The Future of Health Care and LTCP in the US – With or Without Reform

Health Care Reform: What is it?

- Access
- Cost
- Quality

Health Care Reform: Why? Access for the Uninsured:

- 5 Categories:
  - Young invincibles
  - Poor
  - Uninsurable
  - Qualifies for Assistance
  - Undocumented Aliens

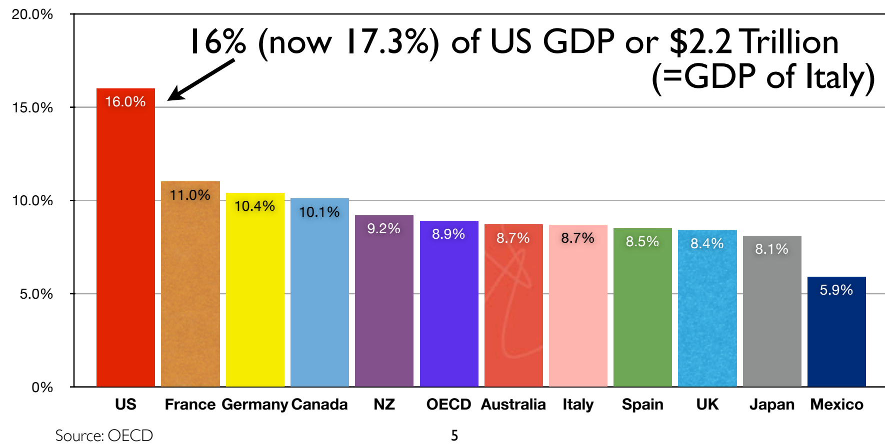
Health Care Reform: Access

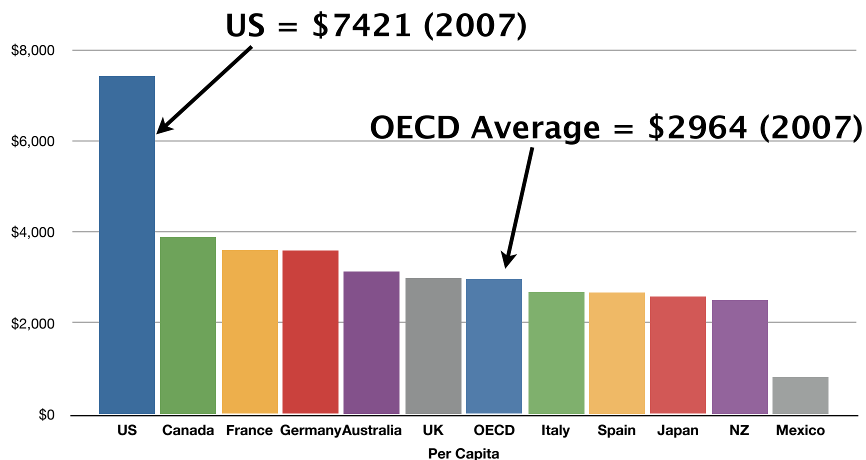
Uninsured Demographics

Hispanics	41.5%
Non-Hispanic blacks	19.9%
Non-Hispanic whites	11.6%
All Adults	16.0%
Ages 18-29	27.6%
Ages 30-44	20.3%
Ages 45-64	14.4%
Ages 65+	3.6%
South	19.7%
West	18.7%
Midwest	13.5%
East	10.5%

Men	17.8%
Women	14.4%
Less than $36,000	28.6%
$36,000-$89,999	8.8%
$90,000+	4.5%

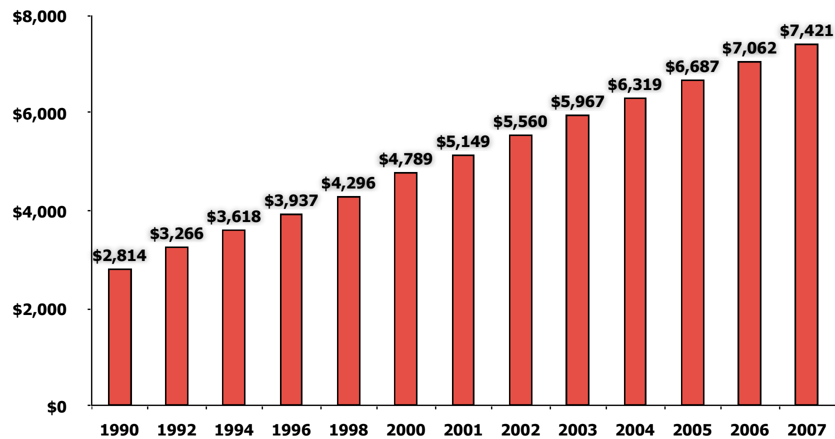
Source: National Journal


Health Care Reform:
Why? Cost
Percent GDP Spent on Health Care
20.0%
15.0%
10.0%
5.0%
0%
16% (now 17.3%) of US GDP or $2.2 Trillion
(=GDP of Italy)
16.0%
11.0%
10.4%
10.1%
9.2%
8.9%
8.7%
8.7%
8.5%
8.4%
8.1%
5.9%
US
France
Germany
Canada
NZ
OECD
Australia
Italy
Spain
UK
Japan
Mexico
Source: OECD
5


Health Care Reform: Why?
National Health Expenditures per Capita
US = $7421 (2007)
OECD Average = $2964 (2007)
$8,000
$6,000
$4,000
$2,000
$0
US
Canada
France
Germany
Australia
UK
OECD
Italy
Spain
Japan
NZ
Mexico
Per Capita
Source: OECD
6

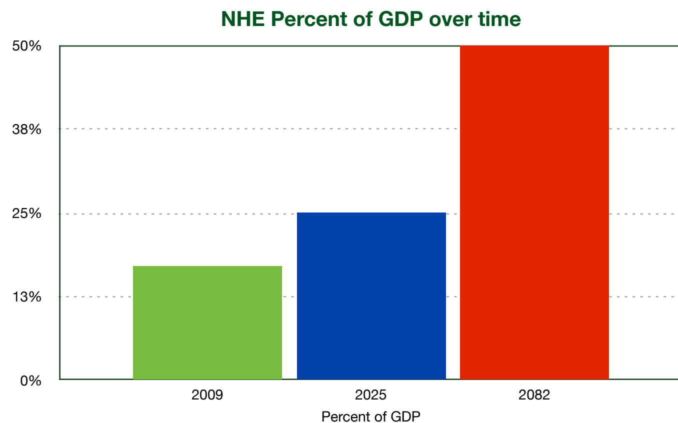
Health Care Reform: Why?

National Health Expenditures per Capita, 1990–2007



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; NHE summary including share of GDP, CY 1960-2007; file nhegdp07.zip).

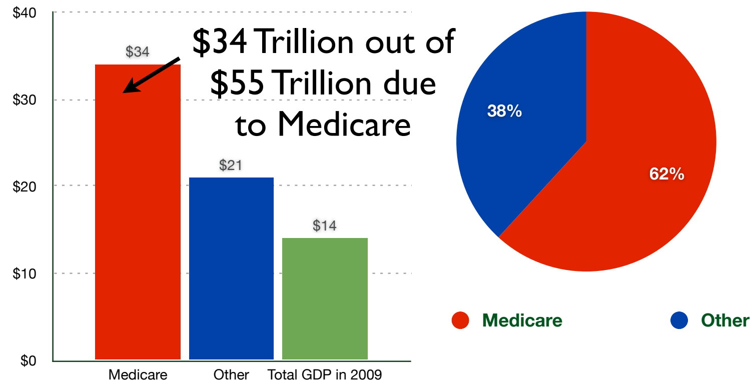
Health Care Reform: Why? Projected Growth



Source: CBO

Health Care Reform: Why? Cost of Medicare

Unfunded Mandates over 75 Years in Trillions

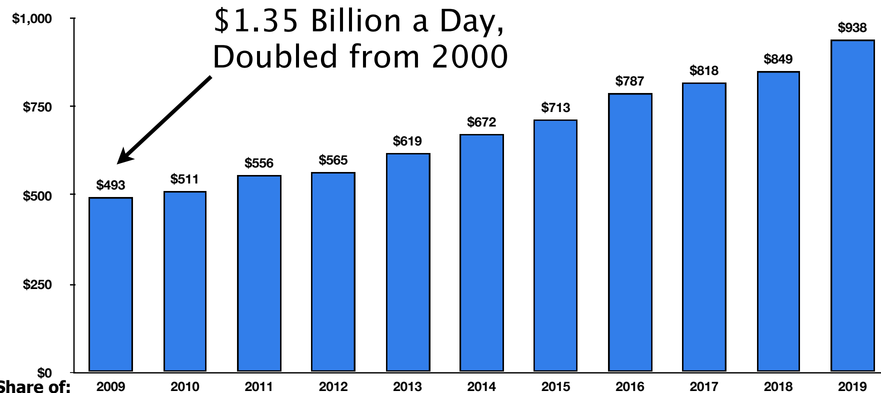


38%
62%

Medicare   Other

Projected Medicare Outlays, 2009-2019

Total outlays in billions:

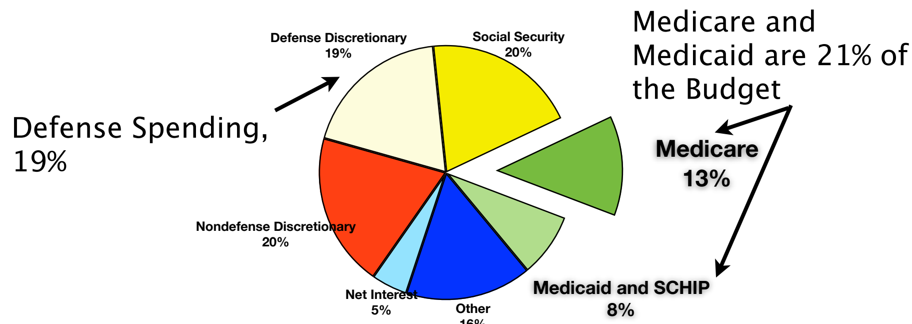


Share of:	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Federal Budget	14%	16%	17%	17%	17%	18%	18%	19%	19%	19%	20%
Gross Domestic Product	3.5%	3.5%	3.7%	3.6%	3.7%	3.9%	4.0%	4.2%	4.2%	4.2%	4.5%

NOTE: Numbers have been rounded to nearest whole number.
SOURCE: Kaiser Family Foundation, based on data from Congressional Budget Office, The Budget and Economic Outlook: An Update, January 2008, and A Preliminary Analysis of the President's Budget and an Update of CBO's Budget and Economic Outlook, March 2009.

Health Care Reform: Why?

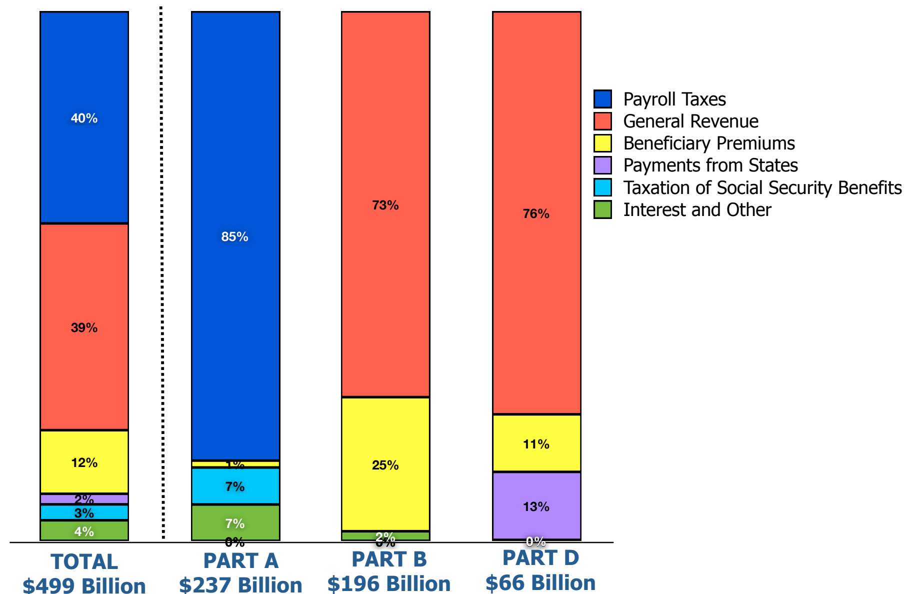
Medicare Spending as a Share of Total Federal Outlays, FY2010



2010 Total Outlays = $3.5 trillion

SOURCE: OMB, Fiscal Year 2010 Budget, February 2009. Budget Summary by Category.

Estimated Sources of Medicare Revenue, 2010



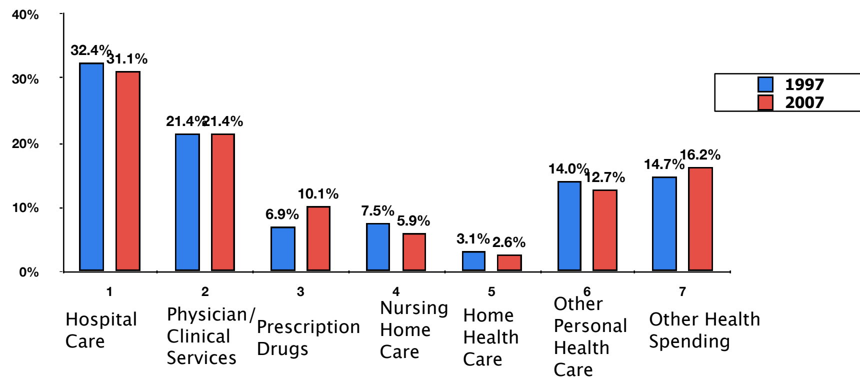
SOURCE: 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Health Care Reform: Why? Cost - Chronic Care

- 23% of all Medicare Beneficiaries:
  - Have 5 or more Chronic Conditions
  - See 12 or more physicians a year
  - Take 50 or more prescriptions a year
  - Cost 68% of the Medicare Budget

Health Care Reform: Why?

Distribution by Type of Service, 1997 & 2007

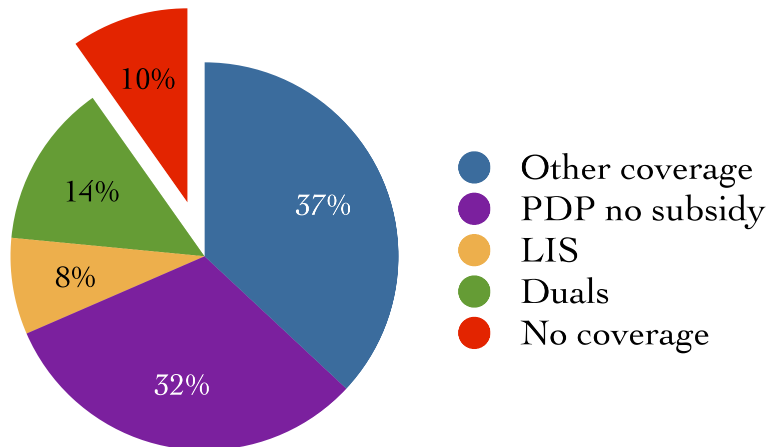


Notes: Percentages may not total 100% due to rounding. Other Personal Health Care includes, for example, dental and other professional health services, durable medical equipment, etc. Other Health Spending includes, for example, administration and net cost of private health insurance, public health activity, research, and structures and equipment, etc.
Source: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2007; file nhe2007.zip).

Numbers in Part D

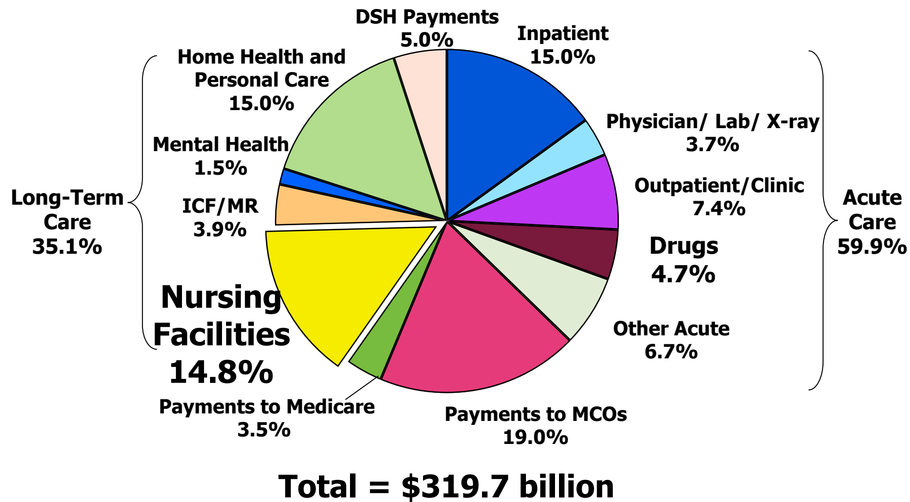
- 41.5 M out of 45 M have Part D coverage or its equivalent
- 24.5 M are in a PDP
- 10 M qualify for the Low Income Subsidy, 6.3 M as dual-eligibles
- New changes in definition of "resources" mean that another 1 M likely to qualify for Low-Income Subsidy (LIS)

PDP Coverage



- Other coverage
- PDP no subsidy
- LIS
- Duals
- No coverage

Medicaid Expenditures by Service, 2007



NOTE: Total may not add to 100% due to rounding. Excludes administrative spending, adjustments and payments to the territories.
SOURCE: Urban Institute estimates based on data from CMS (Form 64), prepared for the Kaiser Commission on Medicaid and the Uninsured.

Health Care Reform: Access

- Change the Medicaid requirements
  - Include Childless adults
  - Increase Income thresholds
- Provide Subsidies for non-Medicaid eligible
- Eliminate Part D Co-pays Duals in Home and Community Based Settings (Assisted Living)

Budget Issues

- Expansion of Access costs money - needs to be offset
- Offsets can occur in one of two ways:
  - Taxes
  - Entitlement Cuts
    - Medicare
    - Medicaid

Offset: Reduce "Waste, Fraud & Abuse"

- Several provisions in Reform Bills strengthening Fraud and Abuse Oversight
- One provision specifically addresses: "Waste" in LTCP, a cost-containment provision aimed at reducing wasteful dispensing of outpatient prescription drugs in long-term care settings
- Concerns about: cost, environment, and diversion.
- CBO scored savings of $5.7B / 10 years

Reform: "Waste" Proposal

Require the Secretary to establish requirements to reduce amounts dispensed in order to reduce waste associated with unused medications, including in the long-term care setting.

To implement this, CMS would require Part D sponsors to implement the following strategies to reduce waste by reducing amounts of unused drugs dispensed in both long-term care and community settings:

Reform: "Waste" Proposal

In long-term care facilities, sponsors would be required to renegotiate contractual terms with long-term care pharmacies to reduce days' fill dispensed for tablets and capsules, for instance, in the short-term to seven days, and by a later date (3-5 years) to automated dose dispensing wherever practicable.
and

Reform: "Waste" Proposal

Require the Secretary to consult with EPA, DEA, State Boards of Pharmacy, pharmacy and physician organizations and other stakeholders to determine/study other ways for plans to reduce waste associated with unused pharmaceuticals.

Issues: Safety, Access, Cost & Burden

- Safety Concerns:
  - Increased volume of prescriptions increases the possibility of errors
- Access Delayed:
  - Higher volume of processing drug utilization management edits (e.g., prior approval, step therapy, etc.) which must be cleared prior to dispensing
- Cost Increases:
  - Significant increases in packaging costs due to increases in dispensing frequency. Average generic dispensing rates for LTCPs exceed 70%, and the cost of additional packaging in many cases would exceed the ingredient costs of the generic drug being dispensed.
  - Substantial increases in dispensing costs and related administrative costs (e.g., order entry, pharmacist verification, etc.)

Issues: Safety, Access, Cost & Burden

- More frequent billing cycles with an increase in associated administrative costs
- Need for additional nursing staff at LTC facilities to manage the receipt, verification, documentation and distribution of hundreds of millions of additional transactions.
- Substantial capital outlays for the purchase of automated dispensing equipment along with ongoing annual maintenance fees for largely unproven equipment.

"Waste": How CMS might implement

- CMS will likely to dictate a plan to the PDPs – thus one approach to the new dispensing rules
- Shorter fills would apply to first fills only, not routine maintenance medications
- CMS appears to be influenced by "new technologies" (remote dispensing)

Waste: Implementation Issues

Pharmacy costs:

- Ingredient cost and Dispensing cost:
  - Dispensing costs average between $12-$13 a script

Pharmacy Reimbursement:

- Reimbursement per prescription is based on a formula composed of a variable component and a fixed component (or dispensing fee, based on 30 day supply).

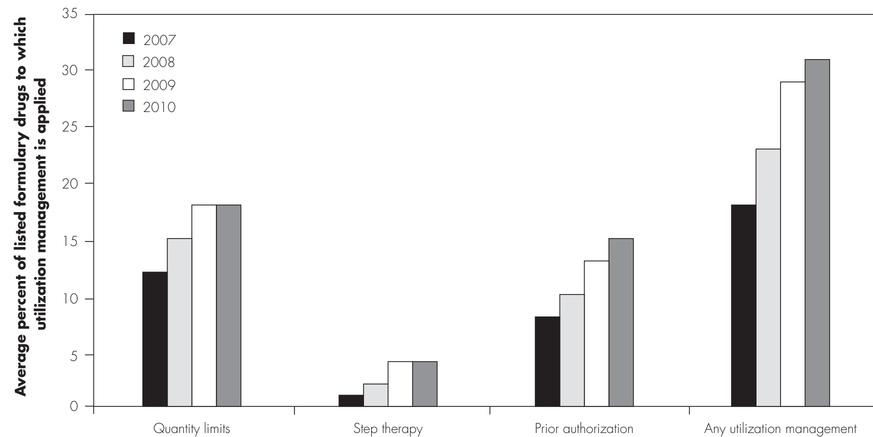
What Happens to "Waste" if Reform Fails?

- CMS action without Reform?
  - Draft Call Letter for 2011 - focus on retail
  - Remember Budget issues
  - 2012 or 2013?

Formularies

- LIS plan had, for the typical enrollee, an average of 83% of reportable drugs listed on its formulary vs. 90% for a non-LIS plan
- Prior Auth
- Step Therapy
- Exceptions
  - 6 classes
  - transition from another PDP
- Quantity limits

PDPs' Use of UM Tools Over Time



LIS Qualifications

- CMS annually sets eligibility limits for LIS.
- CMS did not change the eligibility requirements this year:
- To qualify for the full low-income subsidy income level must be at or below $6,600 ($9,910 if married)
- To qualify for partial low-income subsidies income level must be at or below at $11,010 ($22,010 if married)

Facilitated Enrollment

- Annual Part D - LIS reassignment: Random
- 1.06 M LIS beneficiaries reassigned in 2010 (similar to the number in 2009)
- 4+ plans available in each region in 2010 at no premium cost to the LIS beneficiary

Facilitated Enrollment: Issues in the LTC Setting

- Little recognition between LTC enrollees and those accessing a retail pharmacy
- Vulnerable patient base
  - 60-80% of the 1.6 M "full" duals residing in NFs are mentally impaired and often lack family support
  - A randomly assigned PDP formulary may not align with medical needs

But: Marketing Prohibitions

"Under no circumstances should a nursing home require, request, coach, or steer any resident to select or change a plan for any reason."

Working with the Government

Know your audience:

- Capitol Hill
- CMS

Capitol Hill

- Who to meet?
- How to educate?
- Provide solutions to problems
- Understand their obstacles
- Be Nice

CMS

- Keep up to date:
  - CMS list-serves, associations
- Comment when you care
- Be objective (data, data, data) vs. emotional
- No surprises
- Don't forget Chicken Little
- Be Nice