

# Today's Research on Aging

PROGRAM AND POLICY IMPLICATIONS

Issue 2, April 2007

## Prescription Drugs and Medicare

Out-of-pocket payments for health care services have increased as the cost of health care has risen. Economic arguments in favor of higher out-of-pocket expenses suggest that people make better and more cost-effective health care decisions when they pay for health services at the time they receive these services and when the amount they pay is related to the cost of these services. Policymakers and regulators must, however, also consider the effect of out-of-pocket expenses on certain groups such as low-income persons, the elderly, and the chronically ill.

This newsletter reviews trends in prescription drug spending and research findings concerning the effect of benefit caps and implications for Medicare costs.

### Spending on Prescription Drugs

In the United States, national spending on prescription drugs has risen steadily over the past 20 years and is expected to continue to rise (Poisal et al. 2007). Both the rising cost of prescription drugs and the increased use of prescription drugs contributed to this growth in spending. Between 1990 and 2005, the proportion of national spending on

drugs paid by government programs slowly increased, from 18 percent to 27 percent, while the proportion paid out-of-pocket by individuals rapidly declined, from 55 percent to 25 percent (see figure). Payment for prescription drugs by private insurance increased until 2001, and then began to slowly decline.

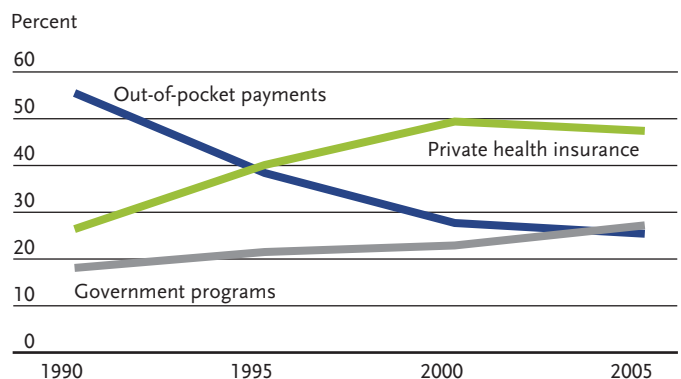
With the full implementation of Medicare Part D in 2006, payment for prescription drugs shifted substantially from private payers to government, and within government programs from Medicaid (a program for low-income individuals) to Medicare (a program for the elderly). Private expenditures (insurance plus out-of-pocket costs) went from 72 percent of national spending on prescription drugs in 2005 to 61 percent in 2006. Government expenditures on prescription drugs rose to nearly 40 percent of all national spending on prescription drugs, with Medicaid spending declining from 19 percent to 11 percent and Medicare spending rising from 2 percent to 22 percent (Poisal et al. 2007).

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- Eligible Beneficiaries Not Enrolled
- Who Is in the Gap?
- Medical Consequences of Benefit Gaps
- Benefit Caps Could Delay Needed Care for Chronic Diseases

This review summarizes research related to the objectives of the National Institute on Aging, with emphasis on work conducted at the NIA demography centers. Our objective is to provide decisionmakers in government, business, and nongovernmental organizations with up-to-date scientific evidence relevant to policy debates and program design. These newsletters can be accessed at [www.prb.org/TodaysResearch.aspx](http://www.prb.org/TodaysResearch.aspx).

**The out-of-pocket share of total national spending on prescription drugs has been declining for more than 10 years.**



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group ([www.cms.hhs.gov/NationalHealthExpendData](http://www.cms.hhs.gov/NationalHealthExpendData), accessed April 9, 2007).

In 2004, before full implementation of Medicare's prescription drug program, the median cost of prescription drugs per person was \$352 among those people with medical expenses. For persons ages 65 and older, the median cost was \$1,285. On average, among the elderly, three-quarters of these expenses were individual out-of-pocket expenses or private insurance costs (see table). Among those with only Medicare insurance, out-of-pocket expenses represented the lion's share, about 78 percent of their prescription drug costs.

One important feature of the drug coverage offered under Medicare's prescription drug program is a benefit gap called the "donut hole." Here is how it works in the standard 2007 Medicare drug plan: Enrollees are charged a \$265 deductible and then 25 percent copayments for their first \$2,400 in total prescription drug costs. But they must pay 100 percent of the next \$3,051 of drug costs. This is the so-called "donut hole" in coverage, which amounts to about \$3,850 in out-of-pocket costs. Enrollees are responsible for only a 5 percent copayment for additional prescription drug purchases during the year. Only about one in 10 Medicare prescription drug plans available nationwide offers the standard plan. However, alternative plans are required to offer benefits of at least the equivalent gross value and the same net value. So plans that cost more must offer that much more value in benefits. Most alternative plans do, however, still have a benefit gap.

### Eligible Beneficiaries Not Enrolled

Failure to enroll in prescription drug plans for which one is eligible may be the greatest benefit gap. An NIA-supported study of failure to enroll in Medicare Part D found that, as of June 2006, just over 7 percent (2.66 million) of those eligible for Medicare prescription drug coverage had not enrolled (Heiss, McFadden, and Winter 2006). Among those who failed to enroll early are healthy persons who use

no prescription drugs and may reasonably delay coverage, but who may get future benefits at a lower cost by enrolling. Also of concern among those not enrolled are people who currently use prescription drugs but have no insurance coverage for drugs and would benefit immediately from enrollment.

The above two groups of non-enrollees include a relatively high share with a high school education or less, suggesting that evaluation of the enrollment options may have been difficult or confusing for them. In survey responses, non-enrollees found the process complicated, reported having difficulty determining whether specific medications are covered, and said they did not have enough information to determine if they would benefit. Many of the problems in providing information to beneficiaries during the early enrollment period have been overcome. However, the array of plans and the process of determining which plans, if any, are in the beneficiary's interest may remain difficult for a substantial segment of the eligible population.

Ongoing research using the Health and Retirement Study (HRS) also suggests that those who have lower cognitive abilities report significantly more difficulty understanding enrollment options and have significantly more problems making the best choice among plans (McArdle 2006). Cognitive abilities measured in the HRS include mental alertness, verbal and numerical abilities, and memory. These skills are known to be important in understanding and interpreting information, and they also vary with education.

### Who Is in the Gap?

Most Medicare prescription drug plans in 2006 included a coverage gap, and most enrollees were in plans with a gap (Cubanski and Neumann 2007). Only 12 percent of enrollees in 2006 had any coverage for drugs in the benefit gap. Of these, only a third had coverage for brand-name drugs.

### In 2004, over one-half of spending on prescription drugs by the elderly was out-of-pocket.

	Percent Spending				
	Out-of-pocket	Private insurance	Medicare	Medicaid	Other
65+ Medicare and other public	28.9	0	6.0	62.0	3.4
65+ Medicare and private	49.7	35.6	6.9	2.0	6.3
65+ Medicare only	77.6	0	9.8	0	12.6
65+	53.7	20.5	7.5	11.0	7.5
Under age 65	36.2	44.6	0.6	16.0	2.6

Source: Agency for Healthcare Research and Quality, Prescription Medicines, Mean and Median Expenses per Person With Expense and Distribution of Expenses by Source of Payment: United States, 2004, Medical Expenditure Panel Survey Component Data.

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Because some enrollees are eligible for Medicaid or are part of the low-income population who have subsidized gap coverage, not all enrollees will be affected if they reach the gap. In 2006, 48 percent of all Part D enrollees (10.9 million) in Medicare were liable for their next \$2,850 in drug costs once they reached the threshold where the coverage gap began.

### Medical Consequences of Benefit Gaps

When people spend a considerable portion of their financial resources on health care, they may not have enough to spend on other basic needs, or they may fail to follow the required course of treatment. In one study, researchers estimated that the rise in out-of-pocket medical expenses during the last years of a spouse's life significantly diminished the financial well-being of the surviving spouse and increased poverty (McGarry and Schoeni 2005). In other studies, researchers demonstrated that increasing copayments for prescription drug benefits may adversely affect health behavior (Goldman et al. 2004, 2006; Hsu et al. 2006; Tseng 2004).

Understanding how prescription drug benefit caps and coverage gaps affect medication use is critical to estimating how Medicare drug benefits may affect future Medicare costs. Studies have compared managed care Medicare beneficiaries with prescription drug benefit caps to those without benefit caps. These studies identified several harmful effects of benefit caps (Hsu et al. 2006; Tseng 2004).

Beneficiaries with benefit caps had:

- Lower use of prescribed medication;
- Higher rates of visits to emergency departments;
- Higher hospitalization rates for nonelective procedures;
- Higher death rates; and
- Higher rates of noncompliance and poorer clinical outcomes among beneficiaries using drug therapy for chronic conditions such as diabetes and hypertension.

Although beneficiaries in plans with caps have substantially lower drug costs, these savings are offset by the cost of hospitalization and emergency department visits.

Based on the association between the level of copayment required and how patients comply with cholesterol-lowering drug therapy, Goldman, Joyce, and Karaca-Mandic (2006) estimated that more than \$1 billion would be saved annually by reducing copayments for those patients who would benefit the most from therapy with those drugs. Patients with lower copayments had higher compliance rates. Higher compliance translates into fewer hospitalizations and fewer emergency department visits.

### What This Means: Benefit Caps Could Delay Needed Care for Chronic Diseases

A major proportion of health care spending in the United States is related to the treatment of chronic disease. The rise in health care spending is associated with increased diagnosis and treatment of chronic diseases as a result of rises in obesity and reductions in the clinical thresholds for treating cardiovascular disease (Thorpe et al. 2005). Efforts to save money on health care spending by limiting benefits have the potential to produce exactly the opposite result if the treatment of chronic conditions deteriorates and results in costly hospital and emergency department visits.

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## The NIA Demography Centers

The National Institute on Aging supports 13 research centers on the demography and economics of aging, based at the University of California at Berkeley, the University of Chicago, Harvard University, the University of Michigan, the National Bureau of Economic Research, the University of North Carolina, the University of Pennsylvania, Pennsylvania State University, Princeton University, RAND Corporation, Stanford University, the University of Southern California/University of California at Los Angeles, and the University of Wisconsin.

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## For More Information

### Medicare Prescription Drug Benefit—An Updated Fact Sheet

[www.kff.org/medicare/7044.cfm](http://www.kff.org/medicare/7044.cfm)

### Health Affairs (Sept. 26, 2005, Web Exclusive)

[www.healthaffairs.org/WebExclusives.php](http://www.healthaffairs.org/WebExclusives.php)

### Search Health and Retirement Survey (HRS) Online Bibliography

<http://hrsonline.isr.umich.edu/biblio/index.html>

### Daniel McFadden, "Free Markets and Fettered Consumers," American Economics Association Presidential Address, Jan. 7, 2006

<http://emlab.berkeley.edu/users/mcfadden/aea/presidentialaddress.pdf>



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