

---

**Wisconsin Family Impact Seminars**  
and the  
**Sonderegger Research Center for Social and Administrative Pharmacy**  
**University of Wisconsin-Madison**

# **Rising Prescription Drug Costs: Reasons, Needs, and Policy Responses**



University of Wisconsin-Extension  
Center for Excellence in Family Studies  
School of Human Ecology  
University of Wisconsin-Madison

---



---

# **Rising Prescription Drug Costs: Reasons, Needs, and Policy Responses**

*First Edition*

**Wisconsin Family Impact Seminars  
and the  
Sonderegger Research Center for Social and Administrative Pharmacy  
University of Wisconsin-Madison  
Briefing Report**

*Edited by*

**Karen Bogenschneider**

Director, Wisconsin Family Impact Seminars  
Associate Professor, Human Development & Family Studies  
and Family Policy Specialist  
University of Wisconsin-Madison/Extension

&

**Jessica Mills**

State Coordinator, Wisconsin Family Impact Seminars  
University of Wisconsin-Madison

**Beth Swedeen**

Content editing

**Meg Wall-Wild**

Layout, production, and copy editing

January 2001

**University of Wisconsin-Extension  
Center for Excellence in Family Studies  
School of Human Ecology  
University of Wisconsin-Madison**

We gratefully acknowledge the financial support of  
The Helen Bader Foundation, Inc.,  
The Lynde and Harry Bradley Foundation,  
The Sonderegger Research Center for Social and Administrative Pharmacy,  
& Elizabeth C. Davies

---

---

## Purpose, Presenters, and Publications

In 1993, Wisconsin became one of the first states to sponsor Family Impact Seminars modeled after the seminar series for federal policymakers.

Because of the success of the Wisconsin Family Impact Seminars, Wisconsin is now helping other states establish their own seminars through the newly created Policy Institute for Family Impact Seminars at the University of Wisconsin-Madison.

Family Impact Seminars are a series of seminars, briefing reports, and follow-up activities that provide up-to-date, solution-oriented research on current issues for state policymakers, legislators and their aides, Governor's Office staff, legislative support bureau personnel, and state agency representatives. Family Impact Seminars analyze the consequences an issue, policy, or program may have for families.

The seminars provide objective nonpartisan research on current issues and do not lobby for particular policies. Seminar participants discuss policy options and identify common ground where it exists.

"Rising Prescription Drug Costs: Reasons, Needs, and Policy Responses" is the 15th seminar in a series designed to bring a family focus to policymaking. This seminar featured the following speakers:

### **David Mott**

Assistant Professor, Pharmacy Administration  
The Sonderegger Research Center for Social and Administrative Pharmacy  
University of Wisconsin-Madison  
425 N. Charter St.  
Madison, WI 53706-1515  
(608) 265-9268  
damott@pharmacy.wisc.edu  
<http://www.pharmacy.wisc.edu/SRC/Index.html>

### **Bruce Stuart**

Parke-Davis Professor of Geriatric Pharmacotherapy  
Director, Peter Lamy Center on Drug Therapy and Aging  
University of Maryland  
Department of Pharmacy Practice and Science  
100 N. Greene St., Suite 600  
Baltimore, MD 21201-1563  
(410) 706-5389  
bstuart@rx.umaryland.edu  
<http://www.pharmacy.umaryland.edu/~lamy/>

**Tom Snedden**

Director, Pharmaceutical Assistance Contract for the Elderly (PACE)  
Pennsylvania Department of Aging  
555 Walnut Street  
5th Floor Forum Place  
Harrisburg, PA 17101  
(717) 787-7313  
tsnedden@state.pa.us  
<http://aging.state.pa.us>

For further information on bringing a family perspective to policymaking, check our website at <http://www.familyimpactseminars.org>. For further information on the Wisconsin Family Impact Seminar series, contact Director, Karen Bogenschneider, Associate Professor, UW-Madison/Extension, or State Coordinator Jessica Mills at 120 Human Ecology, 1300 Linden Drive, Madison, WI 53706; telephone (608) 262-4070 or 262-6766; email [kpbogens@facstaff.wisc.edu](mailto:kpbogens@facstaff.wisc.edu) or [jmills@facstaff.wisc.edu](mailto:jmills@facstaff.wisc.edu).

Each seminar is accompanied by an in-depth briefing report that summarizes the latest research on a topic and identifies policy options from across the political spectrum. Copies are available at:

Extension Publications  
45 N. Charter St., Madison, WI 53715  
Toll-free: (877) 947-7827 (877-WIS-PUBS); Madison: 262-3346  
<http://learningstore.uwex.edu>

Building Policies That Put Families First: A Wisconsin Perspective	Mar. 1993
Single Parenthood and Children's Well-Being	Oct. 1993
Can Government Promote Competent Parenting?	Jan. 1994
Promising Approaches for Addressing Juvenile Crime	May 1994
Welfare Reform: Can Government Promote Parental Self-Sufficiency While Ensuring the Well-Being of Children?	Jan. 1995
Child Support: The Effects of the Current System on Families	Nov. 1995
Teenage Pregnancy Prevention: Programs That Work	Mar. 1996
Programs and Policies to Prevent Youth Crime, Smoking, and Substance Use: What Works?	Feb. 1997
Moving Families Out of Poverty: Employment, Tax, and Investment Strategies	Apr. 1997
Building Resiliency and Reducing Risk: What Youth Need from Families and Communities to Succeed	Jan. 1998
Enhancing Educational Performance: Three Policy Alternatives	Mar. 1998
Long-Term Care: State Policy Perspectives	Feb. 1999
Raising the Next Generation: Public and Private Parenting Initiatives	Oct. 1999
Helping Poor Kids Succeed: Welfare, Tax, and Early Intervention Policies	Jan. 2000
Rising Prescription Drug Costs: Reasons, Needs, and Policy Responses	Jan. 2001

---

# Table of Contents

<b>Executive Summary</b> .....	v
<b>A Checklist for Assessing the Impact of Policies on Families</b> .....	viii
<b>Acknowledgments</b> .....	xi
<b>Why Are Prescription Drug Costs Rising?</b>	
<i>by David Kreling, David Mott, and Joseph Wiederholt</i> .....	1
What Are Recent Trends in Prescription Drug Spending? .....	1
What Factors Drive Prescription Drug Spending? .....	3
How Can We Explain Increases in Drug Spending? .....	9
Who Has Prescription Drug Coverage and How Is It Provided? .....	9
What Are the Primary Sources of Prescription Drug Coverage? .....	11
How Much Do Consumers Pay? .....	11
Conclusion .....	13
<b>How Should Policymakers Determine Eligibility for a Prescription Drug Benefit for the Elderly?</b>	
<i>by Bruce Stuart, Becky Briesacher, and Dennis Shea</i> .....	15
What Definition of Need Can Policymakers Use? .....	15
What Definition of Need Do Current Federal Proposals Use? .....	16
How Many Medicare Beneficiaries Meet Each Definition of Need? .....	16
How Many Medicare Beneficiaries Qualify if More Than One Measure of Need Is Used? .....	18
How Many Medicare Beneficiaries Qualify If Any Measure of Need Is Used? .....	20
What Are the Implications for Policy? .....	21
Conclusion .....	21
<b>What Can Wisconsin Learn from Pennsylvania, the Nation’s Largest State Pharmacy Assistance Program for the Elderly?</b>	
<i>by Tom Snedden</i> .....	23
What Benefits Do PACE and PACENET Provide? .....	23
What Trends Have Occurred in Program Enrollment, Usage, and Cost? ..	24
What Prescriptions Are Covered? .....	25
How Does the Program Work? .....	25
<b>Glossary</b> .....	27
<b>Selected Resources</b> .....	31

---

## Executive Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

# A Checklist for Assessing the Impact of Policies on Families

The first step in developing family-friendly policies is to ask the right questions:

- What can government and community institutions do to enhance the family's capacity to help itself and others?
- What effect does (or will) this policy (or proposed program) have for families? Will it help or hurt, strengthen or weaken family life?

These questions sound simple, but they can be difficult to answer.

The Family Criteria (Ad Hoc) Task Force of the Consortium of Family Organizations (COFO) developed a checklist to assess the intended and unintended consequences of policies and programs on family stability, family relationships, and family responsibilities. The checklist includes six basic principles that serve as the criteria of how sensitive to and supportive of families policies and programs are. Each principle is accompanied by a series of family impact questions.

The principles are not rank ordered and sometimes they conflict with each other, requiring trade-offs. Cost effectiveness also must be considered. Some questions are value-neutral and others incorporate specific values. People may not always agree on these values, so sometimes the questions will require rephrasing. This tool, however, reflects a broad nonpartisan consensus, and it can be useful to people across the political spectrum.

*For the questions that apply to your policy or program, record the impact on family well-being.*

**1**

## **Principle 1. Family support and responsibilities.**

Policies and programs should aim to support and supplement family functioning and provide substitute services only as a last resort.

Does the proposal or program:

- support and supplement parents' and other family members' ability to carry out their responsibilities?
- provide incentives for other persons to take over family functioning when doing so may not be necessary?
- set unrealistic expectations for families to assume financial and/or caregiving responsibilities for dependent, seriously ill, or disabled family members?
- enforce absent parents' obligations to provide financial support for their children?

**2**

## **Principle 2. Family membership and stability.**

Whenever possible, policies and programs should encourage and reinforce marital, parental, and family commitment and stability, especially when children are involved. Intervention in family membership and living arrangements is usually justified only to protect family members from serious harm or at the request of the family itself.

Does the policy or program:

- provide incentives or disincentives to marry, separate, or divorce?
- provide incentives or disincentives to give birth to, foster, or adopt children?
- strengthen marital commitment or parental obligations?
- use appropriate criteria to justify removal of a child or adult from the family?
- allocate resources to help keep the marriage or family together when this is the appropriate goal?
- recognize that major changes in family relationships such as divorce or adoption are processes that extend over time and require continuing support and attention?

**3****Principle 3. Family involvement and interdependence.**

Policies and programs must recognize the interdependence of family relationships, the strength and persistence of family ties and obligations, and the wealth of resources that families can mobilize to help their members.

To what extent does the policy or program:

- recognize the reciprocal influence of family needs on individual needs, and the influence of individual needs on family needs?
- recognize the complexity and responsibilities involved in caring for family members with special needs (e.g., physically or mentally disabled, or chronically ill)?
- involve immediate and extended family members in working toward a solution?
- acknowledge the power and persistence of family ties, even when they are problematic or destructive?
- build on informal social support networks (such as community/neighborhood organizations, religious communities) that are essential to families' lives?
- respect family decisions about the division of labor?
- address issues of power inequity in families?
- ensure perspectives of all family members are represented?
- assess and balance the competing needs, rights, and interests of various family members?
- protect the rights and safety of families while respecting parents' rights and family integrity?

**4****Principle 4. Family partnership and empowerment.**

Policies and programs must encourage individuals and their close family members to collaborate as partners with program professionals in delivery of services to an individual. In addition, parent and family representatives are an essential resource in policy development, program planning, and evaluation.

In what specific ways does the policy or program:

- provide full information and a range of choices to families?
- respect family autonomy and allow families to make their own decisions? On what principles are family autonomy breached and program staff allowed to intervene and make decisions?
- encourage professionals to work in collaboration with the families of their clients, patients, or students?
- take into account the family's need to coordinate the multiple services they may require and integrate well with other programs and services that the families use?
- make services easily accessible to families in terms of location, operating hours, and easy-to-use application and intake forms?
- prevent participating families from being devalued, stigmatized, or subjected to humiliating circumstances?
- involve parents and family representatives in policy and program development, implementation, and evaluation?

5

### Principle 5. Family diversity.

Families come in many forms and configurations, and policies and programs must take into account their varying effects on different types of families. Policies and programs must acknowledge and value the diversity of family life and not discriminate against or penalize families solely for reasons of structure, roles, cultural values, or life stage.

How does the policy or program:

- affect various types of families?
- acknowledge intergenerational relationships and responsibilities among family members?
- provide good justification for targeting only certain family types, for example, only employed parents or single parents? Does it discriminate against or penalize other types of families for insufficient reason?
- identify and respect the different values, attitudes, and behavior of families from various racial, ethnic, religious, cultural, and geographic backgrounds that are relevant to program effectiveness?

6

### Principle 6. Support of vulnerable families.

Families in greatest economic and social need, as well as those determined to be most vulnerable to breakdown, should be included in government policies and programs.

Does the policy or program:

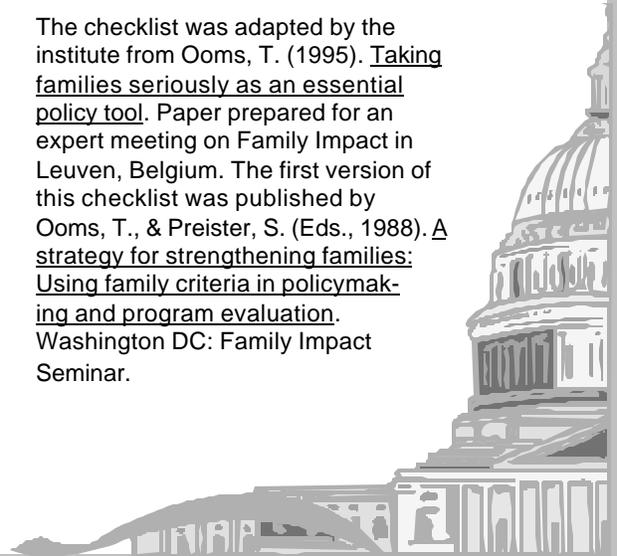
- identify and publicly support services for families in the most extreme economic or social need?
- give support to families who are most vulnerable to breakdown and have the fewest resources?
- target efforts and resources toward preventing family problems before they become serious crises or chronic situations?

The Policy Institute for Family Impact Seminars aims to connect research and policymaking and to promote a family perspective in research, policy, and practice. The institute has resources for researchers, policymakers, practitioners, and those who conduct Family Impact Seminars.

- To assist researchers and policy scholars, the institute is building a network to facilitate cross-state dialogue and resource exchange on strategies for bringing research to bear on policymaking.
- To assist policymakers, the institute disseminates research and policy reports that provide a family impact perspective on a wide variety of topics.
- To assist those who implement policies and programs, the institute has available a number of family impact assessment tools for examining how responsive policies, programs, and institutions are to family well-being.
- To assist states who wish to create better dialogue between researchers and policymakers, the institute provides technical assistance on how to establish your own state's Family Impact Seminars.

The checklist and the papers are available from Director Karen Bogenschneider and Associate Director Jessica Mills of the Policy Institute for Family Impact Seminars at the University of Wisconsin-Madison/Extension, 130 Human Ecology, 1300 Linden Drive, Madison, WI, 53706; phone (608) 263-2353; FAX (608)262-5335; <http://www.familyimpactseminars.org>.

The checklist was adapted by the institute from Ooms, T. (1995). [Taking families seriously as an essential policy tool](#). Paper prepared for an expert meeting on Family Impact in Leuven, Belgium. The first version of this checklist was published by Ooms, T., & Preister, S. (Eds., 1988). [A strategy for strengthening families: Using family criteria in policymaking and program evaluation](#). Washington DC: Family Impact Seminar.



---

## Acknowledgments

For their generosity in providing financial support for the Wisconsin Family Impact Seminar, *Rising Prescription Drug Costs: Reasons, Needs, and Policy Responses*, we extend sincere appreciation to:

The Helen Bader Foundation, Inc., Milwaukee, WI  
The Lynde and Harry Bradley Foundation, Milwaukee, WI  
The Sonderegger Research Center for Social and Administrative Pharmacy,  
UW-Madison  
Elizabeth C. Davies, Private Supporter of Extension programs

We are also grateful to the following individuals for their contributions:

Mark Lederer for his advice and many contributions since the seminars began in 1993;

Theodora Ooms for developing the Family Impact Seminar model and for her continuing technical assistance;

The Commonwealth Fund for their permission to adapt the chapter, *“How Should Policymakers Determine Eligibility for Prescription Drug Benefits for the Elderly?”*

The Kaiser Family Foundation for their permission to adapt the chapter, *“Why Are Prescription Costs Rising?”*

Karla Balling, Deb Hewko, Kelly Merkel, Christy Peterson, and Kristin Schultz for their assistance in organizing this seminar.

The 15th Wisconsin Family Impact Seminar Planning Committee:

Steve Meili	University of Wisconsin-Madison, Law School
David Kreling	University of Wisconsin-Madison, School of Pharmacy
David Mott	University of Wisconsin-Madison, School of Pharmacy
Richard Sweet	Senior Staff Attorney, Wisconsin Legislative Council
James Vavra	Division of Health Care Financing, Wisconsin Department of Health and Family Services

The Wisconsin Family Impact Seminars Legislative Advisory Committee:

Representative Peter Bock	Senator Gwendolyn Moore
Annette Cruz, Governor’s Office	Representative Luther Olsen
Senator Alberta Darling	Senator Mary Panzer
Representative Julie Lassa	Representative Daniel Vrakas
Representative Mark Miller	Representative Joan Wade

The Wisconsin Family Impact Seminars Advisory Committee:

Dick Barrows	Associate Dean, Agricultural and Life Sciences, University of Wisconsin-Madison
Inge Bretherton	Human Development & Family Studies, University of Wisconsin-Madison
Tom Corbett	Institute for Research on Poverty, University of Wisconsin-Madison
Jim Gingles	Health Promotion & Human Development, University of Wisconsin-Stevens Point
Jane Grinde	Wisconsin Department of Public Instruction
Tom Kaplan	Institute for Research on Poverty, University of Wisconsin-Madison
Mark Lederer	Local Government Center, University of Wisconsin-Extension
Carol Lobes	Wisconsin Clearinghouse for Prevention Services
Sally Lundeen	School of Nursing, University of Wisconsin-Milwaukee
Margo Melli	Law School, University of Wisconsin-Madison
Theodora Ooms	Center for Law and Social Policy, Washington, DC
Enis Ragland	Mayor's Office, City of Madison
Dave Riley	Human Development & Family Studies, University of Wisconsin-Madison
Rae Schilling	Department of Family Medicine, Eau Claire Residency, University of Wisconsin-Madison
Terry Shelton	LaFollette Institute, University of Wisconsin-Madison
Denise Skinner	Home Economics, University of Wisconsin-Stout
Sue Springman	Wisconsin Department of Administration
Sue Vergeront	Former Wisconsin State Legislator
Rebecca Young	Former Wisconsin State Legislator

---

## Why Are Prescription Drug Costs Rising?

By David H. Kreling, David A. Mott, & Joseph B. Wiederholt

**T**his chapter explains why spending on prescription drugs has been one of the fastest-growing health care costs in the last decade, with increases exceeding 10 percent annually in all but two years.

*Between 1993 and 1998, three factors have driven the increases in prescription drug spending: increased drug use (43%), changes in use to newer higher-cost drugs (39%), and price increases by manufacturers for existing drugs (18%). About 31% of Medicare beneficiaries and 23% of non-Medicare beneficiaries had no drug coverage in 1996. Low-income families who aren't eligible for Medicaid are most likely to be without drug coverage.*

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

Americans increasingly look to medications to maintain or improve their health. However, increasing concerns have arisen around the rising costs of prescription drugs and the impact these costs have had on health plans, employers, and uninsured or under-insured individuals.

The Kaiser Family Foundation has developed a Chartbook on Prescription Drug Trends that provides information about trends in prescription drug coverage, spending, prices, use, and the structure of the industry. This chapter is a brief overview of the chartbook.

### What Are the Recent Trends in Prescription Drug Spending?

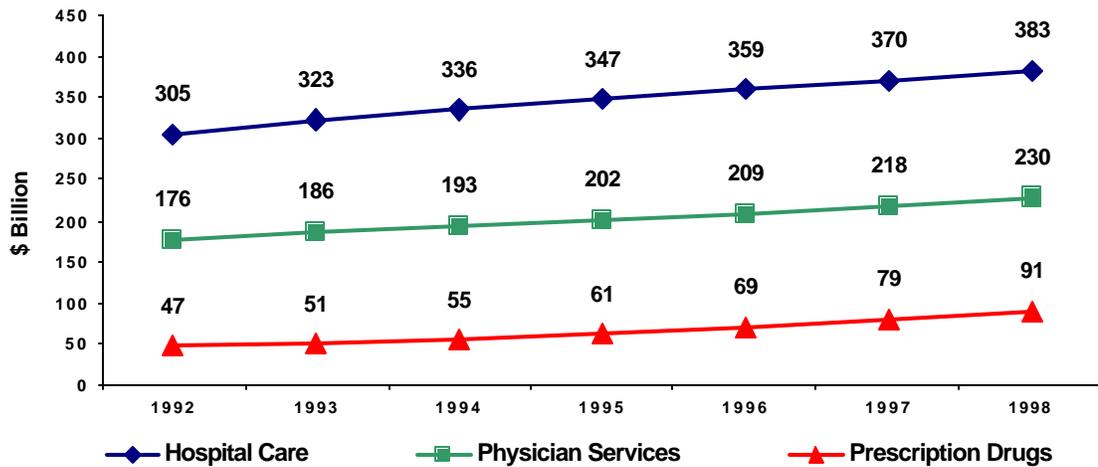
Spending on prescriptions has been one of the fastest-growing components of health care spending in the past decade. This growth has drawn attention to prescription drugs, although they represent only 9% of total personal health care spending.

National spending on prescription drugs totaled \$91 billion in 1998, and is expected to reach \$243 billion in 2008. Although spending on all types of health care continues to increase, drug spending is increasing more quickly.

***Prescription drugs have been one of the fastest growing components of health care spending.***

The \$10 billion annual increase on spending for drugs between 1995 and 1998 is similar to the dollar increases in physician costs and hospital care, although overall spending on these two services are more than double and triple, respectively, the total amount spent on drugs (Figure 1). Between 1995 and 1998, prescription spending grew nearly 50%, while spending on physician services grew by 14% and spending for hospital care grew 10%.

**Figure 1. National Health Expenditures for Prescription Drugs, Hospital Care, and Physician Services, 1992-1998**

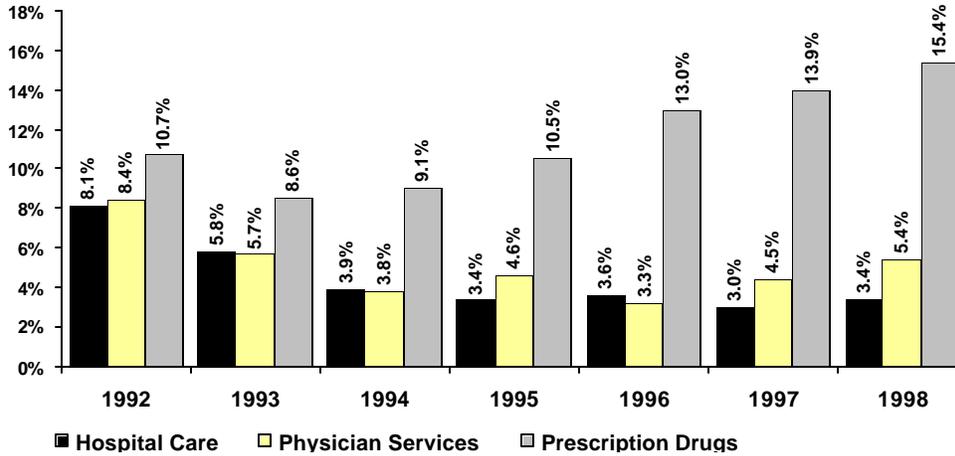


Note: Expenditures for prescription drugs are limited to those purchased from retail outlets such as community or HMO pharmacies, grocery store pharmacies, mail order pharmacies, etc. The value of prescription drugs provided to patients by hospitals as part of a hospital stay, by nursing homes as part of care in a nursing home, or provided by physicians in their offices are not included in prescription drugs but are included in those respective expenditure categories. Consequently, the expenditures for prescription drugs shown here are underestimated and may differ from other estimates (e.g., prescription drug sales by manufacturers estimated by market research firms).

Source: Health Care Financing Administration (HCFA), Office of the Actuary, National Health Statistics Group, HCFA web site: [www.hcfa.gov](http://www.hcfa.gov), 10 January 2000.

The rate of increase in prescription spending has surpassed increases in most other components of personal health care in the past decade, exceeding 10 percent annual increases in all but two years (See Figure 2). In the past five years, the increases in prescription spending have been two to four times the percent increases in other major health care components.

**Figure 2. Annual Percentage Change in Selected National Health Expenditures, 1992-1998**



Note: Percent calculated as percent change from the previous year's amount.

Source: Health Care Financing Administration (HCFA), Office of the Actuary, National Health Statistics Group, HCFA web site: [www.hcfa.gov](http://www.hcfa.gov), 10 January 2000.

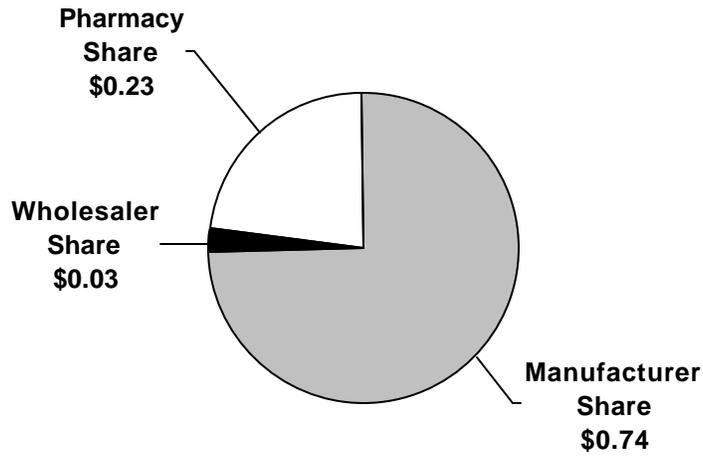
### What Factors Drive Prescription Drug Spending?

Increases in prescription drug spending are affected by three primary factors: price increases, increases in use, and changes in the types of drugs used.

**Price Increases.** The players involved in developing, marketing, and selling prescription drugs include the manufacturer who produces the drug, wholesalers who distribute drugs, pharmacies that dispense the drugs, and ultimately, consumers. Figure 3 shows that when a pharmacy sells a drug, 74 cents of each dollar goes to the manufacturer, the wholesaler gets about 3 cents, and the pharmacy gets the remaining 23 cents.

***Prescription drug spending is driven by price increases, increases in use, and changes in the types of drugs used.***

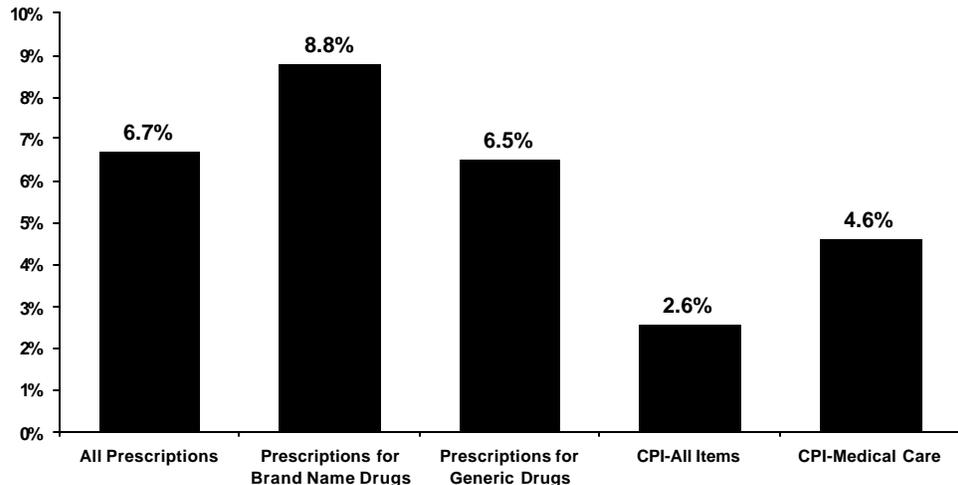
**Figure 3. Distribution of a Dollar of Revenue from a Retail Prescription, 1998**



Note: From each dollar of prescription sales, \$0.74 goes to the manufacturer for producing the drug, \$0.03 goes to the wholesaler for distributing the drug, and \$0.23 goes to the pharmacy for dispensing the drug.  
 Source: National Association of Chain Drug Stores (NACDS), based on data on file, December 1999.

The average annual percent change in retail prescription drug prices from 1991 to 1998 was 6.7% overall, higher than the average rate of inflation of 2.6%, and the average increase of 4.6% for medical care (Figure 4). Prices for brand name drugs grew an average of 8.8% per year, compared with 6.5% for generic drugs. The year-to-year price change for existing drugs have been relatively small compared to the changes in national expenditures for prescription drugs or average retail price.

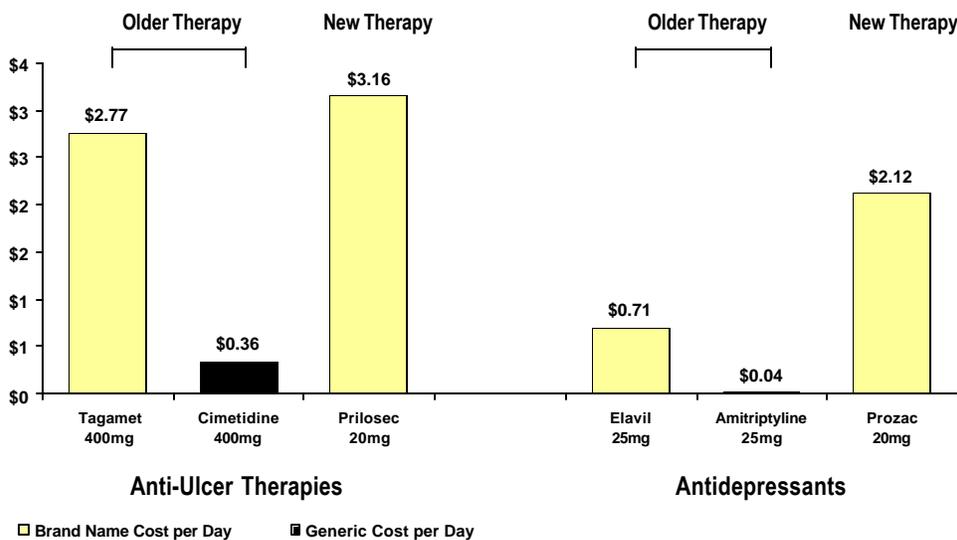
**Figure 4. Average Annual Percent Change in Retail Prescription Prices vs. Consumer Price Index, 1991-1998**



Note: CPI = Consumer Price Index for all urban consumers.  
 Source: Scott-Levin, Source Prescription Audit; and Bureau of Labor Statistics.

The average retail price for brand name drugs has been about three times that of generic drugs. Sometimes, the cost difference is dramatic. Figure 5 shows that the cost a pharmacy pays for the brand name drug Tagamet, an anti-ulcer drug, is nearly 8 times higher than for the generic version, Cimetidine. Among drugs for depression, the brand name Elavil costs nearly 18 times more than the generic version, Amitriptyline.

**Figure 5. Cost of Old and New Therapies, Anti-Ulcer and Antidepressant Medications, 1999**



Source: Sonderegger Research Center analysis, based on:

Brand name cost estimated as Average Wholesale Price (AWP) listed in Drug Topics' *Red Book* price reference, less 18.3% (based on a DHHS Office of Inspector General report on pharmacy acquisition costs for drugs reimbursed under Medicaid that found the difference between AWP and the prices retail pharmacies pay for brand name drugs was 18.3%, OIG report A-06-96-00030, April 1997).

Generic drug cost based on HCFA Medicaid payment amount (Federal Upper Limit) published on the HCFA web site, www.hcfa.gov, December 1999.

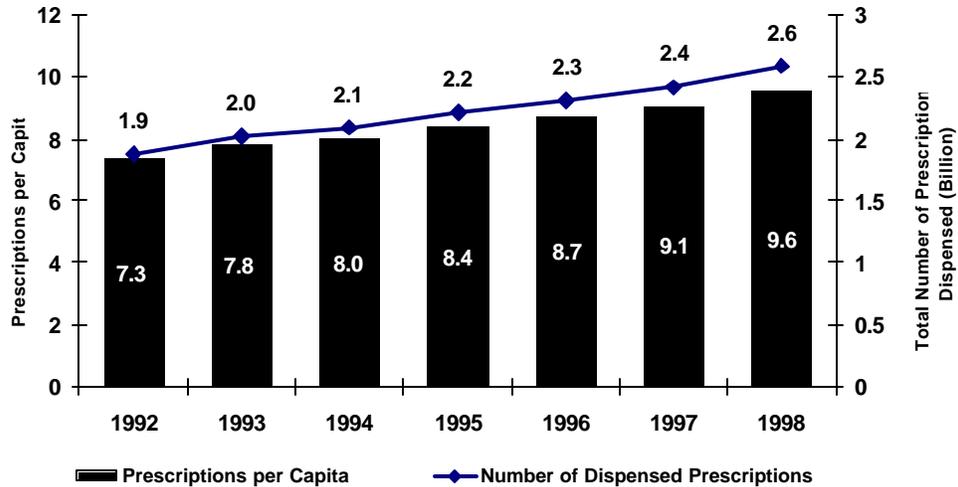
**Brand name drugs cost about three times more than generic drugs.**

New approaches in drug treatment typically cost more than older ones. Among antidepressants, the newer drug Prozac — a selective serotonin reuptake inhibitor or SSRI — is almost 3 times more costly than the previous popular treatment, Elavil—a tricyclic antidepressant.

**Trends in Usage.** The increasing number of overall prescriptions dispensed each year is one of the main factors contributing to rising drug spending. Factors that, in turn, increase prescription drug use include population growth, the aging of the population, an increased number of prescribers, and promotion of prescription drugs to stimulate demand.

Americans use, on average, about 10 prescriptions per year (Figure 6). Between 1992 and 1998, the total number of prescriptions dispensed increased 37%, while the average number per person increased 32%. During the same time, the U.S. population grew only 6%.

**Figure 6. Total Prescriptions Dispensed and Prescriptions per Capita, 1992-1998**



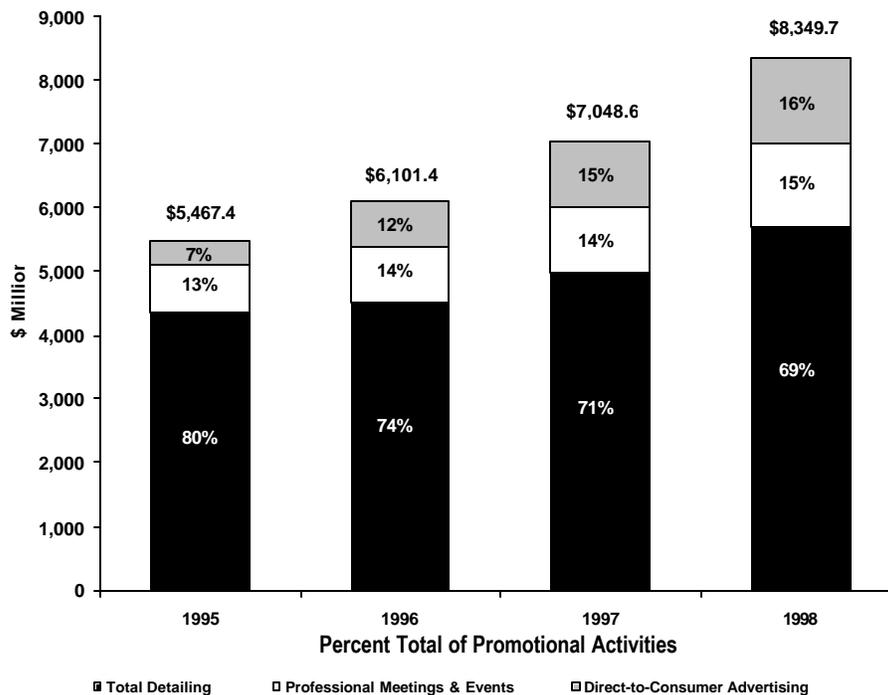
Source: U.S. Census Bureau; and IMS Health, Inc., [National Prescription Audit](#).

The proportion of the U.S. population 45 years old and older grew from 31% to 34% in the past 15 years. The median age in the U.S. in 1998 was 35. Between the ages of 45 and 75, prescription use nearly triples, from an overall average of 4.3 to 11.4 prescriptions per person each year.

Manufacturers promote drugs in several ways, including sales calls to physician offices and hospitals that include free samples; journal advertising; displays and presentations at professional meetings; and, more recently, direct advertising to consumers. In addition, manufacturers often negotiate rebates with insurers and health plans in exchange for incentives to use the manufacturer’s drugs.

The largest part of promotional spending continues to be “detailing,” where a company representative makes personal sales calls and may leave samples. However, direct consumer promotion more than tripled from 1995 to 1998, from almost \$400 million to \$1.3 billion (Figure 7).

**Figure 7. Promotional Spending by Pharmaceutical Manufacturers, 1995-1998**



**Notes:**

**Detailing** includes expenses for competitive personal selling activity (sales calls) to office-based and hospital-based physicians, including the value of samples.

**Professional Meetings & Events** includes expenses for sponsoring or conducting small and large group meetings, symposia, third-party marketing events, and tele/video conferences.

**Direct-to-Consumer** includes expenditures for magazine, newspaper, radio, and TV advertising targeted toward consumers.

Source: Scott-Levin.

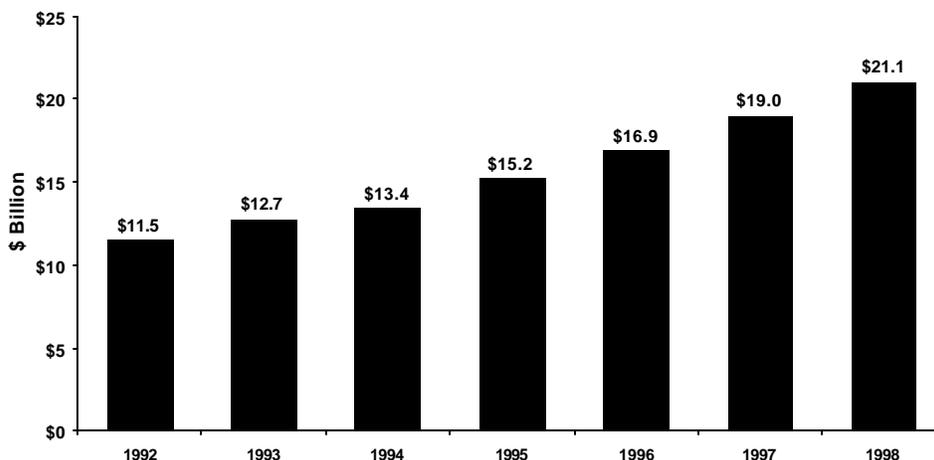
**Changes in Type of Drugs Used.** Because newer drugs are more expensive than older ones, those on the market fewer than 10 years accounted for 75% of the Top 20 drugs by sales. However, these newer drugs comprised only 45% of the Top 20 drugs when ranked by number of prescriptions filled.

New products are available as the result of research by major manufacturers that emphasize research and brand name drugs. Domestic and foreign spending by manufacturers for research and development increased from \$11.5 billion in 1992 to \$21.1 billion in 1998 (see Figure 8). However, research and development as a percentage of sales has remained relatively flat since the mid 1980s. Research and development is a relatively small proportion of total firm sales for both major (11%) and generic drug manufacturers (6%). Among the top 10 major drug companies, research and development spending is less than half of net profit before taxes.

Drug manufacturers historically have been the top ranking U.S. industry for profits as percent of revenue (Figure 9). In 1999, drug company net profits were nearly 19%, compared with a median of 5% for all Fortune 500 firms.

***Historically, drug manufacturers have been the most profitable U.S. industry.***

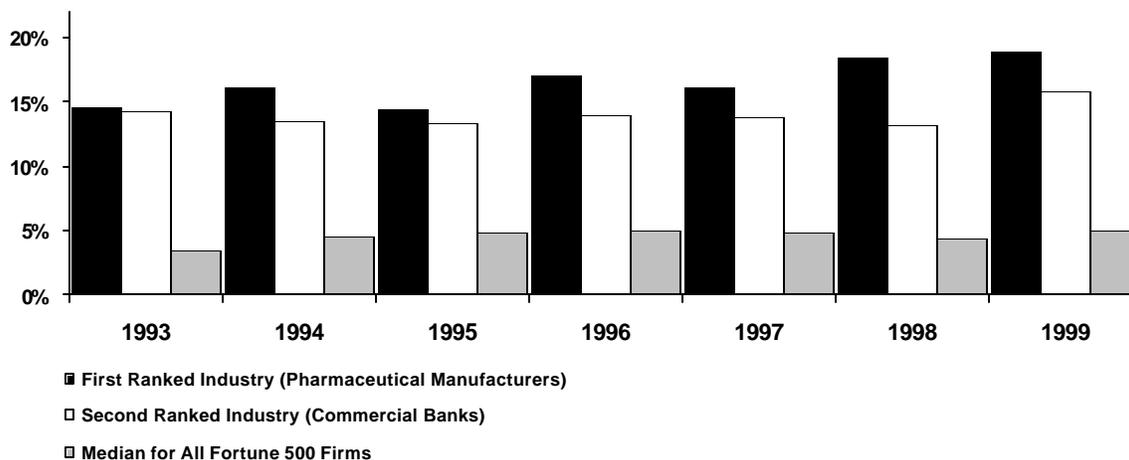
**Figure 8. Research & Development Expenditures for Prescription Drugs by U.S. Pharmaceutical Manufacturers, 1992-1998**



Note: Research and development expenditures for prescription pharmaceuticals only. Includes total expenditures (within the U.S. and abroad) by U.S.-owned research-based pharmaceutical companies (major pharmaceutical firms). Since 1990, foreign expenditures comprised approximately 19% of total research and development expenditures.

Source: Pharmaceutical Research and Manufacturers of America (PhRMA).

**Figure 9. Profitability Among Pharmaceutical Manufacturers Compared to Other Industries, 1993-1999**



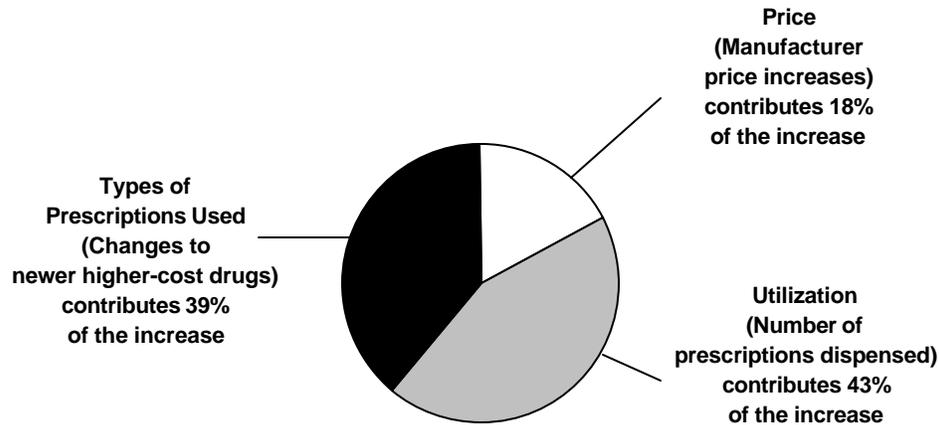
Note: Percent shown is the median percent net profit after taxes as a percent of firm revenues for all firms in the industry. The second ranked industry each year was commercial banks.

Source: *Fortune*, Fortune 500 Industry Rankings.

## How Can We Explain Increases in Drug Spending?

Price inflation, in the form of price changes by manufacturers for existing drugs, has contributed only 18 percent of the increase in prescription drug spending from 1993 to 1998 (Figure 10). The rest of the increase in spending is the result of increased use (43%), and changes in use to newer, higher-cost drugs (39%).

**Figure 10. The Relative Contributions of Price, Utilization, and Types of Prescription Drugs Used in Rising Prescription Drug Expenditures, 1993-1998**



Note: Between 1993 and 1998 the cumulative percent changes in price, utilization, and types of prescriptions used were 11.4%, 28.1%, and 25.4% respectively.

Source: Sonderegger Research Center analysis, based on data from Health Care Financing Administration (HCFA) and IMS Health, Inc.

The introduction and use of newer, more expensive drugs is influencing the average prescription price paid by both consumers and health plans much more than year-to-year price changes made by companies for existing products.

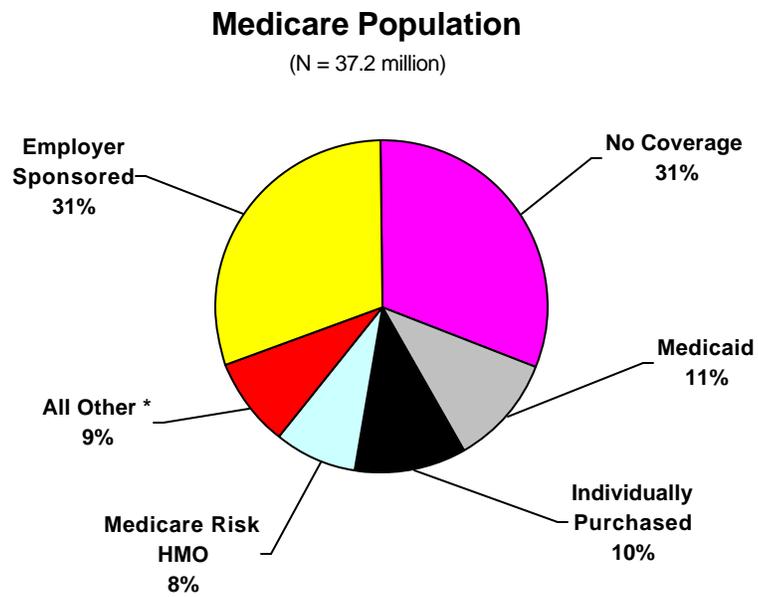
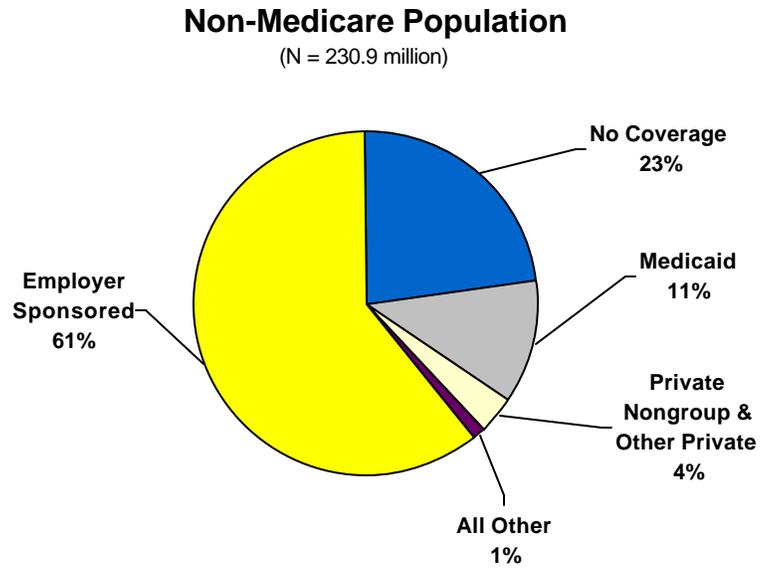
## Who Has Prescription Drug Coverage and How Is It Provided?

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

Of Medicare beneficiaries, 31% or 11.5 million seniors had no drug coverage in 1996. Because Medicare does not cover outpatient prescriptions, coverage came through employers (31%), Medicaid (11%), individual plans (10%), Medicare risk HMOs (8%), or other sources (9%) as shown in Figure 11. Only 53% of Medicare patients had drug coverage the entire year. People with Medicare who are just above the poverty level, very old, and living in rural areas are most likely to have no drug coverage.

***Low-income families who aren't eligible for Medicaid are most likely to be without drug coverage.***

**Figure 11. Insurance Coverage for Prescription Drugs, 1996**



\* All other within the Medicare population includes persons who switched coverage at some time during the year, totalling 7.3% of beneficiaries.

Source: U.S. Department of Health and Human Services; and Paisal, J.A., and Chulis, G.S., *Health Affairs*, March/April, 2000.

## What Are the Primary Sources of Prescription Drug Coverage?

Most Americans get their prescription drug coverage through employers. About two-thirds have employment-based health care coverage, and prescription drug coverage is now common for employees of both small and large firms who have health care coverage. Insured workers with drug coverage increased from 91% in 1988 to 99% in 1999.

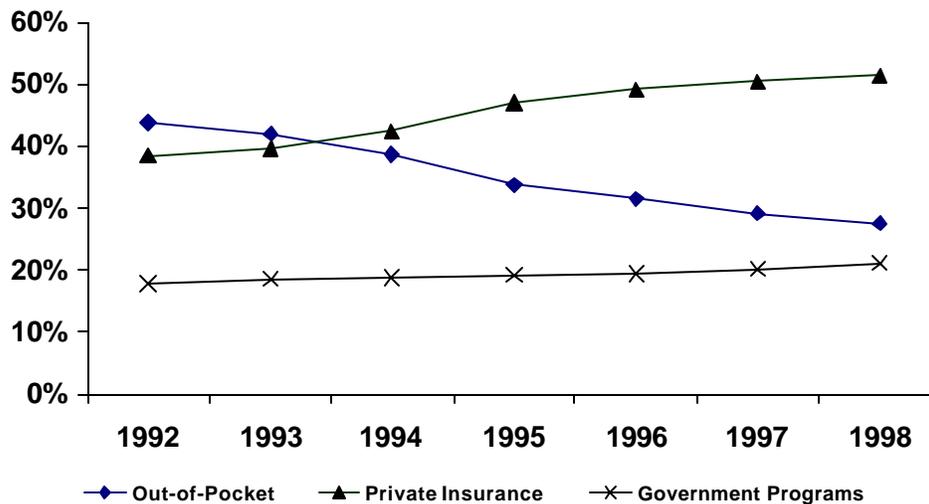
**Most Americans get prescription drug coverage through employers.**

Medicaid is the largest source of public coverage for prescription drugs, covering 11% of Americans in 1996. The Medicaid program in every state provides prescription drug coverage. The Medicaid program may also cover some low-income elderly in the Medicare program.

## How Much Do Consumers Pay?

Since 1992, the proportion of drug costs paid by consumers has decreased from 44% to 28% of total spending, while the share paid by private insurers increased from 38% to 51% (see Figure 12). The share of prescription drug payments by government programs has increased slightly, from 18% to 21%.

**Figure 12. Percent of Total National Prescription Drug Expenditures by Consumer, Private Insurers, and Government, 1992-1998**



### Notes:

Out-of-pocket expenditures - all direct spending by consumers for prescription drugs, such as copayments, coinsurance amounts, deductibles, and amounts not covered by an insurer. Does not include out-of-pocket premiums for health insurance.

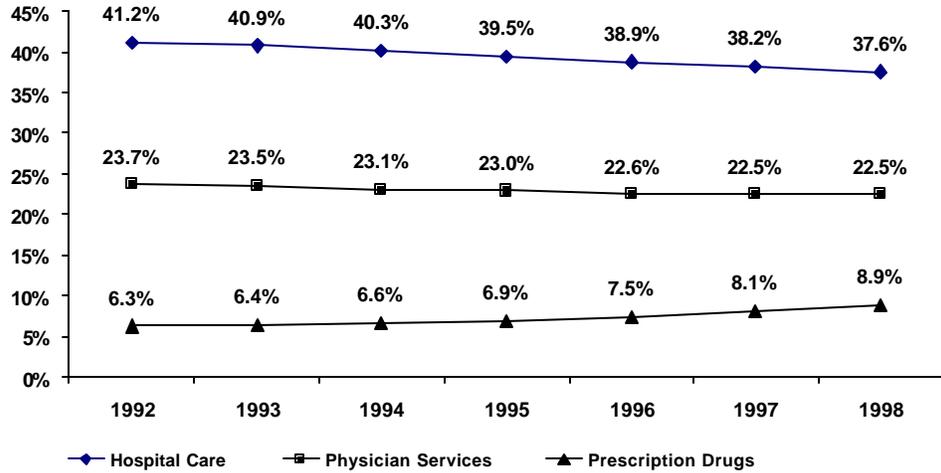
Government Programs - Federal, State, and local spending for prescription drugs. Government includes Medicaid, Medicare, Department of Defense, Veterans Administration, Indian Health Service, state and local hospitals, and public assistance programs.

Private Insurance - payments made by private insurers for prescription drugs for covered beneficiaries.

Source: Health Care Financing Administration (HCFA), Office of the Actuary.

Expenditures for prescription drugs is still just 9% of total personal health care expenditures, but the proportion for drugs has been rising steadily as shown in Figure 13.

**Figure 13. Prescription Drugs, Hospital Care, and Physician Services as a Percent of Personal Health Care Expenditures, 1992-1998**



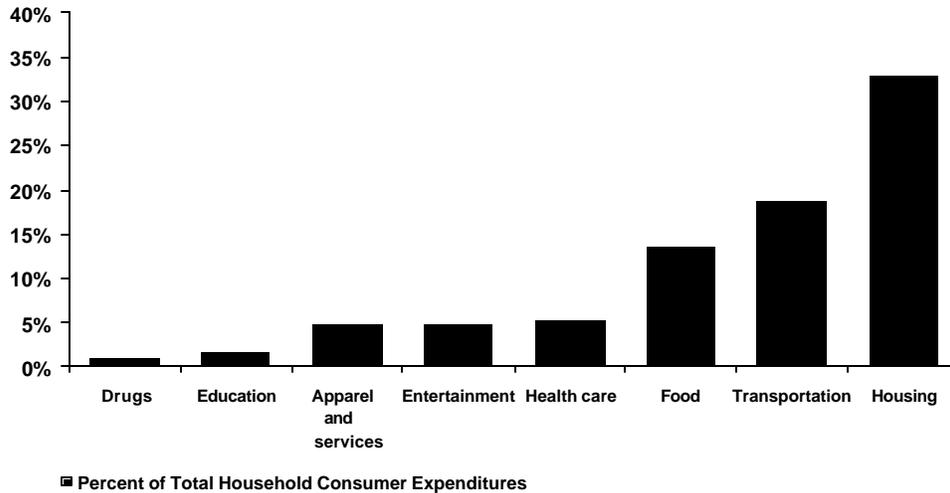
Note: Expenditures for prescription drugs are limited to those purchased from retail outlets such as community or HMO pharmacies, grocery store pharmacies, mail order pharmacies, etc.

Source: Health Care Financing Administration (HCFA), Office of the Actuary.

Compared with spending on other household goods and services, drugs play a small role at about 1% for the average American (see Figure 14). However, older Americans spend more on prescriptions, both in dollars and as a proportion of their household budget. People 65 and older spend 2.7% of their total household budget on prescription drugs.

***On average, 1% of spending on household goods and services is for prescription drugs.***

**Figure 14. Percentage of Consumer Expenditures  
for Selected Categories of Household Goods Purchased,  
1998**



Note. Percents are based on total household expenditures for all goods and services.

Source: Bureau of Labor Statistics (BLS), Consumer Expenditure Surveys, 1998.

## Conclusion

Increased expenditures for prescription drugs are a complex phenomenon. Many factors contribute to the growth, including treatment advances from research and development, promotion of products in traditional and new ways, an aging population with more needs for prescription drugs, and increased insurance coverage for prescriptions. These factors and others contribute to the changes in price, utilization, and types of drugs used that drive expenditures for prescription drugs.

*Adapted with permission from "Prescription Drug Trends: A Chartbook," an analysis by the Kaiser Family Foundation authored by David H. Kreling, David A. Mott, and Joseph B. Wiederholt of Sonderegger Research Center of the University of Wisconsin-Madison and Janet Lundy and Larry Levitt of the Kaiser Family Foundation. The full report can be obtained from the Kaiser Family Foundation web site at [www.kff.org](http://www.kff.org) or by requesting Publication #3019 from the Kaiser Family Foundation Publication Request Line at 1-800-656-4533.*

This chapter was presented at the seminar by Professor David A. Mott who received his B.S. degree in pharmacy from the University of Wisconsin. He received his M.S. and Ph.D. degrees in pharmacy administration from the University of Wisconsin. Before joining the Wisconsin faculty in 1998, he was a faculty member at the Ohio State University College of Pharmacy. His research interests include pharmacy labor economics, the role of prescription drug insurance in drug therapy decision making, and employer-employee decision making regarding health insurance. Dr. Mott is also a licensed pharmacist in Wisconsin.



---

# How Should Policymakers Determine Eligibility for a Prescription Drug Benefit for the Elderly?

By Bruce Stuart, Becky Briesacher, and Dennis Shea

**T**his study examines six ways that policymakers can determine eligibility for a prescription drug benefit for the elderly. The results show that Medicare recipients' need for consistent and stable drug coverage does not necessarily fit neatly into income categories or any single measure of need. People faced with a combination of low income, lack of coverage, and high prescription drug bills have the most urgent need. If a broad definition of need is used—to include people with low incomes, those without continuous coverage, those with high costs, or those with multiple, chronic conditions—nearly 90% of Medicare beneficiaries would qualify.

Who needs Medicare prescription drug coverage most? Who has the greatest needs? That depends on how you define “need.” Most Medicare beneficiaries will not qualify for prescription drug coverage under Medicare if annual income alone is used to determine eligibility. If a broader definition of need is used—to include people without continuous coverage, those with high costs, or those with multiple, chronic conditions—nearly 90 percent would qualify.

This analysis examines the question of Medicare recipients' needs for prescription coverage. Within this discussion, five criteria in addition to income will be used to define need. Next, the proportions of Medicare beneficiaries in each need category that would be eligible for coverage or a subsidized premium are assessed. Finally, this chapter will examine the relationship among the different need criteria.

**Who has the greatest need depends on how you define need.**

## What Definitions of Need Can Policymakers Use?

This study looked at six facets of need, using data to define the criteria from the 1995 and 1996 Medicare Current Beneficiary Surveys.

Annual income related to the Federal Poverty Level. Three income categories were identified: less than or equal to 100 percent of the Federal Poverty Level (FPL); 101 to 150 percent of the FPL; and greater than 150 percent of the FPL.

Lack of access to affordable prescription coverage. Lack of access is not the same as being without coverage. Some Medicare recipients may choose not to enroll in a plan offering prescription benefits. There is no good way to tell which people are voluntarily without coverage and those who cannot afford or find prescription benefits. One possible way is persistent lack of drug coverage over an extended period—two years for this study.

Lack of stable drug coverage. Some people lack coverage for only short periods of time. These people use fewer prescription drugs and spend more for them out-of-pocket than those with continuous coverage.

High out-of-pocket spending. Most health insurance plans pay only a portion of drug expenses—and that portion varies widely depending on the source of coverage. Based on prescription spending in 1996, anyone paying more than \$805 per year out-of-pocket meets this criterion.

Total drug expenses. Older adults who consistently have high total spending are at some risk even if insurance covers a substantial part. For this study, those in the category of high total expenses were those in the upper 20 percent of spenders for two years in a row, averaging \$2085 in annual drug expenses over the two years.

Chronic disease burden. For this study, people with three or more chronic conditions from a list of 10 reported in the Medicare Current Beneficiary Survey qualified for this category. These diseases included Alzheimer’s, arthritis, cancer, chronic lung disease, diabetes, heart disease, hypertension, mental disorder, osteoporosis, and stroke.

### **What Definition of Need Do Current Federal Proposals Use?**

When looking at recent proposals to add a Medicare drug benefit, annual income in relation to Federal Poverty Level (FPL) is clearly the leading criterion in defining need. Many current proposals for providing a drug benefit under Medicare would cover only those with incomes at the Federal Poverty Level or slightly above, which will exclude a significant number of those with true need for assistance.

A proposed plan by Reps. Michael Bilirakis (R-FL) and Collin Peterson (D-MN) would limit eligibility for drug benefits to Medicare beneficiaries with income below 200% of the FPL. Former President Clinton’s plan, meanwhile, promises universal entitlement with a government subsidy for half the premium for older adults above 150% of FPL, with a sliding scale declining to no premium for those between 150% and 135% of FPL.

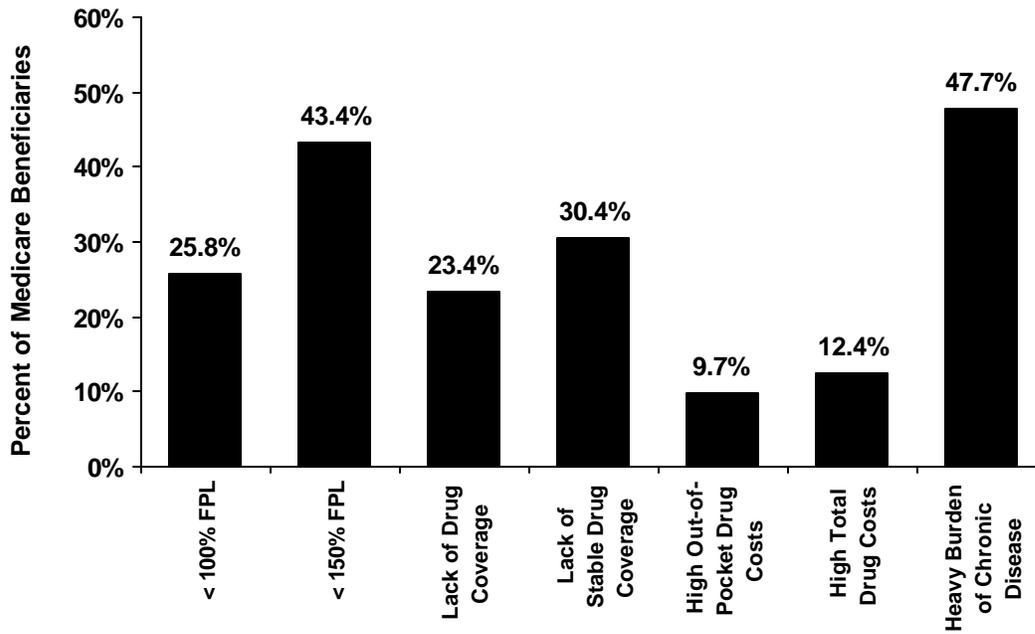
Three other recent proposals also offer fully subsidized coverage for the poor, but provide lower subsidies than the President’s plan for middle- and upper-income beneficiaries. Still other proposals will be put forth by the next Congress, and these will likely contain similar provisions.

### **How Many Medicare Beneficiaries Meet Each Definition of Need?**

When using the five alternative need criteria beyond strict income guidelines, this study found the proportion of Medicare recipients considered “in need” under any one criterion is very different from the proportions under the various other need categories (Figure 1). The share of people on Medicare meeting the need definition varies from less than 10% to nearly 50%. Thus, Medicare beneficiaries’ need for consistent and stable prescription drug coverage does not fit neatly into income categories as a percent of the Federal Poverty Level or any other single measure of need.

***The need for drug coverage does not fit neatly into income categories or any single measure of need.***

**Figure 1. What Percent of Medicare Beneficiaries Meet Each Definition of Need?**

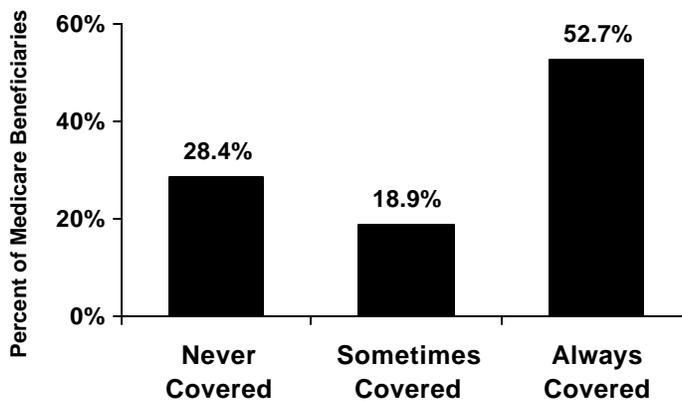


Note. Noninstitutionalized Medicare beneficiaries enrolled in both 1995 and 1996; FPL stands for Federal Poverty Level.

Source: B. Stuart et al., calculated from the 1995 and 1996 Medicare Current Beneficiary Surveys.

If one considers income alone, about 25% would qualify if the income cutoff was below 100% of the Federal Poverty Level (FPL), whereas 43% would qualify if the cutoff was below 150% of the FPL. As shown in Figure 2, if one considers the lack of stable coverage as the criterion, about half would be classified as “in need.” Those needing coverage range from about 2 in 10 (18.9%) who were sometimes covered to about 3 in 10 (28.4%) who were never covered.

**Figure 2. What Percent of Medicare Beneficiaries Currently Have Prescription Coverage?**



Note. Noninstitutionalized beneficiaries enrolled in Medicare throughout 1996.

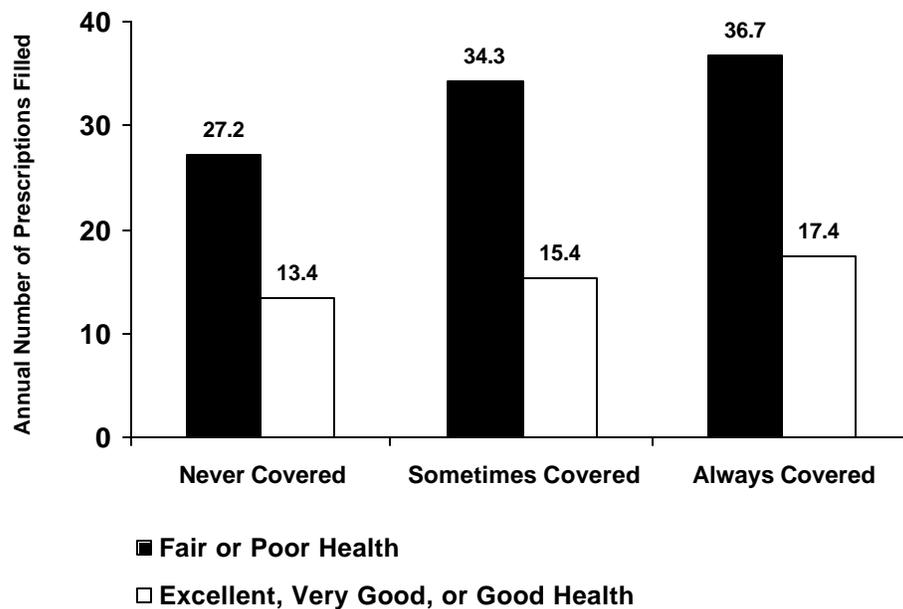
Source: B. Stuart et al., calculated from the 1996 Medicare Current Beneficiary Survey.

Also, the criteria for determining need benefits some subgroups more than others. For example, Black beneficiaries are much more likely to be in need based on income criteria. Yet, based on the other five need factors, whites are more likely to be in need. A greater percentage of the elderly aged 80 or older would receive benefits if the criteria were a lack of any drug coverage or heavy chronic disease burden. However, the disabled would benefit more if the criteria were a lack of stable coverage, high out-of-pocket drug costs, or high total drug costs.

### How Many Medicare Beneficiaries Qualify If More Than One Measure of Need Is Used?

If different measures of need are combined, a different picture emerges. For example, if the lack of stable coverage is combined with health status, those with fair or poor health fill twice as many prescriptions as those in excellent, very good, or good health. As shown in Figure 3, this pattern holds whether or not Medicare recipients have drug coverage.

**Figure 3. How Many Prescriptions Did Medicare Beneficiaries Fill in 1996 by Health Status and Drug Coverage?**

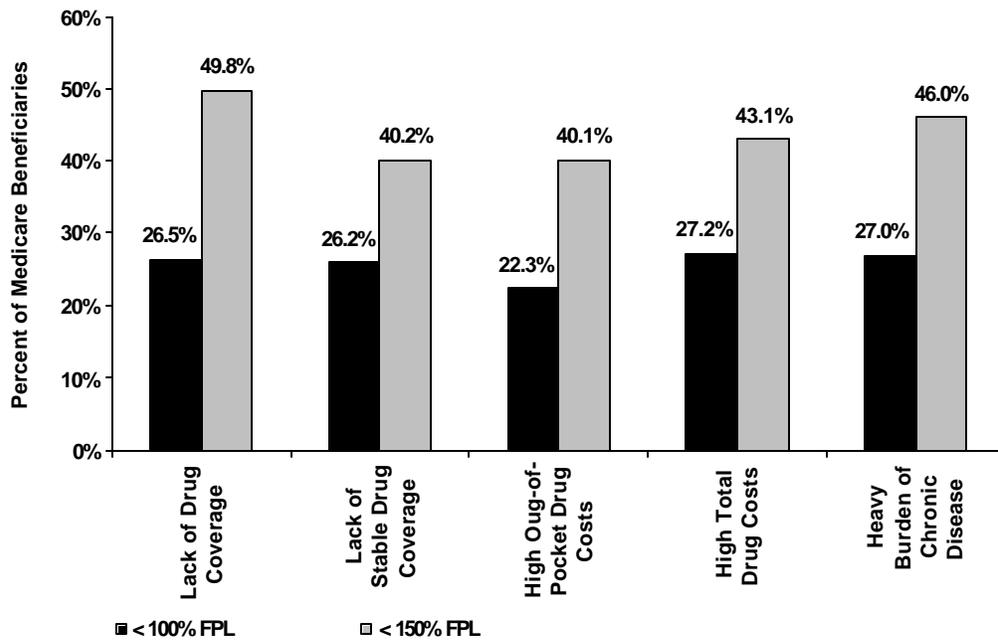


Note. Noninstitutionalized beneficiaries enrolled in Medicare throughout 1996.

Source: B. Stuart et al., calculated from the 1996 Medicare Current Beneficiary Survey.

If income is combined with the other categories of need, between 22% and 50% of Medicare recipients would receive prescription coverage (see Figure 4). If the Federal Poverty Level (FPL) is used as the cutoff for a drug benefit, no more than 27% of alternative-need beneficiaries would be covered. Raising the cutoff to 150% of FPL would increase the coverage rate to between 40% and 50%, but would still exclude more than half of the Medicare population who need coverage based on one of the other criteria.

**Figure 4. What Percent of Poor and Near Poor Medicare Beneficiaries Have Other Needs for Prescription Coverage?**



Note. Noninstitutionalized Medicare beneficiaries enrolled in both 1995 and 1996.

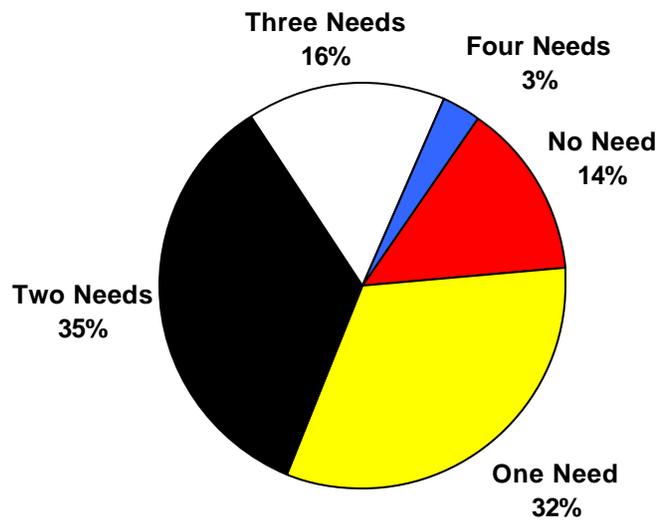
Source: B. Stuart et al., calculated from the 1995 and 1996 Medicare Current Beneficiary Surveys.

In four of the five alternative need categories, average total drug spending is higher for those with incomes above 150% of the Federal Poverty Level. This isn't surprising, because with higher income, people have increased ability to purchase both prescription coverage and medications. This finding suggests that actual spending levels probably understate the true needs of low-income beneficiaries. If drug coverage was universal, these differences probably would decrease or disappear.

### How Many Medicare Beneficiaries Qualify if Any Measure of Need Is Used?

Figure 5 most clearly illustrates the extent of need for subsidized drug coverage. By including any criteria of need—either income-based (less than 150% of poverty), coverage-based (high individual or total spending), or health-based (three or more chronic conditions)—this study finds that nearly 9 out of 10 (86%) Medicare recipients need prescription drug assistance. If a recipient had to have at least two of these criteria, about 54% would qualify for coverage.

**Figure 5. What Percent of Medicare Beneficiaries Have Multiple Needs for Prescription Coverage?**



Note. Noninstitutionalized Medicare beneficiaries enrolled in both 1995 and 1996.

Source: B. Stuart et al., calculated from the 1995 and 1996 Medicare Current Beneficiary Surveys.

This study also highlights how important it is to look at different measures of need. Any one of the need criteria captures between about 10% and 50% of the total Medicare population (see Figure 1). Since 86% of the Medicare population meet at least one of the criteria, using any single measure of need misses at least one-third of the population that could be considered “in need” by an alternative definition.

## What Are the Implications for Policy?

This study shows that Medicare recipients' need for consistent and stable drug coverage does not necessarily fit neatly into income categories or any single measure of need. In fact, no single measure of need is fully successful. Instead, the study shows that determining eligibility deserves careful consideration by policymakers because the need for drug coverage is multi-dimensional and pervasive. People faced with a combination of low income, lack of coverage, and high prescription drug bills have the most urgent need.

Regardless of where the income cutoff is set, a significant portion of Medicare recipients with true needs will be left out. In short, means-testing eligibility can neither assure that people with equal needs are treated the same, nor assure that those with differing need levels receive assistance in proportion to their need.

In addition to means-testing for eligibility, other aspects of a drug benefit have the ability to affect which Medicare recipients will have their needs addressed and which will not.

For example, one important benefit feature is the level of contributions required of beneficiaries, and the level of government subsidy provided. Most current proposals for a Medicare drug benefit take a different approach to means-testing by testing the premium subsidy, rather than the eligibility requirement. People above the income cutoff will pay 25% of a premium under some proposals and as much as 75% under others.

Given the experience with Medicare Part B (with a 75% premium subsidy), most people would probably sign up for a prescription drug program offering the most generous subsidy. Near-universal enrollment is important to assure that all beneficiaries who need the benefit have reasonable access to it.

A premium subsidy of only 25% will likely attract primarily high-cost beneficiaries. Since personal drug spending tends to continue from year to year, beneficiaries with anticipated drug costs below the 75% share of the premium have less financial incentive to sign up. If only high-cost people enroll, premiums will spiral up, making coverage unaffordable for all except those with low income whose costs are fully subsidized. For this reason, getting the premium subsidy right is critical to the success of any Medicare drug plan.

## Conclusion

As the debate over a Medicare prescription drug benefit continues, policymakers need to remember to balance the benefits that might be achieved from using a simple needs assessment against the costs—in terms of the many truly deserving beneficiaries who would be excluded from coverage and the loss of social solidarity that supports the Medicare program itself.

***People faced with low income, lack of coverage, and high prescription drug bills have the most urgent need.***

*This chapter was adapted from a policy brief written by Bruce Stuart and Dennis Shea, "Designing a Medicare Drug Benefit: Whose Needs Will Be Met?" which can be found on the web site of The Commonwealth Fund at [www.cmwf.org](http://www.cmwf.org). Hard copies of this report, #436, and other reports can be ordered from The Commonwealth Fund by calling (212) 606-3800.*

Dr. Bruce Stuart, Ph.D., is the Parke-Davis Professor of Geriatric Pharmacotherapy and Director of the Peter Lamy Center on Drug Therapy and Aging, at the University of Maryland School of Pharmacy. He was recently named a Maryland Eminent Scholar for his work in geriatric drug policy issues. He has numerous publications including a chapter in the U.S. Department of Health and Human Services Report to the President, "Issues in Prescription Drug Coverage, Pricing, Utilization, and Spending: What We Know and Need to Know." He is an experienced researcher having directed numerous grants and contracts for the National Institute on Aging, the Health Care Financing Administration, the Assistant Secretary for Planning and Evaluation, private foundations, and state governments. He received an outstanding teacher of the year award and recently received the best paper award from the Association for Health Services Research. Before entering academia, he worked in state government.

---

# What Can Wisconsin Learn from Pennsylvania, the Nation's Largest State Pharmacy Assistance Program for the Elderly

By Tom Snedden

**T**his chapter describes the largest prescription drug coverage program for older adults in the nation. PACE and PACENET help 264,657 Pennsylvania residents over age 65 who are income-eligible with the cost of their prescription drugs. The programs pay for all but a portion of the cost of each drug prescribed by a doctor. The program is funded by the state lottery and administered by the Pennsylvania Department of Aging.

The Pharmaceutical Assistance Contract for the Elderly (PACE) program in Pennsylvania is the largest state prescription drug coverage program for older adults in the nation. This program helps Pennsylvania residents over age 65 who are income-eligible with the cost of their prescription drugs.

## What Benefits Do PACE and PACENET Provide?

PACE, established in 1984 and administered by the Pennsylvania Department of Aging, pays for all but a portion of the cost of each drug prescribed by a doctor. Enrolled PACE members are responsible for a copayment of \$6 at the time they get the prescription at a pharmacy. The program is funded by the state lottery.

Members must be Pennsylvania residents at least 90 days before application. Gross income from all sources, both taxable and non-taxable, for the previous year must be less than \$14,000 for single people and less than \$17,200 for married applicants. Since the legislature reauthorization of PACE in 1987, the program has implemented a diversity of measures that have significantly reduced outlays in the program, through increase used of lower priced therapeutically equivalent generic medications, significant manufacturer rebates, reduced provider reimbursements, and a comprehensive drug utilization review program.

In 1996, state legislation expanded the PACE program eligibility requirements and created a new program, PACENET (Pharmaceutical Assistance Contract for the Elderly Needs Enhancement Tier). PACENET helps eligible older adults with higher annual incomes. To be eligible, applicants' gross income for the previous year must be less than \$16,000 for single people and less than \$19,200 for married couples.

Enrolled members must first satisfy an annual \$500 deductible before PACENET begins paying for medications. After the deductible is satisfied, cardholders also must make a copayment of \$8 for generic drugs and \$15 for brand names for each prescription.

### What Trends Have Occurred in Program Enrollment, Usage, and Cost?

PACE/PACENET currently has 264,657 people enrolled. Table 1 displays the ongoing trends of declining enrollments, increasing drug use, and rising costs per cardholder in PACE between 1996 and 1999. Enrollment has declined because the income levels are fixed by statute and cannot be changed without legislative action. Even though PACE enrollment declined over 7% in 1999, claims per person increased by almost 11%. PACENET, however, has had increasing enrollment and usage between 1996 and 1999 (Table 2).

**Table 1. Historical Claim and Expenditure Data for PACE Enrolled and Participating Cardholders by Annual Period Based on Date of Service, 1996-1999**

Period	Enrolled Cardholders	Participating Cardholders	Claims per Enrolled Cardholder	Claims per Participating Cardholder	Expenditures per Enrolled Cardholder	Expenditures per Participating Cardholder
1996	299,409	246,123	28.23	34.37	\$805.92	\$980.40
1997	281,153	231,482	30.75	37.35	\$854.39	\$1,037.73
1998	262,117	218,080	32.68	39.28	\$1,007.26	\$1,120.65
1999	242,427	204,956	36.17	42.78	\$1,221.03	\$1,444.25

Source: Pennsylvania Department of Aging Cardholder File, Claims History.

**Table 2. Historical Claim and Expenditure Data for PACENET Enrolled and Participating Cardholders by Annual Period Based on Date of Service, 1996-1999**

Period	Enrolled Cardholders	Participating Cardholders	Claims per Enrolled Cardholder	Claims per Participating Cardholder	Expenditures per Enrolled Cardholder	Expenditures per Participating Cardholder
1996	1,523	740	1.53	3.15	\$0.54	\$1.11
1997	10,793	7,688	20.84	29.25	\$302.85	\$425.16
1998	18,363	13,244	22.21	30.80	\$416.46	\$577.43
1999	22,230	16,767	25.74	34.13	\$581.95	\$771.53

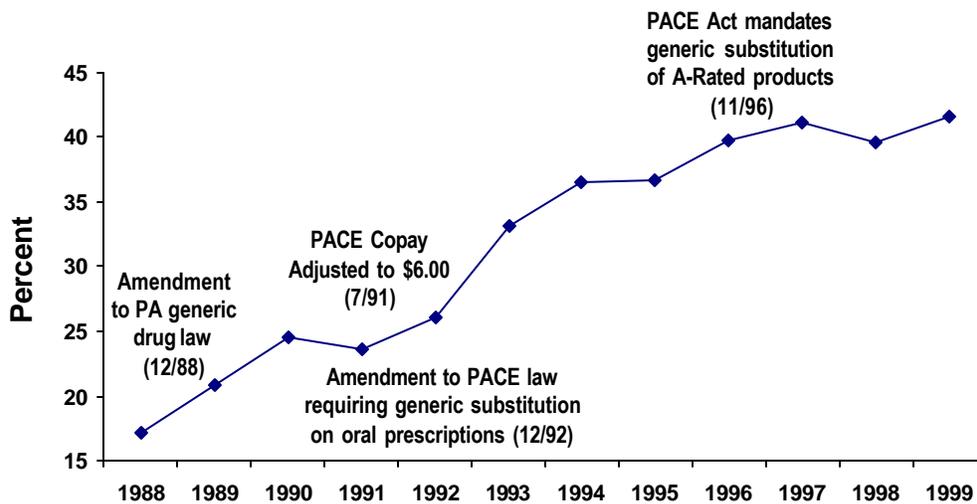
Source: Pennsylvania Department of Aging Cardholder File, Claims History.

Notes: Data include original, paid PACENET claims by date of service. Total claims include deductible claims and copaid claims. Enrolled cardholders are those enrolled for any portion of the reported period. Participating cardholders are cardholders with one or more approved claims during the reported period.

## What Prescriptions Are Covered?

PACE/PACENET covers most prescription drugs, as well as insulin, insulin syringes, and insulin needles. PACE requires that generic drugs be used instead of brand names when an approved generic is available. Since PACE/PACENET began requiring generic substitutions in 1992, use of generic drugs has increased from about 25% to just over 40% (see Figure 1). PACE does not cover experimental drugs, medications for baldness or wrinkles, or any drug that is available without a prescription. Under certain conditions, the Department of Aging provides a PACE/PACENET medical exception process.

**Figure 1. PACE Generic Utilization Rates by Year, 1988-1999**



Source: Pennsylvania Department of Aging Monthly Cost Containment Report.

## How Does the Program Work?

To receive benefits, the enrollee presents a PACE or PACENET card to the pharmacist or other dispenser when filling a prescription. Before filling a prescription, the provider submits a claim to the program.

Six types of providers dispense PACE/PACENET-funded prescriptions. The majority of providers are either independent pharmacies or chain pharmacies. Other providers include institutional pharmacies, nursing home pharmacies, mail service pharmacies, and dispensing physicians.

The state reimburses providers for the average wholesale price of the medication minus 10%, plus a \$3.50 dispensing fee or their usual and customary charge (whichever is less), minus the copayment. A limit of 30 days' supply or 100 units (whichever is less) applies to each claim. The program guarantees reimbursement to the provider within 21 days, paying interest on any unpaid balance after that time. A contractor directly responsible to the Department of Aging assists in conducting many of the day-to-day operations.

*Adapted with permission from a longer publication, "PACE Annual Report to the Pennsylvania General Assembly: January 1 - December 31, 1999" published by Pennsylvania Department of Aging, April 2000. The full report can be ordered by calling the Pennsylvania PACE program at (717) 787-7313.*

Tom Snedden is the Director of Pennsylvania's prescription drug program, Pharmaceutical Assistance Contract for the Elderly, more commonly known as the PACE program. Since 1985 when he assumed the position, he and his staff have spoken with almost every state in the country about what they have learned about prescription drug programs based on their experience with PACE.

---

## Glossary

**A-Rated Product** A drug substitution approved by the Food and Drug Administration.

**Brand Name Drug** Generally, a drug product that is covered by a patent and thus is manufactured and sold exclusively by one firm. Cross licensing occasionally occurs, allowing an additional firm(s) to market the drug. After the patent expires, multiple firms can produce the drug product, but the brand name remains with the original manufacturer's product.

**Coinsurance** A cost-sharing requirement under a health insurance policy that requires the patient to pay a percentage of costs for covered services/prescriptions (e.g., 20% of the prescription price).

**Copayment** A cost-sharing requirement under a health insurance policy that requires the patient to pay a specified dollar amount for each unit of service (e.g., \$10.00 for each prescription dispensed).

**Detailing** Personal selling activities by pharmaceutical manufacturer sales representatives. The representatives inform prescribers, pharmacists, and others about the specifics or details of their firms' products, thus the label "detailing." Sales representatives often leave samples of products for prescribers for trial use among their patients, to stimulate future prescribing.

**Direct-to-Consumer Advertising/Promotion** Advertising for prescription drugs in print, radio, and television media targeted directly to consumers by pharmaceutical manufacturers. Consumers are the targeted audience, even though prescription drugs require a prescription order from a prescriber in order to be dispensed.

**Dispensing Fee** An amount added to the prescription ingredient cost by a pharmacy to determine a prescription price. The dispensing fee represents the charge for the professional services provided by the pharmacist when dispensing a prescription (including overhead expenses and profit). Most direct pay insured prescription programs use dispensing fees to establish pharmacy payment for prescriptions.

**Formulary** A listing of drug products that may be dispensed or reimbursed (positive formulary) or that may not be dispensed or reimbursed (negative formulary). A government body, third-party insurer or health plan, or an institution may compile a formulary. Some institutions or health plans develop closed (i.e. restricted) formularies where only those drug products listed can be dispensed in that institution or reimbursed by the health plan. Other formularies may have no restrictions (open formulary) or may have certain restrictions such as higher patient cost-sharing requirements for off-formulary drugs.

**Generic Drug** A drug product that is no longer covered by patent protection and thus may be produced and/or distributed by many firms.

**HCFA Federal Upper Limit (HCFA FUL)** Amount established by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services as a target amount of payment for a drug in a state Medicaid Program.

**Maximum Allowable Cost (MAC)** The upper limit of ingredient cost for which a third-party payer will reimburse a pharmacy for dispensing certain multiple source drugs (i.e., drugs for which generic equivalents exist). MACs are used by public programs such as Medicaid and by private prescription insurance plans. Although there is no standard list of MAC drugs, often lists for different insurers or prescription programs include many of the same drugs and similar payment limits.

**Mail Order Pharmacy** A pharmacy that dispenses prescriptions to consumers who contact the pharmacy by mailing or faxing their prescription orders and then the prescription is mailed to the consumer. This can be an advantage for homebound patients or other patients without ready access to traditional community pharmacies. Unlike traditional pharmacies, the pharmacies can serve more than the local market where the pharmacy is located. Since there typically is at least a short delay between ordering and receiving prescriptions, these pharmacies generally serve patients on long-term drug therapies and those without immediate drug needs. The average size of prescriptions (number of capsules or tablets) dispensed in mail order pharmacies is larger than in local community pharmacies. Consequently, although mail order pharmacies represent less than 5% of all prescriptions dispensed, they comprise approximately 13% of total retail prescription sales.

**Nonprescription Drug** A drug product that can be purchased without a prescription order.

**Over-the-Counter (OTC) Drug** A nonprescription drug.

**Patent/Patent Life** A patent provides exclusivity in marketing a product. The patent life is the time during which a patent is in force and the product's manufacturer has exclusive marketing rights. The length of a patent for a drug is 20 years which is longer than for other products. The effective patent life for a drug may actually be shorter than 20 years depending on the time between discovery and market launch that is needed for safety and efficacy testing, clinical trials, and FDA approval for marketing.

**Pharmacy Benefit Manager (PBM)** An organization that provides administrative services in processing and analyzing prescription claims for pharmacy benefit and coverage programs. Their services can include contracting with a network of pharmacies; establishing payment levels for provider pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; and operating disease management programs. Many PBMs also operate mail order pharmacies or have arrangements to include prescription availability through mail order pharmacies.

**Prescriber** A health care provider licensed to prescribe drugs. Primary prescribers are physicians, but others may have prescriptive authority, depending on states' statutes and laws. For example dentists, physician assistants, nurse practitioners, optometrists, and others may have authority to prescribe, typically within limits.

**Rebate** An amount that the manufacturer of a drug pays to an insurer or health plan for each unit of drug dispensed. Rebate arrangements exist between manufacturers and Medicaid agencies, HMOs, and other insurers or drug plans, and generally bypass the pharmacy. Rebates are referred to as "after market" arrangements because they do not affect the prices paid at the time of service, but are implemented later, ultimately reducing the payer's expenditures or program costs. The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) requires pharmaceutical firms to give a rebate to the Health Care Financing Administration (HCFA) for distribution to the states for all drugs covered under state Medicaid drug programs. Within the private insurance market, rebates often are associated with preferred drugs, and the rebate or level of rebate is contingent upon achieving market share goals.

**Third-Party Insurer** An entity (a public or private program, health plan, or insurer) that pays or reimburses the patient or pharmacy for all or part of the cost of services provided.

**Usual and Customary (U&C) Charge** The amount a pharmacy or other provider charges self-pay (cash) patients. Some insurance programs dictate that a pharmacy's claim may not exceed its usual and customary charge for the prescription dispensed.

**Wholesale Acquisition Cost (WAC)** The price paid by the wholesaler for drugs purchased from the wholesaler's suppliers (manufacturers). On financial statements, the total of these amounts equals the wholesaler's cost of goods sold. Publicly disclosed or listed WAC amounts may not reflect all available discounts.

*Reprinted, in part, with permission from "Prescription Drug Trends: A Chart-book," an analysis by the Kaiser Family Foundation authored by David H. Kreling, David A. Mott, and Joseph B. Wiederholt of Sonderegger Research Center of the University of Wisconsin-Madison and Janet Lundy and Larry Levitt of the Kaiser Family Foundation. The full report can be obtained from the Kaiser Family Foundation web site at [www.kff.org](http://www.kff.org) or by requesting Publication #3019 from the Kaiser Family Foundation Publication Request Line at 1-800-656-4533.*



---

## Selected Resources

*Compiled by Karla Balling  
Project Assistant  
Wisconsin Family Impact Seminars*

### State Agency Representatives

**Richard Sweet, Senior Staff Attorney**

Wisconsin Legislative Council Staff  
1 East Main Street, Room 401  
P.O. Box 2536  
Madison, WI 53701-2536  
(608) 266-2982  
Richard.Sweet@legis.state.wi.us  
*Interests:* Health administrative rules and health related legislation

**James Vavra, Director of Medicaid Policy and Budget Bureau**

Division of Health Care Financing  
1 West Wilson  
Madison, WI 53701  
(608) 261-7838  
vavraj@dhfs.state.wi.us  
*Interests:* Medicaid reimbursement and policy

### University of Wisconsin-Madison/Extension

**David Kreling, Professor**

Sonderregger Research Center for Social and Administrative Pharmacy  
University of Wisconsin-Madison, School of Pharmacy  
Chamberlin Hall, Room 3152  
Madison, WI 53706  
(608) 262-3454  
dhkreling@pharmacy.wisc.edu  
*Interests:* Pharmacy benefits and reimbursement policy

**Stephen Meili, Clinical Associate Professor**

University of Wisconsin-Madison, Law School  
Law Building, Room 3222  
Madison, WI 53706  
(608) 263-6283  
semeili@facstaff.wisc.edu  
*Interests:* Consumer law, fraud and misrepresentation, bad faith insurance claim denials, unfair debt collection practices, and credit issues affecting lower income consumers.

**David Mott, Assistant Professor**

University of Wisconsin-Madison, School of Pharmacy  
Chamberlin Hall Room 4302  
Madison, WI 53706  
(608) 265-9268  
damott@pharmacy.wisc.edu

*Interests:* Factors associated with drug utilization, health care policy evaluation, and health care workforce evaluation

**Roberta Riportella-Muller, Associate Professor**

Consumer Science, Health Policy Specialist  
University of Wisconsin-Madison/Extension, School of Human Ecology  
Human Ecology Building, Room 370B  
Madison, WI 53706  
(608) 263-7008  
rriorte@facstaff.wisc.edu

*Interests:* Barriers to accessing care for under-served populations and broad extensive knowledge about Medicare programs. Is currently working with Health Care Financing Administration to design an educational program for beneficiaries that will be disseminated through county Extension offices. Has a solid understanding of the issues with Medicare financing problems and how/if extended prescription drug coverage may impact the fiscal viability of the program.

## Community

**Ray Larvuso, M.D., J.D.**

Advocacy and Benefits Counseling for Health  
152 West Johnson, Suite 206  
Madison, WI 53703  
(608) 261-6939 (ext. 204)  
larvuso@safetyweb.org

*Interests:* Barriers to health care benefits for low-income families.

## National Resources

**The Commonwealth Fund**

One East 75<sup>th</sup> Street  
New York, NY 10021-2692  
(212) 606-3800  
ilhi@cmwf.org

*Commonwealth Fund Reports*

*(reports are available at [www.cmwf.org](http://www.cmwf.org)):*

Designing a Medicare Drug Benefit: Whose Needs Will Be Met? (#436)

Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries (#430)

**Department of Health and Human Services**

Office of the Assistant Secretary for Planning and Education

<http://aspe.hhs.gov>

*DHHS Report:*

Prescription Drug Coverage, Spending, Utilization, and Prices: Report to the President, April 2000

**General Accounting Office**

PO Box 37050

(202) 512-6000

[infor@www.gao.gov](mailto:infor@www.gao.gov)

*GAO Report:*

State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets (GAO/HEHS.00.162)

Prescription Drugs: Expanding Access to Federal Prices Could Cause Other Price Changes, August 2000

**Health Care Financing Administration (HCFA)**

7500 Security Boulevard

Baltimore, Maryland 21244

(410) 786-3000

[www.hcfa.gov](http://www.hcfa.gov)

**Kaiser Family Foundation**

2400 Sandhill Road

Menlo Park, CA 94025

(650) 854-9400

1-800-656-4533

[www.kff.org](http://www.kff.org)

*Kaiser Foundation Reports*

*(reports are available at [www.kff.org](http://www.kff.org) or by calling 1-800-656-4533):*

Prescription Drug Trends: A Chartbook (publication #3019)

Kaiser Family Foundation/Health Research and Educational Trust 1999 Annual Employer Health Benefits Survey, 1999

Medicare and Prescription Drugs, A Factsheet, March 2000

Retiree Health Coverage: Recent Trends and Employer Perspectives on Future Benefits, prepared by Hewitt Associates, October 1999

The Role of PBMs in Managing Drug Costs: Implications for a Medicare Drug Benefit, prepared by Mathematica Policy Research, Inc., January 2000

**National Conference of State Legislatures**

1560 Broadway  
Suite 700  
Denver, CO 80202  
(303) 830-2200  
[www.ncsl.org](http://www.ncsl.org)

*NCSL Reports:*

State Senior Pharmaceutical Assistance Programs

[www.ncsl.org/programs/health/drugaid.htm](http://www.ncsl.org/programs/health/drugaid.htm)

Prescription Drug Discount, Rebate, Price Control,  
and Bulk Purchasing Legislation

[www.ncsl.org/program/health/drugdisc.htm](http://www.ncsl.org/program/health/drugdisc.htm)

**National Governors' Association**

Center for Best Practices

Health Policy Studies

Joan Henneberry

(202) 624-3644

[www.nga.org/Pubs/IssueBriefs/2000/Sum000814PharmBenefits.asp](http://www.nga.org/Pubs/IssueBriefs/2000/Sum000814PharmBenefits.asp)



© 2001 by the Board of Regents of the University of Wisconsin System doing business as the division of Cooperative Extension of the University of Wisconsin-Extension. Send inquiries about copyright permission to: Cooperative Extension Publications Operations, 103 Extension Bldg., 432 North Lake St., Madison, WI 53706.

Editors: Karen Bogenschneider, Director, Wisconsin Family Impact Seminars, Associate Professor, Human Development & Family Studies, UW-Madison, and Family Policy Specialist, Cooperative Extension, UW-Extension; and Jessica Mills, State Coordinator, Wisconsin Family Impact Seminars. Produced by the Center for Excellence in Family Studies, School of Human Ecology, University of Wisconsin-Madison. Beth Swedeen, editor; Meg Wall-Wild, designer.

University of Wisconsin-Extension, Cooperative Extension, in cooperation with the U.S. Department of Agriculture and Wisconsin counties, publishes this information to further the purpose of the May 8 and June 30, 1914, Acts of Congress. UW-Extension provides equal opportunities and affirmative action in employment and programming, including Title IX requirements. If you need this material in an alternative format, contact Cooperative Extension Publishing Operations at (608) 262-2655 (Voice & TDD), or the UW-Extension Office of Equal Opportunity and Diversity Programs.

This publication is available from your Wisconsin county UW Extension office or:

Cooperative Extension Publishing Operations  
103 Extension Building  
432 North Lake St., Madison, WI 53706  
Toll-free: (877) 947-7827 (877-WIS-PUBS)  
Madison: (608) 262-3346; FAX (608) 265-8052  
Internet: <http://learningstore.uwex.edu>

BFI15 Rising Prescription Drug Costs: Reasons, Needs, and Policy Responses (2001)