SUBJECT: Creating a state prescription drug program for Medicare beneficiaries

COMMITTEE: Public Health — committee substitute recommended

VOTE: 6 ayes — Gray, Coleman, Capelo, Longoria, Maxey, Uresti

2 nays — Delisi, Wohlgemuth

1 absent — Glaze

WITNESSES: For — Alan Hardy, American Association of Retired Persons; Bruce Bower, Texas Senior Advocacy Coalition; Anne Dunkelberg, Center for Public Policy Priorities; David Gonzales, Texas Pharmacy Association; Lisa McGiffert, Consumers Union; Margorie Powell, Pharmaceutical Research and Manufacturers of America; Karen Reagan, Texas Federation of Drug Stores and Texas Retailers Association; *Registered but did not testify:* Ken Ardoin, Nub Donaldson, and Leo Hauser, Pfizer; Alison Dieter, Texas Gray Panthers; Greg Hoke, Wyeth Ayerst Pharmacy; Robert Jones, Novartis Corp.; Susan Jones, Texas Hospital Association; Linda Rushing, Texas Catholic Conference; John Umphress, Texas Association of Public and Nonprofit Hospitals

Against — None

On — *Registered but did not testify:* Joe Walton and Patricia Gladden, Texas Department of Health; Linda Wertz, Health and Human Services Commission

BACKGROUND: Medicaid is a state-federal program that provides health coverage for poor, disabled, and elderly people. Medicare is a federal program that provides health coverage for people over age 65. Eligibility for Medicaid generally is based on income, while Medicare eligibility is based on age.

Medicare benefits are divided into two categories. In general, Part A covers hospital stays or other inpatient services, while Part B covers outpatient services, laboratory services, and preventative care. Medicare does not offer prescription drug coverage.

Texas has established certain groups for purposes of Medicaid eligibility, tied to state public assistance programs, federal programs, or other special needs:

- qualified Medicare beneficiaries (QMBs) — Medicaid picks up premiums, deductibles, and coinsurance out-of-pocket costs for Medicare recipients up to 100 percent of the federal poverty level (FPL, about $9,000 per year for an individual with assets below $4,000);
- Specified low-income Medicare beneficiaries (SLMBs) — Medicaid picks up Medicare Part B premiums for Medicare recipients up to 120 percent of FPL;
- working disabled — Medicaid picks up Medicare Part A premiums for working disabled people under 200 percent of FPL;
- qualifying individuals (QI-1s) — Medicaid picks up Medicare Part B premiums for Medicare recipients who earn up to about $11,000 per year and otherwise would not be eligible for Medicaid; and
- qualifying individuals (QI-2s) — Medicaid picks up part of Medicare Part B premiums for Medicare recipients who earn up to about $15,000 per year and otherwise would not be eligible for Medicaid.

DIGEST:

CSHB 1094 would create a state prescription drug program, to be developed and implemented by the Health and Human Services Commission (HHSC) in the same manner as the state's Medicaid vendor drug program. The program would be funded only by state money, unless federal funds were available.

The program would provide services to the following groups in order of funding priority: QMBs, SLMBs, working disabled people, QI-1s, and QI-2s. HHSC would have to adopt rules to implement the program and could:

- require cost sharing by eligible beneficiaries;
- authorize the use of a formulary to specify which prescription drugs the state program would cover;
- require prior authorization for benefits;
- establish drug utilization reviews to ensure the appropriate use of prescription drugs under the program; and
- require a pharmacist to substitute a generic equivalent for a prescribed drug unless the practitioner specified otherwise in writing.

This bill would take effect September 1, 2001. HHSC would have to develop and implement the program by January 1, 2002.

SUPPORTERS SAY:

CSHB 1094 would extend the same prescription drug benefits to poor seniors as are provided to eligible people under age 65. Medicaid pays for an unlimited number of prescription drugs for people in Medicaid managed-care programs. When those people turn 65, however, they become ineligible for prescription drug coverage because they can receive Medicare. The state already has determined that these people cannot afford Medicare premiums. Prescription drugs are an integral part of an individual's health care and should be included in the state's assistance for health-care coverage.

Prescription drugs are becoming too expensive for some seniors. Seniors consume the largest amount of prescription drugs, yet they tend to live on fixed incomes. As a result, many are unable to afford the rising costs of prescription drugs. This bill would allow seniors continued access to the prescription drugs they need.

This program would enable the state to limit drug costs through cost sharing, formularies, prior authorization requirements, drug utilization reviews, and generic substitution. Funding by priority group also would ensure that the populations who need the most help received it, but the state would retain a mechanism for limiting cost.

The bill's fiscal note may be inflated because it does not account for the tiered funding. It assumes some level of participation beyond the priority population of QMBs, which may not occur if funding is unavailable.

Twenty-six other states have implemented some type of pharmaceutical assistance program. The majority of those states use a direct subsidy, but some others use a discount method.

This program could be funded with federal money if President Bush's "Offering an Immediate Helping Hand" proposal becomes law. This proposal would provide full prescription drug coverage for Medicare recipients under a certain income level, with subsidies for other individuals.

OPPONENTS SAY:

According to its fiscal note, CSHB 1094 would cost the state $274 million in the first two years alone, money that the state does not have.

The current period of rising caseloads and costs is no time to add beneficiaries. Increases in prescription benefit caseloads due to removing limits on the number of prescription drugs, combined with rising costs, have forced the Medicaid vendor drug program to overspend in the current biennium. If the state cannot pay for the costs of programs it already has in place, it should not add new ones.

Other states have implemented programs that target the same problem but do not cost the state any money. For example, California has a program that allows Medicare beneficiaries to have their prescriptions filled at the rate the state pays for Medicaid. This results in an average 24 percent discount.

OTHER OPPONENTS SAY:

Texas should wait to determine if federal funds will be available for this program. While the program would provide needed services, funding through general revenue would leave the state at total risk for the cost of prescription drugs. If the program were a joint state-federal effort, the fiscal implications would not be as great a concern.

Some states have used tobacco-settlement funds to create a state prescription drug program. Texas could create this program as a secondary priority to the Children's Health Insurance Program with funds provided by the tobacco settlement. This would allow the state to fund at least part of the prescription drug program without general revenue.

NOTES:

The committee substitute added the working disabled, QI-1s, and QI-2s to the eligible populations and prioritized all of the eligible populations for funding as available. It would allow for possible federal funding and would allow HHSC to adopt benefit restrictions and reviews.

The fiscal note estimates a net cost to the state of $274 million in general revenue-related funds in fiscal 2002-03. It assumes that 1.9 million prescriptions would be filled in fiscal 2002 and 2.1 million prescriptions in fiscal 2003. It also assumes 10 percent cost sharing and an average cost of $74.60 per prescription.

The Article 11 “wish list” of both the House- and Senate-approved versions of SB 1 by Ellis, the general appropriations bill for fiscal 2002-03, would provide funding for a prescription drug benefit program in a contingency rider for the Texas Department of Health.

The companion bill, SB 895 by Moncrief, was considered in a public hearing by the Senate Health and Human Services Committee on March 22 and left pending.