Editorial

Enhancing the Benefits of Pharmaceuticals: What Should States Do?

The current focus of state initiatives on lowering drug prices for retail cash customers addresses only the most visible barrier to effective pharmacotherapy for the poor, particularly those >65 years of age. Confronted with increasing numbers of the older, uninsured poor not being able to afford prescription medications, states have responded more quickly than the federal government. States have taken or considered several approaches to improve access to medications, including obtaining federal waivers authorizing the use of Medicaid programs to provide drug discounts to older and low-income persons not otherwise eligible; using state funds to defray copayments; limiting the retail prices of medications for persons with a valid Medicare card; forming purchasing cooperatives; using tax credits[1]; and mandating pharmacy or manufacturer discounts. The common goal is to make the price of prescription drugs more affordable to the states' older citizens who lack insurance coverage for them.

Although well-intended, these price initiatives for the older poor may have unintended consequences. The logistics and resources required to create administrative infrastructures to perform the qualification assessments, develop the information system capabilities, and continue recertification of those eligible for these new programs are considerable. Tax credits would require the patient to make the expenditure initially and thus pose a barrier to the poor. Initiatives that require retail pharmacies to subsidize the cost of drugs would jeopardize their participation in the program.

Although price is an obvious, immediate barrier to pharmaceutical use for some, the exclusive focus on the price of prescription drugs ignores other substantial barriers to the use of pharmaceuticals. Prescription medications can only be dispensed under the authority of a licensed prescriber; consequently, regular access to medical care is the foundation of effective prescription medication use. According to a Kaiser Family Foundation study, more uninsured than insured respondents <65 years of age reported postponing needed medical care for a serious condition (28% vs 5%), not having a doctor or clinic visit within the previous year (54% vs 39%), not having a regular source of medical care (36% vs 9%), not filling a prescription (30% vs 12%), and skipping a recommended medical test or treatment (39% vs 13%).[2] If mandates to reduce prescription drug prices for the older poor are pursued, state legislatures should also include a process that encourages early and continuing contact between patients and their primary care physician.

The absence of health insurance continues to limit effective pharmacotherapy. Even with lower prices for medications, the cost to the older poor who do not have drug benefits may still discourage persistent use of medications in both acute and chronic conditions. Approximately 27% of Medicare beneficiaries have no prescription drug coverage; these patients on average filled substantially fewer prescriptions in 1998 (16.7) than those with prescription drug insurance (24.4).[3] Cost-sharing by older persons and the poor for

their prescription drugs reduces their medication use, for both essential and less essential drugs, and has been associated with increased incidence of serious adverse events and emergency department visits.[4] Initiatives to improve access to prescription medications should also encourage patients to maintain continuity with their pharmacy provider to permit effective drug utilization review.

The complexity of some patients' medical conditions poses another barrier to optimal, or even appropriate, medication use. Patients may receive care from several health care providers and may fill their prescriptions at multiple pharmacies; this fragmentation creates unnecessary and avoidable risks. Prescribing practices for patients ≥65 years of age demonstrate that underutilization, polypharmacy, and inappropriate medication use are not rare and that these practices are associated with substantial morbidity.[5]

The numerous programs and proposals reflect the opportunities and constraints in each state; however, they represent an opportunity for health services researchers to communicate with state legislators regarding the lessons of past research and policy analysis. Reducing out-of-pocket payments for the older poor is an immediate priority, and political realities may dictate incremental initiatives for the near term. The longer-term resolution must address the more fundamental barriers to pharmaceuticals by ensuring adequate health insurance for all.

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References

1. Pear R. States creating their own plans to cut drug costs. *New York Times.* April 23, 2001;A1,14.

2. The Kaiser Commission on Medicaid and the Uninsured. *Uninsured in America: A Chart Book.* 2nd ed. Menlo Park, Calif: Henry J. Kaiser Family Foundation; March 2000.

3. Poisal JA, Murray L. Growing differences between Medicare beneficiaries with and without drug coverage. *Health Aff (Millwood).* 2001;20:74–85.

4. Tamblyn R, Laprise R, Hanley JA, et al. Adverse events associated with prescription drug cost-sharing among poor and elderly persons. *JAMA.* 2001;285:421–429.

5. Hanlon JT, Schmader KE, Ruby CM, Weinberger M. Suboptimal prescribing in older inpatients and outpatients. *J Am Geriatr Soc.* 2001;49:200–209.