Affordable Prescription Drugs for NC Consumers:
The Next Challenge

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Prescription drugs have become an essential component of healthcare. To a large extent this trend is due to the introductions of new drugs that prolong life, improve the quality of life, or replace more intensive and expensive medical treatments. Recently introduced prescription drugs have enhanced treatments for conditions such as stroke, heart disease, mental illness, nausea associated with chemotherapy, and asthma. The importance of prescription drugs within overall therapeutic regimens has led to increased efforts, both public and private, to expand access to pharmaceutical treatments.

At the same time, innovations in drug treatments have been accompanied by a dramatic increase in prescription drug costs. Since 1995 prescription drugs have been the fastest growing component of national health care expenditures. Nationally, outpatient prescription drug spending has increased at double-digit rates and is projected to continue to do so well into the future. Such rapid growth has been associated with an increase in drug utilization, changes in the intensity of prescription drug use, and higher prices of prescription drugs used.

Affordability of prescription drugs is a critical problem for many seniors and disabled individuals in North Carolina. According to the Centers for Medicare and Medicaid Services there are approximately 1.2 million Medicare beneficiaries in North Carolina. Of these, 315,000 currently lack prescription drug coverage from an employer plan, supplemental insurance policy, or public program. CMS data also shows that North Carolina has approximately 549,000 residents with incomes below 150% of the federal poverty level, and whose liquid assets are below $10,000 for an individual and $20,000 for a couple.

AARP North Carolina's research with its members reinforces the need for Medicare beneficiaries to have prescription drug coverage. A survey of AARP members revealed that 34% of our members are spending more than $100 per month on prescription drugs. Half of our members say that buying prescription drugs is a problem for them—20% categorize it is a major problem and 30% as a minor problem. Six in ten members are concerned about their ability to afford the cost of needed prescription drugs over the next two years.

Some elderly North Carolinians are receiving assistance from the Senior Care program. This program, developed with funding from the Health and Wellness Trust Fund, provides a very limited benefit for senior individuals with incomes under 200% of the federal poverty level and who need prescription drugs for cardiovascular disease, diabetes, or chronic obstructive pulmonary disease. The Senior Care program pays 60% of $1,000 in prescription drug costs.

The recently enacted Medicare legislation represents the program's most sweeping expansion in its 38 year history. It will provide some help with prescription drug costs, especially for those North Carolinians in greatest need.

Prescription Drug Benefits under the New Law

Beginning in the spring 2004, Medicare beneficiaries can enroll in the Medicare discount card program that will offer savings between 10% and 25% on prescriptions. The enrollment fee for the discount card is up to $30. Low income beneficiaries (those below 135% of the federal poverty level) do not pay the enrollment fee, and will receive a card with a $600 credit added to it. An additional $600 credit will be added to the card in 2005.

Starting in 2006, Medicare will add a prescription drug benefit. The standard benefit design includes a beneficiary premium of $35 per month; after a $250 deductible, the plan pays 75% of costs up to $2,250. Above that, there is a gap in coverage until the beneficiary's out-of-pocket costs reach $3,600. After that, the plan pays 95% of costs.

The new law provides significant subsidies and benefits for Medicaid-eligible individuals and others with low incomes. For individuals with incomes up to 100% of the federal poverty level, there is no premium, deductible, or gap in coverage; the co-payment will be $1 for generic drugs and $3 for brand-name drugs. For individuals with incomes between 100% - 135% of the federal poverty level, and who have no more than $6,000 in assets as an individual or $9,000 as a couple, there is no premium, deductible, or gap in coverage; the co-payment is $2 for generics and $5 for brand name drugs. For individuals with incomes

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between 135% and 150% of the federal poverty level, there will be a sliding scale premium [less than $35/month], $50 deductible, and no gap in coverage; the co-payment is 15% until the catastrophic cap of $3,600 in out-of-pocket expenses is reached. After beneficiaries in this income category have reached the catastrophic cap, they will pay $2 for generics and $5 for brand name drugs.

According to data from the Centers for Medicare and Medicaid Services, 549,000 North Carolinians will qualify for the low-income subsidy in the new drug program. In fact, North Carolina ranks eighth-highest in the nation in the total number of Medicare beneficiaries eligible for the low-income protections provided in the Medicare Rx legislation.

Some Help – But Not Enough

While these changes in Medicare provide assistance to people who currently have no coverage for their prescription drug costs, the legislation doesn't solve the underlying problem—how to contain rapidly increasing prescription drug costs for both individuals and for large purchasers of drugs, such as Medicaid, and state/local employees, and retirees.

AARP believes that it is essential for NC elected officials and public agency officials to build upon and expand policies that will reduce rapidly increasing prescription drug costs.

Efforts are underway within the NC Medicaid program focusing on improving quality, utilization and cost effectiveness. The Community Care of North Carolina program is showing positive results in reducing costs and improving quality for elderly recipients.

AARP recommends consideration of additional state policies to help citizens who do not qualify for Medicare or Medicaid, and who lack prescription drug coverage, to get relief from rapidly increasing prescription drug costs.

Preferred Drug List

A preferred drug list (PDL) is a list of recommended drugs that generally are selected for effectiveness and price; states have been using PDLs as a primary tactic for saving money and promoting quality in state Medicaid, state employee/retiree programs, and other prescription coverage programs.

North Carolina should follow an example set by Maine and other states, and establish an evidence-based preferred drug list that is available to a broader client base than Medicaid. The Maine Rx Plus Program initially limits eligibility to 350 percent of federal poverty level, and eventually will be open to all state residents without prescription drug benefits. The program coordinates with the new preferred drug list in MaineCare (Medicaid).

Maine Rx Plus was enacted to provide access for all Maine citizens to medically necessary prescription drugs at the lowest possible prices. The original Maine Rx law established that the state would encourage drug manufacturers to offer lower prices to Maine residents, particularly those without drug coverage, by leveraging Medicaid pharmacy expenditures.

AARP has supported the development of an evidence-based preferred drug list because it achieves both goals of saving money and preserving quality for patients. When evaluating whether a PDL proposal will affect consumers positively or negatively, AARP considers whether it creates barriers for people to get the drugs they need at the same time. The criteria that AARP uses to analyze preferred drug list designs are:

- Preferred drug lists should be based on clinical evidence and standards of practice; economic factors should be considered only after safety, efficacy, and therapeutic need have been assessed.
- Preferred drug lists should be administered by a Pharmacy and Therapeutics (P&T) Committee comprised of doctors, pharmacists, and consumers.
- When medically necessary, physicians should be able to prescribe a drug not on the preferred list, and those patients should not pay a higher co-payment. The plan should be required to show cause before denying a certain drug, and should provide patients the right to a timely appeal before an independent, objective third party.
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- Patients should have access to adequate information about the PDL, i.e., how it works, cost-sharing requirements, the drug list, how to request a medicine not on the list, and how to appeal coverage denials.
- The state should monitor and evaluate PDL impact on access and quality of care.

A variety of additional approaches to reducing prescription drug costs have been implemented in other states. These approaches include bulk purchasing arrangements with negotiated price discounts from drug manufacturers, exploration of drug importation from Canada, and requiring pharmacies to extend to uninsured persons the same price discount provided to the Medicaid program. Each of these programs has strengths and weaknesses, but all demonstrate the necessity for state public policy to evolve to help individual consumers who lack prescription drug coverage from any other source.

AARP stands ready to contribute to the public discourse on this crucial topic.