MEDICARE'S DISABLED BENEFICIARIES: THE FORGOTTEN POPULATION IN THE DEBATE OVER DRUG BENEFITS

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EXECUTIVE SUMMARY

The ongoing debate over the addition of a prescription drug benefit to Medicare's benefit package has focused primarily on the needs of the elderly. The needs of Medicare's nonelderly, disabled beneficiaries have received considerably less attention. There are around 5 million Medicare enrollees who are under age 65 but qualify for Medicare because they are totally and permanently disabled. Prescription drug coverage is critical for this population, which is more likely than the elderly to live in poverty, be in poor health, and experience difficulties living independently and performing basic daily tasks.

This analysis draws upon the 1998 Medicare Current Beneficiary Survey Access to Care and Cost and Use Files to describe the prescription drug experiences of Medicare beneficiaries under 65 who are living with disabilities. The key findings are:

- The disabled are heavy users of medications, filling more prescriptions than the elderly in 1998 (34 vs. 25, respectively) and spending more on drugs annually ($1,284 vs. $841).
- Overall rates of drug coverage throughout 1998 were comparable for under-65 disabled and elderly beneficiaries (79% and 76%, respectively). Medicaid was the primary source of drug coverage for the under-65 disabled, assisting one of three such beneficiaries, but was the source for only one of 11 seniors. Elderly beneficiaries, on the other hand, were more likely to have prescription coverage through an employer-sponsored health plan.
- Out-of-pocket drug spending varies by source and stability of coverage. Under-65 disabled beneficiaries who lacked drug coverage for the entire year in 1998 had significantly higher out-of-pocket spending ($499) than did those with full-year coverage ($314).
- Out-of-pocket drug spending also varies widely by type of coverage. For disabled beneficiaries under age 65 who had drug coverage through Medigap, out-of-pocket costs averaged $601 in 1998—more than was paid by those without Medigap coverage ($499). Disabled beneficiaries with employer-sponsored drug coverage and those enrolled in Medicaid had average out-of-pocket drug costs of $375 and $199, respectively.
- Disabled beneficiaries' high drug costs and low incomes make paying for prescription medications particularly burdensome. More than a quarter (27%) of all under-65 disabled beneficiaries spent 5 percent or more of their annual incomes on

prescription drugs in 1998, with the proportion rising dramatically for those with coverage for only part of the year (36%) or no coverage at all (44%).

- Access problems are exacerbated for those with unstable or no drug coverage, particularly among the disabled. Compared with those with full-year coverage, disabled beneficiaries without prescription benefits were nearly three times more likely not to fill all of their prescriptions and more than twice as likely to delay care because of costs.
- The types of medications typically used by the disabled differ considerably from those used by the elderly. Psychotherapeutics, for example, are the prescriptions most commonly filled by the disabled (57% use this group of drugs), but they rank only 10th among drugs used by the elderly (23%). The disabled are also far heavier users of analgesics and central nervous system drugs, whereas the elderly are most apt to use heart medications.

The under-65 disabled Medicare population faces a daunting combination of low income, poor health status, heavy prescription use, and high medication bills. Yet with the exception of Medicaid, disabled Medicare beneficiaries have few options for obtaining stable and comprehensive prescription drug coverage. All of these factors place the disabled at special risk.

Some policymakers have proposed linking a Medicare drug benefit to the medications most often used by the elderly. If that were to happen, the findings presented here suggest that the disabled would be systematically disadvantaged. If the drug benefit consists mainly of government subsidies to private insurers, few disabled beneficiaries are likely to receive assistance. While most recent Medicare prescription drug benefit proposals do not consider restricting the benefit to those medications most often used by the elderly, as some earlier proposals did, this does not mean that access to medications for disabled Medicare beneficiaries would not be difficult. Formulary restrictions, drug utilization review, and other administrative mechanisms can and have been used by public and private payers to restrict access to certain drugs, especially newer, more effective, yet more expensive, psychotherapeutics.[1] As policymakers consider measures to improve drug coverage for the Medicare population, the unique and substantial needs of nonelderly beneficiaries with disabilities should not be forgotten.

[1] L. Gorman. "Treatment Denied: Colorado Health Care 'Reform' and the Mentally Ill." Independence Institute Issue Paper, July 31, 2001.

MEDICARE'S DISABLED BENEFICIARIES: THE FORGOTTEN POPULATION IN THE DEBATE OVER DRUG BENEFITS

INTRODUCTION

Despite concerns about aging baby boomers swamping the Medicare program, beneficiaries under age 65 who are entitled through the Social Security Disability Insurance (SSDI) program represent the fastest-growing segment of the Medicare population. There are around 5 million people who are under age 65 and qualify for Medicare on the basis of disability, representing nearly 14 percent of all Medicare beneficiaries. By 2010, this group is expected to number 7.6 million, or almost 17 percent of the Medicare population.[2] The needs of the under-65 disabled population on Medicare have gone largely unnoticed in the debate over improving prescription drug coverage for Medicare enrollees. Typically, policy proposals extend drug coverage to all Medicare beneficiaries, including the under-65 disabled, but design features and need assessments have still focused almost exclusively on the elderly. The prevailing wisdom seems to be that a benefit designed for the elderly will also work for the disabled. Policies based upon that assumption could prove problematic for a population as vulnerable—and as poorly researched—as Medicare's disabled.

This analysis was conducted to provide policymakers with better information on disabled beneficiaries' need for prescription coverage. It uses 1998 data from the Medicare Current Beneficiary Survey to: (1) compare disabled and elderly Medicare beneficiaries on various dimensions, including demographic characteristics, prescription drug coverage, patterns of drug use and spending, and reported problems with access to care; and (2) compare the characteristics and prescription drug use patterns of disabled Medicare beneficiaries with drug coverage across a range of sources, both for the full year and for only part of the year, and those without it. It also evaluates the impact of specific drug benefit programs available to the disabled in certain states and counties.

Finally, to determine whether the needs of the SSDI population differ according to type of disability, sub-analyses were performed for people with mental and physical impairments; results are presented in detail in the Appendix.

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[2] Qualifications for Medicare disability entitlement are strict: workers can receive Social Security Disability Insurance (SSDI) assistance only after being diagnosed with qualifying medical conditions that are expected to last at least 12 months or result in death. Except for persons diagnosed with end-stage renal disease or amyotrophic lateral sclerosis, SSDI beneficiaries must complete a 24-month waiting period before Medicare benefits commence. National Economic Council, Domestic Policy Council, *Disability, Medicare, and Prescription Drugs*. The White House, July 31, 2000.

Study Methods

Data for this study were obtained from the 1998 Medicare Current Beneficiary Survey (MCBS) Cost and Use and Access to Care files. The MCBS is a longitudinal survey, conducted in the home, of a representative national sample of the Medicare population.[3] The MCBS oversamples beneficiaries under the age of 65, making it one of the best data sources for studying the disabled population. The population for this study consisted of all elderly and disabled Medicare beneficiaries living in the community (e.g., not in an institution) for at least part of the year in 1998.[4] All analyses applied sampling weights to provide nationally representative population estimates.[5] State and county residence codes in the MCBS were used to assess the effects of policies intended to improve access to prescription drug coverage for disabled beneficiaries. The availability of Medicare+Choice plans varies by county and was determined from plan listings obtained from the Centers for Medicare & Medicaid Services (CMS).

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[3] The MCBS is conducted under the auspices of the Centers for Medicare & Medicaid Services (CMS). Begun in the fall of 1991, the MCBS includes interviews with over 12,000 Medicare beneficiaries three times a year using computer-assisted personal interviewing. MCBS interviewers collect extensive information on individuals' use and expenditures for health services, including prescription drugs, source of payment, type of health insurance, access to care, and health and functional status. The interviewers also collect information on socioeconomic status and demographic characteristics.

[4] To distinguish beneficiaries by disabled or elderly entitlement status, the authors used the Medicare administrative designation given as of December 31, 1998. This designation limits the disabled population to only those under the age of 65, since the status effectively disappears once disabled beneficiaries become Medicare-eligible by age. Excluded from the sample are beneficiaries institutionalized year-round and a small group of beneficiaries entitled only through end-stage renal disease.

[5] All analyses used sampling weights supplied for each individual in the MCBS and clustering corrections using survey software in *Stata 7.0*. The authors computed mean values and standard errors around each estimation. Rather than report the standard errors, they followed the practice recommended in the MCBS guidelines of identifying values with standard errors exceeding 30 percent of the estimate. Estimates with a relative standard error greater than 30 percent are designated as potentially unreliable in the tabled findings.

FINDINGS

Beneficiary Characteristics

In 1998, Medicare beneficiaries included approximately 4.8 million community-dwelling disabled and 33 million elderly. The typical disabled beneficiary is a middle-aged (mean age=49.9), unmarried man. At least one of four is nonwhite or Hispanic (Table 1). By contrast, most elderly beneficiaries fall between the ages of 65 and 74 (mean age=74.9), a majority is female, and most are married. Fewer than 15 percent are minorities. Disabled Medicare beneficiaries are at significant economic disadvantage compared with elderly beneficiaries. Medicare's disabled are twice as likely as seniors to live under the federal poverty level (45% vs. 20%), and nearly 80 percent live on modest incomes under 200 percent of the poverty level, compared with just over 50 percent of seniors.[6] Disabled beneficiaries with mental impairments are especially likely to have incomes below the poverty level (Appendix Table A1).

Measures of health status indicate that disabled beneficiaries have much poorer physical, mental, and functional levels than do the elderly. The disabled are twice as likely to report being in fair or poor health (59% vs. 23%) and twice as likely to have trouble performing at least one "activity of daily living" (44% vs. 26%) or one "instrumental activity of daily living" (36% vs. 16%). (Activities of daily living include getting out of bed and being able to feed yourself, while instrumental activities of daily living include using a phone, going shopping, or preparing meals.) The disabled also bear a heavy disease burden compared with nondisabled individuals of the same age. Furthermore, despite being considerably younger than the elderly, disabled beneficiaries are as likely to report having three or more chronic conditions.

Opportunities for Obtaining Prescription Drug Coverage

More than three-quarters of all elderly and disabled Medicare beneficiaries maintained some form of prescription drug coverage in 1998. While rates of continuous and part-year drug coverage were about the same among both elderly and disabled beneficiaries, there were substantial differences in the sources and generosity of coverage (Figure 1). In general, the disabled rely far more heavily than the elderly on public programs for protection from prescription drug costs and, among those with private coverage, their benefits tend to be less generous.[7]

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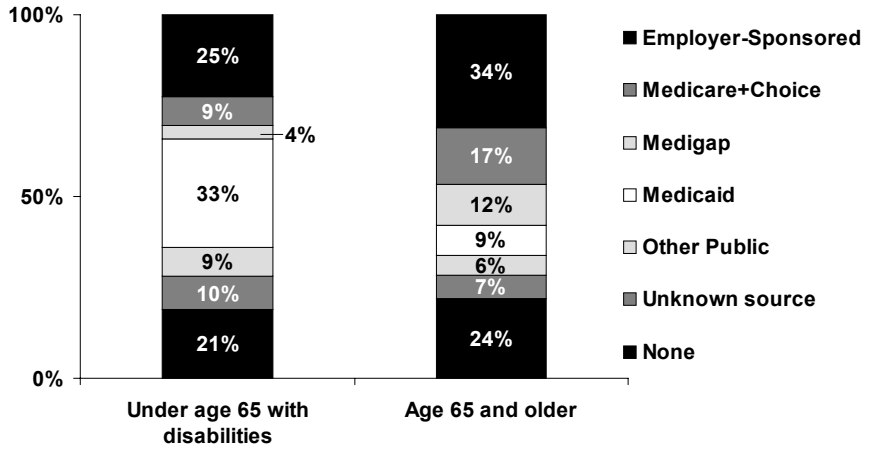
[6] These estimates are higher than those reported from the Current Population Survey (CPS). The major reason for this discrepancy is that the CPS counts all sources of household income while the MCBS counts only income received by the beneficiary or spouse.

[7] Medicaid provides a substantial portion of drug coverage for the disabled with mental impairments (45%) (Appendix Table A1). For those with only physical impairments, drug coverage comes most often through employer-based insurance (30%), although Medicaid is a close second source (25%). Both disabled groups show lower than average enrollment in Medicare managed care plans with drug benefits.

Figure 1. Sources of Prescription Drug Coverage Among Medicare Beneficiaries Throughout 1998, by Entitlement Status



Source: B. Briesacher et al. (analysis of 1998 MCBS for The Henry J. Kaiser Family Foundation and The Commonwealth Fund).

In 1998, one of three disabled beneficiaries received drug benefits from Medicaid—through either traditional Medicaid or the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary Plus (SLMB+) programs—compared with only one of 11 of the elderly (9%).[8] More than one of 12 disabled beneficiaries (9%) obtained drug coverage through other public sources such as the Veterans Administration and state-funded pharmacy assistance programs, compared with one of 16 elderly beneficiaries (6%). Public coverage is particularly prevalent among those with mental impairments (Appendix Table A1).

Private sources of drug coverage are less commonly used by the disabled. For instance, one of four disabled beneficiaries obtained drug coverage from employer-based insurance, compared with one of three elderly beneficiaries. Fewer than 9 percent (8.8%) of the disabled had drug coverage from Medicare HMOs and less than 4 percent received any drug benefits from Medigap plans. The elderly have coverage at rates two and three times higher, respectively, from these sources of coverage.

Differences in sources of coverage among elderly and disabled beneficiaries are due in large part to differences in access to benefits. In 1998, for example, only seven of the 13 states with a state-funded pharmacy assistance program offered eligibility to disabled

[8] National Economic Council, Domestic Policy Council. *Disability, Medicare, and Prescription Drugs*. The White House, July 31, 2000. Twenty-eight percent of the disabled had no prescription coverage in 1996, 22 percent had drug benefits from employer-based coverage, 3 percent from Medigap plans, 4 percent from Medicare managed care plans, and 43 percent from Medicaid.

persons under age 65.[9] While 11 states and the District of Columbia provided full Medicaid benefits—including drug coverage—to all Medicare beneficiaries enrolled in their QMB program and, in some cases, their SLMB+ program, the lack of such coverage in the majority of states creates particular challenges for beneficiaries with disabilities.[10]

In terms of private-sector coverage opportunities, access to individually purchased Medigap policies is guaranteed to the disabled in only nine states. Six states have guaranteed-offer laws that ensure the disabled access to standardized Medigap policies (Plans A through J), although only three of these plans (H, I, and J) include drug coverage. Three states guarantee Medicare beneficiaries with disabilities access to Medigap policies with drug coverage that existed before the standardized Medigap policies were developed.

Among all the public and private sources of drug coverage, only one—the Medicare+Choice program—provides widespread opportunities to the disabled population (Table 2). In 1998, nearly 72 percent of disabled beneficiaries lived in counties served by at least one Medicare+Choice plan, even though these plans are not available in all counties. By contrast, only 14 percent of Medicare's disabled resided in states with Medigap guaranteed-offer laws and about 20 percent in states that granted access to drug coverage through QMB/SLMB+ or state-funded pharmacy assistance programs.

Not surprisingly, drug coverage rates among disabled beneficiaries living in these states and counties appear to be higher than average, suggesting that these policies might be providing some assistance. Nearly 40 percent of the disabled living in QMB/SLMB+ states received drug benefits from Medicaid in 1998, a rate that is a third higher than that among beneficiaries living in states without such programs. State pharmacy assistance programs are one of several other public sources of prescription drug coverage for the disabled. While the MCBS does not identify the other public sources, this study's results show that, in states that have pharmaceutical assistance programs, more than 15 percent of the disabled have prescription drug coverage, compared with just 7.5 percent in states without such programs. This indicates that the programs can work to obtain coverage for the disabled. Likewise, living in counties served by Medicare+Choice plans appears consistent with having higher rates of prescription coverage, especially private coverage

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[9] According to the National Economic Council report, as of 2001, 24 states had some form of pharmacy assistance program, but only nine states offered eligibility to disabled beneficiaries. K. Fox, T. Trail, S. Crystal. *State Pharmacy Assistance Programs: Approaches to Program Design*. The Commonwealth Fund, May 2002. In 1998, the seven states with drug programs that offered eligibility to the under-65 disabled were Connecticut, Illinois, Maine, Maryland, New Jersey, Vermont, and Wyoming.

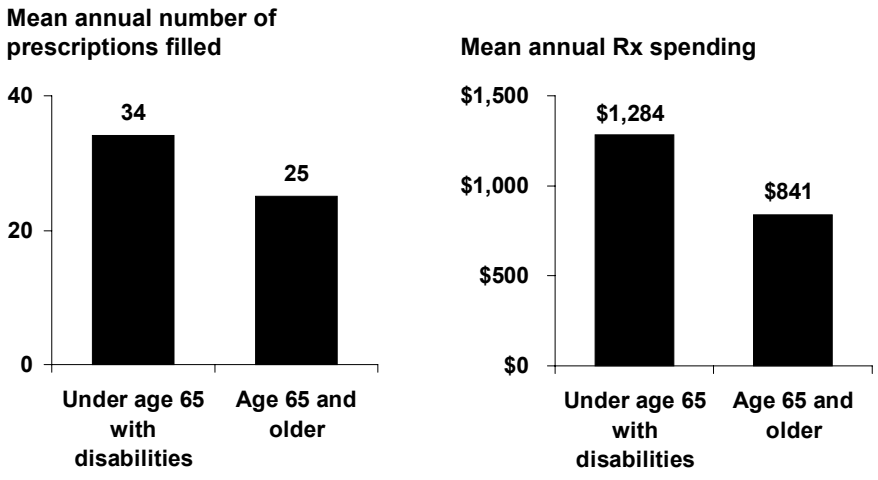
[10] P. B. Nemore. *Variations in State Medicaid Buy-In Practices for Low-Income Medicare Beneficiaries: A 1999 Update*. The Henry J. Kaiser Family Foundation, December 1999. The 11 states were Florida, Hawaii, Maine, Massachusetts, Mississippi, Nebraska, New Jersey, Pennsylvania, South Carolina, Utah, and Vermont.

(39.9% vs. 27.8%). On the other hand, living in a state that guarantees access to a Medigap plan appears to entail far less advantage. Whether any of these programs actually generated additional prescription coverage for the disabled population is difficult to assess without further analysis. However, the magnitude of differences associated with QMB/SLMB+ and Medicare+Choice programs strongly implies that at least these two programs have had that effect.

Prescription Use and Spending

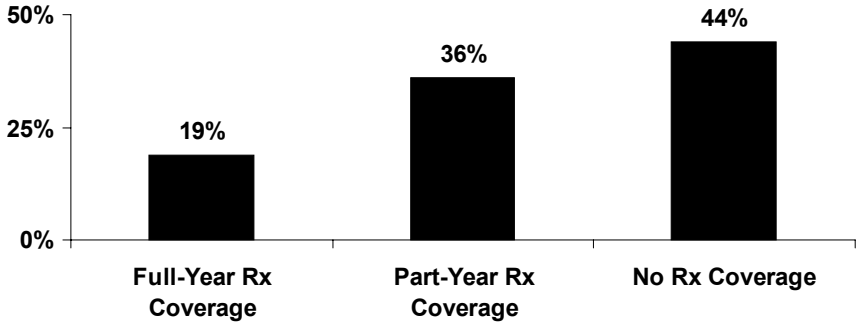
Having reliable prescription coverage is arguably more important for the disabled than it is for the elderly, given the much higher drug utilization and expenditure rates among disabled beneficiaries. While both the disabled and elderly were about equally likely to fill at least one prescription in 1998, the average number of prescriptions filled by disabled users (34) was much higher than for elderly prescription users (25) (Table 3 and Figure 2). Mean annual prescription spending for the disabled was almost 50 percent above that for the elderly ($1,284 vs. $841). With high prescription costs and low incomes, the disabled are particularly hurt by gaps in coverage or loss of benefits. A greater number of disabled beneficiaries than seniors spent 5 percent or more of their annual income on drugs (27% vs. 22%); the proportion who spent 5 percent or more of their income was even greater among the disabled with gaps in coverage (36%) or no coverage at all (44%) (Figure 3). Of course, these disparities reflect differences in baseline income levels, as well as in drug-related health care needs.

Figure 2. Prescription Drug Use and Spending Among Medicare Beneficiaries, by Entitlement Status, 1998



Source: B. Briesacher et al. (analysis of 1998 MCBS for The Henry J. Kaiser Family Foundation and The Commonwealth Fund).

Figure 3. Out-of-Pocket Spending on Prescription Drugs as a Share of Income Among Beneficiaries Under Age 65 with Disabilities, by Drug Coverage Status

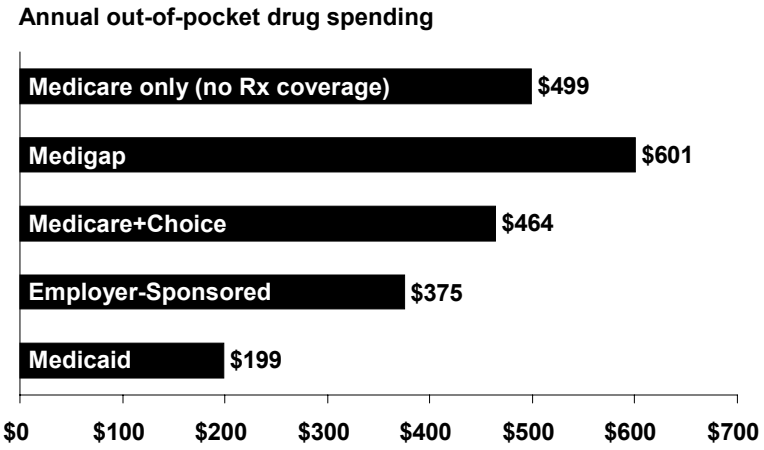


Source: B. Briesacher et al. (analysis of 1998 MCBS for The Henry J. Kaiser Family Foundation and The Commonwealth Fund).

As Table 3 clearly demonstrates, prescription drug coverage has a strong influence on average drug use and spending by disabled beneficiaries. While 75 percent of disabled beneficiaries without drug coverage filled at least one prescription during the year, over 90 percent of those with at least some drug coverage did so. Disabled beneficiaries without drug benefits filled 10 to 13 fewer prescriptions, on average, than those with drug benefits. As a result, mean annual prescription expenditures for the noncovered disabled are 60 to 70 percent below expenditures for those with some drug coverage. Although this may be partially attributable to the higher likelihood of disabled beneficiaries with greater prescription drug needs opting for coverage, the differences are striking and much larger than those found among elderly beneficiaries with and without drug coverage.

While prescription drug utilization among the disabled did not vary substantially by source of drug coverage, there were notable differences in out-of-pocket spending across sources of coverage (Figure 4). For instance, out-of-pocket costs for disabled beneficiaries under age 65 who had drug coverage through Medigap averaged $601—more than was paid out-of-pocket by those without coverage altogether ($499). Those with employer-sponsored drug coverage and those enrolled in the Medicaid program had average out-of-pocket drug costs of $375 and $199, respectively.

Figure 4. Out-of-Pocket Spending on Prescription Drugs Among Beneficiaries Under Age 65 with Disabilities, by Source of Drug Coverage



Source: B. Briesacher et al. (analysis of 1998 MCBS for The Henry J. Kaiser Family Foundation and The Commonwealth Fund).

Tracing spending to the source of coverage reveals that, while the elderly pay a higher percentage of their total drug costs out-of-pocket, disabled beneficiaries actually have higher out-of-pocket costs (Table 4). Among those with drug benefits from Medicare managed care plans, disabled beneficiaries paid nearly double the amount paid out-of-pocket for medications by the elderly. Indeed, except for Medicaid beneficiaries, the disabled spent 19 to 42 percent more out-of-pocket for their prescriptions than the elderly when covered by the same types of insurance plans.

The disabled also tend to pay more, as a share of their incomes, toward drug expenses, regardless of type of coverage. Twice as many disabled as elderly beneficiaries with employer-sponsored plans or Medicare+Choice coverage spent at least 5 percent of their incomes on prescription expenses.[11] Only Medicaid offered substantial relief to the disabled in terms of keeping out-of-pocket costs low relative to income.

Because of the number and types of prescription drugs they use, as well as their lower likelihood of having generous employer-sponsored coverage, Medicare's disabled

[11] The relationship between drug coverage and drug use patterns is generally similar for mentally and physically impaired disabled beneficiaries, except for people with gaps in coverage. For the mentally impaired, those with part-year drug benefits used far fewer medications on average (29) than those with continuous full-year coverage (36) (Appendix Table A2). By contrast, disabled beneficiaries with part-year benefits and only physical impairments filled about the same number of prescriptions as those with coverage for the entire year (36 vs. 37). These patterns are difficult to explain since the generosity of part-year coverage is about the same for both groups.

beneficiaries receive considerably less protection through private sources of drug coverage than do the elderly.

Access Problems and the Need for Prescription Coverage

The disadvantages faced by the disabled described thus far translate into difficulty gaining access to needed medical care and prescription drugs. Compared with 17 percent of the elderly, over a third of the disabled population experienced at least one access problem, including: failure to fill prescribed drugs, trouble getting health care, delays in care because of cost, failure to see a physician for a health problem, and having no usual place of care (Table 5). The disabled are three to four times more likely than seniors to experience difficulties in filling prescriptions, getting care, affording timely treatment, and seeing physicians when sick. Only one measure, having a usual place of care, affects both groups similarly. Two areas are particularly problematic for the disabled: delays in medical attention because of costs and failure to see a doctor when necessary. While 18 percent of disabled beneficiaries identified each of these problems in 1998, only 4 percent of elderly beneficiaries reported delaying care because of cost and only 6 percent went without seeing a doctor even when they were experiencing a health problem.

Access problems are exacerbated for those with unstable drug coverage or no coverage at all, particularly the disabled. Disabled beneficiaries without prescription benefits are nearly three times more likely to fail to fill all of their prescriptions and more than twice as likely to delay care because of cost compared with those with full-year coverage. While about a quarter (24%) of the disabled with gaps in prescription coverage did not see a doctor when they had health problems, only 14 percent of those with continuous coverage did so. The disabled with prescription drug coverage may also have more comprehensive supplemental coverage for other benefits such as physician services, cost-sharing, and billing in excess of Medicare allowed charges. Prescription drug coverage, therefore, may be a proxy for comprehensive supplemental coverage that removes access barriers not just to prescription drugs but to other services as well. For the disabled population as a whole, the only access measure that appears to be unaffected by prescription coverage is "trouble getting health care." As with the other measures, however, the disabled on the whole experience far greater problems on this dimension than do the elderly.[12]

Commonly Used Prescriptions

Another potential issue for the disabled lies in the types of medications they typically use, which differ considerably from those used by the elderly. Table 6 presents the 10 therapeutic drug classes most commonly taken by each entitlement group.

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[12] The disabled with mental and physical impairments were quite similar in their vulnerability to access barriers (Appendix Table A4).

Psychotherapeutics rank as the most-filled drug category among the disabled (filled by 57% of this group) but rank only 10th for the elderly (23%). The disabled are also far heavier users of analgesics and central nervous system drugs than are the elderly, who are most apt to use heart medications.[13] Some policymakers have suggested tying a Medicare drug benefit to the medications most often used by seniors. If that were to happen, the data presented here suggest that the disabled would be systematically disadvantaged.

Table 1. Characteristics of Elderly and Disabled Community-Dwelling Medicare Beneficiaries, 1998

Beneficiary Characteristics	Under Age 65 Beneficiaries with Disabilities	Over Age 65 Beneficiaries
All beneficiaries	4.8 million	33.2 million
Gender		
Female	42.4%	57.5%
Male	57.6	42.5
Race		
White	74.1%	86.7%
Black	16.7	7.9
Other	9.2	5.4
Hispanic ethnicity		
Hispanic	11.3%	6.4%
Non-Hispanic	88.8	93.6
Marital status		
Married	43.9%	56.4%
Single	56.1	43.6
Income in relation to Federal Poverty Level (FPL)		
< 100% FPL	45.3%	20.0%
101%–200% FPL	31.7	32.8
> 200% FPL	23.0	47.2
Self-reported health[a]		
Excellent	4.0%	16.1%
Very good	10.7	28.8
Good	25.6	32.5
Fair	32.9	16.3
Poor	26.4	6.2

[13] Within the disabled population, cardiopulmonary medications are more commonly prescribed to those with only physical impairments, while central nervous system medications are more typical for those with mental impairments (Appendix Table A5). Psychotherapeutic use figures prominently in the medical care of both groups: eight in 10 disabled beneficiaries with mental impairments took a least one psychotherapeutic medication in 1998, compared with four in 10 with only physical disabilities. Both groups are heavy users of analgesics.

Beneficiary Characteristics	Under Age 65 Beneficiaries with Disabilities	Over Age 65 Beneficiaries
Activities of daily living[a]		
0	55.9%	74.2%
1–2	27.4	17.5
3–6	16.7	8.3
Instrumental activities of daily living[a]		
0	63.6%	84.5%
1–2	26.3	11.1
3–5	10.1	4.4
Self-reported chronic conditions[a]		
Mental disorder	36.0%	3.6%
Osteoporosis	9.9	13.4
Alzheimer's disease	1.3	2.4
Arthritis	52.3	59.7
Hypertension	46.4	55.6
Heart condition	34.8	41.3
Chronic lung disease	26.2	14.2
Cancer	19.6	31.6
Diabetes	19.1	15.9
Stroke	12.2	10.4
Number of chronic conditions[a]		
0	8.9%	9.4%
1–2	44.4	43.7
3–4	32.0	36.9
5 or more	14.7	10.0
Source(s) of drug coverage[b]		
Employer plan	24.9%	33.6%
Medicare HMO	8.8	17.2
Individual Medigap	3.8	11.6
Medicaid[c]	33.0	9.4
Other public plan[d]	8.5	6.2
Some coverage but not reported[e]	10.3	6.7
Duration of drug coverage[f]		
Full-year coverage	60.1%	58.5%
Part-year coverage	18.8	17.5
No drug coverage[f]	21.2%	24.0%

Activities of daily living include getting out of bed and being able to feed yourself; instrumental activities of daily living include using a phone, going shopping, or preparing meals.

[a] Calculated only for those beneficiaries who were interviewed on health status in the community setting.

[b] Categories are not mutually exclusive.

[c] Includes regular Medicaid and Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary Plus (SLMB+) programs.

[d] Other public plans include such programs as Veterans Affairs, Department of Defense, and State Pharmaceutical Assistance programs.

[e] Comprises beneficiaries who reported no drug coverage yet had third-party payments for prescriptions.

[f] Calculated only for those beneficiaries who had full-year Medicare entitlement.

Source: Medicare Current Beneficiary Survey, 1998.

Table 2. Availability of Selected Drug Benefit Programs for Disabled Community-Dwelling Medicare Beneficiaries, by Payers and Duration of Drug Coverage, 1998

	Under Age 65 Beneficiaries with Disabilities							
	Lives in State with QMB/SLMB+ Entitlement[b]		Lives in State with Pharmacy Assistance Program[a]		Lives in State with Medigap Guaranteed-Offer Laws[c]		Lives in County with Medicare+Choice Plan(s)	
	Yes	No	Yes	No	Yes	No	Yes	No
All Beneficiaries	21.4%	78.6%	21.1%	87.9%	14.0%	86.0%	71.6%	28.4%
Third-party payers								
All private sources[d]	41.5%	35.0%	33.1%	36.9%	43.6%	35.3%	39.9%	27.8%
Employer	25.7	24.7	23.9	25.1	31.7	23.9	25.6	23.7
Medicare HMO	11.7	8.0	5.9★	9.2	8.5★	8.9	12.2	0.5★
Individual Medigap	5.1	3.5	3.8★	3.8	5.4	3.5	3.6	4.1
All public sources[d]	44.3	36.7	41.0	38.0	38.9	38.2	37.5	40.4
Medicaid	39.9	31.1	32.4	33.0	35.3	32.6	32.4	34.4
Other public[e]	7.9	8.6	15.5	7.5	8.6	8.4	8.3	9.0
Duration of drug coverage[f]								
Full-year	71.9%	56.9%	59.5%	60.2%	70.2%	58.4%	61.5%	56.8%
Part-year	13.6	20.2	19.0	18.7	13.4	19.7	19.8	15.8
No drug coverage[f]	14.5	22.9	21.5	21.7	16.4	22.0	18.7	27.4

★ Relative standard error greater than 30 percent.

[a] Eligibility for program includes disabled beneficiaries under age 65 (CT, IL, ME, MD, NJ, VT, WY).

[b] Full Medicaid benefits, including drugs, are given to QMB/SLMB+ beneficiaries (DC, FL, HI, ME, MA, MS, NE, NJ, PA, SC, UT, VT).

[c] Includes beneficiaries under the age of 65 with disabilities in six states (KS, ME, MI, NH, OR, PA) with guaranteed-offer laws targeted to the disabled, ensuring them access to standardized Medigap policies that may include Plans H, I, and J, along with those in the three states (MA, MN, WI) that offer pre-standard Medigap policies with drug coverage to all beneficiaries.

[d] Categories are not mutually exclusive.

[e] Other public plans includes such programs as Veterans Affairs, Department of Defense, and State Pharmaceutical Assistance programs.

[f] Calculated for only those disabled beneficiaries who had full-year Medicare entitlement.

Source: Medicare Current Beneficiary Survey, 1998.

Table 3. Prescription Drug Use and Spending for Elderly and Disabled Community-Dwelling Medicare Beneficiaries, by Presence and Duration of Drug Coverage, 1998[a]

	Under Age 65 Beneficiaries with Disabilities				Over Age 65 Beneficiaries			
Prescription Use and Spending	**Total**	**Full-Year Rx Coverage**	**Part-Year Rx Coverage**	**No Rx Coverage**	**Total**	**Full-Year Rx Coverage**	**Part-Year Rx Coverage**	**No Rx Coverage**
Beneficiaries filling at least one prescription	91.1%	95.8%	94.4%	75.0%	90.0%	92.2%	90.6%	84.2%
Mean number of prescriptions filled per year by users	33.5	36.5	32.9	23.3	24.7	26.0	25.1	20.8
Mean annual prescription drug spending	$1,284	$1,560	$1,283	$499	$841	$974	$772	$568
Mean annual prescription drug spending out-of-pocket	$388	$314	$496	$499	$379	$278	$460	$568
Percent of drug spending paid out-of-pocket	43.7%	26.4%	49.6%	100.0%	56.0%	37.1%	64.3%	100.0%
Out-of-pocket prescription drug spending as percent of annual income[b]								
0–5%	73.1%	80.7%	64.3%	55.7%	77.7%	86.3%	71.4%	59.8%
5% or more	26.9%	19.3%	35.7%	44.3%	22.3%	13.7%	28.6%	40.2%

[a] Sample consists of beneficiaries who had full-year Medicare entitlement.

[b] Calculated for only those beneficiaries who filled a prescription.

Source: Medicare Current Beneficiary Survey, 1998.

Table 4. Prescription Drug Use and Spending for Elderly and Disabled Community-Dwelling Medicare Beneficiaries, by Source of Drug Coverage, 1998

Prescription Use and Spending	Under Age 65 Beneficiaries with Disabilities					Over Age 65 Beneficiaries				
	Medicaid[a]	Medicare HMO	Employer	Individual Medigap	Other Public	Medicaid[a]	Medicare HMO	Employer	Individual Medigap	Other Public
Beneficiaries with no prescriptions filled	7.1%	5.5%⋆	5.6%	5.9%⋆	4.3%⋆	8.3%	8.3%	10.2%	11.4%	5.3%
Mean annual number of prescriptions filled by users	34.7	37.5	33.4	34.0	37.6	32.0	22.5	23.8	25.5	29.6
Mean annual prescription drug spending	$1,352	$1,247	$1,566	$1,354	$1,629	$1,004	$646	$980	$858	$1,069
Mean annual prescription drug spending out-of-pocket	$199	$464	$375	$601	$484	$179	$255	$264	$507	$393
Percent of drug spending paid out-of-pocket	21.1%	46.2%	29.4%	52.1%	41.6%	24.4%	50.2%	33.7%	64.2%	46.4%
Out-of-pocket prescription drug spending as percent of annual income[b]										
0–5%	84.2%	67.7%	79.2%	61.9%	64.5%	82.8%	86.0%	90.2%	69.9%	70.3%
5% or more	15.8%	32.3%	20.8%	38.1%	35.5%	17.2%	14.0%	9.8%	30.1%	29.7%

⋆ Relative standard error greater than 30 percent.

[a] Includes regular Medicaid and Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary Plus (SLMB+) programs.

[b] Calculated for only those beneficiaries who filled a prescription.

Source: Medicare Current Beneficiary Survey, 1998.

Table 5. Access to Prescription Drugs and Other Medical Care for Elderly and Disabled Community-Dwelling Medicare Beneficiaries, by Presence and Duration of Drug Coverage, 1998[a]

	Under Age 65 Beneficiaries with Disabilities				Over Age 65 Beneficiaries			
Access to Care Measure	**Total**	**Full-Year Rx Coverage**	**Part-Year Rx Coverage**	**No Rx Coverage**	**Total**	**Full-Year Rx Coverage**	**Part-year Rx Coverage**	**No Rx Coverage**
Failed to fill prescribed drugs	6.4%	4.2%	7.7%	11.6%	2.2%	1.9%	2.0%	3.1%
Had trouble getting health care	9.1	8.0	12.3	9.7	2.3	2.3	3.2	1.9
Delayed care because of cost	18.4	11.8	28.3	29.0	4.2	3.0	5.3	6.0
Had health problem but did not see MD	18.1	13.9	23.7	25.5	6.1	5.7	5.7	7.3
Has no usual place for care	7.4	5.0	6.6	15.5	5.9	4.1	6.7	9.6
Any of the above access measures	35.0	27.8	43.5	49.2	16.5	14.2	18.2	21.2

[a] Sample consists of beneficiaries answering Access to Care questions of the 1998 MCBS and who had full-year Medicare entitlement.

Source: Medicare Current Beneficiary Survey, 1998.

Table 6. Most Commonly Filled Prescriptions for Elderly and Disabled Community-Dwelling Medicare Beneficiaries, by Therapeutic Drug Class, 1998

Therapeutic Drug Class	Under Age 65 Beneficiaries with Disabilities % (Rank)	Over Age 65 Beneficiaries % (Rank)
Cardiovascular	38.3 (3)	46.4 (1)
Cardiac drugs	33.4 (6)	40.4 (2)
Diuretics	25.9 (9)	34.2 (3)
Antiinfectives	41.5 (2)	28.1 (4)
GI preps	34.9 (5)	26.8 (5)
Hormones	30.8 (8)	24.1 (6)
EENT preps	—	23.8 (7)
Antiarthritics	31.6 (7)	23.1 (8)
Autonomic drugs	—	23.0 (9)
Psychotherapeutics	57.4 (1)	22.9 (10)
Analgesics	36.1 (4)	—
CNS drugs	22.1 (10)	—

Source: Medicare Current Beneficiary Survey, 1998.

CONCLUSION

These findings show that the disabled population faces a daunting combination of low income, poor health status, heavy prescription use, and high medication bills. Yet, they have few places to turn for relief. Except for Medicaid, which serves as the major source of drug coverage for this population, the avenues by which needy disabled individuals can gain prescription coverage are heavily constrained. Few SSDI disabled are employed, which makes access to employer-sponsored coverage impossible except for those fortunate enough to have it from a previous employer or through a spouse's employer. The availability of Medicare+Choice plans has declined steadily since 1999, and there is evidence that some managed care plans may be discouraging the disabled from enrolling or inadequately serving those with more severe medical needs.[14]

Medicaid plays a pivotal role in providing services to disabled beneficiaries who have high medical costs and heavy prescription drug needs, but recent budget pressures could compromise that coverage. In 1998, elderly and disabled beneficiaries accounted for more than two-thirds of all Medicaid spending and four of five Medicaid dollars spent on prescription drugs.[15] State approaches to restoring solvency to their Medicaid budgets feature strategies designed to contain rising prescription drug costs, such as limits on the number of prescriptions that Medicaid will cover, drug formularies based on prior authorization, and increased copayments. Unless carefully designed and monitored, these policies may undermine the safety net that Medicaid provides to low-income disabled beneficiaries.

Clearly, the most effective way to protect the disabled from the high costs of prescription drugs would be for Congress to enact a comprehensive Medicare drug benefit. However, not just any drug benefit will suffice: the special needs of the disabled require explicit attention. For example, if the Medicare drug benefit were tightly crafted around the medical conditions and prescription use patterns of the elderly population, the disabled—particularly those with mental impairments—would be placed at a severe disadvantage. Mental illness is the single most common qualifying disorder for SSDI, accounting for 25 percent of all new awards, but many disabled beneficiaries also have

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[14] See M. Gold, L. Nelson, R. Brown et al. "Disabled Medicare Beneficiaries in HMOs." *Health Affairs* 16 (September/October 1997): 149–62; and M. A. Laschober, P. Neuman, M. Kitchman, et al. "Medicare HMO Withdrawals: What Happens to Beneficiaries?" *Health Affairs* 18 (November/December 1999): 150–57.

[15] J. Guyer, *The Role of Medicaid in State Budgets,* prepared for the Kaiser Commission on Medicaid and the Uninsured, October 2001.

severe physical conditions such as seizures or paralysis that are relatively uncommon among the elderly.[16]

The high cost-sharing provisions included in most proposals for a Medicare drug benefit would also prove problematic for many disabled beneficiaries. One common provision in the last round of Medicare drug benefit proposals was 50 percent coinsurance for beneficiaries with incomes as low as 135 percent of the federal poverty level. Another feature was the so-called "hole in the donut," a corridor of unprotected coverage for mid-range prescription expenses. Such provisions would place elderly and disabled alike at risk for substantial out-of-pocket costs, but the risk is substantially greater for the disabled, who are less likely to have back-up coverage or incomes sufficient to support uncovered prescription drug purchases. In short, a Medicare drug benefit designed for the elderly will not suffice for the disabled unless their particular needs are assessed and addressed.

[16] M. H. Davis, E. O'Brien, "Profile of Persons with Disabilities in Medicare and Medicaid." *Health Care Financing Review* 17 (1995): 179–211.

APPENDIX

In addition to comparing elderly and SSDI disabled beneficiaries, this analysis profiled differences in drug coverage, use, and cost for disabled persons with and without mental impairments. These results are presented here in a set of tables that parallel those in the main report. Evidence of mental impairment was drawn from two main sources derived from protocols developed by Rosenbach (1995), including the primary or secondary cause of disability entitlement and self-reported health conditions.[17] During the health status section of the MCBS interview, disabled respondents are asked whether they have ever had any of 30 medical conditions (including three questions about mental impairments, mental disorder, mental retardation, and Alzheimer's disease) and if these conditions caused their disability entitlement. Both entitlement cause and self-reported conditions are necessary for identifying mental impairments, since approximately 25 percent of the disabled sample list "other reason" or no recorded cause of entitlement. Included in this group are beneficiaries who answered the facility version of the survey, which includes additional mental condition indicators: mental disorder, Alzheimer's disease, manic depression, depression, dementia, and schizophrenia. Using these criteria, the authors classified 1,887 disabled MCBS respondents into two groups: those with evidence of mental impairment (882) and those with other impairments (1,005).

Appendix Tables A1 through A5 present the findings from this analysis. Although those with mental impairments and those with physical impairments both depend heavily on medications, those with mental impairments are at a substantial economic disadvantage, making access to publicly funded drug coverage especially critical. The share of beneficiaries under the age of 65 with disabilities living in poverty rises to a majority (58%) for those with mental impairments (including those with physical impairments as well), compared with 37 percent of those with physical impairments only. There are surprising similarities between those with mental impairments and those with physical impairments in terms of burden of illness. Disabled beneficiaries with physical impairments only most commonly suffer from arthritis (59%), hypertension (50%), and heart conditions (39%). Nearly as many of those with mental impairments suffer from the same physical conditions (e.g., 42% have arthritis and 40% have hypertension).

The two groups did differ in their sources of prescription drug coverage, however. Only a quarter (24%) of disabled beneficiaries with mental impairments had their drug insurance from employers or Medicare HMOs, compared with 41 percent of those with

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[17] M. Rosenbach. "Access and Satisfaction Within the Disabled Medicare Population." *Health Care Financing Review* 17 (1995): 147–67.

physical impairments only (Table A1). While mean drug use was about the same for both groups (33 vs. 34 prescriptions per year), out-of-pocket costs vary, with those with mental impairments having considerably lower out-of-pocket spending than those with physical impairments alone ($337 vs. $425) (Table A2). Finally, the vast majority of disabled beneficiaries with mental impairments take psychotherapeutic agents (80%), while the most commonly filled prescriptions among beneficiaries with physical impairments alone are cardiovascular medications (filled by 47% of this group) (Table A5).

Table A1. Characteristics of Community-Dwelling Medicare Beneficiaries with Disabilities, by Disability Type, 1998

Beneficiary Characteristics	Disabled with Mental Impairment(s)*	Disabled with Physical Impairment(s) Only
All beneficiaries	1.1 million	3.7 million
Gender		
Female	42.4%	42.4%
Male	57.6	57.6
Race		
White	77.4%	72.0%
Black	13.1	19.2
Other	9.6	8.9
Hispanic ethnicity		
Hispanic	11.3%	11.2%
Non-Hispanic	88.7	88.8
Marital status		
Married	29.2%	54.0%
Single	70.8	46.0
Income in relation to Federal Poverty Level (FPL)		
< 100% FPL	57.9%	36.6%
101%–200% FPL	25.7	35.8
> 200% FPL	16.4	27.6
Self-reported health[a]		
Excellent	6.5%	2.4%
Very good	12.9	9.1
Good	27.7	24.2
Fair	30.1	34.8
Poor	22.6	28.9
Activities of daily living[a]		
0	64.4%	50.2%
1–2	21.4	31.4
3–6	14.2	18.4

Beneficiary Characteristics	Disabled with Mental Impairment(s)★	Disabled with Physical Impairment(s) Only
Instrumental activities of daily living[a]		
0	58.4%	67.1%
1–2	29.9	23.9
3–5	11.7	9.0
Self-reported chronic conditions[a]		
Mental disorder	89.4%	0.0%
Osteoporosis	8.4	10.9
Alzheimer's disease	3.2	0.0
Arthritis	42.1	59.2
Hypertension	40.3	50.4
Heart condition	29.1	38.7
Chronic lung disease	24.5	27.3
Cancer	16.6	21.6
Diabetes	14.3	22.3
Stroke	11.0	12.9
Number of chronic conditions[a]		
0	4.3%	12.0%
1–2	45.9	43.5
3–4	30.9	32.7
5 or more	19.0	11.9
Source(s) of drug coverage[b]		
Employer plan	17.0%	30.4%
Medicare HMO	6.6	10.4
Individual Medigap	4.0	3.7
Medicaid[c]	44.6	25.0
Other public plan[d]	11.0	6.7
Some coverage but not reported[e]	9.3	11.0
Duration of drug coverage[f]		
Full-year coverage	60.7%	59.6%
Part-year coverage	18.4	19.1
No drug coverage[f]	21.0%	21.3%

★ Includes those with only mental impairments as well as those with both mental and physical impairments.

Activities of daily living include getting out of bed and being able to feed yourself; instrumental activities of daily living include using a phone, going shopping, or preparing meals.

[a] Calculated for only those beneficiaries who were interviewed on health status in the community setting.

[b] Categories are not mutually exclusive.

[c] Includes regular Medicaid and Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary Plus (SLMB+) programs.

[d] Other public plans includes such programs as Veterans Affairs, Department of Defense, and State Pharmaceutical Assistance programs.

[e] Comprises beneficiaries who reported no drug coverage yet had third-party payments for prescriptions.

[f] Calculated for only those beneficiaries who had full-year Medicare entitlement.

Source: Medicare Current Beneficiary Survey, 1998.

Table A2. Prescription Drug Use and Spending for Community-Dwelling Medicare Beneficiaries with Disabilities, by Disability Type and Presence and Duration of Drug Coverage, 1998[a]

	Disabled with Mental Impairment(s)★				Disabled with Physical Impairment(s) Only			
Prescription Use and Spending	**Total**	**Full-Year Rx Coverage**	**Part-Year Rx Coverage**	**No Rx Coverage**	**Total**	**Full-Year Rx Coverage**	**Part-Year Rx Coverage**	**No Rx Coverage**
Beneficiaries filling at least 1 prescription	89.5%	94.1%	94.1%★	71.8%	92.3%	97.1%	94.2%★★	77.3%
Mean annual number of prescriptions filled by users	32.7	36.4	28.7	23.5	34.0	36.6	35.8	23.1
Mean annual prescription drug spending	$1,217	$1,481	$1,159	$506	$1,332	$1,619	$136	$495
Mean annual prescription drug spending out-of-pocket	$337	$244	$450	$506	$425	$367	$528	$495
Percent of drug spending paid out-of-pocket	40.8%	22.7%	48.7%	100.0%	45.8%	29.0%	50.3%	100.0%
Out-of-pocket prescription drug spending as percent of annual income[b]								
0–5%	74.1%	82.1%	66.8%	52.6%	72.5%	79.7%	62.5%	57.8%
5% or more	25.9%	17.9%	33.2%	47.4%	27.5%	20.3%	37.5%	42.2%

★ Includes those with only mental impairments as well as those with both mental and physical impairments.

★★ Relative standard error greater than 30 percent.

[a] Sample consists of beneficiaries who had full-year Medicare entitlement.

[b] Calculated for only those beneficiaries who filled a prescription.

Source: Medicare Current Beneficiary Survey, 1998.

Table A3. Prescription Drug Use and Spending for Community-Dwelling Medicare Beneficiaries with Disabilities, by Disability Type and Source of Drug Coverage, 1998

Prescription Use and Spending	Disabled with Mental Impairment(s)★					Disabled with Physical Impairment(s) Only				
	Medicaid[a]	Medicare HMO	Employer	Individual Medigap	Other Public	Medicaid[a]	Medicare HMO	Employer	Individual Medigap	Other Public
Beneficiaries with no prescriptions filled	7.3%	13.9%★★	5.5%★★	7.4%★★	6.0%★★	6.8%	1.8%★★	5.7%★★	4.8%★★	2.4%★★
Mean annual number of prescriptions filled by users	33.6	36.5	35.2	34.2	36.5	36.1	37.9	32.6	33.9	38.8
Mean annual prescription drug spending	$1,365	$1,216	$1,481	$1,526	$1,421	$1,337	$1,261	$1,598	$1,227	$1,861
Mean annual prescription drug spending out-of-pocket	$173	$477	$400	$407	$382	$231	$458	$365	$744	$597
Percent of drug spending paid out-of-pocket	20.0%	42.9%	33.3%	42.7%	42.8%	22.4%	47.5%	28.0%	58.8%	40.2%
Out-of-pocket prescription drug spending as percent of annual income[b]										
0–5%	84.0%	60.6%	79.5%	72.5%	60.3%	84.5%	70.4%	79.1%	54.4%	69.0%
5% or more	16.0%	39.4%	20.5%	27.5%	39.7%	15.5%	29.6%	20.9%	45.6%	31.0%

★ Includes those with only mental impairments as well as those with both mental and physical impairments.

★★ Relative standard error greater than 30 percent.

[a] Includes regular Medicaid and Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary Plus (SLMB+) programs.

[b] Calculated for only those beneficiaries who filled a prescription.

Source: Medicare Current Beneficiary Survey, 1998.

Table A4. Access to Prescription Drugs and Other Medical Care for Community-Dwelling Medicare Beneficiaries with Disabilities, by Disability Type and Presence and Duration of Drug Coverage, 1998[a]

	Disabled with Mental Impairment(s)★				Disabled with Physical Impairment(s) Only			
Access to Care Measure	Total	Full-Year Rx Coverage	Part-Year Rx Coverage	No Rx Coverage	Total	Full-Year Rx Coverage	Part-Year Rx Coverage	No Rx Coverage
Failed to fill prescribed drugs	6.5%	5.1%	8.1%	9.8%	6.2%	3.5%	7.4%	12.9%
Had trouble getting health care	11.9	10.9	12.7	14.3	7.0	5.7	11.9	6.5
Delayed care because of cost	19.7	15.8	22.8	29.5	17.4	8.7	32.3	28.7
Had health problem but did not see MD	18.8	17.2	20.6	22.6	17.5	11.4	26.0	27.4
Has no usual place for care	8.9	6.6	9.7	15.6	6.3	3.7	4.3	15.4
Any of the above access measures	37.0	33.7	38.8	46.1	33.6	23.1	46.9	51.4

[a] Sample consists of beneficiaries answering Access to Care questions of the 1998 Medicare Current Beneficiary Survey and who had full-year Medicare entitlement.

★ Includes those with only mental impairments as well as those with both mental and physical impairments.

Source: Medicare Current Beneficiary Survey, 1998.

Table A5. Most Commonly Filled Prescriptions for Community-Dwelling Medicare Beneficiaries with Disabilities, by Disability Type and Therapeutic Drug Class, 1998

Therapeutic Drug Class	Disabled with Mental Impairment(s)* % (Rank)	Disabled with Physical Impairment(s) Only % (Rank)
Cardiovascular	27.0 (5)	46.8 (1)
Cardiac drugs	18.8 (10)	44.6 (3)
Diuretics	—	35.0 (9)
Antiinfectives	36.1 (2)	45.5 (2)
GI preps	26.1 (7)	41.5 (5)
Hormones	21.2 (8)	38.1 (7)
EENT preps	20.8 (9)	20.9 (10)
Antiarthritics	26.9 (6)	35.1 (8)
Autonomic drugs	—	—
Psychotherapeutics	79.6 (1)	39.6 (6)
Analgesics	28.8 (4)	41.7 (4)
CNS drugs	30.7 (3)	—

* Includes those with only mental impairments as well as those with both mental and physical impairments.

Source: Medicare Current Beneficiary Survey, 1998.

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#494 *Out-of-Pocket Health Care Expenses for Medicare HMO Beneficiaries: Estimates by Health Status, 1999–2001* (February 2002). Lori Achman and Marsha Gold, Mathematica Policy Research, Inc. Analysis by the authors of Medicare Compare found that out-of-pocket spending for Medicare+ Choice enrollees can be substantial and varies significantly with health status. In 2001, the average enrollee in good health spent $1,195 annually out-of-pocket on health care, while an enrollee in poor health spent $3,578, or about three times as much.

#505 *Drug Coverage for Medicare Beneficiaries: Why Protection May Be in Jeopardy* (January 2002). Becky Briesacher, Bruce Stuart, and Dennis Shea. In this issue brief, the authors evaluate trends in prescription drug coverage for Medicare beneficiaries during the 1990s as a way to project their future coverage, costs, and needs. Based on data from 1993 to 1998, the projections indicate that beneficiary drug coverage likely peaked in 1998 or shortly thereafter, and has been in decline ever since.

#496 *Instability and Inequity in Medicare+Choice: The Impact for Medicare Beneficiaries* (January 2002). Jennifer Stuber, Geraldine Dallek, Claire Edwards, Kathleen Maloy, and Brian Biles. This executive summary of an unpublished report (available on the Fund's website only) examines recent changes in seven Medicare+Choice markets and the effects of these changes on Medicare beneficiaries.

#495 *Physician Withdrawals: A Major Source of Instability in Medicare+Choice* (January 2002). Geraldine Dallek and Andrew Dennington, George Washington University. The authors find that provider turnover rates within Medicare+Choice plans vary dramatically from state to state. Of the 38 states with reported data for 1999, six states plus the District of Columbia had turnover rates of 20 percent or higher.

#510 *The 2002 Medicare+Choice Plan Lock-In: Should It Be Delayed?* (December 2001). Geraldine Dallek, Brian Biles, and Andrew Dennington, George Washington University. This issue brief points to large-scale health plan withdrawals and provider turnover in the Medicare+Choice market among reasons to delay or repeal the Medicare+Choice policy to lock beneficiaries into their plans for a specified period.

#491 *National and Local Factors Driving Health Plan Withdrawals from Medicare+Choice* (October 2001). Jennifer Stuber, Geraldine Dallek, and Brian Biles, George Washington University. The authors of this field report found a substantial decline in the number of Medicare+Choice plans in five of seven large markets around the country.

#490 *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages* (October 2001). Geraldine Dallek and Claire Edwards, George Washington University. In this field report, the authors discuss the benefit packages of five Medicare+Choice plans in Cleveland, Ohio, and Tampa, Florida, and find that beneficiaries would have to spend hours calling plans, poring over data, and making complicated calculations in order to make any kind of reasonable comparison of plans.

#474 *One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems* (September 2001). Marilyn Moon and Matthew Storeygard, The Urban Institute. The authors argue that any major change to the Medicare program—such as requiring coinsurance for home health care—must take into account the steep costs seriously ill beneficiaries already pay for health services.

#470 *Medicare+Choice: An Interim Report Card* (July/August 2001). Marsha Gold, Mathematica Policy Research, Inc. *Health Affairs,* vol. 20, no. 4. The author gives Medicare+Choice (M+C) a "barely passing grade," noting disparities between what Congress intended under M+C and what was achieved. The author suggests that while operational constraints help explain experience to date, fundamental disagreements in Congress over Medicare's future mean that dramatic growth in M+C was then, and remains now, highly unlikely.

#467 *Raising Payment Rates: Initial Effects of BIPA 2000* (June 2001). Marsha Gold and Lori Achman, Mathematica Policy Research, Inc. This "Fast Facts" brief, published by Mathematica, examines how the Benefits Improvement and Protection Act (BIPA) changed payment rates to Medicare+Choice plans in counties with a metropolitan area of 250,000 people or more. Available online at www.mathematica-mpr.com/PDFs/fastfacts6.pdf *or* www.cmwf.org/programs/medfutur/gold_bipa_467.pdf.

#463 *Strengthening Medicare: Modernizing Beneficiary Cost-Sharing* (May 2001). Karen Davis. In invited testimony before a House Ways and Means Health Subcommittee hearing, the Fund's president cautioned that any effort to reform Medicare's benefit package must take into account the circumstances of all beneficiaries, including those who are older, low-income, and chronically ill.

#461 *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures* (May 2001). Stephanie Maxwell, Marilyn Moon, and Matthew Storeygard, The Urban Institute. This report presents four possible options for modernizing Medicare that would reverse spiraling costs for beneficiaries and reduce or eliminate the need for private supplemental insurance.

#460 *Trends in Premiums, Cost-Sharing, and Benefits in Medicare+Choice Health Plans, 1999–2001* (April 2001). Marsha Gold and Lori Achman, Mathematica Policy Research, Inc. This issue brief provides an early look at trends in Medicare+Choice plans from 1999 to 2001, revealing continued growth in premiums and a simultaneous continued decline in benefit comprehensiveness.

Medicare Works (Spring 2001). Bruce Vladeck. *Harvard Health Policy Review,* vol. 2, no. 1. Reprinted from *New Jersey Medicine,* March 2000. Available online at http://hcs.harvard.edu/~epihc/currentissue/spring2001/vladeck.html.

#498 *Dynamics in Drug Coverage of Medicare Beneficiaries: Finders, Losers, Switchers* (March/April 2001). Bruce Stuart, Dennis Shea, and Becky Briesacher. *Health Affairs,* vol. 20, no. 2. The authors analyze the sources and stability of prescription coverage maintained by Medicare beneficiaries in 1995 and 1996. The results show that fewer than half of all beneficiaries had continuous drug coverage over this period, while nearly a third gained, lost, or had spells without coverage.

Health Policy 2001: Medicare (March 22, 2001). Marilyn Moon. *New England Journal of Medicine,* vol. 344, no. 12. Copies are available from Customer Service, New England Journal of Medicine, P.O. Box 549140, Waltham, MA 02454-9140, Fax: 800-THE-NEJM, (800-843-6356), www.nejm.org.

#430 *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries* (January 2001). Stephanie Maxwell, Marilyn Moon, and Misha Segal, The Urban Institute. Medicare beneficiaries will have to pay substantially more out of their own pockets for health care in the future, according to this new report. The authors find that those with low incomes and health problems will be at even greater risk than average beneficiaries for costs such as Medicare premiums, medical services, and prescription drugs.

A Moving Target: Financing Medicare for the Future (Winter 2000/2001). Marilyn Moon, Misha Segal, and Randall Weiss, The Urban Institute. *Inquiry,* vol. 37, no. 4. Copies are available from *Inquiry,* P.O. Box 527, Glenview, IL 60025, Tel: 847-724-9280.

#436 *Designing a Medicare Drug Benefit: Whose Needs Will Be Met?* (December 2000). Bruce Stuart, Becky Briesacher, and Dennis Shea. Many current proposals for providing a prescription drug benefit under Medicare would cover only beneficiaries with incomes at the federal poverty level or slightly above. In this issue brief, the authors propose a broader definition of need that includes beneficiaries without continuous and stable coverage, those with high expenditures, and those with multiple chronic conditions. Under this expanded definition, nearly 90 percent of beneficiaries would be eligible for coverage.

Socioeconomic Differences in Medicare Supplemental Coverage (September/October 2000). Nadereh Pourat, Thomas Rice, Gerald Kominski, and Rani E. Snyder. *Health Affairs,* vol. 19, no. 5. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#395 *Early Implementation of Medicare+Choice in Four Sites: Cleveland, Los Angeles, New York, and Tampa–St. Petersburg* (August 2000). Geraldine Dallek and Donald Jones, Institute for Health Care Research and Policy, Georgetown University. This field report, based on research cofunded by The Commonwealth Fund and the California Wellness Foundation, examines the effects of Medicare+Choice—created by the Balanced Budget Act of 1997—on Medicare beneficiaries in four managed care markets.

#394 *Medicare+Choice in 2000: Will Enrollees Spend More and Receive Less?* (August 2000). Amanda Cassidy and Marsha Gold, Mathematica Policy Research, Inc. Using information from HCFA's Medicare Compare consumer-oriented database of Medicare+Choice plans, this report provides a detailed look at changes in benefits offered under Medicare+Choice in 1999–2000, focusing on benefit reductions and small capitation rate increases that are shifting costs to beneficiaries.

#393 *What Do Medicare HMO Enrollees Spend Out-of-Pocket?* (August 2000). Jessica Kasten, Marilyn Moon, and Misha Segal, The Urban Institute. Medicare+Choice plans are scaling back benefits and shifting costs to enrollees through increases in service copayments and decreases in the value of prescription drug benefits. This report examines the financial effects of these actions on Medicare managed care enrollees.

#405 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This summary report, based on The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70, reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#406 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This full report of findings from The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70 reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#371 *An Assessment of the President's Proposal to Modernize and Strengthen Medicare* (June 2000). Marilyn Moon, The Urban Institute. This paper discusses four elements of President Clinton's proposal for Medicare reforms: improving the benefit package, enhancing the management tools available for the traditional Medicare program, redirecting competition in the private plan options, and adding further resources to ensure the program's security in the coming years.

#382 *Drug Coverage and Drug Purchases by Medicare Beneficiaries with Hypertension* (March/April 2000). Jan Blustein. *Health Affairs,* vol. 19, no 2. This article shows that Medicare beneficiaries age 65 and older with high blood pressure are less likely to purchase hypertension medication if they are without drug coverage.

Who Is Enrolled in For-Profit vs. Nonprofit Medicare HMOs? (January/February 2000). Jan Blustein and Emma C. Hoy. *Health Affairs,* vol. 19, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#365 *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter* (January 2000). Bruce Stuart, Dennis Shea, and Becky Briesacher. This issue brief reports that prescription drug coverage of Medicare beneficiaries is more fragile than previously reported, that continuity of this coverage makes a significant difference in beneficiaries' use of prescription medicine, and that health status affects drug coverage for beneficiaries primarily through their burden of chronic illness.

#360 *Understanding the Diverse Needs of the Medicare Population: Implications for Medicare Reform* (November 1999). Tricia Neuman, Cathy Schoen, Diane Rowland, Karen Davis, Elaine Puleo, and Michelle Kitchman. *Journal of Aging and Social Policy,* vol. 10, no. 4. This profile of Medicare beneficiaries, based on an analysis of the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries, reveals that a relatively large share of the Medicare population has serious health problems and low incomes.

#353 *After the Bipartisan Commission: What Next for Medicare?* (October 1999). Stuart H. Altman, Karen Davis, Charles N. Kahn III, Jan Blustein, Jo Ivey Boufford, and Katherine E. Garrett. This summary of a panel discussion held at New York University's Robert F. Wagner Graduate School of Public Service considers what may happen now that the National Bipartisan Commission on the Future of Medicare has finished its work without issuing recommendations to President Clinton. It also examines possible reform opportunities following the November 2000 elections.

#346 *Should Medicare HMO Benefits Be Standardized?* (July/August 1999). Peter D. Fox, Rani Snyder, Geraldine Dallek, and Thomas Rice. *Health Affairs,* vol. 18, no. 4. The only Medicare supplement (Medigap) policies that can be sold are those that conform to the 10 standardized packages outlined in federal legislation enacted in 1990. In this article the authors address whether Medicare HMO benefits should also be standardized for the roughly 6 million Medicare beneficiaries now enrolled in HMOs.

#232 *Risk Adjustment and Medicare* (June 1999). Joseph P. Newhouse, Melinda Beeuwkes Buntin, and John D. Chapman, Harvard University. Medicare's payments to managed care plans bear little relationship to the cost of providing needed care to beneficiaries with different health conditions. In this revised paper, the authors suggest using two alternative health risk adjusters that would contribute to more cost-effective care and reduce favorable risk selection and the incentive to stint on care.

#318 *Growth in Medicare Spending: What Will Beneficiaries Pay?* (May 1999). Marilyn Moon, The Urban Institute. Using projections from the 1998 Medicare and Social Security Trustees' reports to examine how growth in health care spending will affect beneficiaries and taxpayers, the author explains that no easy choices exist that would both limit costs to taxpayers while protecting Medicare beneficiaries from the burdens of health care costs.

#317 *Restructuring Medicare: Impacts on Beneficiaries* (May 1999). Marilyn Moon, The Urban Institute. The author analyzes premium support and defined contribution—two of the more

prominent approaches proposed to help Medicare cope with the health care needs of the soon-to-retire baby boomers—and projects these approaches' impacts on future beneficiaries.

#310 *Should Medicare HMO Benefits Be Standardized?* (February 1999). Peter D. Fox, Rani Snyder, Geraldine Dallek, and Thomas Rice. The only Medicare supplement (Medigap) policies that can be sold are those that conform to the 10 standardized packages outlined in federal legislation enacted in 1990. In this paper the authors address whether Medicare HMO benefits should also be standardized for the roughly 6 million Medicare beneficiaries now enrolled in HMOs.

Budget Bills and Medicare Policy: The Politics of the BBA (January/February 1999). Charles N. Kahn III and Hanns Kuttner. *Health Affairs,* vol. 18, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

Will the Care Be There? Vulnerable Beneficiaries and Medicare Reform (January/February 1999). Marilyn Moon. *Health Affairs,* vol. 18, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

The Political Economy of Medicare (January/February 1999). Bruce C. Vladeck. *Health Affairs,* vol. 18, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.