



Testimony for the Record

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Public Hearing

**“Smart Pharmacy and Managed Care Organization
Assessment”**

Health and Human Services Committee

Commonwealth of Pennsylvania

House of Representatives

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Chairman Oliver, Ranking Member Baker, and Members of the Committee, thank you for the opportunity to testify today on behalf of the Medicaid Health Plans of America and the 12.5 million Medicaid enrollees our member health plans represent. Medicaid Health Plans of America is the leading trade association solely focused on representing health plans in Medicaid. Our mission is to develop and advance public policy that lowers costs and improves access and delivery of quality health care to Medicaid enrollees. I will confine my remarks today to the Smart Pharmacy proposal.

With more than 20 years of experience with coordinating care and providing benefits in the Medicaid program, Medicaid health plans have provided better health outcomes at a lower cost than traditional Medicaid by encouraging prevention and coordinating care for low-income populations, many of whom have multiple chronic conditions. Managed care activities include case management, provider profiling, disease management, utilization review, and pharmacy review. The coordinated application of these strategies assure access to high quality, efficient care and limit unnecessary costs. Health plans in Medicaid have a proven track record in providing comprehensive benefits at a predictable cost through capitation payment rates. The capitation payment model provides definite savings to

states compared with fee-for-service Medicaid. The success of the managed care model depends on the ability of health plans to administer a comprehensive set of benefits and services for members, including pharmacy benefits. Pharmacy benefits are essential components of treating disease and helping patients live longer, healthier lives. Medicaid Health Plans of America is opposed to the Smart Pharmacy proposal because it disrupts coordination of care for enrollees and discourages quality care by taking away an essential component health plans have in managing an individual's health.

Medicaid Health Plans of America opposes efforts to carve-out all benefit categories, including behavioral health, dental, vision, and pharmacy services, because carve-outs detract from the ability of Medicaid health plans to coordinate a member's benefits. Some states have carved-out these benefits, for varying reasons. However, in analyzing the fully at-risk Medicaid managed care capitation model's ability to lower costs for state Medicaid programs, The Lewin Group, a national policy research firm, said in a 2004 report, "Directly carving benefits out of managed care plans (eg. pharmacy and behavioral health) introduces complexities in coordination of

care, forgoes significant savings and dilutes administrative accountability.”¹

Medicaid enrollees suffer real consequences from having multiple sources of coverage that may not communicate with each other and the state suffers from the cost associated with unnecessary duplication of administrative activities and lack of coordination between coverage providers.

Because of a perverse incentive caused by an inequity in federal statute, states are increasingly carving out pharmacy benefits from the benefits provided in the managed care program. Twenty-three states and the District of Columbia have moved to carve out pharmacy from the benefits provided in Medicaid managed care programs. Some completely carved out pharmacy benefits, while others did a partial carve-out of certain classes of drugs. Based on the experience in other states that have carved out pharmacy, if the state assumes the management and cost of pharmacy benefits for individuals enrolled in Medicaid managed care, it is estimated that costs will rise significantly for the state.

This committee is likely familiar with the 2005 Lewin Group report comparing Pennsylvania’s HealthChoices program to the fee-for-service

¹ The Lewin Group. “Medicaid Managed Care Cost Savings – A Synthesis of Fourteen Studies.” July 2004. <http://www.ahip.org/redirect/LewinMedicaidManagedReportJuly2004.pdf>

program and its conclusions that mandatory managed care has brought \$2.7 billion in savings to Pennsylvania's Medicaid program over five years and is far superior in the areas of access, quality, and focus on special needs.² To the extent that Smart Pharmacy brings short-term revenue to the state, savings will be offset with increased drug spending and costs associated with taking away care coordination and pharmacy utilization strategies from health plans in Medicaid managed care.

Medicaid health plans, internally and through their pharmacy benefit managers, achieve pharmacy savings in a number of ways. Most Medicaid health plans generally use the same drug utilization management tools commonly used in the private sector and Medicare, including preferred drug lists, prior authorization, tiered copayments, step therapy, generic substitution, and mail-service pharmacy. Health plans routinely perform comprehensive pharmacy reviews to assess harmful drug interactions and to ensure the medications prescribed are the best course of treatment for the individual. Many medicines are themselves prevention. Alpha and Beta blockers are routinely used in patients with high blood pressure to prevent strokes, heart attacks, and kidney problems. The use of such medicine is

² The Lewin Group. "Comparative Evaluation of Pennsylvania's HealthChoices Program and Fee-for-Service Program." May 2005. <http://www.lewin.com/content/publications/3178.pdf>

integral to all other aspects of care for a patient with high blood pressure. Medicaid health plans are also able to lower costs and provide savings through greater use of routine preventative measures that may avoid the need for costly medications altogether. Plans have less of an incentive to aggressively pursue prevention programs when they are not liable for the pharmacy costs.

In a 2008 Lewin Group analysis, Lewin estimated that carve-in states have pharmacy savings 15.9% greater than carve-out states, primarily through drug mix variation and a reduction in prescription volume.³ They found that the generic fill rate, or the substitution of a generic drug for a brand-name drug, is between 5.6 percent and 12.7 percent greater in carve-in states that provide pharmacy benefits through capitated health plans than carve-out states that do not, and that the usage rate of prescriptions is significantly lower in the Medicaid health plan setting than in the fee-for-service setting. In their estimates, Lewin assumed a five percent pharmacy usage reduction in carve-in states, although they also cite previous studies of 20%-23% reductions in some populations. Clearly, the capitation model used by fully at-risk health plans provides an incentive to lower pharmacy

³ The Lewin Group. Analysis of Drug Rebate Equalization Act's Savings to the Medicaid Program, September 2008.
<http://www.communityplans.net/POLICYSUPPORT/Medicaid/PrescriptionDrugs/tabid/97/Default.aspx>

costs that does not exist in the fee-for-service world, even when states contract with pharmacy benefit managers to administer benefits. However, in carve-out states, additional pharmacy spending has been more than offset by additional revenue from the mandatory rebates. Experience shows the capture of the rebate revenue is the predominant factor leading to the carve-out in every state that has moved to carve out drugs. With no evidence of improved health outcomes or lower drug spending with state assumption of the pharmacy benefit, and much evidence to the contrary, it would be ill-advised to carve out pharmacy at this time based solely on the revenue generated to the state.

This committee is well-aware of the problem. States only capture rebates on medications provided to Medicaid enrollees in fee-for-service programs, providing a strong financial incentive to carve-out the pharmacy benefit from managed care programs. This is a historic relic in federal statute of pre-managed care policy created when the Medicaid Drug Rebate Program was enacted in the Omnibus Budget Reconciliation Act of 1990. Today, 48 states have some managed care component in their Medicaid programs, and fully 64% of Medicaid enrollees receive services from a managed care organization. Since 1991, the number of Medicaid

beneficiaries enrolled in managed care plans has grown from 2.7 million to 29.8 million. Federal statute has not been updated to reflect the proliferation of Medicaid managed care and this federal policy clearly needs updated to reflect modern trends.

Medicaid Health Plans of America believes the Medicaid Prescription Drug Rebate Program should be extended to pharmaceuticals provided to individuals receiving pharmacy benefits through Medicaid managed care and supports federal legislation, the Medicaid Prescription Drug Rebate Equalization Act, to accomplish this change in federal law. Enactment of the Medicaid Prescription Drug Rebate Equalization Act of 2009, H.R. 904 and S. 547, would remove the incentive states have to carve-out pharmacy benefits from the benefits provided by health plans, providing Medicaid enrollees with the full advantages of care coordination provided by health plans. Current cosponsors of the federal legislation include Senator Robert Casey and Representatives Robert Brady, Mike Doyle, and Todd Platts.

By extending the Medicaid Drug Rebate Program to managed care, significant savings is estimated to accrue to the federal and state governments. The Congressional Budget Office has estimated the legislation

would save the federal government \$3.7 billion over five years and \$11.0 billion over ten years.⁴ An independent analysis by The Lewin Group showed savings to be as much as \$7.1 billion over five years and \$17.8 billion over ten years.⁵ Additionally, Lewin estimated savings to the state governments of \$5.5 billion over five years and \$13.6 billion over ten years. Lewin estimated savings to the Commonwealth of Pennsylvania of \$92 million in 2009, and \$544 million between 2009 and 2013.

Medicaid Health Plans of America is working closely with Members of Congress to enact the Medicaid Prescription Drug Rebate Equalization Act to update the federal statute to match today's Medicaid and promote continuity of care in managed care programs. We consider this legislation our top priority and, along with the Association of Community Affiliated Plans, have been working together with a coalition of other organizations to enact the legislation. The legislation has been endorsed by the Partnership for Medicaid, a coalition of 19 stakeholder organizations with a strong interest in Medicaid including the National Association of Public Hospitals and Health Systems, National Association of Children's Hospitals, National

⁴ Congressional Budget Office. Option 75. Budget Options, Volume I: Health Care: December 2008. <http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf>

⁵ The Lewin Group. Analysis of Drug Rebate Equalization Act's Savings to the Medicaid Program, September 2008. <http://www.communityplans.net/POLICY SUPPORT/Medicaid/PrescriptionDrugs/tabid/97/Default.aspx>

Rural Health Association, National Association of Counties, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, National Council for Community Behavioral Health, National Association of Community Health Centers, American Health Care Association, American Public Health Association, AFL-CIO, National Medical Association, and the National Hispanic Medical Association. We also have the support of the National Governors Association, National Association of State Medicaid Directors, and various Governors and state officials.

President Obama included the Medicaid Prescription Drug Rebate Equalization Act proposal in his Fiscal Year 2010 Budget Proposal. This is the first year the policy has been included in the President's request to Congress, and significantly improves its chances for enactment. Obama's budget blueprint recognized the substantial federal savings from the Drug Rebate Equalization Act policy and used it to help pay for expanded coverage and broader health reform efforts. In meetings with the U.S. Office of Management and Budget, officials have expressed concern about state carve-outs and the effect on coordination of care for Medicaid enrollees.

They acknowledged the perverse incentives the current rebate policy creates and the need to enact federal legislation to correct the inequity.

Subsequent to the Medicaid Prescription Drug Rebate Equalization Act being included in the President's Budget, Credit Suisse financial analyst Gregory Nersessian upgraded the prospects of passage of the legislation for this year.

Additionally, the Lewin Group estimated that should the federal legislation pass, most states that have carved out pharmacy from their managed care programs would carve them back in. According to the Lewin Group, "...in states that currently carve-out the pharmacy benefit, it is anticipated that the Drug Rebate Equalization would lead these states to switch to a carve-in model, which in turn would deliver to the Medicaid program drug mix and utilization rate savings that the at-risk health plans have achieved through rigorous management of the pharmacy benefit. On average, we estimate that health plan enrollee prescription drug costs in the carve-out states would be lowered by 15.9 percent."⁶

⁶ The Lewin Group. Analysis of Drug Rebate Equalization Act's Savings to the Medicaid Program, September 2008.
<http://www.communityplans.net/POLICYSUPPORT/Medicaid/PrescriptionDrugs/tabid/97/Default.aspx>

One argument often cited in favor of providing pharmacy benefits in fee-for-service is access to a greater range of prescription drugs provided through open formularies. In exchange for participating in the federal Medicaid Drug Rebate Program, pharmaceutical companies have the ability to have all of their drugs available on the state's preferred drug list, subject to prior authorization if the state decides to implement such a utilization management policy. Medicaid health plans generally have no such open formulary requirement, and may use preferred drug lists with tiered formularies, tiered copayments, and generic promotion to manage pharmacy benefits. Despite that, a survey conducted by Medicaid Health Plans of America and the Association of Community Affiliated Plans in 2006-2007 found that access to pharmaceuticals in our member plans were substantially the same as in the fee-for-service programs in the states where they operate.⁷ Furthermore, the pharmaceuticals available in each of the most common classes of drugs were substantially the same. The data suggests that despite the ability of health plans or their pharmacy benefit managers to limit the pharmaceuticals available or encourage least costly alternatives, patients enrolled in health plans have robust access to pharmaceuticals similar to fee-

⁷ Survey results available upon request.

for-service enrollees. Differences in the availability of pharmaceuticals came in only certain classes of drugs, including athletic performance enhancing drugs, anti-aging drugs, and mental performance drugs.

In conclusion, managed care successfully employs a single point of clinical accountability along with case management, disease management, utilization review, pharmacy review and other best practice strategies to assure access to high quality, efficient care while limiting unnecessary costs. Medicaid Health Plans of America and its member plans oppose efforts to carve out individual components, such as pharmacy benefits, that take away the tools vital to care coordination and disease management and thus detract from the superior cost position of managed care compared with fee-for-service programs. States have few incentives to carve out pharmacy benefits absent the federal rebate and, given the likelihood of enactment of federal legislation to equalize the rebate, Medicaid Health Plans of America would urge the Pennsylvania General Assembly to reject the Smart Pharmacy proposal.