Medicare Rx Drug Benefit and Discount Act

The elderly and disabled have waited long enough for a prescription drug benefit in Medicare and for relief from the high cost of prescription drug prices. House Democrats are committed to providing a comprehensive benefit that is affordable and dependable for all beneficiaries with no gaps or gimmicks in coverage. This benefit will be similar to what seniors and individuals with disabilities get in Medicare now. What we offer senior citizens and individuals with disabilities should be no less generous than what Members of Congress and other Federal employees receive.

The House Democratic proposal adds a new Part D in Medicare that provides voluntary prescription drug coverage for *all* Medicare beneficiaries beginning in 2006.

- ✔ **Premium:** $25 a month
- ✔ **Deductible:** $100 a year
- ✔ **Co-insurance:** Beneficiaries pay 20%; Medicare pays 80%
- ✔ **Out-of-pocket limit:** $2,000 out-of-pocket limit per beneficiary per year
- ✔ **Low-income:** Beneficiaries with incomes up to 150% of poverty pay no premium or cost-sharing. Beneficiaries with incomes between 150 - 175% of poverty pay no cost-sharing and receive assistance with the Part D premium on a sliding scale.

But even with a Medicare drug benefit, seniors and the disabled want the assurances that they won't be overcharged and they don't want the Medicare program to be overcharged. That's why Medicare contractors will obtain guaranteed reductions in prices, and the HHS Secretary will have the authority to use the collective purchasing power of Medicare's 40 million beneficiaries to negotiate lower drug prices - just like he did successfully with Cipro in 2001. In addition, the proposal reduces drug prices for everyone by stopping big drug company patent abuses. The Secretary could also implement measures that will further reduce costs and improve quality for beneficiaries such as: encouraging use of generic drugs, lowering co-insurance for preferred drugs, disease management, and beneficiary and provider education. Medicare would also require contractors to put in place safeguards to check for adverse drug interactions and proper use of medications.

Under the Democratic plan, seniors and individuals with disabilities will be able to keep making the choices that matter. Seniors won't have to leave traditional Medicare to get drug coverage. Nor will they be forced to join a private insurance plan that will restrict access to needed drugs, deny coverage for the medicine their doctor prescribes, or force them to change pharmacies. Democrats will ensure seniors will always be able to obtain the drugs their doctor says they need at reduced prices and will be able to choose where to fill their prescriptions.

Medicare Rx Drug Benefit and Discount Act of 2003

The House Democratic prescription drug proposal, the *Medicare Rx Drug Benefit and Discount Act of 2003*, provides seniors and the disabled with a meaningful, comprehensive benefit for prescription medications in Medicare. The bill would create a new voluntary Part D in Medicare to offer beneficiaries the option to enroll in a dependable and affordable prescription medication benefit that would provide coverage for drugs like they get for other Medicare benefits today.

Access to Fair Prices

The House Democratic proposal ensures that elderly and disabled individuals will access significantly reduced prices on prescription medication. Medicare will use pharmacy contractors (PCs), who will be required as a condition of their Medicare contract to get additional reductions in the cost of drugs for Medicare beneficiaries. Only pharmacy contractors who meet or exceed these standards will be able to participate in Medicare. In addition, the Secretary of Health and Human Services (HHS) will negotiate on behalf of the 40 million Medicare beneficiaries to get discounted prices on certain drugs where there is no competition. Because the Secretary will have the market power of Medicare behind him, the negotiated prices will be significantly lower than prices beneficiaries face today. The Secretary will be able to compare the prices that Medicare pays with the drug prices paid by other payers (i.e., employers) to ensure the Medicare is getting a good deal for beneficiaries and taxpayers.

Access to a Real Medicare Benefit Without Gaps or Gimmicks

The House Democratic proposal provides full coverage for prescription drugs with no gaps or gimmicks. Unlike other proposals which only provide coverage for part of the year (even though beneficiaries must pay premiums for all year), the Democratic proposal provides coverage for every drug for every beneficiary all year long. All beneficiaries, no matter where they live, will be guaranteed a low $25 premium. After meeting the $100 deductible, Medicare will pay 80% of the cost of each preferred prescription medication, and the beneficiary will be responsible for the remaining 20%. (This benefit is identical to coverage seniors get today under Medicare for doctor visits and other Part B services: a $100 deductible and 80/20 cost-sharing.) Beneficiaries will be able to count on this coverage – *with no holes in coverage* – for all of their prescription needs. Once beneficiaries spend $2000 out-of-pocket on prescriptions, Medicare will totally protect beneficiaries against any additional drug costs.

Access to Needed Prescription Medicines

The House Democratic proposal ensures that seniors and the disabled can get Medicare coverage for the medication their doctor says is right for them. Unlike other proposals that allow private insurance plans to restrict or deny access to needed drugs, under the Democratic plan Medicare will always cover the every drug a senior needs. Medicare PCs, under the oversight of the Secretary, may establish a list of "preferred medicines" which are the most clinically appropriate medicines for particular conditions. Medicare will pay 80% of the cost of a preferred medicines. If a beneficiary ever needs a medicine that is not on the preferred list, they (or their doctor) can appeal to get that medicine at the preferred cost-sharing of 20%. If a situation should arise where the senior's appeal is unsuccessful but he is reluctant to change to a different drug (e.g., from a medicine he has been taking

for a long time), he can always choose to stay with his old drug and will be able to get that drug at a reduced price from the PC and receive Medicare coverage for that drug. In all cases, Medicare will give beneficiaries reduced prices and assist them with the cost of the drugs their doctor prescribes.

Dependable Coverage

Under the House Democratic bill, beneficiaries will be able to count on a meaningful Medicare benefit, low premium, affordable cost-sharing, and real stop-loss protection *no matter where they live.* Seniors won't have to worry about whether or not their private insurance plan will be there from year to year or whether a private insurance plan's premium will be affordable next year. They won't have to worry about switching to a new private plan every year and they won't have to worry about their coverage stopping mid-year. Of course, under the Democratic model a senior can always choose to enroll in a Medicare+Choice plan, but they will never be forced to enroll in an unreliable private plan if they would rather have the security and choices offered by traditional Medicare.

Real Choice

The Democratic plan gives seniors and the disabled the *choices* that are important to them. They will always be able to choose traditional Medicare, without penalty of increased premiums or lesser benefits, so they can continue to see the doctor or other health provider they feel most comfortable with. Democrats will not force seniors to enroll in a private insurance plan that can limit choice of doctors or hospitals or limit benefits and increase cost-sharing in order to get prescription drug coverage. The Democratic plan gives seniors and individuals with disabilities real choices without privatizing the Medicare program and turning it over to private insurance companies.

Access to Local Pharmacies

For Medicare beneficiaries, access to a local pharmacy is critical. The House Democratic bill will ensure that the elderly and disabled can always access their local pharmacy. The Secretary will determine broad standards for pharmacy participation to protect beneficiaries and ensure quality and program integrity. Pharmacies must also agree not to charge beneficiaries more than the Medicare-negotiated price and may not discriminate against beneficiaries who are low-income. Pharmacy contractors may also have additional standards to protect beneficiaries, but *any pharmacy that meets the standards must be allowed to participate.*

Protections for Low Income Elderly and Disabled Beneficiaries

The Democratic prescription drug proposal ensures that the new Medicare drug benefit is affordable to all beneficiaries, including those with limited incomes. Medicaid will provide full coverage of premiums and cost-sharing for beneficiaries enrolled in Medicare Part D up to 150% of poverty ($13,470 per year) and assistance with the Part D premium on a sliding scale and nominal cost-sharing for beneficiaries between 150% and 175% of poverty. Unlike the Republican bill, the Democratic proposal preserves the existing Medicaid protections on out-of-pocket costs (cost-sharing may not exceed a nominal amount defined in statute) and ensures that low-income beneficiaries can not be refused treatment if they can not afford their co-payment.

Voluntary Benefit that Preserves Access to Existing Prescription Drug Coverage

Enrollment in the new Medicare Part D benefit is voluntary. Beneficiaries who have existing

prescription drug coverage can always choose to keep that coverage. In addition, in an effort to encourage employers to continue to provide quality retiree benefits, Medicare will provide a subsidy equal to two-thirds of the costs of the retiree prescription drug benefits, if those benefits provide coverage that is at least equal to what Medicare provides.

THE PRESIDENT'S DRUG PLAN:
THE WRONG PRESCRIPTION FOR SENIORS

The President claims to have retreated from his initial proposal to require beneficiaries to leave the traditional Medicare program to obtain any drug coverage. The changes are a fig leaf - in fact, his "new" proposal is not substantively different from his old plan. It would offer only catastrophic coverage for those who remain in traditional Medicare (e.g., starting at $6,000). This year, just 8% of beneficiaries have drug costs above $6,000. The remaining 92% of beneficiaries would have to leave traditional Medicare and join private plans to get even meager drug coverage.

The President's "reform" proposal is nothing but an attempt to privatize Medicare. Approximately 89% of Medicare beneficiaries – more than 35 million seniors and disabled Americans - are in traditional Medicare. The President would force these beneficiaries to choose between the doctors they know and trust and the medications they know they need.

Privatization didn't work in 1965 and it won't work now. Medicare was originally created because private insurers wouldn't provide affordable coverage to seniors. Recent history with the Medicare+Choice program shows they are no more willing to do so today.

The President's $400 billion is woefully inadequate. CBO estimates that Medicare beneficiaries will spend more than $1.8 trillion on prescription drugs between 2004-2013. Even if every dollar of the President's proposal went toward prescription drug coverage, the plan would cover just 22% of beneficiaries' medication needs.

The President's proposal would leave huge gaps in coverage. To fit within his arbitrary budget number, beneficiaries will be forced to face a gap in coverage and spend thousands of dollars just when they need help most. Press accounts have suggested that there is no limit on out-of-pocket spending (e.g., even under catastrophic coverage, seniors would pay 10% of costs).

The President claims to offer seniors coverage like Members of Congress receive. In fact, his plan will fall far short. Compared to federal employees' coverage, the President's plan is worse on all counts. It would require seniors to pay higher premiums, deductible, co-insurance, and out-of-pocket costs. It would also leave seniors with a significant gap in coverage. CRS estimates the value of the President's proposal (based on press reports as of 1/27/03) to be well under half of what Members of Congress get.

Prepared by Committee on Ways and Means Democratic Staff - Charles B. Rangel Ranking Member, 3/3/03

Medicare Prescription Drug Benefit: President Bush v. Democratic Proposal

Plan Element	President's 2003 Proposal (Based on Public Reports as of 2/28/03)	House Democratic Bill (108th Congress)
Guaranteed Minimum Benefit for All Beneficiaries	**NO** Beneficiaries must leave traditional Medicare and join private plans, which may not participate and can offer vastly different benefits and premiums. Those who remain in traditional Medicare *may* receive coverage for catastrophic drug coverage (e.g., over $6,000).	**YES** Medicare covers prescription drugs like other Medicare benefits, with guaranteed benefits, premiums, and cost sharing for all beneficiaries who wish to participate.
Guaranteed Fair Drug Prices	**NO** Private insurers negotiate separately on behalf of subsets of the Medicare population, diminishing the program's group negotiating power.	**YES** The Secretary of HHS uses the collective bargaining clout of all 40 million Medicare beneficiaries to negotiate fair drug prices. These reduced prices will be passed on to beneficiaries.
Premium	**Not specified.** Last year, CBO estimated similar House GOP proposal at **$34/month, $408/year**[1]	Specified in statute. **$25/month, $300/year**
Deductible	**? ($275/year?)**[1]	**$100/year**
Co-insurance	**? (50%** for first $3,050 **100%** for all remaining spending up to the "out-of-pocket" maximum?)[1]	**20%**
Out-of-Pocket Maximum	**N/A.** Beneficiaries must pay 10% coinsurance even after they spend $5,500/year[1]	Beneficiaries pay nothing after they spend **$2,000/year**
Coverage Gaps	**YES** Beneficiaries who need more than $3,050 worth of drugs must pay 100% out-of-pocket (and keep paying premiums) until they spend $5,500 out-of-pocket -- a gap of $3,838/year.[1]	**NO** Beneficiaries always have coverage, with no gaps.
Access to Local Pharmacies	**LIMITED** Private insurers have incentives to limit which pharmacies participate in their network.	**BROAD** Any willing pharmacy must be included in the network.
Access to Prescribed Medicines	**LIMITED** Private insurers have incentives to establish strict formularies and deny any coverage for off-formulary drugs.	**BROAD** Beneficiaries have coverage for any drug their doctor prescribes.
Low-Income Protections	**WEAK** Based on prior GOP proposals, no protections for up to 40% of low-income beneficiaries due to imposition of so-called "assets test."	**STRONG** No cost sharing or premiums up to 150% of poverty; sliding scale premiums between 150% and 175% of poverty. Assets test is waived.

[1] Details as of 1/27/03. Cost sharing amounts shown are benchmarks only. Actual cost sharing amounts will vary depending on the private plan the beneficiary chooses (assuming one is available).

Prepared by Committee on Ways and Means Democratic Staff – Charles B. Rangel, Ranking Member, 3/3/03

PRESCRIPTION DRUG PROPOSALS: MEDICARE BENEFICIARIES PAY MORE THAN TWICE AS MUCH UNDER REPUBLICAN PLANS

The average Medicare beneficiary will need about $3,400 worth of prescription drugs in the first year of a new Medicare prescription drug benefit.

How much would a senior have to pay to get $3,400 worth of drugs under various proposals?

	HOUSE DEMOCRATS	**PRESIDENT** BUSH	**HOUSE REPUBLICANS**
PREMIUM	$300	$408	$408[3]
DEDUCTIBLE	**$100**	**$275**	**$250**
		$1,388 for first $3,050 in drugs	**$150 for first $1,000 in drugs**
COINSURANCE	$660	$350 for remainder of drugs	$500 for next $1,000 in drugs
			$1,400 for remainder of drugs
TOTAL: BENEFICIARY SPENDS	**$1,060 (31%)**	**$2,421 (71%)**	**$2,708 (80%)**
TOTAL: BENEFICIARY SAVES	$2,340 (69%)	$979 (29%)	$692 (20%)

[1] Based on press accounts of President's proposed drug benefit for those who leave the traditional Medicare program and join private plans. About 35 million beneficiaries are currently in the traditional Medicare program. The President's proposal would offer these beneficiaries much less assistance, if any.

Prepared by Democratic Staff of the Committee on Ways and Means, Rep. Charles B. Rangel, Ranking Member (3/3/03)

Bush Administration's Damaging Prescription Drug Plan vs. Democrats' Real Medicare Prescription Drug Benefit

Administration's Revised Prescription Drug Plan Is Almost As Bad As Its Original Plan

"This is not a compromise. It's a hoax. It still forces seniors to abandon their family doctors to join HMOs to get the drug benefit they deserve."
Sen. Ted Kennedy, New York Times, 2/28/03

Reportedly, President Bush will lay out a framework for a revised proposal on prescription drugs in a speech he is giving to the AMA on March 4. According to the New York Times, "*The proposal would offer modest drug benefits to people in the traditional, fee-for-service Medicare program. The government would offer more extensive drug coverage to Medicare beneficiaries who join a private health plan....People in the traditional Medicare program would receive two kinds of assistance: a discount card that could be used at pharmacies and so-called catastrophic coverage protection against very high drug expenses....Expanded drug benefits would be available to people who joined health maintenance organizations, preferred provider organizations or other private plans.*" The original Bush Administration proposal – which has been circulating on Capitol Hill for the past five weeks – would have been slightly more extreme – denying any prescription drug assistance to seniors who stayed in traditional Medicare.

Following are some talking points on the revised Bush plan and the Democrats' plan.

- **Goal of Revised Bush Prescription Drug Plan Is The Same As Original Plan.** The goal of the revised Bush prescription drug plan is exactly the same as the original plan – to force seniors to drop out of traditional, fee-for-service Medicare and join HMOs or other private health plans. The revised plan provides seniors the same dilemma that the original plan did – they have to give up traditional Medicare where they can choose their own doctors in order to have access to something that looks like a prescription drug benefit..

- **Discount Cards & Catastrophic Coverage Do Not Constitute A Drug Benefit!** The Bush Administration appears ready to claim that providing seniors in traditional Medicare with discount cards and catastrophic coverage would provide them with meaningful assistance. However, nonpartisan analysts have determined that discount cards (which Bush also proposed in 2002) fail to provide meaningful assistance to seniors. For example, in 2002, Families USA pointed out, "President Bush's discount card proposal offers little in terms of prescription drug price relief for America's seniors. ... According to the Administration, this proposal at best will provide 12.4% in savings to seniors and for most seniors we believe it will be considerably less." Furthermore, catastrophic drug coverage only helps a small percentage of seniors. For example, it is estimated that less than 8% of seniors would benefit from catastrophic coverage that aided those with out-of-pocket spending on prescription drugs of over $5,500 a year. The remaining 92% of seniors would

get no assistance from this coverage.

- **Under Bush Plan, Seniors Would Be Coerced into Giving Up Their Choice of Doctors, As Well As Guaranteed Access to the Drugs They Need.** The Bush plan to coerce seniors into private health plans would rob seniors of the most important choice they have today – the right to choose their own doctors. In addition, under a plan that places drug benefits under the control of insurance companies, private plans will be able to create strict formularies that limit access to covered drugs. Seniors could therefore lose the guaranteed access they have now to drugs that have been prescribed by their doctors.

- **HMOs Participating in Medicare Have A Poor Record Serving Seniors.** The Bush Administration is putting forward this plan despite the fact that HMOs participating in Medicare have a poor record serving seniors – in the current Medicare+Choice program. For one thing, HMOs are unavailable in many rural communities, and they frequently leave communities that are deemed unprofitable. Indeed, HMOs have dropped 2.4 million seniors from coverage over the past five years. Even more HMOs have dropped prescription drug coverage after promising it to seniors.

- **Bush Devotes Inadequate Resources for Prescription Drugs and Medicare Restructuring.** The Administration, in its budget, is only willing to devote $400 billion to prescription drug coverage and Medicare restructuring over the next 10 years. In addition to covering prescription drugs, this $400 billion is supposed to cover numerous other items – including funding changes to Medicare+Choice payments, fixing physician payments, and covering other reforms. Even if the entire $400 billion were spent on prescription drug coverage, which it clearly won't be, it would be inadequate. CBO estimates that Medicare beneficiaries will spend more than $1.8 trillion on prescription drugs between 2004-2013. Therefore, $400 billion would cover only 22% of seniors' prescription drug spending over the next ten years.

- **Democrats Are Calling for an Affordable, Meaningful Medicare Prescription Drug Benefit, Available to All Seniors.** Over the last six years, Democrats have been fighting to enact a comprehensive Medicare prescription drug benefit that is affordable and dependable for all beneficiaries, with no gaps or gimmicks in coverage. Under the Democratic proposal, seniors would be able to make the choices that matter – the choices of doctors, hospitals, prescription drugs, and pharmacies. Seniors wouldn't have to join an HMO or other private health plan to get drug coverage. Nor would they be forced to give up their doctors and join a private insurance plan that could restrict access to needed drugs, deny coverage for the medicine their doctor prescribes, or force them to change pharmacies.

Consumer Access Provisions

The 1984 Hatch-Waxman Amendments were designed to encourage rapid approval of low-cost generic drugs, while ensuring that brand name companies receive periods of exclusive marketing to permit recoupment of research and development expenses. It has become clear in recent years that both brand-name and generic companies are gaming the system to keep lower cost medicines off the market months and sometimes years beyond the time intended by Congress. These delays cost consumers, employer-sponsored health plans, and government purchasers billions of dollars a year. The consumer access provisions are intended to prevent abuses of the Hatch-Waxman law and allow generic drugs to reach the marketplace more quickly.

Elimination of automatic delays in approval during patent lawsuits: Under current law, when a generic drug files for FDA approval and a brand name company's drug is patented, the brand name company can sue the generic for patent infringement. Hatch-Waxman then forbids FDA from approving the generic drug's application for 30 months. Brand name companies have abused this provision by dragging out lawsuits and by obtaining serial 30-month periods through the last-minute filing of new, sometimes frivolous, patents. This bill would eliminate the automatic 30-month stay.

Preventing collusive agreements between generic and brand name companies: In recognition of the costs of challenging a patent, Hatch-Waxman provides180 days of exclusive marketing to the first generic company to challenge a patent on the brand name drug. Some generic companies who have won this 180-day period have entered into collusive settlements with the brand name company in which they agree, for a substantial sum, not to market for the 180 days, extending the brand name company's monopoly for 6 months. This bill adds provisions to prevent these collusive agreements and to clarify when the 180-day period of exclusive marketing is available to generics.

Preventing misuse of 3-year exclusivity period: Hatch-Waxman provides 3 years of exclusive labeling, but not exclusive marketing, to a company who makes a change in the use or dosage (for example) in an existing drug. Some brand name companies have tried to use this provision to remove generic versions of the drug from the market, even though the generics are sold for the original use. This bill affirms current FDA policy, giving the brand name company the exclusive right to advertise its innovation and include it on the label, without precluding generics sold for the original use from entering or staying on the market.

It is important to note that <u>none</u> of these provisions <u>reduce</u> the patent protections appropriately afforded to brand-name drug companies as a reward for their innovation and R&D expense. These provisions simply close loopholes in the law that enable brand drug companies to block generic market entry even after their patent has expired.

This bill is not pro-generic, it is pro-consumer. It includes provisions to prevent generics and brand companies from engaging in anti-competative deals that keep lower cost drug products off the market.

THE HENRY J. KAISER FAMILY FOUNDATION

FACT SHEET

MEDICARE

MEDICARE AND PRESCRIPTION DRUGS

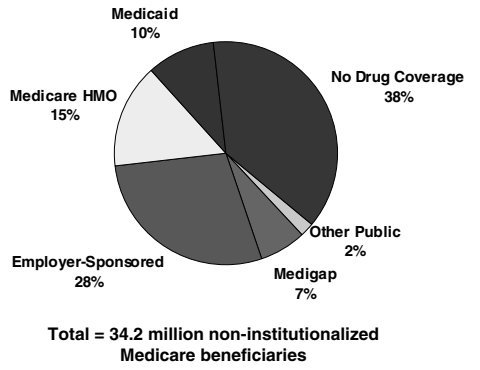
February 2003

OVERVIEW

Prescription drug use increases with age along with the prevalence of chronic and acute health problems. However, because Medicare does not cover outpatient prescription drugs, 38% of seniors and younger beneficiaries with disabilities had no drug coverage in the Fall of 1999 (Figure 1).

Figure 1

Sources of Prescription Drug Coverage, Fall 1999



Total = 34.2 million non-institutionalized Medicare beneficiaries

Note: Analysis of non-institutionalized beneficiaries enrolled in Medicare for a full year and with classifiable drug coverage status.
SOURCE: Laschober, et al., *Health Affairs*, February 2002.

Rising drug costs pose challenges for Medicare beneficiaries, who tend to use more medications (averaging 23 per year in 1999) than do younger adults. CBO projects that total drug spending for the Medicare population will grow from $95 billion in 2003 to $284 billion in 2013, increasing at an average annual rate of over 10% and totaling $1.8 trillion (2004-2013).

SOURCES OF PRESCRIPTION DRUG COVERAGE

Most Medicare beneficiaries have some form of supplemental drug coverage, but access to these benefits is declining.

Employer-sponsored plans, the leading source of drug coverage for seniors, assisted 28% of the Medicare population with drug costs in the Fall of 1999. However, retiree health benefits have been eroding and, as of 2001, only a third of employers with 200+ employees offered coverage to those ages 65+ (Kaiser/HRET, 2002). Looking ahead, 22% of large employers say they are likely to terminate health benefits for future retirees and 85% say they are likely to increase prescription drug cost-sharing (Kaiser/Hewitt, 2002).

Medicare HMOs, or Medicare+Choice (M+C) plans, assisted 15% of all beneficiaries with their drug costs in the Fall of 1999, a share that has decreased in recent years with declining M+C plan participation. Since 1999, the share of M+C enrollees with drug coverage has declined from 84% to 72%, and 41% are now subject to a benefit cap of $750 or less. In addition, more than half (55%) of all plans that offer drug coverage now restrict enrollees to generic drugs, up from 18% in 2001 (Achman and Gold, 2002).

Medigap provided drug benefits to 7% of all Medicare beneficiaries in the Fall of 1999. Of the 10 standard Medigap policies, only 3 (Plans H, I, and J) cover some drug costs. Plans H and I have a $250 deductible and cover 50% of drug costs up to $2,500; Plan J has a $250 deductible, but covers 50% of drug costs up to $6,000. Premiums for policies that cover drug costs have increased dramatically and vary widely.

Medicaid provided drug coverage for 10% of the Medicare population in the Fall of 1999. Targeted to those with low incomes, 53% of Medicare beneficiaries with incomes below the federal poverty level are on Medicaid. Prescription drugs are an optional benefit under Medicaid, but all states cover them. The structure and generosity of these benefits vary considerably. With Medicaid drug costs rising at an annual rate of almost 20% and states in tight fiscal situations, many states are seeking to curtail drug spending (KCMU, 2003).

Under Pharmacy Plus waivers, states can extend drug-only coverage to other low-income Medicare beneficiaries with Medicaid funds, if they accept an overall cap on federal Medicaid funding for their elderly Medicaid populations. As of early February 2003, 4 states (FL, Il, SC and WI) have been approved for such waivers.

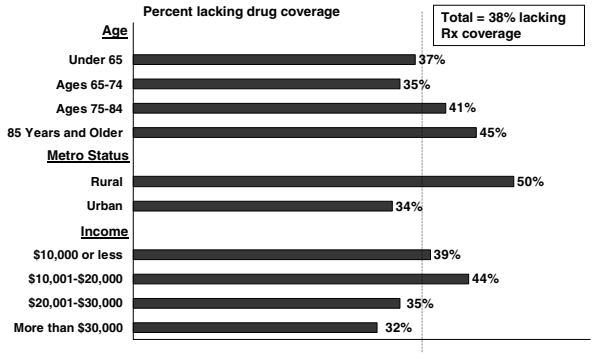
State Pharmacy Assistance Programs help many low-income Medicare beneficiaries not eligible for Medicaid with drug costs. These programs vary widely in terms of structure, eligibility, and benefits. As of January 2003, 34 states had established or authorized a pharmacy assistance program, 27 of which have programs that are now in operation.

WHO LACKS DRUG COVERAGE?

Nearly 4 in 10 beneficiaries lacked drug coverage in the Fall of 1999, disproportionately affecting those living in rural areas (50%), the near-poor (44%), and those 85+ (45%) (Figure 2).

Figure 2

Percent of Beneficiaries Without Prescription Drug Coverage, by Beneficiary Characteristics, Fall 1999



Note: Analysis of non-institutionalized beneficiaries enrolled in Medicare for a full year.
SOURCE: Laschober, et al., *Health Affairs*, February 2002.

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Looking at coverage over the course of the year, a quarter of all beneficiaries lacked drug coverage throughout 1999 (Briesacher, et al., 2002).

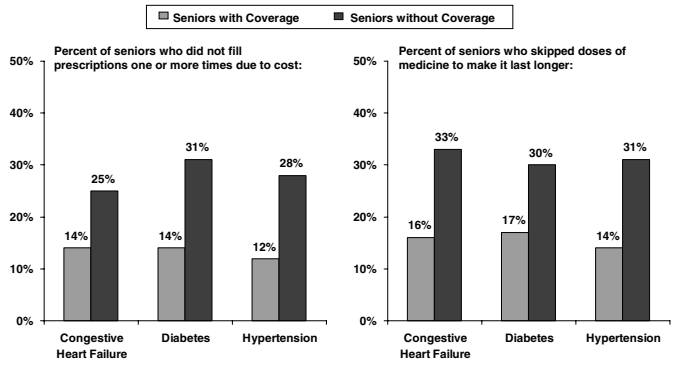
WHY DOES DRUG COVERAGE MATTER?

Beneficiaries without drug coverage average nearly 7 fewer prescriptions per year than do those with coverage (18 vs. 25, respectively) (Briesacher, et al., 2002).

Among seniors with serious health problems such as congestive heart failure and diabetes, one-third of those who lacked drug coverage reported skipping doses to make their prescriptions last longer, according to a 2002 survey of seniors in 8 states (Safran, et al., 2002). Chronically ill seniors without drug coverage were also more apt to go without filling a prescription due to costs (Figure 3).

Figure 3

Percent of Seniors in Eight States Who Reported Forgoing Needed Medicines, by Chronic Condition and Prescription Drug Coverage



Note: Analysis of seniors in sample with classifiable drug coverage.
SOURCE: Kaiser/Commonwealth/Tufts-New England Medical Center 2001 Survey of Seniors in Eight States.

Lack of drug coverage is also associated with higher out-of-pocket drug expenses. While 17% of seniors with drug coverage reported spending at least $100 per month out-of-pocket on medications, this share rose to 43% among those without coverage (Safran, et al., 2002).

Drug coverage may also impact health outcomes. According to a recent study, beneficiaries with a history of heart problems who lack drug coverage are less likely to use higher-cost medications that have proven especially effective among the majority of patients (Federman, et al., 2001). Increased access to newer prescription drugs has also been shown to lower spending on other services such as hospital care due to fewer inpatient stays (Lichtenberg, 2001).

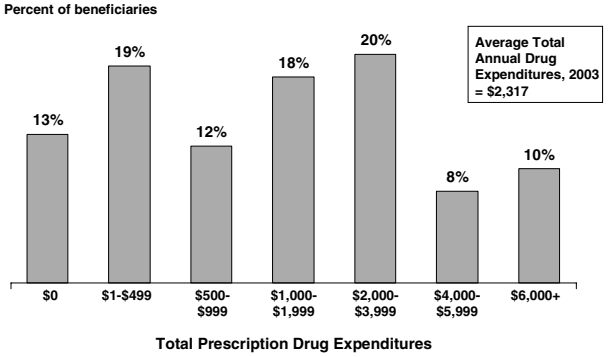
TOTAL AND OUT-OF-POCKET DRUG SPENDING

Average annual per capita drug spending for the Medicare population—an estimated $2,317 in 2003—is increasing rapidly, currently at an annual rate of 12%. Spending is highly skewed across beneficiaries: Almost a third are expected to incur up to $500 in total drug expenses in 2003, while 18% will have expenses of $4,000 or more (Figure 4).

Out-of-pocket drug spending is influenced by many factors, including beneficiaries' health-care needs, access to coverage and the generosity of that coverage, and the prices of the medications they take.

Figure 4

Distribution of Medicare Beneficiaries, by Total Prescription Drug Expenditures, 2003

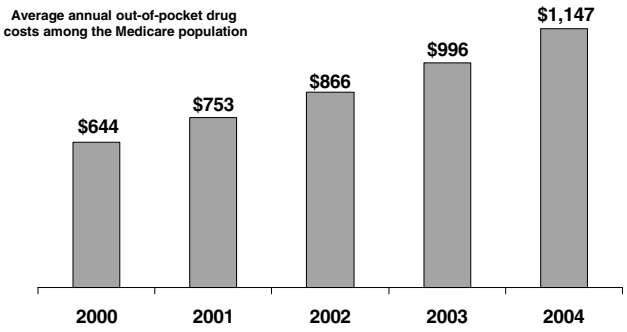


SOURCE: Actuarial Research Corporation analysis for The Kaiser Family Foundation (using CBO's 2003 estimates of prescription drug spending, which reflect adjustments in historical spending and lower expected economic growth in the near term).

Beneficiaries' average annual out-of-pocket drug spending has risen from $644 in 2000 to $996 in 2003 (Figure 5). This trend is projected to continue in the near future due to limits on drug coverage across all sources and other factors, including the continued introduction of new, high-priced drugs; patent extensions for brand-name drugs; and potential increases in demand stemming from direct-to-consumer advertising. According to the Actuarial Research Corporation, 5% of beneficiaries are expected to have out-of-pocket drug expenses of $4,000 or more in 2003.

Figure 5

Growth in Medicare Beneficiaries' Out-of-Pocket Prescription Drug Expenditures, 2000-2004



SOURCE: Actuarial Research Corporation analysis for The Kaiser Family Foundation (using CBO's 2003 estimates of prescription drug spending, which reflect adjustments in historical spending and lower expected economic growth in the near term).

OUTLOOK FOR THE FUTURE

The lack of drug coverage for millions of Medicare beneficiaries, the erosion of drug coverage for many others, and rising drug expenditures have led to a variety of proposals for reform. While policymakers and the public now agree on the need for a Medicare drug benefit, many complex and controversial issues have yet to be resolved. For example, should a drug benefit be implemented alone or as part of a broad overhaul of the Medicare program? Should drug coverage be provided directly under Medicare or primarily through private, risk-bearing plans? How should drug costs be controlled? The ability to reach common ground on these and other challenges will have significant implications for the nation's aged and disabled populations.

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