

# **PHARMACEUTICAL ASSISTANCE FOR THE ELDERLY**

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## FOREWORD

This report has been prepared in response to Senate Concurrent Resolution No. 25 which was adopted during the Regular Session of 1988. The report contains the results of the Bureau's study on the feasibility of establishing a pharmaceutical assistance program for the elderly in Hawaii.

The data presented and the findings and conclusions reached in this report could not have been achieved without the cooperation and assistance of various individuals knowledgeable about the elderly and pharmaceuticals. The Bureau is especially grateful for the input provided by the officials of the states with pharmaceutical assistance programs, namely, Marsha Mains of Connecticut, Jerry Purcell of Illinois, Michael O'Donnell of Maine, John Baker of Maryland, Edward Klane of New Jersey, Marilyn Desmond of New York, Thomas Snedden of Pennsylvania, and Susan Sweet of Rhode Island. The Bureau also extends its appreciation to the licensed pharmacists, the Kaiser Foundation Health Plan, the Hawaii Medical Service Association, the Health Care Administration Division, and the Executive Office on Aging for responding to the Bureau's inquiries; to Greg Lim of the Pharmaceutical Manufacturers Association and Judith Brown of the American Association of Retired Persons for providing information; and to all the state legislative research agencies that responded to the Bureau's inquiry and transmitted information regarding the status of the pharmaceutical assistance issue in their respective states.

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## Chapter 1

### INTRODUCTION

In 1986, Americans spent \$116 billion for health care that was not covered by private insurance or government programs. The largest portion of these out-of-pocket expenses was for physician services and drugs and sundries.<sup>1</sup> Recent studies have revealed data showing a correlation between increases in drug use to the increasing proportion of elderly in the United States.<sup>2</sup> Prescription drug use is high among the elderly because of the high incidence of chronic disease in this population group. Four out of five elderly persons have at least one chronic ailment requiring extended drug therapy.<sup>3</sup>

The importance of prescription drugs in the control of chronic illness and the prevention of more serious and debilitating conditions is widely recognized in medical and geriatric circles.<sup>4</sup> Yet, the affordability of prescription drugs has become an issue nationwide due to the absence of adequate third party coverage for prescription drugs for the elderly. Medicare generally does not provide prescription drug coverage unless the drug is administered in a hospital or skilled nursing facility or the drug is one that cannot be self-administered by the patient and must be administered by a health professional. Those elderly who meet the low income requirements under Medicaid, the state-level medical assistance program, can obtain prescription drugs at no cost under that program in most states. Only Alaska and Wyoming do not offer prescription drug assistance under Medicaid.<sup>5</sup> For those who do not meet the income requirements, prescription drugs must be paid for entirely out-of-pocket unless they have some private drug insurance plan.

Pharmaceutical assistance programs offer direct financial assistance to the elderly in the purchase of prescription drugs. Interest in pharmaceutical assistance programs evolved as it became apparent that many of the poor and near-poor elderly were not following their prescribed drug regimens because they could not afford to purchase the drugs. Noncompliance with drug therapy can lead to more debilitating conditions requiring institutional treatment. As the costs for hospital and nursing home care have skyrocketed and the government's share of these costs (through Medicare and Medicaid) has grown, policymakers have looked to less costly preventive solutions to assure access to proper health care. Pharmaceutical assistance is one of them.

Senate Concurrent Resolution No. 25 (see Appendix A) was adopted during the 1988 Regular Session of the Fourteenth Legislature directing the Legislative Reference Bureau (hereinafter referred to as the Bureau) "...to conduct a study on the feasibility of implementing a pharmaceutical assistance program in the State of Hawaii to assist elderly persons with incomes too high to receive public medical assistance." The Concurrent Resolution expressed concern that the monthly costs of prescription drugs can be prohibitive for elderly who are on fixed income and directed the Bureau to review the programs in Connecticut, Delaware, Illinois, Maine, New Jersey, New York, Pennsylvania, and Rhode Island.

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To determine the feasibility of a pharmaceutical assistance program for Hawaii, the Bureau examined the existing programs in other states, the need among Hawaii's elderly population for financial assistance in the purchase of their prescription drugs, and the cost implications of implementing a pharmaceutical assistance program. Soon after the adjournment of the 1988 legislative session, the federal Medicare Catastrophic Coverage Act of 1988 was reported out of conference committee containing a provision for outpatient prescription drug coverage and was subsequently signed into law on July 1, 1988.<sup>6</sup> The Bureau's review of pharmaceutical assistance programs includes this federal legislation and an assessment of the need for a state-level assistance program in view of the new federal drug assistance program.

## Chapter 2

### COMPONENTS OF A PHARMACEUTICAL ASSISTANCE PROGRAM

The pharmaceutical assistance programs vary in program design and administration depending on the need and size of the target population, availability of funding, and other drug reimbursement programs in place; however, most states have designed their programs with cost control in mind. The pharmaceutical assistance program components fall into six basic categories: (1) the beneficiaries covered; (2) the drugs covered; (3) a cost-sharing mechanism; (4) restrictions on dispensing; (5) a reimbursement procedure; and (6) program controls. There is no "model program" and researchers have emphasized the importance of identifying the "best combination" of options that balance a state's fiscal and therapeutic efficacy in order to best serve the medical needs of the elderly.<sup>1</sup> This chapter generally describes the variations of the program components. Descriptions of the existing state programs and comparisons thereof follow in Chapter 3 and an analysis of the Medicare outpatient prescription drug coverage is presented in Chapter 4.

#### Selection of Beneficiaries

Determination of the target group depends on a state's assessment of where the greatest need for assistance lies and its program objectives. Coverage can be comprehensive and cover all persons, regardless of income or age, or can be very narrowly confined to the most needy elderly group. The pool of beneficiaries can be circumscribed by specifying age or income qualifications, or both. Most states have restricted coverage to the lower income elderly, age 65 and over, who do not qualify for Medicaid with a specified qualifying income. Some states have also extended drug coverage to the disabled. Drug coverage can also be limited to social security beneficiaries; however, this may exclude more people than is desirable as there are many people who have never worked for an employer in the social security system. The beneficiary pool can be further defined by limiting coverage to state residents and specifically excluding those who have other drug insurance coverage.

#### Drugs Covered

In an Urban Institute paper on prescription drugs, Karen Lennox outlined the following options or policy alternatives available for drug coverage: (1) comprehensive coverage where all prescription drugs and over-the-counter drugs are included; (2) coverage for prescription drugs only; (3) coverage where specified drugs or categories of drugs are excluded; or (4) coverage limited to specified drugs or categories of drugs as in a formulary.<sup>2</sup> While comprehensive coverage may be the best option in terms of medical need, the problems associated with this option (i.e., high program expenditures, increased administrative burdens, excessive prescribing, beneficiary overuse, and difficulty in controlling fraud and abuse) are reasons for concern. Coverage of all prescription drugs or legend

drugs (drugs that bear the legend, "Caution: Federal law prohibits dispensing without a prescription") is most common since these are usually the more expensive drugs and they involve medical review of the beneficiary's condition.<sup>3</sup> Limiting the drug coverage further by specifying the inclusion or exclusion of certain drugs and using a formulary can reduce costs and administrative burdens; however, this would require continual review by a drug formulary committee to delete ineffective drugs from the list or include new drugs. A state could base its drug coverage on its Medicaid program's formulary or on the drugs most commonly used to treat chronic illness among the elderly.

### Cost-sharing

Cost-sharing can be in the form of a: (1) deductible where the beneficiary pays a certain amount before benefits accrue; (2) coinsurance where the beneficiary pays a percentage of each prescription; (3) copayment where the beneficiary pays a set fee for each prescription; (4) dollar limit where the beneficiary pays the cost exceeding the limit; or (5) premium or enrollment fee.<sup>4</sup> A cost-sharing mechanism is usually added to a pharmaceutical assistance program to "...limit the effect of the moral hazard of drug insurance, reduce total program expenditures, control unnecessary utilization, and provide incentives to shop around for the lowest cost product."<sup>5</sup> A drawback with the use of a deductible is that there has to be an administrative accounting of all prescription bills in order to ascertain when the deductible has been met. Coinsurance also poses administrative problems in that the amount to be paid by the beneficiary has to be calculated for each prescription. Coinsurance is considered more inequitable than copayment since the heavier burden falls on those with expensive prescriptions, regardless of their income, and it provides an incentive to use lower-cost drugs and could curb total program expenses as drug costs escalate.<sup>6</sup> The imposition of a premium or an enrollment fee can be used to help build the fund from which drug reimbursement payments will be made, but depending on how high the fee is, it may discourage participation.

A cost-sharing mechanism can be innovatively designed to meet the peculiar needs of the state by a combination of some of the options or by establishing a sliding scale of amounts payable based on income or past drug expenditures. States must bear in mind that administrative costs often increase with the complexity of the design.

### Dispensing Restrictions

Although a centralized distribution system by contract between the state and certain pharmacies might be the most efficient administratively as well as economically, it may not be feasible since it would pose an inconvenience to the beneficiaries who live in remote areas and pharmacies not awarded a contract would stand to lose some business. To provide for effective administrative control as well as convenience to the elderly and fairness to pharmacies, most programs require dispensing of covered drugs only through participating pharmacies which voluntarily register for the program.<sup>7</sup>



To discourage wasting and sharing of prescription drugs and to ensure that the beneficiary's drug therapy is under proper medical supervision, a pharmaceutical assistance program should impose a limit on the dosage allowed per prescription. The limit can be by the number of days, drug units, or doses. The smaller the limit, the higher the cost will be to the beneficiary since the coinsurance or copayment is charged on each new prescription or refill.

### Reimbursement Procedure

Karen Lennox noted that the choice between reimbursement of the beneficiary or the dispenser depends on economic as well as administrative considerations. If the beneficiary is reimbursed, the beneficiary would have to pay the dispenser for the drugs and submit claims for reimbursement. Proponents argue that payment for the drugs could motivate the beneficiary to shop around and the physician to prescribe lower priced drugs. There are serious problems with this option, however, as beneficiaries often do not have sufficient cash on hand to pay for the drugs and receipts for claims may be lost or never filed. Administratively, the program would have to process millions of individual claims and mail a multitude of small checks. Reimbursement to dispensers is easier administratively since the dispensers can submit claims in large batches and receive lump-sum payments. Dispenser reimbursement also lends itself to cost control as the program can pose limits on the reimbursement amount by setting maximums and to drug use control as the dispenser can be required to maintain a more complete data base available for utilization review as well as future research.<sup>8</sup>

The claims processing and reimbursement procedure established for a pharmaceutical program would be best implemented if procedures of existing systems could be utilized and possibly enhanced. Most states have contracted the claims processing function to an agent such as Blue Cross/Blue Shield with extensive experience and the state-of-the-art technology and staff to perform this function cost-effectively and efficiently.

### Program Control

An efficient eligibility determination procedure which ensures proper identification of beneficiaries and a procedure for the monitoring of drug use is essential to a pharmaceutical assistance program. Most states require regular reregistration of beneficiaries to ensure an accurate list of active beneficiaries as some will pass away and others may lose eligibility status due to income changes. Identification cards, like the plastic credit card plates, are often issued for easier identification of beneficiaries and claims processing by the pharmacies. Pharmacies are usually required to keep patient records of prescriptions purchased which are periodically reviewed by a drug utilization review team to flag out possible inappropriate prescribing or dispensing practices and to advise physicians and pharmacists of potential drug use problems of certain beneficiaries. Additionally, the keeping of demographic data on the beneficiaries can provide the basis for assessing need for programmatic changes. A statewide computerized data base accessible to all participating pharmacies could serve as a good check on drug

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misuse if beneficiaries are not required to patronize the same pharmacy for all their prescription drugs.

To combat drug misuse and abuse, a program should include an effective informational network involving educational and outreach programs to ensure a properly informed drug using elderly population. A program should also include efforts to ensure awareness among the prescribing physicians and dispensing pharmacists of the peculiarities associated with geriatric drug use.

## Chapter 3

### PHARMACEUTICAL ASSISTANCE PROGRAMS IN OTHER STATES

#### The Eight States With Pharmaceutical Assistance Programs

Senate Concurrent Resolution No. 25 directed the Bureau to review the pharmaceutical assistance programs of Connecticut, Delaware, Illinois, Maine, New Jersey, New York, Pennsylvania, and Rhode Island. The Bureau wrote to these states for information regarding their programs and found that Delaware's program was a privately-run<sup>1</sup> rather than state-run program and that Maryland also had a pharmaceutical assistance program. Accordingly, while Maryland's program will be discussed in this chapter, Delaware's will not.

With the exception of Illinois, all the states with a state-level pharmaceutical assistance program are from the eastern region of the United States. New Jersey, in 1975, was the first state to implement a pharmaceutical assistance program. Maine established its program in 1977 followed by Maryland in 1978 and Pennsylvania in 1983. Connecticut, Illinois, and Rhode Island established programs in 1985 and New York in 1986. Connecticut, Illinois, and New Jersey offer assistance to the elderly in the 65 and older group and the disabled; however, New Jersey limits coverage to those disabled who qualify for disability benefits under the Social Security Act. Maryland offers benefits to persons, regardless of age, who meet the income requirements but are not eligible for public medical assistance. All states have some type of residency requirement for eligibles. The income requirements vary with New York having the lowest at \$9,000 for a single applicant and \$12,000 for a married applicant and New Jersey having the highest at \$13,650 for singles and \$16,750 for the married. Maryland is the only state that also requires beneficiaries to meet an assets test. Although the states vary in the cost-sharing mechanisms, no state program requires the beneficiary to pay a deductible before qualifying for benefits. Most states require a copayment.

Pennsylvania has the largest enrollment with 472,741 beneficiaries and the highest annual program cost at \$142,032,751. New Jersey covered almost 240,000 beneficiaries at a cost of \$95.4 million in fiscal year 1987-1988. Illinois had approximately 60,000 beneficiaries in 1987 with a program cost of about \$23.7 million; Connecticut with 55,000 beneficiaries cost about \$16.5 million; Rhode Island with 17,000 beneficiaries cost about \$1.9 million; Maryland with 17,000 beneficiaries cost about \$7.1 million; Maine with 19,000 beneficiaries cost about \$2 million; and New York with 42,000 beneficiaries cost about \$30 million.

Reimbursement of drug costs are made to the pharmacies in all the programs. New Jersey which began with a beneficiary reimbursement scheme gradually switched to a provider reimbursement system in 1978 and 1979 wherein beneficiaries used a card, along with a \$2 copayment to obtain prescriptions. The program became significantly more attractive since beneficiaries did not have to pay the full cost of the prescription or worry about the confusing claims submission process.<sup>2</sup>

Illinois restricts benefits under its plan only to drugs for the treatment of cardiovascular diseases, arthritis, and diabetes while Maine limits coverage to certain "life sustaining drugs". The remaining states offer wider coverage for all drugs requiring prescriptions, including insulin and insulin syringes and needles. All states have some type of restriction on the length or dosage of the prescription to control wastage and the sharing of drugs, usually a 30-day or 100-dose supply.

The states generally conform to their own state generic drug laws, allowing physicians to decide on brand drugs or generic substitution,<sup>3</sup> but some states do not have a specific provision in the pharmaceutical assistance law concerning generic drugs. Illinois sets the maximum cost of eligible drugs at the generic equivalent price. New Jersey requires the purchase of generic substitutes that are equal or less than the maximum allowable cost or the beneficiary must pay the difference between the generic and the brand-name drug. Pennsylvania also requires patients to pay such differentials if they opt against generics. In New York, the prescriptions are automatically filled by generics unless specifically directed otherwise by the attending physician. Connecticut offers a \$.50 incentive dispensing fee to pharmacists for filling prescriptions with lower-priced generic substitutes unless such substitution is otherwise prohibited by the state's pharmacy law.

All states require the pharmacies participating in their program to keep and maintain patient records. Such records are used to compile statistical data on drug use patterns and to assist the pharmacies in advising physicians and beneficiaries of contraindications regarding the drug being prescribed and other drugs the beneficiary may be taking. The programs all have included a drug utilization review mechanism to deter fraudulent acts and to ensure against drug misuse by the elderly. Typically, this mechanism is in the form of a drug utilization review committee which monitors the prescriptions being filled under the program as well as the pharmacies and physicians by reviewing individual patient records.

Administrative placement of a pharmaceutical program is usually in the department that has programmatic responsibility for the elderly. In Connecticut, Pennsylvania, and Rhode Island, where there are separate departments for elderly matters, the programs have been placed in such departments. In Maine and New Jersey, placement is within a human services department. Maryland has placed its program in its Department of Health and Mental Hygiene and New York in its Executive Department. Illinois is different from the other states since its program is under the purview of the Department of Revenue even though it has a Department on Aging. The reason for this peculiarity is that the program was an outgrowth of an existing tax relief program.

### Connecticut

The Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled (hereinafter ConnPACE) program was established in 1985.<sup>4</sup> The enabling legislation called for a one-year pilot program which was to begin on April 1, 1986. The legislation also created a task force to examine the proposed pilot program and to ascertain whether a different program should

be implemented. The task force recommended some changes which were incorporated into the 1987 amendment to the law which made the program permanent. The ConnPACE program provides coverage to those 65 years of age and older and disabled for all drugs requiring a prescription in the state. Anyone who has other prescription drug coverage is ineligible. The elderly account for 96 per cent of the 54,745 enrolled in the ConnPACE program as of June 30, 1988. The program cost for fiscal year 1987-1988 was \$16,546,370 with funding by state general funds. Beneficiaries are required to pay a \$4 copayment for each prescription purchased under the program. The average cost per elderly beneficiary in 1988 was \$313. The Department of Aging administers the program and contracts with a fiscal intermediary to perform eligibility, enrollment, claims processing, and record-keeping functions. The ConnPACE program estimates that the enrollment will surpass 61,000 by the end of the current fiscal year and has a budget of \$22,135,400. With Connecticut facing budget constraints for all programs, the Department of Aging is looking into alternatives to achieve a potential five per cent cost savings.<sup>5</sup>

### Illinois

Illinois began its program in 1985 as an extension of the Senior Citizens and Disabled Persons Property Tax Relief Act, also known as the "Circuit Breaker".<sup>6</sup> The program provides coverage for drugs to treat cardiovascular diseases, arthritis, and diabetes for persons who are 65 years of age and older and the disabled. The maximum income level allowable to qualify for benefits is \$14,000. Persons receiving prescription drug coverage under another public assistance program are ineligible. The enrollees, numbering over 60,000 in 1987, pay an \$80 enrollment fee and must turn over rights to covered drug benefits under any insurance plan. Under the Circuit Breaker program, qualifying persons can receive rebates of up to \$700 in cash for property taxes and an additional \$80 rebate can be used for the enrollment fee. The \$80 grant is available to some persons not eligible for the main grant. There is a 34-day supply limit on prescriptions and charges on drugs are limited to the wholesale cost plus a dispensing fee which is currently \$3.60. The average annual cost of prescription drugs per enrollee in 1987 was \$17.76. The program which is funded through general funds cost \$23.7 million in 1987. The Department of Revenue which administers the program, contracts with Blue Cross/Blue Shield to process all claims.<sup>7</sup>

### Maine

Maine's pharmaceutical assistance law was enacted in 1977.<sup>8</sup> The program provides prescription drug coverage of life sustaining drugs which include most prescription drugs for heart, blood pressure, diabetes, and arthritis. Those eligible for coverage are elderly persons who are age 62 or older with a maximum income of \$6,600 for single persons and \$7,900 for married couples. Recently, the program was expanded to cover chronic obstructive pulmonary disease drugs. The income guidelines are those used under the Tax and Rent Relief Act and eligibility for the low-cost drug program is determined by the state Tax Assessor. The Department of Human Services which administers the program determines which drugs are life

sustaining within the dual constraints of good medical practice and the annual state appropriation. The use of generic or chemically equivalent drugs is required unless otherwise directed by the prescribing physician. Copayments range from \$2 to \$10 for each prescription, depending on the drug. The program is funded through general funds and the cost in 1987 for its 18,773 beneficiaries was \$2,054,650.41. Costs are expected to rise significantly in 1988 since the legislature expanded the program to include additional drugs.<sup>9</sup>

### Maryland

The Maryland Pharmacy Assistance Program (hereinafter MPAP) which began in 1978<sup>10</sup> is different from the others in that it is based on income qualifications, not age. Maryland has an income eligibility scale that is 1.5 times higher than the income limits under the medical assistance program beginning with \$6,400 for single persons and \$7,000 for a family of two. The income limits are increased automatically when social security benefits are increased. Beneficiaries must also meet asset standards which are the same as used for the state's medical assistance program but at a rate of 1.5 times higher. For fiscal year 1988 the asset limit for a single person was \$3,750 and for a family of two, \$4,275. Persons receiving public medical assistance and nonresidents are not eligible. Maryland's program offers the most liberal coverage among the eight states. The program covers prescription drugs, schedule V cough preparations, prescribed insulin, insulin syringes, and needles, contraceptives (not condoms), and certain nutritional preparations. There is a one dollar copayment for each prescription filled. In fiscal year 1988, Maryland averaged 16,659 enrollees per month (64 per cent of which were age 65 and over) and the cost of the program ran \$7,057,220. The program is administered by the Department of Health and Mental Hygiene with the MPAP staff (seven full-time and three part-time) performing the administrative function of eligibility determination. Unlike the other states which contract a fiscal agent to perform the claims processing function, Maryland's claims processing function is performed by the Department of Health and Mental Hygiene in conjunction with its Medicaid program.<sup>11</sup>

### New Jersey

In 1975, New Jersey became the first state to implement a pharmaceutical assistance program.<sup>12</sup> The Pharmaceutical Assistance to the Aged and Disabled program (hereinafter PAAD) which covers persons age 65 and older and the disabled who are qualified for disability benefits under the Social Security program, served 247,993 clients in fiscal year 1987, of which 229,612 or approximately 92 per cent, were elderly. Persons in the 65 to 75 age group accounted for 41.9 per cent of the PAAD recipients, those in the 76 to 85 age group accounted for 37.5 per cent, and those in the 86 and over age group accounted for 12.5 per cent. Program costs for fiscal year 1987 totalled \$95.4 million, 43.1 per cent of which was funded by casino revenues. While the bulk of the program expenditures is for benefit payments, approximately \$5 million is attributable to administrative costs. New Jersey has the largest program staff with 150 members who perform eligibility determinations and reimbursement recovery functions. Claims are processed by a contractor.

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When the program was first implemented, eligibility was limited to residents over 65 years of age with annual incomes of less than \$9,000 and included provisions limiting the reimbursements above certain percentages of a resident's income. This "spend-down" provision was repealed in 1977 and replaced with a \$1 copayment requirement which was subsequently increased to \$2 in 1985. In 1981 the program was expanded to include persons identified as disabled under the Social Security Act. Reportedly, this has caused some problems as disabled persons who did not work for an employer under the social security system or for some other reason were not part of the social security system will not qualify for benefits until attaining age 65. However, the social security eligibility criterion was imposed as a cost-saving device since it would have cost the PAAD program between \$500 to \$600 to conduct a disability eligibility determination. The cost of the PAAD program grew at a slower rate in fiscal year 1987 than in previous years in part due to the increase in generic prescribing and dispensing which resulted from a greater availability of generic substitutes in the state formulary. New Jersey anticipates implementation of a generic drug incentive in fiscal year 1988 with the hope of limiting further program cost increases.

The PAAD program was initially designed to reimburse the beneficiaries, but since their record-keeping practices were poor, the program was changed to a provider reimbursement process. Blue Cross/Blue Shield which has a contract for the state's Medicaid program, has also been contracted as the fiscal agent for the PAAD program. The PAAD program has been expensive. In 1982, the PAAD cost more than the Medicaid program. There have been continual attempts to keep program costs down.<sup>13</sup>

### New York

New York enacted its Elderly Pharmaceutical Insurance Coverage (hereinafter EPIC) law in 1986 and the law is subject to expiration on September 30, 1991.<sup>14</sup> The program provides coverage for all prescription drugs, insulin, insulin syringes, and insulin needles for persons age 65 and older if their annual income does not exceed \$9,000 for a single person and \$12,000 for a married person. Under the EPIC program, the prescription must automatically be filled by generics unless the attending physician specifically directs otherwise. Enrollees must pay a quarterly registration fee ranging from \$6 to \$19 for single enrollees and from \$5 to \$19 for married enrollees, depending on their income. At the time of purchase, the enrollee must pay a copayment ranging from \$3 to \$15, depending on the cost of the prescription, which amounts to about 40 per cent of the total prescription cost. After an enrollee has paid a certain amount in copayments (\$300 to \$750 depending on income and marital status) the EPIC program will cover the full cost of any additional prescriptions. The EPIC program also offers catastrophic coverage through either a premium or deductible plan. Qualifying incomes for this coverage are higher at \$9,001 to \$15,000 for singles and \$12,001 to \$20,000 for persons who are married and living together.

Initially, program costs were projected to be anywhere between \$130 to \$142 million due to the projection of about 475,000 eligible beneficiaries. The Legislature appropriated \$70 million in the 1987-1988 budget for the EPIC

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program. The EPIC program entered into a \$27 million four-year contract with a data systems corporation to perform applications processing, eligibility determination, mailing of membership cards, processing of claims, and monitoring of pharmacies.

The number of enrollees in the program for the first year was much lower than had been anticipated and the cost to the state was only \$6.5 million. The low enrollment was due to several factors: (1) many elderly appeared reluctant to enroll since they would have to pay money up front and were uncertain as to whether they would benefit from the program since their drug expenses were not very high; (2) the program's eligibility requirements and benefit specifications are somewhat complex; and (3) the original projections were too high since there was no survey on the elderly's prescription drug expenditures and third party coverage to accurately determine the number of eligibles. Concerned about the low enrollment, the EPIC revamped its advertising campaign, simplified the application form, and enhanced its outreach training sessions to draw more participants.

In view of the problems encountered, the EPIC staff has been contemplating program changes which would simplify the program, such as: (1) replacing fees and premiums with deductible amounts; (2) collapsing the fee schedule into a single fee for all enrollees; (3) defining the Home Energy Assistance Program and/or the Real Estate Tax Circuit Breaker Credit populations as categorically eligible for the EPIC program; (4) changing the qualifying income definition from previous calendar year gross income to current gross income; (5) reducing or eliminating the registration fee for the comprehensive program as well as increasing the copayment amount to offset the lost revenue; and (6) collapsing the current copayment schedule to a single fee at the time of purchase.<sup>15</sup>

### Pennsylvania

The Pharmaceutical Assistance Contract for the Elderly (hereinafter PACE) was established in 1983 and began operations in 1984.<sup>16</sup> The PACE program covers individuals who are age 65 and older with incomes of not more than \$12,000 for single applicants and \$15,000 for married applicants. All prescription drugs, insulin, insulin syringes, and insulin needles are covered under the PACE program. The beneficiary pays a \$4 copayment for every prescription and the pharmacist is reimbursed the balance based on a specified formula. On June 30, 1987, there were 472,741 enrollees in the PACE program and the program cost for fiscal year 1986-1987 was \$142,032,751.

More than 53 per cent of the enrollees are over 75 years of age and the ratio of female to male enrollees was nearly three to one. Only one-third of the enrollees were married and while 65 per cent of the men were married, slightly more than 65 per cent of the women were widowed. The average number of prescriptions per person was 25. Although Pennsylvania has the highest program cost, the high cost was anticipated and the state was fiscally prepared to meet such costs as the program grew.



Pennsylvania takes pride in the effectiveness of its utilization review process which has helped to contain the cost of its large program. During its three-year period of operation, the PACE program, through its utilization review process, identified more than 15,000 cases requiring special review and corrective action on nearly 3,000 was taken. To further contain costs, the PACE program made several changes to its program. The dispensing of multisource drugs became mandatory and reimbursements are made at 50 per cent of the average wholesale price if the prescriber permits substitution and a multisource equivalent is listed on the state's generic formulary, regardless of whether or not the provider has multisource versions in stock. The PACE program will also offer a pharmacist consultation fee of one dollar for every original prescription whenever the pharmacist provides information to a physician and the substitution of a multisource drug results. The third cost containment strategy concerns the formula for reimbursement of providers for prescriptions dispensed. The PACE program reimburses providers either the average wholesale price of the drug (plus a \$2.75 dispensing fee) or the usual and customary charge, whichever is less. The reimbursement rates which were based on purchases in quantities of 100 will now be based on purchases in quantities of 1,000 to encourage prudent purchasing practices by the providers and concurrently reduce drug expenditures for the program. Finally, to encourage smaller prescriptions which will result in less waste and sharing of unused drugs, the maximum prescription size for claims will be decreased from a 30-day supply or 100 units to a 30-day supply or 100 doses, whichever is less. Moreover, the dispensing of more frequent prescriptions will increase the number of copayments and will serve to offset the level of reimbursement required by the PACE program. The program anticipates a savings of approximately \$99 million over the next three years through these cost containment efforts.<sup>17</sup>

### Rhode Island

The Rhode Island Pharmaceutical Assistance to the Elderly (hereinafter RIPAE) program began in 1985 as a two-year pilot program which offered coverage for more than 1,000 drugs for the treatment of diabetes, heart problems, and high blood pressure.<sup>18</sup> Coverage was later expanded to include prescriptions for glaucoma and Parkinson's disease. To be eligible for benefits a person must be at least 65 years old with an income of not more than \$12,000 for a single person or \$15,000 for a married person. The amounts expended for medical and pharmaceutical needs which exceed three per cent of the applicant's income is not included in the income ceilings. Excluded from coverage are persons who are covered by another drug coverage plan. The RIPAE program pays up to 60 per cent of the maximum allowable charge for each prescription. Only about two to three per cent of Rhode Island's beneficiaries have drug expenses that exceed \$600. The average annual reimbursement payment per beneficiary is \$125.35.

Prescriptions are limited to a 30-day or 100-dose supply, whichever is less, except for prescriptions with an average wholesale price of less than \$10 which are limited to the greater of the 30-day or 100-dose supply. The RIPAE program requires that prescriptions be dispensed within one year of the original prescription order.

## PHARMACEUTICAL ASSISTANCE FOR THE ELDERLY

For fiscal year 1987-1988, there was a total of 16,813 clients enrolled in the program. The Department of Elderly Affairs administers the program but has contracted with Blue Cross/Blue Shield to process claims at a cost of about \$1.15 per claim. Rhode Island also minimized additional cost at the onset of the program by contracting part of the eligibility determination function to various community service and elderly groups at a rate of about \$2 per claim.<sup>19</sup>

### **Trends in the States Without a Pharmaceutical Assistance Program**

The Bureau wrote to the District of Columbia and those 40 states without a state-level pharmaceutical assistance program to ascertain the extent of interest in establishing a state-level program. Of the 30 jurisdictions that responded to our inquiry, only Florida, Kansas, Massachusetts, Minnesota, Ohio, and Virginia reported having considered legislation to establish a pharmaceutical assistance program. Most of those states cited the potential high cost of a state-level pharmaceutical assistance program as the reason for unsuccessful passage. Virginia noted that it is now in the process of conducting a study while Florida noted that in light of the federal program, legislation for a state-level program may not be pursued again because it carries a big price tag. Interestingly, the District of Columbia reported that the Bureau's letter generated interest in the District and that legislation will be introduced on this matter.

Table 1

## PHARMACEUTICAL ASSISTANCE PROGRAM CHARACTERISTICS

<u>Program</u>	<u>Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled (ConnPACE)</u>	<u>Illinois Pharmaceutical Assistance Program</u>	<u>Maine Low-Cost Drugs for the Elderly Program</u>
Year law enacted/cite	1985/Conn. Gen. Stat. §17-51D et seq.	1985/Ill. Rev. Stat. 1985, ch. 67-1/2, sec. 401 et seq.	1977/Me. Rev. Stat. Ann., tit. 22, §254
Administering agency	Department of Aging	Department of Revenue	Department of Human Services
Funding	General funds	General funds	General funds
Persons covered/excluded	65+ and disabled residents domiciled in state for not less than 183 days before application/those with other plan of insurance or assistance excluded	65+ and disabled state residents	62+
Financial eligibility	Maximum annual income: \$13,300--single \$16,000--married Subject to annual adjustment	Income under \$14,000	Maximum annual income: \$7,600--single \$8,300--married
Drugs covered	All prescription drugs, insulin, insulin syringes, and insulin needles; drugs determined ineffective by FDA not covered	Cardiovascular, arthritis, and diabetes drugs including insulin syringes and needles	Drugs for heart disease, diabetes, arthritis, and chronic obstructive pulmonary disease
Generic drug provision	Provides generic incentive dispensing req as provided under Medicaid program; state pharmacy law permits pharmacist to substitute generics unless physician directs otherwise	Maximum acquisition cost is established at generic equivalent price, where applicable	Requires use of generic or chemically equivalent drugs unless physician indicates otherwise
Dosage restrictions	30-day supply or 120 oral dosage units, whichever greater	34-day supply	Must be dispensed in quantities sufficient to effect optimum economy (at least 30-day supply) unless prescriber otherwise directs
Participant's cost	\$4 copayment for each prescription	\$80 enrollment fee; beneficiary must turn over rights to covered drug benefits under other drug insurance plan	\$3 for chronic obstructive pulmonary disease drugs; \$10 for antiarthritic drugs; and \$2 for other drugs

Program	Year law enacted/cite	Administering agency	Funding	Persons covered/excluded	Financial eligibility	Drugs covered	Generic drug provision	Dosage restrictions	Participant's cost
Maryland Pharmacy Assistance Program (MPAP)	1978/Md. Health-General Code Ann., §15-124	Department of Health and Mental Hygiene	General funds	All persons meeting income eligibility requirements/ persons receiving public medical assistance and nonresidents excluded.	Maximum annual income scale ranging from \$6,100 for single to \$11,950 for family of 10; \$650 for additional persons thereafter. Asset limits also on scale ranging from \$2,500 for single to \$3,000 for family of 6 with \$100 for additional persons.	Prescription drugs declared effective by the FDA, schedule V cough preparations, insulin, insulin syringes and needles, contraceptives (except condoms), and certain formulated nutritional supplements prescribed by a physician	Follows Medicaid rules which require dispensing of generics unless physician in own writing, specifies otherwise	100-day supply	\$1 copayment for each prescription
New Jersey Pharmaceutical Assistance to the Aged and Disabled (PAAD)	1975/N.J. Stat. Ann. §30:4D-20 et seq.	Department of Human Services	General funds; casino funds	65+ and disabled residents legally domiciled in state for 30 days immediately preceding application, excluding seasonal or temporary residents. Disabled must be eligible for social security benefits	Maximum annual income: \$13,650--single \$16,750--married	Prescription drugs, insulin, insulin syringes and needles	Requires purchase of equivalents equal to or less than the maximum allowable cost or beneficiaries pay difference of the brand name drug, unless physician specifies substitution not permitted	Commissioner may limit initial prescription to less than 30-day supply, thereafter may limit to 30-day for acute care and 60-day or 100 doses, whichever greater, for chronic conditions	\$2 copayment for each prescription
New York Elderly Pharmaceutical Insurance Coverage (EPIC)	1986; expires 9/30/91/N.Y. Executive Law §547 et seq.	Executive Department	General funds	65+ residents/persons under public medical assistance or any private 3rd party coverage equal to or better than EPIC excluded	Maximum annual income: \$9,000--single \$12,000--married	Prescription drugs, insulin, insulin syringes and needles/excludes drugs available without prescription, i.e., vitamins	Prescription automatically filled by generics unless specifically directed otherwise by physician	30-day or 100 doses, whichever greater	Quarterly income-based registration fee: \$6 - \$19--single \$5 - \$19--married Point-of-sale copayment \$3 - \$5 with annual maximum copayments set by income; premium or deductible for optional catastrophic coverage

deductibles: 1990--\$50  
1991-- 600  
1992-- 652  
Theater, an amount  
resulting in 16.8% of the  
individuals covered during the  
succeeding year having  
incurred expenses for covered  
outpatient drugs sufficient to  
meet the deductible determined  
by the Secretary.

40% of prescription cost  
20% for home IV drugs and  
immunosuppressive  
therapy drugs during  
1st year after  
transplant  
50% for other drugs in 1990  
and 1991  
40% for other drugs in 1992  
20% for other drugs in 1993  
and thereafter

30-day or for longer period  
authorized by Secretary not  
exceeding 90 days  
wholesale price under \$10  
prescriptions with average  
which ever more for  
less; 30-day or 100 doses,  
30-day or 100 doses, whichever

Physicians may permit generic  
substitutes; patients pay  
difference if they opt against  
generics  
30-day or 100 units, whichever  
less; 15-day for acute  
conditions  
\$4 copayment for each  
prescription; subject to  
change annually

Participant's cost  
Dosage restrictions  
Generic drug provision  
Drugs covered  
Financial eligibility  
Persons covered/excluded  
Funding  
Administering agency  
Year law enacted/cite  
Program

insulin and noninjectable  
drugs requiring prescription--  
cardiac drugs, hypotensive  
drugs, diuretics, anti-  
diabetic agents, insulin,  
disposable insulin syringes,  
vasodilators, anti-  
coagulants, and drugs for  
Parkinson's disease  
No specific provision, but  
state law on generic drugs  
allows pharmacist to dispense  
generics unless physician  
directs otherwise  
Payment limit for nonmultiple  
source drugs and on  
restrictive prescriptions of  
multiple source drugs

insulin and noninjectable  
drugs requiring prescription--  
cardiac drugs, hypotensive  
drugs, diuretics, anti-  
diabetic agents, insulin,  
disposable insulin syringes,  
vasodilators, anti-  
coagulants, and drugs for  
Parkinson's disease  
No specific provision, but  
state law on generic drugs  
allows pharmacist to dispense  
generics unless physician  
directs otherwise

Maximum annual income:  
\$12,000--single  
\$15,000--married  
Maximum annual income:  
\$12,000--single  
\$15,000--married

Full-time residents who are  
65+ persons with drug coverage or  
under any plan of insurance or  
assistance  
55+ and disabled eligible for  
Medicare  
Increases to Medicare Part B  
premium and imposition of new  
supplemental premium on all  
Medicare eligibles  
Department of Health and Human  
Services  
1985 (as a two-year pilot/R.I.  
Gen. Laws, §42-66.21 et seq.  
1983/62 P.S. §2901 et seq.

Department of Aging  
Lottery funds  
Department of Health and Human  
Services  
1985 (as a two-year pilot/R.I.  
Gen. Laws, §42-66.21 et seq.  
1983/62 P.S. §2901 et seq.

Department of Health and Human  
Services  
1985 (as a two-year pilot/R.I.  
Gen. Laws, §42-66.21 et seq.  
1983/62 P.S. §2901 et seq.

Department of Health and Human  
Services  
1985 (as a two-year pilot/R.I.  
Gen. Laws, §42-66.21 et seq.  
1983/62 P.S. §2901 et seq.

Department of Health and Human  
Services  
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1983/62 P.S. §2901 et seq.

Department of Health and Human  
Services  
1985 (as a two-year pilot/R.I.  
Gen. Laws, §42-66.21 et seq.  
1983/62 P.S. §2901 et seq.

Department of Health and Human  
Services  
1985 (as a two-year pilot/R.I.  
Gen. Laws, §42-66.21 et seq.  
1983/62 P.S. §2901 et seq.

Table 2

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS--COST

	Connecticut <sup>a</sup>	Illinois <sup>c</sup>	Maine <sup>d</sup>	Maryland <sup>e</sup>	New Jersey <sup>f</sup>	New York <sup>h</sup>	Pennsylvania <sup>j</sup>	Rhode Island <sup>k</sup>
Total Number of Participants	54,745 (2,217--disabled) (52,528--aged)	60,157	19,000	16,659	247,993	42,351	472,741	16,813
Program Cost								
Administrative	\$ 425,806 <sup>b</sup>	\$ 1,221,000 <sup>b</sup>	\$ 78,000	\$ 151,800	\$ 5,000,000 <sup>g</sup>	\$ 10,000,000	\$ 5,723,358 <sup>b</sup>	\$ 362,891 <sup>l</sup>
Benefit Payments	16,120,564	22,479,000	1,976,563	6,905,420	90,400,000 <sup>g</sup>	20,000,000	136,309,393	1,497,031
Total Cost	\$16,546,370	\$23,700,000	\$2,054,563	\$7,057,220	\$95,400,000	\$30,000,000	142,032,751	1,859,924
Average Annual Benefit Cost per Beneficiary	\$313 (elderly) \$456 (disabled)	\$374	\$240	\$415	\$403 \$387 (elderly only)	\$502 <sup>l</sup>	\$337	\$125

- a. Figures provided by ConnPACE Program for fiscal year 1987-88.
- b. Administrative cost derived by subtracting benefits cost from total program cost.
- c. Figures for 1987 calendar year obtained from Illinois General Assembly. Legislative Research Unit Research Response, File 9-833.
- d. Figures provided by Michael O'Donnell, Pharmacy Consultant, Maine Drugs to the Elderly Program for calendar year 1987.
- e. Figures provided by John Baker, Manager, Maryland Pharmaceutical Assistance Program for fiscal year 1988.
- f. Figures obtained from New Jersey Pharmaceutical Assistance to the Aged and Disabled Fiscal Year 1987 Annual Report.
- g. Estimates of administrative cost and benefit payments provided by Edward Klane, Chief, Bureau of Pharmaceutical Assistance to the Aged and Disabled for fiscal year 1987.
- h. Estimates for fiscal year 1988-89 provided by Marilyn Desmond, Deputy Director, EPIC, except for participant count, as of February 1988, obtained from New York State Senate, Senate Research Service, Issues in Focus, NO. 88-169. Administrative cost is higher than what the expected annual cost will be later since the \$10 million includes a lot of one-time start-up costs.
- i. Since New York has a two-tiered program involving sliding scales of fees, premiums, and deductibles, this amount reflects the net cost to the state after the co-share amounts have been deducted from the gross average cost per beneficiary of \$648.
- j. Figures obtained from Pharmaceutical Assistance Contract for the Elderly Quarterly Report to the Pennsylvania General Assembly, April 1-June 30, 1987.
- k. Figures provided for fiscal year 1987-88 by Skip Centazzo, Rhode Island Department of Elderly Affairs.
- l. Includes \$168,938 for Department of Elderly Affairs costs and \$193,953 for the Blue Cross contract.

## Chapter 4

### OUTPATIENT PRESCRIPTION DRUG COVERAGE UNDER MEDICARE

#### Part I. The Current Medicare Program

Medicare is the federally administered health insurance program for the elderly who are 65 years of age or older, the disabled who are entitled to social security, and most persons with end-stage renal disease. The program is composed of two parts. Part A provides coverage for hospital costs and is free for enrollees. Part B, which covers physician and other medical services such as outpatient hospital services, rural health clinic visits, and home health visits, is an optional program available to enrollees but they must pay a monthly premium.<sup>1</sup>

The Part B premium is annually determined by using a formula that sets the premium rate at 50 per cent of the monthly actuarial rate for enrollees age 65 and over (i.e. 25 per cent of the amount needed to cover program costs for aged beneficiaries). If there is no increase in the social security cost-of-living allowance in a year, the monthly premium will not be increased for that year. Beginning January 1, 1990, the premium will be calculated according to the lower of (1) an amount sufficient to cover one-half of the costs of the program for the aged, or (2) the current premium amount increased by the social security cost-of-living allowance.<sup>2</sup>

Outpatient prescription drugs are covered only in very limited circumstances under the Medicare program. Medicare will generally cover drugs which are administered to a patient in a hospital, but generally will not cover outpatient prescription drugs which can be self-administered by the patient. Part B will cover (1) drugs that require injection by a physician or nurse; (2) self-administered drugs that must be administered by a physician or nurse in an emergency situation; (3) blood-clotting factors for certain hemophilia patients; (4) immunosuppressive drugs which are furnished within one year of an organ transplant covered by Medicare; (5) vaccination against pneumococcal pneumonia and hepatitis B only for those at medium or high risk; and (6) immunization directly related to the treatment of an injury or direct exposure to a disease or condition such as rabies or tetanus.<sup>3</sup>

Approximately 95 per cent of the nation's elderly are enrolled in the Part A program and most of them voluntarily enroll in Part B.<sup>4</sup>

#### Part II. Provisions Under the Medicare Catastrophic Coverage Act of 1988

##### Coverage

The federal Medicare Catastrophic Coverage Act of 1988 (P.L. No. 100-360) which was signed into law on July 1, 1988, provides protection to Medicare beneficiaries from catastrophic hospital and doctor bills resulting from acute illness.<sup>5</sup> Included in the Act is a provision which offers coverage on expenses for prescription drugs and insulin. Currently, the Medicare

program only covers drug expenses when the drugs are administered to the patient in a hospital or skilled nursing facility and must be administered by a health professional. The prescription drug coverage under the Act would provide coverage for all prescription drugs certified as safe and effective by the federal Food and Drug Administration commencing on January 1, 1991 after the beneficiary has met the annual deductible.<sup>6</sup> The deductible is set at \$600 for 1991 and \$652 for 1992. The deductible includes all expenses such as the amounts paid by the beneficiary for drug insurance or cost-sharing amounts under a state-level pharmaceutical assistance program. Thereafter, the deductible is set by the Secretary of Health and Human Services in such an amount so as to ensure that the proportion of beneficiaries qualified for the drug benefit remains at 16.8 per cent of the Medicare population.<sup>7</sup> Medicare will pay 50 per cent of the drug costs after the deductible in 1991, 60 per cent in 1992, and 80 per cent in 1993 and thereafter. Beginning January 1, 1990, outpatient prescription drugs used for home intravenous therapy and immunosuppressive drugs for organ transplant recipients will be covered under Medicare with a deductible of \$550.<sup>8</sup>

### **Restrictions**

The maximum amount of drugs allowed under a prescription covered under this program is a thirty-day supply; however, the Secretary of Health and Human Services is authorized to allow prescriptions for longer periods not to exceed 90 days except in exceptional circumstances.<sup>9</sup> The Act sets different payment limits for (1) multiple-source drugs which do not have restrictive prescriptions and (2) nonmultiple-source drugs and multiple-source drugs which have restricted prescriptions. A restrictive prescription is one where the prescribing physician specifically requires that the prescription be filled by the drug named on the prescription and does not permit generic substitutions. Claims for benefits under this program can only be made through participating pharmacies that are authorized under a state law to dispense outpatient drugs and have entered into an agreement with the Secretary of Health and Human Services.<sup>10</sup>

### **Participating Pharmacies**

Participating pharmacies are required to keep patient records, including records on expenses, for all covered outpatient drugs dispensed to Medicare beneficiaries and to submit information to the Secretary of Health and Human Services as may be required on all covered outpatient drugs purchased by Medicare beneficiaries. Participating pharmacies are required to offer counsel or information to Medicare beneficiaries regarding the appropriate use of dispensed drugs, potential interactions between the drugs and other drugs dispensed to the beneficiary, and the availability of therapeutically equivalent covered outpatient drugs. Participating pharmacies will have a distinctive emblem for public display. The Secretary of Health and Human Services will be required to establish, by January 1, 1991, a point-of-sale electronic system for use by carriers and participating pharmacies in the submission of information regarding covered outpatient drugs dispensed and which will provide pharmacies with the means to determine whether the beneficiary has



met the deductible. Toward this end, the Secretary of Health and Human Services must provide participating pharmacies, upon request, electronic equipment and technical assistance necessary for the pharmacy to submit claims under the electronic system.<sup>11</sup>

Participating pharmacies will be paid an administrative allowance of \$4.50 for each prescription filled under this law in 1990 and 1991, while nonparticipating pharmacies will be paid an administrative allowance of only \$2.50. After 1991, the allowances will be indexed by the GNP price deflator. The Act authorizes the Secretary of Health and Human Services to decrease, by regulation, the administrative allowance for drugs dispensed by a mail service pharmacy.<sup>12</sup>

### Financing

The new catastrophic benefits under the Act will be financed by increases to the basic Part B monthly premium which is \$24.80 for 1988 and \$31.90 for 1989, and by the imposition of a new supplemental premium to be paid by all persons eligible for Part A benefits based on their federal income tax liability. The increases to the Part B premium for the catastrophic benefits will amount to \$4.00 in 1989, \$4.90 in 1990, \$7.40 in 1991, \$9.20 in 1992, and \$10.20 in 1993. Of these amounts, the increases attributable to the prescription drug portion are \$1.94 for 1991, \$2.45 for 1992, and \$3.02 for 1993 (see Table 3 below). There is no premium increase in 1989 or 1990 for the prescription drug coverage.<sup>13</sup>

Table 3

#### PART B PREMIUM INCREASES\*

<u>Year</u>	<u>Total Premium Increase</u>	<u>Catastrophic Coverage</u>	<u>Prescription Drugs</u>
1989	\$ 4.00	\$4.00	\$ 0
1990	4.90	4.90	0
1991	7.40	5.46	1.94
1992	9.20	6.75	2.45
1993	10.20	7.18	3.02

Source: Medicare Catastrophic Coverage Act of 1988, sec. 211, 102 Stat. 733.

\*These increases to the Part B premium are in addition to any increase made because of higher costs of providing medical care. For example, in 1989, the Part B premium will be \$31.90 an increase of \$7.10 from the 1988 rate. Only \$4 of that increase is attributable to the catastrophic provisions while the remaining \$3.10 is for the higher cost of medical care.

PHARMACEUTICAL ASSISTANCE FOR THE ELDERLY

The supplemental premium will be imposed on all persons eligible for Part A benefits for more than six months with a federal income tax liability of \$150 or more. For the first five years the premium rates are set per \$150 of tax liability and there is a cap on the maximum premium to be paid by each enrollee. The premium rates and caps for the five years are shown below in Table 4. The supplemental premium will finance approximately 63 per cent of the catastrophic and prescription drug benefits under the Act, with the remaining 37 per cent financed through the Part B premium increases.<sup>14</sup> A catastrophic drug insurance trust fund has been created into which will be deposited the portion of the supplemental and flat premium for the drug coverage and from which payments for prescription drug benefits will be made.<sup>15</sup>

Table 4

SUPPLEMENTAL PREMIUM

<u>Year</u>	<u>Total Premium Rate Per \$150 Tax Liability</u>	<u>Catastrophic Premium Rate</u>	<u>Prescription Drug Premium Rate</u>	<u>Maximum Annual Premium</u>
1989	\$22.50	\$22.50	\$ 0	\$ 800
1990	37.50	27.14	10.36	850
1991	39.00	30.17	8.83	900
1992	40.50	30.55	9.95	950
1993	42.00	29.55	12.45	1,050

Source: Medicare Catastrophic Coverage Act of 1988, sec. 211, 102 Stat. 690-691.

Medicaid Buy-in

The Omnibus Budget Reconciliation Act of 1986 permits states to cover Medicare premiums, deductibles, and coinsurance for aged and disabled persons with incomes up to a state-established level up to 100 per cent of the federal poverty guideline. States choosing this option must use the resource standards of the Supplemental Security Income (hereinafter SSI) program unless the state's medically needy program has higher standards which can be used. Currently, most states have entered into a buy-in agreement under which they pay the Medicare Part B premiums for their Medicaid beneficiaries who qualify for Medicare. The new law includes a mandatory buy-in schedule which will be phased-in over a three-year period, beginning January 1, 1989, requiring the states to initially buy-in the elderly and disabled with incomes at or below 85 per cent of the federal poverty income guidelines until the third year where the requirement is for those at or below 100 per cent of the poverty guideline. For the five states, one of which is Hawaii, which used more restrictive income eligibility standards than those under the SSI program, the buy-in requirement will be phased in over a four-year period, beginning January 1, 1989, with the buy-in for the first year for those with incomes at or below 80 per cent of the federal poverty guideline.<sup>16</sup>

### Drug Utilization Controls

To assure appropriate prescribing and dispensing practices, the Secretary of Health and Human Services must establish (1) a program which will identify and educate physicians and pharmacists as to the instances or patterns of unnecessary or inappropriate prescribing or dispensing practices and of substandard care with respect to such drugs; and (2) standards for the prescribing of covered outpatient drugs based on accepted medical practice.<sup>17</sup> The Secretary of Health and Human Services is also required to develop, annually update, and disseminate an information guide for physicians concerning the comparative average wholesale prices of at least 500 of the most commonly prescribed covered outpatient drugs wherein drugs are grouped by therapeutic category.<sup>18</sup> Congress expects that participating pharmacies will review the drug profile of beneficiaries for potential adverse drug reactions before filling the prescriptions and that the carriers will review claims retrospectively to identify practitioners exhibiting a pattern of inappropriate prescribing or dispensing.<sup>19</sup>

A Prescription Drug Payment Review Commission, composed of 11 persons with expertise in the provision and financing of covered outpatient drugs, has been established for the purpose of reviewing drug costs and submitting annual reports to Congress concerning the methods of determining payment for covered outpatient drugs. More specifically, the reports are to include information in the increases in manufacturer's prices and pharmacy charges, the level of use of outpatient drugs by Medicare beneficiaries, and the administrative costs relating to covered outpatient drugs. The reports are also to include comments and recommendations regarding the budgetary status of the Drug Insurance Trust Fund.<sup>20</sup>

The Secretary of Health and Human Services is to develop a standard claims form (and a standard electronic claims format) to be used for requests for payment of covered drugs under the Medicare program and other third-party payors. Sample copies of the form must be distributed no later than October 1, 1989 and the official copies no later than October 1, 1990 to pharmacies and other interested parties.<sup>21</sup>

### Follow-up Studies

The Secretary of Health and Human Services has been directed to report to Congress on the expenses incurred by Medicare beneficiaries for outpatient prescription drugs using data from the 1987 National Medical Expenditures Survey conducted by the National Center for Health Services Research and Health Care Technology Assessment. The Secretary is also required to furnish the Director of the Congressional Budget Office with data to enable the Director to submit to Congress estimates for the outlays required for fiscal years 1990, 1991, 1992, and 1993 for the Medicare outpatient drug coverage program.<sup>22</sup>

The Act requires the Secretary of Health and Human Services to conduct studies (1) on the possibility of including experimental drugs which have not yet been approved by the federal Food and Drug Administration and biological products not licensed under the Public Health Service Act such as those

commonly used in the treatment of cancer or in immunosuppressive therapy; (2) to evaluate the potential of mail service pharmacies in reducing costs; (3) of methods to improve utilization review of covered outpatient drugs; and (4) of a longitudinal nature on the use of outpatient prescription drugs by Medicare beneficiaries with respect to medical necessity, potential for adverse drug interactions, cost, and patient stockpiling or wastage.<sup>23</sup> The Act also requires the Comptroller General to compare the average wholesale prices with actual pharmacy acquisition costs by type of pharmacy, determine the overhead costs of retail pharmacies, and study the discounts given by pharmacies to other third-party insurers.<sup>24</sup>

### Part III. The Impact of the Medicare Outpatient Prescription Drug Coverage on the State-level Programs

The Medicare program will provide benefits only for extraordinarily high prescription drug expenses to all qualified persons, regardless of income, while the state-level programs provide coverage only to the economically vulnerable and, in most instances, regardless of how low the drug expenses are. The Medicare program will not totally displace the need for state-level pharmaceutical assistance programs, but it will relieve the financial burden of the state pharmaceutical programs in two ways. First, the Medicaid buy-in requirement will mean that some of the state-level program beneficiaries will become eligible for coverage under Medicaid which will pay their Medicare premiums, deductibles, and cost-sharing payments. (Although the Medicaid program involves state funds, the federal government provides matching funds, so overall state cost of covering such elderly should be less). Second, since the Medicare program pays for drug costs above the deductible amount, the states only need cover the prescription drug amounts up to the deductible and this will allow the states to more effectively contain future costs of their pharmaceutical assistance programs.

Daniel Waldo reported that the mean spending for prescription drugs by the Medicare population is expected to be \$432 in 1991<sup>25</sup> but that 33 per cent of the Medicare population will exceed the annual deductible of \$600 in 1991.<sup>26</sup> The average annual prescription drug expenses per beneficiary in a state pharmaceutical assistance program in 1987 was approximately \$400. Currently, only a small portion, about two to three per cent, of the participants in state pharmaceutical programs have expenses that will be able to meet the deductible of \$600 under the Medicare program. An exception might be New York which reported that the majority of its participants were at the high end of the scale requiring about \$700 in medications.<sup>27</sup> New York, however, only began enrolling members in July 1987 and those joining early were generally those with the highest degree of need.<sup>28</sup> With the trend toward increased use of drug therapy for the aged who are chronically ill and the continuing increases in prescription drug costs, it would not be incorrect to speculate that many more beneficiaries will have prescription drug costs in excess of the deductible by 1991 when the federal drug coverage commences. Pennsylvania has projected that by 1991, one of every six PACE beneficiaries will have drug expenses in excess of \$600.<sup>29</sup>

For those states, like Hawaii, that do not have a pharmaceutical assistance program, the Medicare catastrophic drug coverage may make

implementation of a state program economically feasible or may eliminate the need for a state program entirely. Currently, Hawaii's Medicaid program provides assistance to those who are at or below 60 per cent of the poverty guideline. Under the Medicare Catastrophic Coverage Act, Hawaii will have to provide medical benefits in 1989 to those who are at or below 80 per cent of the poverty guideline and, by 1993, to those at or below 100 per cent of the guideline. The resource standards will also be at or below twice the current SSI standard. This means that in the ensuing years, there will be a lot more elderly persons in Hawaii who will be receiving prescription drug coverage under Medicaid who would otherwise be candidates for a state pharmaceutical assistance program.

Congress, in considering the prescription drug program, was obviously concerned about escalating costs as the program progresses as was the experience in several state-level programs. The large deductible and the coinsurance requirements were included in the federal program to remedy the concerns over cost, but in so doing, Congress has excluded a portion of the elderly population which may be in need of assistance. Congress clearly intended to target assistance to those with "catastrophic drug expenses". The state-level assistance programs have a different target group...those who have limited incomes yet do not qualify for public medical assistance regardless of whether or not their drug expenses are catastrophic. While the Act broadens the net of Medicaid coverage there may be many economically vulnerable elderly above the poverty guideline for whom meeting the \$600 deductible and the coinsurance payments on each drug purchase may still be a hardship.

After the \$600 deductible amount is reached, Medicare will cover only 50 per cent of the drug costs in 1991 while the remaining 50 per cent is the coinsurance portion to be paid by the beneficiary. These expenses would be in addition to the increased Part B premiums and the supplemental premium they must pay to obtain the prescription drug coverage. Although the Medicare payments will increase to 60 per cent in 1992 and 80 per cent in 1993 and thereafter, the monthly Part B premiums and supplemental premium are also subject to annual increases. It should be noted that although the Act separately states the amounts of the Part B premium increases attributable to prescription drugs and catastrophic coverage, a person does not have the option of not taking any coverage if the person enrolls in Part B. The Act requires that all Medicare eligibles (through the supplemental premium based on tax liability) and all Part B enrollees (through the Part B premium increases) pay for catastrophic coverage even if they do not desire catastrophic coverage.

The Medicare program would ease the states' burden in providing pharmaceutical assistance but it is still unclear as to how many economically vulnerable elderly will remain without coverage.

## Chapter 5

### THE NEED FOR PHARMACEUTICAL ASSISTANCE FOR THE ELDERLY

#### The Growing Elderly Population in Hawaii

In 1980, there were 76,300 elderly, 65 years of age and over, which comprised 7.9 per cent of the total state resident population (968,000) and that number is projected to increase to 159,500 or 12.6 per cent of the total population (estimated at 1,267,800) in the year 2000 and to 177,300 or 14 per cent of the total population (estimated at 1,310,000) in the year 2005.<sup>1</sup> If the military which is predominantly a young group is excluded from the count, the population of the elderly increases from 7.9 per cent to nine per cent in 1980 and from 12.6 per cent to 14 per cent in the year 2000.<sup>2</sup> Life expectancy in Hawaii is among the highest in the world at 75 years for men and 81.5 years for women. The average life expectancy for the United States is 70 years for men and 77.5 years for women. Although income levels of the elderly are low and the cost of living in Hawaii is high, a high percentage of them allay financial stress by residing with relatives.<sup>3</sup>

Retirement usually means lower income and limits the financial options for the elderly to finance their health care needs which increase with age. In 1980, 10.5 per cent of persons over age 65 were below the U.S. poverty line and over 59 per cent of the elderly over 65 received federal and state supplemental income in 1980.<sup>4</sup> Recent studies have shown that there is a trend toward higher income levels for the elderly as many have planned early for their retirement years and there are more elderly than younger adults who have assets such as home equity.<sup>5</sup> Such trends, however, can be misleading because most statistical data on the economic status of the elderly are based on the entire group of those age 65 and older although there are large differences between the younger elderly and the very old who are age 75 and older. The very old population is the fastest growing segment of the population and poverty rates increase sharply with age.<sup>6</sup> According to the Villers Foundation, while there are some elderly with incomes well above the average, there is a large number who fall far below the average. Many elderly are "economically vulnerable". That is, although their incomes may be above the poverty line, even up to twice the poverty line, they must struggle to purchase the basic necessities with their limited income.<sup>7</sup>

#### Health Care Costs of the Elderly

The elderly today spend the same proportion of their incomes on health care as they did before Medicare and Medicaid were established two decades ago. The out-of-pocket expenses of the elderly for health care is more than three times the average amount spent by the nonelderly population.<sup>8</sup> Medicare does not cover all of the elderly's health care costs and the economically vulnerable elderly often have difficulty meeting the Medicare Part B premium payments and the required deductibles and coinsurance payments.<sup>9</sup> These elderly cannot afford to purchase private supplemental medical insurance, yet they also cannot qualify for public medical assistance until

they reduce themselves to poverty status to meet Medicaid eligibility requirements.

Forty-two per cent of the total elderly population is poor or economically vulnerable<sup>10</sup> and only 36 per cent of the noninstitutionalized elderly poor is covered by Medicaid.<sup>11</sup> The major reason for this is that eligibility is hinged on participation in the Supplemental Security Income (hereinafter SSI) program and two out of every three elderly poor do not receive SSI benefits. Moreover, 14 states, including Hawaii, have more restrictive eligibility criteria which prevent many SSI participants from receiving Medicaid.<sup>12</sup> Hawaii, however, does provide coverage for the medically needy and for the payment of Medicare Part B premiums with Medicaid funds. Complicating matters is the group of elderly with a strong sense of pride who may choose to maintain their independence and forego necessary medical care rather than seek public assistance. Neglect of health care needs often result in more serious ailments requiring costly treatments.

#### Prescription Drug Use and Expenditure Patterns of the Elderly Population

The most comprehensive data concerning outpatient prescription drug utilization and expenditure patterns of the aged were compiled by the Health Care Financing Administration in 1987 with data from the National Medical Care Utilization and Expenditure Survey (hereinafter NMCUES) of 1980.<sup>13</sup> The information from the NMCUES was developed to assist the U.S. Congress in its deliberations over the issue of outpatient prescription drug coverage under the Medicare program. Since Medicare covers outpatient drugs on a very limited basis, the survey provides meaningful data on the financial burden of prescription drugs among the elderly. The NMCUES found that noninstitutionalized aged Medicare beneficiaries obtained an estimated 288 million prescriptions during 1980 and spent an estimated \$2.3 billion for prescription drugs. Although the aged Medicare beneficiaries in 1980 represented only 10.9 per cent of the total U.S. population, they accounted for 28.6 per cent of all prescriptions and 30.2 per cent of prescription drug charges. The average aged Medicare beneficiary incurred expenses about three times the average of those under age 65. Prescription drug expenses for the aged accounted for 5.5 per cent of their total health care charges. Approximately 68 per cent of the total dollars spent by the aged Medicare beneficiaries was paid out-of-pocket, 13.9 per cent by private health insurance, and 10.8 per cent by Medicaid. The remaining charges were distributed among other payers. About one-half of all prescriptions obtained by the aged consisted of cardiovascular renal agents and drugs used for the relief of pain.<sup>14</sup>

Prescription drug use and expenditures were found to increase with age and women were found to be higher users than men.<sup>15</sup> The poor (income at or below the federal poverty line) aged Medicare beneficiaries accounted for 21.9 per cent of prescription drug use of the Medicare population, the near-poor (income above the federal poverty line up to twice the poverty line) 39.3 per cent, and the nonpoor (income above twice the poverty line) 38.8 per cent. The average number of prescriptions obtained was higher for the poor at 13.7 per cent than the nonpoor at 11.3 per cent. The percentage of

prescription drug charges paid by private insurance was similar among poor and near-poor elderly (7.7 per cent and 10.7 per cent, respectively) but significantly higher for the nonpoor at 20.6 per cent. The financial burden of out-of-pocket expenditures was six times greater for the poor than for the nonpoor.<sup>16</sup>

Although the NMCUES data shed light on the financial burden of the cost of prescription drugs on the elderly, the survey was based on spending in 1980, so there were no comprehensive estimates of the extent of current expenditures for prescription drugs by the aged nor of the expected cost of the proposed program being discussed in Congress. Consequently, Daniel R. Waldo developed estimates of current drug spending by Medicare enrollees and the distribution of such spending in excess of a specified deductible.<sup>17</sup>

Waldo projected that the aged and disabled Medicare population will spend an estimated \$310 per person for outpatient prescription drugs in 1987 and that the mean spending will rise to \$342 in 1988 and to \$432 in 1991. In contrast, the average expenditure for prescription drugs by the elderly was \$96 in 1977. The sharp rise in drug expenditures projected over the 10-year period is attributable not only to the increasing drug prices, but also to the increased use of drugs by the elderly. In 1977, the noninstitutionalized Medicare enrollees consumed 13.7 prescriptions per person at a cost of \$6.59 per prescription while in 1988 the comparable figures are estimated at 16.8 prescriptions and \$18.92 per prescription. These estimates were based on current law assumptions without considering the effects of the proposed Medicare prescription drug coverage or any other caps on out-of-pocket health expenditures.<sup>18</sup>

The Bureau could not obtain accurate and comprehensive statistical data about prescription drug use and expenditures among the elderly in Hawaii. Early on in the course of this study, it became apparent that accurate and meaningful local data on prescription drug use by the elderly could not be obtained because such information could only be extracted if individual patient records were kept on a uniform and coordinated statewide basis or if there was a comprehensive technical survey of elderly persons and their physicians on prescription drug use and costs. The Department of Health was not aware of any comprehensive effort to compile and analyze statistical data on prescription drug use, by and costs to, the elderly population.<sup>19</sup> Nevertheless, the Bureau felt compelled to at least ascertain whether or not Hawaii's elderly outpatient prescription drug use falls within the ball park of the national statistics.

To obtain a rough estimate of the extent of prescription drug use by the elderly, the Bureau surveyed 185 pharmacies licensed with the state Board of Pharmacy. Of the 185, the Bureau received 80 responses and two letters were returned to the Bureau for lack of a forwarding address. Many pharmacies reported that they did not compile statistical data on outpatient prescription drug use by elderly clients. One pharmacy noted that physicians rarely indicate patient's age on the prescription and that it does not ask for age information to avoid charges of invasion of privacy or discrimination. For those pharmacies that are computerized and have such data approximately 30 per cent of the outpatient prescriptions filled



reportedly were for elderly clients. This estimate generally coincides with the national data.

The Bureau could not obtain any estimates relating to the average annual cost of prescription drugs to an elderly person in Hawaii or the number of elderly persons who require but cannot afford to purchase prescription drugs.

### Current Coverage for Prescription Drugs

Testifying before the U.S. Senate Special Committee on Aging in 1987, the American Association of Retired Persons (hereinafter AARP) reported that a 1977 survey showed that only 41 per cent of the age 65 and over population had outpatient prescription drug coverage while 75 per cent of the adults age 19 to 64 were covered. The AARP noted that this 1977 finding preceded the dramatic increases in drug prices which occurred from 1981 and that many insurance companies have since cut back on drug coverage.<sup>20</sup> Accordingly, it can be speculated that the number of uninsured elderly persons is even higher today. A recent report by the U.S. General Accounting Office noted that the U.S. Public Health Service found that 15.5 per cent of the elderly patients who require prescription drugs were unable to pay for their drugs.<sup>21</sup> The AARP corroborated this when its own 1986 survey found that the cost of drugs was the second most important reason given by the elderly for not filling a prescription while this reason ranked fourth in 1982.<sup>22</sup>

In its examination of states with pharmaceutical assistance programs, the U.S. General Accounting Office found that only between four and 27 per cent of the elderly population of those states received benefits. Data were not available as to the proportion of the elderly who did not participate because they did not need prescription drugs or because they could not meet the eligibility requirements.<sup>23</sup>

The Bureau polled the state Medicaid program and three major health insurance carriers to obtain a rough estimate of the extent of prescription drug use and third party coverage for prescription drugs among the elderly. Of the three health insurance carriers, information was secured only from the Kaiser Foundation Health Plan and the Hawaii Medical Service Association (hereinafter HMSA). The Medicaid program reported that it does not maintain statistical data specifically on the prescription drug use experience of the elderly. The only available method of estimating the number of elderly participants in the Medicaid pharmacy program is by applying the percentage of elderly clients in the overall Medicaid program. In 1987, there were 72,000 Medicaid clients, of which 11.5 per cent or 8,280 were in the age 65 and older group. Applying that percentage, it has been roughly estimated that of the 544,124 claims processed in fiscal year 1986-1987, 62,574 can be attributable to the elderly.<sup>24</sup> It is possible that the number of elderly claims could be much higher since there is abundant evidence that the elderly, as a group, tend to have a higher prescription drug use rate than the rest of the population. On the other hand, since there are no hard data on the drug use patterns of elderly in Hawaii, there could have been a significant number of elderly who had very little or no prescription drug expenses.

Hawaii's Medicaid program restricts its drug benefits to the drugs listed in its formulary and restricts the drugs further to use for specific illnesses. There is no copayment requirement.<sup>25</sup> Current Medicaid eligibility is based on 60 per cent of the U.S. poverty guidelines.<sup>26</sup> Elderly persons with higher incomes can still obtain aid through the medically needy category.<sup>27</sup> To qualify for medical assistance on the basis of being medically needy, a person may not have more than \$1,900 (\$2,850 in the case of a household with two eligible persons) in resources. The person's monthly income, remaining after medical expenses have been deducted, may not exceed \$327 for a single person or \$430 for a family of two. The income amounts allowed for monthly maintenance increases with family size.<sup>28</sup>

As noted in Chapter 4, under the Medicare Catastrophic Coverage Act of 1988, the Medicaid program will be required to expand its coverage, on January 1, 1989, by paying the Medicare costs for all disabled and elderly persons who are at or below 80 per cent of the poverty guideline and by 1993 for those at or below 100 per cent of the poverty guideline. The U.S. poverty guidelines for 1988 for all states except Hawaii and Alaska are \$5,770 for a single person and \$7,730 for a family of two. The guidelines set for Hawaii are \$6,650 and \$8,900, respectively.<sup>29</sup> This means that in the next five years, Hawaii's Medicaid program will be covering a larger number of people and many of them might be the elderly who would now benefit from a state-level pharmaceutical assistance program.

The Kaiser Foundation Health Plan reported that there are approximately 7,728 members who are 65 years of age or older who are covered by one of their drug plans. Kaiser's most common drug plan covers all drugs for which a prescription by a physician or a dentist is required by law when such prescriptions are purchased at a Kaiser Foundation medical facility. The patient is required to pay \$1.00 for each prescription as long as the quantity prescribed does not exceed the smallest therapeutic package made by the manufacturer, or 34 days' supply, whichever is greater. Where the prescription is for a greater quantity, the member must pay \$1.00 for each multiple of that quantity or fraction thereof. Refills are similarly handled and must be purchased from the same pharmacy and location.<sup>30</sup>

The HMSA offers 35 different prescription drug plans through employer group contracts. Typically, an HMSA drug plan provides coverage for all federally controlled drugs requiring a prescription. Vitamins for severe vitamin deficiency, insulin, and certain diabetic supplies for the treatment of diabetes may also be covered under certain conditions. The plan will pay 100 per cent of eligible charges for generic drugs and insulin and diabetic supplies. For all other drugs, the plan will pay 80 per cent for original prescriptions and 90 per cent for refills. Benefits are usually limited to a maximum 30-day supply per prescription and prescriptions must be filled by licensed pharmacists. To file a claim under an HMSA drug plan, the beneficiary must present an HMSA membership card to the pharmacist and both the pharmacist and the beneficiary must complete claim forms. The claim forms must be mailed to HMSA by either the beneficiary or the pharmacist, depending on the plan, within one year of the drug purchase. The HMSA reported that approximately 22,100 of its members who are 65 years of age or older are covered under one of its drug plans. This represents about 6.5 per cent of the HMSA's total drug plan population. While the HMSA did not

have available statistical data on the drug use of its total drug plan population, it provided information on one large contract involving a sugar plantation with over 10,000 members. In that contract 2,959 or 29 per cent of the members were age 65 and over and that group accounted for 40,768 or 51 per cent of the total prescriptions for which claims were filed.<sup>31</sup>

Although it is impossible to draw any meaningful conclusions from such sketchy bits of information, it can be speculated that at least 38,108, or 37 per cent, of the 103,000 elderly persons in Hawaii may have some type of prescription drug coverage.

Further suggestive evidence on the extent of prescription drug coverage among Hawaii's elderly stems from the periodic survey of employee benefits plans conducted by the Hawaii Employer's Council which provides a good indication of the prevailing trends in benefits offered by private sector employers. The most recent survey reveals a slight upward trend toward the inclusion of prescription drugs in the employee health plans and the continuation of health coverage after retirement. This coupled with the fact that Hawaii's prepaid health law<sup>32</sup> requires all employers to provide health insurance to their employees could mean that Hawaii might have a good number of elderly who are covered for prescription drugs. The latest survey results published in March of 1988, found that the 189 companies surveyed offered 265 different health care plans, of which 235 or 89 per cent provided prescription drug coverage, either as a rider to the medical plan or as part of the basic plan. The employer paid the full cost of the coverage in 55 per cent of the plans and the full cost of dependent coverage in 34 per cent of the plans. Only in six plans were the employees required to pay the full premium. The survey also found that continuation of benefits are provided in only 114 or 45.1 per cent of the plans and of that amount the premiums were paid in whole or in part by the employer in only 79 or 31.2 per cent of the plans.<sup>33</sup>

In contrast, the survey results in 1982 showed that of the 143 companies surveyed there were 240 health care plans of which 192 or 80 per cent offered prescription drug coverage. The employer paid the full premium in 128 or 66.7 per cent of the plans and only in one plan was the employee required to pay the entire premium. The employer paid the full cost of dependent coverage in 95 or 49.5 per cent of the plans. Retirees were allowed to continue in the health care plan in 85 or 35.4 per cent of the plans. For retirees under age 65, the continuation of health care was allowed in 92 or 38.3 per cent of the plans.<sup>34</sup>

In addition to the Medicaid and private insurance drug plans, elderly persons also can purchase drugs at modest discount prices as many pharmacies throughout the State offer a 10 per cent discount to senior citizens on their drug purchases.<sup>35</sup> The AARP also has a mail order drug discount plan in which Hawaii residents may participate. The Bureau was not able to secure details of this plan or the number of Hawaii participants from the AARP.

## Chapter 6

### CONSIDERING A PHARMACEUTICAL ASSISTANCE PROGRAM FOR HAWAII

#### Arguments for a Pharmaceutical Assistance Program

The elderly on small fixed incomes often do not comply with required drug therapy as directed by their physicians because they cannot afford to pay for the prescriptions. Some elderly persons attempt to stretch their prescriptions by taking their medications at longer intervals or lower dosages than prescribed. Dr. Helene L. Lipton, testifying before the U.S. Senate Special Committee on Aging, noted that while the relationship between noncompliance and drug cost has not been the subject of much empirical research, available studies have indicated that drug costs play a significant role in noncompliance.<sup>1</sup> Dr. Lipton further stated that further research is unnecessary since the results from such studies have been examined in conjunction with health professionals' concerns, patients' personal reports, and data on the elderly's economic status and their out-of-pocket drug expenses and a compelling case can be made for pharmaceutical assistance.<sup>2</sup>

Noncompliance with drug therapy is recognized as a serious problem in the fields of gerontology and medicine. Drug misuse, overuse, and abuse can lead to more serious conditions requiring additional visits to the physician, additional drug purchases, expensive therapeutic or rehabilitative treatment, or even institutionalization in a hospital or long-term care facility. Advocates of pharmaceutical assistance believe that in the long term, government can save money since drug therapy is a lot cheaper than hospital or nursing home care.<sup>3</sup>

#### Arguments Against a Pharmaceutical Assistance Program

Opponents to pharmaceutical assistance programs cite the high cost of maintaining such programs as the main deterrent. New Jersey's pharmaceutical assistance high program cost has been a problem since the inception of the program and although a large portion of the program is subsidized through casino revenues, the state still continues to seek cost control measures. The cost of a pharmaceutical assistance program is difficult to contain not only because the cost of prescription drugs continues to increase, but because the use of drugs for therapeutic purposes is increasing and because some of the new drugs developed for the treatment of certain diseases are inordinately expensive.

In view of the newly enacted federal law enabling the coverage for catastrophic costs of prescription drugs under Medicare (discussed in Chapter 4), a state pharmaceutical assistance program might appear unnecessary or duplicative. Unless there is a demonstrated need for supplemental coverage by a substantial number of elderly, it may not be cost-effective to establish a state program. Even if there is a substantial number of elderly in need, some would argue that there may be more cost-effective means of providing

assistance such as through tax credits or exemptions or the expansion of Medicaid coverage.

Another concern is the potential for inappropriate drug use among the elderly which is already a major concern in the gerontological field. Misuse of drugs occurs frequently among the elderly because of such factors related to the normal aging process such as forgetting whether or not the medication was taken due to periodic lapses in memory, inability to open a "child proof" container because of arthritis or other degenerating physical condition, or inability to read the prescription label due to failing eyesight. The elderly often self-treat common ailments like arthritis, bowel irregularity, and insomnia by taking over-the-counter drugs with the notion that such drugs are risk free. Recently, however, scientists have been increasingly concerned about adverse drug reactions when prescription and over-the-counter drugs are taken concurrently. Adverse reactions to drugs among the elderly are further complicated since they can be missed if symptoms such as confusion, memory loss, and disorientation are dismissed as senility when in fact they may be the side effects of the drugs taken.<sup>4</sup> A study based on 1980 census data found that four out of five Medicare beneficiaries used prescription drugs during the year and that the average beneficiary filled 12.1 prescriptions a year.<sup>5</sup> Another study reported that the average elderly outpatient uses about two to four different drugs while the institutionalized elderly generally consume between four to seven different drugs.<sup>6</sup>

Experts in the field believe that the practice of "polypharmacy", the taking of too many medications, prescription or over-the-counter is a major and frequent cause of illness among the elderly. The incidence of polypharmacy is often associated with the easy accessibility to drugs and the lack of awareness among the elderly as well as the attending physicians and pharmacists as to a person's overall drug use record and the potential harm of mixing various pharmaceutical preparations.<sup>7</sup> Evaluations of the elderly's medication history, including both prescription and over-the-counter drugs, should be routinely undertaken to determine whether or not the medications are providing therapeutic benefit. Unfortunately, today's health care delivery system is such that often there are several providers prescribing medications for a patient and it is usually incumbent on the patient to coordinate and monitor overall care.<sup>8</sup> Some experts, however, believe that today's elderly is an able group which should take charge of their medication decisions and that this could be made possible through more information, education, and increased access to medications.<sup>9</sup>

### Cost Implications for the State

Cost has been the main reason most states have opted against establishing a state-level pharmaceutical assistance program. The cost of a pharmaceutical assistance program is dependent on the number of beneficiaries, the level of drug use, the range of drugs covered, and the administrative requirements. The drug reimbursement cost accounts for at least 90 per cent of the total program cost. Accordingly, the more restrictive the coverage the lower the program costs.

## PHARMACEUTICAL ASSISTANCE FOR THE ELDERLY

The New Jersey program which was the first state pharmaceutical program implemented had an appropriation of \$2.5 million for the first year, but actual costs reached \$35 million. New Jersey subsequently authorized the use of casino revenues to supplement the program appropriations.<sup>10</sup> Moreover, cost containment strategies, such as a generic drug requirement and an increased effort to recover incorrectly paid benefits and from third party insurers, were implemented. For the 1987 fiscal year, New Jersey's program cost grew at a slower rate than in previous years partly due to cost containment efforts.<sup>11</sup> The high cost of the New Jersey program inhibited many states from creating a pharmaceutical assistance program but those states that did, benefited from New Jersey's experience and were more careful in their cost projections and restrictive in the provision of benefits.

Pennsylvania, which began its program in 1983 saw its expenditures rise from \$70 million in fiscal year 1985 to \$150 million in fiscal year 1986 to an estimated \$340 in fiscal year 1987. All expenditures, however, were within original projections as the Pennsylvania program was planned as a phase-in serving the neediest first and slowly expanding. The cost increases have been due primarily to increased enrollments. Pennsylvania takes pride in the effectiveness of its drug utilization review system and its emphasis on generic drugs in keeping the program costs down.<sup>12</sup>

In addition to the reimbursement costs which account for approximately 90 per cent of the total program cost, there are administrative costs to consider. Central to any pharmaceutical assistance program is an effective and efficient enrollment and identification procedure and claims processing and recordkeeping system. Most states began by creating a new office with a staff of about three to five persons to perform eligibility determinations and contracting with a fiscal intermediary for the claims processing and recordkeeping aspects. Hawaii's Medicaid prescription drug program similarly contracts its claims processing function to a fiscal intermediary. Many pharmacies in Hawaii, however, have expressed dissatisfaction with the Medicaid claims processing and reimbursement procedure. A common complaint among the pharmacies concerns the inadequacy and lateness of the reimbursements from the Medicaid program.<sup>13</sup> The Medicare outpatient prescription drug program will also install a claims processing and reimbursement procedure which could probably serve as an excellent base for a state pharmaceutical assistance program. The administrative costs should also include educational programs to encourage participation and to ensure proper drug use by the elderly.

Overall costs can be expected to increase annually as the cost for prescription drugs and the enrollment increase. Some states were able to minimize administrative costs by utilizing existing programs or procedures. Rhode Island's program was incorporated into the Department of Elderly Affairs with little added cost beyond the three staff persons hired.<sup>14</sup> Maine escaped the need to contract a fiscal intermediary by piggybacking their claims processing on to the Medicaid program and saved further administrative costs by requiring that eligibility determinations be made by the state Tax Assessor in accord with the Tax and Rent Relief Act.<sup>15</sup>

While the states could generally estimate the number of elderly persons who would qualify for the pharmaceutical assistance program based on the

income levels of the elderly population, they could not develop accurate information as to the number of persons that would participate in the program because they lacked current local data on the extent of existing third party coverage for the elderly and the average annual expenses of the elderly for prescription drugs. It appears that most states measured the extent of need primarily on the available national data on outpatient prescription drug use of the Medicare population and the information generated from the lobbying efforts of the elderly and their advocacy groups. The problem with relying on national data is that they are usually based on the 1980 census and do not reflect current use patterns. Projecting the program cost based on such data becomes guesswork. If, however, an urgent need for a program is clearly demonstrated a guesstimate might be sufficient as long as the costs are liberally projected.

An accurate estimate on the reimbursement cost to the State for a pharmaceutical assistance program in Hawaii cannot be made unless the target group and the covered drugs are identified. However, a guesstimate can be made by using an average annual drug cost of \$390<sup>16</sup> per person and multiplying that by a percentage of the total elderly population. The Bureau found that in the states with pharmaceutical assistance programs, the ratio of beneficiaries to the over 65 population varied widely from two per cent to 27 per cent.<sup>17</sup> If two per cent of Hawaii's estimated elderly population (103,000)<sup>18</sup> participated in a pharmaceutical assistance program at an annual average drug reimbursement cost of \$390, the total reimbursement cost could be expected to reach \$803,000. Since the reimbursement cost is generally about 90 per cent of the total program cost, the total program cost is projected to be about \$892,667. If the projections were based on 27 per cent participation, the reimbursement cost would be \$10,845,900 and the total program cost would be \$12,051,000. The Bureau emphasizes that these figures have been presented only for discussion purposes in this section and should not be used for any other purpose.

### **Weighing the Need for a Pharmaceutical Assistance Program**

To determine whether or not to implement a pharmaceutical assistance program, there must be a finding of need, and that need must be weighed against available state fiscal resources to cover the program's cost. The extent of need for a new social assistance program is usually brought to the attention of policymakers through forceful lobbying by interest groups or when a crisis erupts. In a study conducted for the Pharmaceutical Manufacturer's Association, it was found that the establishment of the pharmaceutical assistance programs for both New Jersey and Pennsylvania resulted from interest generated by elderly citizens and their advocacy groups.<sup>19</sup> New York enacted its law after years of clamoring by the elderly<sup>20</sup> and after extensive study on the pharmaceutical assistance programs of other states.<sup>21</sup> There has been an absence of a demonstrated interest for a pharmaceutical assistance program among Hawaii's elderly and evidence of a segment of the elderly population in dire need of assistance has not surfaced.

## Chapter 7

### FINDINGS AND RECOMMENDATIONS

Through the next decade, elderly Americans can expect to be saddled with a disproportionately high portion of their income consumed by their health care costs. Interestingly, increased use of drug therapy is an approach commonly used to contain costs today. Although the costs of prescription drugs keep escalating annually, drug therapy is considered more cost-effective since it is preventive and can alleviate or at least diminish the need for expensive surgery, other inpatient treatment, or institutionalization for prolonged periods. With the increasing acceptance of this logic and practice, however, came the realization that while the elderly received Medicare assistance for inpatient treatment, outpatient prescription drugs were not covered. Preventive health care through drug therapy while meritorious could not be effectively promoted when many elderly persons could not afford to pay for such treatment. This issue has been of grave concern at the state level since it is the state-administered Medicaid program which has been carrying the heaviest burden of the total elderly long-term care costs. One-third of the expenses for nursing home care is paid through the Medicaid program. While there is no hard evidence, it is commonly believed that, in many cases, institutionalization could have been avoided if appropriate outpatient drug therapy had been administered.

#### Findings

1. From the experiences of other states, it is clear that a state-level assistance program, could be costly to administer and maintain, depending on the benefits and the number of participants. Moreover, recent data on prescription drug use indicate that usage rates as well as drug costs will continue to rise in the future. Experts in the field, however, believe that government will save money in the long term since there is suggestive evidence that appropriate drug therapy can offset the need for costly hospital and nursing home care which are financed in large part by the Medicare or Medicaid programs. Those states that have a pharmaceutical assistance program, have no regrets as they have found a real need for such assistance among their elderly.

2. After many years of consideration and debate, the United States Congress finally passed a law which provides for prescription drug coverage under Medicare. The program, however, is not comprehensive and does not target the same elderly group as most state pharmaceutical assistance programs. In fact, the program is geared to assist the elderly with "catastrophic" expenses and will not assist those "economically vulnerable" elderly who cannot meet average drug expenses. Nevertheless, the Medicare program will ease the burden on state-level programs since it provides a "cap" on the amount the states will be required to pay per beneficiary. The Medicare Catastrophic Coverage Act of 1988 also requires Hawaii to cover, by 1993, the Medicare premiums, deductibles, and cost-sharing payments for people who are at or below 100 per cent of the U.S. poverty guidelines. With the Medicaid program currently covering only those at 60 per cent of the



poverty guidelines, this means more elderly will qualify for public medical assistance and the number of elderly without prescription drug coverage may be decreased substantially.

3. Most states have avoided implementation of a pharmaceutical assistance program because of the high cost usually associated with such a program. The implementation of the Medicare outpatient prescription drug program may generate new interest among the states without a pharmaceutical assistance program since the state-level programs could become more fiscally manageable with the federal government covering the catastrophic costs.

4. From the experience of those states with pharmaceutical assistance programs, it is evident that a program must be tailored specifically to the state's needs and resources. What works for one state may not work for another. New Jersey's experience is testament to the importance of obtaining current information on the target group in order to accurately project participation and cost. New York's experience is a lesson to other states that the program restrictions and procedures should be made simple so as to be readily understood by the target group. The successes of other state programs indicate that it is best to start with a small program with coverage on a limited number of drugs or coverage for only the most needy and gradually expand at a later time when there is a clearer picture of the State's ability to commit future resources. It is easier to limit benefits at the onset rather than reduce benefits to which beneficiaries have become accustomed.

5. It appears that assistance to the elderly for prescription drug expenses is not a high priority issue among the elderly in Hawaii. There has been no demonstration of need for such a program from the elderly population. There was no response to the Bureau's inquiry from the local AARP office regarding the concern of the elderly for a pharmaceutical assistance program and the Executive Office on Aging reported that it had not received any requests for assistance or expressions of concern regarding the high cost of prescription drugs. The elderly and their advocacy groups in Hawaii have established long-term care as their top priority issue and have been concentrating their efforts on programs in that area.

6. The absence of an overt expression of interest in a pharmaceutical assistance program, however, does not necessarily mean that there is no need for such a program. New York had pointed out that its clients are frail elderly who would not actively participate in a lobbying effort.

7. While the Bureau could not obtain an accurate estimate of how many of Hawaii's elderly have third party coverage for prescription drugs, it can be safely assumed that there are some elderly who are in need of assistance but do not qualify for Medicaid and who will not be helped by the Medicare drug program either because they cannot meet the premium payments, will not expend over \$600 a year on prescription drugs, or cannot meet the coinsurance payments. A state-level pharmaceutical assistance program can complement the Medicare program by providing coverage for this group; however, until the size and the drug use patterns of this group are ascertained, the economic feasibility of a state-level program which supplements the Medicare program cannot be determined.

8. There is a vacuum with respect to current demographic data on the elderly population in Hawaii. Usually, policy decisions regarding new social programs are prioritized based on the urgency of the need and the economic feasibility. The Legislature cannot ascertain the extent of need nor estimate the program cost unless there is current demographic data on the target group.

9. Most pharmacies do not maintain detailed statistical data on drug purchases of elderly patrons; some pharmacies are not even computerized. However, the Medicare Catastrophic Coverage Act of 1988 requires the Secretary of Health and Human Services to establish a point-of-sale electronic system and to develop a standard claims form. The Act also requires the Secretary to conduct a longitudinal study on the use of prescription drugs by Medicare beneficiaries and other studies regarding the program cost and requirements for future outlays. All of these required actions will generate valuable data from which a more accurate assessment of the feasibility of implementing a pharmaceutical assistance program in Hawaii can be made.

### **Recommendations**

1. In view of the potentially high cost of a state-level pharmaceutical assistance program and the absence of a demonstrated need, the Bureau recommends against implementation of a pharmaceutical assistance program for Hawaii's elderly at this time. It would be inadvisable for the Legislature to pursue this issue further unless there is a survey of the elderly population in Hawaii providing accurate data on their current drug use and expenditure patterns. The elderly population should be surveyed on a formal basis and the results should be used to determine whether or not a state pharmaceutical assistance program is needed as a supplement to the Medicare outpatient prescription drug program and to estimate the cost of such a supplemental program. A comprehensive survey of the elderly's needs and economic status could be of inestimable value to the Legislature since current demographic information is required to effectively resolve today's complex issues involving the elderly population. Prescription drug use and expenditures could be just a part of such a comprehensive survey. Such a survey would require special appropriations and would probably be best conducted under the auspices of the Executive Office on Aging.

2. The Legislature should carefully observe the implementation of the Medicare outpatient prescription drug program and assess its impact on the drug needs of Hawaii's elderly, especially with respect to the number of elderly who are added to the Medicaid roll from January 1, 1989 due to the mandatory buy-in requirement. This information, along with the data collected from a comprehensive survey should help to determine whether a state-level pharmaceutical assistance program is really needed.

3. If the Legislature finds that a state-level pharmaceutical assistance program is needed and it decides to establish a program for Hawaii, it is recommended that the program be designed to dovetail with the Medicare outpatient prescription drug program to take advantage of procedures, forms, and electronic data processing systems established by the federal government.

## Footnotes

### Chapter 1

1. U.S. Health Care Financing Administration, "National Health Expenditures 1986-2000", Health Care Financing Review, Summer 1987, Vol. 8, No. 4, p. 14.
2. See Carlene Baum, Dianne L. Kennedy, Deanne E. Knapp, John P. Juergens, and Gerald A. Faich, "Prescription Drug Use in 1984 and Changes Over Time", Medical Care, February 1988, Vol. 26, No. 2; L. Lavange and H. Silverman, "Outpatient Prescription Drug Utilization and Expenditure Patterns of Noninstitutionalized Aged Medicare Beneficiaries", National Medical Care Utilization and Expenditure Survey, Series B. Descriptive Report No. 12, DHHS Pub. No. 86-20212, Office of Research and Demonstrations, Health Care Financing Administration (Washington: U.S. Government Printing Office, 1987); and William Simonsen, Medications & the Elderly: A Guide for Promoting Proper Use (Rockville: Aspen Systems Corporation, 1984).
3. Frank E. Young, "Clinical Evaluation of Medicines Used by the Elderly", Clinical Pharmacology & Therapeutics, December 1987, Vol. 42, No. 6, pp. 666-667.
4. See Craig D. Burrell and Richard A. Levy, "Therapeutic Consequences of Noncompliance" and Mickey Smith, "The Cost of Noncompliance and the Capacity of Improved Compliance to Reduce Health Care Expenditures", Improving Medication Compliance, Summaries of Symposium Presentations, National Pharmaceutical Council (Washington: 1984), pp. 7-10 and 15-17; Earle W. Lingle, Jr., Kenneth W. Kirk, and William R. Kelly, "The Impact of Outpatient Drug Benefits on the Use and Costs of Health Care Services for the Elderly", Inquiry, Vol. 24, Fall 1987, pp. 203-211; and William Simonsen, Medications & the Elderly: A Guide for Promoting Proper Use (Rockville: Aspen Systems Corporation, 1984).
5. U.S. Government Accounting Office, Medicare: Prescription Drug Issues (Washington: 1987), p. 3.
6. P.L. 100-360.

### Chapter 2

1. Greta L. Berry, Michael A. Smyer, and Dan Lago, "State-Level Pharmaceutical Assistance Programs for the Elderly: A National Survey", American Journal of Public Health, February 1988, Vol. 78, No. 2, p. 159.
2. Karen Lennox, Expanding Health Benefits for the Elderly: Volume 2 Prescription Drugs (Washington: The Urban Institute, 1979), pp. 32-38.
3. Ibid., p. 33.
4. Ibid., pp. 51-56.
5. Ibid., p. 51.
6. Ibid., p. 53.
7. Ibid., pp. 40-41.
8. Ibid., pp. 44.

### Chapter 3

1. The Delaware program which began in November, 1981, is administered and funded by the Nemours Foundation under a trust established by Alfred I. duPont. The pharmaceutical assistance program is provided through the Nemours Health Clinic as part of a health care program which provides free comprehensive dental care, eye examinations and glasses, and hearing tests and hearing aids to eligible seniors. Prescription drugs are available at 10 per cent of cost to those residents who are 65 years of age or older and whose incomes do not exceed \$7,800 if single and \$11,000 if married. The state maintains the \$5 million revolving fund used by the program for direct services but the Foundation handles all deposits and withdrawals. Information extracted from brochure published by the Nemours Health Clinic, undated; and New York, State Senate Select Committee on Interstate Cooperation, Pharmaceutical Assistance for the Elderly: Experiences in Six States and in New York, January 1985 update.

2. Ann Zuvekas, Luis Gutierrez, Katherine Eresian, and Peter D. Fox, Pharmaceutical Assistance Programs, prepared for the Pharmaceutical Manufacturers Association by Lewin and Associates Incorporated, July 1987, pp. 14-17.
3. "Characteristics of PAA Programs: Summary/Ranges", June 1987, (unpublished information compiled by the National Pharmaceutical Council and provided to the Bureau by the Pharmaceutical Manufacturers Association).
4. See Conn. Gen. Stat. §17-510 et seq.
5. Information for this section extracted from the following sources: Connecticut, Department of Aging, Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled Quarterly Report April 1, 1988 - June 30, 1988; and telephone interviews with Marsha Mains, Manager, ConnPACE, September 21, 1988 and October 6, 1988.
6. See Ill. Rev. Stat. ch. 67-1/2, §401 et seq.
7. Information for this section extracted from the following sources: Illinois Department of Revenue, Pharmaceutical Assistance Program - Calendar Year 1987 Annual Report, March 1, 1988; Illinois, General Assembly Legislative Research Unit, Research Response prepared by Julia M. Greene, Science Research Assistant, File 9-833, June 28, 1988; and telephone interview with Jerry Purcell, Manager, Aged and Disabled Assistance Division, September 20, 1988.
8. See Me. Rev. Stat. Ann. tit. 22, §254.
9. Information for this section extracted from the following sources: "Pharmaceutical Assistance Programs (PAPs) for the Elderly", CSG Backgrounder, Nov. 1987; and telephone interviews with Michael O'Donnell, Maine Bureau of Medical Services, September 26, 1988 and October 13, 1988.
10. See Md. Health-General Code Ann., §15-124.
11. Information for this section extracted from the following sources: Maryland, Department of Health and Mental Hygiene, Maryland Medical Care Program: Medical Assistance Program, Pharmacy Assistance Program, The Year in Review, Fiscal Year 1986; and telephone interviews with John W. Baker, Manager, Maryland Pharmaceutical Assistance Program, September 23, 1988 and October 6, 1988.
12. See N.J. Stat. Ann. §30:4D-20 et seq.
13. Information for this section extracted from the following sources: New Jersey, Department of Human Services, Pharmaceutical Assistance to the Aged and Disabled, Fiscal Year 1987, Annual Report; letter to Susan Claveria from Randall L. Currier, Deputy Legislative Counsel, New Jersey State Legislature, Office of Legislative Services, June 20, 1988; and telephone interview with Edward Klane, Chief, Bureau of Pharmaceutical Assistance to the Aged and Disabled, October 6, 1988.
14. See 1986 N.Y. Laws, ch. 913.
15. Information for this section extracted from the following sources: New York, Elderly Pharmaceutical Insurance Coverage Program, EPIC Report to the Governor and the Legislature, January 1988; Maryann Riviello, "Pharmaceutical Insurance for the Elderly -- A Fledgling Star in Search of an Audience", Issues in Focus, Senate Research Service, Number 88-169, May 3, 1988; and telephone interviews with Marilyn Desmond, Deputy Director, EPIC, September 22, 1988 and October 6, 1988.
16. See Pa. Stat. Ann. tit. 62, §2901 et seq. (Purdon).
17. Information for this section extracted from the following sources: Pennsylvania, Department of Aging, Pharmaceutical Contract for the Elderly, Quarterly Report to the Pennsylvania General Assembly, April 1 - June 30, 1987; and telephone interview with Thomas M. Snedden, Director, PACE, September 27, 1988.
18. R.I. Gen. Laws §42-66.2-1 et seq.
19. Rhode Island, Department of Elderly Affairs, Rhode Island Pharmaceutical Assistance to the Elderly Quarterly Report, April 15, 1988; telephone interviews with Susan Sweet, Division Chief, September 20, 1988, and Skip Centazzo, Rhode Island Department of Elderly Affairs, October 7, 1988.

#### Chapter 4

1. U.S. Department of Health and Human Services, Health Care Financing Administration, Guide to Health Insurance for People with Medicare - 1988, Pub. No. HCFA 02110, p. 15.
2. U.S., House Conf. Rep. No. 100-661, reprinted in U.S. Code Congressional and Administrative News, pp. 986-987.
3. U.S. General Accounting Office, Medicare: Prescription Drug Issues, Report to the Chairman, Special Committee on Aging, U.S. Senate (Washington: 1987), p. 3.
4. U.S. Health Care Financing Administration, Office of Research and Demonstrations, The Medicare and Medicaid Data Book, 1984, HCFA Pub. No. 03156 (Baltimore: 1983), pp. 1-2.
5. Medicare Catastrophic Coverage Act of 1988, 102 Stat. 683 (1988). (U.S. Code Congressional and Administrative News, July 1, 1988).
6. Ibid., sec. 202(a)(2), 102 Stat. 702.
7. Ibid., sec. 202(b)(3), 102 Stat. 704. The U.S. House Committee on Energy and Commerce found that nearly 5.5 million Medicare enrollees, almost 17 per cent, incur more than \$500 in prescription drug costs and that the average annual cost of those persons is nearly \$1,000, House Comm. Rep. No. 100-105(II), reprinted in [1988] U.S. Code Congressional and Administrative News, p. 869.
8. Ibid., sec. 203, 102 Stat. 721.
9. Ibid., sec. 202(d), 102 Stat. 715.
10. Ibid., sec. 202(b), 102 Stat. 704.
11. Ibid., sec. 202(c).
12. Ibid., sec. 202(b)(4), 102 Stat. 708.
13. Ibid., sec. 211, 102 Stat. 739.
14. U.S. House Conf. Rep. No. 100-661, 100th Cong., 2d Sess., reprinted in [1988] U.S. Code Congressional and Administrative News, pp. 994-995.
15. Ibid., sec. 212, 102 Stat. 739.
16. U.S., House Conf. Rep. No. 100-661, 100th Cong., 2d Sess., reprinted in [1988] Code Congressional & Administrative News, pp. 1031-1035.
17. Ibid., sec. 202(b)(4), 102 Stat. 708.
18. Ibid., sec. 202(b)(4), 102 Stat. 710.
19. Conf. report, p. 191.
20. Ibid. sec. 202(j), 102 Stat. 719.
21. Ibid., sec. 202(l), 102 Stat. 720.
22. Ibid., sec. 202(i), 102 Stat. 718.
23. Ibid., sec. 202(k)(1), 102 Stat. 719.
24. Ibid., sec. 202(k)(2), 102 Stat. 720.
25. Daniel R. Waldo, "Outpatient Prescription Drug Spending by the Medicare Population", Health Care Financing Review, Fall 1987, Vol. 9, No. 1, p. 83.
26. Ibid., Table 2, p. 88.
27. Maryann Riviello, "Pharmaceutical Insurance for the Elderly--A Fledgling Star in Search of an Audience", Issues in Focus, Senate Research Service, Number 88-169, May 3, 1988, p. 9.
28. Telephone interview with Marilyn Desmond, Deputy Director, New York EPIC program, September 22, 1988.
29. Telephone interview with Thomas Snedden, Director, Pennsylvania PACE program, September 27, 1988.

#### Chapter 5

1. Hawaii, Department of Planning and Economic Development, The State of Hawaii Data Book, 1985: A Statistical Abstract, Table 19, p. 39; and The State of Hawaii Data Book, 1984, Table 23, p. 44; Department of Business and Economic Development, The State of Hawaii Data Book - 1987: A Statistical Abstract, Tables 20 and 22.
2. Eleanor C. Nordyke, Richard K.C. Lee, and Robert W. Gardner, A Profile of Hawaii's Elderly Population, Papers of the East-West Population Institute, No. 91 (Honolulu: 1984), p. 8 note.
3. Ibid., pp. 12, 33-34.
4. Hawaii, Executive Office on Aging, The Elderly in Hawaii: A Data Digest, Table 98, p. 134.

5. See U.S. Congress, Subcommittee on Trade, Productivity, and Economic Growth of the Joint Economic Committee, Poverty, Income Distribution, the Family and Public Policy, 99th Cong., 2d Sess., 1986; and U.S. Congressional Research Service, "Economic Status of the Elderly", Issue Brief, updated May 25, 1988.
6. U.S. Congress, House Subcommittee on Health and the Environment of the Committee on Energy and Commerce, Long-term Care Services for the Elderly: Background Materials on Financing and Delivery of Long-term Care Services for the Elderly (Washington: 1986), pp. 4-7.
7. Villers Foundation, On the Other Side of Easy Street: Myths & Facts About the Economics of Old Age (Washington: 1987), pp. 5-7, 22-23.
8. Villers Foundation, p. 26.
9. Ibid., pp. 26-27.
10. Ibid., p. 23.
11. Ibid., p. 42.
12. Ibid.
13. L. LaVange and H. Silverman, "Outpatient Drug Utilization and Expenditure Patterns of Noninstitutionalized Aged Medicare Beneficiaries", National Medical Care Utilization and Expenditure Survey, Series B. Descriptive Report No. 12, DHHS Pub. No. 86-20212, Office of Research and Demonstrations, Health Care Financing Administration (Washington: U.S. Government Printing Office, 1987).
14. Ibid., pp. 7, 9-11.
15. Ibid., p. 10.
16. Ibid., pp. 17-19.
17. Daniel R. Waldo, "Outpatient Prescription Drug Spending by the Medicare Population", Health Care Financing Review, Fall 1987, Vol. 9, No. 1, p. 83.
18. Ibid.
19. Telephone conversation with Doug Kreider, Health Promotion and Education Office, Department of Health, June 21, 1988.
20. U.S. Congress, Senate, Prescription Drugs and the Elderly: The High Cost of Growing Old, Hearing before the Special Committee on Aging, 100th Cong., 1st Sess., July 20, 1987, Serial No. 100-9, p. 51.
21. U.S. General Accounting Office, Medicare: Prescription Drug Issues, Report to the Chairman, Special Committee on Aging, U.S. Senate (Washington: 1987), p. 2.
22. U.S. Congress, Prescription Drugs and the Elderly: The High Cost of Growing Old, p. 51.
23. U.S. General Accounting Office, Medicare: Prescription Drug Issues, p. 5.
24. Information from the Health Care Administration Division, Department of Human Services, August 3, 1988.
25. Ibid.
26. Telephone interview with Winnie Odo, Acting Deputy Administrator, Health Care Administration Division, Department of Human Services, October 4, 1988.
27. The term "medically needy" refers to one of three categories of persons that qualify for Medicaid. The "medically needy" are those who have incomes above the standards established for the categorically needy but whose medical care costs have brought their income to such a low level that they qualify for medical assistance. The "categorically needy" are those who meet the State's definition of "poor" based on financial eligibility levels for Aid to Families of Dependent Children and Supplemental Security Income. The optionally categorically needy are those who are eligible for monetary public assistance but who choose only to accept medical assistance. The elderly persons who would benefit most from a state-level pharmaceutical assistance program would be likely be those that cannot qualify as medically needy.
28. §§17-744-44 and 17-744-48, Hawaii Administrative Rules (Department of Human Services).
29. 53 Fed. Reg. 4213-4214 (1988).
30. Letter and accompanying information to Susan Claveria from Terry Peacock, Senior Account Manager, Kaiser Foundation Health Plan, August 29, 1988.
31. See Hawaii Rev. Stat., §393-1 et seq.
32. Letter and accompanying information to Susan Claveria from Eugene I. Fujii, Administrator, Contracts and Legal Liaison, Hawaii Medical Service Association, October 31, 1988.

33. Hawaii Employers Council, Employee Benefit Plans in Hawaii, Special Pub. No. 178 (Honolulu: 1988), pp. 21-44.
34. Hawaii Employers Council, Employee Benefit Plans in Hawaii, Special Pub. No. 151 (Honolulu: 1981), pp. 28-30.
35. Results of Bureau survey of licensed pharmacies.

## Chapter 6

1. Dr. Lipton noted that a study of 290 chronically ill patients discharged from a general hospital found that the financial burden imposed by drug costs was the primary reason given by patients for noncompliance with drug treatment. The researchers found that the average monthly cost of drugs prescribed for patients who did not comply was almost three times higher than for those who complied. (F. N. Brand, R. T. Smith, and P. A. Brand 1977, "Effect of Economic Barriers to Medical Care on Patients' Noncompliance", Public Health Reports, 92:72-78) Another study of 82 chronically ill patients discharged from three acute care hospitals found that patients cited the cost of drugs as the reason for noncompliance. (A. Donabedian and L.S. Rosenfeld 1964, "Follow-up Study of Chronically Ill Patients Discharged From Hospital", Journal of Chronic Disorders, 17:847-62) A third study of 155 elderly residents of an urban subsidized apartment building revealed that 6.4 per cent of those surveyed reported drug expense as a problem, although only 24 per cent had insurance covering drug expenses. (J. C. Darnell, et al. 1986, "Medication Use by Ambulatory Elderly: An In-home Survey", Journal of the American Geriatric Society 34:1-4) Lipton reported that there have been many studies which have found that the greater the number of drugs taken by patients, the more likely they are to be noncompliant. (B. Malahay 1966, "The Effect of Instruction and Labeling on the Number of Medication Errors Made by Patients at Home", American Journal of Hospital Pharmacy 23:283-92; V. Francis, B. M. Korsch, and M. J. Morris 1969, "Gaps in Doctor-Patient Communication: Patients' Response to Medical Advice", New England Journal of Medicine 280:535-40; M. Weintraub, W. Au, and L. Lasagna 1973, "Compliance as a Determinant of Serum Digoxin Concentration", Journal of the American Medical Association 224:481-85; B. S. Hulka, et al. 1975, "Medication Use and Misuse: Physician-Patient Discrepancies", Journal of Chronic Diseases 28:7-21; D. Parkin, et al. 1976, "Deviation From

Prescribed Drug Treatment After Discharge From Hospital", British Medical Journal 2:686-88; R. D. Caplan, et al. 1976, Adhering to Medical Regimens: Pilot Experiments in Patient Education and Social Support, Ann Arbor: Institute for Social Research, University of Michigan; J. C. Darnell 1986, "Medication Use by Ambulatory Elderly: An In-Home Survey", Journal of the American Geriatrics Society 34:1-4). Since patients taking a number of different drugs would likely incur large drug expenses, there is suggestive evidence that drug costs contribute to inappropriate drug use. U.S. Congress, Senate, Prescription Drugs and the Elderly: The High Cost of Growing Old, Hearing before the Special Committee on Aging, 100th Cong., 1st Sess., July 20, 1987, Serial No. 100-9, pp. 40-41.

2. Ibid., p. 41.
3. For an example of a study measuring the impact of pharmaceutical assistance on other health care use and cost see Earle W. Lingle, Jr., Kenneth W. Kirk, and William R. Kelly, "The Impact of Outpatient Drug Benefits on the Use and Costs of Health Care Services for the Elderly", Inquiry, Vol. 24, Fall 1987. See also, Craig D. Burrell and Richard A. Levy, "Therapeutic Consequences of Noncompliance", and Mickey Smith, "The Cost of Noncompliance and the Capacity of Improved Compliance to Reduce Health Care Expenditures", Improving Medication Compliance: Summaries of Symposium Presentations (Washington: National Pharmaceutical Council, 1984), pp. 7-10 and 15-17.
4. Lennie-Marie P. Tolliver, "Social Perspectives on Geriatric Drug Use", Geriatric Drug Use - Clinical & Social Perspectives, ed. Steven R. Moore and Thomas W. Teal (New York: Pergamon Press, 1985), p. 10.
5. L. Lavange and H. Silverman, "Outpatient Drug Utilization and Expenditure Patterns of Noninstitutionalized Aged Medicare Beneficiaries", National Medical Care Utilization and Expenditure Survey, Series B Descriptive Reports No. 12, DHHS Pub. No. 86-20212, Office of Research and Demonstrations, Health Care Financing Administration (Washington: U.S. Government Printing Office, 1987), p. 6.
6. William Simonson, Medications & the Elderly: A Guide for Promoting Proper Use (Rockville: Aspen Systems Corporation, 1984), p. 14.
7. William D. Poe and Donald A. Holloway, Drugs and the Aged (New York: McGraw-Hill, 1980), p. 4.

8. Tolliver, p. 10.
9. Albert Eckian, "Self-medication with Over-the-counter Drugs", Geriatric Drug Use: Clinical & Social Perspectives, ed. Steven R. Moore and Thomas W. Teal (New York: Pergamon Press, 1985) pp. 39-46.
10. New York, Senate Committee on Aging and Senate Select Committee on Interstate Cooperation, Pharmaceutical Assistance for the Elderly: Experiences in Four States and in New York, August 1982, p. 3.
11. New Jersey, Pharmaceutical Assistance to the Aged and Disabled, PAAD Fiscal Year 1987 Annual Report (New Jersey: 1987), pp. 4 and 14.
12. Telephone interview with Thomas Snedden, Director, Pennsylvania Pharmaceutical Assistance Contract for the Elderly, September 27, 1988.
13. Many pharmacies surveyed by the Bureau reported that the Medicaid reimbursement rate was too low (one pharmacy noted that Hawaii's dispensing fee was in the bottom 10 per cent in the nation) and did not adequately cover the dispensing costs of the pharmacy.
14. Telephone interview with Susan Sweet, Division Chief, Department of Elderly Affairs, September 20, 1988.
15. Telephone interviews with Michael O'Donnell, Maine Bureau of Medical Services, September 26 and October 13, 1988.
16. This estimate was derived by taking the average annual drug cost per beneficiary of the programs in Connecticut, Maryland, New Jersey, New York, and Pennsylvania. The Bureau did not include the annual drug costs of Maine, Illinois, and Rhode Island because those programs are more restrictive in the drugs covered.
17. Table provided by the Pharmaceutical Manufacturers Association entitled "Expanded Drug Coverage for the Elderly", from Pharmaceutical Benefits Under State Medical Assistance Programs (Reston: National Pharmaceutical Council, 1987), pp. 114-115.
18. This is the estimated total population for July 1, 1986 for all persons age 65 and over. Hawaii, Department of Business and Economic Development, The State of Hawaii Data Book, 1987: A Statistical Abstract, Table 20, p. 40.
19. Ann Zuvekas, Luis Gutierrez, Katherine Eresian, and Peter D. Fox, Pharmaceutical Assistance Programs, prepared for the Pharmaceutical Manufacturers Association by Lewin and Associates Incorporated, July 1987, p. 14.
20. Maryann Riviello, "Pharmaceutical Insurance for the Elderly -- A Fledgling Star in Search of an Audience", Issues in Focus, New York Senate Research Service, Number 88-169, May 3, 1988.
21. See New York, Senate Committee on Aging and Senate Select Committee on Interstate Cooperation, Pharmaceutical Assistance for the Elderly: Experiences in Four States and in New York, August 1982 and January 1985 update.



THE SENATE

FOURTEENTH LEGISLATURE, 19<sup>88</sup>

STATE OF HAWAII

FEB 17 1988

S.C.R. NO. 25

## SENATE CONCURRENT RESOLUTION

REQUESTING A STUDY ON THE FEASIBILITY OF IMPLEMENTING A  
PHARMACEUTICAL ASSISTANCE PROGRAM FOR THE ELDERLY.

WHEREAS, the age 65 and over group is the fastest growing segment of our population today, and it is projected that this group will comprise approximately fourteen per cent of Hawaii's resident population in the year 2000; and

WHEREAS, concomitant with the increase in the elderly population is an increased demand for medication as the normal aging process frequently leads to chronic illness; and

WHEREAS, for many elderly persons who are on fixed incomes but who do not qualify for public medical assistance, the monthly cost of prescription drugs can be prohibitive; and

WHEREAS, in response to this growing problem, eight states (Connecticut, Delaware, Illinois, Maine, New Jersey, New York, Pennsylvania, and Rhode Island) have instituted pharmaceutical assistance programs which provide financial assistance to qualified persons for drugs and six states are considering such programs; and

WHEREAS, although pharmaceutical assistance programs are viewed as worthwhile social programs, critics argue that the financial burden on the State and the taxpayers is too great and that there is a potential risk of drug abuse by the elderly since drugs become more readily available; now, therefore,

BE IT RESOLVED by the Senate of the Fourteenth Legislature of the State of Hawaii, Regular Session of 1988, the House of Representatives concurring, that the Legislative Reference Bureau is requested to conduct a study on the feasibility of implementing a pharmaceutical assistance program in the State of Hawaii to assist elderly persons with incomes too high to receive public medical assistance; and

BE IT FURTHER RESOLVED that the study include, but not be limited to, a review of the programs in Connecticut, Delaware, Illinois, Maine, New Jersey, New York, Pennsylvania, and Rhode

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Island; and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau is requested to submit a report of its findings and recommendations to the Legislature, not later than twenty days prior to the convening of the Regular Session of 1989; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Director of the Legislative Reference Bureau.

OFFERED BY:

*Ann Kobayashi*  
*Rene M. Matsumura*  
*Mary-Jane McMurdo*  
*Rene Kojima*  
*Steve Bell*  
*Rich Reed*  
*Deanna R. Clarke*  
*Milt Holt*  
*James Shi*