POLICY BRIEF

CHRONIC CONDITIONS AND DISABILITIES: TRENDS AND ISSUES FOR PRIVATE DRUG PLANS

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CHRONIC CONDITIONS AND DISABILITIES: TRENDS AND ISSUES FOR PRIVATE DRUG PLANS

In the last decade, prescription drugs have dramatically improved the lives of people living with chronic conditions. Medications for heart disease, high blood pressure, and high cholesterol have saved many Medicare beneficiaries' lives. Similarly, anti-inflammatory medications and analgesics have alleviated the symptoms of elderly and disabled people who have arthritis and other muscle and joint problems. Although extremely helpful, such drugs can add up to thousands of dollars per year for an individual.

How can a Medicare prescription drug benefit be designed to ensure adequate coverage for individuals with multiple chronic conditions? Because of its expected drug costs, this particular population is a challenge to insure through private market approaches. Federal regulations and subsidies to maintain affordable premiums and cost-sharing will be needed to ensure access to coverage. Other consumer protections, such as benefit and plan stability requirements, would also be needed for people with multiple conditions and complex drug regimens. This brief examines how selected issues in designing a drug benefit affect people with chronic conditions and disabilities, using the House and Senate bills passed in June 2003 as examples.

Medicare Beneficiaries with Chronic Conditions

Among Medicare beneficiaries not living in a nursing facility, 92 percent have at least one chronic condition; 58 percent have between one and three; and 34 percent have four or more (Figure 1). Arthritis, hypertension, and heart disease are the three most commonly reported chronic conditions in the non-nursing home Medicare population. Other chronic conditions include cancer, osteoporosis, diabetes, lung disease, urinary incontinence, stroke, mental disorders, Alzheimer's disease, and Parkinson's disease. Among disabled beneficiaries under age 65, mental disorders replace heart disease as the third leading chronic condition. A closer examination of disabled beneficiaries' drug coverage and spending needs was conducted by Briesacher, Stuart, and colleagues.[1]

Persons with multiple chronic conditions often have very sophisticated and complex drug regimens designed to treat their conditions as well as minimize drug side effects. For instance, beneficiaries with three chronic conditions fill an average of 24

[1] Becky Briesacher, Bruce Stuart, Jalpa Doshi, Sachin Kamal-Bahl, and Dennis Shea, *Medicare's Disabled Beneficiaries: The Forgotten Population in the Debate Over Drug Benefits* (New York and Washington, D.C.: The Commonwealth Fund and the Henry J. Kaiser Family Foundation, September 2002).

prescriptions per year (Table 1). Because of the large number of prescriptions they fill, beneficiaries with multiple chronic conditions are extremely vulnerable to adverse drug interactions. Once the right combination of drugs is determined for individuals with multiple chronic conditions, changes to these regimens can be extremely problematic. Therefore, the stability of drug coverage—discussed later in this brief—is a crucial component for Medicare drug benefit proposals.

Drug Spending by Beneficiaries with Chronic Conditions

As expected, a beneficiary's annual drug spending[2] rises as the number of chronic conditions increases. Referring back to Table 1, in 2006, those with one chronic condition will spend, on average, $1,819 per year on prescription drugs. Those with five or more such conditions will average $5,673 per year. Some conditions, such as mental disorders, diabetes, and pulmonary disease, are associated with higher annual drug spending than others. The reasons for these differences relate to both the use and costs of drugs for the specified conditions and the probability of a condition's co-morbidity with other medical problems also requiring medications.

Furthermore, spending on drugs for chronic conditions is rising. Using pharmaceutical industry data, a report released by the National Institute for Health Care Management (NIHCM)[3] found that over half (53%) of the drug spending growth in the United States is attributable to drugs treating nine chronic conditions (most of which are common to the Medicare population): high cholesterol, high blood pressure, arthritis, depression, diabetes, pain, allergies, ulcers, and other gastrointestinal disorders. The report states that increases in spending on drugs treating chronic conditions are due to several factors, including a rise in the use of drugs and shifts to more costly (newer) drugs for such conditions.

Our research similarly suggests a growth in the share of beneficiaries taking medications for chronic conditions. Figure 2 depicts the distribution of beneficiaries by their level of drug spending in 1995 and 1999. When comparing 1999 to 1995, we controlled for inflation by examining both years in 2004 dollars. We found that the share of beneficiaries with annual drug spending between $251 and $5,000 increased during the four years. Conversely, the share of beneficiaries who spent $250 or less or more than $5,000 on drugs declined. This trend suggests a growth in spending on drugs for chronic

[2] Drug spending refers to the total amount paid for prescription drugs, including payments made by insurers and/or the beneficiary.

[3] National Institute for Health Care Management, *Prescription Drug Expenditures in 2001: Another Year of Escalating Costs?* (Washington, D.C.: NIHCM, May 2002).

conditions (which necessitate refills) rather than for drugs for episodic conditions, such as infections, which usually are filled only once.[4]

Affording these maintenance drugs has proven to be problematic for many beneficiaries. Research studies have found that people with chronic conditions skipped doses of medicine in order to make their medicine last longer and/or did not refill prescriptions because of cost.[5] Yet it is precisely these drugs that are likely to yield lower health expenses and longer life expectancy over time. Cholesterol-lowering drugs, such as Zocor and Pravachol, for example, averaged $121 and $104 respectively per prescription (usually monthly) in 2001, according to NIHCM. Considering that these drugs generally are prescribed for daily use over months and years, multiple refills of the prescription can translate into high annual costs.

Additionally, beneficiaries desiring to enroll in a private drug coverage plan will logically look for a plan that covers the drugs they are taking. If very strict formularies are allowed, competing plans are not likely to cover all their drugs. More flexible formularies, allowing for multiple combinations of drugs, are important to the coverage needs of Medicare beneficiaries with chronic illness.

Proposed Gap in Coverage: The "Donut Hole"

Beneficiaries with disabilities and/or chronic conditions are particularly vulnerable to exceeding spending caps proposed in both the House and the Senate bills passed in June 2003. These bills allow private plans to limit coverage of a beneficiary's drug spending up to a specified amount. Beyond this limit, there is no coverage until a much higher, catastrophic limit is reached. Consequently, this gap in coverage (often referred to as the "donut hole") leaves beneficiaries liable *in full* for all additional prescriptions until they have spent a specified catastrophic amount out-of-pocket.

Under the House bill, this gap occurs for drug spending between $2,000 and $4,900.[6] Under the Senate bill, the gap occurs for drug spending between $4,500 and about $5,800. Case studies presented in Text Box 1 provide hypothetical examples of how these coverage gaps would affect the out-of-pocket spending (liability) of beneficiaries with chronic conditions. For example, in 2006, a disabled woman under age

[4] Ibid.

[5] See Michelle Kitchman, Tricia Neuman, David Sandman, Cathy Schoen, Dana Gelb Safran, Jana Montgomery, and William Rogers, *Seniors and Prescription Drugs: Findings from a 2001 Survey of Seniors in Eight States* (Washington, D.C., New York, and Boston: Henry J. Kaiser Family Foundation, The Commonwealth Fund, and New England Medical Center, July 2002). See also Center on an Aging Society, *Prescription Drugs* (Washington, D.C.: Georgetown University, September 2002).

[6] People with incomes over $60,000 would have a higher catastrophic threshold.

65 with four or more chronic conditions—a circumstance describing almost 20 percent of the disabled Medicare population—will average an estimated $5,251 in total drug spending. Because a large portion of her drug spending would fall into the "donut holes" of congressional proposals, her total out-of-pocket liability, including the estimated basic premium, would be quite high: $3,547 in the Senate bill and $3,926 in the House bill. This means that under the Senate bill, only 32 percent of her total expenses (drug costs plus premium) would be covered, and under the House bill, only 25 percent. Indeed, under these bills, people with chronic conditions are likely to bear a larger share of their drug costs than people with lower *and* higher drug expenses. Figure 3 depicts this effect in the House and Senate bills. Although the donut hole is noticeably larger in the House bill, the subsidies at lower spending levels are greater in the Senate bill.

Other Design Issues Important to Chronically Ill Beneficiaries

Even assuming that a person with chronic illness can find a good plan initially, it is important to consider what changes can happen over time to a beneficiary's drug benefit. Two issues—community rating of premiums and stability of drug coverage—are of particular interest in designing a drug benefit that includes many people on multiple drugs, especially when relying on private market competition to offer the benefit.

Community rating. To protect beneficiaries with chronic illnesses from paying exorbitantly higher premiums than their healthier counterparts, both the House and the Senate bills require plans to charge community-rated premiums. Under this provision, all enrollees in a particular plan are charged the same premium, keeping in mind that individuals with chronic illnesses still face higher out-of-pocket costs. A disadvantage of community rating, however, is that it may discourage some healthier beneficiaries from enrolling. On the other hand, federal subsidies help lower premiums and thus may attract people with lower than average expected drug costs. Also, stiff penalties for late enrollment will encourage early sign-up. The benefits of community rating, particularly for vulnerable beneficiaries, outweigh the concerns and it is encouraging to see community rating provisions in the House and Senate bills.[7]

Stability of drug coverage. The stability of drug coverage is particularly important to individuals with multiple chronic conditions because of the complexity of their drug regimens, which often involve the coordination of many drugs simultaneously. To increase the stability of coverage for consumers, drug proposals could include provisions that require plans to commit to several years of participation in the market.

[7] Community rating is discussed in more detail in Cristina Boccuti and Marilyn Moon, *Private, Individual Drug Coverage in the Current Medicare Market* (New York: The Commonwealth Fund, October 2003).

Insurers may be reluctant to make such commitments, however, because they would be embarking on a product that has never before been offered. Furthermore, plans may proactively charge higher premiums to offset potential future risk if they are unable to exit the market within a year's time. The Senate bill offers a fallback option—a Medicare-sponsored drug plan—if private plans fail to participate or leave the market area. The stability of this option could be improved by permitting fallback plans to remain in the area for several years. The House bill does not offer a Medicare-sponsored fallback plan and thus does not *guarantee* availability of drug coverage in all market areas.

Another consumer protection that could increase coverage stability would be to require that any changes in a plan's prescription drug formulary be phased in *gradually,* so that beneficiaries continuously enrolled in a plan are not adversely affected. If, for example, a plan drops a drug from its preferred list (the list of drugs for which beneficiary cost-sharing is the lowest), enrollees taking that drug prior to the change should have adequate time to consult with their physicians to determine if, and how, their drug regimen could be changed to avoid extra costs for non-preferred drugs. Some formulary changes reflect improved medical information, but other changes, based more on specific drug prices (and rebates), may not work well for the patient. Both the House and the Senate bills call for "appropriate" notice of formulary changes to enrollees.

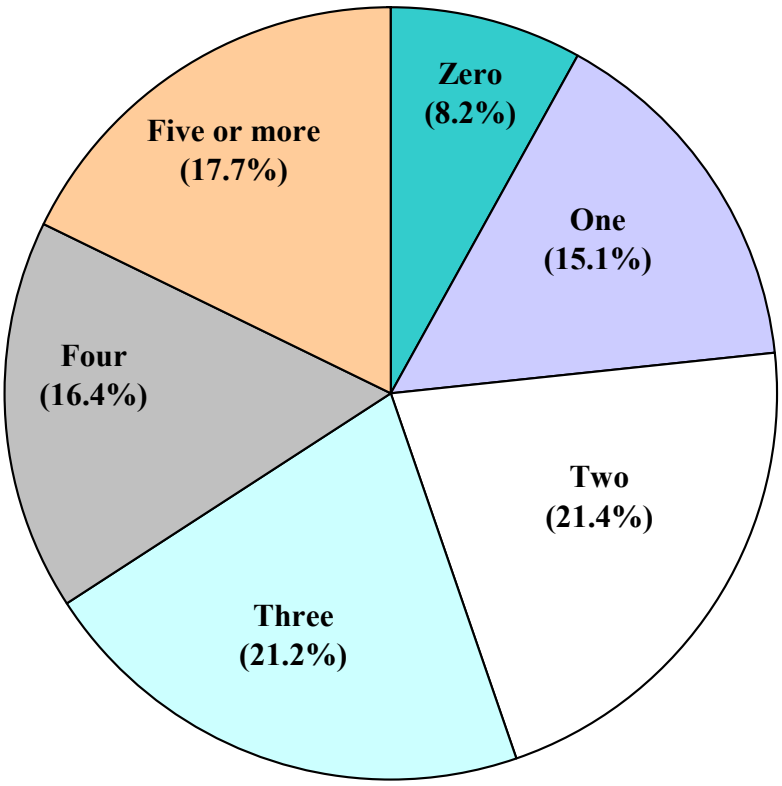
Conclusions

Over half of all non-nursing home Medicare beneficiaries live with *at least* three chronic conditions. Increasingly, prescribed medications help these beneficiaries manage their illnesses and disabilities, stay out of the hospital, and improve the quality of their lives. Prescribed in daily dosages in most cases, these important drugs come at high annual costs. Consequently, offering drug coverage to people with multiple chronic conditions is an expensive undertaking because this population's expected costs are high. Private market approaches, therefore, require considerable federal subsidies to attract plans to participate and to lower premium costs. Additionally, consumer protections to enhance coverage access and stability would be particularly helpful for beneficiaries with multiple chronic conditions and disabilities.

This population also needs drug benefits to last throughout the year. Unfortunately, the June 2003 House and Senate bills have spending limits, which result in coverage gaps (or donut holes). These gaps leave people with chronic conditions vulnerable to high out-of-pocket costs. Indeed, 59 percent of beneficiaries with two or

more chronic conditions incur over $2,000 in drug costs,[8] which under the House bill would have them paying for their drugs *in full* for a substantial part of the year. Particular attention to the concerns of beneficiaries with chronic conditions and disabilities will be necessary as policymakers explore the drug benefit design options currently on the table.

Figure 1
Distribution of Medicare Beneficiaries, by Number of Chronic Conditions, 1999



Source: Urban Institute analysis of the 1999 Medicare Current Beneficiary Survey (MCBS).
Note: Excludes beneficiaries living in a nursing facility.

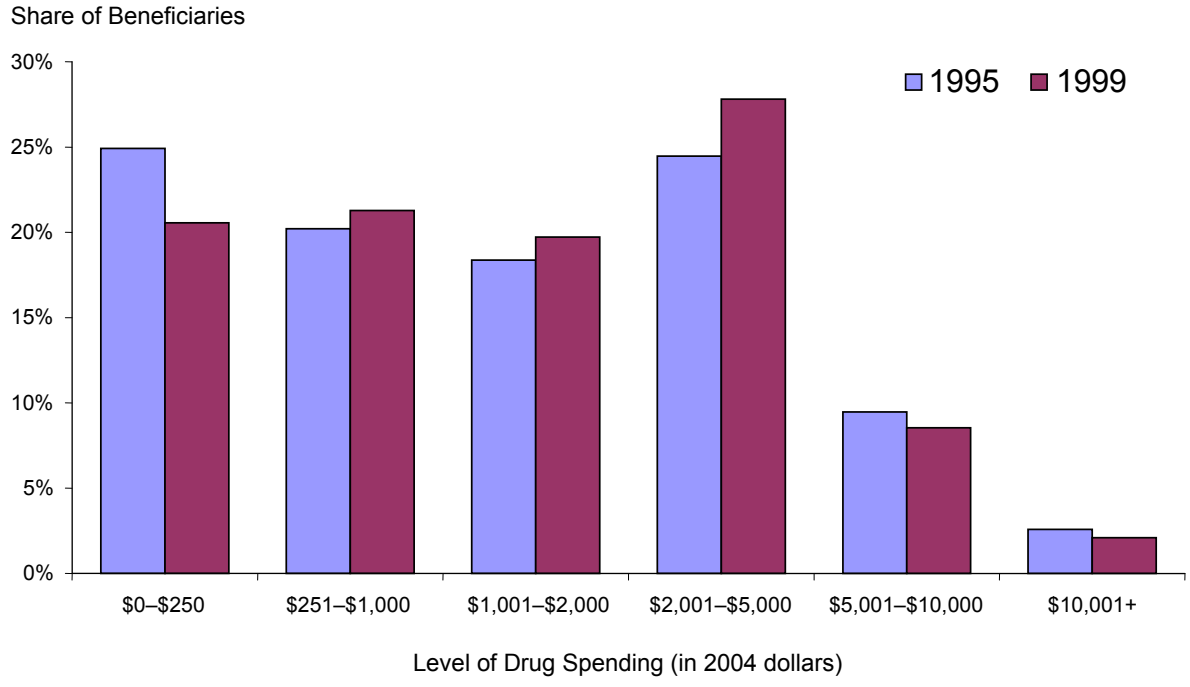
[8] Urban Institute Analysis of 1999 Medicare Current Beneficiary Survey.

Table 1
Annual Prescription Fills and Average Drug Spending, by Number of Chronic Conditions

Number of Chronic Conditions	Prescription Fills	Average Drug Spending (2006 dollars)	Percentage with More than $2,000 in Drug Spending
0	8	$1,346	18%
1	12	$1,819	27%
2	18	$2,543	43%
3	24	$3,426	56%
4	30	$4,046	66%
5 or more	40	$5,673	75%
Total	**23**	**$3,320**	**51%**

Note: Excludes end-stage renal disease and beneficiaries living full-year in a nursing facility.
Source: Urban Institute analysis of 1999 Medicare Current Beneficiary Survey. Spending in 2006 adjusted for Congressional Budget Office estimates.

Figure 2
Change in Distribution of Medicare Beneficiaries, by Level of Drug Spending from 1995 to 1999



Note: Excludes beneficiaries living in nursing facilities.
Source: Urban Institute analysis of the 1999 Medicare Current Beneficiary Survey, adjusted for Congressional Budget Office estimates of 2004 spending.

Text Box 1

Estimated Annual Out-of-Pocket Costs for Beneficiaries with Chronic Conditions Under the House and Senate Bills

Person with heart disease ($4,223): In 2006, a beneficiary with heart disease would have, on average, annual prescription drug spending of $4,223. In this case, what will be this person's out-of-pocket expenses under each proposal in 2006?

Beneficiary Costs Under the Senate Bill	
Premium ($34/month)*	$408.00
100% of ($0 – 275) deductible	275.00
50% of ($275 – *4,223*)	+ 1,974.00
	$2,657.00

Beneficiary Costs Under the House Bill	
Premium ($35.50/month)*	$426.00
100% of ($0 – 250) deductible	250.00
20% of ($250 – 2,000)	350.00
100% of ($2,000 – *4,223*)	+ 2,223.00
	$3,249.00

Disabled person with four chronic conditions ($5,251): Almost 20 percent of disabled Medicare beneficiaries under age 65 have four or more chronic conditions, spending $5,251, on average, in 2006. What would out-of-pocket spending in 2006 be for someone fitting this description?

Beneficiary Costs Under the Senate Bill	
Premium ($34/month)*	$408.00
100% of ($0 – 275) deductible	275.00
50% of ($275 – 4,500)	2,112.50
100% of ($4,500 – *5,251*)	+ 751.00
	$3,546.50

Beneficiary Costs Under the House Bill	
Premium ($35.50/month)*	$426.00
100% of ($0 – 250) deductible	250.00
20% of ($250 – 2,000)	350.00
100% of ($2,000 – 4,900)	2,900.00
0% of ($4,900 – *5,251*)	+ 0.00
	$3,926.00

Catastrophic drug needs ($7,000): What about the 7 percent of Medicare beneficiaries who will have over $7,000 in drug spending in 2006?

Beneficiary Costs Under the Senate Bill	
Premium ($34/month)*	$408.00
100% of ($0 – 275) deductible	275.00
50% of ($275 – 4,500)	2,112.50
100% of ($4,500 – 5,812.50)	1,312.50
10% of ($5,812.50 – *7,000*+)	+ 118.75+
	$4,226.75+

Beneficiary Costs Under the House Bill	
Premium ($35.50/month)*	$426.00
100% of ($0 – 250) deductible	250.00
20% of ($250 – 2,000)	350.00
100% of ($2,000 – 4,900)	2,900.00
0% of ($4,900 – 7,*000*+)	+ 0.00
	$3,926.00

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* Premiums reflect Congressional Budget Office estimates. Actual premiums may vary.
Source: Sample case circumstances are derived from Urban Institute analysis of 1999 Medicare Current Beneficiary Survey. Drug spending projections for 2006 are adjusted for Congressional Budget Office estimates.

Figure 3
Beneficiary and Government Share of Spending, at Individual Expenditure Levels, Under the June 2003 House and Senate Bills