ILLINOIS ECONOMIC
and
FISCAL COMMISSION

A LOOK AT PHARMACEUTICAL TRENDS AND OPTIONS

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EXECUTIVE SUMMARY

A downturn in the national economy over the past fiscal year has forced many state governments to evaluate revenue and expenditure sources. Many states have introduced a variety of revenue enhancing measures (including increasing cigarette, gambling, and sales taxes) and have proposed cost containment measures. Illinois is not exempt from this national situation and has recently enacted legislation for FY 2003 that will ultimately raise specified sin taxes and cut expenditures to what many have categorized as a "bare bones budget".

Many states that are in a similar position as Illinois have looked towards health care expenditures when evaluating costly budget components. Health care costs are experiencing double-digit growth, with the major contributing component being pharmaceutical expenditures. According to the Public Health Institute, the rise in pharmaceutical spending consistently outpaces expenditures on other components of the U.S. health care system. For every year since 1990, the annual percentage change in prescription drug expenditures was significantly greater than the change in hospital and physician expenditures. This fact is alarming for both Illinois citizens (especially low-income seniors) and for budgeters who are trying to evaluate escalating costs in State programs such as Medicaid and the Group Insurance Program.

The following analysis looks at factors driving national trends as well as providing information on how other state entities have addressed pharmaceutical expenditures in their budgets. Also, state pharmaceutical assistance programs are reviewed to investigate which states aid the needy and how they provide assistance. Illinois is included in the analysis and is comparatively evaluated on how it is specifically addressing its constituents concerns over rising pharmaceutical costs. Finally, recent federal initiatives that may have an impact on pharmaceutical prices and aid are discussed.

Some of the key points that are discussed in this report are summarized below:

- The primary reason for the growth of pharmaceutical expenditures is the large increase in utilization. New prescription drug therapies and the ever-growing senior population have made pharmaceuticals increasingly popular. Drug prices also have escalated, but not to the same degree as utilization rates.

- Many states are reviewing prescription drug purchasing policies in order to become more effective and efficient consumers. Controlling utilization may be achieved via charging co-payments and deductibles, utilizing drug formularies and generics, implementing pharmacy benefit managers, reducing participant fraud, and requiring prior authorization.

- To gain better control of prescription drug costs, states are investigating and forming purchasing alliances to negotiate pharmaceutical prices, discounts, and rebates with manufacturers. Alliances may be formed within a state by combining some or all of a particular states' agencies who purchase prescription drugs into one intrastate cooperative effort. In addition, states may also form interstate purchasing pools by combining purchasing efforts with other states. Purchasing cooperatives can be effective in obtaining lower health care prices and improving quality of care through greater market power.

- Prescription drugs are a necessity in several areas of Illinois budget. Pharmaceutical spending takes place in the State Employees Group Insurance Program, correctional institutions, the Medicaid Program, public heath facilities, veterans' hospitals, and low-income senior programs. It appears that all of these programs basically operate autonomously when developing pharmaceutical programs or simply purchasing drugs. The combined state total for spending on pharmaceuticals in FY 2002 exceeded $1.2 billion.

- According to the AARP Policy Institute, as of July 1, 2001, at least 29 states have enacted some kind of pharmaceutical assistance program, and many other states are developing programs. Most of the state programs are funded by general revenue funds or targeted funding sources (such as tobacco settlement funds) and utilize manufacturer rebates. Generally programs require cost sharing by recipients, although the approach (deductibles, annual fees, or co-payments and contributed amount) vary. The majority of programs benefit individuals 65 years and older and half of the participating states offer coverage to people with disabilities who are under age 65. Most prescription drugs are covered, and some programs cover nonprescription drugs. A few states limit coverage to treatments for specific illnesses, such as heart disease and diabetes.

TRENDS IN PHARMACEUTICALS

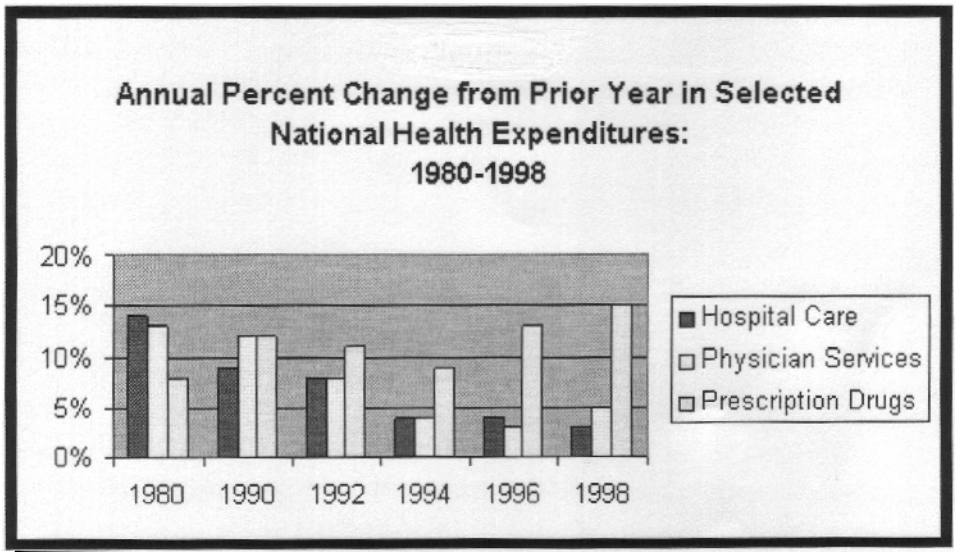
Rising pharmaceutical expenditures are becoming a growing concern for both citizens and governments. The primary reason for this trend is the large increase in utilization. New prescription drug therapies and the ever-growing senior population have made pharmaceuticals increasingly popular. Drug prices also have escalated, but not to the same degree as utilization rates. What remains undetermined by many governmental bodies is how to control both of these factors in order to make pharmaceuticals more affordable to the needy and to State programs that administer to this population. The following section discusses historical pharmaceutical utilization and cost statistics and provides future indicators as to what might be expected in the future unless policy actions are taken.

Increasing Costs

According to the Kaiser Family Foundation, during the past five years, spending on prescription drugs in the United States has increased at an annual rate in excess of 10%. The following chart depicts historical percentage increases for health care expenditures. and illustrates that increases in prescription drug expenditures are outpacing hospital care and physician services. Due to our nation's aging population and growing dependence on cutting-edge pharmaceuticals, it is anticipated that this trend will continue indefinitely under current policy procedures.

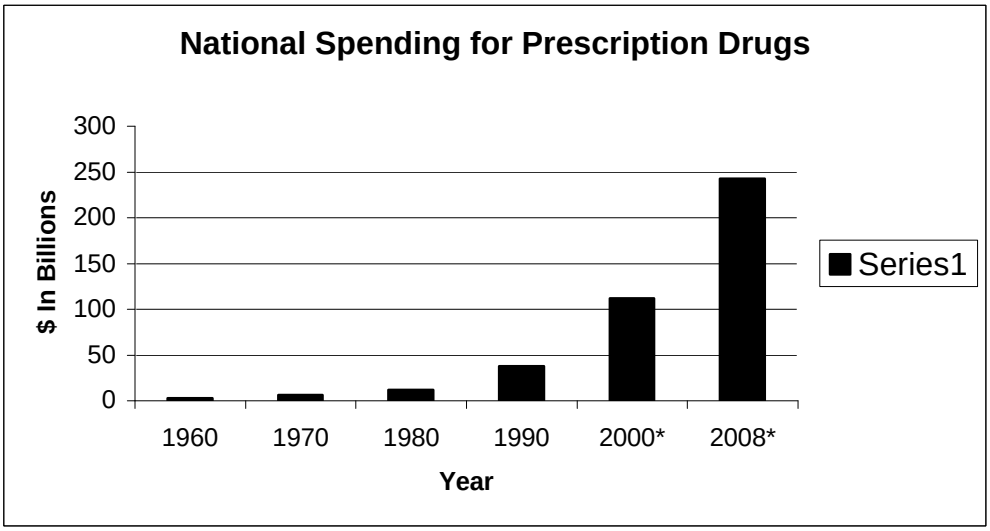
Not only have pharmaceutical expenditures outpaced other healthcare costs, they have increased dramatically over the last thirty years and, as stated previously, it is anticipated that this trend will continue. In fact, between the years 2000 and 2008, the Health Care Financing Administration (HCFA) anticipates that national spending on pharmaceuticals will increase by 117%. Chart 2 provides both an historical and future perspective on national spending for prescription drugs.

CHART 1



Source: Kaiser Family Foundation, Prescription Drug Trends-A Chartbook, July 2000

CHART 2



* Projected
Source: HCFA, Office of the Actuary

Additional studies by the Bureau of Labor Statistics indicate that the average per-capita spending by Americans on prescription drugs was $346 in 1998. The Health Care Financing Agency predicts that spending among seniors is more than double that of what the average American pays. In fact, the agency estimates that on average, older adults spent a total of $742 per person for prescription drugs in 1997 with this amount projected to increase to $1,009 by 2005.

Health plans will mirror the individual cost trend by raising their rates. According to the Segal Company Health Plan Cost Trend Survey, prescription drug benefit trend rates are projected to rise 19.7% for active plan members and retirees under age 65 and 20.9% for retirees age 65 and older. These trend rates are similar for mail order and retail pharmacies.

It is undeniable that pharmaceutical spending is escalating; however the reason for the growth may be surprising. The common belief is that increasing pharmaceutical expenditures are primarily due to manufacturers charging more for prescription drugs. Research shows that neighboring countries are paying significantly less than Americans for needed prescriptions and many are accusing drug manufacturers of price gouging U.S. citizens. However, it also can be argued that the rise in pharmaceutical expenditures should not be totally blamed on drug companies increasing consumer prices.

The National Center for Policy Analysis states that rising drug costs are not directly due to price increases. They are primarily attributable to non-price factors, such as increased volumes of prescriptions, record sales of new products and a changing mix of available products. According to a survey by IMS Health, only 3.2% of a 15.7% increase in drug costs in 1998 could be attributable to price increases.

Another statistic perhaps more relevant to Illinois is that of the price per prescription that the Illinois Circuit Breaker Pharmaceutical Assistance Program has historically paid. For over fifteen years, the program has provided pharmaceutical assistance to Illinois low-income senior citizens and disabled persons for specific covered diseases. The following table provides the cost per prescription that the Circuit Breaker Program has paid between the year 1986 and 2000 and the accompanying percentage increase. It appears that, although the price has grown steadily, the average prescription price increase has been 2.95% over the past ten years, which is not astronomical.

TABLE 1: Illinois Circuit Breaker Pharmaceutical Assistance Program Price per Prescription

Year	Dollars per Prescription	% Increase
1991	$23.42	1.02%
1992	$21.09	-9.93%
1993	$22.44	6.56%
1994	$23.04	2.51%
1995	$23.69	2.80%
1996	$23.92	.97%
1997	$25.12	5.04%
1998	$26.55	5.66%
1999	$28.80	8.50%
2000	$30.63	6.36%
Average Increase		2.95%

Source: Department of Revenue Circuit Breaker Annual Report

In a report titled "Ten Myths About the Market for Prescription Drugs", it is argued that while Americans do pay higher prices for drugs compared to less-developed countries, they must consider that our country is paying for research and development as well. The research and development required to ready a drug for production can cost millions of dollars and take many years to develop. However, the cost of manufacturing a drug is comparatively small. Manufacturers have the ability to choose pricing; therefore, the price may be close to production costs in less developed countries, which could not otherwise afford the drug, and higher in wealthier countries where the price more accurately reflects the drug's value. If all patients paid the lower price, there would be no money for research and development and no new drugs.

Finally, it is clear that prescription drugs may be a lower cost alternative for some individuals who otherwise may need to be treated by a doctor or hospital on a continuous basis. Per dollar spent, drugs offer a better return on health care spending than virtually any other health care option. Using prescription drugs often reduces or eliminates the need for costlier health care services. One recent study published by the National Bureau of Economic Research found that every dollar spent on drugs is

associated with a $4 decline in spending on hospitals. The decline in total spending due to greater use of prescription drugs is particularly notable in the treatment of cancer, heart disease, Alzheimer's, AIDS and mental illness. It is undisputable that prescription drugs have allowed people to live longer, happier, and more pain-free lives than ever before. The question remains as to how long drug therapy will be a cost-effective mechanism for those who need it most.

Increased Utilization: Major Cause

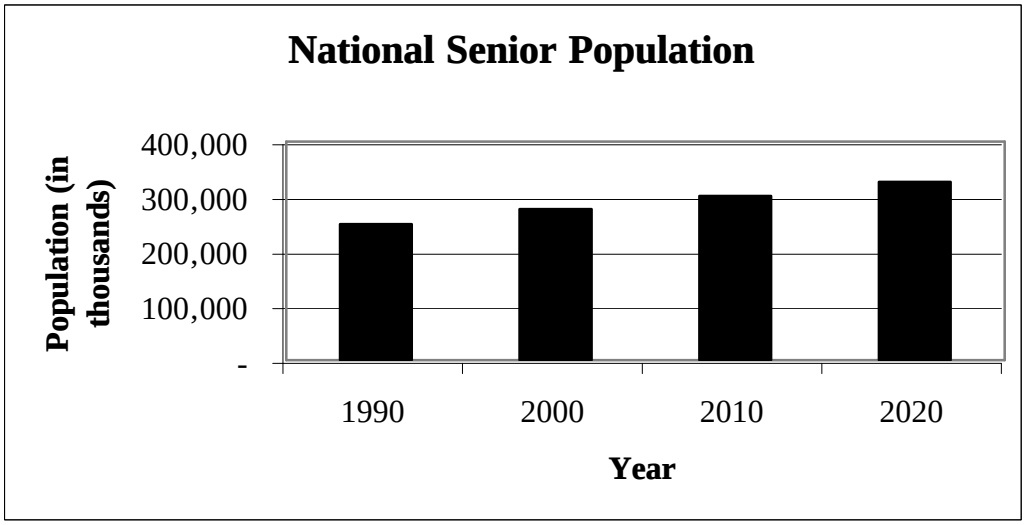
Between 1994 and 1999, 80% of the growth rate in overall pharmaceutical expenditures can be attributed to an increase in utilization. According to the Kaiser Family Foundation, on average, Americans have about ten prescriptions per year. From 1992 to 1998, the number of prescriptions purchased increased by almost 40% while the population growth in the U.S. increased by 6%.

Two predominate factors are the source of pharmaceutical utilization growth. First, our nation is experiencing growth among our aged population who comprise a majority of the prescription drug users. Second, new and improved drug therapies continue to be marketed to the general public, which increase awareness and demand for prescription relief of medical problems.

Statistics indicate that the elderly encompass 13% of the total population, but account for almost one-third of all annual health care expenditures. As this population continues to increase, one can assume that the health care expenditures will directly correlate with the population growth. Moreover, prescription drug coverage is a predominant medical treatment for the elderly and disabled who use a disproportionately high volume of prescriptions. For example, the National Governors Association reports that individuals age 65 to 74 fill an average of 20 prescriptions per year, while individuals age 19 to 44 fill and average of 5 prescription per year. Clearly, the senior population is the cornerstone of the pharmaceutical market and the primary factor when investigating increased utilization.

Charts three and four depict a historical account of how the senior population has grown both in the United States and Illinois. It is anticipated that this will be sustained in future years, thus the consumer base for prescription drugs will be available to the industry for many years.

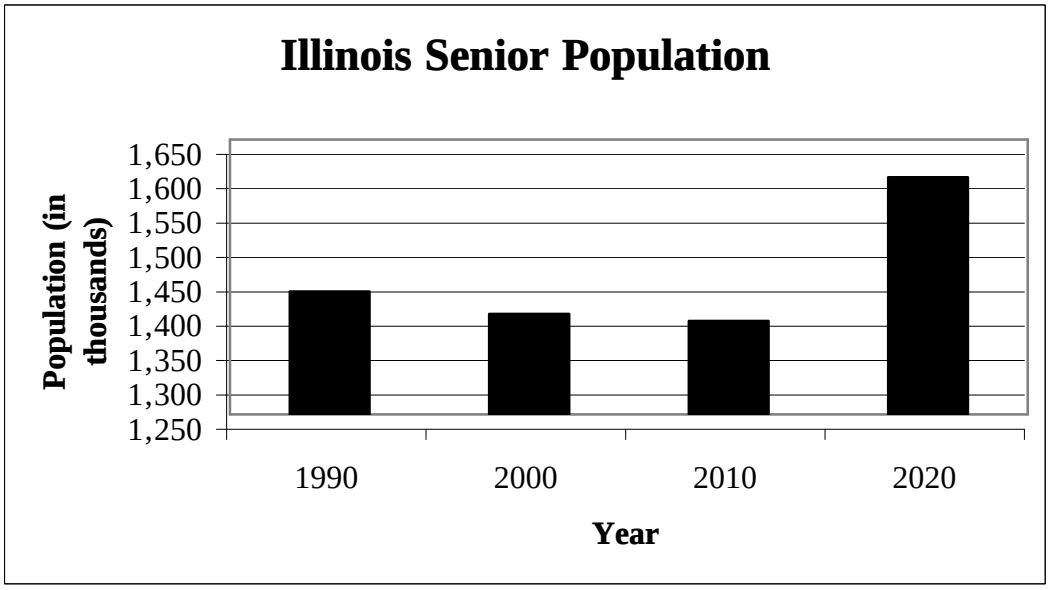
CHART 3



Source: U.S. Census Bureau

As Chart 4 indicates, Illinois senior population may actually decrease between now and 2010, but by 2020, the population is anticipated to increase substantially. Therefore, Illinois will most likely experience many of the pressures that the nation is having from a growing senior population that is more and more dependent upon prescription drugs.

CHART 4



Source: Illinois Bureau of the Budget

Combining all of the previously mentioned statistics, which include a growing senior population, a greater dependence on prescription drugs relative to other health care products, and the continual introduction of new and improved drug therapies, it is probable that the rise of pharmaceutical expenditures could be dramatic.

Controlling pharmaceutical expenditures seems to correlate directly with controlling utilization. This will be especially problematic for many governmental units, as the very population that requires the most financial support, is the one that is anticipated to grow and the most costly constituent as far as pharmaceutical purchases are concerned. There are a number of factors that can aid in controlling utilization (see page 7). However, the popular methods of reducing the number of people who qualify for benefits or increasing the cost of receiving benefits are extremely unpopular and do not meet the governmental goal of aiding the people who are most in need.

COST CONTAINMENT MEASURES FOR REDUCING PRESCRIPTION DRUG EXPENDITURES

Many states are reviewing prescription drug purchasing policies in order to become more effective and efficient consumers. Controlling utilization, limiting name brand drugs, intrastate purchasing pools, and interstate purchasing pools all have provided states with mechanisms to conserve state dollars. The following section outlines some of the cost containment measures that may be utilized. In addition**,** specific examples are provided of states that have utilized some of these methods as well as the projected amount of cost savings attained by the states.

Control utilization

As stated previously, utilization is a key factor in ever-increasing pharmaceutical expenditures. Some states have found ways to control utilization without necessarily eliminating aid to individuals who require benefits. The following are a list of methods that states have implemented that have curbed utilization:

- *Co-payments and deductibles* – Participants partially pay for drugs in order to curb the filling of unneeded prescriptions. Co-payments also provide minimal individual financial support towards government programs, but may make a significant contribution when looked at cooperatively.

- *Drug formularies and generic drugs* – Drug formularies may provide consumers with significant discounts for choosing specific brand name drugs. Many prescription drug plans currently use these financial incentives to encourage the use of lower cost drugs on formulary or preferred lists. Often generic drugs offer the same benefits as brand name drugs, but at a much cheaper price. In fact, generics may be as much as 20% lower than name brand drugs.

- *Pharmacy Benefit Managers (PBMs)*- PBMs negotiate discounts and rebates with drug manufacturers, establish retail pharmacy networks and generic and formulary substitution programs, review drug utilization, administer disease management programs, and oversee physician profiling. PBM's can aid state governments in significantly reducing the cost of pharmaceutical programs such as state employee group insurance programs and senior pharmaceutical assistance programs.

- *Reduce participant fraud and wastefulness* - An enforcement task force is utilized to investigate possible consumer fraud and wastefulness. Careful analysis should be performed when investigating fraud in order to ensure that the cost of the investigation does not exceed the savings achieved from catching perpetrators.

- *Prior Authorization* – Prior authorization before filling a prescription may eliminate possible consumer prescription drug abuse, limit side-effects, reduce the possibility of drug interactions, and counter-balance direct-to-consumer advertising.

Recently, Governing Magazine highlighted three states that were trying an innovative approach to curbing state pharmaceutical expenditures through limiting the use of name brand drugs. These states limited the use of name brand drugs in order to control the utilization of more expensive pharmaceuticals. The following states have varying degrees of success with their programs, but are definitely on the forefront of discovering ways to curb state pharmaceutical expenditures.

MAINE

Maine dramatically reduced its Medicaid pharmaceutical expenditures by simply requiring physicians to prescribe generics or lower-cost alternatives to name brand drugs. Name brand drugs may only be used when a doctor receives permission from a state-sponsored hotline. The approach cut $15 million from the state's Medicaid budget.

FLORIDA

Florida reduced its senior program drug budget by almost $250 million by developing a preferred drug list. In order for drugs to be included on the preferred list, manufacturers must offer the state deep discounts on their products or pay for health programs that will contain other Medicaid costs.

MICHIGAN AND CALIFORNIA

Michigan and California also have adopted preferred lists for their Medicaid programs that are similar to Florida. In addition, Arkansas, Idaho, Oregon, Texas, and Washington states are investigating implementing similar measures for their respective states.

It should be noted that these programs are not without controversy. The Pharmaceutical Research and Manufacturers of America (PhRMA), a group that represents major drug companies has sued Florida, Michigan, and Maine in order to stop preferred lists. PhRMA argued in the Maine case that drug lists are unfair to Medicaid beneficiaries because they limit consumer choice and may adversely affect patients who need special medicines not on the lists. It appears that ultimately the states will prevail. Recently Maine defeated one court challenge when a federal judge ruled that the state could continue its Healthy Maine drug program.

The previously mentioned measures may be combined or used individually to help control drug utilization. Although the measures may achieve some cost containment, they do not necessarily combine a state's purchasing power to achieve total cost

savings. In addition, controlling utilization has the potential to limit access to needed drugs for the sake of cost savings and, thus, could under-mind medical considerations.

Pharmaceutical Purchasing Pools

To gain better control of prescription drug costs, states are investigating and forming purchasing alliances to negotiate pharmaceutical prices, discounts, and rebates with manufacturers. Alliances may be formed within a state by combining some or all of a particular states' agencies who purchase prescription drugs into one intrastate cooperative effort. In addition, states may also form interstate purchasing pools by combining purchasing efforts with other states. Purchasing cooperatives can be effective in obtaining lower health care prices and improving quality of care through greater market power.

Intrastate purchasing pools are formed when multiple prescription purchasing programs within a state (such as a state's employee group insurance program and Medicaid Program) combine efforts in order to attain better buying power with pharmaceutical groups. In addition to greater purchasing power, the state also may eliminate duplicate efforts made among agencies that autonomously enter into pharmaceutical contracts. It should be noted that simply forming a purchasing pool only achieves budgetary efficiency and does not aid the low-income and uninsured in making prescription drugs more affordable. In order to accomplish this objective some states have implemented "buyers" clubs.

Intrastate Purchasing Pools

Intrastate purchasing pools have facilitated "buyers" clubs which form a cooperative compromised of citizens who are uninsured for drugs with an insured group of individuals (such as state employees or Medicaid beneficiaries). The theory is that the large pool of individuals provides the state with greater purchasing power when negotiating with pharmaceutical manufacturers. Generally, participants must pay a fee in order to participate, and receive discounts in return. The discounts are funded via rebates and the price reductions from pharmaceutical companies. Caution is warranted for both states and participants due to the fact that sometimes club participants may find better discounts and lower fees in the private sector. Therefore, governments must perform research that ensures that the fees and discounts that are offered to recipients are fair.

Whether simply forming an intrastate purchasing pool or expanding to include the uninsured, the following states are making an effort to provide more efficient and effective government service to its constituents by better utilizing taxpayer dollars.

TEXAS

Texas appears to be a progressive state at initiating an intrastate purchasing pool. In June 2001, the state enacted a law that combines pharmaceutical purchasing for the departments of health and mental health, state employees, retirees, teachers, the prison system, and any other agency that purchases pharmaceuticals. The law created the

Interagency Council on Pharmaceuticals Bulk Purchasing and it uses the state's existing distribution networks, including wholesale and retail distributors, to distribute the pharmaceuticals. The state estimates approximately $13 million in cost savings for the first two years.

MASSACHUSETTS

Massachusetts also created a state aggregate purchasing program in its fiscal year 2000 budget. The program combines senior pharmacy assistance participants, Medicare and Medicaid enrollees, state workers, uninsured and underinsured individuals into one purchasing pool. The state believes that approximately 1.6 million individuals would be serviced at an estimated cost savings to government and individuals of $200 million. Although the plan has been created, it has not yet been implemented. The legislature is being encouraged to renew discussions regarding this program.

GEORGIA

In February 2000, Georgia issued a joint request for proposal (RFP) for a multi-program contract for PBM services for its State Health Benefit Plan for state employees, the Board of Regents Health Plan for higher education health insurance programs, the Georgia Medicaid program, and the state children's health insurance program PeachCare for Kids.

WASHINGTON

The state of Washington implemented an AWARDS program, which was a buyers' club for citizens over the age of 55. The club was combined with the state employee's medical plan and administered by the plan's PBM in order to form greater purchasing power. A suit filed by the Washington State Pharmacists Association was recently won on the grounds that the executive branch of the state's government did not have the authority to extend state employee PBM contract to cover AWARDS members.

Multi-State Prescription Drug Purchasing Alliances

Some states are pooling together to form multi-state purchasing coalitions in anticipation of developing buying and bargaining clout with pharmaceutical companies. Little up-front cost is required for multiple states to combine their purchasing efforts in order to receive discounted drugs. The following are examples of several multi-state purchasing alliances that have been formed:

MINNESOTA MULTI-STATE CONTRACTING ALLIANCE FOR PHARMACY

The Minnesota Multi-State Contracting Alliance for Pharmacy (MMCAP) has been administered by the Minnesota Department of Administration since 1985. MMCAP pools pharmacy purchasing for multiple agencies and nonfederal governmental units across more than 38 states. Entities are eligible to obtain pharmaceuticals via MMCAP using contracts established with drug manufacturers and other vendors. Currently there are more than 2,600 facilities that receive services from MMCAP. The more entities that join MMCAP, the greater its negotiating power to achieve better prices.

MMCAP is funded through administrative fees from contracted drug manufacturers. There is no membership fee for participating entities. The annual pharmaceutical sales volume is approximately $600 million and Minnesota maintains contracts with more than 130 pharmaceutical manufacturers for more than 6,039 products.

THE MASSACHUSETTS ALLIANCE FOR STATE PHARMACEUTICAL BUYING (MASPB)
Massachusetts created MASPB to improve services and lower drug prices through collective purchasing of pharmaceuticals. The Alliance is similar to Minnesota's MMCAP; however, MASPB utilizes a professional pharmaceutical group purchasing organization (Managed Health Care) to acquire the drug prices as well as to provide reporting services. Recently, California joined MASPB and will undoubtedly add more leverage to the Alliance's purchasing power.

NEW ENGLAND TRI-STATE PRESCRIPTION DRUG PURCHASING COALITION
The coalition brings Maine, New Hampshire, and Vermont into a single entity to collectively review pharmaceutical costs for citizens covered by public programs and uninsured and underinsured individuals. The coalition hopes to decrease the states' cumulative $387 million Medicaid prescription drug spending bill between 10% and 15%.

NORTHEAST LEGISLATIVE ASSOCIATION ON PRESCRIPTION DRUG PRICES
The Association is a partnership of New York, Pennsylvania, and the six New England states. These states' legislatures are stepping up legislative language that may lead to the creation of a regional pharmaceutical buying pool. Each state must introduce and pass the model legislation in order to succeed. It is estimated that by pooling their interest, the Association could cut pharmaceutical expenditures by 40%.

THE PHARMACY WORKING GROUP
Louisiana, Maryland, Mississippi, Missouri, New Mexico, South Carolina, and West Virginia have formed a purchasing pool in order to attain better pharmaceutical prices for their respective states. Last October, the group issued a request for proposal (RFP) for a pharmacy benefits manager (PBM) for the purchasing pool. More than 1.4 million people could be served with a total of $853 in annual pharmacy claims.

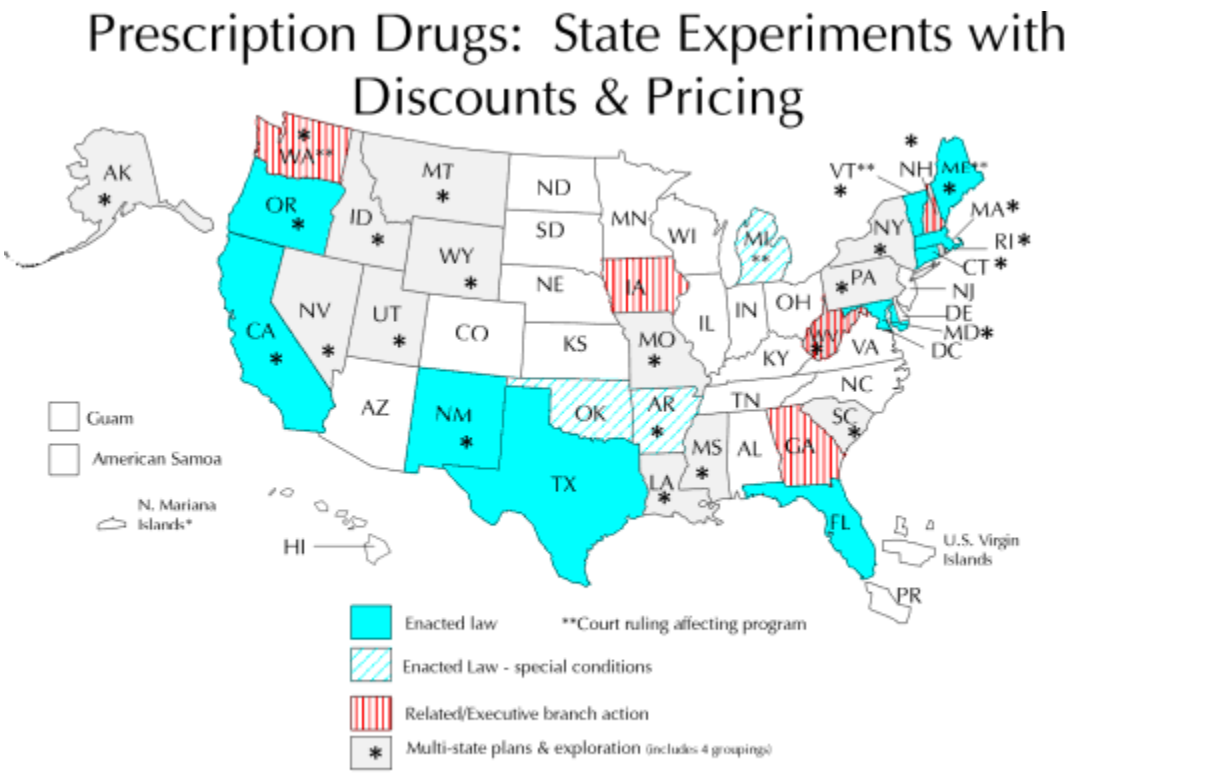
THE REFORMING STATE GROUP
Health policy leaders from Idaho, Montana, Nevada, Oregon, Utah, Washington, Wyoming, and three Canadian provinces have formed an association that is researching strategies for containing prescription drug costs.

Multi-state purchasing pools appear to have many merits for participating states. Pharmaceutical bulk purchasing directly addresses budget relief to states. In some instances it may even allow for the expansion of some drug programs or avert benefit cuts during a time of economic duress. These benefits may be achieved with virtually no costs to the state. Critics of purchasing pools claim that participating states are

merely patching up a problem that is nation-wide. By becoming a purchasing powerhouse, a state is not necessarily solving the root problem of pharmaceutical expenses. Also, only participating pharmaceutical pool states are privy to discounts offered by prescription drug manufacturers; therefore, not all citizens receive comparable coverage.

There are several issues that states must be aware of before entering into such agreements. First, states must consider which populations within their borders will be affected by purchasing pools. Also they must decide with which states to form a coalition. It appears that states that already have formed purchasing pools have similar demographics and are also in the same general geographic location. Legislative authorities with the states must be willing to investigate possible purchasing pools and give entities the authority to move forward. And, finally, states must be prepared to face legal challenges from the pharmaceutical industry.

The following map is provided by the National Conference of State Legislatures. The map depicts states that already have or are considering entering into purchasing pool agreements.



Compiled by National Conference of State Legislatures' Health Care Program, Denver, Colorado 303-830-2200

Data as of April 2002. This map is not intended as a comprehensive analysis of the 50 states.

PHARMACEUTICAL SPENDING IN THE STATE OF ILLINOIS

Prescription drugs are a necessity in several areas of the Illinois budget. Pharmaceutical spending takes place in the State Employees Group Insurance Program, correctional institutions, the Medicaid Program, public heath facilities, veterans' hospitals, and low-income senior programs. It appears that all of these programs basically operate autonomously when developing pharmaceutical programs or simply purchasing drugs. The following outlines the various State agencies and the programs that are responsible for pharmaceutical agreements.

THE DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

The Group Insurance Act of 1971 specifies a "program of health benefits" for employees; however, it does not indicate what health benefits must be provided. The Department of Central Management Services is responsible for administering the State Employees Group Insurance Program that provides health, dental, eye, and prescription drug benefits for state employees. CMS contracts with a PBM to pay claims for its members in the Group Insurance Program. It is projected that in FY 2002 the Department spent approximately $143 million for prescription drugs.

THE DEPARTMENT OF CORRECTIONS

The Department of Corrections purchases prescription drugs for Illinois inmates. The Department spent approximately $8 million for prescription drugs in FY 2002. These amounts exclude AIDS related drugs which the Department spent an estimated $5 million in FY 2002. The majority of correctional facilities have various major medical providers that purchase and dispense all drugs purchased by the Department. The cost of these drugs is mainly incorporated into these contracts. While the Department receives a better price on drugs via contracts, there is not a negotiated "discount" on these drugs and therefore, no way to estimate savings for prescription drugs alone.

THE DEPARTMENT OF HUMAN SERVICES

The Department of Human Services is responsible for purchasing prescription drugs for its patients at the mental health facilities. The Department estimated that approximately $20 million was spent on pharmaceuticals in FY 2002.

THE DEPARTMENT OF PUBLIC AID

The Department of Public Aid has two programs that represent citizens who utilize prescription drugs. The first program, Medicaid, is similar to most other states in that it represents the largest component of prescription drug purchases for Illinois. The Department spent over $875 million on prescription drugs related to the Medicaid Program in FY 2002. A PBM is not used by Public Aid, but discounts are still achieved by the Department. A formula consisting of the average wholesale price less a negotiated discount is utilized for both brand name and generic drugs when determining the price charged for pharmaceuticals.

The second program began June 1, 2002 when the Department was charged with administering an innovative program entitled SeniorCare. Illinois SeniorCare is a model program that provides assistance for all prescription medication to low-income senior citizens. The program allows the state to utilize federal Medicaid dollars in order to extend prescription drug coverage to approximately 368,000 seniors. Broad pharmaceutical benefits will be extended to low-income seniors age 65 and older. The entire program was appropriated $193 million in FY 2003, with only $27 million from the GRF and $166 million provided from the Tobacco Settlement Recovery Fund. It appears from Public Aid's website that SeniorCare will also use a PBM to negotiate pharmaceutical discounts.

THE DEPARTMENT OF PUBLIC HEALTH

The Department of Public Health administers the AIDS Drug Assistance Program (ADAP) through Ryan White Title II and general revenue funds. During FY 2002, ADAP spent approximately $26 million on prescription drugs. ADAP is an eligible entity to receive the 340-B discounted drug pricing through the Veteran's Healthcare Act of 1992. This price is between 25% and 35% less than the average wholesale price. ADAP purchases drugs from Bergen Brunswig, the contracted Prime Vendor for Health Resources and Services Administration (HRSA), the ADAP Funding source. These drugs are shipped to the ADAP contracted mail order dispensing pharmacy, CVS ProCare, in Pittsburgh, PA for dispensing to eligible Illinois ADAP clients throughout the State.

THE DEPARTMENT OF REVENUE

The Illinois Department of Revenue administered the Pharmaceutical Assistance Program in FY 2002, which provides pharmaceutical assistance to the aged and disabled. During FY 2002, the Department spent over $193 million on prescription drug benefits for participants. Future expenditures for this particular program will be comparatively minimal because a new program, SeniorCare (see *The Department of Public Aid* Section), will be fully implemented and administered by the Department of Public Aid in FY 2003, which will dramatically reduce the utilization and spending of the Circuit Breaker Pharmaceutical Assistance Program. The PBM, Express Scripts, was charged with negotiating the rebates with the pharmaceutical manufacturers.

THE DEPARTMENT OF VETERANS AFFAIRS

Veterans Affairs purchases prescription drugs for Illinois veterans. In FY 2002, it is projected that the Department spent over $2 million for pharmaceuticals. In many cases discounts were obtained by the Department's ability to purchase drugs at costs set at Federal Pricing Schedules. In some cases where drugs prescribed are not immediately available though CMS and must be quickly administered, drugs are purchased locally from pharmacies and discounts are generally available if they are paid within a set time frame.

The following section outlines how much each agency has spent on pharmaceuticals in FY 2002:

TABLE 2: FY 2002 Illinois Agencies Pharmaceutical Expenditures

Agency	Dollars Spent ($ in millions)
Central Management Services	$143
Corrections	13
Human Services	20
Public Aid	875
Public Health	26
Revenue	193
Veterans Affairs	2
Total	$1,272

*****The above figures are agency estimates for projected pharmaceutical spending in FY 2002. Actual figures may vary.

As shown in Table 2, Illinois pharmaceutical expenditures are in excess of $1.2 billion. The applicable agencies appear to operate autonomously when purchasing pharmaceuticals and utilize different methods for obtaining discounts. For example, CMS utilizes a PBM to negotiate pharmaceutical discounts, while Public Aid and Corrections do not, and Public Health and Veterans Affairs can both take advantage of federal pricing. It does not appear that Illinois agencies have investigated if they could combine efforts to increase purchasing power and negotiate better pharmaceutical discounts. Nor is it clear that if agencies were to combine their efforts, efficiency and effectiveness would be achieved as it has been reported in other states. One thing is certain, as prescription costs continue to increase and less than stellar State revenues predominate, government leaders will undoubtedly pay closer attention to the application of cost containment measures and areas to where they may be applied.

HELP FOR LOW-INCOME SENIORS AND THE DISABLED

According to the AARP Policy Institute, as of July 1, 2001, at least 29 states have enacted some kind of pharmaceutical assistance program, and many other states are developing programs. Most of the state programs are funded by general revenue funds or targeted funding sources (such as tobacco settlement funds) and utilize manufacturer rebates. Generally programs require cost sharing by recipients, although the approach (deductibles, annual fees, or co-payments and contributed amount) vary. The majority of programs benefit individuals 65 years and older and half of the participating states offer coverage to people with disabilities who are under age 65. Most prescription drugs are covered, and some programs cover nonprescription drugs. A few states limit coverage to treatments for specific illnesses, such as heart disease and diabetes.

The following is a description of ways that States are able to provide pharmaceutical assistance to its senior and disabled populations.

- Direct Subsidy - Direct benefit programs involve the state paying for all or part of the cost of the prescription. Most states (including Illinois) are direct benefit programs.

- Price Discounts - Price reduction programs simply limit the price that can be charged to certain populations

- Tax Credits - Tax credit programs provide state income tax credits for prescription drug purchases.

- Cooperative Purchasing and Buying Pools - Buying pools allow residents to enroll in a purchasing pool or club that contracts with private entities to negotiate discounts from pharmacies or drug manufacturers.

Provided below is a list of states that offer pharmaceutical assistance to its residents. In addition, the chart indicates the type of method used to provide assistance.

TABLE 3: States With Pharmacy Assistance

State	Direct Benefit	Insurance	Price Reduction	Buying Pools	Tax Credits
Arizona	X				
Arkansas	X				
California			X		
Connecticut	X		X		
Delaware	X				
Florida	X		X		
Illinois	X				
Indiana	X				
Iowa				X	
Kansas	X				
Maine	X		X	X	
Maryland	X	X	X		
Massachusetts		X		X	
Michigan	X				X
Minnesota	X				
Missouri					X
Nevada		X			
New Hampshire				X	
New Jersey	X				
New York	X				
North Carolina	X				
Pennsylvania	X				
Rhode Island	X				
South Carolina	X				
Texas	X				
Washington				X	
Vermont	X		X	X	
West Virginia			X		
Wyoming	X				

*As of July 2001

**Source: AARP Policy Institute

Obviously, a majority of the states offering assistance to low-income individuals offer a direct benefit approach. Although this method is the most costly of the options, it provides its recipients with the most comprehensive and effective coverage. Most direct benefit plans utilize general revenue and tobacco settlement funds and limit participation to low-income senior citizens and the disabled. Some states also limit the diseases that are covered by their programs. The following chart indicates states that

have direct-benefit pharmacy assistance programs, the funding source, appropriation amount, and enrollment figures.

TABLE 4: FY 2001 Direct-Benefit Pharmacy Assistance Programs

State	Fund Source	Enrollment	Appropriation (dollars in thousands)
New York	General Revenue & HCRA funds	234,916	$396,400
Pennsylvania	Lottery & general revenue	234,711	368,700
New Jersey*	Casino revenue, General Revenue, tobacco settlement	188,000	345,224
Massachusetts	Cigarette tax & tobacco settlement	60,900	69,200
Illinois	GRF & tobacco settlement, federal Medicaid matching funds	145,089	69,000
Michigan	Sales tax on construction materials & tobacco settlement	46,000	56,000
Maryland*	General Revenue	34,000	37,300
Connecticut	General Revenue	33,850	28,277
South Carolina	Tobacco settlement	34,000	20,000
Indiana	Tobacco settlement	10,000	20,000
Vermont	VHAP and Vscript, Cigarette tax, federal Medicaid matching funds	13,755	17,920
Maine	General Revenue & tobacco settlement	41,000	17,000
Florida	General Revenue	20,500	15,250
Minnesota	General Revenue	4,500	14,342
Rhode Island	General Revenue	33,000	8,100
Delaware (State Funded)	Tobacco settlement	3,577	5,569
Delaware (Private Funded)*	Private foundation	26,000	5,400
Nevada	Tobacco settlement	4,165	4,600
Arizona	Tobacco tax	N/A	3,900
Kansas	N/A	800	1,200
North Carolina	General Revenue	2,076	1,000
Wyoming*	General Revenue	550	600
Arkansas	Medicaid waiver	N/A	N/A
Oregon	Cigarette tax	N/A	N/A
Texas	General Revenue	N/A	N/A

*Enrollment figures are for 2000.

Source: Rutgers Center for State Health Policy Field Report, May 2002

ILLINOIS ASSISTANCE

Illinois Circuit Breaker Program

Illinois has two programs that offer pharmaceutical assistance to low-income senior citizens and the disabled. The first program is an extension of the Illinois Circuit Breaker Program and was initiated in 1985 to provide low-income seniors afflicted with cardiovascular disease with prescription drug assistance. The Pharmaceutical Assistance portion of the Illinois Circuit Breaker Program has expanded over the past seventeen years to include additional diseases as well as additional people via raising the income requirement limit. In FY 2001, the programs had a monthly average of 171,820 enrollees and paid out over $193 million in claims. However, as of June 2002, the SeniorCare Program administered by the Department of Public Aid will significantly decrease the duties and dollars provided by the Circuit Breaker Pharmaceutical Assistance Program.

As stated previously, states that provide direct pharmaceutical benefits to the needy generally fund their efforts via general revenue funds and tobacco settlement funds. Illinois is no exception to this rule. However, many governments are experiencing double digit growth rates in their assistance programs which have many showing an interest in the possibility of Medicaid waivers that would provide pharmacy benefits to low-income individuals not otherwise eligible for Medicaid on a federally-matched basis. Until recently, Vermont was the only state to have been granted such a waiver. However, as of June 2002, Illinois was granted the same privilege, and, if successful, will initiate further participation from other states.

SeniorCare

SeniorCare is a new program sponsored by the State of Illinois that may benefit up to 368,000 eligible Illinois seniors. The program is a Medicaid waiver to provide a pharmaceutical benefit to Illinois seniors (65 or older) with income at or below 200% of the Federal Poverty Level or approximately $17,200 annual income for a single person and $23,200 for a couple. It is estimated that the program will pay for more than 90% of the average eligible senior's drug costs and will cover all formulary drugs.

Low income disabled people and those above the 200% Federal Poverty Level would not be eligible for SeniorCare, but can continue to receive benefits via the Circuit Breaker Program.

Illinois will receive 50% matching funds from the federal government for the SeniorCare Program. It is projected that the program will be cost neutral to the state and federal government. Savings will be achieved due to individuals being able to receive less costly prescription drug therapy rather than requiring more costly institutional Medicaid care.

Illinois will put forth $193 million in appropriated general revenue and tobacco settlement funds and will receive additional federal matching funds to pay for the new

program. SeniorCare's success will undoubtedly be in the national spotlight over the next year in order for the federal government and other states to ascertain whether this endeavor is worth expansion into additional states.

RECENT FEDERAL LEGISLATION

Reimportation of Pharmaceuticals

It is no secret that prescription drugs are available at much cheaper prices in developing countries such as Mexico. When reports circulate about low-income seniors from the United States that have to make a choice between needed prescriptions or other necessities such as food and heat, it is not surprising to hear of these same individuals traveling across the country in order to take advantage of the price-break achieved in Mexico. In fact, there are even senior bus trips that offer the service of caravanning individuals to neighboring countries in order for them to purchase needed drugs at a much reduced rate. Thus, our government is under continuous pressure to follow our neighbors in battling pharmaceutical manufacturers to lower their rates.

The dilemma is not an easy one. Pharmaceutical manufacturers argue that the U.S. is paying for research and development, which offer cutting edge drugs. Our neighbors simply copy already made drugs and are able to sell them at a much cheaper price due to the fact that they do not have the accompanying R&D expense absorption.

Recently the Senate voted 69-30 to allow drugs to be reimported from Canada but then voted 99-0 to require the Secretary of Health and Human Services to certify that it could be done with no increased risk before the law could take effect. This is almost exactly what passed Congress two years ago, but it was never implemented because two HHS secretaries refused to certify that safety wouldn't be compromised (the differences are this time it's Canada only and there are some minor changes in the underlying reimportation amendment). If passed by Congress in its current form, it appears the administration wouldn't certify the safety requirement could be met, so the provision wouldn't take effect.

Medicare Coverage of Pharmaceuticals

As recent as July 2002, the U.S. Senate argued weather to cover prescription drugs under Medicare. Two bills, one backed chiefly by Democrats, the other by Republicans are basically at a crossroad. Undoubtedly this will be a hot campaign topic during the fall elections.

The Democrat bill would have created a government-run prescription drug benefit for Medicare recipients at a estimated cost of $594 billion over several years. Another plan, sponsored by primarily Republicans was a less expensive program that offered coverage via private companies at an estimated cost of $340 billion. Both bills offered government prescription drug subsidies for low-income patients and coverage for any Medicare patient willing to pay, but the details among the bills are quite different.

CONCLUSION

There is no doubt that pharmaceutical expenditures are rising at an alarming rate, which is a budgetary concern for individuals and governments. Although many believe that the main contributing factor to this phenomenon is that pharmaceutical companies are raising the prices of the drugs at an unfair rate, it does not appear to be as simple as that. There are multiple factors that are increasing prescription drug expenditures. Some of these include the growth of the senior population, new and improved drug therapies being marketed to the public, and needed research and development costs that are being absorbed primarily by American consumers.

Many states are trying to utilize their substantial constituency base to gain purchasing power with pharmaceutical manufacturers. Some states are combining buying efforts among their own state agencies for an intrastate buying pool and others are forming cooperatives with other states to increase the consumer base even more. "Buyer" pools have been formed to combine the uninsured citizens with state-covered groups such as Medicaid or Employees Group Insurance so that the uninsured are provided affordable discounted drugs. All of these methods are relatively new and are receiving some legal battles from the pharmaceutical industry. Nevertheless, states are reporting cost savings success.

Although purchasing pools help state budgets, they do not necessarily provide direct pharmaceutical assistance to its most needy constituents. To date, 29 states have some sort of pharmaceutical assistance program and many of them provide the more costly direct assistance to their constituents. Illinois is on the forefront of providing direct pharmaceutical assistance to a possible 368,000 low-income seniors via its new SeniorCare Program. The program is in cooperation with the federal government who will provide 50% of matching dollars to SeniorCare. The start date was June 2002; therefore, actual cost data are unavailable to analyze to determine financial success. However, Illinois will be in the national spotlight in order to determine if this method of funding should be expanded to other states.

The federal government also is investigating remedies to aiding low-income individuals for prescription drug needs. Recently, Congress has discussed reimporting drugs from Canada as well as extending pharmaceutical benefits to Medicare. Both of these options have been stalled, but will undoubtedly be hot topics during the fall elections.

Although a clear-cut solution has not yet been reached regarding pharmaceutical expenditures, it is a platform that has the attention of almost all levels of government. Undoubtedly, new and better methods will be devised in the future that will hopefully provide some resolve to this issue.

BACKGROUND

The Illinois Economic and Fiscal Commission, a bipartisan, joint legislative commission, provides the General Assembly with information relevant to the Illinois economy, taxes and other sources of revenue and debt obligations of the State. The Commission's specific responsibilities include:

1) Preparation of annual revenue estimates with periodic updates;

2) Analysis of the fiscal impact of revenue bills;

3) Preparation of "State Debt Impact Notes" on legislation which would appropriate bond funds or increase bond authorization;

4) Periodic assessment of capital facility plans; and

5) Annual estimates of the liabilities of the State's group health insurance program and approval of contract renewals promulgated by the Department of Central Management Services.

The Commission also has a mandate to report to the General Assembly ". . . on economic trends in relation to long-range planning and budgeting; and to study and make such recommendations as it deems appropriate on local and regional economic and fiscal policies and on federal fiscal policy as it may affect Illinois. . . ." This results in several reports on various economic issues throughout the year.

The Commission publishes two primary reports. The "Revenue Estimate and Economic Outlook" describes and projects economic conditions and their impact on State revenues. "The Illinois Bond Watcher" examines the State's debt position as well as other issues directly related to conditions in the financial markets. The Commission also periodically publishes special topic reports that have or could have an impact on the economic well being of Illinois.

These reports are available from:

Illinois Economic and Fiscal Commission
703 Stratton Office Building
Springfield, Illinois 62706
(217) 782-5320
(217) 782-3513 (FAX)

Reports can also be accessed from our Webpage:

http://www.legis.state.il.us/commission/ecfisc/ecfisc_home.html