Prescription Drug Coverage, Utilization, And Spending Among Medicare Beneficiaries

As the cost and use of prescription drugs move to the forefront of Medicare policy discussions, new survey data shed light on recent trends.

by Margaret Davis, John Poisal, George Chulis, Carlos Zarabozo, and Barbara Cooper

ABSTRACT: Outpatient prescription drugs are not a covered benefit under Medicare. There have been proposals in the past to expand Medicare benefits to include drug coverage, and current discussions dealing with “modernizing” the Medicare benefit package have raised the issue again. Using data from the 1995 Medicare Current Beneficiary Survey (MCBS), we describe the sources and extent of drug coverage among Medicare beneficiaries. The data show that 65 percent of Medicare beneficiaries have some level of drug coverage—a figure much higher than previous published numbers—and that 95 percent of Medicare health maintenance organization (HMO) enrollees have drug coverage. The data provide a baseline to observe future changes in the level of coverage, particularly among Medicare managed care plans.

Prescription drugs play an essential role in the treatment of disease, particularly among the elderly and the chronically ill. Innovations in drug therapies have led to improved health outcomes and quality of life for persons living with chronic conditions such as heart disease, hypertension, diabetes, arthritis, and depression, which are common among the elderly. Yet providing these therapies can be costly, and drug prices have been rising rapidly. In the six years between 1990 and 1995, national spending on prescription drugs increased 51 percent, an average of more than 8 percent per year. The rise in spending reflects both the increasingly

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important role of drugs in the treatment of disease and the rising costs of these drugs. Elderly and disabled Medicare beneficiaries are particularly vulnerable to the high cost of prescription drugs, which are not a covered benefit under Medicare (with limited exceptions).

This DataWatch presents the most current information available from the 1995 Medicare Current Beneficiary Survey (MCBS), which documents the number of noninstitutionalized Medicare beneficiaries with drug insurance coverage, how they are getting that coverage, and the amount that they and insurers are spending for prescription drugs. These data provide an overview of drug use and sources of payment among the entire Medicare population, including managed care plan enrollees.

**Background.** Medicare beneficiaries have several options for obtaining prescription drug coverage, although not all beneficiaries have access to these options. Prescription drug coverage is included in some Medigap plans, in most employer-sponsored plans, as part of Medicaid coverage and in other public programs, and, at least in recent years, in most Medicare risk plans.

Some Medicare beneficiaries can purchase limited supplemental drug coverage through Medigap plans. However, only three of the ten standardized Medigap plans include a prescription drug benefit. In addition, the Medigap drug coverage is limited, with high beneficiary cost sharing: Two of the plans require beneficiaries to meet a $250 deductible and then cover 50 percent of the cost of prescription drugs up to a maximum annual benefit of $1,250. The third plan is the same but has a maximum annual benefit of $3,000. Access to individually purchased Medigap policies can sometimes be limited. Elderly Medicare beneficiaries are guaranteed a six-month open-enrollment period when they first enroll in Part B at age sixty-five or older. However, disabled beneficiaries under age sixty-five are not eligible for an open-enrollment period and often are not able to purchase a Medigap policy. Under federal law, at any time after the open-enrollment period, insurers can refuse to issue Medigap policies on the basis of age or health status and can impose preexisting condition exclusion periods or refuse to cover certain conditions at all. Even insurers that have “guaranteed issue” for Medigap policies without drug coverage underwrite drug coverage purchased outside of the open-enrollment period.

Premiums for Medigap plans with drug coverage are expensive. When the benefits to be included in the model Medigap plans were being debated by the National Association of Insurance Commissioners (NAIC), there was considerable concern over adverse risk selection if drug benefits were added. In fact, the premiums for these plans tend to be much higher than those for other Medigap...
plans, and research has shown that insurance carriers are setting premium rates to account for the presence of adverse selection among plans with drug coverage. Access to the remaining sources of coverage depends largely on a person’s employment status and income, as well as geographic location. Many beneficiaries receive some type of employer-sponsored prescription drug coverage as part of their retiree health benefits. Beneficiaries also can enroll in Medicare managed care plans that provide drug coverage, either as a supplemental policy or as part of the basic risk-plan benefit package. In addition, certain low-income Medicare beneficiaries have access to drug coverage because they qualify for Medicaid coverage (“dual eligibles”). Another source of coverage for beneficiaries in certain states is state-administered prescription drug programs. At least eleven states have implemented special programs to provide drug coverage for low-income elderly or persons with disabilities. Finally, some beneficiaries with a military service connection receive drug coverage through Department of Veterans Affairs (VA) or Department of Defense programs.

**Data Sources And Methods**

The data reported here were compiled from the 1995 MCBS Cost and Use file. The MCBS is a continuing panel survey of about 12,000 aged and disabled beneficiaries. The information in this DataWatch is limited to data about persons participating in community interviews during the year and includes beneficiaries who were enrolled in Medicare at any point during the year.

**Type of supplemental coverage.** We assigned Medicare beneficiaries to different categories depending on their supplemental insurance or supplemental coverage status. Many Medicare beneficiaries hold more than one type of supplemental insurance. Although we consider the effect of additional types of supplemental coverage, we have assigned persons with multiple sources of coverage to the single category that is most likely their primary source of coverage. In addition, to be included in a particular category, beneficiaries had to have spent all of their Medicare-eligible months in that category. Those who switched supplemental insurance coverage during the year were placed in a separate category of “switchers.” Our Medicaid category includes qualified Medicare beneficiaries (QMBs) and specified low-income Medicare beneficiaries (SLMBs) who may not have drug coverage in their Medicaid benefits.

**Prescription drug coverage.** Beneficiaries were considered to have drug coverage if they had it at any point during their eligible months. Previously published reports on prescription drug coverage used beneficiaries’ self-reported data for persons with private insur-
ance and reasonable assumptions for persons in HMOs or with Medicaid coverage to determine whether or not their supplemental insurance included prescription drug coverage. One difficulty with this approach, however, is that, in general, Medicare enrollees do not have a clear idea of what either Medicare or their supplemental insurance actually covers. MCBS prescription drug records contain information on each source of payment that contributed any amount in paying for a prescription. For example, if a person answered “no” to whether his or her policy covered drugs, but our drug payment records showed that the insurer actually paid for prescription drugs for the person, we changed the person’s insurance status to “yes.” It is highly unlikely that an insurer would make a payment unless there was a policy in effect covering drugs.

Our original intention was to use the payment data only to correct self-reported information on drug coverage. Initially, we looked at whether a self-report or assumed coverage corresponded to payment data within the person’s primary insurance category. All previous reports assumed that the person’s drug insurance coverage came from his or her primary supplemental insurance. However, in analyzing the payment data we found that beneficiaries sometimes have drug coverage from a source other than their primary supplemental and sometimes have drug coverage from multiple sources. Clearly, these findings highlight that many beneficiaries attempt to “cobble together” the best total insurance package they can using all of the possibilities available to them.

This led us to create two categories of drug coverage: The main category includes persons who have drug coverage from their primary supplemental coverage; the new category includes persons who do not have drug coverage from their primary supplemental coverage but obtain some drug coverage from another source. The combined result of these efforts is to produce estimates of drug coverage that are considerably higher than previous estimates. Most previous estimates of prescription drug coverage estimated that 50–55 percent of the Medicare population had prescription drug coverage, compared with our estimate of 65 percent (Exhibit 1). Our internal analyses suggest that drug coverage in the Medicare population increased 2–3 percent between 1992 and 1995. Identifying persons with secondary drug coverage added another 3–4 percent. Using more reliable source-of-payment data to correct self-reports and assumptions about drug coverage contributed the remaining 4–9 percent difference. We believe that persons with secondary drug coverage, and those whose payment records contradicted their self-reports or assumptions about drug coverage, were largely omitted from previous analyses.
Survey methods. There is a long-standing debate on whether a household survey is the appropriate way to collect expenditure data on drugs. Critics in earlier reform debates argued that previous surveys seriously underestimated prescription drug use and costs because of poor recall and other methodological problems. Others argued that these critics were overstating the size of the problem. These debates were taking place as the MCBS field procedures were being developed, and special pains were taken to improve its drug use and cost collection procedures. We believe that our field methods generally have improved the drug use underreporting problem, but we acknowledge that underreporting is still a problem.

Payments. We attempted to determine the actual transaction price for each prescribed drug, not the listed or posted price to which discounts (such as senior citizen discounts) are sometimes applied. We also developed a variety of methods for establishing a reasonable transaction price for the drug used when the respondent knew the amount he or she paid out of pocket but did not know the

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**EXHIBIT 1**

Distribution Of Noninstitutional Medicare Beneficiaries, By Type Of Supplemental Insurance And Presence Of Drug Coverage, 1995

<table>
<thead>
<tr>
<th>Type of coverage</th>
<th>Number of persons</th>
<th>Percent distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>With primary drug coverage</td>
</tr>
<tr>
<td>All persons</td>
<td>36,715,848</td>
<td>22,671,434</td>
</tr>
<tr>
<td>No supplemental coverage</td>
<td>(FFS Medicare only) 2,953,582</td>
<td>0</td>
</tr>
<tr>
<td>Supplemental coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare risk HMO</td>
<td>2,507,962</td>
<td>2,383,685</td>
</tr>
<tr>
<td>Medicaidb</td>
<td>4,498,400</td>
<td>3,949,139</td>
</tr>
<tr>
<td>Employer-sponsored c</td>
<td>12,105,983</td>
<td>10,161,803</td>
</tr>
<tr>
<td>Individually purchased only</td>
<td>10,640,789</td>
<td>3,075,376</td>
</tr>
<tr>
<td>All otherd</td>
<td>985,931</td>
<td>773,753</td>
</tr>
<tr>
<td>Switched coverage during the year d</td>
<td>3,023,291</td>
<td>2,327,678</td>
</tr>
</tbody>
</table>

**SOURCE:** HCFA Office of Strategic Planning, data from the Medicare Current Beneficiary Survey.

**NOTES:** FFS is fee-for-service. HMO is health maintenance organization. Data are based on the noninstitutionalized, community-based population and include those who were enrolled in Medicare at some point during the year. Each person has been assigned to one supplementary insurance category, but they may or may not obtain their drug insurance coverage from that source. "With primary drug coverage" means that the person has drug insurance, and it is from their primary supplementary insurance. "With secondary drug coverage" means that the person has drug insurance, but it is not from their primary supplementary insurance.

- Number unreliably because of small sample size.
- Includes beneficiaries receiving full Medicaid benefits, as well as qualified Medicare beneficiaries (QMBs) and specified low-income Medicare beneficiaries (SLMBs).
- Includes those who only had employer-sponsored supplemental insurance and those who had both employer-sponsored and individually purchased supplemental insurance.
- Includes other public programs such as Veterans Affairs, Department of Defense, and State Pharmaceutical Assistance Programs for low-income elderly, as well as non-risk HMOs (cost and health care prepayment plans).
- Includes beneficiaries who did not spend 100 percent of their Medicare-eligible months in one insurance category.
total transaction price (for example, if an HMO, Medicaid, the VA, a state-based plan, a local charity, or other entity made the payment on their behalf). The end result of this process was to establish a realistic average transaction price for each drug, taking payers into account. In individual cases, the average payment may actually have been more or less than the average price we established. But in the aggregate, and on average, we believe that our final price is a reasonable estimate of the total price paid to the dispenser for that patient to obtain that particular drug. In allocating total payments among the various sources of payment, we classified only 2 percent of payments as coming from an unknown payment source.

**Prescription Drug Coverage**

Although Medicare does not offer outpatient prescription drug benefits as part of its traditional fee-for-service benefits package, in 1995 nearly two-thirds (65 percent) of Medicare enrollees living in the community had some form of supplemental insurance that covered outpatient prescription drugs (Exhibit 1). Among persons with drug coverage, 62 percent received their drug coverage from their primary supplemental plan; for an additional 3 percent, payment records indicate coverage from another source. For example, a person may have Medicare and an individually purchased Medigap plan that does not cover his or her drug purchases but may get drugs through a state-based drug coverage plan or the VA. We believe that such persons previously had been classified as not having drug coverage. Slightly more than one-third of noninstitutionalized Medicare beneficiaries had no prescription drug coverage.

Supplemental policies vary widely in the extent to which they include drug coverage. Beneficiaries in Medicare risk HMOs have the highest level of prescription drug coverage (95 percent). Other groups of Medicare enrollees with high levels of drug coverage include persons with Medicaid (88 percent, including QMBs and SLMBs), employer-sponsored supplemental insurance (84 percent), and other public coverage such as a state-based drug plan or VA coverage (78 percent). Most enrollees in these groups obtain their coverage from their primary supplemental insurance, but some receive it from a secondary source (about 2 percent in each category).

Only 29 percent of beneficiaries with individually purchased private Medigap plans had drug coverage from the Medigap plan. This is not surprising, given the high cost and limited coverage available under standard Medigap policies. It is also not surprising that the insurance category with the lowest level of primary drug coverage has the highest share of persons who get drug coverage from a secondary source (7 percent).
Prescription drug use. A recent national survey reported that 80 percent of retired persons take a prescribed drug every day. This is consistent with our findings that 86 percent of Medicare beneficiaries living in the community used at least one prescription drug during 1995 (Exhibit 2). The average such beneficiary used 18.5 prescriptions in 1995.

The presence of supplemental insurance has consistently been shown to increase utilization rates for, and access to, most types of health services. Our data show that this pattern holds true for prescription drug use. Persons with drug coverage averaged 20.3 prescriptions per year, whereas those with no drug coverage averaged 15.3 prescriptions per year.

Persons with no supplemental insurance at all (12.7 prescriptions per year) had prescription drug use rates that were 31 percent below the national average, and again the disparity was even greater when compared with persons holding drug insurance. Beneficiaries with no supplemental coverage are more likely to have lower incomes than the average Medicare beneficiary. In general, economic fac-

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**EXHIBIT 2**

**Percentage Of Medicare Beneficiaries Using Prescription Drugs And Average Prescriptions Per Person, By Type Of Supplementary Insurance Coverage And Presence Of Drug Coverage, 1995**

<table>
<thead>
<tr>
<th>Type of coverage</th>
<th>Percent using prescription drugs</th>
<th>Average number of prescriptions per person</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All persons</td>
<td>With drug coverage</td>
</tr>
<tr>
<td>All persons</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No supplemental coverage (FFS Medicare only)</td>
<td>70</td>
<td>-a</td>
</tr>
<tr>
<td>Supplemental coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare risk HMO</td>
<td>87</td>
<td>87</td>
</tr>
<tr>
<td>Medicaidb</td>
<td>87</td>
<td>91</td>
</tr>
<tr>
<td>Employer-sponsoredc</td>
<td>89</td>
<td>89</td>
</tr>
<tr>
<td>Individually purchased only</td>
<td>87</td>
<td>87</td>
</tr>
<tr>
<td>All otherd</td>
<td>92</td>
<td>95</td>
</tr>
<tr>
<td>Switched coverage during the yeare</td>
<td>87</td>
<td>89</td>
</tr>
</tbody>
</table>

**SOURCE:** HCFA Office of Strategic Planning, data from the Medicare Current Beneficiary Survey.

**NOTES:** FFS is fee-for-service. HMO is health maintenance organization. Data are based on the noninstitutionalized, community-based population and include those who were enrolled in Medicare at some point during the year. Each person has been assigned to one supplementary insurance category, but they may or may not obtain their drug insurance coverage from that source.

a Not applicable.
b Includes beneficiaries receiving full Medicaid benefits, as well as qualified Medicare beneficiaries (QMBs) and specified low-income Medicare beneficiaries (SLMBs).
c Includes those who only had employer-sponsored supplemental insurance and those who had both employer-sponsored and individually purchased supplemental insurance.
d Includes other public programs such as Veterans Affairs, Department of Defense, and State Pharmaceutical Assistance Programs for low-income elderly, as well as non-risk HMOs (cost and health care prepayment plans).
e Includes beneficiaries who did not spend 100 percent of their Medicare-eligible months in one insurance category.
tors—including income and supplemental insurance coverage—play an important role in whether a prescription medication is obtained to treat a health problem: Higher income and more comprehensive insurance coverage increase the chances that an elderly beneficiary will use a prescription drug, whether or not the drug is for a minor illness or for a serious, chronic condition. Similarly, beneficiaries whose only coverage is fee-for-service Medicare have fewer physician visits than do those with any form of supplemental insurance. Also, ambulatory physician visit rates for elderly beneficiaries tend to decline as income declines. This clearly would affect a person’s ability to obtain a prescription, given that a physician contact generally is required to obtain a prescription.

Persons with Medicaid used about twice as many prescriptions on average (25.6) as persons in fee-for-service with no supplemental insurance (12.7), reflecting the higher concentration of older, sicker, and low-income persons in Medicaid. Another interesting finding is the relatively low prescription use rate for persons in Medicare risk plans (15.7 per person per year): 15 percent below average. Studies to date have suggested that persons enrolling in Medicare HMOs are generally healthier and less expensive to care for on average. This may be one reason that Medicare risk plans simultaneously have the highest share of persons with prescription drug coverage (95 percent), coupled with prescription drug use rates well below the national average, although this also may reflect the effect of pharmacy benefit management in an HMO setting.

**Prescription drug payments per person.** Drug expenditures for the average Medicare beneficiary living in the community were about $600 in 1995, accounting for payments from all sources (Exhibit 3). Total average spending per person for those with drug insurance was 60 percent higher than for persons without any drug coverage ($691 versus $432). The lowest average level of spending per person, by far, was for Medicare risk HMOs ($458). In every insurance category spending per person was much higher for persons with drug insurance coverage than for those without it.

Average drug insurance payments per person vary widely by insurance category. The highest average insurance payment per person ($577) for persons with Medicaid is more than five times greater than that for those with Medigap insurance ($112). High deductibles and coinsurance associated with the standard Medigap drug insurance probably account for most of this disparity, although higher prescription drug use rates for Medicaid beneficiaries also contribute to the higher payment rate.

**Shares paid out of pocket.** Average out-of-pocket payments for drug expenses for beneficiaries without any form of drug coverage...
EXHIBIT 3
Average Drug Expenditures Per Person For Medicare Beneficiaries, By Type Of Supplementary Insurance And Presence Of Drug Coverage, 1995

<table>
<thead>
<tr>
<th>Type of coverage</th>
<th>Total expenditures per person</th>
<th>Insurance expenditures per person</th>
<th>Out-of-pocket expenditures per person(^a)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All persons</td>
<td>With drug coverage</td>
<td>No drug coverage</td>
</tr>
<tr>
<td>All persons</td>
<td>$600</td>
<td>$691</td>
<td>$432</td>
</tr>
<tr>
<td>No supplemental coverage</td>
<td>(FFS Medicare only)</td>
<td>352</td>
<td>_(^b)</td>
</tr>
<tr>
<td>Medicare risk HMO</td>
<td>458</td>
<td>472</td>
<td>125</td>
</tr>
<tr>
<td>Medicaid(^c)</td>
<td>727</td>
<td>777</td>
<td>284</td>
</tr>
<tr>
<td>Employer-sponsored (^d)</td>
<td>698</td>
<td>732</td>
<td>484</td>
</tr>
<tr>
<td>Individually purchased only</td>
<td>550</td>
<td>674</td>
<td>480</td>
</tr>
<tr>
<td>All other(^e)</td>
<td>618</td>
<td>677</td>
<td>385</td>
</tr>
<tr>
<td>Switched coverage during the year(^f)</td>
<td>547</td>
<td>600</td>
<td>331</td>
</tr>
</tbody>
</table>

SOURCE: HCFA Office of Strategic Planning, data from the Medicare Current Beneficiary Survey.

NOTES: FFS is fee-for-service. HMO is health maintenance organization. See Exhibit 2 Notes. The category “no drug coverage” is not applicable to insurance expenditures per person and is omitted.

\(^a\) Includes expenditures where the source of payment is unknown.

\(^b\) Not applicable.

\(^c\) Includes beneficiaries receiving full Medicaid benefits, as well as qualified Medicare beneficiaries (QMBs) and specified low-income Medicare beneficiaries (SLMBs).

\(^d\) Includes those who only had employer-sponsored supplemental insurance and those who had both employer-sponsored and individually purchased supplemental insurance.

\(^e\) Includes other public programs such as Veterans Affairs, Department of Defense, and State Pharmaceutical Assistance Programs for low-income elderly, as well as non-risk HMOs (cost and health care prepayment plans).

\(^f\) Includes beneficiaries who did not spend 100 percent of their Medicare-eligible months in one insurance category.

were $432 in 1995, compared with $232 for those with drug coverage. Many persons pay premiums for their supplemental coverage, and some part of those premium amounts undoubtedly goes toward drug coverage. A more precise comparison would add drug insurance premium payments to out-of-pocket payments. Unfortunately, we do not always know from our records whether reported insurance premiums include or exclude drug coverage, or how to split drug coverage premiums out from total premiums.

Among insurance categories, out-of-pocket payments for drug expenses are highest for those with individually purchased Medigap plans ($437) and lowest for persons with Medicaid and those belonging to Medicare risk HMOs ($150 and $160, respectively).

Exhibit 4 shows the share of total spending on prescription drugs paid out of pocket, on average, by all beneficiaries and those with drug coverage. The data show that the average Medicare beneficiary paid half of the cost of prescription drugs in 1995. By contrast, for the entire U.S. population the national average share of prescription drug expenses paid out of pocket was much lower (34 percent).\(^{20}\)

One clear reason for this difference is that a larger share of younger persons have prescription drug insurance. We noted above that 65
percent of Medicare beneficiaries have prescription drug coverage. The Bureau of Labor Statistics estimates that 80 percent of persons employed in medium and large firms have prescription drug coverage. Another possible reason is that the prescription drug coverage held by Medicare enrollees may not be as comprehensive as that held by younger persons.

While the average out-of-pocket share for Medicare beneficiaries is half the total payment, persons with drug coverage paid an average of 34 percent. Persons with Medicaid paid the least out of pocket (21 percent). This seems consistent with the aim of Medicaid to help low-income persons and reflects the low cost-sharing amounts most states apply to Medicaid-covered prescriptions. Beneficiaries with Medigap policies pay 80 percent of their drug expenditures out of pocket (in addition to the premium paid for the coverage). Members of risk HMOs and persons with employer-sponsored insurance both pay about one-third of their drug expenditures out of pocket. These differences again illustrate the wide variation in the level of drug insurance coverage.

Policy Implications

For years policy discussions over whether and how to expand Medicare to include a prescription drug benefit have led to a number of proposals, none of which has ever been permanently adopted.
This issue has again been raised during the deliberations of the National Bipartisan Commission on the Future of Medicare, created by Congress in the Balanced Budget Act (BBA) of 1997. Discussions among the various commission task forces have included the need to consider “modernizing” the Medicare benefit package to make it more consistent with the current structure of private health insurance plans, including adding some type of prescription drug benefit.

The Medicare population clearly has a need for coverage, as the average beneficiary uses eighteen prescriptions per year. Even those without prescription drug coverage use almost thirteen prescriptions per year. Medicare beneficiaries also spend a lot out of pocket for their prescription drugs—much more than the average for the U.S. population (50 percent versus 34 percent of expenses paid out of pocket). A significant portion of the Medicare population now has drug coverage from one or more sources, but there is wide variation in the extent of protection, or lack of protection, from the various sources. Not presented here, but important for further analysis, are the socioeconomic characteristics and health and functional status of beneficiaries in each of the insurance categories—in particular, for those with no drug coverage. Understanding these factors is necessary to further understand the gaps in coverage and vulnerabilities of the population as policymakers attempt to craft options for reform.

Another important finding is the extent to which enrollees in Medicare risk plans have drug coverage, and the relative generosity of that coverage. The MCBS data show that enrollees in Medicare risk plans had very high rates of drug coverage in 1995, when three million Medicare beneficiaries were enrolled in risk plans.

Risk-based Medicare managed care plans are not obligated to provide drug benefits, but a recent unpublished analysis by HCFA of Medicare HMO data indicates that the vast majority of such plans provide some level of prescription drug coverage to their enrollees, which confirms the results of the MCBS analysis. In addition, the HCFA analysis shows a clear correlation between the Medicare capitation payment and the extent of coverage offered. Although the extent of that coverage varies significantly across plans, 40 percent of plans that provide drug coverage in the basic benefit package have no maximum annual dollar caps on their coverage. Of those that do impose limits, about 60 percent have caps of $1,000 or more per year—that is, the vast majority of beneficiaries have no caps on their HMO drug coverage or are subject to a cap that is above the average yearly total of drug expenditures for all Medicare beneficiaries reported in the MCBS data. Whether Medicare HMOs will continue to offer generous drug coverage is unclear.
There has been a good deal of attention recently to the managed care industry’s assertion that payment changes required by the BBA, combined with rising drug costs and other factors, will result in plans’ cutting back in the additional benefits that they now offer to Medicare beneficiaries, such as prescription drugs, or withdrawing from the Medicare managed care market altogether. Again, it will be important to monitor these benefit and enrollment changes, as well as changes in retiree coverage and the Medigap market, as policymakers consider options for prescription drug policies.

The authors thank Frank Eppig, Dan Waldo, Ellen O’Brien, and Jack Hoadley for comments on an earlier draft of this paper.

NOTES

2. Wisconsin, Massachusetts, and Minnesota do not conform to federal standardization requirements. Wisconsin and Massachusetts have drug coverage mandates that apply to Medigap insurers, and, until the effective date of federal preemption provisions of the BBA, these mandates also applied to Medicare risk HMOs. Wisconsin requires plans to offer catastrophic drug coverage, consisting of coverage of 80 percent or actual charges after having met a deductible of $6,250 per year.
3. A few states now require insurers to sell Medigap policies to persons under age sixty-five with disabilities.
10. During that debate both the Congressional Budget Office (CBO) and the Health Care Financing Administration’s (HCFA’s) Office of the Actuary filed reports with Congress indicating that survey reports of drug utilization and costs were probably 10–20 percent underestimated based on the survey data used (the 1987 National Medical Care Expenditure Survey). J. Moeller and N. Mathiowetz, “Correcting Errors in Prescription Drug Reporting: A Critique,” Health Affairs (Spring 1991): 210–211; and Berk et al., “Using Survey Data.”
11. Each MCBS respondent is asked each round (essentially every four months) about all health care events, charges, and payments since the previous inter-
view. Beneficiaries are asked to keep a calendar and retain any insurance statements, payment receipts, check stubs, and so forth, and bring them to the interview. For prescribed drugs, respondents are asked to retain and bring to the interview the prescription bottle, the package it came in, and any receipts they received for each prescription drug used. In addition, interviewers, consulting a list of all prescription drugs reported in the previous interview, ask whether the respondent has taken each of those drugs during the current reference period. This is designed to improve recall and get exact prescription names, dosages, prices, and the form of medication used. Although the patients themselves are usually the best source for amounts paid out of pocket, beneficiaries’ insurance statements are carefully examined to get the sources and amounts of payments from third parties.

12. The first step is to look within the MCBS database to see if a total price is reported for that drug, in that form, and in that prescription size. If no total price exists in the MCBS database, we then refer to a published drug industry source that gives the average national wholesale price of that prescription drug. Different purchasers often pay a different price for the same drug. Information on the typical discount is obtained from average prices that bulk buyers such HMOs and the VA could obtain from drug manufacturers. Similarly, we used information on the level of discounts obtained from state Medicaid rebate programs. In retail pharmacies we found that price markups varied by the size of the average wholesale price. For example, for prescriptions with average prices below $5, the final price was more than double that amount on average. For prescriptions with prices above $20, on the other hand, the pharmacy markup was much smaller on average.

13. Medicare has very limited outpatient prescription drug coverage. In general, drugs that can be self-administered are not covered under Part B. There are a few exceptions to this rule: immunosuppressant medications for transplant patients for a period of thirty-six months, blood clotting factors for hemophilia, erythropoietin (EPO), injectable osteoporosis drugs used to treat a bone fracture, oral anticancer drugs (only covers oral drugs if they are also available parenterally), oral and parenteral antinausea medications when used for treatment of side effects of chemotherapy, and a reasonable supply of antibiotics.


18. Ibid.


22. In 1993 copayment amounts for Medicaid prescriptions varied by state and ranged from $0.50 to $3 per prescription. “Pharmaceutical Benefits under State Medical Assistance Programs” (Reston, Va.: National Pharmaceutical Council, September 1993).