THE HENRY J. KAISER FAMILY FOUNDATION

FACT SHEET

# MEDICARE

## MEDICARE AND PRESCRIPTION DRUGS

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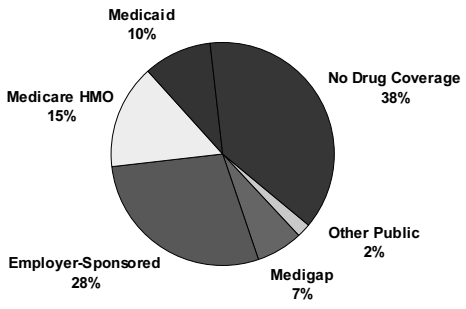
April 2003

### OVERVIEW

Prescription drug use increases with age along with the prevalence of chronic and acute health problems. However, because Medicare does not cover outpatient prescription drugs, 38% of seniors and younger beneficiaries with disabilities had no drug coverage in the Fall of 1999 (Figure 1).

Figure 1

**Sources of Prescription Drug Coverage, Fall 1999**




**Total = 34.2 million non-institutionalized Medicare beneficiaries**

Note: Analysis of non-institutionalized beneficiaries enrolled in Medicare for a full year and with classifiable drug coverage status.
SOURCE: Laschober, et al., *Health Affairs*, February 2002.

Rising drug costs pose challenges for Medicare beneficiaries, who tend to use more medications (averaging 23 per year in 1999) than do younger adults. CBO 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).

### SOURCES OF PRESCRIPTION DRUG COVERAGE

Most Medicare beneficiaries have some form of supplemental drug coverage, but access to these benefits is declining.

**Employer-sponsored plans**, the leading source of drug coverage for seniors, assisted 28% of the Medicare population with drug costs in the Fall of 1999. However, retiree health benefits have been eroding and, as of 2001, only a third of employers with 200+ employees offered coverage to those ages 65+ (Kaiser/HRET, 2002). Looking ahead, 22% of large employers say they are likely to terminate health benefits for future retirees and 85% say they are likely to increase prescription drug cost-sharing (Kaiser/Hewitt, 2002).

**Medicare HMOs**, or Medicare+Choice (M+C) plans, assisted 15% of all beneficiaries with their drug costs in the Fall of 1999, a share that has decreased in recent years with declining M+C plan participation. Since 1999, the share of M+C enrollees with drug coverage has declined from 84% to 72%, and 41% are now subject to a benefit cap of $750 or less. In addition, more than half (55%) of all plans that offer drug coverage now restrict enrollees to generic drugs, up from 18% in 2001 (Achman and Gold, 2002).

**Medigap** provided drug benefits to 7% of all Medicare beneficiaries in the Fall of 1999. Of the 10 standard Medigap policies, only 3 (Plans H, I, and J) cover some drug costs. Plans H and I have a $250 deductible and cover 50% of drug costs up to $2,500; Plan J has a $250 deductible, but covers 50% of drug costs up to $6,000. Premiums for policies that cover drug costs have increased dramatically and vary widely.

**Medicaid** provided drug coverage for 10% of the Medicare population in the Fall of 1999. Targeted to those with low incomes, 53% of Medicare beneficiaries with incomes below the federal poverty level are on Medicaid. Prescription drugs are an optional benefit under Medicaid, but all states cover them. The structure and generosity of these benefits vary considerably. With Medicaid drug costs rising at an annual rate of almost 20% and states in tight fiscal situations, many states are seeking to curtail drug spending (KCMU, 2003).

Under Pharmacy Plus waivers, states can extend drug-only coverage to other low-income Medicare beneficiaries with Medicaid funds, if they accept an overall cap on federal Medicaid funding for their elderly Medicaid populations. As of April 2003, 5 states (FL, Il, IN, SC and WI) have been approved for such waivers.

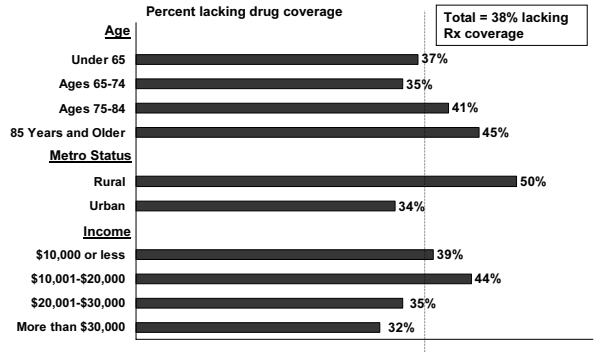
**State Pharmacy Assistance Programs** help many low-income Medicare beneficiaries not eligible for Medicaid with drug costs. These programs vary widely in terms of structure, eligibility, and benefits. As of April 2003, 35 states had established or authorized a pharmacy assistance program, 27 of which have programs that are now in operation.

### WHO LACKS DRUG COVERAGE?

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 85+ (45%) (Figure 2).

Figure 2

**Percent of Beneficiaries Without Prescription Drug Coverage, by Beneficiary Characteristics, Fall 1999**




Note: Analysis of non-institutionalized beneficiaries enrolled in Medicare for a full year.
SOURCE: Laschober, et al., *Health Affairs*, February 2002.

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Looking at coverage over the course of the year, a quarter of all beneficiaries lacked drug coverage throughout 1999 (Briesacher, et al., 2002).

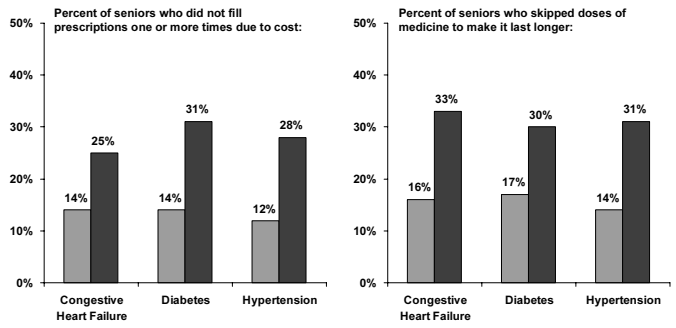
## WHY DOES DRUG COVERAGE MATTER?

Beneficiaries without drug coverage average nearly 7 fewer prescriptions per year than do those with coverage (18 vs. 25, respectively) (Briesacher, et al., 2002).

Among seniors with serious health problems such as congestive heart failure and diabetes, one-third of those who lacked drug coverage reported skipping doses to make their prescriptions last longer, according to a 2002 survey of seniors in 8 states (Safran, et al., 2002). Chronically ill seniors without drug coverage were also more apt to go without filling a prescription due to costs (Figure 3).

Figure 3

**Percent of Seniors in Eight States Who Reported Forgoing Needed Medicines, by Chronic Condition and Prescription Drug Coverage**




**Note:** Analysis of seniors in sample with classifiable drug coverage.
**SOURCE:** Kaiser/Commonwealth/Tufts-New England Medical Center 2001 Survey of Seniors in Eight States.

Lack of drug coverage is also associated with higher out-of-pocket drug expenses. While 17% of seniors with drug coverage reported spending at least $100 per month out-of-pocket on medications, this share rose to 43% among those without coverage (Safran, et al., 2002).

Drug coverage may also impact health outcomes. According to a recent study, beneficiaries with a history of heart problems who lack drug coverage are less likely to use higher-cost medications that have proven especially effective among the majority of patients (Federman, et al., 2001). Increased access to newer prescription drugs has also been shown to lower spending on other services such as hospital care due to fewer inpatient stays (Lichtenberg, 2001).

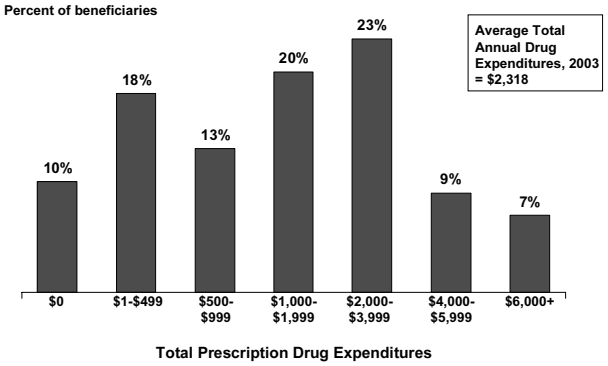
## TOTAL AND OUT-OF-POCKET DRUG SPENDING

Average annual per capita drug spending for the Medicare population—an estimated $2,318 in 2003—is increasing rapidly, currently at an annual rate of about 12%. Spending is highly skewed across beneficiaries: More than a quarter (28%) are expected to incur up to $500 in total drug expenses in 2003, while 16% will have expenses of $4,000 or more, according to the Congressional Budget Office (Figure 4).

Out-of-pocket drug spending is influenced by many factors, including beneficiaries' health-care needs, access to coverage and the generosity of that coverage, and the prices of the medications they take.

Figure 4

**Distribution of Medicare Beneficiaries, by Total Prescription Drug Expenditures, 2003**

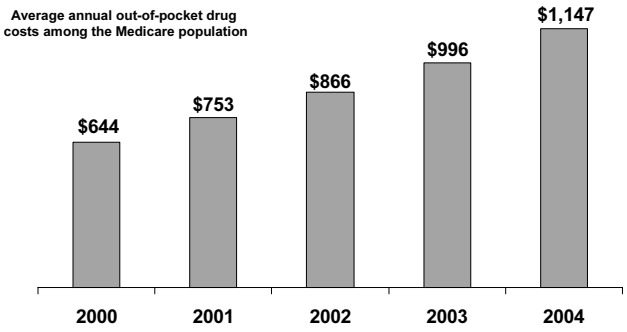



SOURCE: CBO, 2003.

Beneficiaries' average annual out-of-pocket drug spending has risen from $644 in 2000 to $996 in 2003 (Figure 5). This trend is projected to continue in the near future due to limits on drug coverage across all sources and other factors, including the continued introduction of new, high-priced drugs; patent extensions for brand-name drugs; and potential increases in demand stemming from direct-to-consumer advertising. According to the Actuarial Research Corporation, 5% of beneficiaries are expected to have out-of-pocket drug expenses of $4,000 or more in 2003.

Figure 5

**Growth in Medicare Beneficiaries' Out-of-Pocket Prescription Drug Expenditures, 2000-2004**




SOURCE: Actuarial Research Corporation analysis for The Kaiser Family Foundation (using CBO's 2003 estimates of prescription drug spending, which reflect adjustments in historical spending and lower expected economic growth in the near term).

## OUTLOOK FOR THE FUTURE

The lack of drug coverage for millions of Medicare beneficiaries, the erosion of drug coverage for many others, and rising drug expenditures have led to a variety of proposals for reform. While policymakers and the public now agree on the need for a Medicare drug benefit, many complex and controversial issues have yet to be resolved. For example, should a drug benefit be implemented alone or as part of a broad overhaul of the Medicare program? Should drug coverage be provided directly under Medicare or primarily through private, risk-bearing plans? How should drug costs be controlled? The ability to reach common ground on these and other challenges will have significant implications for the nation's aged and disabled populations.

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