

**Statement of Bruce Stuart, Ph.D., Professor and Director of The Peter Lamy Center
on Drug Therapy and Aging at The University of Maryland School of Pharmacy**

**Testimony Before the Full Committee
of the House Committee on Ways and Means**

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Mr. Chairman and distinguished members of the House Ways and Means Committee. My name is Bruce Stuart. I am a Professor at the University of Maryland School of Pharmacy. I also direct the Peter Lamy Center on Drug Therapy and Aging which conducts research on Medicare beneficiaries' drug coverage, utilization, and outcomes. I am pleased to be here this morning to address what I believe should be the core question underlying the debate over a Medicare drug benefit; namely, what will happen to beneficiaries if Congress fails to act? I will show that recent trends in coverage put future beneficiaries at risk of having significantly reduced options for meaningful prescription benefits if legislative action is not taken soon.

First, the good news. The latest data from the Medicare Current Beneficiary Survey (MCBS) show that a higher proportion of beneficiaries had some form of prescription coverage in 2000 than ever before, reaching almost 79% of the beneficiary population with Medicare entitlement for the entire year. That is up from 69% in 1995. Moreover, a higher percentage of those with drug benefits in 2000 maintained them throughout the year than in any previous year for which we have data.

However, aggregate statistics can be misleading. The growth in prescription coverage between 1995 and 2000 is explained by two phenomena, a rise in Medicare HMO enrollment and a rapidly growing segment of beneficiaries with ill-defined and overlapping benefits. There was a slight decline in rates of prescription coverage among beneficiaries who relied on a single prescription plan from an employer, a Medigap policy, Medicaid, or other public program. By examining changes in these sources of prescription coverage, we can develop a reasonably accurate forecast of what beneficiaries will face in the near future.

Supplemental health benefits offered by employers and unions represent the most generous private source of prescription coverage available to Medicare beneficiaries. No

one knows exactly how many beneficiaries are entitled to employer-sponsored coverage. Not all retirees given the opportunity of health insurance choose to take it either because of cost or alternative coverage. Data from the MCBS show that the number of beneficiaries with employer-sponsored health plans peaked in 1997 at 41% of the population and fell slightly to 39% in 2000. The proportion of beneficiaries with prescription coverage under employer plans has remained a steady 34% from 1995 through the latest data release for 2000. These are actually very surprising statistics in light of the pull-back in retiree health benefits reported by employers. According to annual Mercer/Foster Higgins surveys, the number of large employers offering health coverage to Medicare-eligible retirees declined from 57 percent in 1987 to 23 percent in 2001. Why haven't we seen a comparable decline in the MCBS data? Preliminary results from a study my colleagues and I are conducting for The Commonwealth Fund suggest that the answer lies in beneficiary demographics. Younger beneficiaries aged 65 to 69 are more likely to be affected by changing employer policies on retirement benefits than beneficiaries aged 70 and older. Based on MCBS data, we found that the proportion of beneficiaries with employer-sponsored health benefits in the younger age band dropped dramatically between 1995 and 2000, while there was a small increase in coverage for the older group. This pattern does not auger well for future retirees.

The advent of Medicare+Choice in 1997 was followed by a major expansion in HMO enrollments. At the program's peak in 1999, more than seven and a half million beneficiaries had enrolled. Yet 22 percent of them left their plans that year, presumably to get better coverage elsewhere. HMO enrollees represent a large fraction of the beneficiary population with shifting sources of prescription benefits and gaps in coverage. For example, 50% of those who disenrolled from an M+C plan in 1999 were left without prescription coverage. But even among those who stayed, only 65% were able to rely on M+C prescription coverage alone; 20% supplemented HMO drug benefits with other coverage, 7% had outside drug coverage and no M+C prescription benefits, and 9% had no prescription benefits from any source. Today, M+C enrollment has declined by a quarter, and the drug coverage offered by the remaining plans is far less generous than four years ago. Federal lock-in rules now scheduled for 2005 will presumably reduce the rate of M+C turnover, but that will not address the underlying

reasons why beneficiaries move from plan to plan. Indeed, limiting beneficiaries' ability to leave plans that no longer meet their needs will make them worse off, and may well lead to further erosion in M+C enrollments. Plan withdrawals and rising premiums will have a similar effect.

Beyond M+C and employer coverage, the only other private source of prescription benefits available to Medicare beneficiaries is self-purchased coverage through a Medigap plan. In most states, private carriers are permitted to offer three standardized plans (H, I, and J) with maximum prescription coverage of \$1,250 or \$3000 per year. All three plans contain a \$250 deductible and 50% coinsurance. These benefit provisions were created by Federal law over a decade ago, and have not been updated. But even this limited coverage may appeal to older people who have no other options. The catch is that many carriers do not sell the policies that cover drugs, and those that do generally charge high premiums that in some cases actually exceed the maximum value of the coverage itself. According to MCBS data, the proportion of non-institutionalized beneficiaries relying only on these policies hovered around 9% between 1995 through 2000 (another percent or two mixed self-purchased plans with other coverage). The real number may be only half that high. Most experts believe that beneficiary reports of self-purchased drug coverage are inflated with the inclusion of discount cards and other plans that do not provide true insurance. Whatever the real number, the market for Medigap plans is ill equipped to provide meaningful coverage to Medicare beneficiaries who lose benefits because of pull-backs in HMOs and employer plans.

The poorest elderly typically do not qualify for employer-sponsored health insurance and can't afford premiums for individual Medigap policies. Medicaid is available to those who meet Federal and state means tests for income and assets. Dual enrollment in Medicare and Medicaid dropped slowly throughout the nineteen-nineties as a result of rising beneficiary incomes and static income-eligibility criteria. A slight uptick in 2000 may signal a reversal in this trend, but traditional Medicaid is still available only to the poorest poor. Some states have responded to the needs of those too poor to afford adequate medications but not poor enough to qualify for traditional Medicaid by extending full Medicaid benefits, including prescription coverage, to Medicare beneficiaries enrolled in the Federal QMB and SLMB programs. Other states (30 as of

this writing) have enacted pharmaceutical assistance programs that subsidize drug expenses for selected low-income populations. An additional eight states have drug discount card programs for Medicare beneficiaries. The latest development is the CMS “Pharmacy Plus” waiver program that encourages states to develop drug assistance plans paid for through savings in traditional Medicaid. Five states (Illinois, Wisconsin, South Carolina, Florida, and Maryland) have approved Pharmacy Plus programs. Ten others are in the process of developing waiver applications.

This flurry of activity at the state level might lead one to conclude that low-income Medicare beneficiaries’ needs for drug coverage are being adequately addressed. That would be a mistake. According to the MCBS, 48% of beneficiaries below the Federal poverty line were enrolled in Medicaid or another public program offering drug benefits during 2000. Only 20% of beneficiaries in the band between 100% and 150% of the poverty line were enrolled in a public plan. These proportions are not significantly higher than in 1995 when 46% and 18%, respectively, received such benefits. When data become available for 2001 and 2002, we may find that matters have improved. But even if that proves true, the current patchwork of state programs is extremely fragile. Four of the 30 states that have enacted pharmaceutical assistance programs have put them on indefinite hold because of budgetary problems. Massachusetts has frozen enrollment in its assistance program. Some of the largest plans, including the Pennsylvania PACE program are seriously under funded. The initial excitement surrounding the Pharmacy Plus program has turned to concern as states try to figure out how to pay for their new obligations without gutting traditional Medicaid. Unlike the Federal government, state prohibitions against running budget deficits means that assistance programs are most vulnerable to cuts at precisely the time they are most needed.

Let me rephrase the central question I posed at the beginning: What should Congress learn from these recent trends as it prepares to enact a meaningful Medicare drug benefit? My optimism is based on the belief that our government will simply not permit the gains in drug coverage won by Medicare beneficiaries during the nineteen-nineties to be needlessly lost. The first lesson is that strong action must be taken to avoid further erosion in retiree health benefits. Subsidizing prescription coverage will reduce the burden on employers, but additional steps will be necessary to assure that firms

maintain—or better yet—improve upon current coverage. Second, while managed care plans have clearly failed to provide meaningful drug benefits in the absence of government payment, it is just possible that including drug costs in plan capitation rates may actually save the M+C program. Finally, as important as state programs can be in filling gaps in prescription coverage, present circumstances call for a unified national program of prescription benefits available to all Medicare beneficiaries.

Thank you.