Medicare Prescription Drug Improvement and Modernization Act: Comparing the Benefits in Metropolitan and Rural Communities

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The Medicare Prescription Drug Improvement and Modernization Act (MMA), signed into law by President George W. Bush on December 8, 2003, aids primarily individuals age 65 or older and individuals with disabilities by offering a prescription drug program. This research compares the awareness and utilization of benefits of the Prescription Drug Discount Card between individuals in metropolitan and rural communities in Alabama. Findings were obtained from questionnaires administered by community health advisors and are discussed in the context of other research suggesting individuals in the metropolitan areas are better served by the MMA.

The Medicare Prescription Drug Improvement and Modernization Act (MMA) was signed into law December 8, 2003, by President George W. Bush. The bill was created, in part, to offer seniors and individuals with disabilities a prescription drug benefit program, which begins in 2006.[1] The MMA provided immediate assistance in the form of drug credits which began in 2004, with an annual maximum amount of $600 each year available through December 31, 2005, for qualifying participants. The MMA is intended to reach economically disadvantaged areas, especially rural areas. One concern, however, is that information dissemination and the use of prescription drug discount cards may not be as accessible nor utilized as often by rural versus metropolitan residents. For example, individuals in metropolitan communities may have better access to resources such as pharmacies participating in the prescription drug discount pro-

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grams offered by the MMA. Although not everyone is eligible for credit, the Medicare-approved drug discount card, which provides medication discounts based upon contracted pricing agreements with drug companies, is available for Medicare beneficiaries through December 31, 2005.[2]

Medicare

Before MMA. Medicare is a government health insurance program for the elderly and disabled. An individual must be at least 65 years old or be disabled to qualify for benefits. Most recent Social Security Trustees Reports note that 34.6 million elderly and 6 million disabled individuals are enrolled in the mandatory Part A program, and 32.9 million elderly and 5.2 million disabled individuals are enrolled in the voluntary Part B.[3]

Part A of Medicare is mandatory hospital insurance, which includes room, board, and prescription drugs furnished by a hospital, and which supplies extended care for up to 100 days following a hospital stay. Part A also pays for other hospital costs, as well as nursing, hospice, and home health care following the payment of a deductible and coinsurance. Part B of Medicare, supplemental medical insurance, requires the payment of a premium of $66.40 per month after the age of 65. Part B also has an annual deductible of $100, and individuals in this program must pay 20 percent of the cost of most services rendered. This part of the Medicare plan covers the cost of doctors and surgeons.[3] Under Part A and Part B of Medicare, there is no provision for prescription drug benefits.

Today. The new Medicare Prescription Drug Improvement and Modernization Act of 2003 is intended, in part, to help alleviate the financial pressures caused by medical expenses. The key provisions of the new law are a prescription drug benefit, a wellness benefit, a Part B premium subsidy, a Health Savings Account, and increased privatization amongst providers.[3]

Prescription Drug Benefit

The current study deals primarily with the prescription drug benefit and its impact on metropolitan and rural communities. Previously, the Medicare program did not offer any assistance in the purchasing of prescription drugs. Seniors were able to receive drugs at low-to-minimal cost only when hospitalized. Accordingly, many seniors were paying hundreds of dollars each month for medications. As a temporary measure to alleviate some of the financial burdens associated with the cost of prescription drugs, MMA offers clients a drug card that enables them to save money.

Starting January 1, 2006, individuals enrolled in Medicare will be offered the option of purchasing prescription drug insurance. Medicare recipients will also be allowed to receive Medical Advantage plans, which will allow them to be enrolled in a private HMO or PPO that will offer the prescription drug benefit, as well as other medical benefits.[3]

Privatization. The MMA requires that all the new drug benefits be offered only through private insurers. This should lead to increased competition, but no one knows yet what will be the outcome. Because of increased privatization, premiums and coverage will vary for the medical plans, as well as for the geographic regions.

The newly formed MMA legislation seems likely to be more beneficial to individuals in metropolitan areas than in rural areas. This situation is significant because the MMA is intended to primarily aid individuals in rural communities; several provisions pertain specifically to the enhancement of health care in rural areas. Well-documented disparities in the use of health and service providers between rural and metropolitan populations[4] and between racial and ethnic groups[5-7] have raised concerns among rural community leaders about the effect of the MMA.

Need for MMA Benefits in Rural Settings

It is important for elderly individuals in rural communities to have a prescription drug benefit for many reasons:

1. Rural elderly are more likely than urban residents to develop chronic, life-threatening health conditions, such as diabetes or hypertension, for which medications are critical to reducing morbidity and mortality.
2. Even though the rural elderly have a greater need for prescription medications, they are more likely than the urban elderly to lack prescription drug coverage.
3. Because the elderly in rural communities have poorer prescription drug coverage but greater utilization of prescriptions drugs, they experience higher annual out-of-pocket expenses for their prescription drugs than do the elderly in metropolitan communities.
4. Furthermore, the burden of prescription drug expenditures upon the rural elderly is compounded by the typically lower personal incomes among the rural elderly.

If the benefits of the Medicare Modernization Act of 2003 are not being utilized by individuals in rural communities, these individuals will continue to suffer disproportionately from the out-of-pocket expenses incurred for prescription drugs.[8]

Implications of MMA for Rural and Metropolitan Areas

According to the Walsh Center for Rural Analysis,[9] individuals living in rural communities will have a more limited choice of prescription drug plans than individuals in metropolitan communities because of the shortage of providers in rural communities. Many individuals in rural communities will be forced to use “fallback” plans, which provide only standard prescription drug coverage, not other, supplemental, benefits.

It is important to note that individuals in both metropolitan and rural communities likely will continue to participate in a trend toward mail order delivery, which could possibly affect rural pharmacies because their markets would shrink. Moreover, it is possible that many rural health care facilities and providers will not have adequate access to the technology used to process prescriptions electronically, which could leave small rural pharmacies at a further disadvantage. Metropolitan communities are more likely to have the technology necessary to provide electronic processing; therefore, the urban providers should not be adversely affected.[3]

The Current Study

At present, no one really knows how the implementation of the MMA is benefiting recipients; no data are available. To help provide some insight, the current research explored how the MMA is affecting consumers located in both rural and metropolitan areas of western Alabama. Approximately 60 percent of all Alabamians reside in rural areas, but less than 20 percent of the state’s physicians practice in these areas. One consequence is that 38 percent of Alabama’s rural population resides in federally designated “professional primary health care shortage” areas.[10] The state of Alabama has a projected annual Medicaid prescription drug expenditure of $1,958 per eligible couple having full Medicaid benefits, which is the second lowest in the nation.[11] Individuals in Alabama are especially in need of a prescription drug program due to the lack of resources available to them. Furthermore, 14 percent of elderly individuals from rural communities purchase more prescription drugs than do elderly individuals in metropolitan communities.[12] This research attempted to determine what proportions of eligible seniors are currently enrolled in the MMA prescription drug discount program and whether accessibility to participating pharmacies differs for individuals in metropolitan versus rural communities. It was hypothesized that individuals in rural areas will be affected by this act differently than those in urban areas. Another goal of this study was to help inform community members of the steps necessary to ensure that the

MMA is being utilized by individuals in impoverished communities, rural and urban. The following specific research questions were addressed:

1. Is there greater awareness of MMA in metropolitan or rural communities?
2. What percentage of individuals surveyed in metropolitan communities versus those surveyed in rural communities enrolled in the new Medicare prescription drug discount program?
3. Is access to care a contributing factor affecting utilization of MMA benefits for Medicare beneficiaries living in rural areas more than in metropolitan communities?
4. What is the amount saved by being enrolled in the MMA?

Method

Participants

The Medicare Modernization Act deals exclusively with issues that concern participants in the federal Medicare program. This investigation sampled seniors eligible for Medicaid and individuals who would be affected by the act, that is, those eligible for the Medicare program (i.e., those over 65 years of age or disabled). We targeted participants living in one of Alabama's more rural areas, the Black Belt region, and the Birmingham/Tuscaloosa metropolitan areas. The Black Belt consists of 19 contiguous counties centrally located in Alabama. The Birmingham/Tuscaloosa metropolitan areas have a combined population of about 830,000 and are also centrally located in Alabama.

The Black Belt counties were selected for the current study because the Medicare Modernization Act of 2003 has several provisions that deal solely with the improvement of health care and access to health care in rural areas. The Birmingham/Tuscaloosa metropolitan areas were chosen for this study because they make up the largest metropolitan area in the state of Alabama.

Procedure

This study was conducted with the cooperation of the Deep South Network, whose purpose is to eliminate the disparity in death rates between blacks and whites in the Deep South by utilizing the existing relationships of their community health advisors. These Community Health Advisors Research-Partners (CHARPs) distributed questionnaires to participants in both areas. Members of CHARPs have National Institutes of Health

ethics training and a trusting relationship with the participants contacted for this study. CHARPs were instructed to distribute the questionnaire only to individuals age 65 or older, who could read and understand written English. In addition, individuals had to consent to participate by returning the questionnaire. Individuals not meeting the criteria did not receive a questionnaire. MMA is not a focus of the Deep South Network, so none of the participants had received information about the MMA or related assistance from the Deep South Network or CHARPS.

Questionnaire

A questionnaire (see Appendix A) consisting of 13 items whose goal was to examine the knowledge, awareness, and utilization of benefits of the MMA was created using the Delphi process. That is, individuals experienced in the area, including an experienced health care researcher and a faculty member from the Auburn University School of Pharmacy, reviewed a concept draft of the questionnaire and contributed changes or additions. The questionnaire was then pre-tested on a convenience sample of persons similar to the target population but who did not live in those areas. The questionnaire was refined based on these results. Three hundred questionnaires were distributed, 150 in Alabama's Black Belt and 150 in the Birmingham/Tuscaloosa metropolitan areas. Individuals were given a pre-addressed stamped envelope in which to return the questionnaire; consent was assumed upon completion and returning of the questionnaire.

Results and Discussion

Data Analysis

The data from the returned questionnaire were entered into a secure computer database created for data management using Perseus Survey Solutions. Data were analyzed using Statistical Package for Social Sciences (SPSS); cross tabs and frequency tables were created. Forty-two questionnaires from rural participants and 60 questionnaires from metropolitan participants were received, for a response rate of around 34 percent.

Findings

The results (see Appendix B) showed that approximately 81 percent of the rural population and 80 percent of the metropolitan population surveyed had received information regarding the new Medicare prescription drug discount program. Thus, the percentages of awareness were fairly similar in both geographic regions.

The results showed that approximately 55 percent of the rural population and 27 percent of the metropolitan population surveyed are enrolled in the new Medicare prescription drug discount program. Contrary to expectations, more people in the rural communities than in metropolitan communities are enrolled in the program.

Results showed that approximately 69 percent of the rural population and 42 percent of the metropolitan population must travel more than 10 miles to see a doctor. Moreover, only 14 percent of individuals in the rural population travel less than 10 miles to visit a doctor, whereas 57 percent of individuals in the metropolitan population travel less than 10 miles to do so. As hypothesized, individuals in the metropolitan communities have easier access to health care facilities. Similar statistics were found regarding the distance traveled to a pharmacy.

Findings about the amount of savings from prescription drug discount cards are inconclusive due to lack of response to the question.

Discussion

The results from this study were most surprising. A greater percentage of individuals from the rural population surveyed are enrolled in the new Medicare prescription drug discount program compared to the metropolitan population surveyed, even though they are located farther away from health care facilities, such as doctors' offices and pharmacies. The data contradicted the literature in that there was a greater percentage of individuals in rural communities than in metropolitan communities enrolled in the MMA. Future research should extend outside the state of Alabama and consist of a larger participant pool.

References

1. Carlson S, Dosch R, Hansen K. Medicare Prescription Drug Act of 2003. *The CPA Journal*. 2004; 74:62-65.

2. Allendorf L, Emmer, S. The Medicare Prescription Drug Improvement and Modernization Act of 2003. *JAGS* 2004; 52:1013-1015.

3. Bajtesmit, VL. The Medicare Prescription Drug Improvement and Modernization Act of 2003: What Does It Mean for Your Clients? *Journal of Financial Service Professionals*. 2004; 58:49-56.

4. Beachler M, Holloman C, Herman J. Southern rural access program: An overview. *Journal of Rural Health*. 2003; 19S:301-7.

5. Gormick ME. A decade of research on disparities in Medicare utilization: Lessons for the health and health care of vulnerable men. *American Journal of Public Health*. 2003; 93(5):753-759.

6. Smedley B, Stith A, Nelson A. (eds). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. National Academies Press 2003. Washington, DC.

7. Mayberry R, Mili F, Ofili, E. Racial and ethnic differences in access to medical care. *Medical Care Research and Review.* 2000; 57(1):108-145.

8. Coburn, AF, Ziller EC. *Designing a Prescription Drug Benefit for Rural Medicare Beneficiaries: Principles, Criteria, and Assessment*. A Joint Policy Paper of the Maine Rural Health Research Center and the Rural Policy Research Institute, Rural Health Panel. 2000; P2000-14.

9. Mueller C, Mueller K, Sutton J. *A Rural Perspective Regarding Regulations Implementing Titles I and II of the Medicare Prescription Drug Improvement and Modernization Act of 2003*. A Joint Publication of the Walsh Center for Rural Health Analysis and the Rural Policy Research Institute, Rural Health Panel. 2004; P2004-6.

10. Dunkelberger J, Zaworksi L. Taking the Pulse of Health Care. Highlights AAES. Summer 2001; 48.

11. Dale SB, Veridier J. *State Medicaid Prescription Drug Expenditures for Medicare-Medicaid Dual Eligibles*. 2003. The Commonwealth Fund.

12. Agency for Healthcare Research and Quality. Medical expenditure panel survey: MEPS HC-011, 1996 preliminary person level expenditure. 2000.

Appendix A

Questionnaire

Circle or fill in the appropriate answer.

1. What county do you live in? ______________________________

2. Is Medicare your insurance provider? Yes or No

3. Are you signed up in the Medicare Discount Drug Card Program? Yes or No

4. Have you heard of the Medicare Prescription Drug Program? Yes or No

    4a. If yes, how did you hear about the program?
    (Place a check √ by all that apply)
    ___ Doctor
    ___ Family
    ___ Friend
    ___ Media (radio, newspaper, television)

5. Are you currently taking any prescription drugs? Yes or No

6. Do you currently have a Medicare Discount Drug Card? Yes or No

    6a. If you have a Medicare Discount Drug Card, do you believe you pay less money for your prescriptions because of the Card? Yes or No

    6b. Approximately how much money (in dollars) do you think you save each month because of the card? ____________________

7. How often do you visit a doctor? (Circle one)
    Monthly
    Every six months
    Once a year
    Only when I am sick

8. How far do you have to travel to see a doctor? (Circle one)
    Less than 10 miles
    More than 10 miles
    Other_____________

9. How far do you have to travel to the pharmacy or drug store?
   Less than 10 miles
   More than 10 miles
   Other_____________

10. How do you get to the doctor and or pharmacy?
    Drive yourself
    Family or Friends
    Other_____________

11. What is your gender?
    Male
    Female

12. What is your race?
    Black/African American
    White
    Other_____________

13. Circle the highest number of years you have completed in school.
    Less than high school
    High school/GED
    College

Thank you for participating in this project. You may tear off this sheet and keep it for your information.

For more information about this study you may contact me, Maurice Parrom, or Dr. Higginbotham at 205.348.0025.

If you have questions about the Medicare Modernization Act you can see the Center for Medicare and Medicaid Services website at www.cms.hhs.gov/medicarereform/ or contact your pharmacist.

Thank you again for your help.

Maurice Parrom

Appendix B

Participant Responses to Questionnaire Items

Questions	Rural		Urban	
	n	%	n	%
1. What county do you live in?	42		60	
2. Is medicare your insurance provider?				
Yes	39	93	46	77
No	2	5	14	23
3. Are you signed up in the Medicare Discount Drug Card Program?				
Yes	23	55	16	27
No	16	38	28	47
4. Have you heard of the Medicare Prescription Drug Program?				
Yes	34	81	48	80
No	7	17	11	18
4a. If yes how did you hear about the program?				
Doctor	9	21	9	15
Family	4	10	4	7
Friend	9	21	7	12
Media (radio, newspaper, television)	13	31	24	40
5. Are you currently taking any prescription drugs?				
Yes	40	95	54	90
No	0	0	6	10
6. Do you currently have a Medicare Discount Drug Card?				
Yes	16	38	18	30
No	20	48	37	62
6a. If you have a Medicare Discount Drug Card, do you believe you pay less money for your prescription because of the card?				
Yes	16	38	16	27
No	1	2	10	17
7. How often do you visit a doctor?				
Monthly	27	64	18	30
Every six months	9	21	36	60
Once a year	3	7	2	3
Only when I am sick	3	7	3	5
8. How far do you have to travel to see a doctor?				
More than 10 miles	29	69	25	42
Less than 10 miles	6	14	34	57
Other	5	12	0	0

9. How far do you have to travel to the pharmacy or drug store?				
More than 10 miles	32	76	6	10
Less than 10 miles	6	14	49	82
Other	3	7	4	7
10. How do you get to the doctor and or pharmacy?				
Drive yourself	16	38	21	35
Family or Friends	22	52	38	63
Other	1	2	2	3
11. What is your gender?				
Male	10	24	13	22
Female	29	69	47	78
12. What is your race?				
Black	36	86	59	98
White	5	12	1	2
13. Circle the highest number of years you have completed in school.				
Less than high school	23	55	18	30
High school/GED	9	21	31	52
College	9	21	10	17