Approved: 3-14-03
Date

MINUTES OF THE PRESIDENT'S TASK FORCE ON MEDICAID REFORM.

The meeting was called to order by Chairperson Senator Stan Clark at 9:30 a.m. on March 6, 2003 in Room 231-N of the Capitol.

All members were present except:

Committee staff present: Emalene Correll, Legislative Service
J. D. Scott, Legislative Service
Ann McMorris, Secretary

Conferees appearing before the committee:
James Frogue, Washington, D.C.

Others attending: See attached list

Mr. Frogue had compared the Kansas Self-Directed Program and the Cash and Counsel Program and concluded they are not the same. Kansas Plan option to the beneficiary does not include all providers. Reimbursement rate is determined by the beneficiary and counselor in Cash and Counsel; Kansas decides what is reimbursed. In the C&C plan the beneficiary fully controls the money; in Kansas there is no money as it is controlled by the agency. He felt there were significant differences in these programs.

Mr. Frogue provided the committee with information on the American Enterprise Institute Prescription Drug Security Plan and an article on Creating a Prescription Drug Benefit that works. (Attachment 1) This PDS plan is not in place anywhere but it might be a model of the way to go.

The committee members asked questions of Mr. Frogue regarding the Florida pilot program and data available on how the Cash and Counsel program is working. He indicated no data is available as it has not been in operation for a long enough period.

Senator Barnett suggested a group consisting of SRS, Mental Health, and NAMI to work on Care Management. A plan of action for Friday's meeting is to start on charging the SRS and other providers to focus on (1) prescription drugs; (2) targeted care management in high cost areas and the team reimbursed; (3) how to rebuild medicaid; and (4) long term chronic illness, what prevention effort should be made.

Robert Harder had provided a memo with his comments concerning the work and final report of the task force. (Attachment 2)

The next meeting of the Task Force will be on March 7, 2003 following adjournment of the Senate.

Adjournment.

Respectfully submitted,

Ann McMorris, Secretary

Attachments - 2

President's Task Force on Medicaid Reform

DATE: MARCH 6, 2003 9:30 A.M.

Name	Representing
[illegible] Watts	NC-FH Area Agency on Aging
Susan Fout	NC-FH AAA
[illegible] Denner	KHCA
Tom Bulgers	KHCA
Christy Lane	KDOH
Tanya Dorf	SRS
Shli Sweeny	KDOA
Dan Hermes	ACMUCK
Matt Hickam	Long Term Care Ombudsman Office
Mike Kuttles	Ks. Governmental Consulting
[illegible]	KAHC
Gary Robbins	Ks Opt Assn
Susan Kanneer	KS Health Institute

AEI

GALEN INSTITUTE

Prescription Drug Security Plan

The Prescription Drug Security (PDS) plan provides:

1) An up-front subsidy for routine drug expenses
2) Coverage for high-end and catastrophic drug costs
3) Access to competitive discounts on prescription drugs

The PDS plan provides a generous up-front subsidy of $600 a year to help low- to moderate-income Medicare beneficiaries with their routine drug purchases. Those at 200% of poverty and below would receive the full $600, deposited to their personal PDS card account. In addition, they would receive fully-subsidized private insurance coverage for larger drug expenses.

The private catastrophic coverage would pay 80% of beneficiaries' drug costs between $2,000 and $6,000 a year, with full coverage above $6,000.

Deposits to the PDS card and premium subsidies are gradually reduced for those between 200% and 350% of poverty. Medicare beneficiaries with higher incomes would get a tax deduction for making their own card deposits and paying their catastrophic insurance premiums.

Everyone is eligible for competitively negotiated drug discounts.

Subsidy levels:

Beneficiary poverty level	Annual PDS card deposit	Federal premium subsidy	Beneficiary's monthly premium
Under 200%	$600	100%	$0
200-250%	$450	75%	$28
250-300%	$300	75%	$28
300-350%	$150	Phases out	$28 - $111
Above 350%	Tax deductible to $600	Fully tax deductible	$111

Structure of the benefit

Medicare beneficiaries would receive prescription drug coverage for both routine drug purchases and catastrophic expenses, organized through private, competing plans.

President's Task Force
on Medicaid Reform
March 6, 2003
Attachments 1-1

The coverage would include a Prescription Drug Security card with subsidies of up to $600 a year for the purchase of routine medicines. Any unspent balances in the PDS card account could be rolled over to the next year to encourage seniors to make wise purchasing decisions.

Catastrophic coverage is provided in two parts: Beneficiaries pay 20% and the plan pays 80% for drug spending from $2,000 - $6,000 a year. Full coverage triggers at $6,000.

Subsidies to the card account and premium subsidies are gradually reduced as beneficiaries' incomes increase, ending at 350% of poverty. Those with incomes above the subsidy thresholds could participate in the program by creating their own PDS card account and receiving a tax deduction for their $600 contribution and for the cost of their catastrophic premium.

All participants in this voluntary program would be eligible for discounts negotiated by their plans and could select plans that offer them the best prices on the drugs they need, without the limits on choices that would be likely in government-run plans.

Cost to the federal government

PricewaterhouseCoopers estimates the PDS plan would cost $302 billion over 10 years.

Advantages of the PDS plan:

- The biggest subsidies are targeted to low- and moderate-income seniors.
- The program minimizes adverse selection in the catastrophic plan by encouraging healthy beneficiaries as well as those who are sicker to participate in order to get the PDS card deposit, catastrophic coverage, and drug discounts.
- The PDS plan would set in place an infrastructure for overall Medicare reform by establishing an office much like the Office of Personnel Management that oversees the Federal Employees Health Benefits Program. This office would, among other things, qualify the competing private drug plans and provide information to seniors about choices.
- Drug discounts would be privately negotiated, and the government would not set price controls or decide which drugs would or would not be available.
- Participation in the program is voluntary and open to *all* Medicare beneficiaries.
- Because the plan targets the greatest assistance to lower-income seniors, it would be less likely to crowd-out the existing private coverage that millions of seniors already have.

For more information, please contact:

Joseph Antos, American Enterprise Institute, (202) 862-5938; jantos@aei.org
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Creating a Prescription Drug Benefit that Works

Lessons from the States and Private Sector

Merrill Matthews Jr., Ph.D.

Both Democrats and Republicans are committed to passing a prescription drug benefit for seniors. The debate is over how to do it.

Most Democrats want to add the benefit to Medicare, which already provides health insurance coverage to roughly 40 million seniors and disabled people. But the Democratic approach only adds more costs to a program that the Medicare trustees say will be woefully underfunded in the future.

Republicans, by contrast, want to bring in the private sector by letting seniors choose a prescription drug insurance policy offered by private health insurance companies. The problem with the Republican plan is that almost no insurance company currently sells what the Republicans envision.

Is there a way to get an affordable prescription drug policy to seniors? Yes, if Congress will learn from the states and private sector.

Why Medicare Doesn't Cover Prescription Drugs. When Medicare was created, outpatient prescription drugs were a modest part of seniors' total medical expenses. Today, prescription drugs play a vital role in ensuring longer, healthier and more abundant lives. Although many Medicare HMOs have a prescription drug benefit, the traditional Medicare program provides no assistance for most outpatient prescription drugs. Seniors must pay for their drugs out of their own pockets or obtain some type of insurance that will cover them.

Why the Democratic Plan Won't Work. Like Social Security, Medicare is based on a pay-as-you-go system. Money from workers' 2.9 percent

Medicare payroll tax goes to the Hospital Insurance Trust Fund (known as Part A) to pay current retirees' hospital bills. While the HI Trust Fund is now solvent, its trustees predict that by 2015 Part A will spend more than it takes in. According to the trustees, "The HI Trust Fund fails by a wide margin to meet the trustees' long-range test of close actuarial balance." To get the fund into balance over the next 75 years, "[O]utlays would have to be reduced by 38 percent or income increased by 60 percent (or some combination of the two) . . . ."

Those figures exclude Medicare's Supplemental Medical Insurance (Part B) program, which pays physicians' costs and outpatient expenses. That program is funded by premiums paid by seniors from their Social Security checks and general revenues.

Democrats want to create an additional Medicare program — sometimes referred to as "Part D" — to provide prescription drugs. But it is clear that Medicare already faces significant financial challenges, even if there are no changes in the program. Does it make any sense to exacerbate Medicare's financial problems?

The Republican Plan for Private Sector Options. Last year the House passed a plan that would allow seniors to choose prescription drug coverage from a number of private sector plans. The problem is there are almost no stand-alone prescription drug plans.

Although 76 percent of seniors already have some type of prescription drug coverage, that coverage is part of a larger insurance package. According to an analysis by the Center for Medicare and Medicaid Services:

- 32.9 percent of seniors get their coverage from an employer-sponsored plan;
- 10.6 percent are enrolled in a Medicare HMO that provides coverage;

- 14.8 percent purchase supplemental ("Medigap") policies that include coverage; and,

- 12.3 percent are poor and therefore qualify for coverage under Medicaid (knows as "dual-eligibles"), while 5.3 percent rely on other public sources such as the Veterans Administration, Department of Defense or state programs.

Very few have access to stand-alone prescription drug insurance. Fortunately, Nevada has found a solution.

A State-Based Prescription Drug Plan that Works. A few years ago the state of Nevada created a prescription drug benefit for low-income seniors using a private insurance company, and the program seems to be working.

To be eligible you have to be a Nevada resident for at least one year, 62 years old or older, make less than $21,500 a year and not qualify for Medicaid prescription drug coverage. The roughly 7,500 seniors in the program pay only $10 for a generic and $25 for a brand name drug, although the coverage is limited to $5,000 per person per year. The state pays the entire insurance premium.

Fidelity Security Life Insurance Company decided it would take on the challenge of providing the insurance. The reason it's a challenge is that any type of health insurance has to have a balance of healthy and sick people. Since people with high prescription drug expenses want the coverage and those who don't aren't willing to pay much for it, insurers usually lose money. But Fidelity Security was willing to try because it appeared both the healthy and sick would join the plan.

The first year premiums, which are paid by the state, were set at $106 per person per month. In 2002, the premiums went down to $85 per person per month. However, claims averaged only about $43 per person per month. Under the contract, the insurance company would return most of that overpayment to

the state, retaining a portion for administration and overhead. That arrangement changed in 2003: the state will pay the actual claims plus an administrative fee.

A Private Sector Plan that Works. Most private sector insurers have found they cannot provide a prescription drug benefit without serious problems with "adverse selection," in which a health insurance pools gets a disproportionate share of sick people, driving up the premiums and making it unaffordable for many people.

The reason is simple: people, especially seniors, tend not to see prescription drug coverage as insurance. If they are sick, they want the coverage; if they aren't, they don't want to pay for it.

However, the AmNet Prescription Plan (from American Network for Health Care Savings Corporation) has found a way to do it. The company's primary plan lets individual enrollees buy any generic drug for a $10 copay and guarantees the lowest price available for brand name drugs. That plan costs about $35 per month, though you have to participate for a full year.

The company also offers a group plan retirees and workers for about $67.50 per month, which includes brand name drugs and incorporates a $50 or 50 percent copay (whichever is greater).

According to the company, the plan has no claim forms, no deductibles, no pre-existing condition limitations, no waiting periods and no income limits. Applicants fill out a one-page form and send it in with their check or credit card information.

In addition, a computer database monitors each enrollee's drug purchases to ensure they are appropriate and compatible and alerts the pharmacist if it recognizes a problem. If the AmNet Safety Monitoring System detects any potential interaction problems, the pharmacist is alerted not to fill the prescription until the patient's physician has been contacted and approved dispensing.

How does the company avoid getting a disproportionate share of sick people? For its individual plan, the company accepts applications from anyone under 65; it only accepts applications from seniors within the first six months of retirement. After six months, the company will decline an individual application. Thus, retirees have an incentive to get in during the "open season" or face being excluded when they really need prescription drugs. Employer-based groups don't face the same restriction because the employer brings a pool of people.

Lessons to Be Learned. There are some lessons to be learned from these two plans.

First, the government can create an affordable, stand-alone prescription drug benefit, but it must be careful to ensure a range of risks enroll. Nevada pays the premium, so even the healthy would find it a good deal. And AmNet uses a pooling mechanism. Without the ability to attract the healthy and sick, premiums would skyrocket and quickly become unaffordable.

Second, both plans limit their total exposure, through a cap on the per-person costs in Nevada and high copays for brand name drugs under AmNet. As a result, neither plan is as comprehensive as many people would want. On the other hand, they are relatively affordable in tight budget times.

Third, it is possible to bring in the efficiencies of the private sector, but doing it on a national scale won't be easy. There is a lot of room for Congress to make a prescription drug benefit unworkable.

Conclusion: Could one of these plans be a model for federal prescription drug legislation? Moving from state legislation to federal legislation is tricky, and you never want to underestimate the ability of Congress to turn a good idea into bad legislation. But at least a successful model does appear to exist, if Congress is willing learn from it.

— 30 —

Sen. Stan Clark

From: Robert Harder [rharder6@cox.net]

Sent: Wednesday, March 05, 2003 11:05 PM

To: Robert Day; clark@senate.state.ks.us; barnett@senate.state.ks.us; brungardt@senate.state.ks.us; feleciano@senate.state.ks.us; lee@senate.state.ks.us; huelskamp@senate.state.ks.us

Subject: FOLLOW-UP

Senator Clark and members of the President's Committee:

I appreciate the invitation to make comments concerning the work and final report of the Committee. I have found it interesting and challenging to listen to the discussion and to think of what might be some possible answers to the challenges at hand.

The ideas I present have not been screened or tested and some of them may be ideas already in place. The ideas I present will not have been reviewed for legality nor conformity with federal rules and regulations. In that I have been gone from SRS for some period of time, there may well be ideas that SRS is currently doing. One of the points which comes out in these discussions is that SRS is doing a number of things right and how can we add to that solid base. The ideas are presented in the spirit of the Chairman as he wanted a roundtable discussion. A worthwhile process that was beginning to emerge at the close of Wednesday's session.

1. LONG TERM CARE:

a. Less emphasis on institutional care is a move in the right direction. There needs to be a continued emphasis on HCBS. The move should be to make maximum use of consumer choice. Computer screens should be installed to look at exceptional cases and not routine cases. The management of the program should be by exception and not by 100% review.

b. Caps should be incorporated into the eligibility process. A review needs to be made to determine that lien information is incorporated into the eligilibity process and a mechanism for that information to come to Legal in SRS. In this same vein, SRS attorneys should regularly go to the seminars which are being conducted to show middle-class families how they can make themselves eligible even though they have the resources to pay for long-term care.

c. This area of long-term care is a critical area for the well-being of many needy persons in our state and it is the kind of program which makes it possible to live an independent life. Care and nuturing needs to go into this program. On that basis, I would suggest a mult-discipline team of professionals, care-givers, consumers, advocates, SRS, and Aging meet on regular basis to continue to fine tune this program.

(Sorry about this open space, I am still learning how to be my own secretary.)

President's Task Force
on Medicaid Reform
March 6, 2003
Attachments 2-1

d. The Committee ought to consider the possibility of having the office of the

Governor and the office of the Insurance Commissioner develop a comprehensive, state-wide program telling of the benefits of long term insurance for the citizens of KS. This program should include some type of a tax deduction for those persons who participate. The program should be gear to individuals in their 50's because the premiums would be lower and less of a drain to the State from a revenue standpoint. This should be seen as a long-term endeavor geared to changing mind-sets concerning one's elder years.

PRESCRIPTION DRUGS:

a. The thrust in this area would be that of trying to help the local pharmacist and keep them in the program. On that basis, I would ask SRS and the legal staff to look at a new way of paying for drugs. I would recommend that the state pay only acquisition cost and that cost to be the lowest it is costing anyplace in the United States including VA and PHS. This system could be modeled after the way in which the state handles the purchase of liquor through Alcohol Beverage Control.

b. SRS has moved on many different fronts and all of those moves should be kept in place. In the drug area, there is another example of where there is the need for management by exception. The consultant, Mr. Muse, outlined some possible problem areas. Those examples should be examined and then screens put in place to review some of the suggested high utilization areas. A review team should be made-up of consumers/consumer advocates, physicians, pharmacists, and SRS.

c. The Hiawatha patient review system ought to be piloted in several areas throughout the state to see where, how, and what cost it would be to implement such a program on a state-wide basis.

INTERNAL MANAGEMENT:

a. SRS should be called upon to insist to the fiscal agent that SRS wants to lessen the hassle factor to the providers and that this is coming as a charge from the President's Committee. Additionally, the Committee through SRS wants a full-accounting of the aging of unpaid bills and explanations for those in excess of 60 days and still unpaid.

b. The fiscal agent through, SRS, should submit a report accounting for funds not simply in the aggregate by program but also, by individual headcount to make a determination if there is over-spending in relation to increase in caseload or an increase in payments.

c. SRS should sort out and provide to the committee a listing of special programs, like special education, which have evolved over time and they are included or not included in the total medical expenditures.

d. SRS should be asked to review the issues related to managed care to see if there could be a greater number of physicians involved in this area, but it be on the basis of managed care and not simply a gimmick for managed care companies to make extra money.

BEYOND THE STATE:

a. Members of the President's Committee should call a meeting of their counterparts from surrounding states to discuss the possibility of a purchasing coop which could be used to purchase prescription drugs, durable medical equipment and possibly other items as well.

b. The Committee should go to work with your coungterparts in the other states to build the argument that the dual-eligible person should be fully a federal responsibility. This has the beauty of being a simple task without a lot of legislation, it provides immediate relief to the states, and it is the kind-of item that will be done in the future why not now.

A NEW STRUCTURE:

a. In a short period of time, the President's Committee covered a lot of ground. In

that process it became apparent that there were a lot of good activities taking place in the medical assistance program. This did not happen by accident. It happened because there were a lot of good people working to ensure services to the needy populations in KS. It also became apparent that there are new beginnings and new insights which are molding and shaping the medical assistance program. There are individuals working to make sense out of the unsystem-system. It was not always clear that the right people were talking to each other and at the right time. I suggest that the President's Committee recommend that there be a small but representative group made-up of providers, consumers, consumer advocates, SRS, and Aging meet on regular basis to talk about how the system can be made to be more workable and consumer friendly and responsive to the needs of the legislature. They should be expected to report back to the President's Committee in 2004.

These are my best thoughts for the momemt. I am available to be of further assistance, if that is the wish of the Chairman and the Committee. Bob Harder.

2-3