Illinois SeniorCare Program Description

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Executive Summary

Illinois SeniorCare is a five-year demonstration project funded through a Medicaid 1115 demonstration, and the first state pharmacy assistance program started through the Centers for Medicare & Medicaid Services (CMS) Pharmacy Plus program. Illinois SeniorCare provides outpatient prescription drug assistance to low-income seniors in the state of Illinois who are not enrolled in Medicaid. As part of the Medicaid expansion 1115 demonstration agreement terms and conditions for funding the Illinois SeniorCare program, the state of Illinois agreed to budget neutrality (to spend no more in Medicaid services expenditures for enrollees age 65 and older than it would have without SeniorCare), by the end of five years.

Illinois SeniorCare began operation on June 1, 2002, and as of December 2, 2003, it covers 172,333 seniors.[1] As part of a CMS mandated evaluation of the Illinois SeniorCare demonstration, which will examine SeniorCare costs, access, and its impact on Medicaid and Medicare expenditures, Brandeis researchers conducted site visits to Springfield in January 2003, and followed up with phone interviews and background documentation in order to prepare a description of the program. The aim of this paper is to summarize our understanding of the program and its features, its history and its first year of implementation, and identify challenges and key issues for the broader evaluation. Thus, this is a background document with more analytical reports to follow.

Illinois SeniorCare is run by the Illinois Department of Public Aid (DPA) Medical Programs Division in conjunction with the Illinois Department of Revenue (IDR). It covers individuals age 65+ whose incomes are at or below 200 percent of the federal poverty level

(FPL), are U.S. citizens or eligible noncitizens, and are not enrolled in Medicaid. IDR conducts all intake and enrollment related activities for SeniorCare, and DPA oversees all program activities. In the first year of SeniorCare operations, an outside entity was involved, Express-Scripts Inc. (ESI), a pharmacy benefit manager (PBM) that administered the SeniorCare benefit and processed claims. The contract with ESI ended on June 30, 2003 and was not renewed. Claims processing and drug management activities are now being conducted for Illinois SeniorCare through the Illinois Medicaid program.

Illinois SeniorCare is an expansion of an earlier program, Circuit Breaker (CB) Prescription Assistance Program (PAP). Circuit Breaker is an IDR program started in 1979 in Illinois (as well as many other states) to provide property tax relief for low-income seniors. In 1985, a prescription assistance program was added to Illinois Circuit Breaker, which gradually grew in size and scope, providing prescription drug coverage for designated chronic diseases. SeniorCare represents an expansion of benefits beyond PAP; its coverage is not limited to certain chronic diseases; it covers all medications in the Medicaid formulary including some over the counter (OTC) drugs.

When the SeniorCare demonstration program began operation, all members of CB-PAP who were age 65 or older with incomes up to 200 FPL and below (and not enrolled in Medicaid) were rolled over into the SeniorCare program, and now CB-PAP (a state-only financed program) only covers those individuals who are aged or disabled under age 65, at specified dollar income levels between 200 percent and approximately 250 percent FPL (approximately 50,000 members). Individuals must re-enroll in SeniorCare or Circuit Breaker each year.

[1] This includes 166,040 individuals receiving SeniorCare drug benefits, and 6,293 taking a $25 per month rebate if

As of the first "year" of operation (June 1, 2002-June 30, 2003[1]), Illinois Senior Care implementation has followed the design laid out in the operational protocol that Illinois Department of Public Aid submitted to CMS as part of its demonstration. As of the end of the first full fiscal year of the program (through June 30, 2003), 174,250 individuals enrolled, including: 121,000 "roll over members" from Circuit Breaker PAP,[2] 47,782 new enrollees, and 5,468 taking the rebate. SeniorCare program expenditures for the full fiscal year of operation (July 1, 2002 through June 30, 2003) were $215 million total as of June 30, 2003 (not including an additional savings of approximately 21% in price rebates from drug manufacturers). Costs of the first year of Illinois SeniorCare are close to initial state demonstration projections for the first year of the program of $193 million (excluding rebate savings), which were based on estimates calculated early in the demonstration approval process for an initial 12-month period.[3]

Illinois SeniorCare has succeeded in providing outpatient prescription drug benefits to a large number of the state's low-income seniors, within the cost originally anticipated. Several issues emerged, however, during the first year of operation, and some significant changes have been made to the program in its first year. These issues either have been resolved, or are now being addressed, and will be the focus of further analysis during this evaluation. They include: initial problems with customer assistance in enrollment related to communication problems with the public and the dual involvement of IDR and DPA; program shift from use of PBM services

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they are eligible for SeniorCare and do not take the insurance.

[1] Even though SeniorCare became operational on June 1, 2002, the first program year was adjusted to end on June 30, 2003, so that the SeniorCare program year will correspond with the Illinois state fiscal year (SFY) (July 1- June 30). The remainder of this report and all tables refer to statistics as they are reported by the state (usually from July 1, 2002 through June 30, 2003); exact time periods are noted along with statistics in each table and text.

[2] Some members of Circuit Breaker PAP who were "rolled over" into SeniorCare had joined PAP in the months prior to implementation of SeniorCare, expressly in anticipation of becoming SeniorCare members.

[3] See full estimate calculations at www.cms.hhs.gov//medicaid/1115/ilrxbudgetnew.pdf.

to internal management of the benefit through the Medicaid program after the first year of operation; and lower-than-expected re-enrollment by initial SeniorCare members, which necessitated extension of their June 2003 reenrollment deadline by three months, and warranted increased outreach efforts. By October 2003, all but 2600 of the individuals who were granted extensions and still eligible for SeniorCare (and still using the benefits) had re-enrolled in the program. The Medicare Prescription Drug Improvement and Modernization Act enacted in December 2003 is designed to provide prescription drug coverage for a portion of seniors covered through Illinois SeniorCare. At present, the Illinois DPA is reviewing the impact this will have on the program.

Introduction

This report, describing the Illinois SeniorCare demonstration program's development and its first year of implementation, is part of a Centers for Medicare & Medicaid Services (CMS)-sponsored multi-year evaluation of Illinois SeniorCare. The overall evaluation of the Illinois SeniorCare program, conducted by a team from Brandeis University, is charged with examining several aspects of the program, including its design, implementation, cost and utilization patterns, impact on low-income seniors in Illinois, and impact on the state Medicaid budget and Medicare costs for enrollees.

In order to prepare a description of the Illinois SeniorCare program in its first year, Brandeis researchers conducted a site visit to Springfield on January 16-17, 2003. During the site visit, we interviewed SeniorCare officials and representatives of other state and external agencies that have been affiliated with SeniorCare, and obtained consumer perspectives on the program and its implementation. These interviews were followed up with additional series of phone interviews and review of background documentation. The purpose of this paper is to summarize our understanding of the Illinois SeniorCare demonstration program, its history, its design, and its first year of implementation, and to identify challenges and key issues for the evaluation.

Background: Origin of Illinois SeniorCare

The Circuit Breaker Pharmacy Assistance Program (CB-PAP)

Prior to SeniorCare's implementation, Illinois had a state pharmacy assistance program in place connected to its Circuit Breaker tax relief program. The main purpose of the Circuit Breaker program has been to provide relief to low income seniors and the disabled from the burden of property taxes and rent.[1] Eligibility for Circuit Breaker is based on income and property taxes or rent, and is administered by the Illinois Department of Revenue (IDR). Income levels for eligibility for Circuit Breaker and its associated programs are dollar amounts set by statute; the income limit for the program was $21,218 for a single individual in SFY 2003, approximately 250 percent of the federal poverty level (FPL).

Although Circuit Breaker Property Tax Assistance began in 1979 as a tax and rent relief program, in 1985 it added the Pharmaceutical Assistance Program (PAP) as a result of consultation with pharmacists and the Department of Public Health regarding the most common and burdensome diseases in terms of outpatient medication needs. The General Assembly of Illinois sets both the income threshold and covered diseases eligible under CB-PAP. Initially in 1985, PAP covered only medications for cardiovascular disease. As Table 1 shows, the legislature added more chronic illnesses to the covered list over time and expanded eligibility, with a major increase in the number of drugs covered occurring in 2001.

[1] Circuit Breaker tax relief programs were started in many states in the 1970's to address the needs of low-income residents. There are now 35 states with Circuit Breaker programs. Circuit Breaker sets an upper limit on the percent of income that a residential homeowner is required to pay in taxes on an owner-occupied residence, and in some cases (Illinois included) provides rent relief for low-income residents who do not own property.

Table 1: Timeline of Illinois Circuit Breaker Pharmacy Assistance Program growth[1]

Years	Change
1979	Illinois Circuit Breaker program for tax relief for low income seniors initiated: Income limit for singles = $10,000
1985	Pharmacy Assistance Program (PAP) added to Circuit Breaker, covering cardiovascular medications only
1987	PAP expanded to cover arthritis and diabetes
1992-1993	Modifications to benefit: Cap of $800 for prescription drugs added, then changed to percent coverage after $800, and deductible of $25 per month. Single benefit changed to several levels based on income. Copayment up to $10, and annual fee up to $80.
1998	Income limit for single = $16,000 (gradually increased each year)
2000	Income limit for single raised to $21,218 (near 250% FPL), several levels of eligibility defined
2001	Major eligibility and coverage changes: Added Alzheimer's disease, cancer, glaucoma, lung disease, smoking related illnesses, Parkinson's disease, osteoporosis. Annual fee decreased, copayments reduced, and cap increased to $2000. Brand drugs with equivalent generics are covered if physician writes "Dispense as Written." Eligibility now based on projected income.

Diseases included for pharmacy coverage in CB-PAP represent several chronic conditions with the most prominent medication utilization. However, mental illness is not a covered disease in CB-PAP. Neither is ulcer disease, a very common condition treated with some of the most expensive outpatient medications. Outpatient drugs commonly used by seniors for episodes of acute illness are also not covered, regardless of expense, but selected over the counter drugs for covered diseases are. Since the program began, the Illinois General Assembly has also raised the dollar income threshold several times (eligibility is not automatically adjusted for inflation or for changes in FPL). The PAP pharmacy benefit has developed independently of the Medicaid pharmacy benefit (with a separate formulary and somewhat different pharmacy

[1] Source: Illinois Department of Revenue, Circuit Breaker Tax Relief and Pharmaceutical Assistance Programs, 2002 Annual Report.

network), and the IDR has utilized a third party claims processor for CB-PAP (Express Scripts, Inc., a major national PBM) since inception of the program.

IDR has seen a big increase in requests for pharmacy assistance through the Circuit Breaker program in just the past few years. According to program officials, the proportion of Circuit Breaker applicants who also seek prescription assistance (by checking off a box in the Circuit Breaker application) grew from 17 percent in 1999 to 48 percent in 2001. Increasing enrollment, increasing numbers of drugs consumed as the range of covered diseases was increased, and increasing prices for prescription drugs have combined to lead to burgeoning cost of the program. In 1997 Circuit Breaker Pharmacy Assistance covered drugs cost $31.6 million with 52,000 enrollees, and by 2002, after major expansions in 2001 (and prior to implementation of SeniorCare), CB-PAP cost $140 million, with nearly 200,000 enrollees.[1]

Goals and Development of the Senior Care Demonstration Application

Circuit Breaker PAP is a state-funded program, with limited coverage, and no Federal matching funds. According to SeniorCare program managers, state officials reasoned that there was little hope of improvement in the budget outlook for this program, because the population base of relatively sick elders was likely to grow with the aging of the general population, the formulary would likely continue to expand, and the cost of pharmaceuticals was sure to increase. The potential for a Federal match through a demonstration program provided an opportunity to find a financing partner while expanding coverage to include a broader array of important pharmaceuticals. Senior members of the Division of Medical Programs developed the idea of

applying for a Medicaid 1115 demonstration in discussions with the state budget office as Circuit Breaker-PAP was becoming increasingly costly.

The initial conceptualization, budget neutrality projections, and data analyses were conducted by the DPA Division of Medical Programs (DMP). The goal of the demonstration approach and basis for budget neutrality projections was to improve health outcomes and to allow individuals remain in the community and be diverted from institutional care and Medicaid. Goals of the SeniorCare program, as stated in the initial 1115 demonstration application submitted by Illinois were as follows:[2]

- To help preserve health of the senior population by providing financial assistance for costly but essential drugs, thereby providing a more comprehensive primary care benefit
- Improve the quality of life of Illinois' seniors, thereby allowing them to remain in less costly home settings and avoid expensive acute or long-term care services resulting from a lack of access to necessary drugs
- Reduce the speed at which seniors "spend down" and become entitled to all benefits available through the Medicaid program
- Reduce Medicaid expenditures for the dual-eligible population
- Save the Federal government money by improving the health of seniors, resulting in savings to the Medicare program.

[1] Source: Illinois Department of Revenue, Circuit Breaker Tax Relief and Pharmaceutical Assistance Programs, 2002 Annual Report.
[2] See CMS website, (http://ww.cms.gov/medicaid/1115/ilrxap.pdf).

In initial development of the demonstration application, DPA officials projected that the benefit would cost about $1,500 per person per year, net of patient cost sharing and rebates. In Illinois, institutional care costs $32,000 to $33,000 per year. The annual cost of prescription drug coverage is only about five percent of the annual cost of institutional care. Thus, this relationship meant that if SeniorCare could divert even a few near-poor elders from entering a nursing home, it would save considerable money for Medicaid.

DMP began discussing the SeniorCare demonstration in early 2001, and had considerable support on both policy and financial grounds. AARP, as an example, was a strong supporter of the demonstration, as were state legislators.

The demonstration application was submitted in July 2001 and approved in January 2002. Illinois originally requested an eligibility level for the SeniorCare demonstration of up to 250 percent of FPL but CMS approved an eligibility level at or below 200 percent FPL. The approval of a lower eligibility criterion factors in several ways. First, as income levels grow, it is presumed that seniors are more likely to have their own resources, are better able to afford private prescription drug coverage. Second, individuals at a higher income are less likely to enter Medicaid, and the budget neutrality cost model is built upon the premise the demonstration enrollees would have become Medicaid eligible. Other demonstration projects in CMS are approved at this ceiling for a similar reason. Third, a lower eligibility level reduces the cost of the program to CMS. Illinois DPA still believes that it would be cost effective to Medicaid to provide coverage to individuals at higher income levels, and has a pending request to CMS with supporting data to expand eligibility of SeniorCare to 250 percent FPL.

The demonstration as approved was designed to require "maintenance of effort" – the state would still pay as much for prescription drugs for seniors as it had before. This level was easily maintained, because the state was responsible not only for fifty percent of the cost of an expanded drug list for the eligible seniors, but also for the full cost of CB-PAP, which still covered the disabled and individuals age 65 and older between 200 percent and approximately 250 percent FPL.

Expansion of Benefits: from Circuit Breaker Prescription Assistance to Illinois SeniorCare

The Circuit Breaker Program is still in effect for disabled non-elderly up to 250 percent FPL, and for seniors between 200 percent and 250 percent FPL. Table 2 lists differences in program features between CB-PAP and Illinois SeniorCare, as of September 2003. The major expansion of Illinois SeniorCare over CB-PAP is its coverage of all outpatient prescription drugs, not just those for specified conditions as in CB-PAP.

Table 2: Summary of differences in major features between Circuit Breaker Pharmacy Assistance Program and Illinois SeniorCare[1]

Features	Circuit Breaker Pharmacy Assistance Program (CB-PAP)	Illinois SeniorCare
Eligibility	Disabled up to 250% FPL, Aged between 200-250% FPL. Do not have to be citizen, must be resident	Aged at or below 200% FPL and not eligible for Medicaid pharmacy benefits Must be resident and citizen or qualified equivalent
Members (as of 9/30/2003)	50,000	185,000
Program management	Illinois Department of Revenue	Illinois Department of Revenue and Illinois Department of Public Aid
Formulary – diseases covered	Alzheimer's Disease, Arthritis, Cancer, Cardiovascular, Diabetes, Glaucoma, lung disease and smoking related illness, Osteoporosis, Parkinson's Disease (not restricted to Medicaid rebatable drugs)	All diseases/ Medicaid formulary/specified OTC drugs
Enrollment fee	$5 or $25 (income based)	None
Benefits – member cost sharing	$3 for all prescriptions (waived for income <100% FPL)	$1 for generic, $4 for brand (waived for income <100% FPL)
Maximum annual benefit	$2000 drug expenditures "soft cap" after which copay[2] + 20% coinsurance	$1750 drug expenditures "soft cap" after which copay[1] + 20% coinsurance
Claims administration	Pharmacy Benefits Manager (ESI)	Illinois Medicaid
Incentive to keep private insurance	None	$25 monthly rebate if eligible but do not join
Estimated annual program costs for state fiscal year (through June 30, 2003)	$65 million (not net rebates)[3] $64.4 million estimated including rebates	$215 million (not net manufacturer rebates).[4] For first full fiscal year of program through 6/30/03. Approximately $178 million estimated by program including effect of manufacturer drug rebates.

[1] Source: Illinois Department of Revenue, Circuit Breaker Tax Relief Program and Pharmaceutical Assistance Program 2002 Annual Report, and interviews with DPA officials.
[2] Copayment waived for low-income individuals, but 20% coinsurance still required.
[3] Circuit Breaker PAP manufacturer rebates are approximately one percent overall.
[4] SeniorCare manufacturer rebates are approximately 21 percent overall.

Design of the Illinois SeniorCare Program

Illinois SeniorCare Eligibility

Table 3 details the current eligibility requirements for Illinois SeniorCare, with Illinois Circuit Breaker Prescription Assistance program and Illinois Medicaid program as comparisons:

Table 3: Detailed eligibility criteria for Illinois Medicaid, Illinois Circuit Breaker Pharmacy Assistance, and Illinois SeniorCare[1]

	Illinois Medicaid program	**CB-PAP**	**Illinois SeniorCare**
Age 65+	Yes	Yes	Yes
Disabled under age 65	Yes	Yes	No
Percent FPL eligibility	0-100% FPL	At or below approximately 250% FPL	At or below 200% FPL
Income level eligibility (2003)	Up to $8980 single, $12,120 married	Up to $21,218 single/ $28,480 married	Up to $17,960 single/ $24,240 married
Asset test	Yes ($2000 for an individual)	No	No
Illinois resident	Yes	Yes	Yes
U.S. citizen	Citizen or qualified resident	Citizen or qualified resident	Citizen or qualified resident

To summarize the differences in eligibility between Illinois SeniorCare and Circuit Breaker Prescription Assistance Program, SeniorCare covers seniors age 65+ with incomes at or below 200 percent FPL and not eligible for Medicaid, due to income above 100% FPL or income below 100% FPL but with assets above the Medicaid threshold. Illinois SeniorCare does not cover the disabled under age 65. In contrast, CB-PAP covers seniors age 65+ between approximately 200 and 250 percent FPL, and the disabled under age 65 with income up to 250 percent FPL. The application form is the same for both programs, and when submitted, IDR

[1] Source: Illinois Department of Revenue, Circuit Breaker Tax Relief Program and Pharmaceutical Assistance Program 2002 Annual Report, and interviews with DPA officials.

assigns the individual to the appropriate program. The application does not require information about assets, nor does it evaluate Medicaid eligibility. If an individual appears likely to be Medicaid eligible, the individual will be referred to Medicaid.

SeniorCare Program Administration

As noted, Illinois SeniorCare is a joint program of the Illinois Department of Public Aid Division of Medical Programs and the Illinois Department of Revenue. IDR conducts all intake and enrollment related activities for SeniorCare, and DPA oversees all program activities. Policy makers named several reasons for using the Illinois Department of Revenue for the SeniorCare demonstration program rather than designing a new enrollment process within DPA:

- Because CB-PAP enrollment was determined through the Department of Revenue, it was logical that the responsibility for enrollment in the associated Pharmacy Assistance Program was also the responsibility of IDR.
- A single application for both property tax relief and pharmacy assistance would make the process simpler for poor elders.
- A DPA process would have required development of a separate unit with DPA
- A DPA application process would have required clients to apply to the local human services office, and the application for Senior Care would have been embedded within a cumbersome and complex welfare intake system encompassing many programs; officials wanted to have Senior Care viewed as separate from Medicaid, and did not want seniors to have to visit welfare office to enroll.
- The IDR already has established procedures and data sources for verification of income and citizenship.

Within the DPA, several divisions that support Illinois Medicaid are also involved in SeniorCare operations, including: the Bureau of Technical Support, Bureau of Comprehensive Health Services, Bureau of Rate Development and Analysis Bureau of Medical Administrative

Support, Bureau of Program Reimbursement Analysis, and the Bureau of Contract Management. The function of each division is described in detail in the SeniorCare operational protocol submitted as part of the Medicaid 1115 demonstration agreement.

As the program was being designed, according to Illinois SeniorCare officials, several PBMs expressed interest in management and claims administration for Illinois SeniorCare. The decision to go with ESI to administer the drug benefit was based on to two main factors: 1) PBMs paid much lower prices to pharmacies than did Medicaid; and 2) ESI was already the PBM for Circuit Breaker Pharmacy Assistance Program. The state could modify the ESI contract without a lengthy bidding process, saving both time and money. The relationship between DPA and Express Scripts Inc. during the first year of operation, is detailed in the following sections of the report. Several of the above divisions within DPA have now taken on some of the tasks originally conducted by the PBM claims administration, drug management, and member support, as described below.

Illinois SeniorCare Benefit Design Development

The SeniorCare benefit is designed to provide enrollees with incentives toward lower cost drug choices (through tiered copayments and higher cost sharing beyond a dollar limit), but give first dollar help to enrolled seniors. Thus, Illinois SeniorCare has several design strengths that officials believe will lower the cost risk for the demonstration, and that reflect what they viewed as an improvement in terms of cost management incentives over Circuit Breaker PAP.

The SeniorCare enabling legislation mandated that SeniorCare could be no more restrictive than Circuit Breaker PAP, and eliminating an enrollment fee was balanced by

lowering the "soft cap" from $2000 to $1750.[1] The $1 and $4 copayments per one-month prescription average close to $3, which is the CB-PAP copayment for all drugs. SeniorCare has the same network pharmacies as are in the Medicaid network. The SeniorCare benefit is shown in Table 4, with differences by income level noted in **boldface** type.

Table 4: Illinois Senior Care Pharmacy Benefit Description

Item	**Individuals up to 100% FPL**	**Individuals above 100% FPL**
Enrollment fee	None	None
Covered prescriptions	All Medicaid formulary prescriptions	All Medicaid formulary prescriptions
Covered over the counter (OTC) medications	With MD prescription: analgesics, antacids, laxatives, stool softeners, smoking cessation products	With MD prescription: analgesics, antacids, laxatives, stool softeners, smoking cessation products
Copayment	**None**	**$1 generic, $4 brand**
Maximum benefit	**$1750 "soft cap" per person; above that amount, member pays 20 percent of the drug ingredient cost.**	**$1750 "soft cap" per person; above that amount, member pays the copayment ($1 or $4) plus 20 percent of the drug ingredient cost.**
Pharmacy network	All Illinois Medicaid enrolled pharmacies	All Illinois Medicaid enrolled pharmacies
Additional feature to discourage dropping private insurance (discourage "crowd out")	$25 monthly rebate for eligible seniors who have other coverage and do not choose to enroll in the benefit program	$25 monthly rebate for eligible seniors who have other coverage and do not choose to enroll in the benefit program

The "soft cap" is designed to encourage seniors to limit overall drug expenditures (choose lower cost drugs to postpone higher cost sharing level). It also restrains program costs by increasing member share at higher expenditure levels. SeniorCare officials also thought that the absence of an enrollment fee, along with first dollar coverage, would encourage relatively healthy individuals to join the program.

[1] The "soft cap" is a threshold of individual member drug spending in both Illinois CB-PAP and Illinois SeniorCare,

Illinois SeniorCare also has a feature intended to limit the number of individuals who might drop private coverage to join SeniorCare. This is called the "SeniorCare rebate"[1] and offers applicants eligible for SeniorCare $25 per month if they are willing to forego enrollment in the program and maintain their private coverage.[2] The rebate amount was calculated based on an assumption that the senior's share of a prescription drug insurance premium is about twenty percent. Thus, if the overall premium for private prescription drug insurance were about $1500 or $125 per month, the senior's share ($25) would be the same as the rebate amount.

Illinois SeniorCare Formulary

While a PBM initially managed the SeniorCare drug benefit, coverage has always followed the Medicaid formulary. This is made up of "manufacturer rebatable" drugs and selected over the counter medications. These are determined by DPA Medical Programs officials and approved by a medical advisory group (volunteers from the Illinois Medical Society). Pharmacies are reimbursed for the ingredient cost of generic drugs based on the lower of the following amounts: the usual and customary price for the drug at that pharmacy, the Medicaid maximum allowable cost (MAC) list, the Federal Upper Limit, or the average wholesale price (AWP) less 25 percent. In addition, they are paid a dispensing fee of $2.25 per item. Reimbursement for brand drugs is the AWP less 14 percent, plus the dispensing fee of $2.25. The Medicaid manufacturer rebate is not included in this formula, and it applies (at

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beyond which members pay a higher copayment for prescriptions.

[1] This use of the term "rebate," should be distinguished from its use in several sections of this paper with reference to pharmaceutical "manufacturer rebates, " or payments to insurers to lower the aggregate cost of particular prescription drugs.

[2] Application for the rebate is a two-step process: after a SeniorCare enrollment form is sent in, SeniorCare eligibility is established by IDR, the individual is sent another form to apply for the rebate instead of benefits.

varying percentages) to all brand and generic drugs. A SeniorCare preferred drug list is used for several drug classes (all other medications in that class require prior authorization), and new drugs are covered if the manufacturer pays the national Medicaid rebate. Coverage in most therapeutic classes includes virtually all drugs from all manufacturers except for some generic manufacturers. When ESI was managing the benefit, the state of Illinois determined the preferred drug list, but ESI provided management, such as prior authorization services and pharmacy edits for drug utilization management. An additional four percent rebate beyond the 17 percent Medicaid rebate was negotiated for SeniorCare (this accounts for the total rebate estimated at 21 percent noted in tables in this report). This was provided directly to the state and shared evenly with the Federal government.

Five classes of over the counter (OTC) drugs that are covered by Medicaid are also covered by SeniorCare (see Table 4). According to SeniorCare officials, covering OTC drugs is not a huge burden for the program, as it comprises only one percent of all drug costs.

The SeniorCare (and Medicaid) formulary is enforced through the prior approval process. All nonpreferred drugs in therapeutic classes that have preferred drugs now require prior approval through the Medicaid program. Also certain drugs may be on prior approval for reasons other than formulary management, such as those that have high abuse potential or that require particular medical monitoring. Many therapy classes do not have a preferred drug list, so most drugs in classes that do not appear on the preferred list are automatically on the formulary and are available without prior approval. This procedure has caused some confusion for enrollees and consumer advocates, who have mistakenly thought that some drugs were not covered because they are not listed on the preferred drug list. Illinois Medicaid is charged with prior

authorization functions as of July 2003; prior to that, the PBM managing the benefit (Express Scripts, Inc) had a preferred drug list for several classes of drugs, and conducted prior approval for selected drugs.

Illinois SeniorCare Benefit Management

Year 1 of SeniorCare – Pharmacy Benefits Management by Express Scripts, Inc.

ESI was responsible for drug management and claims processing for the first year of SeniorCare operation, ending June 30, 2003. The SeniorCare contract with Express Scripts Inc. (ESI) was an amendment to the Circuit Breaker PAP contract with IDR. By contracting with ESI, DPA was able to implement SeniorCare faster. By using the existing contractor, Illinois also saved the procurement process, as CB-PAP had been competitively procured, and this was a contract extension. When SeniorCare was started, the contractual relationship between the state and ESI did not change, but the volume of business for ESI increased over its volume with CB-PAP alone. ESI also had to implement a new benefit package, differing in coverage details from that of CB-PAP.

ESI negotiated rates with the pharmacies, paid claims, conducted concurrent and retrospective drug utilization review, and provided weekly invoices for claims as well as monthly invoices for prior approval calls. ESI had an 800 telephone line for members with questions about drugs. ESI's pharmacy network was largely the same as the Medicaid network and included nearly all pharmacies in Illinois. ESI provided SeniorCare counts on claims rejections and reversals, documented in SeniorCare quarterly reports. Illinois also contracted with ESI to send letters to physicians and consumers as patient provider education programs. ESI also

offered a menu of pharmacy utilization management programs to the state, like those offered to private insurers. The DPA could institute these programs for additional fees.

Like most PBMs and other insurers, ESI also had a specific program that helped Illinois coordinate benefits with Medicare and thus avoid the costs of drugs covered under Medicare Part B (for specified diagnoses or administered in a special setting). Examples are diabetic supplies, cancer chemotherapy drugs and anti-nausea drugs, and asthma medications. This management of specialty drugs, along with other drug and disease management techniques (such as targeted programs to increase use of generics or preferred drugs, in which physicians are sent letters to encourage cost-effective prescribing for specific patients), was employed for the SeniorCare population, and incurred additional costs to the contracted base cost of the PBM's service.

The base administrative cost contracted by Express Scripts was fifteen cents per prescription claim. Prior approvals were reimbursed at $20 per prior approval request. SeniorCare chose interventions from ESI's menu at a set price per prescription claim, such as 1 cent to 4 cents for each intervention. SeniorCare also paid a $2.55 per prescription dispensing fee[1]. ESI SeniorCare claims administration costs for the state fiscal "year" 2003 were estimated by SeniorCare officials to be $15 million.

Express Scripts managers had frequent interaction with SeniorCare officials during its year of involvement. There were regularly scheduled quarterly meetings, and as necessary, daily discussions. These interactions focused on updates to preferred drug list and sorting out data problems. According to SeniorCare officials, Express Scripts had been easy to work with, information exchange has worked smoothly and the data generated by ESI were generally clean.

[1] Amendment to contract between State of Illinois and ESI parent company DPA contract 2002-24-019.

ESI took care of all claims processing, drug utilization review and management (including prior authorization). ESI also took care of monitoring whether a senior was reaching his or her limit, and maintained a customer support hot line and a website that was designed to be user-friendly but received little use (only 286 log-ons in the first six months of the program).

Pharmacy Benefits Management Changes

After June 30, 2003, the ESI contract was not renewed. The original decision to contract with a PBM for management of the SeniorCare drug benefit had been based in part on the fact that the end price that the state would pay for prescriptions (including the impact of dispensing fees) was lower through the PBM than through the Medicaid program, considering the additional rebate discussed earlier. However, when the PBM was eliminated, the state was able to both lower the dispensing fee to $2.25 per prescription and obtain improved prices for generic drugs through the Medicaid MAC list--changes that resulted in programs savings. SeniorCare also saved an immediate $15 million in PBM management costs, so that overall drug expenditures would be lower with the new internal management arrangement. Enrollees also benefited, according to SeniorCare officials. Under direct DPA administration, SeniorCare members would now use the SeniorCare drug cost (excluding former ESI administration costs per claim) to meet their cap, so enrollees would take longer to meet the $1750 target "soft cap."

Pricing of SeniorCare drugs was converted from ESI pricing in the following manner, and described in a memo to all pharmacists dated June 25, 2003: "…The department has a report of the aggregate amount of money paid to pharmacies by Express Scripts, Inc. (ESI) during the period SeniorCare was administered by ESI. In addition, the department has complete utilization

data for SeniorCare. The department developed rates and ran them through a utilization model based on this data. The rates were developed so that for the exact same volume and distribution of drugs experienced in SeniorCare during the past year, the department would pay out in aggregate the exact amount of money ESI paid."[1]

With the change in management, new membership cards were sent to all SeniorCare enrollees. Management tasks and claims administration were turned over to the DMP divisions that support the Illinois Medicaid program as of July 1, 2003. According to SeniorCare officials, Medicaid pharmacy management features are similar to those of the PBM, in terms of concurrent review and prior authorization for certain medications. The Bureau of Contract Management (BCM), within the DMP, now performs these functions, with the exception of retrospective review and letters to physicians for utilization management (which is being planned at present). Table 5 summarizes changes in claims administration and management with transition away from ESI.

[1] www.seniorcareillinois.com/062503_revision_sc.html

Table 5: SeniorCare compared to Express Scripts, Inc. PBM claims management[1]

Item	Express Scripts Inc. Pharmacy Benefits Manager (June 1, 2002-June 30, 2003)	Medicaid management of SeniorCare (July 1 2003-present)
Covered drugs	Medicaid formulary	Medicaid formulary
Preferred drug list	Medicaid PDL	Medicaid PDL
Pricing for generic drugs	Lower of ESI MAC list pricing, Federal Upper Limit, or (AWP less 14%)	Lower of Medicaid MAC list, Federal Upper Limit, or (AWP less 25%)
Brand drug pricing	AWP less 14%	Medicaid price: AWP less 14%
Dispensing fee	$2.55 per rx	$2.25 per rx
Utilization management: point of service (e.g. refill edits, prior authorization calls)	ESI	Medicaid (BCM)
Retrospective review, physician directed programs	Yes	No
Claims administration costs	ESI per claim, total $15 million	Medicaid staff and resources
Member support	ESI member support line and website, DOR for eligibility	DOR for eligibility, DPA for coverage and claims
Quality assurance	ESI plus Medical Programs Division	Medical Programs Division

Challenges in Transfer of Drug Benefit Management.

SeniorCare administrators report that the transition from ESI to internal management has been generally smooth, but several issues arose that had to be resolved. These issues, which included higher than expected volume of prior authorization calls in the first month and some problems with variables in the eligibility files, were noticed immediately, as soon as enrollees began using their benefit at the pharmacy. As of October 2003, SeniorCare is in the process of resolving these issues. SeniorCare officials approached these problems (and other problems like them) in two steps: an immediate fix to maintain continuity of access (immediate override of drug rejections that appear to be problematic) and within days or weeks, a restructuring of the data system to resolve the problem permanently. DPA has used this approach in addressing the

[1] Sources: Amended contract between state of Illinois and ESI parent company; Interviews with ESI senior account

high volume of calls for prior authorization around June and July, when most people need approvals. Temporary approvals were given when the problem was first noticed as SeniorCare switched from ESI management, and then systems were changed to stagger the dates on which approval will be required in the future.

In addition, some negotiation occurred regarding dispensing fees for SeniorCare prescriptions. Initially Illinois proposed a tiered dispensing fee to encourage use of generic drugs. However, pharmacists objected, and a $2.25 dispensing fee was agreed upon by DPA through a compromise.

SeniorCare Data Systems and Internal Monitoring

Illinois pays its own Medicaid claims and does not contract services to a third party fiscal intermediary as do many state Medicaid programs. In Illinois, 1.5 million people are on Medicaid at any one time, with 2.1 million during some time of the year. With the addition of less than 200,000 more people through Senior Care, no increase in staff or resources was required to handle the added claims volume with the implementation of SeniorCare, especially as an external PBM was administering the benefit.[1] The Medicaid data warehouse is used by SeniorCare program officials to perform analyses and reports for regular monitoring, to check whether payments are correct, and to generate data for the quarterly and annual reports regularly provided to CMS.

representatives; Interviews with Illinois DPA officials.

[1] SeniorCare program administration costs may increase with in-house drug management starting July 2003, but may in part be offset by savings accrued from eliminating PBM administrative costs.

If a SeniorCare enrollee becomes Medicaid eligible during the year, Medicaid assumes primary responsibility for paying claims; the integrated system facilitates administering that policy. During this period, while Medicaid pays for his or her drugs, the individual does not give up SeniorCare enrollment; the enrollee uses the same card but Medicaid pays for the prescriptions. Then, if the enrollee goes off Medicaid during the year, he or she is automatically placed back on SeniorCare without re-enrolling in the program until the standard enrollment year has ended.

Illinois SeniorCare Member Support

There are several support vehicles in the program, and several advocacy groups in the community also address members' questions and concerns. They include:

- IDR has a hot line to call for assistance and questions with enrollment
- DPA has a health benefits hot line
- Department on Aging has an advocacy network that provides support (see later discussion of this)
- ESI (during year 1 of SeniorCare operation) had a hot line for prescription cost sharing related issues.

The support lines within the state agencies (IDR and DPA) were heavily staffed and trained to respond to questions regarding enrollment and benefits. The Department on Aging worked in partnership with Illinois DPA to provide enrollment support (See later discussion). ESI's support role during the first year was directly related to issues regarding the benefit, in

particular assisting enrollees in understanding copayment requirements, issues regarding coverage, and how close individuals were to the cap.

Illinois Context for Prescription Drug Coverage for Low Income Seniors

Prescription Drug Coverage for Seniors

According to the 2000 U.S. Census, approximately 274,576 Illinois residents age 65 and older fall in the income range between 100-199 percent FPL.[1] Several recent sources are available to provide information that is useful in examining the prescription drug coverage status of this population within Illinois: the Medicare Current Beneficiary Survey (MCBS), and a recent survey of low-income seniors in eight states including Illinois, conducted in 2001 by the Kaiser Family Foundation (KFF).[2] This was conducted prior to implementation of Illinois SeniorCare, but while the Illinois Circuit Breaker Pharmacy Assistance Program was in place.

Jen Associates, Inc. has provided a preliminary analysis of the year 2000 Medicare Current Beneficiary Survey (MCBS) examining the sources of prescription drug coverage for Medicare seniors, in the North Central region states, in the income category between $10,000 and $20,000, a similar level to that of SeniorCare enrollees.[3] This is compared to the KFF study noted earlier. Table 6 provides a comparison of prescription drug insurance coverage status reported in each survey, as a means of estimating the size of the population that may be eligible for Illinois SeniorCare. Groups that would be likely to enroll in Illinois SeniorCare are in **boldface** type.

[1] Source: U.S. Census Bureau, 2000 Census, Summary File 3.
[2] Safran et al, "Prescription Drug Coverage and Seniors: How Well are States Closing the Gap?" *Health Affairs Web Exclusive*, July 31, 2002. (www.healthaffairs.org).
[3] States in the East North Central region include: Illinois, Wisconsin, Ohio, Michigan, and Indiana.

Table 6: Prescription drug insurance coverage estimates from two sources

Type of Insurance	2000 MCBS North Central Region ($10,000 to $20,000 annual income) (n=639 weighted)	Eight state survey of low-income seniors: Illinois findings for near-poor (101-200% FPL) (n=292)
Employer based (retiree) with prescription drug coverage	31%	27%
Medicaid	3%	1%
Medicare HMO	20%	11%
VA	Included in other categories	2%
Medigap with rx coverage	**6%**	**11%**
No supplemental rx insurance coverage	**36%**	**34%**
Public state rx	**1%**	**12%**
Other purchased rx coverage	**3%**	**2%**
Total estimated to have no coverage, had CB-PAP at time of survey that would roll-over, or insurance individuals might drop for SeniorCare.	**56%**	**59%**

These numbers are only rough estimates to provide a context for prescription drug coverage for the population covered by SeniorCare, and serve as a guide to potential take-up rates for Illinois SeniorCare for further analysis. Enrollment in Illinois SeniorCare through November 2003 includes 144,000 members within the income group 100-200 percent FPL (see later details), and suggests that over half of seniors in this income category have joined to date. It should be remembered that all individuals in the income category are eligible to enroll in Illinois SeniorCare members by either taking the rebate offer or enrolling for the drug benefit, but the groups noted in the above table would be most likely to need and choose the drug benefit. Finally, these estimates reflect the prescription drug coverage environment when SeniorCare was implemented, and do not take into account coverage changes associated with the enactment of the Medicare Prescription Drug Improvement and Modernization Act after 2005.

Illinois Medicaid and Impact of SeniorCare

In 2002, the total Medicaid population age 65 + for the state of Illinois was approximately 145,000 each month, and a total of 165,000 annually.[1] These seniors who are Medicaid beneficiaries make up nine percent of Illinois Medicaid enrollees.[2] In addition to a relatively low managed care penetration for Medicare Plus Choice in Illinois, managed care penetration for all Medicaid enrollees (all programs, all ages) is also quite low, at 7.4 percent compared to a national average of 57.5%.[3]

The impact of the SeniorCare program on Illinois Medicaid is an issue of critical importance, as CMS requires Medicaid federal budget neutrality for the population age 65 and older by year five of the demonstration. This puts the state of Illinois at risk for the costs associated with implementation of the demonstration and expansion of benefits, as some analyses have noted.[1] Thus, estimates are made at the outset of how the SeniorCare program will impact Illinois Medicaid.

For the SeniorCare demonstration application, Medicaid projections were calculated both with and without SeniorCare. According to a senior program official, determining inputs for the budget neutrality calculations was the biggest hurdle to the demonstration application. Program costs could not be modeled after the CB-PAP program, as several important features were very different, as discussed in the previous section. Information that fed into the budget projections were a combination of historic data from Medicaid and assumptions regarding future growth and expenditures and take-up rates. Using a base year of the state fiscal year (SFY) 2001(which

[1] Illinois Department of Public Aid, Division of Medical Programs, *Illinois Medical Programs: A Primer*, 2002.
[2] www.kff.org/statehealthfacts
[3] http://www.cms.hhs.gov/medicaid/managedcare/mmcpr02.pdf

ended June 30, 2001), five year enrollment and cost trend rates were developed for Illinois Medicaid. At the time the pharmacy program was being developed, the income threshold for Medicaid eligibility was 70 percent FPL, but this has risen from 70 percent to 85 percent to 100 percent of FPL in the past three years, adding to the difficulties in arriving at budget neutrality estimates.

The following summarizes some important assumptions and components of Federal budget neutrality for Illinois SeniorCare:[2]

1. Medicaid program growth and expenditures for beneficiaries age 65 and older, without SeniorCare: 5.5 percent expenditure growth per eligible per year, based on historic growth years 1997-2001; five percent growth in eligibles, increasing rate from 1997.

2. SeniorCare program costs:
    a. Enrollment: based on KidCare experience (as it is a program recently implemented enrolling low-income families), 75 percent of eligible seniors by year five.

    b. Drug expenditures per person: based on Medicaid prescription costs to community residents per eligible age 65+, but five percent lower drug costs because of the expected response of SeniorCare members to the per-prescription cost sharing

    c. Enrollment rebate provided to twenty percent of eligible population (this is conservative, based on national Current Population Survey estimates of the number of elders in this income range who hold private insurance coverage for prescription drugs).

3. Medicaid program growth with SeniorCare

    a. SeniorCare program costs, as above.

    b. Less the decrease in Medicaid enrollment, which was estimated at five percent less than historic growth due to diverted eligibles. The diversion from nursing

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[1] Kaiser Commission on Medicaid and the Uninsured, The Financing of Pharmacy Plus Waivers: Implications for Seniors on Medicaid of Global Funding Caps, May 2003.
[2] See CMS website (http://www.cms.gov/medicaid/1115/ilrxbudgetnew.pdf) for budget neutrality worksheet and notes

homes was based on literature,[1] the NYS EpiCare experience,[1] and some anecdotal reports from providers and others.

It is important to note that there are several cost-related items that were not included in budget assumptions, but that could have considerable impact on the budget neutrality of SeniorCare in both directions over the next few years. In particular:

1. The year 2003 began with rate cuts in payments to all providers. This change will have created savings to the Medicaid program that are unrelated to the existence of SeniorCare. This cost saving was not included in the projections for budget neutrality, but it improves the chances for Medicaid saving (total expenditures for 65+ population less than projections) over the evaluation period.

2. Illinois negotiated additional manufacturer's rebates for some drugs, beyond the Medicaid rebate. These additional rebates equal approximately four percent of drug spend in the program and are split evenly between the state and federal government. These rebates were not included in budget projections. This reduced program costs only in the first year of the project.

3. Inflation in general health care services (excluding prescription drugs) had been relatively low over the historic period on which these projections were based, and recently (since 2002) has risen much more rapidly.

4. Price changes in prescription drugs may fluctuate higher or lower based on generic availability in the coming years and approval of medications for over the counter status.

5. The impact of a Medicare drug benefit could be significant, and will depend on the eventual role of state pharmacy assistance programs.

To assure Medicaid budget neutrality during the demonstration, a federal budget cap was agreed upon and stated in the Terms and Conditions of Approval for the Illinois SeniorCare demonstration. The cap is the Federal share of a projected total cost of the Medicaid program (including the SeniorCare component) at the end of the five-year demonstration, and is

[1] Soumerai et al., "Effects of Medicaid drug-payment limits on admission to hospitals and nursing homes," NEJM 325(15):1072-1077., 1991.

$14,046,722,751. While the cap is a cumulative five-year target, the Terms and Conditions of Approval also lists a schedule of annual cumulative target expenditures. If the state exceeds the cumulative cap at any point, it must submit a corrective plan to CMS. The budget cumulative target for the first year of the SeniorCare demonstration is $3.034 billion, with an eight percent allowable margin.[2] This is discussed further in first year implementation and program costs.

[1] NYS Epicare experience (cite).
[2] http://www.cms.gov/medicaid/1115/ilrxtcs.pdf

Implementation of Illinois Senior Care Year 1

Enrollment

When SeniorCare began operation on June 1, 2002, 121,000 enrollees "rolled over" to SeniorCare.[1] As of June 30, 2003, the end of the first year of operation, there were a total of 177,000 people enrolled in SeniorCare.[2]

Table 7 shows enrollment by category as of December 2, 2003:

Table 7: Enrollment categories Illinois SeniorCare

Category	**Number of enrollees**
Rolled over from Circuit Breaker	121,000
New enrollees	45,040
Rebate takers	6, 293
Total SeniorCare enrollees	172,333 total: 28,360 at or below 100% FPL (copayments waived)[3] 143,973 above 100% FPL

Enrollment in SeniorCare is comparable to the number originally predicted (originally estimated to be 208,000 by end of the second program year, June 30, 2004). The number of individuals that took the rebate is considerably lower than expected, at 2.8 percent of enrollees, rather than the seventeen percent originally predicted. SeniorCare officials suggest several reasons for this, relating to inadequate communication regarding the rebate, lack of interest by those with other coverage, or the two-step process of applying for the rebate.[4] (See June 2003

[1] According to early reports, 148,000 people shifted from Circuit Breaker Prescription Assistance Program to SeniorCare. However, the number was actually lower, due to some of the following problems with the CB-PAP enrollment file: deceased people were still on the rolls due to lack of matches with vital statistics, some people also fully enrolled in Medicaid were mistakenly on the rolls, some people were mistakenly in the files as duplicates.
[2] As of September 30, 2003: 185,000 enrollees.
[3] Enrollees might be less than 100% FPL but ineligible for Medicaid because of assets.
[4] As noted earlier, application for the rebate is a two-step process: after a SeniorCare enrollment form is sent in, SeniorCare eligibility is established by IDR, the individual is sent another form to apply for the rebate instead of benefits.

SeniorCare annual report for a more detailed discussion of this issue.) At the same time, it could be that seniors are supplementing other coverage with SeniorCare. The survey currently being conducted as part of this evaluation should reveal more about other coverage and why fewer individuals than expected applied for the rebate.

Renewing Membership in SeniorCare

Regardless of when during the year an individual signs up for Illinois SeniorCare, renewal is required by July 1 each year. If an individual initially enrolled after January 1, enrollment is good for the following year also (up to 18 months). Renewing membership in SeniorCare has been problematic, as a large portion of enrollees did not renew by the deadline of July 1, 2003 for the coming year. Re-enrollment is further complicated because the state cannot put an expiration date on a drug coverage card due to HIPAA, so individuals do not see their expiration date on their cards.

Enrollees are sent renewal forms six months before their enrollment year ends. Reminders are sent three months later to those who have not re-enrolled. Seniors must by statute reapply for enrollment each fiscal year before July 1, unless the date is extended. In 2003, approximately 140,000 seniors re-enrolled on time. The DPA sent out reminder notices to more than 40,000 people who had not re-enrolled. About 28,000 seniors had still not reapplied as of July 1, 2003, so on July 18, 2003, the Governor of Illinois granted a temporary three-month extension of enrollment and the reenrollment deadline was extended until September 30, 2003 for SeniorCare (though not for the state-only program CB-PAP, which also requires re-

enrollment).[1] On July 25, 2003, over 41,000 temporary cards were sent out to individuals who had not re-enrolled. Temporary re-enrollment was provided for three months, through September 30, 2003. According to Illinois DPA, as of October 2003, outreach efforts were successful, with the following resolution: 14,578 seniors granted an extension were reenrolled in SeniorCare, 11,861 were enrolled in Circuit Breaker PAP, 2008 reapplied and were found ineligible for either program, and 1052 had applications pending as of October 1. Of the remaining 13,343 seniors granted extensions, only 2612 had filled prescriptions, and outreach efforts are continuing.[2]

According to SeniorCare officials, some of the problems regarding reenrollment were due to lack of communication on the part of the DPA with the outreach workers. The Department has resolved to be more proactive regarding getting out information to enrollees and those helping them, to avoid lack of communication in the future. Actions include reviewing the enrollment and reenrollment forms with community senior advocates prior to using them and reviewing the process of informing the public regarding SeniorCare enrollment and coverage issues.

Drug Utilization and Cost Estimates for the First Year of the Program

At the end of its first full fiscal year of program operation, July 1, 2002 through June 30, 2003, the SeniorCare program cost $215 million dollars in total drug costs (approximately $170 million net of rebate income). Table 8 lists utilization and expenditure highlights for the 177,000

[1] Press release July 25, 2003, Illinois SeniorCare website (http://www.seniorcareillinois.com/072503_release_sc.html)
[2] Illinois DPA, Illinois SeniorCare Quarterly Progress Report, July2003-September 2003.

members of the program at for the first full fiscal year, from July 1, 2002 through June 30, 2003:[1]

Table 8: Utilization and expenditures for Year 1 Illinois SeniorCare

Item	**First full fiscal year (July 1, 2002 – June 30, 2003)**
Number of enrollees with prescription benefit	177,000
Average number of individuals using a prescription	117,802
Total program drug expenditures Year 1 in thousands (000)	$215 million (not net of rebates)
Average proportion of enrollees with at least one claim each month	69%
Plan expenditures per user per year	$1832
Average number of prescriptions per user	52.3
Generics as a percent of claims	55.5%
Generics as a percent of state costs	26.6%
Average total cost per prescription (plan and member share)	$39.14
Average member cost share	10.64%
Average total cost per brand drug (plan + member share)	$64.52
Average member copayment per brand drug prescription	$6.86
Average total cost per generic drug prescription	$18.81
Average member copayment per generic drug	$2.05
Number of enrollees reaching $1750 cap by end of year 1[2]	53,162 (approx. 30% of enrollees)

SeniorCare Program Costs and Overall Illinois Medicaid Budget

SeniorCare program drug costs for the first fiscal year were a total of $213 million (when rebates are calculated in, costs could be as low as $170 million), compared to $193 million total initially projected in the demonstration application. The overall number of claims (6.06 million for the first 12 months) was higher than the 4 million initial expectations, but the average program cost per prescription is somewhat less than projected because of higher-than-expected generic rates, making overall costs just above expectations.

[1] Source: Illinois DPA, SeniorCare program status report
[2] Expenditures from July 1, 2002 through June 30 2003 counted toward the "cap."

Medicaid enrollment for age 65+ for the year was approximately 150,000 each month by the end of twelve months, lower than the 155,469 estimated without the demonstration, and very close to the 148,000 estimated in the demonstration projections by June 2003 with implementation of SeniorCare. Medicaid overall costs for the population age 65+ for FY 2003 are not yet finalized so no comparison can be made at this time to the $2.4 billion projected costs of Medicaid for end of year 1, or $3.08 billion budget neutrality target for end of year 1 of the demonstration.

Drugs Purchased through SeniorCare

A major objective of the Illinois SeniorCare demonstration was to expand the array of medications available to low income seniors beyond the medications allowed in Circuit Breaker PAP for the designated medications. Table 8 lists and ranks the top disease classes that have been provided under the SeniorCare benefit, to illustrate how SeniorCare enrollees have used this benefit to purchase drugs that might otherwise not be covered in the earlier CB-PAP.

Table 9: Top ranked therapeutic classes (by total dollars) for SeniorCare members, October 1 through December 30, 2002[1]

Rank	Therapeutic Class	Percent of total SeniorCare drug expenditures for the quarter
1	High blood pressure/heart disease	18.7%
2	High cholesterol	12.7%
3	Diabetes	8.2%
4	**Ulcer disease**	**6.7%**
5	Pain and inflammation	6.5%
6	Asthma	4.4%
7	Blood modifying	4.2%
8	Osteoporosis	3.7%
9	**Depression**	**3.1%**
10	Severe pain	2.6%
11	Galaucoma	2.4%
12	**Infections**	**2.3%**
Total	**Total top 12 classes**	**75.5%**

Note: Drug classes not covered by CB-PAP are in bold.

As Table 9 shows, three of the drug classes in the top 12 expenditure categories for SeniorCare are not covered by CB-PAP, and do not appear on CB-PAP expenditure reports: ulcer disease, depression, and infections (in bold in table 8). These three drug classes together account for 12 percent of SeniorCare total drug expenditures for the quarter. In fact, Prevacid, an antiulcer drug not covered by CB-PAP, ranked second in SeniorCare total drug expenditures during the time period. This illustrates the substantial demand for prescription drugs to treat these conditions presently not covered through CB-PAP.

[1] Source: Semi-Annual Strategic Planning Session Report, Express Scripts, Inc., January 15, 2003

Outreach and Consumer Feedback

Outreach

The following agencies were involved in initial outreach efforts during year 1 of Illinois SeniorCare:

- DPA – held training sessions, including sessions for legislative staff
- Department on Aging – had funds allocated for outreach, through 13 Senior Area Agencies on Aging.
- Department of Insurance – has counselors who help seniors with insurance.

The Bureau of Contract Management (BCM) maintains a hotline for seniors to ask enrollment and program questions for SeniorCare. Staff can look up callers' accounts and answer questions related to eligibility, card replacement, what drugs are covered, and cost sharing. Staff of the Bureau trained staff at other agencies such as the Department on Aging and Department of Insurance to respond to inquiries about SeniorCare. DPA staff provided informational sessions to Illinois legislators and their staff.

The IDR has a hot line of its own that serves all 300,000 people receiving property tax relief and CB-PAP. The IDR hotline answers questions about SeniorCare eligibility and application status. It is helpful to some extent, but in the first months of the program, callers abandoned eighty percent of their calls due to congestion. According to officials, the proportion of calls regarding pharmacy assistance last year far outweighed the number of inquiries for the general taxpayer assistance.

The Bureau of Contract Management, in conjunction with the Department on Aging, also held meetings at senior centers, which were well attended. They often had 50-100 people attend

the sessions even in small communities. A total of twelve informational sessions were held in July and August 2002, during the first few months of the program. The Department on Aging also provides information concerning SeniorCare and assistance for completing applications. The Department on Aging also conducted about 500 seminars in senior housing, places of worship, and health fairs. The agency works with pharmacists as well.

In state fiscal year 2003, Illinois DPA, through interagency agreement, sent $1,000,000 to the Illinois Department on Aging for SeniorCare outreach. Another $176,000 was given to Aging to expand their senior helpline to accommodate additional capacity for SeniorCare related calls. In addition, DPA used $824,000 to pay telecommunication expenses incurred by the Department of Revenue's Circuit Breaker hotline.

Consumer and Advocate Feedback

Advocates from some of Illinois' thirteen Area Agencies on Aging say that this program has been of great benefit to many seniors, and seniors are thrilled about the program. Elder agency representatives and consumer advocates often look for a patchwork of benefits to pay for prescription drugs for their clients. There are rampant stories of people stretching out medications, or not taking any at all, concerning diabetic drugs (insulin and other medications) and treatment for cancer and heart disease. Illinois SeniorCare appears to be helping relieve this problem for a great number of people.

Several areas of confusion have been noted during the first year of implementation, including reenrollment and coverage questions. According to an advocate, a major problem encountered for SeniorCare enrollees was with Medicaid spend down – people who spent down became eligible for Medicaid for one month, but then subsequently were terminated from

Medicaid but should remain eligible for SeniorCare. Spend down is a complex process, and enrollees found it difficult to understand. Out of 147,380 people with SeniorCare cards, 4,400 met spend down (temporarily in Medicaid in that month) as of January 2003, and 3,800 unmet spend down (in SeniorCare, are in Medicaid system but not Medicaid eligible that month). These people could become Medicaid eligible retroactively. While it is difficult for individuals to determine their status from month to month, with SeniorCare, they do not have to use a different drug access card depending on whether they become Medicaid eligible during the year, and the process of purchasing prescriptions is the same, as are pharmacy networks, although copayments for SeniorCare are higher.

Advocates report that some of the barriers to care faced by SeniorCare enrollees are health literacy as well as language barriers. One outreach worker was concerned about lack of customer service for the SeniorCare program and difficulties getting through to the IDR assistance line. Another confusing issue concerned the inconsistencies in caps between the state fiscal year and each individual's initial twelve-month eligibility period. The problem was resolved in spring 2003 when the timing of coverage and cap were changed to the start of the state's fiscal year, July 1. Now coverage and cap are based on the state's fiscal year. An important aspect of the program, knowing when a member is nearing the soft cap of $1750 in expenditures, presents a challenge for individuals. The senior outreach workers, along with pharmacists, help with this information.

Finally, outreach workers noted that the application process (a two-page section in a 17 page booklet from IDR as part of the Circuit Breaker tax relief application) is cumbersome, and

has presented problems, as the IDR is not set up in the same way as are human services agencies to be customer responsive.

Key Issues in Implementation of Illinois SeniorCare

SeniorCare is a popular program with considerable public support, according to both program officials and consumers. Consumer advocates have been quite candid in articulating problems encountered in the enrollment process and other aspects of the program, highlighting problems in communication between the state, enrollees and the public. However, it was clear that this program has been extremely helpful to low income seniors, and problems encountered initially (particularly regarding communication with consumers and advocates) are acknowledged by the program and are in the process of being addressed by a responsive senior management.

The Illinois SeniorCare program implementation appears to be consistent with the program's operational protocols. Several key issues have arisen during the first year, particularly difficulties in the enrollment and re-enrollment process. On the other hand, internal changes that had to be made during the year in member support and information dissemination indicate that program staff and senior management are responsive to issues as they come up. Officials understand the clinical and political importance of finding rapid solutions to enrollees' access problems, and have been able to make ongoing minor and major mid-course corrections as needed. The problems with re-enrollment in particular have been addressed and resolved, as discussed earlier.

Several additional areas will be the focus of further evaluation:

- Budget projections: Budget neutrality projections were based on Medicaid historical enrollee and expenditure growth during the years preceding the start of the demonstration. The assumptions underlying this growth were jointly agreed between CMS and the states in the

negotiations around approval of the demonstrations. Implicit in these calculations is the assumption that the historical trends would continue and that there are no other major factors causing major changes in Medicaid spending, such as a prescription drug benefit for Medicare. In the case of Illinois, a previously planned expansion in the income ceiling for Medicaid took effect on July 1, 2002 (one month after the start of the demonstration), raising the cutoff from 70 percent to 100 percent of the Federal Poverty Level. Changes in discretionary state services, and reduction of state controlled reimbursement rates (such as payments to providers) could slow the growth of Medicaid.[1] Changes in availability and payment for complementary services (by either Medicaid or Medicare) could affect use of community based long-term care services, and indirectly impact Medicaid (and Medicare) spending. Alternatively, future inflation in health services (excluding prescriptions) could also be higher than historical trends. Clearly, after 2005, the new Medicare drug benefit will have an impact on Illinois SeniorCare as with other state pharmacy assistance programs that serve low-income seniors.

- Plan design: Several features of the plan design in Illinois SeniorCare provide an interesting area for further study, including: low copayment differentials between generic and brand prescriptions ($1 versus $4 for a one-month supply, respectively), and the soft cap (beyond $1750 in expenditures, individuals go from a $1 or $4 copayment to the copayment plus 20 percent of ingredient costs). Research questions such as how enrollees change behavior

[1] According to a July 2003 survey of 50 states, most states are restricting their Medicaid budgets through various means, including restricting provider payments, increasing cost containment for prescription drugs, reducing

before, or after meeting the cap, and how the copayment differential affects use of generics, would be interesting to address, both for this program and as lessons for other state programs. The Brandeis evaluation team has just been awarded a grant by the Robert Wood Johnson Foundation to explore this issue in more detail by comparing plan design features across different state programs.

- Pharmacy benefits management changes: The transfer of administrative and management duties from Express Scripts to Medicaid is reported by SeniorCare officials to be generally smooth, with the largest hurdles around eligibility glitches and prior authorization volume. Medicaid has many of the utilization management programs that ESI does, and it will be important to look at how management or utilization may differ from one year to the next going from a PBM to in-house management. Express Scripts showed innovative systems (now common in the private sector) with letters to doctors and electronic communication with pharmacists to try to persuade doctors to switch patients to favored drugs, improve compliance when drugs were missed, etc. How often ESI pursued these strategies relative to the opportunities to do so, how drug management changed when moved from the PBM to Medicaid, and the impact of the end of the contract with the PBM would also be worthy of further study as lessons for other programs, public and private.

- Joint program responsibility across two agencies: The Illinois Department of Public Aid and the Illinois Department of Revenue have different missions, staff, and information systems.

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eligibililty, reducing benefits, and increasing beneficiary cost sharing. (Kaiser Commision on Medicaid and the

The linkages between the two departments for the purposes of SeniorCare are well established at this point. However, initially, a particularly problematic area was the IDR customer assistance line, which was clogged for months due to callers asking about property tax rebates. The departments were aware of these problems with customer service, and met the need to some extent by increased staffing. SeniorCare managers seem to have good relationships with senior advocates, a fact that most likely helps DPA be responsive to consumer concerns. This is also a program area that we will follow during the course of the evaluation.

- Additional federal and state prescription drug initiatives: In December, 2003, the Medicare Prescription Drug Improvement and Modernization Act was enacted, providing a prescription drug benefit for Medicare. Depending on final rules, all state pharmacy assistance programs will be affected, and state pharmacy assistance programs under Medicaid 1115 demonstrations may have particular rules in providing assistance in cost sharing for those receiving pharmacy benefits. At present, Illinois SeniorCare is evaluating options for how to respond to the new legislation.

In addition to federal policy, several new state policies will be interesting to follow during the course of this evaluation. One, a new prescription drug discount "club" for seniors and the disabled, provides for discounts of 20 to 30 percent off the cost of prescription drugs. This program started in January 2004, and is open to all seniors for an annual fee of $25. While this program may not have direct immediate effects on Illinois SeniorCare because

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Uninsured, *State Budgets and Medicaid, preliminary results*, (www.kff.org/content/2003/20030815/prelimresults).

SeniorCare is a more generous program and limited to those seniors with low income, it may affect the overall picture of prescription drug purchasing for seniors in Illinois.

Another policy that may have an impact is the approach recently investigated by the Illinois Special Advocate's Office to purchase drugs from Canada for retirees and state employees. As well, the state is investigating further negotiations with drug manufacturers to obtain increased discounts from manufacturers for the nine state programs that purchase medications. SeniorCare and CB-PAP could be affected by this potential change in the drug pricing environment if either are included in this initiative. Depending on how any of these policies develops, Illinois SeniorCare and other prescription drug programs could see an impact.

Brandeis Site Visit Details

Schedule

Site visit to Springfield, IL January 16-17, 2003

Phone calls and documents exchanged over the course of the year

Brandeis Site Visit Team

Cindy Thomas, Task leader for site visit

Donald Shepard, Principal Investigator of State Pharmacy Assistance Evaluation

Christine Bishop, Task leader for economic evaluations

Roberta Constantine, Project manager (at time of site visit)

Interviewees

Illinois Department of Public Aid

Nine senior managers in the Department of Public Aid, various program offices.

Department of Revenue

Program Administrator

Express Scripts

Three Senior Account Managers

Consumers

Representative from the Suburban Area Agency on Aging