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The Feasibility of Mail Order Pharmacy and Other Cost Containment Strategies in the Low Cost Drugs for the Elderly Program

Staff Report
to the

Joint Standing Committee
on Human Resources

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

A. Purpose of Study

The Joint Standing Committee on Human Resources requested the study to determine whether a mail order option would reduce costs in the Low Cost Drugs for the Elderly Program. In addition, the Committee asked that the structure of the program be examined.

B. Major findings

1. Mail Order Pharmacy

   · The literature is mixed as to whether savings result from mail order pharmacy services. Although unit cost is generally less in mail order programs, overall program costs can increase if utilization rates increase.

   · Analysis of a sample of drugs offered in the Low Cost Drugs for the Elderly program suggests that annual savings of between $140,000 and $205,000 would result from a mail order option, assuming that 25% of program participants opted for mail order.

   · Although anecdotal evidence suggests that the quality of mail order service should be closely monitored, the quality of mail order pharmacy has not been found to be different from the quality of community pharmacies.

   · If a mail order contract were awarded to an out-of-state entity, Maine pharmacies could lose an estimated $1.2 million per year in sales.

2. Program Structure

   · Maine's Low Cost Drugs for the Elderly program is among the more restrictive of similar programs elsewhere in terms of the drugs covered.

   · Maine's income limits are lower than those of similar programs in other states. Maine's age requirement (62) is also lower.

   · Maine's copayment requirements are comparable to those of similar programs in other states.

GLOSSARY

AWP	Average Wholesale Price. Published periodically in the "Red Book," AWP is the national average wholesale price paid for a particular drug. It is commonly used as a benchmark to compare drug costs, to determine reimbursement to pharmacists, and to calculate discounts from mail order firms.
Copayment	The amount per prescription that the consumer must pay. Copayments are generally in the range of $1 to $5 per prescription, although they are sometimes a percentage of the cost of the prescription. Current copayments in the LCDE program are $3 for generic or single-source drugs and $5 for brand-name drugs.
Dispensing Fee	The fee paid to pharmacists per prescription filled in most prescription drug programs. The current dispensing fee in the Low Cost Drugs for the Elderly program is $3.35.
LCDE	The abbreviation used in this report for Low Cost Drugs for the Elderly program.
Medicaid Upper Limits	Medicaid Upper Limits are ceilings on the amount of reimbursement paid for drugs in the Medicaid program. They are established by State and Federal rules.
Unit	A single pill, capsule, syringe or other drug receptacle. AWP is generally expressed per unit.

Introduction

A. Origin and Purpose of Study

During the First Regular Session of the 115th Legislature, the Joint Standing Committee on Human Resources considered LD 403, "An Act to Enhance Medical and Social Services for Maine's Long-term Care Consumers." Section 4 of the Act requires the Department of Human Services to offer optional mail order service to those receiving drugs under the Low Cost Drugs for the Elderly program (LCDE). The Committee heard contradictory claims from opposing sides in the debate, and was not able to resolve questions relating to cost savings and quality.

Also during the First Regular Session, the Committee considered 2 bills to expand the drugs covered under the program (LDs 29 and 48). A related bill to expand eligibility for the program (LD 305) was referred to the Joint Standing Committee on Taxation. All 3 bills were rejected for lack of funds, but they raised fundamental questions about how the program is structured. At several points in the program's history, policy makers have been asked to add therapeutic categories to the regimen of drugs covered under the program. When resources were less scarce, those decisions were relatively easy to make, but in the present fiscal climate, prioritization of services has become critical. Policy makers find it difficult to choose between anti-arthritic drugs and those that treat Parkinson's Disease. While choosing one drug over another for addition to the program is difficult enough, longer-term scarcity could mean that policy makers would need to decide which drugs to remove from the program, which recipients to make ineligible, or how much to increase the copayment amount. These issues led the Joint Standing Committee on Human Resources to request a staff study addressing the following issues:

1. Will a mail order option save money in the LCDE program? Do quality assurance issues outweigh any potential savings? (Addressed in Part I)

2. How might the program's benefits be restructured to facilitate policy making and respond to fiscal constraints? (Addressed in Part II)

B. History of the Low Cost Drugs for the Elderly Program

The LCDE program was created in 1975 as the Free Drugs to the Elderly Program. (Laws of Maine, 1975, c. 619) (See Chart A for history in summary form.) Originally conceived as an effort that would be privately funded by the pharmaceutical industry, the program was given an initial appropriation of $1 for each year of the

biennium. The Commissioner was given broad authority to administer the program within available funds: "The extent and the magnitude of this program will be determined by the Commissioner of Health and Welfare and will be determined on the basis of the calculated need of the recipient population and the available funds." It quickly became apparent that private donations would not support the type of program envisioned by its founders. The Ames company donated $3,000 and Eli Lilly committed to donate a percentage of the State's Medicaid purchases but did so only for the first 2 years. Private funds were used to pay for administration and, in FY 1978, the first General Fund appropriation was made. General Fund appropriations have risen steadily as new drugs have been added, eligibility has been expanded, and the costs of drugs have increased. (See Chart B for General Fund history)

In 1978, eligibility for the program was tied to the Elderly Householders Tax and Rent Refund Program. (Laws of Maine 1978, c. 718) This had the effect of expanding eligibility and reduced administrative costs, since eligibility would be determined by the State Tax Assessor as part of the eligibility determination for the Tax and Rent Refund Program.

In 1979, the Commissioner was given the authority to require a copayment, and references to "free prescription drugs" were changed to "low cost." (Laws of Maine 1979, c. 726)

In 1983, the Commissioner was given the authority to cover medical supplies under the program. (Laws of Maine 1983, c. 290)

In 1987, language was added to require coverage of drugs to treat chronic obstructive lung disease with a $3 copayment, and coverage of antiarthritic drugs with a $10 copayment. (Laws of Maine 1987, c. 746) This was the first time that specific drug categories were listed in the statutes.

The requirement that anticoagulant drugs be covered with a copayment of $2 was added in 1989. (Laws of Maine 1989, c. 563) Also in 1989, a maximum of $2 was set for copayments on any drugs offered under the program, unifying the copayment amount across all of the drug categories. (Public Law 1989 Chapter 564)

In 1991, the budget bill increased the co-payment amount to $3 for generic or single source drugs and $5 for brand name, multi-source drugs, but specified that an individual may not be required to make more than 4 copayments per month and a married couple may not be required to make more than 6 copayments per month. (Laws of Maine 1991, c. 591, Part P, §§ P-3 through P-9) The amendments also repealed

language that required solicitation of private funds and allowed an advisory committee to be established.

As this report was being prepared, the Governor had proposed that the copayment be increased to $6 for generic or single source drugs and $10 for brand name, multi-source drugs. The Governor also proposed to repeal the limit on the number of copayments per month. (Draft of Governor's Proposals for State Budget, Parts M-3 through M-6, November, 1991)

C. Backdrop for Study

This study is undertaken at a time of monumental fiscal strain. On the revenue side, fewer funds are available for any State programs. The LCDE program has been maintained recently by increasing the copayment amount. On the expenditure side, the increase in the cost of prescription drugs has been twice the rate of inflation, rising 80% between 1980 and 1986. (Kirking et al., 1990) Demand for services can be expected to rise dramatically over the next 20 years as the aging "baby boomers" become eligible for services.

I. The Mail Order Option

This Part considers the pros and cons of incorporating an optional mail order service in the LCDE program. Three major issues will be addressed: cost, quality, and impact on Maine businesses.

A. Cost

1. Overview

Although mail order drug service has been offered in this country for over a century, rapid growth of the industry is a relatively recent phenomenon. Initially, drugs were supplied through the mail by community or hospital pharmacies for patients in rural areas. The Veterans Administration was the first to start a formal mail order service when, in 1946, it began mailing prescriptions at no charge to eligible veterans. In 1959, the AARP began a non-profit organization to offer mail order drugs to its members. For-profit ventures followed in 1963. The most rapid growth of mail order has occurred in the past decade, with sales increasing from $100 million in 1981 to $1.5 billion in 1989. Most of that growth has been in the public and corporate sectors. (Horgan, et al., 1990)

Despite this long history and recent explosive growth, little independent empirical data exist regarding the aggregate costs of mail order drugs relative to other drug distribution systems. Many authors have suggested that savings should result from mail order as a result of economies of scale, lower dispensing fees, increased generic substitution rate and increased operating efficiency. It is generally acknowledged that the unit costs of mail order are less than retail, but the literature is mixed as to whether mail order reduces net program costs. Overall program costs can rise if program utilization increases as a response to increased visibility or reduced patient contributions under a mail order program. To a large degree, patient response depends upon the type of system an organization is converting from. For instance, it is generally thought that patients who do not take advantage of major medical reimbursement might use a drug card if it were available. Because program utilization depends on the specifics of the case, published case studies are limited in their usefulness and should be used with extreme caution.

Various studies have been commissioned by mail order firms, card firms, organizations that offer mail order and other entities that have are involved in the mail order controversy. Many of

those studies were reviewed by the Legislature and will not be revisited here. (See Joint Standing Committee on Business Legislation, 1989) Generally speaking, they lack credibility because of the vested interests of the sponsors, and their results tend to contradict one another.

Since the Legislature conducted its study in 1989, one major study was completed that had been ordered by Congress as part of the Medicare Catastrophic Coverage Act. (See Horgan and Knapp, 1989) Unfortunately, when the Act was repealed, the study was suspended, but the authors did complete an initial phase of work. It represents an independent effort to assess the aggregate savings of mail order over other types of drug benefit programs. The authors determined the average cost of a day's supply of medication to be $.56 for mail order firms versus $.58 for community pharmacies. The authors conclude that the "result does not appear to substantiate the mail service pharmacy claim that they could deliver maintenance drugs at substantially lower cost than community pharmacies." (Horgan and Knapp, 1989, p. V-18)

It has been suggested that the longer supply dispensed in mail order programs (generally 90 days) would be wasted if a patient died before the 90 day supply was gone. While no work has been done on the particular issue of patient deaths, the issue of waste in 90-day supplies was examined in 1989. (Wertheimer and Pipalla, 1989) The authors found that 90 percent of the prescriptions for drugs dispensed for chronic conditions were taken by patients for two consecutive quarters, and that 78 percent of all prescriptions were continued through 9 months. The authors concluded that chronic medications can be dispensed economically in 90-day supplies.

There has also been some speculation regarding the impact that mail order would have on drug rebates from manufacturers. During Legislative hearings on LD 403, it was suggested that prescriptions filled in New Jersey may result in rebates going to New Jersey for those prescriptions. In fact, rebates would not be affected, and the following points of clarification should be made:

- Manufacturers are under no obligation to provide rebates on drugs sold in the LCDE program. Federal law requires them to provide rebates to State Medicaid programs only. States are free to pursue additional rebates on a voluntary basis, and at least four states (CT, NJ, NY, PA) have refused to cover drugs in their non-Medicaid drug programs if rebates are not paid.

- In the Medicaid program, the rebate is owed to the state that pays for the drug, not the state that distributes it. Rebates are based upon claims that State Medicaid programs submit directly to the manufacturers. Whether Maine buys a prescription from a local drugstore or from a mail order firm in another state has no impact on the rebate program.

2. New York State Initiative

New York State recently implemented an optional mail order program for Medicaid recipients living outside of New York City. According to Ilene Rutkowski of the New York State Department of Health, savings are easy to estimate in New York because the State normally pays AWP plus a dispensing fee of $2.60. New York's contract with Medco provides for reimbursement to be paid at AWP minus 13.5%, with a dispensing fee of $2.50, so the State saves 13.5% plus $.10 on every prescription filled. Aggregate savings have not been significant because only 521 out of about 150,000 eligible people have used the optional service. Initial marketing efforts consisted of a mailing to all eligible Medicaid recipients; Medco plans a second mailing shortly. New York does not plan to make the program mandatory because a waiver of the Medicaid "freedom of choice" requirement would be needed.

One lesson that can be drawn from the New York experience is that incentives are needed in order to achieve significant participation in mail order programs. New York (which has no copayments in its Medicaid drug program) offers no financial incentive to recipients to use the service. Presumably, the only incentive is the convenience that mail order offers, an incentive that may be worth more to older consumers who may be less mobile.

We should be careful not to overreach in drawing additional conclusions for Maine. First and foremost, New York and Maine use different pricing strategies in their public drug programs. New York's Medicaid Upper Limit program was successfully challenged in court action, resulting in the switch to AWP reimbursement. Maine uses a Medicaid Upper Limits program to determine reimbursement in the ELCD program, resulting in reimbursement that is sometimes less than AWP. Therefore, in order for savings to result in the Maine program, discounts would have to pull prices below the average prices paid, not merely below AWP. In terms of the discount itself, one can reasonably assume that New York State, with a much larger program, would receive a better deal than Maine.

3. Maine Experience

a. Maine State Employee Health Insurance Program

The drug benefit in the State Employee program was examined by the Legislature in 1989 and has been the subject of considerable debate. (See Cost Containment for Prescription Drugs; A Report of the Joint Standing Committee on Business Legislation, December 1989) The State employee program is not at issue here, so no attempt is made to evaluate that program or contribute to the debate. Rather, the mail order experience of the State employee program is examined to see if it has any bearing on the proposed mail order option in the LCDE program.

No one disputes that aggregate costs have increased significantly in the State employee program, but various theories exist as to why they have increased. In the first year that mail order was offered to State employees (FY 88), costs rose by 130%, as compared to 65% the previous year. (Joint Standing Committee on Business Legislation, 1989) In FY 90, the increase was 45% and in FY 91, it fell to 33%. (Derived from State of Maine Employees Prescription Drug Program Review, October 16, 1991, Medco Containment Services, Inc.) Two reasons are most often advanced to explain the dramatic leap in the first 2 years of mail order: 1) the switch from major medical (80% reimbursement after meeting a deductible) to mail order (initially no copayment, no deductible) was a better deal for employees; and 2) the visibility and convenience of the program were greatly enhanced by the mail order option and the card option that was added in the second year. Taken together, the theory suggests, these 2 factors resulted in a much greater utilization rate of the drug benefit than had been the case under major medical reimbursement. Any unit savings that were derived were offset by the increased use of the benefit.

The first contract in the State employee program provided a discount of AWP - 13%, with a dispensing fee. The current contract calls for AWP - 6% for brand name drugs and AWP - 20% for generic drugs, with no dispensing fee. The program was scheduled to issue a request-for-proposals on the program again this year but has delayed the RFP pending the outcome of collective bargaining negotiations undertaken to reduce employee benefits. The program's administrator, Jo Gill, is optimistic that the next contract will provide a better deal than the last, because the mail order industry has become more competitive and more bidders are expected in the next round.

4. An Estimate of Potential Savings in the LCDE Program

An estimate of possible savings in the LCDE program was calculated by comparing actual cost data provided by the Bureau of Medical Services with estimated costs at 2 hypothetical levels of discount. While the results below offer a reasonable estimate of potential savings resulting from a mail order option, they do rely on several assumptions and must be considered with caution. The assumptions, along with a brief outline of the methodology used to arrive at the estimates, are provided here. Calculations are provided in detail in Appendix 1.

a. Methodology

The analysis of 8 drugs done by Medco for the Maine Committee on Aging was reviewed and found problematic for 3 main reasons:

- The Medco analysis assumed that the LCDE program pays AWP plus the dispensing fee of $3.35. In fact the rules governing reimbursement provide that reimbursement be the lowest of estimated acquisition cost (EAC), maximum allowable cost (MAC), or usual and customary (UC), and that AWP be used only when none of the above apply. The actual amount reimbursed is sometimes less than AWP; this has been the basis of the Bureau of Medical Services' claim that mail order would not produce any savings. Rather than assuming AWP, the estimates below are based upon actual cost data for the program for September, 1991. Although program costs do fluctuate from month to month, September appears to be a typical and appropriate period of time to study.

- The Medco analysis assumed that the LCDE program dispenses only 30 days supply at a time. In fact, the rules call for drugs to "be dispensed in quantities sufficient to effect optimum economy." (Rules for the Maine Drugs to the Elderly Program, 11/13/89) The program data for September 1991 shows that most prescriptions are filled for more than 30 days. This is important because a major area of savings in mail order is presumed to be a reduction in the number of dispensing fees paid. The analysis below reflects the actual dispensing costs paid by the program.

- The Medco analysis treated each of the 8 drugs equally in its final analysis, failing to recognize the relative impact that each drug has on total program costs. The

analysis below assigns weight to each drug according to the percentage of total program costs it represents.

Although actual cost data for the LCDE program are available by drug, the number of drugs covered (over 300) made it impractical to evaluate the entire program. For convenience, the 8 drugs originally analyzed by Medco were retained as a sample. It includes both high- and low-cost drugs from various therapeutic categories.

Actual program costs for the 8 drugs were compared with 2 hypothetical scenarios:

- Scenario A: AWP minus 8%, $2.50 dispensing fee, $2 copayment.
- Scenario B: AWP minus 13.5%, $2.50 dispensing fee, $2 copayment.

Although it is not exactly the same, the first scenario is similar in value to the existing contract in the State Employee Health program and probably represents a conservative estimate of what the State might get in the LCDE program, given that the market is appreciably more competitive than it was when the State Employee contract was awarded in 1988. The second scenario is the same as the terms won by New York State in its Medicaid program last year except that New York has no copayment. It is probably optimistic for Maine, given the differences in the size of the programs.

Costs for a 90 day supply for each drug in the sample were calculated at actual LCDE cost, at Scenario A cost and at Scenario B cost. Results from each drug analysis were weighted to reflect the relative impact of each drug on overall program costs, and an estimated savings percentage for the program as a whole was derived. Finally, to estimate dollar savings for 1 year, a participation rate of 25% was assumed, given the copayment incentive of $1 per prescription.

b. Results

Extrapolation of sample analyses results in savings from 11.97% for Scenario A to 17.48% for Scenario B. (See Appendix 1 for detailed analysis.) Based upon a LCDE budget of $4,700,292 in FY 93, savings from an optional mail order program are estimated in the range of $140,000 to $205,000:

- Scenario A: 11.97% X $4,700,292 X 25% participation = $140,656

- Scenario B: 17.48% X $4,700,292 X 25% participation = $205,403

The results suggest that, although the rules of the LCDE program are intended to keep reimbursement to pharmacists below AWP, they do not have that effect consistently. Given the present reimbursement policy, the State could lower the average unit cost it pays in the LCDE by implementing a mail order option with a financial incentive in the form of a lower copayment.

Unlike the State Employee Health program and other programs that convert from a major medical reimbursement system to a card/mail order system, it is not likely that a mail order option would increase significantly the number of eligible people who actually use the program. The LCDE program is already a card program; a mail order option, while perhaps providing better access for elders who are home-bound, would not make the program more visible or appreciably easier to use. Although a copayment incentive would be likely to bring back marginal participants who stopped using the program when the copayment was increased above $2, the significant increase in aggregate costs experienced by the State Employee program would not likely be repeated in the LCDE program.

B. Quality Issues in Mail Order Pharmacy

Several quality issues have been raised by the Maine Pharmacy Association and the Bureau of Medical Services regarding mail order drugs. These issues have been discussed at length in the literature and have been grouped into 3 areas: providing information to patients, monitoring drug therapy, and dispensing the correct medication. (Kirking et al., 1990)

1. Providing Information to Patients

Community pharmacists maintain that they are better able to provide information to patients face-to-face than mail order pharmacists can provide in writing or by telephone. Typically, mail order firms include written instructions and provide a toll-free telephone number for questions.

Mail order firms question whether face-to-face counseling actually occurs in the community pharmacy. Pharmacists report that they tend to provide information selectively, based on their

perception of patient need and desire. (Kirking et al., 1990) In Maine and at least 16 other states, patient counseling by pharmacists is mandated (see 32 MRSA §13784), but the effect of such mandates is unknown. Mail order firms also maintain that the toll-free number is preferable to face-to-face contact for patients who wish to protect their privacy.

2. Monitoring Patient Drug Therapy

Another important function of the pharmacist is to watch for signs of noncompliance, misuse or adverse affects. Both community pharmacists and mail order firms keep records (increasingly computerized) regarding the units of medication dispensed, the recommended daily dosage, and the number of refills dispensed. At least in theory, both have the same opportunity to monitor therapy, assuming a patient patronizes a single pharmacy. If a patient uses more than 1 pharmacy, no single pharmacy or mail order firm will be able to monitor effectively.

3. Dispensing the Correct Medication

Anecdotal evidence of dispensing errors has been offered nationally by retail pharmacy organizations, and in Maine by the Pharmacy Consultant and the Bureau Director of the Bureau of Medical Services. National studies that have been done to compare error rates suggest that mail order firms are as safe as community pharmacies. (Kirking et al., 1990) The administrator of the State Employee Health Program reports that 5 incidents of dispensing error have been reported to her office since the mail order program began in 1987, and in each case, the error was eventually traced to the prescribing physician.

The United States Senate conducted extensive hearings on mail order pharmacy in 1987, gathering various allegations of quality problems. (See U.S. Senate, 1987) The allegations were denied and the hearings were inconclusive. Studies conducted for Congress and for the Maine Legislature have concluded that the quality of mail order pharmacies is similar to that offered by community pharmacies. (Horgan et al., 1990 and Joint Standing Committee on Business Legislation, 1989.)

C. Impact on Maine Business

Mail order pharmacy undoubtedly affects Maine businesses. At issue are which businesses are affected, to what degree they are affected and whether they are at an unfair disadvantage.

1. Which Businesses Are Affected?

Mail order pharmacy (assuming the business goes out-of-state) has a negative economic impact on 2 groups, one being a subset of the other. The first group is pharmacies operated within the State of Maine ("Maine pharmacies"), the second is independently-owned pharmacies ("independents"). The Maine Pharmacy Association reports that out of approximately 250 Maine pharmacies, less than 100 are independents. The distinction is important because the decline of the small "mom and pop" independents, an emotional issue for many, is often tied to the mail order debate when, in fact, it is attributable to many factors.

Also affected is Maine's sole remaining drug wholesaler, J.E. Goold & Co. The wholesale business in Maine is more important to smaller pharmacies, since the larger chains do much of their purchasing direct from the manufacturers.

In addition to those businesses that would bear a negative economic impact, at least 2 Maine businesses could gain from a mail order service in the LCDE program. Action Mail Order in Waterville was recently cited in a New York Times article as one of the "big mail order pharmacies." (Meier, 1991) Also, Wellby Drug has expressed an interest in the mail order business and could be expected to bid on future Maine contracts.

2. To What Degree Are Maine Businesses Affected?

If the estimate that 25% of LCDE participants would use a mail order option is accurate, and if the business went out-of-state, Maine pharmacies would stand to lose about $1.2 million per year, based upon the FY 93 program budget of $4.7 million. Unfortunately, we can not assess accurately the impact of such a loss on any of the affected groups, since aggregate data on Maine pharmacy sales is unavailable. The National Association of Chain Drug Stores, the Pharmaceutical Manufacturers Association, the Maine Pharmacy Association and Action Mail Order were all unable to supply the annual dollar value of drugs sold in Maine.

A very crude estimate of impact may be derived using U.S. sales information for 1989 supplied by the Pharmaceutical Manufacturers Association. They estimate that sales that year totaled $33.3 billion. Based on the 1990 U.S. census, Maine's share of that is about $164 million. This figure includes all drug sales, including those made directly to health care facilities, and while it gives us a feel for how huge the pharmaceutical business is, it

does not give us an accurate picture of the retail pharmacy business.

3. Are Affected Businesses at an Unfair Disadvantage?

This is perhaps the most complicated question, because it involves antitrust issues and the existing relationships among the in-state entities. The question of unfair competition depends on who is competing with whom. Some of the businesses characterized as underdogs against the large, out-of-state conglomerates are hardly small businesses. Wellby, Laverdiere's, CVS, and other chain stores are all tied to large corporate entities. The independents are probably more affected by the expansion of chains than by mail order firms.

The question of whether Maine pharmacies could band together to bid on a mail order contract was submitted to the Attorney General's Office for consideration. Depending on the specifics of the situation, pharmacists could participate in a joint venture to bid on a mail order contract without violating antitrust laws. Generally speaking, if federal laws became an obstacle, Maine could immunize pharmacists under the "state action exception."

The Pharmacy Group of New England (PGNE), based in Portland, is well positioned to assist Maine pharmacies in such a venture. PGNE currently acts as a purchasing organization for 210 stores in Maine and New Hampshire and runs Health Plus, a network of stores that participate in various prescription programs.

II. Structure of the Low Cost Drugs for the Elderly Program

This Part looks at the current structure of program benefits and describes the various alternatives available to policy makers that affect benefits and program costs. Descriptive data from the LCDE program are analyzed and the program's characteristics are compared with those of similar programs in other states.

A. Categories of Drugs Covered

The LCDE program covers 5 broad categories of drugs. The categories and their impact on the cost of the program are shown in Chart C. Heart/hypertension/diabetes is obviously the most significant category, representing 76% of program costs. Anti-arthritic drugs, often referred to as "expensive" in program discussions, are the most expensive per claim but represent only 13% of program costs.

In terms of cost containment, category elimination offers policy makers a very limited strategy. To eliminate heart/hypertension/diabetes would be to eviscerate the program; to eliminate less significant categories would have minor impact on cost.

Of the other states that offer similar drug programs, Maine's is among the most restrictive in terms of drugs covered. Chart D shows that several states cover all prescription drugs with very limited exceptions. The broader programs are obviously more expensive. New Jersey uses dedicated casino revenues to fund its program; Pennsylvania uses lottery proceeds.

Despite the obvious fiscal issues, there continues to be interest in broadening the therapeutic categories in Maine. Last session alone, bills were introduced to cover psychotropics and drugs for the treatment of kidney, Parkinson's, and Alzheimer's diseases. Broadening the program to cover all prescription drugs would obviously increase costs significantly, in at least 2 ways. Of the 21,581 people issued cards in 1991, only 11,451 or 53% actually used the benefit. One can assume that some of the non-participating card holders do not use drugs presently covered but would begin participating if coverage were expanded. Also, costs per participant could be expected to rise as participants used their cards for more types of drugs. Clearly, if the program were to be broadened, significant cost reduction measures would need to be undertaken to make the expansion budget neutral. Some of the options for cost reduction are discussed below.

B. Eligibility

Restricting eligibility for the program would be one way to reduce costs to the program. This approach should be used with extreme caution, however, since preliminary studies suggest that reductions in drug therapy may result in increased institutionalization of older people. (Soumerai and Ross-Degnan, 1990). Eligibility could be restricted by decreasing the income limits or increasing the age requirement. Any changes in eligibility that are not also made to the Elderly Tax and Rent Refund program are likely to increase administrative costs, since the Bureau of Taxation automatically issues a drug card to anyone who meets the Tax and Rent Refund eligibility standards.

1. Income Limits

Chart D shows that Maine's income limits are among the lowest of the programs offered, with only Maryland having lower limits. At least one state (NY) has a sliding fee system in which people with higher incomes may participate but bear a greater cost. The point-of-sale equipment authorized for the Medicaid program in the current budget should allow the Bureau of Medical Services to consider options such as sliding fee scales, since individualized information could be made available to the selling pharmacist.

2. Age

At 62, Maine has the lowest age requirement of any state except Maryland, which does not consider age at all. Chart D shows that 65 is the standard age at which people become eligible for these programs. Age will become a more significant eligibility criterion over the next 20 years as our population ages and the number of people in the 62-65 age range increases.

C. Cost-sharing Strategies

Every state that has an elderly drug program requires participants to share costs through membership fees, deductibles, or copayments. Caps on benefits, another possible cost-sharing approach, is not used by any of the programs. Cost-sharing strategies are designed to raise revenue and to encourage patients to forgo drugs that are marginal or unnecessary.

1. Caps

While capping benefits has been tried in some medicaid programs, it has not been a popular cost-sharing strategy. Prescription caps stop coverage when the patient has reached a predetermined limit, either in dollars or in number of prescriptions. Common limits have been 3 or 4 prescriptions per month.

A study of a 3-prescription-per-month cap in the New Hampshire Medicaid program found that prescriptions dropped suddenly by 46%. The drop was attributable to the poorest of recipients, and the cost of the prescriptions was generally not picked up out-of-pocket. People went without or stretched their medications. The study's authors concluded that "[s]tate drug benefit programs should avoid placing arbitrary caps on patient-level medication use... These strategies have the potential to reduce access to essential medications; they could be associated with important declines in health status and, ultimately, increases in the use of more intensive substitute services, such as hospitalization and nursing home admissions." (Soumerai and Ross-Degnan, 1990, p. 52).

Chart E shows that a 3-prescription-per-month cap in the LCDE program would affect 906 participants, or about 8%. Chart F shows that a limit of $100 per month would affect over 819 participants, or about 7%. Given that the program is designed to offer only life-sustaining drugs, either type of cap should not be expected to decrease the use of marginal or unnecessary drugs. They could obviously decrease program costs by various amounts, depending on the caps that are established.

2. Copayments, Membership Fees and Deductibles

As Chart D shows, copayments are very popular with state drug benefit programs and have been used universally to increase revenue in recent years. Maine's increases are not significantly different from those in other states. New York uses a percentage copayment system (40%), which assures that those who get the most benefit also contribute the most out-of-pocket. In New York, the copayments are required in addition to sliding-scale membership fees or deductibles. New York officials have been disappointed with the participation rate in the program there, and speculate that the patients' share is too high.

The New Hampshire study was able to examine the relative impact of copayments versus caps since the State switched from caps to copayments. The authors found that patients were much more likely to receive necessary drugs under a $1 copayment than

they were under a 3 prescription cap. They concluded that "mild copayments are preferable to patient-level caps from the perspectives of cost, equity, and quality of life..." (Soumerai and Ross-Degnan, 1990, p. 43).

In Maine, the copayment was recently increased from $2 to $3 for generics and $5 for brand names, providing an incentive to recipients to ask for generic substitutions. Whether these levels of copayment can be considered "mild" is subject to debate. It is reasonable to assume that a number of marginal participants drop out of the program and reduce their drug use each time the copayment is increased.

An increase of $1 in the copayment raises approximately $175,000 for the LCDE program, based upon the fact that 176,394 claims were filed in FY 91. The actual savings are probably greater, since an increase in copayment is assumed to decrease the number of claims.

The issue of limiting the number of copayments required has been debated in Maine. When the amount of the copayment was increased in July, 1991, the number of copayments required was limited to 4 per month for an individual and 6 per month for a couple. Chart E suggests that such a policy benefits a relatively small number of participants (906, or about 8%), but they are clearly people who have a greater need. The Bureau of Medical Services has recommended that the limit on copayments be repealed, since it is difficult to administer and has diminished the revenue potential of the copayment increase. Chart G suggests that the amount of revenue at stake is significant, given that the marginal cost to the program of those participants making at least 4 claims per month represents over 20% of program costs. Although administration is difficult under the present processing system, it should be easy to monitor copayment limits when point-of-sale equipment is operating.

D. Miscellaneous Cost Containment Measures

Strategies directed primarily at containing costs include requiring rebates, establishing formularies and improving the prescribing practices of physicians.

1. Requiring Rebates

At least four of the other states' elderly drug programs require manufacturers to provide rebates in order to have their drugs covered under the programs. The Maine Pharmacy Association has recommended this strategy as an alternative cost-saving measure to mail order. The Association recommends

that the required rebate be 12%, parallel to the federal mandate in the Medicaid program. It is significant that the Association supports such an approach, since it could result in administrative burdens for its members if several drugs are excluded from reimbursement. The Bureau of Medical Services is attempting to arrange voluntary rebates in the LCDE program.

2. Establishing Formularies

Maine could establish a formulary to restrict the drugs eligible for reimbursement in the LCDE program. This mechanism was becoming increasingly popular with state medicaid programs before Congress barred it in return for mandated rebates. In theory, formularies restrict those drugs found to be ineffective or marginally effective.

3. Improving Prescribing Practices

Some health analysts have suggested that, rather than restricting choice or imposing financial burdens on patients, managers should try to improve the decisions that physicians make when prescribing drugs. Included in this category is drug utilization review, recently initiated in Maine's Medicaid program. Specific approaches include peer review, regular feedback in the form of audit sheets, and publication of prescription guidelines. These approaches "have been cost-effective and acceptable to practicing physicians, especially when they are carried out in a nonthreatening, supportive manner and when they emanate from credible, unbiased professional organizations." (Soumerai and Ross-Degnan, 1990, p. 52)

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Chart A

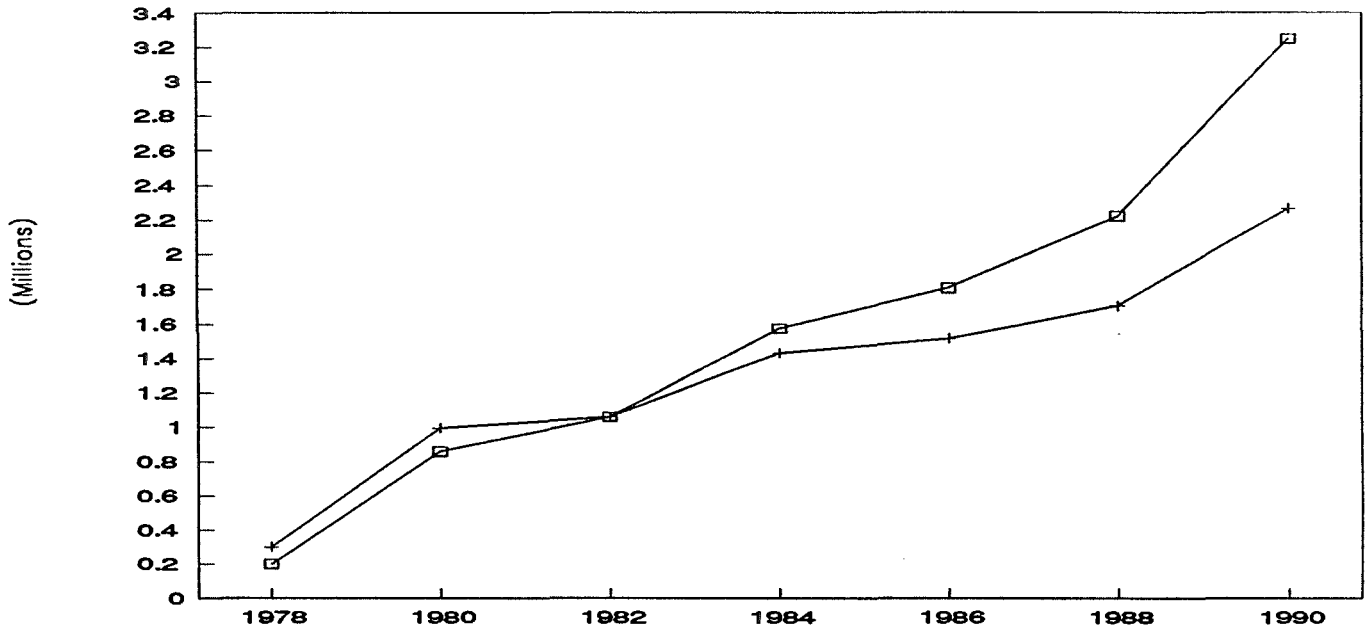
Legislative History of the Low Cost Drugs for the Elderly Program

YEAR	PUBLIC LAW/CHAP. #	SUMMARY OF ACT
1975	P.L. 1975 CH. 619	Program established.
1978	P.L. 1978 CH. 718	Eligibilty requirements determined by State Tax Assessor using Elderly Householders Rent and Tax Refund Act criteria.
1979	P.L. 1979 CH. 726	Copayment authorized and name changed.
1981	P.L. 1981 CH. 470	Technical changes.
1983	P.L. 1983 CH. 290	Medical supplies added to categories.
1987	P.L. 1987 CH. 746	Added prescriptions for Chronic Obstructive Lung Disease with a $3 copayment. Added prescriptions for Antiarthritic Drugs with a $10 copayment.
1989	P.L. 1989 CH. 563	Added prescriptions for Anticoagulant drugs with a $2 copayment.
1989	P.L. 1989 CH. 564	All copayments unified at $2.
1991	P.L. 1991 CH. 591	Copayments increased to $3 for generics, $5 for brand name. Copayments limited to 4 per month for an individual and 6 for a married couple.

Lowcstch.wk1

Chart B

General Fund Appropriations for the Low Cost Drugs for the Elderly Program

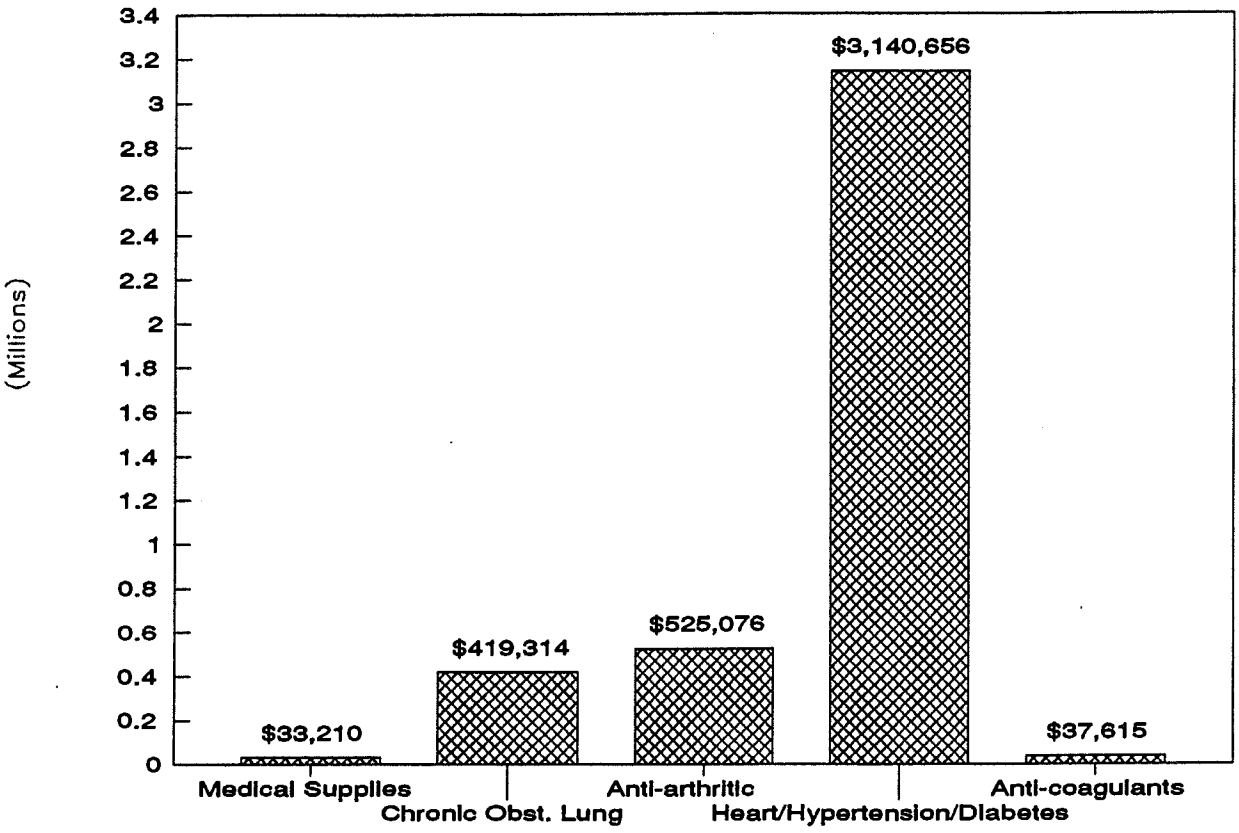


Year	Nominal Dollars	1982 Dollars
1978	$198,857	$300,388
1980	$856,501	$993,621
1982	$1,058,303	$1,058,303
1984	$1,573,137	$1,428,826
1986	$1,803,624	$1,513,107
1988	$2,218,315	$1,701,162
1990	$3,246,088	$2,265,239

Prepared by the Office of Policy
and Legal Analysis (November 1, 1991)
1982 Dollars derived using the Fixed Weighted Price Index
for purchases of goods and services by State and Local Governments

Chart C

Low Cost Drugs for the Elderly Program
Amount Paid in FY91 by Drug Category



Therapeutic	# of Claims Paid	Amount Paid	Average Paid	%of Prog. Costs
Medical Supplies	2,173	$33,210	$15	0.8%
Chronic Obst. Lung	20,249	$419,314	$19	10%
Anti-arthritic	17,216	$525,076	$40	12.6%
Heart/Hypertension/Diabetes	135,084	$3,140,656	$18	75.6%
Anti-coagulants	1,672	$37,615	$23	1%
Totals:	176,394	$4,155,870	$23.6	100%

Compiled by the Office of Policy and Legal Analysis from data supplied by the Bureau of Medical Services and Goold Health Systems (theracat.pm3)

Chart D

States with Drug Programs for the Elderly

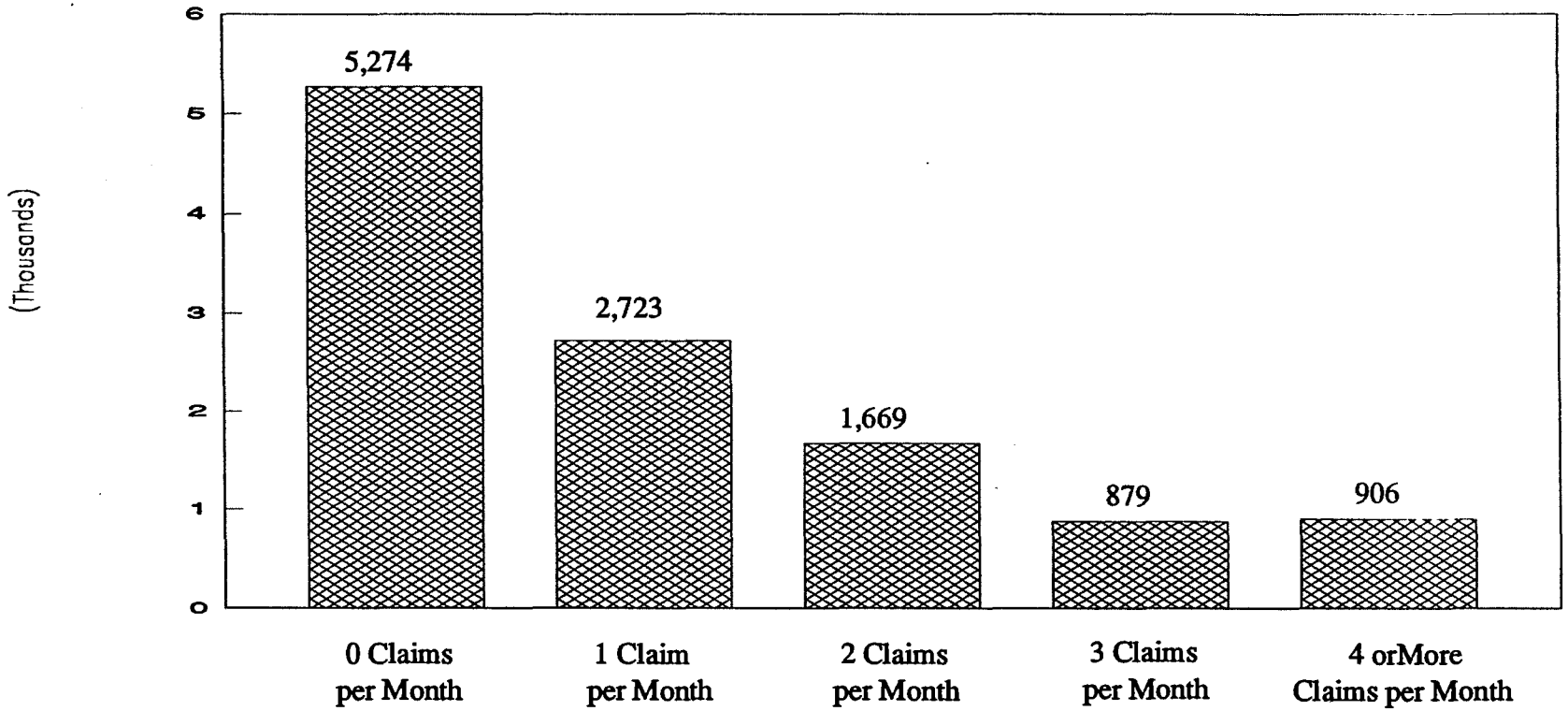
	ELIGIBILITY	COST SHARING	DRUGS COVERED	COMMENTS	STATUTORY CITE
CONNECTICUT 203-566-7613 Robin Cohen	65 and over <$13,800 (single) <$16,600 (married)	Copay: recently increased from $4 to $10	All prescriptions except for cosmetic drugs	Rebates required	17-A-340 Ct. Pharmacy Assistance Contract for the Elderly and Disabled
ILLINOIS 217-524-7142 Alberta Levant	65 and over		Cardiovascular, Diabetes, and Arthritis		Title 67 1/2-401 Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act
MAINE	62 and over or 55 and disabled up to $8400 (single) up to $10,500 (family)	Copay: recently increased from $2 to $3 for generic, $5 for brand	Arthritic, Chronic Obstrucitve Lung, Heart/Diabetic/Blood Pressure, Anti-coagulants and medical supplies		22 MRSA Sec.254 Low Cost Drugs for the Elderly Program
MARYLAND 410-225-1455 Pat Burkholder	No age limit (60% are elderly) $7,450 (single) $10,450 (family)	Copay: recently increased from $1.50 to $4	All maintenance drugs for chronic conditions and all anti-infective drugs		Sec.15-124 (Health General) Maryland Pharmacy Assistance Program
NEW JERSEY 609-588-2724 Mr. Vaccaro	65 and over <$16,000(single) <$19,000 (married)	Copay: expected to increase from $2 to $5	All prescriptions	Rebates required	Title 30:4D-20 Pharmaceutical Assistance for the Aged and Disabled
NEW YORK 518-474-3672 Marilyn Desmond	65 and over up to $15,000 (single) up to $20,000 (married)	Annual membership fee of $24 to $414 or deductable of $415 to $638; 40% copayment	All prescriptions except DESI (less than effective) drugs	Rebates required	547e-Executive Law Elderly Pharmaceutical Insurance Coverage
PENNSYLVANIA 717-787-7313 Ardella Darlington	65 and over <$13,000 (single) <16,200 (married)	Copay: recently increased from $4 to $6	All prescriptions except cosmetic drugs	Rebates required	Aging Title 6 Chapter 22 Pharmaceutical Assistance Contract for the Elderly

Prepared by the Office of Policy and Legal Analysis (November 1991)

Chart E

Low Cost Drugs for the Elderly Program

Number of Program Participants Making Selected Number of Claims per Month During FY91



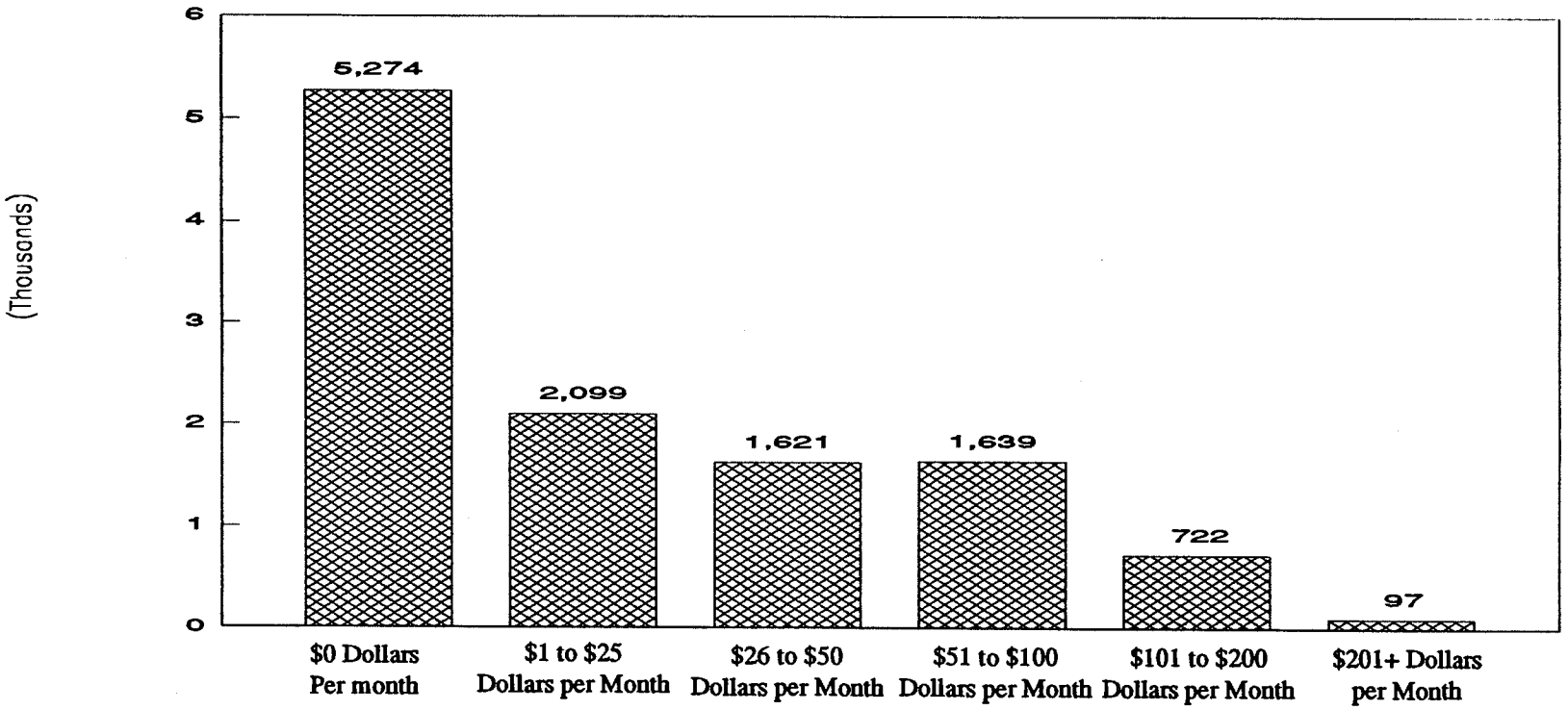
Prepared by the Office of Policy and Legal Analysis from data supplied by the Bureau of Medical Services and Goold Health Systems

CLS-A.pm3

Chart F

Low Cost Drugs for the Elderly Program

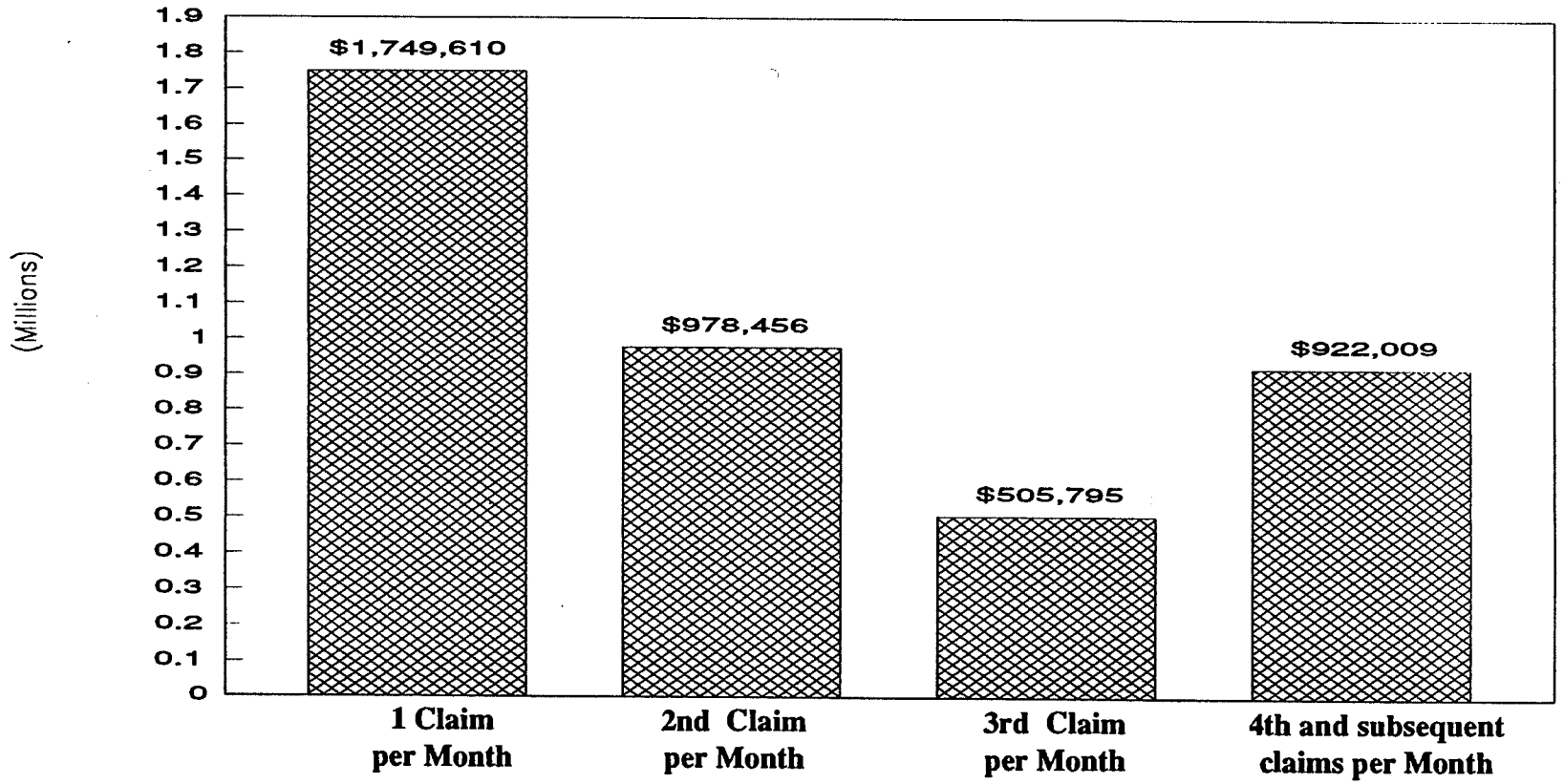
Number of Program Participants Making Selected Amount of Claims per Month During FY91



Prepared by the Office of Policy and Legal Analysis from data supplied by the Bureau of Medical Services and Goold Health Systems
Cost.pm3

Chart G

Incremental Costs of Additional Claims in the Low Cost Drugs for the Elderly Program, FY91



Note: Figures are based on an average claim paid in FY91 of $23.60

Prepared by the Office of Policy and Legal Analysis
from data supplied by the Bureau of Medical Services and Goold Health Systems
Clscst.pm3

APPENDIX 1

ANALYSIS OF INDIVIDUAL DRUGS IN SAMPLE

DRUG: Micronase 5mg

	Actual, Sept. '91	Scenario A: AWP-8%, $2.50 fee $2.00 copay	Scenario B: AWP-13.5%, $2.50 fee $2.00 copay
Units/day[1]	1	1	1
Average paid/claim[2]	33.03	---	---
Average units/claim[2]	81	---	---
Unit cost	.41 (average actual)	.46 (AWP)	.46 (AWP)
Cost 90 days[3]	36.90	41.40	41.40
Discount **(subtract)**	---	3.31	5.59
Dispensing fee **(add)**	reflected in average paid/claim	2.50	2.50
Copay **(subtract)**	reflected in average paid/claim	2.00	2.00
Total 90 days	36.90	38.59	36.31
Savings	---	(1.69)	.59
% Savings	---	(5%)	2%

---

[1]Estimate derived from dosage information in Physician's Desk Reference.

[2]Data supplied for September 91 by Goold Health Systems.

[3]Unit Cost X 90 days X Units/day.

DRUG: Dyazide

	Actual, Sept. '91	Scenario A: AWP-8%, $2.50 fee $2.00 copay	Scenario B: AWP-13.5%, $2.50 fee $2.00 copay
Units/day[1]	1	1	1
Average paid/claim[2]	18.79	---	---
Average units/claim[2]	60	---	---
Unit cost	.31 (average actual)	.32 (AWP)	.32 (AWP)
Cost 90 days[3]	27.90	28.80	28.80
Discount (subtract)	---	2.30	3.89
Dispensing fee (add)	reflected in average paid/claim	2.50	2.50
Copay (subtract)	reflected in average paid/claim	2.00	2.00
Total 90 days	27.90	27.00	25.41
Savings	---	.90	2.49
% Savings	---	3%	9%

---

[1]Estimate derived from dosage information in Physician's Desk Reference.

[2]Data supplied for September 91 by Goold Health Systems.

[3]Unit Cost X 90 days X Units/day.

DRUG: Procardia XL

	Actual, Sept. '91	Scenario A: AWP-8%, $2.50 fee $2.00 copay	Scenario B: AWP-13.5%, $2.50 fee $2.00 copay
Units/day[1]	1	1	1
Average paid/claim[2]	57.95	---	---
Average units/claim[2]	43	---	---
Unit cost	1.35 (average actual)	1.05 (AWP)	1.05 (AWP)
Cost 90 days[3]	121.50	94.50	94.50
Discount (subtract)	---	7.56	12.76
Dispensing fee (add)	reflected in average paid/claim	2.50	2.50
Copay (subtract)	reflected in average paid/claim	2.00	2.00
Total 90 days	121.50	87.44	82.24
Savings	---	34.06	39.26
% Savings	---	28%	32%

---

[1]Estimate derived from dosage information in Physician's Desk Reference.

[2]Data supplied for September 91 by Goold Health Systems.

[3]Unit Cost X 90 days X Units/day.

DRUG: Cardizem SR

	Actual, Sept. '91	Scenario A: AWP-8%, $2.50 fee $2.00 copay	Scenario B: AWP-13.5%, $2.50 fee $2.00 copay
Units/day[1]	2	2	2
Average paid/claim[2]	54.59	---	---
Average units/claim[2]	67	---	---
Unit cost	.81 (average actual)	.61 (AWP)	.61 (AWP)
Cost 90 days[3]	145.80	109.80	109.80
Discount **(subtract)**	---	8.78	14.82
Dispensing fee **(add)**	reflected in average paid/claim	2.50	2.50
Copay **(subtract)**	reflected in average paid/claim	2.00	2.00
Total 90 days	145.80	101.52	95.48
Savings	---	44.28	50.32
% Savings	---	30%	35%

---

[1]Estimate derived from dosage information in Physician's Desk Reference.

[2]Data supplied for September 91 by Goold Health Systems.

[3]Unit Cost X 90 days X Units/day.

DRUG: Lanoxin

	Actual, Sept. '91	Scenario A: AWP-8%, $2.50 fee $2.00 copay	Scenario B: AWP-13.5%, $2.50 fee $2.00 copay
Units/day[1]	1	1	1
Average paid/claim[2]	4.24	---	---
Average units/claim[2]	63	---	---
Unit cost	.07 (average actual)	.09 (AWP)	.09 (AWP)
Cost 90 days[3]	6.30	8.10	8.10
Discount (subtract)	---	.65	1.09
Dispensing fee (add)	reflected in average paid/claim	2.50	2.50
Copay (subtract)	reflected in average paid/claim	2.00	2.00
Total 90 days	6.30	7.95	7.51
Savings	---	(1.65)	(1.21)
% Savings	---	(26%)	(19%)

---

[1]Estimate derived from dosage information in Physician's Desk Reference.

[2]Data supplied for September 91 by Goold Health Systems.

[3]Unit Cost X 90 days X Units/day.

DRUG: Nitrostat

	Actual, Sept. '91	Scenario A: AWP-8%, $2.50 fee $2.00 copay	Scenario B: AWP-13.5%, $2.50 fee $2.00 copay
Units/day[1]	2	2	2
Average paid/claim[2]	4.53	---	---
Average units/claim[2]	98	---	---
Unit cost	.05 (average actual)	.09 (AWP)	.09 (AWP)
Cost 90 days[3]	9.00	16.20	16.20
Discount (subtract)	---	1.30	2.19
Dispensing fee (add)	reflected in average paid/claim	2.50	2.50
Copay (subtract)	reflected in average paid/claim	2.00	2.00
Total 90 days	9.00	15.40	14.51
Savings	---	(6.40)	(5.51)
% Savings	---	(71%)	(61%)

---

[1]Estimate derived from dosage information in Physician's Desk Reference.

[2]Data supplied for September 91 by Goold Health Systems.

[3]Unit Cost X 90 days X Units/day.

DRUG: Tenoretic

	Actual, Sept. '91	Scenario A: AWP-8%, $2.50 fee $2.00 copay	Scenario B: AWP-13.5%, $2.50 fee $2.00 copay
Units/day[1]	1	1	1
Average paid/claim[2]	48.10	---	---
Average units/claim[2]	53	---	---
Unit cost	.91 (average actual)	.85 (AWP)	.85 (AWP)
Cost 90 days[3]	81.90	76.50	76.50
Discount (subtract)	---	6.12	10.33
Dispensing fee (add)	reflected in average paid/claim	2.50	2.50
Copay (subtract)	reflected in average paid/claim	2.00	2.00
Total 90 days	81.90	70.88	66.67
Savings	---	11.02	15.23
% Savings	---	13%	19%

---

[1]Estimate derived from dosage information in Physician's Desk Reference.

[2]Data supplied for September 91 by Goold Health Systems.

[3]Unit Cost X 90 days X Units/day.

DRUG: Lopressor

	Actual, Sept. '91	Scenario A: AWP-8%, $2.50 fee $2.00 copay	Scenario B: AWP-13.5%, $2.50 fee $2.00 copay
Units/day[1]	2	2	2
Average paid/claim[2]	31.27	---	---
Average units/claim[2]	71	---	---
Unit cost	.44 (average actual)	.43 (AWP)	.43 (AWP)
Cost 90 days[3]	79.20	77.40	77.40
Discount (subtract)	---	6.19	10.45
Dispensing fee (add)	reflected in average paid/claim	2.50	2.50
Copay (subtract)	reflected in average paid/claim	2.00	2.00
Total 90 days	79.20	71.71	67.45
Savings	---	7.49	11.75
% Savings	---	9%	15%

---

[1]Estimate derived from dosage information in Physician's Desk Reference.

[2]Data supplied for September 91 by Goold Health Systems.

[3]Unit Cost X 90 days X Units/day.

Extrapolation of Individual Drug Analyses
to the LCDE Program as a Whole

1. Determine percentage of LCDE program costs attributable to each drug in the sample as follows:

$$\frac{\text{Cost of Sample Drug for Sept. 91}}{\text{Total Cost of Program for Sept. 91}}$$

This results in the following percentage of program costs attributable to each drug:

Micronase 5mg	4 %
Dyazide	1.1%
Procardia XL	6.2%
Cardizem SR	2.3%
Lanoxin	.8%
Nitrostat	.3%
Tenoretic 50	.4%
Lopressor	2.8%
Aggregate Impact of Sample	17.9%

2. Calculate the weight for each drug by solving the following equation:

$$\frac{17.9\% \text{ of program costs (total for sample)}}{100\%} = \frac{\% \text{ of individual drug}}{X}$$

Example: Micronase 5mg

$$\frac{17.9\%}{100\%} = \frac{4\%}{X}$$

$$17.9X = 400$$
$$X = 22.35$$

3. Multiply the estimated percentage savings for each drug (from individual drug worksheets) by the assigned weight. Add percentages for aggregate savings, as follows:

	Scenario A	Scenario B
Micronase 5mg	(1.12%)	.45%
Dyazide	.18	.55
Procardia XL	9.70	11.08
Cardizem SR	3.86	4.50
Lanoxin	(1.16)	(.85)
Nitrostat	(1.19)	(1.02)
Tenoretic 50	.29	.42
Lopressor	1.41	2.35
EXTRAPOLATED SAVINGS	11.97%	17.48%

4. Estimate participation in a voluntary mail order option, given a $2 copayment ($1 incentive for generic drugs), and calculate savings for 1 year.

Estimated participation: 25%

Appropriation for FY93: $4,700,292

Estimated Savings FY 93:

Scenario A: 11.97% x $4,700,292 x 25% = $140,656

Scenario B: 17.48% x $4,700,292 x 25% = $205,403

APPENDIX 2

SENATE

GERARD P. CONLEY, JR. DISTRICT 30, CHAIR
STEPHEN M. BOST, DISTRICT 11
BARBARA A. GILL, DISTRICT 32

JULIE JONES, LEGISLATIVE ANALYST
PAUL SAUCIER, LEGISLATIVE ANALYST
PAULA ASHTON, COMMITTEE CLERK

HOUSE

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STEPHEN P. SIMONDS, CAPE ELIZABETH
SHARON ANGLIN TREAT, GARDINER
JASON D. WENTWORTH, ARUNDEL
PEGGY A. PENDLETON, SCARBOROUGH
SUSAN DUBAY DUPLESSIS, OLD TOWN
JOAN M. PENDEXTER, SCARBOROUGH

STATE OF MAINE

ONE HUNDRED AND FIFTEENTH LEGISLATURE

COMMITTEE ON HUMAN RESOURCES

June 17, 1991

The Honorable Charles P. Pray, Chair
Legislative Council
Maine Legislature
State House Station 115
Augusta, ME 04333

Dear Mr. Chair:

The Joint Standing Committee on Human Resources requests authorization for Council staff to conduct research over the interim regarding the Drugs for Maine's Elderly Program. This request arises from the Committee's consideration of LD 403, An Act to Enhance Medical and Social Services for Maine's Long-term Care Consumers. LD 403 has been carried over to the Second Regular Session.

Section 4 of the bill requires that a mail order option be offered to program participants. At issue are whether a mail order option will cut costs and whether quality assurance issues outweigh potential savings.

In addition to the mail order issue, the Committee would like staff to examine possible models for restructuring the benefit base of the program. Historically, only drugs used to treat certain life-threatening conditions listed in the statutes have been covered and each year, worthy requests to cover new categories of drugs are presented to the Legislature. This session alone, the Committee considered 3 bills seeking to cover new categories of drugs. The current structure places the Legislature in the position of choosing one life-sustaining drug over another at a time when resources do not permit coverage of all life sustaining drugs. One possible alternative would be to broaden the categories of drugs but cap the amount of the benefit.

We envision having a staff person work at the direction of the Committee Chairs and present a written report to the full Committee no later than November 1.

Thank you for your consideration.

Sincerely,

Gerard P. Conley, Jr.
Senate Chair

Peter J. Manning
House Chair

LHS2838