REPORT OF THE

HOUSE INTERIM COMMITTEE ON

ACCESS TO AFFORDABLE PRESCRIPTION

DRUGS FOR SENIOR CITIZENS

December 20, 2000

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I. APPOINTMENT OF THE INTERIM COMMITTEE

In October, 2000, the Speaker of the House established the House Interim Committee on Access to Affordable Prescription Drugs for Senior Citizens, and charged the committee with (1) evaluating the obstacles Missourians have in accessing affordable prescription drugs, particularly seniors, as well as other individuals who incur significant costs for prescription drugs; (2) searching for avenues to lower or eliminate those obstacles; and (3) making any recommendations for legislative action it deems appropriate. The Speaker appointed the following House Members to the Interim Committee:

Representative Mark Abel, Co-Chair
Representative Joan Barry, Co-Chair
Representative Sharon Brooks
Representative D.J. Davis
Representative Glenda Kelly
Representative Randall Relford
Representative May Scheve
Representative Quincy Troupe
Representative Rex Barnett
Representative John Griesheimer
Representative Ed Hartzler
Representative Ken Legan
Representative Beth Long
Representative Patrick Naeger
Representative Estel Robirds

The Interim Committee solicited testimony at the following four public hearings:

November 28, 2000	Springfield, Missouri
November 29, 2000	Kansas City, Missouri
December 5, 2000	St. Louis, Missouri
December 6, 2000	Jefferson City, Missouri

II. INTRODUCTION

Like the United States as a whole, Missouri's elderly population is increasing as a proportion of its total population. Data for 1998 from the U.S. Census Bureau and National Center for Health Statistics show that nearly 750,000 Missourians, approximately 14% of all state residents, are age 65 years or older; by the year 2020, the number in this age group is expected to exceed one million, comprising nearly 18 percent of all Missourians[1]. The income and health insurance coverage status of Missouri's seniors are important issues in examining access to affordable prescription drugs. Many older Missourians rely on limited fixed incomes, with estimates showing that nearly nine percent of Missourians age 65 and older fall at or below the federal poverty level (see Appendix A). And although most seniors in the United States have health insurance coverage through the federal Medicare program, this program does not cover the costs of out-patient drugs and prescription medications. Written documentation was provided to the Committee suggesting that among the 40 million seniors enrolled in the Medicare program, approximately 10 percent are classified as poor, and another seven percent as "near-poor"[2]. Estimates on the number of Medicare enrollees during the mid-1990s with supplemental health insurance covering drug costs range from 56 percent (see Endnote 2) to 69 percent[3] However, many of these supplemental policies restrict access to prescription drug coverage through high premiums (some of up to $3,200 per year), moderate to high copayments and deductibles, and annual caps on the total costs of prescriptions which are recoverable. This situation led a representative from the Pharmaceutical Research and Manufacturers of America (PhRMA) to testify that only about 35% of Medicare enrollees have "good" prescription drug coverage through their supplemental health insurance policies. Further, employer-sponsored health plans

which typically offer prescription drug benefits are declining as a form of insurance coverage for seniors; while 35 percent of seniors had such coverage in 1995, this proportion had fallen to 30 percent of seniors by 1998[4]. And, while the Medicaid program does provide comprehensive prescription drug benefits at no or minimal cost, nationwide nearly 60% of Medicare enrollees with incomes below the federal poverty level were not covered by Medicaid in 1997 (see Endnote 2).

Although nationwide elderly persons represent only about 13% of the total population, they account for approximately one-third of the expenditures on drugs. The increasing costs of prescription medications create particular hardships for senior citizens, many of whom rely on fixed incomes. The Committee received written and verbal testimony documenting the increasing costs of prescription medications. The National Conference of State Legislatures reports that the annual rate of increase in prescription drug expenditures has grown from 10.6 percent in 1995 to 17.4 percent in 1999. This rate of increase compares to an estimated increase of 5.3 percent in 1999 for all health spending, and is four times the rate of growth for hospital expenditures (see Endnote 2). State officials report that prescription drugs are the fastest growing component of the Medicaid budget, which is experiencing cost increases for prescription drugs of about 18 percent annually. Another source reports that drug expenditures in the United States more than doubled from $65 billion to $125 billion between 1995 and 1999[5]. Information was provided to the Committee that Medicare enrollees in 1999 spent an average of 19 percent of their income on health care costs, of which 17% was spent for prescription drugs (an average of $410 per enrollee per year). Approximately 85 percent of seniors use at least one prescription drug; among those

age 65-74, the average number of prescription medications per senior is over nine, and among those age 75 and above, the number of prescription medications averages over 11 per elderly individual (from testimony provided by PhRMA). Other testimony provided to the Committee suggests that those 65 of years and older on average use 18 prescription medications[6].

In summary, many seniors have limited or no access to prescription drug coverage through health insurance policies; as a result, these elderly individuals typically face out-of-pocket expenses that are difficult to afford. For at least some low-income elderly, or those with no or limited prescription drug benefits, difficult choices about where to spend limited financial resources may result in not filling the prescriptions needed to treat acute and chronic health conditions or in not taking their medications as prescribed. This situation is of interest from both a humanitarian and public policy perspective, as foregoing needed medications can result in higher societal health-related costs through hospitalizations, costly medical procedures, and nursing home institutionalizations that may be avoided or at least postponed through the proper use of prescribed medications. A representative of the American Association of Retired Persons (AARP) noted that:

> "In many cases, new drugs substitute for or allow patients to avoid more expensive therapies such as hospitalization and surgery. In other cases, drugs facilitate treatment or provide treatment where none existed before, improving the quality and length of life for the patient. As a result, prudent reliance on prescription drugs now goes to the very core of good medical practice."

III. WHY DRUG EXPENDITURES ARE INCREASING

Information about the reasons for the increasing costs of drugs and increasing expenditures on drugs was presented to the Committee. Chief among these appears to be the increased use of prescription medications, as new and more effective medicines are developed, especially treatments for chronic conditions (such as hypertension) that afflict many senior citizens. A Professor in the University of Missouri-Kansas City School of Pharmacy testified that nationwide 1.4 billion medications were prescribed in 1990; this number had grown dramatically by 1999, during which over 3 billion prescriptions were prescribed. Many new drugs available today were not available when the Medicare program was established, and these drugs are expensive to develop and market. Many seniors switch to newer, more expensive medications from older, less costly drugs, because the newer medications often offer distinct advantages or, in some cases, due to patient demand stimulated by the mass market advertising of a particular medication (One physician testified that patients are increasingly requesting particular name brand drugs they have seen advertised, and that the 25 most heavily promoted drugs accounted for 40 percent of the increase in retail drug spending in 1999[7]). The Pharmaceutical Research and Manufacturers of America reports that the time needed to discover and develop a new medication ranges from 12-15 years, and typically costs $500 million per new medicine. The PhRMA reports that only 30 percent of all drugs available generate sufficient revenues to cover or exceed the research and development costs associated with their availability. While costly, innovation in new medications is adding years to life expectancy, and reducing disability rates and death rates from heart disease, cancer, and other diseases among the elderly.

A final reason presented to the Committee for increasing drug expenditures is that the prices of drugs are increasing, although there is not agreement on how much drug price increases contribute to the overall increasing drug expenditures rate. The PhRMA contends that drug prices are comparatively insignificant, as indicated by the rate of inflation in drug prices in 1999 of only 4.2 percent. Others contend that drug prices do significantly contribute to the increasing expenditures on medications, given that patents and patent extensions often insulate drug companies from competition from less costly generic drugs. In addition, drug makers are forced to discount drug prices in international markets where government price controls are common. This means that "there's cost-shifting, where American consumers pay more because people overseas pay less" and, similarly, that "...the pharmaceutical industry has to earn most of its profits in the United States, the only major country where drug prices remain unrestricted"[8]. The importance of drug prices in contributing to the high and increasing rate of expenditures on drugs may also be evidenced by drug industry profits that

> "...surpass almost every other major economic sector. In its annual ranking of America' most profitable industries, Fortune magazine placed the pharmaceutical industry at the top in all three categories - return on revenues, return on assets and return on shareholders' equity - for 1999."[9]

IV. PRESCRIPTION DRUG ASSISTANCE PROGRAMS IN OTHER STATES

As of August, 2000, 22 states have passed some type of pharmaceutical assistance. Some states have expanded their Medicaid programs to provide coverage for additional groups, including low-income seniors; some states are making available Medicaid-type rebates or discount rates for retail drug prices for certain groups, including the elderly; and some states have instituted state price

controls on certain types of drug purchases. The pharmaceutical assistance programs enacted by the following states represent the variety of prescription drug assistance states are providing to their senior residents:

California - The state program prohibits pharmacies participating in the state Medicaid program from charging Medicare beneficiaries more for their prescription drugs than the Medicaid reimbursement rate plus a processing fee.

Maine - The state established the Maine Rx Program, under which the state functions as a pharmacy benefit manager; the state is authorized to decrease prescription drug prices through purchasing alliances and other regional strategies; the state prohibits profiteering among manufacturers, distributors and labelers of prescription drugs; and the state authorized maximum retail prices effective 7/1/03 for certain drugs.

Massachusetts - A state bulk purchasing program is created to include Senior Pharmacy Assistance enrollees, Medicare and Medicaid recipients, state workers, and underinsured and uninsured persons; a Pharmacy Outreach Program is established to assist residents in obtaining free or low-cost medications from pharmaceutical companies; the state revised its Catastrophic Prescription Drug Insurance Program for all elders 65 years of age and older, with sliding scale deductibles and copayments, but no maximum income limit. Persons with incomes of up to 188 percent of the federal poverty level have no premiums or deductibles.

Minnesota - The state established prescription drug benefits for residents 65 years of age and older with incomes at or below 120 percent of the federal poverty level with certain assets limits; payment of a monthly $35 deductible is required for program participation.

Pennsylvania - The state established PACE and PACENET for low-income and moderate-income elderly with minimal copayments and deductibles (PACENET assists seniors with higher annual incomes and requires satisfying an annual $500 deductible); both programs require generic substitution unless such a substitution is contra-indicated.

Washington - An executive order was issued to establish a bulk purchasing plan (dovetailed with the state's medical plan) for prescription drugs for seniors 55 years of age and older; an annual fee of $15 per individual and $25 per family is required to join what amounts to a buyers' club.

V. ISSUES AND RECOMMENDATIONS PRESENTED TO THE COMMITTEE

The Committee received information about the following issues and recommendations through both written and verbal testimony provided at the four public hearings:

Medicaid Spenddown Program - Perhaps the issue of most interest to the majority of persons who testified is the Medicaid spenddown program. Spenddown allows persons who are age 65 years or older, blind or disabled with incomes above the Medical Assistance limit to qualify for Medicaid. The income limit is the Supplemental Security Income (SSI) monthly maximum, currently set at $512 per individual and $769 per couple. Persons with incomes above the SSI limits must "spenddown" to that level (that is, they must present documentation that they have incurred allowable medical expenses totaling or exceeding the amount that their income exceeds the SSI limit) before they become eligible for Medicaid benefits. Once they are determined eligible for Medicaid, comprehensive prescription drug coverage is available. Spenddown eligibility is determined for a three month period on a quarterly basis, and must be re-established

on a quarterly basis.

A number of persons testified that the low SSI income limit on which spenddown eligibility is based presents a hardship for those with limited incomes, since it requires they incur high out-of-pocket expenses before receiving any assistance. Of even more concern to those testifying on this issue is the recent rule change implemented by the Department of Social Services, which allows prescription drug expenses to be counted towards spenddown only on a 31 day basis (rather than on a three month prescription drug expense basis as was the case prior to 12/1/00). Participating pharmacists are not allowed to submit the expense of a 90 day supply of a prescription for spenddown purposes but only the expense of a 31 day supply. This means that it takes longer and is more difficult for persons with incomes above the SSI limit to qualify for Medicaid benefits through the spenddown program. The Committee heard considerable testimony from elderly and disabled individuals with low to moderate incomes and who have significant prescription drug expenses about the financial hardships this rule change is creating. Department of Social Services officials testified that this rule change was made in response to recommendations and written directives from the legislature to implement Medicaid and pharmaceutical-related cost containment measures, including implementing the so-called "31 Day Maximum Supply Limit". According to these officials, the rule change on the 31 day drug expense will save the Medicaid program an estimated $1.7 million.

Finally, some witnesses testified about the abuses in and manipulation of the spenddown program that results primarily because qualifying for the spenddown program is based on incurring

medical expenses rather than actually paying for medical expenses.

Pharmaceutical Usage Practices - Several persons testified about some practices relating to the administration and usage of prescription drugs which waste public funds or at least are not prudent practices from a financial standpoint. These include not allowing patients access to certain cancer fighting medications except through their administration in a hospital or clinical setting. This requirement, it was argued, is not medically necessary and adds considerably to the health care costs for those patients who need one or more of these life-saving medications. Another issue involves lost, stolen or sold Medicaid prescriptions, which one pharmacist testified are refilled at no cost. This adds unknown but probably considerable costs to the Medicaid budget. A third issue involves individuals who are eligible for multiple public assistance programs, and for whom the expense of their medications is sometimes "double billed" to the various programs; there is not currently in place a state oversight practice to monitor Medicaid prescription billings by pharmacies and other health providers, and double-billing practices. Related to the issue of the need for oversight on billing practices is the issue of overseeing prescription drug usage of individuals, in particular the usage among nursing home residents and the elderly population in general. Without such oversight, some individuals may be taking expensive brand name drugs when less costly generic equivalents could be substituted; still others may have considerable quantities of unused medications which, due to death or change in health status, are no longer needed and could perhaps be reissued under certain conditions to those needing the same prescription medication.

Pharmaceutical Company Prescription Drug Assistance Programs - Information was provided about the pharmacy assistance programs that some drug manufacturers have in place to assist individuals in obtaining needed medications. While each company has different eligibility requirements and application processes, typically the assistance requires a referral through the patient's physician and some form of documentation of financial need; if approved for participation, the assistance programs provide the covered medications at no or reduced costs to the patients. The PhRMA reports that in 1999, more than 40,000 Missourians received free or reduced price drugs through these pharmaceutical company assistance programs. Several barriers to using these programs were identified including: (1) not all physicians are aware of the programs and so their patients are not able to participate; (2) some physicians refuse to participate largely because of the time demands created by paperwork; (3) only medications without a generic alternative are usually available; and (4) some patients are discouraged from participating in these program because of restrictions on the supply of prescriptions (often only one month's supply of a medication is available).

Facilitate Use of Generic Equivalents - Because generic equivalents for brand name medications are typically one-half the cost of brand drugs, facilitating the use of generics would result in considerable costs savings both to patients and publicly funded prescription benefit programs. The Committee was urged to encourage and even mandate the use of generic equivalents, even though pharmaceutical industry opposition to such efforts would likely be significant. Many people are not aware, the Committee was told, of the stringent standards established by the Food

and Drug Administration which must be met before a drug is certified as a generic equivalent. Similarly, many patients are not aware of the availability of generic equivalents or have been discouraged from requesting them because of erroneous information about their effectiveness or safety. Testimony was provided that generic drugs are often the "savior" of some patients because these drugs usually are affordable. Finally, other practices which impede the availability of generic equivalents, such as the ability of drug companies to litigate for patent exclusivity extensions, which thereby affords an additional 30 months of protection from generic competition, and the illegal practice of brand drug companies paying generic drug companies not to market a given drug, should be eliminated through changes in or stiffer penalties for noncompliance with existing laws.

Expand the Role of Pharmacists - Several persons testified that because many individuals seek medical attention from a number of physicians and providers but typically fill their prescriptions at the same pharmacy, this puts the community pharmacist in an advantageous position with respect to reviewing all of the medications a given patient is taking. Such a review would allow the pharmacist to determine whether a less expensive alternative medication is available and to make recommendations to physicians about the possible negative side effects from the interactions of the various medications patients may be taking.

Missouri's $200 Pharmaceutical Tax Credit - In 1999, legislation was passed which authorizes a $200 tax credit for unreimbursable pharmaceutical expenses for Missouri residents age 65 years or older. There is a limit of $15,000 in adjusted gross income in order to qualify for the full tax

credit; however, individuals with incomes of up to $25,000 may receive a partial tax credit. The tax credit is refundable (any amount of the credit above the resident's tax liability is refunded), and is effective from January 1, 1999 through December 31, 2004. Although originally estimated to cost $20 million per year, the tax credit program has costs through the first ten months of 2000 of over $82 million. Over 449,000 tax credits have been issued thus far.

Other Issues and Recommendations - Several other issues were brought to the Committee's attention, including recommendations to:

- Expand Medicare such that prescription drug benefits are available to enrollees;
- Expand Medicaid to allow additional senior citizens to qualify for the program's comprehensive health insurance benefits, including prescription drug coverage;
- Subsidize private health insurance premiums so that elderly persons are able to obtain prescription drug coverage;
- Avoid the establishment of price controls on prescription medications;
- Establish a separate state prescription assistance program for seniors and the disabled;
- Establish a state prescription benefit in conjunction with the Medicare program; and
- Seek federal block grants to allow the state to establish a state administered prescription drug benefit program for seniors.

VI. CONCLUSIONS AND RECOMMENDATIONS OF THE COMMITTEE

The Committee recognizes that the need for public assistance to seniors with the costs of prescription medications is imperative. The drain on the state's Medicaid budget from pharmaceutical expenditures is reaching crisis proportions, and many elderly residents are struggling to afford the medications that add years and quality to their lives. Seniors who do without needed medications or in the dosages prescribed because of the costs often face expensive hospitalizations, costly medical procedures, or institutionalization. The Committee also recognizes that there are limited financial resources available to the state, and projections for revenue surpluses by which to fund comprehensive prescription drug assistance programs are not promising. With these realities in mind, the House Interim Committee on Access to Affordable Prescription Drugs for Senior Citizens makes the following recommendations:

1. Request that the Department of Social Services immediately suspend the administrative rule recently implemented which limits prescription drug expenses for the purposes of qualifying for the Medicaid spenddown program to the expenses of a 31 day supply, until there is a full review of the implications of such a policy through comprehensive hearings during the 2001 legislative session (Note: Officials from the Division of Medical Services report that this policy was suspended in mid-December, 2000, after the Committee developed its recommendations but prior to the issuance of this report);

2. Target any state prescription drug assistance efforts to the neediest of our elderly residents, and incrementally phase-in seniors with higher incomes and those with a demonstrated need for assistance with their prescription medication expenses in to any state program that is developed;

3. If federal efforts to expand Medicare coverage to include prescription drug benefits are not developed, pursue efforts to obtain federal block grant funds to allow the states to develop within broad federal guidelines their own prescription drug benefit programs for seniors;

4. Consider the benefits of pursuing a Medicaid waiver which would allow the state to qualify additional numbers of elderly for prescription drug benefits; such an expansion should consider the feasibility of allowing seniors with incomes of up to 150% of the federal poverty level to qualify for Medicaid covering only prescription medications and requiring at least minimal copayments;

5. Institute changes in the state oversight of nursing homes such that there is comprehensive, effective monitoring of prescription drug usage in state licensed nursing homes;

6. Consider strategies the state can adopt which will encourage the availability, marketing and usage of generic drug equivalents;

7. Encourage discussions with health care providers (including pharmacists), policy makers, advocacy groups, and senior citizens about the feasibility of expanding the scope of practice for pharmacists to include reviewing patients' prescription medication usage and making recommendations to physicians and seniors about less costly generic equivalents and possible negative interactions from the usage of multiple prescribed medications;

8. Formalize a review of pharmaceutical use practices with regards to (a) the methods of filling and dispensing medications for lost or stolen Medicaid prescriptions, and (b) billing practices for medications paid for by publicly funded programs;

9. Consider the feasibility of authorizing and compensating community pharmacists for conducting utilization reviews of Medicaid prescription drug usage, as an alternative to

funding a Pharmacy Benefit Manager through the Medicaid program, as proposed by the Division of Medical Services;

10. Develop simplified methods for assisting seniors and those with high prescription medication needs in accessing prescription drug assistance programs; and

11. Eliminate or revise the existing $200 pharmaceutical tax credit, so that the neediest seniors with demonstrated need for assistance with the costs of their prescription medications benefit. Cost savings from a revision in the program may allow the amount of the annual tax credit to be increased from $200 to perhaps as much as $500 per qualifying senior. If eliminated, the costs of the program (the state has expended over $82 million during the first 10 months of this year) could be redirected to fund a meaningful prescription drug benefit program for seniors in the state.

Endnotes

1. See Appendix A.

2. "Inadequate Prescription-Drug Coverage for Medicare Enrollees - A Call to Action", The New England Journal of Medicine, March 4, 1999 (Volume 340, Number 9).

3. "Medicare Beneficiaries and Drug Coverage", Health Affairs, March/April, 2000 (Volume 19, Number 2).

4. Testimony provided by Dr. Steven Zweig, a copy of which may be found in Appendix B.

5. David Noonan, "Why Drugs Cost So Much", Newsweek, September 25, 2000.

6. See Appendix B.

7. See Appendix B.

8. Noonan, p. 26.

9. Noonan, p. 29.

Appendix A: Population Data for Missouri

Missouri Department of Social Services
Division of Aging

- In 1990 the 65 and older population accounted for 14% of Missouri's total population; by the year 2020, this percentage is projected to jump to 18%.

Year	Total Population	65 & Older Population	% of Total Population
1990	5,117,073	715,508	14.0%
1995	5,232,217	735,897	14.1%
2000	5,329,656	743,350	14.0%
2005	5,420,086	760,029	14.0%
2010	5,508,989	808,159	14.7%
2015	5,597,806	900,568	16.1%
2020	5,680,974	1,018,356	17.9%

Source: 1990 Census; Missouri Office of Administration. May 1994 (Scenario R)

- From April 1990 to April 1995, the number of monthly Medicaid nursing home residents increased by over 5,000 persons, or by 25%.

- Assuming the number of nursing home residents will maintain the 1990 to 1995 trend as a percent of the 65 and older population, the number of monthly Medicaid nursing home residents is projected to increase to over 71,000 persons by the year 2020.

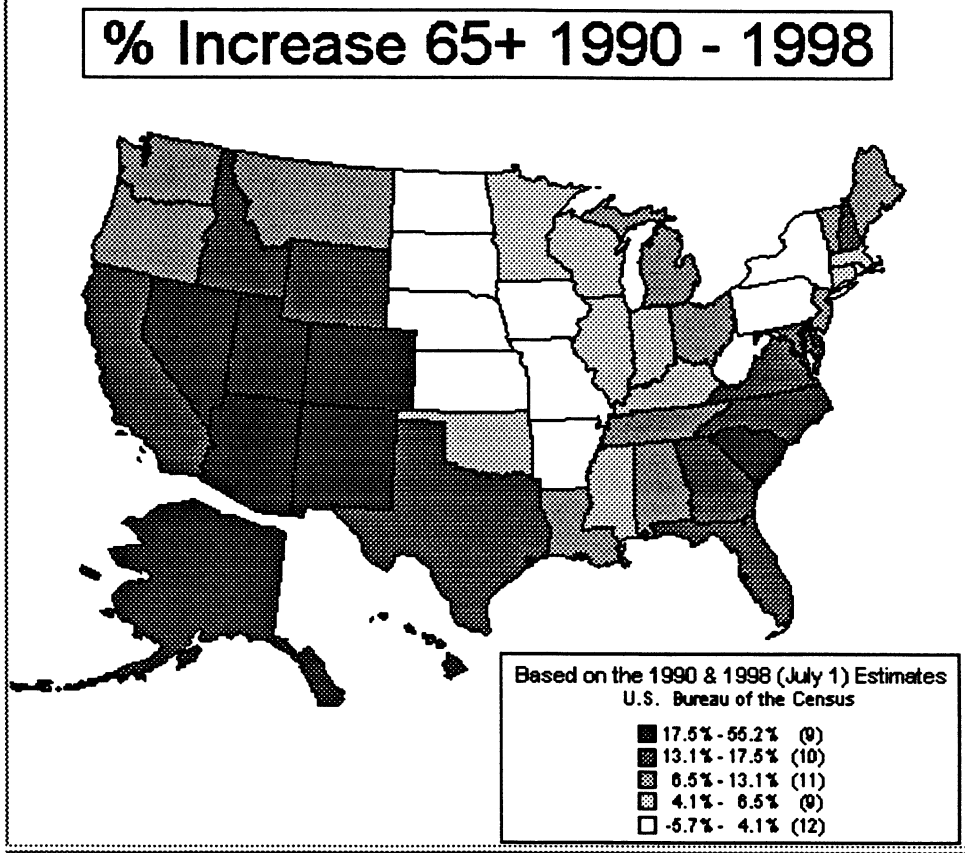
- In April 1990, the number of Medicaid nursing home residents accounted for 3% of the 65 and older population; that percentage is projected to grow to 7% by the year 2020.

Year	Projected Monthly Medicaid Nursing Home Residents	Percent of 65 & Older Population
1990*	21,799	3.1%
1995*	27,280	3.7%
2000	32,553	4.4%
2005	38,213	5.0%
2010	45,970	5.7%
2015	57,174	6.4%
2020	71,377	7.0%

*Actual resident counts from Monthly Management Report, April 1990 & April 1995

R&E/rjv
12/7/95

Figure 5: Percentage Increase in Population 65+ -- 1990 to 1998



Based on Data from the U.S. Bureau of the Census
See: http://www.census.gov/population/estimates/state/5age9890.txt

(top)

Figure 6: The 65+ Population by State: 1998

State Number of Persons	Number	Percent of all Ages	% Increase 1990-1998	Percent below poverty level 1995-1997***
U.S. Total	**34,401,132**	**12.7%**	**10.1%**	**10.6%**
Alabama	568,352	13.1%	9.0%	12.9%
Alaska	33,556	5.5%	49.4%	5.3%
Arizona	617,538	13.2%	28.5%	10.3%
Arkansas	363,232	14.3%	3.9%	17.1%
California	3,614,632	11.1%	15.3%	8.4%
Colorado	401,784	10.1%	21.4%	7.4%
Connecticut	469,112	14.3%	5.3%	5.7%
Delaware	96,326	13.0%	19.2%	9.2%

District of Columbia	72,710	13.9%	-5.7%	20.6%
Florida	2,734,145	18.3%	15.2%	10.4%
Georgia	755,092	9.9%	15.4%	14.0%
Hawaii	158,306	13.3%	26.6%	9.3%
Idaho	139,126	11.3%	14.4%	8.6%
Illinois	1,495,969	12.4%	4.3%	9.0%
Indiana	739,587	12.5%	6.1%	7.0%
Iowa	431,018	15.1%	1.0%	7.4%
Kansas	354,113	13.5%	3.3%	9.8%
Kentucky	492,856	12.5%	5.7%	12.6%
Louisiana	503,750	11.5%	7.5%	16.3%
Maine	174,832	14.1%	7.0%	11.8%
Maryland	591,545	11.5%	14.2%	8.9%
Massachusetts	860,604	14.0%	5.3%	9.7%
Michigan	1,223,040	12.5%	10.2%	8.5%
Minnesota	583,097	12.3%	6.4%	9.8%
Mississippi	336,311	12.2%	5.1%	16.6%
Missouri	745,387	13.7%	3.9%	8.8%
Montana	117,038	13.3%	9.8%	9.7%
Nebraska	228,735	13.8%	2.5%	10.8%
Nevada	200,335	11.5%	55.1%	8.0%
New Hampshire	142,298	12.0%	13.6%	7.7%
New Jersey	1,105,816	13.6%	7.3%	9.9%
New Mexico	198,038	11.4%	21.3%	15.7%
New York	2,423,797	13.3%	3.3%	12.4%
North Carolina	946,753	12.5%	17.5%	12.5%
North Dakota	91,976	14.4%	1.0%	10.4%
Ohio	1,500,851	13.4%	6.5%	8.9%
Oklahoma	448,388	13.4%	5.7%	12.7%
Oregon	432,718	13.2%	10.3%	6.0%
Pennsylvania	1,904,312	15.9%	4.1%	9.9%
Rhode Island	154,327	15.6%	2.7%	12.9%
South Carolina	468,406	12.2%	18.1%	15.6%
South Dakota	105,742	14.3%	3.3%	12.2%
Tennessee	679,212	12.5%	9.7%	13.7%
Texas	1,999,751	10.1%	16.3%	15.8%
Utah	184,098	8.8%	22.1%	4.8%
Vermont	72,573	12.3%	9.7%	8.7%

Virginia	766,976	11.3%	15.2%	11.3%
Washington	651,970	11.5%	13.1%	7.3%
West Virginia	274,689	15.2%	2.3%	13.9%
Wisconsin	690,786	13.2%	5.9%	7.4%
Wyoming	55,527	11.5%	17.4%	10.1%

Source: Population Estimates Program, Population Division, U.S. Bureau of the Census, Washington, DC 20233

See: http://www.census.gov/population/www/estimates/state/98ageby5.txt

Tables compiled by the U.S. Administration on Aging

*** ***Based on Current Population Surveys***

Appendix B: Testimony from Dr. Steven Zweig

Comments before the Interim Committee on Prescription Drugs, December 6, 2000

Steven Zweig, MD, MSPH
Professor and Associate Chair
Department of Family and Community Medicine
University of Missouri-Columbia, School of Medicine

FACTS

1. Medicare is a health insurance program available to virtually every US senior.
    - -Part A is free and covers hospital care limited skilled nursing stays, and specific home health services.
    - -Part B costs $45.50/month and covers professional services with accompanying copays and deductible charges.

2. Medicare does not cover outpatient prescription and over the counter drugs. Privately purchased Medigap policies are expensive costing an additional $300-$500/year or more with an annual $250 deductible, 50% copayment, and an annual benefit cap of $1250 or $3000.

3. Spending on prescription drugs is increasing at a rate far exceeding professional and hospital spending. Between 1990 and 1998, hospital and physician spending increased 57% and 50% respectively and prescription drug spending increased 140% (Health Care Financing Administration data quoted in *USA Today*, 9/28/2000).

4. The 25 most heavily promoted drugs accounted for 40% of the increase in retail drug spending in 1999. Physicians are much more likely to prescribe these heavily promoted drugs (34% more vs. 5% more for all other drugs) (National Institute for Health Care Management data quoted in *USA Today*, 9/28/2000).

5. 86% of Medicare beneficiaries filled at least one prescription in 1995 (*Health Care Financing Review* 1999[Spring]:15-27). Each person fills an average of 18 prescriptions/year. While the average total cost is $1343, the average person with coronary artery disease, high cholesterol, and Type 2 diabetes spends over $3000/year (*Health Affairs* 2000;19:198-211).

6. 65% of Medicare beneficiaries (those not in nursing homes) have some form of insurance coverage for prescription drugs. Of those with coverage:
    - 60% have supplemental plans

  - 47% are employer sponsored
  - 13% are privately purchased Medigap policies
- 20% are members of Medicare HMOs
- 20% are covered by public programs
  - Medicaid 17%
  - Other – VA, Department of Defense, state assistance 3%

  (*Health Affairs* 1999 [Jan-Feb]:213-243)

7. Those without coverage are more likely to have lower incomes (<200% poverty), to be of fair or poor health status, and to be older than 75 years (AARP PPI analysis using Medicare Benefits Simulation Model 1999).

8. Out of pocket spending is great for those without coverage (mean $590 vs. $320/year). [*A Medicare Prescription Drug Benefit*, Medicare Brief #1, National Academy of Social Insurance, April 1999]. Those with privately purchased Medigap policies have the highest out of pocket costs (mean $570/year). Even those with Medicaid for a portion of the year or QMB supplement have high out of pocket costs ($380 and $205/year). Those with employer sponsored plans have high costs ($320/year), but they also have the highest total drug spending.

9. Employer sponsored plans are declining, 35% of seniors in 1995, only 30% in 1998 (*Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 1998: Report of Survey Findings*, p.38).

10. Medigap policies may only be available to those enrolled less than 6 months in Medicare. High prescription drugs users are more likely to disenroll from Medicare HMOs and may not then qualify for their former Medigap plans leaving them with no insurance for prescription drugs (*JAMA* 2000;283:2163-2167).

11. Many poor people do not receive Medicaid benefits. In 1999, an estimated 45% of noninstitutionalized Medicare beneficiaries with incomes below the federal poverty level received no Medicaid assistance (*Issue Brief* no. 39, AARP).

IMPERFECT SOLUTIONS

1. Indigent Drug Programs

I care for an 81 year old retired journalist who by virtue of a good break on his rent lives in a small apartment at Tiger Columns in Columbia. He has Parkinson disease and is increasingly frail. He cannot afford

prescription drug coverage and does not qualify for Medicaid. We have arranged to get his Sinemet from the maker through an indigent drug program. After substantial initial paperwork, every 3 months, we reenroll him in this plan and they send the drugs to me, which I give to him. This past week I received a letter from the company telling me this drug would no longer be available under the plan. While my patients and I appreciate these programs they have several problems:

- Each company has a different application process, requesting different information, and different income levels to qualify.
- Most chronically ill elderly take more than one drug.
- Physicians and patients may not know about these plans or do the work required to apply for them.
- Only drugs without generic alternative are usually available
- Plans can be terminated at any time.

At University Hospital, we have had a program staffed by a social worker to help patients enroll in these plan and to get needed medications. This is a very time consuming process and is not reimbursed. (The best website for such information with phone numbers, addresses and eligibility information for drug companies producing over 900 medications is: www.needymeds.com)

My patient my soon be faced with paying his rent or getting his life-saving medications. Without his medications he will literally freeze-up due to his disease, he will fall, and may suffer serious injury. His only solution may be to enter a nursing home, soon qualify for Medicaid and thereby receive his medications, but at a substantial cost to the Medicaid program (over $3000/month).

2. Cobbled together plans – discontinuity and injury

My 83-year-old father in law has congestive heart failure, coronary artery disease, type 2 diabetes, and treated prostate cancer – fulfilling many of the characteristics of a typical World War II veteran. He has a good doctor in this city and has supplemental insurance of a retired state employee that does not cover prescription drugs. While he does not qualify for full VA health benefits because his income is too great, he makes periodic visits to a VA physician to get some of his prescriptions filled. After weeks of abdominal pain and weight loss, we discovered that his VA doctor had put him on an arthritis drug that his regular doctor did not know about. This drug had caused an ulcer contributing to his current problems. This discontinuity of care precipitated by efforts to get discounted prescriptions caused significant injury.

3. Use of drug samples

Appendix C: List of Witnesses