Enhancements in treatment and access to care for the aging have dramatically improved life expectancy and quality of life for America’s seniors. However, as the dominant mode of care has shifted from inpatient hospital care to management of disease through outpatient drug therapy, health care coverage for seniors has not kept pace. Because Medicare, the federal government program that funds health care for seniors and the disabled, does not pay for prescription drugs, over the years seniors have had to buy additional coverage or pay out of pocket for the drugs they are prescribed.

According to the Department of Health and Human Services, roughly 73 percent of seniors have some form of prescription drug coverage, either through employer-sponsored retiree health insurance, Medicaid, Medigap policies, Medicare HMOs or other third party coverage. Yet, finding coverage is increasingly difficult for seniors as more employer plans and Medicare HMOs drop or scale back drug coverage. Seniors without coverage often pay significantly more than those with drug coverage. If they cannot afford to pay, they may chose not to fill a prescription, potentially risking their health.

In late 2001, The Council of State Governments (CSG) held a forum to address the issue of prescription drug coverage for the elderly. Attendees—state legislators from 11 states—heard from nationally recognized speakers, including:

- Gail Wilensky, Senior Fellow, Project HOPE and former HCFA official under President George Bush
- Bruce Stuart, Director, The Lamy Center on Drug Therapy and Aging, University of Maryland School of Pharmacy
- Tom Donnelly, Principal, Jefferson Government Relations
- Wayne Pines, President, Healthcare, APCO Worldwide
- Dr. Carolyn C. Lopez, Member, American Academy of Family Physicians Board of Directors
- Ken Kaitin, Director, Tufts Center for the Study of Drug Development
- Duane Kirking, Professor & Chair, Department of Social and Administrative Sciences, University of Michigan
- Jack Meyer, Ph.D., President, New Directions for Policy
- Donald Muse, President, Muse & Associate
- Al Lewis, Executive Director, Disease Management Purchasing Consortium LLC, and past president of the Disease Management Association of America

Sessions provided an overview of how prescriptions are developed and priced, a discussion of current trends in coverage, prescription drug utilization by seniors, and pharmaceutical direct-to-consumer advertising. Also included was a review of state strategies for providing coverage to seniors and a discussion of how states can reduce prescription expenditures through disease management programs.

Health care for seniors

Government-sponsored health insurance was first debated in Congress in 1916. After WWII, both members of Congress and the White House proposed legislation many times, but the votes were never sufficient. Finally, in 1965, Congress passed the Medicare amendment to the Social Security Act.
Before Medicare took effect, less than 50 percent of seniors in the United States had health insurance. Coverage for elderly with chronic health conditions was even lower: less than 30 percent. But while Medicare provided coverage on par with other insurance plans of the 1960s, the standard features of today’s employee-sponsored programs—most notably outpatient prescription drug coverage—were not included. In today’s health care marketplace, not having prescription drug coverage has placed a significant burden on seniors.

Who has coverage? Who does not?

According to Dr. Bruce Stuart, Director of the Lamy Center on Drug Therapy and Aging at the University of Maryland School of Pharmacy, from 1993 to 1998 there was a significant growth in the number of full-year Medicare beneficiaries with some form of prescription drug coverage (Figure 1).

Who is most likely to have coverage? Information provided by the Medicare Current Beneficiary Survey reveals that in 1998, beneficiaries with prescription drug coverage tended to be:

- Younger (78% of those under 70 versus 69% of those over 80).
- Better off financially (80% of those with incomes of $50,000 or more a year versus 72% of those with incomes less than $20,000).
- Live in a city (79% urban versus 63% rural).

Why do drugs cost so much?

Many factors affect how much someone is going to have to pay to get a prescription filled at their local pharmacy. Research and development costs, the disease to be treated, how the drug will be used, as well as competition in the marketplace all contribute in determining manufacturer price,” stated Dr. Ken Kaitin, Director, Tufts Center for the Study of Drug Development. Transaction costs on the part of wholesalers and retailers increase price as well.

Determining manufacturer price

The total time it takes to bring a drug to market increased from 8.8 years during the 1960s to 13.9 in the 1990s. (See figure below.) “Clinical trial size, market oriented studies, patient recruitment/re- tention issues, and a focus on chronic and complex indications have worked to lengthen clinical development times,” said Dr. Kaitin. At the same time, the price for developing a new drug has also increased: in 2001, the cost of new drug development, including cost of failed compounds and the cost of capital, was $802 million.

From manufacturer to pharmacy

A wholesaler buys the drug from the manufacturer at a certain price, then sells the drug to a retailer at the manufacturer’s price plus the cost of the transaction. The pharmacy passes these costs, as well as its own transaction costs, on to the consumer. Once the fixed costs of retailers are added, along with taxes and profits, the final costs to consumers could range from 20 percent to 25 percent over the pharmacy’s acquisition price.

Role of a third-party negotiator

When a third-party payer manages benefits, the final price is often much lower. “Because a pharmacy benefits manager may manage the drug benefit for a large number of individuals, it can negotiate discounts at both ends of the pricing chain: from the manufacturer and from the retail pharmacy.” Discounts from the retailer take the form of previously negotiated prices plus a dispensing fee. Discounts from manufacturers take the form of rebates, the value of which can vary. The rebate does not affect the price of the drug; it is a separate transaction between the third-party payer and the manufacturer. However, when the value of the rebate is passed on to the consumer, it is estimated that savings may average about $1.00 per claim.

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3ibid.
4ibid.

Figure 1. Percentage of Medicare beneficiaries with and without prescription drug coverage, 1993–1998

Source and stability of prescription drug coverage

However, there is more to this issue than whether or not someone has prescription drug coverage. It is also important to examine both the source of coverage and the stability of coverage. Figure 2 looks at coverage by type: employer, Medigap, Medicare HMO, Medicaid, other public program, and those seniors combining coverage from multiple plans.

During the mid-1990s, many seniors bought supplemental drug coverage through Medigap and Medicare HMOs. As costs grew too high to make offering such coverage profitable, however, some companies pulled out of certain markets. One comparison showed that the percent of Medicare beneficiaries offered at least one Medicare + Choice plan with prescription drug coverage fell from 61.5% in 1999, to 54.7% in 2000, to 46.9% in 2001.3 Those companies that remained often reduced coverage and raised premiums in order to cover costs.

Figure 2 reveals the role of Medicare HMOs in expanding coverage to more seniors. “Of those gaining coverage during this time, the majority—77 percent—did so through Medicare HMOs,” stated Dr. Stuart. Meanwhile, public sector prescription drug coverage declined from 16 percent to 12 percent.

An important element in understanding the number of seniors with coverage is comparing those with stable and dependable coverage with those who have patched together coverage from many sources or have gaps in coverage for any period of time. According to Dr. Stuart, by 1998, 28 percent of beneficiaries with prescription coverage had a gap of at least a month. Figure 3 provides an overview of coverage stability from 1995 to 1998.

Trends in prescription drug spending

The U.S. spends an extraordinary amount of money on health care—nearly $1.3 trillion in 2000 according to the Centers for Medicare and Medicaid Services (CMS).4 Prescription drugs as a percentage of total health care expenditures has remained relatively stable over the last thirty years, ranging from 5 to 8 percent (Figure 4).

However, although prescription drug costs make up only a small and relatively stable percentage of overall health care expenditures, annual spending increases are significant when compared to other segments of the health care industry (Figure 5). During the last decade, growth of prescription drug expenditures outpaced the growth of hospital and physician expenditures every year except 1992. This growth was a reflection of the move away

Figure 2. Prescription drug coverage of Medicare beneficiaries by source (percentage), 1993–1998

As the dominant mode of care has shifted from inpatient hospital care to management of disease through outpatient drug therapy, health care coverage for seniors has not kept pace.
The Council of State Governments

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from more expensive inpatient hospital care towards less expensive outpatient care and drug therapy.

“There are two ways that medication costs can go up: you pay more or you use more. Changing the mix of medication can affect both factors,” stated Dr. Duane Kirking, College of Pharmacy and School of Public Health, University of Michigan. Dr. Kirking’s research has demonstrated that both increased utilization as well as changing the mix of prescriptions—switching from an older, less expensive medication to a newer, more expensive medication—accounts for the majority of expenditure growth, although increases in drug prices plays a role as well (Figure 6).

Drug costs and usage among seniors

In the debate over drug coverage for seniors, cost and utilization of prescription drugs play major roles in the choice of policy options. Chief among the concerns is that seniors without prescription drug coverage tend to pay more for the same prescription than those with coverage. These seniors are often those who can least afford to pay higher prices for prescription drugs—they make too much to be eligible for Medicaid but make too little to afford Medigap or other prescription drug coverage.

A report published by the Department of Health and Human Services (HHS) states that in 1999, “excluding the effect of rebates, the typical cash customer paid nearly 15 percent more than the customer with third-party coverage. For a quarter of the most common drugs, the price difference between cash and third parties was even higher—over 20 percent.”1 Because insurance companies represent a large number of clients, they are able to negotiate rebates and discounts with manufacturers and

Figure 3. Percent of Medicare beneficiaries with year-around coverage and part-year prescription drug coverage, 1995–1998


Spending by manufacturers on drug promotion

Figure 4. National health care expenditures—selected categories, 1970–1999

Source: Centers for Medicare and Medicaid Services.

Figure 5. Annual percentage increases in health care spending by sector, 1970–1999

Source: Centers for Medicare and Medicaid Services.
Direct-to-consumer advertising
continued from page 4

“DTC advertising promotes awareness of potential health problems, thereby increasing the likelihood of early recognition of disease,” stated Wayne Pines, President, Healthcare, APCO Worldwide. Increased knowledge of treatment options is another oft-cited benefit. “It provides consumers with useful information on product availability, allowing them to become more knowledgeable and make informed, informed decisions with the advice and support of a physician,” he added.

Critics feel, however, that these advertisements may confuse consumers, or encourage them to take unnecessary prescriptions. With the current climate of physician liability and managed care pressures, some analysts worry that physicians may simply give in to demanding consumers rather than prescribing older, cheaper drugs or encouraging lifestyle changes. “It may be difficult, especially for younger physicians, to say no to a patient,” said Dr. Carolyn Lopez of the American Academy of Family Physicians.

Recent survey results

In hopes of determining just what affects DTC had on the viewing public, the FDA conducted a national survey in 1999 of individuals who had seen a doctor at some point during the previous three months. The survey found that overall consumers are asking more questions as a result of DTC advertising, most often of their physician. Furthermore, “a significant minority of respondents said that the DTC ad has caused them to ask a doctor about a medical condition or illness they had not previously discussed.” Other findings include:

- Only two percent visited the doctor because of something they had seen or heard in a DTC advertisement.
- Of those patients who had talked with their physician about a prescription drug, 81 percent said that their doctor had welcomed their question, 79 percent said that their doctor discussed the drug with them, and 71 percent said that their doctor has reacted as though the conversation was an ordinary part of the visit.
- Fifty percent said the doctor prescribed the drug they asked about, 32 percent said the doctor recommended a different drug, and 29 percent said that their doctor recommended a behavioral or lifestyle change to address the problem.

Another survey conducted by the Kaiser Family Foundation in 2001 found that 30 percent of respondents had talked to their doctor as a result of a drug ad. As a result of these conversations, the doctor prescribed the drug 48 percent of the time and recommended a different prescription drug 25 percent of the time. 1


3ibid.

4ibid.


pharmacies on behalf of their members. Individual seniors without coverage, however, do not have this leverage and often pay full retail price for prescription drugs.

Prescription drug utilization by Medicare beneficiaries

Because utilization will have a major affect on how much is spent on prescriptions, estimating current and future use of prescription drugs presents a challenge for policy makers interested in providing prescription drug coverage for seniors.

Figure 6. Components of pharmaceutical spending increases, 1993–1999

Figure 7. Average annual prescription expenditures by Medicare beneficiaries with and without drug coverage, 1993–1998

Source: Centers for Medicare and Medicaid Services
In 1998, for instance, Medicare beneficiaries filled 26 percent more prescriptions than in 1993. At the same time, the average transaction price per prescription filled rose 29 percent. An examination of utilization by type of beneficiary—those who have some prescription drug coverage and those who do not—reveals a distinct difference in usage and costs. Seniors with prescription drug coverage filled 40 percent more than those without coverage, and used newer, more expensive drugs. “By 1998, beneficiaries with coverage spent 80% more than those without drug benefits,” stated Dr. Stuart.

Why do those with coverage spend more on prescriptions? An April 2000 HHS report suggested that Medicare beneficiaries with coverage spend more for several reasons:

- Beneficiaries who take a number of prescriptions or who expect to have higher usage in the future seek out coverage.
- Doctors may be inclined to write more prescriptions, or prescriptions for drugs that cost more, for those beneficiaries with coverage.
- Beneficiaries with coverage may request prescriptions more often or ask about new, more expensive treatments.
- Beneficiaries without coverage may not fill their prescriptions or may alter the dose so that the prescription lasts longer.

Out-of-pocket expenditures also increased during this time. From 1993 to 1998, spending by Medicare beneficiaries with prescription drug coverage increased by 35 percent, and 43 percent for those without. Seniors without coverage spent on average 70 percent more out of pocket than those seniors with coverage (Figure 8).

**State strategies to provide coverage to seniors**

Many states have responded to seniors’ need for drug coverage through a number of programs and strategies over the years. In the past two years, state action to establish or expand senior drug programs increased significantly. More than half of the states now have some form of senior drug assistance program.

States use different means to pay for these programs. Pennsylvania’s PACE program is funded through its lottery revenue. Some states, such as Nevada and Indiana, have used tobacco settlement funds to finance their new programs. Others have used general revenues, cigarette taxes or some combination of state and federal funds through the Medicaid program.

Outlined below are various models that states have used to provide assistance to seniors to purchase prescription drugs. (See Figure 9 for a listing of states with various types of programs.)

**State-administered drug coverage programs**

The oldest and most common type of drug assistance program, state-administered drug assistance programs generally provide broad coverage for prescription drugs. Enrollees may have some cost-sharing requirements, such as premiums, coinsurance, co-payments or deductibles, but most of the prescription drug costs are paid by the state.

For those states with the resources to establish and administer such programs, state-run programs are very popular because they resemble regular insurance. However, for many states, cost is a barrier to providing this type of pharmaceutical assistance. States must have good data of the number of seniors without drug coverage and their income levels as well as the pool of state resources available to assist seniors. Without careful plan-

*An important element in understanding the number of seniors with coverage is comparing those with stable and dependable coverage with those who have patched together coverage from many sources or have gaps in coverage for any period of time.*

**Source:** Medicare Current Beneficiary Survey, 1993–1998
Helping to control costs and improve outcomes

As states have experienced severe budget problems in recent months, drug benefits in Medicaid and pharmaceutical assistance programs have come under intense scrutiny. States are looking for ways to control costs while continuing to provide comprehensive benefits to the greatest number of seniors. The task is not easy.

One cost-containment strategy that state policymakers are examining is disease management (DM) for individuals with chronic illnesses. Other strategies focus on using existing resources more efficiently. Don Muse, a health care analyst who has spoken to many state officials, advises states to examine their claims and spending data to determine where savings can be achieved. From his analysis of spending by various state Medicaid programs, Muse has found that states can save money and improve care by focusing on:

- The chronically ill
- High cost cases, particularly in drug utilization
- Providers with quality and utilization problems.

Disease management

Providing treatment to individuals with chronic conditions is expensive. In 2000, the estimated 125 million individuals (roughly 44 percent of the population) suffering from one or more chronic diseases accounted for 75 percent of total health care spending in the United States. Systematically managing the symptoms and treatment of these illnesses offers a chance for controlling costs.

Disease management is defined as "a comprehensive, multi-disciplinary approach to healthcare delivery that seeks to manage and improve the health status of a defined patient population over the entire course of the disease." Disease management is based on the premise that coordinated care of chronic conditions such as diabetes, asthma, and congestive heart failure will not only result in fewer complications and improved health, but will help keep costs down. Disease management programs seek to closely monitor treatment for chronic disease, educate participating patients about their disease and ensure that patients receive care that follows the latest treatment guidelines. The result is to minimize preventable complications from chronic illness and thereby to lower the number of visits to the emergency room and days in the hospital.

Components of an effective disease management program include:

- General assessment of the population to decide which diseases should be targeted
- Identification of chronically ill individuals
- Case management of care that considers both the patient’s goals and his or her health status
- Use of face-to-face provider interactions, phone calls and web sites, printed education materials, self-monitoring programs, and more to improve health outcomes.

Discount programs

Another way that states have assisted seniors is to give them access to the same price discounts on prescription drugs that are available to those with drug coverage. Seniors still must pay out-of-pocket for their prescription medications, but these programs ensure that seniors pay a lower retail price.

There are several different ways to establish a discount program. California enacted S.B. 393 in 1999 to provide Medicare beneficiaries access to prescription drugs at the Medicaid price. California does not pay anything directly to participants. Instead, seniors pay Medicaid prices when they show their Medicare cards at pharmacies that participate in the state’s Medicaid program. Other states have established discount programs that have an application process and eligibility requirements just like traditional medical assistance programs. Other states issue discount cards to eligible seniors for use at retail pharmacies to receive drug discounts.

Medicaid Expansions

Another option to provide drug coverage to seniors is for states to expand their Medicaid programs to cover more seniors. This option has the advantage of using federal matching funds to enhance state resources. However, with traditional Medicaid expansions, states have had to apply for a Medicaid waiver and provide more than just pharmacy benefits to seniors they enroll. This added enrollment can increase state expenditures significantly, if more seniors end up using Medicaid for physician services, hospitalizations and long term care services.

The U.S. Department of Health and Human Services (HHS) recently announced plans for a Pharmacy Plus waiver that addresses these concerns. States approved under this special waiver could use federal matching funds to provide pharmacy and primary care services to seniors who make up to 200 percent of the Federal Poverty Level under their Medicaid program. States can use cost-sharing techniques, pharmaceutical benefits management and care coordination to contain the cost of the program. The main obstacle for states is the requirement that the program be budget neutral.

In January 2002, Illinois became the first state to use a waiver for pharmacy benefits for seniors with the approval of HHS. Illinois’ own pharmaceutical assistance program was limited to certain drugs for certain conditions and was funded entirely through state revenues. Through the waiver, Illinois is able to leverage its own
### Types of senior prescription drug assistance, Summer 2002

<table>
<thead>
<tr>
<th>Type of assistance</th>
<th>Description</th>
<th>States with programs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. State-administered Drug Coverage Program</strong></td>
<td>State administers a prescription drug insurance program for seniors; state program covers most of the cost for drugs with some cost sharing by enrollees (i.e., premiums, copayments, coinsurance or deductibles)</td>
<td>AZ, CT, DE, FL, IL, MA, MD, ME, MI, MN, MO, NJ, NY, NC, OR, PA, RI, SC, TX, VT, WI, WY</td>
</tr>
<tr>
<td><strong>2. Discount Programs</strong></td>
<td>Seniors receive a reduced retail price for prescription drugs but must pay remainder of the cost out-of-pocket</td>
<td>FL, HI, MD, ME, NM, OR, VT (see also states below)</td>
</tr>
<tr>
<td>a. Discount card</td>
<td>State issues a discount card that seniors use at participating pharmacies</td>
<td>NH, NM, OH, WA, WV</td>
</tr>
<tr>
<td>b. Purchasing cooperative</td>
<td>Program uses group purchasing to receive discounts on drugs</td>
<td>IA</td>
</tr>
<tr>
<td>c. Medicaid price to Medicare enrollees</td>
<td>Seniors enrolled in Medicare use their Medicare card at participating pharmacies to receive the discounted Medicaid price for drugs</td>
<td>CA</td>
</tr>
<tr>
<td><strong>3. Medicaid Drug Coverage Expansions</strong></td>
<td>States have extended Medicaid benefits to aged, blind, and disabled individuals with incomes up to 100% of the FPL; waivers subject to approval by the Centers for Medicare and Medicaid Services (CMS), allow states to expand services and receive matching federal funds.</td>
<td>DC, FL, HI, ME, MA, MI, MS, NE, NJ, PA, SC, UT</td>
</tr>
<tr>
<td>a. Special Medicaid 1115 waivers</td>
<td>Eligible seniors and other individuals can purchase prescription drugs at reduced Medicaid rates</td>
<td>ME, VT</td>
</tr>
<tr>
<td>b. Pharmacy Plus waiver</td>
<td>New federal program allows states with or without separate state drug assistance programs to expand drug coverage under Medicaid</td>
<td>FL, IL, MD, WI, SC (more states with legislation, federal approval pending)</td>
</tr>
<tr>
<td><strong>4. Subsidy for private insurance coverage</strong></td>
<td>State contracts with private company and pays some or all of premiums for drug coverage</td>
<td>MD, NV</td>
</tr>
<tr>
<td><strong>5. Refund/Reimbursement Program</strong></td>
<td>State provides cash refund for some out-of-pocket drug expenses incurred by eligible seniors</td>
<td>IN, KS</td>
</tr>
<tr>
<td><strong>6. Coordination of Manufacturer Pharmacy Assistance Programs</strong></td>
<td>State provides personnel to assist seniors with completing paperwork to apply for pharmaceutical manufacturers’ drug assistance programs</td>
<td>MA, MD, NH, OR, SD</td>
</tr>
<tr>
<td><strong>7. Tax credits</strong></td>
<td>State allows seniors to deduct a portion of drug expenses on state income tax forms</td>
<td>MO, MI</td>
</tr>
</tbody>
</table>

# = Program enacted but not operational; * = Program nullified by court action; ^ = Program since repealed/replaced by other drug assistance programs

Sources: CSG staff research, National Conference of State Legislatures, National Governors Association, and Jack Meyer, President, New Directions for Policy.
Helping to control costs and improve outcomes

continued from page 8

- Pharmacy counseling to assess compliance with drug treatment
- Referral to appropriate sources of financial, health care, and community assistance
- Reporting and evaluating program results.

Disease management may not work well with all chronically ill populations. Both patient and physician cooperation is essential, as is a health care delivery system that allows for integrated care and data collection. However, several states have already experimented with disease management programs and have seen significant savings.

The Virginia Department of Health established the Virginia Health Outcomes Partnership that targeted primary care physicians who treated Medicaid asthma patients. Virginia provided training on disease management and communication skills to doctors in selected areas. In two years, emergency room visits had declined among patients in the targeted areas and Virginia Medicaid had saved $3-5 for every dollar spent in providing disease management support.

Florida has launched a broader initiative that has included asthma, hemophilia, diabetes, AIDS, congestive and renal heart failure, hypertension, sickle cell anemia, and cancer. Florida’s Agency for Health Care Administration has contracted with DM vendors creatively to ensure savings. Companies are paid a flat fee but are also given incentives based on the degree of savings. Figures for the first few years of Florida’s DM programs show that the state’s investments have paid for themselves or produced modest savings. Because there is significant lag time between interventions aimed at chronic illness and the associated savings, it may be a few years before officials know for sure which programs save significant sums of money and which features improve care but only break even.

Al Lewis of the Disease Management Purchasing Consortium cautions policy makers to be wary of vendors who either promise the moon or who need extravagant sums up front to establish a disease management program. As with most new programs, states do have to invest some funds up front to get DM programs going. However, smart purchasers will write contracts that guarantee savings and as well as provide incentives to vendors.

In addition, not all populations are equal when it comes to disease management. Mr. Lewis advises states to focus DM on patients with the following characteristics:

- Stable with low turnover.
- Older and sicker.
- Less educated.
- Reachable.

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Subsidies for private coverage

Some analysts have argued that the best solution to the senior drug coverage problem is helping seniors afford coverage that is already available in the private market. Nevada became the first state to try this approach in 1999. Although the initial legislation was changed in 2001 due to implementation problems, the state has since contracted with a private firm and has enrolled more than 4,000 seniors. Through this program, eligible seniors receive a subsidy for up to 100 percent of the prescription drug coverage premium.

Refund Programs

Under a refund program, seniors must still go through an application process to determine eligibility for the program. Once enrolled, a senior must submit receipts or other documentation of pharmaceutical purchases to the state. After reviewing, the state issues a partial refund or reimbursement for costs incurred.

Tax credits

Another option to extend drug coverage to seniors is to offer tax credits to seniors for a portion of their pharmaceutical expenditures. Usually through the state income tax application, seniors submit documentation of their total expenditures and receive a tax credit for a portion of their prescription drug costs.

Coordination of manufacturer programs

Every pharmaceutical company has a program that assists those who cannot afford their medications. Usually patients must work with their doctors to submit a letter, an application or other documentation that provides evidence of both medical and financial need. The difficulty for low-income seniors is that they often take multiple medications from multiple manufacturers. Since each manufacturer has a different process for applying for pharmaceutical assistance, the process can be very complicated for those most in need. Some states, hampered by scarce resources, have designated funding for staff who can assist seniors with filling out paperwork and managing application cycles for manufacturer assistance programs.
Conclusion

While Medicare significantly improved the lives of the elderly in the United, its lack of a prescription drug benefit has left many seniors vulnerable. As access to coverage through Medicare HMOs and employer-sponsored coverage has declined, many states have risen to the challenge by instituting programs that offer seniors the prescription drug coverage that Medicare does not. Any solutions for providing access to prescription drugs for seniors in need will continue to be an expensive proposition due to the aging of the population and growth in use of prescription drugs. With serious budget problems in almost every state, the challenge now for states is to leverage existing resources to continue to provide assistance to the greatest number of seniors.

Endnotes

6 Ibid.

Trudi Mattheus is Chief Health Policy Analyst and Jenny Sewell is a Health Policy Analyst for CSG. Funding for this report provided by Wyeth Pharmaceuticals.

Helping to control costs and improve outcomes
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Focusing on cost and quality problems

In addition to improving care for the chronically ill, states may be able to hold down costs through targeted interventions to a few high-cost patients and providers.

Health care analysts have long recognized that the dual eligible population—seniors and the disabled enrolled in both Medicare and Medicaid—make up less than one-third of enrollees in Medicaid but are responsible for more than two-thirds of Medicaid expenditures. Moreover, within the dual eligible population, individuals within nursing homes are often the most expensive cases.

Some states have identified their highest cost enrollees within Medicaid and used intensive case management to identify areas for improvement in the efficiency and quality of care. Often, these cases are experiencing problems with effective management of disease, uncoordinated care, and unnecessary complications. Don Muse indicated that overutilization of drugs in nursing homes is particularly problematic. In one state Mr. Muse studied, more than 68 percent of nursing home residents received nine or more prescriptions, resulting in $83 million in expenditures. In the same state, more than 32 percent of nursing home residents received 20 or more prescriptions, resulting in $55 million in costs. While much of this spending is proper, abnormally high pharmacy costs may indicate some degree of inappropriate drug utilization or fraud. In addition, individuals taking more than nine medications have a much higher risk for drug interaction problems and may experience unnecessary and costly complications.

Another strategy that states may use to control costs according to Mr. Muse is to target quality problems among providers. States can examine data regarding complications, medical errors and readmissions to determine which hospitals, nursing homes or other facilities have the most problems. Once these facilities are identified, the state must examine the underlying causes for these problems, whether the facility treats more complicated, high-risk cases or whether there are issues of substandard quality of care.

Endnotes

2 “Overview: Disease Management.” New Directions for Policy.
3 Ibid.

Links to additional resources

- AARP—www.aarp.org
- PhRMA—www.phrma.org
- National Pharmaceutical Council—www.npcnow.org
- Agency for Healthcare Research and Quality—www.ahrq.gov
- Disease Management Association of America—www.dmaa.org
- Rx Health Value—www.rxhealthvalue.com
- Rx Assist—www.rxassist.org
The State Official’s Guide to Health Literacy provides:
- Summary of the issues: Who is affected and how?
- Access to key research and data: How does it affect your state?
- Overview of state policies and actions: What are states doing?
- Critical analysis by practitioners and CSG staff: How can states respond?
- Talking Points card for state officials on the go
- Key reference materials for additional information

Contact Jenny Sewell, Health Policy Analyst, at (859) 244-8154 for more information.