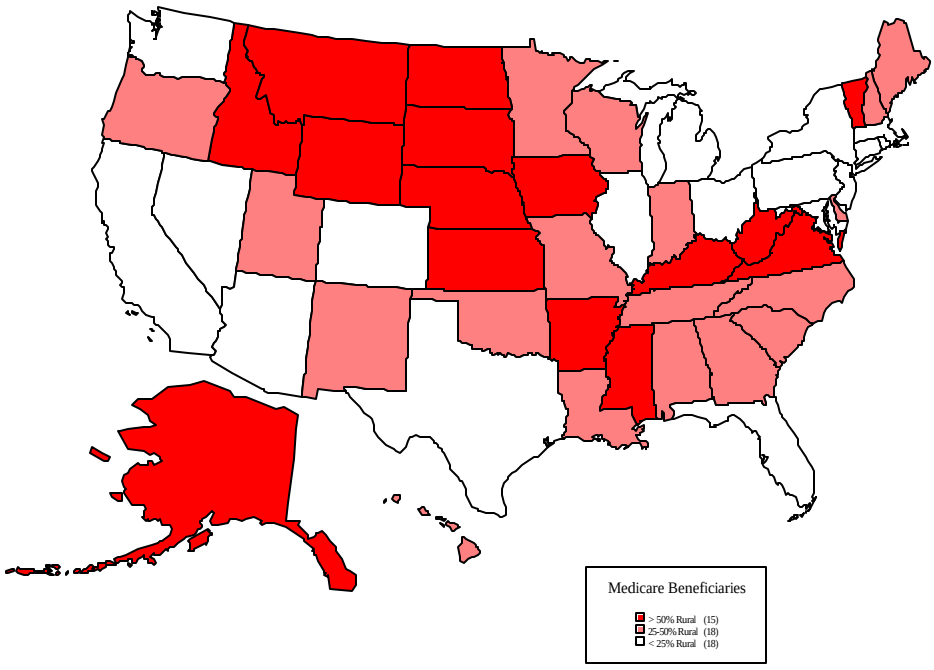
PRESCRIPTION DRUG COVERAGE & RURAL MEDICARE BENEFICIARIES:

A Critical Unmet Need



National Economic Council / Domestic Policy Council

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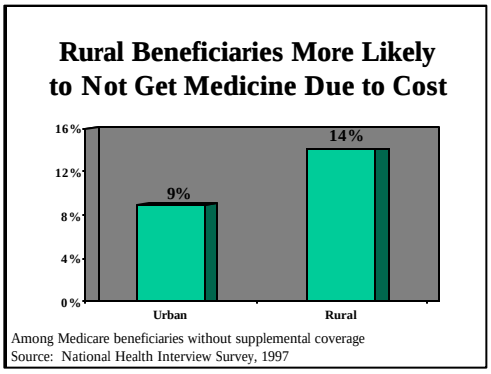
PRESCRIPTION DRUG COVERAGE FOR RURAL BENEFICIARIES: A CRITICAL UNMET NEED

Executive Summary

The 9 million Medicare beneficiaries who live in rural America face special challenges in accessing needed health services – particularly prescription drugs. Rural elderly, who represent nearly one-fourth of the Medicare population, tend to have a greater need for prescription drug coverage, but fewer coverage options. Their incomes are lower, access to pharmacies more limited, and out-of-pocket spending higher. This report, which responds to a request from Senator Baucus (D-MT), documents these challenges and reviews how policy options for prescription drugs would affect rural Medicare beneficiaries.

GREATER NEED FOR PRESCRIPTION DRUG COVERAGE



- **Rural beneficiaries are over 60 percent more likely to fail to get needed prescription drugs due to cost**. About 1 in 7 (13.8 percent) of rural Medicare beneficiaries without supplemental coverage reported not receiving medicine because of cost compared to 8.5 percent of urban beneficiaries.

- **A greater proportion of rural elderly spend a large percent of their income on prescription drugs**. About 29 percent of rural elderly spend more than 5 percent of their income on out-of-pocket prescription drug costs, compared to 21 percent of urban seniors.

- **Rural beneficiaries are more likely to have poor health and lower income**. About 28 percent of rural beneficiaries report fair to poor health, compared to 26 percent of urban beneficiaries. Additionally, about 20 percent of rural seniors have income below poverty compared to 16 percent of urban seniors.

- **Rural beneficiaries use nearly 10 percent more prescriptions.** Rural Medicare beneficiaries fill more prescription drugs than urban beneficiaries (21 v 19 per year).

- **Rural beneficiaries pay over 25 percent more out-of-pocket for prescription drugs than urban beneficiaries.** This reflects both greater need and worse coverage.

    - **Rural elderly are 25 percent more likely to have high out-of-pocket spending than urban seniors, even among the chronically ill.** About one-third of rural seniors versus 25 percent of urban beneficiaries have out-of-pocket spending that exceeds $500. This difference remains even when looking only at older Americans with heart disease, hypertension, stroke, diabetes and cancer: about 45 percent of these rural seniors have out-of-pocket spending that exceeds $500 compared to 36 percent of chronically ill urban seniors.

LESS LIKELY TO HAVE PRESCRIPTION DRUG COVERAGE

- **Rural Medicare beneficiaries are 50 percent less likely to have any prescription drug coverage.** The proportion of rural beneficiaries who lack drug coverage for the entire year is 43 percent compared to 27 percent in urban. This lack of coverage is even more dramatic when looking those who are uninsured for part of the year. About 57 percent of rural Medicare beneficiaries do not have prescription drug coverage for all or part of the year, compared to 44 percent of urban beneficiaries.

- **In rural America, most beneficiaries who lack prescription drug coverage are middle income.** Although rural seniors have lower income than urban seniors, about 45 percent of those without prescription drug coverage have income between 150 and 400 percent of poverty. They would have too much income to qualify for direct premium assistance in most proposed low-income benefits but do not have enough income to afford expensive private insurance.

- **The oldest rural seniors are particularly vulnerable to lacking prescription drug coverage**. Over half (52 percent) of rural seniors age 85 or older have no drug coverage -- over 50 percent higher than the percent of elderly urban seniors (33 percent).

- **Rural beneficiaries are about one-third less likely to have retiree health insurance.** Only about one in four of rural seniors have drug coverage through employer-based retiree insurance, compared to 35 percent of urban seniors.

- **Less than 1 percent of rural beneficiaries are enrolled in Medicare managed care with a prescription drug benefit in the basic benefit.** About 75 percent of rural beneficiaries do not have a managed care option, and no state has more than 30 percent of rural beneficiaries enrolled in managed care. The prescription drug benefit for those enrolled in managed care is limited. Only one-third of rural managed care enrollees have a drug benefit in their basic benefit, and of those with drug coverage, nearly two-thirds have coverage limit of $1,000 or less for brand name and/or generic drugs. This has risen since 1999.

- **Due to lack of alternatives and the critical need for drug coverage, rural seniors disproportionately purchase Medigap.** About 13 percent of rural Medicare beneficiaries receive prescription drug coverage through Medigap compared to 11 percent of urban beneficiaries.

- **Premiums for Medigap for rural beneficiaries are high and increase with age**. A typical 65-year old pays about $164 per month for a Medigap plan that includes limited prescription drug coverage. In Montana, the typical monthly premium for a Medigap plan with prescription drugs is $126 if you are age 65, but $184 if you are age 80 or older. On top of these high premiums, rural seniors with Medigap spend on average $442 out-of-pocket for drug costs – 75 percent more than rural beneficiaries with retiree health coverage.

IMPLICATIONS FOR A PRESCRIPTION DRUG BENEFIT

As this report documents, rural Medicare beneficiaries have a strong need but less coverage for prescription drugs. The President, Democrats in Congress, and the House Republican Leadership have developed specific proposals. While the stated goals of these plans are similar, their impact on rural Medicare beneficiaries differs significantly. Specifically, the Republicans' plan relies primarily on a private insurance model that has not worked for rural Americans. In contrast, the President's plan creates a voluntary, privately-managed option within Medicare fee-for-service that provides a defined benefit for a specified premium. Specific distinctions of the two plans include:

Availability of dependable prescription drug coverage. Because of their lack of managed care options, ensuring access to a reliable drug option for traditional Medicare enrollees is essential for the rural elderly.

- President's plan: Competitively contracts with a private benefit manager in all areas of the nation to ensure access to an affordable option. Also includes financial incentives for managed care and retiree health plans to provide prescription drug coverage.

- Republican plan: Relies primarily on private insurance plans to offer prescription drug coverage– despite insurers' own statements that they will not offer coverage. Since rural beneficiaries have less income and are in poorer health, it is unlikely that private plans will volunteer to serve them.

Affordability of premiums. Rural Medicare beneficiaries have lower incomes which make high prescription drug coverage premiums a barrier.

- President's plan: Pools Medicare beneficiaries nationwide to make premiums for prescription drugs affordable. It would also pay for a meaningful part of the premium (50 percent). In the first year, the prescription drug premiums would be $26 per month.

- Republican plan: Allows private insurers to set their own premiums. This puts rural seniors at a disadvantage since premiums would be based on a smaller number of less healthy people. Moreover, the plan does not provide enough, direct assistance with premiums to make the benefit affordable for rural middle-income beneficiaries.

Assurance of meaningful benefit. The unique health and access problems of rural Medicare beneficiaries make basic protections for a meaningful benefit essential.

- President's plan: Ensures that all beneficiaries receive a high-quality, defined benefit; guarantees access to medically necessary drugs and qualified pharmacies.

- Republican plan: Allows private insurers rather than public policy to determine the minimum benefit. By capitating payments, it would also create pressure to restrict formularies for prescription drugs and access to pharmacists to produce price discounts.

PRESCRIPTION DRUG COVERAGE FOR RURAL BENEFICIARIES: A CRITICAL UNMET NEED

The rural elderly have a unique place in American society. Many are retired farmers, school teachers, and small-town business owners – people who helped lay the foundation for the nation. Yet, rural seniors and people with disabilities often face special barriers to basic needs, including health care. Going to the doctor or drug store can take an hour round trip. This is compounded by the fact that rural Medicare beneficiaries tend to have slightly worse health and lower income than urban beneficiaries.

Recognizing these special characteristics of rural Medicare beneficiaries, Senator Baucus (D-MT) requested that the President provide information on rural beneficiaries and prescription drugs. This report responds to that request. It has three parts. First, it outlines the need for prescription drugs; second, it describes how rural Medicare beneficiaries get prescription drug coverage today; and third it describes some of the implications of policy options for expanding prescription drug coverage for rural beneficiaries.

NEED FOR PRESCRIPTION DRUGS AMONG RURAL BENEFICIARIES

A higher proportion of rural residents are elderly. About 15 percent of rural residents are age 65 or older, compared to 12 percent in urban areas. In part this reflects "aging in place," where older people remain in their communities while younger people move to urban areas. It also results as people return to their communities as they age.[1] In fifteen states, rural beneficiaries outnumber urban beneficiaries, and in another 18 states, the proportion of rural Medicare beneficiaries exceeds the national average.

PROFILE OF RURAL MEDICARE BENEFICIARIES

- Over 9 million Medicare beneficiaries (nearly one in four) live in rural America
  - About 8 million elderly
  - About 1 million people with disabilities
- Nearly 1 million, or one in ten, rural beneficiaries are age 85 or older
- About 5 million rural beneficiaries are women
- About 8 million rural beneficiaries are white, 600,000 are African American, and 300,000 are other racial and ethnic minorities

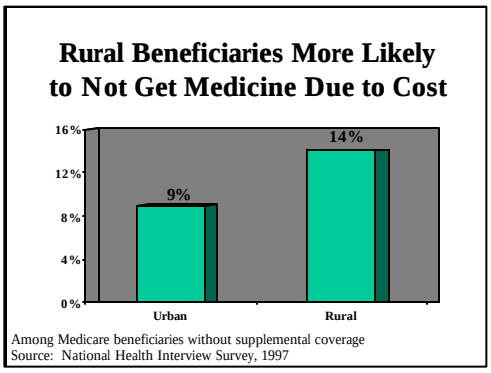
Source: Health Care Financing Administration. 1998

Rural elderly tend to have lower income. About 20 percent of rural seniors have income below poverty compared to 16 percent of urban seniors.[2] The difference is about the same when including all Medicare beneficiaries: about 25 percent of rural beneficiaries are poor compared to 20 percent of urban beneficiaries.[3] Although their costs for some necessities like housing may be lower, their drug costs are not lower than those of urban seniors.

Slightly worse health status. Rural beneficiaries tend to be in worse health than urban beneficiaries. About 28 percent of rural beneficiaries report fair to poor health, compared to 26 percent of urban beneficiaries.[4] They are also slightly more likely to report limitations in activities of daily living

Higher prescription drug use. Rural beneficiaries use, on average, nearly 10 percent more prescriptions than urban beneficiaries: 21 v 19 per year. This is true even among those in poor health. Rural beneficiaries in poor health use an average of 38 prescriptions per year compared to 33 for urban beneficiaries in poor health.[5]

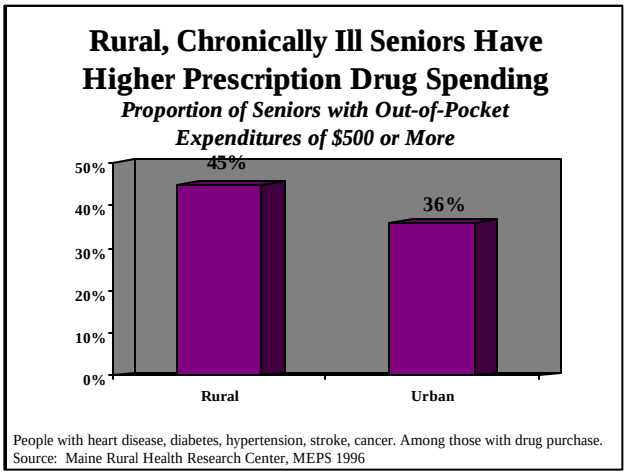
Greater access problems. Rural beneficiaries are over 60 percent more likely to fail to get needed prescription drugs due to cost. About 1 in 7 (13.8 percent) of rural Medicare beneficiaries without supplemental coverage reported not receiving medicine because of cost compared to 8.5 percent of urban Medicare beneficiaries.[6]



Higher spending as a percent of income. Additionally, out-of-pocket prescription drug spending is more likely to represents a high proportion of income for rural older Americans. Among those with any prescription drug purchase, about 29 percent of rural elderly spend more than 5 percent of their income on out-of-pocket prescription drug costs, compared to 21 percent of urban seniors.[7]

Higher out-of-pocket spending. In addition to reflecting the lower average income of rural seniors, the greater impact of prescription drug spending on rural seniors reflects their higher out-of-pocket spending. Rural beneficiaries pay over 25 percent more out-of-pocket for prescription drugs than urban beneficiaries. Rural beneficiaries averaged about $375 in out-of-pocket spending, compared to $300 for urban beneficiaries in 1996. This difference persists across age groups (among those age 85 or older, rural seniors pay $400 versus $343 for urban seniors); health status (among those in poor health, rural beneficiaries pay $590 versus $487 for urban beneficiaries); and income (among beneficiaries with income above 400 percent of poverty, rural beneficiaries pay $386 versus $295 for urban beneficiaries).[8]

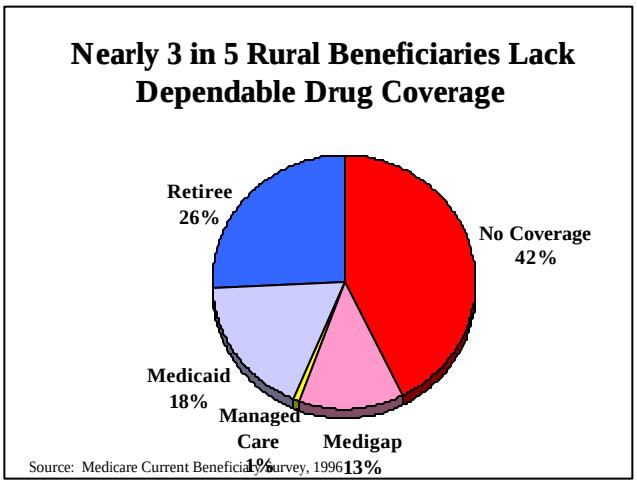
In addition to having higher out-of-pocket spending, rural elderly are more likely to have catastrophic drug costs. One third of rural seniors versus 25 percent of urban beneficiaries have out-of-pocket spending that exceeds $500. This difference remains even when looking only at older Americans with heart disease, hypertension, stroke, diabetes and cancer; about 45 percent of these rural seniors have out-of-pocket spending that exceeds $500 compared to 36 percent of chronically ill urban seniors.[9]



Gap in spending between Medicare beneficiaries with and without drug coverage exist in both rural and urban areas. Rural beneficiaries without prescription drug coverage fill 22 percent fewer prescriptions but pay 72 percent more out-of-pocket than rural beneficiaries without drug coverage.[10] Lack of coverage also contributes towards a greater fraction of seniors having high out-of-pocket drug spending. About 40 percent of rural seniors without drug coverage have out-of-pocket spending that exceeds $500 annually compared to nearly 30 percent of insured rural seniors.[11]

COVERAGE FOR PRESCRIPTION DRUGS AMONG RURAL BENEFICIARIES

The majority of all Medicare beneficiaries as well as rural beneficiaries lack dependable prescription drug coverage. While 99 percent of health insurance plans offered by medium to large firms includes prescription drugs[12], Medicare does not offer this benefit. This leaves Medicare's seniors and people with disabilities seeking out alternative sources of coverage. About 3 out of 5 of rural Medicare beneficiaries lack affordable, dependable coverage.

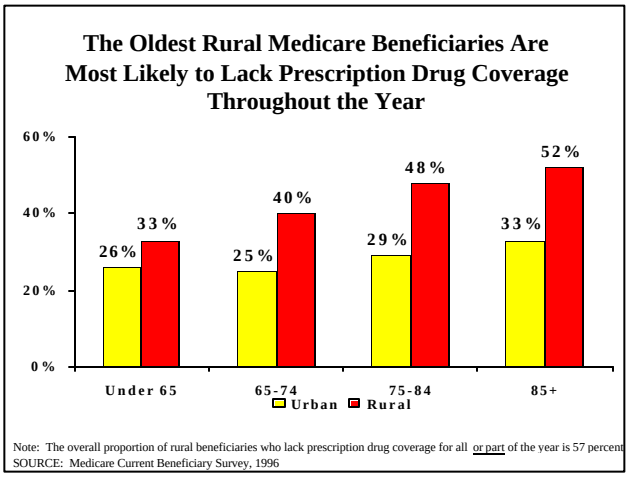


Rural Medicare beneficiaries are 50 percent less likely to have any prescription drug coverage. The proportion of rural beneficiaries who lack drug coverage for the entire year is 43 percent compared to 27 percent in urban. This lack of coverage is even more dramatic when looking those who are uninsured for part of the year. About 57 percent of rural Medicare beneficiaries do not have prescription drug coverage for all or part of the year, compared to 44 percent of urban beneficiaries.[13] A recent study found that Medicare beneficiaries who have drug coverage for only part of the year more closely resemble those who lack coverage throughout the year – having high out-of-pocket spending and lower utilization.[14]

In rural America, most beneficiaries who lack prescription drug coverage are middle income. Although rural seniors have lower income than urban seniors, about 45 percent of those without prescription drug coverage have income between 150 and 400 percent of poverty. The proportion of middle income, rural beneficiaries who lack prescription drug coverage is 43 percent, compared to 45 percent of rural beneficiaries with income below 150 percent of poverty.[15] These beneficiaries would have too much income to qualify for direct premium assistance in most proposed low-income benefits but do not have enough income to afford expensive private insurance.

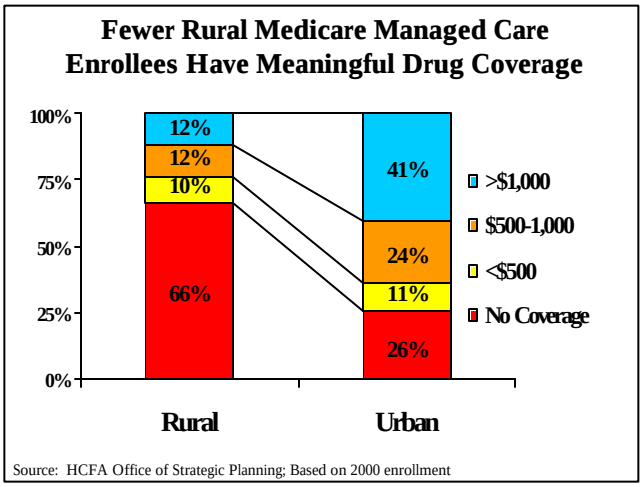
The oldest rural seniors are particularly vulnerable to lacking prescription drug coverage. Over half (52 percent) of rural seniors age 85 or older have no coverage throughout the year. This is over 50 percent higher than the percent of elderly urban seniors who have no coverage (33 percent).

Chronically ill rural beneficiaries also are less likely to have drug coverage. Among beneficiaries with 3 or more chronic illnesses, 42 percent of rural beneficiaries lack insurance compared to 24 percent of urban beneficiaries.[16]



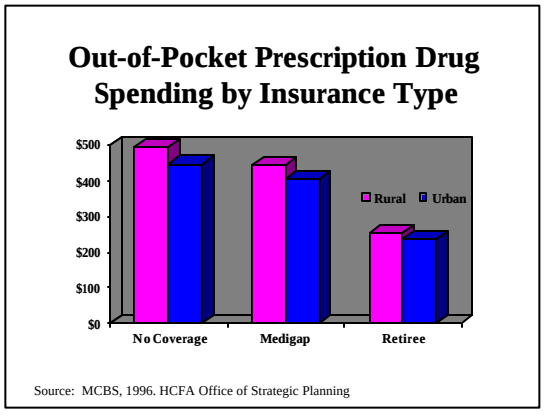
Rural beneficiaries are about one-third less likely to have retiree health insurance. Only 25 percent of rural seniors have drug coverage through employer-based retiree insurance, compared to 35 percent of urban seniors. This results because rural firms tend to be smaller and are not as likely to offer retirees health insurance.

Very few rural beneficiaries receive prescription drug coverage through Medicare managed care. About 75 percent of rural beneficiaries do not have a managed care option, and no state has more than 30 percent of rural beneficiaries enrolled in managed care.[17] This reflects, in part, the lower managed care penetration in rural areas in general. The prescription drug benefit for those enrolled in managed care is limited. Only one-third of rural managed care enrollees have a drug benefit in their basic benefit, and of those with drug coverage, nearly two-thirds have coverage limit of $1,000 or less for brand name and/or generic drugs. This has risen since 1999.[18]



Medigap is often the only option for rural seniors. About 13 percent of rural Medicare beneficiaries receive prescription drug coverage through Medigap compared to 11 percent of urban beneficiaries. Because of few other coverage options, among rural beneficiaries with drug coverage, 23 percent of rural Medicare beneficiaries have it through Medigap, compared to 14 percent of those in urban areas

Premiums for Medigap for rural beneficiaries are high and increase with age. According to recently-released data from the General Accounting Office, a typical 65-year old pays about $164 per month for a Medigap plan that includes limited prescription drug coverage. In most states, where insurers are allowed to "attain age rate," or charge higher premiums to the oldest, the premium would be considerably higher for an 80-year old. For example, in Montana, the typical monthly premium for a Medigap plan with prescription drugs is $126 if you are age 65, but $184 if you are age 80 or older.[19] On top of these high premiums, rural seniors with Medigap spend on average $442 out-of-pocket for drug costs – 75 percent more than rural beneficiaries with retiree health coverage.[20]



IMPLICATIONS FOR A PRESCRIPTION DRUG BENEFIT

As this report documents, rural Medicare beneficiaries have a strong need but less coverage for prescription drugs. The President and Congressional Democratic leadership have proposed a Medicare prescription drug benefit that meets several simple principles: it is voluntary and accessible for all beneficiaries; affordable to beneficiaries and the program; efficiently and competitively administered; provides a meaningful benefit; and consistent with broader Medicare reforms. Recently, the Republican House leadership released an outline of a plan for prescription drugs. It would modify Medigap insurance to offer additional, insurer-designed drug coverage and provide subsidies to insurers in the hope that they are passed back to beneficiaries in the form of lower premiums.

While the stated goals of these plans are similar, their impact on rural Medicare beneficiaries differs significantly. Specifically, the Republicans' plan relies primarily on a private insurance model that has not worked for rural Americans. In contrast, the President's plan creates a voluntary, privately-managed option within Medicare fee-for-service that provides a defined benefit for a specified premium. Specific distinctions of the two plans include:

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- Republican plan: Allows private insurers to set their own premiums. This puts rural seniors at a disadvantage since premiums would be based on a smaller number of less healthy people. Moreover, the plan does not provide enough, direct assistance with premiums to make the benefit affordable for rural middle-income beneficiaries.

Assurance of meaningful benefit. The unique health and access problems of rural Medicare beneficiaries make basic protections for a meaningful benefit essential.

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- Republican plan: Allows private insurers rather than public policy to determine the minimum benefit. By capitating payments, it would also create pressure to restrict formularies for prescription drugs and access to pharmacists to produce price discounts.

STATE	Total Benes.	Rural Beneficiaries #	Rural Beneficiaries %	Rural Managed Care Enrollment		Premium: Medigap Plan I Age 65	Premium: Medigap Plan I Age 80*
Alabama	669,000	244,000	36%	2,543	1%	$135	$211
Alaska	38,000	19,000	51%	-	0%	$131	$203
Arizona	651,000	91,000	14%	17,826	20%	na	na
Arkansas	433,000	258,000	60%	5,107	2%	$193	Same
California	3,783,000	168,000	4%	8,279	5%	na	na
Colorado	451,000	83,000	19%	2,923	4%	$155	$211
Connecticut	510,000	16,000	3%	4,926	31%	$230	na
Delaware	108,000	30,000	27%	61	0%	$147	$230
District of Columbia	76,000	-	na	-	na	na	na
Florida	2,761,000	219,000	8%	8,244	4%	$199	na
Georgia	885,000	350,000	40%	365	0%	$249	$320
Hawaii	159,000	43,000	27%	4,779	11%	na	na
Idaho	159,000	105,000	66%	487	0%	na	na
Illinois	1,626,000	343,000	21%	426	0%	$146	$220
Indiana	841,000	259,000	31%	47	0%	na	na
Iowa	476,000	300,000	63%	-	0%	$123	$194
Kansas	389,000	203,000	52%	36	0%	$143	$219
Kentucky	610,000	342,000	56%	26	0%	na	na
Louisiana	596,000	162,000	27%	16,821	10%	$178	$289
Maine	211,000	98,000	46%	478	0%	$222	Same
Maryland	628,000	59,000	9%	7,653	13%	na	na
Massachusetts	951,000	15,000	2%	1,198	8%	na	na
Michigan	1,379,000	294,000	21%	355	0%	$179	na
Minnesota	644,000	258,000	40%	100	0%	na	na
Mississippi	411,000	287,000	70%	14	0%	$147	$224
Missouri	850,000	319,000	38%	1,749	1%	$150	$229
Montana	134,000	103,000	77%	-	0%	$126	$184
Nebraska	251,000	149,000	59%	-	0%	$126	$191
Nevada	223,000	25,000	11%	1,332	5%	$162	$199
New Hampshire	164,000	55,000	34%	2,380	4%	$125	$202
New Jersey	1,188,000	na	na	na	na	na	na
New Mexico	225,000	104,000	46%	2,412	2%	$175	$276
New York	2,666,000	235,000	9%	10,619	5%	$193	Same
North Carolina	1,095,000	437,000	40%	7,427	2%	$139	$188
North Dakota	103,000	69,000	67%	-	0%	na	na
Ohio	1,689,000	325,000	19%	8,787	3%	$146	$230
Oklahoma	500,000	236,000	47%	3,927	2%	$129	$200
Oregon	481,000	171,000	36%	11,918	7%	$131	$204
Pennslyvania	2,089,000	342,000	16%	53,624	16%	$140	Same
Rhode Island	170,000	na	na	na	na	$130	$190
South Carolina	545,000	184,000	34%	-	0%	$155	$242
South Dakota	118,000	85,000	72%	-	0%	$134	$213
Tennessee	807,000	307,000	38%	4,278	1%	na	na
Texas	2,196,000	509,000	23%	15,800	3%	$150	$201
Utah	198,000	55,000	28%	38	0%	$112	$120
Vermont	86,000	64,000	75%	-	0%	na	na
Virginia	864,000	440,000	51%	594	0%	$107	$147
Washington	718,000	160,000	22%	21,454	13%	$191	Same
West Virginia	335,000	199,000	59%	19	0%	$162	na
Wisconsin	775,000	291,000	38%	551	0%	na	na
Wyoming	64,000	44,000	69%	-	0%	$149	$212
TOTAL	**37,979,000**	**9,154,000**	**24%**	**229,603**	**3%**	**$164**	**$217**

[1] Hobbs FB; Damon BL. (1996). *65 + In the United States.* Washington, DC: US Bureau of the Census.
[2] Maine Rural Health Research Center, Muskie School of Public Service. Data from the Medical Expenditure Panel Survey, 1996.
[3] Health Care Financing Administration Office of Strategic Planning. Data from Medicare Current Beneficiary Survey, 1996.
[4] Health Care Financing Administration Office of Strategic Planning. Data from Medicare Current Beneficiary Survey, 1996.
[5] Health Care Financing Administration Office of Strategic Planning. Data from Medicare Current Beneficiary Survey, 1996.
[6] Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control, National Health Interview Survey (NHIS), 1997.
[7] Maine Rural Health Research Center, Muskie School of Public Service. Data from the Medical Expenditure Panel Survey, 1996.
[8] Health Care Financing Administration Office of Strategic Planning. Data from Medicare Current Beneficiary Survey, 1996.
[9] Maine Rural Health Research Center, Muskie School of Public Service. Data from the Medical Expenditure Panel Survey, 1996.
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[11] Maine Rural Health Research Center, Muskie School of Public Service. Data from the Medical Expenditure Panel Survey, 1996.
[12] EBRI. (1999). EBRI Health Benefits Databook. Washington, DC: Employee Benefit Research Institute.
[13] Independent analysis by Bruce Stuart of MCBS, 1996
[14] US DHHS. (2000). Prescription Drug Coverage, Spending, Utilization, and Prices: Report to the President. Washington, DC: US DHHS, Office of the Assistant Secretary for Planning and Evaluation.
[15] Health Care Financing Administration Office of Strategic Planning. Data from Medicare Current Beneficiary Survey, 1996.
[16] Health Care Financing Administration Office of Strategic Planning. Data from Medicare Current Beneficiary Survey, 1996.
[17] Health Care Financing Administration, managed care data.
[18] Health Care Financing Administration, Office of Strategic Planning, managed care data.
[19] GAO. (2000). Medigap data. GAO/HEHS-00-70R, Letter to Congressman Dingell.
[20] Health Care Financing Administration Office of Strategic Planning. Data from Medicare Current Beneficiary Survey, 1996.

Notes on State Data. Total beneficiaries and rural beneficiaries from annual program data from the Health Care Financing Administration for 1998. The managed care enrollment is for 2000 and comes from a recent report: Shay B; McBride t; Mueller K. (June 5, 2000). A Report on Enrollment: Rural Medicare Beneficiaries in Medicare+Choice Plans. RUPRI Rural Health Panel, 5(1) (PB2000-1). Note: Sample size is small; results may be unreliable. Medigap premium data for is for Plan I for 1999 from GAO (HEHS-00-70R).

Thanks to the HCFA Office of Strategic Planning, Office of Rural Health Policy that funds the Maine Rural Health Research Center, Office of the Assistant Secretary for Planning and Evaluation, and Division of Health Care Statistics, National Center for Health Statistics for analytic input.