Approved: 3-31-93
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Joann Flower at 1:30 p.m. on March 22, 1993 in Room 423-S of the Capitol.

All members were present except:

Committee staff present:
William Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes
Sue Hill, Committee Secretary

Conferees appearing before the committee:
Tom Hitchcock, Executive Secretary, Kansas Board of Pharmacy
Bob Williams, Executive Director of Kansas Pharmacists Association

Others attending: See attached list.

Chair called meeting to order, directing attention to Committee minutes of March 15. If there are corrections, please call the secretary by 5:00 p.m. tomorrow, March 23, 1993. If there are no corrections these minutes will be approved as presented.

Chair drew attention to SB 84 and requested a staff briefing.

Mr. Furse gave a detailed explanation of SB 84, and drew attention to new language proposed, and amendments made by the Senate.

CHAIR OPENED HEARINGS ON SB 84.

Tom Hitchcock, Executive Secretary, Kansas Board of Pharmacy, offered hand out, (Attachment No. 1). He stated support for SB 84, as amended by Senate Committee on Public Health and Welfare. He noted as Mr. Furse had indicated, Sec. (1) is a new section allowing the Board to sanction civil fines against a pharmacist, pharmacy, or distributer in an amount not to exceed $500 for each violation. He noted the Board of Healing Arts, since 1986 has had this authority, the Kansas Board of Nursing was granted the same authority last year for those individuals licensed under their authority. He noted there are 33 other states that have the authority to impose civil fines. A second change for the Board indicated in SB 84, page 2, line 22, would strike the requirement that some record keeping be recorded on the face of a transferred prescription. He detailed rationale. A third change is indicated on page 5, lines 23-29 which would allow the Board to promulgate regulations to exempt from registration a nonresident pharmacy which supplies someone in Kansas a prescription only in isolated transactions. He drew attention to the only amendment made by the Senate Committee on SB 84, page 5, line 24, i.e., verbiage added "non-resident pharmacy". He urged favorable passage of SB 84.

There were questions asked. Mr. Hitchcock detailed current law regarding the transfer of prescription information in cases where a Kansas resident may be visiting in another state and be in need of a prescription on record in the state of Kansas. Mr. Hitchcock when asked, remarked the $500 fine per violation seems adequate to the Board and he offered rationale. He also detailed specific situations wherein a pharmacist had not complied with regulations, and how proposed sanction authority would allow the Board to deal with these types of situations.

Bob Williams, Executive Director of the Kansas Pharmacists Association offered hand out, (Attachment No. 2). He indicated support for SB 84, and drew attention to an amendment to SB 84. He noted the amendment proposed is the same contained in HB 2117, i.e., would prevent any health insurance company, non-profit medical/surgical plan corporation, non-profit hospital service plan corporation, health maintenance organization, or preferred provider organization from denying a Kansas registered pharmacy or licensed pharmacist the right to participate as a provider in a plan as long as that pharmacy is willing to accept the same level of reimbursement terms and conditions as offered to any other pharmacy. The amendment would also prevent any third party from punishing a patient from going to a non-participating provider by requiring different co-payments or deductibles. He detailed rationale. He noted, he has a stack of letters he has received from pharmacists that had been written, at the request of Rep. Helgerson, citing numerous examples of how patient care had been compromised because community pharmacies have been locked out of networks, creating difficulty for the patient obtaining medication. He noted the amendment is not anti-managed care, but very supportive of the managed care concept. He noted HB 2117 was passed favorably in the House Committee on Financial Institutions and Insurance. He urged support of SB 84 in this committee, with the amendments he has proposed. Amendments proposed were detailed by Mr. Williams. He drew attention to the testimony he had provided in support of HB 2117, and noted there is a paper on Pharmaceutical Focus that is informational and noted the last page is directed to open access programs.

Mr. Williams noted he had talked with interested individuals from Kaiser Permanente regarding their concerns on this issue. He distributed another amendment, (Attachment No. 3) and gave a detailed explanation. He noted further amendments proposed on SB 84, i.e., Sec. (l), first paragraph, fourth sentence following "by a health maintenance organization", to amend by adding "as defined in K.S.A. 40-3202, except when the health maintenance organization owns and operates its own pharmacies and those pharmacies are in operation at the date of enactment of SB 84.

Numerous questions followed. It was noted the small town, neighborhood pharmacy is struggling because the closed networks are forming, i.e., an employer contracts with a Chain, or possibly an individual pharmacy as well, to provide exclusive benefits for employees, including prescriptions. It was noted that when pharmacies are excluded from network bidding whether or not the pharmacy, often the smaller or neighborhood pharmacy, agrees to accept the same level of reimbursement, often are locked out of that network and often are not notified that a contract has been offered until after the fact. He noted pharmaceutical benefits must be treated differently than other health care aspects. Drugs affect every aspect of health care, so compliance becomes a key element in this entire system. He explained how the low costs for prescriptions are bid out by larger Chains. He detailed mail-order prescriptions that are involved within Corporation medical plans.

CHAIR CLOSED HEARINGS ON SB 84.

Chair drew attention to bills previously considered for Committee action.

CHAIR DREW ATTENTION TO

Rep. Neufeld offered an amendment to SB 118, (see Attachment No. 4) He detailed the balloon, i.e., page 2, line 18, after "Board members", to add, "and task force members", page 2, line 24 (c) to add, "The chairperson of the health care data governing board may appoint a task force of interested citizens and providers of health care for the purpose of studying technical issues related to the collection of health care data. At least one member of the health care data governing board shall be a member of any task force appointed under this subsection." Further, to redesignate subsections as necessary. He offered rationale.

Rep. Neufeld then made a motion to amend SB 118 per balloon as just described, seconded by Rep. Freeborn.

Discussion ensued, i.e., if there is to be more than one Task Force, the language still should be clarified. It would appear to some there is enough flexibility to allow more than one task force. Mr. Furse, when asked, noted the language could easily be clarified by saying, "task force, or task forces".

At this point, Rep. Sader made a substitute motion to amend SB 118 further in the balloon offered by Rep. Neufeld, in sec. (c) after, "appoint a task force", to add, "or task forces". Motion seconded by Rep. Swall.

Discussion continued.

Rep. Sader and Rep. Swall withdrew their motions.

Discussion continued.

Rep. Neufeld restated his motion, and noted the language changes should read in sec. (c), after "appoint a task force" to add "task forces", along with other recommendations previously detailed in the balloon (Attachment No. 4). Rep. Freeborn as second, agreed.

Discussion began again. Mr. Furse noted, when asked, the Secretary of Health and Environment, or the designee of the Secretary, shall be a non-voting member who shall serve as Chairperson of the governing board.

Mr. Furse indicated to the Chair and members, when reviewing language in SB 118 there were areas that were technically unclear and he provided members with a balloon to address these technical aspects. (See Attachment No. 5). Mr. Furse gave a detailed explanation of changes that might perhaps be addressed, i.e., page 2, line 21, after "board members" to add, "appointed to the board"; page 3, line 19, to delete "department", and add "secretary of health and environment".

Rep. Samuelson moved to amend SB 118 by adopting amendments to clarify technical concerns expressed by Mr. Furse, seconded by Rep. Swall. No discussion. Motion carried.

Rep. Bishop expressed concerns regarding language in SB 118, page 3, Sec. 8 in regard to post audit. He stated the language needs to be clarified, or rather the use of language that is more appropriate or consistent with language used in other legislation in respect to post audit review.

Rep. Bishop moved to amend SB 118 conceptually on page 3, Sec. 8, to clarify the external audit. Motion seconded by Rep. Nichols.

Discussion began, i.e., some members viewed "external evaluation" as being un-defined. It was viewed by some this language should be clarified as to who will conduct the audit and when.

Mr. Furse, when requested, noted possible language additions in this situation might be phrased as, (Three years after enactment a performance audit shall be performed in accordance with the legislative post audit act to identify total cost to the state and providers of data and benefits of the program and to report to the legislature at the next subsequent legislative session.

Discussion continued.

Vote taken. Motion carried.,

Rep. Sader moved SB 118 be reported favorably as amended, seconded by Rep. Bishop. No discussion. Motion carried.

CHAIR DREW ATTENTION TO SB 119.

Rep. Rutledge provided an amendment to members, see (Attachment No. 6). He stated after talking with interested parties, he would propose the following amendments on SB 119, i.e., page 1, line 23, after the stricken language to add, "having a population of less than 100,000 people as"; page 2, line 16, to add "annually for the next four years", line 19, to add after task forces, "concerning the pilot project and including local representation, and a task force or task forces for statewide oversight and policy of managed care systems". Rep. Rutledge detailed rationale, then made a motion to amend SB 119 as he had suggested per balloon in Attachment No. 6. Rep. Neufeld seconded the motion.

Discussion began. Rep. Rutledge explained why dual task forces were recommended, i.e., one for the Pilot Project specifically, one for state-wide oversight. It was noted members appointed to these task forces would not be compensated; each would be reporting to the Joint Committee; the concern of competitive bidding was again discussed at length.

Rep. Rutledge and Rep. Neufeld both agreed to withdraw their motions.

Rep. Rutledge moved to amend SB119 as indicated in the balloon he had detailed, with additional language to include on page 2, line 25, "the task force members shall not be paid compensation, subsistance allowances, mileage or other expenses as otherwise may be authorized by law for attending meetings, or subcommittee meetings of the task force. To amend further in line 21, to change task force to plural. Motion seconded by Rep. Neufeld.

Vote taken. Motion carried.

Discussion began in regard to managed care and the competitive bid situation. A consultant from the Arizona program heard by some members recently while giving a presentation, had indicated that competitive bidding works in their program with little problems. It was noted the competitive bidding is not dis-allowed in SB 119. Some members do have concerns with this issue, but solving the issue seemed difficult, and in the view of some to further amend SB 119 regarding the competitive bid situation is not in the best interest of moving this legislation forward.

At this time Rep. Rutledge moved to pass SB 119 favorably for passage as amended, seconded by Rep. Neufeld. Motion carried.

Chair adjourned the meeting at 3:01 p.m.

The next meeting is scheduled for March 23, 1993.

VISITOR REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE March 22, 93

NAME	ORGANIZATION	ADDRESS
Chip Wheelen	Ks Medical Soc	Topeka
RAN COBB	Wichita Hosp. tals	Wichita
Kathy Buening	Board of Healing Arts	Topeka
Carmine Iredale	"	"
Tom Hitchcock	Bd. of Pharmacy	Topeka
Doug Crihart	Ks HealthCare Assn	Topeka
Dick Smith		Concordia
& Eugene Stephens	SRS/DMC	Topeka
Tom Bruno	Bottenberg & Assoc.	Topeka
Sandra Strand	KINH	Lawrence
Pat Scott	Ks funeral Directors Assn	Topeka
Kristin VanVoorst	PP of Ks	O.P.
[illegible]	[illegible]	Topeka
KEITH R LANDIS	CHRISTIAN SCIENCE COMM ON PUBLICATION FOR KS	TOPEKA
Bob Williams	Ks. Pharmacists Assoc	Topeka
Jane S. Henry	Ks Pharmacists Assn	Olathe, KS
John Ensley	Medco	Topeka
Sharon Stufflebeam	CWA	Topeka
Mack Smith	Ks St. Bd of Mortuary Arts	"
Tom Bell	Ks. Hosp. Ass.	Topeka
Ron Schmoller	BREWSTER PLACE	TOPEKA

Kansas State Board of Pharmacy

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STATE OF KANSAS

JOAN FINNEY
GOVERNOR

SB 84 TESTIMONY
HOUSE PUBLIC HEALTH & WELFARE COMMITTEE
MARCH 22, 1993

MADAM CHAIRMAN, MEMBERS OF THE COMMITTEE, MY NAME IS TOM HITCHCOCK AND I SERVE AS THE EXECUTIVE SECRETARY FOR THE BOARD OF PHARMACY. I APPEAR BEFORE YOU TODAY ON BEHALF OF THE BOARD IN SUPPORT OF SB 84 AS AMENDED.

THE BILL CONSISTS OF THREE (3) CHANGES IN THE PHARMACY ACT. THE FIRST CHANGE APPEARS ON PAGE 1, LINES 13 THROUGH 27, IN THE FORM OF A NEW SECTION. THIS SECTION WILL ALLOW THE BOARD TO SANCTION CIVIL FINES AGAINST A PHARMACIST, PHARMACY OR DISTRIBUTOR IN AN AMOUNT NOT TO EXCEED $500 FOR EACH VIOLATION. IN COMPARISON, THE KANSAS BOARD OF NURSING AND HEALING ARTS BOTH HAVE THE ABILITY TO IMPOSE CIVIL FINES AS DO 33 BOARDS OF PHARMACY IN OTHER STATES.

THE SECOND CHANGE IS ON PAGE 2, LINE 22, WHICH STRIKES THE REQUIREMENT THAT SOME RECORD KEEPING BE RECORDED ON THE FACE OF A TRANSFERRED PRESCRIPTION. IF THE TRANSFER WERE A CONTROLLED SUBSTANCE (CS) PRESCRIPTION, SUCH RECORD KEEPING WOULD NOT BE IN COMPLIANCE WITH FEDERAL DEA REGULATION 21 C.F.R. 1306.26(a)(1).

THE THIRD CHANGE IS ON PAGE 5, LINES 23 THROUGH 29. THIS ADDITIONAL SUBSECTION WILL ALLOW THE BOARD TO PROMULGATE REGULATIONS TO EXEMPT FROM REGISTRATION A NONRESIDENT PHARMACY WHICH SUPPLIES SOMEONE IN THIS STATE A PRESCRIPTION ONLY IN ISOLATED TRANSACTIONS.

THE BOARD OF PHARMACY RESPECTFULLY REQUESTS THE FAVORABLE PASSAGE OUT OF COMMITTEE SENATE BILL 84 AS AMENDED.

THANK YOU.

PHed 3-22-93 Attm #1.

THE KANSAS PHARMACISTS ASSOCIATION
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ROBERT R. (BOB) WILLIAMS, M.S., C.A.E.
EXECUTIVE DIRECTOR

TESTIMONY

SB 84

House Public Health & Welfare Committee

My name is Bob Williams. I am the Executive Director of the Kansas Pharmacists Association. Thank you for the opportunity to address the committee regarding Senate Bill 84.

The Kansas Pharmacists Association supports SB 84. New Section 1 provides the Board of Pharmacy alternatives to licensure revocation and suspension in disciplinary matters by allowing them to fine in an amount not to exceed $500 for each violation.

Paragraph (g) on page 5 of the bill provides an exemption to the law passed last year which requires non-resident pharmacies to register with the Kansas Board of Pharmacy. There are isolated instances when an individual is traveling through Kansas or vacationing in Kansas and receives his/her medication from a pharmacy in another state. The Kansas Pharmacists Association sees no need for these non-resident pharmacies to register with the Kansas Board of Pharmacy in these isolated instances.

Additionally, the Kansas Pharmacists Association offers an amendment to SB 84 which is attached to my testimony. This amendment is the same language as contained in House Bill 2117.

Essentially what this amendment would do is prevent any health insurance company, non-profit medical and surgical plan corporation, nonprofit hospital service plan corporation, health maintenance organization or a preferred provider organization from denying a Kansas registered pharmacy or licensed pharmacist the

Attach 3-22-93 Attm #2

right to participate as a provider in a plan as long as that pharmacy is willing to accept the same level of reimbursement terms and conditions as offered to any other pharmacy. This amendment would also prevent any third party from punishing a patient from going to a non-participating provider by requiring different copayments or deductibles.

Pharmacy has its roots in the retail sector. It has become common practice for retail operations to accept their competitor's coupons and promise to sell their merchandise for the same price as their competitor. Pharmacies functioned much the same way before insurance companies began creating monopolies under the umbrella term "managed care".

Unfortunately, these monopolies have created barriers to pharmaceutical care. I have a stack of letters from pharmacists citing numerous examples of how a patient's care has been compromised because community pharmacies have been locked out of networks. As a result of their involvement in closed networks during the 1980's, the American Association of Preferred Provider Organizations now recommends that their plan members be given the freedom to choose a pharmacy that is readily accessible in order to foster medication compliance. This amendment is not anti managed care, as some would have you believe, but very much supportive of the managed care concept.

HB 2117 was passed favorably by the House Committee on Financial Institutions & Insurance on 10-4 vote. As a result of some procedural problems, and following discussion with House leadership, the decision was made not to run the bill as it came out of committee due to format concerns. We encourage the House Committee on Public Health & Welfare's adoption of SB 84 and our amendment.

Thank you.

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Amendment to SB 84

Section 1. No policy of group health insurance providing benefits for hospital and medical expenses delivered in this state that is offered by an accident and health insurance company, by a nonprofit medical and surgical plan corporation, by a nonprofit hospital service plan corporation, by a health maintenance organization, by a preferred provider organization, by an individual practice association or by a similar mechanism may:

(1) Deny an registered pharmacy or licensed pharmacist as defined in K.S.A. 65-1626 and amendments thereto the right to participate as a provider for any policy or plan on the same terms and conditions as are offered to any other provider of pharmacy services under the policy or plan;

(2) prevent any person who is a party to or beneficiary of any health insurance policy from selecting a registered pharmacy to furnish the pharmaceutical services offered under any policy or plan, if the pharmacy is a provider under the same terms and conditions of the policy or plan as those offered to any other provider of pharmacy services; or

(3) permit or mandate any difference in coverage for or impose any different conditions, including copayment fees, whether the prescription benefits are provided through direct contact with a pharmacy or by use of an out-of-state mail order service so long as the provider selected is a participant in the plan involved.

Sec. 2. All health benefit programs, as defined in section 1, shall provide an annual period of enrollment of at least 30 days during which period any pharmacy registered under article 16 of chapter 65 of Kansas Statutes Annotated may elect to participate in the plan under the terms and conditions then offered unless the pharmacy has lost its status as a provider due to its failure to comply with the terms and conditions of its provider agreement. Health benefit programs are not required to provide actual notice of the period of open enrollment to the pharmacy.

Sec. 3. Any provision in an accident and health insurance policy offered in this state which violates the provisions in section 1 is void.

Sec. 4. The department of insurance shall enforce the provisions of this act.

Section 5. This act shall take effect and be in force from and after its publication in the statute book.

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SB 213

TESTIMONY

HB-2117

HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE

February 8, 1993

Thank you Chairman Bryant for this opportunity to address the committee. My name is Bob Williams, I am the Executive Director of the Kansas Pharmacists Association. I am appearing before the Committee this afternoon in support of HB-2117.

HB 2117 is a pro consumer bill that would prevent prescription plans from interfering with a beneficiary's selection of a pharmacy provider, if that pharmacy elects to participate as a provider under the same terms and conditions of the policy or contractual arrangement.

The bill would also prevent the plan from penalizing the consumer with a higher co-payment or deductible regardless of the provider selected by the beneficiary.

The pharmacy community is dedicated to cost savings and competition. One only has to look at the advertising section of a newspaper on any given day to see the competitive nature of the pharmacy profession. Pharmacists have also been procompetitive by forming volume purchasing groups and have taken a leadership role in the formation of drug utilization review programs which have the potential to save millions of dollars.

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HB 2117

According to an article which appeared in the September 16, 1992 issue of the *New York Times Health*, each year studies indicate that 125,000 people with treatable ailments die simply because they did not take prescribed medications properly. The article further indicates that noncompliance is costing this country $15 billion a year in direct medical costs, lost wages and productivity. Much of the noncompliance problem could be avoided by the utilization of community pharmacies.

Pharmacists provide essential health care services to their patients by reviewing prescriptions prior to dispensing, maintaining patient profiles, advising patients on proper drug utilization, and counseling patients in the interaction between a prescribed drug and nonprescription medication. Exclusive contracts, based on excessive volume created only by economic pressures and limited access to pharmacy services, reduces the opportunity for meaningful face-to-face interaction in pharmacist-patient relationships.

Opponents to HB 2117 would have you believe that they need to enter into these exclusive provider contracts in order to control health care costs. Furthermore they would have you believe that this form of "managed competition" is THE answer to controlling health care costs. According to the January 1986, Vol. 39, issue of the *Vanderbilt Law*,

> "The ability of third party payors to impose uneconomical terms on . . . pharmacies results from two factors: first, the economic power of the group purchasers (usually large insurance carriers), combined with their natural desire to reduce costs; and second, the weak bargaining power of . . . pharmacists, who are precluded by the antitrust laws from joining together to

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bargain collectively. As a result the . . . pharmacist confronts the business dilemma of either acceding to an unprofitable third party agreement or losing a significant amount of new and existing patronage.

". . . pharmacists who enter third party payor agreements often attempt to negate the resulting economic loss by charging higher prices to uninsured patient-purchasers. The burden falls heavily upon uninsured patient-purchasers who do not have insurance coverage, including the non-Medicaid poor. Rather than reduce consumer drug prices generally, third party programs shift cost to the uninsured public. To the extent these programs are uneconomical to . . . pharmacists, they have contributed to a reduction in the number of . . . pharmacies. Because pharmacies, particularly in rural or lower income areas, often provide the only readily accessible source of health care counseling, this result has substantial adverse societal impacts."

With third party prescriptions representing only 35.6% of total prescription sales in the west north central states*, that means the remaining 64.4% of us without third party coverage for prescription drugs are footing the bill. Certainly these "managed monopolies" are not the answer and threaten pharmacies cost savings ability. Both the Kansas Commission on the Future of Health Care and the Joint Legislative Committee on Health Care Decisions for the 90's have been conducting hearings regarding the lack of health care services in rural Kansas communities. Rural hospitals are closing, physicians are not locating in rural communities and now

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HB 2613

these "managed monopolies" are threatening the existence of rural community pharmacies.

The opponents to HB-2117 would also have you believe that HB-2117 would be preempted by the ERISA Act (Employee Retirement Income Security Act). The ERISA Act was intended as either a tax or employee protection measure. ERISA was not passed for the purpose of allowing insurance companies and employers to "blackball" certain pharmacists. The Act was never intended to promote anti-competitive programs, nor was it created to allow insurance companies to create monopolies. On the contrary, it was passed to help protect employees. HB-2117 in no way interferes or conflicts with federal statutes and, in fact, supports and encourages the spirit of ERISA, that being to protect workers from being denied access to medical and/or pharmaceutical services, as well as to assure those individuals the opportunity to select pharmaceutical providers of their choice. In those states where similar legislation has been adopted, we are unaware of any lawsuit directly related to violations of the ERISA Act.

Additionally, we are aware that the Health Insurance Association of America (HIAA) commissioned the Wyatt Company to conduct a study entitled "Cost Analysis of Three State Mandates to Regulate the Provision of Prescription Drug Benefits" where the Wyatt Company's goal was to illustrate the detrimental effects of legislation such as HB-2117. I have attached to my testimony an article published by the National Association of Retail Druggists which points out a number of flaws in the Wyatt study. We also find it curious that the insurance industry points its finger at pharmacy for increasing prescription drug costs when, in fact, a study by the

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National Association of Chain Drug Stores showed that, on the average, it costs $1.25 more to dispense a third party prescription than a private pay prescription.

In conclusion I would like to say that 20 plus states have passed similar procompetitive legislation. The experimentation in the last decade with restricted networks, exclusive networks, discriminatory or mandatory mail order drug programs--all sacrifice consumer access, the cornerstone of competition, in an illusory pursuit of cost savings. Patients have become so complacent about taking their medication that it is costing this country $15 billion annually and pharmacists are forced to raise prices to private pay patients because they are not allowed to participate in monopolistic insurance programs. As we rapidly move towards health care and insurance reform we must begin to put people back into the equation and begin to think about what we are doing to them.

Thank you.

*Lilly Digest 1992 a summary of the 1991 operations of 1,294 independent community pharmacies. Eli Lilly & Company, Lilly Corporate Center, Indianapolis, IN 46285.

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PHARMACEUTICAL
FOCUS

Pharmaceutical Benefits: To Carve or Not to Carve

By

Kenneth R. Cohen and Richard A. Levy, PhD

The following article is the first in a new department that will appear in each issue of the AAPPO Journal entitled Pharmaceutical Focus. The series is intended to create a forum for exploring issues relative to integrating and managing supplemental benefits such as the pharmaceutical benefit in health care plans. Currently, only about half of all preferred provider organizations (PPOs) have managed pharmacy benefit programs, and of those, 74 percent utilize "carve-out" pharmaceutical benefit plans, usually with separate management and fee structures.[1] As a result of these arrangements, most PPO administrators have little practical experience with managed pharmaceutical benefits. It is essential to their organizations' survival that this experience be gained. This article will examine why this is so, and will offer guidelines for the development of a viable carved-out pharmaceutical benefit program.

Pharmaceuticals and Outpatient Therapy

In recent years, utilization of hospitalization has decreased, with more patients being treated in outpatient settings. This major shift has been made possible largely as a result of two factors: the adoption of managed care techniques and the advent of new pharmaceuticals.

These developments have initiated the following important new trends that will prevail into the 21st century: an increased volume of outpatient visits; an increase in the severity and complexity of illnesses treated on an outpatient basis; and a greater reliance on the outpatient use of pharmaceuticals as the primary treatment modality.[2] In such an environment, successful PPOs will be those that effectively manage outpatient pharmaceutical benefits not as an isolated cost center, but as an integrated part of the overall treatment regimen.

Kenneth R. Cohen is Vice President of Managed Care and Richard A. Levy, PhD is Vice President for Scientific Affairs at the National Pharmaceutical Council (NPC) in Reston, VA. The NPC is a research/educational association of research-intensive multi-national pharmaceutical companies. In addition, Mr. Cohen is a member of the Editorial Board of the AAPPO Journal.

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Managing the Outpatient Pharmaceutical Benefit

In an era when outpatient care is becoming a primary treatment modality, sophisticated pharmacy management will be required to control overall costs and to achieve quality outcomes. Pharmaceutical therapies themselves have become increasingly complex, with many seriously ill outpatients maintained on multiple medications. Currently, PPOs are doing very little to insure that medications are taken correctly, stored properly or understood well by these patients who critically rely upon them.

Pharmacy benefit management has become as complex as the pharmaceutical therapies themselves.

Pharmacy counseling for Medicaid patients will be mandated in 1993, but there is little agreement as to how much is required or appropriate, or how well existing systems can serve the true needs of patients. While such counseling is a positive step to manage pharmaceutical care, further investigations are required to insure that quality products are dispensed to the right patients at the right time, place and cost.

Pharmacy benefit management has become as complex as the pharmaceutical therapies themselves. Techniques for the economical utilization of medicines are usually beyond the scope of all but the most highly trained and experienced individuals. General health care benefit managers lack the understanding, skills and time to master such a process. Most benefit managers think that since medications are a small part of the overall budget, they require little attention. General managers may fall prey to offers of "quick fixes" that save money in the pharmacy budget. Without the proper feedback from the overall system, these savings can seem quite attractive; but the system as a whole may be economically disadvantaged.

For example, savings in a pharmaceutical budget can be quickly erased by poor compliance, especially in critical therapeutic situations. Medications not taken properly can lead to further physician visits, utilization of more and costlier medications, increased laboratory and testing costs and eventually to increased hospitalization. Indirect costs, such as loss of workplace productivity, childcare, transportation expenses and disenrollment, may be as great or even greater than costs directly attributed to treatment.

Carve-out Pharmaceutical Benefits

One growing trend within the PPO industry today to properly control pharmaceutical costs and quality is to "carve-out" the pharmaceutical benefit. This trend entails separating the pharmacy plan from the main health care plan, by using separate management and utilization review strategies, actuarial tables and fee schedules.

Carve-outs are popular in pharmaceutical and other areas, such as mental health, dental and vision care, for the following reasons:

- An opportunity exists to isolate and better control costs.
- A concentration of expertise can be applied to the carve-out, attracting an experienced and capable workforce.
- Micro-management of a carve-out benefit may provide opportunities to reduce costs through techniques such as formularies and contracting.

However, despite apparent advantages, the results of carving-out a pharmaceutical benefit can be far different than anticipated. More than any other aspect of medical care, pharmaceutical utilization affects other areas of patient management and can have a major impact on treatment outcomes. Carved-out pharmaceutical plans are often isolated from other cost centers with little or no ability to assess the impact on overall treatment costs. Other problems with pharmaceutical carve-outs include:

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- Separate management for the carve-out plan is usually disconnected from the provider community, often leading to provider-relation issues.
- The managers of a pharmaceutical carve-out seldom have access to confidential patient profiles. Decisions made by these managers, operating in an environment removed from the site of care delivery, may lead to problems with therapeutics, patient acceptance of pharmacy restrictions, and legal issues.
- Multiple layers of internal management can be costly; alternatively, outside management of the carve-out benefit adds another cost, i.e., the profit of the outside contractor.

These positive and negative factors should be carefully weighed prior to implementing a carve-out pharmaceutical benefit.

Guidelines for Plan Design

Regardless of whether or not a pharmaceutical benefit is based on a carve-out design, it must contain certain key features that meet the needs of both employers and patients. These qualities are reflected in the following "checklist"[3] of what the plan should do:

- Cover medications that are not only clinically effective, but will also reduce overall medical care cost.
- Allow prescribers the flexibility to select medications that meet the unique needs of an individual patient.
- Give plan members the freedom to choose a pharmacy that is readily accessible in order to foster medication compliance.
- Encourage personalized counseling by the pharmacist, written instruction sheets and medication monitoring.
- Monitor patient compliance with the therapy.
- Maintain and utilize patient medication records to prevent unnecessary drug interactions and other potential problems.
- Employ strict quality assessment standards.
- Conduct appropriate drug utilization review.
- Promote rational controls on patient utilization.

These guidelines are appropriate for all PPO pharmaceutical benefit designs, whether or not they are carve-out plans. Two additional guidelines should be applied specifically to carve-out plans.

- A carve-out benefit of any type, especially one such as pharmaceuticals that will impact other parts of the total health care program, demands the use of an integrated data management system. In such a system, every provider must enter complete data from their part of the medical encounter. These data must be entered in a common language; it must be on-line, and readily accessible to others who are making key care decisions.
- There must be a center of control (case manager or gatekeeper) who will actually assume responsibility for tracking, balancing and coordinating costs and savings among the multiple service areas within the overall plan.

In the design of any pharmaceutical benefit component, PPOs must remember that the underlying basis of the PPO industry is to provide quality health care to patients. In this era of outpatient treatment, high-quality services cannot be accomplished without proper pharmaceutical management. And, serving the patient well will always be the hallmark of success.

References

1. *Marion Merrell Dow Managed Care Digest: PPO Edition.* Kansas City, MO: Marion Merrell Dow;1992:24.
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In Brief...

Where Little TPAs Come From

Ever wonder just who third-party health administrators are, where they come from, and how they've gotten to be experts on such things as pharmacy reimbursement? According to Fred Hunt, president of the Society of Professional Benefits Managers, very few people wake up one morning and decide to become TPAs. "Rather," he says, "it's a business you tend to grow into. Most new TPAs were old insurance agents, brokers, or members of the group department of an insurance company. They become TPAs on the day when they approach a big client with a 50 percent premium increase and the client says, 'No way! Either get me a better deal or I'm getting a new agent!' As he's recovering from the shock, the agent starts thinking about all this self-funding stuff. So he hangs out a TPA shingle, takes on claims processing, organizes provider networks (like pharmacists), negotiates rates, and then comes back to his client with a better deal."

Most surprisingly, the TPA business has never been better. "Our members say they are incredibly busy," says Hunt, "with old business and especially with new business. In the nine years I've been with the society, we've grown 900 percent—and those are new TPAs bringing in new business."

Continued on page 3

Open Panel Contracts Do *Not* Increase Pharmacy Costs

A popular truism among insurers, HMOs, and other third-party payors is that closed-panel provider contracts save money. Low unit reimbursements can be negotiated if volume can be guaranteed. By contracting exclusively with a finite group, volume can be guaranteed. But, say insurers, if contracts can be opened up, the volume lever goes away and unit reimbursement goes back up.

Sounds logical, but is it true? The Wisconsin Pharmacists Association decided to test the alleged truism empirically; it's ideally situated to do so since Wisconsin has had an open panel law for several years. The study measured pharmacy costs in a six-state area, using Wisconsin as the control state.

The study's major finding stands the truism on its head. In terms of professional fees, the average for all plans, whether open or closed, is virtually identical. In fact, it's slightly lower for open panel plans, at $2.97; closed panels average a fee of $3.01. Significantly, the open panel fees start out quite a bit higher than the closed panel fees, $3.19 for open vs. $2.71 for closed. This finding supports pharmacy's long-held position that the best mechanism for controlling costs is an unrestricted, highly competitive marketplace. Where the market is allowed to operate, costs come down. Where competition is eliminated—that is, in closed panel plans—costs creep upward.

Consumer Resistance to Managed Care

A poll of leading health care journalists conducted by Scott-Levin Associates of Newtown, Pennsylvania suggests growing consumer disaffection against access constraints and managed care cost-cutting approaches. The poll quotes Glenn Ruffenbach of *The Wall Street Journal* as saying, "As third-party mediation of doctor-patient relationships becomes more common, people are going to realize how much of a Big Brother is in there, and they are not going to be happy about it."

William Boyles, editor of *Health Market Survey*, says the term "managed care" has taken on a negative connotation, while Russell Jackson, editor of *Managed Care Outlook*, predicts a "coming outcry from public dissatisfaction with the constraints of managed care." Both journalists, however, believe that managed care is inevitable.

Perhaps the most negative view of public perception was voiced by *Newsweek* columnist Jane Bryant Quinn, who says consumer resistance is growing to the cost-cutting approaches favored by HMOs and PPOs. In addition, Quinn detects a growing fear among enrollees that "the plans want them only when they are well, but that the plans may fail to provide sufficient health care just when it's needed."

Third-Party Rx ™ is published monthly by NARD, 205 Daingerfield Road, Alexandria, VA 22314. 703-683-8200. Editorial offices: 22 49th St., Weehawken, NJ 07087. Editor: Robert McCarthy. Second class postage pending at Alexandria, VA and additional mailing offices. Subscription rates: NARD members, $25 per year; nonmembers, $50 per year; foreign, $70 per year. Contributions and gifts to NARD are not deductible as charitable contributions for federal tax purposes. Postmaster: Send address changes to Third-Party Rx, 205 Daingerfield Road, Alexandria, VA 22314.

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The card that failed by doubling Rx use

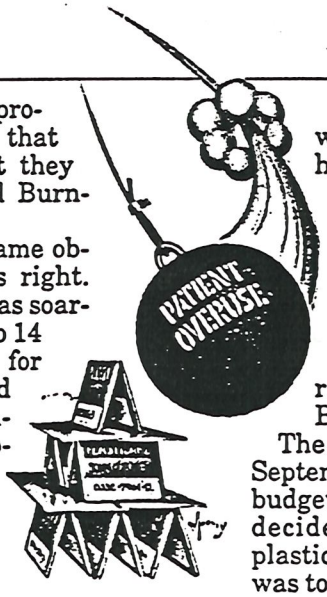
A South Carolina Rx program for state employees and retirees has highlighted what could happen with plastic card programs. When compared with indemnity coverage for drugs, plastic cards tend to increase patients' use of pharmaceuticals.

Under the old indemnity system, state employees and retirees paid up front for their drugs and filed claims with Blue Cross and Blue Shield. The covered beneficiaries averaged six prescriptions yearly, said Robert Burnside Jr., executive director of the South Carolina Pharmaceutical Association.

Enter card plan: In January 1989, however, the state instituted a plastic card program with a co-pay of $4 for generic drugs and $7 for brand-name medications. There was no drug formulary or drug utilization review.

SCPhA warned that the card plan would increase Rx use, but the state chose to brush aside the caution, hoping the plan would be "revenue neutral"—that is, cost no more than the old program. "We told them that was pie-in-the-sky, but they didn't believe us," said Burnside.

By September, it became obvious that SCPhA was right. Prescription drug use was soaring to an estimated 12 to 14 Rxs per covered person for the year. This resulted in a projected $10 million shortfall in the program, to rise to $15 million in 1990.



"Beneficiaries felt that the plastic card was like a credit card—that for $7 they could get anything they wanted," said Burnside. Also, the state had cut back on other health-care benefits for the employees, increased deductibles, and granted only minimal salary raises. "So I think that in the back of a lot of employees' minds was the idea, 'This is the way I'm going to get some of my money back.'"

So, beneficiaries, who in the past might have bought an over-the-counter medication for such ailments as a cough, decided that "for $4 [co-pay] let me get the real stuff, and for $7 give me the real, real stuff," Burnside explained.

The upshot was that by September 1989 the state budget and control board decided to jettison the plastic card program; it was to revert to an indemnity plan on Jan. 1 of this year.

Burnside pointed out that the indemnity system benefits pharmacists, who are reimbursed on the basis of usual-and-customary charges. The plastic card program paid average wholesale price less 9.5% plus a $4 dispensing fee. This is lower than the state's $4.05 Medicaid fee.

Martha Glaser

Third party costs more than cash and carry, chains show

Now a formal study proves what pharmacists have known all along—it costs more to dispense a third-party prescription than a privately paid one. In fact, it's $1.25 more, according to a survey commissioned by the National Association of Chain Drug Stores.

The study, conducted by the Purdue University School of Pharmacy in Indiana, will be used by NACDS to lobby Congress for changes in third-party reimbursement schedules, according to Ronald Ziegler, president of NACDS.

Drugstore chains operating at peak efficiency, said Ziegler, can no longer make allowance for the difference in prescription repayments. "There have been great accomplishments in increasing efficiency in the chain drug industry," he noted. "But the amount of efficiency that can be wrung out is quickly nearing its limit."

At a New York press conference reporting the study findings, Ziegler said reimbursement losses mainly hurt smaller chain drugstores. "Many small independent drugstores, in fact, are going out of business; they just can't operate," he told reporters. "[They're] getting very close to the point ... where [they] can no longer be viable."

Ziegler also criticized pharmaceutical manufacturers, blaming them for higher drug prices. Legislators and third parties are unfairly singling out the retail pharmacist in cost-containment moves, harming business in the process, he said. "There is a phenomenal amount of money tied up for a long time in third-party receivables."

The study polled 695 chain drugstores nationwide. The debate over the catastrophic health-care legislation, now largely repealed, had pushed the association into underwriting the study, said NACDS board chairman Gerald Heller.

Daniel M. Bergin

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In Section 1, first paragraph, fourth sentence, following "by a health maintenance organization..." add the following:

as defined in KSA 40-3202, except when the health maintenance organization owns and operates its own pharmacies and those pharmacies are in operation at the date of enactment of this bill,

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Attach 3

Session of 1993

Substitute for SENATE BILL No. 118

By Committee on Public Health and Welfare

3-1

AN ACT establishing a health care database; providing for powers and duties of the secretary of health and environment; authorizing the collection of health care data from certain persons and entities and establishing a health care governing board.

Be it enacted by the Legislature of the State of Kansas:

Section 1. (a) The legislature recognizes the urgent need to provide health care consumers, third-party payors, providers and health care planners with information regarding the trends in use and cost of health care services in this state for improved decision-making. This is to be accomplished by compiling a uniform set of data and establishing mechanisms through which the data will be disseminated.

(b) It is the intent of the legislature to require that the information necessary for a review and comparison of utilization patterns, cost, quality and quantity of health care services be supplied to the health care database by all medical care facilities as defined by subsection (h) of K.S.A. 65-425, and amendments thereto, and all other health care providers to the extent required by section 5 and amendments thereto.

(c) The information is to be compiled and made available in a form prescribed by the governing board to improve the decision-making processes regarding access, identified needs, patterns of medical care, price and use of health care services.

Sec. 2. (a) The department of health services administration of the university of Kansas and any institute or center established in association with the department is hereby authorized to request data for the purposes of conducting research, policy analysis and preparation of reports describing the performance of the health care delivery system from public, private and quasi-public entities.

(b) The department of health services administration of the university of Kansas may request data for purposes of conducting research, policy analysis and preparation of reports describing the performance of the health care delivery system from any quasi-public or private entity which has such data as deemed necessary by the department.

PH&W 3-22-93 Attm #4

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PH&W 3-22-93 Attm #4

Sec. 3. (a) There is hereby created a health care data governing board.

(b) The board shall consist of seven members appointed as follows: One member shall be appointed by the Kansas medical society, one member shall be appointed by the Kansas hospital association, one member shall be appointed by the executive vice chancellor of the university of Kansas school of medicine, one member representing health care insurers or other commercial payors shall be appointed by the governor, one member representing adult care homes shall be appointed by the governor, one member representing the institute associated with the university of Kansas department of health services administration and one member representing consumers of health care shall be appointed by the governor. The secretary of health and environment, or the designee of the secretary, shall be a nonvoting member who shall serve as chairperson of the board. The secretary of social and rehabilitation services and the insurance commissioner, or their designees, shall be nonvoting members of the board. Board members shall not be paid compensation, subsistence allowances, mileage or other expenses as otherwise may be authorized by law for attending meetings, or subcommittee meetings, of the board. The board members shall serve for three-year terms, or until their successors are appointed and qualified.

(c) The board shall meet at least quarterly and at such other times deemed necessary by the chairperson.

(d) The board shall develop policy regarding the collection of health care data and procedures for ensuring the confidentiality and security of these data.

Sec. 4. (a) The secretary of health and environment shall administer the health care database. In administering the health care database, the secretary shall receive health care data from those entities identified in section 5 and amendments thereto and provide for the dissemination of such data as directed by the board.

(b) As directed by the board, the secretary of health and environment may contract with an organization experienced in health care data collection to collect the data from the health care facilities as described in subsection (h) of K.S.A. 65-425 and amendments thereto, build and maintain the database.

(c) The secretary of health and environment shall adopt rules and regulations approved by the board governing the acquisition, compilation and dissemination of all data collected pursuant to this act. The rules and regulations shall provide at a minimum that:

(1) Measures have been taken to provide system security for all

PH&W 3-22-93 Attm #4 pg 2 of 2

and task force members

(c) The chairperson of the health care data governing board may appoint a task force of interested citizens and providers of health care for the purpose of studying technical issues relating to the collection of health care data. At least one member of the health care data governing board shall be a member of any task force appointed under this subsection.

or task forces

Redesignate subsections

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data and information acquired under this act;

(2) data will be collected in the most efficient and cost-effective manner for both the department and providers of data;

(3) procedures will be developed to assure the confidentiality of patient records. Patient names, addresses and other personal identifiers will be omitted from the database;

(4) users may be charged for data preparation or information that is beyond the routine data disseminated; and

(5) the secretary of health and environment will ensure that the health care database will be kept current, accurate and accessible as prescribed by rules and regulations.

Sec. 5. Each medical care facility or representative of the facilities as defined by subsection (h) of K.S.A. 65-425, and amendments thereto, psychiatric hospital licensed under K.S.A. 75-3307b and amendments thereto, third-party payors, including but not limited to licensed insurers, medical and hospital service corporations, health maintenance organizations, fiscal intermediaries for government-funded programs and self-funded employee health plans, shall file annually health care data with the department as prescribed by the board.

Sec. 6. The secretary of health and environment shall make the data available to interested parties on the basis prescribed by the board and as directed by rules and regulations.

Sec. 7. The secretary of health and environment shall annually make a report to the governor and the joint committee on health care decisions for the 1990's as to health care data activity, including examples of policy analyses conducted and purposes for which the data was disseminated and utilized.

Sec. 8. Three years after enactment an external evaluation or post audit will be performed to identify total costs to the state and providers of data and the benefits of the program.

Sec. 9. This act shall take effect and be in force from and after its publication in the statute book.

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P&W
3-22-93
Attm #4

Session of 1993

Substitute for SENATE BILL No. 118

By Committee on Public Health and Welfare

3-1

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(c) The information is to be compiled and made available in a form prescribed by the governing board to improve the decision-making processes regarding access, identified needs, patterns of medical care, price and use of health care services.

Sec. 2. (a) The department of health services administration of the university of Kansas and any institute or center established in association with the department is hereby authorized to request data for the purposes of conducting research, policy analysis and preparation of reports describing the performance of the health care delivery system from public, private and quasi-public entities.

(b) The department of health services administration of the university of Kansas may request data for purposes of conducting research, policy analysis and preparation of reports describing the performance of the health care delivery system from any quasi-public or private entity which has such data as deemed necessary by the department.

PHHW 3-22-93 Attm # 5

Norm

PHHW 3-22-93 Attm # 5

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(c) The secretary of health and environment shall adopt rules and regulations approved by the board governing the acquisition, compilation and dissemination of all data collected pursuant to this act. The rules and regulations shall provide at a minimum that:

(1) Measures have been taken to provide system security for all

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P&HW
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pg 2 of 3

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secretary of health and environment

Sec. 6. The secretary of health and environment shall make the data available to interested parties on the basis prescribed by the board and as directed by rules and regulations.

Sec. 7. The secretary of health and environment shall annually make a report to the governor and the joint committee on health care decisions for the 1990's as to health care data activity, including examples of policy analyses conducted and purposes for which the data was disseminated and utilized.

Sec. 8. Three years after enactment an external evaluation or post audit will be performed to identify total costs to the state and providers of data and the benefits of the program.

Sec. 9. This act shall take effect and be in force from and after its publication in the statute book.

PHEW 3-22-93 Attm # 5 SB 393

PHEW 3-22-93 Attm #5 SB 393

As Amended by Senate Committee

Session of 1993

SENATE BILL No. 119

By Senators Praeger, Bond, Burke, Emert, Frahm, Harris, Kerr, Langworthy, Lawrence, Ramirez, Ranson, Steffes, Tiahrt and Vidricksen

1-28

AN ACT providing for the establishment of a pilot project to provide medicaid services in certain areas of the state through a system of managed care.

Be it enacted by the Legislature of the State of Kansas:

Section 1. (a) Subject to applicable federal guidelines and regulations and the provisions of appropriations acts, the secretary of social and rehabilitation services shall negotiate and enter into contracts ~~with health care providers~~ for a pilot project to be conducted *in two counties of this state* during the fiscal year ending June 30, ~~1994~~ *1995*. The pilot project under this section shall be conducted in Sedgwick county and in a county ~~having a population of less than 100,000 people as~~ specified by the secretary of social and rehabilitation services *and the task force established under subsection (e)*. The pilot project shall be conducted to provide medicaid services through a system of managed care for Kansas medicaid eligible residents on the basis of a described set of such services to a predetermined population as prescribed by the contracts. No contract entered into under this section shall be subject to the competitive bid requirements of K.S.A. 75-3739 and amendments thereto. The services to be provided for such residents under the contracts shall be provided through a system of managed care as specified in the contracts.

(b) The contract may be entered into by the secretary with a single provider or with a contracting agency to provide such services through a group of qualified health care providers, or both, within the areas of Kansas specified for the pilot project under this section. In determining the location of the pilot project located in a county other than Sedgwick county and the area in which such services shall be provided, the secretary *and the task force* shall consider the availability of health care providers and their willingness to participate in such pilot project at the time the pilot project is to commence under the contract.

having a population of less than 100,000 people as

Rutledge

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(c) If the secretary of social and rehabilitation services determines that waivers from program or other requirements of the federal government are needed to carry out the provisions of this section and to maximize federal matching and other funds with respect to the pilot project authorized under this section, the secretary shall apply to the federal department of health and human services, or other appropriate federal agency, for such waivers. If the secretary determines that waivers are needed, the pilot program established under this subsection shall not commence until such waivers are granted by the appropriate federal agency.

(d) The secretary shall submit a preliminary report on the results of the pilot project to the committee on ways and means of the senate and the committee on appropriations of the house of representatives at the beginning of the 1994 regular session of the legislature. The secretary shall submit additional reports and information regarding the pilot project as requested by such committees during such legislative session

annually for the next four years

(e) The secretary of social and rehabilitation services shall appoint a task force to advise the secretary on matters relating to the implementation of the pilot project established under this section. The task force shall make findings and recommendations concerning the pilot project established under this section and shall report such findings and recommendations to the joint committee on health care decisions for the 1990's and to the legislature on or before the commencement of the 1994 legislative session.

concerning the pilot project and including local representation, and a task force for statewide oversight and policy of managed care systems

task force not to be paid compensa

Sec. 2. This act shall take effect and be in force from and after its publication in the Kansas register.

See same as in 118

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