ENTITLEMENTS IN THE AGE OF AUSTERITY:

MEDICARE PART D

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This dissertation is dedicated to my wife, Toyoko and to my children, Sarah and Jack.

ABSTRACT

Using data from the 2004 to 2008 waves of the bi-annual University of Michigan Health and Retirement Survey (HRS), this dissertation examines Medicare Part D, the prescription drug plan for seniors. This study uses the social contract and elements of political economy theory to develop an investigative framework for analysis of the consequences of social policies such as Medicare Part D.

The study principally examines the consequences of Medicare Part D for enrolled HRS survey participants who use prescription drugs. Employing a longitudinal panel design, the analyses explore the participant experience with Medicare Part D. Specifically this study addresses four basic research questions:

1. What are the demographic characteristics of HRS sample respondents who had Medicare Part D coverage in 2006 and 2008?
2. What are some of the changes in the prescription-drug experience for retirees as a result of enrollment in Medicare Part D?
3. What are the demographic factors associated with the utilization of and satisfaction with prescription drugs through Medicare Part D for Medicare-enrolled HRS survey respondents?
4. How and for whom have out-of-pocket prescription costs changed as a result of enrollment in Medicare Part D?

As a general summary of the results, the results showed that more than 90% of HRS survey respondents had signed up for Medicare Part D in 2006. The analyses also revealed that monthly prescription costs decreased after enrollment in Medicare part D.

Over time, Medicare Part D respondents had lower prescription drug payments per month after enrolling in Medicare Part D, both in 2008 as compared to 2006 and in 2006 as compared to 2006. Demographically, educational attainment was the most significant factor in both increased use of medication and increased use of supplemental insurance plans. This study also showed that prescription-plan payments increased over time and that the sharpest increases in prescription-plan payments occurred between 2004 and 2006, with only a slight increase from 2006 to 2008.

In the domain of political economy, free scientific inquiry meets not merely the same enemies as in all other domains. The peculiar nature of the material it deals with, summons as foes into the field of battle the most violent, mean and malignant passions of the human breast, the furies of private interest.

-Karl Marx

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CHAPTER 1

INTRODUCTION

This dissertation examines the consequences of Medicare Part D, a new prescription drug plan for seniors. The study utilizes longitudinal data from the University of Michigan Health and Retirement Survey (HRS), a dataset that includes information on over 60,000 respondents. This study uses 3 sample years: 2004, 2006, and 2008.

Using social contract theory and political economy theory as a framework, this study attempts to ascertain the efficacy of Medicare Part D both as a social policy and a consumer program. Specifically, this dissertation examines the impact that Medicare Part D has had on the prescription-drug experience of enrolled members who participated in the HRS surveys. To achieve this goal, this dissertation analyzed specific health variables in the HRS data before (2004 sample) and after (2006, 2008 sample) enrollment in Medicare Part D. The goal of this study was to better understand the participant experience with Medicare Part D and to situate the new program within the domain of entitlements and the social contract by highlighting the effects of Medicare Part D enrollment on study participants. The following four research questions were the main focus of this analysis:

1. What are the demographic characteristics of HRS sample respondents who had Medicare Part D coverage in 2006 and 2008?
2. What are some of the changes in the prescription drug experience for retirees as a result of enrollment in Medicare Part D?

3. What are the demographic factors associated with the utilization of and satisfaction with prescription drugs through Medicare Part D for Medicare enrolled HRS survey respondents?

4. How and for whom have out-of-pocket prescription costs changed as a result of enrollment in Medicare Part D?

These questions relate to the social contract on multiple levels. On the one hand Medicare Part D can be examined through a normative view of what a social contract *ought* to be. On the other, a more positivist approach assessing *what is* in the outcome of the empirical analysis on Medicare Part D participant experiences over the sample period.

The relationship between the research questions and the social contract is one in which factors such as demographics and costs may be indicative of which level of “fairness” (outlined in later chapters) is the appropriate metric to assess the efficacy of Medicare Part D as an element of the social contract. In other words, if viewed normatively, what is the appropriate basis for judgment? Secondarily, from an empirical positivist perspective how does the data reflect normative conceptions of fairness?

To address these questions, datasets had to be created and filtered to ensure that the data were tracking and comparing the same people over time A dataset for the 2004 Cohort was created to capture respondents who participated in the 2004, 2006, and 2008 samples and enrolled in Medicare Part D in 2006. This was done by filtering the sample to include only respondents with responses in all 3 survey years: (2004, 2006, and 2008) and whose Household ID (HH) and Personal Identification Numbers (PIN) matched in all 3 years. By doing this, a direct analysis of the same respondents in 2004 (pre-Medicare Part D) and again in 2006 and 2008 was possible.

Chapter 2 presents the origins of Medicare Part D as a social policy, then uses social contract theory and political economy of aging theory to help shape the subsequent discussion. The goal in this chapter is to show that the concept of the social contract has evolved and expanded, with brief periods of stability interrupted by the ever-changing nature of citizens‘ needs and government power. Theories from the political-economy perspective are also used to discuss the role of power in shaping social policies such as Medicare Part D.

Chapter 3 discusses the research methods used in the study. It begins with an overview of the general sample. Next, the chapter presents progressively sophisticated statistical tables that help answer the research questions listed above. The discussion also includes various comparisons between pre-and post-Medicare Part D enrollment in an attempt to assess the impact of the program.

Chapter 4 presents and interprets the findings of the research. Among the preliminary findings, most HRS respondents who signed up for Medicare Part D in 2006 identified themselves as Caucasian, with a mean age of 72 and most (65%) reporting incomes under $60,000 per year. Some of the changes experienced by Medicare Part D participants were that more prescriptions were used after enrolling in Medicare Part D and the out-of-pocket costs of the prescriptions decreased. However, the cost of insurance under Medicare Part D increased, and this had an overall impact on total out-of-pocket costs when combining prescription payments with the insurance payments.

Chapter 5 offers some discussion about the specific research questions, highlighting the significant findings within the research matrix. This chapter breaks down the findings in the research and offers substantive explanations for the findings. In a point

–by-point analysis, this chapter both encapsulates the key findings in the research and attempts to provide evidence from comparable studies to validate the claims made. This chapter concludes by briefly suggesting the future research needs in this field and peering into some potential changes to Medicare Part D.

The relevance of this study is that the world is coming into an age of austerity. Simply put, the United States Government continues to struggle economically. Entitlement programs such as Medicare Part D, which is set to be utilized by some 80 million baby boomers alone, are budget busters. Yet, Medicare Part D is law and therefore is an entitlement that will not likely be taken away without a political fight. This research looks at Medicare Part D at the micro level the enrollee experience, but also at the macro-level, the pledge by the government to provide premium support for retiree prescription care.

The ultimate goals of this research are to contribute to a better understanding of the impact of Medicare Part D not just for enrollees but for society as a whole, and to identify within the data and the literature the strengths and weaknesses of Medicare Part D along with opportunities and threats to its sustainability. The desired outcome is that insights found in this research may better inform health and social policy makers in addressing issues of –entitlements" in the face of looming austerity.

With the ongoing financial crisis the seemingly untouchable halo that has surrounded Social Security, Medicare, Medicaid and other social programs seems to have given way to a financial reality in which cuts are all but inevitable. President Obama's Patient Protection and Affordable Care Act will cut $120 billion dollars over 5 years from Medicare alone (The Heritage Foundation, 2011) and he's a Democrat. From an academic standpoint, the field should conduct exploratory research into various entitlement programs and whether cuts are needed to pinpoint where and how to most effectively continue service delivery to the most needy without bankrupting the country or pushing enormous debts onto future generations. This is why a sociological perspective on the current impact and long-term effects of Medicare Part D is both useful and relevant. As Bernice Pescosolido and Jennie Kronenfeld (1995) notes: ―It is in times of major change that sociologists can make the most meaningful assessments and be most influential on social policy.” This research takes the opportunity to engage the issue of entitlements such as Medicare Part D and makes a meaningful contribution to the discussion.

CHAPTER 2

REVIEW OF THE LITERATURE

This chapter begins with a review of Medicare Part D as a new installment in a long-standing process of exchange between citizens and government via a social contract. The chapter then investigates and extrapolates on the political economy of aging as preferred sociological lens for viewing both the process and consequences of Medicare Part D. Using these theories together, the process of exchange that created Medicare Part D and the beliefs and actions that led to its creation are given careful scrutiny.

To educate the reader and situate Medicare Part D within a larger rubric of Medicare plans, a basic overview of the Medicare is provided in Appendix A for review. Appendix A shows that Medicare Part D fits in with the general framework of what the broader program of Medicare offers. Many of these programs have been studied extensively (Bowers, 2010; Miller, 2010; Salvato, 2010); however, data for Medicare Part D have only begun to be collected and analyzed. Early reviews situated Medicare and Medicare Part D as increasingly costly entitlement programs. The CBPP framed the issue as follows:

> It is the increasing cost of the medical elements of federal entitlement programs like Medicare Part D that suggest concerns. Currently, three health insurance programs—Medicare, Medicaid, and the Children's Health Insurance Program (CHIP)—will together account for 21 percent of the budget in 2010, or $753 billion. Nearly two-thirds of this amount, or $468 billion, will go to Medicare, which provides health coverage, including prescription care to around 46 million people who are over the age of 65 or have disabilities. (Center on Budget and Policy Priorities, 2010)~~.~~

Providing new entitlement programs such as Medicare Part D to seniors is made more financially risky by the fact they are the most costly population medically and are swelling in numbers. The Census Bureau forecasts that the 65-and-over population will rise from 38.7 million in 2008 to 88.5 million by 2050 (Kotz, 2010). Overall, people over 65 spend 4 times as much on healthcare as people under 65. Moreover, although people over 65 currently comprise just 13% of the population, they account for 33% of national healthcare spending (Moody, 2006). At the same time, projected replacement rates for taxpayers to pay the health-care costs of current and near-future retirees have been dropping along with the ratio of workers to beneficiaries, declining from 3.5 to 1 and to 2.3 to 1, respectively, in 2010 alone (Kaiser Family Foundation, 2010).

With an aging demographic and rising costs, it may well be time to go beyond the political rhetoric surrounding entitlement programs such as Medicare Part D and to, in the great sociological tradition, closely examine the deep structures and power relations that underlie and direct the practices of individuals, groups, and organizations (Light & Hughes, 2001).

Another element of Medicare Part D that makes for interesting study is its controversial origin and timing (Brandon, 2010; Camissa et al., 2008; So & Katz, 2010). On the cusp of more than 80 million baby boomers soon to retire (Ydstie, 2008), the federal government created a premium support plan to help provide prescription care to eligible retirees. A basic question is, why? Although policies on healthcare for retirees have long been understood as a complex social problem in most societies, market-driven or not (Cutler, 2007), studying the consequences of Medicare Part D offers a unique opportunity to examine the reasons for its particular design, and why the policy is shaped the way it is.

Previous studies from the field of gerontology (Hooyman &~~,~~ Kiyak, 2005), the sociology of medicine (Moody, 2006), and the political economy of aging (Estes & Wallace, 2005; Minkler, 1999) have played significant roles in establishing the contemporary macro–micro debate about the best approach to address the health needs of retirees. Adding to the debate, political science scholars (Hacker, 2006) and public policy analysts (Dokken, 2000; Light, 2000;) have also made significant contributions to research on entitlement programs targeting seniors by discussing the political realities of the countervailing powers inherent in policy decisions. If "aging and the problems faced by retirees are socially constructed and result from societal conceptions of aging and the aged," (Estes, 2001, p. 39) then the solutions to the problems of aging, and particularly prescription care, may well be found in examining social policies designed to meet those targeted needs.

Origins of a Social Policy

Medicare as a social policy began as law on July 30, 1965, when President Johnson signed the Medicare and Medicaid Bill (Title XVIII and Title XIX of the Social Security Act, respectively) in Independence, Missouri. Medicare is provided by the Social Security Administration (SSA), whereas federal assistance to the state Medicaid programs is administered by the Social and Rehabilitation Service. The resulting Medicare program extended health coverage to American citizens age 65 or older. About 19 million beneficiaries enrolled in Medicare in the first year of the program. Medicaid provided access to healthcare services for certain low-income persons and expanded the existing federal–state welfare structure that assisted the poor.

In 1965 the federal government spent 1% of the total budget on Medicare and Medicaid; the two most frequently used federal health programs. By 2006, 19% of federal spending was directed to Medicare and Medicaid. Nationally, healthcare costs have grown an average of 2.5% faster than the U.S. gross domestic product since 1970 (Kaiser, Family Foundation, 2007). Total spending was $2 trillion in 2005, or $6,700 per person, the most per person in the developed world (Catlin, Coward, & Hefflin, 2006). Today, total healthcare spending represents 16% of the gross domestic product with an expected increase for the next decade reaching $4 trillion in 2015, or 20% of the gross domestic product (Borger, 2006).

In 1965, when Medicare first became federal policy with an eligibility criterion established as 65 years or older, life expectancy was 70.2 years (National Center for Health Statistics, 2007). A baby born in the United States today can expect to live 78.6 years as of 2008. From 2010 to 2030, the proportion of the population over 60 will grow from 18% to 25% in the United States, and the consensus is that programs such as Medicare face serious challenges in meeting future retiree needs given its current cost and scope (Feldstein, 2006).

However, in December 2003, President Bush signed the Medicare Prescription Drug Improvement and Modernization Act into law. At the signing of Medicare Part D, the president stated that ~~b~~y reforming and modernizing this vital program, we are honoring the commitments of Medicare to all our seniors~~,~~” (U.S. Department of Health and Human Services, 2007).

The Medicare Modernization Act (MMA) began a major expansion of Medicare. The legislation relies exclusively on private insurers to deliver the new Part D prescription-drug plans. This was part of President Bush's broader goal of less reliance on government through the creation of social policy reforms such as the partial privatization of Social Security and decreases in Medicaid reimbursements to states. Rather than a defined benefit program, Medicare Part D was established as a premium support program in furtherance of a long-term theme of cost containment. President Bush explicitly empowered private-sector corporations in the insurance and pharmaceutical industries by granting them principle roles in pricing and administering Medicare Part D. Key elements of the bill are highlighted below:

A standard Part D benefit is established. In 2006, it features a $250 deductible, 25% enrollee cost-sharing (or 25% enrollee cost-sharing on average) for drug costs above the deductible up to an initial coverage limit of $2250, and catastrophic drug coverage once the enrollee has reached $3600 in out-of-pocket costs (this translates to $5100 in total drug spending). The enrollee then pays the greater of $2 and $5 co-pays or 5% coinsurance for drug costs in the catastrophic range. The $2 co-pays apply to generic or preferred multiple-source drugs, while the $5 co-pays apply to other drugs. In later years, all dollar figures are indexed to the per capita growth in spending for covered Part D drugs and rounded.

Medicare drug plans must also provide enrollees with access to negotiated drug prices (including for drugs purchased in the coverage gap). Part D plans may offer the standard benefit (defined above) or an actuarially equivalent benefit that meets a multi-part test. The test requires that:

1. The total actuarial value of the alternate coverage equals or exceeds the total actuarial value of standard coverage.
2. The unsubsidized value of the alternate coverage (defined as the amount by which the total actuarial value exceeds the total actuarial value of federal subsidies) equals or exceeds the unsubsidized value of standard coverage.
3. The total payment made for costs below the initial coverage limit under the alternate coverage equals or exceeds the total payments made at that same limit under standard coverage.
4. The alternate deductible does not exceed the standard deductible.
5. The alternate coverage provides the same out-of-pocket limit and beneficiary cost sharing in the catastrophic coverage range as standard coverage. (Medicare Prescription Drug Improvement and Modernization Act 2003)

Again, Medicare Part D is a premium support plan, which means individuals pick a private Part D insurer whose premiums vary by drug plan. The drug plan‘s premium for basic coverage is set at approximately 25.5% of the national, weighted-average plan bid plus or minus the difference between the average (geographically adjusted) and the plan‘s bid. The plan premium is uniform for all enrollees in a region, except that the premium is increased if any late-enrollment penalty that applies or decreased if the enrollee is eligible for low-income assistance. Since May 15, 2006, the penalty for late enrollment has been a 1% increase in premiums for each month of delay in enrollment past the initial enrollment period (Medicare.gov, 2011). The plans may charge an additional premium for any supplemental coverage offered under Medicare Advantage of other policies.

The late-enrollment penalty applies to eligible individuals who do not enroll in Part D by the last day of the period during which they were first eligible to enroll. The penalty is currently calculated as 1% of the average basic enrollee premium. In other words, if a participant delays in signing up for Part D for say 10 months, Part D premiums will always be at least 10% more than other enrollees pay. This is a clear and substantial negative financial consequence for not enrolling in Medicare Part D as soon as one is eligible. The downside to not enrolling is not a one-time penalty but a lifelong one.

Covered Part D drugs are defined as those drugs covered under the Medicaid program plus insulin, insulin-related supplies, certain vaccines, and smoking cessation agents. Drugs currently covered in Parts A and B of Medicare will continue to be covered by those policies, rather than Part D. The definition excludes certain drugs, such as barbiturates, benzodiazepines, weight-loss pills, and fertility drugs. Drug prices negotiated by Medicare Advantage plans and qualified retiree plans are not included in the establishment of a ―best price” for the Medicare program (CMS, 2004).

As a brief overview of the enrollee experience, all Medicare Part D beneficiaries who signed up for the drug benefit pay a monthly premium, $26 per month in 2008. Beneficiaries are responsible for the first $250 in drug expenses and then must pay 25% co-pay until they reach the prescription benefit limit ($2,510 in 2008). Once the prescription benefit limit has been reached, enrollees face a planned gap in coverage requiring them to pay 100% of their drug costs up to $4,050. After the ceiling is reached, Medicare benefits will then pay 95% of drug costs above that amount (Neuman, Kitchman, Voris, 2004). This cycle repeats annually throughout the member‘s participation in Medicare Part D, meaning the coverage gaps requiring participants to pay 100% of their prescription costs reset on a yearly basis.

Why would a prescription program deliberately have gaps? Because the design of the program is not to provide a blank check for senior prescriptions, but to institutionalize a premium support system for private insurers. First introduced into the Medicare debate by Aaron and Reischauer (1995), premium support schemes reflect an idea with widespread support among health economists and policy analysts that price competition among private prescription care providers will ultimately improve the efficiency of healthcare spending. Premium support is a variant of the ―managed competition” purchasing reforms advocated by Enthoven and others (e.g., Enthoven & Singer, 1995). Premium support systems have been widely adopted by large employers and health insurance purchasing groups and are likely responsible for much of the recent growth of managed care among the privately insured.

In premium support systems of care, the federal government negotiates with health plans on a package of health insurance benefits to be provided each year based on a cost-per-recipient basis. The private plans then bid competitively to provide health benefits to members, in this case retirees, who may choose among participating plans based on price and quality. The government contribution toward the plan‘s cost is fixed, so beneficiaries face the full marginal difference in prices among plans.

Adopting a premium support system as the primary method of delivering prescription care to seniors places a dollar limit on benefits. Premium support is not a plan in which the government contribution is fixed by law. Instead, the percentage of the government‘s contribution is based on the weighted average price of all the plans and therefore increases along with the cost of the average plan. This contribution structure provides an incentive for profit private insurers to increase the cost of their plans. Critics of premium support schemes argue that they result in overpayments to private plans for two reasons:

1. The benchmark amount against which plans bid is set too high. It is based on the inflated payments to Medicare Advantage plans that were in place before 2006 instead of actual costs.

2. Risk adjustment is inadequate. Medicare Advantage plans have been attracting healthier-than-average Medicare beneficiaries, but their payments have not been adequately adjusted to reflect this. CMS is required to phase in a new risk adjustment payment system between 2007 and 2010 that is meant to reduce risk adjustment overpayments for that period, but this requirement expired in 2010 (Families USA, 2006).

Lingering questions about the structure of the program continue to be brought forward by skeptics of market based prescription care. As mentioned above, one of the chief complaints about Medicare Part D is that it includes a planned out-of-pocket expense for participants after the so called "Donut Hole" (or coverage gap) begins. The current Donut Hole occurs when the government picks up the bulk of drug costs only until the beneficiary and the government together have spent $2,250 for the year. At that point, beneficiaries must pay 100% of costs until they have spent a total of $3,600 of their own money. Then the federal subsidy resumes, paying 95% of any additional expenses (Lee, & Levin, 2006). But what does this mean in practice?

As an example, say Mrs. Smith has monthly drug costs of $800 for three drugs that cost $300, $200, and $300. Assuming that all of the plans in which she is interested have a $2,400 initial coverage limit and that all of her drugs are on the plans' formularies, she will reach the Donut Hole or coverage gap in 3 months. If she enrolls in a plan offering the standard benefit ($265 deductible and 25% co-insurance), her out-of-pocket (OOP) costs will be $865 per month when she reaches the initial coverage limit. She will incur an additional $2,885 in out-of-pocket expenses before reaching the catastrophic insurance coverage level. She will, therefore, be without coverage for almost 4 months ($800/month in drug costs x 4 = $3,200; Center for Medical Advocacy, 2007).

There is another flaw in Medicare Part D that critics point to: Why are insurance and drug prices market based and not negotiated at the federal level? Families USA, a health-choice consumer consortium, issued a provocative report on Medicare Part D in 2006. Among the early findings,

> The prohibition on federal price negotiation with pharmaceutical companies makes Medicare Part D uncompetitive and unnecessarily costly. Drug price negotiations are one of the main cost control measures instituted by every other developed country in the world. Drug prices in Medicare Part D prescription drug plans cost, on average, 58% more for the most commonly prescribed drugs than prices paid by the U.S. Department of Veterans Affairs (VA), which negotiates bulk prices. (American Federation of Teachers, 2007)

When the government does negotiate lower prices for bulk drug purchases, it saves more than 40% compared to the market cost. Applied to Medicare, this would save about $560 billion over the first 8 years of the program (Cruz, 2006).

The short answer as to why the federal government has not used its enormous power as the biggest purchaser of healthcare is that leadership in Congress did not want to. Instead, Congressional leaders promised subsidies to nearly every private entity involved in elder health: to private health providers to induce them to adopt the (unprofitable) older subscribers they had been dropping, to insurance companies to create drug-only policies, to employers to continue retiree health coverage, and to rural hospitals and doctors who had not been compensated adequately under previous Medicare arrangements and saw this as an opportunity for additional resources.

The result is that for all of the top 20 drugs prescribed to seniors, the lowest price charged by any Part D plan was higher than the highest price secured by the Veterans Administration for the same drug (Families USA, 2006). Even to the present and under the Patient Protection and Affordable Care Act, Congress has refused to empower the Medicare system to negotiate directly with the drug companies as the VA does or to negotiate with private insurers to make insurance prices more affordable (See Figure 1).

Why was this inefficiency enshrined into law? To answer that question, it is necessary to identify the power structure and actors in the development of Medicare Part D. Among these actors, PHARMA was perhaps the most influential special interest group in shaping how the final policy worked (Heaney, 2003). As the primary negotiator for drug companies, this lobby spent a significant sum in advocating for its drug

Lowest Department of Veterans Affairs (VA) Prices and Lowest Medicare Prescriptior Drug Plan (PDP) Prices for the Top 20 Drugs Used by Seniors, April 2006

Drug Name	Strength	Dose Form	Lowest VA Price Per Year	Lowest PDP Price Per Year	Price Difference Per Year	Percent Difference
Actonel	35 mg	tab	$ 372.24	$ 703.32	$ 331.08	88.9%
Aricept	10 mg	tab	$ 1,058.69	$ 1,553.40	$ 494.71	46.7%
Celebrex	200 mg	tab	$ 632.09	$ 902.64	$ 270.55	42.8%
Fosamax	70 mg	tab	$ 265.32	$ 727.92	$ 462.60	174.4%
furosemide	40 mg	tab	$ 8.56	$ 13.44	$ 4.88	57.0%
Lipitor	10 mg	cap	$ 520.44	$ 748.92	$ 228.48	43.9%
Lipitor	20 mg	tab	$ 782.44	$ 1,068.36	$ 285.92	36.5%
metoprolol tartrate	50 mg	cap	$ 7.20	$ 12.00	$ 4.80	66.7%
Nexium	40 mg	tab	$ 848.45	$ 850.44	$ 1.99	0.2%
Norvasc	5 mg	tab	$ 315.84	$ 463.20	$ 147.36	46.7%
Norvasc	10 mg	tab	$ 490.44	$ 636.60	$ 146.16	29.8%
Plavix	75 mg	tab	$ 989.36	$ 1,283.76	$ 294.40	29.8%
Prevacid	30 mg	tab	$ 657.48	$ 862.20	$ 204.72	31.1%
Protonix	40 mg	tab	$ 214.45	$ 1,110.96	$ 896.51	418.0%
Toprol XL	50 mg	tab	$ 162.65	$ 224.52	$ 61.87	38.0%
Toprol XL	100 mg	tab	$ 250.06	$ 336.00	$ 85.94	34.4%
Xalatan	0.005 %	sol	$ 279.84	$ 555.96	$ 276.12	98.7%
Zocor	20 mg	tab	$ 127.44	$ 1,275.36	$ 1,147.92	900.8%
Zocor	40 mg	tab	$ 190.76	$ 1,275.36	$ 1,084.60	568.6%
Zoloft	50 mg	tab	$ 542.12	$ 786.96	$ 244.84	45.2%
Median Difference					**$ 257.69**	**45.9%**

Note: Annual price is calculated based on the price posted by the Medicare drug plans and the Department of Veterans Affairs in April 2006.

Source: Dee Mahan, *Big Dollars, Little Sense: Rising Medicare Prescription Drug Prices* (Washington: Families USA, June 2006).

Figure 1. VA costs versus Medicare Part D.

development clients. Between 1998 and 2008, the pharmaceutical industry spent more on lobbying, by far, than any other health-related industry. Moreover, since 1990, pharmaceutical manufacturers have spent over $87 million in campaign donations, $40 million of which went to congressional candidates. In 2006, the health sector spent $351.1 million to lobby the federal government—an amount that accounted for 13.8% of all spending on lobbying (Steinbrook, 2008). Drug-maker Amgen spent $16.2 million in lobby money, followed by Pfizer at $13.8 million. Other big spenders included Roche ($9 million), Sanofi-Aventis ($8.4 million), Glaxo ($8.2 million), and Johnson & Johnson ($7.7 million), all within the policy creation period for Medicare Part D (Ismail, 2008).

Where did all this lobby money go, and could it possibly have had any influence on how Medicare Part D operates functionally? The Center for Public Integrity (2008) issued a report that identified three benefits secured through these lobbying efforts:

1. Blocking the importation of inexpensive drugs from other countries,
2. Protecting pharmaceutical patents both within the United States and abroad, and
3. Ensuring greater market access for pharmaceutical companies in international free trade agreements. (p 57).

As Medicare Part D policy development largely took place behind closed doors—well away from the electoral limelight (Marmor, 2000)—private interests were able to shape the policy in ways that were beneficial to their financial interests. It is also notable that several key member of Congress who pushed Medicare Part D into law resigned from government soon after to take jobs at companies that benefitted handsomely from the legislation they created. As just one example, former Senator William Tauzin, a major proponent of Medicare Part D legislation, quit Congress two months after the bills passage and is now CEO of PhARMA, with an annual salary of $2 million dollars (Lotke, Hickey, 2006).

As a result of the structure of Medicare Part D, private industry (both drug manufacturers and insurance companies) made record initial profits. The insurer Humana reported that its 2006 third quarter profits (first quarter for Part D) more than doubled, increasing from $46.8 billion to $159.2 billion (a 64% increase per share) in one year. Officials from the country‘s second largest provider of Medicare D plans stated that revenues from the third quarter of 2006 rose from $3.82 billion to $5.65 billion (a 48% increase) in the same time period. These increases were primarily the result of higher enrollment in the company‘s Medicare Advantage plans and new 2006 revenues from stand-alone prescription drug plans (PDPs) for Medicare beneficiaries, (Cassels, 2008).

Like most existing social policies, Medicare Part D was developed through the legislative process. The stakeholders included politicians, lobbyists and further down the line, the general public. Sociologists and policy researchers have observed and written extensively about how a social policy moves through the legislative process on its way to law and note that it is not the individual voter but political contributors and election cycles that fundamentally shape policy (Binstock, 1984; Moon & Mulvey, 1995). These various interest groups create pressure, both in their dollars and in their ability to create a public consciousness around their needs and desires.

Medicare Part D is a premium support program for prescription care for seniors. Ultimately the bill was shaped by three primary interest groups: politicians, pharmaceutical and insurance companies, and advocacy groups. Politicians are often beholden to outside funding. The process of election is a constant cycle of fundraising and policy concessions, so public decision makers are not above rational self-interest. Pharmaceutical companies have an interest in maintaining or increasing drug prices under any proposed new system, and they lobbied hard to advocate their position in policies that affect their industry.

So, what should be done with a program that appears to spend taxpayer dollars inefficiently and yet is now the standard of prescription care for retirees? Ripples of the debate about fiscal austerity versus consumer needs can be seen within the healthcare field itself, with a culture war between traditionalists who want to retain an open-ended system of healthcare within competitive marketplaces, and rationalizers who seek to contain healthcare costs by applying various instruments of managed care (Mechanic, 2001). General reviews of relevant literature on the anticipated and actualized unmet needs for retiree prescription care appear to have generated two schools of thought. On the one hand, many people believe that increasing taxes to pay for entitlement programs is fundamentally and fiscally unsound. These are the scholars (Altman, & Shactman, 2002) and scribes (Mallaby, 2006) who refer to the New Deal legacy of social benefits as ―entitlements," in name only and that these programs should be cut, capped and privatized.

Even within the social sciences, some scholars of the political economy of aging (Binstock, 1983; Thurow, 1996; Wisensale, 1999) have raised issues of generational equity and have pointed to the huge amount of resources consumed by the elderly as a form of intergenerational injustice. Thurow (1996) notes this eloquently (p. 46):

> A new class of people is being created, a large group of affluent, economically inactive, elderly voters who require expensive social services like healthcare and who depend on the government for much of their income. It is a revolutionary class, one that will bring down the social welfare state, destroying government finances, altering the distribution of purchasing power and threatening the investments that all societies need to make to have a successful future.

Others argue that deconstructing benefits programs amounts to the privatization of citizenship, which further entrenches the inequality between rich and poor (Conason, 2005; Dokken, 2000, Hacker, 2002). Still others note that issues of intergenerational justice in health policy have long been problematic when dealing with the aged and that Medicare Part D is just the latest manifestation of a long-standing problem (Estes, 2001; Gordon, 2003, Rudolph & Evans, 2005). An extension of this argument is that elderly healthcare does not constitute a crisis; rather, it is an opportunity to give back to elders who have intrinsic value and institutional memory.

All of these arguments fall under the umbrella assessment of the meaning of a social contract. They essentially argue for or against entitlements on the basis of need, cost and fairness. Each of the above arguments attempts to develop the optimal model by which limited resources should be distributed. Implicitly or explicitly, each position falls within the spectrum of social conservatism (favoring less government involvement in people‘s lives) and social liberalism (which favors more).

This research takes the position that normatively a social program should do the greatest good for the greatest number. Benefits should be distributed equally. Inequality in the distribution of social primary goods must be justified in terms of other social goals, such as the alleviation of elder poverty as a result of health care. In this view, ―all social values-liberty, and opportunity, income and wealth and the bases of self-respect- are to be distributed equally unless an unequal distribution of any, or all, of these values is to everyone‘s advantage," (Rawls, pg. 62).

What makes the immediacy of the problem of entitlement programs in the form of retiree health insurance and prescription coverage more pressing is that private employers have been steadily walking away from their long-term commitments to employee healthcare in retirement. As a piece of the puzzle, private employers are enormously important in providing a supplemental safety net for retirees, but the fiscal climate has made those guarantees very expensive. As a result, over the past 2 decades, the percentage of private-sector employers offering retiree prescription benefits declined dramatically, from 66% in 1988 to 35% in 2006, among employers with 200 or more workers (see Figure 2 for the growth in insurance rates.). Currently, 1 out of 5 large, private-sector employers that offer retiree prescription coverage requires new retirees to pay the full cost of prescription benefits (TIAA-CREF Institute, 2006). Figure 2 shows that health insurance costs, including prescription care, have risen at nearly 4 times the rate of pay and are expected to continue to inflate as more and more people enter retirement.

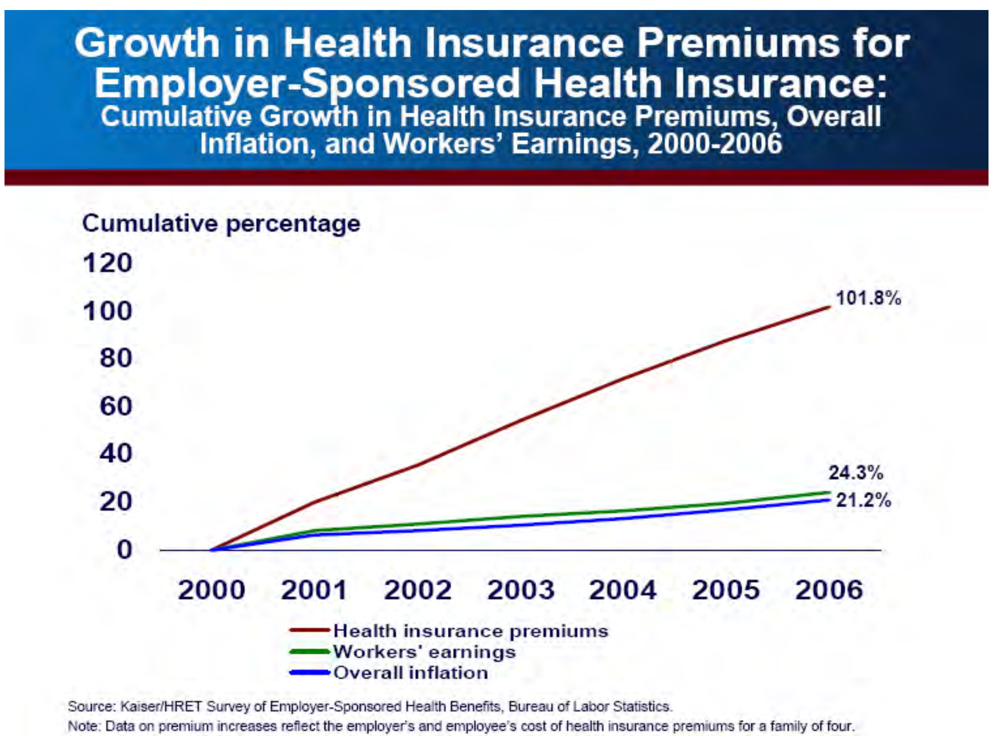

Figure 2. Growth in health insurance premiums for employer-sponsored health insurance.

Traditionally, unions have been helpful in securing health and prescription care for retirees. Over the last several decades however, unions have been subjected to intense economic pressure due to globalization and considerable drops in union membership during the 1980s (falling from 25% of the workforce in 1979 to 16% in 1990). Unions today represent only 7.4% of the private sector‘s workforce (Kochan, 2006). Because the vast majority of people receive their health insurance through their employer and companies (see Figure 3) are increasingly reducing benefits and going nonunion, the balance of risk and responsibility for retiree prescription care is shifting from private employers to the government, particularly for low-income retirees. Perhaps sensing this, the government has preemptively privatized prescription care in anticipation of Baby Boomer needs. As Hacker (2006) notes, most proposals to "modernize" Medicare by introducing premium support are really about shifting the risk of rising health costs from the government to senior citizens (p. 158).

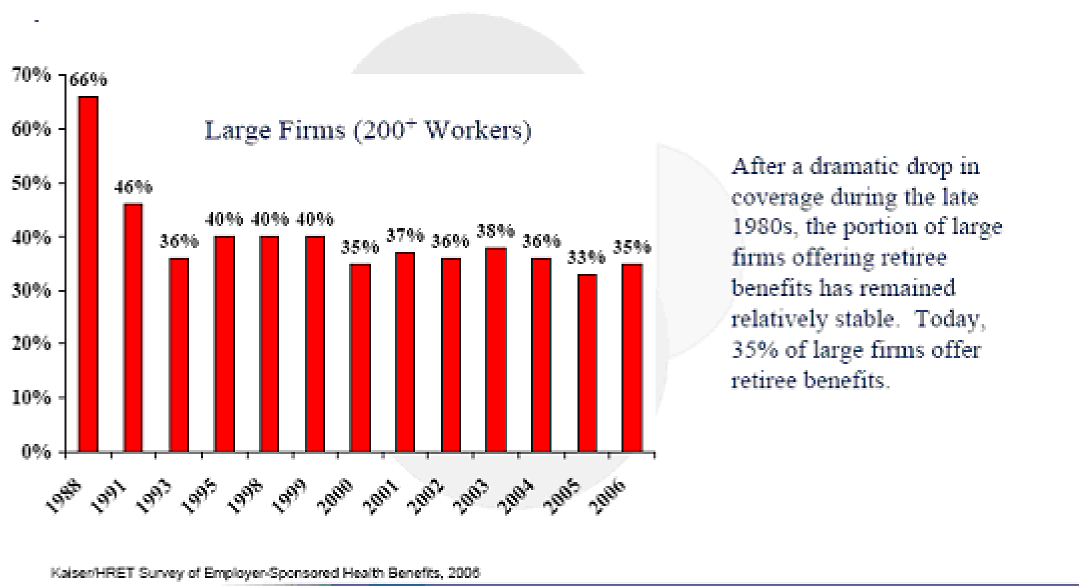

Figure 3. Large firms offering health insurance.

In terms of the impact of Medicare Part D on consumers, Chuck Grassley, Senator from Iowa, speaking on the Senate floor in early 2007, expounded on a position held by many fiscal conservatives in the Senate.

> All of the program's successes have been challenged at various times by the program's opponents and each time they are proven wrong. As the plan continues to return positive results, skeptics are beginning to change their opinion as well. Initially, people were worried no private plans would participate. Then too many plans came forward. Then people said it's going to cost a fortune. And the price came in lower than anybody thought. Then people like me said they're low-balling the prices the first year and they'll jack up the rates down the line. And, lo and behold, the prices fell again. At some point you have to ask: What are we looking for here?

To some, Medicare Part D is viewed as a successful social program. It has plenty of private insurers who want to insure a high risk population, the costs thus far have been below projections and increases in health insurance premiums have been relatively stable. In this view, Medicare Part D has fulfilled its promise to participants. Others however, take a contradictory view. Senator Henry Waxman, who has been active in investigating abuses of Medicare Part D, noted the following in a report to Congress:

> Under Medicare Part D, the six million dual eligible beneficiaries can take the same drugs they got under Medicaid. The only difference is that the federal taxpayer is now paying 30% more. Add it up, and it amounts to a drug manufacturer windfall worth at least $3.7 billion dollars in just the first two years of the Part D program. In fact, the actual windfall could be worth billions more if all drugs used by dual eligible beneficiaries were taken into account.
>
> Some examples: Johnson and Johnson earned over $500 million in additional profits, much of it from just one drug, the anti-psychotic medication Risperdal. Bristol Myers earned a windfall of almost $400 million, thanks to higher prices for the stroke medication Plavix. This is an enormous giveaway. And it has absolutely no justification. The drug companies are making the same drugs. They are being used by the same beneficiaries. Yet because the drugs are being bought through Medicare Part D instead of Medicaid, the prices paid by the taxpayers have ballooned by billions of dollars.
>
> The privatization of Medicare Part D is a great deal for the drug companies. And it's a great deal for the private insurers. It's the taxpayers who

are taking it on the chin. The circumstances that led to passage of the Medicare Part D law were, controversial. The chairman of the House committee that wrote the Part D law now runs PHARMA, the drug manufacturer's trade association. The Administration's top negotiator left the government to lobby for health insurers and drug companies. The Medicare drug benefit is providing real help to seniors and the disabled, and it's going to be a part of our healthcare landscape for years to come: The key question for us is how we can fix the program so that more of the benefit goes to seniors and the disabled - and less winds up in the pockets of the drug companies and insurers." (House Committee on Oversight and Government Reform, 2008)

This research acknowledges that Medicare Part D has in fact been good for participants in three ways: (1) it has increased access to prescription drugs, (2) it has lowered the cost of those drugs, (3) it has inserted the right to prescription care for eligible seniors into the American social contract. All of these benefits however, come at costs. Specifically Medicare Part D is massively inefficient with regard to how it purchases drugs compared to other government run health programs, it has a provision where those insured fall into planned coverage gaps (donut hole), and it is fiscally unsustainable. These pros and cons can be interpreted a number of ways.

The position of this research is that efficiency, that is achieving an objective for the lowest cost, is a critical evaluative element. Within the efficiency model as the ideal type, assessments about efficient allocations of resources are ones that yield the most total value for society from existing resources. Efficient choices are ones that result in the largest benefit for the same cost, or at least cost given benefit (Stone, pg. 61). In this view, Medicare Part D has yielded substantial benefits to consumers, insurers and pharmaceutical companies but has done so inefficiently.

Thus far, this analysis has covered the political elements of the creation of Medicare Part D and has highlighted the relationships between business and government. In this milieu, the representatives for the retiree constituency need to be considered as well. Retirees were principally represented by advocacy groups in the debate about how Medicare Part D should work. For many years the primary advocate for retirees in Washington has been The American Association of Retired People (AARP). As a nonprofit organization, this group advocates for seniors on issues ranging from Social Security to healthcare. The AARP's nonprofit status is an important point in that, prior to its support for Medicare Part D, its resources were limited and its advocacy was focused on supporting legislation that did the greatest good for the greatest number of retirees. With 38 million seniors participating in AARP services and trusting the brand as a nonprofit, this reversal of position by AARP had a significant impact on the acceptance of Medicare Part D by retirees (Cranberg, 2007).

Critics alleged that the AARP held its commercial interests above those of its membership. The AARP began selling members MediGap drug insurance products in 2006, shortly before the legislation was to be implemented. However, there are other, more likely reasons that the AARP decided to endorse the legislation. The organization felt that the $400 billion on the table, inadequate as it was, was unlikely to be there much longer in an era of historic and growing budget deficits. Also, long regarded by Republicans as a "wholly owned subsidiary of the Democrat party" (Oliver, Lee, & Lipton, 2004), the AARP may have decided as an organization that it needed to work with the party in power to lock in preferable language in the bill to allow them to expand their insurance offerings to members.

To illustrate the potential profits for AARP in the newly established Medicare Part D market assuming that AARP, with 38 million members in 2006, captured just 5% of the new $400 billion Medicare prescription drug market over the next 10 years, the organization would collect an additional $20 billion in new insurance revenues. At the AARP‘s average royalty rate of 2.9%, its royalties would raise $58.4 million a year from the Medicare Part D drug entitlement alone (Public Citizen, 2006).

This research argues that AARP had a strong financial incentive to support Medicare Part D and did so. The AARP‘s decision to endorse Medicare Part D began to bear fruit almost immediately and made a considerable impact on the organization‘s 2007 revenue. The AARP has received $4.4 billion over 7 years from United Healthcare and Aetna alone as a conduit to its membership in the sales of insurance. Under the AARP brand name, the organization promotes United Healthcare and Aetna prescription insurance policies to selected members between the ages of 50 and 64 and receives a percentage of the sale (Feld, 2007).

In summation of the policy, Medicare Part D is as rife with conflicts of interest and questionable ethics as any other public policy out there. Sociological analysis should focus on cui bono (who benefits). Insurance companies willing to accept Medicare Advantage enrollees were given a deal whereby they would receive on average 13% more per head for insuring retirees than it would cost to provide the same service under traditional Medicare (Medicare Payment Advisory Commission, 2007). In essence, Medicare Part D guarantees $50 billion in overpayments from 2006 to 2011 to private insurers willing to accept eligible enrollees (Mazza, 2007). Drug makers meanwhile, received an additional $3.7 billion profit during the first 2 years of Medicare‘s prescription drug coverage alone (Silverman, 2007). The concern raised by Congressman Henry Waxman, and one that resonates throughout this research, is that for the vast majority of Medicare beneficiaries‘, Part D will actually increase out-of-pocket expenses for drug insurance:

> Across all prescription drug plans (PDPs) premiums increased an average of 13.2% in 2007. For PDPs with the same deductible and same ―Donut Hole" coverage (or coverage gap) in 2006 and 2007, premiums will increase 11.1% in 2007. For the lowest priced PDPs, premiums increased by 44% for 2007. Premiums for 2009 increased again by 6.9%. (MedicareAdvocacy.org, 2009)

Theoretical Background

Social Contract

Having summarized the origins of Medicare Part D, this chapter turns to the question of what a social policy should look like. What are the most important elements of a balanced and successful social program? Theoretically, this research takes the position that the legitimacy of a program or policy takes form within the context of a social contract. This is not a new idea; the study of a social contract between citizens and government has been of interest to sociologists, economists, and political philosophers since the institutionalization of formal government itself. Over many decades, scholars have attempted to give meaning to law and the rights and responsibilities of affected parties. In each time and place, scholars have had to examine the existing social structure as a means of determining the bonds of the contract. As far back as Plato, the concepts of rights and obligations within this social construct have had life-and-death consequences. In reflecting on the social contract, Plato‘s *Crito* (360 B.C.) discusses breaking Socrates out of prison. Socrates refused, as noted in the following quote:

> Has a philosopher like you failed to discover that our country is more to be valued and higher and holier far than mother or father or any ancestor, and more to be regarded in the eyes of the gods and of men of understanding? Also to be soothed

> and gently and reverently entreated when angry, even more than a father, and if not persuaded, obeyed? And when we are punished by her, whether with imprisonment or stripes, the punishment is to be endured in silence; and if she leads us to wounds or death in battle, thither we follow as is right; neither may anyone yield or retreat or leave his rank, but whether in battle or in a court of law, or in any other place, he must do what his city and his country order him; or he must change their view of what is just: and if he may do no violence to his father or mother, much less may he do violence to his country. What answer shall we make to this, Crito? Do the laws speak truly, or do they not? (Jowett, 1871, p. 51b)

In this ancient understanding of the relationship between the individual and the state, the social contract obligated citizens to their government through reverence and obedience under pain of death or imprisonment. Because the laws of marriage and the state sponsored provision of education and security give credence to the enterprise of the state, so too did the requirement that citizens obeyed their government in the form of taxation, conscription, etc. This is the original bargain between the state and citizens and has been used as justification for the development of law and order in modern civil society.

Plato argued that the legitimacy of the state depends on a sense of duty to country by citizens and that although criticism is allowed under a democracy, obedience is still requisite to fulfillment of the social contract for a citizen of the republic. In this somewhat dated view, the survival of the republic supersedes the survival of the individual. Given the war-prone state of Greece in his time, Plato may well have been right to frame citizen obligations in such a light. Other scholars have updated the social contract model since then.

Thomas Hobbes picked up on Plato‘s theory of the social contract in *Leviathan* (1651) and develops an alternate understanding of the meaning of the social contract. In Hobbes‘s view, all humans are driven by two and only two impulses: fear of death and desire for power. Hobbes notes –in a state of nature, no arts; no letters; no society; and which is worst of all, continual fear and danger of violent death; and the life of man, solitary, poor, nasty, brutish, and short." In the absences of a social contract then, the state of natural man is free to pursue any desire but has to contend with that freedom in others. Thus, a –war of all against all" is Hobbe's original position in the state of nature.

Finding this unsatisfactory, mankind established –civil societies," under which individuals give up certain freedoms (due to violence, theft) but gain membership into a contract with other citizens who follow the same rules. In Hobbes's view of the social contract, by giving up some rights and demanding that others do the same, each person improves their security and thus the security of the state. Hobbes argued that this arrangement is exclusively made in the self-interest of individuals, but its advocacy was focused on supporting the argument that human beings are innately rational creatures. That is, humans have in them the rational capacity to pursue their interests in ways that are both efficient and optimal. In Hobbes's view, human reason acts as –Scouts, and Spies, to range abroad, and find the way to the things Desired" (p. 139).

So, in a Hobbesian analysis of the social contract, humankind does not require a governing state independent of its own, but if a better life might be secured through the existence of such a state, then the individual willingly consents to being governed. In other words, Hobbes presumed that it was unnatural for man to put himself under the control of others (i.e. to have a government), but it is rational to do so if the benefits outweigh the costs. For our purposes, Hobbes's theory is relevant to entitlement programs such as Medicare Part D because his understanding of the social contract centers on the idea that government is an artificial entity brought about by the voluntary participation of the governed as a hedge against what Marx refers to as the furies of private interests, (Marx, 1979, pg. 46).

Expanding on Hobbes‘s concept of the social contract, Jean Jacques Rousseau wrote that ―each of us puts his person and all his power in common under the supreme direction of the general will, and, in our corporate capacity, we receive each member as an indivisible part of the whole” (Book 1, Section 6, 1762). In this view, the social contract is about the compromise of individual freedoms with the obligations one has to society. In entering into this contract, individuals forgo some personal freedoms in exchange for privileges afforded as a member of society.

> Before an aggregate can consent to be governed it must first become a people. Members of mere aggregates, lacking common interests, have only particular wills, wills which look only to the isolated self. An association of a people, on the other hand, is a unity based on common good and it therefore has a collective will, a general will whose object is the common good. It is a community that gives itself a government, and this act is itself a civil act. (Rousseau, Social Contract, Book 1, p. 5)

Rousseau speaks of the general will, which for this study‘s purposes can be loosely construed as the consent of the governed. In Rousseau‘s assessment of the meaning of the social contract it is not simply a fear of death or desire for power that drives mankind into a social contract, but a sublimation of individual desires into the melting pot of the ―general will.” A more complete definition of the social contract, provided by Jean-Jacques Rousseau, is as follows:

> The clauses of the social contract, properly understood, may be reduced to one the total alienation of each associate, together with all his rights, to the whole community; for, in the first place, as each gives himself absolutely, the conditions are the same for all; and, this being so, no one has any interest in making them burdensome to others.
>
> Moreover, the alienation being without reserve, the union is as perfect as it can be, and no associate has anything more to demand: for, if the individuals retained certain rights, as there would be no common superior to decide between them and the public, each, being on one point his own judge, would ask to be so

> on all; the state of nature would thus continue, and the association would necessarily become inoperative or tyrannical.
>
> Finally, each man, in giving himself to all, gives himself to nobody; and as there is no associate over whom he does not acquire the same right as he yields others over himself, he gains an equivalent for everything he loses, and an increase of force for the preservation of what he has. (Rousseau, 1762, Book 1)

John Locke went further in his exploration of the social contract by defining it as the fundamental basis for the relationship between citizens and their government. As he explained in *The Second Treatise of Government* (1690), to escape the state of war Hobbes described and to live a comfortable life, people form a civil society together, which in turn designs and agrees to a government based upon a social contract. In this version of the social contract, man ―divests himself of his natural liberty, and puts on the bonds of civil society . . . agreeing with other men to join and unite into a community" (p. 95) and by submitting to majority rule, forms a government designed to protect citizens' rights. If and when government is no longer representative of the needs of the majority or no longer serves their interests, the polis or masses are free to abandon their obligations to the social contract and pursue another form of governance. In this conception of the social contract, innate to the agreement is a sense of justice and fairness between parties.

To help illuminate the concept of social justice as fairness between contracted parties, a brief examination of social justice as articulated by John Rawls is pertinent to the discussion. In *A Theory of Justice* (1971), Rawls began by stating that ‗justice is the first virtue of social institution" (Rawls, p. 3), asserting that a balanced society is one structured according to principals of justice. Rawls was implying that existing theories of justice, developed first in the field of philosophy but later applied to other social sciences, are not adequate: ‗My guiding aim is to work out A Theory of Justice that is a viable alternative to these doctrines which have long dominated our philosophical tradition''

(Rawls, 1971, p. 18). He dubbed his theory, which was designed to formulate a model of the basic structure of society in accordance with principles of social justice, justice as fairness.

According to Rawls (1971), social justice has two distinct parts. First, Rawls argued that justice obliges “each person to have an equal right to the most extensive total system of equal basic liberties compatible with a system of liberty for all” (p. 302). Second, Rawls states that “social and economic inequalities are to be arranged so that they are both (a) to the greatest benefit of the least advantaged and (b) attach to offices and positions open to all under conditions of fair and equal opportunity” (p. 302).

This theme of justice as fairness is taken to the next level by Deborah Stone in her book *Policy Paradox* (pg. 44). For her, there are a number of different meanings of “fairness” and she uses the example of the distribution of cake to illustrate various interpretations. If thinking about the distribution of cake as a symbolic representation of the distribution of prescription care for seniors, her exploration of fairness is particularly relevant. To start she notes that there are 8 distinct challenges to fairness:

1. Membership (the boundaries of community)
2. Rank-based distribution. (Internal subdivisions of society)
3. Group-based distribution (major internal cleavages in society)
4. Boundaries of the item
5. Value of the item
6. Competition (opportunity as starting resource)
7. Lottery (opportunity as statistical chance)
8. Voting (opportunity as political participation)

For our purposes, the analysis of a normative version of Medicare Part D would do well to focus on the process of distribution (points 6-8). The idea of fairness as a normative standard implies that a fair process produced the end results, in this case Medicare Part D as a social policy. The major challenge to Medicare Part D normatively is in the details concerning how benefits are distributed. While specific measures in this analysis focus on the characteristics whom resources are being distributed, the literature presented here makes a clear normative argument that somewhere within social policies *ought to be* a fair process of distribution.

In assessing the development of the social contract beyond its origins in physical security to a broader vision of security that includes income support and subsidized medical care, the question of a normative standard emerges. In other words, what is the shared understanding of society‘s responsibilities to seniors in need of prescription care or more broadly the various needs of other groups? The basic premise of the normative approach to the social contract rests on the collective belief that political obligation is based on the consent of free individuals, but not on tradition or force (Olev, 2010).

There is a third way to view the social contract, beyond normatively or from a power elite political economy perspective. The pluralist model of the social contract views the formation of social policy as a result of democratic choice and the power struggles that come from competing interests. Pluralist conceptions of democratic process suggest coalitions or groups of citizens representing their interests to government decision makers as the mechanism by which citizens have their concerns and issues addressed. In this model, the size, power, and economic influence of the coalition have significant sway on how the government allocates or cuts programs and how social policy is implemented (Janda, Berry, & Goldman, 2008).

Pluralist views of the social contract see government as a paternal protector aiming for the greatest good for the greatest number of people. Given a consensually validated social policy, all members of society are expected to conform. Thus legitimacy logically follows the assumption of consensus on the part of citizens. In this view, if there is a normative state within the social contract, it is situated in the historical and social milieu of the times and subject to the changes in the general will.

A conflicting approach to understanding the social contract is the political economy model, whose main premise is that important social policy decisions are consistently made by a relative few powerful and influential entities that control both resources and public perceptions. In this view, although voters appear to control government through elections, the real power is wielded by the elite (Mills, 1959), and social policies are constructed to suit the interests of the elite rather than those of the general will.

Because the political economy model identifies the ruling coalition as entrenched within the power structure, it differs from the pluralist model in some key areas. For example, the political economy model describes policy decisions as the result of a continued dominance by the few at the expense of the many rather than a development of consensus through cooperation and compromise. In the political economy model, the utilitarian conceptions of the greatest good for the greatest number of people becomes secondary to the motives and desires of the powerful people who use whatever resources are available to enhance their positions. As Gramsci notes, in implementing functions of social policy and political government, dominant groups employ two basic tactics in developing social policy:

> Stimulating the ―spontaneous” consent given by the great masses of the population to the general direction imposed on social life by the dominant fundamental group; this consent is ―historically” caused by the prestige (and consequent confidence) which the dominant group enjoys because of its position and function in the world of production.
>
> The apparatus of state coercive power which ―legally” enforces discipline on

> those groups who do not ‗consent' either actively or passively. This apparatus is however, constituted for the whole of society in anticipation of moments of crisis of command and direction when spontaneous consent has weakened. (Selections from the Prison Notebooks, p. 12)

A criticism of the political economy approach to studying the social contract is that a properly functioning society is as one that ―equalizes the pre-requisites of liberty, power, wealth and knowledge" (Stone, 2001, p. 129). This criticism was an appeal to the ideal state of the social contract and speaks to the personal power of individuals from within their relative social and economic positions. Non--theoretical understandings of the social contract, however, reflect the reality that equal liberty, power, wealth, and knowledge do not address the real-life circumstances that shape social policy. In fact:

> politicians and bureaucrats desire to serve the ‗public interest' is likely to be only one incentive amongst others, not by any means the strongest. The preoccupation with re-election will lead politicians to go for short-term and high profile projects. They will respond to those groups with most electoral clout or best able to exert political influence rather than the wider populations. (Bellamy, p. 147).

Political economists have long argued that any society contains unequal levels of power that allow dominant groups to use social policy to their advantage. As Stone noted in her seminal work, *Policy Paradox: The Art of Political Decision Making* (2001),

> capitalists, property owners, or elites dominate workers, the poor and the powerless. The needs of the subordinate class, who are also the majority, are suppressed to the point where people do not even recognize their true needs. Capitalism forces people to concentrate on their short-term material interests at the expense of their longer term interests in a different political system. (p. 162)

In the United States, there are sharply competing perspectives on the government's role to provide for the disenfranchised. The politically conservative perspective is to favor personal responsibility, family support, charity, and community support over government support, whereas the political liberal perspective prioritizes a government safety net.)

Still, the government‘s duty to provide a safety net for the vulnerable by way of entitlement programs has long been embedded within societal norms. Using a modern application, very few older adults chose not to accept the benefits of Social Security or Medicaid, and these programs have become entrenched in the collective understanding of the American social contract for younger people as well. Many participants justify their acceptance of entitlement benefits with the rationale that they have ―paid into the system."

With respect to a normative standard for financing entitlements, the operative model for Medicare has been based on a ―pay as you go" financing scheme. In this model, health and retirement security is a safety net for those who are over 65 or disabled, made possible through the exchange of labor and taxes. Those who qualify for benefits have theoretically ―paid into" the system through their working life and, when eligible, are given the right to collect health subsidies and cash payments from the government. This arrangement has been the cornerstone upon which social programs such as Social Security, Medicare, and Medicaid have been financed and accepted by the general public. Medicare Part D is no exception.

However, many scholars and pundits are worried that the financial commitments made by the federal government under the social contract of today are structurally unsound and morally challenged (Mahar, 2010; Summer, Nemore, & Finberg, 2007). They argue that the current incarnation of the social insurance system in the United States, of which Medicare Part D is now a component, may imperil the economic security of the country (Allen, 2010; Moore, 2010; Trapp, 2007) and has placed the needs of current retirees ahead of future retirees in unsustainable ways.

Political Economy

Perhaps the most famous definition of political economy theory is that it is the study of "who gets what, when and how" (Lasswell, 1958). In this study, Lasswell (1958) applied the political economy perspective to prescription care under Medicare Part D to assess the micro-level distribution of benefits for enrollees. In this way, the political economy perspective relies on demographics as a structural pivot point for eligible retirees enrolled in Medicare Part D. With dominant groups in society perpetuating class inequality and health disparities growing as a byproduct health resource allocations (Overbo & Minkler, 1993), how eligible seniors fare under Medicare Part D is an interesting question from a political economy perspective.

> At its core, political economy theory rests on three central assumptions: (a) people have a number of basic interests; that is, desires or goals and attempt to acquire them; (b) power is at the core of social relations. In the view of political economy theorists, power in society is always distributed unevenly and this in itself is a source of conflict—thus those in power have coercive authority over those that do not and (c) values and ideas embedded in the class structure are used to shape arguments benefiting those in power and in framing opposition to their views as radical or otherwise illegitimate. (Estes, 2005, p. 122)

Political economy theory is useful in analyzing Medicare Part D because it begins with the political nature of decision making and is concerned with how politics influence economic choices (Drazen, 2000). Traditionally, sociologists who employ a political economy perspective are interested in the "push-and-pull" between countervailing powers (Light, 2000) and the shaping of the public attitudes and opinions that result (Mechanic, 2001). Political economy theorists within the sociological discipline view society as a mix of competing groups that fight for power. In this perspective, often the outcome of these struggles merely reflects one group's success in temporarily suppressing its rivals.

From a political economy perspective, Medicare Part D can be seen as an example of the social distribution of power and the process of social exchange. Conflict and competition for resources demonstrably influenced both the legislative process and subsequent impacts of Medicare Part D in the larger society. Estes (2001a) explained that

> public policy is understood as the outcome of the social struggles and the dominant, competing and repressed interests of all classes of people within society. Policy represents the structure and culture of advantage and disadvantage embodied in social class, racial, ethnic, gender and age relations. Just as public policy both reflects and stimulates various social struggles, policy is a crucial determinant of the life chances, health conditions and experiences of seniors in different structural locations in the society. (p. 17)

This dissertation pursued lines of inquiry that targeted variables such as gender, race, region of residence, salary, health, drug-coverage, and disease type in the hopes of capturing the inequalities and disparities that political economy theory is so well noted for highlighting. Given that enrollment and utilization of Medicare Part D is reflective of the baseline inequality seen in other social programs (McLaren, 1997; Rodriguez & Villaverde, 2000), variables such as gender (Wei, Akincigil, Crystal, & Sambamoorthi, 2006), race (Sherkat et al., 2005), and health status (Manton, Lamb, & Gu, 2007) might help situate individuals within the larger power structure. Additionally, because individual experiences of social phenomena such as Medicare Part D may vary, the analysis in which appropriate demographic variables are tested may prove useful in examining the relationship between political economy theory and Medicare Part D (Dowd, 1980).

Literature Review Summary

In review, the social contract in its original conception is fundamentally concerned with the negotiation of rights and benefits between citizens and their government. Medicare Part D, on the other hand, is a negotiation between government and private contractors. The sociological literature has established that private insurers received generous compensation under Medicare Part D (Hendersen, 2006), but the outcome for individual enrollees is less clear. The literature logically suggests that exploring variables that assess the impact of Medicare Part D for enrollees may prove fruitful in ascertaining who benefitted from Medicare Part D and to what degree.

From a political economy perspective, politicians and economists across the spectrum agree that Medicare and Medicaid will face significant financial challenges in the near future (see Feldstein, 2006 for a detailed review of the literature) and that the distribution of resources used to create and maintain Medicare Part D is reflective of historic inequalities. Going forward, entitlement programs such as Medicare Part D represent the front line in debates over the notion of a social contract between citizens and their government, how social contracts are structured, and for whose benefit. With the current U.S. national debt growing by approximately $4.17 billion dollars per day (U.S. Debt Clock) proposed spending cuts will need to be made at a national level fairly soon. As the US continues to spend far more than it collects, soft targets such as entitlement programs for vulnerable populations tend to be disproportionately hit as debt service payments continue to command federal dollars (Congressional Budget Office, 2007). Previously sacrosanct programs such as Social Security, Medicare, and Medicaid may well bear the brunt of spending cuts (National Conference of State Legislatures, 2010) in the near-term. Given these trends, exploring the efficacy of Medicare Part D is more important than ever.

CHAPTER 3

RESEARCH METHODS

Within the field of sociology, demographic characteristics have been shown to have important relationships with disability, disease, and death (Syme & Berkman, 2000). The literature on factors associated with drug spending (a proxy for health in this analysis) suggests that access to prescription drugs play a significant role in the health of Medicare Part D beneficiaries. This study explores the consequences of Medicare Part D as a policy whose goal is to ameliorate the problem of prescription costs to retirees.

The primary method used in this analysis focuses on out-of-pocket costs as a metric for assessing the fulfillment of the social contract and a means of addressing a pressing health needs for retirees. There is a slight hesitation to reduce the social contract to mere economics terms; however, as a baseline, costs relative to Medicare Part D participation are perhaps the simplest way to measure the impact on enrollees.

Demographic variables such as race, age, gender, income, medication type, and insurance plan type can all be useful in assessing for whom Medicare Part D enrollment was useful or not. The following research questions were addressed using data from the HRS samples and analyzed in SPSS to generate statistical results.

1. What are the demographic characteristics of HRS sample respondents who had Medicare Part D coverage in 2006 and 2008?
2. What are some of the changes to the prescription-drug insurance costs for retirees enrolled in Medicare Part D during that time period?
3. What are the demographic factors associated with these changes?

4. How are out-of-pocket prescription costs for retiree's different post enrollment in Medicare Part D**?**

The dataset for this study was adapted from the University of Michigan's HRS, which surveys Americans over the age of 50 annually. Supported by the National Institute on Aging, the study examines aging America's physical and mental health, insurance coverage, financial status, family support systems, labor market status, and retirement planning. Using data from 2004, 2006, and 2008, I evaluated the reported prescription experience of HRS participants before and after their enrollment in Medicare Part D.

Background

The following description of the data-collection procedures for the HRS survey comes from the HRS website. The data were cleaned, and a focused dataset was created for the analysis of this study. The original source material for the data-collection process can be found at http://hrsonline.isr.umich.edu/sitedocs/sampleresponse.pdf

Since 1998, the objective of the HRS has been to provide information about the U.S. individuals over the age of 50 through biennial surveys of this age group. Prior to 1998, the target populations were more specific: The original HRS target population was limited to those born between 1931 and 1941, and the sample of the Asset and Health Dynamics among the Oldest Old (AHEAD) study was limited to those born in 1923 or before. For practical reasons, the decision was made to add new cohorts every 6 years rather than at each wave of data collection. Therefore, in 1998 the target population was defined as those born in 1947 or before, and thus approximately age 51 and older.

Because new cohorts were not added in 2000 or 2002, the target populations were approximately 53 and older in 2000 and 55 and older in 2002. In 2004, a supplementary sample was added to make the total sample representative of those born in 1953 or before, and thus, once again, approximately age 51 and older.

Two of the five samples interviewed to date by the HRS~~,~~ and a majority of a third sample~~,~~ came from a screening of 69,337 housing units conducted in 1992. That sample of housing units was generated using a multistage, clustered area probability frame. Of those housing units, 14% (9,419) were determined to be non-sample (unoccupied, or non-households). In all but 214 of the 59,918 identified households, the eligibility of the household members for inclusion in the HRS, AHEAD, or War Baby (WB) samples was determined, for a screening response rate of 99.6%.

The original, inclusive HRS sample consists of individuals born between 1931 and 1941. This sample came from the household screening described above. At the baseline data collection for the HRS sample in 1992, a total of 15,497 individuals were eligible for interviews. This total included persons identified in the household screening, plus their spouses or partners regardless of year of birth. Of those identified in this way, interviews were obtained with 12,654 respondents (7,704 households), for an overall response rate of 81.4%.

The second sample was generated for what began as a separate study, called AHEAD as mentioned above. This sample consists of individuals born in 1923 or before. Those born between 1914 and 1923, and about half of those born in 1913 or before, were identified through the 1992 household screening operation. The other half of those born in or before 1913 were identified using the Medicare enrollment files maintained by the

Health Care Financing Administration (HCFA, since renamed the Centers for Medicare, Medicaid Services, or CMS). For the AHEAD sample, interviews were obtained with 8,222 respondents (6,046 different households), a response rate of 80.4%.

The HRS and AHEAD studies were merged, with a single interview schedule in 1998. At the same time, the third and fourth samples were added. The WB sample consists of those born between 1942 and 1947, inclusive, and was obtained from the same 1992 household screening. The Children of the Depression Age (CODA) sample consists of those born between 1924 and 1930 (the ―missing" birth cohorts between the HRS and AHEAD samples). These individuals were identified from the Medicare enrollment file. Given that many members of these birth cohorts were already part of the study because they were current or former spouses and partners of those in the HRS and AHEAD cohorts, the new samples excluded those individuals with spouses or partners who were born in 1923 or before or between 1931 and 1947. The baseline response rates for the CODA and WB samples in 1998 were 72.5% and 70%, respectively.

In 2004 a new sample cohort of individuals born in 1948–1953 (ages 51–56 in 2004) was introduced, which carries forward the steady state aspect of HRS. The Early Baby Boomer (EBB) sample was obtained through the screening of 38,385 households. Interviews were completed with 3,340 individuals in 2,159 households for individual- and household-interview response rates of 75.6% and 78.4%, respectively. Factoring in the screening response rate yields overall baseline response rates of 69.0% for individuals and 71.6% for households.

The ground rules for following baseline respondents and their spouses in subsequent interview waves were as follows. Persons interviewed in the baseline data collection (i.e., in 1992 for the HRS sample, 1993–1994 for the AHEAD sample, 1998 for the CODA and WB samples, and 2004 for the EBB sample) were included in the reinterview sample, regardless of their year of birth and regardless of any change in marital status. The only exceptions were (a) those who had died and for whom exit interviews were obtained in a previous wave and (b) those who had been permanently removed from the sample at their insistence. There were 1,593 cases meeting either of these exclusion criteria (out of a total sample of about 32,000) at the end of the 2004 data-collection period.

Spouses and partners reported by respondents at any previous wave were included in the re-interview sample. New spouses and partners reported at the time of a re-interview were added to the sample and interviewed. This latter group included spouses and partners who declined to be interviewed at the baseline or follow-up data collection periods.

For panel members who had died, exit interviews were sought with a proxy informant who was knowledgeable about the family and financial situation of the deceased. If the deceased was survived by a widow or widower, the exit interview was sought with the former spouse. If an exit interview had been conducted at a previous wave but the information obtained in that interview was incomplete, generally because the estate had not been settled, a short post exit interview was sought to fill in the missing information.

Mortality Ascertainment

The HRS typically learns of the death of a respondent when an interviewer attempts to reach the respondent for an interview during the main data-collection period. In this case, the respondent‘s spouse or another close family member or friend is asked to provide a final interview on behalf of the respondent (the exit interview). In some instances, HRS staff is notified of a respondent‘s death by a family member between waves. Such notification is not considered definitive. Interviewers are alerted to this in the respondent profile, and the main data-collection period is used to confirm the deceased status of the respondent and pursue an exit interview with a spouse or another close family member or friend. There are also situations in which the respondent is in tracking because the surveyors were unable to locate him or her during a previous wave of data collection.

Tracking resources for confirming the deceased status of respondents and locating an exit proxy reporter include the Social Security Death Index (SSDI), which is accessed through the SSDI website and also through a paid subscription to Insight databases (available only to members of a national tracking team that conducts advanced tracking of respondents).

Exit Interviews

HRS has conducted exit interviews for deceased respondents in every wave starting with the 1995 wave of AHEAD. The exit interview was developed to find out about the status and activities of the respondent from the time of the last interview until his or her death and to find out the circumstances of the death. HRS attempts to complete an exit interview for all deceased respondents, with two exceptions: New spouses for whom a baseline interview was never obtained and respondents who had requested to be removed from the sample prior to their death.

The exit interview is administered to someone knowledgeable about the deceased respondent, preferably a surviving spouse or close family member, and is typically obtained during the field period when the death is first reported. Thus, for most respondents the exit interview occurs less than 2 years following the respondent‘s death. If it is not possible to obtain an exit interview on the first attempt, the family member or proxy is re-contacted during the next data-collection period. If an exit interview has been conducted at a previous wave but the information obtained in that interview was incomplete, generally because the estate had not been settled, a short ―post exit" interview is sought to fill in the missing information.

The response rates for the exit interview have been very high throughout the HRS study. The overall response rate for exit interviews conducted through 2002 is 93%. There appears to be little if any systematic bias in exit response rates for key demographic groups. Response rates were slightly lower for those born between 1931 and 1947 (the year‘s corresponding with the HRS and WB cohorts) than for those born prior to 1931 (88-89% vs. 94%, respectively) and for non-Hispanic Blacks (90.3%)

compared to non-Hispanic Whites (93.4%). By far the strongest predictor of exit response is interview status in the prior wave. An exit interview was completed for 95% of respondents who completed a core interview in the prior wave versus 69% for those who did not.

National Death Index

The HRS constructed linkages to the NDI following the 2000, 2002, 2004, and 2006 waves and will construct another following the 2008 wave. The public-release tracker file is updated with information about which respondents were submitted to NDI, their match status, and the month and year of death for verified matches. Cause-of-death data from NDI+ are available as restricted data only. The NDI data for a given calendar year are available and complete roughly 16 months after the end of the year. Thus, finder files were created in mid-2004 for the 2002 wave and in mid-2006 for the 2004 wave. The finder was submitted in the finder file for every person whose death was reported or discovered during field operations for that wave, plus everyone who was not verified as alive by giving an interview in that wave and anyone whose death was reported previously but was not successfully linked in prior NDI searches.

As of the 2002 wave, 5,644 deaths had been reported and submitted to NDI at least once. Of these, 5,366 or 95.1% were successfully matched. By far the most important determinant was whether the respondent's social security number of the decedent was known; the absence of that information lowered the match rate by nearly 11 percentage points. Social security numbers were missing for about 14% of cases; had they been available, the match rate would have been about 96.5%. The rate for African-American decedents was about 1.5 percentage points lower and that for Hispanic-

Americans about 6 percentage points lower than the rates non-Hispanic Whites and others. Return migration likely accounted for at least some of the Hispanic differential. The match rate was not systematically related to cohort of birth or to whether an exit interview was obtained with a proxy for the decedent.

There were 1,086 HRS participants whose vital status was not determined during the 2002 wave. Of these, 70, or 8.2% were matched to the NDI. Based on the very high match rate of known decedents mentioned above, the belief was that the number of deaths among those not successfully matched must be very small. There remains the question of whether the NDI matches are accurate given that there is no other verification of death. To address this type of error (false-positive matches to NDI), an experiment was conducted after the 2000 wave by submitting 1,000 names of persons who gave live interviews during the 2000 year. Of these, the only successful matches were for persons who had died during the calendar year 2000 but after they had given their interview. Thus, the false-positive rate is essentially zero.

Taking these results together, of the combined total of 5,714 deaths, the tracking procedures recovered 98.8% of the cases, and the NDI recovered 95.1%. Thus, researchers can be fairly confident in using the HRS tracking data in mortality studies even before the NDI confirmation is complete. Limiting the analysis to deaths confirmed by the NDI will understate mortality.

Validation of Mortality Rates

Cumulatively, 16% of the original HRS sample respondents were found to be deceased by the 2004 wave, based on information from the interviewers and from the National Death Index. Over half (55%) of the AHEAD sample died in the decade between their baseline data in 1993-1994 and 2004. For the CODA and WB samples, the cumulative proportions who died between their baseline in 1998 and 2004 were 17.9% and 3.5%, respectively.

Number of Cases by Birth Cohort

Each of the five samples was defined in terms of a specific range of birth cohorts, but because interviews were sought with the spouses and partners of selected individuals, the actual range of birth cohorts observed in each sample was considerably broader. In cases when those birth years fell within the range of another sample, then these spouses and partners formed part of the sample of their own cohort and were given an appropriate sampling weight. If, however, a spouse‘s or partner‘s birth year was outside the range of any sample, then he or she was given a zero sampling weight until his or her cohort was fully represented. Thus, for example, the spouses and partners of the HRS sample members born in 1924–1930 or in 1942–1947 were assigned zero weights in 1992 through 1996 but were given non zero weights starting in 1998 when their birth cohorts became fully represented with the addition of the CODA and WB samples.

Functional Status Versus Disease Conditions

Another controversial issue is whether to measure health status in terms of function or in terms of epidemiology. Function involves asking people about their physical ability to do various tasks, whereas epidemiology asks about the nature of various medical conditions that might result in functional impairment, sooner or later. One big difference between functional measures of health and epidemiological measures is that the functioning measures can involve a degree of adaptation to medical conditions, but a description of the medical condition itself tells us nothing about adaptation. In general, the Health Conditions and Health Status Working Group were persuaded that the most important dimension to measure was functional health, not disease epidemiology. Some potential users of the data took a different view: that a basic inventory of important medical conditions would not only satisfy the demands of an important class of analytic users but might also be less susceptible to misreporting because of the causality problem involving the relationship between health and work.

That is, it may be simpler for a respondent to misreport functioning limitations than to misreport the presence of a heart condition, stroke, asthma problem, and so forth. The Working Group developed a rich set of measures of functional health, going well beyond basic activities of daily living (ADLs) to higher level functioning, such as running and climbing stairs. Instrumental ADLs (managing money, using the telephone) were also included. A disease inventory with measures of severity was included, as were various types of health behaviors, such as smoking, drinking, and exercise.

Data Collection

This analysis was based on module subsets of HRS data collected from the 2004, 2006, and 2008 CORE surveys (Final V1.0 release). The rationale for this dataset comparison is that 2004 was the last year that HRS respondents were not offered Medicare Part D as a prescription option, and the 2006 and 2008 waves spanned the first 4 years into the program. By creating a multistage longitudinal sample with each respondent‘s changes throughout the survey waves, individual cases can be tracked over time.

Broadly, the HRS is a 2-wave mail survey designed to track changes in prescription-drug utilization as Medicare Part D is phased in. The data-collection period for the 2004 interview was March 2004 through February 2005. The data-collection period for the 2006 interview was from March 2006 to February 2007. The data-collection period for the 2008 interview was from February 2008 to February 2009.

The HRS data were already coded into subsamples and were used to track respondent cohorts across the 2004, 2006, and 2008 samples. The HRS sample is comprised of five subsamples. The first subsample, the HRS subsample, consists of people who were born between 1931 and 1941 and were household residents of the conterminous US in the spring of 1992, as well as their spouses or partners at the time of the initial interview in 1992 or at the time of any subsequent interview. The HRS subsample surveys were conducted in 1992 and every 2 years thereafter.

The AHEAD subsample consists of people who were born in 1923 or earlier, were household residents of the conterminous US in the spring of 1992 and were still household residents at the time of their first interview in 1993 or 1994, as well as their spouses or partners at the time of the initial interview or at the time of any subsequent interview. The AHEAD subsample was interviewed in 1993–1994, 1995–1996, 1998, and every 2 years thereafter.

The WB subsample consists of people who (a) were born between 1942 and 1947; (b) were household residents of the conterminous US in the spring 1992; (c) did not have, at that time, a spouse or partner born before 1924 or between 1931 and 1941; and (d) were still household residents at the time of the first interview in 1998. The WB subsample also consists of this group‘s spouses or partners at the time of the initial interview or at the time of any subsequent interview. The WB subsample was interviewed in 1998 and every 2 years thereafter.

The CODA subsample consists of people who (a) were born between 1924 and 1930, (b) were household residents of the conterminous US when first interviewed in 1998, and (c) did not have, at that time, a spouse or partner who was born before 1924 or between 1931 and 1947. The CODA subsample also consists of this group‘s spouses or partners at the time of the initial interview or at the time of any subsequent interview. The Children of the Depression subsample was interviewed in 1998 and every 2 years thereafter.

The EBB subsample consists of people who (a) were born between 1948 and 1953, (b) were household residents of the US when first interviewed in 2004, and (c) did not have, at that time, a spouse or partner who was born before 1948. The EBB subsample also consists of this group‘s spouses or partners at the time of the initial interview or at the time of any subsequent interview. The EBB subsample was interviewed in 2004 and every 2 years thereafter.

The 2006 HRS Core (Early, Version 2.0) data release consists of data obtained as part of the main HRS study. The National Institute on Aging provided funding for the core surveys (NIH U01 AGO9740), with supplemental support from the Social Security Administration. The Institute for Social Research Survey Research Center at the University of Michigan conducted the survey (HRS, 2010).

Survey responses from HRS participants were set up in three waves. The first wave involved some general characteristics of the sample as a whole, such as utilization patterns for prescription drugs across all the sample participants regardless of mitigating demographic factors. Then, for the second wave of the study, the sample was filtered using the variables Household ID (HH) and Personal Identification Numbers (PIN) to ensure that the sample respondents could be tracked over time. With this accomplished, various statistical techniques were then used to make comparisons between the three samples with respect to demographics, prescription costs, and various other related variables.

Chi square analyses were primarily used to test for significant differences in categorical responses between the three samples. To determine the difference between mean scores of the three samples (that measured, for example, the cost of heart medication in 2004 versus 2006 for a particular subgroup), independent *t*-tests were used. When comparing the mean score of three or more cohorts (such as cost of heart medication across groups in all three samples) an analysis of variance procedure (ANOVA) was used with the Huynh-Feldt *F*-test of significance to determine differences among the groups. In cases where two contiguous or interval variables were being compared (for example, the percentage of respondents taking a certain medication who also reported levels of satisfaction with Medicare Part D on a 1–5 scale) correlations were utilized with the Pearson's or Spearman's *r* tests to determine if there was a significant relationship between the variables.

For the second level of the analysis to yield meaningful comparisons, the data files needed to be recoded and assigned value labels for all three samples. An SPSS file was generated containing only those respondent's whose PIN and HH ID matched and appeared in all three samples. By doing this, a realistic comparison of the same people before Medicare Part D and after implementation was made possible.

New enrollment in Medicare Part D for participants with health problems that require prescriptions will generally decrease the cost of prescription care. Most HRS survey respondents will report lower prescription costs after Medicare Part D enrollment because the Medicare Modernization Act is predicated on initial overpayment to private health insurers, 13% over traditional Medicare. Given the political and economic arrangement outlined in the literature review, short-term financial benefits are likely to be reported by respondents by way of reduced prescription costs.

However, those Medicare Part D participants with specific diseases or high numbers of prescription needs may end up paying more for their prescriptions due to formulary changes within the Medicare system. Due in part to which plan a participant chooses, they may be exposed to unexpected costs based on insurance plan type. Picking the wrong plan or medication needed may result in a higher price than before enrollment in Medicare Part D, or the premium insurer's charge to access the medication may increase. It is expected that in a small number of cases, significant variations in the array of choices offered to consumers will lead to increased cost for some eligible enrollees.

Wealthier or more educated HRS survey respondents will more likely report use of supplemental or ―gap" insurance. Prescription-drug coverage is a key component of retiree health, and those who can afford supplemental coverage will likely purchase it. Under this arrangement, the cost of their prescription care may decrease, but the overall cost of being insured will likely increase by way of supplemental premiums.

Gray and O'Leary (2000) noted that, in general, empirical sociological research takes one of two different forms: policy-relevant or policy-oriented. The difference between these two concepts is that research that is policy relevant is seeks to assess existing policy while policy oriented research aims to create new policy. Given the limited nature of the data presented here, this research takes the former position. The expositional but limited nature of the data means that the results will not likely to yield any immediate public policy changes, but they can indeed inform and expand the overall understanding of Medicare Part D. The quantitative mode of inquiry presented here used panel data from the HRS 2004 and tracked respondents who also participated in the HRS 2006 Core Survey and 2008 Early Sample, which included several prescription care-centered modules.

The contribution of this research to general academic knowledge is rooted in the idea that dataset creation is in itself an academic achievement. Amalgamating variables across three sprawling datasets and extracting the most meaningful variables from a list of hundreds takes time, patience, and some professional-level understanding of how the data should be managed.

Although highly regarded as a valuable social science data-collection tool, the HRS survey and datasets are piecemeal and can contain ambiguous or dropped variables from year to year. To try to create a database with 60,000 initial respondents for the 3 years sampled required substantial data management. To begin with, this research required that the desired modules for all three samples be merged into one file. Given that the HRS datasets contain at least 10 different modules with more than 80 subsets of questions, selecting the right modules and variables proved a challenge. In total, this research examined over 175 variables singularly, in paired correlations, and in multiple regressions. Once selected, the variables across all three samples were merged into a newly created dataset, which I have called the “2004 Cohort,” by hand selecting their variable names across the three files and hand entering all the values and labels. The variables are identifiable by first letter, so for example a variable from 2004 would be KXXX, a variable from 2006 would be LXXX, and a variable from 2008 would be MXXX. In summary, this research offers two main contributions to the social sciences field:

1. The datasets created can be used to explore other issues in the field of health and aging.
2. The ability to statistically track changes over time for an apples-to-apples comparison for future years has been established. For example, creating a new dataset that includes 2010 variables when they become available will be easier and yield trend data from 2004 to 2010.

Study Limitations

This study has several limitations. Principally, the data used in this research is archival, meaning that the structure of the question set utilized by the original study does not fully align with the questions needed to fully explore the relevant research questions proposed here. Additionally, there were a number of questions this dataset could not answer or did not ask. As a national sample, the dataset is well regarded, although its structure is limited.

This study is limited to the years 2004, 2006, and 2008. With the cost of prescription care annually rising well above the rate of inflation, one might think cost comparisons are unfair given the 4-year difference between samples 1 and 3. Notwithstanding, the chronological gap between the three samples is relatively small, and the implementation and enrollment in Medicare Part D is expected to be the primary driver for differential experiences with prescription care for eligible participants enrolled in Medicare Part D. Some other limitations to the study are explained below.

First, payment amounts based on self-reported prescription spending may not accurately reflect actual payment. In particular, the self-reported price data may not reflect real costs due to subsidies paid to insurers. In other words, the self-reported data only reflects what the individual can remember paying.

Second, respondents may have underreported the actual costs for prescription drugs or confused payments made for insurance and payments for prescriptions. This may be due to the cross-sectional nature of the HRS study. While this dissertation has three different point-in-time data points for a longitudinal study population, changes made since the origin of the program each year make early pricing analysis more historical than present day.

Third, because the HRS data do not provide detailed information regarding which specific drug plans were involved, only general understandings of the relationship between plans and costs can be made. It would have been wonderful if this dissertation could have made conclusions such as ―HRS survey respondents with Plan X paid an average of Y for medication Z. This is compared to Plan A, for which respondents paid an average of B for medication Z.” Unfortunately, the data are not structured that way, and therefore this preferred line of inquiry could not be investigated. Finally, given that the HRS dataset did not include any information regarding compliance with doctor recommendations for prescription drugs, the study cannot indicate conclusively whether changes in prescribed medication over time were the result of increased access to drugs under Medicare Part D, illness, increased compliance with doctor‘s orders, or other factors

CHAPTER 4

DATA FINDINGS

In 2004 the Health and Retirement Survey (HRS) was collected from 20,129 respondents. In 2006, 18,469 responses were collected. In 2008, 17,217 cases were collected. The data-analysis portion of this research contains three levels of specificity. First, basic frequencies of the sample are provided as a baseline for inquiry into the research questions offered. From the sample, cross-tabulations and ANOVAs were conducted as appropriate to establish the relationships between variables and among them, without comment on how strong the associations were. For the final level of statistical filtration, the Huynh-Feldt test was used (Baguley, 2004).

Sample Data

The following tables present the findings to the research questions asked at the beginning of this analysis. The HRS survey respondents used in the present study had the following characteristics: all were active participants in the HRS for survey years 2004 to 2008, and all had signed up for Medicare Part D by 2006.

Findings by Research Question

Research Question 1: How and for what reason did respondents sign up for Medicare Part D in 2006 and 2008?

Year respondents signed up for prescription coverage. The frequencies and percentages for the year that respondents signed up for prescription coverage are presented in Table 1. Of those who responded, 65.6% reported that they had signed up in 2006, and only 31.9% signed up in 2005.

Table 1. Frequencies and Percentages for Year Respondents Signed up for Prescription Coverage

Year	Frequency	%
1985	1	0.0
2000	1	0.0
2002	2	0.1
2004	5	0.2
2005	665	31.9
2006	1820	65.6
2007	1	0.0
Don‘t know	60	2.2

Primary plan. The frequencies and percentages for the type of primary plan that the respondents had in 2006 and 2008 are shown in Table 2. Of the participants who responded to this item in 2006, 90.8% indicated that Medicare Part D was their primary plan, and only 9.2% reported that they had a private plan. Of those who responded to this item in 2008, 90.6% indicated that Medicare was their primary plan, and only 9.4% reported that they had an additional private plan.

Table 2. Frequencies and Percentages for Medicare as Primary Prescription Drug Plan of Respondents in 2006 and 2008

	2006		2008	
Item choice	Frequency	%	Frequency	%
Medicare	4,653	9.8	3,653	90.6
Private	471	9.2	377	9.4

Reason for not signing up. The frequencies and percentages for the reasons people chose not sign up for Medicare prescription coverage in 2006 and 2008 are displayed in Table 3. Of participants who responded in 2006, 76.2% indicated that they already had good prescription-drug coverage from another source. Of those who responded in 2008, 61.2% reported that they did not need Medicare Part D.

Table 3. Frequencies and Percentages for Reasons for Not Signing Up for Medicare Prescription Coverage in 2006 and 2008.

Reason	2006		2008	
	Frequency	%	Frequency	%
Already have good coverage	3,978	76.2	24	6.5
Didn‘t know it was available	100	1.9	52	14.1
Heard about it too late	31	0.6	0	0.0
Medicare plan too expensive	174	3.3	0	0.9
Medicare plan too restrictive	21	0.4	0	0.6
Haven‘t made a decision yet	267	5.1	0	0.5
Get prescription drugs from VA	141	2.7	0	0.2
Don‘t use enough drugs to make it	246	4.7	0	0.1
Respondent confused about program	134	2.6	67	0.7
Don‘t need it	49	1.9	226	67.5
Didn‘t want t	63	1.2	0	7.8
Respondent on Medicaid	17	0.3	0	10.0

Likelihood of signing up for prescription-drug coverage following year. The frequencies and percentages for the likelihood of signing up for prescription-drug coverage the following year are presented in Table 4. Of participants who responded in 2006, 38.1% reported that they were not at all likely to sign up, whereas 34.8% indicated that they were very likely to sign up. Of those who responded in 2008, 72.9% reported that they were not at all likely to sign up.

Table 4. Frequencies and Percentages for Likelihood of Signing Up for Medicare Prescription-Drug Coverage the Following Year in 2006 and 2008

Item Choice	2006		2008	
	Frequency	%	Frequency	%
Very likely	3,180	34.8	171	4.9
Somewhat likely	1,182	12.9	239	6.9
Not too likely	1,276	14.0	521	15.0
Not at all likely	3,478	38.1	2,533	72.9
Already signed up	3	0.0	10	0.3
Will stay with same plan	14	0.2	0	0.0

Private plan to help pay for prescriptions. The frequencies and percentages for the purchasing of a private plan to help pay for prescription drugs in 2006 and 2008 are shown in Table 5. Of participants who responded in 2006, 59% reported that they purchased a private plan. Of those who responded in 2008, 57.2% indicated that they purchased a private plan.

Table 5. Frequencies and Percentages of Respondents Who Utilized Medicare Part D to Help Pay for Prescription Drugs in 2006 and 2008

	2006		2008	
Item Choice	Frequency	%	Frequency	%
Yes	2,995	59.0	2,373	58.2
No	2,083	41.0	1,690	41.8

Monthly premiums and number of prescription insurance plans. The ranges, means, and standard deviations for monthly premiums and number of prescription insurance plans are presented in Table 6. In 2006, monthly premiums ranged from \$0 to \$1,020, and the mean monthly payment was \$47.18 (*SD* = \$229.29). In 2008, monthly premiums ranged from zero to \$1,350, and the mean monthly payment was \$104.51 (*SD* = \$249.31).

Table 6. Descriptive Statistics for Amount of Monthly Insurance Premiums and Number of Private Plans in 2006 and 2008 for Medicare Part D enrollees

Variable	*N*	Range	Mean	*SD*
2006				
Monthly premium	3,269	0 to 1,020	47.98	229.29
Number of plans	9,699	0 to 12	0.57	0.57
2008				
Monthly premium	703	0 to 1,350	104.61	449.31
Number of plans	8,446	0 to 8	0.52	0.59

In 2006, the number of prescription insurance plans ranged from 0 to 8, and the mean number of plans was 1.57 (*SD* = .57). In 2008, the number of prescription insurance plans ranged from 0 to 8, and the mean number of plans was 1.57 (*SD* = .57).

Research Question 2: What Are Some of the Changes to the Prescription-Drug Experience for Retirees Enrolled in Medicare Part D During That Time Period?

Procedure. To determine whether prescription-utilization patterns measured here as the number of prescription purchases) and prescription costs varied over time, a repeated-measure analysis of variance procedure was conducted. The within-subjects variable was time. Because there were 3 data years, two time contrasts were specified: a linear trend and a quadratic trend. Statistical significance was set at .05.

Prescription utilization patterns. To determine overall use of prescription medicines, a composite variable was created, with *yes*=1. Answers to question items measuring the use of medication for blood pressure, diabetes, insulin, lung, heart, heart attack, angina, stroke, psychiatric, and arthritis were summed within each year. Accordingly, there were three variables of overall medicine use: medicine use in 2004, medicine use in 2006, and medicine use in 2008.

The means and standard deviations for medicine use are displayed in Table 7. On average the mean use of medicines increased by .36 between 2004 and 2008. The repeated-measures ANOVA results are summarized in Table 8. The findings in Table 8 reveal that medicine use increased over time (F (1,7494) = 147.59, p = .000). In addition, there was a significant quadratic trend over time (F (1,7494) = 17.15, p = .000). There was a sharp increase in consumption from 2004 to 2006, but only a slight increase from 2006 to 2008.

Table 7. Means and Standard Deviations for Medicine Use from 2004 to 2008

Year	Mean	*SD*
2004	3.77	2.42
2006	4.04	2.44
2008	4.13	2.42

Note. N = 7,496.

Table 8. Repeated Measures ANOVA Results for Medicine Use Over Time

Variable	*Df*	MS	*F*	Sig.
Linear trend	1	481.65		
Error	7494	3.26	147.59	.000
Quadratic trend	1	41.80		
Error	7494	2.44	17.15	.000

Note. N = 7,496. Overall use of medicine *Huynh-Feldt* F (2,14682) = 91.82, p = .000.

Prescription--plan payments per month. The means and standard deviations for prescription-plan payments per month are displayed in Table 9. The repeated measures ANOVA results are summarized in Table 10. The findings in Table 10 show that prescription--plan payments increased over time (F (1,1584) = 17.19, p = .000). Thus, respondents in 2008 had higher payments (M = 211.41) than respondents in 2004 (M = 187.09). In addition, there was a significant quadratic trend over time (F (1,1584) = 6.81, p = .009) indicating a gradual increase in payments from 2004 to 2006 but only a steeper increase from 2006 to 2008.

Table 9. Means and Standard Deviations for Monthly Prescription Plan Costs 2004-2008

Year	Mean	*SD*
2004	187.09	138.10
2006	190.58	127.94
2008	211.41	232.58

Note. *N* = 1,585. *Note the sample size is per year given the ―2004 Cohort" Criteria

Table 10. Repeated Measures ANOVA Results for Private Plan Payments From 2004 to 2008

Variable	*Df*	MS	*F*	Sig.
Linear trend	1	468,875.02		
Error	1584	27,279.95	17.19	.000
Quadratic trend	1	79,388.59		
Error	1584	11,662.84	6.81	.009

Note. *N* = 3,656. Overall use of medicine *Huynh-Feldt F* (1,2206) = 14.08, *p* = .000.

Monthly prescription drug payments. The means and standard deviations for monthly prescription-drug payments are displayed in Table 11. The repeated-measures ANOVA results are summarized in Table 12. The findings in Table 12 reveal that monthly prescription payments decreased over time (*F* (1,2593) = 22.89, *p* = .000). Thus, respondents in 2008 had lower payments (*M* = 68.75) than respondents in 2004 (*M* = 136.26). In addition, there was a significant quadratic trend over time (*F* (1,2593) = 5.57, *p* = .018). There was a sharp decrease in payments from 2004 to 2006 but only a slight decrease only from 2006 to 2008.

Table 11. Means and Standard Deviations for Monthly Prescription-Drug Payments From 2004 to 2008

Year	Mean	*SD*
2004	136.26	712.03
2006	81.94	279.74
2008	68.75	144.64

Note. *N* = 2,594.

Prescription costs. The means and standard deviations for prescription costs are displayed in Table 13. The repeated-measures ANOVA results are summarized in Table

14. The findings in Table 14 demonstrate that prescription costs decreased over time (*F* (1,8530) = 77.99, *p* = .000). Thus, prescription costs in 2008 were lower (*M* = 54.91) than

Table 12. Repeated Measures ANOVA Results for Monthly Prescription-Drug Payments from 2004 to 2008

Variable	*Df*	MS	*F*	Sig.
Linear trend	1	59,11,346.40	22.89	.000
Error	2593	258,296.98		
Quadratic trend	1	731,557.25	5.57	.018
Error	2593	131,325.86		

Note. *N* = 5,432. Overall use of medicine *Huynh-Feldt F* (1,3248) = 17.05, *p* = .000.

Table 13. Means and Standard Deviations for Prescription Costs From 2004 to 2008

Year	Mean	*SD*
2004	119.61	674.02
2006	42.50	169.34
2008	54.91	130.54

Note. *N* = 8,531.

Table 14. Repeated-Measures ANOVA Results for Prescription Costs From 2004 to 2008

Variable	*Df*	MS	*F*	Sig.
Linear trend	1	17,856,045.11	77.99	.000
Error	8,530	228,959.89		
Quadratic trend	1	11,397,102.90	120.69	.000
Error	8,530	94,435.20		

Note. *N* = 15,974. Overall use of medicine *Huynh-Feldt F* (1,9677) = 90.46, *p* = .000.

prescription costs in 2004 (*M* = 119.61). In addition, there was a significant quadratic trend over time (*F* (1,8530) = 120.69, *p* = .000). There was a sharp decrease in costs from 2004 to 2006 but a slight increase from 2006 to 2008.

Satisfaction with healthcare. The means and standard deviations for satisfaction with healthcare are displayed in Table 15. The repeated-measures ANOVA results are summarized in Table 16. Note that the lower the score, the more satisfied the respondent. The findings in Table 16 highlight that satisfaction with healthcare increased over time (*F*

Table 15. Means and Standard Deviations for Satisfaction With Healthcare From 2004 to 2008

Year	Mean	*SD*
2004	1.92	1.17
2006	1.85	1.11
2008	1.82	1.08

Note. *N* = 8,363.

Table 16. Repeated-Measures ANOVA Results for Satisfaction With Healthcare From 2004 to 2008

Variable	*Df*	MS	*F*	Sig.
Linear trend	1	38.46	42.49	.000
Error	8362	0.91		
Quadratic trend	1	1.25	1.56	.212
Error	8362	0.80		

Note. *N* = 8,363. Overall use of medicine *Huynh-Feldt F* (2,16577) = 23.28, *p* = .000

(1,8362) = 42.49, *p* = .000). Thus, respondents were more satisfied with healthcare in 2008 (*M* = 1.82) than they were in 2004 (*M* = 1.92).

Research Question 3: What Are the Demographic Factors Associated With Utilization and Satisfaction With the Prescription-Drug Experience for Medicare-Enrolled HRS Survey Respondents?

Procedure. The effects of the following seven demographic variables on utilization patterns and satisfaction with prescription care over time were assessed:

- Age
- Educational attainment (completed grade school, completed high school, completed college, completed graduate program)
- Race
- Region of residence

- Salary
- Health
- Drug coverage

Separate procedures were conducted for each variable. This was done because when more than one factor was included in the models, the number of cases for each time period was very low. For continuously measured factors, linear regression procedures were conducted. The dependent measures were transformed into linear and quadratic trends. The linear and quadratic transformations were regressed on the continuously measured factor (e.g., age). For categorical factors, mixed-method ANOVAs were conducted. The dependent measures were also transformed into linear and quadratic trends. Because several linear regression and mixed-method ANOVAs were conducted, only the procedures that yielded statistically significant findings are presented.

Changes in prescription utilization patterns. Age (defined by year of birth), educational attainment, race (categorized into White, Black, and other), region of residence, mean health (defined as the average health rating from the years 2004, 2006, and 2008), and mean drug coverage (defined as the average coverage from the years 2004, 2006, and 2008) did not have any significant effects on change in utilization patterns. However, as revealed in Table 17, mean salary (defined as the average of 2004, 2006, and 2008 salaries) significantly predicted changes in utilization patterns (F (1,71) = 4.86, p = .031). The increase in medicine use from 2004 to 2008 was most significant for those with higher salaries (defined here as total yearly income over $60,000) than for those with low salaries (defined here as total yearly income under $30,000).

Changes in satisfaction with prescription care. Age, race, region of residence, mean salary, and mean drug coverage did not have significant effects on change in satisfaction with prescription care over time. However, education was related to prescription care satisfaction (Figure 4); specifically, educational attainment significantly predicted change in prescription–satisfaction patterns (F (1,8293) = 5.88, p = .001; see Table 18). Note that lower scores indicate greater degrees of satisfaction. Accordingly, as

Table 17. Linear Regression Results for the Effect of Mean Salary on Medicine Use Over Time

Variable	B	*SE*	*F*	Sig.
Between subjects				
Mean salary	1.35	0.00	0.79	.378
Within subjects				
Linear trend	-0.41	0.22	3.30	.073
Linear x mean salary	1.70	0.00	4.86	.031
Quadratic trend	0.10	0.19	0.26	.615
Quadratic x mean salary	-9.10	0.00	1.56	.216

Note. N = 73.

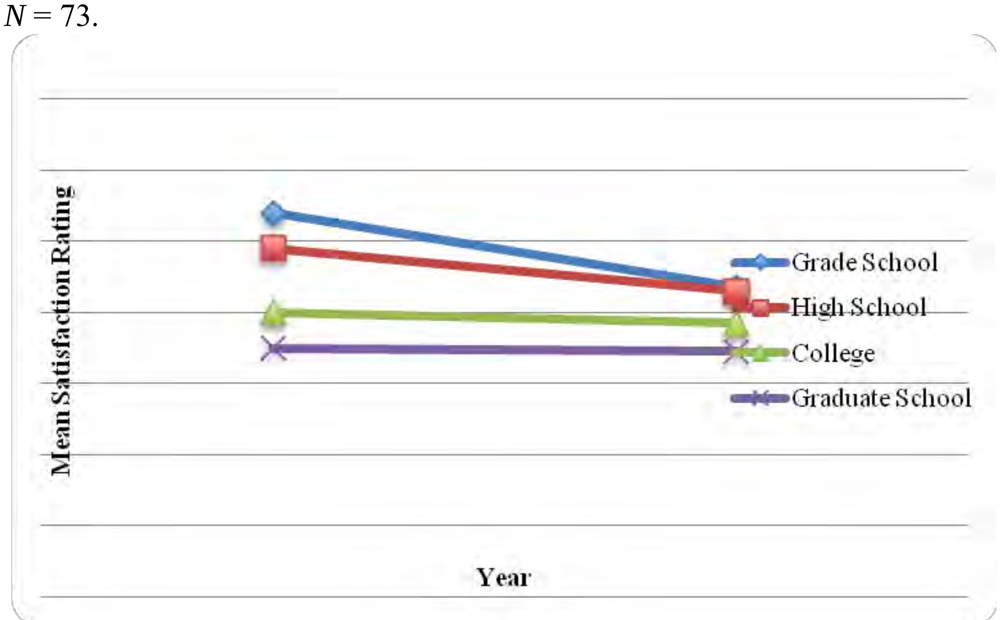

Figure 4. The effect of educational attainment on mean prescription care satisfaction over time. The lower the score the higher the level of satisfaction.

illustrated in Figure 4, mean satisfaction scores were similar over time for respondents with college and graduate degrees. Satisfaction, however, increased over time for respondents with grade school and high school diplomas. Table 19 reveals that mean health ratings significantly predicted change in satisfaction with prescription care (*F* (1,9359) = 11.85, *p* = .000). The increases in satisfaction with prescription care from 2004 and 2006 (on average) to 2008 were steeper at higher than at lower levels of physical well-being.

Table 18. ANOVA Results for the Effect of Education on Prescription Care Satisfaction Over Time

Variable	*df*	MS	*F*	Sig.
Between subjects				
Educational attainment	3	71.49	35.42	.000
Error	8,293	2.02		
Within subjects				
Linear trend	1	24.18	26.70	.000
Linear x educational attainment	3	5.33	5.88	.001
Error	8,293	0.91		
Quadratic trend	1	0.65	0.81	.369
Quadratic x educational attainment	3	0.99	1.24	.292
Error	8,293	0.80		

Note. *N* = 8,294.

Table 19. Linear Regression Results for the Effect of Health Ratings on Prescription Care Satisfaction Over Time

Variable	B	*SE*	*F*	Sig.
Between subjects				
Mean health rating	-0.38	.02	620.46	.000
Within subjects				
Linear trend	-0.13	.03	16.11	.000
Linear x health rating	0.01	.01	1.48	.224
Quadratic trend	-0.08	.03	6.71	.010
Quadratic x health rating	0.03	.01	11.85	.001

Note. *N* =9,361.

Research Question 4: How Are Out-of-Pocket Prescription Costs for Retirees Different Postenrollment In Medicare Part D?

Factors associated with out-of-pocket prescription costs. The effects of the following seven demographic variables on changes in out-of-pocket prescription costs were assessed:

- Age
- Educational attainment
- Race
- Region of residence
- Salary
- Health
- Existing Drug coverage

Separate procedures were conducted for each factor. This was done because when more than one factor was included in the models, the number of cases for each time period was very low. For continuously measured factors, linear regression procedures were used. The dependent measures were transformed into linear and quadratic trends. The linear and quadratic transformations were regressed on the continuously measured factor (e.g., education). For categorical factors, mixed-method ANOVAs were performed. The dependent measures were also transformed into linear and quadratic trends. Because several linear regression and mixed-method ANOVAs were conducted, only the procedures that yielded statistically significant findings are presented.

Out-of-pocket prescription costs. None of the first six variables (age, educational attainment, race, region of residence, salary, and health) had significant effects on change in the amount of out-of-pocket prescription costs over time. However, Table 20 shows that mean drug coverage significantly predicted change in the amount of out-of-pocket prescription costs over time. The decrease in prescription costs from 2004 to 2008 was steeper at higher levels of drug coverage than it was at lower levels of coverage (*F* (1,4740) = 17.24, *p* = .000).

The findings in Table 21 show that ingestion of blood pressure medication varied significantly over time ($\chi 2$ (2) = 8.68, *p* = .045). The percentage of respondents taking blood pressure medication in 2006 (93.1%) was greater than the percentages in 2004 (92%) and in 2008 (92.2%). This may be due to more access to medication as a result of enrolling in Medicare Part D or to trying a new medication and then discontinuing it by 2008.

Table 20. Linear Regression Results for the Effect of Mean Drug Coverage on Amount of Out-of-Pocket Prescription Costs Over Time

Variable	B	*SE*	*F*	Sig.
Between subjects				
Mean drug coverage	-86.56	14.92	33.64	.000
Within subjects				
Linear trend	-186.07	31.19	35.60	.000
Linear x drug coverage	53.08	12.78	17.24	.000
Quadratic trend	42.01	29.11	2.08	.149
Quadratic x drug coverage	-11.05	11.69	.89	.345

Note. *N* = 4,740.

Table 21. Cross-tabulations for Blood Pressure Medication Over Time

	Took blood pressure medication		
Year	Yes	No	Total
2004	5,327	464	5,791
2006	5,886	435	6,321
2008	6,164	518	6,682
Total	17,377	1,417	1,8794

Note. Pearson χ^2 (2) = 6.21, *p* = .045.

The findings in Table 22 reveal that the survey respondents report use of diabetes medication did not vary significantly over time ($\chi 2$ (2) = .54, *p* = .763). The findings in

Table 23 indicate that regular use of prescription drugs varied significantly over time ($\chi2$ (2) = 32.67, p = .000). The percentage of respondents who took prescription drugs regularly in 2006 (63.7%) was higher than the percentage of respondents who took prescription drugs regularly in 2004 (61%). In addition, the percentage of respondents who took prescription drugs regularly in 2008 (68%) was higher than the percentage in 2006.

Table 24 shows that satisfaction with prescription care varied significantly over time ($\chi2$ (4) = 119.17, p = .000). The percentage of *very satisfied* ratings in 2008 (61%) was higher than the percentages of *very satisfied* ratings in 2004 (57.4%) and 2006 (59.9%). Further, the percentage of *not satisfied at all* ratings in 2008 (2.6%) was lower than the percentages of *not satisfied at all* ratings in 2004 (5.3%) and in 2006 (3.2%).

Table 22. Cross-tabulations for Swallowing Diabetes Medication Over Time

Year	Swallowed diabetes medication		
	Yes	No	Total
2004	1,441	511	1,952
2006	1,656	585	2,241
2008	1,777	656	2,433
Total	4,874	1,752	6,626

Note. Pearson χ^2 (2) = .54, p = .763.

Table 23. Cross-tabulations for Regular Ingestion of Prescription Drugs Over Time

	Take prescription drugs regularly		
Year	Yes	No	Total
2004	2,103	1,343	3,446
2006	1,969	1,122	3,091
2008	1,936	913	2,849
Total	6,008	3,378	9,386

Note. Pearson χ^2 (2) = 32.67, p = .000.

Table 24. Cross-tabulations for Satisfaction with Prescription Care Over Time

	Satisfaction with prescription care			
Year	Very satisfied	Somewhat satisfied	Not satisfied	Total
2004	5,482	3,562	505	9,549
2006	5,868	3,617	314	9,799
2008	5,990	3,577	251	9,818
Total	17,340	10,756	1,070	29,166

Note. Pearson χ^2 (4) = 119.17, p = .000.

CHAPTER 5

DISCUSSION

Major Findings by Research Question

Research Question 1: What Are the Demographic Characteristics of the HRS Sample Respondents Who Had Medicare Part D Coverage in 2006 and 2008?

Most survey respondents signed up for Medicare Part D in 2006. Specifically, the findings indicated that 65.6% of respondents signed up for Medicare Part D in 2006 and 31.9% signed up in 2005, when Medicare Part D plan offerings began to appear for public purchase. Survey respondents overwhelmingly indicated that Medicare Part D was their primary prescription plan. In 2006, 90.8% indicated that Medicare Part D was their primary plan, and only 9.2% reported that they had a private prescription plan. In 2008, 90.6% indicated that Medicare Part D was their primary plan, and only 9.4% reported that they had an additional prescription plan.

Over time, prescription-drug insurance premiums increased substantially. In 2006, monthly premiums for prescription insurance ranged from $0 to $1,020, and the mean monthly payment was $47.18 (*SD* = $229.29). In 2008, monthly premiums ranged from $0 to $1,350, and the mean monthly payment was $104.51 (*SD* = $449.31).

The number of respondents with a prescription insurance plan decreased slightly over time. In 2006, the number of respondents with plans ranged from 0 to 7, and the mean number of plans was 1.57 (*SD* = .57). In 2008, the number of prescription insurance plans ranged from 0 to 5, and the mean number of plans was 1.52.

Research Question 2: What Are Some of the Changes to the Prescription-Drug Experience for Retirees Enrolled in Medicare Part D During That Time Period?

The findings show that medicine use increased over time, with respondents in 2008 taking substantially more medications (M = 4.13) than respondents in 2004 (M = 3.77). In addition, data over time revealed a sharp increase in prescription usage from 2004 to 2006 but a slight decrease from 2006 to 2008.

The findings also showed that prescription insurance payments increased over time, with respondents in 2008 having higher payments (M = 211.41) than respondents in 2004 (M = 187.09). In addition, data over time showed a slight increase in payments from 2004 to 2006 with a larger increase from 2006 to 2008.

The findings indicated that monthly drug costs decreased over time, with respondents in 2008 having lower payments (M = 68.75) than respondents in 2004 (M = 136.26). In addition, data over time revealed a sharp decrease in payments from 2004 to 2006 but only a slight decrease only from 2006 to 2008.

Research Question 3: What Are the Demographic Factors Associated With These Changes?

Mean salary significantly predicted change in prescription-utilization patterns. The increase in medicine use from 2004 to 2008 was higher for those with higher salaries (< $60,000) than for those with low salaries (> $30,000). Educational attainment significantly predicted changes in healthcare satisfaction patterns. In particular, satisfaction increased to a greater degree over time for respondents with grade school and high school diplomas than those with 4-year degrees or higher.

Research Question 4: How Are Out-of-Pocket Prescription Costs for Retirees Different Postenrollment in Medicare Part D?

Mean drug coverage significantly predicted changes in the amount of out-of-pocket prescription costs over time. The decrease in prescription costs from 2004 to 2008 was steeper at higher levels of supplemental drug coverage than it was at lower levels of coverage. With respect to satisfaction with prescription care, the percentage of *very satisfied ratings* in 2008 (61%) was higher than the percentages of *very satisfied* ratings in 2004 (57.4%) and 2006 (59.9%). Furthermore, the percentage of *not satisfied at all* ratings in 2008 (2.6%) was lower than the percentages of *not satisfied at all* ratings in 2004 (5.3%) and in 2006 (3.2%).

Discussion

Having established the findings of this research, the task at hand now is to interpret the meaning of the results by linking them to the concepts of the social contract and political economy.) One of the most important findings of this study is that, for Medicare--enrolled HRS survey participants, prescription-drug insurance premiums increased from $47.18 in 2004 to $104.51 in 2008. Over 90% of the sample was enrolled in Medicare Part D by 2006. Eligible participants had to pick a prescription insurer if they did not already have one. This enrollment requirement increased the pool of potential members significantly, with national data indicating some 63% of all eligible seniors enrolled in Medicare Part D as early as 2006 (Davidoff et al., 2006). This means an estimated 43 million seniors gained access to prescription-drug coverage under myriad new Medicare Part D prescription-drug plans (Kaiser Family Foundation, 2006).

Perhaps the reason that Medicare-enrolled HRS respondents experienced such significant increases in prescription insurance costs is because they stayed on the same plan over time. As implementation of Medicare Part D drastically changed the prescription-insurance environment and signing up with an insurer to provide prescription insurance coverage meant reassessing the prescription-insurance market every year, making the most rational decision (i.e., best coverage, lowest cost) became a fluid rather than fixed task. It may well be that many consumers only made that decision to enroll once, when they first had to make a choice of enrolling or facing increased rates, and then just kept the same plan even as costs rose.

There is some evidence that this might be the case. Abaluck and Gruber (2009), in an extensive study on retirees choosing prescription plans under Medicare Part D, noted that seniors place much more weight on plan premiums than they do on expected out-of-pocket costs and that they tend to stay with the plans they select. Meaning, when eligible retirees picked an insurance plan, they probably did so with emphasis on upfront prescription insurance costs rather than other factors and did not revisit their plan options even as premiums increased yearly. Adding to the potential for confusion, some plans with lower monthly premiums have higher prices for medications relative to average national retail prices (Duggan & Morton, 2011). Therefore, what seems like a lower cost scheme for accessing prescription drugs has a higher overall cost in terms of premium plus co-pays for the drugs themselves.

Looking at a package of five commonly used drugs in five large states, a recent study found that the best-priced drug plan in January 2006 was among the worst deals for seniors in 2008 (Vaughn, 2009). This can partly be explained by the concept of a ―loss leader," where some of the insurance company plans enticed seniors with low premium costs in 2006, only to significantly increase those prices over time.

This presumption rests on the idea that reevaluating prescription insurance plans every year is not something many eligible enrollees will do. Vaughan notes, ―The companies bet correctly; nationally, only 1 million seniors of the 17 million Medicare Part D participants switched plans from 2007 to 2008." Another study addressed concerns about loss leaders as endemic to the Medicare Part D insurance market. Given the insurer's desire to lock in market share, even if loss leaders are needed to entice consumers. Winters et al. (2006) argued that considerable turmoil could ensue as insurers and plans come and go and premiums and coverage change.

A second major finding presented in this research is the confounding effect of increased prescription usage and decreased prescription costs. On the one hand, study participants reported taking roughly 36% more medication in 2008 than in to 2004. At the same time, reported monthly prescription costs decreased from $134.26 in 2004 to $68.75 in 2008 for Medicare Part D enrollees participating in the survey. If taking more medications, it would seem logical that monthly prescription costs would be higher, but the data indicates this is not the case.

The increased use of prescriptions may be explained by survey respondents getting older or sicker or beginning to take medications for the first time. Alternatively, some may have started or resumed taking prescribed medications (and refilling prescriptions) upon being covered by Medicare Part D. A third possibility, and the one favored here, is that Medicare Part D facilitated affordable prescription care to those who had been previously underinsured or uninsured.

There is some evidence to support this third interpretation. Prior to the implementation of Medicare Part D, about 25% of the elderly had been paying cash for prescription drugs. As of January 1, 2006, these individuals became eligible to enroll in Medicare Part D and benefitted from lower prices negotiated on their behalf by private prescription plans (Berndt & Frank, 2007). This means that a large percentage of Medicare Part D members in 2006 and 2008, nearly a quarter, were going from a retail prescription market to a subsidized one. Nationally, in 2006, seniors who enrolled in Medicare Part D increased their prescription-drug use by 13%, resulting in an increase of 158 million new prescriptions under Medicare Part D in 2006. Survey respondents in the HRS sample were nearly 3 times as likely to have increased prescription usage after enrolling in Medicare Part D.

Using comparable national data, a recent study found that gaining prescription-drug insurance through Medicare Part D was associated with a 63% increase in the number of annual prescriptions (Kaestner & Khan, 2010). A second study showed that the use of two specific drug types—lipid-lowering heart medication and anti-diabetic medications—rose in the groups with no or minimal previous drug coverage upon enrolling in Medicare Part D (Zhang, Donohue, Lave, O'Donnell, & Newhouse, 2009). This rise in prescription-drug use after enrolling in Medicare Part D may be due in part to new enrollees who suddenly have access to medications that they had already needed but were previously unable to afford. As the results from this dissertation show, the initial spike in the demand for new prescriptions occurred primarily in 2006, when Medicare Part D was first available, and leveled off in 2008. There are several plausible reasons for the increase of prescription utilization in 2006 and decline in 2008. Two plausible reasons for the increase of prescription utilization in 2006 and decline in 2008 are as follows:

1. Subsidized prescription care freed both the physician and the patient to explore prescription treatment options that may have been cost prohibitive prior to Medicare Part D. Because prescribers were now able to prescribe a wider variety of subsidized medications, they may have done so more aggressively as patients could pay for new prescriptive treatment under Medicare Part D.
2. In 2008, the Centers for Medicare & Medicaid Services dropped more than 1,500 drug codes from its list of formulary-approvable drugs. This may have put a damper on experimental treatments and the medication stacking techniques used by prescribers and thus driven down demand for prescription medication in 2008.

Recent studies in the health policy field suggest an association between insurer negotiations and lower drug prices (Medicare Payment Advisory Commission, 2007). In fact, one study found that for every 100,000 additional insurance customers, prescription insurers under Medicare Part D are able to secure a reduction of 2.5% in drug prices (Lakdawalla & Yin, 2009). In a follow-up to that study, Lakdawalla and Yin found that Part D-related insurer size had a direct impact on retail drug prices. For participants in large insurance plans, this amounted to a reduction in prescription costs of 5.8% to 8.5% (Lakdawalla & Yin, 2010).

Typically, negotiations between private prescription insurers are based on membership numbers and can operate using a straight discount or rebates tied to sales volume. As the National Pharmaceutical Council explains:

> There are generally two types of price discounts, both of which are calculated as percentage reductions in a drug‘s ―average wholesale price” (AWP): discounts (a flat percentage off of AWP, given up front) and rebates (a varying percentage off

> of AWP, typically determined after the end of a benefit year and tied to the actual volume of a drug that was sold through the plan‘s pharmacy network). For most rebates, the formula by which the rebate will be calculated is set prospectively in the initial contract negotiation, but the actual calculation of the final rebate amounts is done after the benefit year has ended and final sales volume figures are available. (The National Pharmaceutical Council, 2006, p. 6)

Another important factor to consider in establishing why prescription costs decreased for Medicare Part D participants in this survey is the increased use of generic prescription drugs. Generic drugs have several meanings within the medical literature but are broadly defined in one of three ways:

1. The chemical name of a drug.
2. A term referring to the chemical makeup of a drug rather than to the advertised brand name under which the drug is sold.
3. A term referring to any drug marketed under its chemical name without advertising. (MedicineNet.com, 2010)

This class of drugs is a cheaper alternative to what is known as ―branded drugs.” A brand-name drug is a medication sold by a pharmaceutical company under a trademark-protected name. Brand-name medications can only be produced and sold by the company that holds the patent for the drug (Bihari, 2008). Two reasons branded drugs are so much more expensive than the generic drugs are that (a) generic drugs get to piggyback on the research and development of branded drugs, which saves on average $800 million dollars per drug, and (b) marketing expenses.

The pharmaceutical industry in 2006 spent $4.8 billion on consumer ads for branded drugs in addition to $7.2 billion more marketing products to doctors (Humana, 2010). These costs inevitably get rolled into the price of the drug and passed on to the consumer. A recent CMS analysis found that, by using generics, Medicare Part D beneficiaries could see prescription-drug savings of up to 74% if they joined one of a broad range of low-cost plans and then switched to generics (CMS, 2006). Generic drugs are not a new phenomenon, but the emphasis within Medicare Part D to promote the use of generic drugs is. The total number of prescriptions filled under Part D in 2007 was about 1 billion, of which 65% were filled with generic drugs, 5% were filled with multiple-source brand-name drugs (brand-name drugs that are also available in generic versions), and 30% were filled with single-source brand-name drugs for which no chemically equivalent generic versions were available; Congressional Budget Office, 2010). On a programmatic level, Medicare Part D saved more than $33 billion in 2007 alone due to the use of generic drugs (McKnight, 2010).

A third interesting finding presented in this research is that increased use of prescription drugs was most significant for survey respondents with higher mean salaries as opposed to those with lower mean salaries. For the purposes of this study, salaries were split in thirds. Those in the sample who made less than $30,000 per year (38.3% of the sample) were considered to have a low income, those with salaries of $30,000 to $60,000 (31.8% of the sample) were considered to have a middle income, and those with more than $60,000 (29.9% of the sample) were considered to have a high income.

Given that those with higher incomes could afford prescription drugs prior to the implementation of Medicare Part D, or likely had better access to prescription insurance, why would they choose to use more medications in 2006 and 2008 than in 2004 is something of a mystery. I submit that there are two possible explanations for this trend.

The first is that those eligible Medicare Part D survey respondents with high salaries could afford their medication even if they fell into the so-called Donut Hole. The Donut Hole is a term used to describe a phase of the Medicare Part D plan at the end of the initial coverage phase or when prescription expenses reach their initial coverage limit (around $2,840 in 2010; Medicare.com, 2010). For those who can afford to pay through the donut hole until catastrophic coverage kicks in, continued or experimental use of new medications would not be prohibited by cost. For seniors with lower or fixed incomes who fell into the donut hole, the spike in costs may have caused them to take less medication or discontinue what they were taking when they hit the donut hole. A recent study confirmed this, finding that 26% of Medicare Part D enrollees who fell into the coverage gap reported not filling a prescription, stopping their medication, or using less medication than prescribed. An additional 10% of respondents bought their medication outside the United States, took someone else‘s medication, or obtained free samples (Cronk, 2008).

In other words, Medicare Part D enrollees with high salaries have more financial freedom to purchase medication than seniors on fixed incomes. One study found that after the Part D plan pays out $2,830 in benefits, enrollees must pay 100% of their Rx drug costs until the ―catastrophic limit" is reached. In 2008, the ―catastrophic limit" began after enrollees spent $6,100 for prescription drugs, not including the premiums paid each month for the insurance or the co-pays for each prescription drug (Riley, 2010).

Although $6,100 per year for prescription drugs may seem like a small price to pay for some, for Medicare Part D enrollees on fixed incomes this sum can be substantial. Data from the U.S. Social Security Administration indicate that 54% of married couples and 73% of unmarried persons receive 50% or more of their income from Social Security (2007). With the average Social Security benefits of $12,000 dollars per year (NCPSSM, 2010), it is not hard to see how the Donut Hole could reduce medication usage for lower income people while having little impact on those with higher incomes. Even for

Medicare-enrolled individuals defined in this study as low salaried, prescription expenses coupled with insurance premiums may leave little for the costs of daily living.

In a broader sense, how low-income enrollees fared with Medicare Part D reflects the importance of social class in health. A large body of evidence indicates that socioeconomic status is a strong predictor of health and longevity. Better health is associated with having a higher income, more years of education, and a more prestigious job, as well as living in neighborhoods where a higher percentage or residents have higher incomes and more education (MacArthur Foundation, 2010). This finding has been reiterated consistently in the literature over many years (Adler & Newman, 2002; Scott, 2005; Veenstra, 2007; Wilson, 2009).

A study by Link and Phelan (2000) highlights some of the reasons those is higher social classes have better health and would be likely to be more proactive in their utilization of Medicare Part D. They point to data that shows the following.

- Smoking: once information spread that smoking was bad for your health people of higher socioeconomic status were more likely to quit smoking and less likely to start than people of lower socioeconomic status.

- When HIV/AIDS emerged, it struck all segments of society with little regard for socioeconomic standing. But as public knowledge concerning risk factors improved and as new, expensive treatments became available, the socioeconomic gradient shifted. Today, HIV/AIDS is more common among people who are poorer and less educated.

- Historically coronary artery disease initially was more prevalent among people in the higher socioeconomic brackets. Again, as health conditions and health behaviors improved for persons in higher socioeconomic brackets, the disease distribution shifted. Today, coronary artery disease is more prevalent among people in the lower socioeconomic strata. (pp. 112-113).

What this indicates is that individuals with higher salaries or socioeconomic classes have better access to information and presumably prescription-drug treatments and that they utilize this access to improve their health. Because prescriptions are often used to improve health and stay out of the hospital, it makes some sense that survey respondents with higher salaries would be more likely to utilize the Medicare Part D prescription benefit when it became available and to use more medications consistently over the sample period.

Conclusion

Despite the disadvantages noted in this study, Medicare Part D has some positive attributes. First, it is popular. Second, it is affordable for more seniors today than it was 6 years ago. Finally, it is a ―government” program, and most citizens are willing to accept benefits from the government without looking at the details too closely. Medicare Part D is new to the social-contract mix, and citizens are offered a benefit in the form of a prescription subsidy but asked to navigate a system of choices and to balance competing interests in their plan selections.

However, unlike other programs driven by a social contract, Medicare Part D is a variable coverage program. Enrollees must pick their plans year to year and plan to plan. What appears to be the cheapest plan one year may end up being the most expensive the next. Where one plan covers a given drug in its formulary, another does not. The myriad choices, deductibles, and coverage limits unique to the thousands of available plans put a lot of responsibility on the consumer to make the best choice for their prescription care.

Taken together, this research presents a mixed picture. Regardless of status, prescription costs declined for nearly every category of participant including all the political economy favorites (age, race, gender, income, etc.). Yet, across the board, prescription insurance premiums increased. Whereas Medicare recipients with limited educational backgrounds reported greater satisfaction with healthcare post-Medicare Part D enrollment, those with higher salaries utilized the Medicare Part D prescription-drug subsidy more than any other group by increasing their use of prescription drugs. Some wonder whether the obligations presented under Medicare Part D are unaffordable. David Walker, former GAO Comptroller noted,

> The Medicare Part D prescription drug bill was probably the most fiscally irresponsible piece of legislation since the 1960s. We promise much more than we can afford to keep. Eight trillion dollars added to what was already a $15 to $20 trillion under-funding. We're not being realistic. We can't afford the promises we've already made, much less to be able to pile on top of them. The federal government increased existing Medicare obligations nearly 40% over the next 75 years." (Court, 2007)

Court is not alone in this assessment. Concerns about the sustainability of Medicare Part D are widely shared across the political spectrum (Burns, 2010; Laszewski, 2007; Moran, 2008). In essence many scholars question why an unsustainable social program was created and what the lifespan of the program will be.

Opportunities to study the effect on Medicare of The Patient Protection and Affordable Care Act offer an abundance of further research opportunities. Preliminary data show that The Patient Protection and Affordable Care Act provides a number of additional benefits to Medicare Part D enrollees:

- In 2010, the patient Protection and Affordable Care Act allows for a one-time $250 rebate from Medicare for those who fall into the Donut Hole.
- Beginning in 2011, if participants reach the donut hole, they will receive by law a 50% discount on the total cost of brand name drugs while in the gap.
- Additional discounts for brand-name and generic drugs will be phased in to close the donut hole completely by 2020, and enrollees will merely be responsible for co-insurance premiums. (Mangrello-Jennings, 2010)

On the down side of Medicare Part D, a recent article suggests prices will continue to rise well above the rate of inflation for both prescriptions and insurance premiums:

- Seven of the top 10 national prescription insurance plans will charge higher premiums next year.
- Premiums will go up an average of 10 percent among the top 10 drug plans that have signed up about 70 percent of seniors in 2011.
- Average monthly premiums will rise from under $64 to nearly $91. (Alonzo-Zaldivar, 2010)

Another concern for dual-eligible Medicare Part D enrollees who receive their benefits from Medicare Advantage is that the plan is being phased out. According to the Office of the Actuary at the Centers for Medicare and Medicaid Services, Medicare Advantage cuts stipulated in the Patient Protection and Affordable Care Act will reduce enrollment in Medicare Advantage plans from 14.8 million to just 7.4 million by 2017 (Capretta, 2010). Given that Medicare Advantage currently allows subsidized access to prescription drugs and has 10.2 million Medicare Part D enrollees in its plan—about one fifth of all Medicare participants (Fritze, 2009)—the discontinuation of this plan may have profound effects on the prescription-drug experience for seniors who will need to pick another plan.

Another concern is the structure of the contract between government and the pharmaceutical industry as opposed to directly with citizens (i.e., a public option). The Obama administration claims to have secured an $80 billion dollar giveaway by the pharmaceutical industry, in part by assuring manufacturers there will be no talk of price negotiation for Medicare Part D enrollees (Blumenthal, 2010; Grim, 2009). This means that consumers are left to shop among insurers who negotiate prices based on business strategy and not necessarily in the best interest of the consumer. Finally, and perhaps most pertinent to further research, the Patient Protection and Affordable Care Act further entrenches the idea that private companies are better suited to handle public problems such as prescription care for seniors and that government should simply fund these private entities rather than create a federal health system.

Returning to the question of whether Medicare Part is the product of a normative, pluralist or political economy theoretical frame. It seems clear that pluralism and the furies of private interests as represented here by the political economy perspective had more to do with the implementation of the policy than any normative notion of what such a policy *should* do normatively. What can be said of the normative nature of Medicare Part D however is that is has created a new entitlement for a vulnerable population and has reduced barriers to accessing prescription care universally, eligibility requirements aside. It has also provided a safety net for inter-generationally bonded families that may have had to provide for their older relatives financially with regard to prescription care. It also establishes a baseline for future policy developments that could include more normative goals.

Two practical and simple normative principles that might be included in future iterations of Medicare Part D are as follows:

1. Negotiation of drug prices directly between the federal government and pharmaceutical companies is a fundamental flaw that needs to be corrected. Medicare Part D was purposefully crafted to allow a free-market approach to Medicare Part D federal spending. This is in sharp contrast to another prescription program for seniors run by the Veteran's Administration. The Veteran's Administration provides the same level of prescription support at a federal level for 30% less than Medicare Part D because it sets its own rates.

2. Reduction or elimination of the Donut Hole. In a normative position, the most ill eligible seniors should be the best supported in their hour of need.

> Instead, the current model pushes the most sick into the Donut Hole which results in temporary but dramatic increases in drug costs. In this view, historically poor people, single elderly women, minority groups and people who are seriously ill are all negatively impacted by the Donut Hole. The current remedy is either to address this problem head on or as President Obama‘s revisions indicate in The Patient Care and Protection Act: offers a $250 coupon for prescription care subsidies for those who fall into the Donut Hole.

In the final analysis, the majority of participants in this research are spending less out of pocket for prescription medications, reporting stable health status and general satisfaction with Medicare Part D, today the long-term implications of the Patient Protection and Affordable Care Act portend an uncertain future for senior prescription care. Medicare Part D opened up access to subsidized prescription care for the nearly 25% of those over 65 who did not have prescription-drug coverage before Medicare Part D was created (Population Reference Bureau, 2007). Medicare Part D reduced the cost of prescription drugs through insurer negotiations with pharmaceutical manufacturers and, through the increased promotion and use of generic drugs, addressed a growing social problem. In short, Medicare Part D has become a vital part of the social contract for seniors, and although flawed on a number of levels, the policy appears to have made the prescription experience for seniors better, not worse.

Down the line though, the financial sustainability of entitlement programs such as Medicare Part D will provoke debate and revision. Public awareness that the current allocation of entitlement benefits is inefficiently administered and creates a tremendous burden on the federal budget is becoming more widespread. Given the current budgetary concerns irrespective of entitlement programs, the probability of revisiting federal outlays for entitlement spending seems highly probable.

Signs of entitlement-spending changes can be seen in the now-defeated ―Path to Prosperity" plan advocated by Sen. Paul Ryan (House Committee on Budget, 2011). His plan for entitlement programs such as Medicare Part D is to turn them into voucher programs with strict caps on federal contributions. Although this plan may be far reaching and was passed in the House of Representatives but ultimately defeated in the Senate, its core redefinition of the social contract has significant implications.

The fact that wholesale revisions of the entire Medicare, Medicaid and Social Security system(s) are now out in the open and subject to political jockeying among ―the furies of private interest" suggests that it may not be too far from now when real and permanent revisions are made to entitlement programs such as Medicare Part D. The question is: what types of changes and who will benefit?

APPENDIX A

WHAT IS MEDICARE?

Source: http://www.medicare.gov/medicarereform/drugbenefit.asp

Medicare Part A (Hospital Insurance)

What Is Part A (Hospital Insurance)?

Part A helps cover:

- Inpatient care in hospitals (such as critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals)
- Inpatient care in a skilled nursing facility (not custodial or long term care)
- Hospice care services
- Home health care services
- Inpatient care in a Religious Nonmedical Health Care Institution

Members usually don't pay a monthly premium for Part A coverage if they or their spouse paid Medicare taxes while working. This is called "premium-free Part A."

If applicants aren't eligible for premium-free Part A, they may be able to buy Part A if they meet one of these conditions:

- The applicant is 65 or older, and entitled to (or enrolling in) Medicare Part B and they meet the citizenship or residency requirements.
- The applicant is under 65, disabled, and their premium-free Part A coverage ended because they returned to work.

In most cases, if an applicant chooses to buy Part A, they must also have Part B and pay monthly premiums for both. If the applicant has limited income and resources, their state of residence may help them pay for Part A and/or Part B.

Services Part A Covers

Blood: In most cases, the hospital gets blood from a blood bank at no charge, and the member won't have to pay for it or replace it. If the hospital has to buy blood for the member, the member either pay the hospital costs for the first 3 units of blood allotted in a calendar year or have the blood donated by someone else.

Home Health Services: Limited to medically-necessary part-time or intermittent skilled nursing care, or physical therapy, speech-language pathology, or a continuing need for occupational therapy. A doctor must order the care, and a Medicare-certified home health agency must provide it. Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment (see page 30), and medical supplies for use at home. The member must be homebound, which means that leaving home is a major effort.

Hospice Care: For people with a terminal illness. The member‘s doctor must certify that the member is expected to live 6 months or less. Coverage includes drugs for pain relief and symptom management; medical, nursing, social services; and other covered services as well as services Medicare usually doesn‘t cover, such as grief counseling. A Medicare-approved hospice usually gives hospice care in- home (or other facility like a nursing home).

Medicare covers some short-term inpatient stays for pain and symptom management that can‘t be addressed in the home. These stays must be in a Medicare-approved facility, such as a hospice facility, hospital, or skilled nursing facility. Medicare also covers inpatient respite care which is care given in a Medicare approved facility for primary caregiver respite. A member can stay up to 5 days each time they receive respite care. Medicare will pay for covered services for health problems that aren‘t related to terminal illness. Members can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies that the member is terminally ill.

Hospital Stays (Inpatient): Includes semi-private room, meals, general nursing, drugs as part of inpatient treatment, and other hospital services and supplies. Examples include inpatient care in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and mental health care. This doesn't include private-duty nursing, a television or telephone in the room (if there is a separate charge for these items), or personal care items like razors or slipper socks. It also doesn‘t include a private room, unless medically necessary. If the member is covered by Medicare Part B, it covers the doctor and emergency room services while in a hospital.

Skilled Nursing Facility Care: Includes semi-private room, meals, skilled nursing and rehabilitative services, and other services and supplies (only after a 3-day minimum inpatient hospital stay for a related illness or injury). To qualify for care in a skilled nursing facility, a doctor must certify that the member needs daily skilled care like intravenous injections or physical therapy. Medicare doesn‘t cover long-term care or custodial care in this setting.

Medicare Part B (Medical Insurance)

What Is Part B (Medical Insurance)?

Part B helps cover medically-necessary services like doctors' services, outpatient care, home health services, and other medical services. Part B also covers some preventive services. Medicare members should check their card to find out if they have Part B.

How Much Does Part B Cost?

Members pay a Part B premium each month. Most people will pay the standard premium amount. However, if a member‘s modified adjusted gross income as reported on an IRS tax return from 2 years ago is above a certain amount, the member may pay more. Member‘s modified adjusted gross income is taxable income plus tax exempt interest income. Social Security will notify members if they need to pay more than the standard premium. If eligible members don't sign up for Part B when you are first eligible, members may have to pay a late enrollment penalty.

How You Get Part B

- **If a member receives benefits from Social Security or the Railroad Retirement Board** (RRB), in most cases the member automatically gets Part B starting the first day of the month after turning 65. If the member‘s birthday is on the first day of the month, Part B benefits will start the first day of the prior month.
- **If the member is under 65 and disabled**, they will automatically get Part B after receiving disability benefits from Social Security or certain disability benefits from the RRB for 24 months. The member will receive a Medicare card in the mail about 3 months before their 65th birthday or their 25th month of disability.

Services Part B Covers

There are two kinds of Part B-covered services:

Medically-necessary services — Services or supplies that are needed to diagnose or treat medical condition and that meet accepted standards of medical practice.

Preventive services — Health care to prevent illness or detect it at an early stage, when treatment is most likely to work best.

What You Pay for Part B Services

Costs for Part B services depend on whether members have Original Medicare or are in a Medicare health plan. For some services, there are no costs, but members may have to pay for the doctor‘s visit. If the Part B deductible applies, members must pay all costs until they meet the yearly Part B deductible before Medicare begins to pay its share. Then, after the deductible is met, members typically pay 20% of the Medicare-approved amount of the service. Members can save money if they choose doctors or providers who accept assignment.

Medicare Advantage (Part C)

Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are health plans offered by private companies approved by Medicare. If you join a Medicare Advantage Plan, the plan provides all your Part A (Hospital Insurance) and Part B (Medical Insurance) coverage.

Medicare Advantage plans always cover emergency and urgent care. Medicare Advantage Plans must cover all the services that Original Medicare covers, except hospice care. (Original Medicare covers hospice care even if you‘re in a Medicare Advantage Plan.)

Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most plans also include Medicare prescription drug coverage.

Medicare Advantage Plans must follow rules set by Medicare. However, each plan can charge different out-of-pocket costs and have different rules for how services are obtained (like whether a referral is needed to see a specialist or if members have to go to only doctors, facilities, or suppliers that belong to the plan).

Members usually pay one monthly premium to the Medicare Advantage plan, in addition to a Part B premium.

Different Types of Medicare Advantage Plans

- Health Maintenance Organization (HMO) Plans
- Preferred Provider Organization (PPO) Plans
- Private Fee-for-Service (PFFS) Plans
- Medical Savings Account (MSA) Plans
- Special Needs Plans (SNP)

Other less common types of Medicare Advantage Plans include:

- Point of Service (POS) Plans—Similar to HMOs, but members may be able to get some services out-of-network for a higher cost.

- Provider Sponsored Organizations (PSOs)—Plans run by a provider or group of providers. In a PSO, members usually get health care from the providers who are part of the plan.

What Members Pay in a Medicare Advantage Plan

Member out-of-pocket costs in a Medicare Advantage Plan depend on:

- Whether the plan charges a monthly premium in addition to a Part B premium.
- Whether the plan pays any of the monthly Part B premiums. Some plans offer this option, usually for an extra cost.
- Whether the plan has a yearly deductible or any additional deductibles.
- How much the member pays for each visit or service (copayments).
- The type of health care services the member needs and how often you get them.
- Whether the member follows the plan's rules, like using network providers.
- Whether the member needs extra coverage and what the plan charges for it.
- Whether the plan has a yearly limit on out-of-pocket costs for all medical services.

Medicare Prescription-Drug Coverage (Part D)

Medicare prescription drug coverage (Part D) is available to everyone with Medicare. To get Medicare drug coverage, enrollees must join a Medicare drug plan. Plans vary in cost and drugs covered.

Two types of plans offer Medicare prescription drug coverage:

1. **Medicare Prescription Drug Plans.** These plans (sometimes called "PDPs") add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) Plans, and Medicare Medical Savings Account (MSA) Plans.
2. **Medicare Advantage Plans** (like an HMO or PPO) are other Medicare health plans that offer Medicare prescription drug coverage. You get all of your Part A and Part B coverage, and prescription drug coverage (Part D), through these plans. Medicare Advantage Plans with prescription drug coverage are sometimes called "MA-PDs."

Who Can Get Medicare Drug Coverage?

To join a Medicare Prescription Drug Plan, enrollees must have Medicare Part A and/or Part B. To get prescription drug coverage through a Medicare Advantage Plan, enrollees must have Part A and Part B. (Retrieved from http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-d.aspx)

Four Steps to Get Medicare Part D Prescription Drug Coverage

To help enrollees with Medicare take advantage of the new Medicare prescription drug coverage, there are four steps to think about while making a decision:

1. Getting Started

The decision to get Medicare prescription drug coverage depends on how potential enrollees pay for drugs now and how they get your Medicare coverage. Most people with Medicare pay for drugs and get their Medicare in one of five ways:

- Original Medicare only, or Original Medicare and a Medigap (‗Supplement') Policy without drug coverage. The new Medicare drug coverage will cover half of the costs if the member has this kind of coverage now. Enhanced options are available that provide more coverage.

- Original Medicare and a Medigap (‗Supplement') Policy with drug coverage. The new Medicare drug coverage will generally provide much more comprehensive coverage at a lower cost.

- Retiree or union coverage. In most cases, people with good retiree or union coverage can continue to get it, with new financial support from Medicare.

- Medicare Advantage Plan (like an HMO or PPO) or other Medicare Health Plan, which already include drug coverage and other extra benefits.

- Dual coverage from Medicare with Medicaid drug coverage. These people will automatically get comprehensive prescription drug coverage from Medicare, starting on January 1.

2. Determining what matters most and reviewing plan options

There are two ways members can get Medicare drug coverage. Members can add drug coverage to the traditional Medicare plan through a ―stand alone" prescription drug plan. Or they can obtain drug coverage and the rest of Medicare coverage through a Medicare Advantage plan, like an HMO or PPO that typically provides more benefits at a significantly lower cost through a network of doctors and hospitals. No matter what type of plan chosen members can choose a plan that reflects member needs in terms of cost, coverage and convenience.

- **Cost:** What members pay for the coverage, including premiums, deductible, and payments for drugs.

- **Coverage:** What benefits are provided (like coverage in the ―coverage gap" and other coverage enhancements), which drugs are covered and the rules (like prior authorization) for getting those drugs.

- **Convenience:** Which pharmacies are part of the plan and whether the plan has a mail-order option. (Retrieved from: http://www.medicare.gov)

Who is Eligible for Medicare?

Generally, enrollees are eligible for Medicare if they or their spouse worked for at least 10 years in Medicare-covered employment and enrollees are 65 years or older and a citizen or permanent resident of the United States. If enrollees aren‘t yet 65, they might also qualify for coverage if they have a disability or have End-Stage Renal disease (permanent kidney failure requiring dialysis or transplant).

Here are some simple guidelines. Enrollees can participate in Part A at age 65 without having to pay premiums if:

- Enrollees already get retirement benefits from Social Security or the Railroad Retirement Board.
- Enrollees are eligible to get Social Security or Railroad benefits but haven't yet filed for them.
- Enrollees or their spouse had Medicare-covered government employment. If enrollees are under 65, they can participate in Part A without having to pay premiums if they have:
- Received Social Security or Railroad Retirement Board disability benefits for 24 months.
- End-Stage Renal Disease and meet certain requirements.

While enrollees don‘t have to pay a premium for Part A if they meet one of those conditions, enrollees must pay for Part B if they want it. The Part B monthly premium in 2010 is $110.50. (Note: Most beneficiaries will continue to pay the same $96.40 premium amount they pay today. Note: Enrollees will be eligible for Medicare when they turn 65 even if they are not eligible for Social Security retirement benefits.

APPENDIX B

DATA CREATION

Creation of First Data File (Data File 1)

Variables from the 2004 data files were selected. The Household Identifier (HHID) and (PIN) variables were also selected. Relevant variables from the 2006 and 2008 data files were selected. They were merged into the 2004 data file via the HHID and PIN variable sort. In this data file, each case (or respondent) had as many columns of data or records as there were testing occasions (e.g., three columns for taking blood pressure medication, with each column corresponding to year of interview).

Creation of the Restructured Data File 1 (Data File 2)

The first data file was restructured so each case (or respondent) now had as many rows of data or records as there were testing occasions (e.g., three rows for taking blood pressure medication, with each row corresponding to year of interview).

Creation of Third Data File (Data File 3)

Respondents in the first data file (Data File 1) were filtered using the KN001 and LN001 (Medicare Coverage) variables. Only respondents who indicated that they used Medicare D in 2006 and 2008 were included in this data file.

In this data file, each case (or respondent) had as many columns of data or records as there were testing occasions (e.g., three columns for taking blood pressure medication, with each column corresponding to year of interview).

Creation of Fourth (Data File 4)

The third data file was restructured such that each case (or respondent) now had as many rows of data or records as there were testing occasions (e.g., three rows for taking blood pressure medication, with each row corresponding to year of interview).

Rationale for Restructuring the Dataset

Original Dataset

HH	JN009	KN009	LN009	JN180	KN180	LN180
1	1	1	1	5	5	5
2	5	1	1	5	1	5
3	1	1	1	5	1	5

HH	Year	N009	N180
1	2004	1	5
1	2006	1	5
1	2008	1	5
2	2004	5	5
2	2006	1	1
2	2008	1	5
3	2004	1	5
3	2006	1	1
3	2008	1	5

In the original dataset, note that all of the measurements for a single respondent are on the same data record (i.e., same row). Since cross-tabulation procedures were used with year as the independent variable and with the Medicare variable as the dependent variable, the data was restructured so that each measurement of the same variable (i.e., N009) would be on a different record (i.e., row).

The restructuring syntax created a new variable labeled the “Index” variable. This index variable was then relabeled as “Year” variable and coded “1” as “2004”, “2” as “2006”, and “3” as “2008.

APPENDIX C

2004 UNFILTERED TABLES

The following tables represent statistical procedures run for the 2004 Cohort. The data presented reflects responses that were not filtered by participation in Medicare Part D.

Table 25. 2004 Cohort: Health Measures Over Time 2004-2008

		2004	2006	2008
Perceived health status	%	39	40	37
	N	7839	7293	6431
Health status unchanged	%	51	62	62
	N	10,195	11,364	10,640
Regularly take prescription drugs	%	79	82	84
	N	15,896	15,121	14,443
Self reported high blood pressure	%	53	57	60
	N	10,667	10,531	10,394
Taking blood pressure medication	%	47	51	53
	N	9,472	9,477	9,309
Blood pressure under control	%	51	54	58
	N	10,203	10,064	9,975
Swallowing diabetes medication	%	13	15	16
	N	2,596	2,705	2,753
Take lung medication	%	5	6	7
	N	1,074	1,099	1,136
Take heart medication	%	14	16	16
	N	2,903	2,878	2,789
Take heart attack medication	%	2	16	16
	N	378	2,878	2,789
Take psychiatric medication	%	9	11	11
	N	1,906	1,984	1,887
Take arthritis medication	%	26	25	26
	N	5,226	4,623	4,443

Table 26. 2004 Cohort: Cross-tabulations for Drug Cost Covered by Insurance

	Costs covered by insurance		
Year	Yes	No	Total
2004	12,692	3,092	15,784
2006	10,845	1,313	12,158
2008	13,201	987	14,188
Total	48,641	5,392	42,130

Note. Pearson χ^2 (8) = 1324.07, p = .00.

Table 27. Frequencies and Percentages for Primary Plan of Respondents in 2006 and 2008

	2006		2008	
Item choice	Frequency	Percentage	Frequency	Percentage
Medicare	5,357	88.3	4,798	86.4
Private	707	11.7	731	13.2
Don‘t know	69	0.2	65	0.4
Refused	1	0.0	1	0.0
Total	6,134	100%	5,595	100%

Table 28.Frequencies and Percentages for Reasons for Not Signing Up for Medicare Part D Coverage in 2006 and 2008

Reason	2006 Frequency	2006 %	2008 Frequency	2008 %
Already have good coverage	4,739	15.3	38	0.1
Didn't know it was available	126	0.4	84	0.3
Heard about it too late	38	0.1	0	0.3
Medicare plan too expensive	205	0.7	0	0.0
Medicare plan too restrictive	25	0.1	0	0.0
Haven't made a decision yet	331	1.1	0	0.0
Get prescription drugs from VA	154	0.5	0	0.0
Don't use enough drugs to make it	295	1.0	0	0.0
Respondent confused about program	159	0.5	81	0.3
Don't need it	59	0.2	316	1.0
Didn't want t	83	0.3	0	0.0
Respondent on Medicaid	21	0.1	0	0.0
Other	164	0.5	289	0.9
Don't know	79	0.3	62	0.2
Refused	3	0.0	1	0.0
Missing	24,541	79.1	30,151	97.2

Table 29. Frequencies and Percentages of Respondents Who Purchased a Supplemental Private Plan to Help Pay for Prescription Drugs in 2006 and 2008

Item choice	2006 Frequency	2006 Percentage	2008 Frequency	2008 Percentage
Yes	8,529	–74.0	7,339	74.0
No	2,818	–25.0	2,499	25.0
Don't know	170	1.	140	1.
Refused	2	0.0	0	0.0
Total	11,519	100.0	9938	100.

Table 30. Descriptive Statistics for Amount of Monthly Premiums and Number of Private Plans in 2006 and 2008

Variable	*N*	Range	Mean	*SD*
2006				
Monthly premium	3,874	0 to 1,020	48.17	219.32
Number of plans	18,373	0 to 12	.67	.57
2008				
Monthly premium	987	0 to 1,350	112.13	456.89
Number of plans	17,099	0 to 13	.62	.61

Table 31. 2004 Cohort: Means and Standard Deviations for Medicine Use

Year	Mean	*SD*
2004	3.45	2.40
2006	3.74	2.45
2008	3.88	2.44

Note. *N* = 12,607.

Table 32. 2004 Cohort: Repeated-Measures ANOVA Results for Medicine Use

Variable	*Df*	MS	*F*	Sig.
Linear trend	1	1,168.96	374.69	.000
Error	2,606	3.12		
Quadratic trend	1	46.68	20.46	.000
Error	2,606	2.28		

Note. *N* = 12,607. Overall use of medicine *Huynh-Feldt F* (1.95, 24622.46) = 225.06, *p* = .000.

Table 33. 2004 Cohort: Means and Standard Deviations for Supplemental Prescription Private Plan Payments

Year	Mean	*SD*
2004	212.77	189.99
2006	222.85	198.15
2008	245.04	291.80

Note. *N* = 3,656.

Table 34. 2004 Cohort: Repeated-Measures ANOVA Results for Private Plan Payments

Variable	*Df*	MS	*F*	Sig.
Linear trend	1	1,904,299.23	49.90	.000
Error	3,655	38,166.37		
Quadratic trend	1	89,314.97	5.42	.020
Error	3,655	16,467.07		

Note. *N* = 3,656. Overall use of medicine *Huynh-Feldt F* (1.48,5414.14) = 36.49, *p* = .000.

Table 35. 2004 Cohort: Means and Standard Deviations for Prescription Costs

Year	Mean	*SD*
2004	98.27	552.38
2006	42.34	153.40
2008	51.44	221.22

Note. *N* = 15,974.

Table 36. 2004 Cohort: Repeated-Measures ANOVA Results for Prescription Costs

Variable	*Df*	MS	*F*	Sig.
Linear trend	1	17,512,958.00	102.52	.000
Error	15,973	56.00		
Quadratic trend	1	170,830.91	158.99	.000
Error	15,973	11,257,590.23		
		70,808.58		

Note. *N* = 15,974. Overall use of medicine *Huynh-Feldt F* (1.31,20927.44) = 119.06, *p* = .000

Table 37. 2004 Cohort: Means and Standard Deviations for Satisfaction with Health Care

Year	Mean	*SD*
2004	2.07	1.25
2006	2.01	1.21
2008	1.95	1.17

Note. *N* = 15,539.

Table 38. Repeated-Measures ANOVA Results for Satisfaction with Health Care

Variable	*Df*	MS	*F*	Sig.
Linear trend	1	124.37	122.51	.000
Error	15538	1.02		.797
Quadratic trend	1	0.06	0.07	
Error	15538	0.88		

Note. *N* = 15,539. Overall use of medicine *Huynh-Feldt F* (1.98,30771.82) = 65.54, *p* = .000.

Table 39. 2004 Cohort: Linear Regression Results for the Effect of Number of School Years on Utilization Patterns

Variable	B	*SE*	*F*	Sig.
Between subjects				
School years	-0.09	0.01	85.25	.000
Within subjects				
Linear trend	0.15	0.06	5.79	016
Linear x school years	0.01	0.01	6.57	.009
Quadratic trend	-0.01	0.05	0.06	.801
Quadratic x school years	-0.00	0.00	0.91	.340

Note. $N = 12{,}493$.

Table 40. 2004 Cohort: Linear Regression Results for the Effect of Number of School Years on Healthcare Satisfaction

Variable	B	*SE*	*F*	Sig.
Between subjects				
School years	-0.05	0.00	173.53	.000
Within subjects				
Linear trend	-0.17	0.03	29.02	.000
Linear x school years	0.01	0.00	7.06	.008
Quadratic trend	-0.12	0.03	15.14	.000
Quadratic x school years	0.01	0.00	17.06	.000

Note. $N = 15{,}387$.

Table 41. 2004 Cohort: Linear Regression Results for the Effect of Health Ratings on Healthcare Satisfaction

Variable	B	*SE*	*F*	Sig.
Between subjects				
School years	-.34	0.01	692.65	.000
Within subjects				
Linear trend	-.10	0.03	16.13	.000
Linear x school years	.01	0.01	0.57	.450
Quadratic trend	-.10	0.03	14.73	.000
Quadratic x school years	.03	0.01	17.18	.000

Note. $N = 15{,}416$.

Table 42. Linear Regression Findings for Mean Satisfaction Ratings in 2006

Model	Has Medicare D			No Medicare D		
	B	Beta	R^2	B	Beta	R^2
Take less meds due to cost	.17	.04	.00	--	--	--
Chose plan						
Self vs. other	.43	.11	.01	-.80	-.32	.05
Self vs. automatic	.27	.08	.01	-.48	-.14	.02
Health rating	.15	.15	.02	-.55	-.58	.22
Prescription costs per	.00	-.20 *	.04	.00	.23	.04
month	.00	-.10	.01	-.02	-.48	.14
Cost of monthly premium						

* $p < .05$ ** $p < .01$ *** $p < .001$

Table 43. Linear Regression Findings for Mean Satisfaction Ratings in 2008

Model	Has Medicare D			No Medicare D		
	B	Beta	R^2	B	Beta	R^2
Take less meds due to cost	-.34	-.10	.01	.62	.14	.03
Chose plan Self vs. other						
Self vs. automatic	.02	.01	.00	.76	.18	.06
Health rating	-.02	-.00	.00	-1.39	-.23	.10
Prescription costs per	-.01	-.01	.00	.38	.31	.15
month	-.00	-.12	.01	-.01	-.68 **	.42
Cost of monthly premium	.00	-.04	.00	.00	.23	.09

* $p < .05$ ** $p < .01$ *** $p < .001$

Table 44. 2004 Cohort: Linear Regression Results for the Effect of Number of School Years on Number of Private Plans

Variable	B	*SE*	*F*	Sig.
Between subjects				
School years	15.13	2.12	50.72	.000
Within subjects				
Linear trend	-13.13	15.50	0.72	.397
Linear x school years	2.74	1.14	5.79	.016
Quadratic trend	-.66	11.48	0.00	.954

Quadratic x school years	0.41	0.84	0.24	.627

Note. *N* = 4,474.

Table 45. 2004 Cohort: Linear Regression Results for the Effect of Mean Drug Coverage on Number of Private Plans

Variable	B	*SE*	*F*	Sig.
Between subjects				
School years	-7.78	9.99	0.61	.436
Within subjects				
Linear trend	-11.95	14.21	0.71	.401
Linear x school years	14.22	5.58	6.49	.011
Quadratic trend	8.99	10.16	0.78	.376
Quadratic x school years	-1.24	4.02	0.10	.757

Note. *N* = 3,946.

Table 46. 2004 Cohort: Linear Regression Results for the Effect of Mean Health Ratings on Amount of Out-of-Pocket Prescription Costs

Variable	B	*SE*	*F*	Sig.
Between subjects				
School years	-48.29	6.18	61.13	.000
Within subjects				
Linear trend	-108.95	8.01	6.47	.000
Linear x school years	18.15	0.55	0.68	001
Quadratic trend	25.18	5.08	0.79	.095
Quadratic x school years	-1.59	0.56	0.12	.728

Note. *N* = 3,947.

Table 47. 2004 Cohort: Linear Regression Results for the Effect of Mean Drug Coverage on Amount of Out-of-Pocket Prescription Costs

Variable	B	*SE*	*F*	Sig.
Between subjects				
School years	-92.23	0.22	81.38	.000
Within subjects				
Linear trend	-181.88	2.77	63.76	.000
Linear x school years	53.46	9.15	34.11	.000
Quadratic trend	82.16	9.09	18.52	.000
Quadratic x school years	-25.17	0.56	11.10	.001

Note. *N* = 5,379.

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