Trends in a State Pharmaceutical Assistance Program for Low-income Older Adults in Wisconsin

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ABSTRACT

Introduction: *Many older adults face difficulty in affording their prescription drugs, despite having coverage available through Medicare Part D. SeniorCare is Wisconsin's pharmaceutical assistance program that provides comprehensive drug coverage for low-income older adults who are not eligible for full Medicaid benefits.*

Methods*: We analyzed SeniorCare enrollment and pharmacy claims data from 2014 to 2018.*

Results*: Total drug expenditures increased by 19.3%, with the proportion of expenditures paid by SeniorCare and members decreasing while the proportion paid by other payers increased. Specialty drugs accounted for a substantial and growing proportion of total expenditures (20.4% in 2018) despite accounting for <0.2% of all claims.*

Conclusions*: Total drug expenditures in SeniorCare have steadily increased over time, primarily due to rising average expenditures per drug fill and increased use of specialty drugs. However, SeniorCare members have been largely protected from these increases and have paid a decreasing proportion of costs over time.*

Keywords: Older adults, low-income populations, prescription drugs, health policy

INTRODUCTION

Prescription drugs are an important component in the management of chronic conditions for older adults. Nearly 9 in 10 adults 65 and older report currently taking a prescription medication, with 54% taking 4 or more.[1,2] Although the majority of older adults in the U.S. have prescription drug coverage through Medicare Part D, most older adults (76%) think the cost of prescription drugs is unreasonable.[1] Nearly 1 in 4 older adults say they have difficulty affording prescription drugs, with a higher likelihood seen among those with low income despite the availability of means-tested support through both Medicaid and Medicare.[1,3]

Implemented in 2002, SeniorCare is a unique state prescription drug assistance program for low-income older adults in Wisconsin that provides comprehensive coverage for prescription drugs and over-the-counter insulins.[4] To be eligible for SeniorCare, an individual must be a Wisconsin resident, a U.S. citizen or have qualifying immigrant status, age 65 or older, and not be receiving full Medicaid benefits.

SeniorCare is available to all eligible older adults with costs that vary based on income. However, it is available to low-income older adults with annual income ≤200% of the federal poverty level (FPL) through a Section 1115 demonstration waiver, which provides federal matching funds and grants states flexibility to design and implement programs to promote the health and wellness of vulnerable and low-income individuals.[5] The program has a simple cost sharing structure: a $30 annual enrollment fee and copayments of $5 for generic drugs and $15 for brand name drugs. Members with income ≤160% FPL are subject only to the standard copayment amount, while members with income between 160% and 200% FPL are subject to an additional annual deductible of $500. Members with income ≥200% FPL have additional cost sharing requirements based on their income.

SeniorCare is distinct from other state and federal programs in several ways. First, although a number of states have had drug assistance programs for older adults, following the implementation of Medicare Part D in 2006 many of these programs were discontinued.[6] States that maintained pharmaceutical assistance programs primarily intend them for use as supplements to Medicare Part D coverage.[6–8] They provide assistance with Part D premiums or while an individual is in the Part D coverage gap, and require Part D enrollment to use their programs.[6–8] In contrast, SeniorCare is a voluntary program that is considered creditable coverage by Medicare Part D, meaning it can be used as an alternative to Part D coverage. SeniorCare may also be used to supplement prescription drug coverage from Medicare Part D, employer-sponsored insurance, or other private insurance plans.

Second, federal assistance is available for eligible low-income Medicare Part D enrollees through the low-income subsidy program (LIS, also known as Extra Help),[9] which helps pay premiums, deductibles, and co-payments. However, in addition to meeting certain annual income thresholds, LIS eligibility has an asset test that considers assets such as bank accounts, real estate, and retirement funds. In contrast, SeniorCare does not require any asset testing, so individuals with low income who may be ineligible for the Part D LIS are still eligible for support through the SeniorCare program.

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The landscape of prescription drug coverage has greatly changed during the life course of the SeniorCare program, with implementation of the Medicare Part D prescription drug insurance benefit in 2006 and major changes to the structure of the Part D drug benefit through the Affordable Care Act and related policies.[10] In addition, US health care spending is rapidly increasing, which is driven in part by rapid growth in Medicare spending.[11] Rapid growth in Part D prescription drug spending has led to growing concerns both for Medicare beneficiaries and the Medicare program as a whole.[12] However, no previous study has utilized data from the SeniorCare program, and it is unknown how these issues facing the federal Medicare Part D program have impacted the SeniorCare program or enrolled members.

Given the uniqueness of the SeniorCare program in supporting prescription drug use among low-income older adults for nearly two decades and the comparatively generous eligibility criteria compared to Part D LIS support, it is important to have an understanding of how changes in drug use and spending have impacted the program and its members. This information can be useful to inform policies and programs to support the affordability of prescription drugs for low-income older adults. Therefore, the objective of this study was to evaluate trends in SeniorCare program enrollment, drug utilization, and expenditures from 2014 to 2018.

METHODS

Data source and study sample

We obtained SeniorCare program enrollment and prescription drug claims data for 2014 to 2018 from the Wisconsin Department of Health Services. The enrollment data included dates of enrollment in the SeniorCare program, as well as demographic information such as member age, gender, race, and ethnicity. It also contained the annual income of each individual or married couple and an indicator of waiver eligibility (i.e., having annual income ≤200%). The SeniorCare prescription drug claims data contained drug name, drug ingredient, fill date, drug type (e.g., brand name or generic), days' supply, total copay, total amount paid by SeniorCare, and total amount paid by other payers.

Our study sample was composed of the full population of SeniorCare members with income ≤200% FPL that were enrolled in the program through the Section 1115 waiver (the waiver population) at any point from January 2014 to December 2018. We excluded the non-waiver population (i.e., members with income >200% FPL), as their demographic characteristics were considerably different from the waiver population, and only about 35-45% of non-waiver enrollees had a claim in each year. This is indicative of structural differences between the two populations that would make it inappropriate to combine the two populations, such that there are either differing patterns of drug use, or that non-waiver members were unlikely to use SeniorCare as their primary source of insurance coverage, resulting in missing or incomplete information on prescription drug use. Therefore, we focused on the waiver population given the higher likelihood of complete information on prescription drug use through the SeniorCare program.

Outcome measures

We described trends in the annual number of SeniorCare enrollees and their demographic characteristics. Using the source of payment information contained in the drug claims data, we also identified the proportion of members having SeniorCare as the primary or sole source of drug insurance coverage and those with additional supplemental drug coverage.

We examined trends in drug utilization using the annual number of 30-day drug fills. The drug fills were normalized to 30-day fills using days' supply to account for the variability in the number of days dispensed across fills (e.g., 90-day supply). We also measured the number and proportion of drug fills for brand name and generic drugs in each year, and those for specialty drugs and non-specialty drugs. Brand name and generic drugs were identified using the brand/generic indicator in the drug claims, and specialty drugs were identified using the state's specialty pharmacy drug classification, which defines specialty drugs as those requiring comprehensive patient care services, clinical management, and product support services.[13]

We also examined trends in drug expenditures by measuring total annual expenditures, the proportion of annual drug costs paid by each source of payment, and average expenditures per 30-day fill and per member. Total expenditures were defined as the sum of all payments for a drug from any source, including SeniorCare, members, and other third-party payers (such as Medicare Part D, private insurance, or other sources of coverage). SeniorCare costs were defined as the amount paid by the SeniorCare program, and excluded any amounts paid by other payers. Member costs included all out-of-pocket costs paid by a member, including copayments and any applicable deductible amount. As in the utilization outcomes, we assessed the expenditures by drug type (i.e., brand name or generic drugs, specialty or non-specialty drugs).

Analysis

All outcomes were analyzed using descriptive statistics in each calendar year from 2014 to 2018. The outcomes were analyzed separately for each year to examine annual changes in the outcomes in each year and trends across the entire study period. The mean outcomes in 2014 and 2018 were compared using independent *t*-tests. Statistical significance was set *a priori* at an α of <0.05. All analyses were conducted using Stata/SE, version 16.0.

RESULTS

Member demographics and drug use

A detailed breakdown of the characteristics of the study sample is presented in Table 1. The number of members enrolled in the

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SeniorCare program declined over time by 11.3%, decreasing from 57,827 members in 2014 to 51,276 members in 2018. The average member age was approximately 80 years but shifted over time towards a higher proportion of members age 65-74 years. Nearly three-quarters were female, although this proportion declined slightly over time. The majority of members were non-Hispanic white. The mean annual couple income was approximately $19,000, which is consistent with the eligibility requirements for this group.

Over 80% of SeniorCare members had one or more drug claim in each year, which declined slightly over time. Similarly, the mean annual number of 30-day drug fills per member decreased from 39.7 to 37.4 fills over this same time period. The proportion of SeniorCare members with additional supplemental drug coverage increased; however, approximately 70% of members had SeniorCare as their only source of drug insurance coverage over the study period, indicating high use of the SeniorCare benefit as their primary or sole source of drug insurance coverage.

SeniorCare drug utilization and expenditures

From 2014 to 2018, the total annual number of 30-day drug fills in the member population decreased by 16.5%, from 2,295,818 fills in 2014 to 1,916,660 fills in 2018 (Table 2). Over this same time period, total annual expenditures increased by 19.3%. The average expenditures per 30-day drug fill increased by 40.5% (*P*<0.001), and average expenditures per member also increased by 39.4% (*P*<0.001). Examining program expenditures by source of payment showed that the proportion of total annual expenditures paid by members and by SeniorCare decreased by 4.2 and 2.3 percentage points, respectively, whereas the share of costs paid by other payers increased by 6.6 percentage points. Due to the increasing trends in total expenditures over the five years, in dollar terms, annual member costs decreased by 17.6%, SeniorCare costs increased by 15.6%, and the costs to other payers nearly doubled.

The number of 30-day drug fills decreased for both brand and generic drugs from 2014 to 2018, although the decrease was considerably larger for brand name drugs (Table 2). Approximately 85.8% of all 30-day fills were for generic drugs in 2014, which increased to 89.4% in 2018. Yet generic drugs accounted for only 22.2% of total expenditures in 2014, which decreased to 18.4% in 2018. Despite decreasing brand drug use over time, the total expenditures for these agents increased by 25.1%, which led to a nearly doubling in average expenditures per 30-day fill from $295 to $532 (*P*<0.001). The proportion of total annual expenditures paid by SeniorCare for brand name drugs decreased slightly (-4.1 percentage points); instead, the cost burden for these drugs largely shifted to other payers, increasing by 7.4 percentage points between 2014 and 2018. In contrast, the proportion of expenditures by source of payment for generic drugs remained relatively unchanged over this same time period.

Specialty drugs were significantly more expensive than non-specialty drugs; average expenditures per 30-day fill in 2018 were $7,006 for specialty drugs and $66 for non-specialty drugs (*P*<0.001, Table 2). Although specialty drugs accounted for <0.2% of all SeniorCare claims, their use increased by 74% between 2014 and 2018. Moreover, they accounted for a substantial and growing proportion of the costs; the proportion of total expenditures for specialty drugs increased from 9.2% in 2014 to 20.4% in 2018. Over this time period, total expenditures for specialty drugs increased by 164.7%, which far exceeded the increases in total expenditures (4.5%) for non-specialty drugs over that period. The proportion of total expenditures for specialty drugs paid by members was very low for specialty drugs at approximately 0.5% in each year. Similar to the trends seen for brand name drugs, the source of payments for specialty drugs has slowly shifted from the SeniorCare program to other payers, with the proportion paid by SeniorCare decreasing by 5 percentage points from 87.1% in 2014 to 82.1% in 2018.

DISCUSSION

We evaluated patterns of drug utilization and expenditures in the Wisconsin SeniorCare prescription drug assistance program for low-income older adults by analyzing enrollment and claims data from 2014 to 2018. Despite seeing decreases in the number of members and total number of 30-day fills per member, total drug expenditures increased over time, particularly for brand name and specialty drugs. These trends are similar to those seen in Medicare Part D, where costs for single-source brand name drugs and biologics are increasing faster than the cost savings due to generic use can offset.[14] The generic utilization rate in the SeniorCare population was nearly 90%, which is similar to that seen among Medicare Part D enrollees.[14]

Contrary to trends seen in Medicare Part D, SeniorCare member costs decreased during the study period, in part due to decreased drug utilization and switching to less expensive generic drugs. However, because member copayments were flat and did not change during this time period, the SeniorCare program and other payers have taken on a greater share of the increasing drug expenditures. As with other Medicaid programs, SeniorCare is the "payer of last resort" such that all other insurers must pay for prescription drug costs incurred by a beneficiary before the SeniorCare program will make any payments; thus, pharmacy providers are required to bill Medicare Part D and any other payers (e.g., private insurance coverage) prior to SeniorCare.[15] The costs paid by other payers nearly doubled over the study period, indicating an increasing use of SeniorCare as supplemental coverage for other sources of drug coverage such as Medicare Part D.

Similar to Medicare Part D, substantial growth was seen in the use of and expenditures for specialty drugs. In Medicare, specialty drugs are defined solely based on drug costs, and when the same criteria were used in SeniorCare, the use of

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specialty drugs was consistent to that seen in the Medicare Part D program, at approximately 1% of all drug claims.[14] Specialty drugs were on average far more expensive than non-specialty drugs, and their costs per member increased at a steeper rate. In addition, the flat copayment structure of SeniorCare also contributed to the rapid grown in the cost burden of specialty drugs to the SeniorCare program and other payers. Although the SeniorCare benefit structure protects its members from the rising costs of specialty drugs, many private and public payers including Medicare Part D have adopted approaches such as inclusion of an additional specialty tier containing a higher copayment or coinsurance amount to control the use of specialty drugs.[16] Further evaluation is needed to assess the appropriateness of specialty drug use in the SeniorCare program and the need for additional cost-containment strategies when more cost-effective options may be available (such as generics, non-specialty brand name drugs, or biosimilars).

Previous research has identified a positive association between prescription drug insurance coverage and the use of other health care services, which has had a positive impact on patient health outcomes.[17] Prescription drug use has also been shown to offset medical costs, such that a 1% increase in the number of prescriptions filled by beneficiaries would cause Medicare's spending on medical services to fall by 0.2%.[18] However, our data did not contain information on the utilization of and expenditures for other health care services given that the SeniorCare population is composed of older adults 65 and older who have Medicare for their health insurance coverage. Future research will combine SeniorCare data with Medicare claims data for Parts A, B, and D to provide a more comprehensive picture of prescription drug and health care utilization and spending among SeniorCare members. In addition, this will allow direct comparisons between SeniorCare members and Part D beneficiaries to compare characteristics of enrollees, prescription drug use, medical services use, and overall health care expenditures.

Limitations

The following limitations of this study should be noted. First, this study only used Wisconsin SeniorCare enrollment and claims data, and was not able to capture drug use and spending through other drug insurance and subsidy programs SeniorCare members might have been enrolled in. Secondly, information on other payers was limited to a payment amount and did not contain any information on the identity of the other payer. Future research will link SeniorCare and Medicare data to examine the impact of the SeniorCare program on the Medicare program. Finally, SeniorCare is a unique program in one state, and the results of this study may not be generalizable to other populations.

CONCLUSION

The Wisconsin SeniorCare program has served as an important source of drug coverage for low-income older adults in Wisconsin. Despite growing program expenditures over time, SeniorCare members have been largely protected from these increases and have paid a decreasing proportion of costs over time. However, the growing share of drug costs paid by other payers suggests an increasing use of SeniorCare as a supplementary drug benefit to other drug coverage such as Medicare Part D, and expenditures have increased over time primarily due to rising drug costs for expensive brand name and specialty drugs. State-level policies and programs such as SeniorCare may be increasingly important to support the affordability of prescription drugs for low-income older adults.

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Table 1. Trends in SeniorCare enrollment, demographics, and drug utilization

Year	2014	2015	2016	2017	2018
Number of members (n)	57,827	56,142	54,206	52,879	51,276
Demographic Characteristics					
Mean age	80.2	80.0	79.7	79.5	79.3
Age (%)					
65-74	27.9	29.7	31.5	32.7	33.8
75-84	38.7	37.3	36.3	35.7	35.7
85+	33.5	33.1	32.3	31.5	30.6
Gender (%)					
Male	25.6	26.2	27.0	27.9	28.5
Female	74.4	73.8	73.0	72.1	71.5
Race/Ethnicity (%)					
White, Non-Hispanic	91.8	91.1	90.5	89.6	89.0
Other race/ethnicity groups	3.0	3.1	3.3	3.5	3.5
Missing race/ethnicity	5.2	5.8	6.2	6.9	7.5
Mean annual Couple Income ($)	18,552	18,859	19,125	19,283	19,569
Drug Utilization					
Having drug claims (%)	84.8	84.6	84.1	83.7	81.8
Mean annual number of 30-day drug fills per member	39.7	39.1	38.7	38.0	37.4
Drug insurance coverage (%)					
SeniorCare Only	71.5	70.9	70.2	70.2	67.5
SeniorCare + Other Coverage	13.2	13.8	13.9	13.4	14.3
Unknown Status	15.3	15.3	15.9	16.4	18.2

Source: Authors' analysis of SeniorCare enrollment and drug claims data for the period January 2014– December 2018
Notes: The study sample of each calendar year was the full population of SeniorCare members with income ≤200% FPL

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Table 2. Annual SeniorCare drug utilization and expenditures by drug type

Year		2014	2015	2016	2017	2018
All drugs						
Number of members (N)		49,010	47,522	45,608	44,235	41,927
Number of 30-day drug fills		2,295,818	2,196,129	2,096,209	2,008,878	1,916,660
Total expenditures ($)		102,480,081	106,176,685	107,123,751	113,063,877	122,212,175
Source of payment (%)	*SeniorCare*	*75.9*	*75.8*	*76.3*	*75.5*	*73.6*
	Member	*13.6*	*12.4*	*11.5*	*10.7*	*9.4*
	Other payers	*10.4*	*11.7*	*12.2*	*13.7*	*17.0*
Average expenditures per 30-day drug fill ($)		74	79	84	93	104*
Average expenditures per member ($)		2,091	2,234	2,349	2,556	2,915*
Brand name drugs						
Number of members (N)		30,672	28,366	24,805	23,193	21,339
Number of 30-day drug fills		325,883	264,751	228,172	213,791	202,514
Total expenditures ($)		79,692,847	81,152,030	84,491,081	89,291,934	99,678,772
Source of payment (%)	*SeniorCare*	*80.7*	*80.2*	*80.7*	*79.4*	*76.6*
	Member	*7.7*	*6.7*	*5.8*	*5.2*	*4.4*
	Other payers	*11.6*	*13.1*	*13.5*	*15.4*	*19.0*
Average expenditures per 30-day drug fill ($)		295	357	417	465	532*
Average expenditures per member ($)		2,598	2,861	3,406	3,850	4,671*
Generic drugs						
Number of members (N)		48,431	46,925	45,013	43,643	41,405
Number of 30-day drug fills		1,969,935	1,931,378	1,868,037	1,795,087	1,714,146
Total expenditures ($)		22,787,234	25,024,655	22,632,670	23,771,942	22,533,403
Source of payment (%)	*SeniorCare*	*59.2*	*61.6*	*59.9*	*61.1*	*60.6*
	Member	*34.4*	*31.2*	*32.9*	*31.6*	*31.6*
	Other payers	*6.4*	*7.2*	*7.2*	*7.3*	*7.8*
Average expenditures per 30-day drug fill ($)		20	22	21	23	24*
Average expenditures per member ($)		471	533	503	545	544*
Specialty drugs						
Number of members (N)		287	331	384	430	476
Number of 30-day drug fills		1,657	1,892	2,211	2,400	2,884
Total expenditures ($)		9,417,622	12,488,915	15,800,650	18,805,854	24,928,153
Source of payment (%)	*SeniorCare*	*87.1*	*87.7*	*91.2*	*87.9*	*82.1*
	Member	*0.5*	*0.4*	*0.5*	*0.4*	*0.4*
	Other payers	*12.5*	*11.8*	*8.3*	*11.7*	*17.6*
Average expenditures per 30-day drug fill ($)		7,006	7,156	7,649	8,526	8,733*
Average expenditures per member ($)		32,814	37,731	41,148	43,735	52,370*

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Non-specialty drugs						
Number of members (N)		49,004	47,510	45,601	44,222	41,908
Number of 30-day drug fills		2,294,161	2,194,237	2,093,998	2,006,478	1,913,776
Total expenditures ($)		93,062,459	93,687,770	91,323,101	94,258,023	97,284,022
Source of payment (%)	*SeniorCare*	*74.8*	*74.2*	*73.8*	*73.1*	*71.5*
	Member	*15.0*	*14.0*	*13.4*	*12.8*	*11.7*
	Other payers	*10.2*	*11.7*	*12.8*	*14.1*	*16.8*
Average expenditures per 30-day drug fill ($)		66	70	71	77	84*
Average expenditures per member ($)		1,899	1,972	2,003	2,131	2,321*

Source: Authors' analysis of SeniorCare enrollment and drug claims data for the period January 2014– December 2018
Notes: Average expenditures per member were analyzed among the SeniorCare members who used each drug type. * Significant change compared to 2014, P <0.001

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