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In the Years before the COVID-19 Pandemic, Nearly 13 Million Adults Delayed or Did Not Get Needed Prescription Drugs Because of Costs

Findings from the 2018–19 Medical Expenditure Panel Survey

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Recent congressional negotiations have centered on policies to lower the cost of prescription drugs, which account for up to 14 percent of national US health spending (Conti, Turner, and Hughes-Cromwick 2021; Martin et al. 2020; Roehrig 2019). Lawmakers have sought to add provisions of earlier prescription drug pricing reform bills to the Build Back Better Act, or BBBA (box 1), including one that would authorize the secretary of health and human services to negotiate drug prices for people with Medicare or commercial insurance.[1] Other components of the BBBA could reduce out-of-pocket drug costs for uninsured people by expanding health insurance coverage. Though prescription medicines often provide critical and even lifesaving treatment, rising drug prices place pressure on health insurance premiums and government budgets and can lead to high out-of-pocket cost burdens for patients, including those with health insurance coverage. People may also delay or forgo needed medications in response to high drug costs, worsening their acute and chronic health conditions and sometimes necessitating more expensive treatments (Jha et al. 2012; Roebuck et al. 2011). In 2017, more than 1 in 10 nonelderly adults who were prescribed medication in the past 12 months reported not taking their medications as prescribed to save money, including 1 in 3 who are uninsured.[2]

About US Health Reform—Monitoring and Impact

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A person's exposure to high drug costs varies substantially based on their source of health insurance coverage (if any) and health plan benefit design. Most workers covered by employer plans have tiered cost sharing for prescription drugs (Claxton et al. 2020), and out-of-pocket prescription spending for these adults is highly concentrated among a small portion of the population.[3] Consumers with a typical Marketplace silver plan face out-of-pocket prescription drug costs about twice as high as what they would pay under an employer plan, but cost-sharing subsidies help defray these costs for most people who are enrolled in a silver plan (Thorpe, Allen, and Joski 2015). In contrast, Medicaid enrollees face little or no cost sharing for prescription drugs, but because of their low incomes, even small cost burdens can reduce their likelihood of filling prescriptions (LeCouteur et al. 2004; Ku, Deschamps, and Hilman 2004; Stuart and Zacker 1999; Soumerai et al. 1994; Subramanian 2011). Uninsured and privately insured nonelderly people who use retail prescription drugs have similar median out-of-pocket prescription drug spending, but the uninsured face greater exposure as out-of-pocket costs rise (Carroll, Miller, and Hill 2020).[4]

The Medicare Part D standard drug benefit has a unique and complex cost structure with four phases of coverage: a deductible; an initial coverage period in which beneficiaries pay 25 percent of drug costs out of pocket; a coverage gap in which beneficiaries continue to pay 25 percent of costs for drugs and dispensing fees until their "true out-of-pocket costs" (i.e., cost sharing plus manufacturer discounts for brand-name, biologic, and biosimilar drugs) reach the catastrophic threshold;[5] and a catastrophic coverage phase in which beneficiaries pay 5 percent of costs without any limits on their overall out-of-pocket spending.[6] In 2019, nearly 1.5 million adults enrolled in Medicare Part D had out-of-pocket spending above the catastrophic threshold (Cubanski, Neuman, and Damico 2021a).

In this brief, we explore prescription drug affordability challenges from the consumer perspective using pooled 2018–19 data from the Medical Expenditure Panel Survey, a nationally representative survey of US households. We primarily focus on two groups with comprehensive drug benefits who are targeted by recent policy proposals: adults ages 65 and older with Medicare and adults ages 19 to 64 with year-round private insurance. We examine the extent to which these adults delay or forgo obtaining needed prescription drugs because of the cost and their out-of-pocket spending burdens. However, we also provide insight into unmet needs and affordability challenges faced by uninsured adults. In addition, we examine how drug affordability problems vary by the demographic and health

characteristics of adults with Medicare and private insurance and the prevalence of diagnosed chronic health conditions among those with unmet prescription drug needs. All estimates reflect annual averages for 2018–19. We find the following:

- Nearly 13 million adults delayed getting or did not get needed prescription drugs in the past year because of the cost, including 2.3 million elderly Medicare beneficiaries and 3.8 million nonelderly adults with private insurance, 1.1 million with Medicaid, and 4.1 million who were uninsured at any point during the year.
- About 1 in 10 adults who were uninsured all year (9.5 percent) or part of the year (11.6 percent) reported unmet prescription drug needs, compared with 4.9 percent of Medicare beneficiaries, 3.0 percent of privately insured adults, and 5.6 percent of nonelderly adults with Medicaid.
- For both Medicare beneficiaries and privately insured adults, unmet prescription drug needs were most common among women, people with low incomes, and people with multiple chronic health conditions. Nearly all Medicare beneficiaries and more than 8 in 10 privately insured adults with unmet needs have been diagnosed with a chronic condition such as high blood pressure, high cholesterol, stroke, diabetes, arthritis, and respiratory illnesses.
- More than one-quarter of adults with Medicare (25.4 percent) and 5.3 percent of privately insured adults spent more than 1 percent of their family incomes on their individual out-of-pocket prescription drug costs. More than 3 percent of Medicare beneficiaries—and nearly 7 percent of beneficiaries with unmet prescription drug needs—spent more than 10 percent of their family incomes on prescription drugs.

Though most adults do not face difficulty affording prescription drugs, millions delayed getting or went without medications because of the cost in the years just before the COVID-19 pandemic, including more than 6 million adults with Medicare or private coverage. Most of these adults have been diagnosed with one or more chronic conditions, making the affordability of prescription drugs a critical factor in their long-term health. Policies aimed at reducing drug prices and limiting out-of-pocket spending could increase access to needed medicine for these groups, and efforts to expand coverage to the uninsured population, who have the highest rate of unmet needs, could further improve the affordability of prescription drugs.

BOX 1

Proposed Policies to Reduce Prescription Drug Costs

In recent years, members of Congress have proposed several bills that could substantially reduce prescription drug prices and lower out-of-pocket costs for consumers, including the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3), which passed in the US House of Representatives in December 2019 but did not advance in the Senate. H.R. 3 would have capped out-of-pocket costs in Medicare Part D at $2,000; increased incentives for Part D plans to control costs; required manufacturer rebates for drug price increases that outpace inflation; and allowed the secretary of health and human services to negotiate the prices of at least 50 drugs from a list of up to 250 brand-name drugs per year, and these prices would have been available to both Medicare and commercial plans.[a] Competing proposals, such as the Prescription Drug Pricing Reduction Act (S. 2543) and the Lower Costs, More Cures Act (H.R. 19), shared some elements of H.R. 3, but they did not provide authority for price negotiation, and they capped out-of-pocket costs at $3,100; H.R. 19 also excluded inflation rebates.[b]

At the time of this writing, the BBBA (H.R. 5376), passed by the House of Representatives on November 19, 2021, includes some of these provisions or modified versions of them.[c] Like H.R. 3, the BBBA would cap out-of-pocket spending in Medicare Part D at $2,000 and would allow beneficiaries to spread their out-of-pocket costs over the year. The bill would also lower coinsurance in Part D's initial coverage phase from 25 to 23 percent, establish mandatory rebates for drugs covered by Medicare Parts B and D with prices that increase faster than inflation, increase incentives for Part D plans to negotiate lower prices with drug manufacturers, and limit cost sharing for insulin to $35 per month for people with Medicare and commercial plans.

The BBBA would grant federal authority to negotiate drug prices for Medicare Parts B and D but is more limited than H.R. 3 in its scope. Under the BBBA, prices would be negotiated for high-priced drugs that are outside of their exclusivity periods and lack price competition, and certain orphan drugs and drugs that account for a small share of Medicare expenditures would be exempt. The prices of up to 10 drugs would be negotiated in 2025, rising to 15 drugs in 2026 and 2027 and to 20 drugs in 2028, and negotiations would also cover insulin products. Prices would be negotiated for small-molecule drugs on the market for 9 years and biologic drugs on the market for 13 years. Discounts would be based on the nonfederal average manufacturer price and would increase based on the length of time a drug has been on the market. These negotiated prices would be available for Medicare but not commercial plans. Drug manufacturers would face an excise tax if they do not agree to negotiate.

[a] Elijah E. Cummings Lower Drug Costs Now Act, H.R. 3, 116th Cong. (2019–20).

[b] Billy Wynne and Alyssa Llamas, "New Legislation to Control Drug Prices: How Do House and Senate Bills Compare?" Commonwealth Fund blog, October 24, 2019, https://www.commonwealthfund.org/blog/2019/new-legislation-control-drug-prices-how-do-house-and-senate-bills-compare. See also Martin (2021).

[c] Build Back Better Act, H.R. 5376, 117th Cong. (2021–22); Rachel Sachs, "Understanding the New Drug Price Reform Deal," *Health Affairs Blog*, November 4, 2021, https://www.healthaffairs.org/do/10.1377/hblog20211104.184553/full/; and Cox and colleagues (2021).

Data and Methods

We use pooled 2018 and 2019 data from the Medical Expenditure Panel Survey (MEPS) Household Component, a nationally representative survey of the civilian noninstitutionalized population conducted by the Agency for Healthcare Research and Quality. Along with demographic information,

the MEPS collects detailed information on health service use and expenditures, health care access and affordability, and monthly health insurance status (AHRQ 2021). The household survey asks respondents about prescribed medicines they or their family members obtained, and payment information is collected in a follow-up telephone survey of a sample of households' pharmacy providers. This information is used to impute missing expenditure data.

As noted, our analysis focuses primarily on elderly Medicare enrollees and nonelderly privately insured adults, two groups that would be affected by the passage of proposed legislation to lower prescription drug costs, including the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3) and the BBBA. The Medicare sample includes adults ages 65 and older with Medicare at any point in the year. We exclude those with Medicare and any Medicaid coverage during the year (i.e., "dual eligibles") because these adults automatically qualify for income-based subsidies that limit Part D cost-sharing requirements.[7] The nonelderly privately insured sample includes adults ages 19 to 64 with private health insurance for all months that they are in the MEPS sample.[8] Privately insured adults include those with employer- or union-sponsored insurance, TRICARE or CHAMPVA, nongroup private insurance (including Marketplace coverage), unknown private coverage, coverage from someone outside the household, and other group coverage. Our final sample from the 2018–19 MEPS includes 9,296 Medicare enrollees ages 65 and older and 18,812 privately insured nonelderly adults.

We focus on two main outcomes: cost-related unmet needs for prescription drugs and out-of-pocket spending on prescription drugs. An adult is considered to have an unmet need for prescription drugs if they reported they did not get prescription drugs they needed because they could not afford them or delayed getting prescription drugs over worries about the cost in the last 12 months. Out-of-pocket costs for prescription drugs are paid directly by patients or their families. These costs include deductibles, coinsurance, copayments, and other payments not covered by insurance or other sources. We adjust out-of-pocket spending from the MEPS for inflation so that 2018 data match 2019 prices. We use the Consumer Price Index for medical care to do so, as recommended by the Agency for Healthcare Research and Quality.[9]

We estimate the share of adults with Medicare or private coverage with high out-of-pocket prescription drugs costs in absolute terms (above $500, $1,000, and $2,000) and the share with a high out-of-pocket spending burden as a percentage of income (above 1 percent, 2 percent, and 10 percent). We construct a measure of *individual* out-of-pocket prescription drug spending as a percentage of *family* income. Our family income measure is the total income reported for the health insurance unit. These are subfamily groups that include people who would typically be eligible to be covered under the same health insurance plan. Following another analysis of out-of-pocket spending in the MEPS, when calculating out-of-pocket costs as a percentage of income, we impute family incomes of $100 for those reporting a family income that is $0 or less (Crimmel and Stagnitti 2005). When presenting estimates by family income as a percentage of the federal poverty level, we use the federal poverty guidelines developed by the US Department of Health and Human Services and define family size and income based on the health insurance unit.[10] We also report estimates for cost-related unmet prescription drug needs by whether people have ever been diagnosed with one or more of the following chronic health

conditions: high blood pressure (including multiple diagnoses); heart disease (including coronary heart disease, angina, myocardial infarction, and other unspecified heart disease); stroke; emphysema; chronic bronchitis; high cholesterol; cancer; diabetes; joint pain (including arthritis); and asthma.

Results

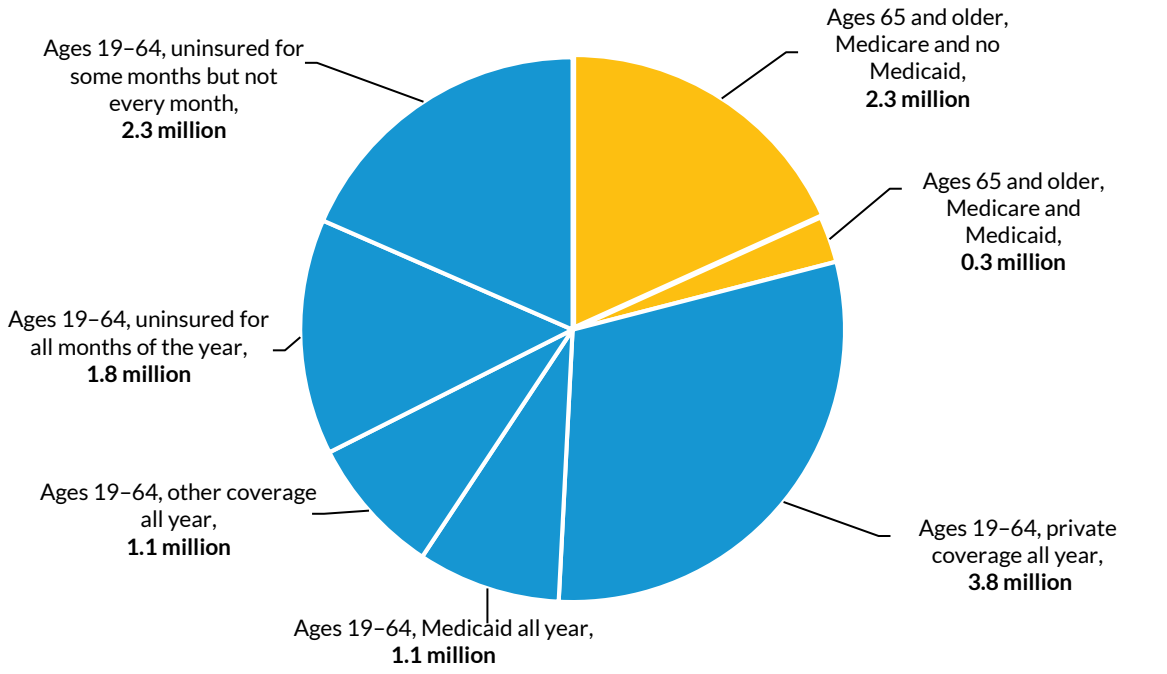
Nearly 13 million adults delayed getting or did not get needed prescription drugs in the past year because of the cost, including more than 2.3 million elderly Medicare beneficiaries and 3.8 million privately insured nonelderly adults.

In 2018–19, an estimated annual average of 12.8 million adults delayed or did not get prescription drugs in the past year because of the cost. This total included more than 2.3 million elderly Medicare beneficiaries (excluding those with Medicaid) and about 3.8 million nonelderly adults with private coverage for a full year (figure 1). An additional 1.1 million nonelderly adults with Medicaid all year, 1.1 million nonelderly adults with other coverage all year, and 4.1 million nonelderly adults who were uninsured for some or all months of the year had unmet prescription drug needs because of costs.

FIGURE 1

Average Annual Number of Adults with Unmet Needs for Prescription Drugs Due to Costs, by Age and Health Insurance Coverage, 2018–19

Of 12.8 million adults ages 19 and older



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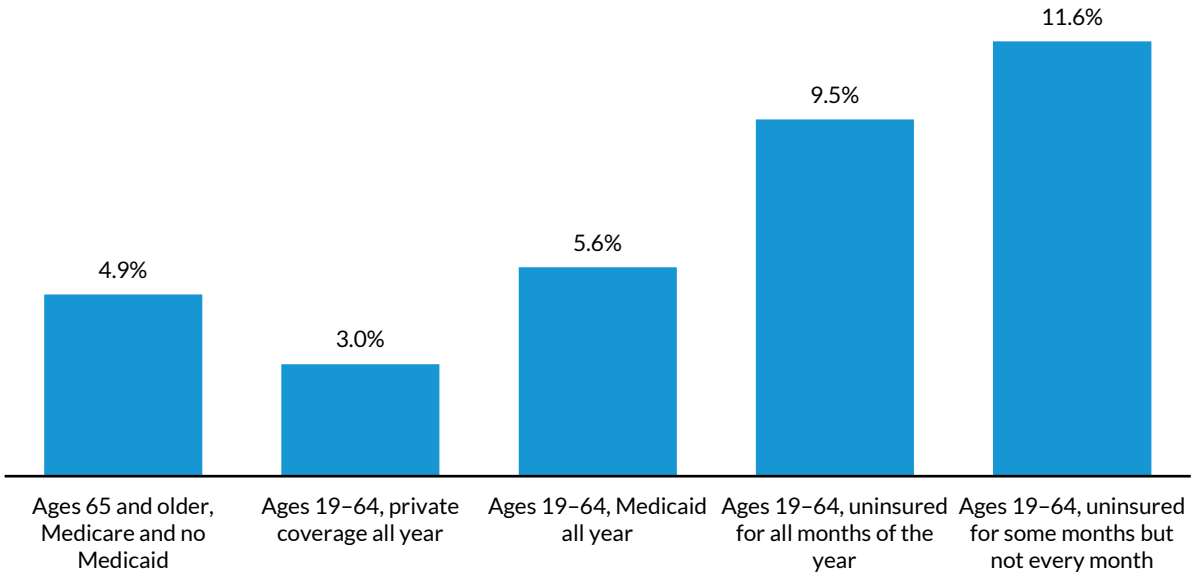
Source: Authors' analysis of the Medical Expenditure Panel Survey Household Component, 2018–19.

Notes: See the Data and Methods section for definitions of coverage categories. Estimates are not shown for a small number of adults ages 65 and older without Medicare during the year who reported unmet prescription drug needs. All values, including the total, have been rounded.

Because insured adults constitute a greater share of the population than uninsured adults, a majority of adults with unmet prescription drug needs had full-year coverage. However, uninsured adults were more likely than insured adults to report these challenges: about 1 in 10 adults uninsured all year (9.5 percent) or part of the year (11.6 percent) reported unmet prescription drug needs, compared with 4.9 percent of Medicare beneficiaries, 3.0 percent of privately insured nonelderly adults, and 5.6 percent of nonelderly adults with Medicaid (figure 2).

FIGURE 2

Average Annual Share of Adults Reporting Unmet Needs for Prescription Drugs Due to Costs, by Age and Health Insurance Coverage, 2018–19



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Source: Authors' analysis of the Medical Expenditure Panel Survey Household Component, 2018–19.
Notes: See the Data and Methods section for definitions of coverage categories. Estimates are not shown for adults ages 19 to 64 with other coverage all year (3.5 percent of adults), adults ages 65 and older with both Medicare and Medicaid (2.4 percent of adults), and adults ages 65 and older without Medicare (0.3 percent).

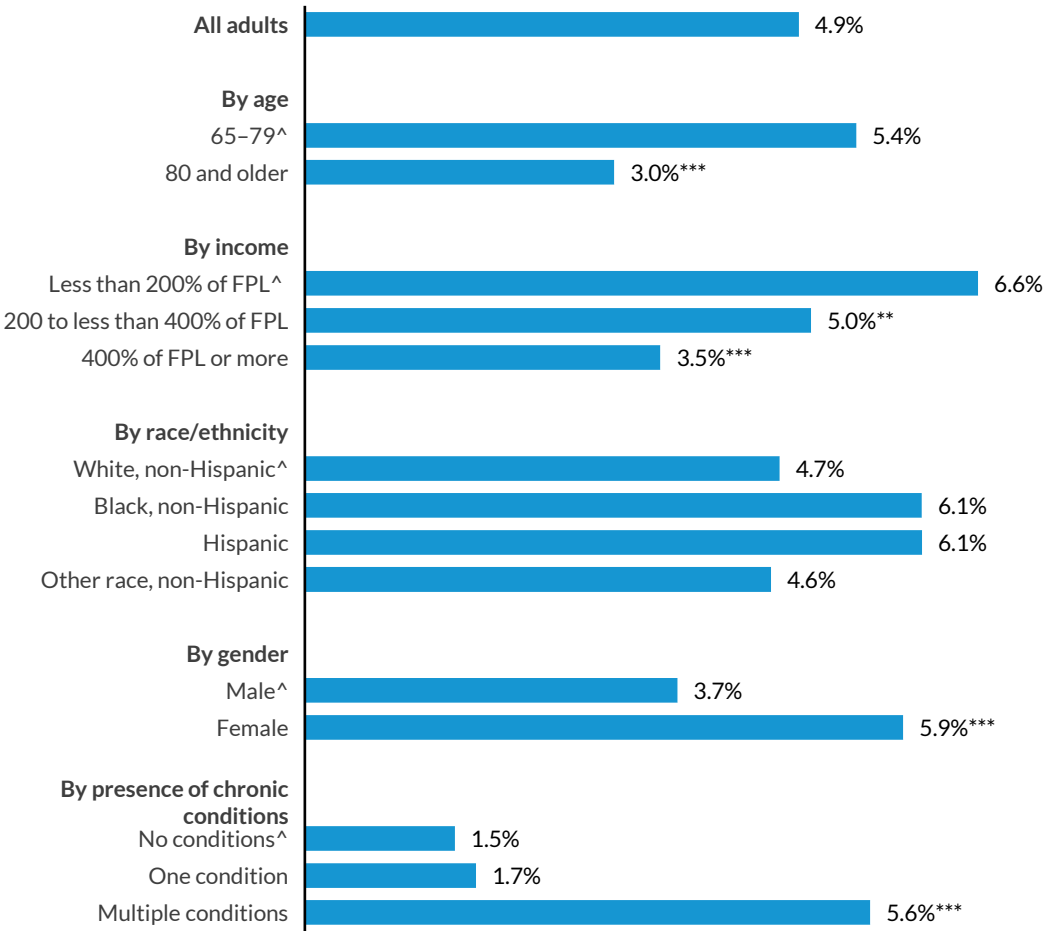
We also observed variation by type of health insurance coverage in the shares of adults who had unmet needs for prescription drugs only or in conjunction with unmet needs for other types of medical care. Prescription drug costs have historically been a challenge in Medicare; the Part D drug benefit has only been available since 2006, and significant coverage gaps were not phased out until 2020. Approximately two-thirds of Medicare beneficiaries with unmet prescription drug needs reported problems affording drugs only and did not report cost-related unmet needs for other types of medical care (data not shown). In contrast, more than half of privately insured adults and most uninsured adults with unmet prescription drug needs also went without other types of medical care because of the cost, reflecting broader challenges paying for care among these groups.

For both Medicare beneficiaries and privately insured nonelderly adults, unmet prescription drug needs were most common among women, people with low incomes, and people with multiple chronic health conditions.

Unmet prescription drug needs among adults with Medicare and private coverage varied by age, income, gender, and self-reported health conditions. As shown in figure 3, Medicare beneficiaries ages 65 to 79 were more likely than those ages 80 and older to report delaying or forgoing needed prescription drugs because of costs (5.4 versus 3.0 percent). Medicare beneficiaries were also more likely to report unmet prescription drug needs if they had family incomes below 200 percent of the federal poverty level (6.6 percent), were female (5.9 percent), or had multiple chronic conditions (5.6 percent). As shown in figure 4, the likelihood of having difficulty affording prescription drugs increased with age for privately insured nonelderly adults (2.4 percent of those ages 19 to 34 versus 3.5 percent of those ages 50 to 64). Unmet needs were also more common among privately insured nonelderly adults who have incomes below 200 percent of the federal poverty level (5.0 percent), are women (3.6 percent), and have multiple health conditions (5.4 percent). There were no statistically significant differences in unmet prescription drug needs across racial and ethnic groups for adults with these types of coverage.

FIGURE 3

Average Annual Share of Adults Ages 65 and Older with Medicare Reporting Unmet Needs for Prescription Drugs Due to Costs, by Selected Characteristics, 2018–19



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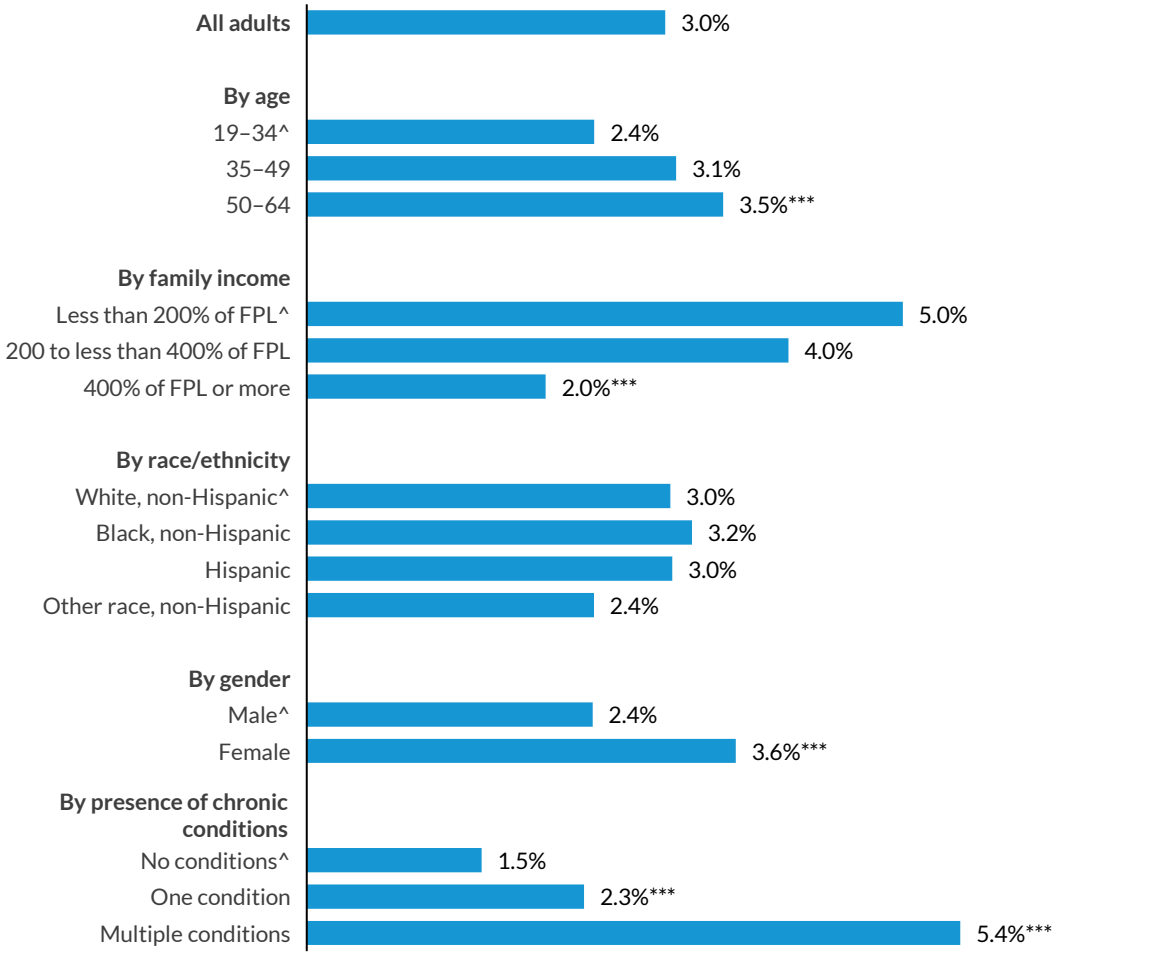
Source: Authors' analysis of the Medical Expenditure Panel Survey Household Component, 2018–19.
Notes: FPL is federal poverty level. Estimates exclude adults with both Medicare and Medicaid. "Other race" includes non-Hispanic adults who are not white or Black or are more than one race.
*/**/*** Estimate differs significantly from the estimate for the reference group (^) at the 0.10/0.05/0.01 level, using two-tailed tests.

FIGURE 4

Average Annual Share of Adults Ages 19 to 64 with Private Coverage All Year Reporting Unmet Needs for Prescription Drugs Due to Costs, by Selected Characteristics, 2018–19



Source: Authors' analysis of the Medical Expenditure Panel Survey Household Component, 2018–19.
Notes: FPL is federal poverty level. "Other race" includes non-Hispanic adults who are not white or Black or are more than one race.
*/**/*** Estimate differs significantly from the estimate for the reference group (^) at the 0.10/0.05/0.01 level, using two-tailed tests.

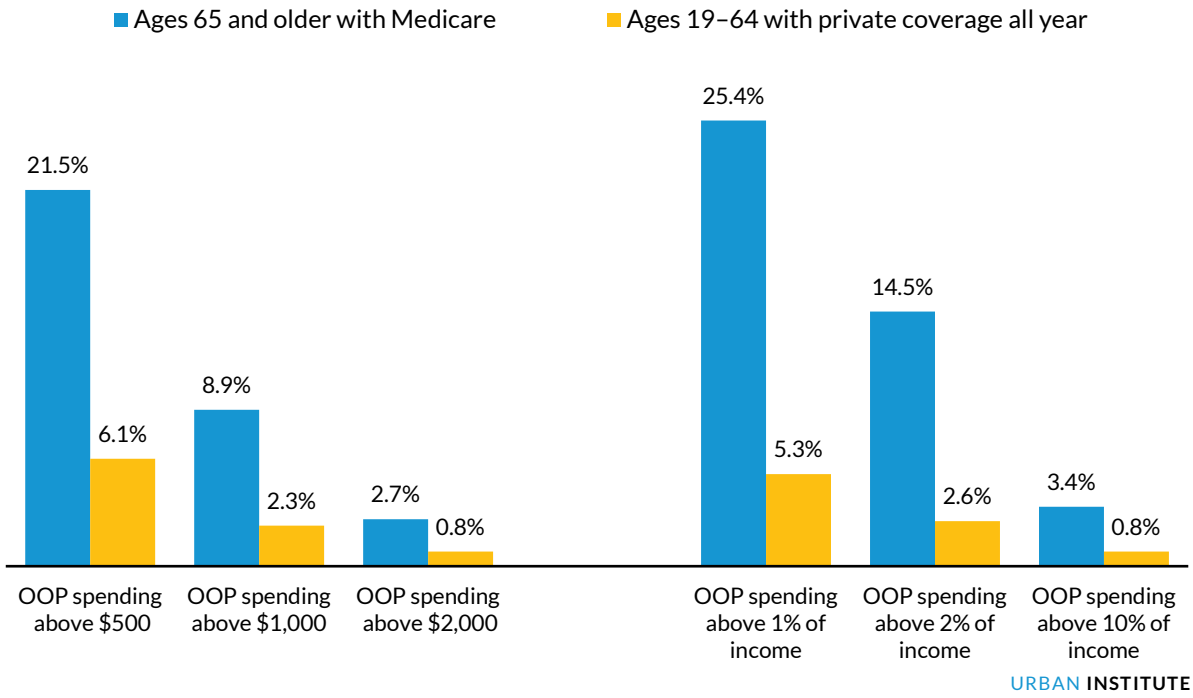
Though most adults with Medicare or private coverage had modest out-of-pocket costs, some experienced high spending burdens relative to their incomes.

Overall, 90.5 percent of Medicare beneficiaries and 62.4 percent of privately insured adults reported filling at least one prescription during the year, and these adults reported median out-of-pocket costs of $178 and $62 (data not shown). However, like spending on other types of medical care, out-of-pocket spending for prescription drugs is highly skewed. Among all privately insured nonelderly adults, 6.1 percent reported out-of-pocket drug costs above $500 and 2.3 percent reported costs above $1,000

(figure 5). These shares were higher among Medicare beneficiaries, more than 1 in 5 (21.5 percent) of whom reported out-of-pocket costs above $500 and nearly 1 in 10 (8.9 percent) of whom reported costs above $1,000. Nearly 3 percent of Medicare beneficiaries, or about 1.3 million people, reported out-of-pocket costs above $2,000, the level at which out-of-pocket Part D spending would be capped under H.R. 3 and the BBBA recently passed by the House.

FIGURE 5

Share of Adults with Medicare or Private Coverage Who Have High Out-of-Pocket Prescription Drug Spending, Overall and as a Share of Family Income, 2018–19



Source: Authors' analysis of the Medical Expenditure Panel Survey Household Component, 2018–19.
Notes: OOP is out-of-pocket. We impute family incomes of $100 for adults with family incomes of $0 or less. Estimates exclude adults with both Medicare and Medicaid.

We find similar patterns in individual out-of-pocket spending as a percentage of family income. More than one in four adults with Medicare (25.4 percent) and 5.3 percent of privately insured adults spent more than 1 percent of their family incomes on prescription drugs. More than 3 percent of Medicare beneficiaries, or 1.6 million people, spent more than 10 percent of their incomes on prescription drugs.

Among both Medicare beneficiaries and privately insured adults, those with cost-related unmet prescription drug needs were more than twice as likely as other adults to report high out-of-pocket drug costs. For instance, about 7 percent of Medicare beneficiaries with unmet needs reported out-of-pocket costs above $2,000 and a similar share reported costs exceeding 10 percent of income, compared with about 3 percent of Medicare beneficiaries who did not report unmet needs (table 1). Privately insured

adults with unmet prescription drug needs were about three to four times more likely than those without unmet needs to report out-of-pocket costs above $2,000 (2.3 versus 0.8 percent) or exceeding 10 percent of income (3.1 versus 0.8 percent).

TABLE 1

Prescription Drug Use and Spending, Health Care Access, and Chronic Health Conditions among Adults Ages 65 and Older with Medicare and Adults Ages 19 to 64 with Private Coverage All Year, by Unmet Prescription Drug Needs, 2018–19

	Ages 65 and Older with Medicare		Ages 19 to 64 with Private Coverage All Year	
	With unmet prescription drug needs	Without unmet prescription drug needs	With unmet prescription drug needs	Without unmet prescription drug needs
Prescription drug use during the year				
Share with at least one prescription fill	97.8%	90.1%***	86.9%	61.6%***
Average number of prescription fills	36	20***	20	8***
Average OOP spending during the year ($)				
Prescription drugs	731	353***	426	148***
Other medical care	1,286	963	1,068	621***
Share with high OOP spending on prescription drugs (%)				
OOP spending above $500	43.9	20.3***	21.1	5.7***
OOP spending above $1,000	23.5	8.2***	8.8	2.1***
OOP spending above $2,000	7.0	2.5***	2.3	0.8**
OOP spending above 1% of income	52.8	24.0***	23.6	4.7***
OOP spending above 2% of income	32.8	13.6***	11.9	2.3***
OOP spending above 10% of income	6.8	3.2**	3.1	0.8***
Share with other cost-related unmet health care needs in the past year (%)				
Medical care (excluding prescription drugs)	32.9	3.2***	58.0	6.6***
Dental care	47.2	12.9***	53.7	11.1***
Share with chronic health conditions (%)				
Any conditions	*98.3*	*94.3****	*81.4*	*61.2****
One condition	4.3	12.7***	23.0	30.0***
Multiple conditions	94.1	81.6***	58.3	31.2***
By condition				
Joint pain (including arthritis)	83.4	70.2***	56.0	37.4***
High blood pressure	75.9	62.3***	40.9	21.7***
High cholesterol	70.4	58.0***	37.0	21.2***
Heart disease	44.2	32.8***	12.0	7.7***
Diabetes	36.1	21.3***	20.7	5.9***
Cancer	32.3	30.3	8.7	6.4*
Asthma	21.7	10.4***	23.5	12.4***
Stroke	16.2	10.4***	3.6	1.2***
Emphysema	10.2	4.1***	1.5	0.4**
Chronic bronchitis	6.6	2.5***	4.6	0.8***
Sample size	**478**	**8,818**	**611**	**18,201**
Weighted share of adults in each coverage group (%)	**4.9**	**95.1**	**3.0**	**97.0**

Source: Authors' analysis of the Medical Expenditure Panel Survey Household Component, 2018–19.

Notes: OOP is out-of-pocket. We impute family incomes of $100 for adults with family incomes of $0 or less. Chronic conditions are those that have been diagnosed. Estimates exclude adults with both Medicare and Medicaid.
*/**/*** Estimate differs significantly from the estimate for adults with unmet prescription drug needs at the 0.10/0.05/0.01 level, using two-tailed tests.

Nearly all Medicare beneficiaries and more than 8 in 10 privately insured nonelderly adults with unmet prescription drug needs had been diagnosed with a chronic condition such as high blood pressure, high cholesterol, stroke, diabetes, arthritis, and respiratory illnesses.

More than 9 in 10 Medicare beneficiaries with and without unmet drug needs (97.8 and 90.1 percent) reported getting at least one prescription filled (table 1). Those with unmet drug needs filled more prescriptions during the year (36 versus 20). Most privately insured nonelderly adults with unmet drug needs (86.9 percent) also filled at least one prescription during the year, compared with 61.6 percent of those without unmet needs. Within each coverage group, average out-of-pocket spending for prescription drugs was more than twice as high for adults with unmet needs than for those without unmet needs, but differences in average spending on other types of medical care were smaller in magnitude.

Adults with unmet prescription drug needs were substantially more likely than other adults to have delayed getting or forgone other medical or dental care. As noted earlier, one-third of Medicare beneficiaries (32.9 percent) and more than half of privately insured adults (58.0 percent) with unmet prescription drug needs also had unmet needs for other types of medical care. These rates were significantly lower for those without any unmet prescription drug needs, at 3.2 percent for Medicare beneficiaries and 6.6 percent for nonelderly adults with private coverage. In addition, approximately half of adults in each coverage group with unmet needs for prescription drugs also reported unmet needs for dental care, at 47.2 percent of Medicare beneficiaries and 53.7 percent of privately insured nonelderly adults. Dental care is not covered by Medicare and is often not available as a benefit for workers and their families (Shartzer and Kenney 2015; Wiatrowski 2013).

Nearly all Medicare beneficiaries with unmet prescription drug needs (98.3 percent) reported having ever been diagnosed with at least 1 of the 10 chronic conditions shown in table 1, including 94.1 percent who reported multiple chronic conditions. Medicare beneficiaries with unmet needs were more likely than their peers to report nearly every condition, including joint pain and arthritis (83.4 percent), high blood pressure (75.9 percent), high cholesterol (70.4 percent), heart disease (44.2 percent), diabetes (36.1 percent), asthma (21.7 percent), and stroke (16.2 percent). We find similar differences among privately insured adults: 81.4 percent of those with unmet prescription drug needs reported at least one condition, compared with 61.2 percent of privately insured adults without unmet needs.

Discussion

High and rising prescription drug costs are a significant public concern that can create affordability problems and unmet needs for consumers (Hamel et al. 2021), including those with and without health insurance coverage. Though prescription drugs account for up to 14 percent of national health

spending, they represent nearly 22 percent of out-of-pocket costs for the Medicare beneficiaries in our sample and nearly 17 percent of such costs for privately insured nonelderly adults (data not shown). In this analysis, we estimate that nearly 13 million adults delayed or went without medications annually because of costs in 2018–19. This included more than 6 million adults with Medicare or private insurance, for whom unmet prescription drug needs were most common among women, those with low incomes, and those with multiple chronic health conditions. Though most adults with Medicare or private coverage had modest out-of-pocket costs for prescription drugs, some experienced high spending burdens relative to their incomes, which could further exacerbate unmet needs for other types of care and limit resources for other needs. In addition, uninsured adults reported prescription drug affordability problems at higher rates than adults with Medicare or private insurance. Approximately 1 in 10 adults who were uninsured for some or all months of the year, or more than 4 million people, delayed getting or did not get prescription drugs because of the cost.

The high cost of prescription drugs remains an ongoing policy challenge, and the estimates in this analysis provide insight into the populations who could benefit most from legislation to reduce prescription drug prices and out-of-pocket costs. Policymakers are considering various proposals in the BBBA to expand health insurance coverage and lower prescription drug costs, some of which are modeled on provisions of H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act. Among other things, H.R. 3 would have allowed the secretary of health and human services to negotiate prices for brand-name drugs that have little competition and account for significant spending. These lower prices would have applied to both Medicare and commercial health insurance plans, potentially yielding substantial savings for governments, employers, and consumers. The Congressional Budget Office has projected that drug price negotiations alone under H.R. 3 would have saved federal programs $456 billion between 2020 and 2029.[11] Other provisions of H.R. 3 would also have had more modest cost implications for the federal government; inflation rebates would have saved an additional $36 billion, and changes to the Part D benefit design and establishment of the out-of-pocket spending cap in Part D would have had a net federal cost of $9.5 billion.[12] The Centers for Medicare & Medicaid Services estimates H.R. 3 would have produced savings of $120 billion for households and $43 billion for private businesses.[13] The legislation's out-of-pocket cap would have reduced out-of-pocket costs for Part D enrollees whose costs exceed $2,000 (more than 1 million people) by an average of about $1,200 annually, with the greatest benefits accruing to those who need the most expensive drugs (Cubanski, Neuman, and Damico 2021b; Dusetzina 2021).

At the time of writing this brief, the BBBA recently passed by the House of Representatives includes the $2,000 out-of-pocket spending cap for people enrolled in Part D, inflation rebates for drugs covered by Parts B and D that apply to both Medicare and commercial plans, and several other provisions that would directly lower cost sharing for people with Medicare and some people with commercial plans. The bill would also provide federal authority for negotiating Medicare drug prices, but the proposed reform would generate smaller savings than the more robust price negotiation provisions of H.R. 3. The Congressional Budget Office estimates that the BBBA's price negotiation provisions would produce savings of about $76 billion between 2022 and 2031, and the inflation rebates would produce savings of about $84 billion during that period.[14]

Though drug price reforms could benefit Medicare beneficiaries and people with private insurance, their effects on premiums, out-of-pocket costs, and prescription drug affordability problems would likely vary for insured consumers. In contrast to targeted prescription drug legislation like H.R. 3, other elements of the BBBA could have a more direct impact on prescription drug affordability challenges facing uninsured adults. These include the extension of enhanced premium subsidies authorized under the American Rescue Plan Act for health plans sold through the health insurance Marketplaces and efforts to provide health insurance to uninsured adults who are in the "coverage gap" in the 12 states that did not expand Medicaid under the Affordable Care Act. However, even if these reforms were passed, the cost of prescription drugs will likely be a persistent policy concern for both uninsured people and people with health insurance who cannot afford their out-of-pocket costs.

Notes

1 Peter Sullivan and Scott Wong, "Democrats Race to Reach Deal on Prescription Drug Pricing," *The Hill*, November 1, 2021, https://thehill.com/policy/healthcare/579483-democrats-race-to-reach-deal-on-prescription-drug-pricing.

2 This includes adults who skipped medication doses, took less medicine, or delayed filling a prescription to save money in the past 12 months. See Cohen, Boersma, and Vahratian (2019).

3 Matthew Rae, Rabah Kamal, and Cynthia Cox, "Who Is Most Likely to Have High Prescription Drug Costs?" Peterson-KFF Health System Tracker, September 29, 2020, https://www.healthsystemtracker.org/chart-collection/who-is-most-likely-to-have-high-prescription-drug-costs/.

4 Similar median out-of-pocket spending by uninsured and privately insured people does not imply similar levels of drug utilization. Uninsured adults are less likely than privately insured adults to use prescription drugs, but they often pay the full cost out of pocket. In contrast, privately insured adults often pay only a portion of their drug costs out of pocket through copayments.

5 In 2022, adults enrolled in Medicare Part D prescription drug plans will face a $480 deductible, an initial coverage limit of $4,430, and a catastrophic threshold of $7,050. See Centers for Medicare & Medicaid Services, "Announcement of Calendar Year (CY) 2022 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies," January 15, 2021, https://www.cms.gov/files/document/2022-announcement.pdf.

6 Medicare beneficiaries enrolled in Part D prescription drug plans automatically qualify for a Low-Income Subsidy (also known as Extra Help) that covers their Part D premiums and most of their out-of-pocket costs if they are enrolled in Medicaid, Supplemental Security Income, or a Medicare Savings Program; beneficiaries can also qualify for the subsidy based on having low income (below 150 percent of the federal poverty level) and limited assets. Part D covers most retail prescriptions, but some prescription drugs are covered under Part B, including many administered by physicians. About half of Medicare beneficiaries with Part D prescription drug coverage are enrolled in a standalone prescription drug plan, and the other half are enrolled in a Medicare Advantage drug plan. Part D plans must offer the standard drug benefit or one that is actuarially equivalent and may also offer enhanced benefits. See KFF (2021) and Kirchhoff (2020).

7 Elderly adults with both Medicare and Medicaid represent 2.4 percent of the adult sample. We also exclude adults ages 65 and older who are not covered by Medicare from our analysis, who constitute 0.3 percent of the adult sample.

8 To determine coverage type, we put all nonelderly adult respondents in one of five mutually exclusive groups with the following hierarchy: full-year privately insured, full-year Medicaid/Children's Health Insurance Program (CHIP), full-year coverage that includes other combinations of private and public insurance, full-year uninsured, or part-year uninsured. We exclude nonelderly adults with full-year coverage that is not private insurance or

Medicaid/CHIP (3.5 percent of the adult sample) from our analysis. These people primarily have a mix of coverage types during a year.

[9] "Using Appropriate Price Indices for Analyses of Health Care Expenditures or Income across Multiple Years," Agency for Healthcare Research and Quality, accessed November 4, 2021, https://meps.ahrq.gov/about_meps/Price_Index.shtml.

[10] "Prior HHS Poverty Guidelines and Federal Register References," US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, accessed November 4, 2021, https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references.

[11] Philip A. Swagel (director, Congressional Budget Office), letter to Frank Pallone Jr. (chairman, Committee on Energy and Commerce, US House of Representatives), regarding, "Budgetary Effects of H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act," December 10, 2019, https://www.cbo.gov/system/files/2019-12/hr3_complete.pdf.

[12] Swagel, letter to Pallone, regarding "Budgetary Effects of H.R. 3."

[13] Centers for Medicare & Medicaid Services, Office of the Actuary, memo regarding, "Updated Financial Impacts of Titles I and II of H.R. 3, 'Lower Drug Costs Now Act of 2019,'" November 8, 2019, https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/HR3-Titles-I-II.pdf.

[14] Congressional Budget Office, "Summary of Cost Estimate for H.R. 5376, the Build Back Better Act," November 18, 2021, https://www.cbo.gov/publication/57627.

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