PRESCRIPTION DRUGS FOR MEDICARE BENEFICIAIRES:

10 IMPORTANT FACTS

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Introduction

The debate about a prescription drug benefit for Medicare beneficiaries is intensifying. Members of Congress from both sides of the aisle have put forward proposals. As the months go by, the out-of-pocket costs for prescription drugs paid by Medicare beneficiaries (those 65 and over and people under 65 who qualify for Medicare due to a disability) pose a growing financial burden. Health policy journals are focusing on the topic. On April 10, 2000, the Clinton Administration released a new Department of Health and Human Services report. This paper presents some of the most important data and facts that policymakers need to have to shape a Medicare prescription drug benefit that is effective in reducing financial burdens on Medicare beneficiaries who need prescription drugs.

Summary: 10 Facts that Should Help Guide Public Policy On Medicare Prescription Drugs

1. Out-of-pocket prescription drug costs impose a large financial burden on Medicare beneficiaries.
2. Prescription drugs, which have never been covered by Medicare, are an increasingly important part of the health care needs of Medicare beneficiaries.
3. The medigap market does not provide high-value (cost-effective) coverage for prescription drugs.
4. Employer-based coverage of prescription drugs for Medicare beneficiaries often provides comprehensive coverage, but it is unavailable for the majority of people.
5. Seniors typically pay higher prices for their prescription drugs than do those with health insurance coverage.
6. Prescription drug costs are increasing rapidly; out-of-pocket costs will continue to be burdensome unless new policy addresses both coverage and the need for discounts or other mechanisms to curb growing costs.
7. Prescription drug expenditures vary dramatically across the elderly population, making it difficult if not impossible to design a voluntary system that can avoid splitting the risk pool – segmenting the healthy from the sick.
8. Medicare beneficiaries without prescription drug coverage use fewer prescriptions than people with such coverage; coverage affects health.
9. Design of benefits matters: an important tool for relieving financial burden is stop-loss protection.
10. Cost control mechanisms that are effective in the private marketplace may not work well for the Medicare program.

1. Out-of-pocket prescription drug costs impose a large financial burden on Medicare beneficiaries.

- A typical senior without prescription drug coverage pays 34% of their after-tax income on health care.[i]
- Even people with good prescription drug coverage can face large out-of-pocket costs for their medications.[ii]
- Out-of-pocket drug spending is significantly higher for those without drug coverage than for those with drug coverage (on average $463 in 1996 for those without coverage, vs. $253 for those with coverage).[iii] Researchers concluded that those without drug coverage are "underserved in receiving drug therapies."[iv]
- In large part because of prescription drug expenditures, 57 percent of people 65 and over have out-of-pocket health care costs greater than 10 percent of their income.[v]
- AARP research found that prescription drugs spending is the single largest component of out-of-pocket spending on health care (other than premium payments). "On average, beneficiaries are expected to spend as much out-of-pocket for prescription drugs as for physician care, vision services, and medical supplies combined."[vi]

2. Prescription drugs, which have never been covered by Medicare[vii], are an increasingly important part of the health care needs of Medicare beneficiaries.

- New drugs can replace surgery (e.g., heart bypass surgery), help prevent brain damage in people who have strokes, lower cholesterol levels, and provide relief for chronic pain.[viii]
- According to the AARP, 80 percent of retirees use a prescription drug every day. Older Americans account for one-third of prescription drug spending, though they represent just 12 percent of the population.[ix]
- The number of prescriptions used by beneficiaries has grown from 16.6 (1992) to 19.5 (1996).[x]

3. The medigap market does not provide high-value (cost-effective) coverage for prescription drugs.

- Because of the premium structure in most policies (which build in premium increases as a person gets older), *older* seniors pay very high premiums for policies with prescription drug coverage. For example, an 80-year-old in South Carolina would pay $2,904 for policy I (with a maximum drug benefit of $1250) vs. $1,863 for a 65 year-old. An 80-year old would pay $1,683 for policy F (with know drug benefit) in South Carolina. (In other words, the 80 year-old is paying an extra premium that is equivalent to the *maximum* benefit under the policy.)[xi]

- 75-year-olds pay, on average, $1,847 more per year for medigap plan I (with a maximum prescription drug benefit of $1,250) than for medigap Plan C, with nearly comparable benefits except for the absence of prescription drugs.[xii]
- In most medigap policies, premiums increase with age, making medigap prescription drug coverage least affordable for the oldest beneficiaries.[xiii]
- Prescription drug coverage through medigap tends to be unstable: about 48 percent of beneficiaries with medigap drug coverage had such coverage for only part of the year.[xiv]

4. Employer-based coverage of prescription drugs for Medicare beneficiaries often provides comprehensive coverage, but is unavailable for the majority of people.

- 8.6 million Medicare beneficiaries, one-quarter of Medicare beneficiaries, had employer-sponsored supplemental insurance that provided year-round prescription drug protection.[xv]
- Only about half of Medicare beneficiaries had any type of drug coverage for the entire year of 1996.[xvi]
- Employer coverage of retirees is eroding: the GAO reported that the proportion of employers offering health coverage to retirees decreased from 40 percent in 1993 to 28 percent in 1999, and employers shifted more of the premium cost to retirees.[xvii] Other studies confirm substantial decreases in employer-sponsored retiree coverage.[xviii]
- Medicare HMO prescription drug coverage is limited; nearly three-quarters of plans cap benefits at or below $1,000. In 15 states, no Medicare managed care basic plans include prescription drugs.[xix]

5. Seniors typically pay higher prices for their prescription drugs than do those with health insurance coverage.

- People without drug coverage ("the typical cash customer") paid nearly 15 percent more than the customer *with* third party coverage in 1999.[xx]
- A series of reports by the Minority Staff, Committee on Government Reform, U.S. House of Representatives found price differentials of over 100 percent between senior citizens and drug companies' most favored customers. In other words, seniors pay more than twice the price that insurance companies and government buyers pay for medications needed for cholesterol, ulcers, high blood pressure, heart problems and depression.[xxi]
- A Families USA study found that prices of the 50 prescription drugs used most often by the elderly increased by more than four times inflation during 1998.[xxii]
- Five price surveys by Public Citizen (with state-based groups) found price discrimination by pharmaceutical manufacturers: on average, seniors are being

charged double the retail price charged by prescription drug makers to their most favored customers.[xxiii]

- According to researchers at the Boston University School of Public Health, Americans paid 32% more than Canadians for the same drugs in the early 1990's, and the differential is probably growing. $16.2 billion could be saved each year if Americans paid the same wholesale prices paid by Canadians.[xxiv]

6. Prescription drug costs are increasing rapidly; out-of-pocket costs will continue to be burdensome unless new policy addresses both coverage and the need for discounts or other mechanisms to curb growing costs.

- While overall health care expenditures grew at 5 percent per year between 1993 and 1998, prescription drug spending grew at an average of 12.4 percent per year from 1993 to 1998, with a growth rate of 15.4 percent in 1998.[xxv]
- Prescription drugs have increased, as a percent of total health care spending, from 5.6 percent in 1993 to 7.9 percent in 1998.[xxvi]
- U.S. drug prices are rising 2.4 times as fast as the overall Consumer Price Index, at an annual rate of 6.1 percent in early 1999.[xxvii]
- Because of rising prescription drug costs, Public Citizen has estimated that a senior with average drug expenditures will have higher inflation-adjusted out-of-pocket expenditures after the fourth year, if the Clinton plan were adopted.[xxviii]

7. Prescription drug expenditures vary dramatically across the elderly population, making it difficult if not impossible to design a voluntary system that can avoid splitting the risk pool – segmenting the healthy from the sick.

- Prescription drug spending for the elderly is largely predictable (since it is often for chronic conditions), increasing the likelihood that adverse selection will be a major factor in a voluntary system.[xxix]
- While average prescription drug spending of people 65 and over was $720 in 1996, those in the top decile spent $3,367. (See chart.) In 1996, more than half of people 65 and over spent less than $500 on prescription drugs. Projections from the 1995 Medicare Current Beneficiary Study estimate 1999 average outpatient prescription drug costs to be $942.[xxx]
- Data from the 1995 Current Medicare Beneficiary Survey for seniors whose prescription benefit was managed by Merck-Medco Managed Care shows a high degree of variation in spending, with mean spending (for people 65 and over with expenditures) $1,343, and spending for those in the 99th percentile $6,597.[xxxi]

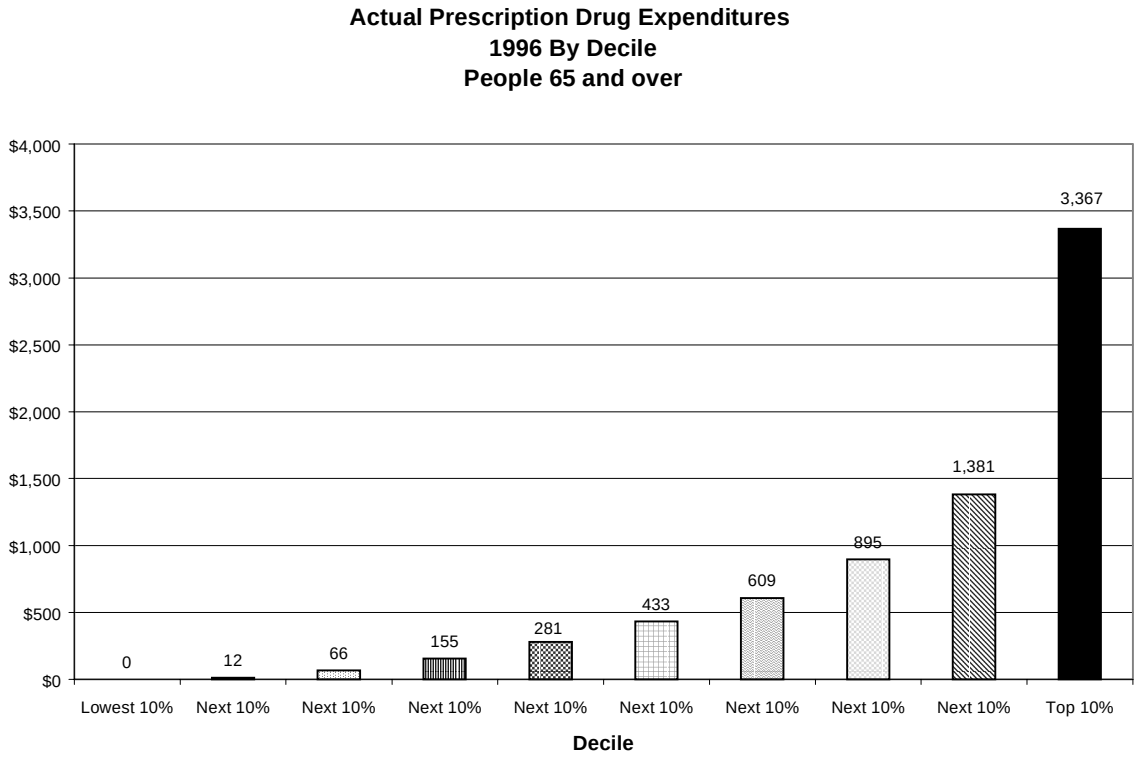

Chart:
Actual Prescription Drug Expenditures
1996 By Decile
People 65 and Over

MEPS 1996, Agency for Healthcare Research and Quality

8. Medicare beneficiaries without prescription drug coverage use fewer prescriptions than people with such coverage; coverage affects health.

- Coverage for prescription drugs lowers the chance that people with hypertension will go without needed antihypertensive drugs.[xxxii] Specifically, the Blustein study "found that a one dollar increase in the out-of-pocket per tablet cost resulted in the purchase of 114 fewer tablets per year."[xxxiii]
- The Medicare population *with* prescription drug coverage spent (on average) $769 on prescription drugs, compared with $463 for those without drug coverage. Among the Medicare population with poor health, people with drug coverage spent $1,340 on prescription drugs, vs. $749 for those without drug coverage.[xxxiv]
- Analysis of data from the 1996 Medicare Current Beneficiary Survey shows that beneficiaries *without* supplemental prescription drug coverage had 16.7 prescriptions filled, while those with year-round coverage had 22.4 prescriptions filled.[xxxv]
- Harvard Medical School researchers estimated that Medicare enrollees whose incomes were less than $10,000 used less than half as many prescription drugs as higher income individuals who had employer drug coverage.[xxxvi]
- When the New Hampshire Medicaid program switched from unlimited prescription coverage to 3 prescriptions per month, the use of "essential life-saving drugs like insulin for diabetes, furosemide for congestive heart failure, bronchodilators for asthma, and lithium for bipolar illness, to decline substantially."[xxxvii] There were numerous adverse effects of this cutback in medicines.

9. Design of benefits matters: an important tool for relieving financial burden is stop-loss protection.

- "Stop-loss" design would limit beneficiary out-of-pocket prescription drug costs through a benefit design that has Medicare pay all prescription drug costs after the beneficiary has out-of-pocket expenditures exceeding a certain level (e.g., $2,000). "Stop-loss" protection provides catastrophic coverage (in contrast to a design that limits coverage to a certain level such as $2,500, thus protecting those with the highest prescription drug costs.
- Policy proposals that lack a stop-loss prescription drug coverage (e.g., July 1999 Clinton plan, Breaux-Frist proposal), many Medicare beneficiaries, especially those with severe chronic diseases, would continue to face high out-of-pocket drug costs.[xxxviii]

10. Cost control mechanisms that are effective in the private marketplace may not work well for the Medicare program.

- Little is known about the effects on costs and quality of care of Medicare prescription drug-use management strategies (such as private pharmacy benefit managers, PBM's).[xxxix]
- Some of the limitations of using PBM's to manage a Medicare drug benefit include: (1) savings can not be ensured if Congress and HCFA do not allow PBMs to use a broad range of techniques to promote the use of cost-effective drugs; (2) potential conflicts of interest (when PBMs use formularies to favor one brand-name drug over another) would be more difficult to resolve in a public program than in the private sector; (3) the public might protest against PBM efforts to promote cost-effective drugs.[xl]

Implications for Public Policy

- A new Medicare prescription drug benefit should be universal, just as coverage for hospital care protects all Medicare beneficiaries.
- Financial burdens on low-income Medicare beneficiaries (e.g., those with incomes below 135 percent of poverty) should be alleviated through a full subsidization of any premiums and cost-sharing.
- The benefit should include a "stop-loss" that limits out-of-pocket prescription drug costs to a certain amount, protecting those with the largest expenditures.
- Competition (e.g., large purchase discounts) must be put to work to lower costs of medicines. A new benefit should assure that prices charged by pharmaceutical companies are in line with underlying costs of developing and distributing prescription drugs, and that there be accountability to the public interest.
- The new benefit should be financed fairly and progressively (e.g., with moderate and high-income beneficiaries paying premiums), and with the subsidy for low-income beneficiaries spread broadly across people of all ages.
- "Choice" of a prescription drug benefit (i.e., having a *voluntary* benefit) should be resisted unless there is a mechanism capable of preventing adverse selection.

Endnotes

[i] Actuarial Research Corporation, cited by Mark McClellan, Ian D. Spatz, and Stacie Carney, "Designing A Medicare Prescription Drug Benefit: Issues, Obstacles, and Opportunities," *Health Affairs,* (vol 19, no 2), March/April 2000, p. 30.
[ii] Earl P. Steinberg, Benjamin Guitierrez, Aiman Momani, Joseph A. Bascarino, Patricia Newman, and Patricia Deverka, "Beyond Survey Data: A Claims-Based Analysis of Drug Use and Spending by the Elderly," *Health Affairs,* (vol 19, no 2), March/April 2000, p. 205.
[iii] John A. Poisal and George S. Chulis, "Medicare Beneficiaries and Drug Coverage," *Health Affairs,* (vol 19, no 2), March/April 2000, p. 256.
[iv]Ibid., p. 255.
[v] *Hidden from View: The Growing Burden of Health Care Costs,"* Consumers Union, January 1998.
[vi] *In Brief: Out-of-Pocket Health Spending by Medicare Beneficiaries Age 65 and Older: 1999 Projections,* AARP, released with AARP Public Policy issue Brief #IB41, December 1999.
[vii]Medicare does cover inpatient medication, and certain oral cancer drugs and drugs after transplants, but not other outpatient prescription medications.
[viii] Ibid., p. 1.
[ix] Statement of Beatrice Braun, M.D., AARP Board Member, before the Senate Aging Committee, February 17, 2000.
[x] *Report to the President*: Prescription Drug Coverage, Spending, Utilization, and Prices, Department of Health and Human Services, April 2000, p. 92.
[xi] Letter from Laura A. Dummit, Associate Director, Health Financing and Public Health Issues, United States General Accounting Office, to The Honorable John D. Dingell, March 1, 2000.
[xii] "Poor Value of Prescription Drug Coverage in Medigap," Gail Shearer, Consumers Union, June 2, 1999, based on policies rated in *Consumer Reports* in September 1998. *See also* Michael E. Gluck, *A Medicare Prescription Drug Benefit,* Medicare Brief, National Academy of Social Insurance, April 1999.
[xiii] "Medicare: New Choices, New Worries," *Consumer Reports*, September 1998.
[xiv]*Report to the President: Prescription Drug Coverage, Spending, Utilization, and Prices*, Department of Health and Human Services, April 2000, p. 9.
[xv] Bruce Stuart, Dennis Shea and Becky Briesacher, "Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter," The Commonwealth Fund, January 2000.
[xvi] *Report to the President: Prescription Drug Coverage, Spending, Utilization, and Prices*, Department of Health and Human Services, April 2000, p. 22, citing Bruce Stuart et. al., "Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter."
[xvii] Statement of the Honorable David W. Walker, Comptroller General, U.S. General Accounting Office, before the Subcommittee on Health, House Committee on Ways and Means, February 15, 2000.
[xviii] Statement of Jennifer O'Sullivan, Congressional Research Service, "Prescription Drug Coverage and Spending for Medicare Beneficiaries," Testimony before Senate Committee on Finance, March 22, 2000. *See also Disturbing Truths and Dangerous Trends: The Facts.*
[xix] National Economic Council/Domestic Policy Council, The White House, *America's Seniors and Medicare: Challenges for Today and Tomorrow*, February 29, 2000.
[xx] *Report to the President: Prescription Drug Coverage, Spending, Utilization, and Prices*, Department of Health and Human Services, April 2000, Executive Summary.
[xxi] For example, see *Prescription Drug Pricing in the 5th Congressional District in Florida: Drug Companies Profit at the Expense of Older Americans,* Prepared for Rep. Karen L. Thurman, Minority Staff Report, Committee on Government Reform, U.S. House of Representatives, May 11, 1999.
[xxii] *Hard to Swallow – Rising Drug Prices for America's Seniors*, Families USA, November 1999.
[xxiii] *Senior Citizens Pay More for Prescription Drugs While Pharmaceutical Profits Soar*, Public Citizen, January 24, 2000, http://www.citizen.org/congress/drugs/factshts/surveysummary.htm.
[xxiv] Alan Sager, Ph.D. and Deborah Socolar, M.P.H., Boston University School of Public Health, *Affordable Medications for Americans,* July 27, 1999. Note: international drug price comparisons pose very challenging methodological issues. See Appendix A, "Issues in Prescription Drug Coverage, Pricing, Utilization, and Spending: What We Know and Need to Know," in *Report to the President: Prescription Drug Coverage, Spending, Utilization, and Prices*, Department of Health & Human Services, April 2000, pages 156-160.

[xxv] Statement of the Honorable David W. Walker, Comptroller General, U.S. General Accounting Office, before the Subcommittee on Health, House Committee on Ways and Means, February 15, 2000.
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[xxvii] Alan Sager, Ph.D. and Deborah Socolar, M.P.H., Boston University School of Public Health, *Affordable Medications for Americans,* July 27, 1999.
[xxviii] *High and Rapidly Increasing Prescription Drug Expenditures Threaten Any Medicare Drug Benefit,* Public Citizen, October 25, 1999, http://www.citizen.org/congress/drugs/factshts/inflation2.htm..
[xxix] Ibid., p. 30.
[xxx] Michael E. Gluck, *A Medicare Prescription Drug Benefit,* Medicare Brief, National Academy of Social Insurance, April 1999.
[xxxi] Earl P. Steinberg, Benjamin Guitierrez, Aiman Momani, Joseph A. Bascarino, Patricia Newman, and Patricia Deverka, "Beyond Survey Data: A Claims-Based Analysis of Drug Use and Spending by the Elderly," *Health Affairs,* (vol 19, no 2), March/April 2000, p. 203.
[xxxii] Jan Blustein, "Drug Coverage and Drug Purchases by Medicare Beneficiaries with Hypertension," *Health Affairs,* (vol 19, no 2), March/April 2000, p. 219.
[xxxiii] Ibid., p. 226.
[xxxiv] John A. Poisal and Goerge S. Chulis, "Medicare Beneficiaries and Drug Coverage," *Health Affairs,* (vol 19, no 2), March/April2000, p. 253.
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[xxxvii] Stephen B. Soumerai, ScD, Professor of Ambulatory Acre and Prevention and Director, Drug Policy Research Program, Harvard Medical School and Harvard Pilgrim Health Care, Testimony before the Subcommittee on Health, House Committee on Ways and Means, February 15, 2000, citing article in *N Engl J Med* 1987; 317:550-6.
[xxxviii] Steinberg, et.al., p. 209.
[xxxix] Helen Levens Lipton, David J. Gross, Marilyn R. Stebbins, and Lori Hytrek Syed, "Managing the Pharmacy Benefit in Medicare HMOs: What Do We Really Know?" *Health Affairs,* (vol 19, no 2), March/April 2000, p. 43.
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