

A DOSE OF REALITY:
THE DEMAND FOR PRESCRIPTION DRUG COVERAGE
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A Dose of Reality: The Demand for Prescription Drug Coverage

ABSTRACT

Current policy initiatives regarding Medicare and prescription drug coverage lack research and insight that are vital to creating a successful program for America's elderly citizens. Too often, proposed policies regarding this issue lack effectiveness in both coverage and cost and do not consider the costs associated with our increasing aged population. The problems associated with uninsured elders, rural elders, and rising prescription drug costs are not accounted for in current policy. Policy makers need to be aware of the risks associated with a government-run prescription drug plan and should shift some of the financial burden of such a policy into the private sector. "A Dose of Reality: The Demand for Prescription Drug Coverage" analyzes the aforementioned problems as well as uncovers who is in the most need of prescription drug coverage among the elder population.

SETTING THE CONTEXT

The baby-boomer generation is the largest socioeconomic group in the United States. The most aged portion of the populace represents what will soon become the largest segment of the American population, and the issues that impact their lives have become prominent themes of current political and social discourse. With advances in technology and medicine, people now live longer, healthier lives. Consequently, issues surrounding the elderly have become contested topics of public argument. Much political debate has developed regarding prescription drug plans for the elderly in light of an insurgent pressure facing our nation's leaders to secure a healthy and stable lifestyle for our elders which is both affordable and equitable.

The distinctions between the Republican and Democrat parties are less significant in today's political environment. Republicans try to be more moderate; Democrats attempt to appeal to voters in the center. The parties of today's political system are merging and, often, the differences between the parties are difficult to identify. Such is true in the case of prescription drug plans; both political parties are fighting to provide prescription drug coverage to the elderly, and both are lacking in terms of an adequate and effective plan that will help those most in need. Although the intentions of policy makers

are positive, the policies and programs offered as a solution are inadequate. American society is aging, and the country is facing a new phenomenon with the retirement of the baby-boomer generation. Few politicians understand the full ramifications of the growing elder population, nor are they aware of the needs of the elderly population; hence, the policies revolving around this section of society are often unsuitable in terms of the true need that exists.

The creation of Medicare in 1965 opened a floodgate of rights and entitlements previously foreign to American culture. At the time Medicare was implemented, approximately one-half of seniors were uninsured and had a greater tendency to be living in poverty than any other population in the country.¹ The original components of Medicare include Part A and Part B², financed through a combination of general revenues, payroll taxes,³ and the deductible and monthly premiums⁴ of persons enrolled in Part B Medicare.⁵ Although sufficient for the needs at the time it was created, Medicare is now facing demands that were unknown to the original authors of the Medicare program. The Medicare program must be changed to meet the needs of our increasingly aging society.

Medicare does not include prescription drug coverage; the progression of pharmaceutical breakthroughs mandates that the Medicare program must reflect the changing needs of its beneficiaries.⁶ Currently, 98% of health insurance plans in the United States offer some form of prescription drug coverage to clients.⁷ Medicare does not provide such an option to its beneficiaries and it must move forward to adapt to the changing needs of 21st century America.⁸

¹Medicare 35th Anniversary Event: Medicare's Milestones, Medicare, <<http://www.medicare.gov/35/milestones.asp>> (2000, November 14).

²Part A of Medicare is offered to seniors at no cost upon retirement; Part B of Medicare is an optional form of coverage for seniors.

³Payroll tax for Medicare is 1.45%.

⁴1999-Part B deductible \$100, monthly premium \$45.50.

⁵Medicare at a Glance, The Henry J. Kaiser Family Foundation, <www.kff.org> (2000, November 14).

⁶Representative Stephen Horn, "Medicare: First, Do No Harm," FDCH Press Release, 27 (September 2000).

⁷Governor George W. Bush, "A Defining American Promise," Bush/Cheney, <<http://www.georgewbush.com/News.asp?FormMode=SP&id=3>> (2000, November 30).

⁸Ibid.

PROJECTIONS OF THE AGING POPULATION

In the United States today, people are living longer and retiring earlier. Currently, there are fewer people working to support the older population; it is projected that this trend will continue through the year 2030. This trend will result in an equal distribution of older and younger people in society rather than a pyramid structure of society which exists today.⁹

The older-aged society of America is growing substantially. In 1998, 5,190 persons celebrated their 65th birthday every day, totaling 1.9 million persons reaching the age of 65 that year. Concurrently, 1.75 million persons age 65 or older died, resulting in a net increase in the elder population of 145,000 persons annually, or 396 per day. Those that are reaching retirement age are expected to live 17.6 years longer than their predecessors. In comparison to the year 1900, the 65-74 age group of is eight times larger, the 75-84 group is sixteen times larger, and the 85+ group is thirty-three times larger.¹⁰

Ethnic distinctions in the elder population must also be noted. The increased elder population also increases the number of minorities in the group. This is important to note in that different races and ethnicities require targeted and specific care. According to a self-assessment of health, African-Americans and Hispanics are more likely to report themselves as having ill health than Caucasians (41.6% Black, 35.1% Hispanic, 26.0% White).¹¹ Currently, 84% of the elderly population is white, 8% are black, and 6% are Hispanic.¹² The white population of elders is expected to decrease to 64% by 2050 while the black population increases to 12% and Hispanics more than double to compose 16% of the elder population.¹³ Health care delivery of the future must be specific not only to the needs of the aging, but also to the diversity of this portion of society.

IS THE NEED FOR PRESCRIPTION DRUG COVERAGE UNIVERSAL?

⁹David A. Wise, ed., *Facing the Age Wave* (Stanford, CA: Hoover Institution Press, 1997), p. 1.

¹⁰ "A Profile of Older Americans-1999," *AARP*, www.aarp.com (2001, March 6), p. 1.

¹¹ "A Profile of Older Americans....," p. 12.

¹² Although the numbers do not total 100%, the purpose of this commentary is to take into account the larger minority groups. Other minorities composing the elder population include the following: 2% non-Hispanic Asian and Pacific Islander, and less than 1% non-Hispanic American Indian or Alaskan Native.

The demand for a prescription drug plan is not without limits as to who needs prescription drug coverage. Roughly two-thirds of seniors have some form of prescription drug coverage.¹⁴ Of the twenty-six million Medicare beneficiaries with outside prescription drug coverage, one-third have employee sponsored insurance, one-tenth are covered through Medigap,¹⁵ one-ninth (the poorest seniors) are covered by Medicaid,¹⁶ and one-twelfth are covered through a Medicare HMO.¹⁷ These statistics are skewed in that of those persons with prescription drug coverage, 47% do not have coverage year-round.¹⁸ One-half of seniors with Medigap coverage do not have coverage for the duration of the year.¹⁹ Medicare Parts A and B, combined, only cover 53% of health care costs. While the remaining 47% of cost is partially absorbed by Medigap, this program does not cover outpatient drug costs.²⁰ In addition, employer-sponsored insurance is decreasing. From 1995 to 1998, employer health coverage dropped from 35% to 30%.²¹ Although a majority of seniors have some form of prescription drug coverage, it is evident that the coverage is limited resulting in higher out-of-pocket expenses for the elderly. This is especially difficult for lower-income seniors that do not qualify for Medicaid yet cannot afford additional prescription drug coverage.

The steadily increasing cost of prescription drugs is especially alarming for those persons without insurance coverage. Statistics show that the uninsured usually require more intensive health services, have low incomes, and are less likely to buy the necessary prescriptions as recommended by

¹³ Federal Interagency on Aging Related Issues, "Older Americans 2000: Key Indicators of Well-Being," www.agingstats.com (2001, 14 March).

¹⁴ Representative Horn, "Medicare: First..."

¹⁵ Medigap is an optional program for Medicare beneficiaries to cover prescription drug costs.

¹⁶ Medicaid is a federal social insurance program designed for low-income persons.

¹⁷ Medicare and Prescription Drugs, [The Henry J. Kaiser Family Foundation](http://www.kff.org), <www.kff.org> (2000, November 3).

¹⁸ The Department of Health and Human Services, Report to the President: Prescription Drug Coverage, Spending, Utilization, and Prices, [The Department of Health and Human Services](http://aspe.hhs.gov/health/report/drugstudy/), <<http://aspe.hhs.gov/health/report/drugstudy/>> (2000, October 25).

¹⁹ President Clinton Releases New Prescription Drug Coverage and Pricing Study, [Access America for Seniors](http://www.seniors.gov/articles/0400/clinton_prescriptions.html), <http://www.seniors.gov/articles/0400/clinton_prescriptions.html> (2000, October 25).

²⁰ Governor George W. Bush, "Saving Social Security and Medicare," [Bush/Cheney](http://www.georgewbush.com/News.asp?FormMode=SP&id=3), <<http://www.georgewbush.com/News.asp?FormMode=SP&id=3>> (2000, November 30).

²¹ "Medicare: Beneficiaries and Prescription Drug Coverage: Gaps and Barriers", [AARP](http://research.aarp.org/health/ib39.html), <http://research.aarp.org/health/ib39.html> (2001, March 8).

their physicians.²² Seniors without drug coverage do not receive discounts or rebates available to the insured resulting in a typical price increase, per prescription, of 15%.²³ Persons without insurance purchase one-third less the amount of prescription drugs, yet still pay two times the amount of out-of-pocket expenses when compared to persons that are insured.

According to the Domestic Policy Council and the National Economic Council, one-fourth (nine million) of Medicare recipients are classified as rural.²⁴ Typically, rural elders have lower incomes, more limited access to pharmacies, and an out-of-pocket expense greater than do urban elders. Although rural elders have increased needs, the coverage options available to them are few. Costs are higher for rural elders, and they are 60% more likely to forego filling prescription drugs than urban elders. In that health care costs require a greater percentage of their income,²⁵ rural elders pay 25% more out-of-pocket expenses than do urban elders. Forty-five percent of rural elders have chronic illnesses in comparison to 36% of urban elders, resulting in 33% of rural elders having out-of-pocket expenses exceeding \$500, compared to 25% of urban elders.²⁶

A lack of preventive care for rural elders, as well as the nature of work²⁷ in such regions, are probably key issues explaining the occurrence of chronic illness among the rural elderly. The rural elderly are 50% less likely to have prescription drug coverage; those that have coverage are more likely than urban elders to lack coverage for the entire year (43% rural versus 27% urban).²⁸ It is speculated that the benefits reach coverage limitations sooner for rural elders since drugs for chronic illnesses are more expensive. More than half of rural elders age 85 or older do not have prescription drug coverage. This proportion is 50% more than their urban counterparts. Several problems for the rural elderly stem

²²President Clinton Releases New Prescription Drug Coverage...

²³DHHS, Report to the President:...

²⁴In this study, no criterion were given for the classification of "rural elder," hence, assumptions must be made.

²⁵Rural elders typically have lower-incomes, therefore, the impact of out-of-pocket expenditures as a percentage of income is greater.

²⁶President Clinton Releases New Report on the Special Challenges Facing Rural Seniors Who Need Prescription Drugs, [Access America for Seniors](http://www.seniors.gov/articles/0600/rural_senior_drugs.html), <http://www.seniors.gov/articles/0600/rural_senior_drugs.html> (2000, October 25).

²⁷Occupations in rural areas, like coal mining, typically put those persons at higher risk for job-related illness.

from the fact that 45% of those persons without drug coverage in rural areas have annual incomes 150%-400% of the federal poverty level, do not qualify for Medicaid assistance, and cannot afford additional insurance for drug coverage. Employee-based drug coverage is also lower in rural regions (25% rural versus 35% urban).²⁹ Again, the nature of the work in rural areas can attribute to the trend of employee-based insurance.

In an attempt to make prescription drug coverage more readily available to seniors, Medicare+Choice was developed in the Balanced Budget Act of 1997 and offers private insurance for seniors as an alternative to Medicare. Frequently, the insurance plans include a prescription drug benefit; however, Medicare+Choice is often not available to rural seniors because the reimbursement rates for providers are too low and they choose not to participate in the program.³⁰ Also, the Medicare HMO may not be available in rural areas and the main option left is to purchase a Medigap policy.

Medigap, however, is still very costly to the consumer, with additional out-of-pocket expenditures ranging from \$300 to \$500 annually in premium costs alone. The standard Medigap coverage is a \$250 deductible, a 50% rate of cost-sharing, and a cap of coverage ranging from \$1,250 to \$3,000 depending upon the choice of the enrollee. Also, participation in the Medigap program is only guaranteed in the first six months of Medicare enrollment³¹ If one does not opt for the insurance coverage at that time, he or she could be denied later. The plight of rural elders is quite different from that of urban elders; regardless, the overarching need for pointed prescription drug coverage is evident regardless of demographics.

The urgency to develop a plan that will be fiscally responsible, yet effectively implemented to those persons that need the benefit, comes to fruition in that the Medicare base is growing rapidly. Currently, Medicare covers thirty-nine million beneficiaries; by 2030, Medicare will be expected to cover

²⁸President Clinton Releases New Report...Rural Seniors...

²⁹President Clinton Releases New Report...Rural Seniors...

³⁰Governor George W. Bush, "Saving Social Security..."

³¹ "Medicare: Beneficiaries and Prescription..."

seventy-six million recipients.³² With more persons retiring, the tax base from which Medicare draws a portion of its funding will shrink. The coming of retirement age for the baby-boomer generation will lead to the financial deprivation of Medicare if the program is not carefully monitored. The current ratio of workers to Medicare recipients is 4:1; in 2030, the ratio of workers to Medicare recipients will be 2:1.³³ Due to the decreasing ratio of workers to recipients, the creation of a prescription drug plan could create catastrophic costs for the federal government if the plan is not thoughtfully implemented.

The development of a prescription drug plan for seniors will be paid for by all tax-paying citizens, not solely by the person enjoying the benefit. Although this is the nature of a redistributive policy,³⁴ some argue that the senior citizen population in America is not as financially unstable as projected. The rate of poverty is decreasing among the elderly, as Social Security has assisted in bringing the poverty level of seniors down to 12% compared to 28% thirty years ago.³⁵ According to the U.S. Census Bureau, the median net worth of retirees is \$86,000 annually. Comparatively speaking, the net worth of retirees is fifteen times the net worth of persons age thirty-four or below, and three times the net worth of persons age thirty-five to forty-four. In the past eleven years, the median income of retirees has increased 8%,³⁶ quite possibly because of the nature of persons retiring. The AARP³⁷ reports that persons in their sixties have more discretionary income³⁸ than any other group of the population. Twenty percent of elders have a net worth of \$250,000 or more.³⁹ Persons noted in the latter group are not in need of a governmental prescription drug plan.

WHY ARE OUT OF POCKET COSTS INCREASING?

³²League of Women Voters and the Henry J. Kaiser Family Foundation, *Join the Debate: Your Guide to Health Issues in the 2000 Election*, The Henry J. Kaiser Family Foundation, <<http://www.kff.org/content/2000/1574voterguide.pdf>> (2000, November 1).

³³Governor George W. Bush, "Saving Social Security..."

³⁴Redistributive policy is a policy that takes from one group of people in society in order to benefit another group.

³⁵David K. Brown, "The Future of Social Security," *MSGEC Practice Matters*, 2000.

³⁶Andrew Sullivan, "Old Guard," *New Republic*, vol. 223 iss. 15, 09 (October 2000): 6.

³⁷American Association for Retired Persons (AARP).

³⁸Discretionary income is defined as income remaining after the payment of rent, food, clothing, etc.

³⁹Andrew Sullivan, "Old Guard," ...

The nature of healthcare as a field is changing the method in which patients receive care. There is a substantial increase in outpatient facilities, mid-level practitioners, and alternative care as a direct result of healthcare changing from fee-for-service to managed care. In an effort to decrease costs, the aforementioned methods of practice have been implemented in health care facilities and subsequently, out-of-pocket expenses have increased, leaving patients with no alternative but to absorb the additional costs or reject care. Prescription drugs are not covered in outpatient care; therefore, prescription drug costs are subject to having a substantial impact on the person receiving the care.

The rising cost of prescription drugs increases the challenges that policy-makers face regarding this issue. Between 1993 and 1998, annual prescription drug costs increased 12% nationwide. All other health care spending increased only 5% annually.⁴⁰ Of the 5% increase in health care spending nationally, 44% of the increase is due to prescription drug costs.⁴¹ Of health related costs for the elderly, prescription drugs account for one-sixth of annual costs.⁴² In 1998, 80% of Medicare recipients had a regular regimen of prescription drugs. Of the fifty most commonly used drugs among the elderly, the price for those drugs increased four times the inflation rate.⁴³ From January 1994 to January 1999, the price of thirty-one of the thirty-nine drugs most frequently used by the elderly increased in price at least five times.⁴⁴

Although the actual production of prescription drugs is not expensive, the initial cost of research and development requires monetary compensation to enable drug companies to continue the development of new drugs.⁴⁵ It costs approximately \$500 million and 12-15 years to research, develop,

⁴⁰Medicare at a Glance.

⁴¹ Deanna Bellandi, "Health Plans Face Higher Medical Costs," Modern Healthcare, vol.30, iss. 50, December 2000: p. 24.

⁴²Medicare at a Glance.

⁴³League of Women Voters and the Henry J. Kaiser..., Join the Debate...

⁴⁴ Kathleen Haadad, "Hard to Swallow: Rising Drug Prices for America's Seniors," Families USA, Publication #99-107, November 1999: p. 4.

⁴⁵Robert J. Barro, "Attention Customers: Creativity Never Comes Cheap," Business Week, iss. 3701, October 2000: pp. 36-38.

and test a new prescription drug. Pharmaceutical companies argue that the value of a saved life is an appropriate benefit from the increasing cost of prescription drugs.⁴⁶

The life-saving nature of recent discoveries in pharmaceuticals make the value of affordable prescription drugs almost immeasurable; yet, availability is still a relevant issue. New drugs are not valuable if they are not affordable to those in need of the medication. Americans have two choices: lower drug prices resulting in decreased production of new drugs, or higher drug prices resulting in increased production of new drugs.⁴⁷ Regardless of the reasoning behind increasing prescription drug prices, the issue of consumer affordability is still a serious consideration.

FULL MEDICARE VERSUS MEDICARE/PRIVATE

There are two policy models that the legislators are using when developing prescription drug policy: Full Medicare and Medicare/Private. The two types of plans are similar with respect to low-income subsidization of costs and stop-loss coverage.⁴⁸ Current prescription drug plans provide provisions for persons unable to pay for prescription drug coverage and persons that have extraordinary prescription drug costs. When estimating future costs, Full Medicare provides a 5.5% increase a year for prescription cost increases. Increases for changes in utilization are not included in projected costs. If the amount of drug spending increases at a faster rate than drug prices (as is predicted to occur), a large amount of stop-loss⁴⁹ claims would be filed, and the government would be responsible for payment. In an effort to remove the burden of stop-loss costs from the federal government, the Medicare/Private plan provides for insurance companies to absorb the financial burden of stop-loss claims. If this were to occur, a possible outcome is that insurance companies may raise the stop-loss threshold to avoid full payment.⁵⁰ If the federal government adopts a Medicare/Private policy, it should be mandated that the insurance companies participating in a

⁴⁶ PhRMA, "Why Do Medicines Cost So Much?" www.phrma.org (2001, March 6).

⁴⁷Robert J. Barro, "Attention Customers:...", pp. 36-38.

⁴⁸Dr. Beth Fuchs; Julie James; James May; et. al., Analyzing Options to Cover Prescription Drugs for Medicare Beneficiaries, [The Henry J. Kaiser Family Foundation](http://www.kff.org), <www.kff.org> (2000, October 23).

⁴⁹ Stop-Loss Threshold: The point at which an insurance company pays 100% of costs.

⁵⁰Dr. Beth Fuchs, et.al., Analyzing Options to Cover Prescription Drugs...

collaborative effort with Medicare cannot raise premiums, co-pays, deductibles, or stop-loss thresholds without government approval.

Full Medicare with stop-loss provisions mandates that a beneficiary choose whether or not to enroll in the program at the time he or she becomes eligible for Medicare. A single, standard benefits package would be available for enrollment. A national premium, based on a percentage of benefit costs, would be withdrawn from Social Security checks. The government would negotiate drug prices and contracts would be established based on geographical region.

Comparatively, the Medicare/Private plan allows beneficiaries to choose from an array of government approved private insurance companies. Although the private insurance companies would have to meet certain government criteria, a variety of benefit packages (different premiums, co-pays, deductibles, etc.) would be available to the beneficiary. Rather than insurance risk and loss being borne by the federal government, the Medicare/Private plan places the financial burden in the hands of the insurance companies.⁵¹

EFFORTS TO ESTABLISH PRESCRIPTION DRUG COVERAGE

The attempt to pass prescription drug coverage into law is not a new phenomenon. Efforts to establish prescription drug coverage within Medicare have been attempted in recent decades but to no avail. No longer can policy-makers ignore the necessity of creating a prescription drug plan that meets the needs of the people without sacrificing individual satisfaction within the client base.

In 1988, Congress passed the Medicare Catastrophic Coverage Act in an effort to expand the reach of Medicare. The act established a prescription drug benefit for outpatient care. In 1989, this act was reversed as a result of complaints about an increase in premium cost to the beneficiaries.⁵² More recent efforts include the Rx Medicare 2000 Act (H.R. 4680), which marginally passed in June of 2000 by a vote of 217-214. The act provides for voluntary enrollment into Medicare Part D, which allows seniors to choose among private insurance plans for prescription drug coverage. Low-

⁵¹Dr. Beth Fuchs, et.al., Analyzing Options to Cover Prescription Drugs...

⁵²Medicare 35th Anniversary Event...

income premiums and catastrophic drugs are covered under the new legislation. It is expected that drug costs will decrease 39%.⁵³ In this plan, Part D benefits are a collaborative effort with private insurance companies, with various coverage options, premium rates, and co-payment rates are available for seniors to choose from.⁵⁴

Senate Bill 2541, the Medicare Expansion for Needed Drugs Act (MEND), covers 50% of prescription drug costs up to \$5000 annually. Upon complete implementation, the plan would cover catastrophic drug costs. The components of the plan include the following: an addition of Part D Medicare, negotiated prices for drugs, the reduction of premiums with government contributions, free coverage for persons with an annual income at or below 135% of poverty, and partial assistance for persons with an annual income between 135% to 150% of poverty.⁵⁵

Former President Clinton offered a plan designed to cover half of all prescription drug costs up to \$5000 annually; upon full implementation, a stop-loss component to the coverage would be added.⁵⁶ Opponents of Clinton's plan argue that a government-run, single-option program will not allow for seniors to choose coverage that will best suit their needs, which would result in unnecessary expenditures for the federal government.⁵⁷ Although a fervent effort was made on the part of Congress and the President to develop a bipartisan prescription drug policy, the implementation of such a policy is yet to be seen on a national level.

PRESIDENT GEORGE W. BUSH: PRESCRIPTION DRUG DISCOUNT CARDS

On July 12, 2001, President Bush offered a solution that does not require Congressional approval and that can take immediate effect.⁵⁸ In early September, a federal judge ruled on behalf of

⁵³Justification as to how a decrease in drug costs will be accomplished is not noted in literature regarding this issue.

⁵⁴Representative J. D. Hayworth, "Hayworth, House Pass Prescription Drug Plan For Seniors, 217-214 Voluntary Program Would Reduce Lifesaving Drugs By Up to 39%," FDCH Press Release, 27 (September 2000).

⁵⁵Mary Jane Fisher, "Democrats Start Drive for Medicare Drug Benefit," National Underwriter/Life & Health Financial Services, vol. 104 iss. 20, 15 (May 2000): 1-3.

⁵⁶President Clinton Releases New Prescription Drug...

⁵⁷Representative Horn, "Medicare: First..."

⁵⁸Bush Unveils Plan to Cut Drug Costs for Seniors," CNN.com, <http://www.cnn.com/2001/ALLPOLITICS/07/12/bush.medicare/> (2001, October 9), p.2.

the National Association of Chain Drug Stores, providing for a court injunction to temporarily halt the progression of Bush's discount drug card plan.⁵⁹ In addition, the impact of terrorist attacks on the United States has had a substantial impact on the agenda of government as a whole. President Bush expected the discount drug card program to be implemented immediately and quickly; however, the obstacle of the injunction has prohibited the plan's implementation.

According to President Bush, the discount card would allow senior citizens to receive discounted pharmaceuticals when prescribed medication. With the discount card, it is expected that the discount would be between 15% and 30%.⁶⁰ Sources outside the Bush administration suggest that the discounts will be slightly lower, ranging from 10% to 25%.⁶¹ Companies enrolled could charge a one-time \$25 fee to each enrollee, and the initial purchase of the drug card for the government would cost, according to President Bush, approximately one dollar.⁶² The Bush administration expected the plan to be implemented as early as October of 2001 and no later than January 2002; however, as mentioned earlier, unforeseen circumstances have altered the administration's agenda in terms of domestic issues.⁶³

HOW MUCH DO SENIOR CITIZENS SPEND ON PRESCRIPTION DRUGS?

Most seniors will not reach the stop-loss thresholds of the proposed plans. For out-of-pocket prescription costs, only 10% of seniors spend more than \$1000, and only 4% spend more than \$2000 annually.⁶⁴ One-half of seniors spend less than \$200 on prescription drugs per year,⁶⁵ and in 1999, Medicare beneficiaries spent an average of \$400 a year for prescription drugs.⁶⁶ Perhaps these costs

⁵⁹ "Administration Disappointed by Injunction on Drug Discounts," [CNN.com](http://www.cnn.com/2001/ALLPOLITICS/09/07/bush.drugdiscount/index.html), <http://www.cnn.com/2001/ALLPOLITICS/09/07/bush.drugdiscount/index.html> (2001, October 9), p. 1.

⁶⁰ "Bush Unveils Plan to Cut...", p. 1-2.

⁶¹ "Info, savings key to Medicare discount," [CNN.com](http://www9.cnn.com/2001/HEALTH/07/12/medicare.discount.explainer/index.html), <http://www9.cnn.com/2001/HEALTH/07/12/medicare.discount.explainer/index.html> (2001, October 9), p. 1

⁶² "Bush Unveils Plan to Cut...", p. 1-2.

⁶³ "Thompson describes Medicare changes, drug discounts," [CNN.com](http://www9.cnn.com/2001/ALLPOLITICS/07/12/tommy.thompson.cnn/), <http://www9.cnn.com/2001/ALLPOLITICS/07/12/tommy.thompson.cnn/>, (2001, October 9), p. 1.

⁶⁴ Andrew Sullivan, "Old Guard..."

⁶⁵ Ramesh Ponnuru, "Dr. Feel-Good: Bush and Gore Peddle Their Drug Plan," [National Review](#), vol. 52 iss. 18, 25 (September 2000): 22-24.

⁶⁶ League of Women Voters and the Henry J. Kaiser..., Join the Debate...

are low because some of these seniors already have prescription drug coverage. Persons with above average out-of-pocket spending⁶⁷ tend to be in poor health, limited in physical capabilities, 75 years of age or older, without prescription drug coverage, and in possession of private supplemental insurance. These persons tend to spend between 4-7% of their annual income on prescription drugs alone; 21-30% of their income is spent on health care costs as a whole.⁶⁸ In addition, those with higher out-of-pocket spending, typically, do not qualify for Medicaid in that their income is between 135-200% of poverty, and a higher percentage of their income is spent on prescription drugs.⁶⁹

It is concluded that the out-of-pocket expenses for seniors will remain relatively the same even with the implementation of a new prescription drug policy. Under the Bush plan, seniors have to pay a deductible which, for half of the population, will not be met within one year. Those that do meet the deductible are still subjected to out-of-pocket expenses up to \$6000 with Bush's plan. As noted earlier, 96% of seniors do not even exceed \$2000 per year for prescription drug costs. Consequently, the stop-loss threshold will barely be utilized and those seniors that do not require several or expensive prescriptions will be left out of the equation once again.

RECOMMENDATIONS OF APPLICATION FOR PRACTITIONERS IN THE FIELD

It is possible that policy-makers will pass legislation that is inadequate for the needs of the elderly. Most treatment plans require some form of medication, and the issue of consumer affordability is still relevant. It is likely that patients will have to absorb the cost of prescription drugs at some point in time. As has been discussed, the cost of prescriptions is increasing and those without insurance are suffering the most, as they are the most likely to have chronic illnesses, live in rural areas, and have decreased access to pharmacies and health care facilities.

Most proposed plans are minimally beneficial to Medicare participants. Alternatives to out-of-pocket spending for the elderly need to be pinpointed and communicated with the community utilizing

⁶⁷ For this data, out-of-pocket spending is defined as including premiums for Medicare Part B, cost-sharing, and supplemental insurance coverage.

⁶⁸ "How Much Are Medicare Beneficiaries Paying for Out-of-Pocket Prescription Drugs," AARP, http://research.aarp.org/health/9914_how_much_1.html (2001, 8 March).

Medicare's services. Resources for discounted prescriptions outside the government need to be made known to those that are the most in need. Several pharmaceutical companies have patient assistance programs that help those without the financial resources to purchase prescription drugs. Other options, such as clinical trials and alternative therapies, need to be discussed with patients as an optional form of treatment. Hospitals and providers need to ensure that some form of charity care or an assistance program are in place for their most needy patients. Persons that have not reached retirement age need to be educated as to the importance of preventive health care and healthy living. Preventing chronic illness in future enrollees will be beneficial to the Medicare program in that those persons retiring will be in better health and will require less financial support. Patients, providers, administrators, and politicians need to work collaboratively and collectively for the common good and the end goal without missing those persons most in need.

Often, doctors can perform clinical trials on patients that meet certain criteria, and clinical trials are typically free to the patient. The patient or his or her caretaker should inquire about such an option.⁷⁰ Another method of avoiding high out-of-pocket expenses is to investigate the possibility of using alternative therapies or medicines. This form of medication is being widely used by a diverse population of physicians, caretakers, and healthcare providers. The patient should inquire as to possible alternative therapies for his or her personal case.⁷¹

Pharmaceutical companies offer a vast array of reimbursement and assistance programs for patients. In a recent study by Phrma, it is estimated that the pharmaceutical companies that were members of Phrma provided over \$500 million of product to 1.8 million people in 1998. A significant portion of the drugs targeted for reimbursement are used by Medicare beneficiaries.⁷² Elderly patients

⁶⁹ "How Much Are Medicare Beneficiaries Paying..." AARP.

⁷⁰ Refer to Appendix 1 for resources regarding Clinical Trials.

⁷¹ Refer to Appendix 2 for resources regarding Complementary and Alternative Therapies.

⁷² Laura A. Dummit, "Prescription Drug Companies-Drug Company Programs Help Some People Who Lack Coverage," FDCH Government Account Reports, 2000 (16 November).

should ask their case managers or social workers for assistance in applying for the assistance or reimbursement programs offered by pharmaceutical companies.⁷³

Beyond providing a safe and secure environment for the patient, health care facilities can do a lot to ensure that the patient has access to the best and most recent type of care available. Aside from providing an atmosphere that is conducive to the needs of the elderly, administrators can do more to ensure that patients receive the prescriptions that they need. Administrators can, and should, expand the formularies at health care facilities in order to give the patient more options in terms of medication. Although the final say on the reimbursement of prescription drugs is up to the insurance plan, administrators can make it possible for patients to have a greater chance of having a medication approved if the formulary is large. Also, through increasing the formulary, patients without insurance coverage can possibly choose between medications (i.e., generic versus name brand drugs) and perhaps be more inclined to purchase the drugs prescribed to them.

Administrators can also implement programs that encourage case management and the involvement of a social worker for long-term patients. A form letter with an indication of the pharmaceutical resources and options available to the patient should be given to every patient upon admittance to inpatient and outpatient care facilities. Included in the letter should be the process which the patient and/or his or her caregiver must go through for each assistance program, and the documents needed for requisition of medications. For patients that prefer verbal confirmation, video and audio tapes of information should be made available in lieu of, or in addition to, written plans. Maintaining a file for the patient regarding insurance and financial status could be very beneficial in terms of cost and benefit for both the patient and the facility.

In addition, administrators can, and should, encourage team-based treatment teams that can determine the treatment plan as well as establish the method of payment for services rendered. If the patient has insurance, thought should be given to the types of medications and services covered under his or her plan. If the patient has limited or no insurance, treatment plans and options (i.e., clinical

⁷³ Refer to Appendix 3 for resources regarding Prescription Drug Company Reimbursement Programs.

trials) can be researched based on the resources available to him or her through various programs. Charity care is another option for the administrators of a health care facility. Federal poverty guidelines can serve as a foundation upon which charity care can be determined for services, office visits, and prescription drugs. A sliding-fee scale or a reduced rate for services can also prove to be a way in which administrators can reduce the out-of-pocket costs for patients with limited, exhausted, or no insurance coverage. Providers of health care need to take responsibility and ensure that the patient has the highest quality care during and after his or her visit to a health care facility.

Rx FOR Rx PROPOSALS

All factors considered, the goal of a prescription drug initiative must first be established and clearly articulated. What is the true intent and purpose of policy proposals relative to prescription drug coverage? Are policy makers trying to establish a free drug policy or a greater access policy? This is a determination and distinction that needs to be made.

Free drug plans are extremely costly and risky to the government; the economy is too unstable and unpredictable to be able to assure citizens that the services are guaranteed. Secondly, a free drug program sponsored by the government may deter employers from purchasing or subsidizing employee based benefits packages during employment and through retirement. Shrinking private sector insurance coverage is risky and may force the government to absorb additional costs.

If the objective is to establish greater access and affordability for the elderly in America, then the stop-loss threshold needs to be decreased. Perhaps the solution is to create an incentive program to private insurance companies that will provide greater access to seniors for prescription drug coverage. This type of a plan would be less costly to the government as the financial burden would be shared by the private sector and the federal government.

Considering premium and deductible costs, most senior citizens would save money by *not* enrolling in a prescription drug plan. Medicaid will continue to cover the costs of low-income seniors under current plans for prescription-drug plans; however, lower-middle and middle-class seniors are still at a disadvantage in the plans being presented. The issues surrounding this part of the senior

population still exist. They are not poor enough to qualify for Medicaid yet they are not wealthy enough to purchase prescription drug coverage. An option is that the guidelines for Medicaid coverage for the elderly be loosened in order to help a greater portion of the senior citizen population and truly assist those that need the help in this situation. It should be out of genuine concern for the elderly, and the associated problems of access, that a collaborative effort between the private sector and the government be utilized to create the ultimate, ideal solution to the prescription drug problem for the elderly.

OVERALL CONCLUSIONS

Issues involving the elderly have an impact on all sections of society. Caretakers, families, providers, insurance companies, and tax-paying citizens all play a vital role in the state of the elder population. Ignoring the needs of the elderly will do nothing but perpetuate the problems associated with this sector of society; conversely, disregarding the risks of implementing costly programs for the elderly will have a devastating effect on society as a whole. Programs designed to expand access to prescription drug coverage or to provide free prescription drugs to the elderly need to be thoughtfully implemented and carefully designed in order to avoid harmful consequences in the federal government. Issues of health, cost, prescription drug prices, and persons currently insured all need to be taken into consideration if the government wants to provide a program that will be helpful to those most in need; namely, the lower-middle and middle class seniors. Prescription drug coverage for the elderly is sure to be a debated topic in the months and years to come. The consequences of implementing a faulty plan will have a greater long- term and far-reaching effect.

Appendix 1

<i>Cancer Clinical Trials - Where to Find More Information</i> ⁷⁴	
www.leukemia-lymphoma.org	www.clinicaltrials.org/
www.cancertrials.nci.nih.gov/	www.cancer.org
www.cancernet.nci.nih.gov/pdq.htm#clinical trial	www.centerwatch.com
www.oncolink.upenn.edu/	www.fda.gov/

⁷⁴ Where Can I Find More Information on Cancer Clinical Trials?" [The Leukemia & Lymphoma Society, www.leukemia-lymphoma.org](http://www.leukemia-lymphoma.org) (2001 January 3).

Appendix 2

<i>Complementary & Alternative Therapies - Where to Find More Information</i> ⁷⁵	
www.cancer.org (1-800-ACS-2345)	www.nci.nih.gov/
www.aicr.org (1-800-843-8114)	altmed.od.nih.gov/
www.bu.edu/COHIS/	www.oncolink.upenn.edu/
www.fda.gov	www.reutershealth.com/
www.sph.uth.tkmc.edu/utcam/	www.quackwatch.com

⁷⁵ "Where Can I Find Reliable Information?" The Leukemia & Lymphoma Society, www.leukemia-lymphoma.org (2001 January 3).

Appendix 3

Prescription Drug Assistance Programs	
www.phrma.org	Eli Lilly 1-888-443-6927
www.rxassist.org	Genetech, Inc. 1-888-249-4918
www.express-med.com	Gilead Sciences 1-800-226-2056
www.needymeds.com	Glaxo Wellcome 1-800-722-9294
www.lorenbennet.org/freemedts.htm	Janssen 1-800-652-6227
www.cfoa.org	Liposome 1-800-345-2252
www.aoa.dhhs.gov	MGI Pharma, Inc. 1-888-743-5711
Alza 1-800-609-1083	Novartis 1-800-654-0118 *2
Amgen, Inc. 1-800-272-9376	Ortho Biotech, Inc. 1-800-553-3851
Anesta 1-877-229-1241	Parke-Davis 1-908-725-1247
AstraZeneca 1-800-424-3727	Pfizer, Inc. 1-800-869-9979
Aventis 1-800-221-4025	Pharmacia & Upjohn 1-800-242-7014
Bayer 1-800-998-9180	Roche Laboratories, Inc. 1-800-443-6676 *2
Berlex 1-800-473-5832	Roxane Laboratories 1-800-274-8651
Bristol-Myers Squibb 1-800-272-4878	Sigma-tau 1-800-999-6673
Chiron 1-800-775-7533	SmithKline Beecham 1-800-699-3806

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