CHAPTER 1

PRESCRIPTION DRUG COVERAGE

Prescription drugs play a critical role in contemporary medicine and most health insurance policies cover prescription drugs as an integral part of the benefit package. However, this was not the case in 1965 when Medicare was enacted. Consequently, Medicare does not include coverage of outpatient prescription drugs as a basic benefit. While today, over 85 percent of Medicare beneficiaries use at least one prescription drug annually, beneficiaries must obtain drug coverage through a supplemental policy, by enrollment in a Medicare+Choice plan which includes coverage for prescription drugs, or through Medicaid.

This chapter explores the sources of drug coverage and the nature of coverage that is provided to Medicare beneficiaries through different kinds of supplemental policies. Survey data is employed to analyze the sources of coverage for the Medicare and non-Medicare population in 1996 as well as the economic and demographic characteristics of those who have drug coverage and those who do not. Analysis of data on the duration of coverage for the Medicare population is also presented. Next, differences in coverage rates by alternative measures of health status are explored. Lastly, trends in drug coverage for the Medicare and non-Medicare population are analyzed.

Key findings include:

- Only 53 percent of Medicare beneficiaries had drug coverage for the entire year of 1996, although 69 percent had coverage for at least one month during the year.

- Most sources of drug coverage are potentially unstable. Almost 48 percent of beneficiaries with drug coverage through Medigap and 29 percent who were covered through Medicare HMOs had drug coverage for only part of the year. Additionally, while employer-sponsored retiree coverage, the most prevalent single source of drug benefits, covered 32 percent of Medicare beneficiaries in 1996, 14 percent of those beneficiaries had only part year coverage from their former employers.

- Drug benefits are becoming less generous. There is considerable evidence that cost sharing for prescription drugs is increasing and that overall caps on coverage are both becoming more common and are being set at lower levels. For example, Medicare+Choice plans generally have reduced drug benefits and

increased enrollee out-of-pocket costs in 2000. Eighty-six percent of plans have annual dollar limits on drugs, including 70 percent of plans with annual caps of $1000 or less, and 32 percent with caps of $500 or less per enrollee - levels that are up from 35 percent and 19 percent in 1998.

- Drug coverage is likely to decline as fewer employers offer health benefits to future retirees. For example, one employer survey recorded a drop from 40 percent in 1993 to 28 percent in 1999 in the number of large firms offering health benefits to Medicare eligible retirees. Additionally, employers have tightened eligibility rules and increased cost-shifting to retirees. Of those employers that still offer medical coverage, the survey found that 40 percent are requiring Medicare-eligible retirees to pay the full cost of their benefits, compared to 28 percent in 1995.

- Individuals with incomes between 100 percent and 150 percent of poverty, or individuals age 65 or older with incomes between $7,527 and $11,287 in 1996, have the lowest rate of coverage. Although coverage varies by income, nearly one-fourth of beneficiaries with incomes over 400 percent of poverty lack coverage.

- Beneficiaries are less likely to have coverage if they are very old or live outside of a metropolitan area. About 37 percent of beneficiaries age 85 and above lacked coverage at any time during 1996, compared to 28 percent of beneficiaries age 65 through 69. About 43 percent of beneficiaries living in rural areas lacked any drug coverage, compared to 27 percent of beneficiaries living in urban areas.

- Coverage rates vary little by self-reported health status, but are considerably higher for those with five or more chronic conditions. By all measures, at least one-fourth of those in any category of health status lack coverage.

- Nearly one in four in the non-Medicare population never had any coverage for drugs in 1996. About 80 percent of those with full-year coverage got that coverage through employers.

SOURCES AND NATURE OF COVERAGE

Most people who have medical insurance obtain drug coverage through the same source that provides their overall insurance: most commonly an employer or union plan, private nongroup coverage, or Medicaid. Nearly all employer plans include

drug benefits for active workers (although not necessarily retirees). Coverage of prescription drugs by Medicaid is optional under federal law, but every state's program includes this benefit.[1]

Because Medicare generally does not cover outpatient prescription drugs, beneficiaries who have drug coverage obtain it as part of a supplemental plan, which usually also covers Medicare's deductibles and coinsurance and may include benefits for other services excluded from Medicare. There are several ways for beneficiaries to obtain supplemental coverage: retiree health benefits, private Medigap policies, Medicare+Choice plans,[2] Medicaid, and other federal and state programs.

Different sources of prescription drug coverage vary in the extent of coverage, the amount participants must contribute toward the cost of their drug spending, and how a participant obtains the benefits.

Employer and Retiree Plans

Employer-sponsored health benefits are the single largest source of drug coverage for both the Medicare and non-Medicare population. As will be discussed below, in 1996 employer-sponsored plans were the source of coverage for about 60 percent of the non-Medicare population and 32 percent of Medicare beneficiaries.

Until the late 1980s, prescription drug coverage was often not a distinct benefit, but was included in conventional major medical plans if it was included at all. It was subject to the overall deductible for all services and to the same coinsurance amounts (typically 20 percent) that applied to other medical care.[3] Two developments have led to major changes in employer drug benefits.

The first is the widespread use of managed care plans, such as health maintenance organizations (HMOs), preferred provider organizations, and point of service plans, which now cover 89 percent of workers, although a smaller percent of retirees.[4]

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[1] Access to Medicaid drug coverage by Medicare beneficiaries will be discussed below.

[2] Medicare+Choice plans are not literally supplemental plans but serve as an alternative to the traditional Medicare fee-for-service program and typically include supplemental benefits.

[3] Congressional Research Service, *Health Insurance and the Uninsured: Background Data and Analysis*, Washington, 1988.

[4] Mercer/Foster Higgins. *National Survey of Employer-Sponsored Health Plans, 1999.* These results are based on a survey of employers with 500 or more employees.

Managed care plans offer a distinct drug benefit; only about 10 percent impose a deductible, and a copayment—for example, $5 for generic drugs and $10 for brand-name drugs—is used in place of a coinsurance percentage.[5]

The second is the growth of pharmacy benefits managers (PBMs).[6] Most managed care plans contract with a PBM to administer their drug benefits. In addition, many employers have "carved out" prescription drug benefits from their general health plans and contract separately with a PBM.[7] Unlike indemnity insurers, PBMs process and pay claims at the point of sale. They develop formularies (lists of preferred or approved drugs), negotiate discounts with manufacturers and retail pharmacies, encourage use of mail-order pharmacies, and take other steps to control drug costs. (A fuller description of PBM practices is provided in Chapter 3.) PBMs are not insurers; they usually do not accept financial risk for the costs of services, although their contracts with managed care plans or employers may include some incentives for cost reduction.

Some large managed care organizations, such as Kaiser Permanente and Aetna, manage their own drug benefits instead of contracting with a PBM. As the practices of these organizations are similar to those of PBMs, the single term PBM will be used in this report to cover all types of entities that manage prescription drug benefits. Some other insurers, such as indemnity plans or self-insured employer plans, may not manage drug benefits, but simply pay claims submitted by enrollees. Overall, an estimated 78 percent of people with non-Medicaid drug coverage are in PBMs, while the rest are in plans managing their own benefits or in unmanaged plans.[8]

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[5] "Brand-name" drugs are those sold by the manufacturer that initially developed them or by another manufacturer with a license from the initial developer. "Generic" drugs are those sold by other manufacturers after the patent protection for a brand-name drug has expired; they are similarly formulated and have biologic effects equivalent to those of a brand-name drug. Copayments may also vary depending on whether the drug is on the PBMs preferred list or formulary. According to the Mercer/Foster Higgins survey, in 1999, 32 percent of large employers raised one or more cost-sharing components to their benefit plans.

[6] For more information on the role of PBMs see Anna Cook, et al. *The Role of PBMs in Managing Drug Costs: Implications for a Medicare Drug Benefit*. Report prepared for the Kaiser Family Foundation, January 2000.

[7] Kaiser Family Foundation and Health Research and Educational Trust (HRET), *Employer Health Benefits: 1999 Annual Survey*. Kaiser-HRET estimates that 34 percent of employees were in carve-outs in 1999.

[8] Testimony of Jeff Sanders, Pharmaceutical Care Management Association, before the Senate Finance Committee, 1999.

Although still the single largest source of Medicare supplemental drug coverage, retiree health benefits have been eroding in the last decade. In part, this decline is a response to accounting rule changes that required firms to account for benefits promised to future retirees as a current liability. In some cases, firms may provide more generous coverage for active workers than for retirees because of the role of benefits in recruiting employees. According to a recent employer survey, about 41 percent of large firms offered health benefits to retirees in 1998 compared to 66 percent in 1988. Of these, 80 to 85 percent provided benefits to Medicare beneficiaries; the remainder covered only early retirees in the period before Medicare eligibility.[9] Another survey recorded a drop from 40 percent in 1993 to 28 percent in 1999 in the number of large firms offering health benefits to Medicare eligible retirees.[10]

Smaller firms are less likely to offer health benefits to retirees. One survey found that only 8 percent of smaller firms, those with fewer than 200 workers, offered retiree coverage in 1998.[11] The Mercer/Foster Higgins survey of medium-sized firms with 500 to 1000 employees, reported that 22 percent of employers offered coverage to Medicare-eligible retirees in 1999.[12]

The impact of the decline in employer sponsorship of retiree health benefits will be felt more strongly in the future. Most firms that have dropped coverage have done so for their active workers planning to retire in the future, rather than for current retirees.[13] Since effective rates of change vary by firm and by the age of the workers, it is difficult to predict the rate of coverage decline.

Additionally, there are indications that the nature of coverage offered to retirees has changed. Of those employers that still offer medical coverage, 40 percent are requiring Medicare-eligible retirees to pay the full cost of their benefits compared to 28 percent in 1995.[14] Further, many firms that continue to offer retiree coverage have tightened the eligibility rules for future retirees. For example, the percentage of large employers

[9] Kaiser / HRET. For this survey, large employers are defined as those employing 200 or more workers.

[10] Mercer/Foster Higgins.

[11] Kaiser/HRET.

[12] Mercer/Foster Higgins.

[13] Kaiser/HRET.

[14] Mercer/Foster Higgins.

who require employees 55 years or older to have between 10 and 15 years of employment to qualify for benefits rose from 30 percent in 1991 to 49 percent in 1998.[15]

In recent years, increasing numbers of employers who provide retiree health benefits have permitted or required Medicare-eligible retirees to enroll in a Medicare+Choice plan (see below). The employer may pay the plan's premium for its usual supplemental coverage and may also negotiate additional supplemental benefits on behalf of the retirees.[16]

Some drug coverage is provided in 80 percent of retiree health benefit plans.[17] However, many employers are looking for ways to reduce the costs of these benefits. One recent survey of large employers found that 40 percent would consider cutting back on prescription drug coverage for Medicare-eligible retirees in the next three to five years.[18]

Private Medigap and Other Nongroup Coverage

Medicare beneficiaries may buy individual Medicare supplemental policies, known as Medigap plans, from private insurers. By law, an insurer selling Medigap must offer one or more of ten standardized plans. Three of these, known as plans H, I, and J, include some prescription drug coverage.[19] These three Medigap plans impose a $250 deductible. They then pay 50% of covered charges up to a maximum plan payment of $1,250 for plans H and I and $3,000 for plan J. Some beneficiaries who bought policies before this law took effect have non-standardized plans; little is known about how

[15] Kaiser / HRET.

[16] In results using the MCBS in this report, all beneficiaries in Medicare+Choice plans are classed in the Medicare+Choice category even though some have supplemental coverage paid for by their former employer.

[17] Mercer / Foster Higgins.

[18] Hewitt Associates, *Retiree Health Coverage: Recent Trends and Employer Perspectives on Future Benefits*, Kaiser Family Foundation, Oct. 1999.

[19] Insurers may offer a high deductible version of Plan J which generally has lower premiums than the regular Plan J. Under this high-deductible option, the purchaser pays $1,530 out-of-pocket per year before the plan pays anything. The purchaser must still meet a $250 deductible on prescription drugs before drug coverage begins.

many of these include drug coverage.[20] A few states are also exempt from using the standardized plans.[21]

Many carriers do not offer the plans with drug coverage, and those who do may refuse coverage to applicants perceived to be high-risk. Carriers must accept all beneficiaries aged 65 and above during a limited open enrollment that ends 6 months after the beneficiary first qualifies for Medicare; no open enrollment requirement applies to disabled beneficiaries under the age of 65.[22] In addition, twelve states have laws requiring community rating or preventing Medigap insurers from raising premiums as policy holders age, a practice known as attained-age rating.[23]

Premiums for the plans with drug coverage are much higher than for other Medigap plans, both because of the cost of the drug benefit itself and because the benefit is likely to attract beneficiaries who incur higher general medical expenses. An analysis of June 1999 premiums for some of the major Medigap carriers found that the premium for individuals aged 65 averaged $1,000 higher for plan J than for plan F, the most similar plan without drug benefits; the gap between premiums for the F and J plans increased for older beneficiaries in plans that used attained-age rating. In some cases, the incremental premium for adding drug coverage was greater than the maximum value of the benefit.

Some Medigap plans have begun to use PBMs. Since July 1998, United HealthCare, a health plan that also sells Medigap policies through AARP, has employed a PBM to negotiate lower drug prices for its H, I, and J policyholders at preferred pharmacies. Through their PBM, United HealthCare is also able to offer point of sale copayments and drug-interaction screening to its Medigap policyholders. However, most plans are

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[20] Rice et al. found that 15 percent of nonstandardized policies sold in a sample of six states in 1994 included prescription drug benefits. There is no data on the value of these benefits. "The Impact of Policy Standardization on the Medigap Market," *Inquiry*, 1997.

[21] Federal law permits insurers in Minnesota, Massachusetts, and Wisconsin to offer different state-regulated Medigap policies. Wisconsin law requires Medicare Supplement policies to contain a catastrophic prescription drug benefit. This benefit must cover at least 80% of the charges for outpatient prescription drugs after the purchaser meets a drug deductible of no more than $6,250 per calendar year.

[22] Medigap carriers must also offer open enrollment to beneficiaries who have lost supplemental coverage as a result of the termination of a Medicare risk HMO contract, or in certain other circumstances. However, they are not required to offer one of the plans with drug coverage during this special open enrollment period.

[23] HHS analysis.

still indemnity plans, which reimburse participants for their drug expenditures after the fact and do not manage the benefit.

The category of individually purchased coverage also includes a variety of additional supplements. Some individuals purchase non-Medigap policies, such as private long-term care insurance or drug-only policies. The exact number of these policies and the value of the benefits they include is unknown. The term "Medigap" will be used to describe the entire category of individually purchased Medicare supplemental insurance in the remainder of this report.

There is no reliable source of information about the nature of the drug benefits provided to non-Medicare enrollees in private nongroup insurance plans, or about how these benefits are administered.

Medicare+Choice Plans

In 2000, about 6 million Medicare beneficiaries are enrolled in Medicare+Choice (M+C) coordinated care plans. This number has grown from about 3 million in 1996 enrolled in risk HMOs, comparable to today's Medicare+Choice plans. When a Medicare beneficiary chooses to enroll in an M+C plan (usually an HMO), the contracting organization receives a fixed monthly payment from Medicare to furnish all Medicare-covered services. If it is projected that the plan can furnish these services at a cost less than the Medicare payment, the plan must share the savings with enrollees by providing supplemental benefits. As a result of this rule, or simply to compete for market share, most M+C plans have offered enrollees supplemental coverage. These supplemental benefits often include some drug coverage, at a much lower premium than enrollees would have had to pay for an equivalent Medigap plan. In addition, unlike Medigap plans, M+C plans must accept all applicants, regardless of health status (other than individuals with End Stage Renal Disease, [ESRD]) or age. M+C plans have thus been an attractive source of supplemental coverage for beneficiaries willing to accept the restrictions on provider choice that plan membership entails.

In 1996, 95 percent of enrollees in risk HMOs had at least some drug benefit.[24] More recently, some plans have reduced benefits. While complete information is not available, HCFA has estimated that in 1999, 84 percent of HMO enrollees were in plans

[24] MCBS.

that included drugs as a basic benefit.[25] (Other enrollees may have obtained drug coverage by purchasing a high-option plan.)

Drug benefits in Medicare HMOs vary widely. About 54 percent of enrollees with drug coverage in 1999 were in plans that imposed an annual dollar limit on all drug payments, most commonly between $1,000 and $2,000. Another 24 percent were in plans that had a limit on payments for brand-name drugs but no limit for generic drugs, while 22 percent were in plans that had no payment limit for drugs. Copayments typically ranged between $5 and $10 per prescription; higher copayments were often imposed for brand-name drugs. (Note that this description is based on the basic plans offered to all enrollees. Some plans offer supplemental benefits at a higher premium. There is no information on the level of benefits offered by employer-sponsored plans through M+C contractors.) As is the case for other enrollees in managed care plans, drug benefits are commonly administered by a PBM or are managed directly by the organization.

There is considerable geographic variation in the level of drug coverage offered by M+C plans. The most generous coverage appears to be associated with high payment areas in which multiple plans compete for enrollees. For example, in 1999 all plans with unlimited drug benefits and no copayments were located in Florida. Plans with annual caps of $2000 or more were concentrated in Miami, Phoenix, and Los Angeles. In general, where plans are available in rural areas, they tend to charge higher premiums and offer no drug coverage or significantly less generous drug coverage.[26]

In 2000, M+C plans generally have reduced drug benefits and increased enrollee out-of-pocket costs. For example, 86 percent of plans have annual dollar limits on drugs, including 70 percent of plans with annual caps of $1000 or less, and 32 percent with annual caps of $500 or less per enrollee, up from 35 percent and 19 percent respectively in 1998. Additionally, while over one million beneficiaries lived in areas in 1999 with

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[25] HCFA analysis of *Medicare Compare*. MCBS data capture information on drug coverage in 1996 for enrollees of Medicare managed care plans who have employer-sponsored drug coverage through the Medicare contracting organization as well as information on beneficiaries whose source of drug coverage is a "high option" plan offered by a Medicare contracting organization (today's M+C organization). HCFA administrative files, used for the 1999 analysis, do not include information on whether beneficiaries obtain drug coverage by selecting high option plans rather than as part of the basic benefit package. This understates the overall proportion of beneficiaries with drug coverage in M+C plans.

[26] HCFA analysis.

M+C plans available that offered zero copayments for prescription drugs, all beneficiaries will now be subject to copayments for generic and brand-name drugs.[27]

Medicaid

While coverage for outpatient prescription drugs is optional under Medicaid, all states provide this benefit for families and children enrolled in the program. In addition, certain low-income Medicare beneficiaries may qualify for Medicaid and receive full Medicaid benefits, including prescription drug coverage. Medicaid eligibility can be achieved in several ways. Medicare beneficiaries may qualify for Supplemental Security Income (SSI) or related cash assistance if they are elderly or disabled and meet an income limit that is well below the federal poverty level (FPL), $11,250 for a couple in 2000. In most states, receipt of SSI means automatic enrollment in Medicaid. Beneficiaries may qualify for a state's "medically needy" Medicaid program by meeting a state-established income test, often by "spending down"—incurring medical bills sufficient to reduce their income and assets to the required level. Those in need of long-term care may meet special eligibility limits for home- and community-based service programs.

Low-income Medicare beneficiaries who fall outside these categories may qualify for Medicaid assistance that does not include prescription drug coverage.[28] "Qualified Medicare Beneficiaries" (QMBs), with incomes below 100 percent of FPL, receive Medicaid assistance for Medicare cost-sharing and Medicare's Part B premium. A state may choose to extend full Medicaid benefits to this group with federal matching funds by raising their income eligibility to 100 percent of FPL, but most have not. "Specified Low-income Medicare Beneficiaries" (SLMBs), with incomes between 100 percent and 135 percent of FPL, receive Medicaid assistance for Part B premiums only. In 1996, an estimated 90 percent of Medicare beneficiaries receiving Medicaid had drug coverage.[29] This may include some cases where QMBs or SLMBs received drug coverage through state-only programs.

Medicaid programs may impose only "nominal" copayments for prescription drugs, and no copayments for certain services, such as those furnished to children. All but 17 states impose some copayments, typically $1 to $2 for prescription drugs. Although

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[27] HCFA, *Medicare+Choice: Changes for the Year 2000*, 1999.

[28] The discussion here omits a variety of other special population groups defined in law and accounting for very small numbers of participants.

[29] MCBS.

most states enroll families and children in managed care, very few have enrolled aged or disabled beneficiaries. Additionally, many states that use managed care have excluded prescription drugs from the contracts and provide the benefits directly on a fee-for-service basis.[30] Thus most Medicare beneficiaries who receive their drug coverage through Medicaid receive drugs on a fee-for-service basis.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) governs the provision of pharmaceutical benefits under Medicaid. Under the law, pharmaceutical manufacturers are required to enter into rebate agreements with the Department of Health and Human Services (HHS) in order for these companies to sell their products to state Medicaid programs (see Chapter 3 for further discussion of Medicaid rebates). The agreement establishes a basic rebate of the greater of Average Manufacturer Price (AMP) minus the manufacturer's best price or 15.1% of the AMP for single source and innovator multiple source drugs. At the same time, OBRA 90 prohibits state Medicaid programs from using some of the same management techniques as PBMs. In particular, states may not use restrictive formularies, although they can develop programs for prior authorization and drug utilization review to manage the drug benefit. Some states control costs by capping the number of prescriptions that a beneficiary can fill within a month, restricting refills, or limiting the amount of medication that can be dispensed at one time. Arkansas, Nevada, Oklahoma, Texas, Wisconsin, and Wyoming, for example, limit Medicaid recipients to three prescriptions per month, with some exceptions. West Virginia restricts beneficiaries to ten prescriptions per year.[31]

Other Sources of Drug Coverage

Some Medicare beneficiaries and non-Medicare individuals receive a degree of assistance in purchasing drugs through other federal and state programs. The most important is the Department of Veterans Affairs (VA). When a VA physician prescribes a drug, a veteran may fill the prescription at a VA pharmacy, or through a VA mail-order program, usually with only a small copayment. Eligibility for VA services thus functions as the equivalent of insurance, but only for prescriptions written by a VA physician. Medicare generally does not cover VA services, so a veteran may have to pay for the physician visit to access the drug benefit. However, visits are free for the indigent and for veterans with service-related conditions.

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[30] One reason is that states cannot receive Medicaid rebates on drugs provided through HMOs.

[31] National Pharmaceutical Council. *Pharmaceutical Benefits under State Medical Assistance Programs, December 1998.*

Currently, 16 states operate pharmacy assistance programs, which cover about 750,000 individuals.[32] These programs generally cover low-income elderly people who do not qualify for Medicaid drug coverage; about half are available to other population groups, typically the disabled.[33] Some of the programs cover the same range of drugs covered under the state's Medicaid program. Others are restricted to "maintenance" drugs required for certain chronic conditions.

A very small number of Medicare beneficiaries are assisted in drug purchases by Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), worker's compensation, or other coverage sources.

Some people without insurance may receive certain drugs for free. Some manufacturers operate programs that make certain drugs available to uninsured people meeting specified eligibility criteria. The Pharmaceutical Research and Manufacturers of America (PhRMA) estimates that the programs for which they have data filled 2.7 million prescriptions for nearly 1.5 million people in 1998.[34] In addition, manufacturers commonly distribute samples to be dispensed by physicians and clinics. IMS Health reports that for the twelve months ending September 1999, companies gave drug samples with a retail value of about 7 billion dollars to office-based physicians.[35]

Other individuals without coverage may purchase discount cards from groups like AARP which enable them to receive a percentage discount for prescriptions purchased in participating pharmacies. Many pharmacies also offer discounts to seniors. Discounts of this type are not classified as drug coverage. There is no centralized source for data on the number of people taking advantage of these discounts or the value of the discounts they receive.

PRESCRIPTION DRUG COVERAGE IN 1996

[32] National Conference of State Legislatures, news release, March 10, 2000.

[33] This count does not include disease-specific programs that may provide some assistance with drug costs, such as the AIDS drug assistance programs funded by the Ryan White CARE Act.

[34] Direct communication, PhRMA.

[35] IMS Health. Integrated Share of Voice Report. (It should be noted that the MCBS and MEPS data on utilization and spending to be presented in Chapter 2 exclude samples or other free medications.)

This section presents information from surveys on the source and extent of drug coverage in 1996. MCBS is used for the Medicare population, and MEPS for the non-Medicare population. Unless otherwise noted, all results reported in this chapter from MCBS and MEPS are statistically significant (at the 0.05 level, based on a two-tailed test). See the Introduction of this report for details. Further discussion of methodology can be found in Appendix B.

Medicare Beneficiaries

Sources of drug coverage for Medicare beneficiaries were unstable in the mid 1990s. In 1996, the most recent year for which data are available, an estimated 69 percent of Medicare beneficiaries had drug coverage for at least one month of the year, although only 53 percent had coverage for the entire year. Table 1-1 groups beneficiaries according to their primary source of Medicare supplemental coverage—that is, the source that assisted them with Medicare cost-sharing expenses. Not every beneficiary who had drug coverage obtained it through the same source that provided the beneficiary's primary supplement. About 5 percent of those with drug coverage obtained it through a different source; this was most common for those whose primary supplement was an individually purchased plan.

Table 1-1. Medicare Beneficiaries with Prescription Drug Coverage for at Least One Month, by Primary Source of Medicare Supplemental Coverage, 1996

Primary supplement	With drug coverage (000s)	Without drug coverage (000s)	Percent without drug coverage	Source of coverage for beneficiaries with drug coverage (%)
Medicare risk HMO	3,729	215	5.5%	14.5%
Medicaid	4,408	512	10.4%	17.2%
Employer Sponsored.	12,045	1,535	11.3%	47.0%
Individually purchased	4,192	6,292	60.0%	16.4%
Other public sources	1,246	178	12.5%	4.9%
FFS Medicare only	-	2,891	100%	---
Total	25,621	11,623	31.2%	100%

Source: Information and Methods Group, Office of Strategic Planning, Health Care Financing Administration: Medicare Current Beneficiary Survey Cost and Use File, 1996.

The likelihood of having drug coverage varies by different types of supplemental coverage. Only 40 percent of beneficiaries with Medigap or other individual coverage as a primary supplement had a drug benefit. On the other hand, almost 95 percent of

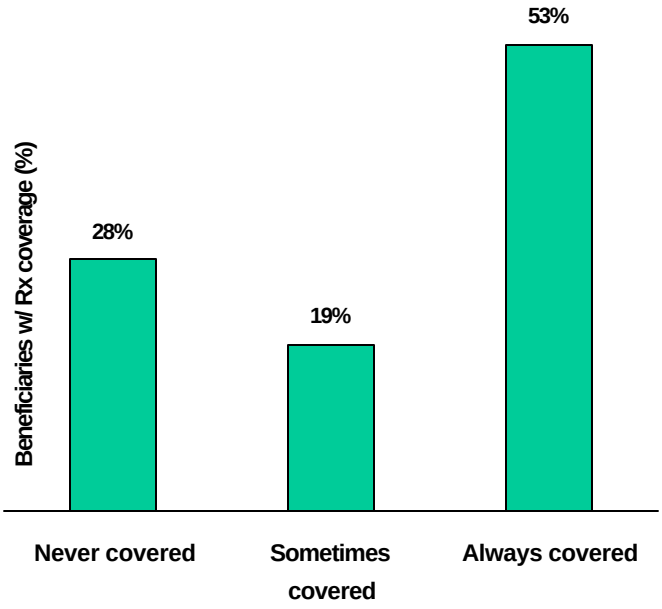
risk HMO enrollees had some drug coverage. Almost 3 million beneficiaries had no form of supplemental coverage, whether for drugs or for other services.

Among all beneficiaries with drug coverage for at least one month in 1996, nearly half, 47 percent, were covered through an employer-sponsored retiree plan. Medicaid provided drug benefits for 17 percent of covered beneficiaries; Medigap was the primary supplement for about 16 percent of covered beneficiaries; and 14.5 percent of those with coverage were enrolled in a Medicare risk HMO. Almost 5 percent of beneficiaries with coverage obtained it through a variety of small public programs.

However, as was noted earlier, not all beneficiaries who had drug coverage had it for the entire year. Information on this issue was not collected as part of this study. The following information (see Figure 1-1) is derived from an independent analysis of 1996 MCBS data conducted by Bruce Stuart, et al. of the University of Maryland for the Commonwealth Fund.[36]

[36] Stuart, Bruce, Dennis Shea, and Becky Briesacher, *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter*, New York, Commonwealth Fund, Issue Brief, January 2000.

Figure 1-1. Duration of Prescription Drug Coverage for Medicare Beneficiaries in 1996



Note: This analysis includes only noninstitutionalized beneficiaries enrolled in Medicare for the entire year.

Source: Bruce Stuart, Dennis Shea, and Becky Briesacher, *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter*, New York, Commonwealth Fund, Issue Brief, January 2000

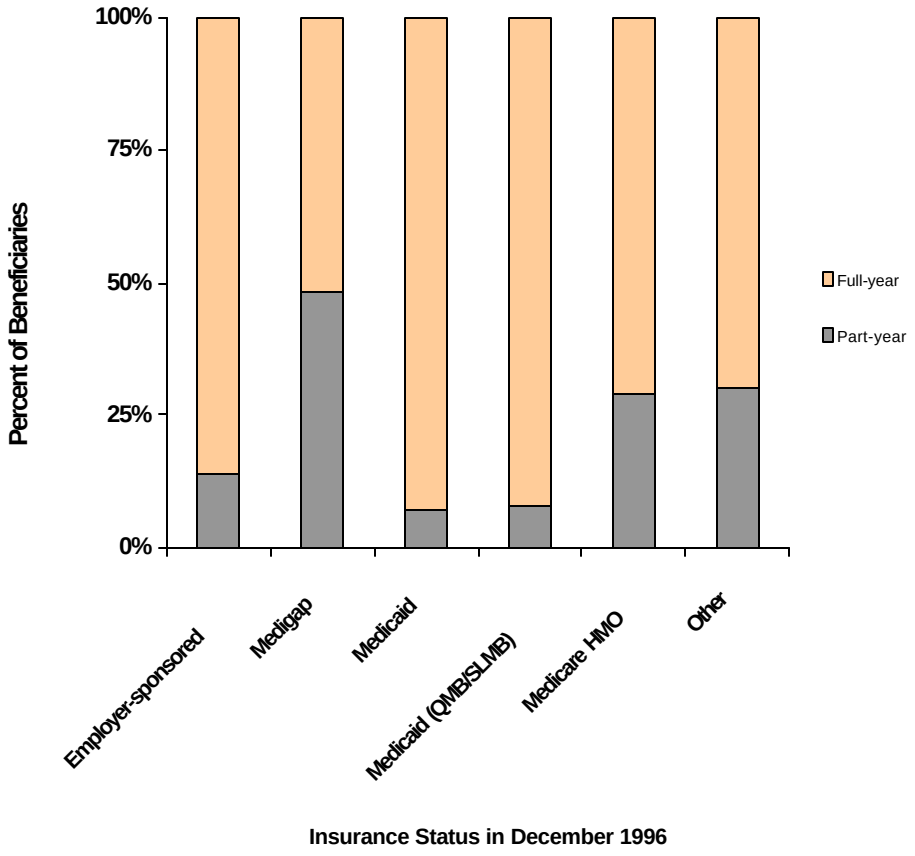
The authors' month-to-month examination of supplemental insurance shows that prescription coverage in 1996 was often fragmented and non-continuous. Over one in four Medicare beneficiaries (about 6.3 million people) who had coverage at any time during 1996 had coverage for only part of that year. For people with part-year coverage whose period of coverage could be ascertained, the average duration of coverage was 6.6 months. Thus, while the data presented in Table 1-1 indicate that 69 percent of beneficiaries had drug coverage for at least one month in 1996, only 53 percent had coverage for the entire year.

Table 1-2 shows partial and full-year drug coverage rates by source of supplemental insurance for those Medicare beneficiaries who had drug coverage for at least one month during 1996.[37] Beneficiaries with every kind of Medicare supplement experienced changes in their coverage status in 1996, but changes for some types of

[37] Note that the sample for Table 1-2 is somewhat different from the Table 1-1. Numbers for Table 1-2 are derived from an MCBS sample of persons enrolled in Medicare for the entire year and thus excludes decedents and new Medicare entrants.

coverage were particularly dynamic (see Figure 1-2). Almost 48 percent of beneficiaries with drug coverage through Medigap policies and 29 percent who were enrolled in Medicare HMOs had drug coverage for only part of the year. Almost 14 percent of individuals with employer-sponsored drug coverage had part-year coverage. Individuals dually eligible for Medicare and Medicaid had the most stable coverage during the year, with only 7 percent experiencing gaps in drug coverage.[38]

Figure 1-2. Duration of Coverage for Beneficiaries who had Coverage in 1996, by Source of Coverage



Note: This analysis includes only noninstitutionalized beneficiaries enrolled in Medicare for the entire year.

Source: Bruce Stuart, Dennis Shea, and Becky Briesacher, *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter*, New York, Commonwealth Fund, Issue Brief, January 2000.

[38] These data are based on a beneficiary's source of coverage in December. The proportions would probably vary somewhat if a different month were used as the basis for comparison.

Table 1-2. Duration of Prescription Drug Coverage for Medicare Beneficiaries Who Had Coverage in 1996

Source of coverage in December 1996	Of full-year beneficiaries covered at any time in 1996, percent who had:	
	Part-year coverage	Full-year coverage
Total	26%	74%
Employer-sponsored	14%	86%
Individual Medigap	48%	52%
Medicaid	7%	93%
Medicaid QMB/SLMB	8%	92%
Medicare HMO	29%	71%
Other	30%	70%

Note: This analysis includes only noninstitutionalized beneficiaries enrolled in Medicare for the entire year.

Source: Bruce Stuart, Dennis Shea, and Becky Briesacher, *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter*, New York, Commonwealth Fund, Issue Brief, January 2000.

Drug coverage for individuals with Medigap policies was particularly tenuous. While MCBS reports that 39.8 percent of Medicare beneficiaries with Medigap or other private nongroup policies had drug coverage in 1996, that number is misleading. Compared to other categories of supplemental insurance, beneficiaries with Medigap were most likely to have drug coverage from another source and most likely to have part year coverage. About 16 percent of Medigap policyholders with drug coverage got their coverage from a secondary source, and only 25 percent had coverage for the full year. Additionally, as noted above, this category includes an unknown number of non-Medigap policies, such as private long-term care insurance or drug-only policies. There is no data on the value of the drug coverage provided under these plans. Overall, only 21 percent of Medigap or other private nongroup insurance policy holders had drug coverage from that source for the full year.

In an additional analysis, Stuart et al. analyzed drug coverage for those individuals continuously enrolled in Medicare for 1995 and 1996.[39] Only 46 percent of beneficiaries had drug coverage throughout the entire two-year period. Six percent of these beneficiaries maintained coverage throughout the period by switching from one source of coverage to another at least once. While 11 percent of beneficiaries gained coverage

[39] Bruce Stuart, et al., "Dynamics in Prescription Coverage of Medicare Beneficiaries: Finders, Losers, Switchers," Commonwealth Fund Issue Brief, forthcoming.

at some point during the period, 8 percent lost coverage and 12 percent had intermittent coverage.

CHARACTERISTICS OF INDIVIDUALS WITH AND WITHOUT COVERAGE

Table 1-3 shows drug coverage rates for beneficiaries with coverage for at least one month in 1996 by income as a percent of the federal poverty threshold (in 1996 the threshold was $7,525 for an individual and $9,491 for a couple age 65 or older).[40] Coverage is lowest for beneficiaries between 100 and 150 percent of poverty. These beneficiaries may not qualify for Medicaid or may be eligible only for limited QMB/SLMB benefits, and they may be unable to afford to purchase coverage on their own. Above this level, coverage rises fairly steadily with income, although about 23 percent of Medicare beneficiaries with incomes above 400 percent of poverty had no drug coverage at any time in 1996 (see Figure 1-3).

Table 1-3. Medicare Beneficiaries with and without Prescription Drug Coverage, For at Least One Month, by Income, 1996

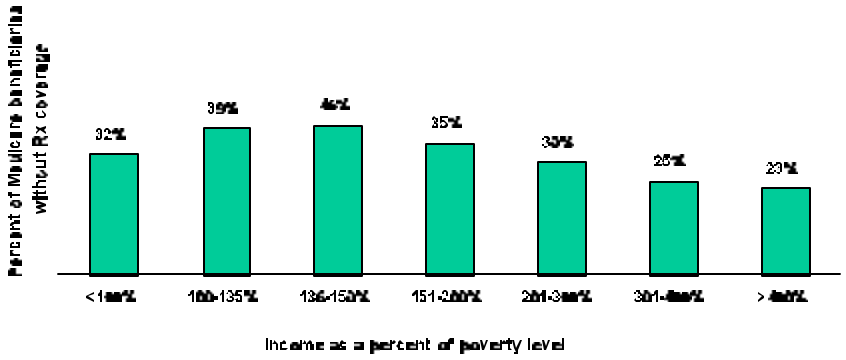
Income as percent of poverty	With drug coverage (000s)	Without drug coverage (000s)	Percent without drug coverage
<100%	5,498	2,619	32.3%
100-135%	2,829	1,795	38.8%
136-150%	1,020	676	39.8%
151-175%	1,708	926	35.2%
176-200%	1,812	995	35.5%
201-300%	5,178	2,226	30.1%
301-400%	3,094	1,031	25.0%
>400%	4,482	1,355	23.2%
Total	25,621	11,623	31.2%

Note: Not all differences in coverage rate by income groups are statistically significant. The differences between the groups with the highest rates of coverage and the groups with the lowest rates of coverage are statistically significant. The Federal poverty threshold for couples 65 and over in 1996 was $9491.

Source: Information and Methods Group, Office of Strategic Planning, Health Care Financing Administration: Medicare Current Beneficiary Survey Cost and Use File, 1996.

[40] Income includes that of the beneficiary and a spouse, if any, not that of other family or household members.

Figure 1-3. Medicare Beneficiaries Who Never Had Drug Coverage During the Year, by Income, 1996



Source: Information and Methods Group, Office of Strategic Planning, Health Care Financing Administration: Medicare Beneficiary Survey Cost and Use File, 1996

Table 1-4 shows the number of beneficiaries without coverage by income as a percent of all beneficiaries without coverage. The majority of beneficiaries without drug coverage in 1996, 56 percent, had incomes above 150 percent of poverty and 40% had incomes above 200 percent of poverty.

Table 1-4. Medicare Beneficiaries Who Never Had Drug Coverage During the Year, by Income, as Percent of All Beneficiaries without Coverage, 1996

Income as percent of poverty	Beneficiaries without drug coverage (000s)	Percent of total without coverage (000s)
<100%	2,619	22.5%
100-150%	2,471	21.0%
151-200%	1921	16.5%
>200%	4612	40.0%
Total	11,623	100.0%

Note: The Federal poverty threshold for couples 65 and over in 1996 was $9491.

Source: Information and Methods Group, Office of Strategic Planning, Health Care Financing Administration: Medicare Current Beneficiary Survey Cost and Use File, 1996.

Table 1-5 shows coverage rates for at least one month in 1996 by age. Disabled nonelderly beneficiaries are slightly more likely to have coverage than the elderly. More disabled beneficiaries may have incomes low enough to qualify for SSI and thus receive Medicaid; the disabled account for 12 percent of all beneficiaries but 34 percent of beneficiaries with Medicaid. On the other hand, they are less likely to have employer coverage or be enrolled in Medicare risk HMOs.

Among the elderly, rates of coverage drop steadily with age. There are a number of possible explanations. First, the very old tend to have lower incomes than younger elderly people and may not be able to afford Medigap—especially because Medigap premiums often rise with attained age. Second, retiree health benefits are a relatively recent phenomenon; the very old may be more likely than the younger elderly to have retired before such coverage became prevalent.

Table 1-5. Medicare Beneficiaries with and without Prescription Drug Coverage for at Least One Month, by Age, 1996

AGE	With drug coverage (000s)	Without drug coverage (000s)	Percent without coverage
0-44	1,038	432	29.4%
45-64	2,093	781	27.2%
65-69	6,841	2,644	27.9%
70-74	6,025	2,658	30.6%
75-79	4,599	2,229	32.6%
80-84	2,964	1,640	35.6%
85+	2,061	1,238	37.5%

Source: Information and Methods Group, Office of Strategic Planning, Health Care Financing Administration: Medicare Current Beneficiary Survey Cost and Use File, 1996.

Table 1-6 shows rates of coverage for at least one month in 1996 by sex. Males are slightly more likely to have coverage than females; as male beneficiaries tend to be younger than female beneficiaries, this finding is consistent with the age differences shown in Table 1-5. Also, males are more likely to have worked and have access to retiree insurance.

Table 1-6. Medicare Beneficiaries with and without Prescription Drug Coverage for at Least One Month, by Sex, 1996

SEX	With drug coverage (000s)	Without drug coverage (000s)	Percent without coverage
Male	11,561	4,917	29.8%
Female	14,059	6,706	32.3%

Source: Information and Methods Group, Office of Strategic Planning, Health Care Financing Administration: Medicare Current Beneficiary Survey Cost and Use File, 1996.

Table 1-7 shows coverage for any part of 1996 by race. Differences in coverage rates by race are not statistically significant.

Table 1-7. Medicare Beneficiaries with and without Prescription Drug Coverage for at Least One Month, by Race, 1996

RACE	With drug coverage (000s)	Without drug coverage (000s)	Percent without coverage
White	21,804	10,176	31.8%
Black	2,397	1,016	29.8%
Other	1,420	431	23.3%

Note: "Other" includes Asian, Hispanic, and North American Native.

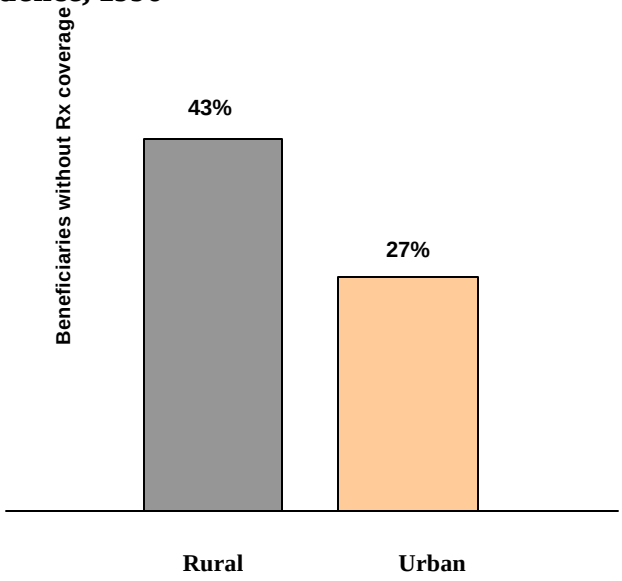
Source: Information and Methods Group, Office of Strategic Planning, Health Care Financing Administration: Medicare Current Beneficiary Survey Cost and Use File, 1996.

Table 1-8 and Figure 1-4 show coverage for at least one month in 1996 according to whether the beneficiary resides in a metropolitan statistical area. Beneficiaries outside metropolitan areas have a much lower rate of coverage. While 57 percent of beneficiaries living in rural areas had coverage for at least one month in 1996, 73 percent of beneficiaries living in metropolitan areas had some drug coverage. Rural beneficiaries also had less full-year coverage; only 44 percent had coverage throughout the year.[41] By contrast, 49 percent of beneficiaries living in urban areas had coverage

[41] Note sample size for part-year coverage is based on an MCBS sample of persons enrolled in Medicare for the entire year and thus excludes decedents and new Medicare entrants. Bruce Stuart, University of

for the full year. One factor is probably more limited availability of Medicare HMOs, which tend to be concentrated in metropolitan areas. HCFA projects that, in 2000, about 29 percent of beneficiaries live in areas with no access to a Medicare+Choice plan. In addition, nonmetropolitan beneficiaries are less likely to have employer-sponsored drug benefits, probably because their jobs were less likely to have offered retiree benefits.

Figure 1-4. Beneficiaries Who Never Had Drug Coverage During the Year, by Metropolitan Residence, 1996



Source: Information and Methods Group, Office of Strategic Planning, Health Care Financing Administration: Medicare Beneficiary Survey Cost and Use File, 1996

Table 1-8. Medicare Beneficiaries with and without Prescription Drug Coverage for At Least One Month, by Metropolitan Residence, 1996

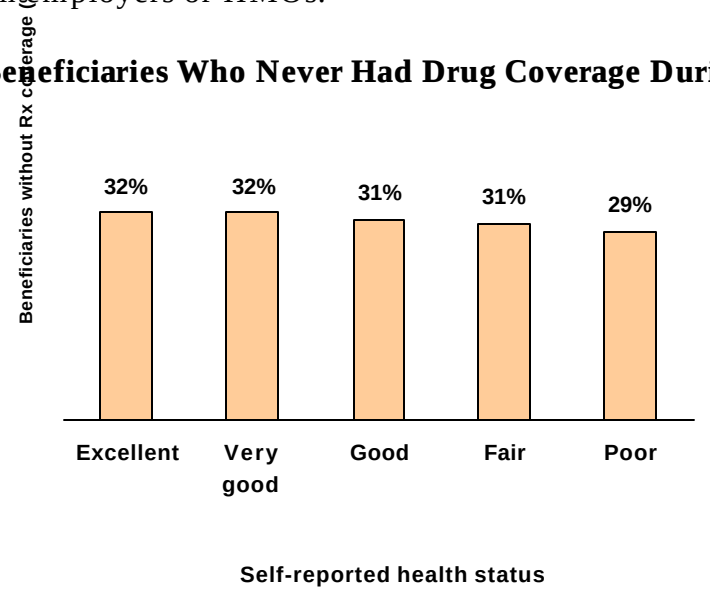
Residence	With drug coverage (000s)	Without drug coverage (000s)	Percent without coverage
Metropolitan	19,932	7,414	27.1%
Non-metropolitan	5,660	4,203	42.6%

Source: Information and Methods Group, Office of Strategic Planning, Health Care Financing Administration: Medicare Beneficiary Survey Cost and Use File, 1996

Maryland, direct communication.

Table 1-9 and Figure 1-5 show coverage for at least one month in 1996 by self-reported health status. Differences in coverage rates by health status are not statistically significant. However, differences in source of coverage are significant: those reporting poor health are more likely to have coverage through Medicaid and less likely to have coverage from employers or HMOs.

Figure 1-5. Beneficiaries Who Never Had Drug Coverage During the Year, by Health Status, 1996



Source: Information and Methods Group, Office of Strategic Planning, Health Care Financing Administration: Medicare Beneficiary Survey Cost and Use File, 1996

Table 1-9. Medicare Beneficiaries with and without Prescription Drug Coverage for at Least One Month, by Self-Reported Health Status, 1996

Health Status	With drug coverage (000s)	Without drug coverage (000s)	Percent without coverage
Excellent	4,186	1,967	32.0%
Very Good	6,742	3,193	32.1%
Good	7,693	3,468	31.1%
Fair	4,496	1,970	30.5%
Poor	2,451	1,000	29.0%

Source: Information and Methods Group, Office of Strategic Planning, Health Care Financing Administration: Medicare Current Beneficiary Survey Cost and Use File, 1996.

Additionally, unstable drug coverage was evident for individuals with self-reported poor health status. Almost 21 percent of individuals with fair to poor health status had only part-year coverage in 1996.[42]

However, self-reported health status is a subjective measure that may or may not be related to actual need for drugs or other health services. The next three tables use different measures as alternative indicators of a likely need for prescription drugs.

The first is functional status, which measures the extent to which an individual requires assistance in performing "activities of daily living" (ADLs), such as bathing, dressing, toileting, or eating, or with "instrumental activities of daily living" (IADLs), such as meal preparation or managing money. Prior analysis of MCBS data has shown that poorer functional status is strongly correlated with the need for acute care services.[43] As Table 1-10 shows, drug coverage does not differ very much by functional status. The most severely disabled beneficiaries have about the same rate of coverage as those with no limitations.

Table 1-10. Medicare Beneficiaries with and without Prescription Drug Coverage, by Functional Status, 1996

Functional Status	With drug coverage (000s)	Without drug coverage (000s)	Percent without coverage
No limitations	19,592	8,949	31.4%
Requires assistance with:			
IADL only	1,130	458	28.8%
1 or 2 ADLs	2,979	1,384	31.7%
3 or more ADLs	1,920	832	30.2%

Source: Information and Methods Group, Office of Strategic Planning, Health Care Financing Administration: Medicare Current Beneficiary Survey Cost and Use File, 1996.

Table 1-11 shows coverage rates for any part of 1996 by the number of chronic conditions reported by a beneficiary from a list of ten possible conditions.[44] Those

[42] Stuart et al.

[43] J. Feder and J. Lambrew, "Why Medicare Matters to People Who Need Long-Term Care," *Health Care Financing Review*, (Winter 1996): 99-112.

[44] The conditions were heart problems, cancer, arthritis, lung disease, mental disorders, Alzheimer's, diabetes, hypertension, bone disease, and stroke.

reporting 5 or more chronic conditions had a somewhat higher coverage rate than those reporting fewer chronic conditions, and considerably higher than those reporting none. They were also more likely to have coverage through Medicaid or other public programs. Yet, many had gaps in their coverage. Of the more than 74 percent of these beneficiaries that had coverage for at least one month during the year, 21 percent only had coverage for part of the year.[45]

Table 1-11. Medicare Beneficiaries with and without Prescription Drug Coverage, by Number of Chronic Conditions, 1996

Chronic Conditions	With drug coverage (000s)	Without drug coverage (000s)	Percent without coverage
0	2,419	1,311	35.1%
1-2	11,255	5,383	32.4%
3-4	9,221	3,986	30.2%
5+	2,727	943	25.7%

Source: Information and Methods Group, Office of Strategic Planning, Health Care Financing Administration: Medicare Current Beneficiary Survey Cost and Use File, 1996.

Finally, table 1-12 shows coverage rates for any part of 1996 for beneficiaries who did and did not have an inpatient hospital admission during the year. The two groups had about the same rates of coverage.

Table 1-12. Medicare Beneficiaries with and without Prescription Drug Coverage, by Use of Inpatient Hospital Services, 1996

Any inpatient admission	With drug coverage (000s)	Without drug coverage (000s)	Percent without coverage
No	21,118	9,522	31.1%
Yes	4,503	2,101	31.8%

Source: Information and Methods Group, Office of Strategic Planning, Health Care Financing Administration: Medicare Current Beneficiary Survey Cost and Use File, 1996.

In sum, on three measures that might be related to need for services—self-reported health status, functional status, and inpatient hospital use—MCBS shows no statistically significant difference in drug coverage between healthier and sicker or more disabled individuals. These findings do not rule out the possibility of self-

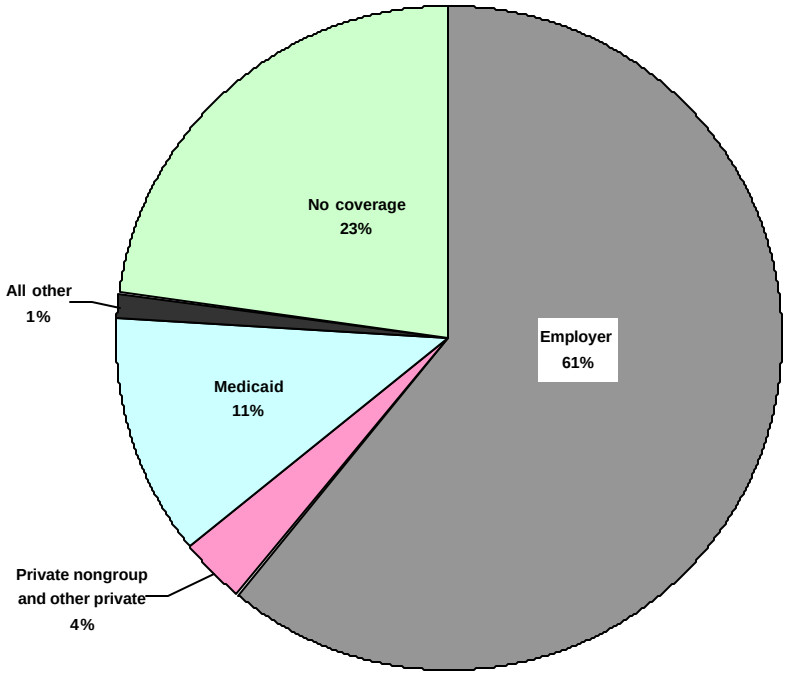
[45] Stuart et al.

selection; within each defined subpopulation there are likely to be some individuals with a greater need for prescription drugs than others, and these individuals may be more prone to obtain insurance. Moreover, on one measure, number of chronic conditions, sicker individuals do have significantly higher rates of coverage. Evidence about utilization and spending related to the question of selection is reviewed in Chapter 2. These findings, however, do suggest that healthy Medicare beneficiaries are not the only ones who lack coverage for prescription drugs. In general, an equal proportion of covered and non-covered beneficiaries have health problems.

Non-Medicare Population

To put drug coverage for Medicare beneficiaries in perspective, Table 1-13 and Figure 11-6 show sources of drug coverage for the non-Medicare population in 1996.[46] Nearly one in four people had no drug coverage during the year.

Figure 1-6. Sources of Drug Coverage for Non-Medicare Population, 1996



Source: Center for Cost and Financing Studies, Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey Household Component

[46] Individuals who had drug coverage at any time during the year are classified as covered in this survey.

Table 1-13. Percent of Non-Medicare Population with Drug Coverage at Any Time During the Year, by Source of Coverage, 1996

Source of coverage	Number (000s)	Percent
Employer	140,303	60.7%
Private nongroup and other private	8,268	3.6%
Medicaid	26,291	11.4%
All other	2,991	1.3%
Total with coverage	177,853	77.0%
No drug coverage	53,109	23.0%
Total	230,962	100.0%

Source: Center for Cost and Financing Studies, Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey Household Component, 1996.

The sources of coverage are very different for the non-Medicare population. Three-fifths of the nonelderly, or about 80 percent of those with coverage, have drug coverage through employer groups, compared to a third of the elderly. Many fewer non-Medicare individuals purchase individual coverage. The non-Medicare population is slightly more likely to have drug coverage through Medicaid. While Medicaid benefits for Medicare beneficiaries (specifically QMBs and SLMBs) may or may not include drug coverage, all states provide drug benefits to the non-Medicare classes of Medicaid eligibles, such as pregnant women and children, certain families, and disabled people who do not receive Medicare. Of those without drug coverage, the majority lacked any form of health insurance that covered physician and hospitalization expenses.

Table 1-14 shows coverage rates by ratio of family income to the federal poverty threshold. The near-poor, those between 100 and 200 percent of FPL, have the lowest coverage rate; over a third are without drug coverage. This is the same income range with lowest coverage rates in the MCBS data for Medicare beneficiaries. As with the latter group, individuals at this income threshold may earn too much to qualify for Medicaid but lack the means to obtain their own coverage. However, there is more of a correlation between income and drug coverage in the non-Medicare population compared to the Medicare population. Thus, about 23 percent of Medicare beneficiaries with incomes above 400 percent of poverty lack drug coverage, compared to 14 percent of the non-Medicare population. This probably is in part a result of the types of jobs held by those at different income levels: low-wage workers are less likely to be offered health insurance by their employers.

Table 1-14. Drug Coverage of Non-Medicare Population, by Income, 1996

Income as a percent of poverty	With drug coverage (000)	Without drug coverage (000)	Percent without coverage
< 100	22,425	9,987	30.8%
100-199	26,797	15,371	36.5%
200-399	59,563	16,459	21.9%
> 400	68,796	11,229	14.0%
Total	177,853	53,109	23.0%

Note: The total includes 335,000 people with negative family income; the sample size for this group is too small for reliable coverage estimates.

Source: Center for Cost and Financing Studies, Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey Household Component, 1996.

Finally, coverage in the non-Medicare population varies by individual health status. Table 1-15 shows rates of drug coverage by self-reported health status. Those reporting poor health have the highest rate of coverage, but those in excellent or very good health have higher coverage rates than those in good or fair health.[47] Further research would be needed to determine whether confounding variables, such as employment status or income, are affecting the results.

Table 1-15. Percent of Non-Medicare Population with Drug Coverage, by Self-Reported Health Status, 1996

Health status	Percent without drug coverage
Total	23.0%
Excellent	22.7%
Very good	21.9%
Good	24.6%
Fair	25.0%
Poor	16.4%

Note: Total row includes persons with unknown perceived health status.

Source: Center for Cost and Financing Studies, Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey Household Component, 1996.

[47] The differences between "poor" and "fair," "very good" and "good," and "very good" and "fair" are statistically significant; those between "excellent" and the other groups are not.

TRENDS IN DRUG COVERAGE

Medicare Beneficiaries

The percentage of Medicare beneficiaries with drug coverage for at least one month of the year increased from 57 percent in 1992 to 69 percent in 1996.[48] Within the most recent two years for which we have data, the share of beneficiaries with prescription drug coverage for at least part of the year grew from 65 percent in 1995 to 69 percent in 1996, largely because of rapid growth in Medicare HMO enrollment during 1996. Data for more recent years are not yet available.[49] However, as William Scanlon of the General Accounting Office (GAO) and Lisa Alecxih of the Lewin Group recently testified before the House Commerce Committee, there are reasons to believe that coverage rates will erode in the future, if they have not already.[50]

- Employers are continuing to cut back retiree benefits or requiring enrollees to pay much or all of the cost. Most of the changes affect current workers retiring after a given future date, not current retirees. It is likely that fewer new beneficiaries will have access to this source of drug coverage in coming years. However, given different effective dates of changes in retiree coverage, it is difficult to predict accurately how rapidly coverage might decline.

- Some Medicare HMOs have been reducing their drug benefits. If all 1999 enrollees remained in the same plans in 2000, the number with drug coverage as part of the basic package would drop from 84 percent to 82 percent. This figure does not include enrollees whose plans have terminated their contracts and who may not be able to find drug coverage elsewhere. Continuing growth in the cost

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[48] Because of changes in the methodology used by MCBS to measure drug coverage, figures from 1992 - 1994 are not fully comparable with data collected in 1995 and 1996.

[49] Current Population Survey data on general insurance coverage are available. However, the CPS is not a reliable source for estimating supplementary coverage of Medicare beneficiaries, because it does not separately identify Medicare HMO enrollees. Some may report themselves as having Medicare only, others as having private nongroup coverage. Between 1996 and 1998, the CPS shows the share of beneficiaries with employer coverage and with Medicaid remaining approximately the same. It shows a sharp decline in other private coverage; nearly 1.6 million fewer beneficiaries reported this coverage in 1998 than in 1996. But there is no way of knowing how much of the change is related to actual loss of coverage, shifts to HMO enrollment, or simply changes in how respondents reported their coverage.

[50] Testimony before the House Commerce Subcommittee on Health and Environment, "Seniors' Access to Affordable Prescription Drugs: Models for Reform," February 16, 2000. For a fuller analysis of factors that might lead to declining coverage, see the White House report, *Disturbing Truths and Dangerous Trends: The Facts about Medicare Beneficiaries and Prescription Drug Coverage*, July 1999.

of drugs may cause further reductions in drug benefits in the future. It could also increase the premiums charged for the drug benefits that are offered, in turn affecting levels of enrollment.

- In addition to these factors that may lead to a declining rate of coverage in future years, other factors (discussed above) may make the coverage that remains less complete. There is considerable evidence that cost sharing for prescription drugs is increasing and that overall caps on coverage are both becoming more common and are being set at lower levels (especially for Medicare+Choice plans).

General Population

Multi-year data on trends in drug coverage for the non-Medicare population are not readily available. However, there is evidence that health insurance coverage generally has eroded slightly since 1996. Table 1-16 shows the proportion of noninstitutionalized civilians without Medicare receiving coverage from different sources at any time during 1996 and 1998, as measured by the March supplement to the Census Bureau's Current Population Survey (CPS). While enrollment in employer plans increased somewhat, the gain was more than offset by a sharp decline in Medicaid participation. Over the two years, the share of the non-Medicare population with no coverage grew by nearly a percentage point.

Table 1-16. Distribution of Health Insurance Coverage by Type of Insurance, 1996 and 1998

Source of coverage	1996	1998
Employer	64.7%	65.5%
Other private	9.9%	9.2%
Medicaid	11.5%	9.8%
Other	3.2%	3.1%
None	18.1%	18.9%

Note: Columns sum to more than 100 percent because some people had multiple sources of coverage during the year. In 1998, use of Indian Health Service facilities is no longer treated as insurance.

Source: Institute for Health Policy Solutions analysis of March 1997 and March 1999 Supplements, Current Population Survey.[51]

[51] The Census Department advises that Medicaid coverage is underreported in the CPS compared with enrollment and participation data from the HCFA. Changes in Medicaid coverage estimates from one year

For people with coverage, prescription drug benefits may be less generous now than in 1996. Because rising prescription drug spending has been driving overall growth in employer health plan costs (see Chapter 2), many employers are reportedly focusing on restraining the cost of drug benefits. In the last year, a reported 32 percent of employers with 500 or more workers modified drug benefit design, for example, by increasing financial incentives for participants to use generic or on-formulary drugs. Ten percent have limited coverage for some new drugs or other treatments.

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to the next should be viewed with caution.