Committee Minutes:

Health Care Task Force

House Majority Caucus Room

State Capitol, Boise, Idaho

Monday, February 23, 2004

4:30 p.m.

MINUTES

The meeting was called to order at 4:58 p.m. by Co-Chairman Bill Deal. Other Task Force members present were: Senator Fred Kennedy, Representatives Kathie Garrett, Gary Collins, Margaret Henbest, and Max Black. Co-Chairman Dean Cameron, Senators Joe Stegner, Sheila Sorensen and John Goedde were absent and excused. Staff member present was Lisa Lalliss-Skogsberg.

Others present included: Jeffrey Lewis and Ynez Cross, Heinz Family Philanthropies; Christine Pickford Ph.D. and Melanie Decker, Employers Health Coalition of Idaho (EHCI); JoAn Condie, Idaho State Pharmacy Association; Kathleen Allyn, Medicaid Division, Idaho Department of Health and Welfare; Joe Gallagos, AARP; Jack E. Jones, AARP and Area 3 Advanced Council on Aging; Ken McClure, Idaho Medical Association (IMA); Julie Taylor, Blue Cross of Idaho; Woody Richards, Moffatt Thomas; Shad Priest, Department of Insurance; Pam Eaton, Idaho Retailers Association; Lyn Darrington and Norm Varin, Regence BlueShield of Idaho; Molly Steckel, Idaho Psychological Association; Melanie Decker, DirecTV, and Colleen Brenton, Micron.

Representative Margaret Henbest made a unanimous consent request to approve the minutes of January 15, 2004. There was no objection.

Mr. Jeffrey Lewis, President of Heinz Family Philanthropies (Heinz), distributed to the Task Force a Medicaid Pharmacy Report, State of Idaho, dated November 21, 2003. A copy is available in the Legislative Services Office. This is a summary of a full report which can be obtained from **Mr. Lewis**. **Mr. Lewis** stated that "over the past few years, Heinz has undertaken a number of groundbreaking studies assisting Governors and state legislators in addressing the problem of skyrocketing prescription drug costs. At the request of Governor Kempthorne and the state legislature, the foundation provided the State of Idaho with a grant to hire Mercer Government Human Services Consulting to perform a comprehensive analysis incorporating

both a detailed examination of the state Medicaid pharmacy program and a concurrent study of the efficiency of provider practices within the state. This report exclusively presents the findings from the detailed analysis of the state's Medicaid pharmacy program completed by members of Mercer's Government Pharmaceutical Practice."

Mr. Lewis commended the Idaho Department of Health and Welfare (IDHW) and the Medicaid Division for their work. There are things in the report **Mr. Lewis** might take exception to, but he complimented IDHW for clearly trying to be aggressive, and doing the best job possible. **Mr. Lewis** said that Idaho is looking for every way to figure out drug-related issues and how Idaho can get the best value for its dollar. **Mr. Lewis** commented that Idaho is one of the few states that is not political, swaying to one side or the other, but rather staying focused on the substance and the client, which is a credit to the work Medicaid does.

Mr. Lewis continued by stating that Heinz did an exhaustive analysis of pharmacy spending under Medicaid; every state in the country has problems and are looking at a trend line on prescription drug spending that is anywhere from 18% to 40%. Idaho averages about 15% in a good year. Prescription drug issues are very complicated; Idaho has implemented a series of steps (some while Heinz was writing the report) and is ahead of the curve on these issues. Heinz consultants looked at these issues in totality; that was good news. The better news was that there are other opportunities that Idaho can still consider. There are some things that the legislators have to decide, for example, how aggressive a state wants to be in the marketplace (in terms of operating the state Medicaid program.) Medicaid is going forward in a positive way with the preferred drug list the state has implemented; the question is how aggressive Idaho wants to be in terms of greater savings and how quickly they want these savings. Some states have been very aggressive, getting bigger savings more quickly; Idaho has been very methodical. It was a state decision to maintain a balance between Medicaid and the state legislature; this was also up to the Governor. **Mr. Lewis** gave numbers on how Idaho could achieve better savings, but as long as Idaho's legislature is comfortable with the approach they are taking, it's a solid road to continue to follow. There are things Idaho needs to think about differently that don't necessarily impact Medicaid directly.

Mr. Lewis reported that Florida has been one of the most aggressive states in the country with regard to preferred drug lists. Florida did this because they have superb staff there who decided to take on the pharmaceutical industry in a very aggressive way. Florida negotiated with Pfizer, as an example, and Pfizer said they would guarantee Florida a savings of $14 million to stay on Florida's preferred drug list and to avoid prior authorization. Prior authorization means that before a prescription can be filled, a physician has to be called by the pharmacist, causing a delay and additional paperwork. In Florida's effort to achieve greater savings in this current fiscal year, Florida plans to save $62 million through an aggressive preferred drug list and aggressive negotiations with pharmaceutical manufacturers. Florida has a huge elderly population and a growing Medicaid population as well. California in fiscal year 2001 saved an additional $106 million through an aggressive preferred drug list and supplemental rebates. These illustrations were raised to show that states who aggressively go after the pharmaceutical industry reap benefits.

Fiscally, Idaho should be more aggressive in terms of dollars and cents, but **Mr. Lewis** could not fault what Idaho is doing because Idaho is looking at drug costs from the best perspective of good policy and what is in the best interest of the people served, which is to their credit. **Mr. Lewis** introduced **Ms. Ynez Cross** who is a pharmacy consultant with Heinz. **Ms. Cross** addressed the Maximum Allowable Cost (MAC) comparison, stating that it is a program that reimburses pharmacists for a reasonable profit margin on generic drugs. There were abnormalities in the marketplace in generic drug pricing due to competition; in Idaho in the Medicaid program, they utilize the greater of the Health Care Financing Administration (HCVA) federal limit or the state MAC program. When Heinz looked at the state MAC program as it stands today, it included 740 basic drugs, not a bad MAC program; however, there is still opportunity for savings. The Medicaid program has secured a vendor and they are finalizing the contracting; they have proactively moved forward in expanding the number of generic drugs that are covered under that reimbursement program. That will be between 2%-4% of annual drug expenditures, so it's a very material savings, second only to the preferred drug list. The program is also the most widely accepted, it is commonly used in the commercial marketplace, and there would be a seamless transition to the pharmacists. **Mr. Lewis** commended Medicaid for moving forward, and Heinz encourages the state to review this program in a year to see if Medicaid has been as aggressive as they can be, depending on their fiscal savings. Another important thing to address, due to a systems enhancement from the vendor Electronic Data Systems (EDS), is that there are many things that Medicaid can now do to enhance what happens behind the scenes in real time using technology that will provide savings to the state and efficiently utilize manpower. Because this system upgrade has taken place, some manual intervention has shifted and some labor can now do new prior authorizations which expands efficiency without increasing staffing. The system that has been operating (which had not been as competitive to the commercial marketplace) is now getting much closer as a standard without additional expense to the state; that is affecting Medicaid positively, as well as pharmacies.

Mr. Lewis mentioned that the pharmaceutical analysis done by Heinz looks at the role of pharmacists in the whole process when a prescription is being filled. The Heinz report gives dollar values of changing one thing versus changing another. **Mr. Lewis** asked the Task Force to think about how the world of pharmacy has changed, emphasizing that the pharmacists become the one personal contact that people see and talk with, as compared to their very busy doctors. In the Medicaid field and non-Medicaid field, there are states, Iowa for example, who pay pharmacists what is called an enhanced dispensing fee for the work they do for cognitive therapy. Pharmacists spend time talking with patients, both Medicaid and private, looking at possible drug interactions for their customers, advise them accordingly, and give them advice on brand name versus generic drugs. There is a point in the Medicaid program that Heinz will fund programs where pharmacists are being rewarded for enhanced cognitive therapy. When a pharmacist helps a patient to prevent them from entering a hospital emergency room unnecessarily, that pharmacist will receive an enhanced reimbursement. The role of pharmacy needs to be reevaluated. The pharmacist really is the one person in the medical world who spends a great deal of time with Medicaid patients in the private sector and they should be rewarded for that as opposed to penalized. **Mr. Lewis** has advised legislators on mail order programs and to more aggressively seek changes; he sees a value for mail order up to a point. When quality pharmacists deliver good value, particularly in community pharmacies which are rapidly disappearing, **Mr. Lewis** hopes there will be a way to keep these small businesses open.

One of the things **Mr. Lewis** recommended to the Task Force was how to build an enhanced reimbursement rate for pharmacies actively involved in enhanced cognitive therapy. **Mr. Lewis** volunteered to set this up in Idaho, and will give the Task Force more information on that since he believes that pharmacists do far more today than what they are paid to do, which is dispense prescriptions.

Mr. Lewis emphasized that the state's RegenceBlueshield health insurance plan for state employees needs to be looked at by Idaho legislators. Is Idaho getting the most for their money through that "blue plan" and is Idaho receiving rebate dollars that may come through from a pharmacy benefit manager to an insurer, and if so, how many dollars are being passed to the state as an employer? Unless the state performs an audit on that "blue plan or insurer," an audit of both the relationship between the insurer, the Pharmacy Benefits Manager (PBM) and the rebates that accrue to the insurer that are passed on to the PBM, a state does not know how much is in its coffers. **Mr. Lewis** advised the legislators to look at Idaho's insurance plan for state employees and to have that plan audited by an outside auditor to look at the rebate contracts that exist between the PBM and the insurer to determine what is being delivered and what is not, what is in Idaho's contract and if it's not being delivered, find out why. An audit is the only way Idaho will get an answer to these questions. When a state's employee health insurance plan is being looked at, with a prescription drug benefit, a separate audit in terms of compliance is important to do as well. When a state looks at a formulary, is that state allowing drugs not in the formulary to be filled, how often does that happen? The audit needs to check under the surface to determine what drugs are on the formulary. To give an example, cosmetic drugs such as Viagra and Retin-A, that may be important to individuals for personal reasons, are questionable in terms of their value with regard to insurance costs. Look at Idaho's insurance plan to find out how much money is being spent on these particular drugs. When a state does not have extra dollars to work with, every dollar counts. In the event a state is spending $40-$50,000 on Retin-A, which is often used by older people for their skin, that drug may be important to someone individually, but in terms of real medicine, if it's not for real dermatology, a state needs to ask why they pay for it. The same would apply to life-enhancing drugs like Viagra, or Propecia for baldness. When the focus is on Medicaid programs, sometimes what exists in the state insurance programs for state employees is forgotten; this is important because a state wants to apply the same microscope to both programs to get the best value for the state's dollar. An audit would reveal what has been promised versus what has actually been delivered.

Mr. Lewis addressed the Federal Program 340-B through the Department of Public Health. He said some states have gotten creative, i.e. the Texas Department of Corrections used federal dollars instead of Texas state dollars for prescription drugs for certain populations of inmates. Rhode Island's state legislature has found, on a preliminary basis, that 340-B funding has the potential of saving between $5-$13 million for certain groups that are eligible for 340-B funding. **Mr. Lewis** offered to send one of the Heinz specialists to Idaho to look at Idaho's data to confirm whether Idaho could benefit from enhanced 340-B funding.

Mr. Lewis expressed two concerns as Medicare goes forward in terms of the prescription drug benefit that takes place in 2006 at some juncture and, in the interim the prescription drug benefit card; the real issue is, will it stand in its current form or be changed? **Mr. Lewis** is also concerned about uninsured Idaho citizens who can work, for example, for Wal-Mart but not

qualify for health insurance or small businesses who cannot afford to offer benefits. Heinz designed a program in Ohio that became law with an unusual alliance between AFL-CIO, pharmaceutical manufacturers, AARP, the Council of Churches and others to put together what they called "Ohio's Best Rx." The focus is on the elderly and the uninsured, and Ohio is the first state in the nation where the uninsured will be able to buy prescription drugs at the state price. The legislation was designed to look at the weighted average of what a state plan is paying; in Ohio they have about seven different state programs providing prescription drug benefits to some population, excluding Medicaid from this discussion, looking only at non-Medicaid based programs, based on this weighted average, on a drug by drug basis. A 30-day supply of Lipitor costs $100 at a retail counter cash price but the state price for that same drug is $60, and an uninsured person in Ohio's Best Rx Program would have access to Lipitor at the $60 price. It's a tremendous savings for any person paying full price at a retail counter. That is the good part; the bad part is that the pharmacy who has been filling these prescriptions at the full cash price won't like this. At some point in the balance of these issues of how to deal with the uninsured problem, if a state cannot afford to put them under an enhanced Medicaid program, like Maine did, or if the federal government is not offering more waivers under Medicaid in terms of allowing states to lift their Medicaid ceilings of 300% of the federal poverty level, a state has limited options with which to work. Trying to help an uninsured population, an employed population as well as unemployed, Heinz designed this alliance in Ohio as the one response that is fiscally realistic for a state. There is an up-front cost to a state in implementing the program, but in terms of delivering real value in real time to real people, it's an immediate assistance and very helpful.

Mr. Lewis continued that the other program opportunity is what Heinz calls the physician/patient assisted program (PAPS), which often involves private entities that operate in states taking responsibility for a fee of $25-$30, to sign up an elderly and uninsured person with chronic illness for a program that pharmaceutical manufacturers offer, if that person is income-qualified. Patient-assisted programs guide a person through the red tape and, if that becomes an interest of Idaho's legislature, Heinz will be happy to help. Heinz is soon going to be doing a pilot project in four different cities across America and could include Idaho in that project. Looking at the problem of health care costs and health insurance costs, Heinz has looked at different opportunities with minimal cost to a state. Heinz, at the same time, looks for savings opportunities where programs deliver great value and allow state legislators to demonstrate to the public the kinds of positive things legislators are elected to do and want to do, but are often not able to do because of limited revenue.

Representative Margaret Henbest asked about Mr. Lewis' Medicaid Pharmacy Report on page 6 under "Opportunity for Consideration," and the recommendation to go to a reimbursement AWP (average wholesale price) of 13%-14% instead of 12% which Idaho has now, or to drop the dispensing fee. In the presentation, enhanced reimbursement for pharmacists was suggested, and **Representative Henbest** asked whether **Mr. Lewis** was leaning toward rewarding pharmacists or would he drop the AWP? **Mr. Lewis** answered that he thought Idaho should look at a combination, maintaining a balance, and protecting the pharmacists as much as possible. **Mr. Lewis** wanted to give Idaho a series of options and fiscal numbers with those options, allowing Idaho current data showing what Idaho has to work with. The reality is that it is easy to lower a dispensing fee, but there are other ways to look at this. In the pharmacy world, the pharmacies

need to be protected, particularly community pharmacies (independents), allowing them to survive by rewarding pharmacists for doing more to help keep Medicaid patients out of hospitals, emergency rooms and nursing homes. The Ohio model is a great example and **Mr. Lewis** will provide that information to the Task Force.

Ms. Cross added that Heinz does provide benchmarks and the report shows that Idaho does pay more in a dispensing fee as well provide a reimbursement honoring an AWP discount; there are obviously many factors a state looks at when they balance looking at additional services. Heinz has seen states that said they want to be sure they get additional services rather than reducing a cost, and they want enhanced reimbursement; many states have looked at chains versus independents differently because they have differences in how they do business, so some states have chain versus independent reimbursement, and it's a balancing act. **Ms. Cross** would argue that for Idaho to keep at this high a dispensing fee, at this high a reimbursement and to add more fees, there is some concern at the federal level. Centers for Medicare and Medicaid Services (CMS) have pointed out there are some disparities.

Representative Henbest inquired about getting drugs at discounted rates for certain populations, and stated that one of the challenges has been the cost up front and asked if there were any expertise that Heinz could give to Idaho in terms of streamlining this. **Mr. Lewis** answered that Maine is unique, having a federal waiver, so Maine was able to draw on some additional pharmaceutical money and probably will not be replicated in the near future by CMS. Heinz recommended that "Ohio's Best Rx" charge a transaction fee between 25 cents and one dollar each time a prescription is filled, and that money goes directly back to the state. Ultimately a pool of revenue is generated that is paying for the administration of the program, in a short term rather than long term, and more importantly it allows a state, as this program grows, to reduce the transaction fee and reach a balance at some point. If there is an up-front expense, the transaction fee allows a state to protect itself. If the dispensing fee paid to a pharmacist is $5, it would then be $6, the one dollar going to the state. If you use Lipitor as an example, $100 versus $60 (plus $6 dispensing fee) the $34 savings is significant. **Ms. Cross** added that Ohio is developing a partnership, although not everyone is thrilled about it, but everyone is coming to the table with give and take. The other extreme example is California, where they basically said that if a person wants to fill Medicaid prescriptions, an uninsured person's prescription must be filled at the same price. California put severe risk on their Medicaid reimbursement; also California is not drawing on any pharmaceutical manufacturer money through rebates or transaction fee money and that puts all the burden on the pharmacist. **Ms. Cross** suggested that Idaho try to find a balance between the pharmacists taking some loss, but there would be some money coming from the drug companies on the back end, such as in Ohio.

Representative Henbest asked about Idaho's state health plan for employees and the pharmacy benefit managers. **Ms. Henbest** understands that across the nation some savings dollars have not been appropriately dispensed to the states, or to whomever has contracted with a state, and asked if there were any recommendations from Heinz regarding who they would suggest to do these audits. **Mr. Lewis** answered that Heinz could provide a list of recommended firms for those audits.

Representative Max Black inquired about providing drugs to the uninsured at a state price and asked if Idaho had a program to do that, what type of legislation or programs have to be initiated to look into the possibility of that? How does a state appease these pharmacists if you take away that profit? **Mr. Lewis** pointed out that the pharmacist is not the issue, unless the pharmacist owns the drug store. There is no way to satisfy an individual who owns a community pharmacy today who is getting full cash price for prescriptions. If the state declares they want to protect the uninsured, an individual who owns a community pharmacy is not going to be happy. Chain drug stores are in the same situation, but the way to protect them is to become a voluntary program; if the pharmacy does not wish to participate, they don't have to since it is not mandatory. Making it a voluntary program creates an interesting situation in the marketplace; a state may find that some pharmacies are going to have to participate because if one chain drug store does this and a community pharmacy doesn't, then customers are going to go where there is volume and it's a question of doing business. In terms of profits, there is no way to satisfy a pharmacist who owns the drug store.

Representative Black asked what states were doing that and **Mr. Lewis** responded that Ohio is the first state and is in the rule-making process right now.

Mr. Lewis summarized by saying that a state must look at the people behind the program and the struggles they deal with in terms of fiscal issues. **Mr. Lewis** pushes Medicaid programs very hard, but is very familiar with what Idaho is trying to do and the balance between what they want to do and what they need to do in their relationship with the legislature, and that is a delicate balance. Idaho's Medicaid Division is going that extra mile and this is a time to commend them for doing a great job and encourage them to continue getting the best value for Idaho's dollar. **Ms. Cross** added that Medicaid in Idaho has taken care to methodically do their job well; there are changes that, in theory, might occur more rapidly, but Medicaid took the time to make sure they had the staff to do the job well, both with physicians as well as pharmacists.

Representative Kathie Garrett expressed her appreciation on behalf of the representatives who have worked with Medicaid; the next step that the Task Force will be looking at, with JFAC's help, is evaluating the figures next year to see how Idaho has progressed.

Ms. Chris Pickford, Employers' Health Coalition of Idaho (EHCI), passed out a pamphlet with that same title, a copy of which is available in the Legislative Services Office. **Ms. Pickford** stated that EHCI has provided high quality, appropriate, cost-effective health care for 154,000 Idaho people since 1981. EHCI has had employee cost increases of 52% on average over the years from 1998 to 2002. During that same period, medical costs went up 42%, hospital fees rose 33%, x-rays and lab fees rose 66%, and prescription costs rose 72%. Once a group reaches about 5,000 covered lives, then it resembles other groups, but with different demographics, so what EHCI experiences applies to Medicaid and the state health plan.

Ms. Pickford asked two speakers to answer questions posed by the Task Force on October 8, 2003, to address surgery costs that DirecTV experienced in its Boise group versus surgery costs in other parts of the country, and secondly what EHCI companies are finding out about Idaho medical costs versus medical costs in other states.

Ms. Melanie Decker, DirecTV, spoke with regard to the October 8, 2003 Task Force meeting when DirecTV presented results of a company-wide analysis which analyzed health care costs for 2002. **Senator Fred Kennedy** had asked for clarification on a specific statistic quoted which stated that in 2002 the average per surgery cost in DirecTV's total population for the Hughes Medical Plan, which DirecTV is part of, was $236; however, in Boise this cost was $628. To further clarify that statistic, **Ms. Decker** explained that this figure does not represent a single specific procedure, but rather the $236 average was calculated taking the total cost of surgeries for the total population for that year and dividing it by the total number of members for that year; total Boise surgery costs divided by the total number of members in the Idaho plan reflected the $628 average. Information was recently gathered by DirecTV for the 2003 population, and DirecTV is very committed to finding solutions to the rising health care costs in Idaho. In the coming months, DirecTV will be analyzing this information and will share their findings with the Task Force in the future.

Co-Chairman Deal asked how the frequency of surgeries in Idaho compared to the entire population of their company. **Ms. Decker** said she is analyzing this and will report back to the Task Force in the future. **Representative Henbest** expressed curiosity whether the Boise population had more surgeries or if the surgeries were more expensive, or a combination of the two which resulted in the surgery costs in Idaho being almost three times higher than the company's national average in other locations. **Ms. Decker** agreed to gather current 2003 data and report back to the Task Force with those figures.

Ms. Colleen Brenton, Micron Technology, provided a handout for the Task Force members entitled "EHCI, CPT Code Allowed Rates - State Comparison" in response to **Senator Dean Cameron's** question at the October 8th Task Force meeting about Idaho information being compared to findings based on cost. Member companies submitted their most frequently utilized current procedural technology (CPT) codes that identify specific procedures in treating plan enrollees and their dependents. Micron identified ten medical procedures that companies had in common, keeping in mind these are not necessarily the most expensive costs per company, but ten medical procedures that they had in common with the different demographics involved. The spreadsheet shows the procedure performed and is extremely clinical, the average reimbursement rate for the member companies, and the average rate for other states in the West, both individually and as an average. The states have been bound to privacy by requests from the entity from which Micron obtained this cost information, but **Ms. Brenton** revealed that the states involved are Washington, Utah and Oregon, in no particular order. The spreadsheet is a proprietary document provided only to the Task Force members.

Representative Black asked about the demographic information where it states the median household income for 1999 and asked if this was the employers being referenced. **Ms. Pickford** responded that the figure was from the most recent federal census data, population at large, and that information was included because on the cost compared to other state averages, Idaho has ten medical procedures listed, and in six of those the cost was greater than the average of the other states. However, if you look at those other three states compared to Idaho, with the demographic data, Idaho has lower median household income of the four states, Idaho has the largest percent of individuals in those four states below the poverty level, and Idaho has the lowest median value of homes, so if Idaho has lower labor costs and lower housing costs, you

might expect that the medical costs would look somewhat similar, so that is a question that EHCI is presenting with this information. Are the costs per procedure perhaps more expensive?

Ms. Pickford handed out a document entitled "A Dartmouth Atlas Quick Report for Idaho, Montana, Nevada, Utah and Wyoming." A copy is available in the Legislative Services Office. She said the Dartmouth Atlas is familiar to those who discuss Medicare costs. It pertains to elective surgeries. Idaho ranked highest for joint replacement for degeneration of the knee joint and surgery for back pain. The charts address cost, and if the cost is more, **Ms. Pickford** queried whether that was because the surgery costs more per procedure or because there are a higher number of procedures being done.

Representative Henbest stated that she was somewhat familiar with this information, having to do with frequency rate and not cost per procedure. **Ms. Pickford** answered this data was based on physician cost codes bringing together total surgery costs.

Co-Chairman Deal thanked the attendees for compiling the information presented at the Task Force meeting. The meeting was adjourned at 5:54 p.m.