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Drug Coverage for Medicare Beneficiaries: Why Protection May Be in Jeopardy

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Following a period of growth over the last decade, trends suggest that Medicare beneficiaries' access to affordable prescription drug benefits has begun to decline. Since the late 1990s, the engines that had been driving that growth—employer health plans and Medicare HMOs—have been offering increasingly less generous benefits to fewer people. There is no evidence that the private market or current public programs can reverse this decline in the coming years.

This analysis evaluates trends in prescription drug coverage for Medicare beneficiaries during the 1990s as a way to project their future coverage, costs, and needs. Projections are based on data from 1993 to 1998, the most recent year for which published data are available. The results indicate that beneficiary drug coverage peaked in that year, or shortly thereafter, and has been in decline ever since. Even while coverage was expanding, beneficiaries' spending on prescriptions was on the rise: the elderly with drug benefits spent 35 percent more out-of-pocket in 1998 than they did in 1993.

The prescription coverage outlook for Medicare beneficiaries will most likely further deteriorate without concerted and timely government action. If access to affordable drug benefits is not greatly expanded, elderly Americans—most of whom already make do on modest or low incomes—will find it even more difficult to obtain the medications they need.

Beneficiary Drug Coverage and Spending 1993–98[1]

Trends in Prescription Coverage

From 1993 to 1998, the number of beneficiaries with some prescription coverage increased from 64.6 percent to 76.0 percent of

From 1993 to 1998, prescription coverage through employer-based plans was the most important source of drug benefits. However, these plans offered little growth in coverage after 1995.

the Medicare population (Table 1).[2] The most rapid expansion occurred from 1994 to 1997, when coverage grew from 4 to 6 percent per year. The growth rate slowed to less than 2 percent from 1997 to 1998.

This pattern of growth was far from uniform across the various sources of prescription coverage available in the 1990s. Beneficiaries with a single source of prescription benefits in a given year accounted for most of the increase (Table 1). Medicare HMO enrollments accounted for nearly all the growth in coverage for these individuals, rising from just 4 percent of beneficiaries in 1993 to almost 13 percent in 1998. Prescription coverage from employer-sponsored plans represented the single most important source of drug benefits during the period, reaching nearly 29 percent of the beneficiary population by 1998. However, employer plans offered little growth in coverage after 1995. Prescription coverage under self-purchased Medigap plans peaked a year earlier, in 1994, at nearly 10 percent of the Medicare population, but declined to 8 percent by 1998. Even larger declines were recorded for publicly funded plans—Medicaid and other programs such as state pharmacy assistance programs and Veterans Administration programs. Taken together, drug coverage under public plans dropped from 16 percent of the Medicare population in 1993 to less than 13 percent in 1998.

These shifting patterns reflect only one aspect of how prescription coverage for Medicare beneficiaries changed during the 1990s. Table 1 shows that the proportion of beneficiaries with evidence of drug coverage from multiple sources grew from 11 percent to about 14 percent during the period. We estimate that about a third of these individuals were able to maintain continuous coverage by switching from one plan to another during the year (Stuart, Shea, and Briesacher 2001), while the rest had sporadic coverage from various sources. However, even larger numbers of beneficiaries were unable (or perhaps unwilling) to maintain continuous prescription coverage from their primary source of

Table 1

Prescription Drug Coverage of Medicare Beneficiaries by Source, 1993–1998[a]

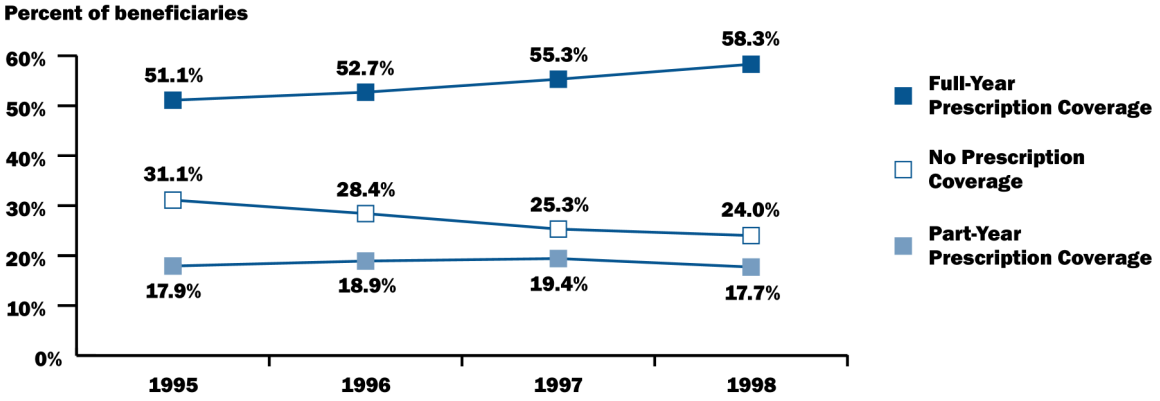
Sources of Prescription Coverage	1993	1994	1995	1996	1997	1998	Percent Change 1993–98
All sources	64.6%	65.3%	68.9%	71.6%	74.7%	76.0%	17.7%
Beneficiaries with a single source of coverage	53.4%	54.0%	57.8%	58.5%	60.0%	62.1%	16.3%
Employer-sponsored	25.6	25.9	27.9	28.2	28.0	28.7	12.2
Medigap	7.8	9.6	8.5	8.9	8.6	8.1	4.1
Medicare HMO	4.1	5.0	7.4	8.2	10.7	12.9	211.6
Medicaid	11.3	11.5	9.9	9.3	9.1	8.9	–21.1
Other public	4.6	4.7	4.2	3.9	3.6	3.6	–22.1
Beneficiaries with multiple sources of coverage[b]	11.2%	11.3%	11.1%	13.1%	14.7%	13.9%	24.1%

[a] Noninstitutionalized beneficiaries with full-year Medicare enrollment.

[b] Includes small numbers of beneficiaries with evidence of third-party payments for prescription drugs but no identified benefit plan.

Source: Medicare Current Beneficiary Surveys, 1993–1998.

Figure 1
Stability of Prescription Drug Coverage Among Noninstitutionalized Medicare Beneficiaries, 1995–1998



Source: Medicare Current Beneficiary Surveys, 1995–1998.

drug benefits. In all, 17 to 19 percent of beneficiaries had coverage for only part of the year from 1995 to 1998 (Figure 1).[3] Further, among people with some coverage, those with continuous coverage decreased from 74 percent in 1995 to 72 percent in 1998.

Trends in Prescription Spending

Table 2 presents data from 1993 and 1998 showing changes in total and out-of-pocket prescription spending for Medicare beneficiaries.[4] Total drug expenditures per person increased dramatically regardless of prescription coverage status, although growth in spending was slower for those without coverage. In 1993, beneficiaries with no drug benefits incurred prescription drug expenditures just 60 percent of those of people with some form of coverage. By 1998 that fraction had declined to 55 percent. For beneficiaries with coverage, growth in per-person drug expenditures was greatest for "dual eligible" Medicare/Medicaid recipients and least for those enrolled in other public programs.

For beneficiaries without drug coverage, the increase in their out-of-pocket spending on prescription drugs equaled the change in their total spending on prescriptions—51 percent. However, those who had benefits paid 35 percent more out-of-pocket in 1998 than they did six years earlier. Clearly, the additional coverage did not protect these beneficiaries from rising prescription costs.

The most dramatic percentage increase in out-of-pocket drug spending occurred among Medicare HMO enrollees. From 1993 to 1998, Medicare HMO enrollees saw their out-of-pocket costs more than double, to 40 percent of their total drug expenditures. Although high, this pales before the 67 percent paid out-of-pocket by beneficiaries with only Medigap coverage in 1998. Medigap policies with prescription benefits covered only one-third of Medicare beneficiaries' prescription drug expenses. The only two sources of drug coverage that provided significant protection to beneficiaries in 1998, compared with 1993, were Medicaid and employer-sponsored plans.

Another way to measure the level of protection that prescription coverage provides is to examine out-of-pocket spending as a percent of beneficiary income. Figure 2 shows that, despite expanding drug coverage in the 1990s, more Medicare beneficiaries spent

Medigap policies with prescription benefits covered only one-third of Medicare beneficiaries' prescription drug expenses.

Table 2
Total Prescription Spending and Out-of-Pocket Prescription Spending for Medicare Beneficiaries by Presence and Source of Drug Coverage, 1993–1998[a]

Presence and Source of Prescription Coverage	Total Prescription Spending			Out-of-Pocket Prescription Spending			Out-of-Pocket Spending as a Percent of Total Prescription Spending		
	1993	1998	Percent Change 1993–98	1993	1998	Percent Change 1993–98	1993	1998	Percent Change 1993–98
No coverage[b]	$368.90	$ 555.42	50.5%	$368.91	$555.32	50.5%	100.0%	100.0%	0.0%
Any coverage	615.13	1007.08	63.7	241.09	326.49	35.4	39.2	32.4	–30.4
Percent difference	60.0%	55.1%		153.0%	170.1%				
Beneficiaries with a single source of coverage									
Employer-sponsored	$637.36	$1101.97	72.9%	$247.33	$288.04	16.5%	38.8%	26.1%	–32.6%
Medigap	519.08	852.44	64.2	370.47	569.58	53.7	71.4	66.8	–6.4
Medicare HMO	395.90	679.28	71.6	122.02	273.03	123.8	30.8	40.2	30.4
Medicaid	636.38	1223.00	92.2	128.70	174.51	35.6	20.2	14.3	–29.4
Other public	729.24	1116.30	53.1	281.24	484.84	72.4	38.6	43.4	12.6
Beneficiaries with multiple sources of coverage[c]	$643.60	$1038.19	61.3%	$277.64	$370.96	33.6%	43.1%	35.7%	–17.2%

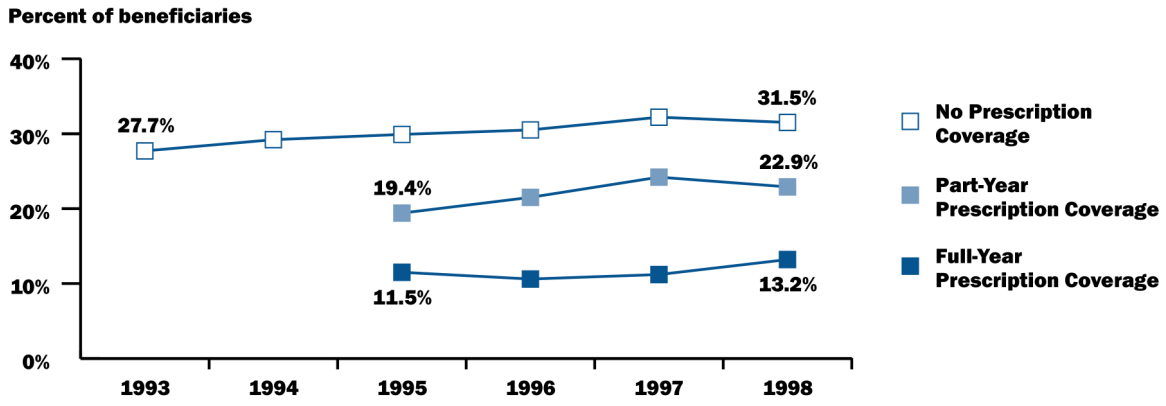
[a] Noninstitutionalized beneficiaries with full-year Medicare enrollment.

[b] Total spending and out-of-pocket spending differ because of the small group of medications covered by Medicare.

[c] Includes small numbers of beneficiaries with evidence of third-party payments for prescription drugs but no identified benefit plan.

Source: Medicare Current Beneficiary Surveys, 1993–1998.

Figure 2
Proportion of Medicare Beneficiaries Spending 5 Percent or More of Income on Prescriptions, by Drug Coverage Status, 1993–1998



Source: Medicare Current Beneficiary Surveys, 1993–1998.

5 percent or more of their incomes on prescriptions in 1998 than in 1993. The trend holds regardless of whether they had prescription drug coverage or not. By 1998, almost one-third of all beneficiaries without coverage spent more than 5 percent of their income on prescriptions. A much smaller fraction of people with full-year drug benefits fell into this category, but the trend is upward just the same. Those with part-year drug coverage were about twice as likely to spend 5 percent or more of income on drugs compared with those with full-year coverage.

Beneficiary Drug Coverage and Spending Since 1998

Our empirical analysis ends at what may have been the high point in drug coverage for Medicare beneficiaries. There are good reasons to believe that, if coverage did not peak in 1998, then it did shortly thereafter. Recent developments in premiums and offer rates for private sources of drug benefits from employers, private insurers, and Medicare+Choice managed care plans all point in that direction.

New retirees may not be as fortunate as those in the 1990s. Although employer-sponsored health insurance plans were a stable and generous source of drug benefits at least until 1998, recent data cast doubt on the sustainability of such coverage. Periodic surveys conducted by Hewitt Associates show continued erosion in the number of large employers offering retiree health benefits, dropping from 80 percent in 1991 down to 66 percent by 1999 (Hewitt Associates 1997; 1999). When asked if they are seriously considering further retrenchment, 30 percent of the employers interviewed in 1999 indicated they would consider dropping all retiree coverage in the next three to five years, and 40 percent said they would consider cutting back on prescription benefits (Hewitt Associates 1999). These are particularly ominous findings because large employers have traditionally been much more likely to offer retiree health benefits than small employers. Because employers typically grandfather current retirees when making benefit policy changes (McArdle 2000), the impact of these changes should accelerate with the influx of new retirees into the Medicare system.

Medicare beneficiaries without access to employer-sponsored health benefits can buy individual Medigap policies that offer limited prescription coverage (up to $1,250 after deductible and coinsurance payments for the standard H and I plans, and up to $3,000 for plan J). Some beneficiaries have access to non-standardized policies with more generous drug coverage, either because they live in a state exempt from the 1989 federal law authorizing the standardized plans or because they continued to renew policies purchased prior to July 1992, when the federal law took effect.[5] A recent study by Chollet (2001) found that most Medigap policyholders with drug benefits bought their coverage before 1992. This would help explain the decline in Medigap coverage rates after 1994, noted in Table 1, as older policyholders die and fewer new retirees take up coverage. Indeed, this movement may accelerate in the future if Medigap premium rates continue to climb. From 1998 to 2000, the premiums for Medigap policies with drug coverage rose 37 percent, more than twice the increase for Medigap policies without drug coverage (Weiss Ratings 2001).

Despite expanding drug coverage in the 1990s, more Medicare beneficiaries spent 5 percent or more of their incomes on prescriptions in 1998 than they did in 1993.

Medicare HMOs Drop Out

Medicare HMOs typically included prescription drug benefits in the 1990s, making them an attractive option. As late as 1997, virtually all Medicare+Choice HMO plans offered prescription benefits (Poisal and Murray 2001). But by 2001, only 70 percent did so (Gold 2001). The cost to beneficiaries enrolling

More than 300 HMOs have dropped out of Medicare+Choice since 1999, leaving beneficiaries with fewer choices.

in Medicare+Choice plans has also risen sharply. In 1999, 80 percent of plans offered zero-premium policies (i.e., premiums equal to the Part B monthly amount). By March 2001, only 46 percent of plans had zero premium options (Gold 2001). Compounding the financial burden, the extra premiums buy less coverage today. In 1999, 36 percent of Medicare+Choice plans offered drug coverage with an annual benefit cap greater than $1,000. By 2001, that had dropped to 22 percent (Gold 2001).

These numbers have received less public attention than HMOs dropping out of the Medicare+Choice program in the last two years. More than 300 plans have left the program since 1999, leaving beneficiaries with fewer choices. In 2001, 67 percent of beneficiaries lived in regions served by one or more Medicare+Choice plans, down from 72 percent in 1999. Total Medicare+Choice enrollments dropped by nearly 1 million people during this two-year period (Gold 2001). In an attempt to turn these trends around, Congress passed the Benefits Improvement and Protections Act (BIPA) in 2000. The early evidence suggests that BIPA has had minimal effect (Gold and Achman 2001). The Medicare program anticipates that plan withdrawals will affect several hundred thousand beneficiaries in 2002, as the five largest Medicare HMOs all announced dropping business in next year's Medicare+Choice filings (Appleby 2001). Even if the number of plans stabilizes, the combination of rising premiums and reduced drug benefits will make Medicare+Choice plans a less desirable choice for beneficiaries in search of prescription coverage.

Rising Drug Costs a Major Factor in Declining Coverage

The rising cost of prescription drugs places beneficiaries' coverage in jeopardy. Expenditures on prescription drugs increased an estimated 19 percent from 1999 to 2000, capping four years of double digit increases (NIHCM 2001). Moreover, it is projected that the rate of growth will be about 15 percent annually through 2004 (Mullins et al. 2001). The increases are fueled by price, volume, and, most importantly, a steady shift to newer, more expensive therapies. Our trend analysis showed that Medicare beneficiaries who have no prescription coverage feel the impact of increasing prescription costs most keenly. But even those with coverage feel the effects through higher premiums, reduced benefits, and fewer choices of coverage. If the forecasts prove correct, there is little relief in sight.

Taken together, these findings suggest that the increased availability of prescription coverage in the mid-1990s will not continue and has already begun to decline. There is no evidence that either the private market or public programs as currently designed can solve the problem of prescription coverage for Medicare beneficiaries in the coming decade. In fact, our analysis of the six-year period from 1993 through 1998 showed that out-of-pocket prescription costs rose continually even as prescription coverage was rising.

These data, together with projections for the future, presage a looming crisis in the elderly's access to prescription drugs if nothing is done soon to address the situation. Adding prescription coverage to the Medicare benefit package is the only sure solution.

Notes

[1] Our estimates come from the Medicare Current Beneficiary Survey (MCBS) Cost and Use files for 1993–1998. Each annual sample consists of all beneficiaries with full-year Medicare entitlement who live outside of a facility for at least part of the year. (We exclude a small group of people who were newly entitled or died during the year in order to distinguish those with full-year and part-year drug coverage. People who live in facilities are omitted because prescription use is not captured in the MCBS.) We then classified individuals according to whether or not they have any prescription coverage and, if so, the source of coverage. The sources of coverage included employer-sponsored plans, Medicare HMOs, Medigap plans, Medicaid, and "other" coverage sources, including state pharmacy assistance plans, Veterans Administration coverage, and unknown sources of private coverage. In cases where people had more than one source of coverage or had third party payments for prescription fills but did not report the source, we assigned them to a mixed plan category.

[2] The estimated coverage rate of 76 percent is 3 percentage points higher than the figure in Poisal and Murray (2001). They base coverage on the full-year and part-year Medicare population while we use only the full-year enrolled population. The difference means that beneficiaries who are not enrolled in Medicare for the entire year have lower drug coverage rates than those who are. This difference was only 1 percentage point in 1996 (see Stuart, Shea, and Briesacher 2000). The implication is that fewer new Medicare enrollees have prescription coverage and that this trend is accelerating.

[3] Limitations in MCBS reporting preclude estimating duration of coverage for beneficiaries in 1993 and 1994.

[4] In 1998, the MCBS applied a new methodology to estimate prescription payment amounts, which increased per capita total drug spending by about 8 percent more than it would have been under the original methodology. See Poisal and Murray 2001 for a discussion of the new method.

[5] Massachusetts, Minnesota, and Wisconsin have such exemptions.

References

J. Appleby, "More HMOs to Drop Medicare Patients," *USA Today* (Sept. 20, 2001): 6B.

D. Chollet, Senate Committee on Finance, Medigap Coverage of Prescription Drugs: Testimony on "Finding the Right Fit: Prescription Drugs and Current Coverage Options," Apr. 24, 2001, 107th Congress, first session.

M. Gold, "Medicare+Choice: An Interim Report Card," *Health Affairs* 20 (Jul./Aug. 2001): 120–138.

M. Gold and L. Achman, "Rising Payment Rates: Initial Effects of BIPA 2000," *Monitoring Medicare+Choice—Fast Facts Number 6* (Washington D.C.: Mathematica Policy Research, Inc., June 2001).

Hewitt Associates LLC, *Retiree Health Coverage: Recent Trends and Employer Perspectives on Future Benefits Reforms* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, October 1999).

Hewitt Associates LLC, *Retiree Health Trends and Implications of Possible Medicare Reforms* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Sept. 1997).

M. A. Laschober et al., "Medicare HMO Withdrawals: What Happens to Beneficiaries?" *Health Affairs* 18 (Nov./Dec. 1999): 150–157.

F. McArdle, "Role of Retiree Benefits in Health Insurance's Future," [Letter] *Health Affairs* 19 (Mar./Apr. 2000): 274–275.

D. Mullins et al., "The Impact of Pipeline Drugs on Drug Expenditure Growth Trends," *Health Affairs* 20 (Sept./Oct. 2001): 210–215.

NIHCM Foundation, *Prescription Drug Expenditures in 2000: The Upward Trend Continues* (Washington, D.C.: National Institute for Health Care Management, May 2001).

J. A. Poisal and L. Murray, "Growing Differences Between Medicare Beneficiaries with and Without Drug Coverage," *Health Affairs* 20 (Mar./Apr. 2001): 74–85.

B. Stuart, D. Shea, and B. Briesacher, *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter* (New York: The Commonwealth Fund, Jan. 2000).

_____. "Dynamics in Drug Coverage of Medicare Beneficiaries: Finders, Losers, Switchers," *Health Affairs* 20 (Mar./Apr. 2001): 86–99.

Weiss Ratings, "Prescription Drug Costs Boost Medigap Premiums Dramatically," [Press Release] Mar. 26, 2001, available at www.weissratings.com/NewsReleases/Latest/index.htm.

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