

Legislative Committee to Look At Possibilities of ‘Consumer Driven’ Medicaid

The General Assembly’s research and audit arm, the Legislative Budget and Finance Committee, will investigate whether a consumer approach to cutting Medicaid expenses could be adopted by Pennsylvania. The Senate approved the resolution, SR 200, last week that authorized the study.

If the Committee finds that such an approach could be adopted by Pennsylvania, then the sponsor of the resolution, Jane Orié, R-Allegheny, would likely author a bill establishing a pilot program in Pennsylvania, according to her office. A preliminary report from the Committee is due by August 1, 2006.

“Right now we’re in a cycle of year-to-year increases in Medicaid, and our only approach has been, and really can be, increase spending, or cut back services or reimbursements rates,” said a spokesman for Orié’s office. “When you start to look at some things in the current system like why a 60 year-old male has pregnancy coverage, you know there are things in the system that can be change, and money saved.”

Florida has been the most recent state to move towards a consumer driven plan. A pilot plan has been rolled out in two counties. Under the approach, a counselor walks new Medicaid enrollees through a range of plans and coverage policies, which are offered by private insurers competing for the policies.

“What we’re trying to do is fit coverage to a person’s needs, and not throw the same range of benefits at every person,” said a spokesman for Florida Governor Jeb Bush’s office. “Our goal of course is to save money, but also we believe the quality of care will improve as well.”

The spokesman added that managed care would likely end up being used even more as a way of stemming Medicaid costs.

“With the focus being on monitoring care, we expect to use managed care more than ever,” the spokesman said. “It fits very nicely with our new approach.”

Other states that have either adopted some form of consumer driven Medicaid plan, or are now crafting such a plan, include South Carolina, Georgia, Kentucky, Vermont, Colorado, Arkansas, and Massachusetts.

SENATE RESOLUTION

No. 200 Session of 2005

INTRODUCED BY ORIE, CORMAN, RAFFERTY, BROWNE, ERICKSON,
BOSCOLA,
CONTI, WENGER, VANCE, LEMMOND, WONDERLING, FONTANA, COSTA,
RHOADES AND ARMSTRONG, NOVEMBER 15, 2005

SENATOR CORMAN, PUBLIC HEALTH AND WELFARE, AS AMENDED,
MARCH 15, 2006

A RESOLUTION

1 Directing the Legislative Budget and Finance Committee to
2 perform a study of cost control measures for the Medicaid
3 program.

4 WHEREAS, The Medicaid program, a Federal-state partnership,
5 was established to provide a safety net for persons who are
6 financially unable to provide health care for themselves and
7 their families; and

8 WHEREAS, Over the life of Medicaid, increasing costs, gaps
in
9 coverage and creative and inventive ways of achieving
10 eligibility by persons who would not normally fall within the
11 safety net have led experts to conclude that the system, as
12 currently structured, is financially unsustainable and flawed;
13 and
14 WHEREAS, Despite expending increasing percentages of total
15 State revenues on Medicaid, the Commonwealth experienced great
16 difficulty in balancing its 2005-2006 fiscal year Medicaid
17 budget; and

1 WHEREAS, Despite ever-increasing outlays, access to care for
2 Medicaid patients continues to decline; and

3 WHEREAS, Revenue shortfalls necessitated cuts in Medicaid
4 benefits and provider reimbursements, which limit patient
choice
5 and relegate our most vulnerable citizens to a substandard
6 system of care; and

7 WHEREAS, Current projections suggest that the Commonwealth
8 will experience great difficulty in balancing the 2006-2007
9 fiscal year budget and may further cut benefits and
10 reimbursements; and

11 WHEREAS, Past incremental reforms, similar to those utilized
12 in balancing the 2005-2006 fiscal year budget, have neither
13 contained costs nor remedied flaws in the Medicaid program; and

14 WHEREAS, Many states are experiencing similar financial and
15 access-to-care dilemmas in their provision of services to
16 Medicaid enrollees; and

17 WHEREAS, It is estimated that, under currently structured
18 Medicaid defined benefits programs, all states will expend
19 between 80% and 100% of states' revenues on Medicaid in 2020;
20 and

21 WHEREAS, Some states have begun a process to determine what
22 steps they can take to continue to provide this necessary
safety

23 net for economically disadvantaged individuals and families,
24 even as costs increase and revenues diminish; and

25 WHEREAS, Florida, South Carolina, Georgia, Colorado,
26 Arkansas, Massachusetts, Vermont, Kentucky and other states are
27 contemplating or have begun to implement a defined
contribution,

28 consumer-directed approach to structural reform within the
29 Medicaid program; and

30 WHEREAS, This kind of reform would empower Medicaid patients
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1 to be fully engaged in the provision and ownership of their
2 health care; and

3 WHEREAS, Where similar programs have been instituted,
patient

4 satisfaction has been measured at 97%; and

5 WHEREAS, Pennsylvania should explore whether patient-
directed

6 Medicaid programs may be implemented in this Commonwealth;
7 therefore be it

8 RESOLVED, That the Legislative Budget and Finance Committee
9 review legislative and administrative Medicaid structural
10 changes and Federal waiver submissions contemplated or
11 implemented in other states to determine whether they may be
12 implemented on a pilot basis in this Commonwealth; and be it
13 further

14 RESOLVED, That the Legislative Budget and Finance Committee
15 review appropriate statutory and regulatory laws to ascertain
16 whether there are any statutory or administrative barriers at
17 the Federal and State levels that may hinder implementation;

and

18 be it further

19 RESOLVED, That the Legislative Budget and Finance Committee
20 provide recommendations on statutory and administrative

language

21 changes commensurate with any necessary barrier removal and
22 implementation; and be it further

23 RESOLVED, That the Legislative Budget and Finance Committee
24 provide the Senate with a preliminary report no later than
25 February 15 AUGUST 1, 2006, and a final report no later than

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26 June 1 NOVEMBER 30, 2006.

AmeriHealth CEO, Daniel J. Hilferty, to Present at National Managed Health Care Congress

President and CEO of AmeriHealth Mercy, Daniel J. Hilferty, will participate in a Keynote Panel, "Exploring Innovative Approaches to Expanding Access and Alternative Healthcare Financing Strategies" on Wednesday, April 26th at 9:00 a.m. at the upcoming 18th Annual

National Managed Health Care Congress (NMHCC), being held April 24-26, at the Washington DC Convention Center. Panel topics include state strategies to expand access to health insurance and restructuring community care.

Anne Morrissey, Senior Vice President and General Manager, Pennsylvania Managed Care for AmeriHealth Mercy and Keystone Mercy Health Plans, will moderate the State Medicaid Directors Panel Discussion - "Federal Reform and State Restructuring: Examining the Future of Medicaid Managed Care" on Tuesday, April 25th at 3:30 p.m. The panel will explore the value of Medicaid Managed Care, how reducing eligibility requirements will affect Medicaid members, and innovative strategies for managing pharmaceutical costs.

With more than 20 years of experience exclusively serving the Medicaid population, AmeriHealth Mercy and its affiliates comprise the largest family of Medicaid managed care plans in the United States, touching the lives of more than 1.6 million members in eight states, Pennsylvania, New Jersey, Kentucky, South Carolina, Virginia, California, Rhode Island and Indiana. For

more information on AmeriHealth Mercy and PerformRx, visit <http://www.amerihealthmercy.com> or visit the AmeriHealth Mercy booth, #629, in the NMHCC Exhibit Hall.

The 18th Annual National Managed Health Care Congress brings together senior executives from Fortune 500 companies, hospitals, and health plans to discuss and discover practical solutions to control costs, improve quality, and increase access. Visit <http://www.nmhcc.com> for more information.

Research and Markets: HMO's Pharmaceutical Expenditure Decreased From 89.5% to Reach 81.3%

Research and Markets has announced the addition of Recent HMO Pharmacy Trends to their offering.

Business Implications

-- The size of the HMO population in the United States gives it great influence over the U.S. pharmaceutical market. HMOs have been especially aggressive in introducing cost-containment mechanisms into their pharmacy programs in both private and public sector programs. This emphasis on cost control shows no signs of abating in the near future. Indeed, a recent slowdown in the annual growth rate of HMO pharmacy spending suggests that cost-containment measures have been at least somewhat effective, an achievement that will encourage the continuation of this strategy.

-- HMOs are generally successful at enforcing their formulary restrictions, although formulary adherence has declined slightly in recent years. Formulary drugs' share of commercial HMOs' total pharmaceutical expenditures declined from 89.5% in 2000 to 75.1% in 2003, then recovered to 81.3% in 2004.

-- Most commercial HMO members who have a pharmacy benefit are in two- or three-tier formularies. In 2004, 83% of commercial HMOs had at least some of their members in two-tier formularies and 95% made use of three-tier formularies for at least some members. The use of four- or five-tier formularies for at least some members increased from 6% of commercial HMOs in 2003 to 12% in 2004.

-- The highest mean copayment for preferred brands rose from \$31.38 in 2003 to \$47.18 in 2004, an increase of 50%. The highest mean copayment for nonpreferred brands grew by 42%, from \$50.87 in 2003 to \$72.27 in 2004. Such aggressive increases present HMO members with an unambiguous choice between greater use of generics and increased out-of-pocket costs.

-- The introduction of the new Medicare prescription drug benefit on January 1, 2006, will have a major impact on Medicaid pharmacy provision. Dual eligible beneficiaries will receive their prescription drug coverage under Medicare rather than Medicaid. This development will substantially reduce the states' pharmaceutical spending, but also their bargaining power with drug manufacturers. As a result, 72% of states expect to receive reduced manufacturer rebates. To compensate, states might form multistate purchasing pools to increase their negotiating strength with pharmaceutical companies.

-- In 1999, 84% of Medicare HMO enrollees had access to generic and branded drug coverage, but only 25% of enrollees had such coverage in January-February 2004. The new Medicare prescription drug benefit, scheduled to take effect on January 1, 2006, is intended to broaden access to drug coverage in the Medicare population. This benefit will be available through Medicare HMOs, but the Centers for Medicare and Medicaid Services (CMS) expects only a minority of Medicare beneficiaries to choose this option.

The impressive size of the HMO population in the United States gives it great influence over the U.S. pharmaceutical market. HMOs' aggressive cost-control measures, fluctuating membership, and changing pharmacy benefits, along with the influence of Medicare reform, will ensure that the HMO/pharmaceutical industry relationship remains dynamic and an arena that warrants close attention.

This Decision Resources report is based largely on data from annual HMO pharmacy surveys conducted by HealthLeaders-InterStudy. We examine overall HMO pharmacy survey data, including total pharmaceutical spending, formulary usage and design, patient copayments, coinsurance, and the use of pharmacy benefit managers. We then focus on pharmacy trends in the public sector (Medicare and Medicaid HMOs) and consider the future impact of the new Medicare prescription drug benefit (Medicare Part D), which is scheduled to take effect on January 1, 2006