U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

THE GRAYING OF MEDICARE'S DISABLED POPULATION:

IMPLICATION FOR A MEDICARE DRUG BENEFIT

March 2002

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

ASPE develops or reviews issues from the viewpoint of the Secretary, providing a perspective that is broader in scope than the specific focus of the various operating agencies. ASPE also works closely with the HHS operating divisions. It assists these agencies in developing policies, and planning policy research, evaluation and data collection within broad HHS and administration initiatives. ASPE often serves a coordinating role for crosscutting policy and administrative activities.

ASPE plans and conducts evaluations and research--both in-house and through support of projects by external researchers--of current and proposed programs and topics of particular interest to the Secretary, the Administration and the Congress.

Office of Disability, Aging and Long-Term Care Policy

The Office of Disability, Aging and Long-Term Care Policy (DALTCP), within ASPE, is responsible for the development, coordination, analysis, research and evaluation of HHS policies and programs which support the independence, health and long-term care of persons with disabilities--children, working aging adults, and older persons. DALTCP is also responsible for policy coordination and research to promote the economic and social well-being of the elderly.

In particular, DALTCP addresses policies concerning: nursing home and community-based services, informal caregiving, the integration of acute and long-term care, Medicare post-acute services and home care, managed care for people with disabilities, long-term rehabilitation services, children's disability, and linkages between employment and health policies. These activities are carried out through policy planning, policy and program analysis, regulatory reviews, formulation of legislative proposals, policy research, evaluation and data planning.

This report was prepared under contract #HHS-100-01-0023 between HHS's ASPE/DALTCP and the University of Maryland. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. The e-mail address is: webmaster.DALTCP@hhs.gov. The Project Officer was Andreas Frank.

THE GRAYING OF MEDICARE'S DISABLED POPULATION:
Implications for a Medicare Drug Benefit

Dennis Shea
Penn State University

Becky Briesacher
Bruce Stuart
Jalpa Doshi
University of Maryland, Peter Lamy Center

March 28, 2002

Prepared for
Office of Disability, Aging and Long-Term Care Policy
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Contract #HHS-100-01-0023

TABLE OF CONTENTS

LIST OF FIGURES AND TABLES

EXECUTIVE SUMMARY

The policy debate over a Medicare drug benefit has focused almost exclusively on the needs of Medicare's elderly beneficiaries. While they represent more than 85 percent of the Medicare population, it is important to remember that Medicare also covers almost 5 million recipients of Social Security Disability Insurance (SSDI). If a drug benefit is to meet the needs of the entire Medicare population it must address the particular circumstances and needs of the disabled as well as the aged. There are actually two groups of Medicare disabled that warrant attention. First, there are the SSDI recipients themselves who, by statute, are all under 65 years of age. The second group comprises Medicare beneficiaries who are 65 and older, but who originally qualified for Medicare under SSDI. There are currently over 2 million beneficiaries who have aged out of SSDI, but still retain the characteristics and needs associated with younger disabled beneficiaries. We refer to this group as the "disabled aged."

This report is intended to provide policymakers with critical information on prescription coverage, use, and cost for both younger and older disabled Medicare beneficiaries using data from the 1995 through 1998 Medicare Current Beneficiary Surveys. Our key findings are summarized below.

- **Spending**: Prescription drug spending among SSDI disabled and disabled aged beneficiaries is substantially higher than for the remainder of the Medicare population. SSDI beneficiaries, on average, spent more than $1,200 annually on prescription drugs, 40 percent more than the overall mean for Medicare beneficiaries in 1998. Disabled aged beneficiaries spent almost $1,300 on drugs that year. During the period 1995 to 1998 prescription spending among all Medicare beneficiaries rose 45 percent. The rate of increase for SSDI beneficiaries was also 45 percent, but for the disabled aged it was 60 percent.

- **Coverage**: SSDI and disabled aged Medicare beneficiaries are slightly more likely than the overall Medicare population to have prescription drug benefits, but they rely much more heavily on Medicaid and other public sources. The SSDI and disabled aged are less likely to receive employer coverage than other Medicare beneficiaries. While coverage expanded for both disabled groups from 1995 to 1998, the trends differ between them. SSDI beneficiaries had rising levels of employer and Medicare Health Maintenance Organization (HMO) coverage, with declining coverage from Medicaid. Disabled aged beneficiaries saw reductions in employer coverage and rising levels of coverage from Medigap and Medicare HMOs.

- **Burden**: While out-of-pocket spending on prescription drugs among SSDI beneficiaries is just 1 percent higher than for the general Medicare population, the low income of disabled beneficiaries means their drug spending as a percentage of income is much greater. In 1998, nearly two in five SSDI beneficiaries spent over 10 percent of their annual incomes on prescription

drugs, up from fewer than one in three in 1995. The situation is even worse for disabled aged Medicare beneficiaries, of whom 43 percent spent more than 10 percent of their income on drugs in 1998.

INTRODUCTION

This report profiles the prescription spending and coverage patterns of disabled Medicare beneficiaries before and after they turn age 65. Older beneficiaries who had disabling conditions in their younger years represent a growing segment of the Medicare population as definitions of disability expand and life expectancy rises. Yet, we know very little about the interplay of disability and older age and how that affects patterns of medication use and drug spending. Wide disparities in drug use and spending have been documented between younger disabled beneficiaries and seniors.[1] The question we address here is whether these differences grow with advancing age. Most prescription drug benefit plans available to Medicare beneficiaries have been crafted to help seniors, so it is conceivable that some access problems may resolve for disabled beneficiaries once they reach age 65. On the other hand, as disabled beneficiaries age and grow increasingly frail and deplete their economic resources, the need for drugs may well increase.

In a prior study we showed that the under-65 SSDI population faces a daunting combination of medication access problems related to low income, poor health status, heavy prescription use, and high medication bills.[2] 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 access prescription coverage are heavily constrained. Few qualify for employer-sponsored health insurance plans, most state pharmaceutical assistance programs cover only seniors, and managed care plans have been accused of discouraging the disabled from enrolling. Most research in this field classifies disabled beneficiaries through Medicare's administrative designation of SSDI, which applies strictly to beneficiaries below age 65. However, the fact that official disability status disappears once these individuals reach their 65th birthday does not remove the physical and mental impediments that led to their original Medicare entitlement.

The present study classifies "disabled" Medicare beneficiaries according to their original entitlement status. This approach increases the size of the disabled Medicare population by nearly half: in 1998 there were 4.8 million under-65 SSDI recipients and another 2.1 million disabled aged persons 65 and older. We examined trends in health status, prescription spending, use, and benefit coverage for both populations over four years using data from the Medicare Current Beneficiary Survey (MCBS) from 1995 to

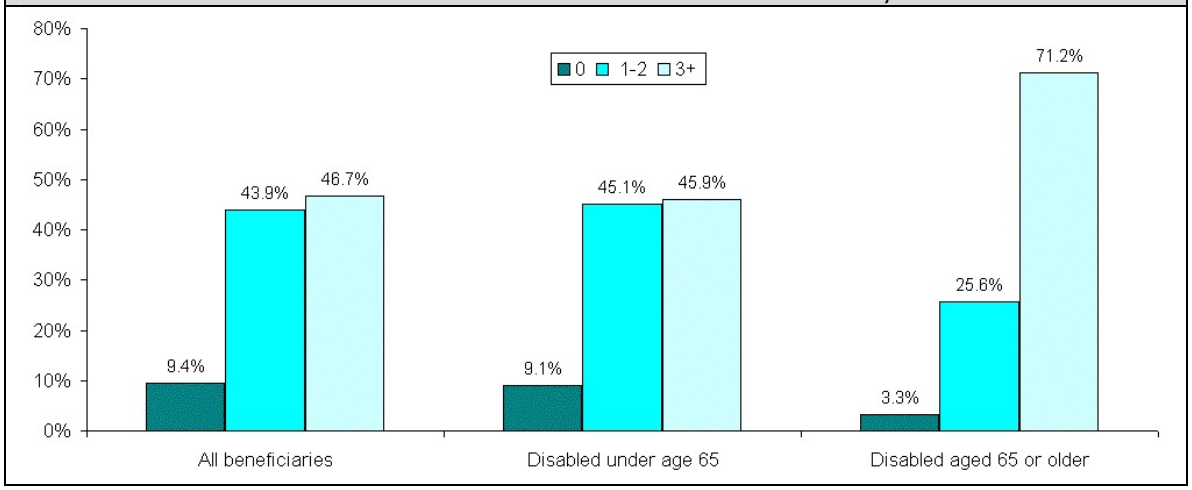
[1] B. Briesacher, B. Stuart, J. Doshi, S. Kamal-Bahl, D. Shea. *The Medicare Disabled: A Forgotten Population in the Debate over Drug Benefits*. Report by The Kaiser Family Foundation and The Commonwealth Fund, forthcoming.

[2] B. Briesacher, B. Stuart, J. Doshi, S. Kamal-Bahl, D. Shea. *The Medicare Disabled: A Forgotten Population in the Debate over Drug Benefits*. Report by The Kaiser Family Foundation and The Commonwealth Fund, forthcoming.

1998.[3] Highlights from that analysis are presented below. Appendix tables present a more detailed set of statistics comparing the SSDI and disabled aged populations over this time period.

As age increases, disabled beneficiaries develop more chronic conditions than the average senior. Before age 65, disabled beneficiaries generally report about the same number of common chronic illnesses as seniors. This means, at a very basic level, that medical care for most of these individuals centers around the management of one or two conditions. After age 65, three-quarters of all disabled aged individuals exhibit three or more chronic conditions, half again as many suffered by younger disabled beneficiaries. These conditions reflect complex co-morbidities, with particularly high prevalence of heart disease, chronic lung disease, and diabetes.

FIGURE 1. Number of Common Chronic Conditions, 1998



Disabled beneficiaries spend more on prescription drugs than other beneficiaries and the difference is accelerating. Prescription drug spending among SSDI disabled and disabled aged beneficiaries is substantially higher than for the remainder of the Medicare population. SSDI beneficiaries spent $1,203 on prescription drugs in 1998, 40 percent more than the overall mean for Medicare beneficiaries. Disabled aged beneficiaries spent $1,299 on drugs that year. During the period 1995-

[3] The MCBS is a nationally representative in-home survey of approximately 12,000 Medicare beneficiaries per year. The survey over-samples beneficiaries under the age of 65 making it one of the best data sources for studying the SSDI disabled population. Although Medicare does not provide insurance coverage for prescription drugs, the MCBS surveys Medicare beneficiaries about their prescription drug coverage and drug use and cost. Trained interviewers request detailed information and examine prescription bottles and bills to identify prescriptions filled, names of drugs, total payments, payment sources, and other information. When information is missing, the MCBS uses administrative data and statistical techniques to make an estimate or "imputation" of the information. For example, when information on the total cost of the prescription is missing, an administrative drug pricing source, the National Drug Data File User Manual (known as "The Blue Book") is used to impute prices. Depending on the source of insurance payment, this price might be adjusted downward to reflect the discounts that some insurers negotiate from drug companies. Overall, a recent study by the Centers for Medicare and Medicaid services suggests that the MCBS captures approximately 85 percent of all prescription expenditures. This means that the estimates provided in this report may, in fact, underestimate the spending by disabled persons.

1998 prescription spending among all Medicare beneficiaries rose 45 percent. The rate of increase for SSDI beneficiaries was also 45 percent, but for the disabled aged it was 60 percent ($812 to $1,299).

FIGURE 2. Self-Reports of Chronic Illnesses

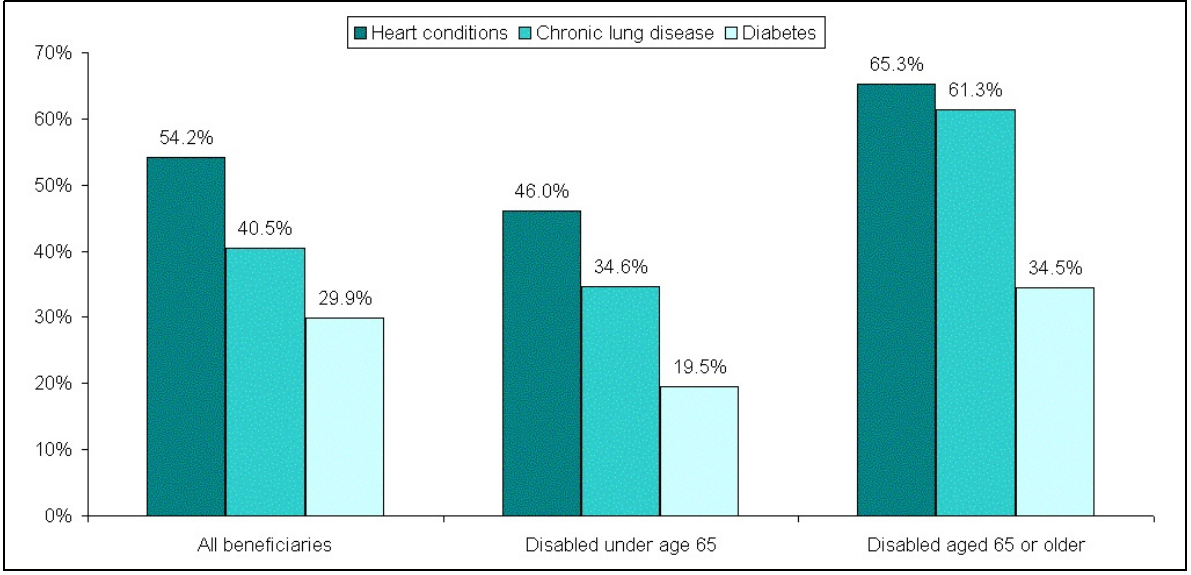
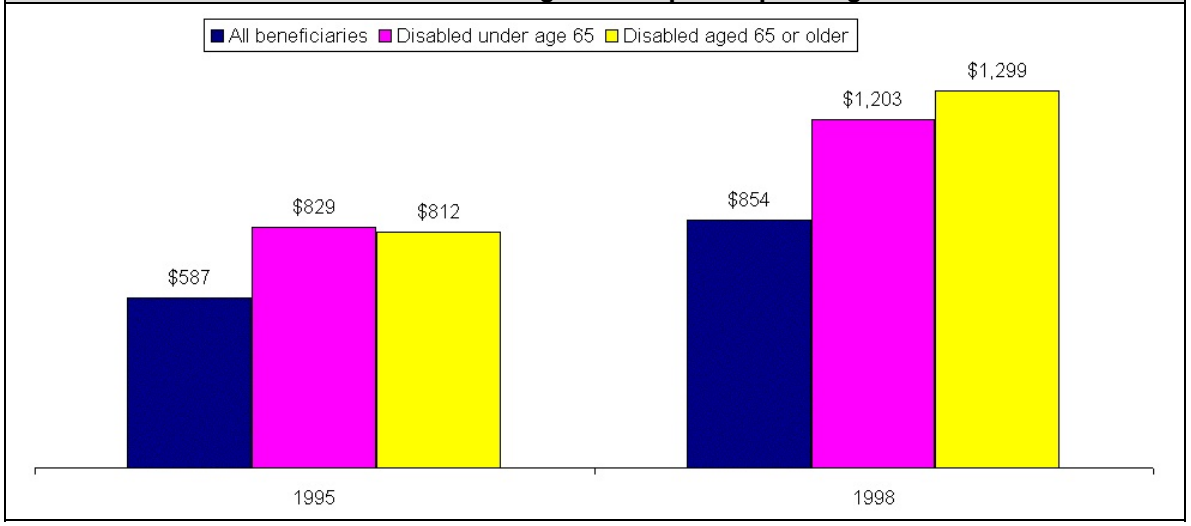
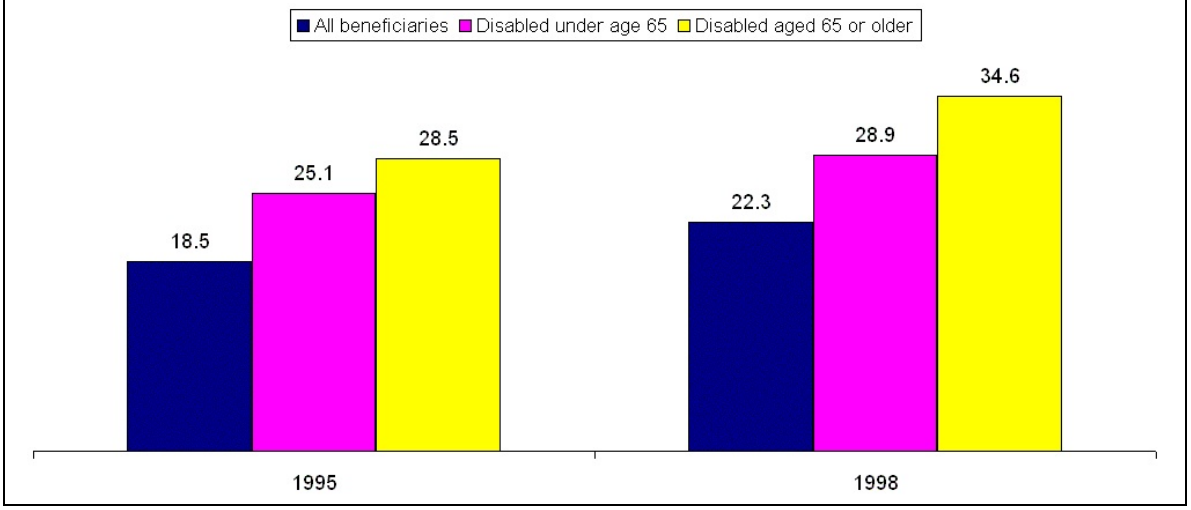


FIGURE 3. Average Prescription Spending



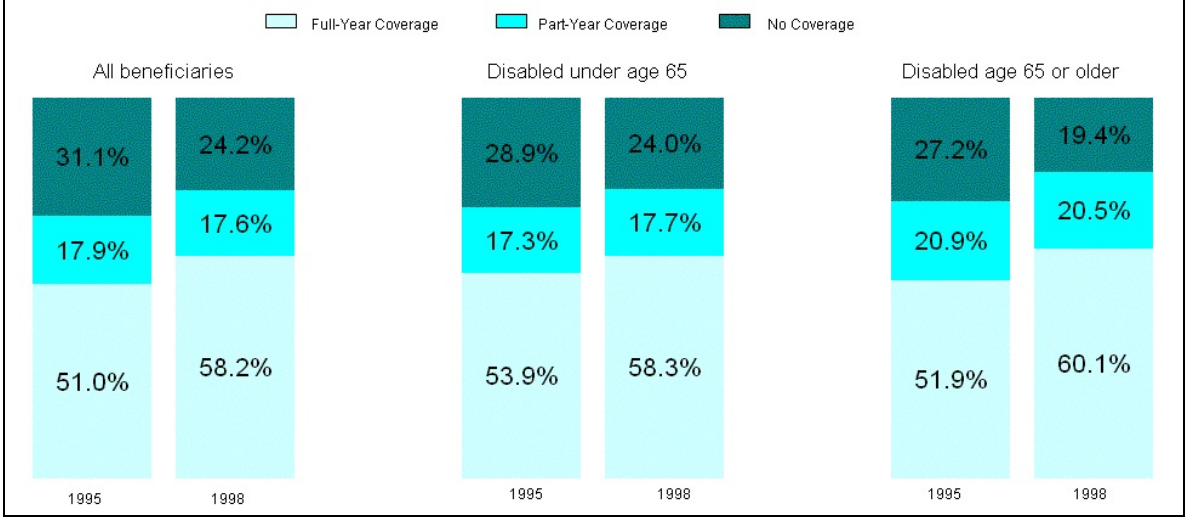
Disabled beneficiaries use many medications and their need increases as they get older. High levels of medication use are common to all Medicare beneficiaries but especially for the disabled who take even more medications as they get older. Younger disabled beneficiaries fill about 30 percent more prescriptions than the overall Medicare population. After age 65, this difference rises to over 50 percent. Between 1995 and 1998 medication use increased almost 20 percent across the entire Medicare population. For the disabled aged, average prescription use rose from 29 per year in 1995 to 35 in 1998.

FIGURE 4. Average Number of Prescriptions Filled in a Year



The proportion of Medicare beneficiaries with drug coverage grew in the last half of the 1990s for all entitlement groups. Both younger and older disabled beneficiaries are slightly more likely to have prescription drug coverage than other Medicare beneficiaries. Prescription coverage rates improved for every entitlement group between 1995 and 1998, but the gains were greater for the aged disabled. By 1998, over 80 percent of this group had some form of prescription coverage. However, aged disabled beneficiaries are also more likely to have gaps in their prescription benefits than either SSDI or aged non-disabled beneficiaries.

FIGURE 5. Rates of Drug Coverage

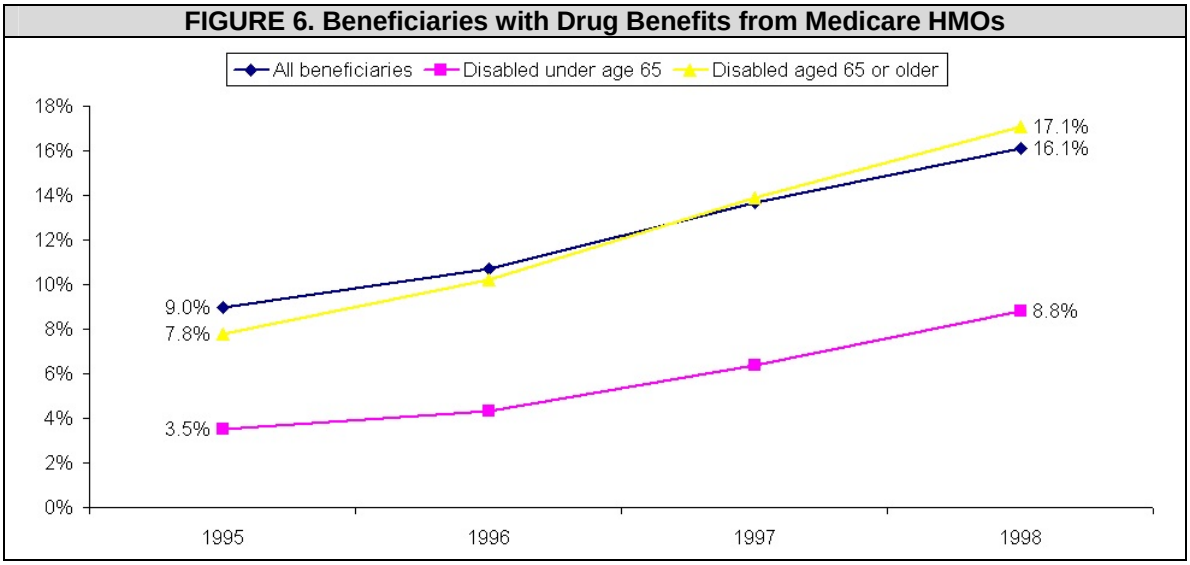


Sources of drug coverage differ greatly between older and younger disabled beneficiaries. The similarity in prescription coverage among younger and older disabled beneficiaries masks a major difference in source of drug benefits between the two groups. Before reaching their 65th birthdays, disabled beneficiaries rely heavily upon Medicaid as their main source of drug benefits, although this dependence dropped

dramatically between 1995 and 1998. In contrast, Medicaid enrollment among aged disabled persons is a third lower. This is not to say that aged disabled beneficiaries do not still rely upon Medicaid: they are twice as likely to have this form of drug coverage as other seniors. However, aged disabled beneficiaries have other options not as readily available to SSDI recipients, most notably through Medicare HMOs.

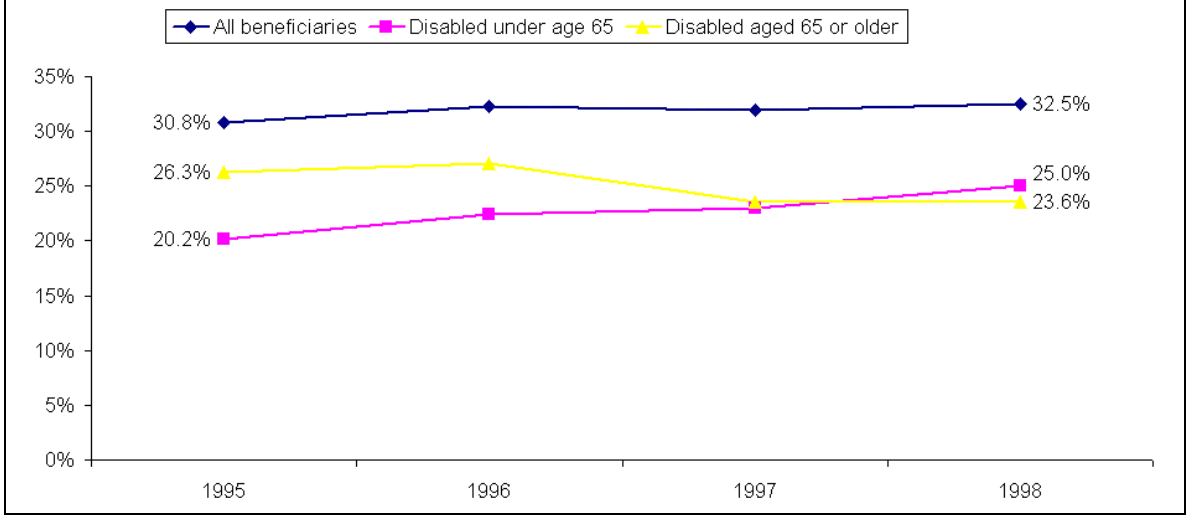
As shown in the next figure, enrollment in Medicare HMOs grew significantly from 1995 to 1998 for both groups of disabled, but the drug coverage (or prescription coverage) rates were twice as high among the aged disabled. By 1998 more than 17 percent of these beneficiaries received prescription benefits from Medicare HMOs, a percentage point above the average for all beneficiaries combined. In that year more aged disabled had drug benefits from managed care plans than from Medicaid.

FIGURE 6. Beneficiaries with Drug Benefits from Medicare HMOs



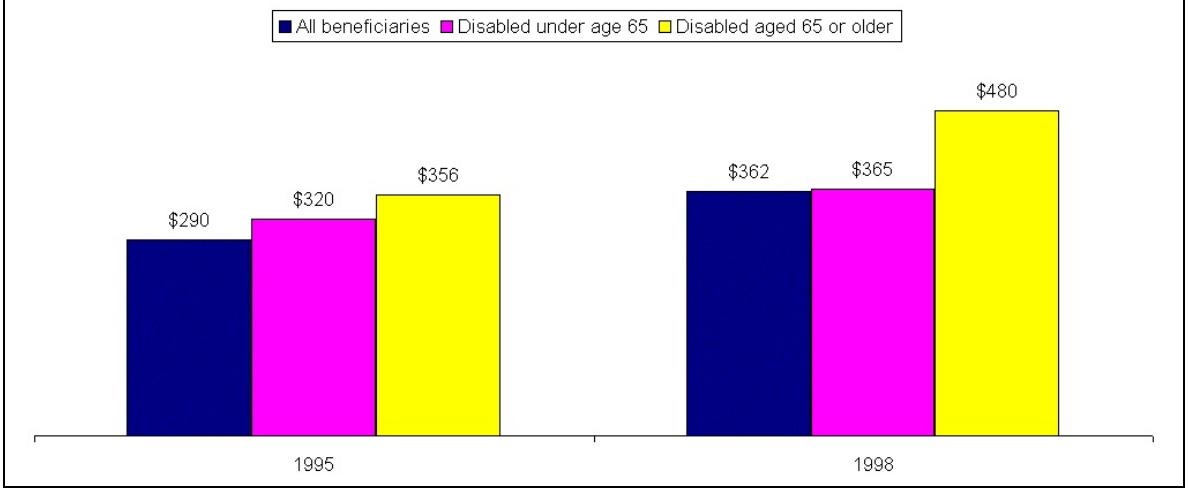
As a whole, the disabled Medicare population has fewer opportunities for prescription coverage from employer-sponsored plans compared to other beneficiaries. What opportunities there are also appear to be shrinking for aged disabled beneficiaries. In 1995, aged disabled beneficiaries were a third more likely to have drug benefits from employers compared to younger SSDI beneficiaries. However, after 1996, disabled seniors experienced a large decline in retiree drug coverage and by 1998 were actually less likely to have this type of coverage than SSDI recipients. The reasons for this unusual trend are unknown.

FIGURE 7. Beneficiaries with Drug Benefits from Employer-Sponsored Plans



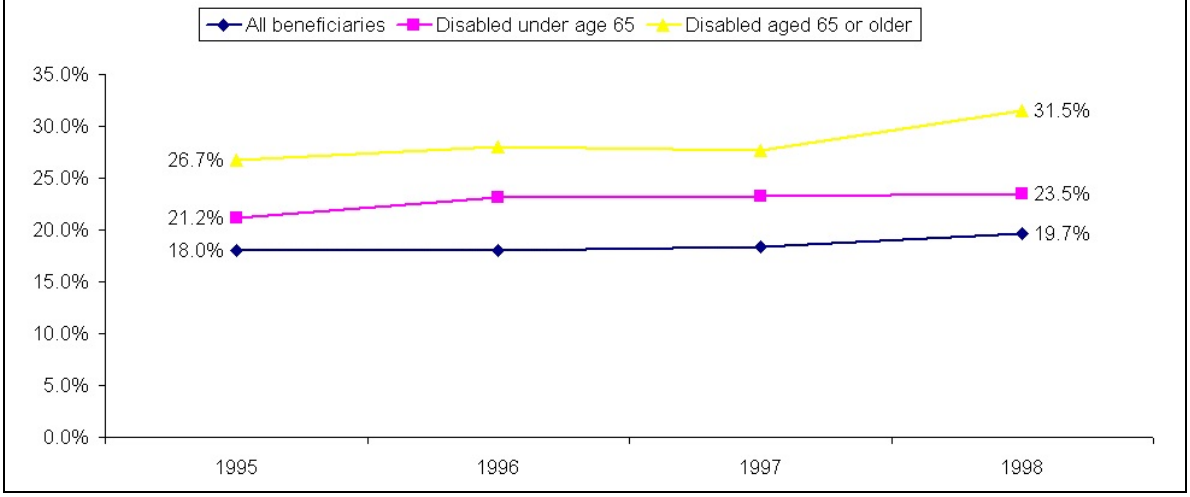
Rising levels of drug coverage have not insulated older disabled beneficiaries from the burden of rising drug costs. How good is the protection from high out-of-pocket costs afforded by different types of prescription coverage? The burden of out-of-pocket spending is especially important to disabled beneficiaries because most have very limited resources to pay for medical costs not covered by insurance. In 1998, over 70 percent of the entire disabled Medicare population lived below 200 percent of the federal poverty level compared to 50 percent of other beneficiaries (see appendix Table 1). As seen in the chart below, drug costs paid out-of-pocket by SSDI disabled beneficiaries are somewhat higher than the average for all Medicare beneficiaries, but there is a large percentage increase for aged disabled beneficiaries. Drug costs paid directly by beneficiaries grew during the late 1990s, impacting those individuals with the highest levels of prescription spending. Aged disabled beneficiaries experienced a 35 percent increase in average annual out-of-pocket spending on drugs between 1995 and 1998, compared to 14 percent for the younger disabled population, and 25 percent for the Medicare population overall.

FIGURE 8. Out-of-Pocket Drug Costs



Uncovered prescription costs drain resources of aged disabled beneficiaries. The limited incomes of disabled Medicare beneficiaries means that even modest amounts paid directly for prescription drugs can represent a burden. By 1998, for example, almost one in three aged disabled individuals spent more than 5 percent of their incomes on prescription drugs. This represents a five percentage point increase in the number of disabled aged 65 and older beneficiaries in just four years. By comparison, just under a quarter of younger SSDI disabled beneficiaries spent over 5 percent of their incomes on drugs in 1998. For the Medicare population as a whole the rate was under 20 percent that year.

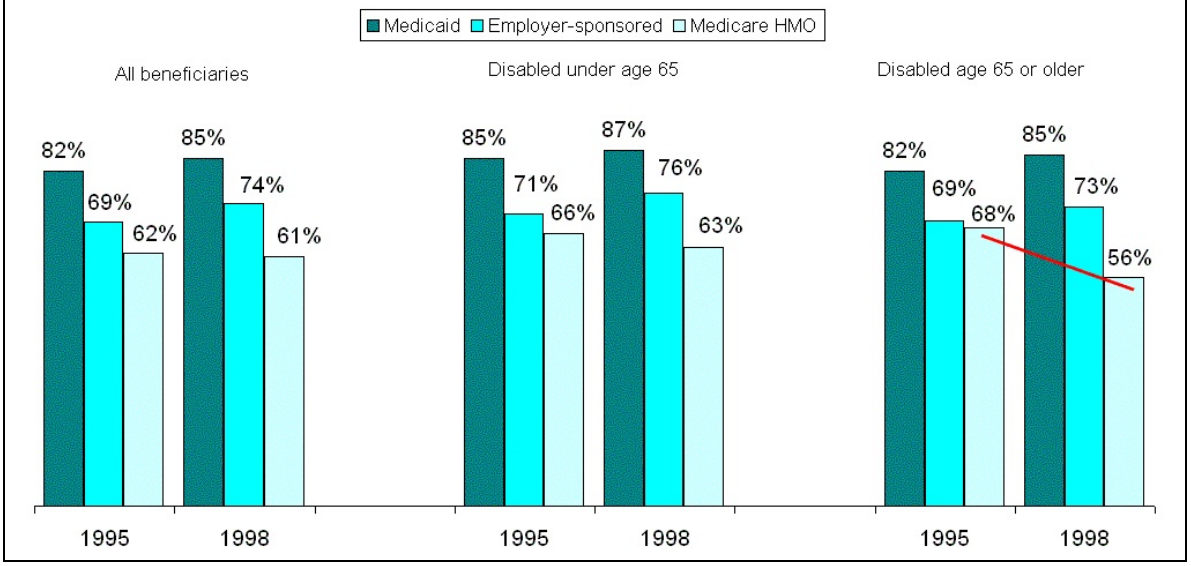
FIGURE 9. Beneficiaries Paying Over 5% of Their Incomes for Drug Costs



New sources of prescription coverage offer less protection than traditional sources. How can prescription coverage be growing yet the burden of out-of-pocket spending on drugs costs also be rising? The increases we see here reflect, at least in part, changes in drug coverage over the latter half of the decade of the 1990s. We have already shown that disabled beneficiaries tend to lose their Medicaid and employer-sponsored drug coverage after age 65 and gain it from Medicare HMOs. During the

study period, Medicaid and employer-sponsored plans paid relatively large portions of drug costs for covered beneficiaries (70-90 percent), while Medicare HMOs paid much less on average (around 60 percent). In fact, between 1995 and 1998, traditional coverage became more generous, while managed care plans cut back. This drop in drug coverage from Medicare HMOs affected older disabled beneficiaries the most (68 percent in 1995 to 56 percent in 1998).

FIGURE 10. Portion of Drug Costs Paid by Insurers



CONCLUSION

These data from the MCBS show that reaching age 65 brings added burdens to Medicare's disabled population. As they age, disabled beneficiaries bear an increasing burden of chronic illness, which spurs greater medication use and spending. However older beneficiaries have more limited access to traditionally generous sources of prescription coverage through Medicaid and employer-sponsored plans. Higher enrollment rates in Medicare HMOs help some, but these organizations offer more limited prescription coverage. As a result, the aged disabled bear higher out-of-pocket costs for drugs than other beneficiaries, a situation made worse by their limited economic resources.

APPENDIX

TABLE 1. Characteristics of Community-Dwelling Disabled and Aged Medicare Beneficiaries, 1998			
Characteristics	**All Beneficiaries**	**Disabled Beneficiaries**	
		Age <65	**Age 65 or Older**
All beneficiaries	38.0 million	4.8 million	2.1 million
Age			
<45	4.0	31.5	--
45-64	8.7	68.5	--
65-69	24.1	--	38.6
70-74	22.5	--	25.7
75-79	18.7	--	19.0
80+	22.1	--	16.7
Gender			
Female	55.6	42.5	47.7
Male	44.4	57.5	52.3
Race			
White	85.2	74.2	79.2
Black	9.0	16.7	15.8
Other	5.9	9.1	5.0
Hispanic Ethnicity			
Hispanic	7.0	11.3	7.2
Non-Hispanic	93.0	88.7	92.8
Income in Relation to Federal Poverty Level (FPL)			
<100% FPL	23.2	45.2	34.8
101-200% FPL	32.7	31.7	37.6
>200% FPL	44.1	23.1	27.7
Urban/Rural Residence			
Urban	75.0	70.9	72.6
Rural	25.0	29.1	27.4
Census Region			
Midwest	23.4	23.0	20.3
South	35.3	39.1	40.5
Northeast	20.8	18.1	18.5
West	18.8	16.8	17.8
Self-Reported Health			
Excellent	14.4	4.1	4.5
Very good	26.1	10.7	13.9
Good	31.5	25.6	32.9
Fair	18.7	32.9	27.6
Poor	9.0	26.3	21.0
Activities of Daily Living (ADLs)			
0	71.1	55.7	49.6
1-2	18.7	27.3	29.7
3-4	6.1	11.8	12.5
5-6	4.2	5.2	8.2
Instrumental ADL			
0	81.5	63.3	65.7
1-2	13.2	26.6	23.6
3-5	5.3	10.1	10.8

TABLE 1 (*continued*)			
Characteristics	**All Beneficiaries**	**Disabled Beneficiaries**	
		Age <65	**Age 65 or Older**
Self-Reported Chronic Conditions			
Mental disorder	8.1	36.3	11.0
Alzheimer's	2.6	1.3	3.0
Arthritis	58.3	52.0	73.9
Hypertension	54.2	46.0	65.3
Heart condition	40.5	34.6	61.3
Chronic lung disease	15.4	23.8	27.8
Cancer	29.9	19.5	34.5
Diabetes	16.3	19.0	27.7
Stroke	10.8	12.1	21.8
Osteoporosis	12.9	9.8	15.4
Number of Chronic Conditions			
None of the above	9.4	9.1	3.3
Only one	19.1	22.3	7.7
Two	24.8	22.8	17.9
Three	21.4	17.5	22.1
Four	14.8	14.3	24.8
Five or more	10.5	14.1	24.3
SOURCE: Medicare Current Beneficiary Survey, 1998			

TABLE 2. Status of Prescription Drug Coverage of Community-Dwelling Disabled and Aged Medicare Beneficiaries, 1995-1998			
Prescription Coverage Status[a]	**All Beneficiaries**	**Disabled Beneficiaries**	
		Age <65	**Age 65 or Older**
1995			
No Coverage	31.1%	28.9%	27.2%
Part-Year Coverage	17.9	17.3	20.9
Full-Year Coverage	51.0	53.9	51.9
1996			
No Coverage	28.4	26.8	22.3
Part-Year Coverage	18.9	17.8	23.4
Full-Year Coverage	52.7	55.4	54.3
1997			
No Coverage	25.4	22.4	20.9
Part-Year Coverage	19.4	19.3	23.7
Full-Year Coverage	55.2	58.3	55.4
1998			
No Coverage	24.0	22.4	19.4
Part-Year Coverage	17.7	18.8	20.5
Full-Year Coverage	58.3	58.8	60.1
a. Beneficiaries with part-year and full-year prescription coverage are calculated as proportions of the MCBS sample with Medicare entitlement for the entire year.			

TABLE 3. Sources of Prescription Drug Coverage of Community-Dwelling Disabled and Aged Medicare Beneficiaries with Prescription Coverage, 1995-1998			
Source of Prescription Coverage	**All Beneficiaries**	**Disabled Beneficiaries**	
		Age <65	**Age 65 or Older**
1995			
Employer-Sponsored	30.8%	20.2%	26.3%
Private Self-Purchased	10.9	3.9	6.4
Medicare HMO	9.0	3.5	7.8
Medicaid	12.4	35.1	19.9
Other Public	6.7	8.1	10.2
Some Coverage but not Reported	5.3	7.3	9.2
No Coverage	31.1	28.9	27.2
1996			
Employer-Sponsored	32.3	22.4	27.1
Private Self-Purchased	11.7	4.0	8.6
Medicare HMO	10.7	4.3	10.2
Medicaid	11.6	33.9	19.7
Other Public	6.2	7.2	10.3
Some Coverage but not Reported	6.5	7.7	11.0
No Coverage	28.4	26.8	22.3
1997			
Employer-Sponsored	31.9	23.0	23.6
Private Self-Purchased	11.6	3.8	10.8
Medicare HMO	13.7	6.4	13.9
Medicaid	12.0	32.7	22.1
Other Public	6.3	8.4	9.4
Some Coverage but not Reported	7.8	12.5	9.1
No Coverage	25.4	22.4	20.9
1998			
Employer-Sponsored	32.5	25.0	23.6
Private Self-Purchased	10.6	3.8	10.8
Medicare HMO	16.1	8.8	17.1
Medicaid	11.5	30.6	20.8
Other Public	6.5	8.5	10.9
Some Coverage but not Reported	7.2	10.4	9.3
No Coverage	24.0	22.4	19.4
SOURCE: Medicare Current Beneficiary Survey, 1995-1998			

TABLE 4. Mean Annual Prescription Drug Expenditures for Community-Dwelling Disabled and Aged Medicare Beneficiaries by Status and Source of Coverage, 1995-1998			
Status and Source of Prescription Coverage Status[a]	**All Beneficiaries**	**Disabled Beneficiaries**	
		Age <65	**Age 65 or Older**
1995			
No Coverage	$436	$524	$568
Part-Year Coverage	524	851	610
Full-Year Coverage	755	1,132	1,081
Employer-Sponsored	726	1,494	984
Private Self-Purchased	583	910	985
Medicare HMO	491	711	911
Medicaid	717	760	884
Other Public	807	919	1,013
Some Coverage but not Reported	603	824	648
ALL	587	829	812
1996			
No Coverage	468	516	621
Part-Year Coverage	623	980	923
Full-Year Coverage	827	1,340	1,140
Employer-Sponsored	786	1,526	1,165
Private Self-Purchased	668	1,117	1,028
Medicare HMO	544	1,092	934
Medicaid	631	1,066	1,043
Other Public	893	1,511	1,023
Some Coverage but not Reported	744	1,097	942
ALL	657	992	930
1997			
No Coverage	535	468	709
Part-Year Coverage	672	916	802
Full-Year Coverage	883	1,329	1,211
Employer-Sponsored	858	1,369	1,298
Private Self-Purchased	751	1,419	989
Medicare HMO	601	1,117	881
Medicaid	889	1,057	1,097
Other Public	962	1,471	1,189
Some Coverage but not Reported	710	736	713
ALL	720	964	978
1998			
No Coverage	520	486	716
Part-Year Coverage	753	1,278	1,073
Full-Year Coverage	1,042	1,590	1,640
Employer-Sponsored	1,036	1,566	1,960
Private Self-Purchased	880	1,354	1,373
Medicare HMO	688	1,247	1,003
Medicaid	1,158	1,403	1,478
Other Public	1,161	1,629	1,411
Some Coverage but not Reported	936	1,177	1,360
ALL	854	1,203	1,299

a. Beneficiaries with part-year and full-year prescription coverage are calculated as proportions of the MCBS sample with Medicare entitlement for the entire year.

TABLE 5. Mean Annual Number of Prescriptions Filled for Community-Dwelling Disabled and Aged Medicare Beneficiaries by Status and Source of Coverage, 1995-1998			
Status and Source of Prescription Coverage[a]	**All Beneficiaries**	**Disabled Beneficiaries**	
		Age <65	**Age 65 or Older**
1995			
No Coverage	15.9	18.6	23.0
Part-Year Coverage	18.5	28.5	25.4
Full-Year Coverage	21.7	31.9	34.7
Employer-Sponsored	18.8	35.8	29.5
Private Self-Purchased	17.4	22.7	32.5
Medicare HMO	16.6	24.1	29.9
Medicaid	25.5	25.8	33.0
Other Public	25.4	29.7	32.6
Some Coverage but not Reported	22.3	28.0	29.1
ALL	18.5	25.1	28.5
1996			
No Coverage	16.7	17.8	24.8
Part-Year Coverage	20.6	29.6	34.9
Full-Year Coverage	22.3	35.0	36.4
Employer-Sponsored	18.7	31.1	31.6
Private Self-Purchased	18.7	31.5	35.3
Medicare HMO	16.8	26.1	31.3
Medicaid	28.1	31.2	40.3
Other Public	26.6	43.0	34.3
Some Coverage but not Reported	25.5	33.4	36.9
ALL	19.5	27.4	31.9
1997			
No Coverage	17.3	16.1	27.1
Part-Year Coverage	21.8	27.8	29.1
Full-Year Coverage	23.8	34.2	36.6
Employer-Sponsored	20.2	30.9	32.2
Private Self-Purchased	20.5	28.9	30.4
Medicare HMO	19.8	31.6	30.8
Medicaid	29.3	30.2	39.8
Other Public	27.9	36.5	35.0
Some Coverage but not Reported	24.7	26.0	31.5
ALL	20.9	26.7	32.0
1998			
No Coverage	16.4	17.0	27.0
Part-Year Coverage	21.5	30.9	30.2
Full-Year Coverage	25.2	35.5	40.2
Employer-Sponsored	22.3	31.5	40.8
Private Self-Purchased	23.0	32.0	34.3
Medicare HMO	21.7	35.5	34.3
Medicaid	31.1	33.2	40.2
Other Public	29.4	36.0	37.3
Some Coverage but not Reported	25.6	28.9	34.0
ALL	22.3	28.9	34.6

a. Beneficiaries with part-year and full-year prescription coverage are calculated as proportions of the MCBS sample with Medicare entitlement for the entire year.

TABLE 6. Mean Annual Out-of-Pocket Prescription Drug Spending of Community-Dwelling Disabled and Aged Medicare Beneficiaries by Status and Source of Coverage, 1995-1998			
Status and Source of Prescription Coverage Status[a]	**All Beneficiaries**	**Disabled Beneficiaries**	
		Age <65	**Age 65 or Older**
1995			
No Coverage	$434	$521	$568
Part-Year Coverage	314	390	344
Full-Year Coverage	222	247	275
Employer-Sponsored	224	433	301
Private Self-Purchased	347	389	575
Medicare HMO	189	239	295
Medicaid	133	117	162
Other Public	273	290	266
Some Coverage but not Reported	330	317	302
ALL	290	320	356
1996			
No Coverage	468	516	622
Part-Year Coverage	357	451	436
Full-Year Coverage	219	254	279
Employer-Sponsored	213	385	321
Private Self-Purchased	388	516	575
Medicare HMO	167	272	320
Medicaid	146	169	143
Other Public	297	507	363
Some Coverage but not Reported	388	404	337
ALL	302	341	378
1997			
No Coverage	535	467	709
Part-Year Coverage	389	429	444
Full-Year Coverage	241	275	313
Employer-Sponsored	243	366	348
Private Self-Purchased	423	438	538
Medicare HMO	200	376	325
Medicaid	151	160	200
Other Public	333	420	427
Some Coverage but not Reported	388	330	364
ALL	332	327	416
1998			
No Coverage	519	486	715
Part-Year Coverage	392	492	491
Full-Year Coverage	281	316	426
Employer-Sponsored	275	375	533
Private Self-Purchased	511	601	731
Medicare HMO	270	464	445
Medicaid	179	190	216
Other Public	408	484	443
Some Coverage but not Reported	398	365	439
ALL	362	365	480

a. Beneficiaries with part-year and full-year prescription coverage are calculated as proportions of the MCBS sample with Medicare entitlement for the entire year.

TABLE 7. Percent of Annual Prescription Drug Expenditures of Community-Dwelling Disabled and Aged Medicare Beneficiaries Paid by Third Parties by Status and Source of Coverage, 1995-1998			
Status and Source of Prescription Coverage Status[a]	**All Beneficiaries**	**Disabled Beneficiaries**	
		Age <65	**Age 65 or Older**
1995			
No Coverage	0%	0%	0%
Part-Year Coverage	40.1	54.2	43.5
Full-Year Coverage	70.6	78.2	74.5
Employer-Sponsored	69.2	71.0	69.4
Private Self-Purchased	40.4	57.3	41.6
Medicare HMO	61.6	66.4	67.6
Medicaid	81.5	84.6	81.6
Other Public	66.1	68.4	73.7
Some Coverage but not Reported	45.2	61.6	53.4
ALL	50.5	61.4	56.2
1996			
No Coverage	0	0	0
Part-Year Coverage	42.6	54.0	52.8
Full-Year Coverage	73.6	81.0	75.5
Employer-Sponsored	72.9	74.8	72.4
Private Self-Purchased	41.9	53.8	44.1
Medicare HMO	69.3	75.1	65.7
Medicaid	82.9	84.1	86.3
Other Public	66.7	66.4	64.5
Some Coverage but not Reported	47.9	63.2	64.2
ALL	54.0	65.7	59.4
1997			
No Coverage	0	0	0
Part-Year Coverage	42.1	53.2	44.6
Full-Year Coverage	72.7	79.3	74.1
Employer-Sponsored	71.7	73.2	73.2
Private Self-Purchased	43.6	69.1	45.6
Medicare HMO	66.7	66.4	63.1
Medicaid	83.0	84.8	81.8
Other Public	65.4	71.4	64.1
Some Coverage but not Reported	45.4	55.1	48.9
ALL	53.9	66.1	57.5
1998			
No Coverage	0	0	0
Part-Year Coverage	48.0	61.4	54.3
Full-Year Coverage	73.1	80.1	74.0
Employer-Sponsored	73.5	76.1	72.8
Private Self-Purchased	41.9	55.6	46.8
Medicare HMO	60.8	62.8	55.7
Medicaid	84.5	86.5	85.3
Other Public	64.5	70.3	68.6
Some Coverage but not Reported	57.4	69.1	67.8
ALL	57.6	69.7	63.0

a. Beneficiaries with part-year and full-year prescription coverage are calculated as proportions of the MCBS sample with Medicare entitlement for the entire year.

TABLE 8. Ratio of Total Prescription Drug Spending to Income of Community-Dwelling Disabled and Aged Medicare Beneficiaries, 1995-1998			
Prescription Drug Expenditures as a Percent of Income	**All Beneficiaries**	**Disabled Beneficiaries**	
		Age <65	**Age 65 or Older**
1995			
No Prescription Expenditures	13.6	15.7	8.2
0-5% of Income	51.1	39.6	37.3
5-10% of Income	16.4	15.3	21.7
Greater than 10% of Income	18.9	29.3	32.8
1996			
No Prescription Expenditures	13.4	14.4	8.2
0-5% of Income	49.2	34.8	34.2
5-10% of Income	16.9	15.3	21.6
Greater than 10% of Income	20.5	35.5	36.1
1997			
No Prescription Expenditures	12.2	11.8	6.8
0-5% of Income	48.4	35.6	32.8
5-10% of Income	18.0	17.1	23.7
Greater than 10% of Income	21.4	35.6	36.8
1998			
No Prescription Expenditures	11.2	10.2	5.0
0-5% of Income	46.2	32.8	32.5
5-10% of Income	18.5	19.0	19.7
Greater than 10% of Income	24.2	38.0	42.8

TABLE 9. Ratio of Out-of-Pocket Drug Spending to Income of Community-Dwelling Disabled and Aged Medicare Beneficiaries, 1995-1998			
Prescription Drug Expenditures as a Percent of Income	**All Beneficiaries**	**Disabled Beneficiaries**	
		Age <65	**Age 65 or Older**
1995			
No Prescription Expenditures	16.5	23.1	12.2
0-5% of Income	65.6	55.8	61.1
5-10% of Income	10.2	11.3	14.0
Greater than 10% of Income	7.8	9.9	12.7
1996			
No Prescription Expenditures	16.1	21.0	12.1
0-5% of Income	65.8	56.0	60.0
5-10% of Income	10.3	10.8	16.8
Greater than 10% of Income	7.7	12.3	11.2
1997			
No Prescription Expenditures	14.9	19.2	10.9
0-5% of Income	66.7	57.6	61.3
5-10% of Income	10.5	12.6	15.2
Greater than 10% of Income	7.9	10.7	12.5
1998			
No Prescription Expenditures	13.6	17.6	7.8
0-5% of Income	66.7	58.8	60.8
5-10% of Income	11.0	12.9	14.5
Greater than 10% of Income	8.7	10.6	17.0

PRESCRIPTION DRUGS AND PEOPLE WITH DISABILITIES: A PRIMER FOR DATA AND RESEARCH

Reports Available

Medication Use by Medicare Beneficiaries Living in Nursing Homes and Assisted Living Facilities

HTML	http://aspe.hhs.gov/daltcp/reports/2002/meduse.htm
PDF	http://aspe.hhs.gov/daltcp/reports/2002/meduse.pdf

Medication Use in Long-Term Care Facilities and Community Settings for Medicare Beneficiaries with Cardiovascular Disease

HTML	http://aspe.hhs.gov/daltcp/reports/2002/cdmeduse.htm
PDF	http://aspe.hhs.gov/daltcp/reports/2002/cdmeduse.pdf

The Graying of Medicare's Disabled Population: Implication for a Medicare Drug Benefit

Executive Summary	http://aspe.hhs.gov/daltcp/reports/2002/grayinges.htm
HTML	http://aspe.hhs.gov/daltcp/reports/2002/graying.htm
PDF	http://aspe.hhs.gov/daltcp/reports/2002/graying.pdf

To obtain a printed copy of this report, send the full report title and your mailing information to:

U.S. Department of Health and Human Services
Office of Disability, Aging and Long-Term Care Policy
Room 424E, H.H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201
FAX: 202-401-7733
Email: webmaster.DALTCP@hhs.gov

RETURN TO:

Office of Disability, Aging and Long-Term Care Policy (DALTCP) Home
[http://aspe.hhs.gov/_/office_specific/daltcp.cfm]

Assistant Secretary for Planning and Evaluation (ASPE) Home
[http://aspe.hhs.gov]

U.S. Department of Health and Human Services Home
[http://www.hhs.gov]