

Trends in employer-provided prescription-drug coverage

Prescription-drug costs have been rising faster than the rate of inflation; although coverage remains an integral part of employee health care plans, covered employees share a greater portion of the cost of prescription drugs and are being offered cost-saving incentives more than ever before

Elizabeth Dietz

Prescription drugs are an integral part of the high-quality health care those living in the United States have come to know. More than 60 percent of Americans fill at least one prescription annually.¹ U.S. expenditures on prescription drugs reached \$162.4 billion in 2002, more than 10 percent of the total spent on all health care.² From 1993 to 2003, while the general rate of inflation remained relatively low, medical care costs continued to rise rapidly, with prescription-drug costs one of the contributing factors.³ Chart 1 depicts the Consumer Price Index (CPI) growth rates in the prices of prescription drugs and medical supplies, all medical care, and all items over the 1993–2003 period.

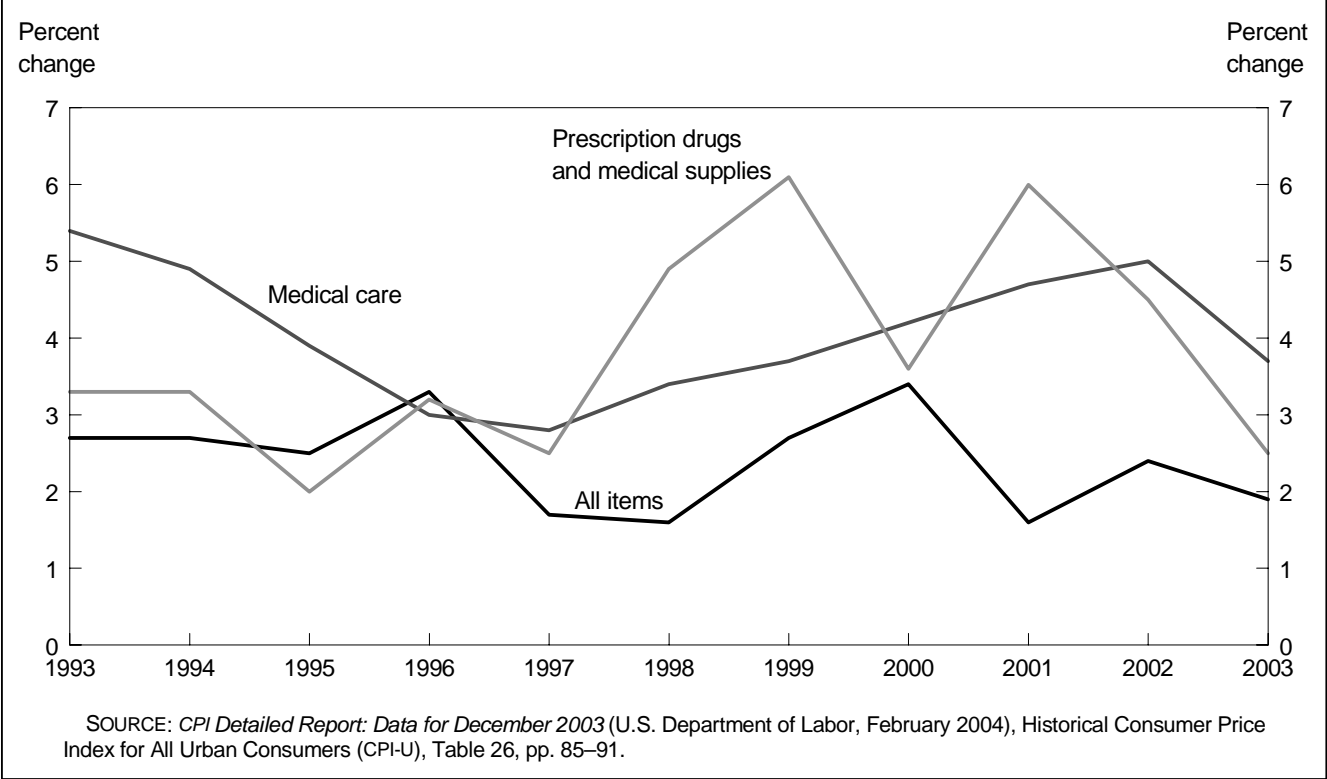
As one of the main sources of health coverage in the United States, private-sector employers are striving to contain the cost of employee medical plans and, along with them, the cost of prescription-drug coverage. Employers have implemented a variety of methods to stem the rising costs of providing such coverage. This article examines Bureau of Labor Statistics (BLS, the Bureau) data on employer-provided prescription-drug coverage and discusses how cost-saving methods have emerged over the past decade.

Data considerations

Since the late 1970s, the Bureau has produced information on the incidence and detailed plan provisions of employer-provided medical benefits. The most recent data are from the benefits portion of the 2002–03 National Compensation Survey (NCS), a forerunner of which was the Employee Benefits Survey (EBS). Among the differences between the NCS and the EBS are that (1) the 1993, 1995, and 1997 EBS data cited in this article represent full-time workers in private establishments of 100 or more workers, (2) the 2000 NCS data pertain to full-time workers regardless of establishment size, and (3) the 2002–03 NCS data represent all private-industry workers regardless of establishment size or part- or full-time status.⁴ Despite these differences, there is still enough similarity in the surveys for a valid comparison of prescription-drug coverage over the 10-year period examined. Given the relatively small portion of part-time workers that have prescription-drug coverage,⁵ it is unlikely that prescription-drug data for part-time workers have much impact on estimates for all workers. As for the difference between the surveys in the scope of the establishment size, the pattern

Elizabeth Dietz is an economist in the Division of Compensation Data Analysis and Planning, Bureau of Labor Statistics. E-mail: dietz.liz@bls.gov

Chart 1. Consumer Price Index, December-to-December 12-month percent change, selected items, 1993–2003



of prescription-drug provisions tends to be similar in larger and smaller establishments. For example, the 1996 EBS data on full-time workers in establishments with fewer than 100 workers were similar to the 1997 data on full-time workers in establishments with 100 or more workers.⁶ Also, the 2002–03 NCS benefits data show that the percentage of workers with prescription-drug coverage is similar in larger and smaller establishments. (See table 1.)

Prescription drugs in the economy

U.S. aggregate spending for prescription drugs more than tripled over the 1993–2003 period.⁷ Two main factors drove the increase in expenditures: rising prices and increasing utilization of prescription drugs. As regards the first factor, the average price of a prescription rose from \$22.06 in 1990 to \$45.79 in 2000.⁸

Although this price rise, most notably for newly marketed drugs, accounted for 29 percent of the increase in spending, growing consumption was responsible for the bulk of the increase.⁹ From 1992 to 2002, the number of prescriptions purchased increased 74 percent (from 1.9 billion to 3.3 billion), while the U.S. population grew 12 percent; the average number of prescriptions filled per person per year increased from 7.3 to

11.6.¹⁰ With an aging society, a longer average lifespan, and the increasing use of prescription drugs to treat chronic illnesses and an expanding scope of maladies, expenditures are expected to continue to rise rapidly, reaching \$445.9 billion, or 17 percent of all personal health care spending, by 2012.¹¹

This scenario is of considerable concern to private employers, which are a primary provider of health insurance. More than 160 million Americans—approximately 64 percent of the entire U.S. population—are covered by an employer-based health plan.¹² More than 93 percent of private health insurance coverage was obtained through the workplace (from a current or former employer or union) in 2001.¹³ Among people 18 to 64 years, 82.0 percent of workers had health insurance that year, compared with 74.3 percent of nonworkers.¹⁴ Health plans are a major benefit cost to employers, having commanded 6.5 percent of the total compensation dollar in December 2003.¹⁵ Chart 2 illustrates the volatility of health insurance costs in comparison to the cost of benefits as a whole and the cost of wages and salaries. Prescription drugs account for less than 20 percent of all employer health costs, but they are among the most volatile.¹⁶ Although employer-provided medical insurance coverage¹⁷ has declined over time—from 63 percent¹⁸ of all private-industry workers in 1992–93 to 45 percent¹⁹ in 2002–03—

prescription-drug coverage has remained a component of almost all these plans. In 2002–03, 41 percent of workers surveyed had prescription-drug coverage.

Cost containment measures

The most basic way for a health insurer to contain costs is to limit the goods and services covered. For goods associated with pharmacology, health plans typically exclude proprietary medicines, medical appliances or devices, nonprescription drugs, in-hospital drugs,²⁰ blood and blood plasma, and immunization agents. Also, plans generally place limits on the quantity dispensed in any one prescription. In addition, some plans require precertification, or preauthorization, of medications by a pharmacy review panel. One type of precertification is “step therapy,” the practice of requiring the patient to use a covered medication and to be evaluated for whether the medication is effective on him or her before a similar, excluded medication is prescribed.²¹ Some plans encourage the use of recently approved over-the-counter drugs by mailing coupons to purchase these drugs at a discount to enrollees who have been taking similar prescription drugs.²² Other plans implement preventive measures such as health education programs for employees,²³ which tend to offset costs in the long run. Still other plans offer prescription-drug cards, which require a monthly fee and allow the card holder (and, often, family members) discounts on prescription drugs.²⁴

In addition to adopting these cost-saving techniques, private employers have implemented methods designed to shift a portion of the price of prescription drugs to their health plan participants, and they have structured plans to give enrollees incentives to choose lower cost alternatives. The Bureau tracks data on several such methods. In the next section, selected methods are described, and data on their prevalence in the 1993–2003 period are presented.

Trends revealed in the data

The Bureau tracks data on the percentage of workers with

prescription-drug coverage; specific types of limitations, such as copayments per prescription for brand-name drugs; annual deductibles; annual maximum limits on reimbursement; and the percentages of workers in plans that offer higher coverage for generic drugs, at selected (network) pharmacies, and for mail-order drugs. With the 2002–03 survey, the Bureau published data for the first time on the percentage of workers participating in prescription card plans and the percentage of those in plans that give higher reimbursement for formulary drugs (that is, drugs on a list of medications) than for drugs not on the formulary. (See table 1.) The survey data show that, among the methods listed, higher reimbursement for generic drugs is the most widely applied method of cost containment for private-industry workers, regardless of their occupational group, their bargaining status, the size of the establishment they work in, or the industry group to which they belong.

Copayments. Most workers are in plans that require a copayment for each prescription—a set amount, rather than a proportion of the prescription’s cost. For example, under this type of plan, the enrollee would pay \$10 for each prescription filled, regardless of whether the retail cost of the same purchase would be \$10 or \$100. According to the Kaiser Family Foundation, average copayments for generic drugs increased from \$7.42 in 2000 to \$9.47 in 2003.²⁵ BLS data show that copayment amounts for brand-name drugs rose dramatically from 1997 to 2003. (BLS data on copayment levels and averages traditionally have been published by fee arrangement and are discussed later, under the subsection titled “Prepaid and indemnity plans compared.”)

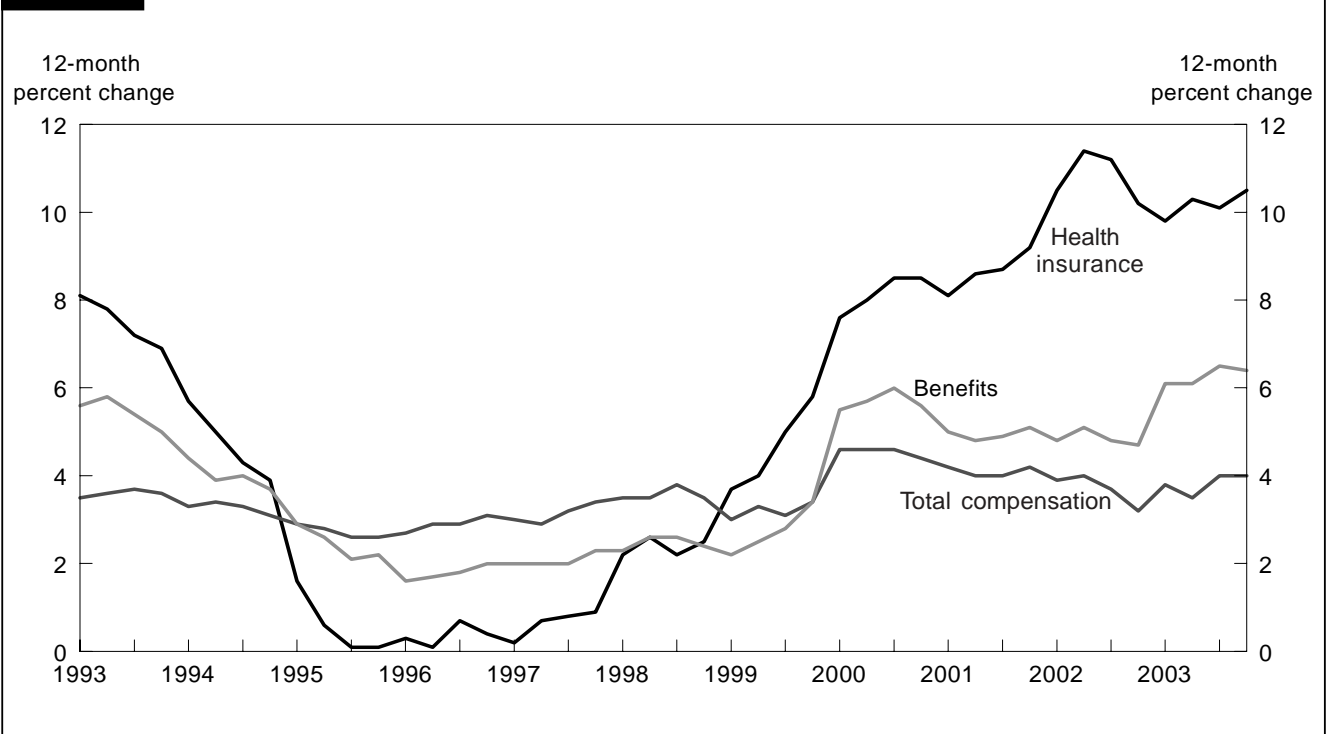
Generic drugs and tiered plans. Generic drugs tend to be priced lower than their brand-name counterparts. The average retail price of a prescription for a brand-name drug in 2000 was \$65.29, as opposed to \$19.33 for a generic-drug prescription.²⁶ When enrollees choose a generic over a brand-name drug to fill a prescription, the plan sponsor accrues substantial savings; therefore, many plans offer more generous

Table 1. Prescription-drug benefits, summary of coverage, all private workers, National Compensation Survey, 2002–03

| Benefit | Occupational group | | | | Bargaining status | | Industry | | Establishment size | |
|--|--------------------|--------------|-------------|---------|-------------------|----------|-----------------|-------------------|------------------------|---------------------|
| | All workers | White collar | Blue collar | Service | Union | Nonunion | Goods producing | Service producing | Fewer than 100 workers | 100 or more workers |
| Higher reimbursement for generic drugs | 83 | 84 | 78 | 90 | 70 | 84 | 78 | 85 | 83 | 83 |
| Coverage for mail-order drugs | 70 | 73 | 65 | 75 | 65 | 71 | 65 | 73 | 64 | 75 |
| Prescription card plan | 9 | 8 | 12 | 6 | 11 | 9 | 11 | 8 | 10 | 9 |
| Higher reimbursement for formulary drugs .. | 27 | 30 | 22 | 22 | 21 | 27 | 22 | 29 | 25 | 28 |

SOURCE: 2002–03 National Compensation Survey benefits data.

Chart 2. Employment Cost Index, 1993–2003



coverage for generic substitutes. According to BLS data, the percentage of employees in plans that offer this type of cost-saving incentive has increased markedly, from 25 percent in 1993 to 83 percent a decade later. (See chart 3.)

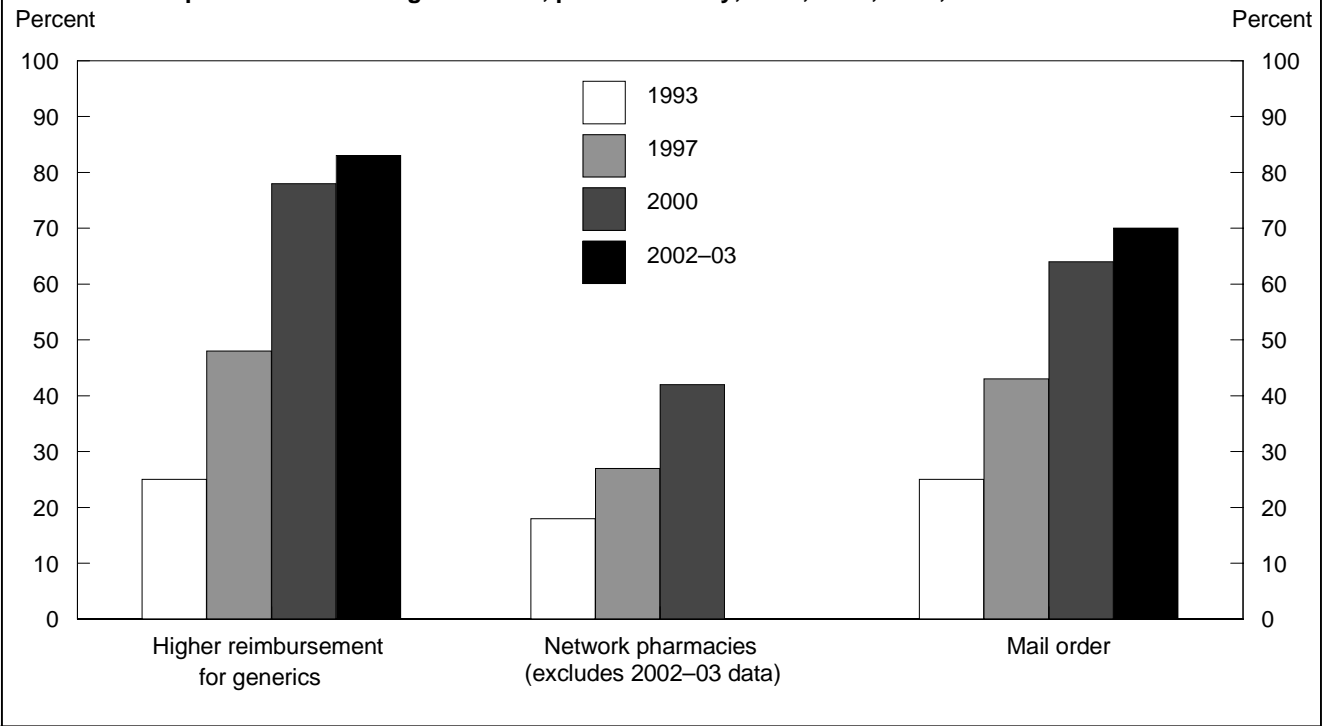
As part of the coverage of generic and brand-name drugs, many plans employ a cost structure known as a “tiered system.” In such a system, a formulary includes drugs that are covered at the highest level; medications not on the formulary usually require a higher copayment by the enrollee. For example, a three-tiered plan might require a \$10 copayment for a generic drug on the formulary, a \$20 copayment for a brand-name drug on the formulary, and a \$30 copayment for any drug not on the formulary (regardless of whether the drug is generic or a brand-name drug). Although the Bureau does not publish percentages of workers in two- or three-tiered plans, the Kaiser Family Foundation reports that 63 percent of covered workers were under three-tiered plans in 2003, up from 27 percent in 2000.²⁷ The rise in participation in tiered plans and in plans with higher coverage for generic drugs has provided enrollees with incentives to choose less costly drugs; however, the level of participation in plans with brand-name drug coverage has remained consistent, at 99 percent to 100 percent, over time.²⁸

Mail-order drugs. Many plans cover mail-order drugs more generously than those purchased in a local pharmacy, which

reduces costs through its large volume of sales. The plan provider contracts with a pharmacy to purchase large quantities of commonly prescribed drugs at discount prices. In turn, patients are given the incentive of higher coverage for purchasing through their mail-order service. Mail-order prescription refills also are used for longstanding conditions such as diabetes. Patients who have prescriptions for chronic conditions tend to receive larger refills (for example, a 90-day supply) through mail-order pharmacies than do those who refill through traditional pharmacies (which tend to limit prescriptions to a 30-day supply).²⁹ In 1993, mail-order drugs were offered to only 25 percent of employees with prescription-drug coverage. By 2003, the benefit was offered to 70 percent of employees with coverage. (See chart 3.)

Network pharmacies. Some plans cover “in-network” pharmacy purchases more generously than those which are out of network, because the plan has arranged for special discounts through specific pharmacies or pharmacy chains. Network pharmacies work in a similar manner as mail-order pharmacies, in the sense of saving through volume. A plan provider contracts with one or more pharmacy chains for discount prices. In turn, the chains are guaranteed a large volume of prescription-drug sales. The plan provider offers an in-network and an out-of-network option, with higher coverage given for in-network purchases. Network pharmacies

Chart 3. Percentage of employees with employer-sponsored prescription-drug coverage subject to specified cost-saving measures, private industry, 1993, 1997, 2000, and 2002–03



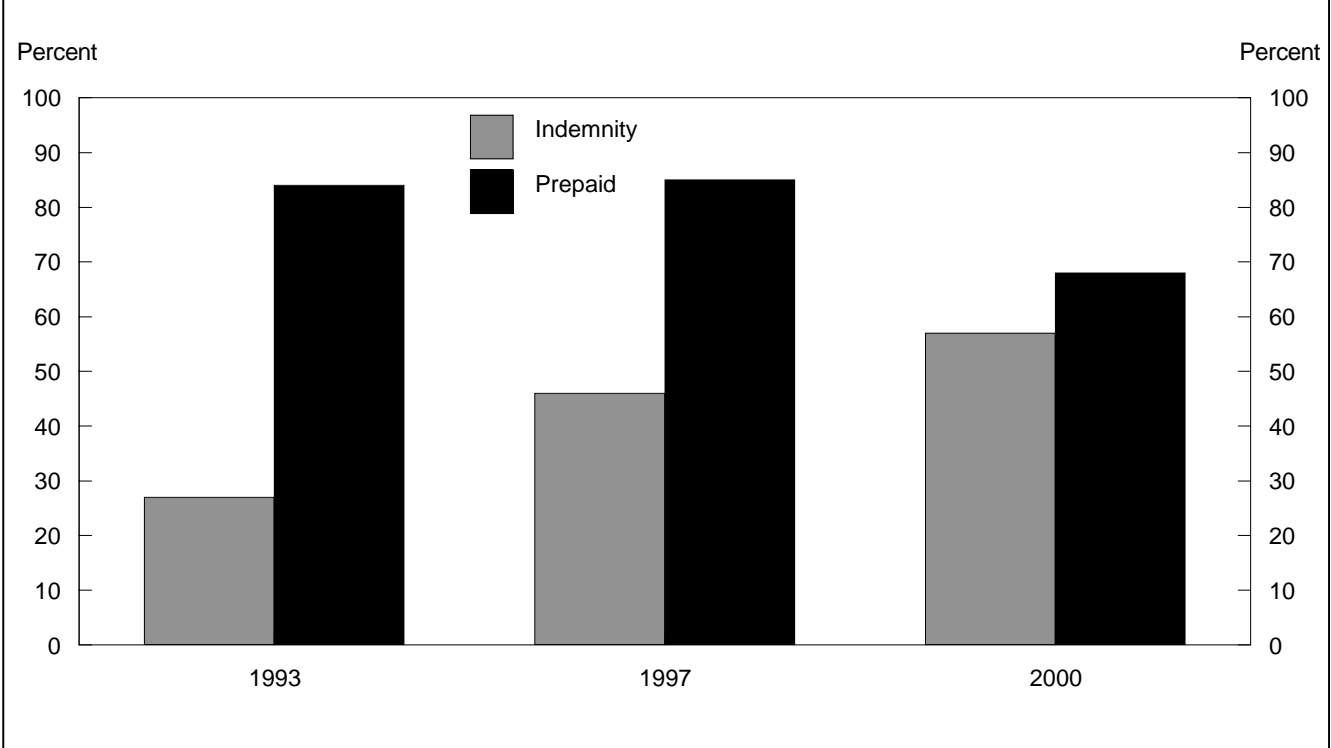
are a cost-saving measure that has not taken hold quite as rapidly as incentives for using generic drugs and mail-order coverage over the past decade. Still, the incidence of this benefit among employees covered by health plans rose from 18 percent in 1993 to 42 percent in 2000.³⁰ (See chart 3.)

Prepaid and indemnity plans compared. The 1993 EBS and the 2002–03 NCS published data on prescription-drug coverage in prepaid plans, previously classified as health maintenance organizations (HMO’s), and for indemnity plans, previously classified as “non-HMO’s.” Prepaid plans introduced many cost-saving methods to the health insurance field, and the data show that indemnity plans have adopted some of these methods in greater numbers over time. With regard to prescription drugs, in 1993, 84 percent of employees covered under prepaid plans required a copayment on brand-name prescriptions, while only 27 percent of employees covered under indemnity plans were charged copayments. Over time, copayments became much more common in indemnity plans, rising to 57 percent of covered employees in 2000.³¹ (See chart 4.) Over the 1993–2003 period, copayment amounts have increased greatly in both indemnity and prepaid plans. The percentage of workers covered by indemnity plans with a \$10 or greater copayment³² for brand-name prescription drugs increased from 19 percent in 1993 to 79

percent in 2000, while the percentage covered by prepaid plans increased from 10 percent in 1993 to 78 percent in 2000.³³ (See chart 5.) In 2003, both the majority of workers participating in indemnity plans and the majority participating in prepaid plans were required to make a copayment of \$15 or more. The average copayment for a brand-name prescription under indemnity plans increased from \$8.70 in 1997, to \$14.11 in 2000, to \$16.75 in 2002–03; under prepaid plans, the copayments increased from \$7.65, to \$12.46, to \$17.00 during the same years.³⁴

A related cost-savings incentive is for enrollees to choose generic equivalents over brand-name prescription drugs when such generics are available. In a typical plan that includes this incentive, if no generic equivalent is available, the plan will cover the brand-name drug at the most generous level—for example, with the first-tier copayment per prescription; however, if a generic equivalent is available, the enrollee can choose between the generic drug, covered at the first level, and the brand-name drug. If the enrollee chooses the brand-name drug, he or she must pay the difference in cost between the generic and the brand-name drug in addition to the copayment. For example, if the first-tier copayment is \$10 per prescription, the market price of a brand-name drug costs \$40, and its generic equivalent costs \$15, then the enrollee would pay \$35: \$10 for the copayment,

Chart 4. Percentage of employees covered by plans requiring a copayment per prescription for brand-name drugs, by fee arrangement, private industry, 1993, 1997, and 2000



plus \$25 for the difference between the generic and brand-name drugs. The EBS did not track this feature in 1993; the first year the Bureau collected such data was 1995. The data show that this cost-saving incentive has grown from applying to under 10 percent of covered employees in 1995 to applying to 15 percent and 20 percent in 2000, for indemnity and prepaid plans, respectively.³⁵

Less-often-used methods of cost containment. Coinsurance is a method of cost sharing in which the enrollee must pay a percentage of the cost of each prescription filled. For example, one coinsurance arrangement is that the plan pays 80 percent of the cost and the enrollee pays 20 percent. Despite its cost containment possibilities, relatively few plans require coinsurance. Similarly, yearly deductibles and yearly maximum reimbursement limits for prescription drugs have remained relatively uncommon among prepaid and indemnity plans over the 1993–2003 period.

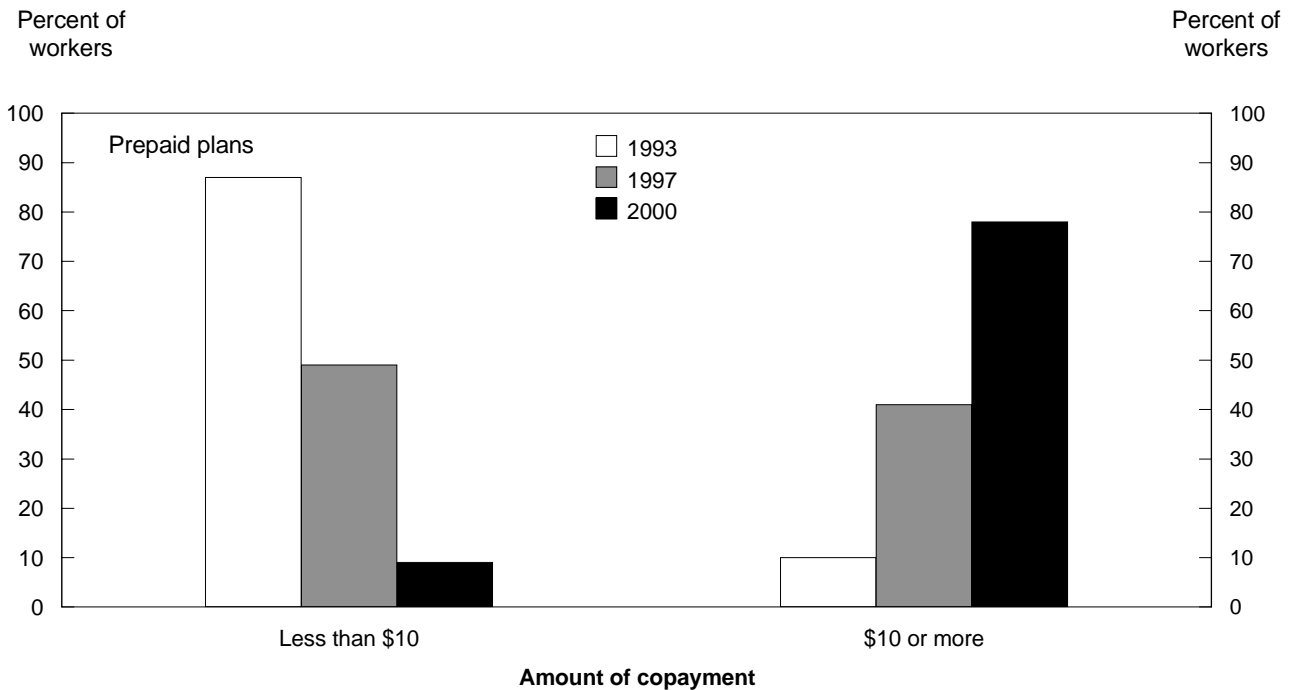
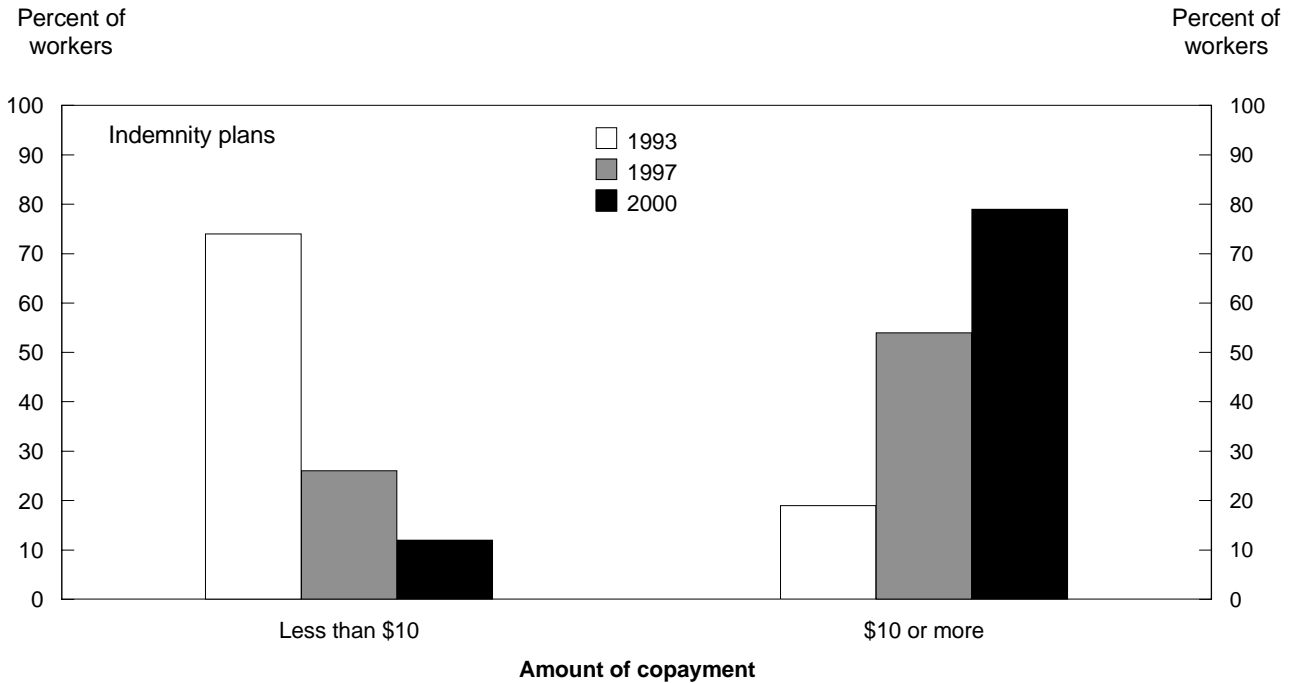
Coverage in the public sector

Private employers are not the only ones reacting to increasing prices and demand for prescription drugs. With a growing population of elderly, who are most likely to need prescription drugs for ongoing, chronic conditions and to

have multiple prescriptions per individual,³⁶ there has been a great amount of public pressure for the Federal Government to help make prescription drugs more affordable. Prescription-drug coverage was the major initiative behind the October 2003 passage of the Medicare Reform Act, which will provide coverage for the elderly.³⁷ In addition, many State and municipal governments have looked into purchasing drugs for their programs more cheaply.³⁸ The EBS collected data on workers' benefits in State and local government establishments biannually from 1990 through 1998 (except for 1996); the NCS has collected such data since 1999, but only on private-industry establishments. Neither program surveyed workers in Federal establishments.³⁹

A LOOK OVER THE PAST DECADE shows that prescription-drug coverage remains an integral part of employer-provided health plans. Although continuing to offer brand-name coverage, these plans have moved toward greater cost containment measures for prescription drugs, including the use of incentives to choose lower cost alternatives. With so many individuals covered through employer-based health plans, the effects of cost shifts from employer to employee are broad reaching. The magnitude of the effects of these shifts is beyond the scope of this study, but the effects can be seen in the aggregate data: while private health insurance spending for

Chart 5. Percentage of workers in indemnity plans, and percentage of workers in prepaid plans, subject to copayment per prescription, by amount of copayment, 1993, 1997, and 2000



prescription drugs has been one of the most rapidly increasing health care costs, it slowed in 2002 as growth in out-of-pocket spending increased. This slowdown has been attributed in part to the wider application of tiered drug formularies, which shift more of the cost to consumers.⁴⁰ Facing

the tandem pressures of rising costs and increasing utilization of prescription drugs, employers will no doubt continue to use a variety of cost containment measures. To capture the latest trends, the NCS will continue to track developments in prescription-drug coverage among employer-sponsored medical plans. □

Notes

¹ Rachel Christensen Sethi, *Employee Benefit Research Institute Issue Brief No. 265*, January 2004, p. 1.

² Centers for Medicare and Medicaid Services, on the Internet at both <http://www.cms.hhs.gov/statistics/nhe/historical/t2.asp> and <http://www.cms.hhs.gov/statistics/nhe/historical/chart.asp>, Jan. 8, 2004 (visited Mar. 26, 2004).

³ The All Items Consumer Price Index for All Urban Consumers (CPI-U; 1982–84 = 100) went from 145.3 in December 1993 to 184.3 in December 2003, an increase of 26.8 percent; the Medical Care CPI-U (1982–84 = 100) moved from 205.2 in 1993 to 302.1 in 2003, an increase of 47.2 percent; and the Prescription Drugs and Medical Supplies CPI-U (1982–84 = 100) grew from 225.7 in 1993 to 329.1 in 2003, an increase of 45.8 percent. (See *Consumer Price Index Detailed Report* (Bureau of Labor Statistics, December 2003), table 25, “Historical CPI for all urban consumers, 1993–2003,” pp. 78–84.)

⁴ For more details on the differences between the EBS and the NCS, see Allan P. Blostin, “National Compensation Survey: a wealth of benefits data,” this issue, pp. 3–5. Additional information about the benefits portion of the NCS can be obtained on the Internet at <http://www.bls.gov/ncs/ebs/home.htm>.

⁵ According to *National Compensation Survey: Employee Benefits in Private Industry in the United States, 2000*, Bulletin 2555 (Bureau of Labor Statistics, January 2003), table 94 (p. 79) and table 96 (p. 81), only 13 percent of part-time workers had prescription-drug coverage, while 59 percent of full-time workers had such coverage. In 2003—to pick a representative year—95 percent of the participants in medical insurance plans were full-time workers.

⁶ *Employee Benefits in Small Private Establishments, 1996*, Bulletin 2507 (Bureau of Labor Statistics, April 1999), pp. 39, 56–57; and *Employee Benefits in Medium and Large Private Establishments, 1997*, Bulletin 2517 (Bureau of Labor Statistics, September 1999), pp. 4, 42–43, 71–72.

⁷ Centers for Medicare and Medicaid Services, on the Internet at <http://www.cms.hhs.gov/statistics/nhe/historical/highlights.asp>, Jan. 8, 2004 (visited Mar. 26, 2004).

⁸ *Prescription Drug Trends: A Chartbook Update*, Kaiser Family Foundation, November 2001, Exhibit 13, p. 27.

⁹ Sethi, *Brief No. 265*, p. 1.

¹⁰ IMS health and expenditure data, Centers for Medicare and Medicaid Services, on the Internet at <http://www.cms.hhs.gov/statistics/nhe/default.asp>, cited in Kaiser Family Foundation, *Prescription Drug*

Trends, Fact Sheet 3057–02, May 2003, on the Internet at www.kff.org (visited Mar. 26, 2004).

¹¹ “Health Spending Projections for 2002–2012,” in *Health Affairs*, Feb. 7, 2003, on the Internet at <http://www.healthaffairs.org>, cited in Kaiser Family Foundation, *Prescription Drug Trends*, Fact Sheet 3057–02.

¹² Employee Benefit Research Institute, *EBRI Notes*, March 2004, Figure 3, p. 10.

¹³ *Health, United States, 2003, with Chartbook on Trends in the Health of Americans* (Hyattsville, MD, National Center for Health Statistics), September 2003, table 127, pp. 326–28.

¹⁴ *Prescription Drug Coverage, Spending, Utilization, and Prices: Report to the President* (U.S. Department of Health and Human Services, April 2000), cited in Kaiser Family Foundation, *Prescription Drug Trends*, Fact Sheet 3057–02.

¹⁵ *Employer Costs for Employee Compensation Historical Listing (Quarterly) 2002–03* (Bureau of Labor Statistics, Feb. 26, 2004), table 3, p.11.

¹⁶ Strazewski, Len, “Prescription Drug Cost Containment: Attacking rising health care costs one piece at a time can pay dividends,” *Benefits Business*, February 2003; on the Internet at <http://www.roughnotes.com/rnmagazine/2003/february03/02p76.htm> (visited Mar. 26, 2004).

¹⁷ The term “medical coverage” is used throughout the remainder of this article to refer to coverage for medical conditions, such as hospitalization, physician visits, and other goods and services typically covered by medical plans. Included among such coverage is that for prescription drugs. Separate coverage for dental or vision care was excluded from the analysis.

¹⁸ *Employee Benefits in the United States, 1992–93* (Bureau of Labor Statistics, March 1995), table titled “Percent of employees participating in selected benefits, by private and public sectors and full-time and part-time status, United States, 1992–93,” inside front cover; and *National Compensation Survey: Employee Benefits in Private Industry, 2003* (Bureau of Labor Statistics, forthcoming).

¹⁹ Due to changes in survey methodology, the percentage of workers participating in medical care in 2003 excludes 8 percent of workers who had some type of coverage (medical, dental, vision, or some combination) that could not be identified in the survey data collection process. Omitting these workers may serve to exaggerate the decline in medical care coverage. In his article, “New statistics for health insurance from the National Compensation Survey” (this issue, pp. 46–50), Michael Lettau imputes a coverage type

for the 8 percent of workers with missing data. He shows that, after imputation, 51 percent of workers had medical care coverage in 2003.

²⁰ In-hospital drugs are prescription drugs provided to hospital patients and are usually covered under the patient's medical plan as part of hospital room and board.

²¹ Information on precertification and step therapy is available on Aetna's Internet site, <http://www.aetnapharmacy.com>.

²² Sethi, *Brief No. 265*, p. 8.

²³ *Fundamentals of Employee Benefit Programs*, 5th ed. (Washington, DC, Employee Benefit Research Institute, 1997), pp. 228–29.

²⁴ See, for example, *Benefit News Advisor*, Jan. 28, 2004, on the Internet at http://www.benefitnews.com/detail.cfm?id=5554&terms=|00||ar||96||95||cards||eb||d_2||01||99||prescription||nw||97||98| (visited May 21, 2004).

²⁵ Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits*, 2000–03 annual surveys, as reported in Sethi, *Brief No. 265*, p. 34.

²⁶ *Prescription Drug Trends—a Chartbook Update* (Menlo Park, CA, and Washington, DC, Kaiser Family Foundation, November 2001), Exhibit 13, p. 27.

²⁷ Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits*, 2000–03 annual surveys, as reported in Sethi, *Brief No. 265*, Figure 11, p. 32.

²⁸ See *Employee Benefits in Medium and Large Private Establishments, 1993*, Bulletin 2456 (Bureau of Labor Statistics, November 1994), table 84, p. 77; *Employee Benefits in Medium and Large Private Establishments, 1997*, table 83, p. 71; *National Compensation Survey: Employee Benefits in Private Industry in the United States, 2000*, table 34, p. 34.

²⁹ For more information on mail-order prescription drugs, see Cathy Baker and Natalie Kramer, "Employer-sponsored prescription drug benefits," *Monthly Labor Review*, February 1991, pp. 31–35.

³⁰ 2002–03 NCS data on employee participation in plans with network pharmacy incentives are not included in this article because the data did not meet BLS standards.

³¹ 2002–03 NCS data on employee participation in indemnity and prepaid plans with copayments for brand-name prescription-drug coverage are not included in this article because the data did not meet BLS standards.

³² The 1993 EBS and 2002–03 NCS published data, not on the average copayment per prescription, but rather, on the percentage of employees whose plan requires a copayment at a particular level.

³³ 2002–03 NCS data on employee participation in indemnity and prepaid plans by copayment level for brand-name prescriptions are not included in this article because the data did not meet BLS standards.

³⁴ Averages exclude those workers who are not required to make a copayment. The 1997 and 2000 figures are for full-time employees only, and the 1997 figure includes only workers in establishments with 100 or more employees. The 2000 and 2002–03 figures include workers in all sizes of establishments.

³⁵ 2002–03 NCS data on employee participation in indemnity and prepaid plans with this feature were not included in this article because the data did not meet BLS standards.

³⁶ Center for Financing, Access and Cost Trends, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey Household Component, 1997–2000, Figure 6, "Average Utilization for Outpatient Prescription Drugs for Those with a Purchase by Age, 1997–2000," on the Internet at <http://www.meps.ahrq.gov/papers/st21/stat21.htm> (visited Mar. 26, 2004).

³⁷ The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173, was signed into law on December 8, 2003. For an analysis of this recently passed legislation, see "Prescription Drug Coverage for Medicare Beneficiaries: An Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003" (Washington, DC, Health Policy Alternatives, Inc., for the Henry J. Kaiser Family Foundation, Jan. 14, 2004).

³⁸ Sethi, *Brief No. 265*, pp. 6–8.

³⁹ When it is fully implemented, the NCS will include workers in State and local government establishments of all sizes.

⁴⁰ Centers for Medicare and Medicaid Services, Jan. 8, 2004; on the Internet at <http://www.cms.hhs.gov/statistics/nhe/historical/highlights.asp> (visited Mar. 26, 2004).