Health and Human Services Commission

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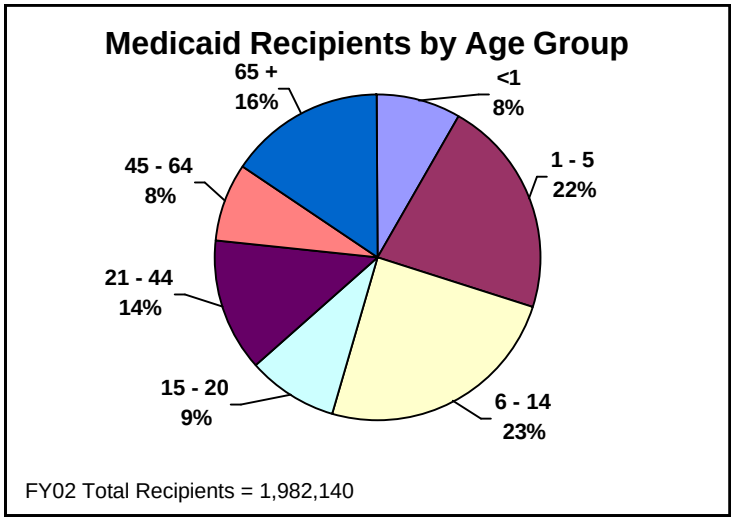
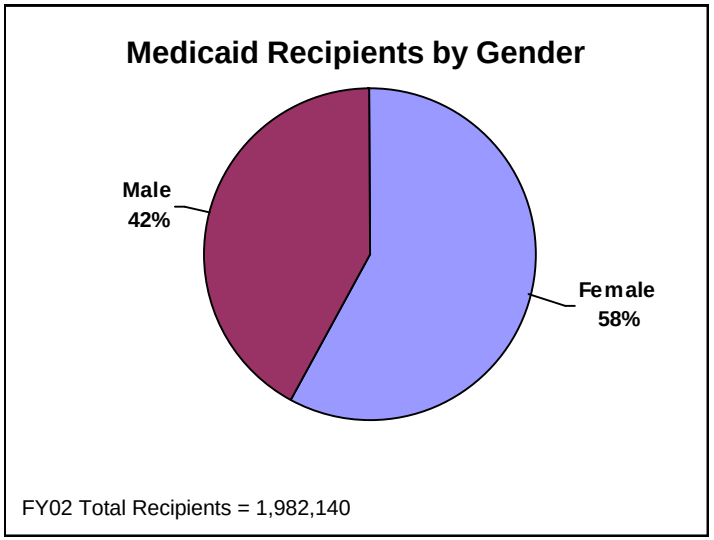
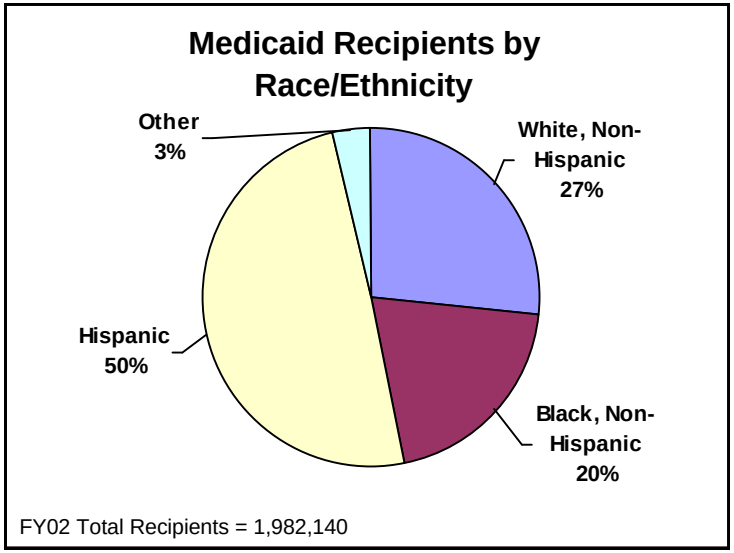
Subcommittee on Medical Costs

February 26, 2002

Medicaid Health Care Costs





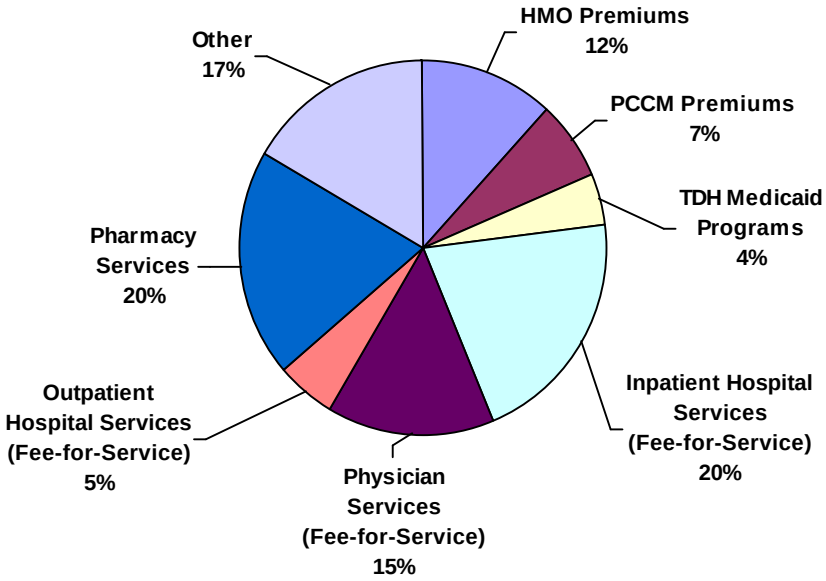


What is Medicaid? Medicaid pays for health care expenses for low-income persons who meet eligibility guidelines and who have no other way to pay for care.

Who is covered? Beneficiaries include children, single parents, pregnant women, and poor and low-income elderly or disabled individuals. Approximately 62 percent of Texas Medicaid recipients are under age 21.

What are the benefits? The acute care component of the Medicaid program pays for typical health services including physician and other medical professional services, inpatient and outpatient hospital services, lab and x-ray services and pharmaceuticals. Medicaid makes all payments directly to service providers instead of to recipients.

What services does Medicaid pay for?



This presentation will focus on acute care Medicaid costs, which do not include the long-term care costs, such as Nursing Facilities, ICFs-MR. The exception to this is drug costs associated with all Medicaid clients, which are included in the Vendor Drug Program costs that are presented in this presentation.

Four areas account for the majority of acute care Medicaid services. They are:

- Inpatient hospital services $1,372 million in FY01
- Physician services $ 981 million in FY01
- Outpatient hospital services $ 339 million in FY01
- Pharmacy services $1,322 million in FY01

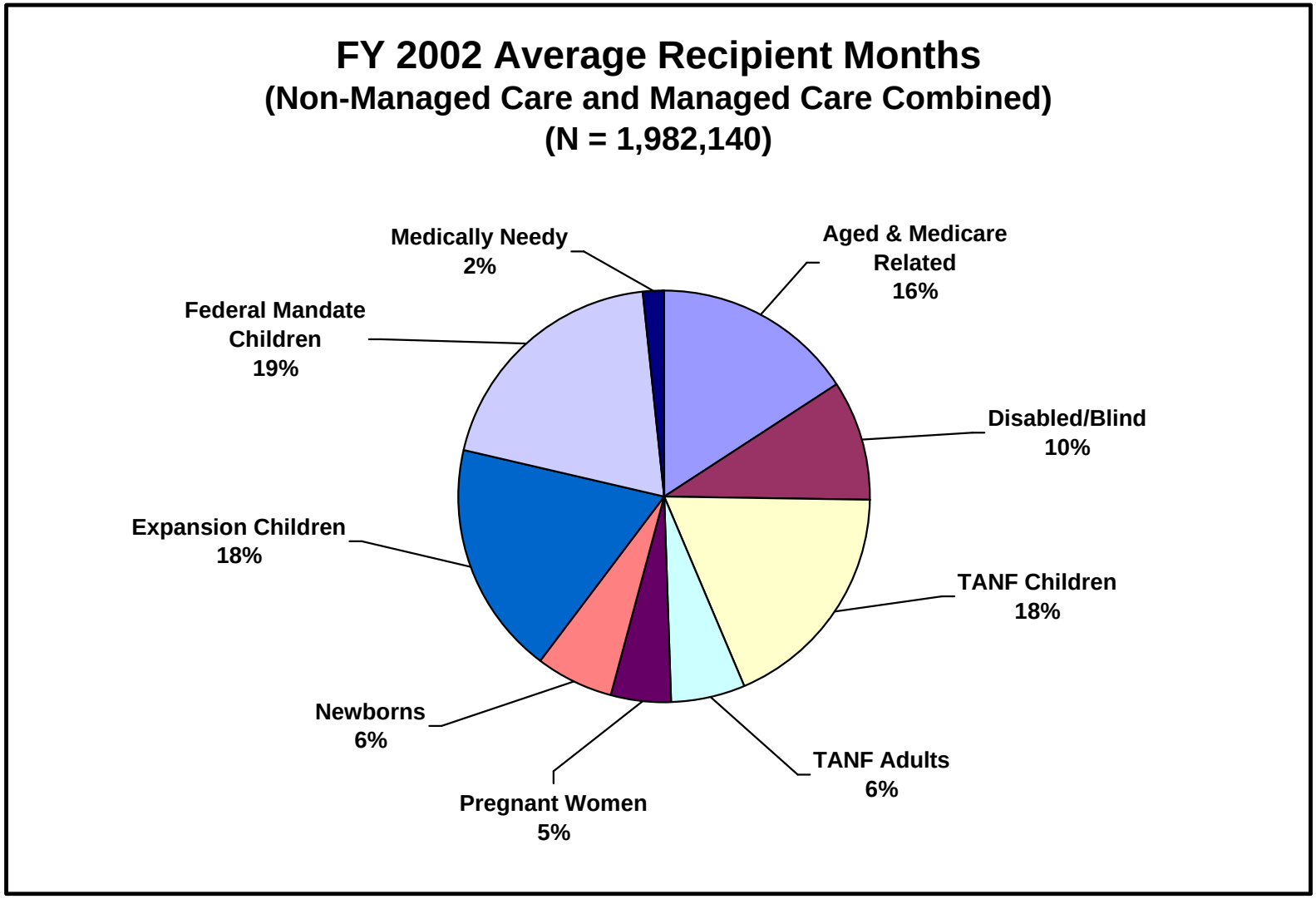
- In terms of total expenditures, seven of the top ten services are related to deliveries and the care of newborns. In terms of volume, deliveries and newborn care accounts for eight of the top ten services.

- For outpatient services, private duty nursing for children in the Texas Health Step Comprehensive Care Program ranks number one in total expenditures. This is closely followed by base fees for emergency room and outpatient clinic visits. Emergency room and outpatient clinic visits are the top two services in terms of volume. Top-ranking outpatient procedures include a variety of diagnostic laboratory tests and radiological procedures.

- New-generation anti-psychotic drugs are first and second on the list of top ten drugs ranked by total expenditures. Anti-ulcer medications are third and fifth on this list. In terms of volume, analgesics (pain medication), anti-inflammatories and antibiotics account for six of the top ten.

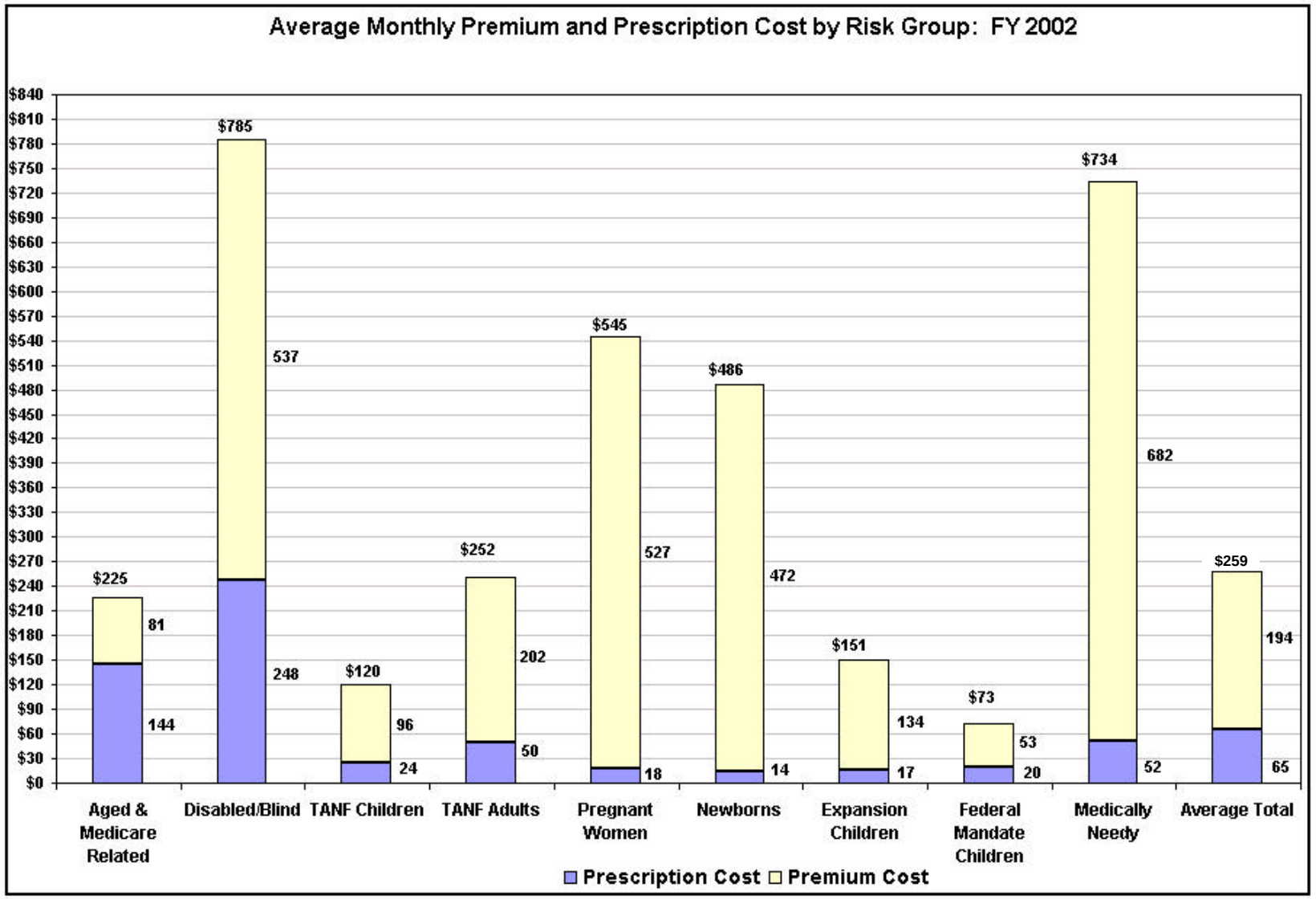
Medicaid Spending by Risk Group

Medicaid enrollees are categorized into nine separate groups for the purpose of monitoring and projecting costs. Each risk group represents unique patterns of utilization and therefore costs to the program. The following chart illustrates the proportion of the nine risk groups in the Medicaid enrolled population.



Medicaid Spending by Risk Group

Overall costs for each of the nine risk groups is represented by the sum of blended premiums and vendor drug costs. Blended premiums refer to the expenditure for acute care medical services (both HMO and FFS) such as physician services, inpatient and outpatient care, etc. Vendor drug costs include pharmaceutical products and services.

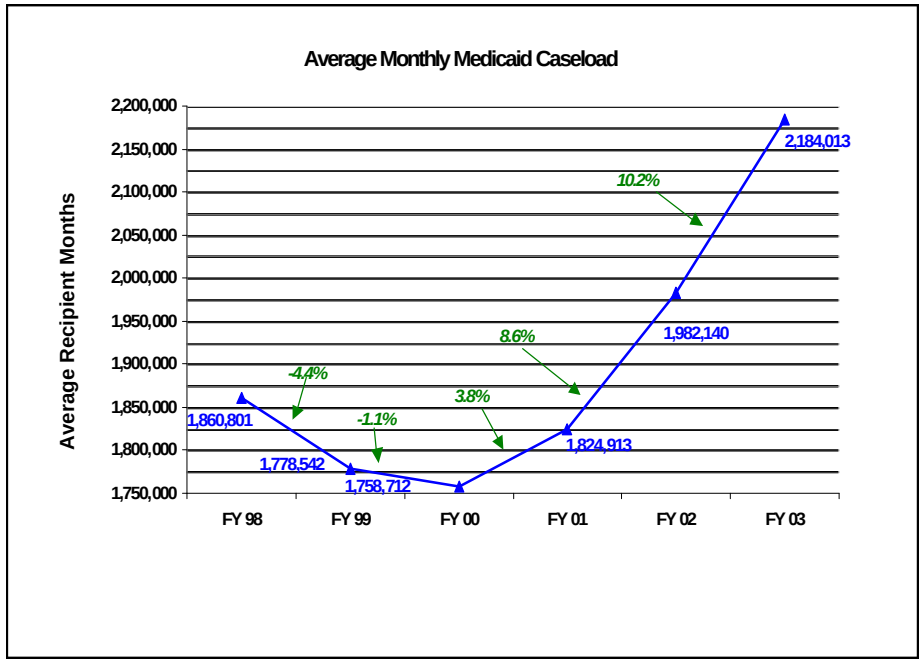


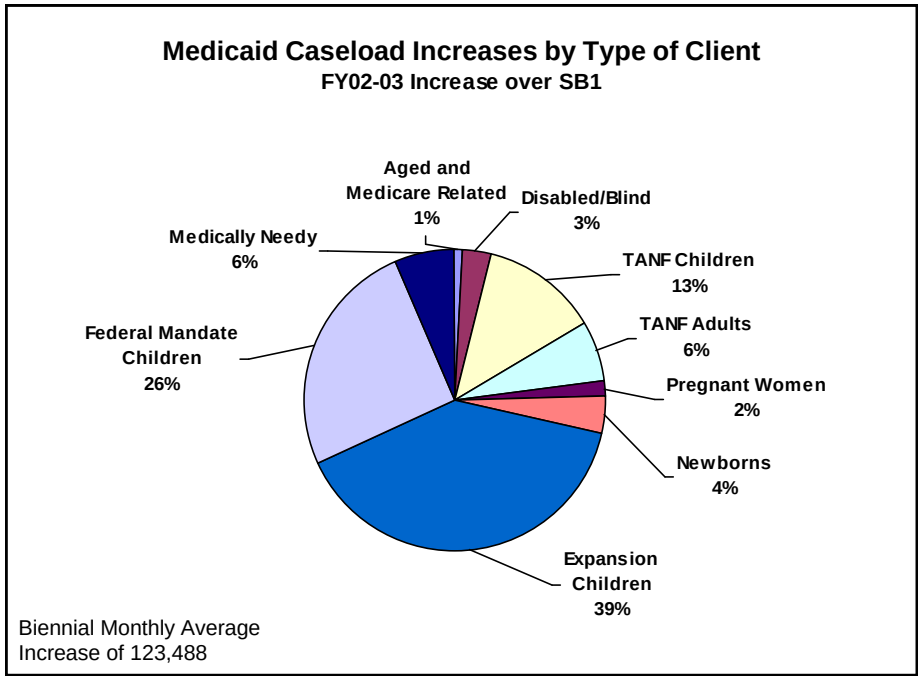
What is driving Medicaid costs?

- Caseload Growth
- Pharmaceutical Benefit
- Dual Eligibles
- CCP
- Cost-Reimbursed Services

Caseload Growth

Medicaid caseloads have increased since FY 2000, and are projected to continue to increase through FY 2003. The average number of Medicaid recipients for FY02/03 is projected to be 123,488 more than budgeted.





Pharmaceutical Benefit

New and more expensive drugs combined with increased utilization by Medicaid recipients has created significant pressures on the Medicaid budget in recent years. The federal government estimates that prescription drug costs will increase an average of 12.6 percent per year over the next ten years. If that projection holds, the biennial expenditures in the Texas Medicaid Vendor Drug program will grow from $3.1 billion in FY02/03 to roughly $7.6 billion in FY2010/2011.

Increased costs have been attributed to:

Increased utilization	43%
Newer/more expensive products	39%
Price increases for existing products	18%

In an effort to mitigate the escalating pharmaceutical costs in Medicaid, several strategies have been developed and are in varying stages of implementation. The following initiatives intended to reduce spending in the VDP have been, or soon will be implemented and are expected to reduce GR spending by over $70 million in FY02/03.

Initiative	Savings
• Audit-related drug pricing reductions	$10.0 million
• New MACs related to federal price changes	$ 4.4 million
• Reimbursement formula change due to statewide audits (public hearing in March)	$21.3 million
– RFP to evaluate appropriateness of dispensing fee	

- Increased utilization review activities — $25.8 million
  - New MACs related to patent expiration
  - Maximum daily dosage limits
  - Age and gender limits for certain drugs
  - Physician notices for high volume users
  - Clinical pathway development (best practice) for eight drug classes
  - Pharmacy data management system
- Rebates for drugs administered in physicians' offices — $ 0.4 million
- CHIP rebates/cost savings — $15-$20 million
- Bulk purchasing — $ 3.0 million

Other strategies currently under development include:

- Co-pay for pharmaceuticals (non-generic) – waiver approval required — $2.5-$3.0 million (in 03)
- Four brand/34 day supply limits — $25.0 million (in 03)
- MAC of "AB"-related generic products (drugs with narrow therapeutic index) — $ 1.8 million (in 03)
- Mail order prescriptions for homebound clients — $ 1.0 million (in 03)
- Additional manufacturer rebates/product discounts in proportion to the budget shortfall for VDP have been discussed with the industry. Negotiations are ongoing.

Dual Eligibles

- To reduce state Medicaid expenditures, the state pays Part A and Part B Medicare premiums for various individuals. Beneficiaries then receive services covered by Medicare.

  State expenditures are impacted by caseload size and by the amounts of the Medicare premiums which are determined by the federal government.

- Approximately 63 percent of FY 2002/03 the cost increase projected for the Medicare strategy is due to change in the Medicare premiums. The remaining 37 percent is attributable to caseload growth.

CCP

- The Texas Health Steps (CCP) provides a variety of medically necessary and appropriate health care services that are beyond the scope of the premium arrangement to children under age 21.

- About half of the cost increase projected for CCP is the result of Medicaid caseload growth in the children's categories. Rising costs for such services as private duty nursing, inpatient psychiatric care, and durable medical equipment and supplies account for the balance.

Cost Reimbursed Services

- Cost reimbursed services include reimbursements to Federally Qualified Health Centers, reimbursements for Graduate Medical Education and emergency care for immigrants. Emergency care for immigrants, primarily deliveries, represents about 78 percent of cost reimbursed services.

- Approximately 80 percent of the increase in these costs is due to caseload growth. The remaining 20 percent is associated with service costs.

Other Cost Containment Initiatives

The 77th Legislature directed the Health and Human Services Commission to achieve a total of $205 million in general revenue cost savings in the Medicaid program. Strategies to achieve these savings include the following:

Medicaid Administration – Estimated $89 million GR savings.

Reducing the Trust Fund Balance – The trust fund will be reduced by 8/31/03. The funds are available for transfer at this time; however, interest earnings should be allowed to continue to be earned through the balance of the biennium. Other TMAS contract adjustments have been made (THQA and B & D) for a total estimated savings of $89M.

Hospital Payments – Estimated $48.5 million GR savings.

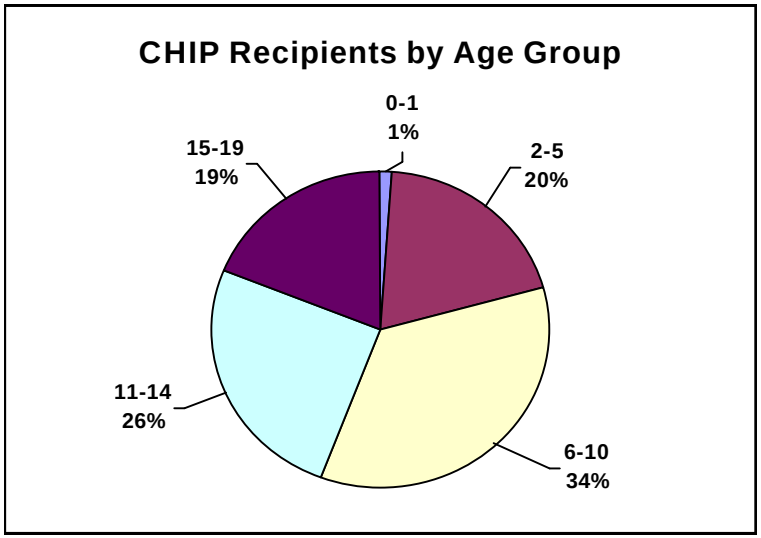
Targeted reductions in hospital reimbursements will begin 4/1/02 and yield an estimated $48.5M. The Hospital Payment Advisory Committee and the hospital associations are working on an alternative plan that may be substituted for payment reductions. That plan is to be presented by the end of this month.

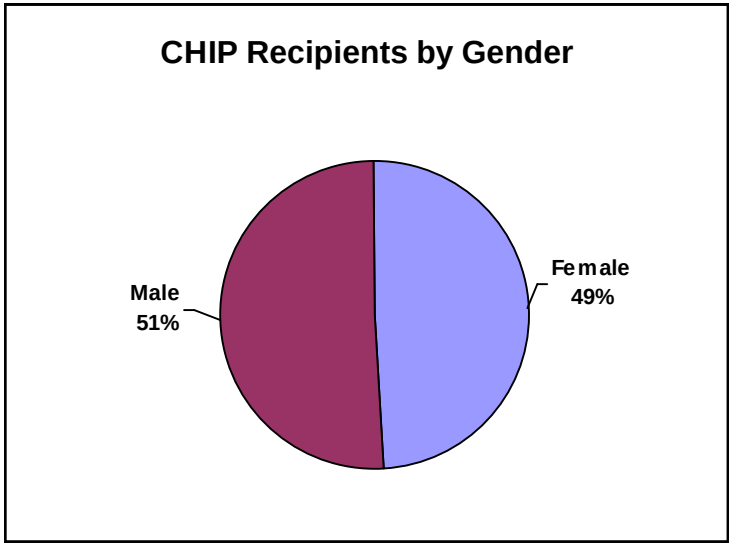
Other strategies planned but not yet begun.

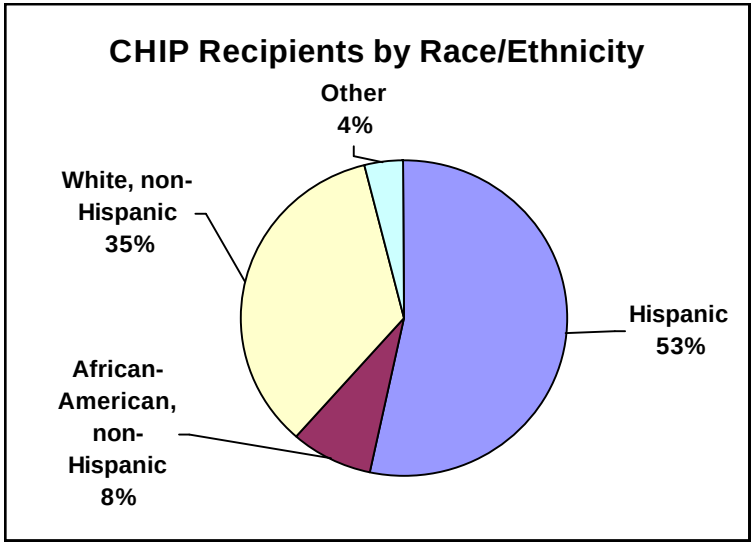
Several other cost savings measures will be implemented by the fourth quarter FY02. These include:

- Competitive contracting for medical equipment and supplies
- Amending the administration support contract with NHIC for FY03
- Implement case management for high cost/high need individual
- Move toward market-based reimbursement of hospital inpatient care

CHIP Health Care Costs





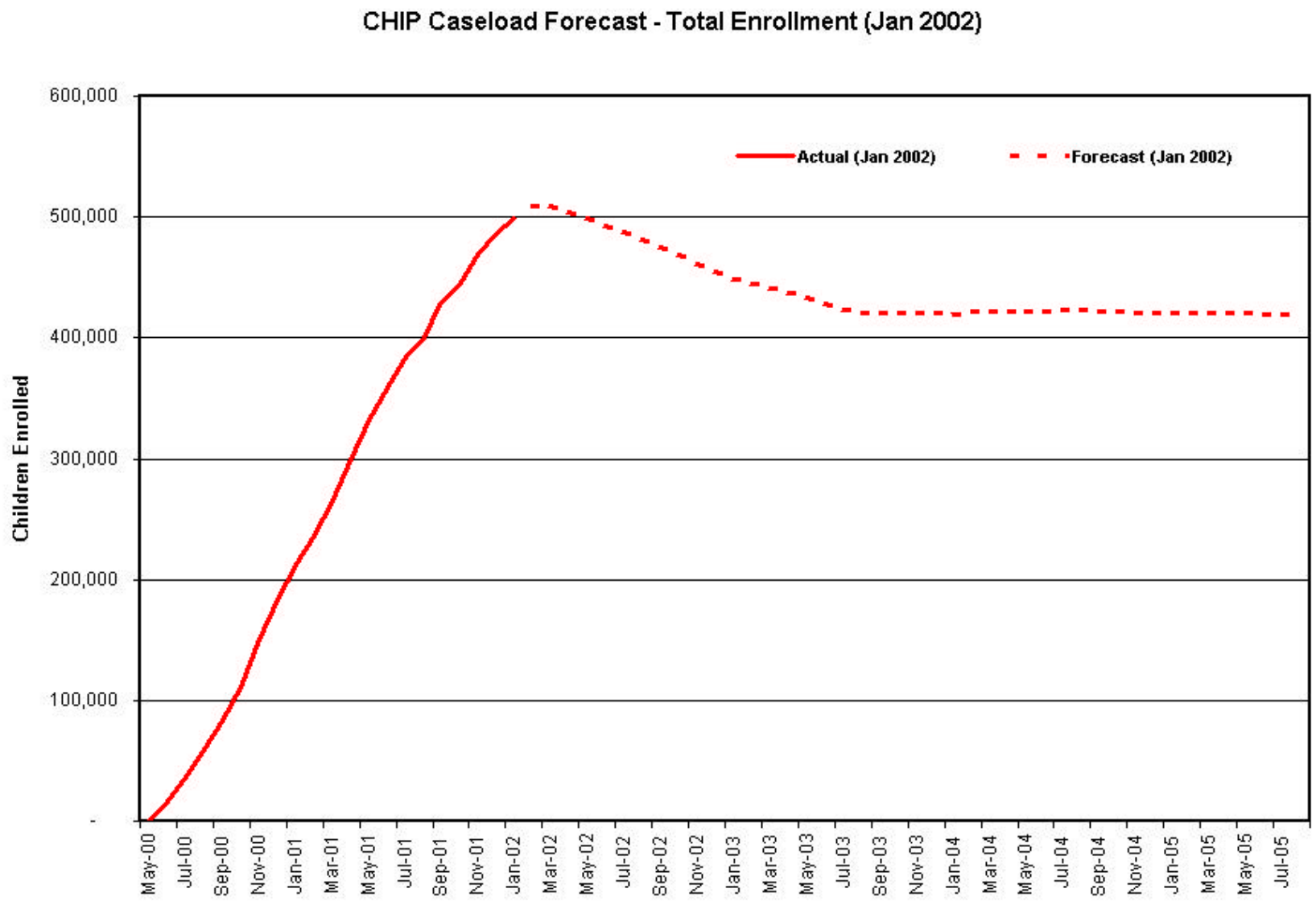


Note: Percentages may not total due to rounding.

What is CHIP? CHIP provides health insurance for children from low-income families.

Who is covered? The program serves Texas children under the age of 19, whose household income does not exceed 200% of the federal poverty level ($36,200 for a family of four), and who are deemed ineligible for Medicaid.

What are the benefits? CHIP enrollees receive health care and dental care from participating health plans, medical groups and dentists. The health and dental care includes services that are similar to those offered to state employees.


CHIP Caseload Forecast - Total Enrollment (Jan 2002)
Children Enrolled
600,000
500,000
400,000
300,000
200,000
100,000
-
Actual (Jan 2002)
Forecast (Jan 2002)
May-00
Jul-00
Sep-00
Nov-00
Jan-01
Mar-01
May-01
Jul-01
Sep-01
Nov-01
Jan-02
Mar-02
May-02
Jul-02
Sep-02
Nov-02
Jan-03
Mar-03
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Jul-03
Sep-03
Nov-03
Jan-04
Mar-04
May-04
Jul-04
Sep-04
Nov-04
Jan-05
Mar-05
May-05
Jul-05

What is driving CHIP costs?

The CHIP premium rates for the second year of the program increased approximately 17.7 percent, on average, as compared to first-year rates.

- In developing the premium rates for this year, we assumed that the average cost of medical services would increase six percent and the average cost of prescription drugs would increase 18 percent per year. These cost increase factors include both utilization and inflation components.

- Regarding utilization rates, while trend assumptions for inpatient hospital services utilization was as expected, outpatient hospital services, physician services, lab and X-ray services, behavioral health, prescription drugs, and other services utilization exceeded expectations by 25 percent on average.

CHIP Cost Containment Initiatives

CHIP Prescription Drug Benefit (PDB) Carve-out

- Prescription drugs remain a significant cause of inflation in the cost of health care services purchased by CHIP, conservatively estimated at 18 percent. By carving out the CHIP prescription drug benefit (PDB) HHSC can negotiate better prices and rebates with manufacturers because of the volume of prescription medications purchased by the Medicaid and CHIP programs. HHSC will begin implementation on March 1, 2002.

Description of Medicaid Services and Risk Groups

Services Covered by the Pure Premium

The premiums paid under managed care and fee-for-service include most acute care services including inpatient hospital, physician, lab, X-ray, and outpatient hospital services. The premiums do not cover prescription drugs, medical transportation, or nursing home care. The fee-for-service premiums do not cover services classified as cost reimbursed which include services provided by Federally Qualified Health Centers, State Hospital Physicians, Texas Health Steps medical screens, Family Planning, and charges under the Comprehensive Care program. Unlike fee-for-service, the managed care premium includes Texas Health Steps medical screens, family planning and Comprehensive Care program services. Cost reimbursed services represent a minority of acute care services provided by Medicaid.

Risk Group Definitions

The Medicaid program pays a premium for people in the following nine risk groups.

Aged & Medicare Related:

- Individuals over age 65 and any individual with Medicare coverage.

Disabled & Blind:

- Individuals who are Blind or Disabled. The majority of these people receive Supplemental Security Income (SSI).

TANF (formerly AFDC) Adults:

- Individuals age 21 and over that are eligible for the TANF program. This group may include some women who are pregnant.

TANF (formerly AFDC) Children:

- Individuals under age 21 that are eligible for the TANF program. This group may include some women who are pregnant and children less than one year of age.

Pregnant Women:

- Pregnant women having family income below 185 percent of the Federal Poverty Limit.

Newborn:

- Children under age one born to Medicaid-eligible mothers. The premiums for this risk group are broken into two sub-groups:
  - Regular Newborn: Newborn children less than 4 months of age.
  - Extended Newborn: Newborn children 4 through 12 months of age.

Expansion Children:

- Children under age 18, ineligible for TANF because of the applied income of their stepparents or grandparents.
- Children under age 1 with family income below 185 percent of Federal Poverty Limit.
- Children ages 1-5 with family income below 133 percent of Federal Poverty Limit.

Federal Mandate Children:

- Children under age 19 born after 10-1-83 with family income below 100 percent of Federal Poverty Limit. These children are between 6 and 18 years old.
- Children under age 19 born before 10-1-83 with family income below the Medically Needy (about 25 percent of poverty) standards limit. These children are between 17 and 19 years old.

CHIP Phase I

- Children under age 19 born before 10-1-83 with Family income between the Medically Needy standards limit and 100 percent of poverty. These children are between 18 and 19 years old.

Medically Needy:

- Spend Down: Individuals whose family income is below the Medically Needy Standard limit (about 25 percent of poverty) after qualified medical bills are subtracted from their income.
- Non-Spend Down: Children under age 18 in families with income between the TANF level (about 17 percent of poverty) and the Medically Needy Standard limit. This group also includes many adults who are parents or guardians of these children as well as parents or guardians of children in some of the other risk groups.