Approved: February 28, 2003
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE.

The meeting was called to order by Chairperson Senator Susan Wagle at 1:30 p.m. on January 28, 2003 in Room 231-N of the Capitol.

All members were present except: Senator Chris Steineger

Committee staff present: Mr. Norm Furse, Revisor of Statutes
Ms. Margaret Cianciarulo, Administrative Assistant

Conferees appearing before the committee: Dr. Robert St. Peter, President, Kansas Health Institute
Mr. James Vendier, J.D., Senior Fellow, Mathematics Policy Research, Washington, D.C.

Others attending: see attached guest list

Introduction of bills

Upon calling the meeting to order, Chairperson Wagle presented requests from the Long Term Care Task Force Committee. There were two bill requests. Chairperson Wagle then said she would entertain a motion to put recommendations in as Committee bills. It was moved by Senator Barnett, seconded by Senator Jordan and the motion carried.

She then recognized Senator Barnett who stated he had a bill request from his hospital who is interested in being able to partner with other providers and physicians to help minimize the impact from a surgery hospital that was recently built. He also included that this is a tax supported county hospital . Senator Barnett said they are still researching with Ms. Correll and Mr. Furse as to how the language can be flushed out and true statutory limitations so it is a conceptual request. Senator Barnett then made a motion to introduce this bill request, Senator Brungardt seconded and the motion carried.

Educational Presentation - Kansas Health Institute - Health Care Spending Growth and State Policy Options

As there were no other requests for bill introduction, the Chair then introduced Dr. Robert St. Peter, President, Kansas Health Institute, who gave an introduction to health care spending and offered some background of the health institute, a non-profit organization. He stated their presentation would focus on a very specific aspect of overall health care spending, namely, prescription drug spending and Medicaid. He then provided a framework for thinking about health care spending: what is it that drives health care costs?

1.) The basic part of the overall equation is the cost that it takes to provide a certain type of medical service (unit cost of health care);

2.) Range of types of things that are available, that are driven by technology and improvements in the types of things that can be offered; and

3.) The demand for these types of services (not only, how much it costs, but how much is being provided).

Dr. St. Peter stated that the above three things taken together generally are considered the pieces that go into the health care cost equation. However, the unit cost increases are not the main overall increase in health care (ex. What it is we are buying, ex. Dose of penicillin) The availability of newer technologies and the cost associated with those and the increase of demand for all of these services are typically felt to contribute a lot more to the increase in health care cost.

And finally, he listed what effects demand when generated by:

1) The patient - we have certain expectations of what we are entitled to and to add to this is the emergence of direct consumer advertising and the overall aging of the population (ex. Increase in eligibility of Medicaid ;

2) The physicians - in response to defensive medicine (ex. What are the consequences of not ordering all of the possible tests available?) and big business demand generated by the system (ex. Health care not-for-profit);

3) A financing system for what consumers actually see is the direct cost to them of health care, but so much of the cost of health care to the typical insured person is invisible to them (ex. Consumer's prescription deductibles with the insurance companies picking up the remainder) ;

4) Life style choices - compare what the health care system is spending 50 years ago as opposed to today (Ex. obesity, nutrition, exercise, tobacco, alcohol, sexually transmitted diseases, and violence); and lastly,

5) The role of government regulation (ex. implementation of HIPAA designed as a method for simplifying administration aspects of health care but are generating very real costs for health plans for providers and employers being able to comply with the HIPAA legislation and mandated coverages).

Dr. St. Peter then introduced Mr. Jim Vendier, J.D., Senior Fellow, Mathematics Policy Research, Washington, D.C., to talk about prescription drug component. Dr. St. Peter did not offer a paper copy of his presentation.

Mr. Vendier provided an introduction and an overview regarding:

1.) Medicaid prescription drug spending trends;

2.) State options to control Medicaid Rx spending;

3.) State pharmaceutical assistance programs for non-Medicaid elderly, disabled, and chronically ill;

4.) Medicaid refunding for Rx coverage for non-Medicaid populations; and

5.) Implementations of Medicare prescription drug coverage proposals.

He concluded by saying it is important to focus in assessing cost containment options, and innovation, new technology, and aging of the population will continue to drive costs. A copy of his presentation is (Attachment 1) attached hereto and incorporated into the Minutes by reference.

The Chair thanked the conferees for their presentation then asked the Committee for questions or comments. Senators Barnett, Jordan, Salmans, and Wagle asked a range of questions from poly-pharmacies, cancer chemo drugs (chemo prescriptions sold out of doctors offices), 20% rebates for the states, to the cost driver of people on 20 or more pills for mental illness.

Adjournment

As it was going on 2:30 p.m., the Chair concluded the meeting by again thanking Mr. Vendier and Dr. St. Peter for sharing their information with the Committee.

The next meeting is scheduled for Wednesday, January 29, 2003.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

3-5-03

GUEST LIST

DATE: January 28, 2003

NAME	REPRESENTING
JIM VERDIER	MATHEMATICA POLICY RES.
Ken Hursh	KDHR - work comp
Chuck Getty	Kansas Health Inst.
Bob St. Peter	
Anthony Wellever	KS Health Inst.
Vickie Burgess	Burgess & Assoc.
Robert Day	SRS
Mike Hammond	Assoc. of CMHCs & KS
Wade Anderson	Kansas NEA
Ron Seeber	Heinz Law Firm
Bob Williams	KS Pharmacists Assoc
Kim Mullin	InterHab
Josie Torres	KACIL
Jennifer [illegible]	ASSISTIVE TECHNOLOGY FOR KANSANS
Barbara Belcher	Merck
Harry Boom	Dept of Admin
G.A.R.Y Robbins	
Bob Harder	UMC-KS
Paul Johnson	PACK
Lonnie Ann Lower	KATHP

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: January 28, 2003

NAME	REPRESENTING
Travis Barnhart	KNASW
Candace Bevan	WIBA

at 1

Prescription Drugs

Cost and Access Issues for States

Jim Verdier
Mathematica Policy Research, Inc.

Topeka, KS
January 28, 2003

MATHEMATICA
Policy Research, Inc.

Introduction and Overview

- Medicaid prescription drug (Rx) spending trends
- State options to control Medicaid Rx spending
- State pharmaceutical assistance programs for non-Medicaid elderly, disabled, and chronically ill
- Medicaid funding for Rx coverage for non-Medicaid populations
- Implications of Medicare prescription drug coverage proposals

MATHEMATICA
Policy Research, Inc.

Senate Public Health & Welfare Committee
Date: January 28, 2003
Attachment 1-1

Medicaid Prescription Drug Spending

- Rose by 18.1% a year from 1997 through 2000 *(Bruen, 2002)*
- Predicted to rise by 17.0% in 2001, 15.6% in 2002, and 13.9% a year from 2002-2007 *(CMS actuaries)*
- Overall Medicaid expenditures projected to grow by 8.7% a year from 2002-2007 *(CMS)*
  - Well above projected growth in state revenues

Medicaid Rx Spending *(Cont.)*

- 80% of Medicaid Rx spending is for elderly, disabled, and chronically ill (SSI and related) – 27% of Medicaid enrollees
  - Over 40% of Rx spending is for Medicare-Medicaid dual eligibles – 19 percent of Medicaid enrollees
  - Only 20% of spending is for mothers and children (TANF and related) – 73% of enrollees
- 20-30% of total Medicaid drug spending is for residents of nursing facilities
  - Paid directly by the state (not in NF per diem)
  - Drugs supplied by large specialized pharmacies
  - Little monitoring by states

State Spending Control Options

- Components of drug spending increase, 1997-2000 *(Kaiser Chartbook Update, Nov. 2001)*
  - Drug price increases (24%), increased utilization (48%), switches to newer, higher-cost drugs (28%)
- Price Options
  - Rebates from drug companies
    - Authorized by 1990 and 1993 federal legislation that also limits exclusions from state formularies
    - How to get more than Medicaid "best price" rebate?
    - FL, MI, OR use of "preferred drug lists" to get higher rebates
  - Pharmacy dispensing fees and AWP discount
  - What can PBMs and MCOs do?

Spending Control Options *(Cont.)*

- Utilization Options
  - Generic and therapeutic substitution
  - "Fail-first" or step therapy requirements
  - Limits on number of prescriptions per month
  - Beneficiary cost sharing
    - Co-pays limited in Medicaid (50 cents to $3)
    - Federal regulation also allows co-insurance up to 5% (42 CFR sec. 447.54(a)(2)
  - Prior authorization
  - Drug utilization review (DUR)
  - Disease management programs
  - What can PBMs and MCOs do?
    - MCOs don't get federal Medicaid rebate

State Pharmaceutical Assistance Programs

- As of July 2001, 24 states had state-funded direct benefit/subsidy programs for non-Medicaid elderly and disabled *(Commonwealth, May 2002)*
  - Most are small and new
    - Only six cover 10% or more of state Medicare beneficiaries (NJ, NY, ME, PA, RI, and VT)
    - Only eleven established before 1997
  - Most have high cost sharing and limited benefits
  - 10 states also use various price reduction strategies
  - See NCSL and NGA Web sites for current details
    - www.ncsl.org and www.nga.org

CMS "Pharmacy Plus" Waivers

- Sec. 1115 waivers that permit states to extend Medicaid Rx benefit to non-Medicaid populations
  - Permit states to obtain Medicaid funding for state pharmaceutical assistance programs
  - Waivers granted so far to IL and WI
    - Applications pending or expected from CT, NJ, MA, SC, and FL
  - Biggest problem
    - Must be budget neutral over five years
    - Must be offsetting Medicaid savings from reduced enrollment of seniors/disabled, reduced utilization of Medicaid-funded services (nursing facilities, home health)
    - Savings from reduced use of Medicare-funded services (hospitals, home health, etc.) don't count

Implications of Medicare Prescription Drug Coverage

- Would reduce need for state-funded Rx programs
- Would result in a major reduction in Medicaid Rx costs
  - Dual eligibles account for over 40 percent of Medicaid Rx costs
  - Pending House and Senate Medicare Rx coverage bills would take over most of state Rx costs for dual eligibles
- What are the prospects?

Conclusion

- In assessing cost containment options, focus on economic incentives and political implications
  - Who wins and who loses
  - There are few, if any, pain-free "technical" solutions
- Innovation and new technology will continue to drive costs up
  - What happens if users pay more of costs?
- Aging of the population will also continue to drive costs
  - Will future older populations be less ill and disabled?