OBJECTIVES: The Medicare Prescription Drug Improvement and Modernization Act will provide drug benefits for a large proportion of persons aged 65 years and older in the United States. Few studies have examined the beliefs and attitudes of older adults with respect to prescription drug insurance programs. The objective of this study was to better understand the nature and range of older adults’ beliefs regarding prescription drug benefits.

METHODS: This study employed a qualitative, focus group design. Three focus groups with a total of 19 community dwelling adults aged 65 years and older were conducted in June 2003. The participants were members of the Minnesota Seniors Federation and included persons with and without prescription drug insurance. Discussions were structured and guided by an interview schedule developed a priori. The focus groups were audiotaped and transcribed verbatim. Thematic textual analysis was used to identify codes and categories from the language and ideas of the group participants.

RESULTS: Study participants identified a variety of important drug benefit facets. The common themes identified from the 3 groups were: (1) prescription drug access, (2) drug benefit comprehensibility, (3) powerful others, (4) affordability, and (5) equity.

CONCLUSION: Older adults view drug benefits as complex entities composed of at least 5 dimensions. In addition to more commonly discussed issues such as access and affordability, seniors evaluate several other aspects of drug insurance programs such as fairness, the ease with which plan terms can be understood, and the degree to which outside actors influence plan policies.

KEYWORDS: Prescription drug benefits, Medicare, Older adults, Focus groups

M edications are an essential part of medical treatment, and this is especially true for older adults (aged 65 years and older). On average, older Americans obtain 22.6 prescriptions annually, more than twice the U.S. average for all age groups.¹ It is estimated that drug spending among these individuals will grow at more than 10% per year from $95 billion in 2003 to $284 billion in 2013.² Older adults account for only 15% of the population, but they account for nearly 40% of medication expenditures.³

Although older adults use many medications to maintain and improve their health, insurance coverage for prescription drugs is often absent, inadequate, or unstable.⁴,⁵ Past research suggests that when older adults lack drug benefit coverage, there are serious impacts on their access to prescription medicines.⁶,⁷ For example, Safran et al. found that seniors lacking drug coverage were 2 to 3 times more likely to not have a prescription dispensed.⁸ Tseng et al. reported that seniors who had exceeded prescription coverage payment caps were more likely than those who had not to use less than the prescribed amount of medicines for chronic health conditions.⁹

Estimates such as these prompted passage of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003.⁴ MMA is the most sweeping revision of the Medicare program to date and has as one of its primary aims the reduction of financial barriers that may prevent beneficiaries from obtaining needed drugs.⁵ From June 2004 until January 2006, beneficiaries can receive Medicare Prescription Drug discount cards. After this, participants can receive benefits from managed care plans or from stand-alone prescription drug plans if they choose to remain in the traditional Medicare fee-forservice program.¹⁰

The various provisions of MMA were negotiated with little direct input from older adults. However, developing a more complete understanding of older adults’ beliefs regarding drug benefits is important for several reasons. First, the Medicare program is a large social insurance program, providing health care coverage for roughly 40 million Americans, the vast majority of whom are older adults. To the extent that government is an instrument of the people, social programs should reflect their preferences and values. Second, insight into program participants’ beliefs, values, and preferences regarding drug benefits will provide information that can be useful in designing benefit descriptions under MMA. Third, Medicare beneficiaries’ beliefs regarding various aspects of drug benefits may impact their choices and influence satisfaction and other humanistic outcomes associated with the delivery of prescription drug benefits under MMA.

Previous Research

Two streams of research are relevant to the current study. The first of these involves the use of hypothetical choice
experiments to investigate preferences for various drug benefit attributes. For example, Holdford and Carroll used conjoint analysis to study the effects of varying 3 drug plan attributes (copayment amount, freedom to choose one's pharmacy, and use of a restrictive formulary) on likelihood of prescription benefit plan choice. In a second study, Cline and Mott used discrete choice modeling to study hypothetical drug benefit plan choices in a survey of 1,086 older adults. Respondents were asked to choose a plan that would best meet their needs from a menu of 4 drug benefit plans. These plans varied with regard to 4 attributes (copayment amount, monthly premium, use of a restrictive formulary, and required use of a mail-service pharmacy). Together, the results of these studies suggest that financial components of drug plans, such as lower copayments and lower premiums, are related positively to choices while access components, such as the inability to choose one's pharmacy and the use of a restrictive formulary, are associated negatively with plan choices.

A second area of research related to the current investigation is the study of drug benefit plan satisfaction. Desselle studied drug plan satisfaction using in-person surveys of 504 community pharmacy patrons. The survey utilized a scale designed to account for several facets of drug benefits, including the use of restrictive formularies, out-of-pocket costs, and the ability to choose one's pharmacy. Motheral and Heinle examined the correlates of drug benefit plan satisfaction using mail survey responses of 3,819 individuals enrolled in a large pharmacy benefit management plan. The findings of these 2 studies are consistent with those of plan choice studies; individuals who believed that their plan had no coverage limitations were more satisfied, as were those free to patronize a pharmacy of their choice. Lower out-of-pocket costs (e.g., copayments, coinsurance amounts, and premiums) also were associated with higher member satisfaction levels.

These studies have contributed to our understanding of the facets of prescription drug programs that consumers deem important. Specifically, they have identified the importance of drug plan attributes impacting access (e.g., formularies, restrictive pharmacy networks) and affordability (e.g., premiums, copayments). However, these studies suffer from 2 shortcomings. First, with one exception, these investigations were conducted among working age adults receiving drug benefits through private insurers. Second, these studies employed preconceived conceptual frameworks that limited the drug benefit attributes studied. The goal of this study was to extend the findings of prior research and better understand the nature and range of older adults' views on prescription drug benefits in general and as part of the Medicare program.

### Methods

#### Design and Data Collection

The current study was a qualitative investigation employing focus groups for data collection. The method allows the researcher to capitalize on communication between research participants to generate pertinent information. The focus group method was chosen because of its speed of completion, high internal validity, and flexibility to explore unanticipated issues. Approval was obtained from the Institutional Review Board at the University of Minnesota before data collection began. A purposive sample of older adults belonging to the Minnesota Seniors Federation (MSF) metro chapter was employed to meet the objectives of the study because they had certain characteristics in common that relate to the topic of this study. The MSF is a statewide, nonprofit organization open to Minnesota seniors aged 55 years and older and is similar to AARP in its advocacy efforts.

The participants chosen for the study included seniors with and without drug insurance who were aged 65 years and older. Seventy-four potential participants responded to a recruitment advertisement in a monthly publication of the MSF. They were telephoned by the authors and invited to attend 1 of 3 focus groups. Nineteen participants agreed to participate. Three groups, composed of 6 or 7 persons each, were used to achieve “saturation” (the point at which the participants provided no new information to the researchers). No individual participated in more than 1 group.

#### The Focus Group Discussion

The focus group interviews were conducted in June 2003 at the MSF offices. Before beginning each session, study volunteers completed informed-consent forms and a short demographic questionnaire. The aims and methods to be used were first reviewed with the participants by the moderator and then by a research assistant. At the beginning of the focus group session, the moderator attempted to create a thoughtful, nonthreatening atmosphere and set the tone for the discussion. For example, the researchers dressed casually, introduced themselves to each participant upon arrival, and served light refreshments before and throughout the sessions. The route of questioning in these groups centered on (a) the attributes of prescription drug plans most salient to the participants, (b) the participants' understanding of these attributes and their functions, and (c) the language used by the participants to describe and talk about drug plan attributes. The participants were encouraged to respond to all the issues raised by the moderator but were informed that they had the right not to respond to any issue. Each group was audiotaped and field notes also were taken. Each session was approximately 2 hours in length. Each study participant received a $20 honorarium.

Every effort was made to maintain control and create an environment that encouraged shy individuals to participate fully in the discussion. In order to overcome interviewer bias, the moderator made minimal interventions and maintained a neutral position by not presenting his own views during data
collection. In addition, an interview guide was employed to provide consistency among groups (Figure 1).

Analysis of Text
Analysis of the sessions was performed according to steps outlined by Krueger and Casey and Morgan. The tapes were transcribed verbatim on a word-processing file, and the resulting text was analyzed in a descriptive and interpretive manner. In addition, group-to-group validation was carried out to identify themes consistently across groups. The transcripts and field notes were read several times by each of the 4 study investigators independently, and the main themes were extracted.

Theme extraction was based on convergence and external divergence; that is, identified themes were internally consistent but distinct from one another. The participant statements referring to a particular theme were grouped together under each theme after examining them further for convergence as well as comparing them with initial concepts and categories. Once the primary analysis was completed, the interpretations were discussed among the 4 study investigators. Agreement was negotiated as a valid interpretation of the text, and this discussion was driven by the study objectives as well as consistency among the emergent themes. When the final set of analyses was finished, all investigators agreed upon major themes.

To ensure quality and credibility of analysis, researchers identified negative cases for some themes. These included comments from participants that did not fit into the pattern or themes. These cases were few enough to be considered exceptions to the rule; hence, to an extent, they proved the rule. Triangulation done by using multiple analysts also provided a quality check on selective perception and blind interpretive bias that could occur through a single person doing all of the analysis.

Results
The 3 focus groups were composed of a total of 12 females and 7 males. Approximately 53% of the participants were between 75 and 84 years of age, and the remainder were within 65 and 74 years. A large proportion of the participants were highly educated, with 8 (42%) holding a master's, PhD, or other professional degree. Not surprisingly, all participants used one or more prescriptions, with more than half (52.6%) using 3 or more prescriptions on a daily basis. A slight majority of the participants (52.6%) reported their physical health as “very good” or “excellent,” and none of the participants reported it as “poor.”

Thematic analysis of the focus group transcripts identified 5 common themes: (1) prescription drug access, (2) drug benefit comprehensibility, (3) powerful others (4) affordability, and (5) equity. The next 5 sections describe these themes in detail, with both researcher interpretation and verbatim examples of participants' comments and discussion.

1. Prescription Drug Access
Prescription drug access refers to factors facilitating or inhibiting the acquisition of medication. Several subtopics emerged within this theme, including issues related to benefit portability (differences in access within and across states), ease of access through mail-order service, and ease of access through reimportation.

Participants were upset with the way their prescription drug access often changed when they traveled to a different state. They failed to understand the provisions of their drug benefit policies that allowed payment for their prescriptions within the state of Minnesota while refusing to pay elsewhere in the United States. They had different stories to narrate related to this portability issue:

I got an asthma attack when I went to Florida. I had to buy my medicine, as there was no choice. You got to breathe. Then you'll decide what you are going to do next. About the medicine: I turned the expenses into the insurance company and they said, “You can't do that.” (Participant [P])

I said I'm going to Florida; do I need to let you know that I might have an emergency when I'm down there, and she laughed. That's ridiculous, you know. But I was trying to find out what happens. (P10)

I didn't go in to an emergency room, I went to an urgent care clinic, and they didn't want to pay for that prescription because it was out of the state of Minnesota. (P12)

Many members of each group had favorable opinions of mail-order pharmacies. Currently, mail-order programs are viewed as a necessary and standard component of pharmacy
benefit management services. Growth in the number of prescriptions dispensed by mail-order pharmacies has been rapid. Among those aged 65 years and older, the proportion using mail-order pharmacies rose significantly—from 17% to 27%—between 1998 and 2001. Some representative comments from study participants included:

I like the mail-order service where you can get 3 months of service on time. This month thing drives me nuts because I am away from home a lot, and to have it renewed every month is terrible. (P8)

I like the ease of ordering. I can do it by phone as long as I have got the prescription. I can get a 90-day supply, and I don’t have to run to some place to pick it up, anyway. (P7)

Each of the 3 focus groups included discussions regarding reimportation of drugs from Canada. Among the reasons discussed for reimportation, cost appeared to be the primary impetus for this decision. However, more relevant to the theme of access, many study volunteers talked about easy access to medications as well as being pleased with the quality of service and products when using Canadian pharmacies.

You can understand that a lot of people are going to Canada for their drugs; you go to Canada, and they will give you a 90-day supply just like that. (P3)

I get my orders in about 10-15 days from the time I fax the order up to Canada. They have never made a mistake. And one of the things I really like is all my drugs come in the original sealed containers from the manufacturers, nobody counting pills. So you don’t have to worry about somebody making a mistake or tampering with the containers. You’re getting the original drugs. (P16)

2. Drug Benefit Comprehensibility

Like most insurance policies, drug benefits typically contain a great many provisions, defining who is covered, where they are covered, what medications are paid for, and how they are paid for. Drug benefit comprehensibility is the ease with which the drug plan’s provisions can be understood. Focus group participants often expressed confusion about the terms and cost containment policies used by pharmacy benefit plans as well as health insurance policies in general. Seniors discussed the fact that they could not easily comprehend the reasons underlying various features.

It’s very difficult to understand the insurance company; but then, insurance has never really made sense, though. (P7)

I tried to get from BlueCross 3 months supply because I go down south often. They wouldn’t give it to me. It’s so unreasonable that you are the same patient, it’s the same doctor, the same order, and you just want a larger quantity because you are on the drug for a whole year. I don’t know why BlueCross wouldn’t do it. (P3)

My husband, one time, when he lived, had a double hernia surgery. Medicare would pay for one side and not another. They told us if he had gone to the hospital and had one side done, gone home, and then gone back in then. . . . Think of the waste, you know? (P4)

Although many participants were not even aware of the existence of formularies as a tool to contain costs, a small proportion of patients had experiences with formularies that caused a great deal of confusion and inconvenience. These study volunteers suggested that formularies are not very popular from the perspective of the elderly population.

You go to the doctor, you get diagnosed, and he prescribes the medicine, and you take it to the pharmacy and the pharmacist comes and says, “Sorry, it’s a formulary problem.” (P13)

I was really sick. I couldn’t wait to go to the doctor to get the medicine, and the word was even foreign to me, like the “formulary”? (P10)

An aversion to insurance benefit complexity also was apparent when participants discussed the drug discount card program being discussed at the time for possible inclusion in the Medicare drug benefit. These older adults expressed concern that they might have to purchase more than one discount card plan to cover all of their medications.

I know what I don’t want. I don’t want discount cards from every separate pharmaceutical company. Who wants to mess around with a whole pocket full of cards, and half the time you wouldn’t know which company made this drug anyway? (P12)

3. Powerful Others

The participants were cognizant of social, political, and economic forces outside their control that impact the costs and use of medicines. To describe this notion, we used the theme “powerful others,” which is similar to the external locus of control construct found in the health behavior literature. The outside forces included the actions of pharmaceutical companies and legislators. Many study participants believed that direct-to-consumer advertising (DTCA) contributes to the high prices and unnecessary use of pharmaceuticals.

I think advertising for prescription drugs should be done away with. This would prevent or would help to prevent people from wanting drugs that they don’t really need. Doctors prescribe it because they are asked. (P6)

The patients demand the physician to prescribe the stuff. They ask for it, and when they don’t get it, they go to another physician. (P19)
The pharmaceutical companies don’t want to have price controls, but they make a huge margin. The price is going up and you know the other share is the advertising cost. They spend more on promoting their drugs than they do on research. (P18)

Participants also identified the lobbying efforts of pharmaceutical manufacturers as forces influencing the formation of drug benefit policies and reimbursement decisions by lawmakers. I would like to tell my congressman, “Please, if you take any money under the table from the pharmaceutical companies, don’t let it influence your decisions to help us.” (P8)

To have some agency controlling the cost of drugs would be a good thing. But again, you would have to fight all the pharmaceutical companies to have it done. (P9)

4. Affordability

Affordability refers to the effective out-of-pocket costs of prescription medications relative to the individual’s income. We used the term “affordability” to describe this theme since the study participants defined the issues related to the costs of prescription drugs by comparing the costs of other necessities with that of prescription drugs. Many participants expressed varying degrees of outrage at the high costs of their prescription drugs. Many had powerful stories to relate reflecting the economic barriers associated with paying for prescription drugs.

But do you realize that I have very small earnings, haven’t worked much in my married life, and I get a very small Social Security check. It would take all but $11; my Social Security check is $496 and this would be $487. So I didn’t have much of anything else. No one else to support me, but God! There goes the whole thing. That is really discouraging. . . . (P8)

I can’t have food or I can’t have the drugs. Well, I would like to spend money on other things, too. (P5)

We used to pay like $24 for a 90-day supply of Fosamax. And now it says $40. Just recently went up, which was discouraging. That’s something congressmen should realize.

People can’t afford to buy the drug and they get sick. (P3)

Many volunteers believed that they could not afford their medicines because drug companies spend more on advertising and promotion than research, thus contributing to the increase in prescription costs. The drug companies spend about 36% of the budget on advertising; they make about 18% profits a year whether the economy goes up or down. And we all have to pay the cost. (P3) 36% of the pharmaceutical companies’ budget in advertising! Terrible . . . Terrible. . . . It can reduce the price of drugs. (P1)

The MSF offers the Canadian Prescription Drug Importation Program through which they provide members with medications at discount prices negotiated by the Canadian government with many pharmaceutical companies. The program also lowers medication costs by charging in Canadian dollars, which historically trade at a substantial discount to the U.S. dollar. The overwhelming response of the members regarding drug importation from Canada reinforced the observation that, to cope with inadequate prescription drug coverage and rising costs, seniors are buying medicines from Canada, despite the fact that they would prefer to purchase their medications in the United States.

I wrote a note to the doctor saying that, in order to be able to afford my drugs, we really want to do this. “Would you please cooperate?” and I needed a prescription sent for this drug up to Canada and gave him the form; I had filled it all out. (P13)

Because I weighed it all, and I can do better buying 2 drugs through Canada and 1 drug here, and I cut my premiums in half. (P10)

Now, I would by far prefer to buy all of my drugs in the United States at 1 place. So they know everything that I am taking. I am going for it because of the cost. (P12)

Not surprisingly, group participants placed much emphasis on the out-of-pocket costs associated with drug benefits.

I had a copay, which kept going up every year. But I am fortunate. I had experiences with many people whose copayments are very costly. (P17)

I would like a plan with a low copay. (P4)

Other group members felt fortunate for having prescription drug insurance, which made it possible for them to afford drugs.

I think I am fortunate because my insurance pays 80% of my prescriptions. But there was a time when we had to pay for our prescription and send all the receipts in to get paid. One month, in between, my husband and I had to pay $749. My husband had lung cancer, so there were a lot of medications. But I am very fortunate now that I go to the drugstore, and they just fill Pravachol, which is $90 or something; I get it for $15. It would cost $275 a month for my prescription drugs, while actually I pay $47, and you can’t beat that, I know. (P9)

I became aware of how important prescription coverage was when we were raising our family. Our kids were fairly healthy—they get sick once in a while—and it was kind of an acute thing. I developed chronic asthma and started taking some drugs, and month after month, it dragged us down. If we hadn’t had coverage, it would have been much
harder for us. So I was introduced to this chronic thing pretty young, and as I got older, some other things have cropped in, too. So it's no relief for months . . . and insurance coverage is really important to me. (P13)

5. Equity

Study volunteers in all 3 groups repeatedly raised the issue of fairness in prescription drug payment plans. The participants believed that a Medicare drug benefit should be uniform with respect to both premiums and benefits and should be uniform across the United States.

I just wanted to repeat what we said; you know, we want something that is affordable and fair to everybody. And I think in the long run, we save; the country saves because people who don't get or take their medications because they can't afford to buy them become ill and end up in the hospital. And Medicare ends up paying for the health care because the person didn't take drugs. And it is very important that we understand that. (P7)

. . . there shouldn't be some states that give a copay and others that don't give it. We all pay into the same system, so we should be treated all equal. (P5)

Well I think what's important is everybody should be covered to the same extent, and one thing that I would like to tell my senators is, “Give us the same plan as what you senators and representatives have.” We all need equal. (P2)

Participants also discussed geographic differentials in payments to managed care organizations participating in the Medicare + Choice program that have resulted in inequities in the benefits offered by these plans.25 They don't reimburse every state and every county the same although we all pay into the system in the same way from our paychecks. Why are these people from other states getting higher reimbursements for Medicare? (P3)

It's not going to be fair unless they equalize the rate for Medicare. (P3)

I think they should have the same thing all over; Medicare should be the same all over the United States. (P10)

Discussion

The purpose of this study was to build on the results of past research and explore the nature and range of older adults' beliefs about prescription drug insurance in general and as part of the Medicare program. Textual analysis of transcripts from 3 focus groups revealed 5 distinct themes that were consistent across the groups utilized in this study: (1) prescription drug access, (2) drug benefit comprehensibility, (3) powerful others, (4) affordability, and (5) equity. Consistent with previous research, 2 of the themes (access and affordability) related to individuals' ability to purchase medications required for maintaining or improving their health.11,14 The other 3 themes we uncovered are less prominent in the literature. In the next paragraphs, we will discuss the 5 themes and suggest a framework and ideas for future research in each area.

Factors that impact older adults' access to prescription drugs often were discussed during these focus groups. One of these factors was the portability of insurance benefits. This likely is important to many seniors because many individuals who live in cooler climates enjoy spending winter months in Sunbelt states. This raises an important issue for the Medicare prescription drug benefit because many of the private insurers expected to offer plans under this program will be regionally based and may not have contracts with pharmacies outside the beneficiary's home area. A second factor affecting medication access often mentioned during these groups was the use of mail-order pharmacies. Participants liked the convenience of home delivery and of being able to receive a 90-day supply for many medicines. These findings are in accordance with findings from Cline and Mott's study of hypothetical drug plan choices.12 Those authors reported that individuals currently using mail-order pharmacies were more likely than those using other types of pharmacies to choose a plan requiring mail-order use.

Although no studies known to the authors have investigated drug plan comprehensibility per se, health plan understanding, especially with regard to the Medicare program, has been studied.26,27 For example, Bann et al. studied Medicare beneficiaries' knowledge of 7 program policies using a short quiz administered as part of the 1997 and 1998 Medicare Beneficiary Surveys.26 They found that a majority (78%) understood that Medicare did not cover all health care expenses but that far fewer understood that Medicare health maintenance organizations (HMOs) typically cover more services than the traditional Medicare fee-for-service program (37%) or that one could disenroll from an HMO and still be covered by Medicare (46%). In our study, the participants described similar issues, especially with regard to discount cards and formularies. In a recent survey of Medicare beneficiaries, more than half (56%) reported that they did not understand the new Medicare drug benefit well.28 Given that MMA relies upon markets (which require a reasonable degree of information and understanding on the part of purchasers) to deliver cost containment and quality improvements, comprehensibility may be key to the success or failure of the Act.

Participants in these focus groups recognized the influence that actors external to the medication use process, such as pharmaceutical manufacturers, exert on the demand for and cost of medications, a theory that has received some empirical support.29 Respondents also implied that this was a source of concern for them. Comments suggested that DTCA was perceived as persuasion, as opposed to information. It also
was apparent that some of these older adults believed that DTCA represents a harmful intrusion into the doctor-patient relationship. Some study participants understood and discussed the lobbying efforts of the pharmaceutical industry and their potential impact on the provisions of the Medicare drug benefit.30,31 Together, this evidence suggests that it may be worthwhile to include the concept of powerful others in future studies examining older adults’ drug benefit beliefs.

A great deal of study has been devoted to the effects of insurance coverage for prescription drugs on various aspects of affordability among older adults.5,7,32,33 Researchers have found that more generous drug benefits are associated with a lower likelihood of not receiving needed medications and cutting back on necessities such as food. Participants in our study confirmed that drug benefits were instrumental to their receiving necessary medicines, in addition to being an important component of household financial well-being. Among working-age adults, drug insurance satisfaction studies show that higher out-of-pocket expenses are associated with significantly lower satisfaction ratings.13,14 Our results imply that the cost-sharing provisions of a drug benefit are recognized and are likely to figure prominently in choices among and evaluations of drug benefit plans.

Equity was the fifth and final theme that we uncovered in our study. There was a clear sense that study subjects desired fairness for everyone in prescription drug payment plans. Not only did they desire uniformity with respect to premium and benefits but they also expressed the feeling that, since they did their duty by paying taxes their whole life, they now deserve coverage for their prescription drugs. There was a sense that drug manufacturers were taking advantage of the U.S. senior citizen population through charging high prices for drugs, and study participants were upset that the government wasn’t doing enough about it.

Such a reaction to prescription drug payment and procurement is consistent with the influences that shaped this generation. Our study subjects, aged 65 years and older, were either entering childhood or young adulthood during the New Deal and World War II. These influences shaped this generation as they watched older people making great sacrifices on their behalf. Reaching maturity in an era of conformism, they avoided risking their reputations while making early and unconditional commitments to family and career.34 As adults in the 1960s, they were further influenced as the government expanded its role as a protector via Medicare and Medicaid legislation. Now, as senior citizens, this generation of individuals wants to participate, to listen, to be seen as “hip,” often volunteering as teachers’ aides, museum docents, organizers of “grandtravel” trips, and as activists for causes they believe in.35

Our findings related to equity and fairness as one of the 5 themes related to drug benefit beliefs is consistent with this generation’s characteristics. What is not known is how the next generations set to reach older adulthood (Baby Boomers, followed by Generation X) will view prescription drug benefits. There is some evidence to suggest that these generations may not value equity and fairness as much as they would value maximizing their personal utilities.34 Further inquiry into and tracking of older adults’ drug benefit beliefs would be prudent in this area.

Older Adults’ Drug Benefit Beliefs: A Preliminary Framework

A primary building block of any scientific theory is the concept.35 A concept refers to some portion of reality.36 Using focus groups and thematic analysis, we elucidated 5 recurrent themes in older adults’ discussions surrounding drug insurance benefits. We suggest that these 5 themes may serve as preliminary concepts describing seniors’ drug benefit beliefs. We have attempted to define, both abstractly and concretely, these 5 concepts. For example, at an abstract level, “access” was defined as “factors that facilitate or inhibit one’s acquisition of prescription medicines.” A concrete, or operational, definition can be derived directly from the comments of focus group participants (e.g., the presence or absence of drug benefit portability problems, etc.)

Taxonomies are frameworks composed of multiple theoretical concepts that are useful for organizing multiple variables associated with a given phenomenon.36 Using the 5 themes or concepts derived from our analysis, we suggest a preliminary taxonomy of older adults’ drug benefit beliefs (Figure 2). Our proposed taxonomy provides a simplified description of the complex phenomenon of beliefs regarding prescription drug

![FIGURE 2](https://www.amcp.org/Vol.11.No.1JanuaryFebruary2005/JMCPJournalofManagedCarePharmacy83/figure2.png)
insurance. The taxonomy comprises 5 overlapping circles that signify the manner in which the 5 themes intermingle when seniors evaluate prescription drug plans. The analogy of overlapping circles is used to signify the fact that some subthemes are multidimensional and appear under more than one concept. For example, “Reimportation” appears under “Prescription Drug Access” and also under “Affordability.” This is a preliminary framework, offered as a possible guide for future empirical and conceptual work in areas of inquiry surrounding drug benefits.

**Implications for Managed Care**

A taxonomy such as that proposed here may prove useful to managed care practitioners and administrators. Offering stand-alone prescription drug plans to Medicare beneficiaries is a new business venture for most pharmacy benefit managers. The proposed framework provides some insight into the dimensions along which Medicare recipients might evaluate various drug plan offerings in their areas and, as such, may guide benefit administrators in the rational design of such products. Although the trade-offs between access and affordability are widely recognized, understanding that customers value ease of comprehensibility and perceived equity may help a pharmacy benefit manager gain a competitive advantage in this market segment. The taxonomy may also be valuable in the design of satisfaction measurement instruments in this population.

**Future Research**

Results of this study suggest several paths that future researchers might follow. Replicating this study among various groups of older adults could serve to confirm or disconfirm the results reported here and may suggest other themes not identified in this study. Future studies might examine each theme in detail, e.g., the various aspects of affordability, providing a more complete conceptualization of each. Investigators also might seek to develop quantitative measures of the beliefs identified in this study. These measures could be used to develop a ranking of the relative importance of each theme. Such measures might also be useful for profiling differences in beliefs that may exist among various geographic, demographic, and political subgroups. Although preliminary in nature, the proposed framework could help guide this future research.

**Limitations**

The results of this study should be interpreted in light of several limitations. First, all participants volunteered for this study and, therefore, may have been more knowledgeable than the typical older adult with respect to the topic of drug benefits. However, the emphasis in focus group research is to select people who are conversant with a given phenomenon so this is not necessarily a bias. Second, there may have been some interviewer bias. However, every effort was made to control this by maintaining a neutral position and intervening only to facilitate smooth discussion. Third, statements could be categorized in more than one way. Hence, identified themes cannot be regarded as exclusive or exhaustive. Fourth, the present study sample was drawn from a select geographic area. Seniors from different regions may not share the perceptions and views identified here. Finally, this study included only 3 focus groups. A more extensive study with more groups of older adults may reveal more significant themes not discovered in this analysis.

The findings of this largely exploratory investigation indicate that many older adults may have preferences for a Medicare drug benefit not like that introduced under MMA. For example, study volunteers often discussed the impact of high out-of-pocket expenses, a feature that many beneficiaries will encounter under the new Medicare drug benefit. Similarly, many participants mentioned ease of comprehensibility, while MMA introduces a complex benefit design requiring program participants to make a variety of choices that were not hitherto necessary. Further research will be necessary to better understand the impact of drug benefit beliefs on program performance and beneficiary outcomes.

**Conclusion**

The goal of this study was to develop a better understanding of the nature and range of older adults’ beliefs and attitudes with regard to drug benefits in general and as part of the Medicare program. Participants conceptualized prescription drug insurance as a complex, multidimensional phenomenon. As in past research, we found that factors impacting access and affordability were quite important to members of this group. In addition to these attributes, our results suggest that at least 3 other facets of prescription drug insurance plans are meaningful to seniors: drug benefit comprehensibility, powerful others, and equity.

**DISCLOSURES**

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Cline served as principal author of the study and was responsible for study concept and design. Analysis and interpretation of data and drafting of the manuscript were the work of Cline and authors Kiran Gupta, Reshmi L. Singh, and Jon C. Schommer, critical revision of the manuscript was the work of Cline, Singh, and Schommer.

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Older Adults’ Drug Benefit Beliefs: A Focus Group Study


