

PRESCRIPTION DRUG SPENDING AND COVERAGE AMONG RURAL MEDICARE BENEFICIARIES IN 2003

Regardless of whether they live in rural or urban areas, persons age 65 and older receive important health care coverage through Medicare. However, Medicare currently does not cover most outpatient prescription drugs. The drug benefit established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 will be effective in 2006. Thus, in 2003, Medicare beneficiaries either obtained drug coverage from some other public or private source, or paid for their drugs entirely out of pocket. For that year, spending on prescription drugs was the largest single component of beneficiary out-of-pocket spending on health care, excluding the costs of health care premiums.¹ Although all beneficiaries can be vulnerable to the high costs of prescription drugs, the nearly 25 percent of beneficiaries age 65 and older who live in rural areas spent more out-of-pocket, on average, than those who lived in urban areas.

This *Data Digest* examines the out-of-pocket spending burden of prescription drugs on non-institutionalized rural Medicare beneficiaries age 65 and older.² Also, it highlights the differences in income and prescription drug

coverage among rural and urban beneficiaries.³ Unless otherwise noted, all data presented in this *Data Digest* are projections for non-institutionalized beneficiaries age 65 and older in the year 2003.⁴ Actual data for 2003, when available, or projections based on *more recent* Medicare Current Beneficiary Surveys or other sources may differ from the numbers presented here.

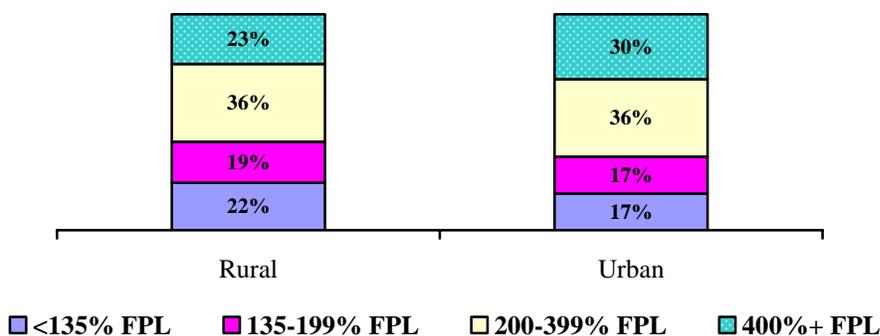
Medicare Beneficiary Characteristics

Two important ways in which rural and urban Medicare beneficiaries differed are their *income levels* and *insurance coverage*.

➤ Income Levels

Figure 1 shows that rural beneficiaries tended to have lower incomes than their urban counterparts. Forty-one percent of rural beneficiaries had incomes below 200 percent of poverty compared to 34 percent of urban beneficiaries. In 2003, the federal poverty thresholds, as determined by the U.S. Census Bureau, for persons age 65 and older were \$8,825 (for individuals) and \$11,122 (for couples).⁵

Figure 1
Distribution of Medicare Beneficiaries⁺ by Income as Percent of FPL, 2003



⁺Non-institutionalized Medicare beneficiaries age 65 and older.

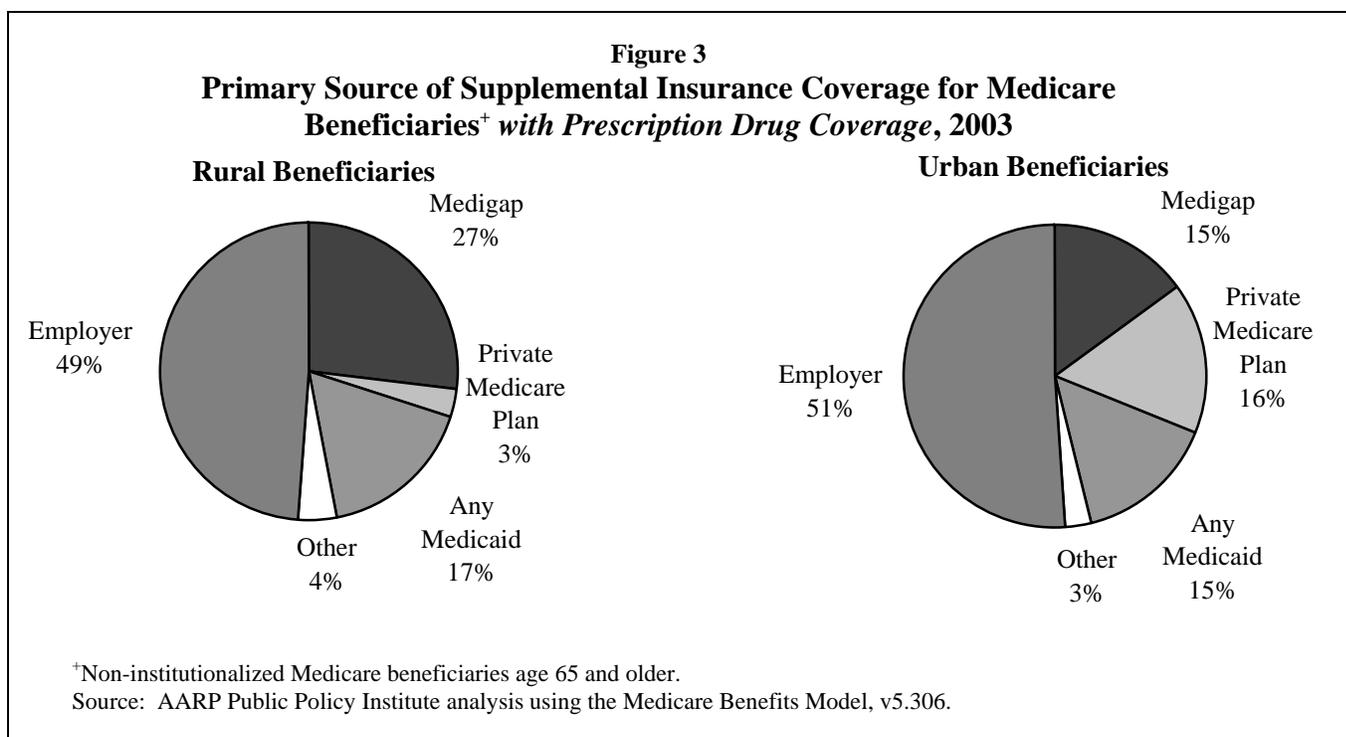
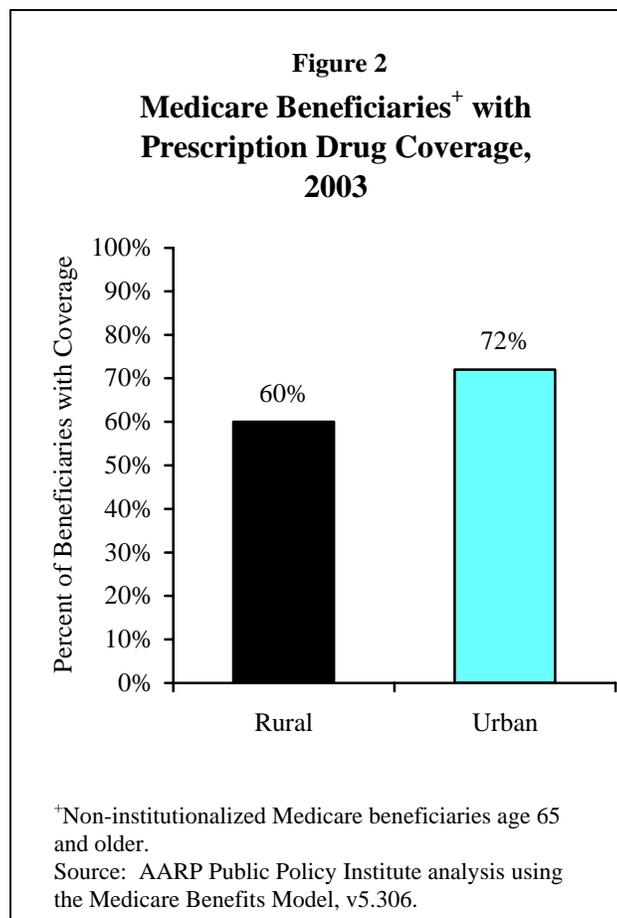
FPL: Federal Poverty Level (U.S. Census Bureau definition)

Source: AARP Public Policy Institute analysis using the Medicare Benefits Model, v.5.306.

➤ **Insurance Coverage**

Figure 2 illustrates that 60 percent of rural beneficiaries had some type of prescription drug coverage in 2003, compared to almost three quarters (72 percent) of urban beneficiaries. Figure 3 highlights that about half of both rural and urban beneficiaries *with prescription drug coverage* had employer-sponsored coverage as their primary source of supplemental insurance. Further, Medicaid was an important source of public supplemental coverage for both rural and urban Medicare beneficiaries.

Rural beneficiaries with drug coverage were more likely to have individual Medigap policies as their primary source of supplemental coverage and were less likely to be enrolled in private Medicare plans than their urban counterparts.⁶ (This finding holds in general—rural beneficiaries were more likely to have Medigap and were less likely to be in a private health plan, regardless of drug coverage status.) Prescription drug coverage under Medigap is generally perceived as providing a limited benefit, with higher coinsurance (50%) and annual benefit limits that are not commonly found in employer-provided plans. Consequently, the majority of beneficiaries with Medigap do not have any drug coverage.⁷



Out-of-Pocket Spending on Prescription Drugs

As shown in Figure 4, rural beneficiaries spent more out of pocket on prescription drugs than their urban counterparts, on average, both in dollars and as a percent of their incomes. Medicare beneficiaries living in rural areas spent an average of \$995 (or 8 percent of their annual incomes) out of pocket on prescription drugs. This compares to an average of \$780 (or 6 percent of their incomes) for urban beneficiaries.

The \$995 that rural beneficiaries spent on prescription drugs accounted for 27 percent of their total out-of-pocket health care spending, which was estimated to have been \$3,720 in 2003. In comparison, the

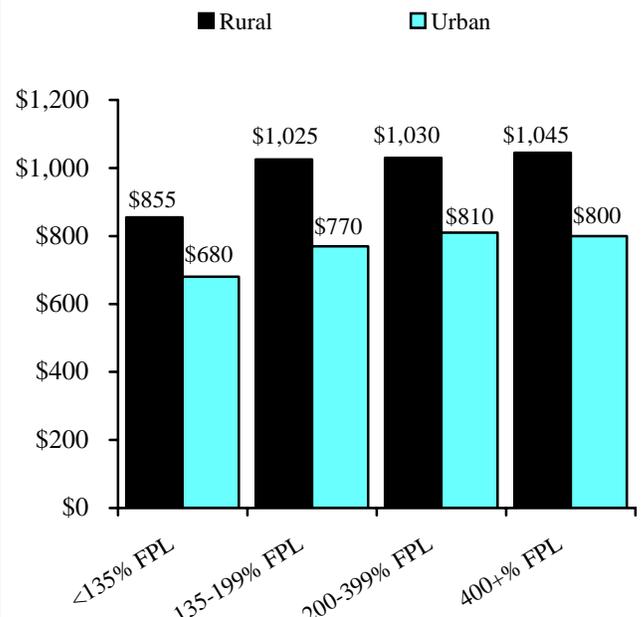
\$780 that urban beneficiaries spent on drugs accounted for 23 percent of their total out-of-pocket health care spending of \$3,370. Across all income categories, beneficiaries living in rural areas consistently spent more out of pocket on prescription drugs than did those in urban areas (see Figure 5). Of all income groups examined, beneficiaries with incomes between 135 and 199 percent of the federal poverty level had the greatest rural-urban gap in out-of-pocket spending on prescription drugs—\$255 more per year for rural beneficiaries than for their urban counterparts—although this gap was only slightly larger than that for beneficiaries with income greater than 400 percent of poverty.

Figure 4
Medicare Beneficiaries^{††} Out-of-Pocket Spending on Health Care, 2003

	All	Rural	Urban
Average out-of-pocket spending on health care	\$3,455 (22% of income)	\$3,720 (25% of income)	\$3,370 (21% of income)
Average out-of-pocket spending on prescription drugs	\$830 [§] (6.1% of income)	\$995 (7.8% of income)	\$780 (5.6% of income)
Out-of-pocket spending on prescription drugs as a percent of total health care expenses	24%	27%	23%

^{††}Non-institutionalized Medicare beneficiaries age 65 and older.
Source: AARP Public Policy Institute analysis using the Medicare Benefits Model, v5.306.

Figure 5
Medicare Beneficiaries^{††} Out-of-Pocket Spending on Prescription Drugs, by Income as Percent of FPL, 2003



^{††}Non-institutionalized Medicare beneficiaries age 65 and older.
FPL: Federal Poverty Level (U.S. Census Bureau definition)
Source: AARP Public Policy Institute analysis using the Medicare Benefits Model, v5.306.

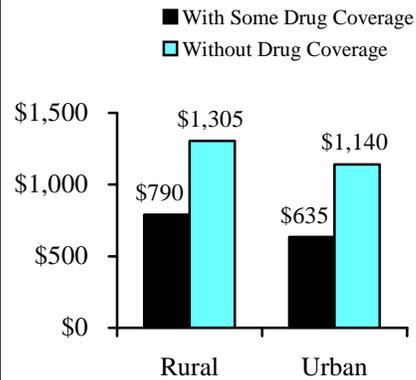
Insurance Coverage and Out-of-Pocket Spending

As shown in Figure 6, regardless of whether or not they had prescription drug coverage, rural beneficiaries spent more out of pocket on prescription drugs than urban beneficiaries in 2003. Among those with at least some drug coverage, rural beneficiaries spent an average of \$155 more than urban beneficiaries. This rural-urban difference was comparable to that among beneficiaries who lacked any prescription drug coverage. Furthermore, rural beneficiaries without any prescription drug coverage spent substantially more out of pocket on prescription drugs—over \$500 more, on average—than rural beneficiaries with drug coverage.

Furthermore, except for beneficiaries with Medicaid or in private Medicare plans (e.g., HMOs), rural beneficiaries with drug coverage spent more out of pocket on prescription drugs than urban beneficiaries with the same source of supplemental

insurance coverage (see Figure 7).⁹ Both rural and urban beneficiaries with Medigap who had drug coverage spent more on prescription drugs than those with other types of supplemental coverage.

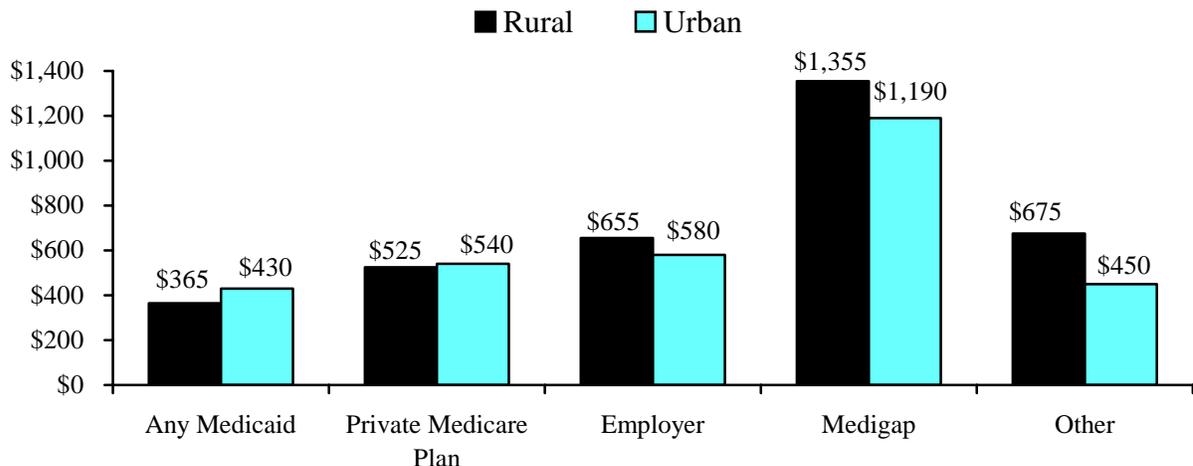
Figure 6
Medicare Beneficiaries⁺ Out-of-Pocket Spending on Drugs, by Presence of Prescription Drug Coverage, 2003



⁺Non-institutionalized Medicare beneficiaries age 65 and older.

Source: AARP Public Policy Institute analysis using the Medicare Benefits Model, v5.306.

Figure 7
Average Out-of-Pocket Spending on Prescription Drugs by Medicare Beneficiaries⁺ with Prescription Drug Coverage, by Primary Source of Supplemental Insurance, 2003



⁺Non-institutionalized Medicare beneficiaries age 65 and older.

Source: AARP Public Policy Institute analysis using the Medicare Benefits Model, v5.306.

Conclusions

The need for an outpatient prescription drug benefit has been especially great for rural Americans. Like those in urban areas, rural Medicare beneficiaries have been vulnerable to the growing costs of outpatient prescription drugs. However, rural beneficiaries are more likely to have lower incomes and are less likely to have any drug coverage than their urban counterparts. According to the projections from this analysis, rural beneficiaries spent more out of pocket on prescription drugs than their urban counterparts.

Policymakers recently passed legislation that will add prescription drug coverage to Medicare. The availability of such coverage could reduce many beneficiaries' out-of-pocket spending and provide a much needed source of drug coverage to rural beneficiaries starting in 2006.

¹Out-of-pocket spending for prescription drugs includes only direct spending on drugs; it does not include additional premiums for drug coverage through supplemental insurance. Total out-of-pocket spending includes Medicare cost-sharing, Part B and private insurance premiums, physician balance billing, and the cost of goods and services not covered by Medicare. It does not include the costs of home care or long-term nursing home care.

² All dollar figures are rounded to the nearest \$5.

³ Analyses presented in this *Data Digest* follow the geographic categorization of beneficiaries (i.e., *metropolitan area/nonmetropolitan area*) used in the Medicare Current Beneficiary Survey (MCBS). However, for ease of exposition, the terms *urban* and *rural* are used.

⁴ The data are taken from the Medicare Benefits Model, version 5.306. This desktop microsimulation model, developed for AARP's Public Policy Institute by The Lewin Group, projects health care expenditures for Medicare beneficiaries from the 1998 MCBS Cost and Use files and other data sources. The MCBS is a longitudinal survey that uses a nationally representative sample (from states, the District of Columbia, and Puerto Rico). The model trends MCBS statistics forward using actual and projected data from multiple sources, including: (1) the Congressional Budget Office, (2) Centers for Medicare and Medicaid Services (CMS) Office of Managed Care, (3) the CMS National Health Accounts, (4) the Bureau of the Census Current

Population Survey, and (5) the Social Security Administration.

⁵ www.census.gov/hhes/poverty/threshld/thresh03.html.

⁶ Private health plans typically have been less likely to be offered in rural areas. There are many barriers to plans operating in rural areas not related to payments, such as difficulty organizing and maintaining provider networks. In addition, plan payment increases have not stimulated market entry by plans in rural areas.

⁷ Since 1992, Medigap benefit packages in most states have been limited to 10 standardized plans (A, B, C, ..., H, I, J). Only a small fraction of all beneficiaries with Medigap policies have prescription drug coverage through one of the three standardized plans that includes a prescription drug benefit (plans H, I, and J). Some beneficiaries with Medigap have a pre-standardized (i.e., pre-1992) Medigap policy that includes prescription drug coverage.

⁸ This figure is somewhat lower than the \$996 in 2003 that was reported in other publications (e.g., Henry J. Kaiser Family Foundation. April 2003. *Medicare and Prescription Drugs*. Henry J. Kaiser Family Foundation, Fact Sheet #1583-06, Washington, DC) and was based on an Actuarial Research Corporation analysis which used CBO's 2003 estimates. The reasons for the disparity include, among others, differences in populations (e.g., the Medicare Benefits Model beneficiary population is only the non-institutionalized, whereas the CBO estimate imputes spending for the institutionalized) and differences in the calculation process (e.g., the Medicare Benefits Model methodology examines out-of-pocket drug spending at the individual beneficiary level whereas the CBO estimate computes total drug spending at the aggregate population level and then applies a predetermined ratio of out-of-pocket spending to total drug spending).

⁹ These differences in spending within a supplemental coverage type could be due to such factors as rural-urban differences in numbers of prescription drugs used, the prices of prescription drugs, the types of prescription drugs used, and/or generosity of supplemental coverage.

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AARP Public Policy Institute, November 2004
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