HEALTH POLICY MEMO

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# Prescription Drug Cost-Sharing and Low-Income People: Five Good Reasons to Keep It Minimal

Prescription drugs aren't the only health care expenses that people on Medicare have to bear. Most have many health care expenses, besides prescription drugs, that Medicare doesn't cover. These costs are a particular hardship on the nearly one-third of those in Medicare who have incomes below 160 percent of the federal poverty level. And these costs won't disappear if a drug benefit is enacted. That's why any compromise bill should not raise coinsurance or copayment rates above levels in the current Senate or House bills and, like the Senate bill, **should have no gap in coverage for those with low incomes**.

There are many reasons why increasing cost-sharing for low-income beneficiaries isn't a good way to find savings when crafting a drug benefit. Here are five.

**1** **Drug costs aren't low-income beneficiaries' only health expenses.** A Medicare drug benefit will provide needed coverage for an essential component of health care and will thus give some financial protection to those in Medicare. However, it will not relieve Medicare beneficiaries of other out-of-pocket health care costs—costs that can be overwhelming. They will still have to pay for Medicare premiums, deductibles, and copayments; services Medicare excludes (from eyeglasses and dental care to very expensive services like long-term care and custodial care); and insurance to help cover items Medicare doesn't. In fact, ***excluding*** prescription drugs, the 87 percent of beneficiaries in fee-for-service Medicare are projected to spend an average of $2,087 out-of-pocket on health care in 2003.[1] At that spending level, ***even with 100 percent drug coverage***, an individual with an income of $12,123 (135 percent of poverty) could still expect to spend 17 percent of his or her income on health care.

**2** **Cost-sharing places a disproportionate burden on low-income people.** For those with low incomes, meeting basic living expenses is an enormous challenge. Below is an annual budget developed using the Department of Labor's consumer expenditures for individuals over 65, HUD's fair market rent schedule, and public transit costs for a large urban area.[2] (Items like clothes, insurance, a car, or any entertainment—things most of us consider essential—are excluded.). For those with incomes of $12,123 (135 percent of poverty), these essential expenses can consume $2,160 more than their annual incomes; add in health care costs, not including prescription drugs, and they are $4,247 in the hole. For those with $14,368 in income (160 percent of poverty) this bare-minimum budget plus health care costs requires $2,002 more than their income. Low-income seniors and people with disabilities have to make tough choices—choices between food, housing, transportation, and health care—just to get by. The difference between paying $2 or $5 or $10 for a prescription can mean the difference between filling a prescription or not. Cost-sharing for prescription drugs is one more burden, one more tough choice to make.

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## Projected Budget

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|---|---|
| Fair market rent plus utilities, 2-bedroom apartment, urban area | $ 9,492 |
| Food (pprepared at home) | $ 2,557 |
| Public services (less electric), phone, other household operations | $ 1,454 |
| Public transportation | $ 780 |
| Minimal annual budget, non-health care expenditures | **$ 14,283** |
| Health care, ***excluding prescription drugs*** | $ 2,087 |
| Minimal annual budget, ***excluding prescription drugs*** | **$ 16,370** |

**3** **Cost-sharing diminishes access to medications.** Because of the heavy burden it places on those with low incomes, even minimal cost-sharing can reduce the ability to purchase needed medicines. This has been demonstrated among Medicaid beneficiaries, a group that generally has good drug coverage and lower than average out-of-pocket health care costs. In a national survey, 26 percent of Medicaid beneficiaries reported that they could not afford medications because of copayments.[3] Imposition of even a $0.50 drug copayment in South Carolina resulted in an 11 percent decline in drug use, including a decline in the use of drugs for life-threatening or hard-to-manage medical conditions.[4] And a 2001 study found that, for the poor and elderly, cost-sharing led to a reduction in the use of essential drugs—drugs that either prolong life or prevent deterioration of health.[5]

**4** **Reduced access to medications results in poorer health outcomes.** Not surprisingly, reduced access to medication can lead to poorer health outcomes. One study found that a reduction in the use of essential medicines—following an increase in patient cost-sharing—resulted in an increase in emergency room visits and hospital and nursing home admissions.[6]

**5** **Poorer health outcomes for low-income people are bad for everyone.** Poorer health outcomes and increased use of emergency rooms, hospitals, and long-term care facilities—these all cost society money: Higher use of expensive services, an increased strain on the health care system, a heavier burden on caregivers. If a drug benefit imposes such onerous cost-sharing on the low-income in Medicare that they cannot afford the drugs they need, Congress may miss an opportunity to reduce Medicare and Medicaid spending on other services. They may miss an opportunity to improve the health status of the low-income elderly and people with disabilities. And they will certainly miss the opportunity to give low-income Medicare beneficiaries a meaningful drug benefit.

It is critical to keep cost-sharing to a minimum for low-income individuals if a Medicare drug benefit is truly to reach the one-in-three Medicare beneficiaries in such great need of assistance. The low-income subsidy should not be whittled away by increasing the financial burden on those who can afford it least.

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[1] MedPAC reported average out-of-pocket spending in 2000 was $2,496. Using historic MedPAC data, data on beneficiary drug spending, and data on beneficiary average out-of-pocket increases, Families USA projected average out-of-pocket spending and average prescription drug spending for 2003. MedPAC, *Healthcare Spending and the Medicare Program* (Washington: MedPAC, June 2003).

[2] Sources for expenditure data are the Department of Housing and Urban Development (HUD), *2003 Fair Market Rents*; Department of Labor, *Consumer Expenditure Survey 2000-2001,* average annual expenditures for selected items for individuals over 65, available online at (http://www.bls.gov/cex/2001/CrossTabs/agebyinc/x65orup.PDF); and costs for public transit in Chicago, assuming two trips per day, five days a week.

[3] Judy Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations* (Washington: Kaiser Commission on Medicaid and the Uninsured, March 2003).

[4] Ibid.

[5] Ibid.

[6] Congressional Budget Office, *Issues in Designing a Prescription Drug Benefit for Medicare* (Washington: October 2002).