COST OVERDOSE:

Growth in Drug Spending for the Elderly, 1992 - 2010

A REPORT BY

Families USA

1334 G Street, NW

Washington, DC 20005

202-628-3030

Support for this report was generously provided by
The Retirement Research Foundation

July 2000

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Families USA Publication No. 00-107

Families USA
1334 G Street, NW
Washington, DC 20005
Phone: (202) 628-3030
Fax: (202) 347-2417
E-mail: info@familiesusa.org
Website: www.familiesusa.org

INTRODUCTION

Prescription drugs are the fastest growing component of health care spending.[1] For health plans, employers, and consumers alike, prescription drug expenditures are increasing faster than any other health care service. Growing prescription drug expenditures are of concern to everyone who has to pay the higher costs—employers, health plans, and consumers. The burden of these rising costs falls most heavily on those consumers who do not have insurance coverage for prescription drugs—particularly Medicare beneficiaries, who rely more heavily on prescription drugs.

To gain a better understanding of prescription drug spending for and by the elderly, Families USA, in conjunction with the PRIME Institute at the University of Minnesota, analyzed data from the most recent years' Medicare Current Beneficiary Survey as well as from the Health Care Financing Administration (HCFA), Office of the Actuary. Although several recent studies have examined total spending for prescription drugs in the United States, until now, none has looked at past as well as future prescription drug spending exclusively for the elderly. Our study examines seniors' prescription drug spending starting in 1992, the first year the Medicare Current Beneficiary Survey was undertaken in the 1990s. The study also provides projections for seniors' drug spending through 2010.

This analysis provides past and projected data concerning cumulative as well as per person senior drug spending. To understand the factors causing this rise in drug spending, we analyzed several key components of those costs, including: changes over time in the total number of prescriptions filled by seniors, sometimes referred to as volume; average per person increases over time in those prescriptions; and increases over time in the average cost per prescription. The data also demonstrate how drug spending is consuming a growing portion of seniors' overall health care costs.

Projections for this report were developed by the PRIME Institute. The PRIME Institute was established in 1991 in the College of Pharmacy, University of Minnesota, as an independent and global research, education, and consulting organization whose mission is the study of economic and policy issues related to pharmaceuticals. Projections for expenditures in years after 1996 were based on trend data from the HCFA Office of the Actuary's forecast of future health and drug expenditures. As a result, the projections for health care and prescription drug spending for the elderly are consistent with HCFA's overall projections for the annual rate of growth in per capita health and drug spending through 2010.

Our study finds that during the 1992-2000 period, all of the indices of elderly prescription drug spending rose rapidly. Projections for the next decade indicate that this growth will continue unabated. While overall elderly health spending is projected to grow considerably faster than general inflation, drug costs increases will grow even faster, continuing to outpace overall health spending growth for the elderly.

KEY FINDINGS

Although seniors constitute only 13 percent of the population, they account for 34 percent of all prescriptions dispensed and 42 cents of every dollar spent on prescription drugs. (See Table 1 and Figure 1.)

Figure 1

Seniors Consume a Disproportionate Share of Drug Expenses

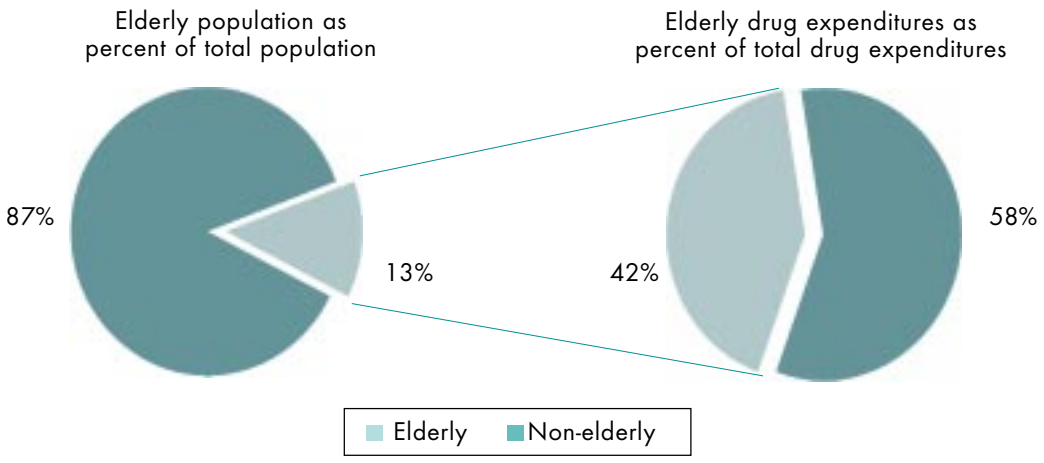


Table 1

Prescription Drug Use by, and Spending for, the Elderly, 1998 (numbers in millions)

	Total	Elderly	Elderly as Percent of Total
Population	270.2	34.4	13%
Prescription Drugs Dispensed	2,732.7	932.7	34%
Prescription Drug Expenditures	$102,687.5	$42,899.2	42%

Source: U.S. Census Bureau and data compiled by PRIME Institute for Families USA.

Prescription Drug Spending Per Senior

- Annual spending per elderly person for prescription drugs grew from $559 in 1992 to $1,205 in 2000, an increase of 116 percent. (See Table 2.) At the same time, overall per senior health care spending grew by 59 percent, nearly half as fast as drug spending. As a result, per senior prescription drug spending as a share of total health care spending grew from 7.4 in 1992 to 10 percent in 2000.

Table 2

Total Health Care and Prescription Drug Spending Per Senior, 1992-2010

Year	Total Health Care Expenditures Per Senior	Prescription Drug Expenditures Per Senior	Prescription Drug Expenditures as Percent of Total Senior Health Care Expenditures
1992	$ 7,554	$ 559	7.4%
1994	$ 9,059	$ 648	7.2%
1996	$ 9,998	$ 769	7.7%
1998*	$ 10,822	$ 984	9.1%
2000*	$ 12,028	$ 1,205	10.0%
2005*	$ 15,922	$ 1,912	12.0%
2010*	$ 21,149	$ 2,810	13.3%

* projections

Source: Data compiled by PRIME Institute for Families USA.

- By 2010, annual per person spending on drugs for the elderly is projected to reach $2,810 a year, an increase of 133 percent over spending in 2000. During this period, per senior overall health care spending is projected to increase by 76 percent.
- Over the 18-year period from 1992 to 2010, prescription drug spending per elderly person is projected to grow by 403 percent, more than twice the rate of overall growth in per senior health care spending, which is expected to grow by 180 percent. The portion of senior health spending devoted to prescription drugs will have grown from 7.4 percent in 1992 to 13.3 percent in 2010.

Total Prescription Drug Spending for Seniors

- Spending on prescription drugs for the elderly grew from $18.5 billion in 1992 to $42.9 billion in 2000, an increase of 132 percent. During this same period, total senior health care spending grew by 71 percent. (See Table 3.)

Table 3

Total Health Care and Prescription Drug Spending for Seniors, 1992-2010

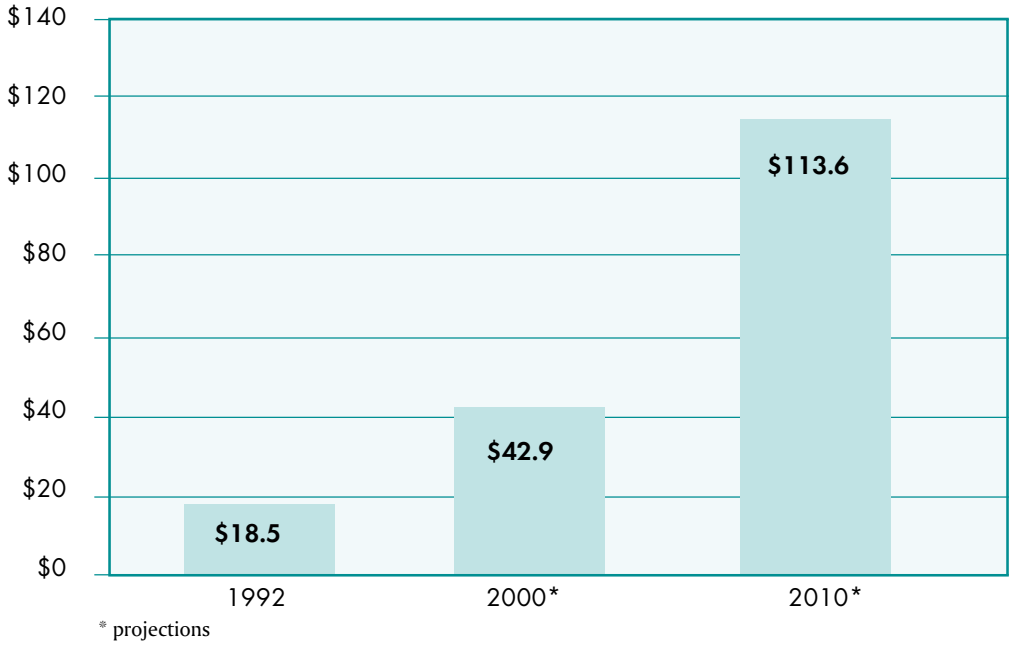
Year	Total Health Expenditures for Seniors (in billions)	Total Prescription Drug Expenditures for Seniors (in billions)
1992	$ 249.7	$ 18.5
1994	$ 307.8	$ 22.0
1996	$ 347.3	$ 26.7
1998*	$ 380.5	$ 34.6
2000*	$ 428.1	$ 42.9
2005*	$ 590.5	$ 70.9
2010*	$ 854.6	$ 113.6

* projections

Source: Data compiled for PRIME Institute for Families USA.

- By 2010, total prescription drug purchases for the elderly are projected to reach $113.6 billion, an increase of 165 percent over spending in 2000 (see Figure 2). Total senior health care spending is projected to grow by nearly 100 percent during this same 10-year period.

Figure 2
Spending on Prescription Drugs for the Elderly, 1992 - 2010 (in billions)



* projections

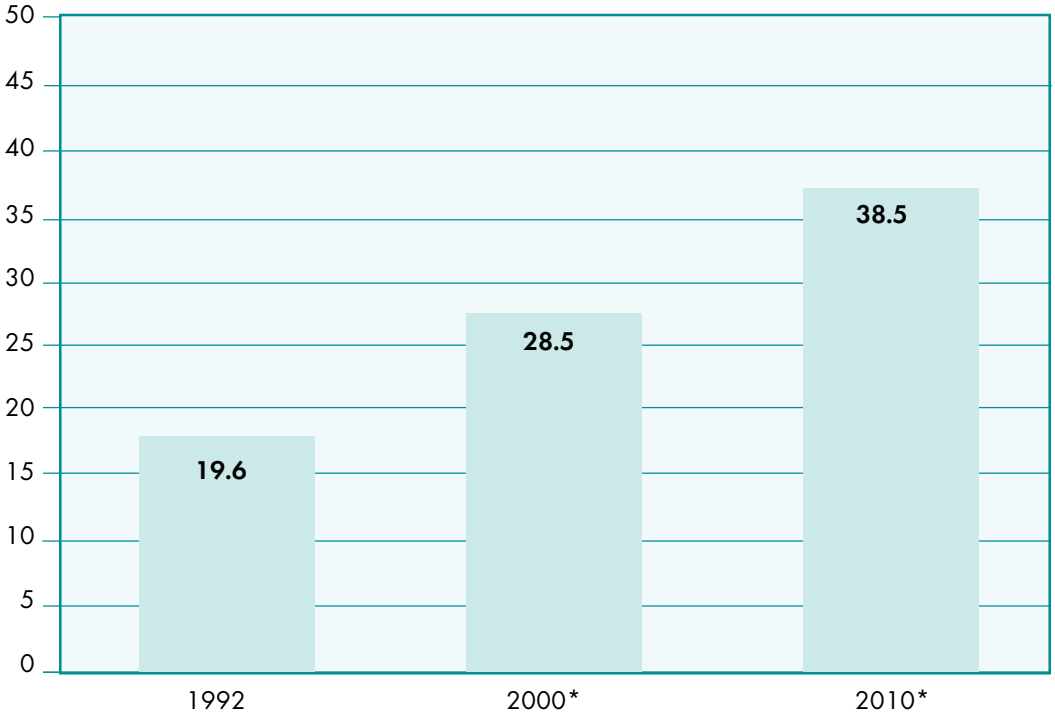
- Over the 18-year period from 1992 to 2010, total prescription drug spending for the elderly is projected to grow by 514 percent, more than twice the rate of growth in overall senior health care spending, which is expected to grow by 242 percent.

Changes in the Number of Prescriptions for Seniors

- The average number of prescriptions per elderly person grew from 19.6 in 1992 to 28.5 in 2000, an increase of 45 percent. (See Figure 3.)
- By 2010, the average number of prescriptions per elderly person is projected to grow to 38.5, an increase of 10 prescriptions, or 35 percent, per senior since 2000. (See Table 4.)
- From 1992 to 2010, the average number of prescriptions per senior will grow by 96 percent.
- The overall total number of prescriptions for seniors grew from 648 million in 1992 to over 1 billion in the year 2000—and is projected to grow to almost 1.6 billion in 2010.

Figure 3

Average Number of Prescriptions Per Senior, 1992 - 2010



* projections

Table 4

Prescription Drug Use Among Seniors, 1992-2010

Year	Number of Prescriptions Per Senior	Total Number of Prescriptions for all Seniors (in millions)
1992	19.6	648.1
1994	20.7	704.7
1996	22.6	786.1
1998*	26.5	932.7
2000*	28.5	1,014.3
2005*	34.4	1,276.5
2010*	38.5	1,557.1

* projections

Source: Data compiled by PRIME Institute for Families USA.

Average Cost Per Prescription for Seniors

- The average cost per prescription for the elderly increased from $28.50 in 1992 to $42.30 in 2000, an increase of $13.80 per prescription or 48 percent. (See Table 5.)

Table 5

Average Prescription Drug Cost for Seniors, 1992-2010

Year	Average Drug Prescription Cost
1992	$ 28.50
1994	$ 31.23
1996	$ 33.99
1998*	$ 37.08
2000*	$ 42.30
2005*	$ 55.54
2010*	$ 72.94

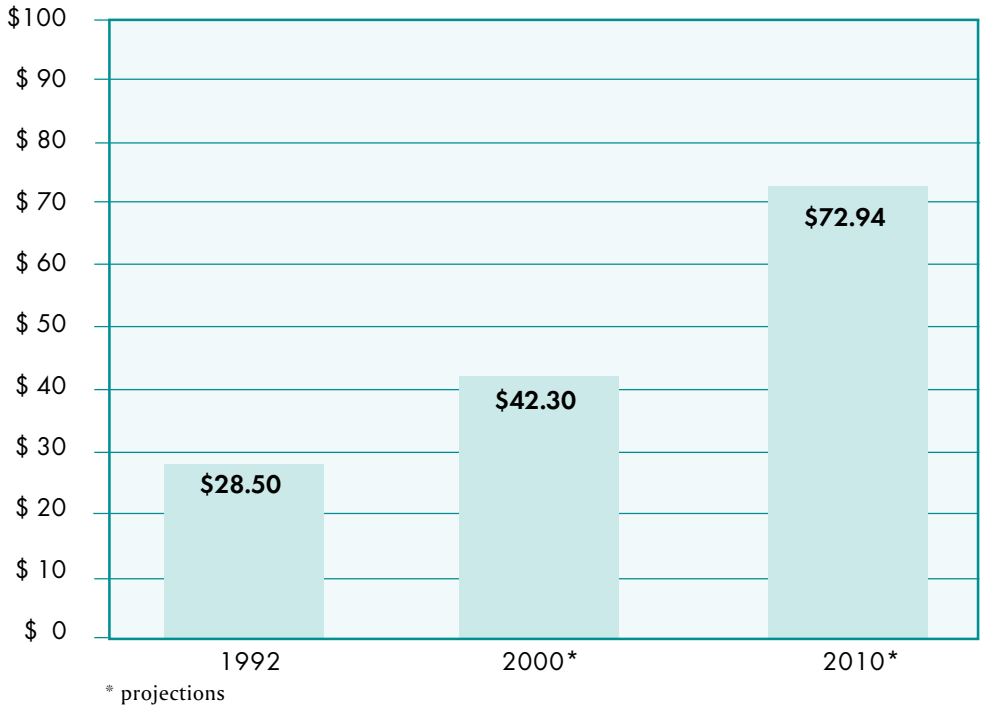
* projections

Source: Data compiled by PRIME Institute for Families USA.

- By 2010, the average cost per prescription for seniors is projected to reach $72.94, an additional increase of $30.64 per prescription, or 72 percent over the average prescription cost in 2000. (See Figure 4.)
- Over the 18-year period from 1992 to 2010, the average cost per prescription is projected to increase by 156 percent.

Figure 4

Average Cost Per Prescription for Seniors 1992 - 2010



* projections

Out-of-Pocket Spending on Prescription Drugs

- In 1996, out-of-pocket spending on prescription drugs represented 18 percent of all out-of-pocket health care spending (see Table 6), and the average Medicare beneficiary paid nearly one-half (47 percent) of all prescription drug costs out of pocket. (See Table 7.)
- The portion of overall drug expenses that the elderly pay out of pocket appears to vary significantly from one state to another. Similarly, big state-to-state differences are seen in the portion of overall out-of-pocket health spending by seniors that is consumed by out-of-pocket drug costs. To understand these variations, we examined data for 1996—the last year for which state-by-state data can be arrayed—for the 25 states[2] with the largest senior drug expenditures.
  - Medicare beneficiaries in 13 of the 25 states spent 18 percent or more of their total out-of-pocket health care costs on prescription drugs. In Kentucky, Oklahoma, and South Carolina, beneficiaries spent 41 percent, 33 percent, and 31 percent, respectively, of their out-of-pocket health care costs on prescription drugs. (See Table 6.)
  - Medicare beneficiaries in the remaining 12 states spent less than 18 percent of their out-of-pocket health care costs on prescription drugs. In Missouri, Kansas, and Ohio, beneficiaries spent 12 percent, 13 percent, and 14 percent, respectively, of their out-of-pocket health care spending on prescription drugs.
  - In Kentucky, Oklahoma, and Iowa, seniors paid 67, 66, and 63 percent, respectively, of their total drug costs out of pocket. (See Table 7.)
  - In California, Michigan, and Maryland, seniors paid 30, 35, and 38 percent, respectively, of their total drug costs out of pocket.

Table 6

Out-of-Pocket Health Care and Prescription Drug Spending for the Elderly, by State (1996)

State	Total Out-of-Pocket Health Care Expenditures Per Senior	Total Out-of-Pocket Prescription Drug Expenditures Per Senior	Prescription Out-of-Pocket Drug Expenditures as Percent of Total Out-of-Pocket Health Expenditures
AL	$1,482	$417	28.2%
CA	$1,597	$218	13.7%
CO	$1,711	$269	15.8%
FL	$1,891	$341	18.0%
GA	$1,778	$455	25.6%
IL	$2,149	$368	17.1%
IN	$2,003	$442	22.1%
IA	$2,320	$486	20.9%
KS	$3,228	$425	13.2%
KY	$1,191	$492	41.3%
ME	$2,650	$363	13.7%
MD	$1,891	$365	19.3%
MA	$1,856	$278	15.0%
MI	$1,952	$296	15.1%
MO	$3,402	$405	11.9%
NJ	$2,002	$313	15.6%
NY	$2,196	$304	13.8%
OH	$2,636	$355	13.5%
OK	$1,462	$480	32.8%
PA	$2,334	$430	18.4%
SC	$1,597	$499	31.3%
TX	$1,722	$363	21.1%
VA	$1,762	$364	20.7%
WA	$1,995	$377	18.9%
WI	$2,506	$401	16.0%
U.S. Average[1]	**$2,022**	**$364**	**18.0%**

[1] Represents the national average for all Medicare beneficiaries.

Note: Percentages may not total due to rounding.

Source: Data compiled by PRIME Institute for Families USA.

Table 7

Per Person and Out-of-Pocket Prescription Drug Expenditures for Seniors, by State (1996)

State	Total Prescription Drug Expenditures Per Person	Total Out-of-Pocket Prescription Drug Expenditures Per Person	Out-of-Pocket Prescription Drug Expenditures as Percent of Total Drug Expenditures
AL	$826	$417	50.5%
CA	$738	$218	29.5%
CO	$628	$269	42.9%
FL	$773	$341	44.1%
GA	$765	$455	59.5%
IL	$776	$368	47.4%
IN	$763	$442	57.9%
IA	$774	$486	62.8%
KS	$774	$425	54.9%
KY	$734	$492	67.0%
ME	$755	$363	48.1%
MD	$962	$365	38.0%
MA	$610	$278	45.6%
MI	$836	$296	35.3%
MO	$802	$405	50.5%
NJ	$816	$313	38.3%
NY	$743	$304	40.9%
OH	$690	$355	51.5%
OK	$725	$480	66.2%
PA	$927	$430	46.3%
SC	$848	$499	58.9%
TX	$745	$363	48.7%
VA	$746	$364	48.8%
WA	$738	$377	51.1%
WI	$710	$401	56.5%
U.S. Average[1]	**$769**	**$364**	**47.3%**

[1] Represents the national average for all Medicare beneficiaries.

Note: Percentages may not total due to rounding.

Source: Data compiled by PRIME Institute for Families USA.

METHODOLOGY

This report uses data from the Medicare Current Beneficiary Survey (MCBS), an ongoing household panel survey of approximately 12,000 elderly and disabled Medicare beneficiaries. The MCBS contains data on all Medicare covered services as well as data on services not covered by Medicare, such as prescription drugs and long-term facility care. This analysis was limited to elderly persons (those age 65 or older) and did not include persons with disabilities under the age of 65.

Using the MCBS cost and use files, expenditures for both total health services and prescription drugs were extracted from the MCBS for each year from 1992 to 1996. Since household surveys are known to underreport both expenditures and events, these data were adjusted to account for underreporting (see Appendix for further details).

To determine out-of-pocket spending, adjusted expenditures for each type of service included in the analysis were broken down by source of payment and state for each of the five years from 1992 to 1996. National and state-level population estimates were made with the sample data multiplied by the full and replicate cross-sectional weights using the WestVarPC® 2.11 software. State level estimates are reported for the top 25 states by drug expenditures and include only states with 100 or more sample subjects in each year from 1992 to 1996.

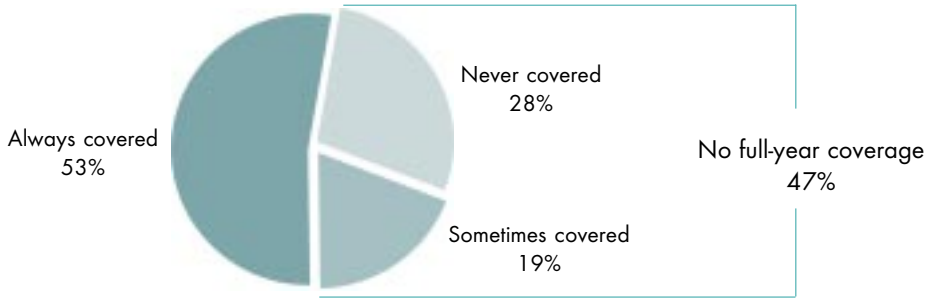
Projections for expenditures in years after 1996 (the last year of actual data) were made using trend data from HCFA forecasts of future health and drug expenditures. The per capita total health expenditures and prescription drug expenditures for the elderly found in the MCBS data for 1996 were increased for the years 1997 to 2010 by the annual rate of growth for similar per capita expenditures found in the HCFA forecasts (Health Care Financing Administration, Office of the Actuary, National Health Statistics Group). Per capita expenditures were multiplied by U.S. Bureau of the Census population data and projections to estimate total expenditures for the elderly population from 1997 to 2010.

BACKGROUND

People age 65 and older rely more heavily on prescription drugs than any other age group. In 1998, the elderly consumed 34 percent of all prescriptions dispensed. Despite this greater reliance on prescription drugs, the elderly remain the only insured group that does not have prescription drug coverage as part of its primary insurance. Nearly half of all Medicare beneficiaries lack full-year prescription drug coverage; nearly two-thirds of this group is without coverage all year, and the rest are covered for only part of the year (Figure 5).[3]

Figure 5

Nearly Half of Medicare Beneficiaries Are Without Drug Coverage



Source: Bruce Stuart, Dennis Shea, and Becky Briesacher, *Prescription Drugs for Medicare Beneficiaries: Coverage and Health Status Matters*, The Commonwealth Fund, February 2000.

The primary sources of private-sector prescription drug coverage for Medicare beneficiaries are employer-sponsored retiree coverage, Medicare+Choice managed care plans, and Medigap coverage. For those Medicare beneficiaries who have private-sector prescription drug coverage, this coverage is increasingly unaffordable and unreliable.

Employer-sponsored retiree coverage is the most common source of prescription drug coverage for the elderly. Roughly 30 percent of all seniors (11.7 million) have drug coverage through their former employers,[4] but em-

ployer-sponsored retiree coverage is declining. Among firms with 1,000 or more employees, the percentage offering retiree coverage dropped from 80 percent in 1991 to 67 percent in 1998.[5] The trend is similar across firms of all sizes. According to a recent Mercer/Foster Higgins survey, the overall percentage of firms offering retiree coverage dropped from 40 percent in 1994 to 28 percent in 1999.[6]

In 1999, approximately 13 percent (5.2 million) of Medicare beneficiaries had some prescription drug coverage through the Medicare managed care plan, Medicare+Choice.[7] Medicare+Choice is, however, an increasingly unreliable source of prescription drug coverage for seniors. Plans covering prescription drugs are not offered consistently across the country. Some plans are dropping out of Medicare+Choice or are dropping drug coverage; and other plans are reducing their prescription drug coverage.

Medicare beneficiaries in 11 states—Alabama, Arkansas, Iowa, Nebraska, North Dakota, South Carolina, South Dakota, Utah, Vermont, West Virginia, and Wyoming—do not have access to any plan offering drug coverage in 2000. In an additional four states (Delaware, Louisiana, North Carolina, and New Mexico), beneficiary access to plans with drug coverage decreased by 10 percent or more from 1999 to 2000.

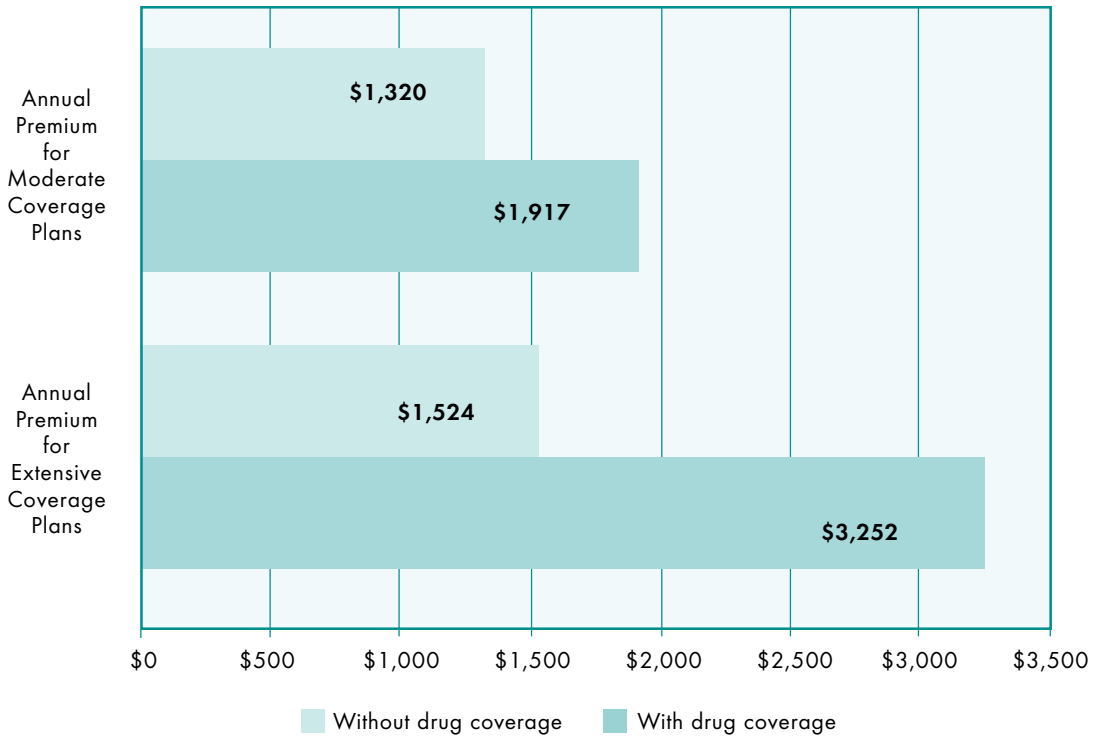
For those beneficiaries who do have access to Medicaid+Choice plans with drug coverage, the value of the drug benefit is decreasing. In 2000, 86 percent of all plans limit drug benefits. Between 1999 and 2000, the proportion of plans with annual limits of $500 increased 50 percent, from 21 percent of plans in 1999 to 32 percent in 2000. During the same period, the number of beneficiaries living in areas where plans required copayments on brand name drugs averaging $25 or above more than tripled, and the number of beneficiaries affected by these high copayments increased from 275,000 in 1999 to 1 million in 2000.[8]

Roughly 8 percent of Medicare beneficiaries (3.3 million) purchase individual Medigap policies with prescription drug coverage.[9] Among the ten standard Medigap policies, three offer prescription drug coverage, with two offering very modest coverage and a third offering more extensive coverage. The modest coverage policies require a $250 deductible and a 50 percent

copayment and limit coverage to $1,250 annually. The policy with more extensive coverage has the same deductible and coinsurance requirements but limits coverage to $3,000 annually. While it is difficult to isolate the precise cost of the prescription drug benefit in the three Medigap policies covering drugs, it is clear that those policies are considerably more expensive than plans without such coverage. The premium differential between the most expensive Medigap drug policy and the closest comparable non-drug policy exceeds $1,700 per year (see Figure 6). Thus, Medigap drug policies are unaffordable for many seniors.[10]

Figure 6

Prescription Drug Benefit Makes Medigap Coverage Much More Expensive



Note: All Medigap policies with drug coverage have a $250 deductible and 50 percent coinsurance. The moderate coverage plan is limited to $1,250 annually and the extensive coverage plan is limited to $3,000 annually. Annual premiums are averages of quotes for a 65-year-old woman in selected areas. (See Source for details.)

Source: Marilyn Moon, *Assessing The President's Proposal to Modernize and Strengthen Medicare*, The Commonwealth Fund, forthcoming July 2000.

For the poorest Medicare beneficiaries, Medicaid offers assistance with prescription drug coverage. Approximately 13.8 percent of Medicare beneficiaries get drug coverage through Medicaid (4.6 million) or other public programs providing drug coverage to Medicare beneficiaries (0.8 million).[11] Medicaid eligibility for seniors varies by state, and many states have more than one eligibility category for seniors. In most states, seniors must have $6,000 or less in annual income—roughly 73 percent of the federal poverty level, which is the eligibility level for the Supplemental Security Income (SSI) program—to be eligible for Medicaid assistance. However, 11 states and the District of Columbia have opted to expand Medicaid eligibility for seniors to 100 percent of poverty ($8,350 in 2000 for a single person living alone). In addition, 35 states have established Medically Needy programs that allow seniors to count their health expenses paid out of pocket against their income to meet special eligibility levels.[12]

At any point in time, 35 percent of Medicare beneficiaries are without any insurance for prescription drugs.[13] Over the course of the year, nearly half of Medicare beneficiaries (18.4 million) are without coverage for some or all of the year.[14] For those Medicare beneficiaries who have no coverage for prescription drugs, the price of drugs is a growing obstacle. Meanwhile, prescription drug prices, particularly those most commonly used by the elderly, have been rising consistently faster than the rate of inflation.[15] While health plans and other insurers are able to negotiate with drug manufacturer for discounted prices, Medicare beneficiaries who do not have prescription drug coverage are the most sensitive to the escalating prices of prescription drugs. They are unable to take advantage of the volume purchasing discounts that health plans and other insurers are able to negotiate. Consequently, they are the only group (other than those under 65 without health insurance) paying full retail price for their prescriptions. Because the majority of those without drug coverage have incomes at or below 200 percent of the federal poverty level ($16,700 in 2000 for a single person living alone), prescription drug costs can quickly consume a large share of their income.

Seniors with prescription drug coverage are also affected by increased drug costs. These costs are inevitably passed on to consumers in the form of higher Medigap premiums, greater cost-sharing, and, in the case of managed care, reduced benefits. The growing use of prescription drugs is a challenge for health plans and insurers. According to two recent studies, growth in the volume of drugs dispensed—which includes increases in the number of people taking prescription drugs as well as increases in the number of prescriptions per person—accounts for the majority of the increase in drug spending.[16] For health plans and other insurers, rising drug expenditures result in more aggressive cost containment techniques, such as utilization review and stricter drug formularies, which limit coverage to a list of preferred drugs. Each of these responses to high costs has implications for the patients' abilities to get the drugs they need.

DISCUSSION

Implications of Rising Drug Expenditures

Recent advances in the development of medications to treat conditions common among the elderly offer life-extending and life-enhancing benefits. At the same time, the costs of these drugs are prohibitive for many seniors, especially those with no coverage for prescription drugs. Without the ability to afford these drugs, many of the elderly will not benefit from these medical advances.

As prescription drugs play a larger role in the delivery of health care, they will consume a greater share of health care dollars. In 1980, prescription drugs consumed 4.9 percent of national health care spending. By 1999, prescription drugs, as a share of national health care spending, had reached 8.2 percent.[17]

For people age 65 and older, Medicare has typically covered about half of all health care costs. The remaining 50 percent of health care expenses are generally paid for by seniors out of pocket or through Medigap coverage.[18] To the extent that seniors remain uncovered for prescription drugs,

over time they will be shouldering a growing share of their health care costs out of pocket.

The data in this report demonstrate that seniors pay higher amounts per prescription than younger persons. Seniors fill 35 percent of all prescriptions dispensed, but their drug expenditures constitute 42 percent of total drug expenditures. In addition, expenditures for prescription drugs are rising faster than overall health care spending, both in the aggregate and per person.

The data in this report also show that the number of elderly people taking prescription medications has been rising and will continue to rise through the next decade. A number of factors contribute to this ongoing increase: the entry of new drugs to treat conditions that previously were not susceptible to drug treatment; the use of existing drugs to treat conditions for which they were not originally approved (often called "off-label" use); and the influence of direct-to-consumer advertising on consumer preference and demand for drugs.[19]

For Medicare beneficiaries who currently have drug coverage, growth in volume will inevitably increase the cost of drug coverage or limit the value of the drug benefit as insurers look to control drug costs. This, in turn, may lead to a decline in the number of seniors who have coverage. The cost of Medigap policies with drug coverage is likely to increase, and the number of Medicare+Choice plans offering drug benefits is likely to continue to decline. Cigna Corporation recently reported it would no longer serve Medicare markets in 11 states beginning January 2001. Aetna, Inc. will also terminate participation as a Medicare+Choice provider in a number of markets in January 2001. Experts estimate that the number of beneficiaries affected by this latest round of Medicare managed care pull-outs will be between 400,000 and 1 million people.[20] While these plan pull-outs may not leave an area entirely without Medicare+Choice plan options, the number of plans will likely be smaller and the availability and scope of drug coverage will continue to decline.

Out-of-Pocket Spending by State

Our data indicate significant variations by state in out-of-pocket spending for drugs by the elderly. These variations in out-of-pocket spending may be explained by a number of factors, including:

- *The level of Medicare payments to Medicare+Choice plans in the state*
  Medicare+Choice plan payments vary by geographic area. As a result, plans in areas that receive higher-than-average payments are more likely to offer meaningful drug benefits than plans serving other locations. Although recent legislative changes are designed to minimize the differences in area-by-area Medicare payments rates, some disparity still exists and will result in varying levels of drug coverage.

- *The state's Medicaid eligibility levels for persons age 65 and older*
  As mentioned earlier, states have the flexibility within their Medicaid programs to expand income eligibility for seniors above the Supplemental Security Income (SSI) level (approximately 73 percent of the federal poverty level) to 100 percent of poverty. As of 1999, only 13 states had SSI and Medicaid levels above 73 percent of poverty.[21]

- *The existence of a state pharmacy assistance program*
  Today, 21 states have state-funded programs to assist low- and moderate-income seniors and, in some cases, the disabled with the cost of prescription drugs.[22] While state pharmacy assistance programs generally have income ceilings, the nature of these programs varies. Some programs cover only drugs for specific conditions, others cover all drugs up to a certain dollar amount.

- *State insurance regulations*
  All types of insurance are regulated at the state level. In the case of Medigap policies, the federal government established ten standard policies, but the states regulate pricing and offering of Medigap

policies, within general federal guidelines. For example, in New York and Maine, all Medigap insurers are required to community rate policies, i.e., insurers must charge the same premium for the same policy regardless of age. In Connecticut and Massachusetts, insurers are required to make plans available on a guaranteed basis beyond the federally protected six-month open enrollment.[23]

Each of these factors has the potential to affect the availability and cost of drug coverage for seniors.

CONCLUSION

The convergence of the two trends described in this report—growing reliance on prescription drugs by the elderly and mounting costs for those drugs—is a crisis for America's senior citizens. The elderly already pay a significant portion of prescription drug expenditures out of pocket. Today, many seniors are without any prescription drug coverage. For those fortunate enough to have prescription drug coverage, that coverage is diminishing. Thus, unless seniors are assured of prescription drug coverage through Medicare, many will find that needed medications are unaffordable.

ENDNOTES

[1] Katharine Levit, Cathy Cowan, Helen Lazenby, Arthur Sensenig, Patricia McDonnell, Jean Stiller, Anne Martin, and the Health Accounts Team, "Health Spending in 1998: Signals of Change," *Health Affairs* 19, no. 1 (January/February 2000): 124-147.

[2] The 25 states included in this report are: Alabama, California, Colorado, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Missouri, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, South Carolina, Texas, Virginia, Washington, and Wisconsin.

[3] Bruce Stuart, Dennis Shea, and Becky Briesacher, *Prescription Drugs for Medicare Beneficiaries: Coverage and Health Status Matter* (New York: The Commonwealth Fund, February 2000).

[4] David Gross and Normandy Brangan, *Medicare Beneficiaries and Prescription Drug Coverage: Gaps and Barriers* (Washington, DC: AARP Public Policy Institute, June 1999).

[5] Frank McArdle, Steve Coppock, Dale Yamamoto, and Andrew Zebrak, *Retiree Health Coverage: Recent Trends and Employer Perspectives on Future Benefits* (Menlo Park, CA: Henry J. Kaiser Family Foundation, October 1999).

[6] William M. Mercer, *Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 1998: Report of Survey Findings* (New York: William M. Mercer Companies LLC, 1999).

[7] Gross and Brangan, op cit.

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[17] Sheila Smith, Stephen Heffler, Mark Freeland, and the National Health Expenditures Projection Team, "The Next Decade of Health Spending: A New Outlook," *Health Affairs* 18, no. 4 (July/August 1999): 86-95.

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[19] Direct-to-consumer advertising is a relatively new phenomenon in the United States. The advertising of prescription drugs by name to consumers was prohibited until 1997. Beginning in 1997, the FDA permitted drug manufacturers to run advertisements for specific drugs. Since this change in regulation, there has been a tremendous increase in marketing by manufacturers. In 1999 alone, drug manufacturers spent $905 million on direct-to-consumer advertising and this amount does not include advertising in medical journals or other efforts directed toward physicians. Spending on direct-to-consumer advertising is expected to reach $2 billion in 2000.

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APPENDIX I: DATA SOURCES AND METHODOLOGY

Data on expenditures for both total health services and prescription drugs were extracted from the Medicare Current Beneficiary Survey (MCBS) for each year from 1992 to 1996. The MCBS is an on-going household panel survey of approximately 12,000 elderly and disabled persons eligible for Medicare benefits. The MCBS "Cost" and "Use" public use files contain data on all Medicare covered services as well as data on services not covered by Medicare, such as prescription drugs and long-term facility care. Medicare covered services reported in the household survey were compared to actual Medicare payment records and the cost and use file was adjusted to account for identified differences. The drug use data, however, were based upon self-reported data in the household survey. This analysis was limited to elderly persons (those age 65 or older) and did not include persons with disabilities who did not otherwise meet this age criterion. Adjusted expenditures for each type of service included in the analysis were broken down by source of payment and state for each of the five years from 1992 to 1996. National and state-level population estimates were made with the sample data multiplied by the full and replicate cross-sectional weights using the WestVarPC® 2.11 software.

Household survey reports are known to result in under-reporting of health-related events and expenditures. About 15 percent of total payments for medical events were found to be under-reported when compared to actual Medicare payment records (Eppig, FJ and Chulis, GS, "Matching MCBS and Medicare Data: The Best of Both Worlds," *Health Care Financing Review*, Vol. 18, No. 3, Spring 1997, pp. 211-229). Household survey reports of prescription drug use have also been shown to under-report prescription drug expenditures when compared against actual pharmacy records (Berk, ML, Schur, CL, and Mohr, P, "Using Survey Data to Estimate Prescription Drug Costs," *Health Affairs*, Fall 1990, pp. 231-243). The level of under-reporting for prescription drugs has been estimated to be about 23 percent. The

MCBS data used in this analysis were corrected for under-reporting assuming 15.0 percent under-reporting for total health expenditures and 22.7 percent under-reporting for prescription drugs.

Projections for expenditures in years after 1996 (the last year of actual data) were made using trend data from HCFA forecasts of future health and drug expenditures. The per capita total health expenditures and prescription drug expenditures for the elderly found in the MCBS data for 1996, as described above, were increased for the years 1997 to the year 2010 by the annual rate of growth for similar per capita expenditures found in the HCFA forecast of future health expenditures (Health Care Financing Administration, Office of the Actuary, National Health Statistics Group). The number of elderly persons in the population was taken from U.S. Bureau of the Census data and projections (*Resident Population Estimates of the U.S. by Age and Sex: 1990-1995*, Population Estimates Program, Population Division, U.S. Bureau of the Census, Nov 26, 1999 [http://www.census.gov/population] and *Resident Population of the U.S.: Middle Series Projections for 1996-2010*, U.S. Bureau of the Census, March 1996 [http://www.census.gov/population/projections/www/natproj.html]). Elderly population expenditure estimates for the years 1997 to 2010 were made by multiplying estimated per capita expenditures times the estimated number of elderly persons expected in each year. All projections assume there are no legislative changes affecting drug pricing or coverage for persons age 65 and older.

State level estimates are reported for the top 25 states by drug expenditures. Also, the state estimates were made using only states with 100 or more sample subjects in each year from 1992 to 1996. The individual subject expenditures were multiplied by the cross-sectional weights to estimate the state-level expenditures.

CREDITS

This report was written by:

Amanda McCloskey

Director of Health Policy Analysis, Families USA

The following Families USA staff contributed to the preparation of this report:

Ron Pollack, Executive Director

Peggy Denker, Director of Publications

Nancy Magill, Production Assistant

Christopher Fellabaum, Administrative Assistant

Data for this report were developed by:

Stephen W. Schondelmeyer, Pharm.D., Ph.D.

PRIME Institute

University of Minnesota

Cover Design by:

Gallagher Wood Design

Cover Illustration by:

John M. Yanson