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# ISSUE BRIEF

AMERICAN ACADEMY of ACTUARIES

## Providing Prescription Drugs to Seniors: A Patchwork of Coverage

*Prescription drug coverage for seniors is a key issue being debated at both the federal and state levels. Increasing costs of drugs, high utilization by the elderly, and declining access to reasonable and affordable coverage highlights the debate on what to do about providing prescription drug coverage for seniors.*

*There are a number of possible alternatives to adding a prescription drug benefit to Medicare, such as continuing or encouraging prescription drug coverage through existing mechanisms, or considering a rollout of a pilot program to assess the impact of plan designs, adverse selection and pricing on the overall costs of providing prescription drug benefits to Medicare beneficiaries.*

*The American Academy of Actuaries' prescription drug work group believes the data on prescription drug coverage should be studied further before such a benefit is added to Medicare. The desire to move quickly to provide a Medicare prescription drug benefit should be weighed against the financial impact it will have on the program, which faces urgent financial problems that will continue to accelerate if not addressed.*

*The prescription drug work group developed this issue brief to outline the programs available in the private sector that provide prescription drugs for seniors and to further discuss issues related to prescription drug coverage for this population. This issue brief complements the monograph, "Providing Prescription Drug Coverage for Medicare Beneficiaries," which was released in July 2000 and is available on the Academy's website at [www.actuary.org](http://www.actuary.org).*

*The American Academy of Actuaries is the public policy organization for actuaries of all specialties within the United States, providing clear actuarial analysis to elected officials, regulators and the news media.*

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### Introduction

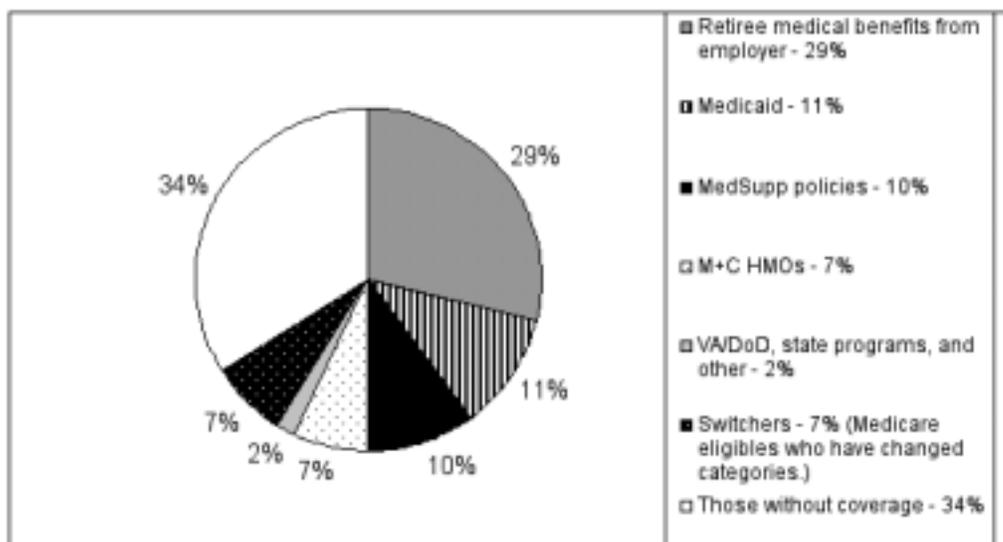
From 1993 to 1998, prescription drug spending grew at twice the rate of total national health spending, and drug cost increases have grown at double-digit rates since 1995.<sup>1</sup> This trend has had a significant impact on seniors (those age 65 or older) who generally have more acute and chronic conditions requiring treatment by prescription drugs. The proportion of annual total household expenditures that consumers aged 65 and over spend out-of-pocket on prescription drugs (2.7%) is more than two times greater than that for ages 55-64, and almost three times as large as all consumers (1.0%).<sup>2</sup>

The high cost of new prescription drugs, increases in utilization and unit cost of older drugs, and the reduction in the availability of employer alternatives for drug benefits have raised the question of how prescription drug coverage should be provided to seniors. This issue brief outlines the programs currently available in the private sector for seniors and further discusses some of the issues related to providing prescription drug coverage to this population.

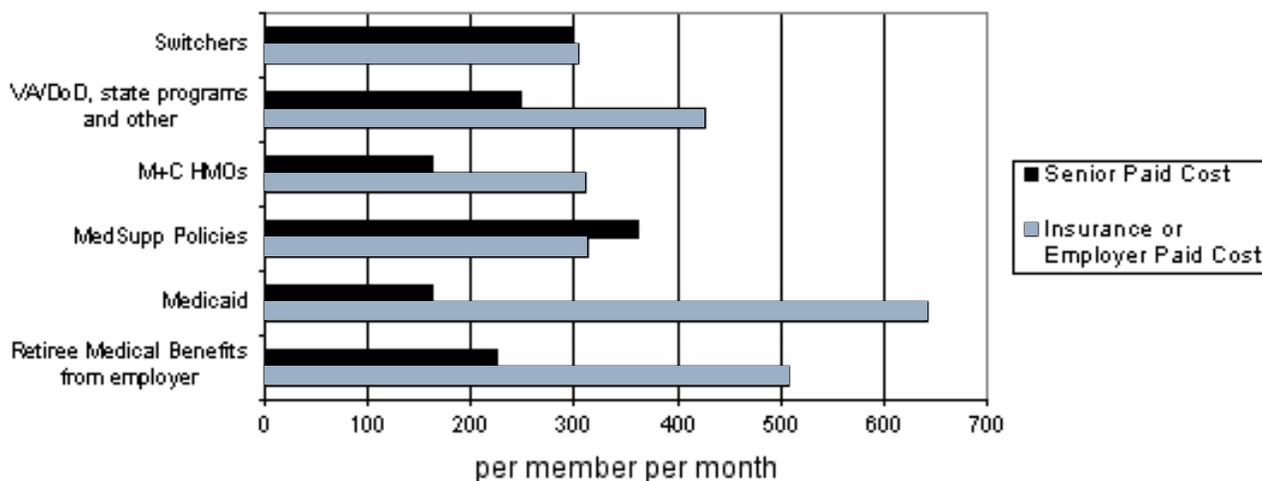
## Prescription Drug Coverage Options

Prescription drugs are an essential part of health care for many senior citizens and, arguably, have improved their quality of life. Prescription drug coverage for the elderly is a “patchwork” of various types of coverage frequently determined by employment history, income, and geography. Seniors may participate in one of six major types of programs: retiree medical benefits from prior employers, Medicaid, Medicare+Choice (M+C) health plans, Medicare supplement policies, Veterans Administration (VA) or Department of Defense (DoD) coverage, or state drug subsidy programs. Charts 1A and 1B provide a 1995 estimate of the amount of coverage available to those seniors eligible for Medicare<sup>3</sup> and the approximate 1995 costs:

**Chart 1A**  
**Prescription Drug Coverage for**  
**Medicare Eligibles 1995 (% by source)**



**Chart 1B**  
**Medicare Eligibles**  
**Estimated Average Drug Expenditures in 1995**



Tables include Disabled, Aged – non-institutionalized. The percentages by category in Table 1A have not significantly changed since 1995 and are, therefore, still applicable today.

*Source:* Davis, et al, “Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries,” *Health Affairs*, Jan/Feb 1999.

### ***Retiree Medical Benefits***

Many large employers provide their current retired employees with medical and prescription drug benefits as an inducement to employment, as part of union bargaining agreements, or for other reasons. However, employers have drastically reduced or eliminated coverage for many future retirees or have increased retiree contributions. From 1993 to 2000, the percent of employers offering retiree medical coverage to future retirees age 65 and over has dropped from 40% to 24%.<sup>4</sup> The proportion of seniors covered by retiree medical benefits and the extent of such coverage may continue to drop in the future.

### ***Medicaid***

For many low-income seniors, Medicaid provides a very high level of health care benefits (including prescription drugs) if their income or assets meet the state-specific eligibility tests. Medicaid typically provides “first dollar” benefits (i.e., no deductibles or co-payments) since it is assumed that eligible seniors do not have sufficient income to cover any required out-of-pocket payments. Eligibility for coverage also varies greatly from state to state; a senior who qualifies in a “generous” state might not be eligible in one with stricter income standards.

### ***Medicare Supplement Policies***

Medicare supplement policies are purchased by seniors to pay for health care costs not covered by Medicare. The plans reimburse seniors for deductibles, co-payments or coinsurance, and defined additional benefits. Only three of the standard Medicare supplement policies (plans H, I, and J) cover prescription drugs. Those plans are limited to 50% of costs (with an up front deductible of \$250) up to an annual maximum of either \$1,250 or \$3,000, depending on the policy chosen.

Medicare supplement policies with prescription drug coverage are usually available only during the “open enrollment” window for six months following attainment of age 65 or actual date of retirement if later. Some policies with drug coverage can be purchased later, but these usually are subject to strict underwriting screens that restrict enrollment.

Most of the Medicare supplement policies with drug coverage are experiencing severe adverse selection (which occurs when a disproportionate number of individuals who are high utilizers of services enroll in a benefit plan and cause the costs of that benefit plan to be much higher than expected). In 2000, the premiums for these options frequently cost between \$200 and \$300 per month per person, a premium level that is frequently unaffordable to many seniors, except those with a high income or high prescription drug use.<sup>5</sup>

### ***Medicare+Choice Health Plans***

Until recently, M+C “risk contractors” (i.e., health plans that contracted to cover all Medicare benefits for a fixed capitation payment from the federal government) provided high levels of prescription drug coverage in certain markets (e.g., Southern California, Florida, the New York City metro area, etc.). As a result of the Balanced Budget Act of 1997 (BBA), the rate of increase in payments to M+C plans was lowered and drug coverage in most locations has been reduced or eliminated.

In addition, many M+C health plans are charging out-of-pocket premiums. For example, most M+C plans now restrict coverage to an annual maximum of \$1,000 or less in prescription drug benefits and charge premiums from \$20 to \$200 per month.<sup>6</sup> Any senior in the contract area of an M+C plan can obtain coverage. In most rural areas and many other parts of the country, however, M+C plans either do not operate, or if they operate, do not offer prescription drug coverage.

### ***Veterans Administration and Department of Defense Coverage***

A significant number of seniors are eligible for prescription drug coverage as a result of a career of service in the armed forces. This coverage usually must be provided through a VA or DoD medical facility. As a result, there is a natural limit on the amount of coverage that can be obtained, since only seniors living close to VA or DoD facilities can take full advantage of coverage. Legislation recently passed by Congress creates a “Tricare for Life” program that will likely provide high levels of prescription coverage for military retirees and their dependents.

### ***State Subsidy Programs***

Approximately 23 states have passed state-run drug subsidy programs for low-income seniors, although budgetary constraints for the programs frequently mean that states must restrict eligibility. According to a recent U.S. General Accounting Office survey, there were 14 state programs in 1999 providing supplemental pharmacy coverage to aged and disabled beneficiaries (some had started as early as 1975). The data is incomplete but it appears that there were approximately 750,000 beneficiaries receiving supplemental drug benefits during 1999. Six or seven of the states either did not report or did not have data available, or their programs had not yet taken effect.<sup>7</sup>

State expenditures for those programs can only be roughly estimated. The actual expenditures reported were approximately \$765 million for the 14 states; the New York data, which is a large part of the total, related to 1998 rather than 1999. With the establishment of these programs, state subsidies may well be more than \$1 billion at this time. This subsidy is still a relatively small part of the estimated \$43 billion in total senior drug expenditures.<sup>8</sup>

### ***Drug Cost Factors***

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A major factor contributing to high drug cost trends is a shift in the proportion of prescription drug expenditures paid by consumers to private insurers resulting in induced increases in utilization. Other factors include greater drug utilization, price increases, repatenting and repackaging of old drugs, and high prices for newly approved drugs.

For example, the annual cost per person for prescription drugs for all age groups increased 17.4% in 1999. Increases in the use of drugs accounted for 6.2% of the overall increase, while inflation accounted for 5.4% of the overall increase. Changes in the therapeutic mix of the drugs and the strength mix of the drugs accounted for 3.3% of the increase. The impact of the cost of new drugs added 1.8% to the increase. For seniors, these increases have been much greater. For instance, the increase in the use of drugs for seniors is reportedly between 10% and 11% compared to 6.2% for the overall population.<sup>9</sup>

The average number of prescriptions and amount spent per prescription are higher among individuals with prescription drug coverage. For example, Medicare-only beneficiaries (i.e., those without prescription drug coverage) spend a relatively smaller share of their health care expenses on prescription drugs.<sup>10</sup>

A recent paper from the American Academy of Actuaries outlined prescription drug trends for Medicare supplement plans. The Medicare supplement plans with prescription drug coverage showed average annual trends of 15% from 1996 to 1998, compared to annual trends of 8.7% for all other Medicare Supplement plans without these benefits.<sup>11</sup>

### ***Utilization and Price Increases***

Utilization of prescription drugs is increasing due to the aging of the population, more medical providers prescribing drugs, and promotion of drugs by pharmaceutical manufacturers to physicians and hospitals. Manufacturers have also been more aggressive in marketing directly to the consumer, and consumer access to drugs has increased, including availability through the Internet.

Increases in consumer drug expenses have been higher than manufacturer price increases because they reflect shifts from older, less expensive drugs to newer, more expensive drugs. The prices manufacturers charge for new drugs are influenced by perceived market advantages and incremental value of a therapeutic advancement, research and development costs, financing marketing efforts to stimulate sales, and higher drug pricing while they are under patent protection.

The variety of prescription drugs prescribed continues to change as a result of new drug therapies. Although generic drugs account for almost 45% of prescriptions dispensed because they are less expensive than brand

name drugs, they make up less than 20% of the dollar amount of prescription sales.<sup>12</sup> Research and development activities of pharmaceutical manufacturers are a factor in the number of new drugs available each year.

### ***Selection and Benefit Design Issues***

Seniors generally have a much higher prevalence of chronic health conditions, such as diabetes, arthritis, congestive heart failure, chronic obstructive pulmonary conditions, and obstructive diseases of the coronary arteries. These chronic conditions are usually controlled by a long-term regimen of drugs. Individuals with high drug costs associated with these chronic conditions are able to predict their own prescription drug costs for the next year with a much higher degree of certainty than is characteristic of the rest of the population. This may result in severe adverse selection for any voluntary or optional prescription drug coverage for seniors.

When considering adverse selection associated with any prescription drug benefit provided to the elderly, there are three main items to be addressed:

- The beneficiaries' ability to predict prescription drug costs may result in severe adverse selection for any voluntary or optional drug benefit in the senior market.
- The benefit design will magnify the adverse selection potential or diminish the catastrophic protection under a voluntary or optional drug benefit system. A "front loaded" (i.e., first dollar benefit) benefit design will minimize the adverse selection, but could leave the beneficiary liable for catastrophic events, while a "back-loaded" (i.e., high deductible with a long coinsurance "tail") benefit design may accentuate adverse selection and trend.
- The high correlation of prescription drug costs with other health care expenses means that adverse selection from a prescription drug benefit will carry over in the form of "collateral selection" to any associated coverage for medical care.

### **Medicare Overhaul Issue**

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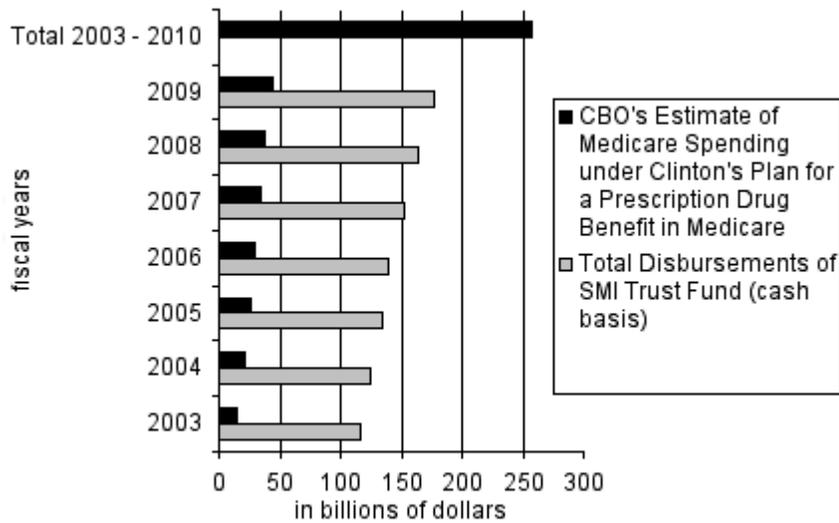
Medicare faces urgent financial problems that demand action. Recent shifts of substantial Part A benefits to Part B, large increases in FICA tax revenue due to an increased employment base, and the effects of the BBA (1997) in reducing Medicare claim costs, have created an interim improvement in Medicare experience. However, the longer term cost and demographic issues remain.

In 1999, there was a sizable increase in the Medicare Part A Trust Fund for the first time in seven years. Before 1999, increases to the FICA tax revenue and the additional income tax revenue on 35% of Social Security income from high income Social Security beneficiaries were not large enough to exceed the actual disbursements for claims and administrative costs under Medicare Part A. In spite of the favorable changes to the Part A Trust Fund, it is still expected that Medicare costs, relative to GDP, will nearly double in the next 30 years.

Serious imbalances in the financing of Medicare are already evident and will continue to accelerate without major congressional action. The magnitude of the financial problems raises the possibility that continuing the Medicare program, in its current form, may not be possible in the future.

The following chart shows the projection of total cash disbursements of the SMI Trust Fund for Part B expenditures between 2003 and 2009. It also shows the effect of adding a universal Medicare prescription drug benefit program as proposed by President Clinton in 2000. The prescription drug expenditure adds approximately 13% in the year 2003 to Part B expenditures and 25% in the year 2009. A major unknown in all of the proposals is the effect of possible price controls on prescription drugs and the pharmaceutical industry. The use of formularies, including negotiated discounts or exclusion of many drugs because of cost or other considerations, makes the cost estimates very speculative.

## SMI Trust Fund Disbursements vs. Cost of Clinton Rx Drug Proposal



*Source:* Congressional Budget Office Testimony, “A CBO Analysis of the Administration’s Prescription Drug Proposal”, May 11, 2000.

*Source:* 2000 Annual Reports of the Board of Trustees of the Supplementary Medical Insurance Trust Funds, Table II.D1, “Operations of the SMI Trust Fund (Cash Basis) during Fiscal Years 1970-2009”.

## Conclusion

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Prescription drug coverage for the elderly was a dominant topic during the presidential campaign in 2000 and continues to be a key health care issue at the federal level. Increasing costs of drugs, high utilization by the elderly, and declining access to reasonable and affordable coverage continues to highlight the debate on what to do about providing prescription drug coverage for seniors. No doubt, Congress will feel even more of a need to address this issue quickly in light of the continuing trend of employers to no longer offer retiree coverage for prescription drugs and other medical expenses. The desire to move quickly on this issue should be considered against the potential financial impact of providing prescription drug benefits for all seniors under Medicare.

As this issue brief indicates there are a number of possible approaches to providing prescription drug coverage through existing mechanisms, such as M+C health plans, Medicare supplement coverage, Medicaid and employer coverage. There are advantages to continuing private coverage voluntarily, even though the problems of adverse selection may be serious and affordability problems may result. A major objective of some proposals is to maintain the level of current sources of support for retiree prescription drug programs and to minimize major additional cost directly through the Medicare program.

There are still many unknowns related to the impact of providing prescription drug coverage for the Medicare population. However, the American Academy of Actuaries encourages further study of the data. It would be advantageous to examine data from state programs such as those in Massachusetts and Pennsylvania. It would also be beneficial to consider a rollout of a pilot program to test the impact of certain types of plan designs, adverse selection, and pricing on the overall costs of providing prescription drug benefits to Medicare eligibles.

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<sup>1</sup> Kaiser Family Foundation, "Prescription Drug Trends," September 2000.

<sup>2</sup> Kaiser Family Foundation, "Prescription Drug Trends, A Chartbook," July 2000.

<sup>3</sup> Medicare provides coverage for almost 98 percent of the population age 65 and over.

<sup>4</sup> William M. Mercer, "National Survey of Employer-Sponsored Health Plans 1999."

<sup>5</sup> Families USA, "Cost Overdose: Growth In Drug Spending For The Elderly," July 2000.

<sup>6</sup> Medicare Health Plan Comparison Database ([www.medicare.gov/mphCompare/home.asp](http://www.medicare.gov/mphCompare/home.asp))

<sup>7</sup> General Accounting Office, "State Pharmacy Programs: Assistance Designed To Target Coverage And Stretch Budgets," September 2000.

<sup>8</sup> Families USA, "Cost Overdose: Growth In Drug Spending For The Elderly," July 2000.

<sup>9</sup> Express Scripts, "1999 Drug Trend Report," June 2000.

<sup>10</sup> AARP Public Policy Institute Research Group, "Out-of-Pocket Spending on Health Care by Medicare Beneficiaries Age 65 and Older: 1999 Projections," December 1999.

<sup>11</sup> American Academy of Actuaries' Medicare Supplement Insurance Work Group, "Report to the National Association of Insurance Commissioner," June 2000.

<sup>12</sup> Kaiser Family Foundation, "Prescription Drug Trends, A Chartbook," July 2000.



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