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NATIONAL HEALTH POLICY FORUM

The Basics

State Pharmacy Assistance Programs

State Pharmacy Assistance Programs (SPAPs) are state-sponsored programs that provide senior citizens and individuals with disabilities increased access to prescription drugs. These programs operate outside the state/federal Medicaid program and are usually funded exclusively with state dollars. In 2001, states appropriated an estimated $1.5 billion to SPAPs, and program expenditures have been growing by an average of 15 percent each year. To date, 29 states have pharmacy assistance programs in operation, and nine more states have enacted laws to create SPAPs but have not yet implemented them (see Table 1). Many programs began in the early 1980's, and the oldest SPAPs date back nearly 30 years.

There are two types of SPAPs currently in operation:

- The vast majority of states (24 of the 29) have *direct-benefit programs*, meaning that the state subsidizes the bulk of the prescription drug costs for enrollees, who contribute in the form of modest copayments and, in some cases, monthly premiums, deductibles, and coinsurance. (See "What About Cost Sharing?")
- Many states that offer direct benefit programs also offer *discount programs* through which states help facilitate lower prices for prescription drugs. These discounts are typically provided either through the use of a discount card or through purchasing pools. Twenty states have discount programs in operation; six states offer the discounts but no direct benefit subsidy.

WHO IS ELIGIBLE?

Though most SPAPs target low-income individuals who are not eligible for Medicaid, many states have expanded their programs to serve individuals with higher incomes as well. All states provide coverage to those aged 65 and older, and half of the programs cover individuals with disabilities under age 65. Eligibility levels range from 100 percent of the federal poverty level (FPL) ($9,310 for an individual in 2004) in Arkansas and Louisiana to 500 percent of the FPL in Massachusetts ($46,550 for an individual in 2004). A few states have moved toward offering the benefits regardless of income, adjusting cost-sharing requirements accordingly.

Most states have elected not to use *asset tests* (consideration of bank accounts, cars, homes and burial plots as income for eligibility purposes), and several states that use them have increased the income limits because they posed a barrier to enrollment.

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In addition, a few programs have adjusted eligibility limits for individuals who have prescription drug expenses that are considered "catastrophic" (ranging from 3 percent to 40 percent of income).

WHAT DRUGS ARE COVERED?

Like most Medicaid programs, SPAPs cover most drugs in a therapeutic class through use of "open formularies." A *formulary* is a list of covered drugs that is available without prior approval. States negotiate with most major drug manufacturers for rebates that enable them to cover the FDA-approved prescriptions that the elderly utilize most often. In addition, most SPAPs cover insulin and the related products needed for diabetes management. Many programs have exclusions for certain "lifestyle" drugs and most over-the-counter medications.

Some SPAPs contract with private insurers or pharmacy benefit managers (PBMs) to negotiate prices with drug manufacturers and manage the formularies. This often results in the use of a "closed formulary," which restricts coverage to a limited number of drugs in a therapeutic class and can reduce access to certain drugs.

WHAT ABOUT COST SHARING?

All SPAPs require some level of cost sharing, but the requirements range from nominal to significant, depending on the state and the income of the individual.

The vast majority of states require a co-payment for each prescription drug purchase. *Co-payment* amounts are sometimes tied to the income of the individual and can range from $1 to $30 per prescription. Many states also have lower co-payments for generic drugs and for "preferred" drugs than for name brand and "non-preferred"drugs, to encourage patients to use less costly alternative drugs or drugs that have better rebates available.

A few states also use *deductibles* (a set amount of out-of-pocket expenses that must be incurred before the benefit is activated) and *coinsurance* (payment of a percentage of the cost of the drug). The amounts vary significantly by state and are sometimes greater for individuals at higher incomes. Several states use a combination of co-payments and other cost-sharing requirements.

Only a few states require monthly premiums or enrollment fees and thus rely more heavily on payments related to the volume of drugs that is purchased.

WHAT ARE PHARMACY PLUS WAIVERS?

Since early 2002, the Centers for Medicare and Medicaid Services (CMS) have approved four states' requests to receive federal Medicaid funds to help finance the cost of prescription drug coverage for individuals with incomes below 200 percent of the FPL ($18,620 for an individual in 2004). Known as "Pharmacy Plus Waivers," these programs (except in Wisconsin) built off of existing SPAPs and enabled the states to expand prescription drug coverage to low-income individuals who are not otherwise eligible for Medicaid. With the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, it is not clear whether these programs will continue to operate or be subsumed into the new Medicare prescription drug benefit.

HOW WILL SPAPS INTERACT WITH MEDICARE RX?

Because the MMA includes provisions specifically designed to assist low-income individuals—through a $600 subsidy for use with the Medicare drug discount card and through subsidizing the costs associated with accessing the new Medicare prescription drug benefit—the role of SPAPs will be changing dramatically in the coming months. In preparation for the transition, CMS has convened a group of SPAP directors to serve as an advisory committee as the implementation process continues. (See also *The Basics: Medicare Prescription Drug Discount Card Program*)

For more information:

- Kimberly Fox, Thomas Trail, Stephen Crystal, "State Pharmacy Assistance Programs: Approaches to Program Design," The Commonwealth Fund, May 2002, at http://www.cmwf.org/programs/medfutur/fox_statepharmacy_530.pdf.
- National Conference of State Legislatures, "State Pharmacy Assistance Programs, 2004 Edition," available at http://www.ncsl.org/programs/health/.

TABLE 1

State Pharmacy Assistance Programs in Operation*

STATE	YEAR ENACTED/ EXPANDED	TYPE OF PROGRAM	ENROLLEES *(AS OF DATE)*
Arizona	2003 / 2004	Discount	Auto enroll for 1.1 million
California	1999 / 2001	Discount	Est. 1.3 million eligible
Connecticut	1986	Subsidy	51,753 (Mar. 2003)
Delaware	1981 (private initiative)	Subsidy	10,000 (2001)
	1999	Subsidy	5,000 (Oct. 2002)
Florida	2000	Subsidy / Pharmacy Plus	46,312 (May 2003)
	2000	Discount	Not available
Illinois	1985	Subsidy	57,444 (May 2003)
	2001	Pharmacy Plus	170,482 (May 2003)
	2003	Discount	58,000 (Jan. 2004)
Indiana	2000	Subsidy	14,893 (June 2003)
Iowa	2002	Discount	68,000 (July 2003)
Kansas	2000 / 2003	Subsidy	1,500 (June 2003)
Maine	2000 / 2003	Subsidy	73,000 (Jan. 2004)
	2001	Discount	79,000 (Jan. 2004)
Maryland	1979	Subsidy	47,700 (2003)
	2000	Subsidy	29,490 (Dec. 2002)
	2001	Discount	24,000 (Jan. 2004)
Massachusetts	1996 / 2001	Subsidy	87,000 (Dec. 2003)
Michigan	1988 / 2000	Subsidy	13,034 (May 2003)
Minnesota	1999	Subsidy	6,708 (May 2003)
Missouri	1999 / 2001	Subsidy	21,000
Nevada	1999 / 2001	Subsidy	7,500 (Nov. 2002)
New Hampshire	2000	Discount	12,000 (Feb. 2002)
New Jersey	1975	Subsidy	227,500 (Mar. 2003)
	2001	Subsidy	Included above
New York	1987	Subsidy	297,000 (Nov. 2002)

(*continued* ▸)

SPAP Summary – *continued*

STATE	YEAR ENACTED/ EXPANDED	TYPE OF PROGRAM	ENROLLEES *(AS OF DATE)*
North Carolina	1999	Subsidy	1,710 (May 2002)
	2001	Subsidy	17,646 (July 2003)
Ohio	2002	Discount	Est. up to 500,000 eligible
Oregon	2003	Discount	165 (June 2003)
Pennsylvania	1984	Subsidy	192,384 (May 2003)
	1996	Subsidy	32,142 (May 2003)
Rhode Island	1985	Subsidy	39,600 (July 2002)
South Carolina	2000	Subsidy / Pharmacy Plus	42,000 (Nov. 2002)
Vermont	1996	Subsidy	11,550 (Nov. 2002)
	1989 / 2000	Subsidy	19,025 (Dec. 2002)
West Virginia	2000	Discount	17,000 (July 2003)
Wisconsin	2001	Subsidy / Pharmacy Plus	90,000 (July 2003)
Wyoming	1988 / 2002	Subsidy	1,291 (June 2003)

Source: NCSL Web site, http://www.ncsl.org/programs/health, viewed April 26, 2004.

**Note: The state legislatures in Alaska, Arkansas, Hawaii, Montana, New Mexico, South Dakota, Tennessee, Texas, and Washington have authorized SPAPs, but the programs have not yet been implemented.*