State Pharmaceutical Assistance Programs

Summary
While the U.S. Congress and the Bush administration debate the inclusion of a prescription drug benefit under the Medicare program, many states are designing and implementing individual pharmaceutical assistance programs for their low-income populations. States believe that providing access to prescription medications will help individuals improve their health status and reduce their overall medical costs.

Currently, 26 states have pharmaceutical assistance programs in operation, and many other states are developing programs. Most of the state programs are funded by general fund revenue or a targeted funding source, such as tobacco settlement funds. The majority of state pharmaceutical assistance programs provide benefits through direct subsidy or discounts. There are other options, however, including tax credits or measures that reduce retail prices, such as bulk or cooperative purchasing programs and drug buying pools.

Many of the state pharmaceutical assistance programs share common characteristics. Most programs require cost sharing by recipients, although it varies in approach (deductibles, annual fees, or copayments) and varies greatly in amount. The majority of programs target people ages 65 years and older, although half also offer coverage to people with disabilities who are under age 65. Most if not all prescription drugs are covered, and some programs cover nonprescription drugs. A few states limit coverage to treatments for specific illnesses, such as heart disease and diabetes.

This Issue Brief examines the commonalities and variations across state-based pharmacy assistance programs and delineates the program characteristics and policy decisions that surround four of the large, established programs—those in Maryland, Michigan, New York, and Pennsylvania. The Issue Brief reviews the history, funding sources, eligibility and cost sharing requirements, and cost containment strategies of each of these four state programs.
Need for State Pharmaceutical Assistance Programs

The Medicare Program

The Medicare program, which provides health care benefits to 34 million aged persons and 5 million disabled individuals, does not cover most outpatient prescription drugs. Nevertheless, in 1996 more than two-thirds of Medicare beneficiaries received outpatient drug coverage through programs other than standard Medicare. Most of those received benefits from employersponsored retirement insurance, Medicare supplemental policies (Medigap), Medicare managed care (Medicare+Choice), or Medicaid. The other one-third of Medicare beneficiaries had no outpatient prescription drug coverage.

Importance of Access to Pharmaceuticals

Prescription drug coverage is particularly important for the elderly and persons with disabilities, who use a disproportionately high volume of prescriptions. These populations are more likely to have multiple conditions treated with pharmaceuticals. For example, individuals age 65 to age 74 fill an average of 20 prescriptions per year, while individuals age 19 to age 44 fill an average of only 5 prescriptions per year. Pharmaceutical therapy is the most common medical treatment for the elderly, who encompass 13 percent of the total population but who account for about one-third of all annual health care expenditures.

According to a recent Health Care Financing Administration (HCFA) study published in *Health Affairs*, seniors enrolled in the Medicare program who are without prescription drug coverage fill fewer prescriptions than do Medicare beneficiaries with drug coverage. Further, Medicare beneficiaries without drug coverage spend less on medications. In 1998 Medicare beneficiaries without drug coverage filled 16.7 prescriptions, a 2.4-percent decline from 1997. These beneficiaries spent approximately $550 on their medications, which is almost the same amount spent the previous year. Meanwhile, Medicare beneficiaries with drug coverage filled more than 24 prescriptions per person—a 9 percent increase from 1997. In addition, total spending for covered beneficiaries increased by 14 percent from 1997. The differences in the number of prescriptions filled and in total drug expenditures are much greater for those in poor health. Clearly, there is a wide disparity in prescription drug access between Medicare beneficiaries with some type of coverage and those without.

An increase in enrollment in Medicare managed care in the early 1990s led to increased pharmaceutical coverage. The HCFA data show, however, that this type of drug coverage leveled off in 1998. The number of Medicare beneficiaries enrolled in managed care plans with prescription drug coverage has more recently been declining. In 2001 fewer than half of all Medicare beneficiaries will have access to a Medicare managed care plan with a no-cost drug coverage feature, compared to 73 percent who had no-cost coverage under Medicare managed care in 2000.

To help more low-income elderly and persons with disabilities obtain low-cost pharmaceuticals, states have created their own pharmaceutical assistance programs. A separate study from *Health Affairs* reports that residents of states with pharmaceutical assistance programs were 60 percent more likely to have continuous drug coverage than individuals living in states without such programs.
**State Pharmaceutical Expenditures**

State spending on pharmaceuticals is growing every year. Rising state expenditures for pharmaceuticals may be attributed to eligibility expansions; an increase in prescription drug use among the elderly and persons with disabilities; new therapeutic agents for previously untreatable diseases; improvements in medical treatment guidelines for currently treated diseases; greater patient knowledge and, therefore, involvement in disease treatment; and rising health care expenditures in general. Eighty percent of the growth rate in overall pharmaceutical expenditures from 1994 through 1999 was related to an increase in utilization. In 1998 Medicaid payments for outpatient prescription drugs rose to $14.5 billion, from an estimated $4.8 billion in 1990, an increase of about 15 percent annually. In Georgia, for example, average pharmaceutical expenditures per recipient increased by 20 percent in 2000. Other states are experiencing similar increases in their pharmaceutical benefit costs.

**State Profiles**

**Maryland Program Characteristics**

The Maryland Pharmacy Assistance Program (MPAP) was established in January 1979 to assist individuals of all ages—including the underinsured, uninsured, and Medicare recipients—with long-term maintenance prescription drug costs. The average monthly enrollment during the first six months of fiscal 2001 was 35,901 beneficiaries. Thirty-five percent of enrollees are ages 65 and over, and 64 percent of enrollees are between the ages of 21 and 64.

**Eligibility and Coverage**

In 1991, because of budget constraints, the state implemented cost containment measures. These measures restrict the availability of maintenance drugs through a drug formulary. The limited formulary includes anti-infectives and maintenance drugs. Eligibility for the program is based on household size, family income, and assets (single persons with an annual income of up to $10,000 and assets up to $3,750; married couples with an annual income of up to $10,850 and assets up to $4,500).

**Cost Sharing**

MPAP has no premium requirements or annual cap on benefits. The program does charge a $5 copayment per prescription.

**Administration and Budget**

The Beneficiary Services Administration in the Maryland Department of Health and Mental Hygiene, which is the state Medicaid agency, administers MPAP. The program is funded with state general fund revenues. For fiscal 2000, MPAP annual program costs were $45.1 million, while administrative costs totaled $581,334.

MPAP uses a simplified enrollment and administrative process. The state simplified the application process by creating a one-page application; instituting a fast turnaround policy (including same-day determination for emergencies); establishing clear income and asset limits, with no exceptions; and by requiring no premiums or deductibles. MPAP has no age or medical condition restrictions, no annual cap on benefits, and no centralized outreach program. The program has required annual eligibility renewal. Efforts are underway, however, to increase the
eligibility period for those individuals whose income is unlikely to change, such as older residents collecting Social Security or other retirement benefits.

The state integrated the pharmacy program with the Maryland Medicaid Information System (MMIS) to process electronic claims. It uses prospective drug utilization review (ProDUR) at the point of sale and a single system for persons who are eligible for both Medicare and MPAP. The program has the ability to use a powerful mainframe system for generating reports and mailings.

Cost Management Tools

In 1991 budgetary issues forced the state to limit the drug formulary and increase copayments. As a result, certain budget-related policy restrictions were put in place, including limiting access to two-income households; establishing lower income-eligibility limits, compared to some other state programs; and limiting the formulary to maintenance drugs.

Other

Governor Glendening recently signed the Senior Prescription Drug Relief Act establishing and expanding several pharmaceutical assistance programs for elderly residents. The new law modifies the Short-Term Prescription Drug Subsidy Plan to increase program participation. The Short-Term Prescription Drug Subsidy Plan provides pharmacy assistance to Medicare beneficiaries at or below 300 percent of the FPL. Beneficiaries will pay a $10 monthly premium and copayments of $10 to $35 per prescription, with a $1,000 annual benefit cap.

The law also creates the Maryland Pharmacy Discount Program as a part of the state’s Medicaid program. This program is contingent upon approval of a Medicaid 1115 waiver amendment from the federal government. Should the federal government reject this amendment, the state would move forward with the discount program by administering it through MPAP.

Further, the legislation expands the state’s Medbank program, which helps the elderly acquire free medications through pharmaceutical companies. Currently, the Medbank program operates through the Maryland Health Care Foundation and exists in only two geographic areas—Western Maryland and Baltimore City/Baltimore County. Under the new law, the Medbank program is expanded statewide.

Michigan Program Characteristics

The Elder Prescription Insurance Program (EPIC) was established in 2000 to replace the state’s two existing state pharmaceutical programs targeted to the senior population—Michigan Emergency Pharmaceutical Program for Seniors (MEPPS) and the Senior Prescription Drug Tax Credit program. EPIC is expected to be implemented on October 1, 2001, replacing MEPPS and the tax credit. In Michigan, state pharmaceutical costs are growing at a rate of 14 percent to 20 percent each year. The state estimates that up to 225,000 residents are potentially eligible for the EPIC program.

Eligibility and Coverage

EPIC was created to enhance access to prescription drugs for certain elderly and disabled Michigan residents. Residents ages 65 and older, with family income less than or equal to 200 percent of the federal poverty level, are eligible for the program. No deductions in calculating income are allowed. Additionally, program participants must not be institutionalized and must have established Michigan residency at least three months prior to applying for benefits.
Furthermore, the participant cannot have Medicaid benefits or other prescription drug insurance, except for Medicare, Medicare supplemental insurance, or other future federal senior prescription drug insurance. Drug coverage is similar to that provided under the Medicaid program.

Cost Sharing

The EPIC program has several cost sharing requirements, including an annual administrative fee of $25 and a dispensing fee equal to that found in the Medicaid program. If the physician prescribes a brand-name drug but does not indicate “dispense as written” (DAW) to the pharmacist, a copayment of $15 for the brand-name medication is required when a generic substitute is available. Copayments cannot exceed 20 percent of the cost of an individual prescription drug, with a maximum monthly copayment amount calculated according to income. Individuals with income at or below 100 percent of the federal poverty level are expected to pay a monthly copayment of no more than one-twelfth of 1 percent of their annual income. For those with income between 175 percent and 200 percent of the federal poverty level, the copayment is no more than one-twelfth of 5 percent of their income.

Administration and Budget

The Michigan Department of Community Health is conducting a competitive bid process to select a contractor to perform the eligibility determinations and enrollment functions. Additionally, the state will select a pharmacy benefit manager for the EPIC program. EPIC will be funded with tobacco settlement funds ($30 million) and revenue currently used for the MEPPS program ($20 million). The EPIC budget is projected to be approximately $50 million for the first year of program operation.

The state made several decisions to control EPIC costs while simultaneously increasing program access. The first of these decisions was that EPIC would not be administered by the state’s Medicaid program. The state concluded that, because entitlement programs have a stigma associated with them, a connection to Medicaid would discourage senior enrollment. To ensure that those individuals in greatest need receive benefits, the state is staggering EPIC enrollment. The program first will enroll MEPPS beneficiaries, then tax credit beneficiaries. Next, providing that the total program budget is not consumed by MEPPS and tax credit participants, the state will enroll additional individuals. A pharmacy benefit manager will provide the actual benefit and administer enrollment.

Cost Management Tools

The state is using drug utilization review (DUR) to determine the most appropriate care for EPIC enrollees. Although a third-party contractor is administering the program, EPIC is mirroring some of the Medicaid program elements, including charging copayments for brand-name drugs when generic substitutes are available and instituting income limitations. Finally, EPIC uses an open formulary—with some exceptions—and an inducement to use generics. The program will not cover nonessential drugs, such as those for weight loss or baldness.

New York Program Characteristics

New York’s Elderly Pharmaceutical Insurance Coverage program, also known as EPIC, was established in 1987 to assist low- and moderate-income seniors with their prescription drug costs. New York expects approximately 142,000 enrollees annually in its lower-income fee plan and another 73,000 in its upper-income deductible program.
Eligibility and Coverage

EPIC uses an open formulary with a manufacturer rebate program and includes coverage for legend drugs, insulin, syringes, and needles. EPIC does not offer drug coverage for medications manufactured by non-rebate participating companies. EPIC enrollment depends upon annual income and is a cost sharing program.

In 2000 New York expanded its EPIC program by raising the income eligibility level to $35,000 for individuals and $50,000 for married couples. The EPIC expansion was implemented on January 1, 2001. EPIC program eligibility is not tied to the federal poverty level. Participants must be age 65 or older, and must not have other equivalent or better prescription drug coverage.

Cost Sharing

The EPIC expansion reduces copayments by 20 percent and simplifies the copayment schedule from five tiers to four. Additionally, quarterly fees were reduced for low- and moderate-income seniors, and a new deductible plan was added for higher-income seniors. For EPIC’s lower-income fee plan, there is an annual fee of $8 to $300, with no deductible. For this population, the annual limit on copayments is $291 to $1,160, after which no copayment is required. Copayments are based on the cost of the prescription: prescriptions up to $15 cost $3; $15.01 to $35 cost $7; $35.01 to $55 cost $15; and over $55 cost $20. For EPIC’s upper-income deductible plan, there is an annual deductible between $530 and $1,715. Annual limits on total cost sharing for this population are $1,050 to $2,000 or 6 percent to 8 percent of income.

Administration and Budget

The New York State Health Department administers all components of the EPIC program. The EPIC Panel is the program’s governing body, which comprises five state agencies: the Department of Health, the Director of the State Office for Aging, the Director of Budget, the Superintendent of Insurance, and the Commissioner of the Department of Education. The state uses a fiscal intermediary contract. The contractor is responsible for major program operations, including participant enrollment and eligibility, provider enrollment, customer relations, outreach, claim processing and reimbursement, drug utilization review, system development and support, and rebate invoicing (the state receives, processes, and audits rebate payments). The EPIC program is funded through state general fund revenue and a portion of tobacco funds. The budget for April 2000 to March 2001 was $238.2 million. The expected budget for April 2001 to March 2002 is $396.4 million for program benefits and $11 million for program administration.

Cost Management Tools

EPIC has an open formulary with a manufacturer rebate program, which is a modified Medicaid rebate rate. The state uses a four-tier copayment program to provide incentives for using generics. The program eligibility and benefit levels are not tied to the federal poverty level. The state’s use of annual enrollment fees, deductibles, copayment limits, and a four-tier copayment structure complicate EPIC program administration and restrict access. Furthermore, although the state recently lowered its annual enrollment fees and copayments, program participation tends to be limited to those with high drug costs.

The state uses a drug utilization review (DUR) program operated by a contractor. The DUR is a prospective denial/override system and is retrospective through prescriber interface. Specifically, EPIC’s prospective DUR program will reject point-of-sale claims, based on criteria set to identify
the potentially most severe drug interactions, therapeutic duplication, high dose, and early refill—
defined as when less than 50 percent of the days’ supply has lapsed. About 4 percent of the
program’s claims are rejected for DUR edits. The pharmacy, however, can override the rejection
by resubmitting the claim with appropriate DUR response information showing proper
intervention (discussion with the patient or prescriber, or pharmacist review of the case). The
retrospective system reviews all prescriptions recently purchased to identify potential problems
with a drug interaction, duplicative therapies, overuse or the use of multiple pharmacies and
prescribers. Following clinical reviews by staff pharmacists, information letters and claim profiles
are sent to prescribers. About 40 percent of prescribers respond to the letters, and a significant
change in therapy occurs in about 30 percent of the cases. DUR’s philosophy is to ensure the
health and safety of seniors, provide information to them, defer to the professional judgment of
health care providers, and intervene only when absolutely necessary.

**Pennsylvania Program Characteristics**

The Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) program was
implemented in 1984, and the PACE Needs Enhancement Tier (PACENET) was implemented in
1996. PACE and PACENET provide a comprehensive, defined drug benefit to seniors.
Originally, PACE was implemented to establish a program of limited pharmaceutical assistance
for eligible residents. PACENET expanded eligibility to additional seniors. Pennsylvania
estimates that 935,000 individuals are eligible for the PACE and PACENET programs. As of
March 2001, 211,711 individuals were enrolled in PACE and 23,000 were enrolled in
PACENET.

**Eligibility and Coverage**

PACE and PACENET cover most prescriptions, as well as insulin, syringes, and needles. The
programs do not cover experimental drugs, medications for baldness or wrinkles, or
nonprescription drugs. PACE and PACENET require generic substitution for brand-name
multisource products when a Food and Drug Administration (FDA) approved, A-rated generic is
available. Participants must be age 65 or older and residents of Pennsylvania for at least 90 days.
Eligibility is based on income one year prior to application. Under PACE, income must be at or
below $14,000 for singles and at or below $17,200 for married couples. Under PACENET,
income must be at or below $16,000 for singles and at or below $19,200 for married couples.

**Cost Sharing**

There is no deductible under PACE; however, there is a copayment of $6 per prescription. Under
PACENET, there is a $500 annual deductible. Copayments per prescription are $8 for generic
drugs and $15 for brand-name medications. Both programs have a reimbursement limit of 30
days supply or 100 units (tablets or capsules)—whichever is less—for each claim.

**Administration and Budget**

The Pennsylvania Department of Aging administers the PACE and PACENET programs, which
are funded with state lottery funds. For state fiscal 2002, the state estimates an annual budget of
$359 million (before manufacturer’s rebates) for PACE and PACENET, including administration
costs of $9.5 million—$1,450 net per PACE enrollee and $1,000 net per PACENET enrollee, after rebates.
PACE and PACENET are not insurance products, discount programs, entitlement programs, or part of the state’s Medicaid program. The state believes that entitlement programs have a stigma associated with them that discourages senior enrollment.

**Cost Management Tools**

To control program costs, PACE and PACENET use several mechanisms, including manufacturer rebates and drug utilization review (DUR). Specifically, almost all prescription drug claims reimbursed by PACE or PACENET are subject to mandatory therapeutic DUR edits, which are intended to prevent overdosing, overuse, duplicative therapy, and drug-to-drug interactions. A prescriber or pharmacist may, however, request a medical exception; if there is sound medical basis for waiving the DUR criteria, PACE or PACENET staff will override the DUR edit. Furthermore, to contain costs, eligibility is based on fixed incomes and not the federal poverty level. PACE and PACENET also utilize an aggressive pharmacy provider audit program, whereby field auditors review prescription records and program billings to ensure compliance with rules and regulations.

**Characteristics of State Pharmaceutical Assistance Programs**

The majority of states with pharmaceutical assistance programs provide direct subsidies to participants. Direct subsidy programs pay the difference between a copayment paid by the beneficiary and the cost of the prescription. Some direct subsidy programs also include an annual deductible or an annual or monthly fee. These programs use age, income level, and other criteria to target benefits to a specific population.

**Bulk, Wholesale, and Purchasing Cooperative Programs**

Bulk, wholesale, or purchasing cooperative programs reduce prescription drug costs without using state funds for the actual purchase. For example, the Iowa Prescription Drug Purchasing Co-op, expected to be implemented by July 1, 2001, seeks to negotiate volume discounts with drug manufacturers for co-op members, either directly or through a private contractor.

**Multistate Drug Buying Pools**

Vermont, New Hampshire, and Maine have formed a tri-state buying pool to purchase prescription drugs for their Medicaid populations. The states are reviewing proposals from pharmacy benefit managers (PBMs) for the management of the tri-state pharmacy benefit. The PBM would negotiate lower prices with drug manufacturers and suppliers on behalf of the states. The states must first get approval from the U.S. Department of Health and Human Services; they expect, however, to implement the program in the spring of 2001.

**Drug Discount Programs**

Other states are implementing drug discount programs, including California, which requires retail pharmacies to charge beneficiaries an amount not to exceed the Medicaid (MediCal) reimbursement rate. The beneficiary then pays the Medicaid-discounted drug price plus 15 cents to cover the pharmacy transaction fee.
**Tax Credits**
A few states, including Missouri, offer a tax credit to reimburse seniors for a portion of their prescription drug costs. For example, under Missouri’s Pharmaceutical Tax Credit, individuals ages 65 or older with an annual income below $25,000 may receive the tax credit. Under Missouri’s current program, a maximum tax credit of $200 is available to seniors with income below $15,000 per year. Above $15,000, the tax credit is reduced by $2 for every $100 increase in income, up to $25,000. Governor Bob Holden, elected in January 2001, has proposed replacing the tax credit with a catastrophic drug plan that targets those seniors with the highest drug costs.

**Program Components**
Most of the programs in the 26 states with direct subsidy or discount pharmaceutical assistance programs have similar characteristics.

- In most cases, cost sharing by participants is required, although it varies in type and amount. States use a variety of cost sharing strategies, including annual enrollment fees, annual or monthly deductibles, copayments, and dispensing fees.
- The programs target people ages 65 years and older, although some programs also offer coverage to people under age 65 who have disabilities, or to other low-income populations.
- Most if not all prescription drugs are covered, and some programs cover nonprescription drugs. A few states limit coverage to treatments for specific illnesses such as heart disease and diabetes.
- The majority of states use only state revenue to fund their programs. The source of funding, however, varies—from state general fund appropriations to other dedicated revenue, including local foundation support, special revenue funds, excise taxes on tobacco products, sales tax on construction materials, the lottery, and casino revenues.
- Most state programs incorporate one or more cost management tools typically used by pharmacy benefit managers (PBMs) to contain pharmaceutical program expenditures. Some of these cost management tools include:
  - drug formularies;
  - drug utilization review (DUR);
  - generic substitution;
  - prior authorization;*
  - multitiered copayment structures; and
  - negotiated manufacturer rebates and drug discounts.
Program administration varies among state programs. Many states have implemented programs, separate from Medicaid, to avoid the perceived stigma sometimes associated with entitlement programs. Some separate state programs, however, administer and use the policies of the Medicaid program to simplify program functions such as enrollment.

**Pharmaceutical Company Prescription Drug Patient Assistance Programs**

In addition to state pharmaceutical assistance programs, most private, research-based pharmaceutical companies, including AstraZeneca Pharmaceuticals;® DuPont;® Hoffman LaRoche, Inc.;® Merck and Company, Inc.;® Monsanto Company;® Pfizer Inc.;® the Proctor and Gamble Company;® and Wyeth-Ayerst Laboratories,® have developed programs to provide prescription medicines free of charge to physicians whose patients might not otherwise have access to necessary medicines. Although each individual pharmaceutical company determines the eligibility criteria and benefits for its program, the majority of programs have several common elements.

- They target low-income individuals without drug coverage.
- The patients must not have access to private insurance, health maintenance organizations (HMOs), Medicaid, Medicare, state pharmacy assistance programs, Veteran’s Assistance, or any other social service agency support.
- There are no cost sharing requirements.
- The programs provide temporary coverage of most outpatient products.
- They rely on provider involvement to assist their patients with the application process for pharmacy program benefits.
- The providers play a significant role by obtaining the company program application, completing all or a portion of the form, and receiving and dispensing the medication to the patient.

According to a Pharmaceutical Manufacturers Research Association survey, in 1998 its members’ patient assistance programs provided $500 million in drug products to 1.5 million people.

**Future of Programs**

In 1998 prescription drug expenditures for all populations in the United States totaled $91 billion, more than double the spending in 1990. From 1999 to 2000, the number of Medicare beneficiaries with no-cost prescription drug coverage through a Medicare HMO declined by 11 percent. In the absence of a federal prescription drug benefit, Governors and state policy makers continue to explore options to provide pharmaceutical benefits to the elderly and disabled populations. During their 2001 state-of-the-state addresses, 12 Governors from states across the country cited as one of their top priorities either the expansion or implementation of state pharmaceutical assistance programs.
As states develop pharmaceutical assistance programs, flexibility is critical to sustain the programs and to reach the appropriate populations. States need to use cost sharing strategies such as those used by employer-sponsored insurance programs. States also need the ability to contain program costs through the use of mechanisms such as managed care, targeted populations and benefits, and appropriate physician prescribing practices.

**Glossary of Technical Terms**

**Beneficiary:** An individual who receives benefits from or is covered by a health insurance policy or program, such as a state pharmacy program. Also referred to as an Enrollee.

**Brand-name Drugs:** A drug that is the product of a specific pharmaceutical company. This is also known as propriety trademark name. No other pharmaceutical company, other than the original, can manufacture brand-name drugs until the patent expires.

**Copayment:** Requires a health plan beneficiary to pay a specific charge for a specific service, such as $5 to fill a prescription. The beneficiary is typically responsible for the payment at the time the service is rendered.

**Cost Sharing:** Requires a health plan beneficiary to pay some portion of the medical or pharmaceutical cost. The term includes copayments, deductibles, annual fees, and premiums.

**Deductible:** The amount a program participant must pay before health services are completely covered by the health plan or program.

**Dispense as Written (DAW):** A directive from a prescribing physician to indicate that the pharmacy should not alter the prescription in any way. Pharmacies typically alter physician prescriptions in order to substitute a generic drug for a prescribed brand-name drug.

**Dispensing Fee:** An additional amount, other than the negotiated formula for reimbursing the prescription ingredient costs, paid to a pharmacy for each prescription.

**Drug Formulary:** A list that identifies preferred medications for treatment of specific diseases. The list is usually subject to periodic review and modification. An open formulary allows coverage for both formulary and nonformulary medications. A closed formulary limits coverage to only those medications on the preferred list.

**Drug Utilization Review (DUR):** A quantitative evaluation of prescription drug use, physician prescribing practices, or patient drug use, to determine the appropriateness of drug therapy. DUR often focuses on patient overutilization.

**Enrollee:** An individual who receives benefits from or is covered by a health insurance policy or program, such as a state pharmacy program. Also referred to as a beneficiary.

**Fiscal Intermediary:** The agent that has contracted with providers of service (state pharmacy programs) to process claims for beneficiary reimbursement. The intermediary may perform functions other than financial services, such as providing consultative services or serving as a center for communication with providers and auditing provider records.

**Generic Drug:** A chemically equivalent duplication of a brand-name drug whose trademark patent has expired. Generic drugs must be of identical composition with respect to the active ingredient of the brand-name drug. Generics must meet official standards of identity, purity, and quality of the active ingredient(s) of their brand-name counterparts.
Generic Substitution: Dispensing a generic medication in place of a brand-name drug.

Legend Drug: A medication that, by law, can be obtained only by prescription and that bears the label, “Caution: federal law prohibits dispensing without a prescription.”

Maintenance Drug: Medications used for long periods to control chronic conditions.

Medicaid Management Information System (MMIS): Federal guidelines for a computer system designed to achieve national standardization of Medicaid claims processing, payment, review, and reporting for all health care claims.

Medicaid Rebate: Under federal law (P.L. 101-508, OBRA 1990), pharmaceutical manufacturers must enter into rebate agreements with the federal government in order for the Medicaid program to cover their products. Generally, the rebates are based on a fixed percentage of the average price paid by wholesalers. The average wholesale price is the published suggested price of a drug.

Prior Authorization: The process of obtaining prior approval from the health insurance plan or state program as to the appropriateness of a service or medication before prescribing or dispensing certain medication. Prior authorization for a service or medication does not guarantee coverage.

Additional Resources:
NGA State Pharmaceutical Assistance Programs information:

http://www.nga.org/center/divisions/1,1188,C_ISSUE_BRIEF^D_843,00.html

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4 Patricia Neuman, “Improving Prescription Drug Coverage: Opportunities and Challenges for Reform” (testimony before the Senate Committee on Finance, on behalf of the Henry J. Kaiser Family Foundation, March 22, 2001).


7 Ibid.
8 Ibid., 79.
9 Ibid., 84.

10 Ibid.


15 To be eligible for New York EPIC’s low-income fee plan, annual income cannot exceed $20,000 for singles and $26,000 for married couples.

16 To be eligible for New York EPIC’s upper-income deductible plan, annual income cannot exceed $35,000 for singles and $50,000 for married couples.

17 Multitiered copayments encourage program participants to use generics or formulary drugs by charging lower premiums for generics or on-formulary prescription medications. For example, under the first tier, generics may carry a minimal copayment of $5. The second tier might be for brand-name drugs that are listed on the state’s drug formulary and carry a copayment of $15, while a third tier may be for off-formulary drugs with a copayment of $25.


19 An example of one of these programs is the Sharing the Care program, which is Pfizer’s pharmaceuticals access program that donates most of its leading medicines to low-income, uninsured patients through a network of more than 350 community, migrant and homeless health centers across the country. Sharing the Care was developed in partnership with the National Association of Community Health Centers and the National Governors Association. Sharing the Care works through federally funded community health centers that have received 330e, 330g or 330h Public Health Service grants from the Bureau of Primary Health Care. Participating health centers span 47 states and serve patients in settings ranging from inner-city neighborhoods to rural communities. Since its inception in 1993, Sharing the Care has provided more than $250 million worth of Pfizer medicine through 4.8 million prescriptions at no charge and helped more than 1.5 million patients.


21 Ibid.

22 Poisal and Murray, 74.

23 Ibid., 83-84.