The following overview knits together a collection of articles that focus on prescription drug issues as they relate to the Medicare Program. In general, the articles examine the following themes: drug cost management; drug cost estimation, and racial disparities in drug coverage and use. These commentaries provide information on private-sector experience in administering a drug benefit, models that might be used to estimate take-up rates and their associated costs, and several in-depth looks at racial disparities by various chronic conditions.

INTRODUCTION

This edition of the Health Care Financing Review focuses on the issue of Medicare prescription drug coverage, use, and spending. The recent passage by Congress of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), the most sweeping change to the program since its inception in 1965, make the issues presented here especially timely and highly relevant.

Background

When Congress created the Medicare Program in 1965, the topic of prescription drugs was largely ignored. This was due, in part, to the fact that medication costs in the mid-1960s were not viewed as a heavy financial burden on beneficiaries.

Debate regarding the addition of a drug benefit began shortly thereafter in May 1967 when President Lyndon Johnson appointed the Task Force on Prescription Drugs. The debate intensified in 1988 when the Medicare Catastrophic Coverage Act was passed, providing beneficiaries with a short-lived drug benefit. That legislation was subsequently repealed 1 year later following a rebellion by seniors fearing higher taxes and higher premiums.

In 1997, Congress created the National Bipartisan Commission on the Future of Medicare. The 17-member panel was charged with making recommendations on how to best reform the Medicare Program. Although there was consensus among the members that prescription drugs should be added to a modernized Medicare package, the commission was unable to garner the "super majority" (as mandated by the 1997 BBA) required to make a formal recommendation to Congress.

With the passage of the MMA, beginning in mid-2004, Medicare beneficiaries will have access to a Medicare-endorsed prescription drug discount card. The card is expected to yield average savings of between 10 and 25 percent. Moreover, low-income beneficiaries will receive a $600 subsidy to help offset their drug-spending burden.

The full-scale drug benefit goes into effect in 2006. It will allow beneficiaries to voluntarily sign up with a private plan that offers drug coverage, or sign up for a stand-alone drug benefit. The premium is currently set to approximately $35 per month with a $250 deductible (http://www.medicare.gov/publications/pubs/pdf/11054.pdf). Medicare will cover three-quarters of the drug costs between $250 and $2,250 and 95 percent of all drug expenditures over
$3,600. The beneficiary is responsible for all of his or her own drug costs between $2,250 and $3,600. Additional assistance will be available to enrollees with low incomes and limited assets.

Having looked briefly at the various efforts to add drugs to Medicare, as well as a few of the particulars of the new law, we turn now to some of the key issues that have vexed the program for years. Among many others, these are the matters tackled by policymakers as they finalized details on the scope and depth of coverage making a pharmacy benefit a reality for over 40 million beneficiaries.

Managing Costs

Throughout the 1990s, as the costs for prescription therapies rose, the utilization and expenditure gaps widened between Medicare beneficiaries with and without drug coverage (Poisal and Murray, 2001). During that time, costs rose sharply due to four primary factors (Berndt, 2001).

- Drugs were perceived as being a small fraction of overall health care expenditures, hence little attention was paid to escalating costs.
- A significant growth in third-party coverage.
- Introduction of successful new drugs.
- Aggressive technology transfer and marketing efforts.

It is safe to say drug costs are no longer perceived as trivial relative to overall health care spending. Policy-related issues that have dramatic impacts on the overall cost of a benefit, such as deciding which drugs to cover (brand, generic; both), deciding whom to cover (low-income, everyone), and determining the appropriate depth of coverage (first-dollar coverage, limited liability) were given vast consideration.

Drawing on the private-sector experience, as well as that of some government entities, Fox identifies many of the questions faced by policymakers related to the management of cost and utilization of a drug benefit in a FFS setting. For instance, one of the more controversial questions surrounding the implementation of a drug benefit was, "How broad should the pharmacy network be?" Fox points out that health plans (those who bear the financial risk) willing to narrow their network to 75 to 80 percent of the pharmacies in the area can expect to receive slightly higher discounts off of the average wholesale price than health plans that permit wider networks.

Estimating Costs

Of course, with every legislative drug proposal came a need for a cost estimate. This "scoring" was carried out primarily by the U.S. Congressional Budget Office and the Office of the Actuary, CMS. Both entities relied heavily on the MCBS for their projections (Adler, 1994). Two articles (Poisal and Wrobel et al.) in this issue deal directly with cost estimates derived from the MCBS.

Because surveys (including the MCBS) are subject to recall error, it's not surprising that different agencies arrived at dissimilar estimates using the same data source due to differing assumptions about the accuracy of reporting. As a result, CMS
conducted a survey of MCBS sample person’s pharmacies to quantify the accuracy of the MCBS prescription drug reporting rates.

Poisal found that the net-adjusted under-reporting rate for drug expenditures among MCBS respondents in 1999 was 17 percent. Amid other findings, he reports that approximately one-quarter of Medicare beneficiaries actually overreported their aggregate drug expenditures. He also estimated that the net-adjusted median per capita drug expenditure in 1999 was approximately $1,000. Finally, at the prescription level, beneficiaries tended to report drug purchases that were relatively expensive and not report scripts that were relatively inexpensive.

With the passage of a Medicare pharmacy benefit, researchers and policymakers alike will now place a greater emphasis on the need to accurately predict future drug costs and their impact on the Medicare trust funds. Wrobel, Doshi, Stuart, and Briesacher, point out the most challenging forecast will be the first one because it will be made without access to actual drug spending data. Consequently, the initial predictions will likely come from simulations conducted on the MCBS.

Among the principle findings from their analyses, the authors showed that it is, indeed, possible to predict almost one-quarter of the variation in Medicare drug expenditures using a prospective model that examines basic demographics and claims-based indicators for medical conditions (drawn from Medicare’s current risk-adjustment methodology). The addition of past drug expenses more than doubled their model’s predictive power.

Wrobel et al. also concluded that medical conditions that are predictive of Medicare expenditures are not necessarily the same as those that predict high drug expenses, and vice versa. What’s more, this research confirmed prior studies (which are few in number) that prescription drug expenditures are highly persistent and very dependent on the presence of chronic condition(s). Consequently, the authors warn, there is a potential for powerful adverse selection if beneficiaries are given the choice to purchase drug insurance at a single market price.

Who Will Sign Up?

Arguably, one of the most difficult aspects of estimating the future costs of a Medicare drug assistance plan is trying to determine how many beneficiaries will actually sign up for this new, voluntary benefit. The contribution from Shea, Stuart, and Briesacher, focuses on the take-up rate among enrollees and examines the extent to which the new benefit may “crowd-out” existing forms of drug coverage. The results from their simulations are important for two key reasons:

• They help identify subgroups likely to benefit from the expansion, as well as those likely to be left behind.

• They provide an understanding of crowd-out implications, helping to determine if the new benefit will increase overall insurance or merely replace existing private coverage.

Shea et al. report that prior research indicates that there will likely be some collapsing of the private market, although one of the main causes of coverage change will be the response of individual beneficiaries proactively shifting the source of their coverage; not necessarily employers and former employers altering their current benefit packages. The authors find that participation rates in a Medicare drug plan for beneficiaries who already have employer-sponsored coverage should remain below 10 percent in both a low-benefit plan ($250 deductible, 50 percent coinsurance, $2,000
cap, and $6,000 stop loss), as well as a moderate-benefit plan (no deductible, 50 percent coinsurance, $2,500 cap, and $4,000 stop loss). Only when a premium subsidy of at least 75 percent is introduced into the simulations does the participation rate (among those with employer-sponsored coverage) climb into the double-digits (low-benefit 14 percent, moderate-benefit 22 percent).

Finally, a sensitivity analysis revealed that raising or lowering the deductible (from $250 to $0 or to $1,000) changed the predicted participation rates by just 5 to 10 percent for most demographic groups. However, lowering the coinsurance rates (from 50 to 20 percent) dramatically boosted participation rates for many demographic groups, including the disabled. Their rates climbed from the low 40s to the low 60s.

Racial Disparities

There are two articles in this issue that deal with racial differences in drug use and spending in the Medicare population. Studying diabetes, heart disease, and hypertension, Briesacher, Limcangco, and Gaskin set out to determine whether the presence of drug coverage reduced or eliminated racial and ethnic differences in drug use for Medicare’s chronically ill, and whether specific types of coverage (e.g. Medicaid, employer-sponsored, etc.) were more successful in improving access to minorities.

Shore, Brown, and Lavin, on the other hand, limited their analysis exclusively to Medicare beneficiaries enrolled in Medicaid. Similar to the Briesacher et al. article, Shore et al. focused on dually eligible beneficiaries with at least one of four chronic conditions (heart disease, chronic obstructive pulmonary disease, diabetes, and stroke and cerebrovascular and other vascular diseases). Both studies found sizable differences by race in both drug use and spending, even when controlling for other health-related demographic and socioeconomic factors.

Briesacher et al. found that minorities relied more heavily on public programs for drug assistance when compared with white beneficiaries. At the same time, minorities were less likely to have private drug coverage either from an employer-sponsored plan or a Medigap plan. They also found that only M+C drug coverage was the only coverage that tended to favor minorities.

Among diabetics, Briesacher et al. state that white beneficiaries without drug coverage used one-third more medications relative to black and Hispanic beneficiaries without coverage. They also spent 20 to 40 percent more on prescription drugs. Even employer-sponsored drug coverage did not reduce the disparities between white and minority beneficiaries with diabetes. Enrollees with heart disease and hypertension experienced very similar patterns to those with diabetes.

In the 10 States studied by Schore and colleagues, black beneficiaries filled roughly 20 percent fewer prescriptions than white beneficiaries in every State. The disparity was the same for expenditures, although in New Jersey, spending for black beneficiaries was slightly higher than that for white beneficiaries.

Schore et al. conclude that the differences between the races do not appear to be explained by differences in the incidence rate of the chronic diseases studied, nor to a difference in access to physicians. Moreover, even when the analysis is limited to the same medical condition, high-cost heart disease, for instance, black beneficiaries spend just $126 per month on medicine, compared with $146 for white beneficiaries.
The final article in this issue of the *Review* features a brief analysis on the prevalence of prescription drug discount cards in the Medicare population during fall 2002. Among other findings, Eppig and Poisal point out that about 10 percent of beneficiaries who did not have drug coverage in 2002 reported having a discount card. This compares to about 2 percent of those enrollees with drug coverage. Medicare is not the only public health insurance program under scrutiny with respect to prescription drugs. In the next issue of the *Review*, we will explore the pharmacy trends in Medicaid. Included in that edition will be a look at Medicaid drug spending in the 1990s, drug-access issues, and an analysis on generic drug cost containment.

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