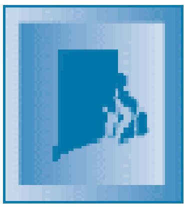


RIPEC

Comments on Your Government

A SPECIAL PUBLICATION OF THE RHODE ISLAND PUBLIC EXPENDITURE COUNCIL

FY 2005 State Budget – Part II

Rhode Island Pharmaceutical Assistance Program for the Elderly

Growth in the cost of pharmaceuticals continues to outpace both overall inflation and health care inflation. Prescription drugs represent the fastest growing segment of health care expenses, and are expected to continue rapid growth over the next decade[1]. According to the *Kaiser Family Foundation*[2], growth in drug costs represents an increasing share of total health care costs. In 1990, approximately 8.6 percent of the net growth in health care expenditures nationwide was attributable to pharmaceutical expenditure growth. This has since increased to approximately 20.0 percent of the net growth in health care expenditures in 2000.

There are many factors driving the cost of pharmaceuticals in the United States. According to a recent study prepared for the Rhode Island Legislature by *Heinz Family Philanthropies*[3], manufacturer price inflation accounts for nearly one-third of the overall increase in drug costs. However, increasing utilization of pharmaceuticals is the largest driver nationally, where nearly 48.0 percent of the growth in the costs of drugs is driven by an increase in the number of people using pharmaceuticals as well as multi-use of pharmaceuticals. Americans are living longer, medical practitioners are increasingly using pharmaceuticals in lieu of hospitalization, and the industry continues to introduce new products.

These trends have a number of implications for the Federal and State budgets across the country. Recent Federal action – the *Medicare Prescription Drug Improvement, and Modernization Act of 2003 (MMA)* – introduced a series of programs to provide temporary assistance to Medicare beneficiaries with prescription drug costs before the permanent Medicare drug coverage program begins in 2006.

In Rhode Island, there are a number of agencies and programs in the State that provide pharmaceutical assistance – most through Medicaid-related programs. The following analysis reviews the State's program to provide pharmaceutical assistance to Rhode Island's low income elderly population as well as the impact the Federal MMA will have on State expenditures.

The Rhode Island Pharmaceutical Assistance for the Elderly Program (RIPAE) provides subsidies for pharmaceuticals to low-income and middle-income residents age 65 and older. Subsidies range from a high of 60.0 percent of the cost of the allowable prescriptions to 15.0 percent, depending on income. Assistance is provided by paying for a range of medications for eligible Rhode Islanders. Prescriptions used for treating Alzheimer's disease, diabetes, heart problems, cholesterol, asthma and other medical conditions are covered under this program.

Summary of Findings

- Rhode Island has the 6th highest concentration (14.5 percent) of elderly in the Nation, with the baby-boomer generation approaching eligibility for RIPAE by 2010;

- Caseloads for RIPAE have increased by 62.5 percent since FY 1996 – principally due to liberalized eligibility requirements and additional public awareness of the program;

- An elderly Rhode Islander can have annual income that is 405 percent of the Federal Poverty Level and still be eligible for State pharmaceutical assistance;

- On average, prescription drugs make up about 26.0 percent of total out-of-pocket medical costs in the U.S. – this is projected to increase to 32.5 percent by 2013; and

- Recent Federal actions (pharmaceutical discount cards) will mitigate some of the growth in expenditures for the State in FY 2005, saving the State $2.1 million in general revenues.

Next Steps

- Maximize opportunity to implement recommendations from the recent Heinz Report through the new Rhode island Office of Health and Human Services;

- Pursue direct contracting with drug manufacturers, such as rebate programs, to reduce administrative costs; and

- Pursue aggressive campaign to shift eligible RIPAE participants to the Federal Medicare prescription drug program to generate State savings.

Demographic Trends - The following discusses the changes in the elderly population in the U.S. as well as in New England. It is important to understand the trends related to the age 65 and over cohort because this age group uses approximately 35.0 percent of the pharmaceuticals across the country.

Since 1990, total U.S. population increased by 13.2 percent. The elderly population (age 65 and older) increased by 12.0 percent. In 2000, the elderly represented approximately 12.4 percent of the Nation's population, representing a slight decline from 1990 (12.6

Table 1
Population of People 65 Years and Older

	1990					2000					Change	
State	Total Population	65 and Older	Percent 65+	U.S. Rank	Median Age	Total Population	65 and Older	Percent 65+	U.S. Rank	Median Age	Total Population	65 and Older
Connecticut	3,287	446	13.6%	13	34.4	3,406	470	13.8%	10	37.4	3.6%	5.4%
Maine	1,228	163	13.3%	17	33.9	1,275	183	14.4%	7	38.6	3.8%	12.2%
Massachusetts	6,016	819	13.6%	14	33.5	6,349	860	13.5%	12	36.5	5.5%	5.0%
New Hampshire	1,109	125	11.3%	38	32.8	1,236	148	12.0%	36	37.1	11.4%	18.4%
Rhode Island	1,004	151	15.0%	4	33.9	1,048	152	14.5%	6	36.7	4.5%	1.2%
Vermont	563	66	11.8%	34	33.0	609	78	12.7%	26	37.7	8.2%	17.1%
New England	13,207	1,770	13.4%			13,923	1,892	13.6%			5.4%	6.9%
United States	**248,710**	**31,242**	**12.6%**		**32.9**	**281,422**	**34,992**	**12.4%**		**35.3**	**13.2%**	**12.0%**

Source: RIPEC Calculations based on U.S. Census Data

percent were 65 and older). The median age increased from 32.9 in 1990 to 35.3 in 2000. The Nation's age distribution continues to move towards the older age cohorts. In the 2000 Census, the baby-boom age cohort (born between 1946 and 1964) was age 36 to 54 and represented 28.0 percent of the Nation's population. The 50-54 year old age group experienced the largest percentage growth since 1990 – increasing by 55.0 percent.

In New England, total population increased by 5.4 percent – less than half the national rate. The growth in elderly populations over the decade (6.9 percent) represented faster growth than overall population in the New England states. In 2000, approximately 13.6 percent of the New England population is age 65 or older, representing a slight increase from a decade ago (13.4 percent). New Hampshire experienced the fastest growth in both total population and in those age 65 and above over the past decade. The median age ranged from 32.8 in New Hampshire to 34.4 in Connecticut in 1990. In 2000, the median age ranged from 36.5 in Massachusetts to 38.6 in Maine.

Among the New England States, Rhode Island had the highest concentration of elderly, with nearly 14.5 percent age 65 for more – ranking the State 6th highest in the Nation and the highest in New England. Rhode Island had 15.0 percent of its population considered elderly in 1990, ranking it 4th highest. It should be noted that both Maine and Vermont experienced significant change in their elderly populations as a percent of total populations. Maine's elderly population increased from 13.3 percent in 1990 to 14.4 percent in 2000, changing its ranking from 17th to 7th highest in the Nation in a decade. Vermont's elderly population as a percent of total population increased from 11.8 percent in 1990 to 12.7 percent in 2000, increasing its ranking from 34th to 26th highest in the Nation.

In Rhode Island, the State's population increased by 4.5 percent since 1990, and the age group 65 years and older increased by 1.2 percent. As noted above, the percentage of people age 65 and older declined slightly, from 15.0 percent in 1990 to 14.5 percent in 2000. The State's percentage went from 4th highest in the country to 6th highest during this period. Rhode Island's median age of 36.7 in 2000 represented the 7th highest in the Nation, and more than one year older than the national average. The U.S. Census projects that the total number of people in Rhode Island age 65 and older will remain essentially flat; while the State's total population is expected to grow at slightly less than 1.0 percent.

Elderly Incomes - Nationally, approximately 10.2 percent of the people age 65 and older are at or below the Federal poverty level. In New England, approximately 9.6 percent of the elderly population was at the Federal Poverty Level, with a low of 6.4 percent in Connecticut and a high of 13.1 percent in Maine. Rhode Island had 11.8 percent of its elderly population at the Federal poverty level in 2000, ranking second highest among the New England States.

If one looks at twice the Federal Poverty level, similar trends can be observed. Nationally, approximately 37.6 percent of the elderly population is at or below 200 percent of the Federal poverty level. Approximately 37.4 percent of the New England elderly population was at 200 percent or below the poverty level. However, New England states ranged from a low of 28.5 percent in Connecticut to 51.3 percent in Maine. Rhode Island had 38.7 percent of the elderly population at or below 200 percent of the Federal poverty level.

Table 2
People 65 Years and Below Various Poverty Thresholds

State	Total Population	65 and Older	Percent 65+	U.S. Rank	200% of Poverty Actual	200% of Poverty Percent	150% of Poverty Actual	150% of Poverty Percent	100% of Poverty Actual	100% of Poverty Percent
Connecticut	3,406	470	13.8%	10	134	28.5%	68	14.5%	30	6.4%
Maine	1,275	183	14.4%	7	94	51.3%	59	32.2%	24	13.1%
Massachusetts	6,349	860	13.5%	12	327	38.0%	198	23.0%	93	10.8%
New Hampshire	1,236	148	12.0%	36	59	39.9%	30	20.3%	11	7.4%
Rhode Island	1,048	152	14.5%	6	59	38.7%	40	26.2%	18	11.8%
Vermont	609	78	12.7%	26	35	45.2%	20	25.8%	6	7.7%
New England	13,923	1,892	13.6%		708	37.4%	415	21.9%	182	9.6%
United States	281,422	34,992	12.4%		13,159	37.6%	8,428	24.1%	3,576	10.2%

Note: Populations are expressed in thousands

Source: RIPEC Calculations based on U.S. Census Data

In Rhode Island, approximately 68 percent of the households who are 65 years old or more earn less than $35,000. This compares to approximately 42.0 percent of all households nationwide earning less than $35,000. The median income of households aged 65 or older is 45.0 percent less than all households nationwide regardless of age.

Elderly demographic changes contribute to a wide range of pressures on Rhode Island's health care system. In the SHAPE Report prepared by RAND for Blue Cross/Blue Shield, a number of issues related to projected population and demographic shifts were discussed[4]. The issue of demographic demands on hospital and related medical services was central to the findings and recommendations of the SHAPE Report.

For example, while the elderly represent approximately 14.5 percent of Rhode Island's population, they account for nearly 50.0 percent of all hospital days. Longer average lifetimes will lead to increased pressure on the supply of adult acute care hospital beds, and the SHAPE Study projects a need for an additional 1,600 long-term nursing facility beds in Rhode Island. These trends influence pharmaceutical use as well.

Prescription Drug Trends - Overall, health care spending in the United States as a percentage of gross domestic product (GDP) is projected to increase from 15.3 percent in 2003 to 18.4 percent in 2013[5]. While projections show a modest slowdown in overall health spending in 2003 and 2004, subsequent years are showing accelerated spending growth that exceed 7.0 percent annually. Therefore, health spending growth is projected to continue to outpace overall economic growth during this period.

Prescription drug expenditures have been and are projected to continue to be a major component of health care expenditure growth. These same projections note that the rate of growth in pharmaceuticals will also experience a slower rate of growth during the forecast period given that several top-selling drugs are scheduled to lose patent protection and there are continued efforts to increase consumer co-shares for pharmaceutical purchases. Annual pharmaceutical expenditure growth peaked in 1999 at 19.7 percent. Growth is projected to slow to 12.4 percent in 2005. Pharmaceutical expenditure growth rates will continue to exceed 10.0 percent through the forecast period. In 2003, expenditures for prescription drugs in the U.S.

represented 11.0 percent of all personal health care expenditures in the Nation. This is expected to increase to 15.5 percent by 2013.

Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) - Medicare is a health care program for people age 65 and older and those with certain disabilities. Recently, the Federal Government took several actions that will impact many aspects of Medicare, as well as providing new prescription drug benefits that may impact many of those currently enrolled in RIPAE. The prescription drug initiatives are discussed below.

The new legislation introduces Medicare-approved drug discount cards that will be available in the late spring of 2004. The discount card initiative is an eighteen month transitional program until the Federal government implements a permanent Medicare prescription drug benefit in 2006 (discussed below). The discount card is designed to help eligible participants (non-Medicaid eligible) to save up to 25.0 percent on prescription drugs. According to a recent study[6], discount cards are projected to provide an average savings of 17.4 percent over current retail prices. Given the lower costs of generic drugs, the savings are projected to exceed 40.0 percent, but savings for brand name pharmaceuticals are projected at 14.0 percent. However, since brand name drugs represent over 88.0 percent of total pharmaceutical out-of-pocket spending, the net savings to participants is projected to be approximately 17.4 percent for all prescription drug purchases.

It should be noted that the MMA provides that single people with incomes of no more than $12,670 and married couples with income of no more than $16,860 may qualify for up to $600 in additional resources to use in conjunction with the discount cards to help pay for prescriptions. The discount card and income assisted subsidy are designed to terminate when the full Medicare drug coverage program begins in 2006.

The MMA establishes a permanent prescription drug benefit program starting in 2006. The program will permit those who are Medicare eligible to enroll in the prescription drug plan. While each plan will differ slightly, on average those who participate in the program will have a projected monthly premium of $35.00, and they will be required to pay the first $250.00 of prescription costs (deductible). Medicare will then pay 75.0 percent of the prescription costs between $250.00 and $2,250. The participant will pay the difference. The Medicare participant will pay 100 percent of the costs above $2,250 until the annual cost exceeds $3,600, where the Medicare program will pay 95.0 percent of the costs exceeding $3,600. Those who meet certain income guidelines will not have to pay the premiums or deductibles.

Rhode Island Pharmaceutical Assistance Program for the Elderly (RIPAE) - The RIPAE program, administered by the Department of Elderly Affairs, began in 1985 as a pilot program, providing a 60.0 percent subsidy on limited drugs for those who were 65 years of age and had income of no more than $9,000 (individual) or $12,000 (couple) in annual income. In FY 1988, the program became permanent and the scope of eligible drugs under the program and the eligibility requirements have been expanded since its inception. Chapter 42-66-2 of the Rhode Island General Laws outlines eligibility for the program as well as the types of drugs deemed eligible for subsidy from the State.

Eligibility - There are two aspects of eligibility for the program as it currently exists. First, one must reach the age of 65 prior to being able to take advantage of the program.

Table 3
Pharmaceutical Assistance to the Elderly Program

New Income Eligibility Threshold - Effective July 1, 2003			
Single	$17,155 or less	$17,156 - $21,535	$21,536 - $37,687
Married	$21,445 or less	$21,446 - $26,919	$26,920 - $43,070
State-Consumer Share of Prescriptions			
State Share	60.0%	30.0%	15.0%
Consumer Share	40.0%	70.0%	85.0%

Source: RI General Laws (42-66.2-5)

Second, one must meet certain income thresholds to be eligible for assistance. The thresholds are adjusted annually according to the Social Security cost of living adjustment. Income is defined as the sum of Federal adjusted gross income and all nontaxable income, such as transfer payments, pension or annuity and alimony.

The General Assembly recently expanded the eligibility guidelines for participation in the program. For FY 2001 and thereafter, the General Assembly created two additional income classes of eligibility, albeit with a lower State share for prescriptions. Individuals with other drug coverage must exhaust benefits prior to eligibility for the RIPAE program.

In FY 2002, the State added catastrophic coverage to the lowest income class of the program – providing 100 percent of the costs for drugs after the total co-payment has reached $1,500 in a single year. The program permits people between 55-65 and collecting social security disability insurance to take advantage of the State's discounted rates and provide a 15.0 percent co-pay on eligible drugs.

As of July 1, 2003, assistance for those elderly that are married is available for net incomes of less than $43,070. For single elderly, the maximum net income is $37,687. The program is designed so that the greater the income within these parameters, the greater the participant's share of the cost. For example, as Table 3 shows, the State's share ranges from 60.0 percent for an unmarried participant whose income is less than $17,155 to 15.0 percent for that individual with income between $21,536 and $37,687.

In February 2004, the Federal Department of Health and Human Services updated the poverty guidelines. Poverty levels depend on the number of individuals in the family unit. Because several State programs use this as a baseline for determining eligibility, RIPEC included the calculations for different thresholds. This also permits one to compare the income thresholds for RIPAE to Federal poverty guidelines. As one can see, the RIPAE income thresholds exceed Federal poverty levels. For a single person over 65, there is a benefit in Rhode Island for incomes up to 405 percent (maximum of $37,687 annual income) of the FPL. For a married couple, there is a benefit for those with incomes of up to 345 percent (maximum income of $43,070) of the FPL.

Table 4
2004 Federal Poverty Guidelines

Size of Family Unit	Poverty Threshold	150% of Poverty	200% of Poverty
1	$9,310	$13,965	$18,620
2	12,490	18,735	24,980
3	15,670	23,505	31,340
4	18,850	28,275	37,700
5	22,030	33,045	44,060
6	25,210	37,815	50,420
7	28,390	42,585	56,780
8	31,570	47,355	63,140
Each additional	$3,180	$4,770	$6,360

Note: Does not include AK and HI - they have unique poverty thresholds

Source: Federal Regiser, Vol 69, No 30, February 13, 2004 pp 7336-7338

Drug Coverage – RIPAE covers a range of pharmaceuticals, such as drugs to treat Alzheimer's disease, diabetes, heart problems, cholesterol, and asthma. Additional categories of eligible drugs and related materials include cardiac drugs, disposable insulin syringes, glaucoma and drugs designed to treat chronic respiratory diseases. The 2002 General Assembly expanded the program to permit participants to purchase non-formulary drugs at the program's discounted rates. The State now permits participants to purchase non-eligible pharmaceuticals at State discounted rates (no additional cost to the State).

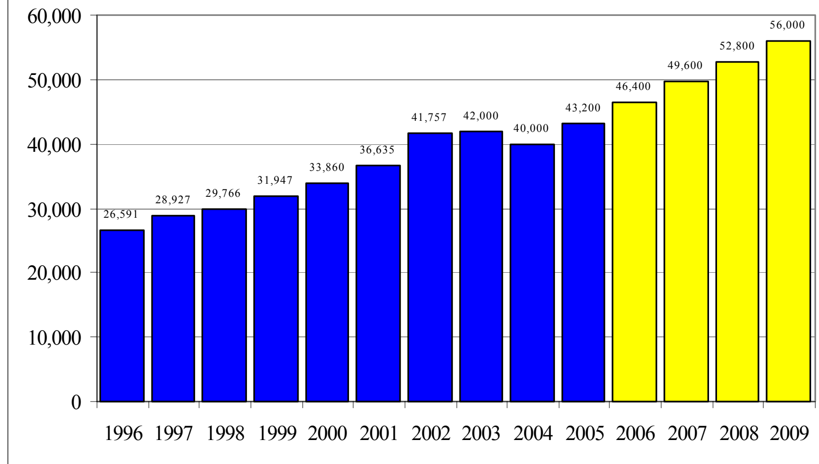
Manufacturer Rebate Program – Federal regulations require drug companies to offer rebates on all drugs covered through the Federal Medical Assistance Program (Medicaid). The Pharmaceutical Manufacturers Rebate Program, while not part of Medicaid, is modeled after the Medicaid regulations. Rhode Island requires drug manufacturers to provide rebate agreements to participate in RIPAE. The Department of Elderly Affairs submits quarterly invoices and in turn the State receives rebates from the manufacturer based the Medicaid Program.

On average, the State's rebate is approximately 15.0 percent of the average manufacturer price. The manufacturer is required to calculate the rebate based on 100 percent of the drug costs even though the State only incurs no more than 60.0 percent of the cost of the drug. In FY 2005, rebates are projected to total $4.7 million, which are deposited into the State's general fund. The rebates offset the total cost of the RIPAE program.

RIPAE Caseloads - In 1996, 26,591 people were eligible for the RIPAE program. This has since increased to an estimated 43,200 in 2005. This represents a 62.5 percent increase during this period. As noted above, in FY 2001, eligibility for the program was expanded, thus the State's caseload increased in more recent years. The Department of Elderly affairs recently reconciled its enrollment records with Vital Statistics of the State Department of Health. This permitted the administration to eliminate "non-actives" and deceased. This has re-based the overall enrollment of the program, as reflected in the enrollment graph below.

RIPAE has experienced an annual gross increase in enrollment of 5,200 participants, but has had enrollment decreases of approximately 1,750 each year primarily due to deaths. Therefore, the program experiences a net increase in annual enrollment of nearly 3,500 persons. This translates to a net gain of nearly 68 persons per week. The Department of Elderly Affairs projects a slowing of enrollments over the next five years due to lower birth rates for "War-year" babies –born from 1940 – 1945. However, the Department expects enrollments to begin increasing when the Baby Boomer generations move into eligibility age by 2010.

Table 5
Projected RIPAE Enrollment



RIPAE Budget Impact - The General Assembly recently expanded the prescription drugs covered under RIPAE to include anti-infective and arthritis-related drugs. As noted above, the Legislature also expanded the eligibility guidelines for participation in the program. This expansion of services and eligible Rhode Islanders, combined with continued growth in pharmaceutical costs, has resulted in continued growth in the expenditures for the program.

Total RIPAE expenditures increased from $6.8 million in FY 1996 to $15.0 million in FY 2005 (assuming the Governor's projected savings discussed below are realized), representing an $8.2 million increase. This translates into a 121.0 percent increase during this period. If one adjusts the expenditure data by inflation (2005 dollars), expenditures doubled over this period of time. The Governor's FY 2006 – FY 2009 budget forecast expects the program's cost to continue to grow at a rate of approximately 12.5 percent annually, increasing to $27.3 million by FY 2009. The forecast does not include any assumptions on the number of RIPAE participants that can be shifted to the Federal MMA program which begins in 2006.

The FY 2004 revised budget request includes an additional $1.0 million for the RIPAE program. The FY 2004 revised budget of $15.4 million represents a $2.0 million (15.1 percent) increase over FY 2003 experience. The Governor has requested $15.0 million in FY 2005, which would represent a 3.0 percent decline from FY 2004 revised spending.

The FY 2005 budget includes projected general revenue savings of $2.5 million through moving eligible participants to the Federal discount card program and permitting participants to use mail order to fill prescription needs. If these program initiatives were not available to the State in FY 2005, the program would have required $16.9 million in funding. In other words, the projected savings represent nearly 15.0 percent of the total costs of the program in FY 2005.

The Department of Elderly Affairs estimates that approximately 15,000 of the 40,000 RIPAE participants are likely eligible for the Federal discount card program, of which it projects nearly 7,500 would actually participate. The Department estimates this will save the State nearly $2.1 in FY 2005 in

Table 6
Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE)
(Millions)

Fiscal Year	Direct Drug Expenditures	Consultant Processing	Agency Admin	Total Expenditures	Percent Change	Percent Direct Benefit
1996	$6.2	$0.3	$0.3	$6.8		91.3%
1997	7.1	0.2	0.3	7.6	10.9%	93.4%
1998	7.1	0.2	0.2	7.5	-0.2%	94.3%
1999	5.9	0.1	0.2	6.3	-16.6%	94.1%
2000	6.9	0.2	0.2	7.3	15.5%	95.3%
2001	9.4	0.3	0.3	9.9	37.0%	94.6%
2002	11.5	0.4	0.2	12.1	22.0%	94.8%
2003	12.9	0.5	0.1	13.4	10.5%	95.8%
2004	14.8	0.4	0.2	15.4	15.1%	95.9%
2005	14.3	0.4	0.2	15.0	-2.8%	95.6%

Source: RIPEC calculations based on Budget Office Information

State funding for RIPAE services given client access to Medicare prescription drug discount cards. The implementation of the MMA would increase the Federal benefit, which in turn should translate into additional savings to the State. However, it should be noted that it is anticipated that the Federal program beginning in 2006 will have higher income and personal asset thresholds, perhaps limiting the number of Rhode Islanders that can participate in the Federal program.

As noted above, the Governor has also proposed to permit RIPAE participants to voluntarily participate in mail order programs to fill their prescription needs. Current law does not permit such flexibility, but in doing so the State would experience a net savings of nearly $400,000, which is built into the Governor's FY 2005 budget request.

Generally, the amount of the RIPAE budget allocated for direct benefits represents 95.6 percent of the total RIPAE budget – up from 91.3 percent in FY 1996. Administrative costs to support RIPAE have declined from 3.0 percent in FY 1996 to 1.5 percent in FY 2005. The State allocates similar percentages for private contracts with Blue Cross/Blue Shield for processing claims and program assistance.

RIPEC Comments - State programs providing direct assistance to Rhode Islanders continues to be the fastest growing component of the State budget. Assuming the Governor's budget were adopted, expenditures supporting grants and benefits would represent 47.0 percent of the total growth in expenditures since FY 1996.

There are several factors driving the level of expenditures for grants and benefits to individuals. Most recognize economic forces as well as socio-economic and demographic trends (i.e. income levels and age cohorts) play critical roles in the expenditure responsibilities of the State. In addition, policymakers constantly adjust, refine and expand programs based on policy shifts.

While the RIPAE program is relatively small compared to other grant and benefit programs (such as Medicaid), it represents a program that has evolved over time, influenced by socio-economic forces, Federal actions and State policy decisions. It provides an excellent case study to understand how these and other forces impact the direction and expense of programs established to provide direct assistance to selected populations.

There are several factors driving RIPAE that are important to keep in mind. The State expanded RIPAE by including additional classes of medication and by expanding the eligibility requirements. Pharmaceutical usage is increasing, the costs of the products continue to increase, people are living longer, and managed care programs are increasing member costs for pharmaceuticals. The baby-boomer generation is fast approaching the age where they will be eligible for this program. Once eligible, many of these individuals may take advantage of this program.

According to PriceWaterhouseCoopers (PwC), health care costs increased by 13.7 percent (67.0 billion) from 2001 to 2002.[7] Premium expenditure growth due to drug, medical devices and other medical advances represented nearly 22.0 percent of the net growth in health care premiums during this period. In other words, of the $67.0 billion increase in health care premiums from 2001 to 2002, nearly $15.0 billion was driven by drug and medical advances.

In addition, the PwC findings noted that nearly 15.0 percent of the growth in health care spending was attributable to increasing consumer demand. It is estimated that increasing demand will continue to add about 2.0 percent annually to healthcare costs. This is driven by the increasing demands of the Baby-boomer generation for quality health care, new technologies and state-of-the-art pharmaceuticals.

In addition, Americans are paying an increasing amount of their out-of-pocket medical costs for prescription drugs. In FY 2005, nearly 26.0 percent of the average out of pocket medical expense was for prescription drugs. This is projected to increase to 32.5 percent by 2013.[8]

Given the increasing demand medical costs are having on the overall economy and the out-of-pocket medical expenses for average Americans, there is a need for continued vigilance regarding proposals to contain costs as well as those to expand program services or eligibility.

The recent Heinz Family Philanthopies report discussed earlier in this analysis outlined a series of recommendations related to controlling pharmaceutical costs in Rhode Island. The recommendations were designed to impact the various State agencies and programs that are involved in providing pharmaceutical to Rhode Islanders. State policymakers should consider the potential savings to taxpayers through several of these actions.

The Heinz Report recommends pursuing a number of changes to the State employee health care programs, which would require efforts through collective bargaining. These changes include modifying the cost-sharing formulas for generic and retail brands of pharmaceuticals, reducing the maximum initial supply of a medication from 60 days to 31 days, and considering an individual $100 deductible before drug benefits take effect. These and other changes to health care programs for State employees could generate well over $10.0 million in savings to the State.

In addition, the Heinz Report recommended implementing a preferred drug list (PDL), which has the potential for generating annual general revenue savings to the State of nearly $10.0 million. Should several State agencies coordinate their PDL among each other, there is potential for additional savings.

The Heinz Report also recommends a series of changes to re-align reimbursement dispensing fees, pharmacy discounts and coordinated procurement of pharmaceuticals. The Report also noted there are opportunities through direct contracting with pharmaceutical manufacturers and through pharmacy benefit administrators to generate additional savings to the State.

The Heinz Report outlines a number of initiatives that may prove useful to the State in controlling pharmaceutical costs in the near future. However, this will require considerable coordination on the part of all the human services agencies as well as the Department of Administration. RIPEC believes the new Office of Health and Human Services led by the Managing Director offers a unique opportunity to implement many of these changes so that the State can generate the savings from a more coordinated human services function.

Direct contracting, particularly when it comes to pharmaceutical rebate agreements, may be an area where the Department of Elderly Affairs can reduce future administrative costs of the RIPAE program. In addition, efforts need to continue to pursue qualifying current RIPAE participants for new Federal programs in order to alleviate some of the financial pressure on the State's general revenue budget. As the Federal program gains momentum, the Department of Elderly Affairs needs to enhance communication and enrollment efforts for moving people to Federal programs should they be eligible.

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[1] Stephen Heffler, et al., "Health Spending Projections through 2013" *Health Affairs* February 2004.
[2] The Henry Kaiser Family Foundations, "Prescription Drug Trends – A Chart Book Update", November 2001.
[3] The Heinz Family Philanthropies, "Coordinated Contracting of Prescription Drugs: A Fiscal and Policy Strategy for the State of Rhode Island – The Rhode Island Blueprint", February 2004.
[4] RAND, "SHAPE: Statewide Health Assessment Planning and Evaluation Study", November 2002.
[5] Stephen Heffler, et al., "Health Spending Projections through 2013" *Health Affairs* February 2004.
[6] Juliette Cubanski et al., "Savings From Drug Discount Cards: Relief for Medicaid Beneficiaries", *Health Affairs*, April 2004
[7] PricewaterhouseCoopers, "The Factors Fueling Rising Health Care Costs", April 2002.
[8] Stephen Heffler, et al, "Health Spending Projections through 2013" *Health Affairs* February 2004.