



THE KAISER COMMISSION ON  
**Medicaid and the Uninsured**

**Pharmacy Plus: Trade Offs Between Expanding  
Rx Coverage and Global Caps in Medicaid  
&  
Will Pharmacy Benefits Pay for Themselves?  
Findings from the Research**

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**&**  
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**May 15, 2003**

Figure 1

## Pharmacy Plus Waivers: An Overview

- The Administration announced the Pharmacy Plus initiative in January 2002
- Uses “Section 1115” waiver authority to allow states to secure federal Medicaid matching funds for Rx programs for low-income seniors and/or the disabled
- As a condition of securing Pharmacy Plus waivers, the Administration requires states to accept global funding caps in Medicaid for seniors and/or the disabled
- Size of caps are set through private negotiations with HHS and their generosity varies widely across states

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Figure 2

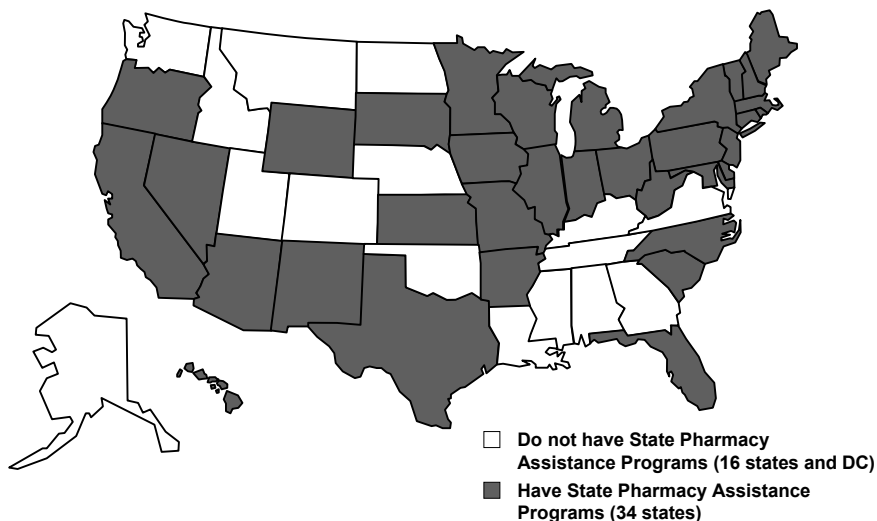
## States' Interest in Pharmacy Plus Waivers

- **Strong state interest**
  - Extensive need for Rx coverage
  - Fiscal incentives to pursue federal Medicaid matching funds to help refinance some of the cost of existing state-funded Rx programs
- **More than a dozen states are pursuing**
- **Some states not pursuing because of concerns about global funding cap in Medicaid**

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Figure 3

## States with Pharmacy Assistance Programs



Note: Arizona, Arkansas, Hawaii, New Mexico, Ohio, Oregon, South Dakota, and Texas have enacted, but not yet implemented their programs. California, Hawaii, New Hampshire, Iowa, New Mexico, Ohio, South Dakota, and West Virginia have discount programs only. **KAISER COMMISSION ON SOURCE: NCSL, <http://www.ncsl.org/programs/health/drugaid.htm> (updated April 2003). Medicaid and the Uninsured**

Figure 4

## Status of Pharmacy Plus Waivers as of May 13, 2003

	5 Approved		9 Pending		
	Covers Seniors	Covers Disabled	Covers Seniors	Covers Disabled	
Florida	✓		Arkansas	✓	
Illinois	✓		Connecticut	✓	✓
Indiana	✓		Delaware	✓	✓
South Carolina	✓		Maine	✓	✓
Wisconsin	✓		Massachusetts	✓	
			Michigan	✓	
			New Jersey	✓	✓
			North Carolina	✓	
			Rhode Island	✓	

Note: Although Maryland has a waiver to use federal Medicaid matching funds for a small pharmacy program for seniors, Maryland is not included on this list because, rather than obtaining a new Pharmacy Plus waiver, it amended an existing Medicaid managed care waiver.

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Figure 5

## Pharmacy Plus Waivers: Non-financial Elements

- Can be used to expand an existing Rx program or establish a new one
- Limited to people with income below 200% of FPL
- Can cover seniors and/or the disabled
- Medicaid requirements generally do not apply
  - No limits on cost-sharing (e.g., 50% co-insurance in IN)
  - States can limit the drugs that are provided or impose benefit caps (e.g., \$160 a month limit on benefits in FL)
  - Enrollment caps allowed

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Figure 6

## Pharmacy Plus Waivers: Financing Requirements

- To enforce “budget neutrality,” HHS requires global funding caps in Medicaid
- Under caps, states are allocated a limited amount of money to use over 5-year life of waivers for:
  - All Medicaid expenditures on the elderly and/or disabled population
  - Cost of Pharmacy Plus Rx program
- Size of cap is based on an estimate of the amount a state would spend on elderly and/or disabled Medicaid beneficiaries over next five years in the absence of the waiver
- If state hits cap, the federal government no longer will match its expenditures on its Rx program or elderly and/or disabled Medicaid beneficiaries

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Figure 7

## **Examples of Expenditures Subject to Capped Funding Under Pharmacy Plus Waivers**

*Under Pharmacy Plus, states must place all of their expenditures on behalf of elderly and/or disabled Medicaid beneficiaries under the cap, including for:*

- Prescription drugs
- Lab and x-ray services
- Durable medical equipment
- Home and community-based care services
- Nursing home care
- Medicare premiums and cost-sharing obligations

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Figure 8

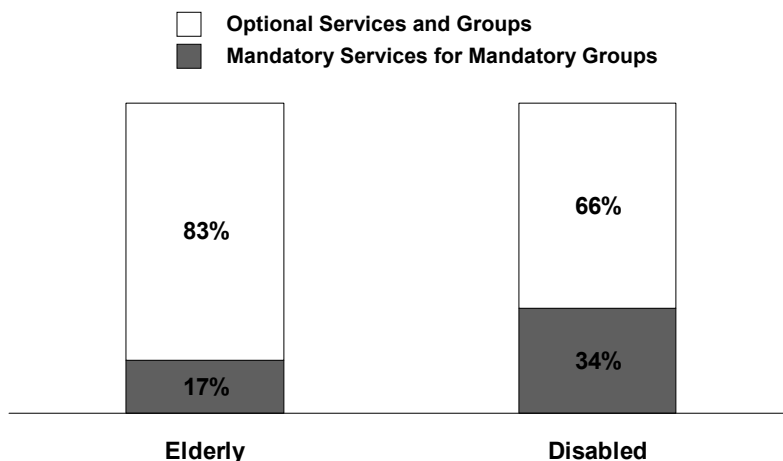
## **Implications of Global Funding Caps**

- **Loss of open-ended federal Medicaid matching funds**
  - For higher than expected costs
  - For new initiatives
- **New fiscal incentives to reduce Medicaid spending on elderly and/or disabled beneficiaries**
  - Reduces risk of reaching cap
  - “Frees up” resources to refinance existing state-funded prescription drug programs
- **If they need to cut in response to caps, states have many options under current law**
  - Reduce optional expansions of eligibility
  - Drop or modify optional benefits
  - Scale back home and community-based care waivers
  - Reduce nursing home payment rates
- **Caps may apply to a significant portion of a state’s Medicaid budget**

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Figure 9

## Medicaid Expenditures on the Elderly and Persons with Disabilities, 1998



Note: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.

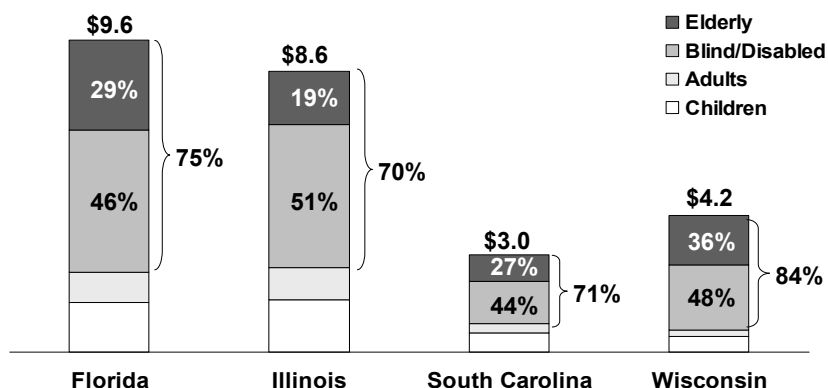
Source: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

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Figure 10

## Medicaid Spending by Enrollment Group in States with Pharmacy Plus Waivers, 2002

\$ Billions



Notes: Percentages based on 1998 proportion of spending by enrollment group applied to 2002 total spending. Does not include administrative costs or Disproportionate Share Hospital payments.

SOURCE: Urban Institute estimates based on data from CMS.

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Figure 11

## Factors Affecting a State's Risk of Reaching its Pharmacy Plus Cap

- Generosity of funding cap
- Rate of growth in Pharmacy Plus prescription drug spending
- Rate of growth in Medicaid spending
- Accuracy of assumptions about the effect of new or expanded Rx program on Medicaid spending

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Figure 12

## States' Funding Caps on Elderly Medicaid Beneficiaries Under Pharmacy Plus Waivers

State	Size of cap for 5-year life of waiver (billions)	Average annual growth rate allowed under cap	Historical Growth Rate in Elderly Medicaid Spending		
			Last year	Last three years	Last five years
Florida	\$16.67	8.0%	9.2%	8.9%	8.0%
Illinois	\$14.05	10.8%	4.2%	7.4%	7.0%
South Carolina	\$4.96	7.4%	7.8%	11.1%	n/a
Wisconsin	\$8.37	8.4%	10.3%	7.2%	5.4%

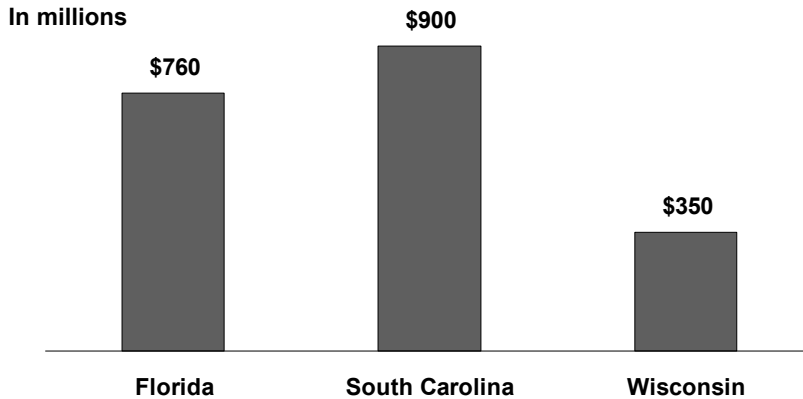
Note:  
Funding caps are set in terms of total, rather than federal expenditures. CMS enforces budget neutrality over the five-year life of a state's waiver, not in a given year.

Source: KCMU analysis of data provided by states to CMS. Historical growth rates reflect data available to states at the time they submitted their Pharmacy Plus applications.

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Figure 13

### Extra Federal Funding States Could Have Received Under Pharmacy Plus Waivers if Their Caps Were as Generous as Illinois

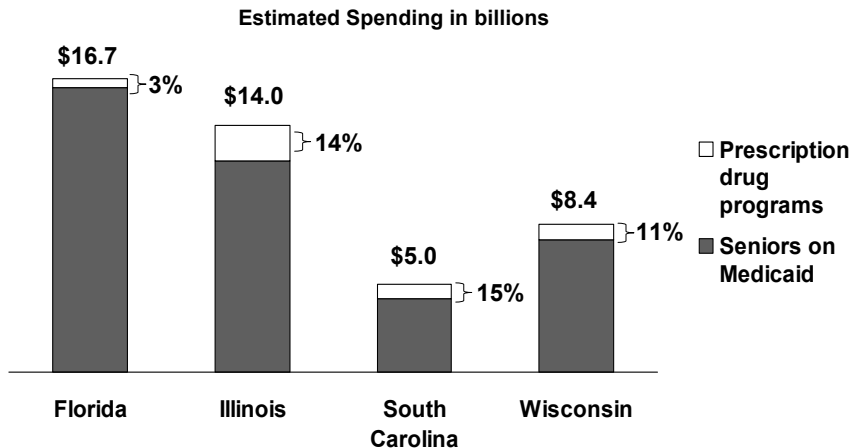


SOURCE: KCMU. Figures represent estimates of the additional federal matching funds that would have been available to these states over the five-year life of their Pharmacy Plus waivers if their caps were set using the same growth rate allowed under the Illinois Pharmacy Plus cap (10.8%). The analysis used fiscal year 2003 Medicaid matching rates to estimate federal funding available under the alternative caps.

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Figure 14

### Expected Spending on Medicaid for Seniors v. Prescription Drug Programs Under Pharmacy Plus Funding Caps



SOURCE: KCMU analysis of state spending estimates submitted as part of their Pharmacy Plus waiver applications.

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Figure 15

## States' Diversion Rate Assumptions Under Pharmacy Plus Waivers

State	Number of elderly people diverted from Medicaid by Pharmacy Plus program		Number of Pharmacy Plus enrollees per senior diverted from Medicaid		Reduction in Medicaid caseload due to Pharmacy Plus program (%)	
	Year 1	Year 5	Year 1	Year 5	Year 1	Year 5
Florida	5,900	5,900	10	10	3.0%	2.8%
Illinois	7,500	41,442	26	9	4.6%	21.0%
South Carolina	4,325	22,060	12	3	5.0%	24.5%
Wisconsin	1,626	13,115	87	11	2.5%	18.6%

Source: KCMU analysis of data provided to states on the budget neutrality worksheets submitted to CMS as part of the Pharmacy Plus waiver application process.

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Figure 16

## Conclusions

- **Pharmacy Plus funding caps have potentially serious implications for state budgets and Medicaid beneficiaries**
- **Funding caps apply to all spending on elderly and/or disabled populations on Medicaid, not just Pharmacy Plus prescription drug programs**
- **A function of the waiver negotiation process, the generosity of caps varies markedly across states**
- **States have adopted highly optimistic assumptions about the Medicaid savings they will experience as a result of their Rx programs, increasing chances they will hit funding caps**

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# Can Prescription Drug Benefits Pay for Themselves?

## Findings from the Literature

Prepared for the Kaiser Commission on Medicaid and the Uninsured based on an upcoming paper

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Georgetown University  
Health Policy Institute  
May 15, 2003

Figure 2

### Will there be cost offsets?

- The theory underlying Pharmacy Plus Waivers is that the provision of prescription drug coverage will lead to a decline in Medicaid enrollment and spending.
- Cost offsets are not the primary goal of the drug coverage expansions; the primary goal is to expand access to prescription drugs for the low-income elderly, improving health and quality of life.
- But since the spending caps are based on assumption of cost offsets, there is a need to assess the empirical basis for the cost offsets hypothesis.
- This paper examines the research literature to determine whether Medicaid cost offsets are likely

Figure 3

## Pathways to achieving cost offsets

- Subsidies for prescription drugs will prevent spend-down to Medicaid for the low-income elderly with high out-of-pocket drug costs.
- Prescription drug treatment will substitute for unnecessary hospital and nursing home care.
- Prescription drug treatment will reduce future demands on medical and long-term care resources.

Figure 4

## Findings from the Literature

- First place to look for evidence of cost offsets: studies of coverage expansions
  - ◆ Little direct evidence
  - ◆ Therefore, need to examine a broader range of studies (indirect evidence)
- Studies of limits on access in Medicaid
- Studies of cost savings from specific drugs or drug classes
- Studies of the cost effectiveness of newer drugs

Figure 5

## Drug coverage expansions

- Studies of pharmaceutical assistance programs
- Pennsylvania PACE evaluation (Stuart and Lago 1989)
  - ◆ Authors expected to find lower rates of Medicaid enrollment and spending
  - ◆ Should have been able to detect changes in enrollment if even 1 in 300 PACE enrollees were diverted from Medicaid
  - ◆ However, despite enrollment of more than 460,000 low-income seniors in PACE, no evidence that Medicaid spend-down was averted
  - ◆ “These instances are rare enough that they have no discernable impact on aggregate enrollments and expenditures”
- Other studies of pharmacy assistance programs find cost offsets for hospitalizations; but results are questionable, studies fail to control for other factors likely to affect medical care use among enrollees.

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Figure 6

## Effects of reducing access to prescription drugs

- Studies of prescription drug cap in New Hampshire in 1981 (3 prescription limit per month for Medicaid patients) (Soumerai et al 1987, 1991)
  - ◆ Use of prescription drugs for elderly using medication for chronic illnesses declined, nursing home admissions increased
  - ◆ Study did not examine all elderly patients; only subgroups *already* diagnosed with chronic illnesses
- Canadian study of impact of increased cost sharing for prescription drugs (Tamblyn et al 2001)
  - ◆ Decline in use of “essential” medications
  - ◆ Increased emergency room visits, hospitalizations, nursing home admissions

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Figure 7

## Studies of specific drugs or classes

- Improvements in health outcomes and reductions in costs associated with particular therapies for particular groups of patients
- HIV/AIDS
  - ◆ Tremendous improvements in health from antiretrovirals
  - ◆ Some studies find evidence of cost offsets (reduced hospitalizations)
  - ◆ Others find increased costs, but drugs are “cost effective” from societal point of view
- Schizophrenia
  - ◆ Mixed evidence; some evidence of higher medication and outpatient costs, lower inpatient costs
- Drugs for conditions associated with increased nursing home admission among the elderly (hip fracture, Alzheimer’s disease, rheumatoid arthritis)
  - ◆ Limited evidence of reduced nursing home use, or reduced medical and long-term care costs.

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Figure 8

## Studies of newer drugs

- Studies by economist Frank Lichtenberg (2001, 2002)
- Increased spending on drugs that specifically manage disease, preclude or delay surgeries, reduce hospital admissions or lengths of stay should pay for themselves
- Finding: \$1 increase in Rx spending associated with \$3.65 reduction in hospital spending
- Patients who take newer drugs have lower health spending than those taking older drugs
- For Medicare population, reduction in age of drugs reduces spending by all payers by 8.3 times as much as it increases drug spending
  - ◆ most of the Medicare non-drug cost reduction (2/3rds) is due to reduced hospital costs

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## Conclusions

- Only one study (Stuart and Lago 1989) provides **direct** evidence of impact of expanded drug coverage for the low-income elderly on Medicaid enrollments, use of other medical and long-term care services, and spending
- **But that study finds no evidence of cost offsets**
- Other studies provide some **indirect** evidence
  - ◆ e.g. cost offsets for particular drugs or particular subpopulations
- But evidence is mixed and **studies are of limited relevance** for assessing the Pharmacy Plus diversion theory
  - ◆ They do not assess the impacts of a broad coverage expansion
  - ◆ Do not really test the diversion theory in the inverse since analysis of impacts is often limited to a narrow subgroup

**Eligibility, Enrollment Caps, Benefits and Cost Sharing in  
Approved Pharmacy Plus Programs, May 2003**

<b>State</b>	<b>Eligibility</b>	<b>Enrollment Cap</b>	<b>Pharmacy Plus Benefits</b>	<b>Cost Sharing</b>
Florida	Medicare Beneficiaries Aged 65+ 88-120% FPL	Yes	Same as Medicaid prescription drug coverage except has a \$160 per month benefit limit	Copayments: \$2 per generic drug \$10 per preferred drug \$30 per non-preferred drug
Illinois	Aged 65+ 0-200% FPL	Yes	Same as Medicaid prescription drug coverage	Enrollment fee: 0-100% FPL: \$5 100-200% FPL: \$25  Copayments: 0-100% FPL: none 100-200% FPL: \$3 per drug  Other cost sharing: After reaching a \$1,750 benefit threshold, 20% coinsurance and a nominal copayment for each additional drug
Indiana	Aged 65+ 0-135% FPL	Yes	Coverage for all drugs covered by Medicaid, but there is a \$500 to \$1,000 per year limit on benefits determined by income level	Coinsurance: 50% of the cost of the prescription
South Carolina	Aged 65+ 0-200% FPL	Yes	Same as Medicaid prescription drug coverage and includes pharmacy case management services (Has a limit of 4 drugs per month, exceptions allowed)	Deductible: \$500  Copayments: \$10 per generic drug \$21 per name brand drug
Wisconsin	Aged 65+ 0-200% FPL	Yes	Same as Medicaid prescription drug coverage	Enrollment fee: \$20  Deductible: 0-160% FPL: none 160-200% FPL: \$500  Copayments: \$5 per generic drug \$15 per name brand drug

Note: For 2003, the federal poverty line (FPL) is \$8,980 a year for one person and \$12,120 a year for a couple. In some cases, states appear to have implemented cost-sharing requirements that are more modest than allowed under their Pharmacy Plus waivers.

Source: KCMU review of the application and approval materials for Pharmacy Plus waivers available on the CMS web site at [www.cms.gov](http://www.cms.gov). The terms and conditions of Indiana's waiver have not yet been posted.