

Beyond pharmaceutical manufacturer assistance: Broadening the scope of an indigent drug program

SAUL WEINER, JILL DISCHLER, AND CHERYL HORVITZ

Pharmaceutical assistance programs have been instituted at many clinics and hospitals in the United States. These programs evolved to help medically uninsured and underinsured people obtain medications directly from pharmaceutical manufacturers at little or no cost. The intent has been not only to aid indigent patients and improve their quality of care but to reduce the bad debt resulting from uncompensated medication assistance at hospitals and clinics serving large indigent populations. Furthermore, there is evidence that free prescription drugs improve medication compliance and thereby reduce overall hospitalization rates and the total cost of caring for the poor.¹

We describe a program at the University of Illinois at Chicago Medical Center (UICMC) run by a social worker and a pharmacist that taps all available public and private resources to assist indigent patients with medication costs. Patients receive medications at UICMC's expense only as a last resort.

Background

Efforts to assist patients with medi-

Abstract: A medication assistance program at a university medical center is described.

The program was implemented in July 1999 by the ambulatory care pharmacy at the University of Illinois at Chicago Medical Center (UICMC). A full-time pharmacist and a full-time social worker run the program, along with support from technicians and a student extern. The program functions like a clinic, with both scheduled appointments and drop-ins. Patients are referred by UICMC providers or may self-refer. Sources of assistance include Medicaid, Medicare Part B, several state programs, manufacturers' programs, drug samples, private insurance plans and HMOs, and the patients themselves in the form of small payments. Patients receive medications at UICMC's expense only as a last resort. The medication assistance program helped 231 patients in the six months from July to December 1999. Program costs totaled \$110,537, but \$237,985 was saved. Only 13% of the sav-

ings came from pharmaceutical companies; 63% came from Medicaid. Experience with the program suggests that medication assistance initiatives should be structured to tap the full spectrum of resources for indigent patients, that programs be staffed by personnel with relevant experience, that program staff be prepared to work closely with patients and to follow up, and that the institution's charitable goods and services be restricted to patients for whom there are no other resources.

A highly proactive medication assistance program at a university medical center improves the access of indigent patients to medications and is cost-effective.

Index terms: Ambulatory care; Charity; Economics; Health benefit programs; Health care; Industry, pharmaceutical; Pharmaceutical services; Pharmacists; Prescriptions; Sociology

Am J Health-Syst Pharm. 2001; 58:146-50

ation costs in a structured manner date at least to the early 1990s.² A review of the literature indicates that several approaches have been tried.^{1,3-17} The first and most common approach involves soliciting pharmaceutical companies and nonprofit organizations that offer drug subsidy programs. Two reports describe the co-

ordination of prescriptions for indigent patients through pharmaceutical manufacturer programs by a pharmacy technician in a state psychiatric center³ and by an inpatient pharmacy department in a university hospital.⁴ A study at one center found that cost savings and reduced paperwork were achieved by targeting spe-

SAUL WEINER, M.D., is Assistant Professor of Medicine and Pediatrics, Department of Medicine, College of Medicine, University of Illinois at Chicago (UIC). JILL DISCHLER, PHARM.D., is Clinical Assistant Professor and CHERYL HORVITZ is Social Service Representative, Department of Pharmacy Practice, College of Pharmacy, UIC.

Address reprint requests to Dr. Weiner at the Department of Medicine, College of Medicine, University of Illinois at Chicago,

840 South Wood Street, M/C 787, Chicago, IL 60612-7323 (sweiner@uic.edu).

The assistance of Pete Antonopoulos in gathering data and managing software applications is acknowledged.

Copyright © 2001, American Society of Health-System Pharmacists, Inc. All rights reserved. 1079-2082/01/0102-0146\$06.00.

cific drug manufacturers.⁵ Another study describes how a medical center avoided the administrative hassles of working directly with drug manufacturers by arranging for a nonprofit organization to manage the paperwork.⁶ None of the reports indicate an effort to uncover potential state and federal sources of insurance.

Prutting et al.⁷ reported a multidisciplinary approach to medication assistance in an adult primary care clinic that involved exhausting all avenues of coverage. A similar approach was described by Fenske⁸ for a Detroit hospital, although the assistance was restricted to indigent patients discharged from an inpatient unit. While the objectives were similar to ours, UICMC has created a *program* for working with indigent patients, as opposed to just a *system* for coordinating existing personnel. Specific personnel at UICMC have been trained and designated exclusively to serve this vulnerable population. This approach provides a continuity of service that would otherwise be nearly impossible to provide. Patients with spend-down requirements (monthly deductibles) for Medicaid, for example, often need close follow-up assistance to maintain their benefits. Since our program occupies a physical space in the ambulatory care pharmacy, patients know where they can go to get help.

Description of the program

UICMC serves a diverse patient population, including a substantial number of medically indigent individuals. Payer mix by gross revenue is nearly 11% uninsured, 29% Medicaid, 13% Medicare, and 47% commercial insurer or HMO. Approximately 10 years ago, UICMC developed an emergency drug fund to provide indigent patients with an emergency supply of medications upon hospital discharge under a deferred-billing agreement. The fund reimbursed the UICMC pharmacy for charges to uninsured patients who reported that they could not afford their medica-

tions. While the emergency drug fund was available, patients were rarely screened for financial resources or medical or prescription insurance. Undoubtedly many were eligible for various state- or manufacturer-sponsored programs but lacked the knowledge or motivation to apply. Although patients were billed, collections were minimal. Finding a better approach became imperative.

The medication assistance program was implemented in July 1999 by the ambulatory care pharmacy on the basis of a smaller indigent care program that had been pilot tested in the cardiology clinic. The program is run by a full-time pharmacist and a full-time social worker, both of whom have experience working with government agencies and pharmaceutical companies to meet the needs of uninsured and underinsured patients. In addition, two pharmacy technicians and a student extern participate part-time. While it is not unusual for medical centers to use pharmacists and social workers to assist patients, the program at UICMC may be unique in providing a single site to address a broad range of medication and insurance issues arising throughout a medical center.

The medication assistance program functions like a clinic, with both scheduled appointments and drop-ins. Approximately eight patients are seen daily. Two hundred thirty-one patients benefited from the program during its first six months; multiple appointments with program staff were required in most cases. While some of the patients referred themselves, most were referred by the ambulatory care clinics or the emergency department or arrived after discharge from the inpatient wards.

A referral occurs when a patient lacks insurance coverage or private resources to pay for needed medications. The referring provider completes a one-page form that details a patient's insurance status and the medications and dosages that are

needed. The form must be signed by a physician. When patients arrive at the medical center's pharmacy with the form, they are instructed to pay \$5 toward the cost of each medication (up to a maximum of \$30 for a month's supply of all medications) and told that they will be billed for the balance. If future medication needs are likely, patients are scheduled to meet with program staff. If they do not follow through, they are generally ineligible for additional program benefits.

Cost savings

Savings from the medication assistance program result from switching patients from nonpaying to insured or partially insured status and from enrolling patients who previously relied on the emergency drug fund in public and private assistance programs. With respect to the savings resulting from new insurance opportunities, the following sources provide the highest return in our region:

- *Medicaid.* Medicaid assists with medical and prescription drug coverage for patients with limited income and medical disability, as defined by Social Security Administration and state of Illinois guidelines. Patients often require additional advocacy from the program's social worker to negotiate eligibility for spend-downs and other assistance. For patients at our institution, Medicaid is by far the most underutilized resource.
- *KidCare health insurance.* Illinois's implementation of the federal Children's Health Insurance Program offers health care coverage, including prescription medications, to children of the working poor up to 18 years of age.
- *Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act.* The state of Illinois provides assistance for patients with an annual income of less than \$16,000 who are over 65 years of age or medically disabled for approved medications used for heart and blood

REPORTS Indigent drug program

pressure problems, diabetes (including insulin syringes and needles), and arthritis. The program (often called the Circuit Breaker program) initially provides all covered medications for a monthly fee of \$15 or \$25 until the cumulative retail cost reaches \$800, at which time an additional monthly 20% copayment is required.

- **Medicare Part B.** Part B of Medicare provides prescription assistance for immunosuppressive medications for transplant patients for up to 44 months after transplantation.

With respect to shifting the cost of drugs away from the hospital and clinics, the medication assistance program considers several sources:

- **Medications received from drug manufacturer assistance programs.**
- **Sample medications dispensed while patients await coverage from state- or manufacturer-sponsored programs.** Switching among brands of the same drug may be necessary. Occasionally, a different drug is given upon the physician's approval.
- **Deposits and ongoing payments toward medication debt.** Patients contribute a minimum of \$5 per medication toward the total cost of a 30-day supply of their medications and assume responsibility for the balance of the

debt. The outstanding debt is covered by the assistance program's budget until the patient pays.

- **Copayment deferment for commercial or private insurance plans and HMOs that cover prescriptions.** Helping patients with copayments enables the medical center to collect from insurance companies.

The savings produced by these sources and several other less frequently utilized resources from July through December 1999 are presented in Table 1. Savings attributable to drug samples and drug manufacturer assistance programs are based on retail prices, and savings from various payers, such as Medicaid, are based on contractual reimbursement rates. This approach reflects cost savings in terms of the local market value that payers are able to negotiate for pharmaceutical products.

The medication assistance program cost \$110,537 for the six months, including \$87,991 for salaries and benefits, \$694 for clerical supplies, \$18,000 for office space, and \$3,852 for overhead. Although new, the program has yielded savings considerably in excess of costs (savings of \$237,985, expenses of \$110,537). This reflects, for the six-month period, a per patient saving and cost of

\$1030 and \$479, respectively, or a benefit-to-cost ratio of 2.2:1. Only 13% of the savings came from pharmaceutical manufacturer programs. Sixty-three percent came from Medicaid, 8% from drug samples, 4% from third-party payers, and 3% from the Circuit Breaker program.

Case examples

The following case examples illustrate the problem-solving approach of the medication assistance program to improving access to care for uninsured and underinsured patients and reducing costs to the institution.

- J.B. was a 37-year-old man who seven years earlier received a kidney transplant at our medical center. Medicare coverage provided immunosuppressive medication for only 44 months after the surgery. J.B. was receiving immunosuppressive therapy with mycophenolate mofetil, which costs \$517 per month, and tacrolimus, which costs \$1602 per month. He also took several potent antihypertensive agents costing a total of \$187 per month. As a part-time security guard, he earned \$8000 per year. The medication assistance program was able to meet J.B.'s needs through a patchwork of sources. Roche provided mycophenolate mofetil and Fujisawa

Table 1.
Cost Savings under Medication Assistance Program, July through December 1999

Month	Savings (\$)							Total
	Medicaid ^a	CRBR ^b	PMA ^c	Drug Samples	Patients ^d	Third-Party Payers ^e	Other Sources ^f	
Jul	15,034	2,327	84	1,290	225	2,182	0	21,142
Aug	14,894	1,425	1,162	3,740	550	638	1,124	23,533
Sep	25,158	1,020	4,394	3,974	700	2,332	3,632	41,210
Oct	48,584	750	6,321	2,241	1,100	0	4,019	63,015
Nov	36,285	1,420	11,353	4,803	1,402	4,134	3,373	62,770
Dec	11,710	551	7,714	2,107	630	0	3,603	26,315
Total	151,665	7,493	31,028	18,155	4,607	9,286	15,751	237,985

^aIncludes Illinois KidCare program. Based on the contractual drug reimbursement rates that the public payers agreed to pay the institution.

^bCRBR = Circuit Breaker Pharmaceutical Assistance Program. Based on the contractual drug reimbursement rates that the public payers agreed to pay the institution.

^cPMA = Pharmaceutical manufacturer assistance programs. Based on the prescription cash price for patients had they purchased the medication at the outpatient pharmacy.

^dCash collected from patients toward deferred medication billing debt.

^eReimbursement from prescription insurance companies. Patients may not have been aware of the insurance or known how to use the prescription benefit.

^fCost avoidance in cases in which patients were assisted with enrollment or with discovery of existing prescription insurance of which they were unaware. The prescription benefit is restricted to non-University of Illinois at Chicago Medical Center (UICMC) pharmacies, and patients are encouraged to use this benefit elsewhere. Also includes Medicare Part B covering immunosuppressives for transplant patients up to 44 months after transplantation and federal Title 1 grant funds for established HIV-clinic patients.

provided tacrolimus through their assistance programs, which require paperwork every three months. Recently, UICMC assistance program staff applied for a state Circuit Breaker pharmaceutical assistance card, which was available to J.B. because his annual income was less than \$16,000 and he was disabled. The Circuit Breaker program would reduce the cost of J.B.'s antihypertensives. While the Circuit Breaker application was pending, J.B. received samples of various antihypertensives, such as a clonidine patch and extended-release nifedipine. Although J.B. was eligible for Medicaid, he had a \$330 monthly spend-down. The program helped him by providing invoices for the deferred-billing medications, invoices that he had to give to his Medicaid caseworker. When his debt reached \$330—which occurred every few months—he was entitled to a month of full coverage by Medicaid. By juggling these sources, the assistance program was able to reduce J.B.'s monthly drug expenses from over \$2306 to \$15–\$52.

- R.L. was a six-year-old boy with short-gut syndrome who needed medications costing \$1134 per month. Although hospitalizations and clinic visits had been reimbursed through the father's health plan, the family claimed it did not have medication coverage. There was no process at the institution for reviewing health insurance policies when a patient or family reported a gap in coverage. As a result, the medical center had been supplying all medications at no charge through its emergency drug fund for three years. With the institution of the medication assistance program, it was discovered that the patient's health plan did include medications (with a \$10–\$20 copayment per medication). Medication assistance program staff, in conjunction with pediatric social workers, applied to the Division of Specialized Care for Children, a state program that considers payment for uncovered medical debt for disabled children in families

with a household income below \$34,000. In the meantime, the family owed a monthly copayment of \$90. The result was a cost avoidance to the medical center of \$6804 over the July–December 1999 period.

- S.D. was a 71-year-old woman with hypothyroidism, diabetes, hypertension, and coronary artery disease living on an income of \$520 per month. She had been enrolled in Medicaid's Qualified Medicare Beneficiary program, which covered the 20% copayment for all Medicare-covered benefits, but not her medications. Since her income was far too low for her to afford her medications, she depended on the medical center's emergency drug fund. Unlike patients who viewed this fund as a free resource, S.D. took her debt seriously and often declined to renew her medications, even though she was told they were needed. S.D.'s Medicaid eligibility was reviewed under the medication assistance program, and it was determined that her income had been sufficiently low since 1993 for her to have been fully enrolled in Medicaid with full medication coverage and no spend-down. An appeal was made to the Illinois Department of Public Aid, which corrected the error but stated that there was no mechanism to provide S.D. with back pay for the expenses she had incurred. The assistance program contacted an attorney through the Public Welfare Coalition to represent S.D. in obtaining compensation for her financial loss, but she declined to pursue the matter, saying she did not want to "cause trouble." All her medications, however, are now fully covered by Medicaid.

These case examples show how the program's staff both advocate for patients and shield the institution from inappropriate use of its resources. Only after all potential external sources of coverage are exhausted may patients purchase medications from the medical center pharmacy under a deferred-payment agreement. The outstanding debt is cov-

ered by the medication assistance program's budget until the patient pays.

Discussion

Helping indigent patients find health care coverage can be tremendously beneficial not only to the patients but also to the institution. In the brief time since its inception, the medication assistance program has saved UICMC tens of thousands of dollars by reducing the bad debt that resulted from underutilization of external sources, particularly Medicaid. Medical center resources are better channeled toward individuals who most need financial assistance. Such a program can be cost-effective for medical centers that are serving many indigent patients and need to cut the cost of doing so.

The overall savings associated with a program like ours are modest. While the program will continue to screen and serve as many patients as possible, there will always be many more whose needs cannot be satisfactorily met with existing resources. Inevitably, institutions serving a substantial indigent population will either continue to absorb large losses or deny patients the medications and services they need. Hence, while such a program can benefit many patients and pay for itself, it should not be seen as a solution to the financial burden of a large uninsured and underinsured patient population.

We offer four recommendations with respect to medication assistance programs. First, patients' needs cannot be addressed cost-effectively without a full assessment of patients' eligibility for public and private insurance programs, most of which are underutilized. In the absence of a procedure for assessing financial need and providing financial assistance, the medical facility will unnecessarily subsidize services and medications for patients with untapped external sources of coverage. This results in an avoidable expense to providers.

Second, assisting the medically indigent with financial matters requires specialized knowledge. Personnel must know how to access the resources that are available nationally, at the state level, and in the community.

Third, program staff must be prepared to work closely with patients, advocate for them, and follow up. Once patients are matched with sources of aid, they should be helped as needed with paperwork and negotiations. Staff members may need to frequently contact primary care providers, pharmacists, government caseworkers, and pharmaceutical manufacturers. Patients may have to be seen periodically as new expenses or bureaucratic hurdles arise. Medical indigence is generally a chronic problem that requires ongoing financial help.

Fourth, all published studies of which we are aware found that investing in staff to work with indigent patients saved the institution money. Every health care institution with a substantial uninsured or underinsured patient base should invest in personnel who can assist patients with financial matters. A well-run program will restrict an institution's charitable goods and services to patients for whom there are no other resources.

The United States has over 40 million people who lack health insur-

ance and many more who are underinsured. Few health care institutions are unaffected by the expenses associated with caring for this population. While a medication assistance program is not a complete solution, it can bring substantial relief.

Conclusion

A highly proactive medication assistance program at a university medical center improves the access of indigent patients to medications and is cost-effective.

References

1. Nykamp D, Ruggles D. Impact of an indigent care program on use of resources: experiences at one hospital. *Pharmaco-therapy*. 2000; 20:217-20.
2. Turowski RC, Rakay-Bianco MM, Visconti JA. Prescription assistance programs: options for assisting the uninsured and underinsured. *Hosp Pharm*. 1993; 28:948,951-5,958-60,963-8.
3. Hotchkiss BD, Pearson C, Lisitano R. Pharmacy coordination of an indigent care program in a psychiatric facility. *Am J Health-Syst Pharm*. 1998; 55:1293-6.
4. Connelly P. Hospital taps underused resource to help pay for indigent medications. *Hosp Pharm Times*. 1994; Aug: 7-8.
5. Decane BE, Chapman J. Program for procurement of drugs for indigent patients. *Am J Hosp Pharm*. 1994; 51:669-71.
6. Ptachcinski RJ, Herbstritt CM. The use of PMA indigent drug programs to offset ambulatory drug costs. *Pharm Manage Advis*. 1994; 1:1-3,11.
7. Prutting SM, Cerveny JD, MacFarlane LL et al. An interdisciplinary effort to help patients with limited prescription drug benefits afford their medication. *South Med J*. 1998; 91:815-20.

8. Fenske DL. The Rx to ease a community's burdens. A Detroit hospital helps low-income patients obtain prescription medication. *Health Prog*. 1994; 75(8):52-3.
9. DuLac AR, Johnson KE, Glover DG et al. Development of a patient assistance program to facilitate support for indigent care. Abstract presented at ASHP Midyear Clinical Meeting. Las Vegas, NV; 1998 Dec 6-10.
10. Hulbert DM, Himstreet JE, Grubbs JH. Pharmacy technician managed medication assistance program to reduce indigent care costs in pharmacy. Abstract presented at ASHP Midyear Clinical Meeting. Las Vegas, NV; 1998 Dec 10.
11. Braman K. Pharmacy reimbursement assistance program: medications for indigent patients. *Issues Pharm*. 1996; 2(2): 1,4-8.
12. Asplen L. Patient assistance programs: making them work for you. *Hosp Pharm Rep*. 1996; Oct:54-5.
13. Cho HH, Allen SJ. The implementation of a program for procurement of prescription drugs for indigent patients. Paper presented at 14th Annual Eastern States Conference for Pharmacy Residents and Preceptors. Baltimore; 1995 Apr 27-29.
14. Prucha TB. Controlling inventory costs through utilization of drug replacement and reimbursement programs. Abstract presented at ASHP Midyear Clinical Meeting. Las Vegas, NV; 1995 Dec 3-7.
15. Decane BE, Chapman J. Program for procurement of drugs for indigent patients. *Am J Hosp Pharm*. 1994; 51:669-71.
16. Davenport SB, Garrison WO, O'Neal WM et al. Improving reimbursement of ambulatory prescriptions through indigent care programs by a multidisciplinary approach. Abstract presented at ASHP Midyear Clinical Meeting. Atlanta, GA; 1993 Dec 5-9.
17. Harrell T, Chase P. Developing an innovative program to meet indigent patient medication needs. Abstract presented at ASHP Midyear Clinical Meeting. Las Vegas, NV; 1990 Dec 2-6.