Wisconsin Family Impact Seminars

and the

Sonderegger Research Center for Social and Administrative Pharmacy
University of Wisconsin-Madison

Designing a State Prescription Drug Benefit: Strategies to Control Costs

University of Wisconsin-Extension
Center for Excellence in Family Studies
School of Human Ecology
University of Wisconsin-Madison

Designing a State Prescription Drug Benefit: Strategies to Control Costs

First Edition

Wisconsin Family Impact Seminars
and the
Sonderegger Research Center for Social and Administrative Pharmacy
University of Wisconsin-Madison
Briefing Report

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Purpose and Presenters

In 1993, Wisconsin became one of the first states to sponsor Family Impact Seminars modeled after the seminar series for federal policymakers. Because of the success of the Wisconsin Family Impact Seminars, Wisconsin is now helping other states establish their own seminars through the newly created Policy Institute for Family Impact Seminars at the University of Wisconsin-Madison.

Family Impact Seminars are a series of seminars, briefing reports, and follow-up activities that provide up-to-date, solution-oriented research on current issues for state policymakers, legislators and their aides, Governor's Office staff, legislative support bureau personnel, and state agency representatives. Family Impact Seminars analyze the consequences an issue, policy, or program may have for families.

The seminars provide objective nonpartisan research on current issues and do not lobby for particular policies. Seminar participants discuss policy options and identify common ground where it exists.

"Designing a State Prescription Drug Benefit: Strategies to Control Costs" is the 16th seminar in a series designed to bring a family focus to policymaking. This seminar featured the following speakers:

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Wisconsin Family Impact Seminar Briefing Reports

Each seminar is accompanied by an in-depth briefing report that summarizes the latest research on a topic and identifies policy options from across the political spectrum. Copies are available at:

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Or, visit the Policy Institute for Family Impact Seminars website at:

http://www.familyimpactseminars.org (enter a portal and click on State Seminars).

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Executive Summary

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

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

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

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

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

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

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

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

Some states restrict coverage to specific types of drugs such as maintenance drugs or drugs to treat specific conditions. Unlike private insurers, state programs generally do not use formularies, lists of prescription drugs which are covered by the program. Pennsylvania does not cover certain high-cost drugs for which a less expensive alternative is available. The state hires a panel of national experts to advise them on which high-cost drugs can be excluded from coverage.

Beneficiary cost sharing varies among states. In general, copayments and coinsurance are more common than benefit caps and deductibles. Three programs use coinsurance which requires enrollees to pay a fixed percentage of the cost of a prescription, giving enrollees a stronger incentive to use less expensive drugs. Six programs use a flat copayment which requires enrollees to pay the same amount for each type of prescription. Six programs use a tiered copayment structure with higher standard copayments for more expensive or brand name drugs than for generic products. In Maine, the program changed its policy from a flat copayment to a coinsurance amount equal to 20% of the drug's price. A Maine program official estimated that this change cut program costs by 10%.

Annual benefit limits and deductibles, which are common in private health insurance, are not often used in state programs because these programs serve needy and low income populations.

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

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

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

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

A Checklist for Assessing the Impact of Policies on Families

The first step in developing family-friendly policies is to ask the right questions:

- What can government and community institutions do to enhance the family's capacity to help itself and others?
- What effect does (or will) this policy (or proposed program) have for families? Will it help or hurt, strengthen or weaken family life?

These questions sound simple, but they can be difficult to answer.

The Family Criteria (Ad Hoc) Task Force of the Consortium of Family Organizations (COFO) developed a checklist to assess the intended and unintended consequences of policies and programs on family stability, family relationships, and family responsibilities. The checklist includes six basic principles that serve as the criteria of how sensitive to and supportive of families policies and programs are. Each principle is accompanied by a series of family impact questions.

The principles are not rank ordered and sometimes they conflict with each other, requiring trade-offs. Cost effectiveness also must be considered. Some questions are value-neutral and others incorporate specific values. People may not always agree on these values, so sometimes the questions will require rephrasing. This tool, however, reflects a broad nonpartisan consensus, and it can be useful to people across the political spectrum.

For the questions that apply to your policy or program, record the impact on family well-being.

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Principle 1. Family support and responsibilities.

Policies and programs should aim to support and supplement family functioning and provide substitute services only as a last resort.

Does the proposal or program:

- ❍ support and supplement parents' and other family members' ability to carry out their responsibilities?
- ❍ provide incentives for other persons to take over family functioning when doing so may not be necessary?
- ❍ set unrealistic expectations for families to assume financial and/or caregiving responsibilities for dependent, seriously ill, or disabled family members?
- ❍ enforce absent parents' obligations to provide financial support for their children?

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Principle 2. Family membership and stability.

Whenever possible, policies and programs should encourage and reinforce marital, parental, and family commitment and stability, especially when children are involved. Intervention in family membership and living arrangements is usually justified only to protect family members from serious harm or at the request of the family itself.

Does the policy or program:

- ❍ provide incentives or disincentives to marry, separate, or divorce?
- ❍ provide incentives or disincentives to give birth to, foster, or adopt children?
- ❍ strengthen marital commitment or parental obligations?
- ❍ use appropriate criteria to justify removal of a child or adult from the family?
- ❍ allocate resources to help keep the marriage or family together when this is the appropriate goal?
- ❍ recognize that major changes in family relationships such as divorce or adoption are processes that extend over time and require continuing support and attention?

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Principle 3. Family involvement and interdependence.

Policies and programs must recognize the interdependence of family relationships, the strength and persistence of family ties and obligations, and the wealth of resources that families can mobilize to help their members.

To what extent does the policy or program:

- ❍ recognize the reciprocal influence of family needs on individual needs, and the influence of individual needs on family needs?
- ❍ recognize the complexity and responsibilities involved in caring for family members with special needs (e.g., physically or mentally disabled, or chronically ill)?
- ❍ involve immediate and extended family members in working toward a solution?
- ❍ acknowledge the power and persistence of family ties, even when they are problematic or destructive?
- ❍ build on informal social support networks (such as community/neighborhood organizations, religious communities) that are essential to families' lives?
- ❍ respect family decisions about the division of labor?
- ❍ address issues of power inequity in families?
- ❍ ensure perspectives of all family members are represented?
- ❍ assess and balance the competing needs, rights, and interests of various family members?
- ❍ protect the rights and safety of families while respecting parents' rights and family integrity?

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Principle 4. Family partnership and empowerment.

Policies and programs must encourage individuals and their close family members to collaborate as partners with program professionals in delivery of services to an individual. In addition, parent and family representatives are an essential resource in policy development, program planning, and evaluation.

In what specific ways does the policy or program:

- ❍ provide full information and a range of choices to families?
- ❍ respect family autonomy and allow families to make their own decisions? On what principles are family autonomy breached and program staff allowed to intervene and make decisions?
- ❍ encourage professionals to work in collaboration with the families of their clients, patients, or students?
- ❍ take into account the family's need to coordinate the multiple services they may require and integrate well with other programs and services that the families use?
- ❍ make services easily accessible to families in terms of location, operating hours, and easy-to-use application and intake forms?
- ❍ prevent participating families from being devalued, stigmatized, or subjected to humiliating circumstances?
- ❍ involve parents and family representatives in policy and program development, implementation, and evaluation?

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Principle 5. Family diversity.

Families come in many forms and configurations, and policies and programs must take into account their varying effects on different types of families. Policies and programs must acknowledge and value the diversity of family life and not discriminate against or penalize families solely for reasons of structure, roles, cultural values, or life stage.

How does the policy or program:

- ❍ affect various types of families?
- ❍ acknowledge intergenerational relationships and responsibilities among family members?
- ❍ provide good justification for targeting only certain family types, for example, only employed parents or single parents? Does it discriminate against or penalize other types of families for insufficient reason?
- ❍ identify and respect the different values, attitudes, and behavior of families from various racial, ethnic, religious, cultural, and geographic backgrounds that are relevant to program effectiveness?

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Principle 6. Support of vulnerable families.

Families in greatest economic and social need, as well as those determined to be most vulnerable to breakdown, should be included in government policies and programs.

Does the policy or program:

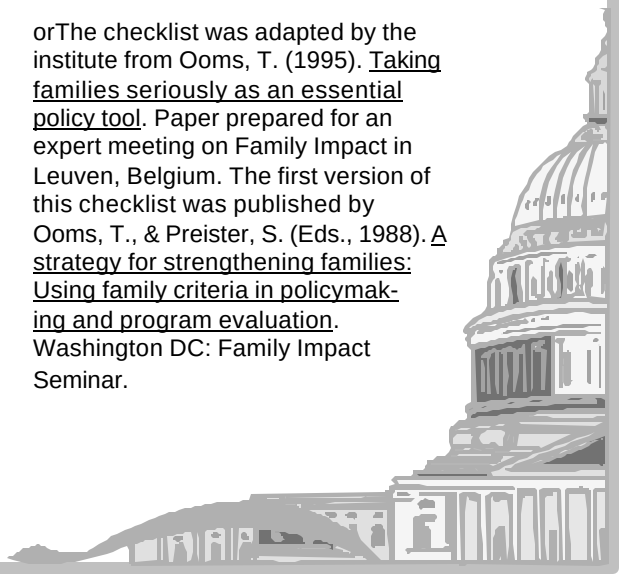
- ❍ identify and publicly support services for families in the most extreme economic or social need?
- ❍ give support to families who are most vulnerable to breakdown and have the fewest resources?
- ❍ target efforts and resources toward preventing family problems before they become serious crises or chronic situations?

The Policy Institute for Family Impact Seminars aims to connect research and policymaking and to promote a family perspective in research, policy, and practice. The institute has resources for researchers, policymakers, practitioners, and those who conduct Family Impact Seminars.

- To assist researchers and policy scholars, the institute is building a network to facilitate cross-state dialogue and resource exchange on strategies for bringing research to bear on policymaking.
- To assist policymakers, the institute disseminates research and policy reports that provide a family impact perspective on a wide variety of topics.
- To assist those who implement policies and programs, the institute has available a number of family impact assessment tools for examining how responsive policies, programs, and institutions are to family well-being.
- To assist states who wish to create better dialogue between researchers and policymakers, the institute provides technical assistance on how to establish your own state's Family Impact Seminars.

The checklist and the papers are available from Director Karen Bogenschneider and Associate Directors Bettina Friese and Jessica Mills of the Policy Institute for Family Impact Seminars at the University of Wisconsin-Madison/Extension, 130 Human Ecology, 1300 Linden Drive, Madison, WI, 53706; phone (608)263-2353; FAX (608)262-5335; http://www.familyimpactseminars.org.

orThe checklist was adapted by the institute from Ooms, T. (1995). Taking families seriously as an essential policy tool. Paper prepared for an expert meeting on Family Impact in Leuven, Belgium. The first version of this checklist was published by Ooms, T., & Preister, S. (Eds., 1988). A strategy for strengthening families: Using family criteria in policymaking and program evaluation. Washington DC: Family Impact Seminar.



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What Strategies Can States Use to Control Costs and How Effective are They?

By David Kreling

This chapter reviews the effectiveness of nine different strategies for controlling costs in prescription drug programs. For example, the potential savings of encouraging the use of generic over brand name drugs is large even after taking into account consumer cost sharing incentives or higher dispensing fees. Cost sharing in prescription drug programs can drive drug costs down. Coinsurance is more apt to alert consumers to differences in drug costs than copayments. Drug utilization review can improve the quality of drug use and cut costs. The chapter also discusses formularies, disease management programs, mail service prescriptions, negotiated prices from pharmacies, and rebates from manufacturers.

Along with increased attention to prescription drug costs and growth in prescription expenditures has come interest in cost control measures. Of particular interest have been strategies to control costs through prescription drug program administrators, known as PBMs (pharmacy benefit managers).

PBMs usually are private firms that contract with health plans and specialize in claims processing and administrative issues involved in operating a prescription drug program. Health Maintenance Organizations (HMOs), state governments, and others also may perform similar functions and use similar strategies to control costs.

This report examines nine different PBM cost control methods for prescription drug costs including negotiated prices with pharmacies, generic substitution, rebates, copayments, coinsurance, formularies, disease management programs, mail service prescriptions, and drug utilization review. Cost control strategies in prescription drug programs are usually targeted at pharmacies, drug manufacturers, or consumers but also can reach prescribers. Evidence of the potential effectiveness of each of these strategies is described below and summarized in Table 1.

Pharmacy payments/reimbursement—Negotiated prices

The standard approach used to determine the price or reimbursable amount for a dispensed prescription is to provide an ingredient cost for the drug dispensed, plus a dispensing fee. Determining the ingredient cost and the amount of the dispensing fee often varies depending on whether the drug is a brand name or generic.

Since PBMs make large purchases representing everyone in a drug coverage program, their reimbursement formulas are established to get volume discounts from pharmacies. Levels of prices paid by PBMs generally are among the lowest accepted by pharmacies.

In 1996, a study commissioned by the Health Care Financing Administration (HCFA) reported that typical dispensing fees for PBMs in the study ranged from $1.85 to $4, usually with $2 to $3 fees for brand name drug prescriptions and $3 to $3.50 for generics. These fees were lower than the average $4.12 average dispensing fee for state Medicaid programs. PBM ingredient cost payments commonly were the average wholesale price (AWP) less 13% and ranged from AWP less 10% to 15%; Medicaid programs commonly paid AWP less 10%.

Similarly, the 1999 Novartis Pharmacy Benefit Report showed an average discount of 14.3% off the average wholesale price (AWP) among 108 Health Maintenance Organizations (HMOs) surveyed in 1998. For pharmacies in the HMO provider networks, the dispensing fees averaged $1.98 for brand name drug prescriptions and $2.06 for generics.

Restricting sales to selected pharmacies allows for additional discounts in ingredient cost payments of between one and a few percent, and dispensing fee reductions between 50 cents and $1 (HCFA, 1996). Because PBM reimbursement rates generally are low, additional rate cuts for restricting the pharmacy network tend to be small. Also, many states have laws that PBM's cannot exclude pharmacies willing to accept the payment terms offered. Thus, the choice of restricting networks becomes a decision for the pharmacies as much as a choice for the PBM.

The research on the effect of negotiated prices is limited and dated. Studies have shown different revenues and/or cost shifting between payers (Kotzan & Carroll, 1991; McMillan et al. 1990). Anecdotal reports of downward pressure on margins because of decreased payments appear in pharmacy trade journals and in chain drugstore annual reports (Walgreen, 1999). Continuing to decrease prices to control costs could have quality implications. To ensure economic survival, pharmacies focus on dispensing high volumes of prescriptions. As the rate of prescriptions dispensed each hour increases, however, professional contact time with patients decreases. The rushed pace can also result in dispensing errors.

Generic Substitution

The goal of generic substitution is to increase the use of generic drugs and have them dispensed whenever possible. Generic substitution cost control measures can involve or be directed to the consumer, pharmacist, or prescriber.

Measures to increase the use of generic drugs can be directed toward the consumer, pharmacist, or prescriber.

Consumer use of generic drugs can be encouraged by decreasing their cost for prescriptions dispensed with generics through a lower copayment or coinsurance rate. Or, consumers may have to pay the difference in cost between a generic and a brand name if the generic is not accepted. Pharmacists can receive higher dispensing fees for generics. With maximum allowable cost (MAC) programs, the pharmacy receives reimbursement only in the amount of costs of the generic. If the brand name is dispensed, the pharmacy would have to absorb the difference in cost between the brand name drug and the generic. Prescribing profiles on physicians can evaluate whether they prescribe generics. This identifies physicians who do not prescribe generics so they can receive educational intervention and/or sanctions.

The potential savings on generics compared with brand names is large even after taking into account lower consumer cost sharing requirements or higher pharmacy dispensing fees. In one report (Wyeth-Ayerst, 1999), efforts aimed at pharmacists (such as increased dispensing fees for generic drugs) were less successful than incentives aimed at consumers (such as requiring consumers to absorb cost differences between brand and generic drugs). The percentage of generic prescriptions has grown from 33% in 1993 to 45% in 1998 (Kaiser, 2000a).

The potential savings on generics compared with brand names is large.

Using generics to control costs has possibilities. However, potential savings from generic drug use when patents expire and generics become available are offset by adoption of new drugs. New drugs typically cost more, and may offer improvements over older drugs. To the extent that generic drug use can be increased without compromising patient health, generics can be an effective cost control measure.

Manufacturer Price Concessions—Rebates

Rebates are money returned by a seller to a purchaser and can be considered a negotiated price discounting strategy targeted to drug manufacturers. Manufacturers pay a rebate based on the amount of the firm's products that are dispensed by pharmacies providing prescription service to beneficiaries or enrollees. The rebates are usually a percent of the value (at the manufacturer transaction price) of a drug dispensed. They occur separately from the claims submission/payment cycle as an after-market arrangement. The rebate is paid to the PBM and then passed on to the drug program sponsor (e.g., HMO, employer, or health plan) or paid directly to the sponsor.

Rebates may occur because the PBM is a volume purchaser. Rebate arrangements also may have some purchase volume or market share requirement, so the discount truly reflects a volume difference. Market share stipulations in rebate offers often are connected to incentives, such as formulary inclusion or pharmacist and patient incentives to influence market shares of rebated products.

A report for the Health Care Financing Administration in (HCFA) 1996 based on in-depth interviews with eight PBMs, reported rebates generally were lower and less universally available than within state Medicaid programs (HCFA, 1996). The amount of rebate per claim was about $1, representing an average of 5% of drug spending.

In response to the Medicaid rebate program, some new forms of rebates have begun. Health Care Financing Administration (HFCA) regulations require rebates on all products as a requirement for inclusion in Medicaid programs. Also, Medicaid must receive the best rebates available in the market. If a rebate better than the rate provided to HCFA is provided to another purchaser, the manufacturer must provide an equal level of rebate to HCFA for Medicaid. To avoid paying additional rebates, yet provide incentives, manufacturers may establish different arrangements that benefit PBMs or drug program sponsors, such as special project funds, incentives for information like claims data, or education programs for pharmacists (HCFA, 1996).

If rebates detract from the most cost-effective drug choices, they may lead to false economies.

Rebates are intended to reduce net drug program costs and their impact can be substantial (HCFA, 1995). However, instead of maximizing rebates, the emphasis should be on minimizing total costs (PBM News, 2000). Although a 20% rebate may seem attractive, that level of rebate applied to a brand name prescription that averages $50 yields a net price of $40, considerably more than the average price of a generic drug at approximately $17. If rebates detract from the most cost-effective drug choices, they may lead to false economies.

Since rebates are usually associated with newer, brand name drugs, they continue to foster a mind set that focuses on newer, typically more expensive brand name drugs and may lead to less emphasis on the most cost effective therapies.

Cost Sharing—Copayments

Cost sharing in prescription drug programs require consumers to pay a portion of the cost of each prescription. As a cost control effort, they are targeted toward consumers in an attempt to shift responsibility for the cost of use and raise consumer awareness about the costs of their drug use.

Copayments require consumers to pay a fixed dollar amount each time they get a prescription filled. Differential brand/generic copayments require higher copays on prescriptions for brand names and lower amounts on generics. Some plans include an additional third tier of copayment for non-formulary (non-preferred) drugs. The third tier copayments are the highest, often sizably more than the brand name copayment, since non-preferred drugs are typically brand names without rebates.

Research shows that copayments can reduce the number of prescriptions used, thus reducing expenditures. The effects vary, however, across different types of drugs (Nelson et al., 1984; Reeder & Nelson, 1985; Reeder et al., 1993). In one study of Medicaid beneficiaries, copayments were less effective in reducing drug use than limiting paid prescriptions to three per month (Soumerai et al., 1987). One study showed a $3 to $5 copayment was associated with a 5% reduction in the number of prescriptions, but the average ingredient cost increased, offsetting the decrease in use (Smith, 1993). In another study, when the consumer's copayment was the full cost difference between the brand name and the generic drug, the proportion of generic drugs dispensed increased (Ganther, 1996).

Copayments are currently the most common cost sharing requirement in prescription drug plans. In one report, the average copayment was $6.17 for generics, $9.65 for brand names, and $13.77 for non-formulary brand names (Novartis, 1999). About 70% of HMOs have a three-tiered system, with $5, $15, and $25 copayments respectively for generics, brand names, and non-formulary drugs (PBM News, 1999).

The effect of tiered copayments has been to increase the cost share paid by consumers and, thus, reduce program costs. One report suggested that moving from a $5/$10 copayment structure to a three-tiered $5/$10/$25 structure could save between 7% and 8% of a health plan's overall drug costs (Express Scripts, 2000).

However, as their costs rise, consumers may be discouraged from obtaining important prescriptions or refills, potentially increasing other health care use. Overall health costs may increase if higher copayments drive use to lower cost drugs when more costly drugs actually are more effective or cost effective.

Cost Sharing—Coinsurance

With coinsurance cost sharing, consumers pay a percentage of the cost of each prescription dispensed. The coinsurance percent typically is fixed and does not vary by the type of drug dispensed (brand name, generic, or non-formulary). As the cost of the prescription increases, the amount of cost share also increases. This direct correlation between the drug used and the amount the patient pays out-of-pocket, contrasts with a copayment where the out-of-pocket cost is constant for a given drug type, (e.g., generic) regardless of actual cost.

Coinsurance alerts consumers to differences in drug costs and can drive drug costs down.

Since the amount of cost sharing per prescription varies based on the cost of the drug, coinsurance can alert consumers to differences in drug costs, provided the coinsurance rate is high enough. Conceivably, this consumer awareness could drive drug use to lower cost (generic or older) drugs.

A 1998 survey of 375 employers using PBMs found about 30% of employers had a coinsurance requirement for their prescription drug coverage (Wyeth-Ayerst 1999). The coinsurance rate for most of those employers was 20%. About a quarter of these employers required different coinsurance rates for brand name and generic drugs.

Coinsurance allows consumers to be more aware of the differences in costs of drugs they use. As the cost of a prescription goes up, the amount paid by the consumer increases. People who use more expensive drugs pay more than those who use less expensive drugs, such as generics. However, not knowing what the cost share will be for each prescription can make cost sharing less appealing to consumers and benefit managers than the more familiar copayments. Also, if more costly drugs are more effective, coinsurance may drive use to less effective drugs which actually could result in higher overall health costs.

Formularies

A formulary is a list of covered or reimbursable drugs. An open formulary includes all drugs. A closed or restricted formulary only covers listed drugs. Closed formularies may vary in breadth, ranging from including only one select drug within a therapeutic category or drug group to including multiple drugs within a category or group. A preferred or partially restricted/closed formulary specifies the drugs covered, but allows exceptions to the list, usually with increased cost sharing or prior authorization.

A survey of employers found most (80%) have open formularies, with only 10% having either a closed or preferred formulary (Wyeth-Ayerst 1999). One possible explanation for the low use of closed formularies was that employers value rebates less than unrestricted access and the satisfaction of their beneficiaries.

Formularies can reduce program costs if high cost drugs are omitted from formularies, or if the formulary is associated with tiered copayments and/or rebates. At the same time, formularies may create unintended consequences. If changes are made in the drugs that are included or preferred on the formulary, switches in drug therapy can occur. Switches or interruptions in therapy have implications for therapeutic outcomes (both good and bad). Formulary changes also generate the possibility of disgruntled prescribers, patients, and pharmacists who have to deal with switching drugs and therapies. Formularies also may affect therapeutic outcomes by restricting access to drugs that might be optimum for some patients.

Disease Management (DM) Programs

Disease management is identifying patients with specific medical conditions and providing intensive care and monitoring of drug use and effects. The goal is to maximize drug therapy effectiveness and minimize total treatment costs of the disease. Appropriate drug use is emphasized by educating patients and encouraging their compliance with the prescribed dosage. The target of disease management programs is the consumer and pharmacists may be paid separate service fees to educate consumers, in attempts to improve their drug use.

Results from a survey of PBMs, HMOs, and employers found that 75% of PBMs offered disease management programs in 1998 (Novartis, 1998). Overall, 76% of HMOs reported having disease management programs in place, particularly in asthma, diabetes, congestive heart failure, gastrointestinal disorders, and high cholesterol.

Conceptually, the idea of combining enhanced health outcomes and better disease control for patients with reduced overall health care spending is appealing. However, drug costs can increase because patients who comply with the recommended dose may use more drugs. Because disease management programs focus on maximizing outcomes, the therapeutic enhancements offered by new drugs are emphasized, resulting in increased use of newer drugs. Critics of disease management programs say they merely are veiled efforts to increase use of manufacturers' products. Few evaluations of the effects of these programs are available.

Disease management programs can result in increased use of newer drugs.

Mail Service Prescriptions

Consumers may be encouraged or required to use mail service pharmacies, especially for prescriptions for long-term, chronic therapy. Mail service pharmacies generally offer deeper discounted pricing for prescription dispensing (Wertheimer & Andrews, 1995). Although a higher copayment is typically charged, larger quantities of drug are dispensed. This results in a lower overall consumer cost than the multiple monthly copayments required for the same quantity of drug.

The proportion of health plans and employers that include mail service in their drug benefit is increasing (Novartis, 1999; Wyeth-Ayerst, 1999). For HMOs, mail service prescriptions were 5.6% of prescriptions and 8.8% of the total drug budget in 1998 (Novartis, 1999).

Problems associated with mail service pharmacy include shortcomings in professional services available, lack of face-to-face communication and patient consultation, consumers forced into receiving medications by mail, delays in receipt of medications, and the stability and integrity of mailed drugs (Ghoshal, 1996-97; Hadzija & Shrewsbury, 1999). From a consumer perspective, research has found patrons of mail service pharmacies are satisfied with services and specifically with the financial aspects and technical quality of services (Birtcher & Shepherd, 1992; Johnson et al., 1997). An additional issue is ownership of mail service pharmacies by PBMs and the potential to steer prescription business to themselves through their mail subsidiaries.

Drug Utilization Review

Drug utilization review (DUR) is a process of evaluating drug use to identify and intervene to correct drug use problems. One goal can be to reduce costs associated with inappropriate prescribing and use of drugs. Another goal is to improve patient health through proper use of drugs. Retrospective DUR can review past claims and usage for patterns of misuse. When misuse is found, interventions can attempt to change future prescriptions or educate patients about compliance with the recommended dosage. DUR also can be used when drugs are dispensed to assess all the drugs in the pharmacy or PBM records. This concurrent DUR relies on computer programs which check for drug interactions, patient overuse or underuse, or drugs that may be inappropriate given the patient's condition, alerting the dispensing pharmacist if problems are found. Concurrent DUR generally is part of an on-line claims adjudication process.

Nearly all PBMs offer DUR. Concurrent DUR is more popular than retrospective DUR among both HMOs and employers. The percent of employers using PBM concurrent DUR increased from 65% in 1996 to 76% in 1998 (Wyeth-Ayerst, 1999). Among HMOs, the most common alerts were for early refills, use of nonformulary drugs, drug interactions, prior authorization notices, and inappropriate pharmacy reimbursement (Novartis, 1998).

Reviews of DUR studies in outpatient settings have shown both quality and cost improvements (Kreling & Mott, 1993; Kozma et al., 1993). To the extent that DUR can avoid interactions and duplication, it can save money. Concurrent DUR also can alert pharmacists to potential switches to formulary drugs, and thus steer drug use to preferred or less costly products. If under-utilization is corrected after DUR, drug program costs can increase, with potential paybacks in other areas if the disease is better controlled and other costs are avoided. In spite of concerns, most experts probably would agree that DUR has been a positive component of PBM drug programs.

Drug utilization review can improve the quality of drug use and cut costs.

Conclusion

PBMs would not use cost control strategies if there was not some belief they could be effective. Theory and logic suggest the techniques used should work, and some successes have been supported by research. However, prescription expenses continue to increase and have been the most rapidly growing component of health care in recent years. This suggests that cost control mechanisms have not been as successful as desired, or that successes have been overshadowed by other factors.

Table 1. Summary of PBM Cost Control Strategies and Effects

This table summarizes several containment techniques and their potential consequences. The effects column indicates whether the effects are positive (+) and/or negative (-) and the degree of effect is indicated by the number of +/- signs. Questionable or uncertain impacts are noted with a question mark (?).

Technique	Target	Effect(s)	Potential Consequences
Negotiated Prices			
Reduced reimbursement	Pharmacies	+/-	Price for a given prescription is reduced; May reduce access to pharmacies if discounts require restricting the pharmacy network; Increased efficiency (speed) in dispensing may reduce patient contact and de-emphasize evaluation of the prescription and drug use for appropriateness and cost savings.
Generic Substitution			
Increased dispensing fees for generic drugs, MAC programs, and/or dispensing rate incentives	Pharmacies	++/?	Decreased cost (increased dispensing of lower cost generic drugs generally exceeds amounts spent on higher dispensing fees and/or incentives); High rates of generic dispensing on suitable prescriptions (from MAC and incentives), but limited by the extent of prescribing for suitable (multisource) drugs; Differential fees or incentives too small to motivate serious pharmacist effort?
Differential copayments for generic and brand name drugs; generic copays lower	Consumers	+++/?	Increased acceptance and use of generic drugs; More program cost paid by consumers; Relatively low difference in copayments may limit response; Low difference in copayments can reduce consumer awareness of real cost of brand name vs. generic drug use.
Rebates			
Money returned by drug manufacturers based on volume of use or market share	Pharmaceutical Manufacturers	+/-	Ultimately lower program cost for rebated drug; When combined with other incentives, increased use of rebated drugs; May overlook total cost picture since brand name drugs are emphasized for rebates.

Technique	Target	Effect(s)	Potential Consequences
Copayments			
Increased copayment amounts overall - a fixed dollar amount for each prescription filled	Consumers	+/?	Increased consumer sensitivity to their drug use; Shifts additional cost to the consumer for each prescription; Increased out-of-pocket expenses can affect consumer perceptions of quality of their prescription benefit.
Three-tiered copayments - dollar amount paid by the consumer for generic vs. brand vs. non-formulary/non-preferred	Consumers	+++/-	Increased use of formulary or preferred drugs; More program cost paid by consumers; Increased consumer awareness of the cost of their drug use; Continues emphasis on brand name (rebated/formulary) drugs; Increased consumer cost can reduce use of high cost drugs; if they are more effective or cost-effective, overall health costs can increase.
Coinsurance			
Consumer pays a percentage of each drug use	Consumers	+++/-	Increased consumer awareness of the cost of their drug use because of the direct relationship between resource use and out-of-pocket cost; More program cost paid by consumer (depending on coinsurance rate); The unpredictability of consumer costs may be unacceptable; Consumers may avoid high cost drugs even when they are more effective or cost-effective.
Formularies			
A list of covered or reimbursable drugs	Consumers (and prescribers/ pharmacists)	+/-	Increased use of desired drugs (formulary/preferred); Decreased program costs are possible if combined with rebates or tiered cost sharing; Can retain a focus on brand name drugs which can divert attention from the total cost picture; If restrictiveness reduces access to cost effective drugs, can increase overall costs; Changes in formularies can cause therapy interruptions/switches and require extra efforts by pharmacists and prescribers.

Technique	Target	Effect(s)	Potential Consequences
Disease Management Programs			
Educating patients with specific medical conditions to improve their drug use	Pharmacists and Consumers (and prescribers)	+/-?	Increased appropriateness of drug use (and decreased overall health care costs?); Can increase drug use and drug program cost; Increased pharmacist effort (and patient time) and expense.
Mail Service Prescriptions			
Mail service prescriptions often for long-term chronic therapy	Consumers	+/-	Decreased cost for prescriptions (deeper discounts, but may be balanced by larger quantities dispensed and fewer copayments); Increased convenience for consumers; Delay in receipt of prescriptions can cause therapy interruptions; Decreased direct pharmacist interaction and patient consultation.
Drug Utilization Review (DUR)			
Evaluating drug use to correct drug use problems	Pharmacists, Prescribers, and Consumers	++/-?	Increased appropriateness of drug use (decreased duplications, interactions, increased formulary/preferred drugs); Can decrease access and interrupt therapy (if overutilization screens are too sensitive); Increased pharmacist time to respond to alerts and prescriber time for therapy changes.

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How 14 States Have Designed Pharmacy Assistance Programs

by John Hansen

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

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

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

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

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

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

Which States Were Involved in the Study?

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

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

How Have States Established Eligibility?

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

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

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

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

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

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

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

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

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

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

How Large Were the State Programs?

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

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

Did States Restrict the Type of Drugs Covered?

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

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

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

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

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

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

Did States Require Program Participants to Share in the Cost?

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

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

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

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

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

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

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

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

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

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

How Were the Programs Funded?

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

Table 4. Funding Sources for State Pharmacy Assistance Programs

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

Source: State programs

Did States Get Manufacturer Rebates?

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

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

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

How Were the Programs Administered?

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

Nine of the 14 states administer their programs through the agency administering Medicaid.

Table 5. Administrative Information on State Pharmacy Assistance Programs

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

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

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

Some legislatures intentionally separated their drug assistance programs from Medicaid to avoid perceived stigma.

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

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

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

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

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

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

Conclusion

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

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

This chapter was adapted from a larger report, "State Pharmacy Programs Assistance Designed to Target Coverage and Stretch Budgets." —Report NO. HEHS—00-162.

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State Senior Pharmaceutical Assistance Programs

by the National Conference of State Legislatures

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

A growing number of states have established programs to provide pharmaceutical coverage or assistance, primarily to low-income elderly or persons with disabilities who do not qualify for Medicaid. Most programs utilize state funds to subsidize a portion of the costs, usually for a defined population that meets enrollment criteria.

Growing Numbers

As of January 2001, a total of twenty-six states have authorized some type of pharmaceutical assistance program; twenty-two states have enacted laws to create programs, four others are by executive branch action only. To date, twenty-four state programs are in operation; Kansas has an enacted law and Iowa has an agency program that is not yet in operation. Twenty states provide a direct subsidy using state funds. Missouri provides a subsidy only by a year-end tax credit. Five additional states have recently created programs that offer a discount only (no subsidy) for eligible or enrolled seniors: California, Iowa, New Hampshire, Washington, and West Virginia.

Recent Activity

The newest programs began operation in December 2000 and January 2001 in Florida, Nevada, South Carolina, Washington and West Virginia. During the 2000 legislative session, Indiana enacted a new program in March; a Kansas program was authorized in May and a Florida program was signed into law in June. The South Carolina legislature passed a similar program in an appropriation bill. Major expansions in eligibility were enacted in several states including Illinois, Massachusetts, New York, and Rhode Island; generally these changes take effect in 2001.

Table 1 provides profiles on each of the individual state subsidy programs, including state law citations. Note that several states have more than one program. The table also includes the year of creation, basic eligibility requirements, and contact information within each state for further details. The National Conference of State Legislatures website, from which this chapter is drawn, is frequently updated (http://www.ncsl.org/programs/health/drugaid.htm). From this site, you can link to program descriptions and authorizing legislation in many of the states.

Table 1. Individual State Subsidy Programs

State	Program Name	Recipients*	Eligibility**	Year/Law Citation	Contact/Telephone/ Dates of Operation***
California	Discount Prescription Medication Program *(retail discounts via pharmacies)*	n/a* *(est. 1.3 million eligible)*	Medicare recipients, 65 or disabled; no income limit In effect: 2/1/2000	1999 SB 393	Dept. of Health Services (916)657-4213 HICAP: (800)434-0222
Connecticut	Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled Program (ConnPACE)	31,666* (FY'00)	Minimum age: 65 Single: $14,700 ('00) Married: $17,700 *($200 increase over '99)* Disabled: < age 18 on SSDP	1986 [§17b-491 et seq.]	CT Dept. of Social Services (860)832-9265
Delaware (1)	Delaware Prescription Drug Assistance Program (DPAP) In effect: 1/14/2000	2,539 (8/00)	Minimum age: 65 Single: $16,488 ('00) Married: $22,128 Disabled: eligible for SSDI	1999 (S. 6 of 1999) [Del.Code tit.16 §3001]	Division of Social Services (800)996-9969 ext. 17 (302)577-4900
Delaware (2)	Nemours Health Clinic Pharmaceutical Assistance Program	26,000 ('00)*	Minimum age: 65 Single: $12,500 ('00) Married: $17,125	1981 private initiative	(302)651-4405 (800)292-9538
Florida ***New***	Pharmaceutical Expense Assistance Program	n/a *(est. 30,000 eligible)*	Minimum age: 65 and Dually-Eligible Medicare-Medicaid Individual: $10,200 (90%-120% of FPL) effective 7/1/2000 *(part 2 is a discount program for 65 & over Medicare beneficiaries)*	2000 S 940 (signed by Governor, 6/8/2000)	Agency for Health Care Administration (850)414-8306 (888)419-3456 **Subsidy program effective date 1/1/01**

State	Program Name	Recipients*	Eligibility**	Year/Law Citation	Contact/Telephone/ Dates of Operation***
Illinois ***New***	Pharmaceutical Assistance Program	53,555*	Minimum age: 65 Single: $21,218 ('01) Married: $28,480 Disabled: over 16. (see Table 2 for expansion)	1985 [320 ILCS 25/4]	(217)524-0435 In IL: (800)624-2459 Dept. of Revenue
Indiana ***New***	Indiana Prescription Drug Fund "HoosierRx"	n/a *(est. 66,000 eligible)*	Minimum age: 65 Single: $11,280 Couple: $25,992 $20 million appropriated	2000 S. 108, § 6 (law signed 3/13/2000)	Law effective date 9/1/2000; 50% discount/ cash refunds available 10/1/2000)
Iowa	(see discounts, Table 2)	/	/	*(Not in law)*	
Kansas ***New***	Senior Pharmacy Assistance Program	n/a *(3,000 est. by 2001)*	Minimum age: 67 Single: $12,525 ('01) 150% of FPL Married: $16,875 *copayment: 30%*	2000 HB 2814 (signed 5/16/2000)	Effective date 7/1/2001 Dept. of Aging (785)296-1299 **Not yet operational**
Maine (1)	Low Cost Drugs for the Elderly Program	24,900 ('99)	Minimum age: 62 Single: $15,244 (1/00) Married: $20,461 Disabled: age 55 or over	1975 36 M.R.S. § 6161 - 6166	(888)600-2466 (207)287-2674
Maine (2) ***New***	Maine Rx Program (discount prices, based on Medicaid & manufacturer rebates)	n/a* *(325,000 estimated eligible in '01)*	Minimum age: none All Maine residents with an Rx enrollment card	2000 S.1026; Chapter 786, §2681 (signed 5/11/2000)	Law provides for operation to begin 1/1/2001; delayed to 4/1/01. Bureau of Medical Services

State	Program Name	Recipients*	Eligibility**	Year/Law Citation	Contact/Telephone/ Dates of Operation***
Maryland (1)	Maryland Pharmacy Assistance Program	34,000* ('00) *Budget $37.3M*	Minimum age: no limit Single: $9,650 ('00) Married: $10,450 Disabled: yes No limitation by age or medical condition. $3750 max. assets	1979 [Health-General §15-124]	(410)767-5394 (800)492-1974
Maryland (2) ***New***	Short-Term Prescription Drug Subsidy Plan (limited to residents of 17 underserved counties)	1,004 (9/00)	Minimum age: 65 & eligible for Medicare+Choice; $460 annual premium; $1000 annual benefit limit	2000 S.855; Chapter 565 (signed 5/18/2000)	Law effective 7/1/2000 Sec. Of Health & Mental Hygiene
Massachu-setts (1)	The Pharmacy Program *formerly Senior Pharmacy Assistance Program*	62,600 (9/2000)	Minimum age: 65 Single: $15,708 ('00) Married: $21,156 *see Massachusetts (3) for 2001 expansions*	1996 [Ch. 118E, §16B & Ch. 170 of 1997]	Exec. Office of Elder Affairs (800)243-4636 (617)727-7750
Massachu-setts (2)	Pharmacy Program Plus *In effect Jan. 2000 to Dec. 31, 2000 only*	7,170* (9/2000)	Minimum age: 65 Single: $41,220 Married: $55,320 *Over 10% of income spent on prescription drugs for 3 months.* Disabled: Recipients of SSI/SSDI or Medicare	1999 H.4900 Chapter 127 of 1999 see §213	Exec. Office of Elder Affairs (800)243-4636 (617)727-7750
Massachu-setts (3) ***New***	Subsidized Catastrophic Prescription Drug Insurance Program (intended to replace Senior Pharmacy programs #1 & #2 above in 2001)	n/a*	Minimum age: 65 No upper income limit; No premium or deductibles under 188% of FPL ($15,698). Disabled: $15,698	2000 Sec. 46 of H.5300 enacted 7/28/2000	Not yet operational (Goes into effect 4/1/2001)

State	Program Name	Recipients*	Eligibility**	Year/Law Citation	Contact/Telephone/ Dates of Operation***
Michigan (1)	Michigan Emergency Pharmaceutical Program for Seniors (MEPPS)	12,968 ('99)	Minimum age: 65 Single: $12,360/year ('99) Married: $15,921/year	1988 & 1994	Office of Services to the Aging (517)373-8230
Michigan (2)	State Medical Program ------- *Elder Prescription Insurance Coverage (EPIC) Program*	20,000	Minimum age: none Single: $246/month Family: $401/month	1988 ------- *EPIC: 1999*	MI Dept. of Community Health ------- *EPIC implementation 1/1/2001*
Minnesota	Senior Citizen Drug Program In effect Jan. 1999	5,000	Minimum age: 65 Single: $10,260, *assets under $10,000 (10/00)* Married: $13,740	1997 - Chapter 225, Art 4 [Statute §256.955]	(651)297-3462 (651)296-6627
Missouri	State income tax credit for legend (prescription) drugs In effect Aug. 1999	See note below	Minimum age: 65 Single: up to $15,000 = $200 credit. Credit reduced by $2 for each $100 income.	1999 S14	Dept. of Revenue (573)751-4081
Nevada	SenioRx Insurance	0 n/a	Minimum age: 62 Family: $21,500 ('00) sliding scale co-pays over $12,700 (subsidy for prescription drugs private insurance policies; uses tobacco funds)	1999-A.474 (Ch.538, § 10, signed 6/9/99)	Aging Services Division, DHR (775)688-2964 (702)486-3545 Operational as of 1/1/2001

State	Program Name	Recipients*	Eligibility**	Year/Law Citation	Contact/Telephone/ Dates of Operation***
New Hampshire	(see discounts, Table 2)	/		(not in law)	
New Jersey	PAAD - Pharmaceutical Assistance for the Aged and Disabled	188,000* (9/00) *(includes 163,958 aged + 23,400 disabled)*	Minimum age: 65 Single: $18,587('00) Married: $22,791 Disabled: age 21	1975 [Ch.30: 4D-20 et seq.]	(609)588-7048 In NJ: (800)792-9745
New York	EPIC - Elderly Pharmaceutical Insurance Coverage	117,000 (5/00)	Minimum age: 65 Single: $18,500 ('00) Married: $24,400 (will expand 1/2001 to: Single: $35,000 Married: $50,000)	1987 law [Executive 19-K §547 et seq.]	(518)452-6828 In NY: (800)332-3742
North Carolina	Prescription Drug Assistance Program *(pilot program in 30 counties until 6/30/00; statewide as of 7/1/00)*	2,500 (9/00)	Minimum Age: 65 Single: $12,360 ('00) 150% of FPL For persons diagnosed with heart disease or diabetes	1999 - H 168 [Part XI of Chapter 237 of 1999]	Public Health Dept. (919)715-3338 Began operation May 2000
Pennsylvania (1)	PACE - Pharmaceutical Assistance for the Elderly	208,000 (12/00)	Minimum age: 65 Single: $14,000 ('01) Married: $17,200	1984, P.L.351, No. 91 §502 [72 PS §3761-501 to 709]	PA Dept. of Aging 717-652-9028 In PA: (800)225-7223
Pennsylvania (2)	PACENET - PACE Needs Enhancement Tier	22,000 (12/00)	Minimum age: 65 Single: $16,000 ('01) Married: to $19,200	1996 P.L. 741, No. 134	PA Dept. of Aging (717)652-9028 In PA: (800)225-7223

State	Program Name	Recipients*	Eligibility**	Year/Law Citation	Contact/Telephone/ Dates of Operation***
Rhode Island	RIPAE - Rhode Island Pharmaceutical Assistance for the Elderly	31,000 (9/99)	Minimum age: 65 Single: $15,558 ('00) Married: $19,449 *Excludes income spent on medication if greater than 3% of total income.* Single: $34,999 ('01) Couple: $39,000 ('01)	1985 [§42-66.2 - 5] 2000 expansion	Dept. of Elderly Affairs (401)222-2858 (800)322-2880
South Carolina ***New***	SilverxCard - Seniors' Prescription Drug Program	34,000 (1/5/01)	Minimum age: 65 Single: $14,612 ('00) Married: $19,678	2000 H.3699 became law 5/19/2000	Office of Insurance Services (877)239-5277 (803)734-1061 **Operational as of 1/1/2001**
Vermont (1)	VHAP - Vermont Health Access Program (Medicaid funded via 1115 waiver)	7,303*	Minimum age: 65 Single: $12,360 ('99) Married: $16,590 Disabled: Recipients of disability benefits through SS or Medicare	1996 [Act 14 of 1996, §14 + HCFA 1115 waiver]	(800)529-4060
Vermont (1a) ***New***	Pharmacy Discount Program (PDP) - expansion of VHAP, above (provides retail discount only; no state subsidy)	200* (as of 1/3/01) (est. eligible 69,000)	Minimum age: none any Medicare-covered individual; others w/o coverage Single: $25,056 Couple: $33,756	2000: H 842 section 117	Operational as of 1/1/2001
Vermont (2)	VSCRIPT	2,125*	Minimum age: 65 Single: $18,540 ('00) Married: $24,885 225% of FPL Disabled: Recipients of disability benefits through Social Security	1989 [33 VSA §§1991-1994] as expanded by §122-123 of Act 62 of 1999]	(800)529-4060

State	Program Name	Recipients*	Eligibility**	Year/Law Citation	Contact/Telephone/ Dates of Operation***
Washington	(see discounts, Table 2)	/	/	/	/
West Virginia	(see discounts, Table 2)	/	/	/	/
Wyoming	Minimum Medical Program	550* (1/00)	Minimum age: no limit Income: $8350; *100% of federal poverty level. ('00)*	1988 [Dept. of Health Regula-tions]	Dept. of Health/ Medicaid 307-777-7531 307-777-6032 800-442-2766

* = program includes adult disabled; ** = age & maximum income (year); *** = dates of operation for new programs are based on statute; actual implementation schedules may vary based on agency administrative practices.
New = Year 2000 or 2001
FPL= Federal Poverty Level
N/A = Not available

These recently created programs provide for a reduced or discounted retail price for eligible participants, but do not provide a state subsidy for the purchase of prescription drugs. In a few states, discount programs have been added to or integrated with subsidy programs. For examples, see Maine and Vermont in Table 1 above.

Table 2. State Agency Pharmaceutical Discount Programs (In Operation)

State	Discount Program Name	Recipients*	Eligibility**	Year/Law Citation or Authority	Contact/Telephone/-Dates of Operation***
California	*(see description in Table 1)*	-	-	*1999 (see Table 1)*	-
Florida	Prescription Discount Program *(also see description in Table 1)*	n/a enrollment not required	Any Medicare beneficiary 65 or over. *Discounts based on Medicaid provided by retail pharmacies.*	*2000 (see Table 1)*	7/1/00
Iowa	Iowa Pharmacy Cooperative Discounts only	*300 in 1st week*	(regulations on eligibility not finalized)	*(not in law)*	Iowa Dept of Elder Affairs (515)242-3333 (866)282-5817 **Not yet operational-7/1/2001**
Maine (3) ***New***	Medicaid waiver discount program	n/a *(est. 225,000 eligible)*	Income limit: Medicare enrollees up to 300% of FPL	*(not in law)*	HCFA granted Medicaid waiver, 1/19/2001 **Not yet operational**
New Hampshire	New Hampshire Senior Prescription Drug Discount Program	75,000 (est.)	Minimum age: 65 No income limit No enrollment fee	*(not in law)*	Division of Elderly and Adult Services (800)351-1888 Pilot program operational 1/2000
Vermont	Pharmacy Discount Program (PDP)		(see descriptions in Table 1)		
Washington	A Washington Alliance to Reduce Prescription-Drug Spending (AWARDS) (retail discount only)	/	Minimum age: 55 No income limit $15 annual enrollment charge	*(not in law) Exec. order 00-04 WAC 246-30*	(court challenge pending) **Operational as of 1/15/2001**
West Virginia	SPAN II (retail discount only)	2,000 (1/5/01)	Minimum age: Medicare eligible Income: $25,050 Couple: $33,750 (Enrollment opened on Nov. 1, 2000) No enrollment fee	*(not in law) Executive order 20-00 signed 10/18/00.*	Toll-free (877)987-4463 **Operational as of 12/15/2000**

* = program includes adult disabled; ** = age & maximum income (year); *** = dates of operation for new programs are based on statute; actual implementation schedules may vary based on agency administrative practices.

Eligibility standards

The figures listed in these tables are based on language in state statutes or other state regulations. They are examples of the scope of individual programs; they are not intended as full descriptions of eligibility requirements for individuals. Please consult state program administrators for additional details and conditions.

State Pharmaceutical Assistance and Tobacco Funds

The availability of tobacco settlement funds for year 2000 was a substantial factor in stimulating discussion and legislative activity relating to prescription drug subsidies. The following states appropriated tobacco settlement funds toward state Senior Pharmaceutical Assistance programs in 1999-2000.

- Delaware (S 420 of 2000; S. 6 of 1999) $7.5 million.
- Illinois (HB 3872, HB 4437 of 2000); $35 million appropriated.
- Indiana (S 108 of 2000) $20 million Maine (LD 2510) $10 million for expanded coverage.
- Massachusetts (H5300, sec 46(b) of 2000) $10 million - original 1996 program used tobacco tax revenue.
- Michigan - FY2001 budget - $33 million for prescription drugs for seniors (signed 7/2000).
- Nevada (Ch 538 of 1999) - 15% of total available revenue.
- New Jersey (S2000 of 2000; $29 million in FY 2000; $38 million in FY2001, of which $25 million is authorized in FY 2001 budget).
- New York- $55.7 million for FY2001 for expansion of EPIC; funds reduce the cost of drugs and expand the program.
- Ohio earmarked up to $12 million for a future emergency elderly prescription drug benefit.

Several other states expanded health services for seniors or low income populations, without earmarking the funds to a specific pharmaceutical assistance program.

Recent Legislative Activity

During 1999-2000, almost half of the states passed legislation pertaining to senior pharmacy programs. State legislation is summarized by the NCSL and most bills can be accessed through the NCSL website.

Compiled by Richard Cauchi, Senior Policy Specialist, National Conference on State Legislatures, Health Care Program, Denver, Colorado. Cauchi's contact information can be found on page 48.

This information was accessed through the National Conference on State Legislatures website on February 14, 2001.

Wisconsin Medicaid's Pharmacy Program

Summarized by James Vavra,
Division of Health Care Financing
Department of Health and Family Services

Program Summary

Under current law, Wisconsin Medicaid covers legend (prescription) drugs and over-the-counter drugs and supplies listed in the Wisconsin drug index. A licensed physician, dentist, podiatrist, nurse prescriber, or optometrist can prescribe these drugs. In addition, physicians may delegate prescription authority to a nurse practitioner or physician assistant.

Wisconsin Medicaid has an open drug formulary. That means legend drugs are covered if they meet all the following criteria:

- They are FDA approved
- The manufacturer signed a rebate agreement with the Health Care Financing Administration
- The manufacturer has reported data and prices to First DataBank

Medicaid reimbursement for legend drugs is the lesser of:

- Average wholesale price (AWP) as defined by First DataBank minus 10% plus a dispensing fee. This applies to most brand drugs.
- Maximum allowed cost (MAC) plus a dispensing fee. This applies to multi-source branded and generic drugs.
- Usual and customary amount as billed by the pharmacy to private pay clients.

Wisconsin Medicaid reimburses many over-the-counter (OTC) generic drugs. Covered OTCs are reimbursed using the same formulas as legend drugs.

Reimbursement for legend drugs may have certain restrictions such as:

- Prior Authorization. Less than 1% of the covered drugs require prior authorization.
- Diagnosis Restriction. Exclusion or otherwise restricted coverage if the prescribed use is not for a medically accepted indication.

Certain drugs may be excluded from coverage and are on the Medicaid Negative Formulary drug list. These include drugs that are:

- Less-than-effective as defined by the FDA.
- Experimental or have no medically accepted indications.

Wisconsin Medicaid has some offsets to Medicaid reimbursement. These are:

- Copayments from recipients. Recipients pay $1.00/legend drug prescription/month to a maximum of $5.00/month/provider and $.50/ OTC prescription. Children and nursing home residents are exempt from copayment.
- Manufacturer drug rebates. Under federal law, manufacturers must pay state Medicaid programs a rebate of at least 15.1% for brand drugs and 11% for generic drugs in order to have their drugs covered. Wisconsin Medicaid collected $58.6 million for drug rebates in FY 2000. This is about 18.1% of pharmacy expenditures.

Wisconsin Medicaid collected $58.6 million for drug rebates in 2000.

Wisconsin Specific Drug Programs

Wisconsin has implemented a number of innovative, cost-effective, quality measures to enhance the Medicaid pharmacy program. These include:

- The MAC list.
- Selective Use of Prior Authorization.
- Pharmaceutical Care.
- Point-of-Sale Claim Submission.
- Drug Utilization Review.

Each of these measures is described in further detail below.

The MAC List

The federal Department of Health and Human Services, Health Care Financing Administration (HCFA) issues a drug list at least two times a year. This list includes drugs that are available generically from at least three companies as well as a recommended maximum allowed cost (MAC). In addition, states may have their own MAC lists and set prices differently from the HCFA issued prices as long as the overall amount spent for generic drugs is no more than it would have been using the HCFA prices. Wisconsin Medicaid issues its MAC list quarterly and has one of the most extensive MAC lists in the country. If a product is available generically, Wisconsin generally adds it to the state's MAC list. Maximum prices allowed are based on prices for which drugs are readily available through wholesalers in Wisconsin. When a drug is on the MAC list, Wisconsin will only reimburse the generic price unless the prescriber writes "brand medically necessary" on the prescription. Because Wisconsin's MAC list is more extensive than HCFA's, the savings to the state are considerably higher than they would be using the HCFA list alone.

Selective Use of Prior Authorization (PA)

Under prior authorization requirements (PA), Wisconsin requires pharmacists to receive approval of certain drugs from the Department of Health and Family Services (DHFS) before they may be reimbursed. This may be done electronically for most drugs requiring PA. Wisconsin requires drug prior authorization for the following reasons:

- Potential drug abuse or misuse
- Cosmetic use only (for example, weight-loss drugs not used to treat morbid obesity)
- To encourage use of therapeutically equivalent drugs when generics are available in that classification. This is known as targeted use of PA.

Targeted use of PA has been shown to slow the rate of increase in drug expenditures without impeding access to necessary and appropriate drugs. Categories of drugs are reviewed for similar products, some of which are available generically and some only brand. When this situation exists, Wisconsin may recommend requiring PA for the brand drug and not the generic to encourage the use of less costly but equally effective generic drugs. This assures high quality to our recipients. Before any changes are made to the PA requirements, drug manufacturers are notified and a review process previously agreed to by them is followed.

Wisconsin's experience shows that prior authorization can slow the rate of increase in drug expenditures.

Wisconsin's experience with implementing PA requirements for certain ulcer treatment drugs demonstrates that using PA can slow the rate of increase in drug expenditures. For example, on September 22, 1999, Wisconsin removed the PA requirement for two generic Histamine-2 ulcer-treatment drugs, Ranitidine and Cimetidine. However, Wisconsin continued to require PA for certain brand name Histamine-2 ulcer-treatment drugs, namely, Axid and Pepcid. In order to receive PA approval for Axid and Pepcid, a patient must have tried and failed Ranitidine or Cimetidine for 30 days, or had an adverse reaction. Since this change, prescriptions and expenditures for the brand name drugs have dropped by over 65%. Total expenditures in this category only rose by 1.4% from SFY 99 to SFY 00 despite an 11.9% increase in overall prescription volume. Further, this change resulted in a greater than 66% shift in the use of brand name ulcer drugs to generic and a savings of over $1 million in the first year.

Other categories of drugs where Wisconsin has used a similar PA approach include:

- Brand name non-steroidal anti-inflammatory drugs (NSAIDs), effective July 15, 2000. Generic NSAIDs do not require PA. These drugs are used to treat pain symptoms.
- Certain brand name ACE Inhibitor drugs, effective August 15, 2000. These drugs are used to treat high blood pressure. The scientific literature indicates that all long-acting ACE Inhibitors are therapeutically equivalent.

Pharmaceutical Care

Under 1995 Wisconsin Act 27, the biennial budget, Wisconsin Medicaid was required to develop an incentive based pharmacy payment system that pays for pharmaceutical care (PC) services.

Pharmaceutical care is a nationwide movement promoting a patient-centered, outcomes oriented practice of pharmacy. Its purpose is to maximize the effectiveness of medications for the patient through intervention by the pharmacist.

Wisconsin's pharmaceutical care program provides pharmacists with an enhanced dispensing fee for pharmaceutical care services given to Medicaid fee-for-service recipients. This enhanced fee reimburses pharmacists for additional actions they take beyond the standard dispensing and counseling for a prescription drug. Under managed care, each HMO develops its own policy regarding drug prices, dispensing fees, and whether to pay for pharmaceutical care services.

Drug reimbursement includes both a drug price and dispensing fee. Pharmaceutical care does not affect drug prices. However, the methodology for determining the dispensing fee changes under pharmaceutical care. An enhanced pharmaceutical care dispensing fee requires the pharmacist to meet all basic requirements of federal and state law for dispensing a drug plus completing specified activities that result in a positive outcome both for the recipients and the Medicaid program. Pharmacies may receive an enhanced PC dispensing fee only when their service increases patient compliance or prevents potential adverse drug problems.

Pharmacies may receive enhanced dispensing fees only when their service increases patient compliance or prevents drug problems.

An Example of Pharmaceutical Care

A recipient asks the pharmacist for a refill of a current prescription on a date almost two weeks after the normal refill date. This may indicate that the recipient is non-compliant in his or her use of the prescribed medication and is taking an insufficient dose to deal with the indicated medical problem. The pharmacist:

- Notes that a prescription refill order is greater than one week late.
- Asks the recipient why the prescription is being refilled late. The recipient says he sometimes forgets to take the medicine.
- Educates the recipient on the need for compliance with the dosing schedule for taking the medication.
- Alternatively, recommends to the recipient that, if the physician agrees, the current prescription may be changed to a higher strength, time-release formula. Time-release capsules need to be taken less frequently and, therefore, assure better and easier compliance.
- Contacts the physician concerning the compliance problem and recommends the time-release formula of the same prescription. The physician agrees, to assure compliance.
- Documents the intervention.

Since this intervention resulted in a positive outcome—improved compliance—the pharmacist may bill Medicaid.

On the other hand, if the patient had said they were late for their refill because they had seen their physician who changed the directions to half the original dose, the service would not be billable because there is no compliance problem.

Each claim submitted by a pharmacist for reimbursement for PC services must provide the Medicaid program with the following information:

- the reason for the intervention;
- the action taken by the pharmacist;
- the result of that action; and
- the level and complexity of the service provided by the pharmacist.

Pharmacy Point of Sale (POS)

Wisconsin Medicaid implemented a pharmacy point-of-sale (POS) electronic claims management system for Medicaid fee-for-service providers statewide beginning September 22, 1999. The POS system enables providers to submit real-time claims electronically for legend and over-the-counter drugs for immediate adjudication and eligibility verification. The real-time claims submission verifies recipient eligibility, including other health insurance coverage, and monitors Medicaid drug policies. Claims are also screened against recipient medical and prescription history within the Medicaid system. Once these processes are complete, the provider receives electronic response indicating payment or denial within seconds of submitting the real-time claim.

The following have occurred since the implementation of POS:

- POS has been a great success. It allows pharmacies to submit claims and receive notification of coverage before drugs are dispensed.
- Currently most of the state's 1200 pharmacies are participating in real-time transactions.
- As many as 30,000 real-time transactions are being processed every day.
- The average system response time is 0.4 seconds.
- 90-95% of all drug claims received by Medicaid are submitted real-time.
- Claims with "other health insurance" listed must be billed to that other insurance first. Before POS, Wisconsin did not cost-avoid. Wisconsin continues to be one of the few states in the country that denies claims up-front if records indicate the recipient has other health insurance that pays for drugs.
- Claims for the same drug on the same day by one recipient at different pharmacies are now denied since claims history is updated real-time and all Medicaid pharmacy claims are reviewed.

Wisconsin is one of few states that deny claims up-front if the recipient has other drug coverage.

Drug Utilization Review

The federal Omnibus Budget Reconciliation Act of 1990 (CFR Section 456.703-456.705) calls for a Drug Utilization Review (DUR) program for all Medicaid outpatient drugs in order to improve the quality and cost-effectiveness of recipient care. There are three components to the Medicaid DUR program: prospective DUR, retrospective DUR, and an educational program.

Prospective drug utilization review (DUR) screens certain drugs for potential problems before the prescription is dispensed.

Prospective DUR. The Medicaid prospective DUR system assists pharmacy providers in screening certain drug categories for clinically important potential drug therapy problems before the prescription is dispensed to the recipient. These problems include therapeutic duplication, drug/drug interactions, early and late refills, cumulative side effects, and drug contraindications for pregnancy, certain diseases, and specific ages. Wisconsin Medicaid's system provides the pharmacist with drug and medical information from most claims submitted to Medicaid regardless of its origin. Thus, pharmacists are provided with more complete information than they otherwise would be able to obtain. Prospective DUR enhances clinical quality and cost-effective drug use.

Retrospective DUR. The Medicaid retrospective DUR program provides for the ongoing periodic examination of paid claims data and other records in order to identify patterns of fraud, abuse, gross overuse or inappropriate or medically unnecessary care associated with specific drugs or groups of drugs. With the implementation of POS, Wisconsin Medicaid will continue to look for trend data among physicians and pharmacists through retrospective DUR.

Educational Program. The Department of Health and Family Services uses DUR program data to educate prescribers and dispensers on common drug therapy problems with the aim of improving prescribing and dispensing practices.

Individual pharmacies are responsible for prospective DUR. Wisconsin Medicaid is responsible for providing the retrospective DUR program and the educational program.

As required by the Omnibus Budget Reconciliation Act of 1990, a Medicaid DUR Board comprised of practicing physicians and pharmacists from around the state has been appointed to oversee the entire Medicaid DUR program. The Wisconsin Medicaid DUR Board reviews and approves all criteria used for both prospective and retrospective DUR.

Glossary

A-Rated Product A drug substitution approved by the Food and Drug Administration.

Brand Name Drug Generally, a drug product that is covered by a patent and thus is manufactured and sold exclusively by one firm. Cross licensing occasionally occurs, allowing an additional firm(s) to market the drug. After the patent expires, multiple firms can produce the drug product, but the brand name remains with the original manufacturer's product.

Coinsurance A cost-sharing requirement under a health insurance policy that requires the patient to pay a percentage of costs for covered services/prescriptions (e.g., 20% of the prescription price).

Copayment A cost-sharing requirement under a health insurance policy that requires the patient to pay a specified dollar amount for each unit of service (e.g., $10.00 for each prescription dispensed).

Detailing Personal selling activities by pharmaceutical manufacturer sales representatives. The representatives inform prescribers, pharmacists, and others about the specifics or details of their firms' products, thus the label "detailing." Sales representatives often leave samples of products for prescribers for trial use among their patients, to stimulate future prescribing.

Direct-to-Consumer Advertising/Promotion Advertising for prescription drugs in print, radio, and television media targeted directly to consumers by pharmaceutical manufacturers. Consumers are the targeted audience, even though prescription drugs require a prescription order from a prescriber in order to be dispensed.

Dispensing Fee An amount added to the prescription ingredient cost by a pharmacy to determine a prescription price. The dispensing fee represents the charge for the professional services provided by the pharmacist when dispensing a prescription (including overhead expenses and profit). Most direct pay insured prescription programs use dispensing fees to establish pharmacy payment for prescriptions.

Formulary A listing of drug products that may be dispensed or reimbursed (positive formulary) or that may not be dispensed or reimbursed (negative formulary). A government body, third-party insurer or health plan, or an institution may compile a formulary. Some institutions or health plans develop closed (i.e. restricted) formularies where only those drug products listed can be dispensed in that institution or reimbursed by the health plan. Other formularies may have no restrictions (open formulary) or may have certain restrictions such as higher patient cost-sharing requirements for off-formulary drugs.

Generic Drug A drug product that is no longer covered by patent protection and thus may be produced and/or distributed by many firms.

HCFA Federal Upper Limit (HCFA FUL) Amount established by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services as a target amount of payment for a drug in a state Medicaid Program.

Legend Drug A prescription drug.

Maximum Allowable Cost (MAC) The upper limit of ingredient cost for which a third-party payer will reimburse a pharmacy for dispensing certain multiple source drugs (i.e., drugs for which generic equivalents exist). MACs are used by public programs such as Medicaid and by private prescription insurance plans. Although there is no standard list of MAC drugs, often lists for different insurers or prescription programs include many of the same drugs and similar payment limits.

Mail Order Pharmacy A pharmacy that dispenses prescriptions to consumers who contact the pharmacy by mailing or faxing their prescription orders and then the prescription is mailed to the consumer. This can be an advantage for homebound patients or other patients without ready access to traditional community pharmacies. Unlike traditional pharmacies, the pharmacies can serve more than the local market where the pharmacy is located. Since there typically is at least a short delay between ordering and receiving prescriptions, these pharmacies generally serve patients on long-term drug therapies and those without immediate drug needs. The average size of prescriptions (number of capsules or tablets) dispensed in mail order pharmacies is larger than in local community pharmacies. Consequently, although mail order pharmacies represent less than 5% of all prescriptions dispensed, they comprise approximately 13% of total retail prescription sales.

Nonprescription Drug A drug product that can be purchased without a prescription order.

Over-the-Counter (OTC) Drug A nonprescription drug.

Patent/Patent Life A patent provides exclusivity in marketing a product. The patent life is the time during which a patent is in force and the product's manufacturer has exclusive marketing rights. The length of a patent for a drug is 20 years which is longer than for other products. The effective patent life for a drug may actually be shorter than 20 years depending on the time between discovery and market launch that is needed for safety and efficacy testing, clinical trials, and FDA approval for marketing.

Pharmacy Benefit Manager (PBM) An organization that provides administrative services in processing and analyzing prescription claims for pharmacy benefit and coverage programs. Their services can include contracting with a network of pharmacies; establishing payment levels for provider pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; and operating disease management programs. Many PBMs also operate mail order pharmacies or have arrangements to include prescription availability through mail order pharmacies.

Prescriber A health care provider licensed to prescribe drugs. Primary prescribers are physicians, but others may have prescriptive authority, depending on states' statutes and laws. For example dentists, physician assistants, nurse practitioners, optometrists, and others may have authority to prescribe, typically within limits.

Rebate An amount that the manufacturer of a drug pays to an insurer or health plan for each unit of drug dispensed. Rebate arrangements exist between manufacturers and Medicaid agencies, HMOs, and other insurers or drug plans, and generally bypass the pharmacy. Rebates are referred to as "after market" arrangements because they do not affect the prices paid at the time of service, but are implemented later, ultimately reducing the payer's expenditures or program costs. The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) requires pharmaceutical firms to give a rebate to the Health Care Financing Administration (HCFA) for distribution to the states for all drugs covered under state Medicaid drug programs. Within the private insurance market, rebates often are associated with preferred drugs, and the rebate or level of rebate is contingent upon achieving market share goals.

Third-Party Insurer An entity (a public or private program, health plan, or insurer) that pays or reimburses the patient or pharmacy for all or part of the cost of services provided.

Usual and Customary (U&C) Charge The amount a pharmacy or other provider charges self-pay (cash) patients. Some insurance programs dictate that a pharmacy's claim may not exceed its usual and customary charge for the prescription dispensed.

Wholesale Acquisition Cost (WAC) The price paid by the wholesaler for drugs purchased from the wholesaler's suppliers (manufacturers). On financial statements, the total of these amounts equals the wholesaler's cost of goods sold. Publicly disclosed or listed WAC amounts may not reflect all available discounts.

Reprinted, in part, with permission from "Prescription Drug Trends: A Chart-book," an analysis by the Kaiser Family Foundation authored by David H. Kreling, David A. Mott, and Joseph B. Wiederholt of Sonderegger Research Center of the University of Wisconsin-Madison and Janet Lundy and Larry Levitt of the Kaiser Family Foundation. The full report can be obtained from the Kaiser Family Foundation web site at www.kff.org or by requesting Publication #3019 from the Kaiser Family Foundation Publication Request Line at 1-800-656-4533.

Selected Resources

Compiled by Karla Balling and Jessica Mills
Wisconsin Family Impact Seminars

Legislative Support Bureaus

Richard Sweet, Senior Staff Attorney
Wisconsin Legislative Council Staff
1 East Main Street, Room 401
P.O. Box 2536
Madison, WI 53701-2536
(608) 266-2982
Richard.Sweet@legis.state.wi.us
Interests: Health administrative rules and health related legislation

State Agency Representatives

James Vavra, Director of Medicaid Policy and Budget Bureau
Division of Health Care Financing
1 West Wilson
Madison, WI 53701
(608) 261-7838
vavrajj@dhfs.state.wi.us
Interests: Medicaid reimbursement and policy

University of Wisconsin-Madison/Extension

David Kreling, Professor
Sonderegger Research Center for Social and Administrative Pharmacy
University of Wisconsin-Madison, School of Pharmacy
Chamberlin Hall, Room 3152
Madison, WI 53706
(608) 262-3454
dhkreling@pharmacy.wisc.edu
Interests: Pharmacy benefits and reimbursement policy

Stephen Meili, Clinical Associate Professor
University of Wisconsin-Madison, Law School
Law Building, Room 3222
Madison, WI 53706
(608) 263-6283
semeili@facstaff.wisc.edu
Interests: Consumer law, fraud and misrepresentation, bad faith insurance claim denials, unfair debt collection practices, and credit issues affecting lower income consumers.

David Mott, Assistant Professor
University of Wisconsin-Madison, School of Pharmacy
Chamberlin Hall Room 4302
Madison, WI 53706
(608) 265-9268
damott@pharmacy.wisc.edu
Interests: Factors associated with drug utilization, health care policy evaluation, and health care workforce evaluation

Roberta Riportella-Muller, Associate Professor
Consumer Science, Health Policy Specialist
University of Wisconsin-Extension
University of Wisconsin-Madison, School of Human Ecology
Human Ecology Building, Room 370B
Madison, WI 53706
(608) 263-7008
rriporte@facstaff.wisc.edu
Interests: Barriers to accessing care for under-served populations and broad extensive knowledge about Medicare programs. Is currently working with Health Care Financing Administration to design an educational program for beneficiaries that will be disseminated through county Extension offices. Has a solid understanding of the issues with Medicare financing problems and how/if extended prescription drug coverage may impact the fiscal viability of the program.

Community

Ray Larvuso, M.D., J.D.
Advocacy and Benefits Counseling for Health
152 West Johnson, Suite 206
Madison, WI 53703
(608) 261-6939 (ext. 204)
larvuso@safetyweb.org
Interests: Barriers to health care benefits for low-income families

Federal Government

Department of Health and Human Services

Health Care Financing Administration (HCFA)
7500 Security Boulevard
Baltimore, Maryland 21244
(410) 786-3000
http://www.hcfa.gov

Office of the Assistant Secretary for Planning and Education
http://aspe.hhs.gov

DHHS Report:
Prescription Drug Coverage, Spending, Utilization, and Prices: Report to the President, April 2000

General Accounting Office

PO Box 37050
(202) 512-6000
infor@www.gao.gov
http://www.gao.gov

GAO Reports:
Prescription Drugs: Drug Company Programs Help Some People Who Lack Coverage (GAO-1-137)

Prescription Drugs: Expanding Access to Federal Prices Could Cause Other Price Changes, August 2000

State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets (GAO/HEHS.00.162)

National Organizations

American Association of Retired Persons (AARP)

Research Center/Public Policy Institute
601 E Street NW
Washington, DC 20049
(800) 424-3410
http://research.aarp.org/ppi/index.html

AARP Reports:

How Much Are Medicare Beneficiaries Paying Out-of-Pocket for Prescription Drugs? (#9914)

Prescription Drug Benefits: Cost Management Issues for Medicare (#2000-09)

The Commonwealth Fund

One East 75th Street
New York, NY 10021-2692
(212) 606-3800
ilhi@cmwf.org
http://www.cmwf.org

Commonwealth Fund Reports
(reports are available at www.cmwf.org):

Designing a Medicare Drug Benefit: Whose Needs Will Be Met? (#436)

Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries (#430)

Families USA

1334 G Street NW
Washington, DC 20005
(202) 628-3030
Fax: (202) 628-3030
Info@familiesusa.org
http://www.familiesusa.org

Families USA Reports:

Cost Overdoes: Growth in Drug Spending for the Elderly, 1992-2010 (#00-107)

Hard to Swallow: Rising Drug Prices for America's Seniors (#99-107)

Still Rising: Drug Price Increases for Seniors 1999-2000 (#00-103)

Kaiser Family Foundation

2400 Sandhill Road
Menlo Park, CA 94025
(650) 854-9400
1-800-656-4533
http://www.kff.org

Kaiser Foundation Reports
(reports are available at www.kff.org or by calling 1-800-656-4533):

Kaiser Family Foundation/Health Research and Educational Trust 1999 Annual Employer Health Benefits Survey, 1999

Medicare and Prescription Drugs, A Factsheet, March 2000

Prescription Drug Trends: A Chartbook (publication #3019)

Retiree Health Coverage: Recent Trends and Employer Perspectives on Future Benefits, prepared by Hewitt Associates, October 1999

The Role of PBMs in Managing Drug Costs: Implications for a Medicare Drug Benefit, prepared by Mathematica Policy Research, Inc., January 2000

National Conference of State Legislatures

1560 Broadway
Suite 700
Denver, CO 80202
(303) 830-2200
http://www.ncsl.org

NCSL Reports:

AIDS Drug Assistance Programs (ADAP)-NCSL Issue Brief, 2000, describes state-federal funded programs that pay for certain drug treatments for people with HIV/AIDS

Making Medicines Affordable-NCSL State Legislatures magazine article, December 1999

The NCSL Health Policy Tracking Services (HPTS)-reports that almost 300 bills filed in 37 states in year 2000 related to pharmaceutical assistance for the elderly. HPTS reports: (202) 624-3567

New England Tackles High Drug Prices-NCSL State Legislatures magazine article, March 2000

Northeastern States Seek Cure for a Common Ill: Prescription Drug Costs-NCSL State Health Notes, June 5, 2000

Prescription Drug Discount, Rebate, Price Control, and Bulk Purchasing Legislation
http://www.ncsl.org/programs/health/drugdisc.htm

State Senior Pharmaceutical Assistance Programs
www.ncsl.org/programs/health/drugaid.htm

National Governors' Association

Center for Best Practices
Health Policy Studies
(202) 624-5300
http://www.nga.org

Joan Henneberry
(202) 624-3644

Background on State Pharmaceutical Programs
Samantha Ventimiqlia
(202) 624-5376

NGA Reports:

State Inititiatives to Promote Cost-Effective Use of Pharmacy Benefits
http://www.nga.org/cda/files/000814PHARMBENEFITS.PDF

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BFI16 Designing a State Prescription Drug Benefit: Strategies to Control Costs (2001)