CENTER for STUDYING HEALTH SYSTEM CHANGE

Issue Brief

Findings from HSC

NO. 105 • APRIL 2006

THE COMMUNITY SAFETY NET AND PRESCRIPTION DRUG ACCESS FOR LOW-INCOME, UNINSURED PEOPLE

By Laurie E. Felland, Erin Fries Taylor and Anneliese M. Gerland

While the new Medicare drug benefit has helped alleviate concerns about prescription drug access for elderly and disabled Americans, many low-income, uninsured people under age 65 continue to rely on community safety nets to get needed medications. As the number of uninsured Americans increases, safety net providers are stretching limited resources to meet growing prescription drug needs, according to findings from the Center for Studying Health System Change's (HSC) 2005 site visits to 12 nationally representative communities. Despite redoubled efforts—centered on obtaining discounted drugs and donated medications—to make affordable drugs available to needy patients, safety net providers and community advocates report that many low-income, uninsured people continue to face major barriers to obtaining prescription drugs.

Need for Prescription Drug Assistance Grows

Not surprisingly, low-income, uninsured people report more problems obtaining prescription drugs because of costs than people with insurance. For example, 26 percent of uninsured adults in 2003 did not purchase at least one prescription drug because of cost, compared with 8.7 percent of people with employer coverage.[1] Moreover, prescription drug prices and utilization have continued to rise.[2]

Yet low-income, uninsured people generally lack access to state and federal pharmaceutical assistance programs and often cannot afford to fill prescriptions at retail pharmacies. While a number of states have prescription drug assistance programs, they have been targeted primarily toward Medicare beneficiaries. Although the federal government started providing prescription drug coverage for Medicare beneficiaries in 2006, many states with drug assistance programs have provided ongoing support to seniors by, for example, supplementing their cost-sharing requirements. And in early 2006 many states stepped in to cover prescription drugs temporarily for dually eligible Medicare and Medicaid beneficiaries when problems arose with Medicare coverage.

Communities play a key role in providing prescription drugs for low-income, uninsured people, who often seek medications from the same safety net providers who offer medical services and prescribe the medications, according to HSC's 2005 site visits to 12 nationally representative (see Data Source). Safety net hospitals and community health centers (CHCs) typically have on-site pharmacies or contract with outside pharmacies to offer a full range of medications, usually charging patients a copayment. Free clinics and other small providers often can dispense only limited quantities or types of medications. To help control drug costs, safety net providers frequently use generic drugs, and some have adopted preferred drug lists. As the number of uninsured Americans rises, community safety net providers are treating more uninsured patients without proportionate funding increases.

Safety Net Rx Strategies

To help subsidize and reduce the cost of prescription drugs for low-income, uninsured people, safety net providers—in some cases in collaboration with community-level programs—have built on existing strategies and developed new ones. Many CHCs and safety net hospitals have access to a federal prescription drug discount program. And while all types of safety net providers have long dispensed manufacturer drug samples to patients, they have developed more structured ways of obtaining ongoing supplies of the most commonly prescribed medications. These strategies include—in general order of prominence—increased use of federal discounts; obtaining donated prescription drugs from manufacturers; use of public and private

Many safety net providers rely on pharmaceutical manufacturer assistance programs to obtain free or reduced-cost prescription drugs for patients.

funding to subsidize drugs; and establishing discounts for uninsured people at local retail pharmacies.

340B Discounts

Since 1992, community health centers that are federally qualified (FQHCs) and safety net hospitals receiving federal disproportionate share hospital (DSH) payments have been eligible for discounts on brand name and generic prescription drugs through the federal 340B Drug Pricing Program, which requires pharmaceutical manufacturers to give eligible providers discounts equal to or greater than those received by Medicaid.[3] Providers distribute these drugs to patients through their own pharmacies or through contracted retail pharmacies, charging patients a sliding-scale fee based on income. A 2004 study estimated that the 340B discounts saved providers participating in the program at least 27 percent of annual outpatient drug expenditures.[4]

Use of the 340B program has grown in recent years.[5] While all of the 12 HSC communities have at least one safety net provider participating in the 340B program, some communities—including Boston, Cleveland, Indianapolis, Miami and Seattle—have a broad network of participating hospitals and health centers. And more safety net providers across the communities recently have applied for the program. Furthermore, recent federal legislation expanded 340B pricing to outpatient drugs at certain children's hospitals, although these hospitals may have difficulties meeting DSH requirements.[6]

Manufacturer Assistance Programs

Many safety net providers—including those that participate in 340B—rely on pharmaceutical manufacturer assistance programs to obtain free or reduced-cost prescription drugs for patients. As a group, manufacturers have significantly increased the amount of drugs donated through these programs, with the number of free prescription medicines distributed growing from approximately 3 million in 1998 to 22 million in 2004, according to the Pharmaceutical Research and Manufacturers of America (PhRMA), an industry trade group.

Manufacturer assistance programs vary but are typically available to uninsured people, generally with household incomes below 200 percent of the federal poverty level, or $40,000 for a family of four in 2006. Applicants also must demonstrate citizenship or legal immigrant status. However, eligibility requirements, including age and income restrictions, vary, and some programs do not publicly disclose their requirements. Application processes also differ by drug company and/or by program, and many companies run multiple programs to cover different medications.

To help people navigate the varied eligibility criteria and application processes for the multiple programs, some states and not-for-profit groups have worked with drug manufacturers to establish Web sites, such as *www.Rx4NJ.org* and *www.needymeds.com*, and PhRMA has a Web site called the Partnership for Prescription Assistance at *www.pparx.org*. While market observers indicate these Web sites are helpful, the sites do not offer a single standardized application for multiple companies' programs. In addition, applicants' health care providers (physicians and other staff) need to be involved in authorizing the requests and dispensing the medications.

Given the complexity of the application process, many safety net providers help uninsured patients apply for manufacturer assistance programs. In recent years, providers increasingly have tapped into manufacturer assistance programs through a number of approaches:

- Many providers have hired staff and devoted other resources to bring in more donated prescription drugs. A health center in Lansing, for example, found that dedicating one full-time staff member to this effort generated more than $300,000 worth of free medications in one year. In Cleveland, the county hospital now assists physicians in obtaining donated drugs for their patients through automated prompts in the hospital's electronic medical record system.

- Some safety net hospitals and CHCs have arranged for bulk replacement,

a process where drug manufacturers stock providers' pharmacies with medications that providers dispense to patients determined to be eligible for the manufacturer's assistance program but who have not applied individually. This practice allows the pharmacy to offer these medications immediately to patients, rather than pursuing each individual application. The county hospital in Indianapolis acquired more than $3 million worth of free drugs through bulk replacement last year, double the level from two years earlier.

- Some community programs that rely on private physicians donating medical care to uninsured patients also help patients obtain prescription drugs from manufacturers. Such donated-care programs, in which participating physicians agree to provide a certain amount of free medical care each year, are administered through local medical societies or other community organizations and often help link enrollees to manufacturer prescription drug assistance programs. In fact, the need for prescription drugs is reportedly the main benefit people seek when applying to the program in Little Rock. Plus, including prescription drugs is important to physician participation in donated-care programs because of concerns about treating patients who cannot afford to fill prescriptions.

Given the implementation of the Medicare drug benefit, pharmaceutical manufacturers are now re-examining their drug assistance programs. To the extent that manufacturers focus less on Medicare beneficiaries in the future, there may be an opportunity to offer donated drugs to additional low-income, uninsured people.

Safety Net Programs to Coordinate Care

Another way a few communities fund prescription drugs for low-income, uninsured people is through programs that provide primary and preventive care through safety net providers, coordinate access to specialty care and encourage appropriate use of other services, such as emergency care. Prescription drugs are included as a vital part of managing patients' conditions. In addition to tapping into available 340B discounts through participating hospitals and health centers, these programs use a portion of their funding from federal and state DSH payments, state charity care pools or local property taxes to offer medications to enrollees, usually for a small copayment. Such programs in Lansing, Indianapolis and Boston offer prescription drugs to a large and growing number of people. For example, the Health Advantage program in Indianapolis now serves about 50,000 people—half of the county's uninsured population.

Private Funding and Discount Cards

Some safety net providers have pursued funding from private, usually local, philanthropies to subsidize drug costs. While free clinics are particularly reliant on private funding, some CHCs and hospitals also have turned to foundations for assistance when existing programs and funding could not fulfill the need.

In a few communities, local drug card programs have been initiated recently that allow residents to purchase discounted prescription drugs from retail pharmacies. Local governments in Lansing and northern New Jersey, for example, have negotiated discounts with retail pharmacies. Such discounts vary considerably across programs and medications. In some cases, discount cards are part of a broader medical discount program. For instance, the new HealthCare Connect program in Phoenix provides discounts on medical services and prescription drugs.

Impact of Rx Strategies

In general, individual safety net providers and programs report that pursuing these strategies has helped keep low-cost medications available to their low-income, uninsured patients. Yet the ability and capacity to use the range of strategies varies across providers, and several inherent limitations remain for both safety net providers and their patients.

- *Provider costs*: Although the 340B program allows many safety net providers to purchase prescription drugs at a discount, these providers still must subsidize drug costs for patients. And while many safety net providers and communities have streamlined how they participate in manufacturer assistance programs, the time and resources required to tap into these programs is prohibitive for small providers and free clinics with more limited budgets. Moreover, many safety net providers feel increasingly strapped for resources as they try to cope with a rising number of uninsured patients and they find it harder to keep pace with the rising cost of drugs, even when significant discounts are available.

- *Patient costs*: Although generally a small percentage of the total medication cost, the copayments or other cost sharing required by safety net providers and prescription programs can pose barriers for low-income people, and some providers have increased their pharmacy copayments over the last few years. Plus, recent discount-card initiatives typically require significant out-of-pocket spending. Although providers often offer a short-term supply of medication to patients unable to contribute to the cost, such patients may struggle to comply with a longer-term drug regimen. Manufacturer assistance programs can help fill the gap, but patients treated by providers without bulk replacement arrangements still must wait to receive donated medications and periodically must re-apply.

- *Eligibility restrictions*: Numerous respondents across communities noted that individuals with incomes just above the thresholds of manufacturer assistance and other programs face particular barriers in accessing prescription drugs. In addition, the requirements of most manufacturer programs limit their impact in communities where there are many undocumented immigrants who do not qualify, such as Orange County, Phoenix and Miami. Even for eligible individuals, the application process for manufacturer assistance programs remains complex, and some research suggests that the assistance programs have difficulty meeting all of the medication needs for many patients.[7]

Data Source

Approximately every two years, HSC researchers visit 12 nationally representative metropolitan communities to track changes in local health care markets. The 12 communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. In 2005, HSC researchers interviewed an array of market stakeholders about how low-income people obtain prescription drugs. These respondents included executives of approximately 40 safety net providers (the main safety net providers in each community, including hospitals, community health centers and free clinics), in addition to directors of local prescription drug programs, state policy makers, consumer advocates and others.

ISSUE BRIEFS are published by the Center for Studying Health System Change.

600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512
Tel: (202) 484-5261
Fax: (202) 484-9258
www.hschange.org

President: Paul B. Ginsburg
Vice President: Jon Gabel
Director of Site Visits: Cara S. Lesser

CENTER for STUDYING HEALTH SYSTEM CHANGE

Furthermore, only about half of low-income, uninsured people are aware of a safety net provider in their community.[8] Given the considerable role safety net providers play in obtaining prescription drugs, there remain many low-income, uninsured people who may not have the same access to low-cost medications as those who, for instance, are treated at a community health center.

Policy Implications

While policy makers have focused on extending prescription drug coverage to Medicare beneficiaries, the prescription drug needs of nonelderly, low-income people without coverage are a growing problem. Despite federal efforts to expand primary care services for low-income, uninsured people over the past few years, there has been a lack of significant new resources at the federal or state levels specifically dedicated to prescription drugs for this population. At the same time, safety net providers report that funding has not kept pace with the increased number of patients they treat.

To address the growing demand for prescription drugs, safety net providers have made acquiring free or reduced-cost medications an integral part of their daily operations. Even with an expanded set of strategies in place, providers and patients struggle with rising demand and costs, and prescription drug access remains a challenge across communities. With state budgets recovering from the economic downturn, more resources may become available for state prescription drug assistance programs. Moreover, steps to expand and facilitate the use of strategies that lower drug costs for providers and patients—such as 340B and manufacturer assistance programs—could help reduce the strain on safety net providers and extend medications to more people.

Notes

1. Cunningham, Peter J., "Medicaid Cost Containment and Access to Prescription Drugs," *Health Affairs,* Vol. 24, No. 3 (May/June 2005).
2. Strunk, Bradley C., Paul B. Ginsburg and John P. Cookson, "Tracking Health Care Costs: Declining Growth Trend Pauses in 2004," *Health Affairs,* Web exclusive (June 21, 2005).
3. National Conference of State Legislatures, "States and the 340B Drug Pricing Program," *http://www.ncsl.org/programs/health/drug340b.htm.* Furthermore, the Office of Inspector General at the Department of Health and Human Services has recommended greater oversight of the 340B program to ensure that drug manufacturers are calculating prices correctly for providers. Source: BNA Health Care Policy Report, "Discount Program for Public Hospitals Needs Stronger Oversight, HHS Official Tells Panel," Vol. 14, No. 1 (Jan. 2, 2006).
4. Schmitz, Robert, et al., *The PHS 340B Drug Pricing Program: Results of a Survey of Eligible Entities,* Mathematica Policy Research, Inc., report to the Health Resources and Services Administration (August 2004).
5. Health Resources and Services Administration, "Growth of 340B Covered Entity Sites (All Types)," (Chart), *ftp://ftp.hrsa.gov/bphc/pdf/opa/Historical_charts.pdf.*
6. "Federal Drug Discount and Compliance Monitor," *www.DrugDiscountMonitor.com*, Vol. 3, No. 2 (February 2006).
7. Office for Oregon Health Policy and Research, "Oregon's Medically Needy Program Survey Summary Report," (February 2004).
8. May, Jessica H., Peter J. Cunningham and Jack Hadley, *Most Uninsured People Unaware of Health Care Safety Net Providers*, Issue Brief No. 90, Center for Studying Health System Change, Washington, D.C. (November 2004).