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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.

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Our members

Aetna Better Health of Michigan 1,2,3

Michigan Complete Health 3

Harbor Health Plan 2,3

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 1,3

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**

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MAHP VISIONS

- *MAHP members expand coverage access for Consumers. Michigan will provide should be a national leader in providing health insurance coverage options to the State's population.*
- *Michigan's health insurance industry improves value, affordability, choice and competition. By fostering competition, Michigan will become one of the top 25 competitive states for health insurance.*
- *MAHP members will advocate for the improved health status of Michigan consumers. MAHP members will work with partners in government, the provider community, community organizations, and business leaders to improve the health status of Michigan residents in areas that MAHP members serve through meaningful transparency and a focus on integrating benefits.*

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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)
- As requested by the market

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Essential Health Benefits

Federal Requirements

Ambulatory Patient Services	Emergency Services	Hospital – Surgical and Overnight	Maternity and Newborn Care	Mental Health and Substance Abuse
Prescription Drugs	Rehabilitative and Habilitative Services and Devices	Laboratory Services	Preventive and Wellness Services	Pediatric Oral and Vision care

Michigan

Additional Benefits Legislated in Michigan				
Breast Cancer Coverage and Services	Hospice Care	Home Health Care	Diagnostic Testing	Mental Health Parity

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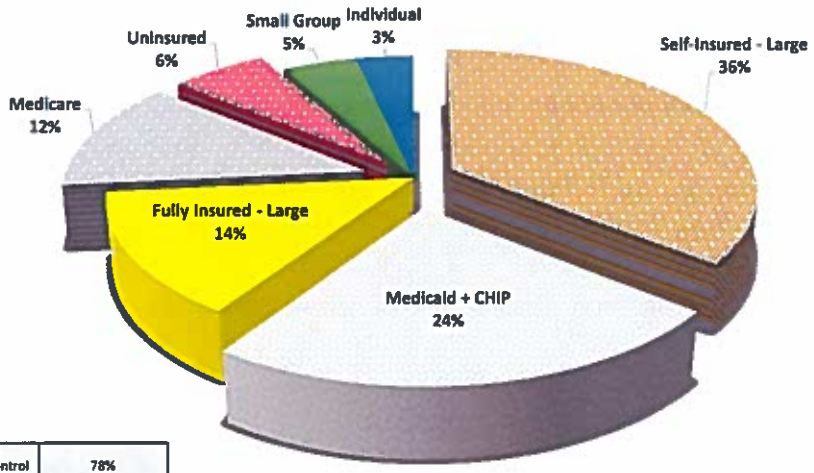
Health Care Coverage – By Source - 2017



Federal/Other Regulatory Control	78%
Michigan Control	22%

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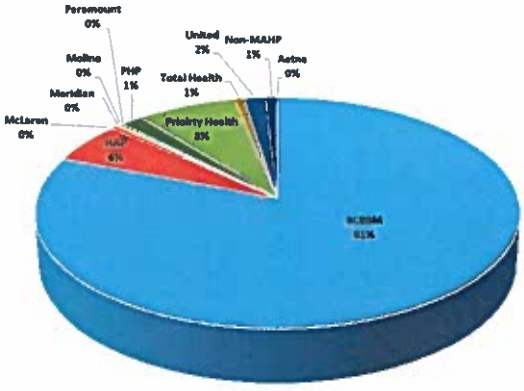
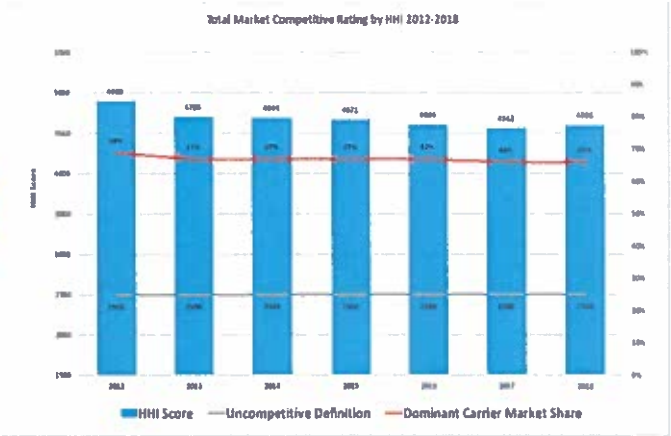
Health Care Competition





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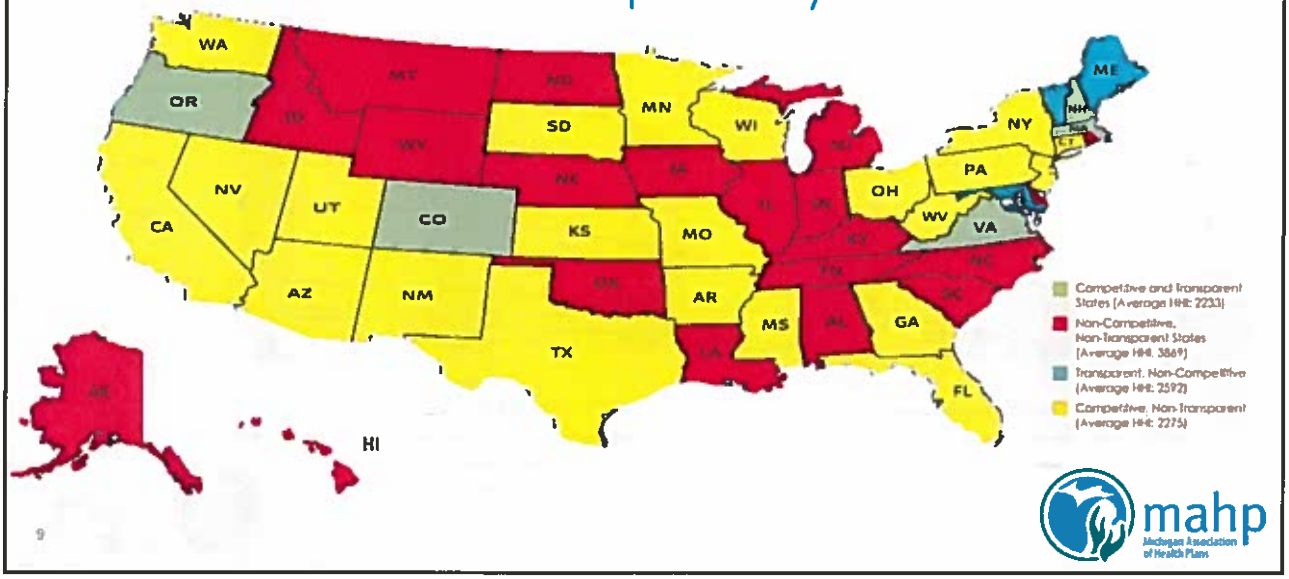
Health Care Competition + Transparency



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Insurance Premiums

Underlying Cost Pressures for Health Insurance:

- The rising costs of healthcare – average 6% per year since 1990
- 3.5% surcharge on premiums for Insurance Exchange (Proposed Decrease to 3.0% in PY2020)
- Unhealthy population mix: 20% population drives 80% cost due to chronic diseases and co-morbidities
- Mandated benefit design changes on carriers (EHB)
- Minimum Medical Loss Ratios – Large Group 85%, Small and Individual 80%
- Cost shifting concerns (Government payers, auto, uninsured)
- Pharmacy cost trends (estimated at 23% total cost)

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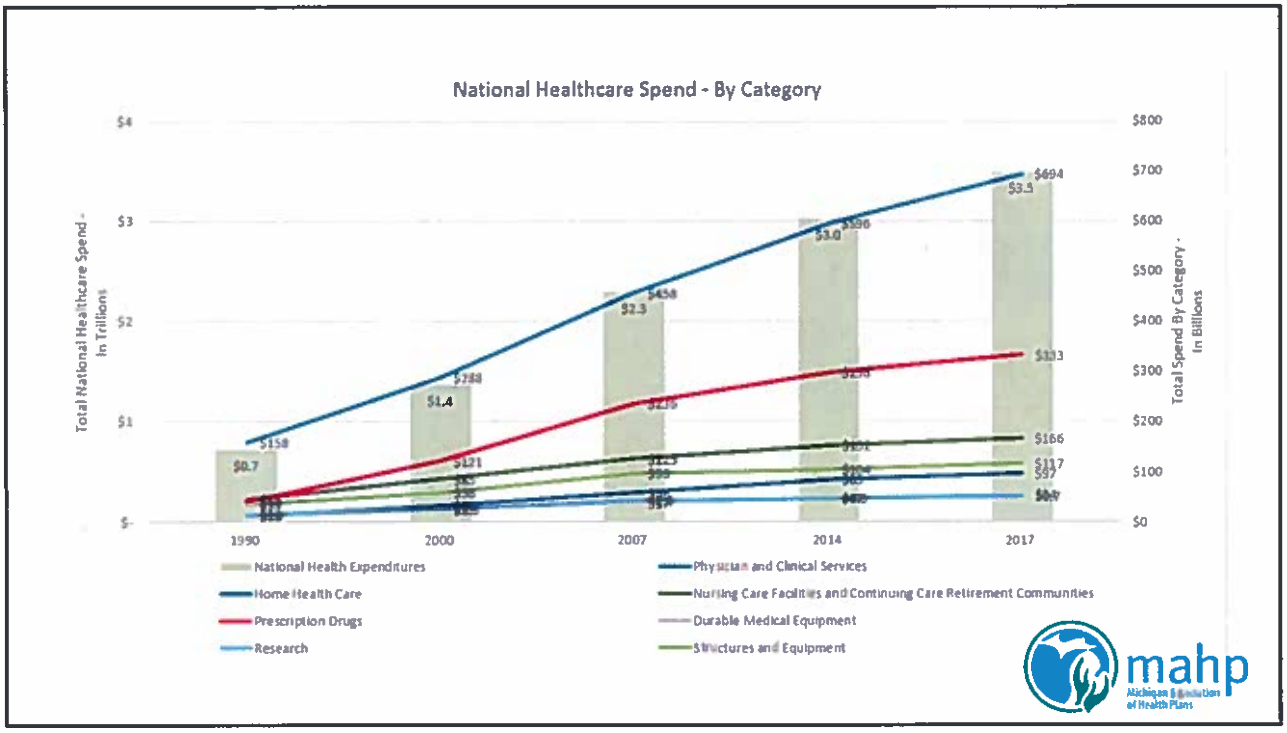
National Healthcare Spend - By Category
Total National Healthcare Spend - In Trillions
Total Spend By Category - In Billions
$4
$3
$2
$1
$-
$800
$700
$600
$500
$400
$300
$200
$100
$0
1990
2000
2007
2014
2017
$158
$788
$2.3
$3.0
$3.5
$694
$458
$133
$166
$117
$97
$1.4
$0.7
$121
National Health Expenditures
Physician and Clinical Services
Home Health Care
Nursing Care Facilities and Continuing Care Retirement Communities
Prescription Drugs
Durable Medical Equipment
Research
Structures and Equipment
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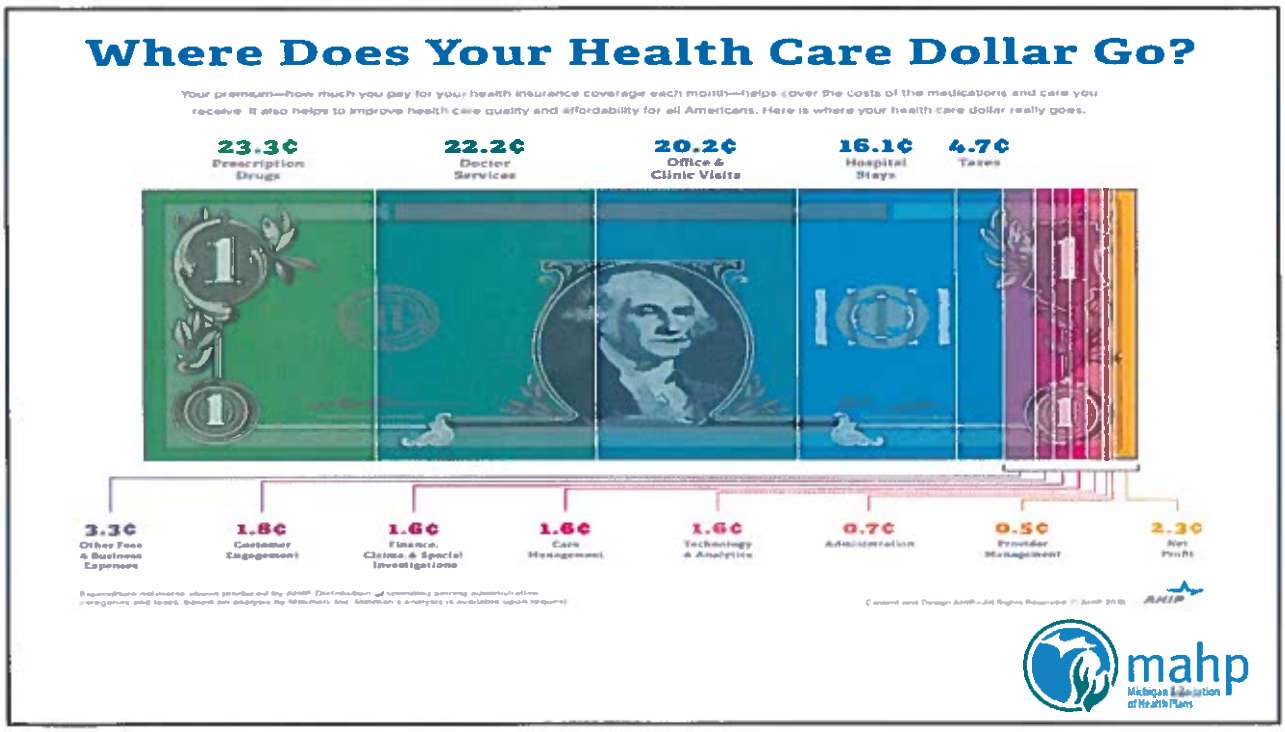
Where Does Your Health Care Dollar Go?
Your premium—how much you pay for your health insurance coverage each month—helps cover the costs of the medications and care you receive. It also helps to improve health care quality and affordability for all Americans. Here is where your health care dollar really goes.
23.3¢
Prescription Drugs
22.2¢
Doctor Services
20.2¢
Office & Clinic Visits
16.1¢
Hospital Stays
4.7¢
Taxes
3.3¢
Other Fees & Business Expenses
1.8¢
Customer Engagement
1.6¢
Finance, Claims & Special Investigations
1.6¢
Care Management
1.6¢
Technology & Analytics
0.7¢
Administration
0.5¢
Provider Management
2.3¢
Net Profit
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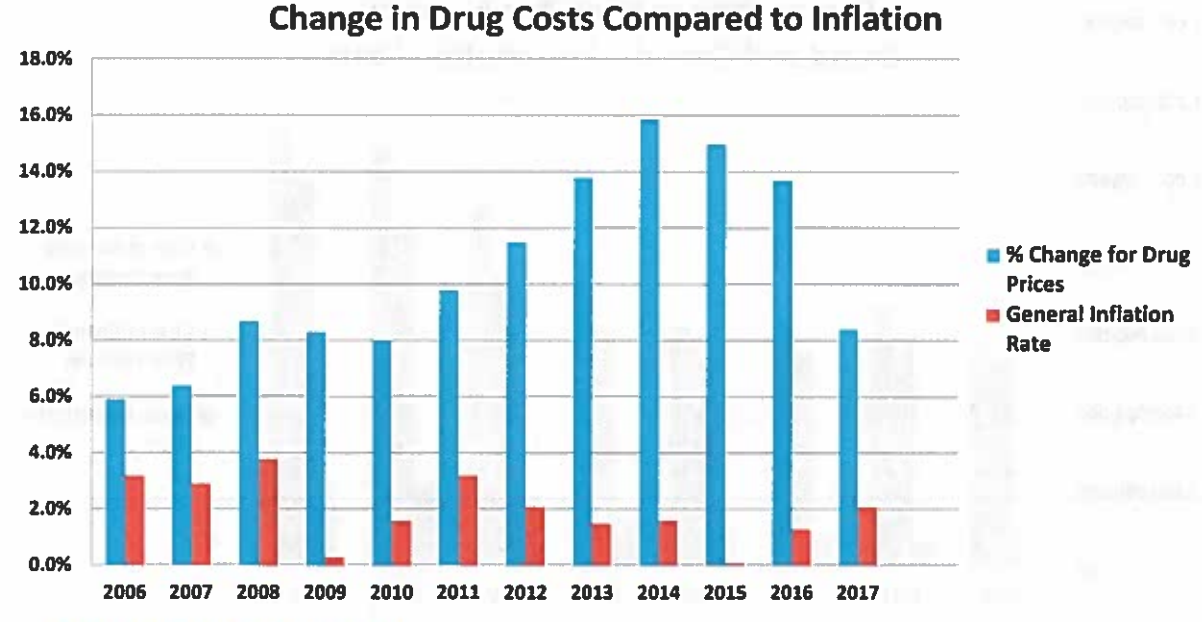
Prescription Drug Spending Growth Slower but Continues to Rise

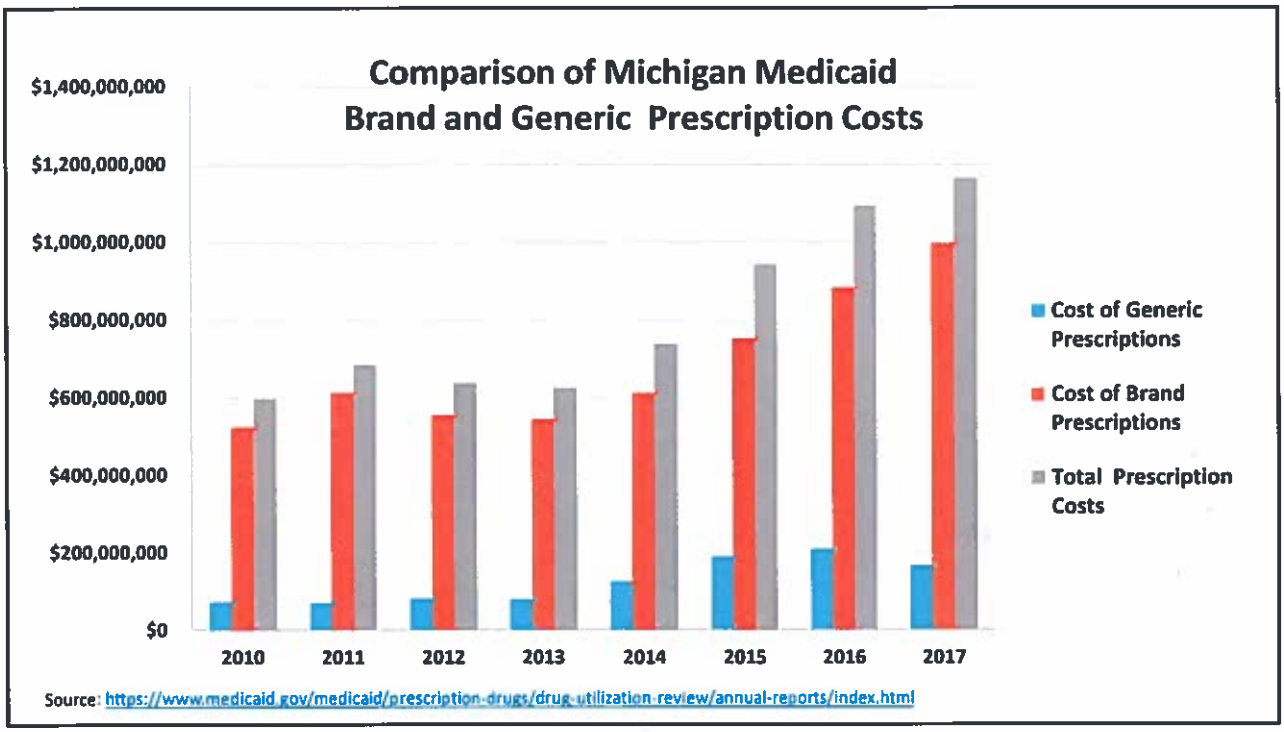
- **U.S. prescription drugs spending rose to $453 billion in 2107; a 6% growth compared to previous increases of 12.5% over previous 2 years**
- **Spending growth slower than previous years, however prices for brand prescriptions continues to rise, increasing by 58% over the past 5 years**
- **Spending continues to shift from traditional drugs to specialty drugs which now account for 46.5% of drug expenditures**
- **Biologic specialty drugs comprise 11.5 billion in spending**

IQVIA Institute April 2018: Medicine Use & Spending in the U.S. – A review of 2017 and Outlook to 2020



Source: http://www.aarp.org/rxpricewatch Dec. 2017

Commercial Rx Spend Mix – 2014-2017

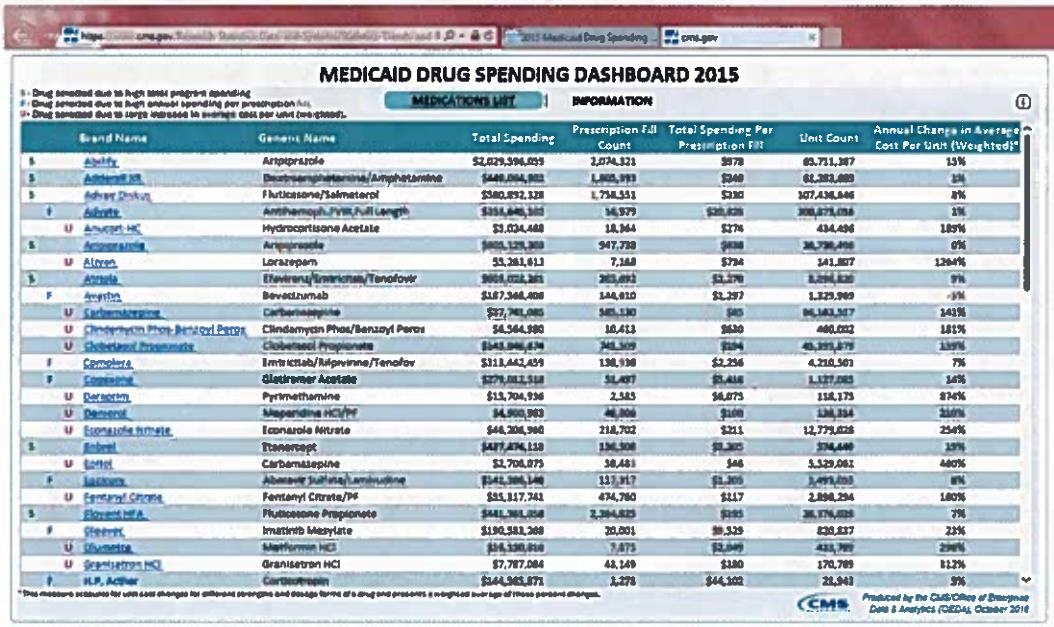


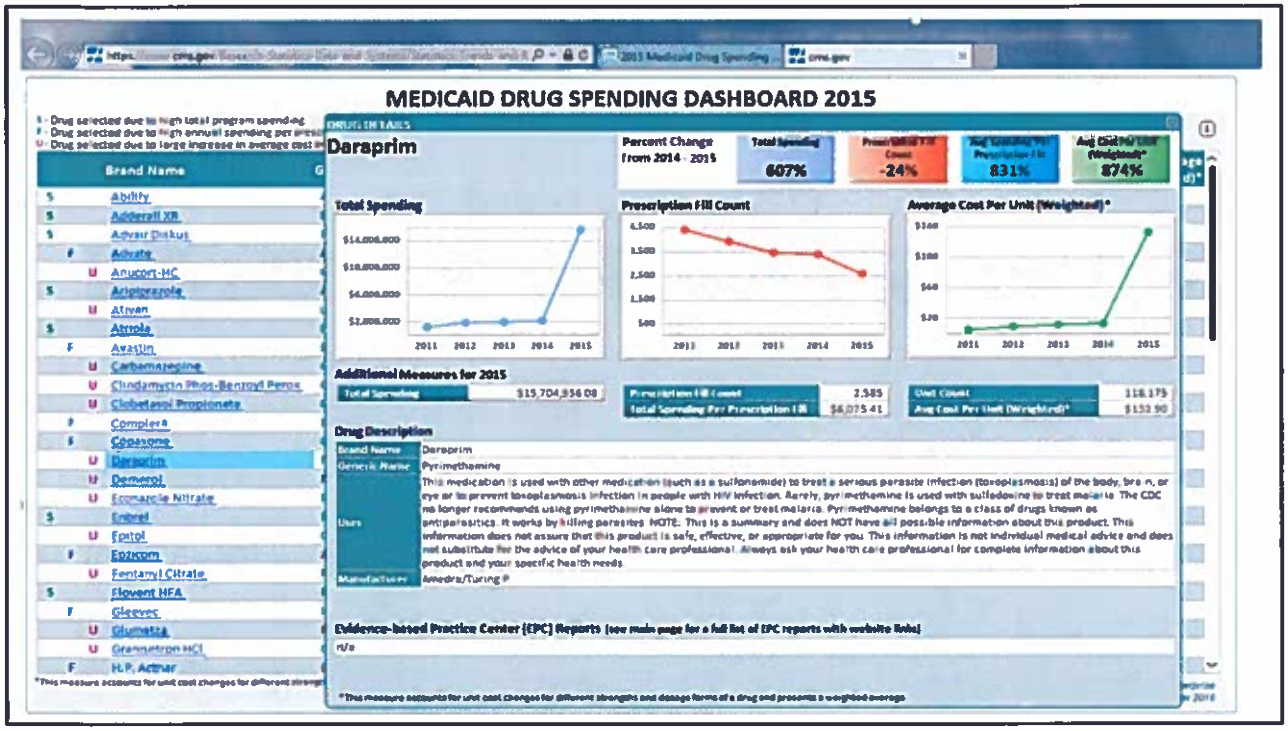
Source: https://www.medicaid.gov/medicaid/prescription-drugs/drug-utilization-review/annual-reports/index.html

Top 10 Drugs Reported on data.Medicaid.gov

32% of Drug Spend

Volume Rank	Drug Name	Indication for Use	$ Volume (Millions)	2017 Volume Rank	Cost Trend
1	HUMIRA	Rheumatoid Arthritis	$23.2	13	4.0%
2	BASAGLAR	Diabetes	$22.6	19	-0.1%
3	SYMBICORT	Asthma/COPD	$22.6	2	5.7%
4	VENTOLIN	Asthma/COPD	$15.7	3	2.3%
5	NOVOLOG	Diabetes	$11.2	7	1.6%
6	QVAR	Asthma/COPD	$8.5	4	7.8%
7	CHANTIX	Smoking Cessation	$8.4	9	12.0%
8	ENBREL	Rheumatoid Arthritis	$8.2	12	8.2%
9	HUMALOG	Diabetes	$8.1	8	4.3%
10	INCRUSE	Asthma/COPD	$7.1	38	-1.1%
Total			$135.5		3.2%




MEDICAID DRUG SPENDING DASHBOARD 2015
Daraprim
Percent Change from 2014 - 2015
607%
-24%
831%
874%
Total Spending
Prescription Fill Count
Average Cost Per Unit (Weighted)*
Additional Measures for 2015
Drug Description
Brand Name
Generic Name
Users
Manufacturer
Evidence-based Practice Center (EPC) Reports


MEDICAID DRUG SPENDING DASHBOARD 2015
Lantus; Lantus Solostar
Percent Change from 2014 - 2015
39%
18%
17%
15%
Total Spending
Prescription Fill Count
Average Cost Per Unit (Weighted)*
Additional Measures for 2015
Drug Description
Brand Name
Generic Name
Users
Manufacturer
Evidence-based Practice Center (EPC) Reports

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.

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Medicaid FFS RX Expenditures

Fiscal Year	Appropriated Expenditures	Change year to year
2014	$263.7 million	
2015	$268.0 million	1.6%
2016	$319.4 million	16.0%
2017	$537.5 million	40.0%
2018	$423.0 million	-27.1%
2019	$332.2 million	-27.3%

Prescription Drug Trends for Michigan Medicaid Managed Care Organizations

Eligibility Category	FY17/16	FY18/ FY17	Average FY18/FY16
TANF	-1.7%	5.1%	1.7%
ABAD	5.4%	9.1%	7.2%
CSHCS	6.6%	3.3%	4.9%
HMP	10.9%	4.9%	7.9%

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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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 780,0000 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.

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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.

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Federal Reform

Potential topics of future reform:

- Changing age bands to 5:1
- Reinstating Cost-Sharing Reductions
- Stabilization of the Individual Market via a 1332 Innovation Waiver
- Moving Medicaid to per-Capita Grants.

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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	• Guaranteed coverage, no waiting list or caps	• No guarantee (can use wait lists or caps)	• May be guaranteed for certain groups
Federal Funding	• Guaranteed, no cap • Responds to program needs (enrollment and health care costs) • Can fluctuate	• Capped • Not based on enrollment, costs or program needs • Fixed with pre-set growth	• Capped per enrollee • Not based on health care costs and needs • Fixed with pre-set growth per enrollee
State Matching Payments	• Required to draw down federal dollars • Federal spending tied to state spending	• Unclear • Federal spending not tied to state spending beyond cap	• Unclear • Federal spending not tied to state spending beyond per enrollee cap
Core Federal Standards	• Set in law with state flexibility to expand	• Uncertain what the requirements would be to obtain federal funds	

KAISER FAMILY

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