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A Social Justice Perspective on Medicare Part D in an Age of Reform: Critical Implications of Trends in Health Care Policy and Advocacy

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This article examines the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) in its current form and explains why a critical perspective is useful when analyzing the policy and reform efforts. Using this approach, we consider the development of the policy and describe ways that gender and racial differences may hinder equal access to medications for some of the most vulnerable older adults. This article explores the implications of gender and racial disparities under the MMA and ramifications of health care reform efforts that could potentially impede, rather than promote, a social justice agenda. Beyond the political advantage of the MMA's current structure, reconsideration should include the potential for disproportionate negative economic and health effects for women and people in historically disadvantaged minority groups.

Key words: Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA); Medicare Part D; critical analysis; health care advocacy; policy practice

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) is the largest benefit expansion in the history of the program. To respond to the need to provide older adults with drug coverage, the MMA added the Part D benefit to Medicare (Madden et al., 2008; Journal of Sociology & Social Welfare, September 2012, Volume XXXIX, Number 3

Mayes, 2005). While it was politically popular, it appears that Medicare Part D (referred to as “Part D” throughout this article) may not provide a meaningful benefit for the most vulnerable older persons (Bass, 2005). Several groups within the population of older adults face systemic disadvantage because of higher-than-average rates of disability and poverty (Larkin, 2004; Parish & Lutwick, 2005) and chronic lack of insurance (Svihula, 2008). Costs of medical care, even with public subsidies, deplete the resources of poor and near-poor adults, feeding a cycle of economic hardship and worsening health. In this article, we focus on women and racial/ethnic minorities living in or near poverty who have lived with the effects of economic disadvantage resulting from inequitable social policies (Abramovitz, 1996). Gender and racial/ethnic differences associated with economic disadvantage and disproportionate negative health effects due to unequal out-of-pocket cost burden seem to be neglected in Part D; there appears to be little political impetus to reconcile the disparities.

This article discusses a core provision of the MMA, the Part D coverage gap, as it relates to prescription drug coverage and access to medications. The analysis draws on critical race and gender perspectives (Delgado & Stefancic, 2001) and a theory of social justice as applied to the construction and implementation of Part D (Larkin, 2004). We highlight the importance of critically analyzing the impact of disadvantages throughout the life course that can result in economic and health disparities under the benefit. Challenges and benefits of solutions that have been attempted, specifically the Low-Income Subsidy (LIS) Program and potential outcomes of the health care reform (Patient Protection and Affordable Care Act, or PPACA) of 2010, are discussed. Recent moves toward a more progressive premiums or benefits schedule for Part D—like those in other major social support programs (e.g., Social Security)—are a start (Goldman & Joyce, 2008; Mayes, 2005), along with narrowing the coverage gap. We conclude with recommendations for policy reform and practice.

The Medicare Modernization Act and Part D

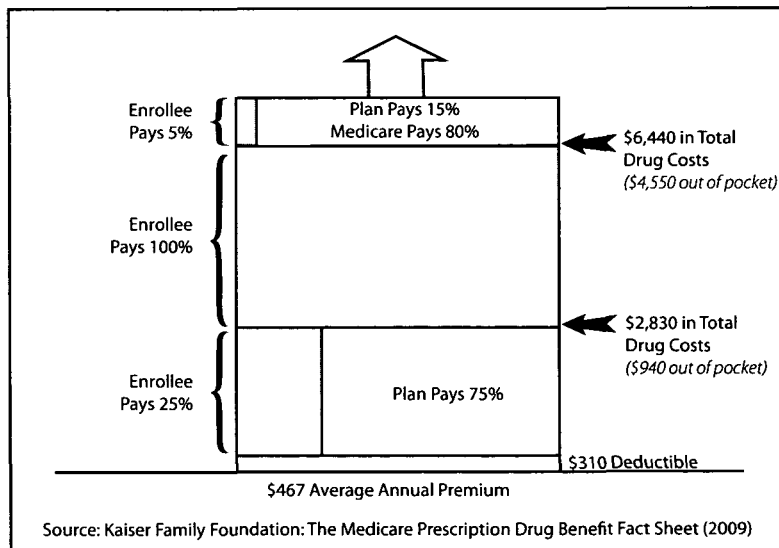
Core Provision of the MMA: Part D and Economic Disadvantage

Expanded use of the private sector to deliver health care

benefits was a primary tenet of the MMA. Unlike the traditional Medicare program, Congress required that Part D be available to beneficiaries exclusively through private, standalone prescription drug plans that allow insurance providers considerable latitude in designing the benefits plans offered (Hoadley, 2006). The structure of the plans includes prescription drug restrictions, formularies, and cost-sharing requirements that directly affect the price beneficiaries pay for medications. In addition, the MMA prohibits the federal government from negotiating with pharmaceutical companies, a strategy that assists other government health plans, such as the Veterans Administration, to secure lower prices for prescription medications (Geyman, 2006; Slaughter, 2006).

The standard Part D benefit plan requires an annual premium, deductible, and prescription copayments. Congress created the coverage gap, also referred to as the doughnut hole, as a cost-containment measure. Entering the gap means that prescriptions that were previously covered become the sole responsibility of the older adult. Under the 2010 standard benefit, before they reach the gap beneficiaries paid a \$310 deductible and 25 percent copay per prescription, until they reach benefit threshold or incur \$2,830 in total drug costs (see Figure 1).

Figure 1. Standard Medicare Prescription Drug Benefit in 2010



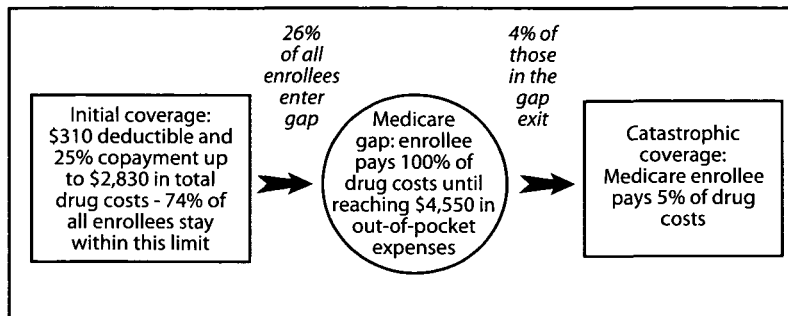
Up to now, beneficiaries have been responsible for 100 percent of their prescription drug costs while in the doughnut hole. Because of the new health care reform law, the PPACA, beneficiaries in 2010 received a \$250 rebate if they entered the coverage gap. In 2011, beneficiaries paid 50 percent of brand name prescriptions that are covered by their particular plan, until they spend \$4,550 out-of-pocket. Once beneficiaries reach this limit, they become eligible for “catastrophic coverage,” and Medicare and the benefit provider pay for 95 percent of their drug costs for the remainder of the year (Kaiser Family Foundation, 2009a). The cycle renews annually.

The threshold that marks entrance into the coverage gap increases each year as well. The size of the gap in coverage and the rate of increase in other cost-sharing components of Part D are indexed by the increase in the annual cost of the drug benefit rather than the average annual cost of living due to inflation—reflected by the Cost of Living Allowance, or COLA, which helps determine a person’s disposable income. The gap increases at a greater rate than beneficiaries’ ability to pay, because the cost of medications rises faster than inflation. For example, out-of-pocket costs for prescription medications rose at a rate of nearly ten times the average COLA, which was only 2.85 percent over the same period. Between 2006 and 2010, the amount beneficiaries paid while in the coverage gap rose roughly 26 percent from \$2,850 to \$3,610 (see Figure 1). However, the cost of living adjustment (COLA) over this same time period increased by only 8.2 percent (U.S. Bureau of Labor Statistics, 2008). By comparison, the COLA increase for Social Security benefits remained consistent with the actual average cost of living adjustment. Thus, the Part D out-of-pocket cost increases are out of proportion with the Part D benefit and Social Security income (Automatic Determinations, 2011). This is significant, as many older adults depend on their Social Security benefits to cover out-of-pocket medical costs.

Svihula (2008) estimated that approximately 26 percent of Medicare Part D enrollees—nearly 7 million beneficiaries—will encounter prescription drug expenses high enough to reach the doughnut hole, and that the overwhelming majority will remain there. Out-of-pocket prescription drug spending typically doubles when a beneficiary enters the coverage gap.

Though catastrophic coverage reinstates insurance for those who emerge from the doughnut hole, only four percent of beneficiaries incur enough out-of-pocket spending to benefit from this provision (see Figure 2) (Hoadley, Hargrave, Cubanski, & Neuman, 2008).

Figure 2. Annual Medicare Prescription Drug Benefit Lifecycle



Theory and Practice: Critical Perspectives, Cumulative Disadvantage, and Social Justice

By applying critical theories of race, gender, and social justice to Medicare policy and prescription drug coverage, we can suggest ways to fill gaps in understanding about economic and health disparities (Larkin, 2004). While there is not a single, unified critical race theory, there are basic tenets comprising critical perspectives: first, discrimination and oppression for minority groups are social norms, rather than exceptions (Delgado & Stefancic, 2001). Second, power hierarchies based on race and other socially-constructed attributes serve a social function, to maintain the hegemony of dominant groups. Third, this function is amplified by the exploitation of differences within groups (e.g., skin color). A fourth principle is that the intersections of race, gender, and class increase the ability of dominant groups to exploit these differences (Hill Collins, 1993; Delgado & Stefancic, 2001). Fifth, critical analysis may be adopted and applied to problems stemming from sexism, classism, and other socially constructed problems (Hill Collins, 1993). Finally, critical race and gender analyses assume that the lived experiences of disadvantaged groups are unique and people in these groups are exclusively

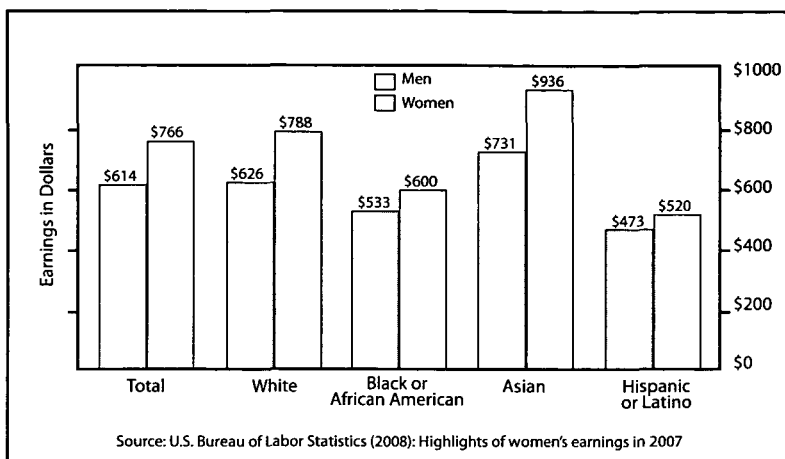
positioned to observe and interpret their needs and solutions (Delgado & Stefancic, 2001; Harding, 1991; Smith, 2004). Our analysis of Part D relies chiefly on the first, second, and fourth tenets to identify areas where pervasive effects of historic and current differential treatment of women and people of color are likely to perpetuate inequality and worse health.

Income Inequalities and Health Disparities

The Part D coverage gap, Congress' main mechanism to control the cost of the prescription drug benefit, does not account for economic disparities or gender-related health differences. While it can be argued that the MMA and Part D were written in gender- and ethnic/racially-neutral language, their potential impact and implications are not neutral. Failure to acknowledge the different experiences of these groups with regard to health and economic status can further perpetuate inequalities (Estes, 2001). Women's likelihood of lower income and higher prevalence of chronic conditions intersect, accelerating depletion of resources and compromising their ability to afford prescription medications, thus deepening the relationship between financial and health disparities. The stated goal of Part D is to promote access to prescription medications through the establishment of a drug benefit (Oliver & Lee, 2009). Yet, disadvantages throughout the life course can increase the need for pharmaceuticals for older women and persons of color and—at the same time—inhibit equal access to this benefit.

The ability to afford pharmaceuticals and maintain adherence to a medication regimen are largely dependent on retirement income and savings. Income in later life is typically based on pre-retirement experiences, and racial/ethnic and gender inequities increase with advancing age (Crystal & Shea, 1990). Wages for females and Blacks and Hispanics have consistently lagged behind those received by White males, and women and minorities are more likely to have been segregated into positions without retirement or pension benefits (Gonyea & Hooyman, 2005). As illustrated in Figure 3, women employed in the paid labor market continue to be compensated less than men for comparable work (Mink, 1998; United States Bureau of Labor Statistics, 2008).

Figure 3. Median Usual Weekly Earnings of Full-Time Wage and Salary Workers, by Sex, Race, and Hispanic or Latino Ethnicity, 2007 Earnings



Since Social Security is based on a 40-year work history, older women, Blacks, and Hispanics who received lower wages and/or have fewer years in the labor force will be subject to lower benefits in later life than White males on average (Olson, 1994). Thus, they have less income available to purchase prescribed medications. Income inequalities are even more pronounced for African Americans who experience racial discrimination and disproportionately lack equal educational and economic opportunities throughout the life course (Kail, Quadagno, & Keene, 2009). Furthermore, wealth inequality, even beyond employment income, reduces access to benefits that require significant out-of-pocket spending (Collins, Estes, & Bradsher, 2001). While poverty in old age is twice as likely for women as for men, it is three times higher for Blacks and Hispanics than non-Hispanic Whites (Finkle, Hartmann, & Lee, 2007; Gonyea & Hooyman, 2005; Wright & Devine, 1994).

Economic disadvantage because of lower income is frequently accompanied by a higher prevalence of chronic health conditions; both problems feed each other. Racial and gender inequities in morbidity exist throughout the life course and health trajectories continue to diverge with increasing age (Clark, 1997; Kelley-Moore & Ferraro, 2004). Women are more likely to report functional limitations, a higher number of chronic conditions, and rate their health as poor or fair than

their male counterparts (Murtagh & Hubert, 2004). As the result of increased morbidity, females and African Americans are more reliant on pharmaceuticals (Goulding, 2005). Yet, their ability to afford prescribed medications is more often compromised because of lower SES. Compared to White males, older women and Blacks spend a higher proportion of their income on pharmaceuticals (Rogowski, Lillard, & Kington, 1997; Sambamoorthi, Shea, & Crystal, 2003). This suggests that they will continue to experience a disproportionately heavier financial burden under Part D (Wei, Akincigil, Crystal, & Sambamoorthi, 2006).

Beneficiaries who incur enough spending to reach the coverage gap show lower drug consumption (Pedan, Lu, & Varasten, 2009; Sun & Lee, 2007; Zhang, Donohue, Newhouse, & Lave, 2009) and decreased adherence (Hsu et al., 2008) because of increased out-of-pocket expenditure requirements. Though rationing to save money and partial adherence is far from a healthy solution, individuals can maintain a small degree of control over both financial and health conditions without giving up entirely on either.

In addition, beneficiaries with certain chronic illnesses associated with living in poverty, such as depression and diabetes, have a greater risk of encountering the coverage gap because they spend more on medications. They are, therefore, at greater risk of nonadherence (Hoadley et al., 2008; Stuart, Simoni-Wastila, & Chauncey, 2005). Fifty-one percent of older adults with diabetes who reached the benefit threshold demonstrated a decline in out-of-pocket spending on medications, suggesting that they may have become noncompliant after losing support in the gap (Hoadley et al., 2008). Because older women and Blacks experience higher rates of diabetes (Gellad, Huskamp, Phillips, & Haas, 2006; Schoenborn & Heyman, 2009) and a greater number of depressive symptoms (Skarupski, Mendes de Leon, Barnes, & Evans, 2009), they could face a greater risk of encountering the coverage gap and becoming nonadherent. That is, people may be excluded from benefits while ongoing treatment is needed to sustain life or quality of life. Catastrophic coverage available past the gap—if reached—could come too late.

Solutions at the Intersections of Economics, Politics, and Health Inequities

Because medication costs are a primary barrier to prescription drug access under Part D (Madden et al., 2008), an attempt has been made to provide cost-sharing assistance for older adults with limited means through the Low-Income Subsidy (LIS) Program. The MMA stipulates that individuals whose income and assets are below a specified level or who receive Medicaid benefits are eligible for a subsidy to help cover the cost of medications (Kaiser Family Foundation, 2009b). The LIS replaced previous programs that ran concurrent with Medicaid, called State-supported Pharmaceutical Assistance Programs (SPAPs). Some states continue to utilize SPAPs as supplementary or wraparound coverage for Part D beneficiaries receiving the LIS (National Conference of State Legislatures, 2010).

Subsidies previously available before Part D through the Medicaid and SPAP programs typically paid a greater share of prescription drug costs and contained prescription drug formularies that were less restrictive (Bakk, Woodward, & Dunkle, 2012). Beneficiaries utilizing the LIS program have had problems accessing medications (Kaiser Family Foundation, 2008) because of program complexity, limited drug plan availability, cost-sharing requirements, and formulary restrictions (Bakk, Woodward, & Dunkle, 2012; Donohue & Frank, 2007; Morden & Garrison, 2006; West et al., 2007). For persons who qualify for the LIS, premium and cost-sharing assistance can be considerable (Kaiser Family Foundation, 2009b). Yet, a substantial number of Part D beneficiaries with incomes between 100 and 200 percent of the federal poverty line are not eligible because their income or assets exceed program guidelines. An estimated 2.37 million low-income Medicare beneficiaries do not pass the asset test. They report continuing to cut back their spending on basic needs and have more problems with medication nonadherence (Briesacher et al., 2010). Nearly half of those failing the test are widows, and almost all are older women living alone (Rice & Desmond, 2005).

Thus, the viability of the LIS as a means of providing benefits to at-risk older adults is questionable. Research pertaining

to the efficacy of the LIS as a means of providing assistance to women and minorities is also somewhat limited. People in these groups are more likely to qualify for LIS assistance (Rice & Desmond, 2005), but racial/ethnic and gender comparisons of actual enrollees and experiences with utilization of the subsidy are unavailable. More research is needed in this area. It is critical that this impact be monitored because older Blacks and Latinos face greater health risks associated with restrictions in coverage and increased cost-sharing requirements.

The Patient Protection and Affordable Care Act (PPACA) signed into law on March 23, 2010 will gradually reduce the beneficiary cost-sharing requirements in the coverage gap from 100 percent to 25 percent by 2020 (Kaiser Family Foundation, 2009a, 2010), significantly decreasing the doughnut hole. The need to reduce or eliminate the Part D coverage gap has been recognized (Kaiser Family Foundation, 2010), and the PPACA is an important step toward reconciling both financial and health disparities. Some key provisions are expected to help women and people of color. For example, an expansion of benefits that cover long-term care proposed in the law should have a positive effect on women who live longer, especially those living with serious chronic conditions. The law also provides up to 50 percent for some brand name prescription medications in the doughnut hole. By 2020, the discount will increase to 75 percent. This is significant, but perhaps a bit misleading because "phasing out" the gap (Kaiser Family Foundation, 2011) could be construed as eliminating copays altogether. Phasing out the gap simply brings the benefit in line with the coverage before the gap. This will help those who would be devastated when they suddenly enter the doughnut hole, but it still does not address those problems faced by near-poor older adults who can barely afford any copayments (Bakk, Woodward, & McGuire, 2012). It also does not address income and assets limits provided for the "poorest poor."

As Families USA and other advocates for the reform point out, one very important advancement in the PPACA is that it looks to improve the economic and social situations for future generations. The PPACA specifically targets workforce diversity in order to alleviate some of the historic disparities in income and wealth that lead to worsening health because of

inability to pay. Such improvements could also address physical stress effects of cumulative disadvantage and discrimination on women and people of color (Health Reform Central, n.d.).

However, there are reasons to be cautious. It has also been suggested that insurers could react to these provisions by increasing Part D premiums to manage the change (Davidoff et al., 2010). Because the cost of prescription drugs continues to increase faster than inflation (Kaiser Family Foundation, 2009a), medication costs may still pose significant difficulties for economically vulnerable populations, especially those who exceed the LIS income/asset thresholds, because cost-sharing is still required. The second caveat is that while the law in its final form calls for a significant reduction in cost-sharing (to 25 percent), the remaining costs will still be out of reach for many Part D beneficiaries (Ettner et al., 2010). Failing to completely close the coverage gap will do little to ease economic burdens that lead to older adults rationing their own medications. Finally, threats to repeal the law are still in the air. While a full repeal is extremely unlikely, as the Senate has not passed the bill and President Obama has promised to veto it, some parts of the bill may be in danger. If reforms to Part D provisions that assist the worst off beneficiaries, such as narrowing the coverage gap, are not maintained, the most vulnerable adults will face even greater economic hardship and more serious health outcomes.

Recommendations

Three main recommendations emerge. First, because prescription drug needs and the ability to purchase prescribed medications vary depending on gender and racial/ethnic affiliation, the law should be written with greater flexibility to better account for multiple, co-occurring, and stress-related illnesses that are often associated with cumulative disadvantage earlier in life. Second, lower lifetime earnings should be taken into account when determining benefit levels. Social Security benefit rates may be a good indicator of the appropriate subsidy for beneficiaries, as they have been shown to be functional over time and are directly connected

to low-income older adults' ability to afford their medications. Similarly, indexing the Part D benefit to inflation or the cost of living, rather than drug costs, may improve the law's sensitivity to beneficiaries' actual needs. Because the MMA imposes a disproportionate and inequitable share of cost-sharing requirements on women and persons of color, ensuring that the adjustments to the coverage gap are realized and maintained in health care reform can reduce the risk of nonadherence due to cost, as well as consequent adverse health outcomes that magnify and perpetuate inequalities. A secondary benefit of such a change is that all low-income beneficiaries who may have been affected by unfair treatment in the workplace or throughout the lifespan (e.g., people in unsafe jobs that cause lasting health problems) will also benefit from such policy reforms.

Conclusion

The MMA, with truly substantial modifications, can recognize economic disadvantage that older women and racial minorities face as the result of inequalities experienced throughout the life course (Shuey & Willson, 2008). Such changes acknowledge the link between Medicare and other safety net programs, like Social Security. These recommendations do not necessitate lessening the influence of private insurers, but rather shifting the idea that health care is a right for beneficiaries (Larkin, 2004).

The synthesis of the critical race and gender, cumulative disadvantage, and social justice frameworks used in this analysis uncovers the potentially serious effects of differential life experiences and indicates potential pathways to equitable access to prescription medications. The results of this analysis of political and economic factors on the health and well-being of older adults can be used to advocate for socially just solutions and policy changes. Service providers can take the standpoints of older adults who are living with the effects of lifelong disadvantage into account when working with Medicare beneficiaries and take action to promote systems change as a primary intervention (Sosulski, 2009).

Advocates for older adults will need to be vigilant in order to monitor the progress of Medicare policy and Part D

benefits, in particular. Social service providers and policymakers can advocate for greater social justice by recognizing gaps in the law that allow the most vulnerable groups to suffer from economic uncertainty and consequent health crises. More research, policy analysis, and policy development are needed to ensure that issues of gender and race are fully considered in this age of reform in order to create changes that enhance older adults' health and well-being.

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