State Pharmacy Assistance Programs: Additional Charts

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Contents

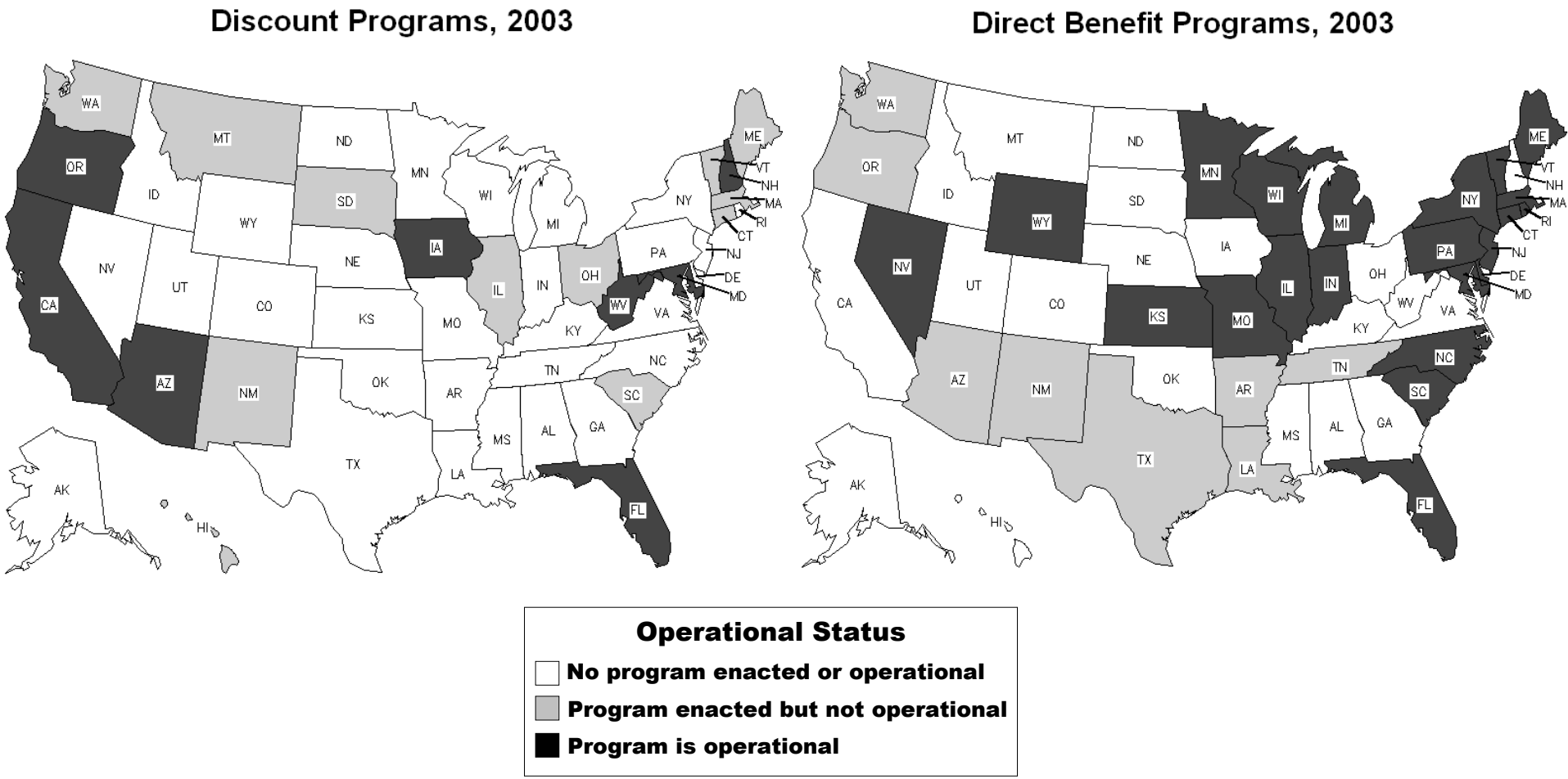
Section 1: Program Design and Eligibility

Chart S-1:
State Interventions for Addressing Prescription Drug Affordability, 2003

- As of August 2003, 38 states had authorized some type of program to reduce the costs of prescription drugs for a portion of their residents, and several states had authorized more than one type of program.[1]
- Thirty states had enacted a direct benefit program, and programs in 22 of those states were operational.[1]
- Twenty states had authorized discount programs to reduce the costs of prescription drugs to consumers at little or no cost to the state.[1] These programs had been legally challenged in Vermont, Maine, and Washington, and their future is uncertain.
- In the 11 states with both types of programs, the direct benefit programs are targeted to persons with lower incomes and the discount programs typically have no income limits.
- All states in the Northeast had some type of state pharmacy assistance program in 2003. New Hampshire was the only state in the Northeast not to have a direct benefit program.
- Most states in the Midwest also had direct benefit programs.
- Several states in the South and West had operational programs, and several more had authorized programs that were not yet operational.

[1] National Conference of State Legislatures' web site: *State Pharmaceutical Assistance Programs, 2003 Edition*, http://www.ncsl.org/programs/health/drugaid.htm. August 27, 2003.

Chart S-1:
State Interventions for Addressing Prescription Drug Affordability, 2003

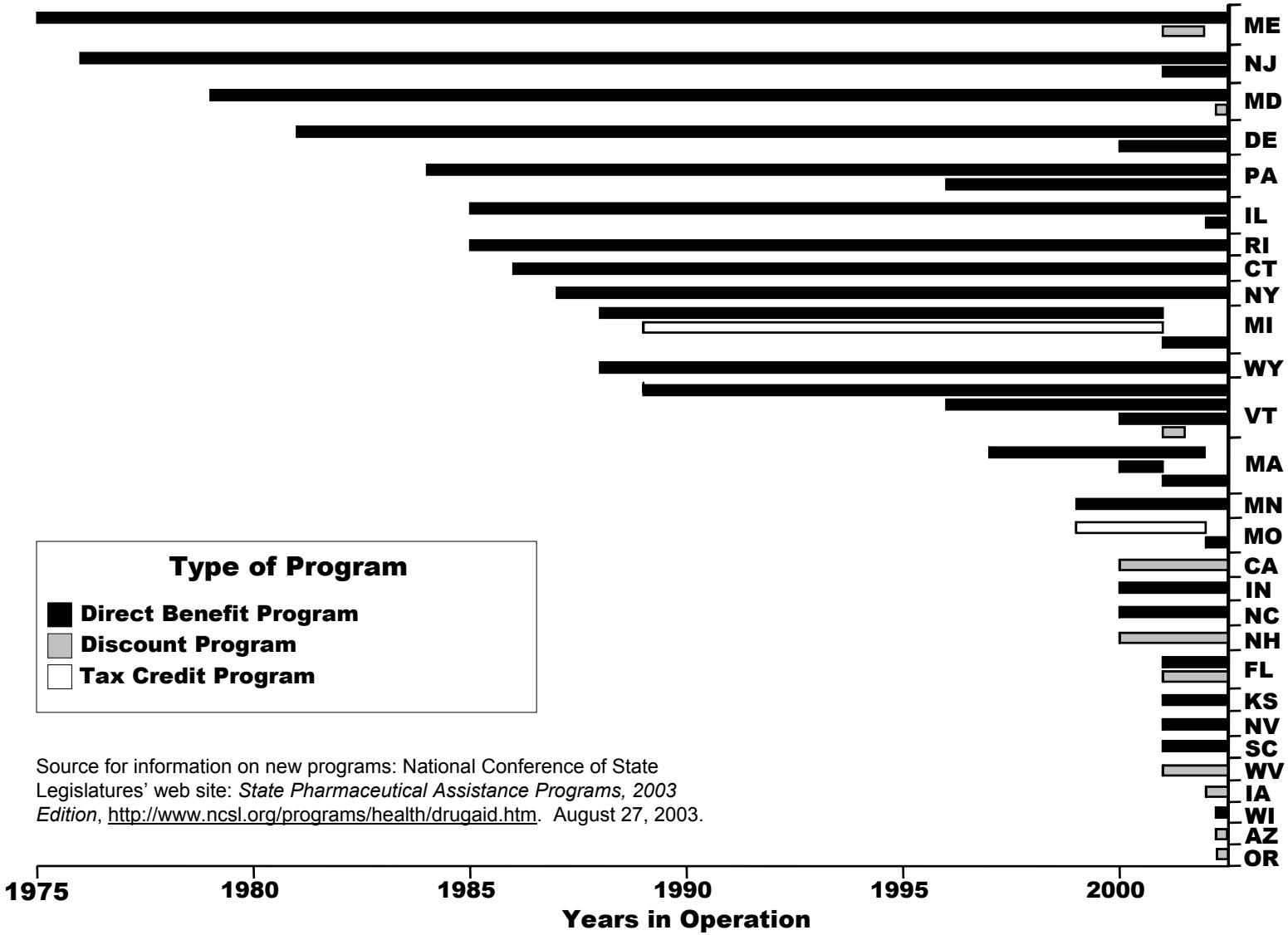


Source: National Conference of State Legislatures' web site: *State Pharmaceutical Assistance Programs, 2003 Edition*, http://www.ncsl.org/programs/health/drugaid.htm. August 27, 2003.

Chart S-2:
Number and Type of Programs Over Time by State, 2003

- Maine and New Jersey have the longest standing programs, initiated in 1975 and 1976, respectively.
- All of the longest standing programs are direct benefit programs. The first tax credit program was implemented by Michigan in 1989, and the first discount programs were implemented by California and New Hampshire in 2000.
- Discount programs have been suspended in 3 states by order of the courts, and tax credit programs in Michigan and Missouri have been replaced by direct benefit programs.
- Direct benefit programs in Michigan and Massachusetts were discontinued and replaced with new programs based on different models of pharmacy coverage.
- Four states have more than one operational direct benefit program. These different programs are usually targeted to persons with different income levels, and the programs for higher income individuals have higher cost-sharing requirements than the lower income programs.
- The remainder of the chart book will focus only on direct benefit programs since they have the longest history and the most financial impact both for the states and for individual enrollees.

Chart S-2:
Number and Type of Programs Over Time by State, 2003

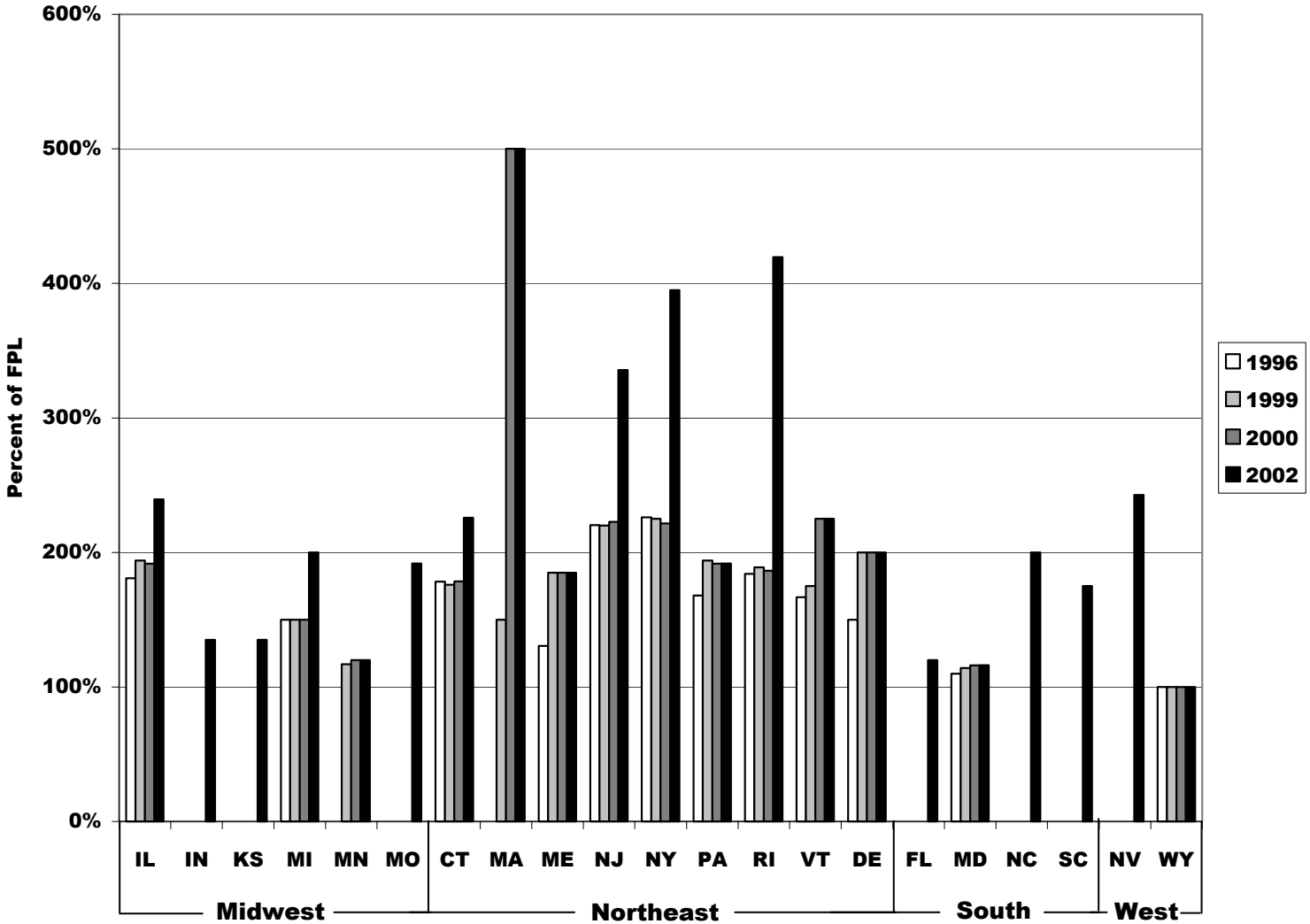


Source for information on new programs: National Conference of State Legislatures' web site: *State Pharmaceutical Assistance Programs, 2003 Edition*, http://www.ncsl.org/programs/health/drugaid.htm. August 27, 2003.

Chart S-3:
Trends in Income Eligibility Levels as a Percent of FPL by State and Region

- Most states with programs in place from 1996 to 2002 enacted at least one major income eligibility expansion during this time. Maryland and Wyoming are the only states that did not significantly expand eligibility between 1996 and 2002. Maryland has since been granted a Medicaid 1115 waiver extension to provide pharmacy benefits to Medicare enrollees with incomes below 175% FPL (the current income eligibility limit is 116% FPL).
- States in the Northeast enacted large income eligibility expansions between 2000 and 2002. Massachusetts increased income eligibility from approximately 150% FPL to 500% FPL, New Jersey increased from 223% FPL to 336% FPL, New York increased from 222% FPL to 395% FPL, and Rhode Island increased from 186% FPL to 419% FPL.
- Several states in the Midwest and South implemented new programs in 2002, and, among the new programs, Nevada had the highest income eligibility level at approximately 243% FPL.
- In expanding drug coverage to higher income groups, states generally required higher cost-sharing from higher income enrollees. Chart 2-6 shows the ways that states adjust cost-sharing for people with different incomes.
- Note that, since incomes and the cost of living varies among states, poorer states that have lower income requirements may be able to reach the same proportion of residents as do more well-off states that have higher income requirements.
- Maine sets income eligibility at 210% FPL for applicants who spend 40% of their income on prescription drugs, and Delaware has no income limits for applicants who spend 40% of their income on prescription drugs. In addition, Missouri disregards income spent on Medicare premiums when calculating income eligibility, effectively raising income eligibility levels from 135% FPL to 144% FPL.

Chart S-3:
Trends in Income Eligibility Levels as a Percent of FPL by State and Region



Sources: *EPIC Evaluation Report to the Governor & Legislature: October 1987-September 1995*. New York State Department of Health. United States General Accounting Office. (2000). *State Pharmacy Assistance Programs: Assistance Designed to Target Coverage and Stretch Budgets*. GAO/HEHS-00-162, Washington, DC: Author. Rutgers' Center for State Health Policy Survey of State Pharmacy Assistance Programs, December 2000 and August 2002.

Chart S-4:
SPAP Other Eligibility Requirements

- In addition to income requirements, some SPAPs have eligibility requirements for assets, length of state residency, existing prescription drug coverage, and other requirements.
- Maryland and Minnesota were the only two SPAP states that had asset tests. In 2002, these were $10,000 for singles and $18,000 for couples in Minnesota, and $3,750 for singles and $4,500 for couples in Maryland.
- Most states allow current residents to enroll in their programs, but some require applicants to have been state residents for up to one year.
- Most states exclude persons with any kind of other drug coverage from eligibility. However, some states allow persons to receive SPAP benefits after their other benefits have been exhausted (3 states) or if their other coverage is less generous than that available through the SPAP (3 states). Pennsylvania and Illinois have no such restrictions on other coverage, but beneficiaries in Illinois must assign their other benefits to the state.
- While all SPAPs exclude persons from eligibility if they already receive Medicaid prescription drug coverage, a few states exclude persons if they are eligible for but not enrolled in Medicaid.

Chart S-4:
SPAP Other Eligibility Requirements

State	Asset Test	Length of State Residency	Eligibility if Have Other Prescription Drug Coverage	Other Eligibility Requirements
CT	No	6 months	After exhaust other benefits	None
DE	No	Current	Not eligible	Must not be eligible for Nemours Health Clinic pharmaceutical benefit
FL	No	Current	Not eligible	None
IL	No	Current	Eligible if assign benefits to state	Widows or widowers who turned 63 or 64 before the deceased claimant's death are also eligible
IN	No	90 days in the last year	Not eligible	None
KS	No	Current	Not eligible	Must not have voluntarily cancelled a local, state, federal, or private prescription drug program within six months of application to the program; must not be eligible for or enrolled in any other local, state, or federal prescription program; must be a current recipient of the QMB or LMB programs.
MA	No	Current	After exhaust other benefits	Persons with disabilities must meet income requirements and work no more than 40 hours per month unless they were enrolled in the previous Pharmacy or Pharmacy Plus programs. Persons with disabilities were automatically eligible for Prescription Advantage if the submitted an enrollment form prior to April 1, 2002 and were a Massachusetts resident and not eligible for MassHealth (Medicaid).
MD	$3,750 single $4,500 couple	Current	Not eligible	People detained in a correctional (federal, state, local) system are not eligible
ME	No	Current	Not eligible	None
MI	No	3 months	Not eligible	Applicant cannot be residing in an institution. Enrollees in the previous MEPPS and prescription tax credit programs are deemed eligible for EPIC. Regular enrollment is closed. Additional emergency enrollment requirements are: the cost of prescriptions must be at least 10% of a single person's monthly household income or 8% of a couple's monthly household income. Applicants must have unfilled prescriptions or authorized refills due within 30 days of the application date. Documentation from the attending physician must verify that the condition is an emergency. At least one unfilled prescription must meet the EPIC program definition of a medical or psychiatric emergency. The emergency coverage period is 45 days and is available up to two times a year.
MN	$10,000 single $18,000 couple	180 days	Not eligible	No prescription drug coverage through health insurance in the four month period prior to the application month. Not eligible for Medicaid without a spenddown. Enrollment in Medicare. Enrollment in the QMB or SLMB Medicare supplement program. (Asset and income levels are the same for both the Prescription Drug Program and SLMB; Asset levels are the same for QMB, SLMB, QIs and PDP)
MO	No	12 months	Other coverage must be less generous	None
NC	No	Current	Not eligible	None
NJ	No	Current	Other coverage must be less generous	None
NV	No	12 months	Eligible	Must not be eligible for Medicaid prescription benefits
NY	No	Current	Other coverage must be less generous	None
PA	No	90 days	Eligible	None
RI	No	Current	After exhaust other benefits	None
SC	No	6 months	Not eligible	None
VT	No	Current	Not eligible	None
WY	No	Current	Not eligible	None

Section 2: Program Enrollment and Take-up

Chart S-5:
1999 to 2002 Enrollment Trends for All SPAPs by State and Region

- In 2002, most persons were enrolled in Northeastern (71%) or Midwestern (18%) states.
- Several states saw substantial increases in enrollment from 1999 to 2002. Enrollment in New York increased 138% from 1999 to 2002, while Illinois had a 246% increase from 1999 to 2001 (the last year data were available from the state) and Massachusetts had a 145% increase in enrollment from 1999 to 2002. All three of these states implemented major expansions to their programs during this time period.
- Minnesota, which started up its program in 1999, saw a 281% increase in enrollment from 1999 to 2002.
- Enrollment in Pennsylvania's programs decreased 6% from 1999 to 2002. This was mainly because the state uses fixed income limits rather than indexing eligibility limits to cost-of-living increases. In effect, this reduces the eligibility level in real dollars from year to year.

Chart S-5:
1999 to 2002 Enrollment Trends for All SPAPs by State and Region

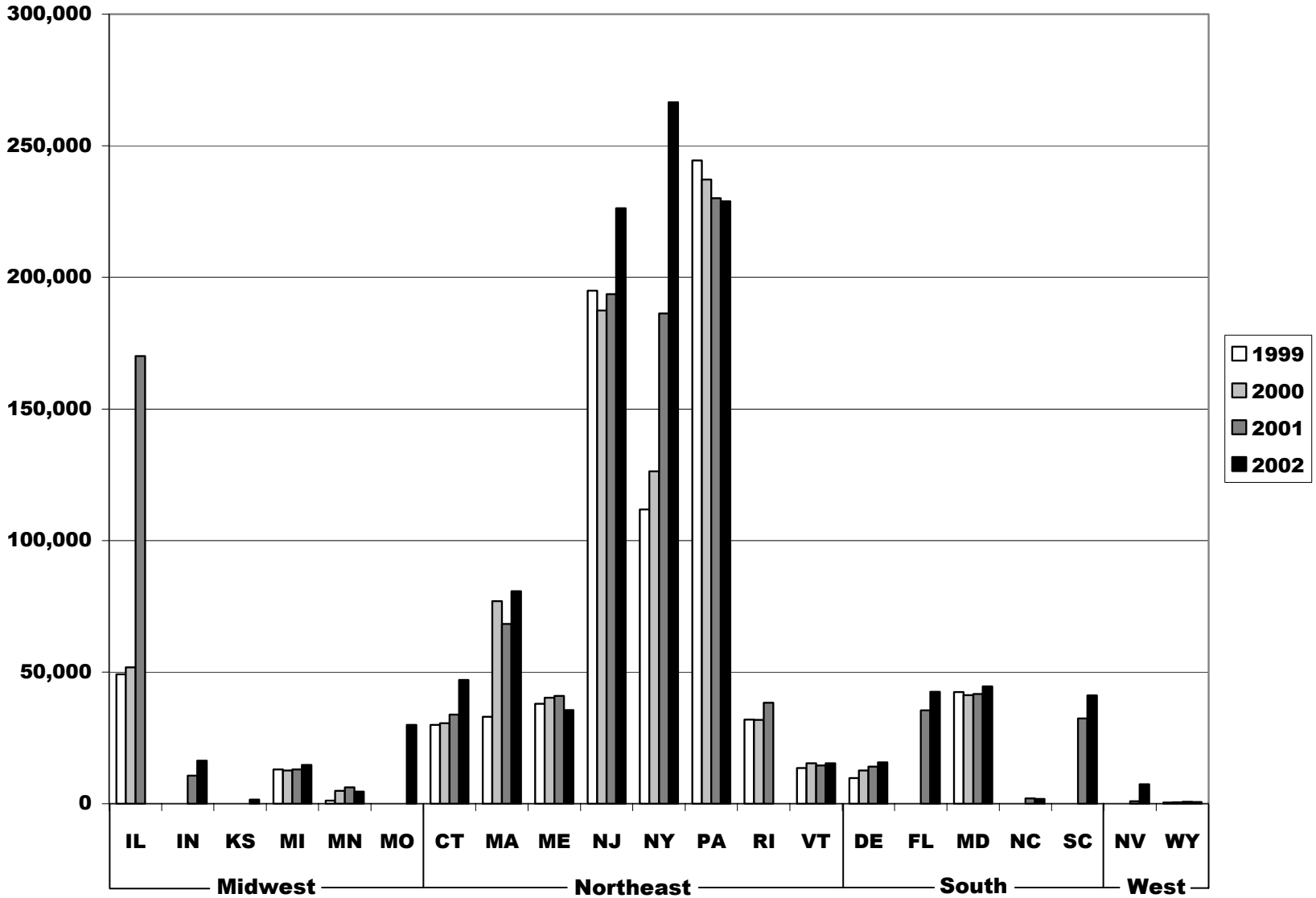
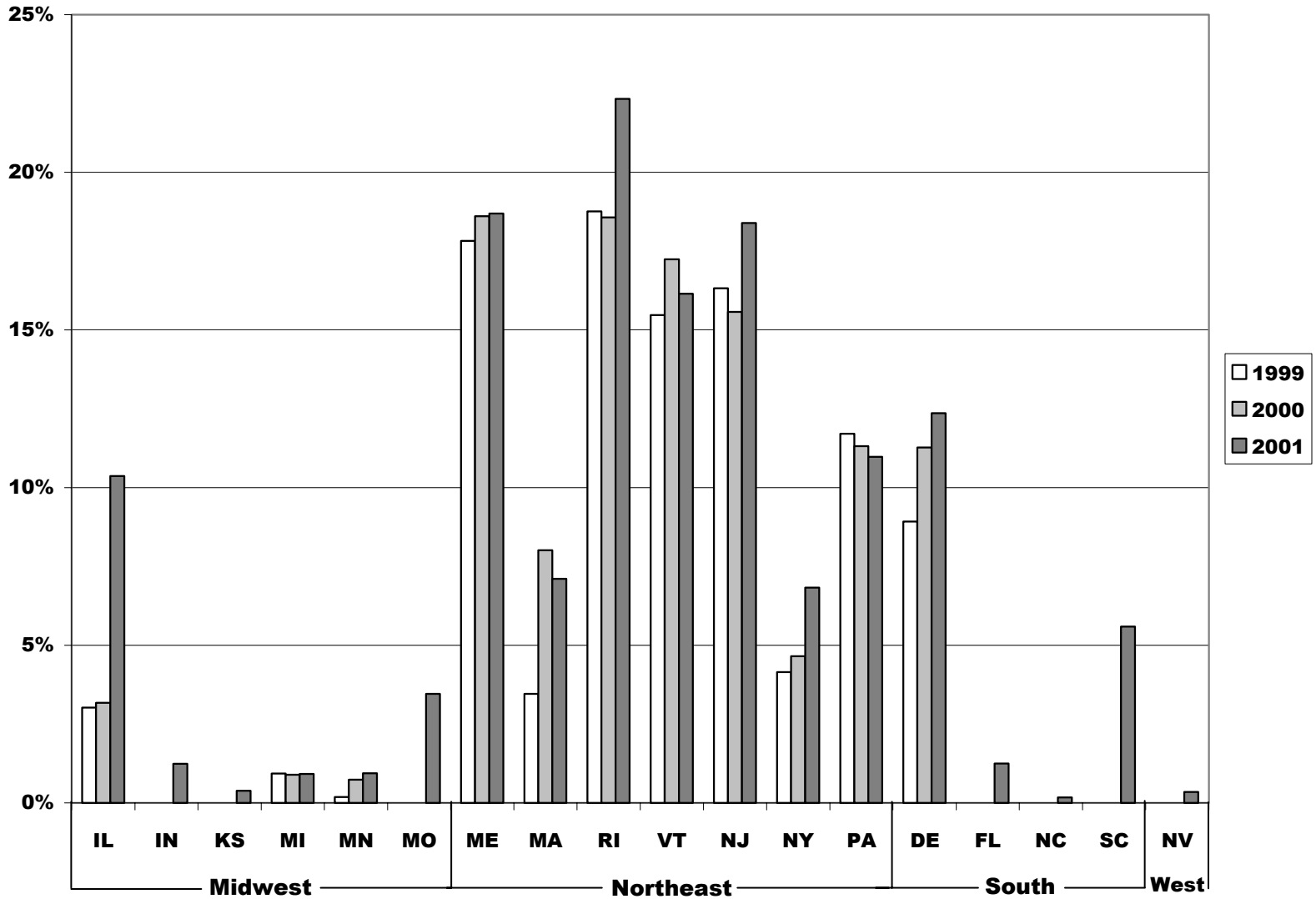


Chart S-6:
1999 to 2001 Trends for SPAP Enrollment as a Percentage of Medicare Enrollment by State and Region

- With enrollment increases, several states have made large gains in covering a greater proportion of Medicare beneficiaries from 1999 to 2001.
- Illinois went from covering 3% of the state's Medicare population in 1999 to covering 10.4% in 2001, and Massachusetts went from covering 3.5% of its Medicare enrollees in 1999 to 8.8% in 2001.
- A combination of decreasing SPAP enrollment and increasing Medicare enrollment in Pennsylvania resulted in a decrease in the proportion of Medicare enrollees covered in the state from 11.7% in 1999 to 11.0% in 2001.

Chart S-6:
1999 to 2001 Trends for SPAP Enrollment as a Percentage of Medicare Enrollment by State and Region



Note: Data for Maryland and Wyoming were not included in this analysis since the programs in those states do not just cover Medicare beneficiaries. Delaware enrollment includes both the state funded DPAP program and the privately funded Nemours program.

Chart S-7:
Percent of All Medicare Income-Eligible, Non-Medicaid Population Enrolled in SPAPs and Program Features for FY 2002

- As shown in Chart 4-10, well-established, older programs and those that do not have caps on benefits or the number of people who can enroll tended to have the highest enrollment rates.
- Programs with up-front fees or deductibles tended to have moderate enrollment rates in FY 2002.
- A system of consumer cost sharing using coinsurance (cost-sharing at the point of sale, based on a percentage of a prescription's cost) rather than co-pays (set dollar amounts per prescription) did not appear to be associated with lower enrollment among income-eligible Medicare beneficiaries. No consistent relationship was noted between enrollment rates and limitations on the number of conditions covered or expenditures per enrollee.

Chart S-7:
Percent of All Medicare Income-Eligible, Non-Medicaid Population Enrolled in SPAPs and Program Features for FY 2002

State	% Enrolled of Income/Age Eligible	Fee	Deductible	Coinsurance	Limit Number of Conditions Covered	Benefit Cap	Enrollment Cap	Year Implemented	Year of Most Recent Expansion	2002 Cost per Enrollee
PA	42.4%		X*					1984	2001	$1,798
RI	40.8%			X	X			1985	2001	$280
DE	40.8%			X		X		1981	2000	$366
VT	39.6%		X*	X*	X*			1989	2000	$1,598
ME	37.0%			X	X			1975	1999	$651
NJ	33.8%			X*				1976	2001	$2,031
CT	23.7%	X						1985	2002	$1,337
IL	23.4%	X			X*			1985	2001	$855
SC	22.8%		X					2000	NA	$496
NY	17.5%	X	X					1987	2001	$1,482
MA	13.8%	X	X					1997	2001	$1,079
MO	13.2%	X	X	X		X		2002	NA	NA
FL	9.1%					X	X	2001	2002	$156
NV	8.3%					X	X	2001	2002	$1,023
IN	7.7%			X		X		2001	NA	$385
MI	3.4%	X		X			X	1988	2001	$1,355
MD	2.5%				X			1979	2002	$1,641
KS	1.6%			X		X		2001	NA	$528
NC	0.4%			X	X	X		2000	NA	$732
WY	0.4%					X		1988	NA	$1,644

Note: Data for Illinois and Rhode Island are from 2001. Minnesota was not included in this analysis due to the small CPS sample size in the state. Delaware enrollment includes both the state funded DPAP program and the privately funded Nemours program.
*Applies only to some programs in the state.

Source: Estimates were calculated from three-year averages from the March supplement of the 2000, 2001, and 2002 CPS and are based on all persons meeting age, disability, and income eligibility requirements and having no Medicaid coverage http://www.bls.census.gov/cps/cpsmain.htm.

Section 3: Management of Program Cost and Quality

Chart S-8:
Pharmacy Reimbursement and Manufacturer Rebate Formulas

- Chart 3-5 shows the formulas SPAPs use to reimburse pharmacies for claims and to collect rebates from pharmaceutical manufacturers.
- For pharmacy reimbursement: AWP is the listed Average Wholesale Price for prescription drugs; FUL is the Federal Upper Limit reimbursement price established by the US Department of Health and Senior Services for generic drugs used by Medicaid programs; MAC is a separate Maximum Allowable Cost list for generic drugs established by some states; EAC is the Estimated Actual Cost of drugs purchased by pharmacies; and WAC is the listed Wholesale Acquisition Cost for drugs.
- In theory, programs reimburse pharmacies only for the price that pharmacies pay for drugs and then pay the pharmacies a dispensing fee to cover the costs of dispensing the drug. In practice, reimbursements are typically greater than — but sometimes lower than — what pharmacies actually pay to purchase drugs from wholesalers. However, a 1996 Health Care Financing Administration study estimated the actual cost for a pharmacy to dispense a Medicaid prescription to be between $6 and $8, and most SPAP dispensing fees would not cover that cost.[1]
- For manufacturer rebates: AMP is the listed Average Manufacturer Price for prescription drugs, and the Medicaid base rate is AMP – 15.1% for brand name drugs and AMP – 11% for generic drugs. Pharmaceutical manufacturers are also required to provide Medicaid with rebates that equal the best price given to private purchasers, and manufacturers must give Medicaid an additional rebate on a drug if the price of that drug increases more in a year than the Consumer Price Index (CPI).
- Of the 21 SPAPs, 14 have statutory requirements that manufacturer rebates must be the same as the Medicaid base rate, although only nine of those 14 states require both the Medicaid CPI adjustment and best price.
- There is only 1 state that does not collect rebates.

[1] Kreling, D. H., Lipton, H. L., Collins, T., and Hertz, K. C. (1996). *Assessment of the Impact of Pharmacy Benefit Managers*. Washington, DC: Health Care Financing Administration, US Department of Health and Human Services; NTIS pub # PB97-103683.

Chart S-8:
Pharmacy Reimbursement and Manufacturer Rebate Formulas

	Pharmacy Reimbursement					Manufacturer Rebates		
State	**Brand Formula**	**Generic Formula**	**FUL**	**State MAC**	**Dispensing Fee**	**Base Rebate Formula**	**Medicaid Best Price**	**Medicaid CPI Adjustment**
CT	AWP - 12%	AWP - 12%	N	N	$4.10	Same as Medicaid	Y	Y
DE	AWP - 12.9%	AWP - 12.9%	Y	Y	$3.65	Same as Medicaid	Y	Y
FL	AWP - 13.25%	AWP - 13.25%	Y	Y	$4.23	Same as Medicaid with supplemental rebates	Y	Y
IL	AWP - 14%	AWP - 50% (MAC)	Y	Y	$2.55	Negotiated by PBM[1]	N	N
IN	AWP - 13.5%	AWP - 20%	Y	Y	$4.90	Negotiated by PBM	N	N
KS	NA	NA	NA	NA	NA	No rebates collected	N	N
ME	AWP - 13%	AWP - 13%	Y	Y	$3.35	Same as Medicaid	Y	Y
MD	Lower of WAC + 10% or AWP - 10%	Lower of EAC, State MAC or FUL	Y	Y	$4.21	Same as Medicaid	Y	Y
MA	Retail: AWP - 13%; Mail order: AWP - 21.5%	Retail: AWP - 13%; Mail order: AWP - 21.5%	N	Y	Retail: $2.50 Mail order: $0	Negotiated by PBM	N	N
MI	AWP - 15.1%	AWP - 15.1%	Y	Y	$3.77	Same as Medicaid		
MN	AWP - 9%	AWP - 9%	Y	Y	$3.65	Same as Medicaid	N	N
MO	AWP - 10.43%	AWP - 20%	N	N	$4.09	AMP - 15% for both brand and generic	N	N
NV	Negotiated by PBM. Averages AWP - 14%	MAC	N	Y	Negotiated by PBM. $2.50 on Avg.	Negotiated by PBM	N	N
NJ	AWP - 10%	AWP - 10%	Y	Y	From $3.73 to $4.07 by volume and services	Same as Medicaid	Y	N
NY	AWP - 10%	AWP - 10%	Y	N	Generic: $4.50 Brand: $3.50	Same as Medicaid	Y	Y
NC	AWP - 10%	AWP - 10%	Y	Y	$4.90	Same as Medicaid	N	Y
PA	AWP - 10%	AWP - 10%	N	N	$3.50	AMP - 17% for both brand and generic	N	N[2]
RI	AWP - 13%	AWP - 13%	Y	Y	$2.75	Same as Medicaid	N	N
SC	AWP - 10%	AWP - 10%	Y	Y	$4.05	Same as Medicaid	Y	Y
VT	AWP - 11.9%	AWP - 11.9%	Y	Y	$4.25	Same as Medicaid	Y	Y
WY	AWP - 11%	AWP - 11%	N	Y	$5.00	Same as Medicaid	Y	Y

1 Illinois' new SeniorCare waiver program uses the same rebate formula as Medicaid.

2 Pennsylvania has a slightly different formula from Medicaid for calculating the CPI adjustment.

Chart S-9:
Point-of-Sale DUR Edits Used by SPAPs, 2002

- Prospective Drug Utilization Review (ProDUR) programs monitor enrollees' drug use patterns and alert pharmacists at the point-of-sale to potential hazards of prescriptions. In the design of ProDUR programs, states have a choice of which types of potential problems to monitor and what actions are necessary for pharmacists to resolve these problems.
- The decision of what types of problems to monitor is usually determined by a DUR committee operated either by the state or the state's PBM. For the 14 states that responded to this question, all 14 monitored drug to drug interactions, therapeutic duplication (using multiple drugs within the same therapeutic category), drugs prescribed at a higher dose than is indicated by the manufacturer, and refilling a prescription earlier than was prescribed (a possible indicator of overuse). Several states went beyond those basic alerts to monitor issues such as duration of therapy (13 states) and whether the prescription dosage was appropriate for the age of the recipient (10 states).
- Unless the pharmacist contacts the prescribing physician and changes or cancels the prescription, ProDUR systems generally use two methods to allow pharmacists to resolve these issues and dispense the prescription. The system can either deny the claim unless the pharmacist contacts the PBM or other entity to seek approval for the prescription (often called prior authorization or PA), or the system can issue an informational warning that the pharmacist can manually override on the system.
- Prior authorization is the more stringent of the two methods, and states have used PA to varying degrees to help prevent prescribing errors. States have also noted that using PA in this way can also save the state money by preventing the dispensing of unneeded or harmful drugs.

Chart S-9:
Point-of-Sale DUR Edits Used by SPAPs, 2002

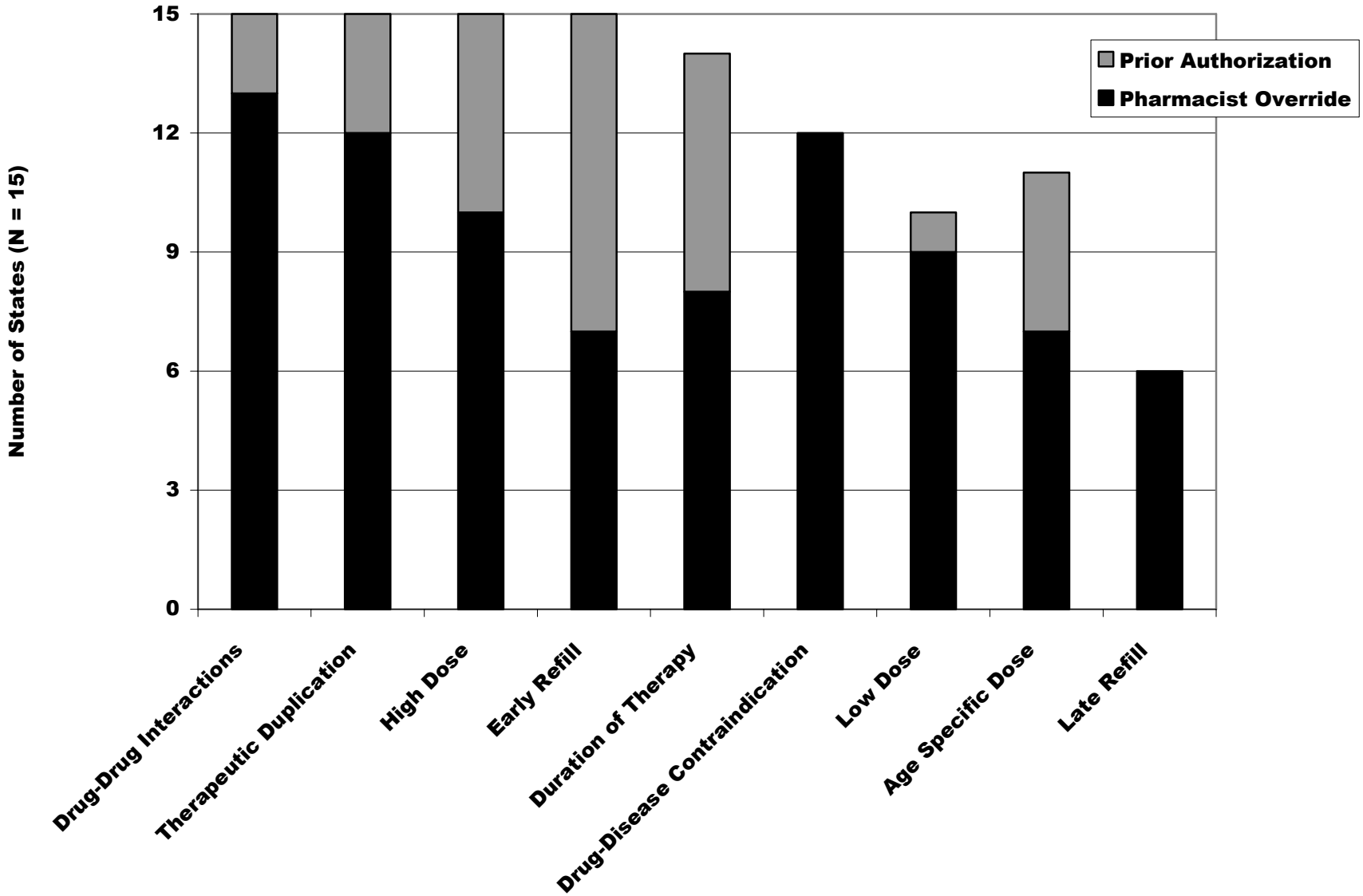


Chart S-10:
Categories of Drugs Subject to Preferred Drug Lists / Prior Authorization in Selected SPAPs, 2003

- In addition to formularies and ProDUR, states can attempt to influence drug utilization through the use of preferred drug lists (PDLs) or prior authorization programs. In these programs, drugs that are not on the PDL, or, in some cases, all drugs in a class, have to receive prior authorization either from the state or the PBM before they can be dispensed. In contrast to ProDUR, drug cost is the main factor in the decision to put drugs on PDLs.
- Of the 21 states with SPAPs, 11 have some form of PDL and/or prior authorization program. This chart shows the categories of drugs that are subject to prior authorization for 7 of these states.

Sources: Florida Agency for Health Care Administration. *Florida Medicaid Preferred Drug List*. http://www.fdhc.state.fl.us/Medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml Accessed 3/18/03.

Illinois SeniorCare Program Preferred Drug List: Updated February 27, 2003. http://www.seniorcareillinois.com/html/scpreferred_drug_list_.html. Accessed March 5, 2003.

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Michigan Department of Community Health. *Changes to the Michigan Pharmaceutical Product List, Effective February 1, 2002 (Last Updated 7/1/02), Therapeutic Classes Reviewed List*. http://www.michigan.gov/documents/329druglist_15113_7.PDF Accessed March 5, 2003.

Minnesota Department of Human Services. *Pharmacy Program Information for Providers (MN DHS)*. http://www.dhs.state.mn.us/provider/pharm/default.htm. Accessed March 18, 2003.

Office of Vermont Health Access. *Pharmacy Benefit Management Program: "Quick" Preferred Drug List and Drugs Requiring PA*. http://www.dsw.state.vt.us/districts/ovha/drugquickcat.pdf. Accessed March 5, 2003.

Source for Wyoming's Prior Authorization List is the 2002 Center for State Health Policy Survey.

Chart S-10:
Categories of Drugs Subject to Preferred Drug Lists / Prior Authorization in Selected SPAPs, 2003

Drug Categories	Florida	Maine	Michigan	Minnesota	Vermont	Wyoming	Illinois
ACE Inhibitors	X		X		X		X
Acute Migraine	X	X			X		X
Alzheimers Drugs	X		X				X
Angiotensin Blockers	X		X		X		X
Anorexiants / Weight loss	X	X	X*		X		
Antianxiety	X		X		X		
Antibiotics	X		X		X		X
Antidepressants / SSRIs	X		X		X		X
Anti-Emetics	X				X		X
Antifungals	X	X	X		X		X
Antiparkinson Agents	X						X
Antivirals	X		X				X
Beta Blockers	X	X	X		X		
Beta-Adrenergic Agents	X		X		X		X
Calcium Channel Blockers	X	X	X		X		X
CNS Stimulants	X	X	X*		X		X
Coronary Vasodilators	X		X		X		
Cox II Inhibitors	X	X		X	X	X	X
Estrogen Agents	X						X
Glaucoma Agents / Miotics	X				X		X
Glucocorticoids	X		X		X		
Growth Hormone		X			X		X
Hepatitis C Agents	X				X		
Insulins	X		X				X
Lipotropics	X		X		X		X
Narcotics	X	X	X		X		X
Non-Sedating Antihistamines	X	X	X		X		X
NSAIDS	X	X	X		X		
Ossification Enhancers / Osteoporosis Agents	X		X		X		X
Platelet Inhibitors	X		X		X		X
PPI's/H2 Blockers	X	X	X	X	X	X	X
Sedative Hypnotics	X	X	X		X		X
Viagra/erectile disfunction	X	X	X*		X		X
Other Drugs	X	X	X		X		X

*These types of drugs are not covered under the Michigan program.

Notes: Maine also has dose consolidation limits for 251 drugs. Source: Program web pages.

Chart S-11:
Total SPAP Drug Expenditure Trends by State and Region, 1999 to 2002

- Most expenditures on SPAPs are in the Northeastern states of New York, Pennsylvania and New Jersey.
- Several states reported large increases in expenditures between 1999 and 2002. These were mainly due to program expansions in eligibility or benefits. However, expenditures increased over time for all programs.
- One-year increases in expenditures ranged from 11.5% from 1999 to 2000 in Illinois to 580% from 2001 to 2002 in Nevada.

Chart S-11:
Total SPAP Drug Expenditure Trends by State and Region, 1999 to 2002

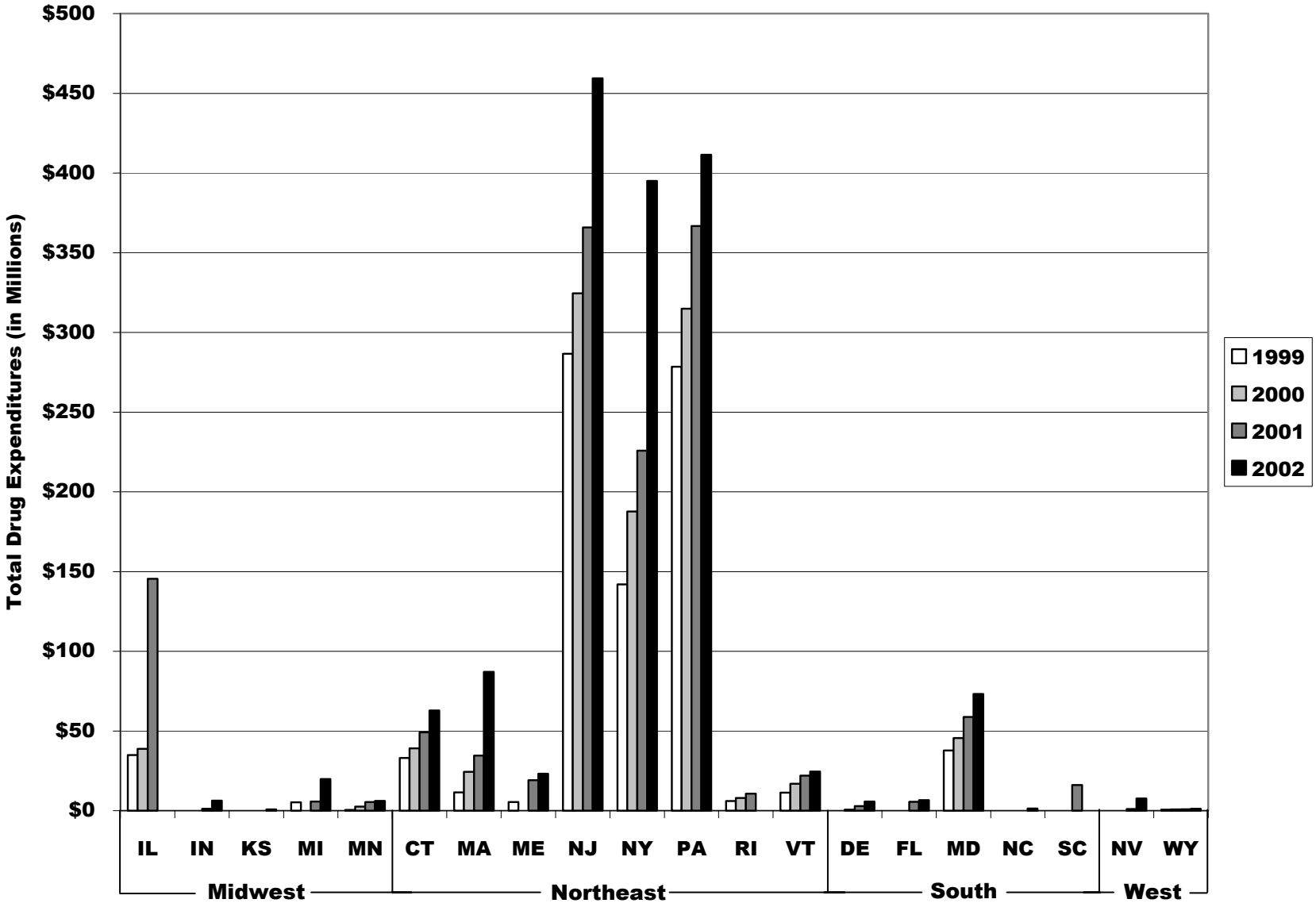

Chart S-12:
Annual Drug Expenditures Per End-of-Year Enrollee for Specific Programs by Cost-Sharing Features and Coverage, 2002

- In general, as expected, programs with more generous benefits — low or no coinsurance, cost caps, or deductibles — have higher costs per enrollee than do those with less generous benefits.
- Programs within the same state that have different benefit levels often have very different costs per enrollee. For example, the costs per enrollee were very different for programs in New York ($1,874 for the fee program, $1,187 for the deductible program), New Jersey ($2,257 for PAAD, $455 for Senior Gold), Pennsylvania ($1,652 for PACE, $854 for PACENET) and Vermont ($1,833, $1,820 and $742 for VScript, VHAP, and VScript Expanded, respectively).

Chart S-12:
Annual Drug Expenditures Per End-of-Year Enrollee for Specific Programs by Cost-Sharing Features and Coverage, 2002

State	Fee	Deductible	Coinsurance	Benefit Cap	Limit Number of Drugs or Conditions	Annual Expenditures Per Enrollee
NJ PAAD						**$2,257**
NY Fee	$8 to $300 by income					**$1,874**
VT VScript					Maintenance Drugs only	**$1,833**
VT VHAP						**$1,820**
PA PACE						**$1,652**
WY				3 Prescriptions per month (and oxygen services, if needed)		**$1,644**
MD					Maintenance Drugs only	**$1,641**
MI	$25		20%			**$1,355**
CT	$25					**$1,337**
MN		$35 a month				**$1,335**
NY Deduct		$530 to $1,715 by income				**$1,187**
NV						**$1,023**
DE			$5 or 25%	$2,500 per year		**$1,013**
IL	$5 or $25 by income			Increased cost sharing after reach $2,000 per year	9 Conditions	**$855**
PA PACENET		$500				**$854**
VT VScript Expanded		$275	41%		Maintenance Drugs only	**$742**
NC			40%	$1,000 per year	3 Conditions	**$732**
ME			$2 or 20%		13 Conditions	**$651**
KS			30%	$1,200 per year		**$528**
SC		$500				**$496**
NJ Senior Gold			$15 plus 50% of the remaining cost of the drug			**$455**
IN			50%	$1,000 per year by income		**$385**
MA	$0 to $99 by income	$0 to $125 by income				**$354**
RI			40%, 70%, or 85% by income		15 Conditions	**$280**
FL				$160 a month		**$156**

Notes: Data for Illinois, New York, Pennsylvania, Rhode Island, and South Carolina are from 2001. Data for New York and Pennsylvania are from program annual reports.

Chart S-13:
Trends in Annual SPAP Drug Expenditures Per End-of-Year Enrollee by State and Region, 1999 to 2002

- Changes in annual drug expenditures per enrollee from 1999 to 2002 varied widely between states, with some states showing decreases at points.
- This variability seems to be due to program expansions which increase enrollment during the year, but result in a substantial number of enrollees who do not use the program for a full year, and whose costs to the program are less than those of enrollees using the program throughout the year. Therefore, the cost per enrollee at the end of the year is not representative of the cost per person enrolled in the program throughout the year for every state.
- However, some states, such as Pennsylvania, did not implement a substantial program expansion between 1999 and 2002, and costs per end-of-year enrollment for Pennsylvania increased from $1,139 in 1999 to $1,798 in 2002, a 58% increase.

Chart S-13:
Trends in Annual SPAP Drug Expenditures Per End-of-Year Enrollee by State and Region, 1999 to 2002

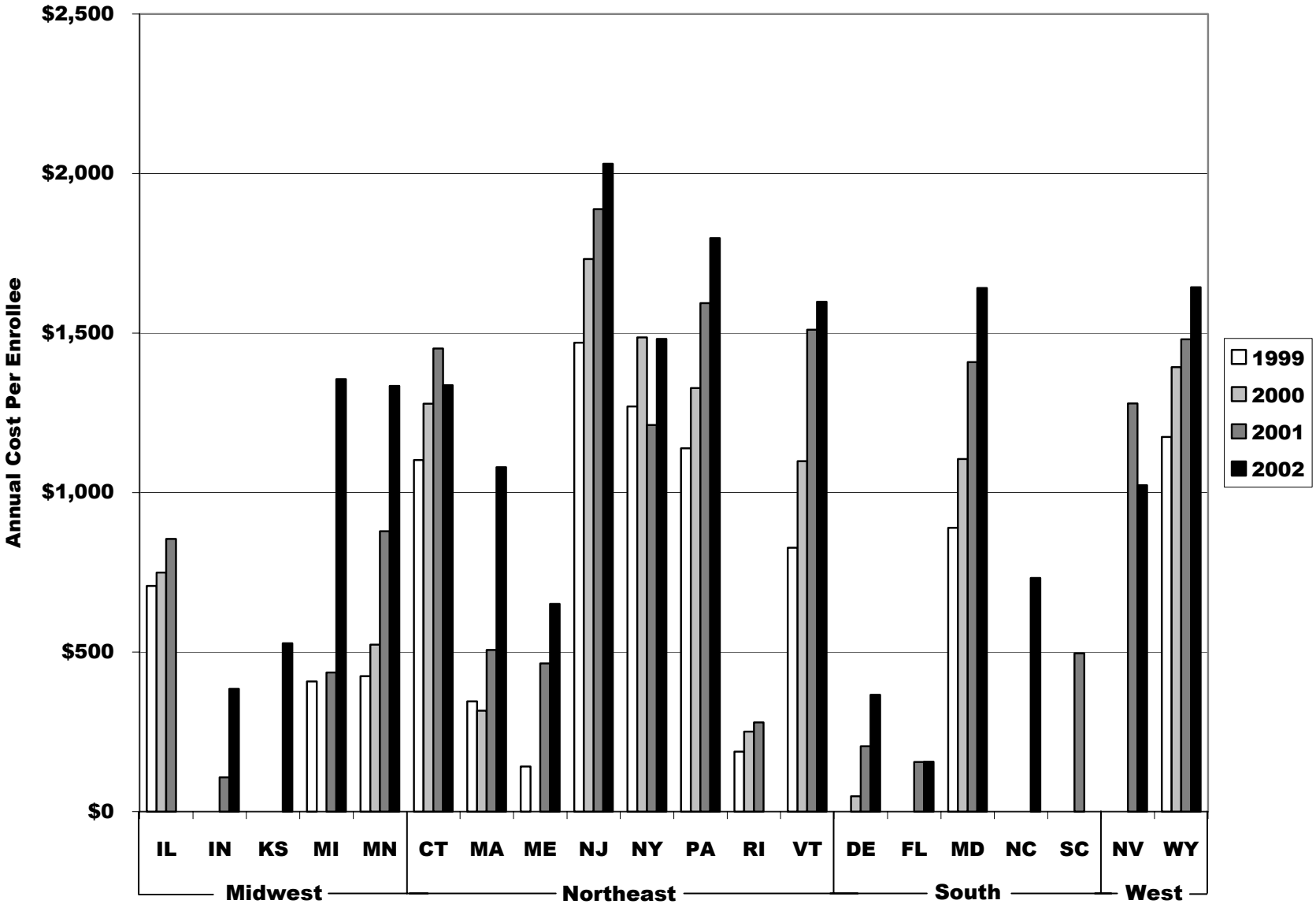

Chart S-14:
Trends in Annual Number of Claims Per End-of-Year Enrollee by State and Region, 1999 to 2002

- Trends in the number of claims per end-of-year enrollee varied considerably across states.
- Some states, such as New Jersey, had fairly stable claims per enrollee rates, while other states, such as Vermont, Maine, Michigan and Minnesota saw large increases in claims per enrollee from 1999 to 2002.
- These states typically either expanded the number or types of drugs available through their programs (Vermont, Maine and Michigan) or had new programs or eligibility expansions in 1999/2000 (Vermont, Maine, Delaware and Minnesota). These newer and expanded programs experienced enrollment increases in 1999 and 2000, so that not all enrollees had access to program benefits throughout the year. By 2001 and 2002, enrollment had slowed somewhat, and more enrollees had access to the benefit for the entire year and were able to have more prescriptions covered under the programs.

Chart S-14:
Trends in Annual Number of Claims Per End-of-Year Enrollee by State and Region, 1999 to 2002

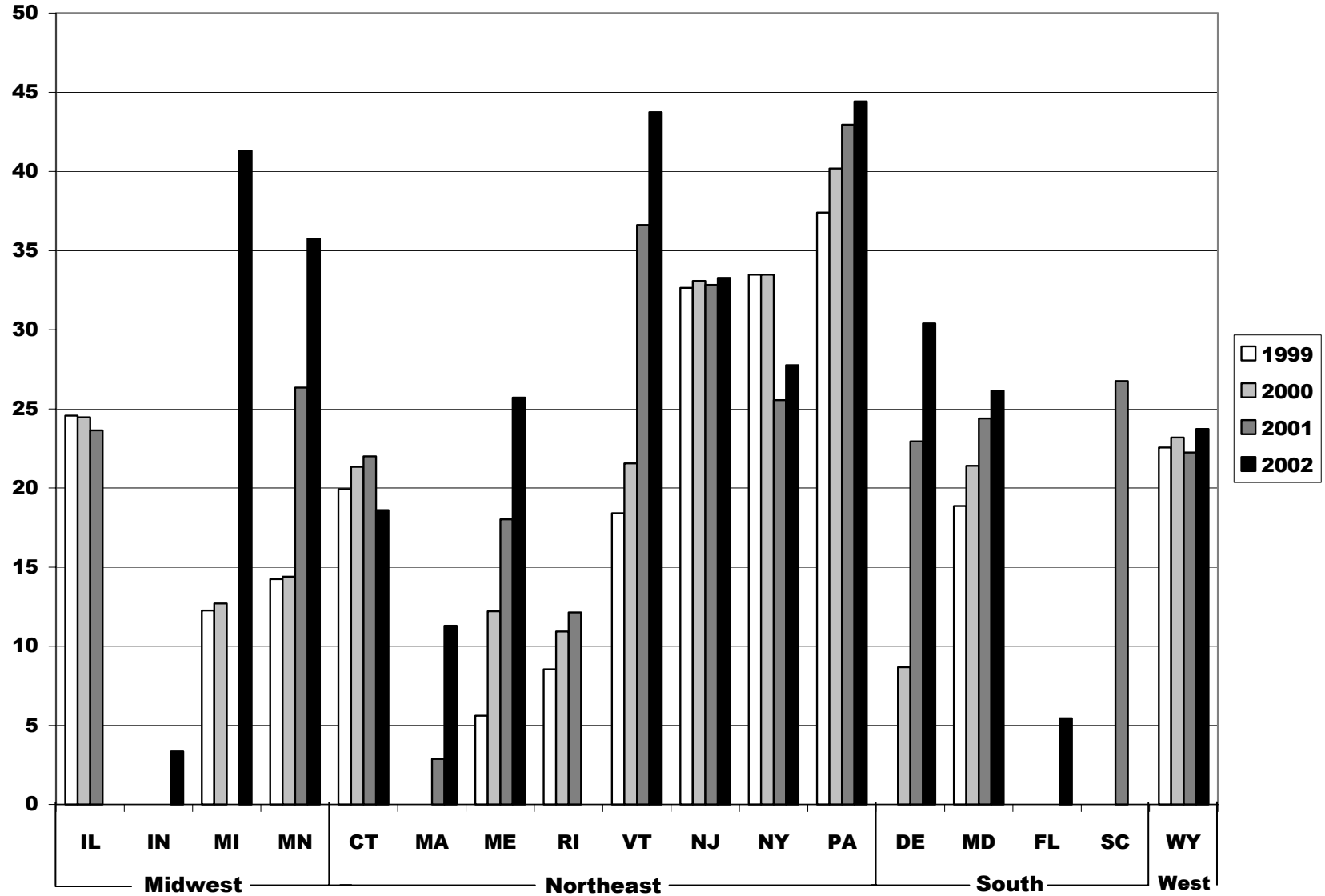

Chart S-15:
Trend in State Cost Per Claim by Region, 1999 to 2002

- State cost per claim trends were typically either somewhat flat or increased steadily from 1999 to 2002.
- Vermont had a 28.4% decrease in cost per claim from 2000 to 2002.

Chart S-15:
Trend in State Cost Per Claim by Region, 1999 to 2002