Master Plan for Aging
Recommendation

Expand Access to Essential Prescription Drugs

Issue Statement: Despite the coverage provided by Medicare, access to essential prescription drugs remains a challenge for many of California's seniors, in particular for those that are above the cutoff levels for Medi-Cal and/or for Medicare Low Income Subsidy (LIS) A major contributing factor is the financial burden represented by high drug prices and the out-of-pocket share of these that older adults are required to pay, (even with reductions to the coverage gap from the 2018 Bipartisan Budget Act). For older adults below 65 who do not yet qualify for Medicare, the problem can be even more severe.

MPA Framework Goal: Goal 3- Health and Well-Being: We will maintain our health and well-being as we age

MPA Framework Objective: Objective 3.2- Californians will have access to quality and affordable person-centered health care that aligns with our preferences and values.

Recommendation: Pursue multifaceted regulatory /policy approach that addresses high cost of drugs, see specific recommendations for consideration below.

Target Population and Numbers:

- Adults 65 and over that do not qualify for Medi-Cal or Medicare LIS
- "Pre Medicare" older adults not covered under Medi-Cal

Detailed Recommendations:

- Near term:
    - Ensure that seniors are made aware of and directed to prescription drug discount programs [Legislature, California State Board of Pharmacy]
    - Improve drug transparency laws in CA to better reveal scope of problem across entire supply chain [Legislature]
    - Require robust/meaningful usage of now-available (and soon Medicare mandated) drug price comparison tools on EHR to make clear possible lower cost alternatives at point of care [DHCS]
    - State mandated Continuing Medical Education (CME) on high drug cost financial toxicity to patients [CA Med Board]
- For exploration: Improve Medicap access and coverage (Medigap insurance largely state-regulated)
    - It is worth considering addressing Part B drugs (those administered in hospital or physician office settings) – these types of drugs are both costly and are being produced in larger numbers and can drive high coinsurance/out-of-pocket spend. Medigap coverage can be a way to address these- as an insurance

regulator, the state may be able to compel ways of expanding coverage (guaranteed issue, waving pre-existing conditions limits, etc.)
    - CA can mandate guaranteed continuous issue for Medicap (currently seniors who may have more serious health conditions who are dissatisfied with Medicare Advantage and switch back to fee-for-service Medicare may not be able to get Medigap due to preexisting conditions) [CDI]
    - Most Medigap plans in CA are attained-age rated (policies increase in price as policyholder ages) rather than issue-age or community rated– can be more expensive for the very old; state can ensure that access to education about options is prioritized [CDI]
    - CA can do above for those under 65 who have Medicare due to long-term disability (currently only 6month open enrollment after Part B effective date)
    - The state may explore forming a statewide Medicap or Medigap-like plan [CDI]
- Aspirational:
    - Require hospitals to provide discharge fill of medications (e.g. 7-day supply) to promote continuity of medications [DHCS]
    - California no longer has a State Pharmaceutical Assistance Plan (SPAP) – explore reinvigorating this program e.g. with Part D plan subsidies or secondary coverage [Legislature, DHCS]
    - California has been unafraid to test boundaries- worth exploring what levers state insurance regulators may have over Part D plans [CDI]
    - Place excise tax on pharma industry for price increases above rate of inflation, use proceeds to fund above [Legislature]
    - For below 65yr seniors, consider using insurance regulatory authority to mandate minimal cost sharing for specific drugs that are important in supporting arrival at age 65 in good health [CDI]

Evidence that supports the recommendation:

- Evidence of issue
    - One-fourth of older adults (23%) who take prescription drugs say it is difficult to afford their prescription drugs, including about one in ten (8%) saying it is "very difficult." As is true among the public as a whole, there are certain groups of older adults who are much more likely to report difficulty affording medications, including those who report being in either "only fair" or "poor" health (45%), whose household income is less than $30,000 annually (34%), and who take four or more prescriptions (28%) https://www.kff.org/health-reform/issue-brief/data-note-prescription-drugs-and-older-adults/
    - One out of every seven U.S. seniors – about 7 million people aged 65 or older – were unable to pay for prescribed medicine in the past 12 months. This jumps to 20% among seniors living in households with annual incomes under $60,000

https://news.gallup.com/poll/248081/westhealth-gallup-us-healthcare-cost-crisis.aspx

- Discounts required under California's prescription-drug discount program for Medicare beneficiaries offer substantial savings. Many patients, however, especially those who use independent pharmacies or who live in low-income neighborhoods, may not receive the discounts https://www.nejm.org/doi/full/10.1056/NEJMsa122601
- Most states with transparency laws targeted PBMs (15 states) or insurers (11 states); 2 states passed laws that targeted pharmacies, and no states passed laws that targeted wholesalers (Table 2). Only Nevada and Vermont passed laws that targeted 3 distinct supply chain segments (i.e., manufacturer, insurer, and PBM); no state passed laws that targeted more than 3 supply chain segments. Importantly, no state passed laws that together revealed true transaction prices or profits across all supply chain segments https://healthpolicy.usc.edu/research/state-drug-pricing-transparency-laws-numerous-efforts-most-fall-short/

Examples of local, state or national initiatives that can be used as an example of a best practice:

- **Local:**
- **State:** Other states with SPAPs (e.g. FL, NY); States which have continuous guaranteed Medigap issue
- **National:**
- **Other:**

Implementation:

- **State Agencies/Departments:** See brackets after each recommendation for relevant agencies/departments
- **State Legislature:** CT, MA, ME, NY have continuous or annual guaranteed issue protections for Medigap; AR, CT, ME, MA, MN, NY, VT, WA require Medigap premiums to be community rated
- **Local Government:**
- **Federal Government:**
- **Private Sector**:
- **Community-Based Organizations:** California Health Advocates
- **Philanthropy:** Public awareness and education campaigns around prescription drug affordability and access to safe and cost-effective medications for all CA seniors.
- **Other:**

Person-Centered Metrics:

- Prescription abandonment (unfilled Rx) by seniors

- Medication rationing (Rx filled less than for number of days covered) by senior
- OOP drug costs

Evaluations:

- Please see below data sources

Data Sources:

- Medicare Part D fill rates
- Pharmacy data on Rx returns in-pharmacy that are filled but not dispensed to patient (i.e. refusal to take due to price)
- California is creating statewide Healthcare Payments Database which may include prescribing data
- Rate of switching to lower cost Rx from POC transparency tools

Potential Costs/Savings: Any policies/regulations proposed will undoubtedly be considered from the perspective of impact on state budget. Savings or costs to the state are not considered in this initial document; however, strongly suggest that the potential savings for California's aging individuals should also be considered. For example, there is no limit on co-insurance payments or out-of-pocket spending for drugs through Medicare Part B. Similarly, from the transparency/switching perspective, the savings to seniors offered lower out-of-pocket cost alternatives at the point of care as well as access to assistance programs will have impact at the individual level. (Improvement in drug adherence/reduction in prescription abandonment due to lower out-of-pocket costs also represent downstream savings to patients and payors alike.)

Prioritization: High priority for CA seniors who are forgoing or rationing medications they need due to cost burden.

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