HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HM 1077 Medicare Prescription Drug Benefits
SPONSOR(S): Farkas
TIED BILLS: None. **IDEN./SIM. BILLS:** SB 1180 (s)

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care	17 Y, 1 N	Chavis	Collins
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

HM 1077 urges Congress to enact financially sustainable, voluntary, universal, and privately administered outpatient prescription drug coverage as part of the federal Medicare program. The memorial also requires that copies of the memorial be dispatched to the President of the United States, the President of the United States Senate, the Speaker of the United States House of Representatives, and to each member of the Florida delegation to the United States Congress.

Medicare, the principal source of government-provided health coverage for the elderly in the United States, does not provide coverage for prescription drugs. According to the U.S. Department of Health and Human Services (HHS), about 25% of Medicare beneficiaries have no drug coverage during the year, and many others have only partial coverage.

Ever rising drug prices hit the millions who lack drug coverage the hardest --particularly Medicare beneficiaries. Medicare beneficiaries without drug coverage fill an average of one-third fewer prescriptions a year than those with drug coverage. The uninsured with chronic illnesses are much more likely to go without medicines that are essential to maintaining their health and functioning than are the insured with similar health conditions.

At the same time that millions lack drug coverage, drug prices are rising well above the rate of inflation. From 1997 through 2001, national spending on prescription drugs rose close to 20% each year. The Congressional Budget Office (CBO) projects that Medicare beneficiaries will use about $1.8 trillion worth of drugs between 2003 and 2012. About $1.1 trillion will be paid by third parties (including employers, state governments, and Medicare+Choice plans) and about $700 billion will be spent out-of-pocket by beneficiaries.

The state has created various programs to help address this problem, including: The Prescription Affordability Act for Seniors; The Medicare Prescription Discount Program, The Silver Saver Program, and acceptance of Medicare assignments at Community Health Care Centers and Rural Health Clinics.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[x]	No[]	N/A[]
2. Lower taxes?	Yes[x]	No[]	N/A[]
3. Expand individual freedom?	Yes[x]	No[]	N/A[]
4. Increase personal responsibility?	Yes[x]	No[]	N/A[]
5. Empower families?	Yes[x]	No[]	N/A[]

For any principle that received a "no" above, please explain:

B. EFFECT OF PROPOSED CHANGES:

HM 1077 urges Congress to enact financially sustainable, voluntary, universal, and privately administered outpatient prescription drug coverage as part of the federal Medicare program. The memorial also requires that copies of the memorial be dispatched to the President of the United States, the President of the United States Senate, the Speaker of the United States House of Representatives, and to each member of the Florida delegation to the United States Congress.

Medicare

Prior to 1965, nearly half of the elderly had no health insurance and many others had inadequate coverage. On July 1, 1966, Medicare, authorized by Title XVIII of the Social Security Act, offered health insurance to almost all Americans age 65 or older. Coverage consisted of hospital insurance (Part A) and supplemental medical insurance (Part B), and benefits mirrored those then available from Blue Cross and Blue Shield plans. A payroll tax paid by employees, employers, and the self employed funded Part A, which was available without cost to all those 65 or older who were insured under the old age retirement and survivors program of Title II of the Social Security Act. Part B was open to all aged citizens and legal aliens who had resided in the country for 5 or more years. Beneficiaries who voluntarily enrolled in Part B paid a monthly premium of $3.00, which was estimated to be enough to fund 50% of Part B costs, and federal general revenues covered the remainder.

The Social Security Amendments of 1972 authorized the only major eligibility expansion of Medicare. The act granted benefits to those people under 65 who received Social Security disability cash payments for at least 24 months. The act also added people with end-stage renal disease who required maintenance dialysis or a kidney transplant.

Federal employees began paying the Medicare payroll tax in 1983 and all newly hired state and local employees began doing so in 1986. Thus, most government employees and retirees are now eligible for Part A under the same circumstances as other workers. Over the years, several categories of workers, such as domestic servants, were brought under Title II and thus also Medicare Part A. The number of people enrolled in Medicare has grown steadily over the years increasing at an average rate of about 2% per year.

Medicare and Prescription Drugs

For Americans 65 and over, the issue of drug costs is more of a concern. Medicare, which provides the elderly with almost universal health insurance coverage, does not cover prescription drugs outside the hospital, with only a few specific exceptions. Medicare beneficiaries are 14% of the U. S. population,

but account for 43% of pharmaceutical prescriptions.[1] In addition, because Medicare does not cover outpatient prescription drugs, 38% of seniors and younger beneficiaries with disabilities had no coverage in the Fall of 1999.[2] The Congressional Budget Office projects that total drug spending for the Medicare population will grow from $95 billion in 2003 to $284 billion in 2013, increasing at an average annual rate of over 10% and totaling $1.8 trillion (2004-2013).[3] While most Medicare beneficiaries have some form of supplemental drug coverage, access to these benefits is declining. Nearly 4 in 10 beneficiaries lacked drug coverage in the Fall of 1999, disproportionately affecting those living in rural areas (50%), the near-poor (44%), and those age 85+ (45%).[4]

The evidence in support of the need for drug coverage is compelling. Comparisons made between Medicare beneficiaries with and without drug coverage show those in poor health with no drug coverage fill 36% fewer prescriptions than those with coverage, and those with incomes below the poverty line and without coverage fill 48% fewer annual prescriptions than those with coverage.[5] Other studies have shown the negative effects of reducing drug coverage among poor elderly patients and the consequences of inadequate drug coverage for elderly patients receiving medications that can prevent serious adverse health consequences.[6]

The Value of Medicine

Pharmaceuticals provide at least four types of value:

- Drugs can directly and indirectly reduce treatment costs overall by offsetting spending elsewhere in the health system;
- Improvements in health care can increase productivity;
- Medical innovations can reduce the incidence of disease or chronic condition and improve the quality of life for those living with the disease or chronic condition and for their caretakers; and
- Advances in medicines save lives.

The Impact of the Lack of Prescription Coverage on States

People eligible for both Medicaid and Medicare, often called “dual eligibles,” are a fast-growing, low-income, aging or disabled, ill, and expensive population with significant special needs.

- Approximately 6.2 million elderly and disabled individuals are eligible for both Medicare and Medicaid. This population relies on Medicaid to pay Medicare premiums and to cover benefits that Medicare does not cover.
- Seventy-seven percent of the dually eligible have an annual income below $10,000.
- Dual eligibles often suffer from chronic conditions such as diabetes (24%), pulmonary disease (20%), stroke (15%) and Alzheimer’s disease (12%).
- Nearly one-quarter of dual eligibles are in nursing homes.
- For Medicaid, the dually eligible represent approximately 19% of beneficiaries and 35% of program expenditures; for Medicare, they represent about 17% of beneficiaries and 24% of program costs.

---

[1] The Henry J. Kaiser Family Foundation, 2001.
[2] Laschober, et al., “Health Affairs,” February 2002. [http://www.healthaffairs.org/WebExclusives/Laschober_Web_Excl_022702.htm]
[3] Congressional Budget Office (CBO), Projections of Medicare and Prescription Drug Spending, Statement of Daniel L. Crippen, Director, before the Committee on Finance, United States Senate, March 7, 2002. [http://www.cbo.gov/showdoc.cfm?index=3304&sequence=0]
[4] Laschober, et al, “Health Affairs,” February 2002.
[5] Poisal JA, Murray L., “Growing differences between Medicare beneficiaries with and without drug coverage,” Health Affairs (Millwood). 2001;20:74-85.
[6] Adams AS, Soumerai SB, Ross-Degnan D, “The case for a Medicare drug benefit coverage: a critical review of the empirical evidence,” Annual Review of Public Health. 2001;22:49-61.

- In 2002, total state spending on prescription drugs for dual eligibles was $6.88 billion.
- In 2002, state and federal Medicaid drug spending for the dually eligible was 48.5% of total Medicaid drug spending. Average prescription drug costs per dual eligible are more than $1,000 annually. On average, this population fills more than three prescriptions per month.[7]

Florida Programs

More than 25 states currently have prescription drug assistance programs that provide medications to varying populations—some cover all persons who meet eligibility criteria, and some are directed to the elderly, especially those who no longer work and for whom Medicare is their sole medical coverage. The plans run the gamut of eligibility criteria, income levels, copayment requirements and other requirements.[8]

In 2000, Florida enacted its first prescription assistance program for elders, the "Prescription Affordability Act for Seniors." This law provides a discount to all Medicare residents and a monthly benefit program. Other programs include:

- The Medicare Prescription Discount Program. This program enables beneficiaries to obtain prescription drugs at lower costs.
- The Silver Saver Program. Florida elders with limited income have access to prescription assistance requiring a small copayment for each prescription.
- The Florida Medicaid Program. Medicaid programs pay for some or all of Medicare's premiums, deductibles, and co-insurance for certain people who have low income and are entitled to Medicare. Prescription benefits are typically included.

In addition, Community Health Care Centers are located throughout the state. These centers accept Medicare assignment. Typically, the Medicare annual $100 (Part B) deductible is usually waived; traditional benefits are offered by most centers; and on-site pharmacy services and dispensing of drugs are available at most sites. Many sites also offer dental services and other health care related services. Income eligible seniors receive services for free or on a sliding scale. Rural Health Clinics usually offer the same benefits, as listed above, with the exception of the waiver of the Part B annual deductible.

Private Programs

Some pharmaceutical manufacturers offer programs that provide prescription drugs at free or reduced prices to needy patients for a limited time period. Each company has its own program with special requirements, forms and procedures. Not all pharmaceutical companies participate in these programs and most companies will only send their application forms to a physician's office or social worker, and occasionally to a patient. Such programs include:

- Pharmaceutical Research and Manufacturers of America. This organization offers a directory of prescription drug assistance programs that lists the names of the drug, the company, and toll-free numbers to call. [www.phrma.org]
- Needy Meds. This organization provides information about drug companies, categories, and a list of 947 medications and their assistance program contacts. [www.needymeds.com]
- National Organization for Rare Disorders. This organization assists uninsured or under-insured individuals in securing life-saving or life-sustaining medications. The program also administers early access programs for Investigational New Drugs under the U.S. Food and Drug Administration's approved "Treatment INDs" program. [www.rarediseases.org]

[7] National Governors' Association, Center for Best Practices, Health Policies Study Division, 2003. [http://www.nga.org/cda/files/032603FACTSDUAL.pdf]
[8] RxAssist, A national program supported by the Robert Wood Johnson Foundation. [http://www.rxassist.org/pdfs/state_programs.pdf]

In addition, there are Pharmaceutical Company Discount Programs for those with limited income, including:

- Together Rx providing a discount of between 20-40% with a discount card. [www.together-rx.com]
- Pharmacy Care Alliance, also providing a discount of between 20-40% with a discount card. [www.nacds.org]
- Eli Lilly providing 30-day prescriptions for $12 with a discount card. [www.lillyanswers.com]
- GlaxoSmithKline providing 30-40% savings for seniors and disabled through their "Orange Card." [www.gsk.com]
- Novartis providing 30-day prescriptions for $12 with a discount card and a 25-40% savings with their "Care Card." [www.novartis.com]
- Pfizer providing 30-day prescriptions for $15 and their "Share Card." [www.pfizerforliving.com]

C. SECTION DIRECTORY:

None.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Medicare prescription drug benefits have long been the subject of intense debate. While the vast majority of the public supports government coverage of prescription drugs for Medicare beneficiaries, the pharmaceutical industry has expressed concerned that government negotiated prices could threaten
their profit margin and impact their ability to conduct research and development on new medications.

D. FISCAL COMMENTS:

Providing access to prescription drugs will help individuals improve their health status and reduce their overall medical costs and reduce the costs of state programs to provide such assistance.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES