

Issue Brief

Prescription Drug Access, Quality and Affordability in Maine

Prescription drugs are an essential part of health care delivery and have contributed to increasing the quality and life expectancy of patients through the treatment of diseases and conditions.

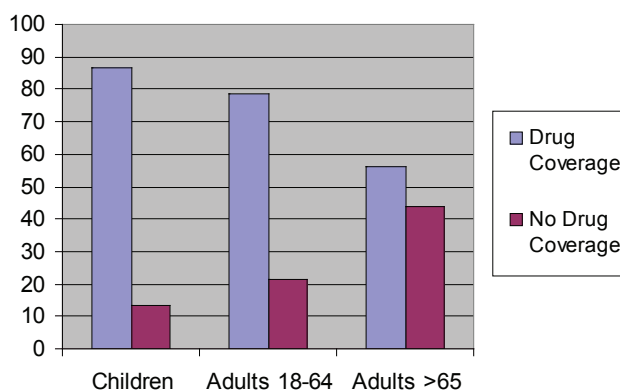
The increasing reliance on pharmaceuticals as a primary treatment modality coupled with the escalating costs of prescription drugs, raises policy concerns about securing access to affordable medications for those in need, encouraging safe medication use and quality prescribing, and controlling prescription drug costs within public benefit programs.

This brief summarizes what Maine has done in pharmaceutical policy in terms of expanding access, improving quality of prescribing and controlling costs as well as remaining issues that policymakers may need to monitor.

Rx Access: Who Is Covered?

Despite the importance of prescription drugs in maintaining health, not all Mainers have access to affordable medications. According to a household survey of Maine residents in 2002, 272,000 (22%) residents did not have drug coverage.¹ The elderly and disabled, who are most likely to suffer from multiple conditions requiring multiple medications, were disproportionately at risk

Figure 1: Percent of Mainers without Prescription Drug Coverage by Age, 2002



Source: Maine Health Insurance Coverage Household Survey, 2002.

because Medicare did not cover outpatient prescription drugs until 2006 (Figure 1, above).

While most non-elderly adults have prescription drug coverage through employer-sponsored insurance, over 136,000 Mainers have no health insurance for any kind of medical care. Non-elderly Mainers are at higher risk of having no drug coverage if they live in rural areas, or if they purchase insurance through the individual market.^{2,3}

Access to prescription drugs is important to the health and welfare of the citizens of Maine. Vulnerable groups with inadequate or without prescription coverage, including those with low-incomes, the elderly and disabled, and those with chronic illness are more likely to delay medications as prescribed and have more health

Fast Facts

- In 2002, 22% of Maine residents did not have drug coverage.
- Non-elderly Mainers are at higher risk of having no drug coverage if they live in rural areas, or if they purchase insurance through the individual market.
- In Maine, only 52% of Medicare beneficiaries have enrolled in Part D plans and nearly one quarter still have no credible drug coverage.
- One study of 1,200 elderly and disabled Maine Medicaid beneficiaries revealed that as many as 46% had received one or more potentially inappropriate prescriptions.
- The number of Mainers found eligible for Lower Income Subsidy (LIS) is lower than the national average.

Author: Kimberley Fox
Muskie School of Public Service
(207) 780-4950, kfox@usm.maine.edu

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problems as a result.^{4,5} Non-adherence to necessary medications can also result in greater use of other health services, thereby increasing overall system costs.⁶

Maine has been a leader in establishing programs that improve residents' access to affordable prescription drugs. Maine was the first state to offer a prescription drug benefit for low-income Medicare beneficiaries through its Drugs for the Elderly (DEL) program in 1975, which was later extended to the disabled. It also has passed landmark legislation to make drugs more affordable through the Maine Rx Plus program, which extends Medicaid-level or deeper discounts to uninsured Mainers up to 300% of the federal poverty level (FPL). Table 1 (below) lists all the programs currently available to Maine residents that provide prescription drug coverage.

Table 1: State Programs Offering Prescription Drug Assistance in Maine, 2006

Program Name	# Enrolled
MaineCare	224,606
Medicare Part D pharmacy wrap for duals	46,050
Low Cost Drugs for the Elderly and Disabled (DEL)	38,560
Maine Rx Plus	36,147
DirigoChoice	11,131
HIV/AIDS Drug Assistance Program	376

Sources: OMS Program Eligibility Data as of Oct 2006. ADAP Enrollment as of Dec 2006, Dirigo Choice Enrollment as of Aug 2006.

For those ineligible for public programs, assistance may be available through community health centers and free clinics, hospital programs and private pharmaceutical assistance programs (PAPs) sponsored by drug manufacturers. The Maine Health Access Foundation has recently funded safety net providers across the state to help enroll uninsured Maine residents in the variety of private and public programs available.

Medicare Part D

In 2006, Medicare offered outpatient prescription drug coverage for the first time through the new Part D prescription drug benefit. The benefit is administered by private companies and may be purchased through stand-alone Prescription Drug Plans (PDPs) or through Medicare Advantage managed care plans that offer a drug benefit (MA-PD).

For a monthly premium ranging from \$13.70 to \$82.30 in Maine in 2007, Part D plans offer coverage for drugs on their formulary

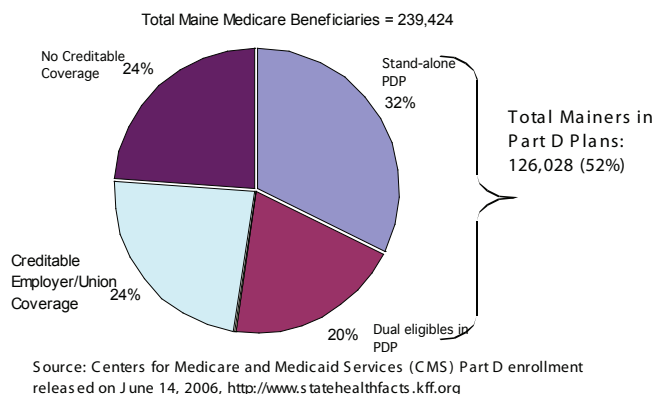
that may include a deductible, copayments, and a coverage gap for prescription drug costs in excess of \$2250 but less than \$5100—commonly referred to as the “donut hole.” All consumer cost sharing is indexed to inflation and subject to increase annually. Enrollment in Part D is voluntary, but if existing enrollees did not enroll by May 2006 or if new members do not enroll when they become eligible for Medicare, they will pay a premium penalty for every month they do not enroll.

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Low-income Medicare beneficiaries can get “extra help” to pay for Part D plan premiums and copayments, known as Low Income Subsidies (LIS). LIS is available to Medicare beneficiaries whose incomes fall below 150% FPL and who meet the minimum asset requirements.ⁱ Those eligible for full or partial LIS pay no or reduced premiums and deductibles, modest copayments and are exempt from the donut hole. Effective January 2006, Medicare beneficiaries enrolled in Medicare and receiving full Medicaid benefits (known as “dual eligibles”) no longer receive drug benefits through Medicaid but were automatically enrolled into a Medicare PDP and the LIS. Medicare beneficiaries that are enrolled in Medicare Savings Programs (MSP), where Medicaid pays for their Part B premiums and some of their cost sharing, are also automatically eligible for LIS. All other LIS eligibles must apply for these benefits in addition to enrolling in a Part D plan.

Enrollment in Part D and the LIS in particular has been significantly lower than anticipated in Maine and nationally. In Maine, only 52 percent of Medicare beneficiaries have enrolled in Part D plans (Figure 2, below). Nearly 70% of these people previously had drug coverage through either MaineCare or the Drugs for the Elderly program. Approximately one quarter of Maine Medicare

Figure 2: Prescription Drug Coverage Among Maine Medicare Beneficiaries, 2006



ⁱIn 2007, resource limits are \$7,620 (\$12,190 if married) for the full low-income subsidy and \$11,710 (\$23,410 if married) for partial low-income subsidies.

beneficiaries still have no creditable drug coverage (drug coverage of comparable value to the Medicare benefit.)

The number of Mainers found eligible for LIS is lower than the national average. As of November 2006, SSA had received nearly 27,000 applications from Mainers, but determined less than 10,000 (34%) eligible compared to 38% nationally.

How Maine has responded

Maine has been a leader in its response to the Medicare Part D benefit and protecting residents that were previously covered by state programs. It was the only state to reassign dual-eligibles randomly assigned by CMS to plans that did not cover their drugs and to assign DEL recipients into Part D plans that best matched their current drug regimen and pharmacy. The state was also one of the first to extend emergency coverage for dual-eligibles and DELs when appropriate coverage could not be accessed through their Part D plans.

Maine provides supplemental state Part D wrap benefits for the duals and enrollees in the Drugs for the Elderly program to hold them harmless relative to the benefit they previously received through the state. Maine is one of only a few states in the country that has elected to help the duals pay for Part D copayments (100% for generics and 50% for brands) that were previously not required in MaineCare.⁷ The state will also pay higher premiums for duals that need coverage above the basic plan. For DELs that enroll in a Part D plan with which the state has a contract, the state pays the premium cost for a basic plan, half the deductible, 50% of copayments for brand name drugs, 100% for generic drugs and 80% of costs during the donut hole. To get more people automatically eligible for LIS, Maine eliminated the asset test in the Medicare Savings Programs. For both duals and DELs, with prior approval the state will pay for off-formulary drugs or those pending an appeal to the Part D plan. Through a contract with the Legal Services for the Elderly, the state is also assisting members with Part D appeals.

Maine joined four other states in legally challenging the clawback provisions of Medicare Part D, which requires states to help pay toward Part D coverage for the dual-eligibles. The Supreme Court refused the states request for a hearing, but the states expect to continue to pursue this issue through the U.S. district court.

Continuing policy concerns

While national surveys suggest general satisfaction with Medicare Part D, certain subgroups (e.g. dual-eligibles) may be at risk of reduced access and require continued education and outreach. A recent survey of the Medicaid working disabled in Maine revealed that even with the state re-assigning people to plans that met their needs, 15% still had to switch a medication they had been taking

previously. Only a third of those surveyed knew they could change plans monthly and less than half knew where to go for help in changing plans.⁸

There are also continuing concerns about access to drugs during the donut hole for those that do not qualify for either the federal low-income subsidies

or the DEL program. Several bills have been introduced at the federal level both to eliminate the donut hole and to allow the federal government to negotiate prices. At the state level, there is continued exploration of ways to include prescription drug spending for imported drugs and other reduced-price drug programs in the out-of-pocket spending that counts toward the donut hole (including PAPs).

The low number of Mainers found to be eligible for the LIS program has ramifications for the state to the extent that many individuals that are denied LIS eligibility will be relying more heavily on the state pharmacy assistance programs to supplement the basic Part D benefit. This will leave less state funds for other purposes. The actions already taken by Maine to reduce the resource requirements in the Medicare Savings Programs may help to avert LIS asset barriers if these changes are publicized. Raising income eligibility for these programs could also get more individuals automatically LIS eligible.

Nationally, press reports have suggested that the Part D benefit may be driving independent pharmacies, particularly in rural areas, out of business. Further study of the impact in Maine may be required.

Finally, there is likely to be continued litigation and negotiations around the clawback provision and reimbursement for state emergency coverage.

Improving Quality Of Prescribing

For those who have access to prescription drug coverage, there are increasing concerns about the appropriateness and quality of drugs prescribed.

- One study of 1,200 elderly and disabled Maine Medicaid beneficiaries revealed that as many as 46% had received one or more potentially inappropriate prescriptions.⁹
- A report released by the Institute of Medicine in July 2006

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found that medication errors are common and that at least 1.5 million preventable adverse drug events occur each year.¹⁰

- Every year about 700,000 people in the United States go to the emergency room because of health problems related to drugs. One of every six patients then has to be admitted to the hospital for care.

The issue of drug quality and safety has gained momentum in policy circles across the country. In 2006, at least 16 states proposed legislation or passed laws to allow for the development and regulation of electronic transmission of prescription drug orders, as well as establishing Internet prescribing practices to provide increased protection for consumers purchasing prescription drugs over the Internet. Several states (Iowa, Mississippi, South Carolina, and Vermont) have also established electronic prescription drug databases to monitor the misuse, abuse and diversion of prescription drugs and controlled substances.

Maine recently passed legislation requiring internet posting of all clinical trial results, including adverse results, one of the first states to do so. The law requires that DHS conduct a public education campaign on drug safety and effectiveness.

Maine also passed legislation to control the disposal of unused prescriptions in the community, which serves to reduce the potential for misuse or adverse events.

Future Policy Options

The Institute of Medicine's Preventing Medication Errors report calls for states as regulators and payers to motivate the adoption of practices and technologies that can reduce medication errors and ensure that professionals have the competencies required to deliver medications safely. Some policy changes they recommend that Maine might consider include:

- Medicaid and other payers using explicit financial incentives to motivate improvement in medication use. This could also include providing feedback to providers about potentially inappropriate prescribing.
- State policies that remove any barriers to e-prescribing and passage of legislation consistent with Medicare's e-prescribing provisions.
- Medication error reporting requirements and setting standards for error prevention technology.
- Quality improvement initiatives related to community pharmacy practices including providing objective information on effectiveness, prescribing and safety information to health providers.

Quality initiatives that encourage medication management have proven successful at a local level in Maine. A project funded by the Robert Wood Johnson Foundation intended to reduce inappropriate prescribing among Maine dual-eligibles through pharmacist-physician consultations significantly changed prescribing behaviors. The rate of potentially inappropriate medications fell by 56% for new prescriptions written.¹¹

Addressing Affordability And Controlling Drug Costs

Within public and private health benefit plans, over the last decade pharmaceutical costs have been increasing at a greater rate than other health care services. As one of the largest prescription purchasers through Medicaid and the state employee health benefits programs, Maine has taken a number of steps to control escalating costs of prescription drugs to state and private insurance programs, while also protecting consumers subject to retail prices.

What Maine has done

Maine has been among the most aggressive states in the country to enact legislation to protect consumers from high drug prices. As indicated above, the Maine Rx Plus Program has become a national model for extending Medicaid or lower level discounts to uninsured residents. Other Maine policies targeted toward consumers include requiring pharmacies to provide usual and customary prices of drugs for cash customers and to post a notice of this requirement.

In addition, the state has taken aggressive steps to control costs within the state Medicaid program and to encourage pricing transparency targeted at lowering drug costs to both public and private payers. Among the most notable policies, Maine:

- Established a preferred drug list (PDL) in the MaineCare program and negotiated supplemental rebates from manufacturers;
- Created a Sovereign States Drug Consortium with Vermont and Iowa to pool Medicaid purchasing power across state programs (The program is intended in part to offset MaineCare's reduced negotiating power resulting from the transfer of the dual-eligibles from Medicaid to Medicare Part D);
- Requires pharmacy benefit managers (PBMs) to disclose rebates, conflicts of interest and discounts from drug manufacturers that PBMs are required to pass on to employers rather than retaining as PBM profits; and
- Requires disclosure of marketing and advertising spending by drug manufacturers as well as distribution of samples.

Future issues in cost containment

The state has made considerable strides in passing legislation to control drug costs in public programs and in addressing drug affordability for consumers. As innovative new approaches to containing costs, these policies warrant continued state monitoring to assess their impact.

The state may also want to consider greater collaboration with other states in expanding or enhancing these initiatives. More than 15 states are members of the Oregon Drug Effectiveness Review Project, a collaboration of public and private organizations that have joined together to provide systematic evidence-based reviews of the comparative effectiveness and safety of drugs in many widely used drug classes and to apply the findings to inform public policy and related activities including the development of preferred drug lists.

At the same time, some federal laws could threaten some of the gains states have made in negotiating deeper discounts with manufacturers. Some states have raised concerns that language in the U.S. Free Trade Agreement could be interpreted as limiting state affordable prescription drug options. Several states, including Maine, have passed resolutions objecting to trade agreements limiting imports and price regulation and have called on Congress and the Office of the United States Trade Representative to enact interpretive guidance to insure these agreements do not restrict state prescription drug programs or Medicaid.

For further information:

Jude Walsh, Governor's Office of Health Policy and Finance
jude.e.walsh@maine.gov

Brenda McCormick, MaineCare
Brenda.mccormick@maine.gov

Kim Crichton, Maine Health Access Foundation
kcrichon@mehaf.org

Web sites:

Maine pharmacy programs:
<http://mainecarepd.org/>

Medicare Part D:

<http://www.maine.gov/dhhs/beas/medicare/www.medicare.gov>
http://www.cms.hhs.gov/States/06_InformationforStateOfficials.asp
<http://www.kff.org/medicare/>

Quality issues:

<http://www.iom.edu/?id=35961>
<http://www.ohsu.edu/drugeffectiveness/>

Other Rx Policy Websites:

<http://www.nlarx.org>
<http://ncsl.org/programs/health/pharm.htm>

References

1. Prescription drug coverage data drawn from Maine Household Survey, 2002, Institute for Health Policy.
2. Ziller, E. Kilbreth, B. Health Insurance Coverage Among Maine Residents, The Results of a Household Survey, 2002. Prepared for the Governor's Office of Health Policy by the Institute for Health Policy, Muskie School of Public Service, University of Southern Maine, May 2003.
3. Ziller, E, Coburn, A, Yousefian, A. Rural residents more likely to be underinsured. Maine Rural Health Research Center Research and Policy Brief, Institute for Health Policy, Muskie School of Public Service, 2006.
4. Stuart, B, Grana, J. (1998) Ability to Pay and the Decision to Medicate. *Medical Care*, 36(2), 202-211.
5. Heisler M., Langa, K, Eby E, Fedrick AM, Kabeto M, Piette JD. (2004) The health effects of restricting prescription medication use because of cost. *Medical Care*, 42(7); 626-634.
6. Klein D, Turvey C, Wallace R. (2004); Elders who delay medications because of cost: health insurance, demographic, health and financial correlates. *The Gerontologist* 44: 779-787;
7. Kennedy J, Erb C. (2002). Prescription noncompliance due to cost among adults with disabilities in the United States, *American Journal of Public Health*, 92 (7), 1120-1124.
8. Lexchin, J., Grootendorst, P. (2004). Effects of Prescription Drug User Fees on Drug and Health Services Use and on Health Status in Vulnerable Populations: A Systematic Review of the Evidence, *International Journal of Health Services*, 34 (1), 101-122; Soumerai, S., Ross-Degnan, D., Fortess, E., and Walsler, B. (1997) Determinants of Change in Medicaid Pharmaceutical Cost Sharing: Does Evidence Affect Policy? *The Milbank Quarterly* 75 (1), 11-34.
9. Fox, K, Schofield, L. The Pharmacy Coverage Safety Net: Variations in State Responses to Supplement Medicare Part D. Muskie School of Public Service, University of Southern Maine, February 2006.
10. Gray, C. Medicare Part D Survey of MaineCare Workers with Disabilities Dual Eligibles: Experience Before and During Transition March 2006 Telephone Survey, Institute for Health Policy, Muskie School of Public Service, June 2006.
11. Tupper J. MaineNET Project Brief, 2005 at. <http://muskie.usm.maine.edu/projectbriefs/MaineNET.jsp>
12. Institutes of Medicine (IOM), Preventing Medication Errors, National Academies Press, Washington, D.C., 2007, 124-125.