Does North Carolina Need a Pharmaceutical Assistance Program for Older Adults?

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In his 2000 State of the Union address, President Bill Clinton echoed a sentiment that older Americans have been expressing for years: affordable prescription drugs are "the greatest growing need of seniors."[1] For the last two years, the North Carolina Coalition on Aging has called for state legislation addressing access to prescription drugs, and in 1999 the Governor's Advisory Council on Aging included prescription assistance to older adults among its recommendations to the governor.[2]

In 1997 the Health Care Financing Administration estimated that 89 percent of older adults (those sixty-five years of age and over) regularly use at least one prescription drug, spending an average of $742 per year on prescription medications. By the year 2005, this average yearly cost for medications is expected to rise to $1,000 per person.[3] Although older adults make up only 12.7 percent of the U.S. population,[4] they consume more than 32 percent of all prescription medications.[5]

Yet at the time in their lives when Americans require more prescription drugs, they are most likely to be without insurance to help pay for the drugs. Medicare, the primary insurance for older Americans, does not pay for most prescription drugs outside hospital settings. Although an estimated 65 percent of all older Americans have prescription drug coverage (through Medicaid, employer-sponsored coverage, Medigap policies, and other private policies), only 36 percent of seniors with incomes under $10,000 have such benefits.[6]

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Americans with low incomes may be forced to choose between medications and basic necessities. In a national survey conducted in 1995, "among persons aged 50 and over with an annual income of $10,000 or less, 40 percent reported that they had to cut back on essentials such as food or heat to pay for prescription drugs."[7] Research indicates that older adults with low incomes purchase as little as one-quarter of the medications they require.[8] This problem is compounded by the rising price of pharmaceuticals.[9]

The State Division on Aging has estimated that, in the year 2000, among older adults in North Carolina living at or below 200 percent of the federal poverty level (two times $8,050, or $16,100 per year for an individual), about 56 percent (roughly 275,000 people) are without prescription insurance. A survey of 600 older adults in eastern North Carolina found that 44 percent resorted to various strategies, some dangerous, to manage their prescription costs, including taking less than the amount prescribed or going without prescribed drugs altogether.[10] The consequences of such strategies can be significant. One recent study found that underuse of drugs for high blood pressure was associated with preventable hospital readmissions, and another estimated that 5.5 percent of all hospitalizations (approximately two million annually) resulted from noncompliance with medication regimens, leading to an annual cost of $7 billion.[11]

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This article draws on lessons from academic literature, interviews with aging-policy experts, and analysis of existing data to suggest parameters for a North Carolina pharmaceutical assistance program.

Criteria for a North Carolina Program

Between 1977 and 1996, eleven states enacted programs to assist low-income older adults in obtaining prescription medications at affordable prices.[12] North Carolina's response to the dilemma of prescription drug affordability has come from community-based programs, at least thirty-one of which now exist in the state.[13] These programs include community health clinics that distribute manufacturers' samples as well as independent nonprofit organizations that offer an array of services, such as financial assistance, medication education, and help in obtaining access to manufacturers' assistance programs.

In considering whether to establish a statewide pharmaceutical assistance program in North Carolina, policy makers must address two important factors, cost and need:

- *Cost*. Administrators of state pharmaceutical assistance programs have identified the growth of program cost as their primary concern.[14] Therefore, to be feasible, any North Carolina program would have to satisfy some cost criteria. Of course, in evaluating cost, one must take into account the potential for savings in overall health care services as a result of a program's implementation.
- *Need*. A second criterion for a North Carolina program is that it focus services on the older adults most in need of access to affordable medications. As of January 1, 1999, North Carolina raised the income eligibility level for Medicaid to 100 percent of the federal poverty level. This means that adults sixty-five years of age and over with an annual income of $8,050 or less and limited assets can qualify for Medicaid, which offers a prescription drug benefit. However, older adults between 100 and 200 percent of the federal poverty level, currently $8,050 to $16,100 per year for an individual, remain vulnerable to lack of prescription drug coverage.

Selected State Programs: Features and Examples

Existing state pharmaceutical assistance programs vary in terms of guidelines but generally share the following characteristics:

- A defined eligibility age (usually sixty-five)
- A maximum income eligibility level
- A "copayment" (a fixed dollar amount that a person must pay) for each prescription

Despite these common characteristics, the cost per beneficiary ranges widely across states, from $86.23 in Vermont to $933.65 in New Jersey in 1995. The number of beneficiaries also ranges widely, from 4,400 in Vermont to almost 332,000 in Pennsylvania in 1995. These latter two states also represent the minimum and maximum overall expenditures in 1995: $380,000 and $248 million, respectively.[15]

Little data exist on the number of older adults served by North Carolina's community-based programs. They have been described as "a patchwork" in which "efforts to improve access to medications are duplicated, solutions [are] fragmented, or only a limited amount of assistance [is] provided"[16]

Senior PHARM*Assist*,[17] an effective nonprofit program in Durham County, is an example of a community-based program in North Carolina. It places as much emphasis on educating older adults, their physicians, and their pharmacists about appropriate and effective medication use, as it does on increasing access to medications. Also, it gathers data about outcomes to discover the effectiveness of various strategies and programs.

Serving more than 600 older adults in Durham County, Senior PHARM*Assist* had a fiscal year 1998 budget of approximately $395,000.[18] Of Senior PHARM*Assist's* current budget, 51 percent is from foundations, with other funding coming equally from individuals, businesses, and government. Older adults with incomes up to 140 percent of the federal poverty level ($11,270 per year in 1998–99) are eligible for services. They pay the first eight dollars of any prescription, with Senior PHARM*Assist* paying the remainder. There is no limit on the number of prescriptions. The average yearly benefit paid by Senior PHARM*Assist* on behalf of its medication-eligible clients is $660. Senior PHARM*Assist* reimburses local retail pharmacies at rates below those of Medicaid, in effect working with pharmacists to reduce prices.

Senior PHARM*Assist* considers a geriatric formulary and prospective medication review to be among its innovative characteristics. A "formulary" is a list of all medications that are paid for by the program.[19] Senior PHARM*Assist* has established a committee of pharmacists, physicians, nurse practitioners, and other professionals to develop a formulary of cost-effective medications known to be safe for older adults. Through this program feature, Senior PHARM*Assist*, unlike some state pharmaceutical assistance programs, avoids paying for expensive medications that have limited therapeutic benefits.[20]

"Prospective medication review" means that older adults meet with a staff pharmacist to generate a list of all medications they take and to discuss their reasons for taking each medication, the possible side effects, and potential interactions among the drugs. This information also is used to alert the client's physicians and pharmacists to possible drug-related problems.

Potential Impact of a North Carolina Program

Evaluation of the potential cost of a pharmaceutical assistance program in North Carolina involves a two-part inquiry: (1) Is it possible to identify savings in the health care system to balance the cost of such a program? (2) What should the eligibility guidelines be?

Possible Savings

Gina Upchurch, director of Senior PHARM*Assist*, cites data from a 1996 study indicating a 31 percent decrease in the percentage of Senior PHARM*Assist*

clients who made an emergency room visit after one year in the program. The study also found a 29 percent decrease in the percentage of clients who stayed in the hospital overnight after one year of participation in the program. To derive these figures, clients and family members were surveyed regarding hospitalizations and emergency room visits upon enrollment in the program and after one year of enrollment. In 1998 the national average cost per inpatient hospital day was $1,245.[21] Thus Senior PHARM*Assist's* reduced rate of hospitalizations and emergency room visits illustrates the potential savings.

A 1987 analysis of Medicare expenditures comparing older residents of New Jersey and eastern Pennsylvania found a significant decrease in the cost of inpatient hospital care among New Jersey residents after enactment of the state's drug assistance program.[22] Other researchers have concluded that limiting access to prescription drugs could increase the risk of nursing home placement for low-income older adults.[23]

Eligibility Guidelines

North Carolina's decision to raise the income eligibility level for Medicaid may provide about 50,000 of the state's lowest-income older adults with prescription drug coverage. The Fiscal Research Division of North Carolina's General Assembly estimates that this expansion will cost the state $57 million in fiscal year 2000.[24] Even with this action, though, an estimated 219,000 older adults between 100 and 200 percent of the poverty level are without drug coverage and thus are vulnerable to high prescription drug costs.[25]

Despite the limited options available to older adults to pay for prescription drugs, program benefits or eligibility may need to be constrained, at least initially. The state already has made a significant financial commitment to low-income older adults through the Medicaid expansion. Other demands, such as the Hurricane Floyd recovery effort, may limit additional funding. Administrators of pharmaceutical assistance programs in other states believe that starting with a limited program that can be expanded is better than cutting benefits from a generous program after costs escalate.[26]

The second criterion for a state pharmaceutical assistance program is that it focus on the most vulnerable low-income older adults. Discussions with North Carolina state and local advocates for the aging and an analysis of income eligibility levels for existing state pharmaceutical assistance programs suggest that people at 100 to 150 percent of the federal poverty level are the most vulnerable to the high cost of prescription drugs. Therefore a North Carolina pharmaceutical assistance program might best set a maximum income eligibility level of $12,075 per year for an individual, or 150 percent of the federal poverty level.

Closely associated with selecting the income eligibility level for the program is determining the level of copayments, if any. Although copayments generate savings and instill a sense of responsibility for health care, they have been shown to cause patients to reduce use of needed health care services, particularly when they are applied to people whose incomes are below 200 percent of the federal poverty level.[27] The most prudent course may be to limit copayments for this population to nominal amounts and include an annual ceiling on the total amount of copayments paid by a patient.

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Recommendation

One way to initiate pharmaceutical assistance in North Carolina is through a public-private partnership among the state, charitable foundations, and communities. Demonstration projects might be established initially in six to eight counties to encourage a racially and geographically diverse pool of participating older adults. Foundations might provide seed funding to communities through a competitive-grant process. The goals of the demonstration projects would be as follows:

- To improve access to affordable prescription drugs
- To educate older adults, pharmacists, and physicians about appropriate use of medications
- To integrate pharmaceutical assistance with existing services when possible
- To save costs in the health system by meeting the foregoing goals

A flexible framework for awarding grants would encourage innovation among projects in meeting these goals. The North Carolina Department of Health and Human Services might form a board of administrators of pharmaceutical assistance programs, aging-policy professionals, pharmacists, physicians, and older adults to provide technical and organizational assistance to communities that receive grants. Such a board would set minimum standards that programs must meet, including the following:

- A geriatric formulary
- Prospective medication review
- Copayments
- An income eligibility level of 150 percent of the federal poverty level
- A strategy to assist ineligible clients and to refer them to other pharmaceutical assistance services
- Participation of local pharmacists, businesses, health providers, and councils on aging
- Uniform procedures for evaluation of program performance

A five-year seed grant might be necessary to give projects time to generate reliable data, as measured by rates of hospitalization, emergency room visits, medication knowledge, self-perception of health status, and physicians' perception of health status, among other indicators. Projects able to prove cost savings might eventually be absorbed into existing service systems, or they might incorporate as free-standing nonprofit organizations. Projects also might develop alliances with community hospitals or county social service offices.[28]

A public-private partnership of this nature requires the support of a wide range of groups—policy makers, foundations, professionals in aging, communities, pharmacists, and other health care providers. To gain such support, programs will have to limit start-up costs, demonstrate savings in other sectors of the health system, generate reliable outcome data within a reasonable time, and show the ability to win private support to match public investment. If they can attain these goals, North Carolina should be able to deliver beneficial and cost-effective pharmaceutical assistance to its neediest older adults.

Notes

1. The 2000 State of the Union address is available at http://www.washingtonpost.com/wp-srv/politics/special/states/docs/sou00.htm.

2. The two organizations' statements are available at the North Carolina Division of Aging's Web site, http://www.dhhs.state.nc.us/aging/drugs.htm.

3. Division on Aging, North Carolina Department of Health and Human Services, A Study of Options for Making Prescription Drugs More Affordable for Older Adults at 1 (Raleigh, N.C.: NCDHHS, 1997).

4. *Statistical Abstract of the United States*, available at http://www.census.gov/statab/www/part1.html.

5. E. W. Lingle, Jr., et al., *The Impact of Outpatient Drug Benefits on the Use and Costs of Health Care Services for the Elderly,* 24 Inquiry 203 (1997).

6. Telephone conversation with Gina Upchurch, director, Senior PHARM*Assist* (March 3, 1999); L. Lagnado, *Proposal's Aim: Help "Near Poor" Pay for Medicine,* Wall Street Journal, March 4, 1999, at B12.

7. Division on Aging, A Study of Options at 1.

8. Lagnado, *Proposal's Aim* at B12.

9. From 1980 to 1990, prescription drug prices rose at an annual rate of 13.8 percent while overall prices in the American economy rose at an annual rate of just 5.3 percent. S. D. Sullivan et al., *The Economics of Prescription Drug Coverage for the Elderly: Implications for Health Care Reform,* 18 Generations: Journal of the American Society on Aging 55 (1994).

10. Division on Aging, A Study of Options at app. 2, p. 1.

11. Lingle et al., *The Impact* at 56.

12. Division on Aging, A Study of Options at 4.

13. Telephone conversation with Glenn Pierce, director of the North Carolina Association of Free Clinics (Feb. 15, 1999). The number includes free community pharmacies and clinics that offer varying levels of services.

14. Stuart Bratesman, Jr., *Pharmaceutical Assistance Programs for the Low-Income Elderly: A Review of Findings from a Survey of the Literature,* Duke Long-Term Care Resources Occasional Policy Paper Series, No. 3, May 1997, at 2.

15. All the information on state pharmaceutical assistance programs was gleaned from Division on Aging, A Study of Options.

16. Gina Upchurch et al., *Access to Medications for Low-Income North Carolina Citizens: Without Funds, How Can They Follow Doctor's Orders?,* 55 North Carolina Medical Journal 173, 173 (1994). About 50,000 North Carolinians were served by community pharmaceutical programs in 1997. It was not possible to determine how many older adults were among those served. Telephone conversation with Pierce.

17. All information regarding Senior PHARM*Assist* was obtained in an interview with Gina Upchurch, executive director, in Durham, North Carolina, on February 5, 1999, and through subsequent e-mail correspondence with her.

18. Senior PHARM*Assist* has both funded and unfunded clients. "Funded" clients are those who meet income guidelines and for whom the program purchases medication in addition to providing pharmaceutical consultation and educational services. "Unfunded" clients do not meet income guidelines and are not eligible for medication reimbursement but still benefit from pharmaceutical consultation, educational services, and assistance in gaining access to corporate pharmaceutical assistance programs.

19. K. S. Levin, A Guide to Implementing a Community-Based Pharmaceutical Assistance Program Modeled after Senior PHARM*Assist*, Durham, NC (Durham, N.C.: Senior PHARM*Assist*: 1998).

20. Interview with Upchurch.

21. Selected Community Hospital Statistics: 1995–99, available at http://www.hcfa.gov/stats/indicatr/indicatr.htm.

22. Lingle et al., *The Impact* at 208.

23. S. B. Soumerai & D. Ross-Degnan, *Experiences of State Drug Benefit Programs,* Health Affairs, Fall 1990, at 45.

24. Fiscal Research Division, North Carolina General Assembly, Current Issues in Budgeting: State of North Carolina, handout at presentation to Publication Administration 222 (Institute of Government course) (Feb. 4, 1999).

25. Division on Aging, A Study of Options at app. 2, p. 3.

26. Bratesman, *Pharmaceutical Assistance Programs* at 5.

27. *See, e.g.,* Massachusetts Health Care for All, The Affordability of Health Care for Massachusetts's Working Families (Boston: Massachusetts Health Care for All, Dec. 1989); Joseph Newhouse et al., Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance, No. R-2847-HHS (Santa Monica, Cal.: Rand Corp., Jan. 1982).

28. These options emerged in a telephone conversation with Gina Upchurch, executive director, Senior PHARM*Assist* (March 3, 1999); a telephone conversation with Sandra Leak, associate director, Duke Long Term Care Resource Center (Feb. 19, 1999); and a conversation with John Saxon, faculty member, Institute of Government, The University of North Carolina at Chapel Hill (March 1999). The precedent for seed funding from foundations with eventual absorption into Medicaid comes from the Medicaid Community Alternatives Program (CAP), an option for North Carolina counties.