



Health Services 100

Lab 6

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May 9, 2003

Agenda

- Medicare
 - Medicaid
 - Pharmaceuticals
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- Medicare
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Medicare

- Approximately 40 million beneficiaries
 - Over 65, disabled and end stage renal disease
 - Funded from:
 - Mandatory contributions while working
 - General tax revenues
 - Premiums
 - Deductibles and co-payments
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Why the Elderly?

- Prior to 1965, less than half of the elderly had health insurance, and almost 30% had incomes below FPL
 - Medicare focused on the elderly because they are a “deserving” vulnerable population
 - Medicare was supposed to be an interim step toward comprehensive national health insurance
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Social Insurance for the Aged

- Medicare signed into law on 7/30/65, as Title XVIII of the Social Security Act
 - Medicare Part A: social insurance
 - Financed through payroll taxes
 - Medicare Part B: voluntary health insurance
 - Financed through monthly premiums and general tax revenue
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Who Is Eligible for Medicare?

- Individuals age 65 and over
 - Workers who have paid into Social Security during lifetime (40 quarters of employment), or spouse of a worker automatically qualify for Part A
 - Everyone eligible for Part A may elect to enroll in Part B, but must pay a monthly premium, which is deducted from Social Security benefits (\$54.00/month in 2002)
 - Disabled individuals who qualify for SS benefits
 - End-stage renal disease patients
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What Does Medicare Cover?

■ Part A:

- 90 days of inpatient care per benefit period, plus 60 “lifetime reserve” days
 - Benefit period starts with first day of hospital care and ends 60 days after discharge from a hospital or nursing home
 - 190 lifetime days of psychiatric inpatient care
 - 100 days of post-hospital care per benefit period in a skilled-nursing facility (SNF)
 - Unlimited home health agency visits
 - Hospice care
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What Does Medicare Cover?

- Part B:
 - Most physician services
 - Other allied health professionals
 - Outpatient hospital services
 - Durable medical equipment
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How Is Medicare Financed?

- Part A:
 - Payroll tax 1.45% each from employer and employee
 - Part B:
 - Monthly premium from beneficiaries (~25% of total)
 - General tax revenues (~71% of total)
 - Interest on trust fund (~4% of total)
 - Administrative expense (~1.8% of expenditures)
 - Both parts have some cost-sharing from beneficiaries
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What is Medicaid?

- Joint federal-state program
 - Title XIX of the Social Security Act, 1965
 - Entitlement, for low-income people
 - Grafted onto existing system
 - Federal responsibilities (HCFA --> CMS)
 - Fund program
 - Broad oversight
 - Each state has a unique Medicaid program
 - Approximately 40 million low income aged, blind, disabled, & poor women/children
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What is the role of the states?

- State Medicaid agencies
 - Set criteria & determine eligibility
 - Determine the type, amount, duration, and scope of services
 - Set payment rates for services
 - Administer own program
 - Claims processing
 - Provider certification
 - Participation is voluntary
 - Arizona was the last state to establish program in 1982
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Who are the beneficiaries?

- Broad federal guidelines
 - American citizens
 - Undocumented ineligible except for emergency care
 - Legal immigrants
 - All states must cover pregnant women <133% FPL
 - 2001 FPL for family of 3 is:
 - \$14,630 in the mainland
 - \$18,290 in Alaska
 - \$16,830 in Hawaii
 - Until recently, linked with AFDC
 - Eligibility categories + means test
 - States specify levels
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Beneficiaries

- Three basic groups
 - Parents & Children (biggest group)
 - 21 million low income children
 - 8.6 million low income adults in families with children
 - Elderly
 - 4 million > 65
 - Blind or disabled
 - 7 million
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Beneficiaries

- Mandatory eligible groups
 - Low income families with children who met state AFDC eligibility criteria on 7/16/96
 - SSI recipients
 - Infants born to Medicaid-eligible women
 - Children under age 6 and pregnant women whose family income is < 133% FPL
 - Certain Medicare beneficiaries (“dual eligibles”)
 - Recipients of adoption and foster care
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Beneficiaries

- Categorically needy:
 - Like mandatory group, but more liberal eligibility criteria
 - Infants up to age 1 and pregnant women in families with income <185% FPL
 - Optional targeted low income children
 - Certain blind, aged, or disabled adults who have incomes above mandatory guidelines
 - Institutionalized individuals with income/resources below specified limits
 - TB infected persons who would be financially eligible for Medicaid at the SSI (supplemental security income) level
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Beneficiaries

- Categorically needy (cont.):
 - Medically needy, e.g., pregnant women
 - Too much income to qualify for the mandatory or categorically needy groups
 - “Spend down” to Medicaid eligibility
 - Medicaid DOES NOT provide medical assistance to all poor persons
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States must cover

- Inpatient care, physician services, lab & x-ray
 - Prenatal care, EPSDT (early periodic screening and diagnostic treatment) for children < 21
 - Nursing home care
 - Health center (FQHC) and rural health clinic (RHC) services
 - Nurse-midwife & nurse practitioner services
 - Family planning services
 - States receive federal matching funds for these
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States may cover

- Prescription drugs, prosthetic devices
 - Dental & vision care for adults
 - Nursing facility services for < 21 years
 - Institutional care for individuals with mental retardation
 - Home and community-based care for frail elderly
 - States receive federal matching funds for these
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Welfare & Its Reform

- 1935: AFDC and SSI
 - Cash assistance to needy families & children
 - Would be automatically eligible for Medicaid
- “Personal Responsibility & Work Opportunity Reconciliation Act” (P.L. 104-193)
 - Aims:
 - Give states flexibility to redesign cash assistance programs
 - Encourage work and end welfare dependence
 - AFDC --> TANF
 - TANF = Temporary Assistance to Needy Families
 - Ended open-ended federal funding & eliminated cash entitlement to eligible families

Impact on Medicaid

- Broke link between AFDC and Medicaid
 - 40% of Medicaid population (1996)
 - Set Medicaid eligibility standard at AFDC levels in effect on 7/16/96
 - Problems with breaking the “link”
 - Need to reach out to Medicaid eligibles
 - 1996: 23% of eligible children were not covered
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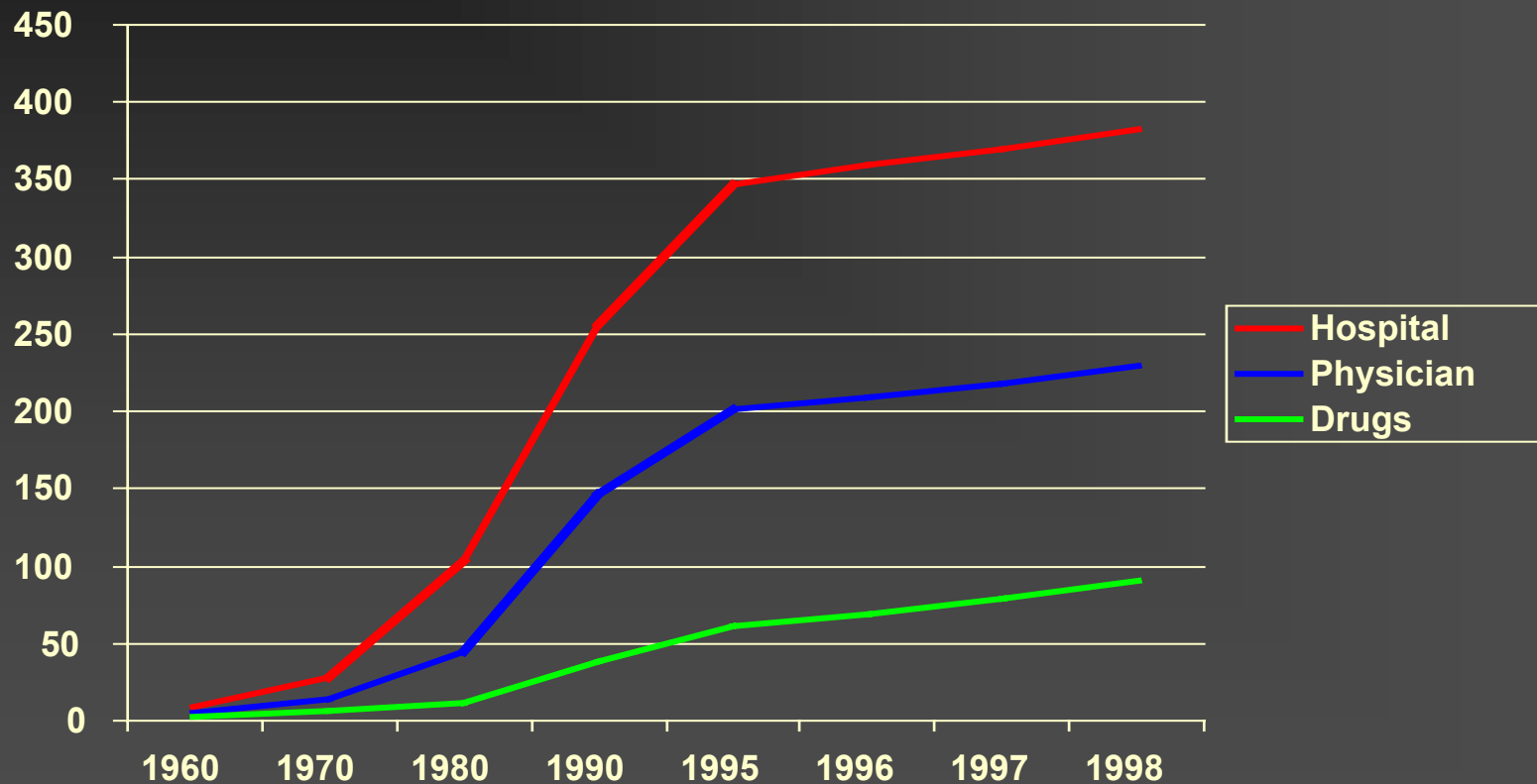
Trends in Pharmaceutical Expenditures

- National health expenditures totaled \$91 billion in 1988
- Projected to reach \$243 billion in 2008
- Since 1995, prescription drugs increases exceeded 10 percent in all but 2 years
- Increase are 2 to 4 times the increases of other health care sectors

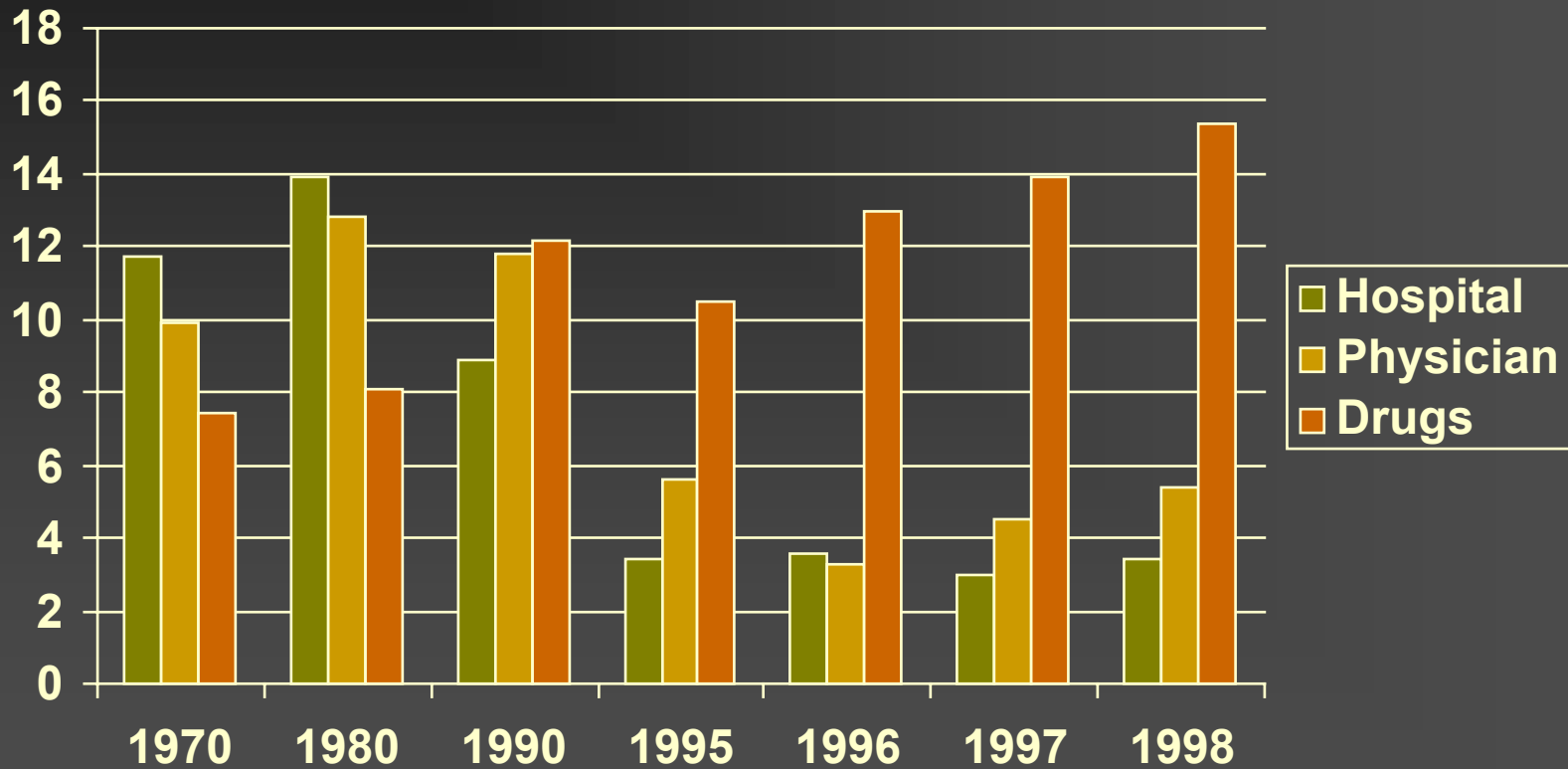
Pharmaceutical Sales

All Drugs	1999	2000	Percent change
Total Sales (billions)	\$111.1	\$132.0	18.8 percent
Total Rx (millions)	2,712.4	2,915.2	7.5 percent
Average Price/ Rx	\$40.96	\$45.27	10.5 percent

Health Care Expenditures



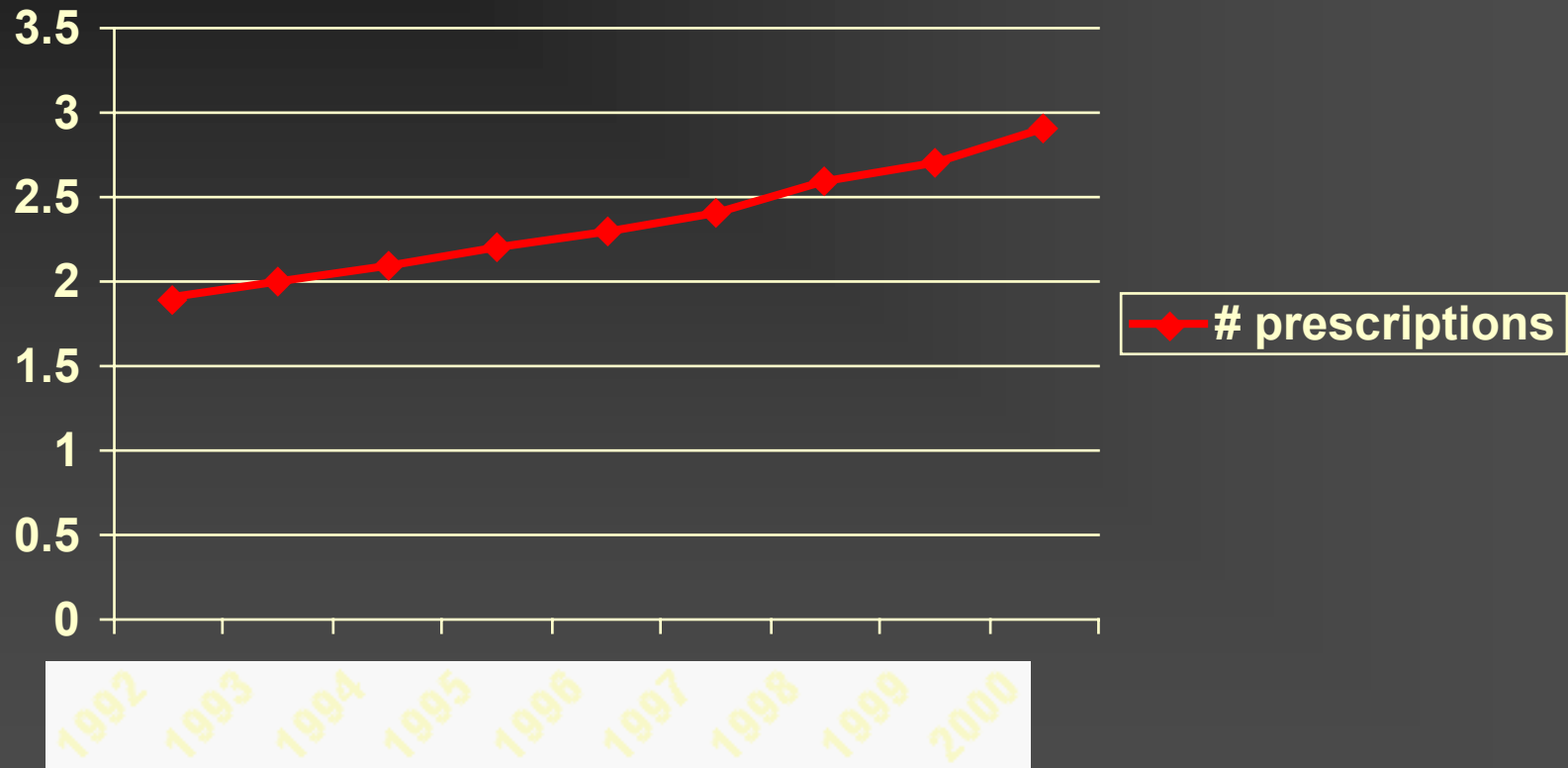
Percent increase in HC expenditures



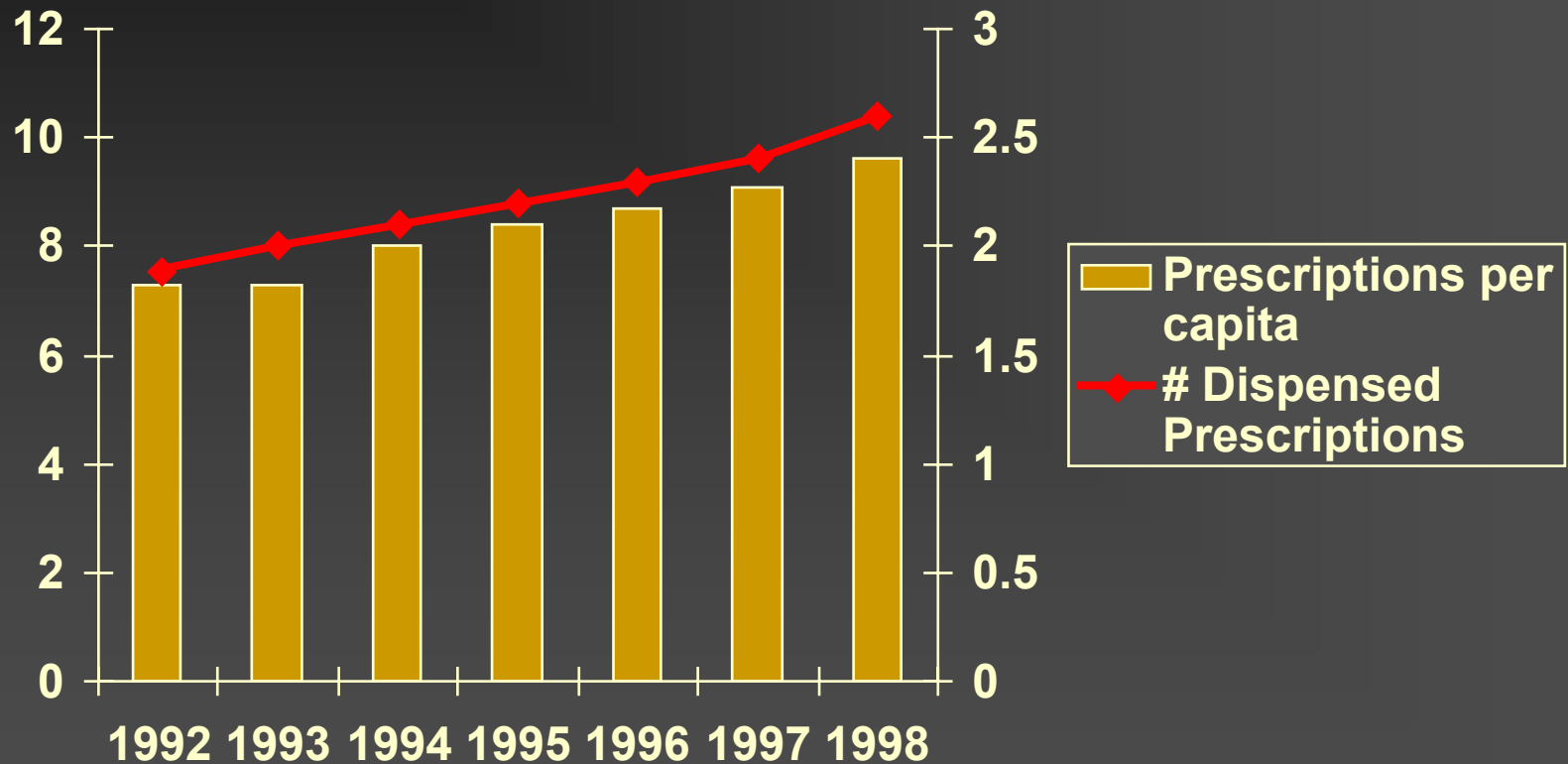
Trends in Financing (non-Medicare)

- About 77 percent had prescription drug coverage in 1996
 - Employer (61 percent)
 - Medicaid (11 percent)
 - Other private sources (5 percent)
- The remainder (23 percent) have no coverage
 - Mostly near poor (100-200 percent of FPL)

Number of Prescriptions (billions)



Total Prescriptions Dispensed and Prescriptions Per Capita



Change in Total Drug Expenditures by Therapeutic Category, 1999-2000

Type of Drug	2000 Sales	Share of Sales	2000 Avg. Price/Rx
Antidepressant	\$10.4 b	7.9 %	\$ 68.07
Antiulcerant	\$9.5 b	7.2%	\$105.04
Cholesterol Reducer	\$8.2 b	6.2%	\$ 83.22
Antiarthritic	\$7.8 b	5.9%	\$ 33.14

How Are Prices Determined?

Supply Side

- Research costs
 - Substantial
 - Incurred before drug is sold
 - Do not vary with output = fixed
 - Marketing
 - Incurred in early life cycle
 - Do not vary with output = fixed
 - Manufacturing costs
 - Only variable costs
 - Are approximately 30% of product's value
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How Are Prices Determined?

Demand Side

- Therapeutic advance
 - Prices of rival products
 - Numbers of existing substitutes
 - Patent expiration
 - Rate of price advance
 - Imitative (“me too”): low → high
 - Innovative: high → maintain price
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Pharma Distribution Levels

- Manufacturers
- Wholesalers
- Retailers (Pharmacies)
- Consumers

Manufacturers

- Major pharmaceutical firms
- Generic pharmaceutical firms
- Selling price (to wholesalers primarily)
 - Average Manufacturer Prices

Wholesalers

- Serve as middlemen that distribute drugs from manufacturers to pharmacies
 - “Cost Plus” = Wholesale Acquisition Cost
 - “List Less” = Average Wholesale Price less a discount price

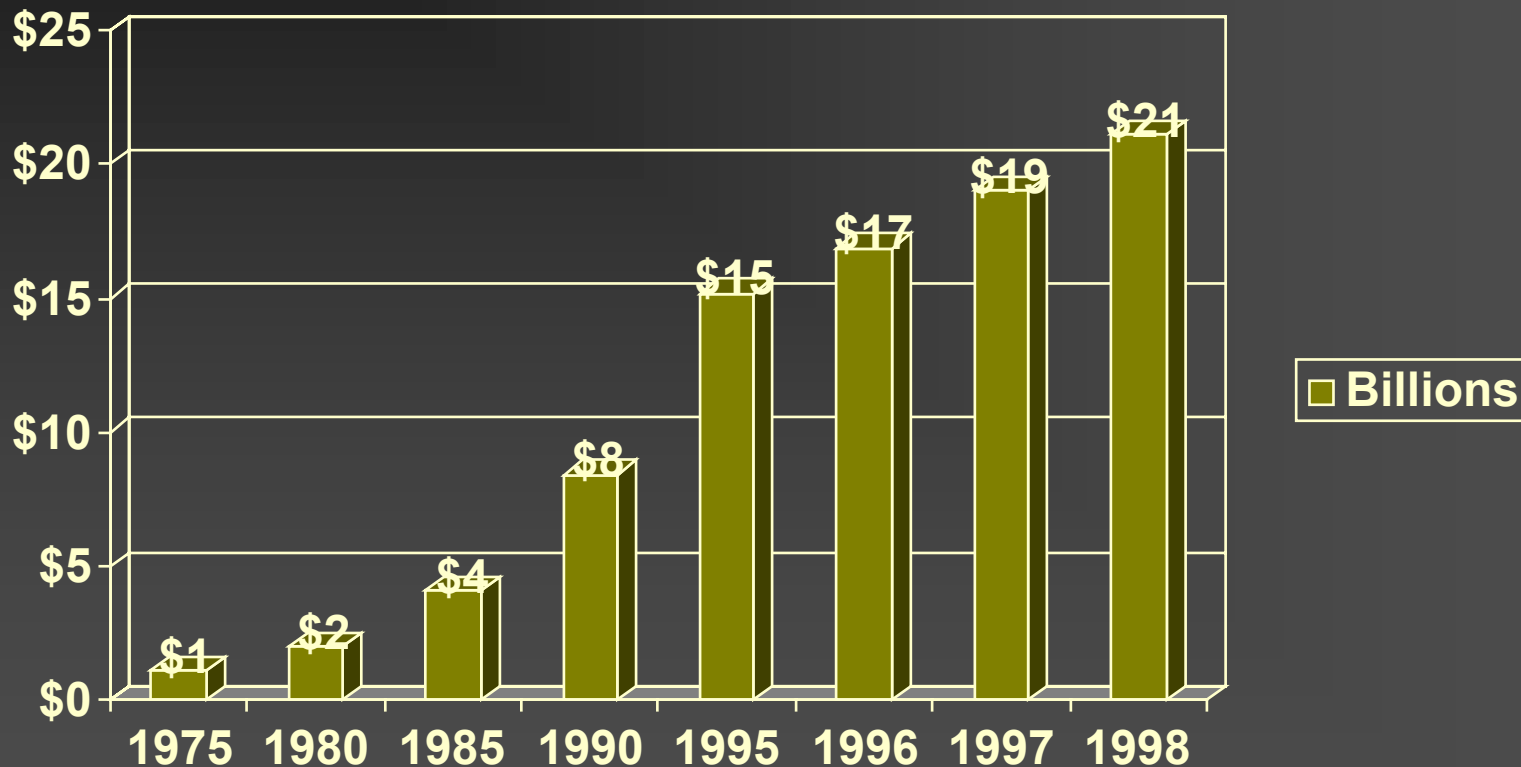
Retailers (Pharmacies)

- Their costs to buy drugs (from wholesalers)
= Actual Acquisition Cost, AAC=AMP
- Selling Prices
 - Usual & Customary (U&C) Retail Price = cost of drug plus pharmacy mark-up
 - “Service Benefit” Insurance Coverage = insurer’s payment formula + professional dispensing fee

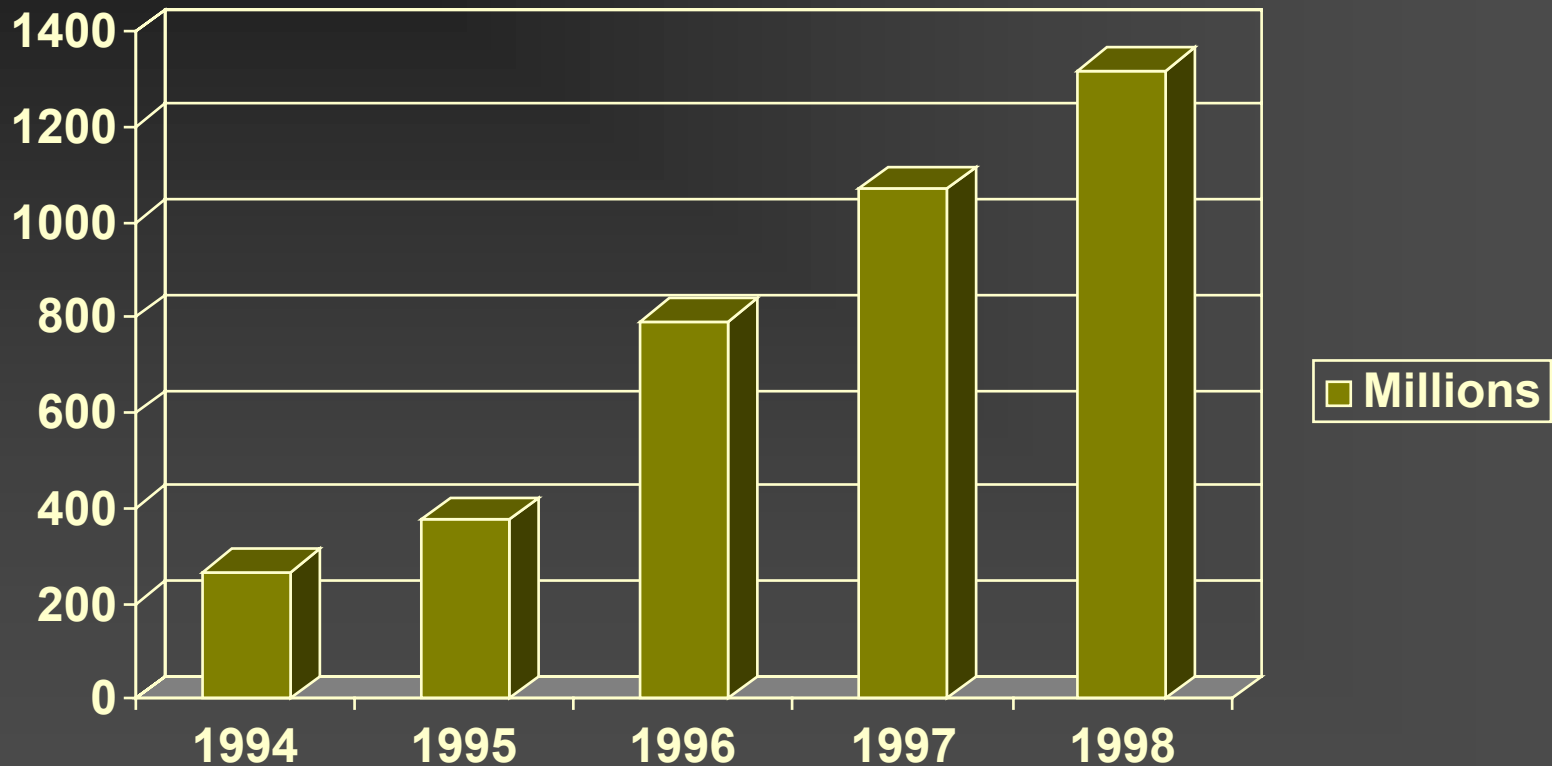
Consumers

- Their cost to buy drugs (from pharmacies):
 - If uninsured = usual & customary prices
 - If insured = co-payment or coinsurance amount

R&D Expenditures by U.S. Pharma Companies



Direct to Consumer Spending



Cost Containment Strategies

- Negotiated Prices
 - Generic Substitution
 - Rebates
 - Copayments
 - Coinsurance
 - Formularies
 - Mail Service Prescriptions
 - Drug Utilization Review
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Negotiated Prices

- Undertaken by Plans or a contracted Pharmacy Benefit Manager
 - Try to use market power to negotiate lower prices
 - Doesn't encourage careful evaluation of new drugs' appropriateness or effectiveness
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Generic Substitution - Pharmacies

- Provides incentives to pharmacies to provide generics instead of brand-name drugs
 - Fees not high enough to motivate change in behavior
 - Limited in availability of generics
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Generic Substitution - Consumers

- Offer consumers generic substitutes at a lower price
 - Consumer education about additional option
 - Copayments currently not different enough to provide incentives to change
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Rebates

- Lower program costs for drugs
 - Different from negotiated prices – savings awarded by manufacturer to the payor after the purchase
 - Medicaid Rebate Program – Federal government receives 15 percent discount and guarantee of lowest price
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Copayments

- Plans instituting three-tier system
 - Generics \$5
 - Brand name \$15
 - Off formulary \$25
 - Places consumer at risk for costs
 - New drugs may be more cost-effective
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Coinsurance

- Consumers pay 20 percent of all pharma costs
 - Consumers more aware of financial costs
 - Unpredictable cost may not be acceptable
 - May discourage appropriate, preventive use of prescription drugs
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Formularies

- Like a preferred provider network – but for drugs
 - Drugs on formularies may be lower negotiated prices or part of rebate
 - Encourages consumers to use certain drugs
 - Administratively difficult – many changes may be difficult for outside pharmacists
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Disease Management

- Encourages pharmacists to work with consumers with chronic disease
 - Consumer education
 - Encourage compliance & appropriate use
 - May actually increase drug use and costs
 - Increases burden on pharmacists
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Mail Service Prescriptions

- Heavy discounts for prescription drugs
 - Usually prescribed larger quantities
 - Convenience for consumers (home-bound)
 - Delays results in therapy interruptions
 - Decreased pharmacist involvement/monitoring
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Drug Utilization Review

- Reviewing past drug use (claims analysis) to catch inappropriate drug use
 - May encourage appropriate drug use
 - Perceived as second-guessing physician judgment
 - Changes may disrupt therapy
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