



Where We Stand:

Medicare Prescription Drug Coverage

A 2002 Update

The Academy of Managed Care Pharmacy (AMCP) prepared its position statement on **Medicare Prescription Drug Coverage** as part of its **Where We Stand** series in the Fall of 1999. Since then there has been new information and considerable debate on the issue of prescription drug benefits for seniors, but as yet, no legislative action enacting a Medicare prescription drug benefit. The fundamental position of AMCP as set forth in our position statement remains unchanged. This insert has been prepared to update our position statement with the latest information and developments on this important issue.

Financial Sustainability

AMCP believes it is essential for a Medicare prescription drug benefit to be financially sustainable to guarantee its availability on a continuing basis. We indicated that this could be accomplished in a number of ways, including use of a designated portion of the federal budget surplus. When our position was adopted, the Congressional Budget Office (CBO) had projected a budget surplus of nearly \$1 trillion over the ten-year period 1999–2009. A number of proposals were made to use part of this surplus to fund a Medicare prescription drug benefit.

Since then, the financial status of the federal government has changed. An economic downturn, the war on terrorism, and a significant tax cut have essentially eliminated the projected surplus. As of March of 2002, CBO projects a *deficit* over the next ten years (2003–2012) of \$102 billion (the Social Security trust fund surplus is not taken into consideration). The lack of budget surplus funds to use for a new Medicare prescription drug benefit makes enactment of legislation more difficult and places more emphasis on the other possible financing methods identified in our earlier statement: beneficiary cost-sharing; proceeds from litigation against the tobacco industry; new taxes; and savings generated by pharmaceutical care that offset costs with savings in other types of medical services.

Use of Generic Drugs

AMCP believes a Medicare drug benefit must be managed to be effective and affordable. Among the tools we cited as being available to manage prescription drug utilization is the use of generic drugs. Generic drugs contain the same active ingredients but are less costly than brand-name drugs because the drugs have gone off patent. Generics cost 40% to 60% less than their brand name equivalents.ⁱ

Generic market share, as a percentage of total prescriptions written in the US, reached 42.5% in 1996 and has remained within one percentage point of this level through 2000 (42.3%), with small fluctuations up and down. In 1996, generic drugs totaled 20.5% of annual retail prescription sales but had declined to 17.8% by 2000.ⁱⁱ

A recent study, "Greater Use of Generics: A Prescription for Drug Cost Savings," by researchers from Brandeis University concluded that \$250 billion over 10 years could be saved for Medicare beneficiary drug costs if incentives to use generics were used to the same degree they are used in private sector health plans.ⁱⁱⁱ Use of generics not only would save money on benefits from the government's perspective, but would also lower beneficiary out-of-pocket costs for premiums and cost-sharing.

Meeting the Covered Population's Needs

As noted in our original statement, the Medicare population uses a substantially greater amount of pharmaceuticals than younger populations, and therefore, a corresponding need exists for proper drug management as well as clear and precise communication of the benefit.

In 2000, almost 3 billion prescriptions were dispensed in the United States, up from 2.2 billion in 1995.^{iv} The average over age 65 insured population uses 24 prescriptions per year; those without drug coverage use an average of 17 prescriptions per year (based on 1998 data).^v

The vast majority of Medicare beneficiaries age 65 and older experience two or more chronic illnesses at the same time: 62% of 65–74 year olds, 76% of people age 75–84; and 82% of those age 85 and older.^{vi} The most common therapy for chronic conditions involves medication use. The number of Americans of all ages with two or more chronic conditions will increase from 60 to 81 million between 2000 and 2020.^{vii}

The cost implications of this level of medication utilization and incidence of chronic disease among the elderly is enormous, particularly in light of the following findings:

Prescription drug prices have been increasing by more than 15% per year for the last several years. Between 1988 and 2002, drug spending will have increased over five-fold from \$30.6 billion to \$160.9 billion; by 2011, prescription drug spending will account for 14.7% of total health spending, compared with 9.4% in 2000. Although the rate of increase for the period 2000 to 2011 is expected to moderate, annual increases in spending for drugs is projected to grow by double digits for the entire period. The introduction of new and more sophisticated drugs, which has helped fuel the recent rise in expenditures, will slow for a bit over the next few years but is expected to pick up again towards the end of the decade. Such spending projections do not even take into account the potential for new drug discoveries made possible by the sequencing of the human genome.^{viii}

As prescription drug use increases, so does the need for adequate management. Medication errors were cited in the recent reports on health care quality as a major problem, accounting for over 7,000 deaths annually, more than the number of deaths from workplace injuries.^x Outpatient deaths due to medication errors increased more than 8 fold between 1983 and 1993.^x The potential for even more problems related to medication use will increase as more and more new products are introduced.

Pharmaceutical Benefit Management

During the past several years the health care delivery system has responded to the increased use and costs of pharmaceuticals. In our earlier statement, we noted that pharmacy benefit management (PBM) companies contract with health plans and employers to administer pharmacy benefits to groups, but that they do not enroll individuals. Since then, however, some large PBMs have initiated programs to provide services to individuals, including access to discounted prices, mail order, health education, and drug use evaluation services. While such programs improve the situation for those without pharmacy benefits, they still fall short of the full integration of pharmaceutical care services with other dimensions of patient care we believe are so important for achieving high quality care while containing health care costs. AMCP believes that all comprehensive health benefits programs, including Medicare, must include prescription drug coverage and that this coverage and the programs associated with it (drug utilization review, patient counseling, monitoring and management of therapy, patient health education) should be part an integrated health care delivery system that coordinates the care of patients to assure that therapeutic objective are achieved. ♦

References

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- ^v Poisal, J.A. and L. Murray, *Medicare and Drug Cost Growth*, *Health Affairs*, March/April 2001.
- ^{vi} AARP, *A Report to the Nation on Trends in Health Security*, Washington D.C., 2002, p. 37.
- ^{vii} National Institute for Health Care Management, Expert Voices, *Chronic Conditions*, January 2004, Issue. 4.
- ^{viii} Heffler, Stephen et al., Health Spending Projections for 2001–2011: The Latest Outlook, *Health Affairs*, March/April 2002.
- ^{ix} Institute of Medicine, *To Err is Human. Building a Safer Health System*, National Academy Press, Washington DC, 1999, p. 23.
- ^x *To Err is Human*. p. 28.

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