# Executive Summary

The number one issue before state legislatures in 2001 will be access to prescription drug coverage, according to participants at a recent conference sponsored by the National Conference of State Legislatures. In the next 8 years, state and local taxes spent on prescription drugs outside Medicare or Medicaid will jump from $10 to $24 billion, according to the Health Care Financing Administration. To date, 22 states have already passed prescription drug legislation. This briefing report addresses why states are so interested in prescription drugs and provides answers to questions that policymakers often ask about this issue.

In the first chapter, Professors David Kreling, David Mott, and Joseph Wiederholt discuss why spending on prescriptions has been one of the fastest-growing health care costs. The rate of increase in prescription spending has surpassed increases in most other components of personal health care in the past decade, exceeding 10 percent annual increases in all but two years. In the past five years, the increases in prescription spending have been two to four times the percent increases in other major components of health care. Even though prescription drug spending is increasing more quickly, the dollars spent on physician's costs and hospital care are double and triple, respectively, the amount spent on prescription drugs.

Between 1993 and 1998, three factors have driven the increases in prescription drug spending: increased drug use (43%), changes in use to newer higher-cost drugs (39%), and price increases by manufacturers for existing drugs (18%). Use of drugs has been higher due to population growth, an increased number of prescribers, promotion of prescription drugs to stimulate demand, and the aging of the population. Between the ages of 45 and 75, prescription use nearly triples, from an overall average of 4.3 to 11.4 prescriptions per person each year.

Newer, higher-cost drugs are available as a result of research by manufacturers. Expenditures for research and development, however, are a relatively small proportion of sales for both major (11%) and generic drug manufacturers (6%). Historically, drug manufacturers have been the most profitable U.S. industry with a profit margin of 19% compared to 5% for all Fortune 500 companies.

The average annual percent change in retail prescription drug prices from 1991 to 1998 was 6.7% overall, higher than the average rate of inflation of 2.6%, and the average increase of 4.6% for medical care. For each dollar spent on prescription drugs, 74 cents goes to the manufacturer, 23 cents to the pharmacist, and 3 cents to the wholesaler.

More than three-quarters, or 77% of Americans who aren't covered by Medicare had prescription drug coverage in 1996, mostly through their employers (61%), followed by Medicaid (11%); those without prescription coverage (23% or over 53 million people) typically have no health insurance coverage at all. Of Medicare beneficiaries, 31% or 11.5 million seniors had no drug coverage in 1996. Low-income families who aren't eligible for Medicaid (between 100% and 200% of the Federal Poverty Level) are most likely to be without drug coverage.

Since 1990, the proportion of drug costs paid by consumers has decreased from 48% to 28% of total spending, while private insurers have increased their payments from 34% to 51%. The share paid by government programs has increased slightly from 18% to 21%. For the average American, about 1% of spending on household goods and services is for prescription drugs.

In the next chapter of the report, Bruce Stuart, Becky Briesacher, and Dennis Shea discuss how policymakers could determine eligibility for a prescription drug benefit for the elderly. Determining eligibility deserves careful consideration by policymakers because who has the greatest need depends upon how you define need. This study considered six different ways of defining need including two income cutoffs, lack of consistent and stable coverage, high prescription drug bills, and multiple chronic diseases.

In recent proposals to add a Medicare drug benefit, annual income in relation to Federal Poverty Level is clearly the leading criterion in defining need. This study shows that if annual income alone is used to determine eligibility, most Medicare beneficiaries will not qualify for prescription drug coverage under Medicare. If the income cutoff was below 100% of the Federal Poverty Level, about 25% would qualify. If the income cutoff was raised to less than 150% of the Federal Poverty Level, about 43% would qualify but more than half of the Medicare population would be excluded. If the criterion was lack of stable coverage, about half of Medicare beneficiaries would be considered “in need” and about half would not.

The study shows that Medicare recipients’ need for consistent and stable drug coverage does not necessarily fit neatly into income categories or any single measure of need. In fact, no single measure of need is fully successful. People faced with a combination of low income, lack of coverage, and high prescription drug bills have the most urgent need. If a broad definition of need is used–to include people with low incomes, those without continuous coverage, those with high costs, or those with multiple chronic conditions–nearly 90% of Medicare beneficiaries would qualify. Thus, using any single measure of need misses at least one-third of the population that could be considered “in need” by one of the alternative definitions.

Another important consideration for policymakers is the level of contribution required by beneficiaries. For example, people above the income cutoff will pay 25% of a premium under some proposals and as much as 75% under others. If beneficiaries anticipate drug costs below the 75% share of the premium, they are less likely to sign up. If only high-cost people enroll, premiums will spiral up, making coverage unaffordable. Getting the premium subsidy right is critical to the success of any Medicare drug plan.

In the third chapter, Director Tom Snedden describes the largest prescription drug coverage program for older adults in the nation. The Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) program and the Pharmaceutical Assistance Contract for the Elderly Needs Enhancement Tier (PACENET) help 264,657 Pennsylvania residents over age 65 who are income-eligible with the cost

of their prescription drugs. The programs, established in 1984 and 1996 respectively, pay for all but a portion of the cost of each drug prescribed by a doctor. The program is funded by the state lottery and administered by the Pennsylvania Department of Aging. Even though enrollments declined over 7% in 1999, claims per enrolled person increased almost 11%.