting income eligibility.
Delaware	10,000 Seniors	13% ⁽¹⁾	The Nemours Foundation ⁽¹⁾	Low income senior	Seniors meeting the income eligibility guidelines.

⁽¹⁾ 1994 National Pharmaceutical Council Statistics

SOURCE: "EPIC EVALUATION REPORT TO THE GOVERNOR & LEGISLATURE: OCTOBER 1987-SEPTEMBER 1995"
EPIC is New York's Elderly Pharmaceutical Insurance Coverage Program

COMPARISON OF STATE PHARMACY PROGRAMS - TABLE F-2

	Income Limits Program Eligibility	Enrollment Fees	Copays	Unique Features
New York	\$17,500 Single \$23,000 Married	Annual fees range from \$24-\$414 based on a sliding income scale	\$3-\$23	Fees, deductibles as cost share. Seniors receive free drugs after reaching copay maximum. Maximum of 30 days supply or 100 doses, whichever is greater.
New Jersey	\$17,056 Single \$20,913 Married	None	\$5	Pays for certain diabetic testing materials. Maximum of 60 day supply or 100 doses, whichever is greater.
Pennsylvania	\$13,000 Single \$16,200 Married	None	\$6	Maximum of 30 days supply or 100 capsules or tablets, whichever is less.
Illinois	\$14,000 Single & Married	Lower income senior pay \$40 annually, and \$15 monthly. Moderate income seniors pay \$80 annually, and \$25 monthly.	20% of the remaining costs after program pays the first \$800.	Enrollment fee is based on the federal poverty level. Seniors receive the first \$800 of prescriptions at no cost, after paying a monthly deductible of \$10 or \$25. Maximum of 34 days supply or 100 unit doses for maintenance drugs.
Connecticut	\$13,800 Single \$16,600 Married	\$25 Annual Fee	\$12	Maximum of 30 days supply or 120 units whichever is greater.
Maryland	\$8,500 One Person \$9,250 Two People Average of \$850 for each additional person. Maximum asset test for all households.	None	\$5	Maximum of two refills up to a total of 100 units.
Maine	\$10,100 Single \$12,500 Married	None	20% with \$2 minimum	Allows a 90 days supply per prescription. Only covers chronic medications.
Rhode Island	\$14,248 Single \$17,811 Married	None	40%	Seniors over income can deduct medical and pharmaceutical expenses that exceed 3% of their gross income, from reported income.
Vermont	Single \$12,900 Married \$17,200	None	80%	Eligibility income is based on federal Adjusted Gross Income
Delaware	\$11,600 Single \$15,900 Married	None	20%	Funded by the Nemours Foundation from the estate of Alfred I. duPont.

1994 DATA - TABLE F-3

	Number of Claims Per Year	Gross Cost of All Prescriptions Including Copayments ⁽¹⁾	Gross Cost of Drugs Per Enrollee Per Year ⁽²⁾	Average No. Of Claims Per Enrollee	Gross Average Cost Per Claim ⁽³⁾	Net State Cost of Prescriptions ⁽⁴⁾	Net Benefit Per Enrollee
New York	3.0 million	\$120.9 million	\$1,130	28	\$40.30	\$ 55.8 million	\$521
New Jersey	5.5 million	\$241.4 million	\$1,059	24	\$43.89	\$161.0 million	\$706
Pennsylvania	9.0 million	\$287.4 million	\$ 927	29	\$31.93	\$206.1 million	\$665
Illinois	1.5 million	\$ 48.9 million	\$ 699	21	\$32.60	\$ 29.4 million	\$420
Connecticut	693,000	\$ 34.9 million	\$ 742	15	\$50.36	\$ 26.8 million	\$570
Maryland	578,000	\$ 20.5 million	\$ 689	19	\$35.47	\$ 14.5 million ⁽⁵⁾	\$487
Maine	80,000	\$ 5.7 million	\$ 204	3	\$71.25	\$ 4.1 million	\$146
Rhode Island	316,000	\$ 9.7 million	\$ 422	14	\$30.70	\$ 4.2 million	\$183
Vermont	64,000	\$ 1.3 million	\$ 256	13	\$20.31	\$233,000	\$ 46
Delaware	156,500	\$ 3.5 million	\$ 350	16	\$22.36	N/A	N/A

(1) Total cost of drugs including copayments, based on the amount paid by the program.

(2) Gross costs of prescriptions per current number of enrollees (Pg.1).

(3) Gross cost of all prescriptions divided by number of claims per year.

(4) Gross cost of prescriptions less copayments, fees, and manufacturer's rebates.

(5) Includes a reduction of manufacturer's rebate revenue estimated at 15% (\$3,075,000) per KPMG Peat Marwick LLP study.

TABLE F-4

	Pro-DUR System	Formulary Enhancements/ Limitations	Number of Enrolled Pharmacies	Reimbursement to Pharmacies	Percentage of Generic Claims	Generic Substitution	Participant, Pharmacy, or Physician Incentives
New York	Pro DUR; denial/ override implemented in February, 1996	Covers all prescription drugs including insulin and syringes. Exceptions include OTC, DESI, and drugs of manufacturers not participating in the rebate program.	3,894	Dispensing fee \$2.75 or \$3.00 (full service pharmacy) Lower of AWP (less 5% discount for high volume) or usual and customary	36%	Required, unless specified by physician	Sliding copay scale encourages generic use.
New Jersey	Pro DUR with alerts March, 1996	No OTC, DESI or drugs not covered by manufacturer's rebate. Senior must pay the difference between brand and generic if a physician prescribes a generic but the senior wants a brand.	2,100	Dispensing fee \$3.73-\$4.06. AWP discounted by 0-6%, or usual and customary	30% ⁽¹⁾	Required, unless specified by physician ⁽¹⁾	None ⁽¹⁾
Pennsylvania	Pro DUR denials only, no override or reversals. Physician may submit a medical exception request for a medical necessity and a reconsideration may be granted.	No experimental, DESI, OTC, cosmetics or drugs not covered by manufacturer's rebate.	3,018	\$2.75 dispensing fee. Lower of AWP or usual and customary.	37%	Requires generic substitution for telephone RX's if a generic is available	None

TABLE F-4 CONTINUED

	Pro-DUR System	Formulary Enhancements/ Limitations	Number of Enrolled Pharmacies	Reimbursement to Pharmacies	Percentage of Generic Claims	Generic Substitution	Participant, Pharmacy, or Physician Incentives
Illinois	Pro DUR alert system	Covers cardiovascular RX, anti-arthritic, diabetes including insulin needles and syringes.	2,000 plus	\$3.60 dispensing fee. Lower of 90% of AWP or MAC	43% ⁽¹⁾	Generic fill unless brand is specified by physician ⁽¹⁾	Plan pays only up to the cost of generic ⁽¹⁾
Connecticut	Batch processing only, retrospective DUR	Does not cover antihistamines, multivitamins, antismoking, DESI, experimental, diet, cosmetic, contraceptive, cough preparations or drugs not covered by manufacturer's rebate.	700	\$4.10 dispensing fee, AWP less 8%	25% ⁽¹⁾	Requires generic fill unless brand is specified by a physician ⁽¹⁾	None ⁽¹⁾
Maryland	Pro DUR with denials, 1993. Prior approval needed for early refills.	DESI drugs and experimental drugs are not covered.	1,000	\$4.66 dispensing fee. WAC plus 10%	Not available	Requires generic fill unless brand is specified by a physician ⁽¹⁾	Plan only pays for the cost of a generic ⁽¹⁾
Maine	Pro DUR alerts and denial override with retrospective review	Cover only cardiac, diabetes, respiratory, blood pressure and arthritis drugs	320	\$3.35 dispensing fee. Providers must bill the lowest amount submitted from any third party payor capped at 90% of AWP.	60% ⁽¹⁾	Requires generic fill unless brand is specified by a physician ⁽¹⁾	Lower cost generics result in lower copays ⁽¹⁾

TABLE F-4 CONTINUED

	Pro-DUR System	Formulary Enhancements/ Limitations	Number of Enrolled Pharmacies	Reimbursement to Pharmacies	Percentage of Generic Claims	Generic Substitution	Participant, Pharmacy, or Physician Incentives
Rhode Island	Pro-DUR with TDM alerts and denials. Alert on 9 categories and deny on 4.	Covers only drugs for diabetes, cancer chemotherapy, high blood pressure, circulatory, cholesterol, heart, asthma, chronic respiratory and Parkinson's disease.	200	\$2.50 dispensing fee AWP less 13%	28% ⁽¹⁾	None ⁽¹⁾	None ⁽¹⁾
Vermont	Electronic claims submission but no Pro DUR	Covers only maintenance prescriptions. New program for Medicare seniors at poverty level; covers maintenance and acute prescriptions.	145	\$4.25 dispensing fee. AWP less 10%	Not available	Requires generic fill unless brand is specified by a physician ⁽¹⁾	Lower cost generics require lower copay. ⁽¹⁾
Delaware	Not applicable	Does not cover injectibles	In-house pharmacy	Not applicable	Not available	Mandatory generic fill ⁽¹⁾	Not applicable

⁽¹⁾Reported in the KPMG Peat Marwick LLP study.

TABLE F-5

	Benefit or Eligibility Expansion or Contraction	Current Cost Containment	Future Cost Containment	Program Enhancements	Wish List
New York	Enrollment is generally stable with modest growth.	Deferral of 1991 program changes	Possible increase to copays, fees, copay maximums, or deductible maximums, reduce payments to providers, (AWP less a percentage.)	Increased Income limits, 1994	COLA on income eligibility. Implement benefit improvements (EPIC reform). Simplification of the program.
New Jersey	Enrollment is stable.	POS/ProDUR implementation March, 1996.	PBM is being considered. A six-month study of cost savings options is in process.	COLA on income eligibility limits effective January, 1995 based on federal Social Security COLA.	
Pennsylvania	Enrollment decreased during the last few years, however savings generated from future cost containment will be used to expand enrollment.		Looking to establish an in-house PBM by using therapeutic substitution and equivalency, and also investigating other managed care options. Looking to give incentives to providers for patient counseling. Looking to reduce payments to providers to AWP less 10-15%.		Would like to increase the income limits established in 1991. Would like to tailor the formulary to generate program savings.

TABLE F-5 CONTINUED

	Benefit or Eligibility Expansion or Contraction	Current Cost Containment	Future Cost Containment	Program Enhancements	Wish List
Illinois	Enrollment is stable.	Participant must pay the difference for brand medication if a generic substitute is available. In 1995, physicians will be requested to voluntarily prescribe drugs from the ones preferred by the formulary. Receives third party payments on behalf of members enrolled in the program.	Reviewing utilization to generate cost containment.		Would like to increase the income level for married seniors. Would like to increase the disabled age from 16 to 18, and make eligibility criteria for the disabled more stringent.
Connecticut	Enrollment is generally stable with modest decline.	Instituted a \$25 annual fee. Added HCFA CPI index penalty to the rebate formula. BC/BS reimbursed the program for claims that they should have paid.	Will implement a state of the art POS claims processing system including prospective DUR in 1996. This will reduce cost on early refills and duplicate therapies. Planning to reduce payments to providers to AWP less 12%.	In 1994, excluded the Medicare Part B premium from SS income for eligibility determinations.	Would like to have a larger outreach staff and do more outreach for the program.

TABLE F-5 CONTINUED

	Benefit or Eligibility Expansion or Contraction	Current Cost Containment	Future Cost Containment	Program Enhancements	Wish List
Maryland	The program is currently in a cost containment mode.	Formulary limited in 1991 to include only maintenance, long term, anti-infective including AZT, insulin and needles, specific chemotherapy, antidepressants and benzodiazepines.	Physicians are expected to prescribe the generic. There are brand overrides if the medication is deemed medically necessary.	COLA on income eligibility limits based on federal Social Security COLA. State grant to provide primary medical care including prescriptions, for income eligible recipients 21-65 years old, having no other medical coverage. Need to meet medical guidelines.	Moving toward paperless application processing. Currently using optical scanning. Implemented a pilot project with health department area offices to submit applications via electronic fax.
Maine	Program has been in a cost containment mode since 1991.	Providers and physicians are encouraged to prescribe low cost drugs and generics first. In 1995, providers reimbursed AWP less 10%.	Reviewing utilization to generate cost containment	COLA on income eligibility limits based on federal Social Security COLA. Program expanded in 1992 to include 27,000 persons under the age of 65 that were formerly in the Medical Assistance Programs (GPA & MASO)	Would like to have a formulary and mandate use of less expensive drugs.
Rhode Island	Enrollment is stable due to budgetary constraints.	1995 Provider payments were reduced to AWP less 13% this year.		COLA on income limit eligibility based on federal Social Security COLA.	Would like to expand the formulary to include all drugs.

**Outpatient Prescription Drug Benefit
Medicare Catastrophic Coverage Act and Health Security Act¹**

	Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360)	Health Security Act
Coverage	<p>Part B coverage of outpatient prescription drugs, prescription biologicals and insulin. Drugs must be approved for safety and effectiveness under the Federal Food, Drug and Cosmetic Act, marketed before 1938 or, marketed between 1938 and 1962 but not yet subject to an FDA effectiveness hearing (at the time of passage, only nitroglycerin patches fell into this category). Biologicals are dispensed by prescription and licensed under the Public Health Service Act (including therapeutic serum, antitoxins, vaccines, blood, blood products, and allergenic products.</p> <p>Intravenously administered drugs are only covered if administered in the individual's home and the Sec determines that the drug can be safely administered at home. Home IV antibiotics are covered unless the Secretary determines otherwise.</p>	<p>All drugs, biologicals and insulin approved by the FDA for all labeled indications and certain off-label indications.</p> <p>Off-label indications covered if use is listed in 1 of 3 national drug compendia (or other authoritative compendia) or based on evidence in peer reviewed journals approved by the Secretary. If even 1 national compendia reports use unfavorably, coverage will be denied.</p> <p>Home infusion therapies, P/E, immunosuppressive, other currently covered outpatient drugs subsumed.</p> <p>Sec has discretion to exclude from coverage certain products (fertility drugs, anorexia treatments, drugs used for cosmetic reasons).</p>
Eligibility	Part B enrollees. Non-voluntary.	Part B enrollees. Non-voluntary.

¹ Under current law, Medicare pays for very few outpatient prescription drugs (for example, immunosuppressives for 1 year following a transplant, certain oral anti-cancer drugs, and certain anti-emetics used in conjunction with anti-cancer therapy). The payment limit (effective January 1, 1998) is generally the lesser of the actual charge or 95% of AWP, plus a dispensing fee (at the Secretary's discretion). A Report to Congress on the effects of this payment methodology on AWP of drugs is due 7/1/99.

Deductible	<p>\$550 in 1990; \$600 in 1991; \$652 in 1992; in succeeding years, the Secretary will determine deductible such that an average of 16.8% of Part B enrollees (excluding HMO, CMP and HCPP enrollees) exceed the deductible.</p> <p>Deductible does not apply to home IV therapies initiated while beneficiary was an inpatient, or to immunosuppressive within 1 year of a transplant.</p>	<p>\$250 in 1996. Indexed in future years to ensure that approx the same number of individuals meet the deductible each year (estimated to be about 58%). Future years estimates were \$269 in 1997, \$288 in 1998, \$308 in 1999, and \$330 in 2000.</p>
Copayments	<p>Copayment amounts are phased-in to allow build up of reserves. Copayment amounts are 50% in 1991; 40% in 1992; 20% in 1993 and thereafter.²</p> <p>Immunosuppressives: 20% in year following a transplant. Otherwise, copayment amount is 50% in 1990 and 1991; 40% in 1992; 20% in 1993 and thereafter.</p> <p>Home IV Drugs: 20%.</p>	<p>20%.</p>
Out of Pocket Cap	<p>No out of pocket cap for drug related expenses.³</p>	<p>\$1,000 in 1996. In future years, indexed so that approx the same percentage of beneficiaries meet the limit each year (estimated to be 2.3%). Future year estimates were \$1,064 in 1997, \$1,130 in 1998, \$1,198 in 1999, and \$1,272 in 2000.</p>

² The Secretary has authority to make adjustments to coinsurance in 1993 if premium revenues are insufficient to maintain required contingency margins. Contingency margin is 75% in 1992, 50% in 1993, 25% in 1994, 25% in 1995 and 20% thereafter.

³ An out of pocket cap applied to Part B services, exclusive of drugs. The cap was \$1,370 in 1990, and set thereafter so that 7% of beneficiaries reached the cap. Individuals responsible for 1 hospital deductible per year (spell of illness concept eliminated), and 20% coinsurance on first 8 days of SNF care. Hospital coinsurance eliminated.

<p>Payment Amount</p>	<p>Lesser of actual charge or applicable payment limit.</p> <p><u>Payment limit for non-multiple source drugs and multiple source drugs with restrictive prescriptions</u> (essentially, brand names): Generally, the lesser of the number of tablets or units x AWP per tablet/unit + the administrative allowance OR the 90th percentile of the actual charge per tablet adjusted to reflect the number of tablets/units dispensed.</p> <p><u>Payment limit for multiple source drugs without restrictive prescriptions</u> (generics): number of tablets/units x unweighted median average wholesale price per tablet/unit + administrative allowance.</p> <p>Sec may take into account regional variations into account when determining AWP.</p>	<p><u>Payment limit for single source drugs and multiple source drugs with restrictive prescriptions</u> (brand names): Lower of actual charge, 90th percentile of actual charges in a previous period (computed on a geographic basis determined by the Sec), or estimated acquisition cost + dispensing fee.</p> <p><u>Payment limit for multiple source drugs without restrictive prescriptions</u> (generics): Lower of actual charge or median of all generics estimated acquisition cost in the same therapeutic class x units dispensed + dispensing fee.</p> <p>Payment based on generic, unless physician indicates brand name.</p> <p>Sec has relatively broad authority to establish estimated acquisition cost.</p>
<p>Dispensing Fees</p>	<p>\$4.50 for drugs dispensed by participating pharmacies in 1990 and 1991 (\$2.50 for non-participating pharmacies); future increases reflect % increase in the GDP deflator for the 12 month period ending August the previous year. Dispensing fee may be reduced for mail order prescriptions.</p>	<p>\$5 dispensing fee, indexed annually to CPI. Dispensing fee may be reduced for mail-order prescriptions.</p>

Premiums	63% of total catastrophic benefits financed through annual supplemental premium on beneficiaries eligible for Part A for more than 6 months in the year. Estimated 40% of beneficiaries pay supplemental premium -- 5% pay maximum amount.				<p>The portion of the Part B premium attributable to drugs equals 50% of the portion of the monthly actuarial rate (for enrollees age 65+) that is attributable to the drug benefit.</p> <p><u>Estimated increase in Part B premiums:</u></p> <p>1996 - \$9.00 1997 - \$9.30 1998 - \$9.80 1999 - \$10.30 2000 - \$10.60</p> <p>Benefit would be financed by: General revenues: 43% of incurred costs Deductibles and coinsurance: 36% Beneficiary premiums: 13% Rebates: 8%</p>	
	<u>Supplemental Premium rates</u>					
		Basic*	Drug*	Total*		Max
	1989	\$22.50	\$0	\$22.50		\$800
	1990	27.14	10.36	37.50		850
	1991	30.17	8.83	39.00		900
	1992	30.55	9.95	40.50		950
	1993	29.55	12.45	42.00		1050
	*Per \$150 in federal income tax liability					
	1994 and thereafter: based on previous calendar year premium indexed by projected growth rates in outlays and premiums					
In addition, a flat premium -- paid by all beneficiaries -- is added to the regular Part B premium to finance 37% of total catastrophic benefits.						
<u>Flat Premiums</u>						
	Basic	Drug	Total			
1989	\$4.00	\$0	\$4.00			
1990	4.90	0	4.90			
1991	5.46	1.94	7.40			
1992	6.75	2.45	9.20			
1993	7.18	3.02	10.20			
Thereafter set to reflect program costs.						

<p>Cost Containment</p>	<p>Formularies prohibited.</p>	<p>Formularies prohibited.</p> <p>Rebate program for brand name drugs (not generics).</p> <p><u>Basic rebate</u>: rebate amount is greater of the difference between the average manufacturer retail price and average manufacturer non-retail price -- or -- 17% of the average manufacturer retail price⁴.</p> <p><u>Additional Rebate</u>: manufacturers will remit an additional rebate equal to drug units subject to the rebate multiplied by the amount by which the average retail price exceeds the average manufacturer retail price for a base quarter, updated by CPI-u.</p> <p>Sec would negotiate rebates for new drugs within 6 months of introduction -- without agreement, Sec could exclude new drug from Medicare coverage.</p> <p>Manufacturers required to provide price information to Sec for calculation of rebates.</p> <p>Prior approval for drugs indicated by Sec (for example, drugs subject to misuse, new drugs not yet subject to rebate, or brand names when generic is available).</p>
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⁴ The Medicaid rebate program is based on the manufacturer's best price. This approach has been criticized for encouraging manufacturers to eliminate deep discounts to some providers in order to not be required to provide the same discount to Medicaid.

Drug Utilization Review	Sec will establish a program to identify and educate physicians and pharmacists concerning instances of unnecessary or inappropriate prescribing or dispensing, substandard care or adverse drug reactions.	Sec will establish a program to identify and educate physicians and pharmacists about instances of unnecessary or inappropriate prescribing or dispensing, substandard care, drug reactions, and use of generics. DUR program may incorporate elements of Medicaid DUR (established under OBRA 90) or other elements as necessary. ⁵
Claims Processing	<p>Electronic Point of Sale System.</p> <p>Sec has authority to contract with a variety of entities to administer the benefit. Contracting may be on a regional basis, and payment may be cost based or not.</p> <p>Payments to pharmacies and beneficiaries on a monthly basis.</p> <p>Standardized claims form.</p> <p>Participating pharmacies accept assignment; agree not to refuse to dispense drugs to any enrollee; keep individual beneficiary records; offer counseling on drug usage and interactions; advise beneficiaries on availability of generics; do not charge beneficiaries more than the amount charged to the general public (as determined by Sec); provide price and other information as requested to Secretary.</p>	<p>Electronic Point of Sale system.</p> <p>Sec has authority to use a variety of entities -- including drug benefit management (DBM) firms -- to administer the benefit. Benefit may be administered on a regional basis.</p> <p>Standardized claims form.</p> <p>Estimated 1 billion claims/year at \$.80 to \$.90 per claim to process (1994 estimate for FY 1996).</p> <p>All pharmacies accepting Medicare payment must accept assignment, answer beneficiary questions, and submit claims for beneficiaries.</p>

⁵Although not detailed in legislative language, HCFA anticipated the DUR program would include prospective identification of drug-drug interactions, therapeutic duplication, early refills, drug-disease contraindications, and drug-allergy contraindications. Retrospective DUR would include identification of patterns of inappropriate dispensing, unnecessary scripts, and fraud/abuse.

<p>Maintenance of Effort -- Employer Sponsored Plans</p>	<p>Employers who provide retiree coverage that duplicates Medicare benefits (excluding drugs) by at least 50% of the national average actuarial value of the catastrophic benefit are required to provide additional benefits or refunds equal to the actuarial value of the duplicate benefits for 1 year.</p> <p>Does not apply to multiple employer arrangements with multi-employer collective bargaining agreements.</p>	<p>None for retirees age 65+.</p>
<p>Managed Care / Medicare + Choice</p>	<p>Managed care organizations must maintain records of individual enrollee drug expenses. Any expense that would have counted toward the Part B drug deductible must count toward the managed care plan's drug deductible.</p> <p>Payments to cost based plans offering outpatient drug coverage will be adjusted to reflect Medicare drug coverage.</p>	

<p>Other</p>	<p>Federal Catastrophic Drug Insurance Trust Fund established. Same membership as SMI Board of Trustees.</p> <p>Secretary must publish and distribute physician guide listing AWP for a day's supply of commonly used drugs.</p> <p>Annual Report to Congress detailing Trust Fund status and other budgetary information.</p> <p>Periodic audits of pharmacies.</p> <p>Prescription Drug Payment Review Commission to be established.</p> <p>Various HHS, GAO and PDPRC studies.</p>	<p>Equal access to discounts provision: requires manufacturer discounts be directly proportional to the impact of the purchaser's terms on the manufacturer's cost. Discounts may not be made solely based on class of trade.</p>
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Employee Benefits Survey, Bureau of Labor Statistics -- Full-time Employees, Medium and Large Private Establishment

Drug Benefit Characteristics - Brand Name	Non- HMO - 1993	Non-HMO - 1995	HMO - 1993	HMO - 1995
Percentage with Drug Benefit	100%, (1% covered in full)	100%, (<0.5% covered in full)	100%,(4% covered in full)	100%, (3% covered in full)
Deductible - Subject to major medical limits of plan ¹	70%	58%		
Subject to separate yearly deductible	4%	6%	6%	2%
Cost Sharing - Copayment	27%	45%	84%	89%
< \$5	~ 8%	5%	25%	9%
\$5	8%	11%	35%	40%
\$5.01 - \$9.99	5%	11%	13%	13%
\$10	4%	12%	8%	17%
>\$10	1%	4%	<0.5%	6%
Unspecified	1%	2%	3%	4%
Cost Sharing - Subject to separate coinsurance rate	10%	8%		
Separate Yearly Maximum	1%	1%	9%	3%
Coverage for Mail Order Drugs	25% (for both HMO and non-HMO combined)	32% (for both HMO and non-HMO combined)		
Higher reimbursement for generic drugs	25% (for both HMO and non-HMO combined)	41% (for both HMO and non-HMO combined)		
Higher reimbursement for use selected pharmacies	18% (for both HMO and non-HMO combined)	27% (for both HMO and non-HMO combined)		

¹Medical limits of plan refers to overall plan deductible and coinsurance provisions.

**Employee Benefits Survey, Bureau of Labor Statistics -- Full-time Employees,
State and Local Governments**

Drug Benefit Characteristics - Brand Name	Non- HMO - 1994	HMO - 1994
Percentage with Drug Benefit	100%, (<0.5% covered in full)	100%, (1% covered in full)
Deductible - Subject to major medical limits of plan ²	60%	
Subject to separate yearly deductible	4%	3%
Cost Sharing - Copayment	41%	88%
< \$5	~ 8%	13%
\$5	5%	39%
\$5.01 - \$9.99	8%	20%
\$10	13%	11%
>\$10	5%	5%
Unspecified	<0.5%	1%
Cost Sharing - Subject to separate coinsurance rate	7%	
Separate Yearly Maximum	4%	3%
Coverage for Mail Order Drugs	29% (for both HMO and non-HMO combined)	
Higher reimbursement for generic drugs	37% (for both HMO and non-HMO combined)	
Higher reimbursement for use selected pharmacies	19% (for both HMO and non-HMO combined)	

²Medical limits of plan refers to overall plan deductible and coinsurance provisions.

FEHB - Blue Cross Blue Shield: Standard and High Option

Drug Benefit Characteristics	Non- PPO 1998	PPO 1998
Subject to separate yearly deductible	yes	yes
Deductible Amount	\$50.00 (\$100 per family)	\$50.00 (\$100 per family)
Cost Sharing - Copayment	40% of billed charge - Standard Option 35% of billed charge - High Option	20% of PPA - Standard Option 15% of PPA - High Option
Separate Yearly Maximum	No	No
Coverage for Mail Order Drugs	see notes at right	yes: \$12.00 co-pay per prescription or refill - Standard Option \$8.00 co-pay per prescription or refill - High Option (Mail order co-pays do not count toward catastrophic OOP limit)
Higher reimbursement for generic drugs	No	No
Claims processing	Enrollee pays full cost at time of purchase, and submits paper claim form for reimbursement	All preferred retail pharmacies file claims for reimbursement
Catastrophic Protection - Maximum Out-of-Pocket Costs (OOP drug costs include the prescription drug deductible and co-insurance on retail drug purchases; does not include co-payments associated with mail order drugs)	\$3,750.00 - Standard Option \$2,700 - High Option	\$2,000 - Standard Option \$1,000 - High Option

Office of Research and Demonstrations

RESEARCH BRIEFS

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Impact of the Medicaid Drug Rebate Program on Expenditures, Utilization, and Access

Background

- The Omnibus Budget and Reconciliation Act of 1990 mandated drug manufacturers to pay Medicaid rebates effective January 1, 1991. Medicaid pays for approximately 15% of all prescription drugs dispensed in the United States. Until the rebate program, this purchasing power was not tapped because individual States had difficulty in obtaining volume discounts.
- The rebate mechanisms apply to all States uniformly. However, the rebate calculation varies according to drug patent status, best price and inflation adjustment.
- The rebate program was successful in achieving the intent of the legislation: obtaining volume discounts to Medicaid as afforded to other large purchasers and holding costs down for the Medicaid program.

Medicaid Drug Utilization

- Medicaid enrollment remained stable at 21 to 23 million people from 1975 to 1988 but grew to 32.7 million in 1993. In 1988, 67% of all those on medical assistance received prescription drugs, which rose to 73% in 1993.

- The aged, disabled and blind represent 34% of Medicaid enrollees and account for 76% of prescription drug expenditures. In contrast, AFDC children represent 47% of Medicaid enrollees but only 11% of prescription drug expenditures.

Medicaid Drug Expenditures

- Medicaid drug expenditures grew from \$4.4 billion in 1990 to approximately \$8 billion in 1993, not including rebates.
- Medicaid spent an average of \$57.58 on prescription drugs per beneficiary in 1975, \$128.97 in 1983 and \$333.50 in 1993. Medicaid drug recipients averaged 12.4 prescriptions in 1975, 13.0 in 1983, and 14.6 in 1993.
- Drug program expenditures increased 63.3% (1993 constant dollars) from 1988 to 1993 with inflation and rebates taken into account. The single largest factor contributing to the growth in drug expenditures was the expansion of Medicaid eligibles. If no growth had occurred in the number of eligibles or recipients and general inflation and rebates accrued had been accounted for, the estimated drug expenditures in 1993 would have been \$3.1 billion in 1988 constant dollars.

Continued on next page.



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Impact of the Medicaid Drug Rebate Program on Expenditures, Utilization, and Access—Continued

Effects of the Rebate Program

- Rebates collected from 1991 through 1993 were \$2.51 billion. These rebate payments resulted in a 4.6% reduction in FY 1991 drug expenditures, a 13.0% reduction in FY 1992, and a 17% reduction in FY 1993.
- The administrative costs of the rebate program by State Medicaid programs were less than 1%, on average, of the rebates collected.
- The amount of change in drug expenditures after rebates varied widely across states, while the rebate amount as a percent of drug expenditures was relatively stable.
- After adjusting for rebates and enrollment growth, seven of eight case study states had less than a 7% increase in expenditures over the two year period (1990 to 1992). This was equal to or less than the general rate of inflation.
- Changes in drug expenditures were analyzed by 48 therapeutic categories in the 8 states before and after rebates. Before rebates 28 of the 48 therapeutic categories in Missouri doubled in drug expenditures from 1990 to 1992. In contrast, Arkansas actually had a decrease in expenditures for approximately one-fourth of the therapeutic categories. After rebate all but one category in Missouri showed an increase in expenditures while approximately one-half of the categories in Arkansas decreased in expenditure.
- After adjusting for inflation (1993 constant dollars), the average prescription payment less collected rebates collected in FY 1993 (\$18.80) was less than the average Medicaid prescription payment experienced in 1989 (\$19.08).
- The national average of percent change in annual drug expenditures per recipient 1990 versus 1992 after rebates and adjusted for inflation was -2.9% with 25 States above and 25 States below this percentage.

Table 4.6 Prescription Medicine Expenditures for Noninstitutionalized Medicare Beneficiaries, by Source of Payment, and by Demographic, Socioeconomic, and Health Characteristics, 1994

Community-Only Residents¹

Beneficiary Characteristic ²	Total Expenditures (millions of \$)	Source of Payment (as a percent of row total)					Expenditures Per Beneficiary
		Medicare	Medicaid	Private Insurance	Out-of-Pocket	Other Source	
All Beneficiaries	\$19,039	0.08	12.10	27.68	51.91	8.23	\$536
	282	0.02	0.58	0.76	0.13	0.29	8
Health Status							
Excellent	1,646	0.03	5.80	31.58	55.11	7.48	285
	122	0.02	1.10	2.38	1.72	0.32	15
Very Good	3,763	0.03	6.57	32.06	53.78	7.56	411
	109	0.01	1.89	1.01	1.58	1.02	8
Good	5,732	0.12	10.37	29.06	53.29	7.16	524
	290	0.05	1.30	1.99	2.16	0.76	21
Fair	5,009	0.03	16.05	24.76	50.25	8.91	770
	139	0.02	1.81	1.37	0.54	1.22	12
Poor	2,852	0.15	19.65	21.98	47.65	10.57	932
	55	0.06	0.84	0.86	3.00	1.96	21
Functional Limitation							
None	8,162	0.04	6.65	32.20	53.16	7.95	405
	119	0.01	0.82	0.76	0.93	0.34	7
IADL only ⁴	5,143	0.04	16.20	24.27	50.56	8.93	652
	65	0.00	0.95	1.92	1.75	0.48	9
One to two ADLs ⁵	3,456	0.22	13.87	26.47	52.45	6.99	717
	85	0.11	1.53	1.72	0.94	1.12	19
Three to five ADLs	2,274	0.08	19.73	21.00	49.62	9.57	876
	163	0.04	2.01	1.81	1.80	1.80	60

Table 4.6 Prescription Medicine Expenditures for Noninstitutionalized Medicare Beneficiaries, by Source of Payment, and by Demographic, Socioeconomic, and Health Characteristics, 1994

Community-Only Residents¹

Beneficiary Characteristic ²	Total Expenditures (millions of \$)	Source of Payment (as a percent of row total)					Expenditures Per Beneficiary
		Medicare	Medicaid	Private Insurance	Out-of-Pocket	Other Source	
All Beneficiaries	\$19,039	0.08	12.10	27.68	51.91	8.23	\$536
	<i>282</i>	<i>0.02</i>	<i>0.58</i>	<i>0.76</i>	<i>0.13</i>	<i>0.29</i>	<i>8</i>
Metropolitan Area Resident							
Yes	14,162	0.08	11.69	29.69	49.47	9.07	538
	<i>358</i>	<i>0.04</i>	<i>0.50</i>	<i>0.71</i>	<i>0.16</i>	<i>0.35</i>	<i>13</i>
No	4,871	0.07	13.30	21.81	59.03	5.79	531
	<i>86</i>	<i>0.03</i>	<i>1.14</i>	<i>1.06</i>	<i>0.26</i>	<i>0.20</i>	<i>5</i>

Source: Medicare Current Beneficiary Survey, CY 1994 Cost and Use Public Use File.

Note: Standard errors are shaded and in italics. See Appendix A for additional information on standard errors. See Appendix B for definitions of terms and variables.

- 1 The term *community-only residents* includes beneficiaries who resided only in the community during the year. It excludes beneficiaries who resided part of the year in the community and part of the year in a long-term care facility, and beneficiaries who resided only in a long-term care facility during the year.
- 2 Due to missing values for some variables, expenditures for individual categories may not sum to total expenditures for all beneficiaries.
- 3 Medicare beneficiaries with end-stage renal disease (ESRD) are included within the subgroups of "Aged" and "Disabled."
- 4 IADL stands for Instrumental Activity of Daily Living.
- 5 ADL stands for Activity of Daily Living.

Table 4.12 Prescription Medicine Expenditures for Noninstitutionalized Medicare Beneficiaries per User, by Insurance Coverage, and by Demographic, Socioeconomic, and Health Characteristics, 1994

Community-Only Residents with at Least One Prescribed Medicine in 1994¹

Beneficiary Characteristic	Total ²	Medicare	Supplemental Health Insurance			
		Fee-for-Service Only	Medicaid	Individually-Purchased Private Insurance	Employer-Sponsored Private Insurance	Both Types of Private Insurance
Expenditures per User	\$629	\$526	\$766	\$583	\$684	\$718
	10	27	8	7	20	32
Race/Ethnicity						
White non-Hispanic	637	550	853	586	685	731
	9	19	27	10	23	37
Black non-Hispanic	617	493	725	551	667	584
	24	33	27	105	49	73
Hispanic	591	440	664	524	767	498
	42	125	92	70	109	30
Other	422	359	500	480	442	497
	36	83	85	135	174	28
Income						
Less than \$2,500	784	694	963	683	876	1,559
	48	230	190	13	105	554
\$2,500 - \$4,999	539	479	548	632	549	297
	58	174	16	136	105	72
\$5,000 - \$7,499	664	544	750	556	631	635
	25	88	26	34	48	321
\$7,500 - \$9,999	610	482	805	556	656	657
	24	16	85	14	22	23
\$10,000 - \$14,999	652	558	850	590	754	788
	8	31	105	14	32	42
\$15,000 - \$19,999	628	532	1,227	595	698	710
	8	128	185	7	38	40
\$20,000 - \$24,999	577	474	730	564	642	529
	13	42	165	37	54	47
\$25,000 - \$29,999	671	447	930	597	769	736
	15	48	336	34	6	209
\$30,000 or more	610	515	488	587	645	779
	21	56	123	26	22	73

Table 4.12 Prescription Medicine Expenditures for Noninstitutionalized Medicare Beneficiaries per User, by Insurance Coverage, and by Demographic, Socioeconomic, and Health Characteristics, 1994

Community-Only Residents with at Least One Prescribed Medicine in 1994¹

Beneficiary Characteristic	Total ²	Medicare	Supplemental Health Insurance			
		Fee-for-Service Only	Medicaid	Individually-Purchased Private Insurance	Employer-Sponsored Private Insurance	Both Types of Private Insurance
Expenditures per User	\$629	\$526	\$766	\$583	\$684	\$718
	10	21	8	7	20	32
Health Status						
Excellent	386	309	490	379	428	371
	19	38	98	34	12	57
Very Good	501	348	633	474	550	638
	8	28	90	21	3	32
Good	601	499	677	566	659	752
	26	44	22	2	41	72
Fair	825	678	805	797	963	889
	8	37	43	22	19	107
Poor	1,008	688	1,027	1,001	1,199	1,378
	10	73	88	91	63	213
Functional Limitation						
None	498	414	592	453	556	594
	11	13	18	5	13	24
IADL only ⁴	728	644	826	712	778	814
	7	57	27	25	44	112
One to two ADLs ⁵	783	544	803	739	914	982
	21	75	34	69	70	41
Three to five ADLs	954	682	971	962	1,128	1,008
	63	64	118	106	46	92

Table 4.12 Prescription Medicine Expenditures for Noninstitutionalized Medicare Beneficiaries per User, by Insurance Coverage, and by Demographic, Socioeconomic, and Health Characteristics, 1994

Community-Only Residents with at Least One Prescribed Medicine in 1994¹

Beneficiary Characteristic	Total ²	Medicare	Supplemental Health Insurance			
		Fee-for-Service Only	Medicaid	Individually-Purchased Private Insurance	Employer-Sponsored Private Insurance	Both Types of Private Insurance
Expenditures per User	\$629	\$526	\$766	\$583	\$684	\$718
	<i>10</i>	<i>21</i>	<i>8</i>	<i>7</i>	<i>20</i>	<i>32</i>
Metropolitan Area Resident						
Yes	630	525	781	605	673	727
	<i>14</i>	<i>29</i>	<i>11</i>	<i>19</i>	<i>20</i>	<i>30</i>
No	628	532	734	539	731	686
	<i>3</i>	<i>25</i>	<i>9</i>	<i>40</i>	<i>23</i>	<i>62</i>

Source: Medicare Current Beneficiary Survey, CY 1994 Cost and Use Public Use File.

Note: Standard errors are shaded and in italics. See Appendix A for additional information on standard errors. See Appendix B for definitions of terms and variables.

- 1 The term *community-only residents* includes beneficiaries who resided only in the community during the year. It excludes beneficiaries who resided part of the year in the community and part of the year in a long-term care facility, and beneficiaries who resided only in a long-term care facility during the year.
- 2 Expenditures for beneficiaries enrolled in Medicare HMOs are not shown separately in the table, but are included in the total. See entry for *Personal health care expenditures* in Appendix B, for additional information.
- 3 Medicare beneficiaries with end-stage renal disease (ESRD) are included within the subgroups of "Aged" and "Disabled."
- 4 IADL stands for Instrumental Activity of Daily Living.
- 5 ADL stands for Activity of Daily Living.

PRESCRIPTION DRUGS -- MCBS ANALYSIS
DISCUSSION NOTES

1. Overview

Beneficiaries with reported drug coverage.

By demographic characteristics.

By health status.

Compared to Medicare population without coverage.

Type of coverage - HMO, Private, Medicaid, etc.

Percent of beneficiaries who used Rx drugs.

Cost of Rx drugs to different populations.

By demographic characteristics.

By health status.

With subset of beneficiaries who reported using Rx drugs compare covered versus non-covered for OOP expenses. Covered beneficiaries can be stratified by type of coverage.

Types of drugs the Medicare population is using by therapeutic class.

Total costs of drugs by therapeutic class.

OOP expenses for the drugs.

By insurance type.

By demographic factors.

By health status.

2. Adequacy of Coverage

Look at adequacy of drug coverage by analyzing OOP expenses in several different ways.

OOP as a percent of total Rx costs.

OOP as a percent of income.

Stratify population by:

High, medium, and low users of Rx drugs.

Demographic characteristics.

Health status.

Type of Rx coverage (HMO, Medicaid, Private ES, etc.)

Possible Table Shells on Spending by Payer Source

Sheet 1 of Excel File

1. Run for total population
2. Break out same tables by three categories of health status:
 - Excellent and good
 - Fair
 - Poor
3. Break out same tables by total Medicare health spending
 - <\$1000
 - \$1000 - \$5000
 - >\$5000

Sheet 2 of Excel File

1. Run for total population with any drug expenses
2. Break out same table by same two categories of health status
3. Break out same table by e groups of total Medicare health spending :
 - <\$1000
 - \$1000 - \$5000
 - >\$5000
4. Break out same table by total out-of-pocket spending
 - <\$250
 - \$251 - \$500
 - \$501 - 1000
 - \$1001 - \$2000
 - >\$2000

Distr. Bene Drug Coverage	Number	Percent											
Employer													
Individual													
Both Priv.													
Medicare only													
HMO only													
HMO plus other													
Medicaid													
Other													
Total													
											Percentile	Tot. Drug	Spending
Dist. of Tot Drug Spending (number and % benes)	<\$100	<\$200	<\$300	<\$500	<\$800	<\$1000	>\$1000	>\$5000			(insert \$ amt)		
Employer													
Individual													
Both Priv.													
Medicare only													
HMO only													
HMO plus other													
Medicaid													
Other													
Total													
											Percentile	Drug OO	Spending
Dist. of Drug O-O-P Spending (number and % benes)	<\$50	<\$100	<\$200	<\$300	<\$500	<\$800	<\$1000	>\$1000	>\$1500		25th	50th	75th
											(insert \$ amt)		
Employer													
Individual													
Both Priv.													
Medicare only													
HMO only													
HMO plus other													
Medicaid													
Other													
Total													

Plan Spending Coverage		Benes Total											
Pcnt Tot. Drg. Spd. Pd by Pln	Employer	Individual			Both		HMO		Medicaid		Medicare only		
	% Benes	%pd.O-O-P/&mean	% Benes	%OOP/&mn	% Benes	%OOP/&mn	% Benes	%OOP/&mn	% Benes	%OOP/&mn	% Benes	%OOP/&mn	
0%													
<50%													
50 - 80%													
80 - 90%													
> 90%													
Total - Mean % Paid													
Plan Spending Coverage		Drug spending											
Pcnt Tot. Drg. Spd. Pd by Pln	Employer	Benes \$250 or less			Both		HMO		Medicaid		Medicare only		
	% Benes	%pd.O-O-P/&mean	% Benes	%OOP/&mn	% Benes	%OOP/&mn	% Benes	%OOP/&mn	% Benes	%OOP/&mn	% Benes	%OOP/&mn	
0%													
<50%													
50 - 80%													
80 - 90%													
> 90%													
Total - Mean % Paid													
Plan Spending Coverage		Drug spending											
Pcnt Tot. Drg. Spd. Pd by Pln	Employer	Benes \$251 -<\$500			Both		HMO		Medicaid		Medicare only		
	% Benes	%pd.O-O-P/&mean	% Benes	%OOP/&mn	% Benes	%OOP/&mn	% Benes	%OOP/&mn	% Benes	%OOP/&mn	% Benes	%OOP/&mn	
0%													
<50%													
50 - 80%													
80 - 90%													
> 90%													
Total - Mean % Paid													
Plan Spending Coverage		Drug spending											
Pcnt Tot. Drg. Spd. Pd by Pln	Employer	Benes \$500-\$1000			Both		HMO		Medicaid		Medicare only		
	% Benes	%pd.O-O-P/&mean	% Benes	%OOP/&mn	% Benes	%OOP/&mn	% Benes	%OOP/&mn	% Benes	%OOP/&mn	% Benes	%OOP/&mn	
0%													
<50%													
50 - 80%													
80 - 90%													
> 90%													
Total - Mean % Paid													
Plan Spending Coverage		Drug spending											
Pcnt Tot. Spd. Paid by Plan	Employer	Benes \$1000- 2000			Both		HMO		Medicaid		Medicare only		
	% Benes	%pd.O-O-P/&mean	% Benes	%OOP/&mn	% Benes	%OOP/&mn	% Benes	%OOP/&mn	% Benes	%OOP/&mn	% Benes	%OOP/&mn	
0%													
<50%													
50 - 80%													
80 - 90%													
> 90%													
Total - Mean % Paid													
Plan Spending Coverage		Drug spending											
Pcnt Tot. Spd. Paid by Plan	Employer	Benes >\$2000			Both		HMO		Medicaid		Medicare only		
	% Benes	%pd.O-O-P/&mean	% Benes	%OOP/&mn	% Benes	%OOP/&mn	% Benes	%OOP/&mn	% Benes	%OOP/&mn	% Benes	%OOP/&mn	
0%													
<50%													
50 - 80%													
80 - 90%													
> 90%													
Total - Mean % Paid													

Tabulations from the NEHIS Plan File

Table 1

Questions	Codes	Enrollment			
		Total Employees Covered (EESCOVNU)	Total Retirees (RETMAJNU)	Total Early Retirees (RETU65MA)	Total Retirees (65+) (RETO65MA)
Total					
Cover Outpatient Prescription Drugs?	S8				
Limit Outpatient Prescription Drugs?	S9A				
Was There a \$ Limit For Outpatient Prescription Drugs?	S9AOV				
\$ Limit for Outpatient Prescription Drugs	S9AOVAMT				
Generic Required For Outpatient Prescription Drugs?	S10				
By Type of Plan (E3=1)					
HMO (E3=1)					
Cover Outpatient Prescription Drugs?	S8				
Limit Outpatient Prescription Drugs?	S9A				
Was There a \$ Limit For Outpatient Prescription Drugs?	S9AOV				
\$ Limit for Outpatient Prescription Drugs	S9AOVAMT				
Generic Required For Outpatient Prescription Drugs?	S10				
PPO/EPO (E3=2)					
Cover Outpatient Prescription Drugs?	S8				
Limit Outpatient Prescription Drugs?	S9A				
Was There a \$ Limit For Outpatient Prescription Drugs?	S9AOV				
\$ Limit for Outpatient Prescription Drugs	S9AOVAMT				
Generic Required For Outpatient Prescription Drugs?	S10				
POS (E3=3)					
Cover Outpatient Prescription Drugs?	S8				
Limit Outpatient Prescription Drugs?	S9A				
Was There a \$ Limit For Outpatient Prescription Drugs?	S9AOV				
\$ Limit for Outpatient Prescription Drugs	S9AOVAMT				
Generic Required For Outpatient Prescription Drugs?	S10				
Conventional, Fee for Service (E3=4)					
Cover Outpatient Prescription Drugs?	S8				
Limit Outpatient Prescription Drugs?	S9A				
Was There a \$ Limit For Outpatient Prescription Drugs?	S9AOV				
\$ Limit for Outpatient Prescription Drugs	S9AOVAMT				
Generic Required For Outpatient Prescription Drugs?	S10				
Single Service Prescription Plan (E3=7)					
Cover Outpatient Prescription Drugs?	S8				
Limit Outpatient Prescription Drugs?	S9A				
Was There a \$ Limit For Outpatient Prescription Drugs?	S9AOV				
\$ Limit for Outpatient Prescription Drugs	S9AOVAMT				
Generic Required For Outpatient Prescription Drugs?	S10				

Table 2 By Establishment Size

Table3 By State

Table 4 By SIC