

FY 2017



mahp
Michigan Association
of Health Plans

MAHP: Who We Are

- The Michigan Association of Health Plans is a nonprofit corporation established to promote the interests of member health plans.
- MAHP's mission is "to provide leadership for the promotion and advocacy of high quality, accessible health care for the citizens of Michigan."
- Represents 13 health plans covering all of Michigan and more than 45 related business and affiliated organizations. Our member health plans employ about 8,000 persons throughout the state.
- Member health plans provide coverage for more than 3 million Michigan citizens – nearly one in every three Michiganders.
- Member health plans collect and use health care data, support the use of "evidence based medicine", and facilitate disease management and care coordination in order to provide cost-effective care.



Our members

Aetna Better Health of Michigan ^{1,2,3}

Fidelis SecureCare ³

Harbor Health Plan ²

Health Alliance Plan ^{1,2,3}

Molina Healthcare of Michigan ^{1,2,3}

Physicians Health Plan ¹

Total Health Care Plan ^{1,2,3}

McLaren Health Plan ^{1,2,3}

Meridian Health Plan ^{1,2,3}

Paramount Care of Michigan ¹

Priority Health ^{1,2,3}

Upper Peninsula Health Plan ^{2,3}

United Healthcare Community Plan ^{1,2,3}

Key: 1 = Commercial Health Plan 2 = Medicaid Health Plan

**3 = Medicare Advantage or Medicare Special
Needs Plan**



MAHP VISION

- *By 2020, Michigan will provide health insurance coverage and options to more than 99% of the State's population.*
- *By fostering competition, by 2020 Michigan will become one of the top 25 competitive states for health insurance. Today, we are third least competitive.*
- *Michigan's Health Plans will work with partners in government, the provider community, community organizations, and business to improve the health status of Michigan residents.*



What Health Plans Do

Utilization Management:

- Techniques that provide safeguards against inappropriate care
- Prior authorization
- Claims review to identify inappropriate care

Disease & Case Management:

- Early identification of high-risk patients for early intervention
- Focus attention on individuals based on indicators (use of analytics)

Network Design:

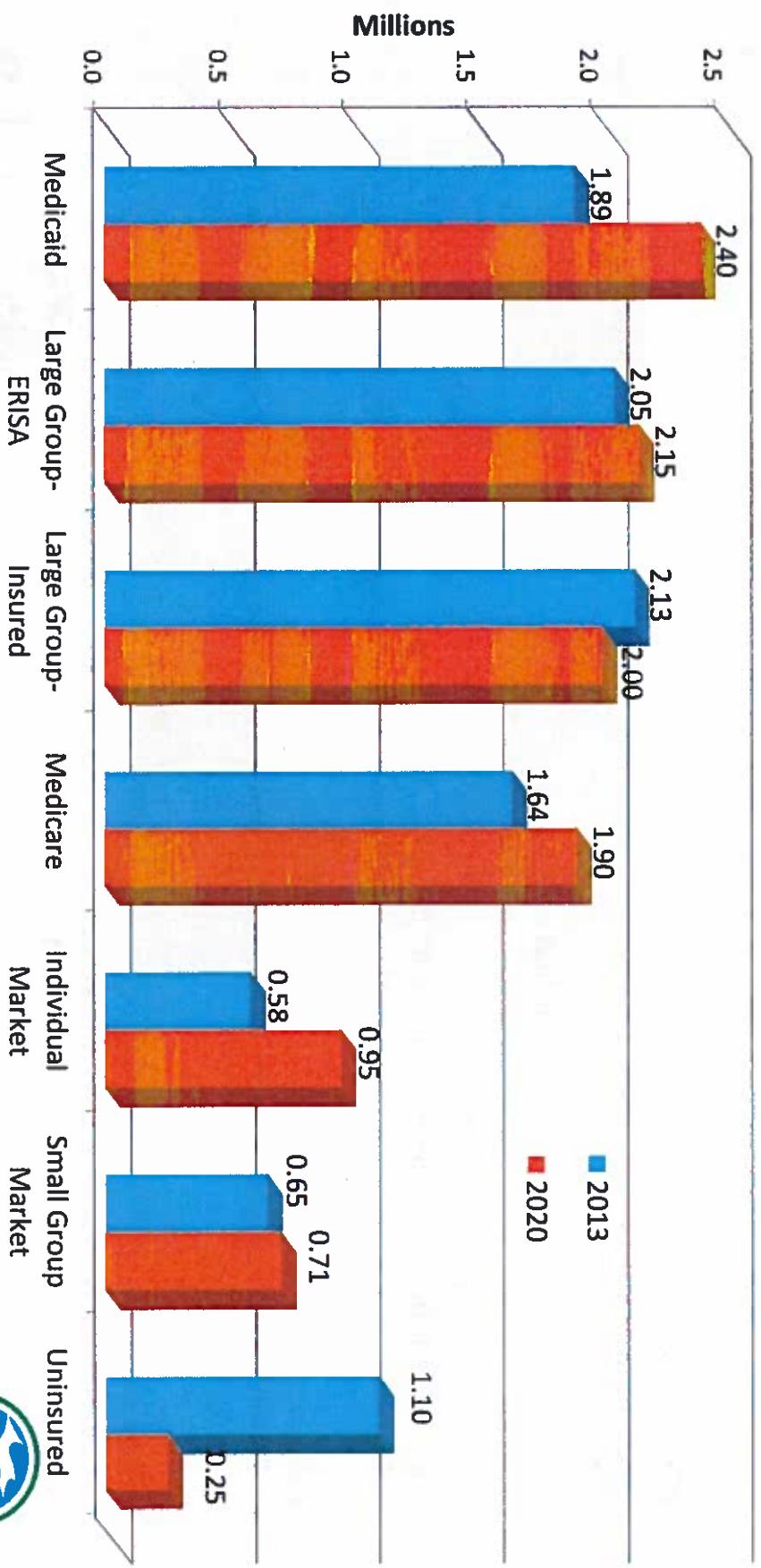
- Carefully pooling providers who provide excellent care at lower costs
- Tiered networks

Benefit Design:

- Cost sharing through copays and deductibles
- Saving/spending accounts (HSAs, FSAs)



Michigan health care coverage 2013 – and 2020



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Essential Health Benefits

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and Newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care



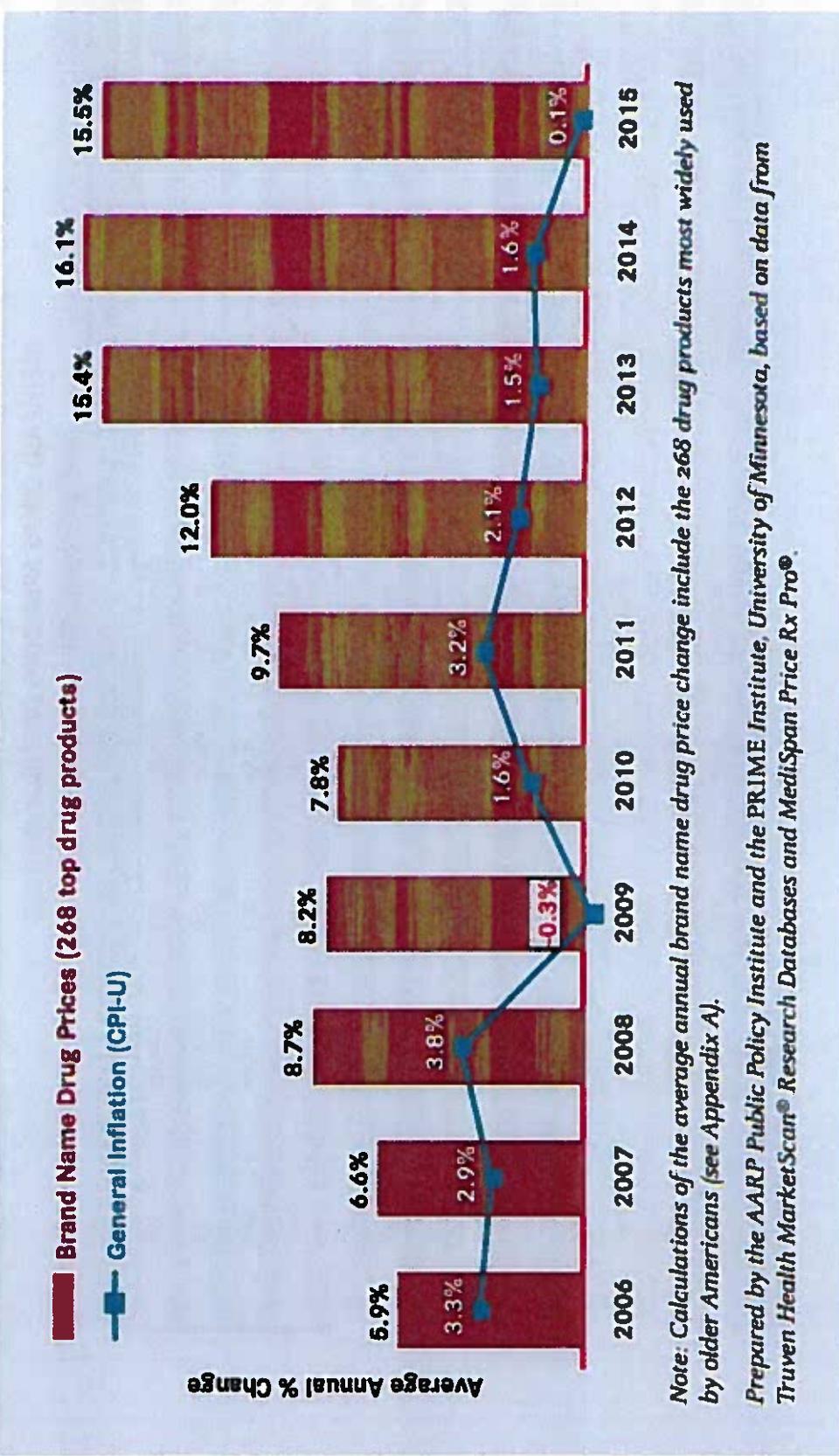
Insurance Premiums

Underlying Cost Pressures for Health Insurance:

- 2.3% Federal excise tax on manufacturers of medical devices
- 3.5% surcharge on premiums for Insurance Exchange
- Limits on Medical Underwriting (Age/Smoking/Geography). 20% population drives 80% cost because of chronic diseases and co-morbidities
- Benefit design changes forced on carriers (EHB/QHP)
- Minimum Medical Loss Ratios – Large Group 85%, Small and Individual 80%
- Cost shifting concerns (Government payers, auto, uninsured)
- Pharmacy cost trends (estimated at 19% total cost)



AVERAGE ANNUAL BRAND NAME DRUG PRICES CONTINUE TO GROW SUBSTANTIALLY FASTER THAN GENERAL INFLATION IN 2015



Note: Calculations of the average annual brand name drug price change include the 268 drug products most widely used by older Americans (see Appendix A).

Prepared by the AARP Public Policy Institute and the PRIME Institute, University of Minnesota, based on data from Truven Health MarketScan® Research Databases and MediSpan Price Rx Pro®.

MEDICAID DRUG SPENDING DASHBOARD 2015

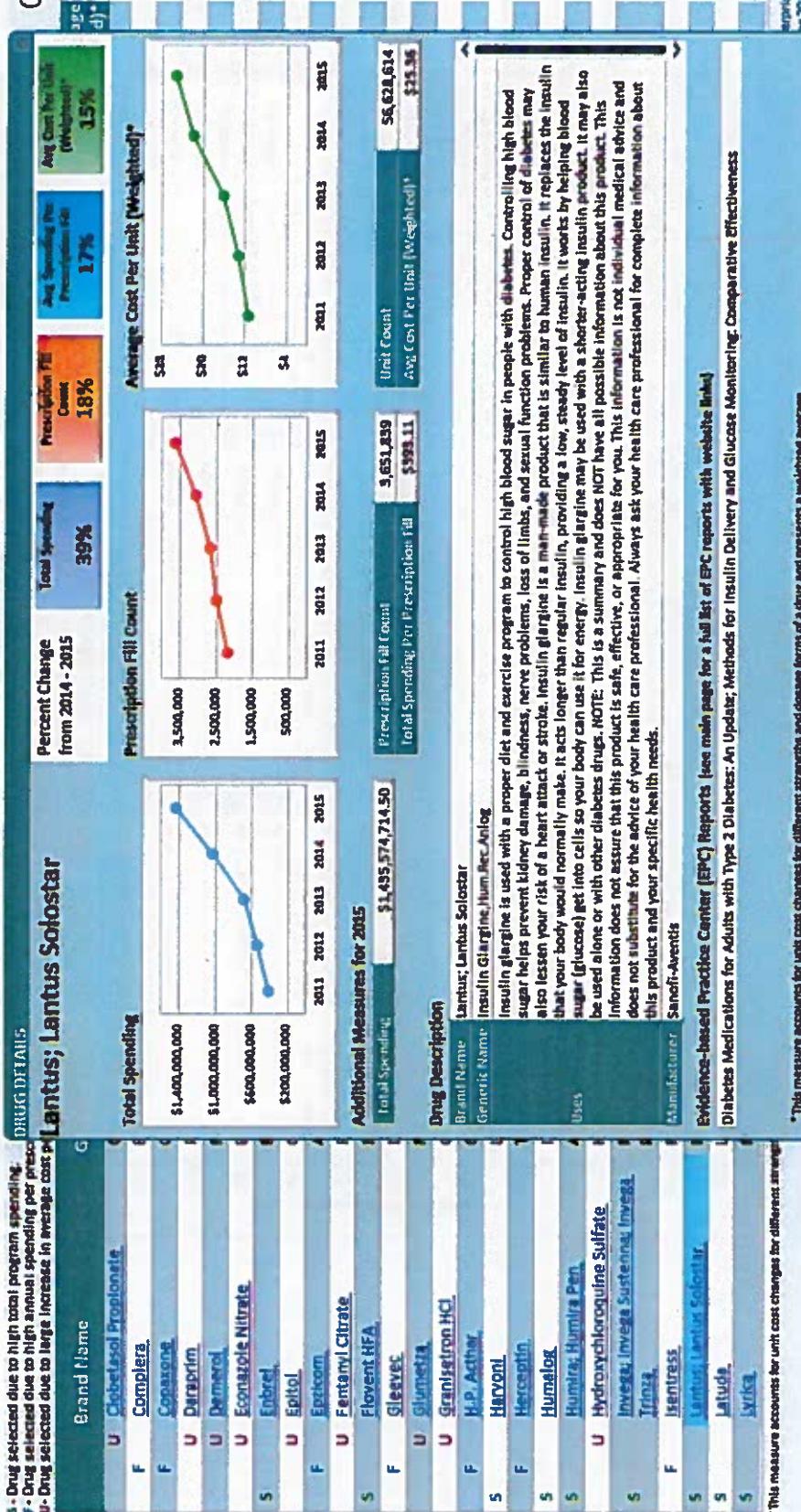
[MEDICATIONS LIST](#) | [INFORMATION](#)

Brand Name	Generic Name	Total Spending	Prescription Fill Count	Total Spending Per Prescription Fill	Unit Count	Annual Change in Average Cost Per Unit (Weighted)
S Abilify	Aripiprazole	\$2,029,596,059	2,074,321	\$978	65,711,387	-15%
S Adderall XR	Dextroamphetamine/Amphetamine	\$469,064,902	1,805,993	\$249	61,281,669	1%
S Adrafinil Disulf.	Fluticasone/Salmeterol	\$580,892,228	1,758,551	\$330	107,435,646	8%
F Adderall	Amphetamine/Full Length	\$31,645,102	15,579	\$2,028	300,873,015	1%
U Amicar-HC	Hydrocortisone Acetate	\$5,024,488	18,364	\$274	434,496	189%
S Aripiprazole	Aripiprazole	\$605,123,203	947,738	\$638	28,720,496	0%
U Ativan	Lorazepam	\$5,263,613	7,168	\$734	141,807	126%
S Atosle	Eflufenoz/Etrinol/Entenovir	\$601,023,261	265,692	\$2,270	8,056,830	9%
F Avastin	Bevacizumab	\$187,568,406	144,610	\$1,297	1,329,969	-5%
U Carbamazepine	Carbamazepine	\$37,741,065	585,130	\$65	86,169,517	141%
U Clindamycin Phos/Benzoyl Perox	Clindamycin Phos/Benzoyl Perox	\$6,564,980	10,413	\$630	460,002	181%
U Clofibrate Propionate	Clofibrate Propionate	\$143,846,774	741,509	\$194	45,390,879	15%
F Completa	Emtricitab/Flipivirine/Tenofovir	\$313,442,459	138,938	\$2,256	4,210,501	7%
F Concorine	Glibenclamide Acetate	\$273,012,518	51,487	\$5,418	11,227,085	14%
U Daraprim	Prymethamine	\$15,704,936	2,585	\$5,075	118,175	87%
U Demeclocycline	Meprobamate HCl/PP	\$4,900,953	48,895	\$100	135,314	210%
U Econazole Nitrate	Econazole Nitrate	\$46,206,960	218,702	\$211	12,779,028	254%
S Enbrel	Etenemcept	\$437,474,118	136,508	\$3,205	574,449	39%
U Epitol	Carbamazepine	\$2,706,075	58,483	\$46	5,529,081	460%
F Epitcam	Abacavir Sulfate/Lamivudine	\$141,386,148	117,317	\$1,205	3,499,055	8%
U Fenfluramine Citrate	Fentanyl Citrate/pF	\$55,317,741	474,760	\$117	2,898,294	160%
S Flavonol HCA	Fluticasone Propionate	\$441,361,058	2,204,825	\$195	26,376,028	7%
F Gilevate	Imatinib Mesylate	\$190,583,768	20,001	\$9,529	820,837	23%
U Glimepiride	Metformin HCl	\$16,130,816	7,873	\$2,049	433,709	29%
F Granisetron HCl	Granisetron HCl	\$7,787,064	43,149	\$180	170,769	312%
F H.P. Acthar	Octreotide	\$144,545,871	3,278	\$44,102	24,943	5%

*This section accounts for unit cost changes for different strengths and dosage forms of a drug and presents a weighted average of these patient charges.



MEDICAID DRUG SPENDING DASHBOARD 2015



Source

Period

Year

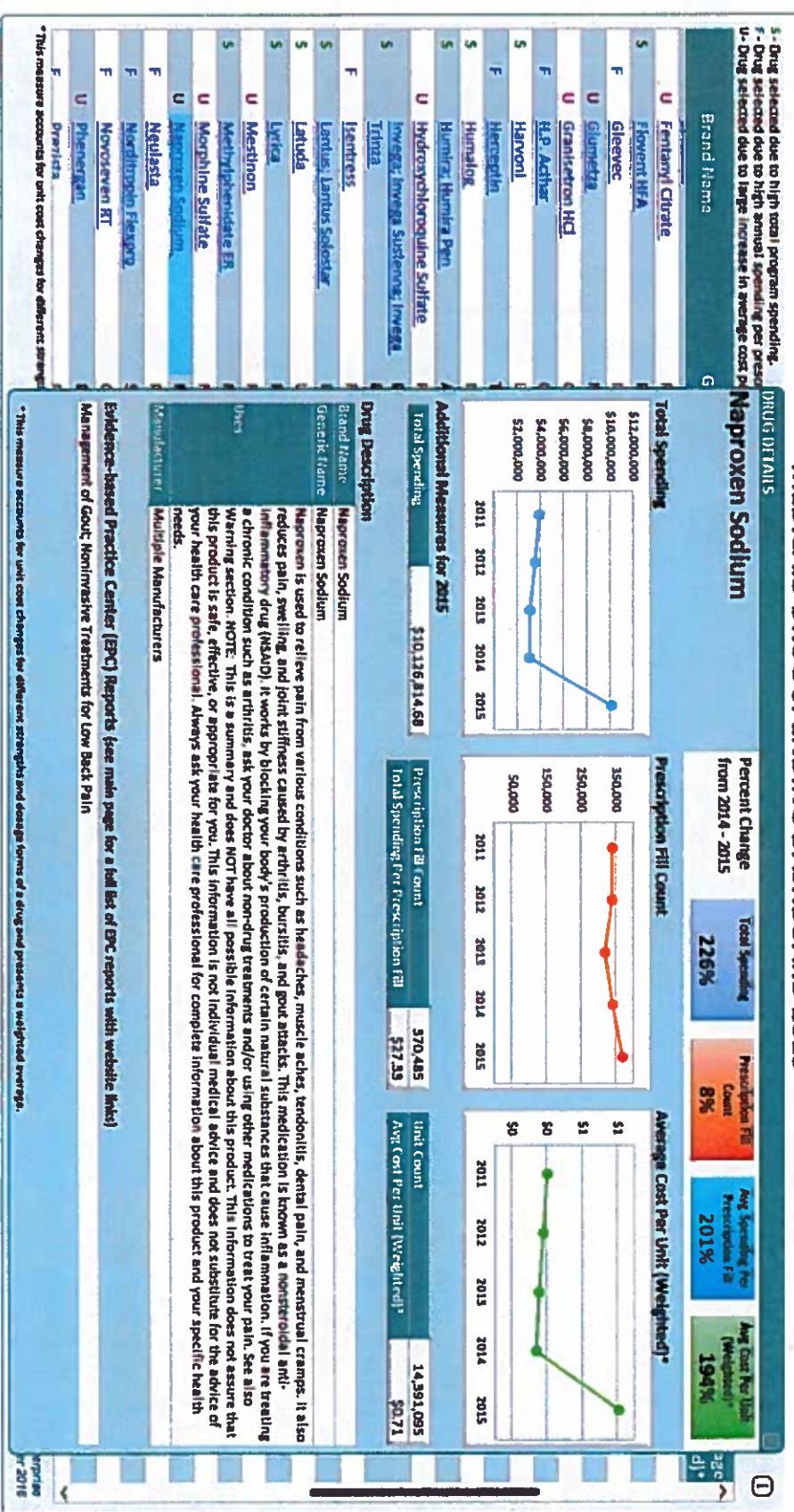
2016

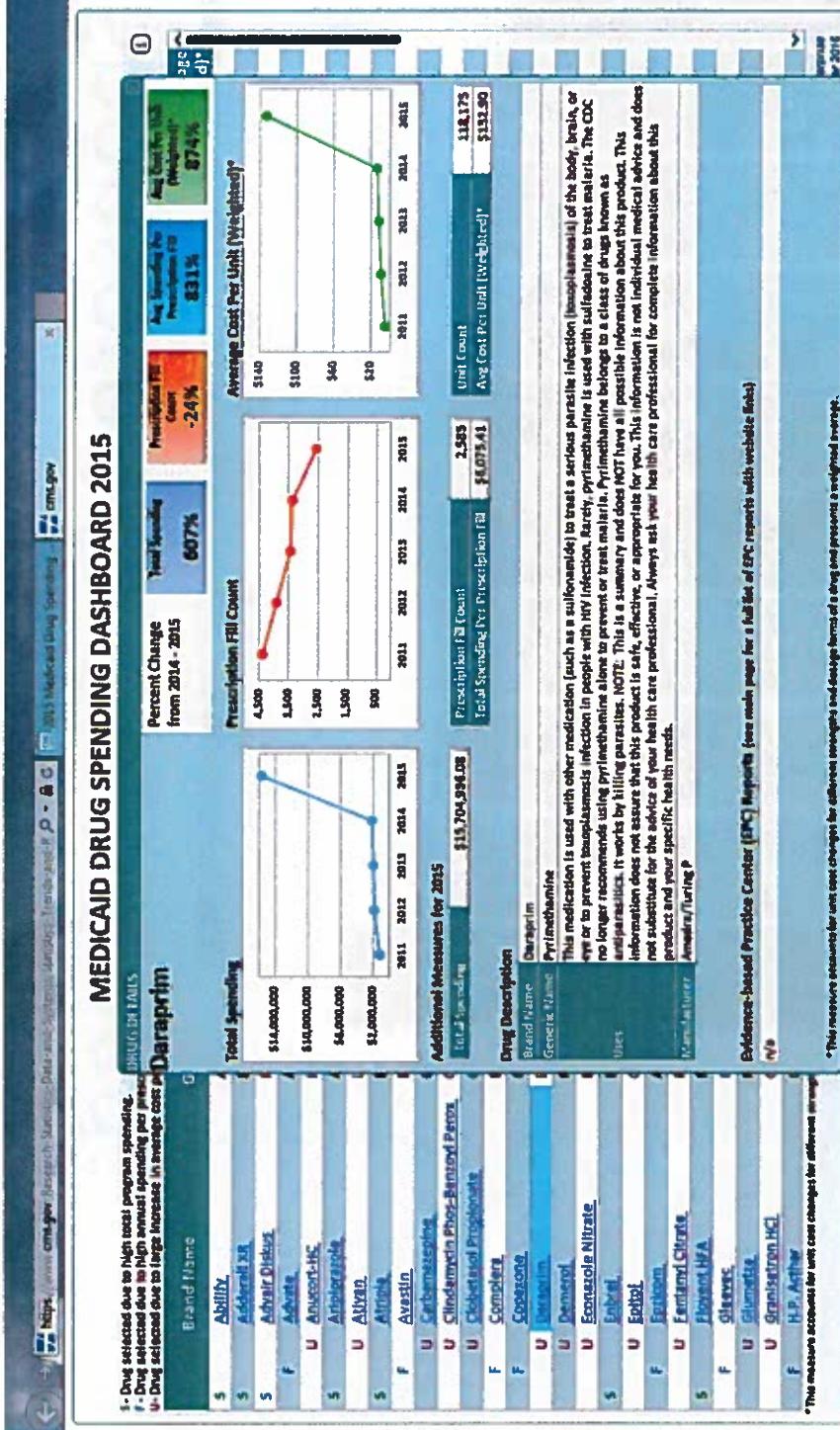
Note

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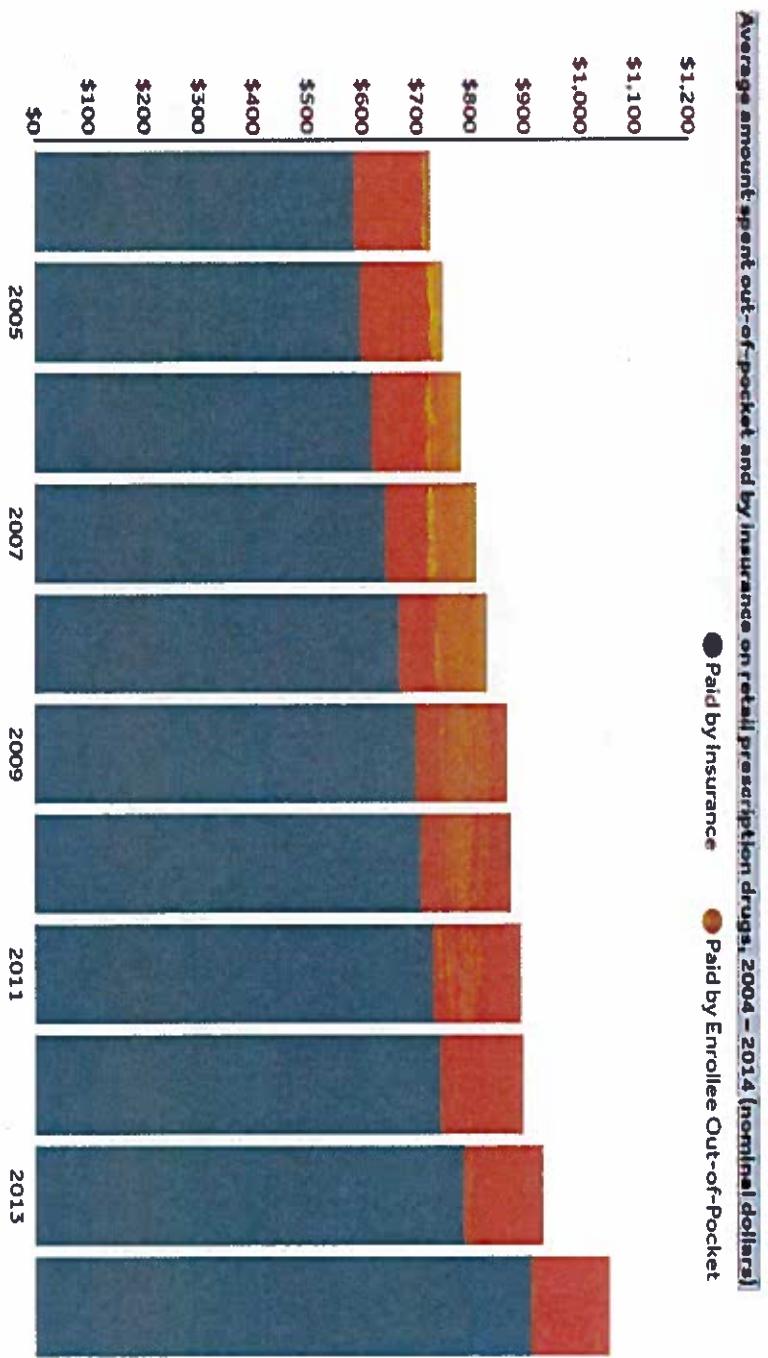
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MEDICAID DRUG SPENDING DASHBOARD 2015



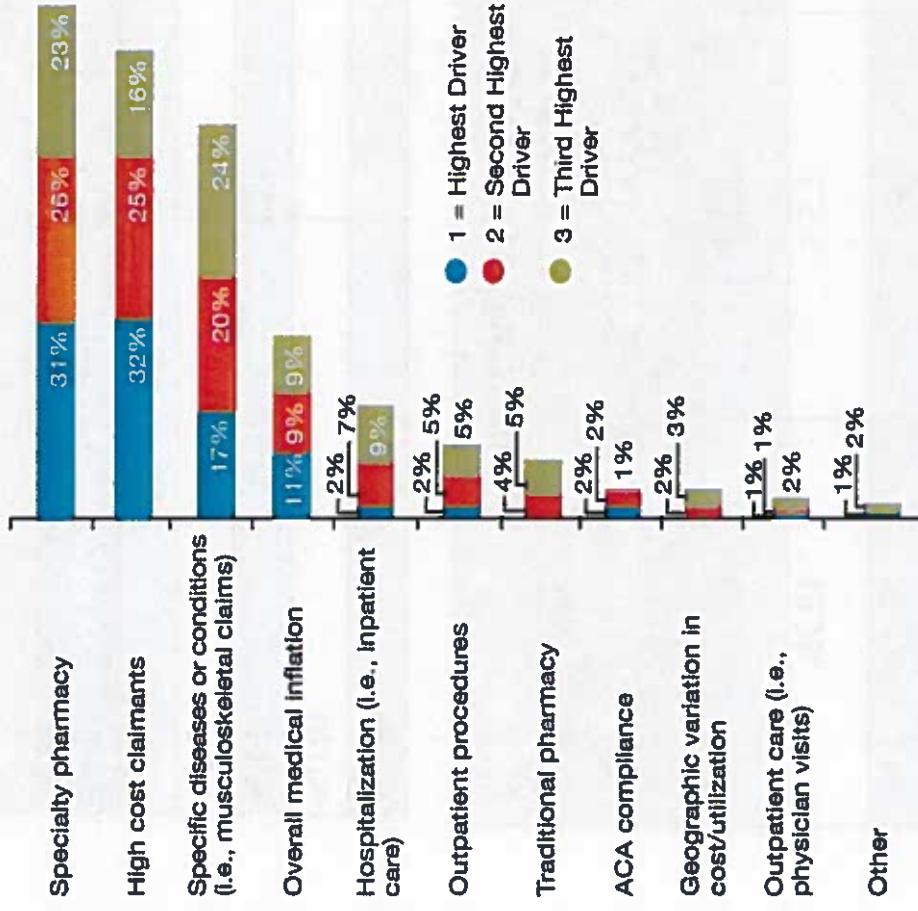


Employer Sponsored Rx Cost Trends



Source: Kaiser Family Foundation analysis of Truven Health Analytics MarketScan Commercial Claims and Encounters Database, 2004-2014

Top Cost Drivers of Rising Health Care Costs



National Business Group on Health (NBGH); Large Employers 2017 Health Plan Design Survey, Aug. 9, 2016.

(NBGH is a membership association of primarily large U.S. employers. The NBGH Large Employers 2017 Health Plan Design Survey was completed during the months of May and June 2016, by 133 large U.S. employers, covering 15 million Americans)



Note: Other responses included: inefficient use of the health care system (e.g., inappropriate use of the emergency room).

Medicaid FFS RX Expenditures

Fiscal Year	Actual Expenditures	Change year to year
2013	\$248.4 million	
2014	\$263.7 million	5.8%
2015	\$268.0 million	1.6%
2016	\$319.4 million	16.0%
2017	\$537.5 million (allocated)*	40.0%

Prescription Drug Trends for Michigan Medicaid Managed Care Organizations

Eligibility Category	FY14 / FY13	FY15 / FY14	Average FY15/FY13
TANF	16.4%	8.1%	12.3%
ABD	32.9%	5.5%	19.2%
CSHCS	31.5%	14.9%	23.2%

Medicaid

- Initiated in 1970's. State contracted with HMOs on a voluntary enrollment basis
- In the late 1980's, expanded to Clinic Plans – unlicensed risk-based for outpatient services, shared risk with the State for inpatient services
- In 1997, mandated managed care state-wide contracting with over 30 qualified health plans competing on price bids
- Re-contracted in 2000, 2004, 2009 and 2016 using competitive bid on quality, network, capacity, and financial status
- Estimated 3% of the State's GDP
- Currently 11 Medicaid Health Plans (was 14). Mix of profit and non-profit, local and national.



17

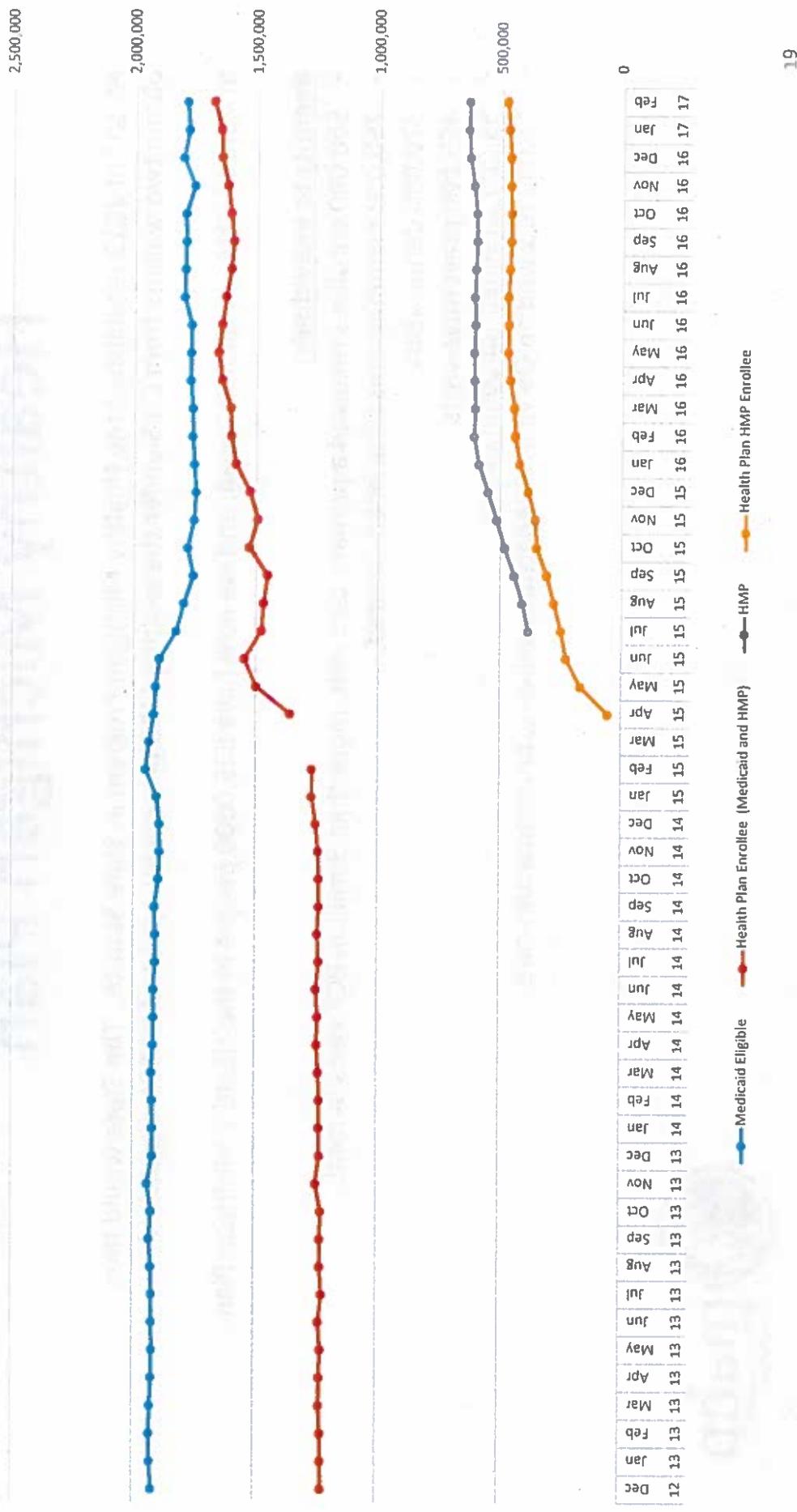
Managed Care

- **Medicaid services are managed and costs are predictable—savings over \$400 million/year (compared to FFS)**—Nearly \$5 billion in savings to Taxpayers since 2000.
- **Managed care provides greater access to care**
 - Primary care providers open to Medicaid
 - No wait list for Medically necessary and clinically appropriate services
- **Smart Incentives built into Medicaid Contracts with private health plans**
 - Provides the structure that generates state savings
 - Return on Investment (improved health status, access and costs savings)
- **Medicaid services under managed care are accountable**
 - Audited data related to clinical quality of care measures (HEDIS)
 - Use of external measures to determine customer satisfaction (CAHPS)
 - Contract performance standards (Status improvement, access measures, etc.)
 - Reporting requirements as licensed HMOs and Contracted Medicaid Plans



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Medicaid Since 2012



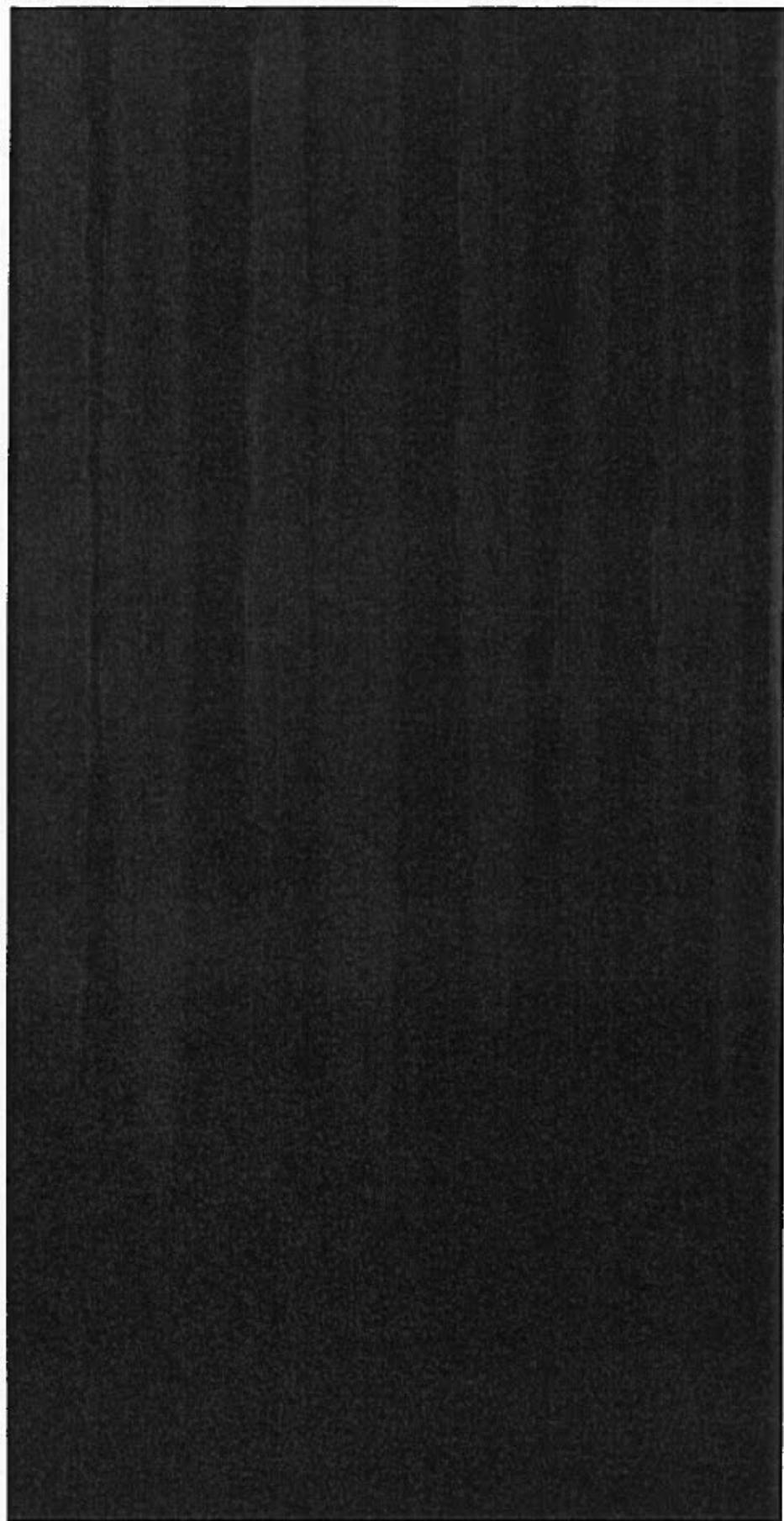
Healthy Michigan Plan

PA 107 of 2013 established the Healthy Michigan Program in State Statute. The State would then obtain two waivers from CMS under the existing 1115 process (as opposed to ACA expansion).

In April of 2014 enrollment began, and we now have 625,000 people in the Healthy Michigan Plan.

Benefits to Individuals:

- 590,000 enrollees received a primary care visit, more than 3 million PCP visits in total.
- 250,000 mammograms have been covered.
- 320,000 dental visits
- 465,000 preventive visits
 - 55,000 screened for colon cancer
 - 15,000 received an OB visit, antepartum, delivery, or postpartum care.



Healthy Michigan Plan

Benefits to the Health Care System:

- More than two-thirds of those employed reported that HMP coverage helped them be more productive at work.
- Nearly 50% reduction in uncompensated care from 2013 to 2015
- Costs to hospitals decreased by almost \$300 million

Benefit to Taxpayers:

- Macro economic benefit of increased economic activity corresponding in increasing tax revenue estimated up to \$200 million annually.
- Decreased state expenditures on behavioral health and corrections - \$235 million annually.



Federal Reform

Potential topics of future reform:

- Removing individual and employer mandates and replacing with a tax penalty for not maintaining continuous coverage.
- Changing age bands to 5:1
- Keeping tax credits and subsidies, but tiered by age to favor younger adults.
- Creation of high-risk pools for beneficiaries with preexisting conditions.
- Allowing States to set their EHB.
- Moving Medicaid to per-Capita Grants.



Figure 1

A block grant or per capita cap would be a fundamental change to Medicaid financing.

	Current Medicaid Program	Block Grant	Per Capita Cap
Coverage	<ul style="list-style-type: none"> Guaranteed coverage, no waiting list or caps 	<ul style="list-style-type: none"> No guarantee (can use wait lists or caps) 	<ul style="list-style-type: none"> May be guaranteed for certain groups
Federal Funding	<ul style="list-style-type: none"> Guaranteed, no cap Responds to program needs (enrollment and health care costs) Can fluctuate 	<ul style="list-style-type: none"> Capped Not based on enrollment, costs or program needs Fixed with pre-set growth 	<ul style="list-style-type: none"> Capped per enrollee Not based on health care costs and needs Fixed with pre-set growth per enrollee
State Matching Payments	<ul style="list-style-type: none"> Required to draw down federal dollars Federal spending tied to state spending beyond to state spending cap 	<ul style="list-style-type: none"> Unclear Federal spending not tied to state spending beyond per enrollee cap 	<ul style="list-style-type: none"> Unclear Federal spending not tied to state spending beyond per enrollee cap
Core Federal Standards	<ul style="list-style-type: none"> Set in law with state flexibility to expand 	<ul style="list-style-type: none"> Uncertain what the requirements would be to obtain federal funds 	



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