THE FOLLOWING IS A CORRECTION OF THE ANALYSIS DATED 5-7-87

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SR. CITIZENS; PRESCRIPTION DRUG PROGRAM

House Bill 4141 (Substitute H-2)
Revised First Analysis (11-17-87)

Sponsor: Rep. Thomas C. Mathieu
Committee: Senior Citizens & Retirement

THE APPARENT PROBLEM:

Medicare does not cover prescription drugs, so those senior citizens who can neither qualify for assistance under Medicaid nor obtain private health insurance coverage for prescriptions have a difficult time obtaining the medications they need. Seniors who, when forced to choose between medications and other necessities, forgo prescribed medications sometimes develop far more serious conditions than those the prescriptions were intended to combat. The result can be hospitalization that could have been avoided with proper drug treatment. This is not only a calamity for those directly affected but adds costs to the health care system as a whole. Some people advocate the creation of a state-sponsored trial program aimed at helping some older persons to obtain necessary medications.

THE CONTENT OF THE BILL:

The bill would amend the Older Michiganians Act to establish the Older Person's Prescription Drug Coverage Program. Under the program some people 62 years of age and older would be eligible for assistance in purchasing prescription drugs. The program would be administered by the Office of Services to the Aging (OSA), and a special task force would be created to oversee and evaluate the program.

To be eligible for the program, a person could not qualify for Medicaid, and could not have an annual income in excess of $9,000 or, for a couple, $12,000. (These figures would be adjusted annually by OSA based on changes in the urban consumer price index.). A single person could not have assets totaling more than $15,000, and a couple's assets could not exceed $20,000. In both cases the maximum allowable assets would not include a primary residence, an automobile, burial plots, prepaid funeral plan, life insurance policies, and personal possessions and household furnishings. Further, an inpatient or resident in a health care facility or mental health facility licensed or operated by the state would not qualify for the program, unless they were residents of licensed homes for the aged. People would apply for participation in the program to the Office of Services to the Aging; the form used by OSA would include a statement regarding the applicant's sources of income.

People accepted into the program would have to use all other third-party reimbursements for prescription drugs available to them before applying for program benefits, and would have to pay $5 or 50 percent of the cost toward each prescription, whichever was less. (The co-payment requirement could be adjusted annually.) No limit on the number of prescriptions is specified in the bill, but the number could be revised annually by the director of OSA. The term "prescription" would include insulin, syringes, and needles. It would be a misdemeanor for a health care provider to submit or aid in the submission of a false or fraudulent claim or to make a claim duplicating other benefits. A provider who committed a violation would also have to repay the program in an amount three times the amount of the financial benefit received.

OSA would be required to establish a benefits and coverages panel to ensure the responsible dispensing and control of the distribution of drugs provided under the program. The panel would have to include at least one physician, a biochemist, a registered nurse, and three pharmacists, including at least one clinical pharmacist. The office would also have to establish a dispensing fee for pharmacists, not to exceed the fee paid to participating pharmacists under Medicaid. Its other responsibilities would include determining the eligibility of applicants; entering into contracts with public and private entities for the processing and payment of claims and for management reporting, including, at a minimum, cost analysis and utilization monitoring; and promulgating rules to implement the program.

The special task force mentioned earlier would have nine members; the director of OSA, who would serve as the chair; the insurance commissioner or a designee; the director of the Department of Public Health or a designee; a representative of the Department of Management and Budget appointed by the department director; two representatives of the Board of Pharmacy, appointed by the director of the Department of Licensing and Regulation; and three representatives of older people, appointed by the OSA director. In addition to overseeing and evaluating the program, the task force would have to report twice a year to the director of OSA on its activities and make recommendations for improvements in the program. The task force would also have to report within two years after the bill's effective date to the appropriate House and Senate committees on the feasibility of continuing the program. The bill would take effect one year after its enactment, and its provisions would no longer apply three years after the bill's effective date.

MCL 400.582 et al.

BACKGROUND INFORMATION:

A similar bill passed the House in 1986.

FISCAL IMPLICATIONS:

The House Fiscal Agency reports that the costs of implementing House Bill 4141 would be $20.3 million for the first year of the program's operation, and $34.5 million for the second year. (5-6-87)

According to the Department of Social Services, the bill would result in a net savings to the state, although the amount cannot be determined. The bill would require a "substantial" increase in the expenditure of state funds, but the increase would be offset by savings in the Medicaid program due to reduced hospitalizations for drug-induced problems. (3-2-87)

OVER

ARGUMENTS:

For:

The bill would establish enabling legislation for a three-year trial program to help older people who do not qualify for Medicaid pay for their prescription drugs. The costs of medication are said to be increasing faster than almost any other health-related service. There are few forms of help for seniors; private insurance is not always available or affordable, and Medicare doesn't cover prescriptions. Older people who do not take their prescribed medications often suffer a deterioration in their health and sometimes, as a result, need to be hospitalized, which adds unnecessary costs to the health care system. The program has cost controls built in: the number of prescriptions available and the size of the required co-payment can be adjusted if need be; costs and utilization will be monitored by program managers; and a benefits and coverages panel will be created to make sure providers do not abuse the program and that participants are not victims of drug abuse. Furthermore, a special task force, including representatives from management and budget, the insurance bureau, and the pharmacy board, will oversee and evaluate the program, eventually recommending whether it should be continued.

Against:

The bill has a laudable goal, but enough questions remain to be answered that some people have urged the legislature to study the program further. What if the bill results in costs far beyond the amount saved? While there are provisions in the bill to scale back the number of prescriptions per person and raise the level of co-payment, will that be politically feasible once the program is under way? The money for the program is supposed to come from savings anticipated from deferred costs in the Medicaid program, but no estimates of the savings have been provided. While it is true that older people should not be denied needed medications because of inability to pay, who should be? Are there other deserving segments of the population with similar or competing needs who could benefit from Medicaid program savings? Once the program is under way, and has a constituency, it will be hard to discontinue, even if that is the recommendation of the special task force. Finally, there are questions about the wisdom of locating the program in the Office of Services to the Aging, which is not traditionally associated with programs of this kind.

Response: Several things need to be made clear. First, the bill is enabling legislation and not an appropriations bill. Second, the program will not begin until a year after the bill is passed. There is time to address questions that arise about details of the program. Finally, the bill is a trial program with careful oversight and evaluation built in.

Against:

There are several technical details that still need to be addressed in the bill. For instance, the bill provides a separate income limit for single and married persons. Yet, no mention is made as to whether these limits represent gross or net income or what, if any, types of income deductions will be considered. Further, the bill specifies that a person may not participate in the prescription drug program if eligibility for Medicaid exists. However, there is no mention of the General Assistance Medical program. These technical details should be addressed before the bill is passed, or they will lead to confusion when the bill is implemented.

POSITIONS:

The Foster Grandparent Program for Livingston, Ingham and Eaton counties supports the bill. (5-4-87)

A representative of the Region VII Area Agency on Aging testified in support of the bill. (5-4-87)

A representative of the Michigan Senior Power Day Steering Committee testified in support of the bill. (5-4-87)

A representative of the St. Joseph County Commission on Aging testified in support of the bill. (5-4-87)

The State Long-Term Care Ombudsman, Citizens for Better Care, supports the bill. (5-4-87)

A representative of the Volunteer Programs for Services to the Aging of Calhoun County testified in support of the bill. (5-4-87)

A representative of the Pastoral Ministry to the Elderly testified in support of the bill. (5-4-87)

The Director of the Office of Services to the Aging testified in support of the bill. (5-4-87)