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An Assessment of Proposals for a Medicare Outpatient Prescription Drug Benefit: The Rural Perspective

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Table of Contents

Page

Executive Summary....1

Analysis of Proposed Legislation....6

Equity....6

Access....9

Costs....13

Quality....18

Choices....23

References....29

RUPRI Rural Health Panel....30

Recent Health Policy Documents....32

RUPRI Mission, Vision, and 2003 Program of Work....33

List of Tables

Table 1. Summary of Provisions Affecting Rural Health Care Delivery....2
Table 2. Equity: An Assessment of Provisions....8
Table 3. Access: An Assessment of Provisions....11
Table 4. Costs: An Assessment of Provisions....16
Table 5. Quality: An Assessment of Provisions....21
Table 6. Choices: An Assessment of Provisions....26

Executive Summary

This *Policy Paper* assesses legislative proposals to add an outpatient prescription drug benefit to the Medicare program and their implications for the delivery of services and the welfare of beneficiaries in rural areas. Included are comments on five proposals introduced in the 107th Congress: one that was passed by the House of Representatives, an alternative proposed in the House, and three that were voted on, but did not pass, in the Senate (to advance a proposal in the Senate required 60 votes). These proposals are:

- H.R. 4954, the "Medicare Modernization and Prescription Drug Act of 2002" (passed by the House of Representatives on June 28, 2002)

- H.R. 5019, the "Medicare Rx Drug Benefit and Discount Act of 2002" (introduced on June 17, 2002); supported by House Democrats

- S. 2625, the "Medicare Outpatient Prescription Drug Act of 2002" (introduced on June 14, 2002); introduced by Senator Graham (and other Democratic Senators)

- S. 2729, the "21st Century Medicare Act" (introduced on July 15, 2002); introduced by Senator Grassley (and others from both parties, and Senator Jeffords)

- Introduced as an Amendment to S. 812 (Generic Drug legislation), the "Medicare Prescription Drug Discount and Security Act of 2002" (introduced on July 16, 2002); introduced by Senators Hagel, Ensign, Lugar, and Gramm

This analysis identifies specific provisions in these proposals but does not assess the overall merits of each proposal. The provisions of competing proposals are analyzed using principles, developed by the Panel[1] in May 2001 to analyze proposals for Medicare redesign (SM-1, RUPRI Rural Health Panel, 2001), that focus on equity, access, costs, quality, and choices. Building on these principles, the *Paper* assesses the key features of these proposals against a set of criteria patterned after but not the same as those used in the Panel's previous analysis of outpatient prescription drug proposals, completed jointly with the Maine Rural Health Research Center (P2000-14, Coburn & Ziller, 2000).

Table 1 (see page 2) identifies provisions in the various legislative proposals that are either consistent or inconsistent with these principles and criteria.

[1]Rural Policy Research Institute (RUPRI) Rural Health Panel

Table 1. Summary of Provisions Affecting Rural Health Care Delivery

Principle: Equity. The Medicare program should maintain equity vis à vis benefits and costs among its beneficiaries, who should be neither disadvantaged nor advantaged merely because of where they live.

Criterion	Provisions Consistent With The Criterion	Provisions Inconsistent With The Criterion
Rural beneficiaries should have opportunities to enroll in plans that include outpatient prescription drug benefits comparable to those available to urban beneficiaries.	• The same basic prescription drug benefit will be available to all beneficiaries. • A basic benefits plan must be guaranteed in all locations. • Plans shall provide beneficiaries with access to negotiated prices, regardless of whether they are covered with respect to those drugs.	• Coverage of all areas is not mandated if only incentives will be used to attract health plans to underserved areas. • The outpatient prescription drug benefit will take a market-based approach.

Principle: Access. The Medicare program should ensure that beneficiaries have reasonable access to all medical services, including having essential services within a reasonable distance/time of their residence and being able to afford medically necessary services.

Criteria	Provisions Consistent With The Criteria	Provisions Inconsistent With The Criteria
Rural beneficiaries must have access to at least one plan and preferably a choice of plans that offer actuarially comparable benefits to those offered in urban areas.	• Pharmacy benefit managers (PBMs) must cover service areas no smaller than a state. • Incentives can be provided to entice PBMs to expand service areas to smaller rural areas. • The Secretary must assure that there are at least two plans in each eligible beneficiary's area. • The Secretary must develop procedures to provide coverage for beneficiaries that reside in areas not covered by any contracts.	• The Secretary will develop procedures for providing a catastrophic coverage benefit in areas where prescription drug discount cards are not offered.
The Medicare outpatient prescription drug benefit should not undermine rural Medicare beneficiaries' access to local pharmacy services.	• PBMs should ensure that local pharmacies have a reasonable opportunity to participate as providers. • The Secretary shall give special attention to access, pharmacy counseling services, and delivery in rural and hard-to-serve areas through the use of incentives to pharmacists. • Contractors must take into account pharmacies' resources and time used in implementing the program when establishing pharmacy dispensing fees, so that rural pharmacies can afford to participate.	

Principle: Costs. The Medicare program should include mechanisms to make the costs affordable, both to beneficiaries and to the taxpayers financing the program.

Criteria	Provisions Consistent With The Criteria	Provisions Inconsistent With The Criteria
The benefit structure of the outpatient prescription drug program should be structured so that it simultaneously balances the goals of cost containment and affordability for the rural Medicare beneficiary. The goal of cost containment can be achieved by the judicious use of (a) deductibles, (b) coinsurance rates, and (c) premiums.	• Deductible, copayment, and premium provisions are included.	
Proposals should enact (d) reasonable out-of-pocket limits and (e) subsidize the premiums. These provisions are especially important to rural residents because a greater proportion of rural beneficiaries have lower heath status as compared to urban beneficiaries.	• Out-of-pocket costs for most Medicare beneficiaries will be lower relative to the status quo for the many beneficiaries who currently have either no prescription drug coverage or limited coverage. • Appropriate low-income subsidies are included.	• Some proposals have provisions that impose high out-of-pocket costs on Medicare beneficiaries.
Proposals should be structured to provide protection against rapid growth in prescription drug prices, necessary to meet the goals of cost containment for the program and affordability to the taxpayer.	• Formularies and negotiations are used to control prices.	

Principle: Quality. The Medicare program should promote the highest attainable quality of care for all beneficiaries, defined in terms of health outcomes for beneficiaries.

Criteria	Provisions Consistent With The Criteria	Provisions Inconsistent With The Criteria
The outpatient prescription drug benefit shall include quality standards and programs to improve rural health outcomes.	• Quality standards and quality assurance measures, including medication therapy management, will be established.	
Rural provider organizations should have access to resources and mechanisms for training personnel and implementing rural-appropriate quality assurance and improvement systems.	• Providers, pharmacies, and enrollees will be educated with regard to formulary and inappropriate prescribing.	
Rural provider organizations should have access to resources and mechanisms to acquire and develop information systems. Associated computer and telecommunications infrastructure requirements shall be appropriate for rural provider system size and scope.	• Specific funding is provided for information systems and infrastructure development to support quality improvement provisions.	• Information systems and infrastructure development are not supported with designated funding.
Advisory committees considering infrastructure issues shall include members sensitive to the rural challenges of implementing and operating a rural Medicare outpatient prescription drug benefit.	• Rural representatives are required on committees that advise quality improvement strategies.	• Advisory committees may be constituted without rural representatives.

Principle: Choices. The Medicare program should ensure that all beneficiaries have comparable choices available to them—among health care plans (e.g., benefits covered and out-of-pocket expenses potentially incurred) and among health care providers.

Criteria	Provisions Consistent With The Criteria	Provisions Inconsistent With The Criteria
If the outpatient prescription drug benefit proposal is predicated upon offering beneficiaries a choice of privately sponsored plans as a central principle of the proposal, then rural beneficiaries should have a choice of these plans available to them.	• See *Access* principle, first criteria.	• See *Access* principle, first criteria.
Choice of pharmacists should be assured. This will require offering at least one option in reasonable proximity to the beneficiary (in the closest community) and at least one option that is the low-cost choice available through the plan, which may include mail-order.	• Plans are required to contract with any provider willing to meet their conditions and must allow beneficiaries to obtain prescription drugs from any provider, sometimes paying extra for that choice (point-of-service).	• The point-of-service option alone does not constitute adequate choice.
Private plans applying to provide or manage the outpatient prescription drug benefit should be required to provide proof of long-term solvency, so that rural beneficiaries have consistent choices available to them.	• Plans must meet minimum solvency standards.	
Enrollment periods need to be of sufficient length to allow beneficiaries unfamiliar with choosing among alternative plans (disproportionately rural beneficiaries) to make informed decisions.	• Beneficiaries will have time to make an enrollment decision that is at least equivalent to the current Part B time line.	
Educational activities should allow for the unique characteristics of rural areas and permit education by those most familiar with these characteristics. Local civic groups and area agencies on aging are likely candidates to provide education to rural beneficiaries.	• Plans must provide beneficiaries with benefit information that the Medicare administrator specifies and that includes consumer satisfaction surveys.	• Beneficiaries have only one source of information through a single dissemination of printed material and a phone number for questions.

Analysis of Proposed Legislation

The database for this analysis is the five proposals listed in the Executive Summary. Our summaries are restricted to the text of the bills—we do not infer intent or attempt to render specificity where, at this time, there is none**.** The various bills reflect different approaches to changing the Medicare program—by adding a benefit to the existing program (H.R. 5019 and S. 2625); establishing the benefit through means of private plans as a new methodology in Medicare (H.R. 4954); trying to blend the private and public approaches (S. 2729); or providing a targeted, limited benefit (Hagel, et al., amendment). This *Policy Paper* will not address how the specific provisions derived from those approaches might affect rural beneficiaries differently than they affect urban beneficiaries.

This analysis is organized using the principles—equity, access, costs, quality, and choices—developed by the Panel to apply to any significant changes in the Medicare program. Specific criteria are described for each principle and applied to the five proposals considered here. The Panel identifies specific provisions that are of particular benefit to rural beneficiaries and others that are problematic.

Equity

The Medicare program should maintain equity vis à vis benefits and costs among its beneficiaries, who should be neither disadvantaged nor advantaged merely because of where they live.

Equity, a fundamental concept of social justice, serves as the rural cornerstone of any Medicare redesign dialogue. Medicare equity can be defined as "the degree to which Medicare treats all beneficiaries with fairness and justice, regardless of age, health, gender, race, income, *place of residence* [emphasis added], or personal preference" (National Academy, 1999).

The current Medicare system, combining the traditional defined benefits and additional plans that can be purchased, allows an outpatient prescription drug benefit for some (primarily for beneficiaries in high payment areas where Medicare+Choice plans still offer the benefit, and for a dwindling number of beneficiaries with employer-based retirement benefits) but not for many others (most rural beneficiaries) (see "Designing a Prescription Drug Benefit for Rural Medicare Beneficiaries: Principles, Criteria, and Assessment" [P2000-14]). Adding a national outpatient prescription drug benefit is a movement toward egalitarianism, presuming it is available to all beneficiaries. The advantage of making an outpatient prescription drug benefit universally available, though, could be less than completely equitable if the benefit is not the same in all areas. If a new Medicare benefit is divided into options with various levels of coverage, there is potential for rural beneficiaries to have only the least desirable option available to them. The application of the equity principle, then, is through an assessment of comparability of plans available in rural and urban areas.

Equity Criteria Applied to an Outpatient Prescription Drug Benefit

1. Rural beneficiaries should have opportunities to enroll in plans that include outpatient prescription drug benefits comparable to those available to urban beneficiaries.

Rural Considerations: Equity

The strongest provision for an egalitarian notion of equity is to provide exactly the same benefit package to all beneficiaries. The next best assurance is that the same basic plan is available to everyone even though some alternatives may be available in urban areas that are not available in rural areas. Either of these alternatives would be a considerable improvement over the current circumstances, in which rural beneficiaries are not assured of any outpatient prescription drug benefit.

When multiple plans are encouraged to participate in Medicare, the legislative provisions most favorable to the principle of equity for rural beneficiaries are those that create the maximum likelihood that enriched benefit packages are also available to rural beneficiaries. This can be done by defining service areas such that rural areas are incorporated into the same service areas as urban areas. Another approach is to offer incentives to plans that either extend service areas to include rural places or that offer benefits in service areas that are exclusively rural.

Any legislation that creates an opportunity for health plans to offer benefits beyond a specified standard package risks creating an inequitable situation for rural beneficiaries, although on balance, such legislation could still improve on the status quo. The principle of equity could be satisfied by this situation, although not optimally so.

Table 2. Equity: An Assessment of Provisions

***Principle*: The Medicare program should maintain equity vis à vis benefits and costs among its beneficiaries, who should be neither disadvantaged nor advantaged merely because of where they live.**					
Equity Criterion	**Provisions in H.R. 4954 (House R)**	**Provisions in H.R. 5019 (House D)**	**Provisions in S. 2625 (Graham)**	**Provisions in S. 2729 (Grassley)**	**Provisions in Amendment to S. 812 (Hagel)**
1. Opportunity to enroll in plans that include outpatient prescription drug benefits	Section 1860B: Actuarial value of the standard coverage plan shall be the same across plans; different plans can be offered that exceed the actuarially equivalent coverage of the standard coverage; plans shall provide beneficiaries with access to negotiated prices, regardless of whether or not they are covered with respect to those drugs	Section 1859D: A single benefit package is made available to all beneficiaries; there are no provisions for more than one such package	Section 1860F (a): All beneficiaries have the same basic plan; plans could reduce the copayment; all beneficiaries have access to negotiated prices for drugs	Section 1860D-6 (c): Standard package defined in terms of costs to the beneficiary; plans allowed to offer additional benefits; all enrollees have access to negotiated prices	Section 1860F: Secretary contracts with plans that offer discount cards; in areas with no plan, Secretary assures access to negotiated prices for prescription drugs (including discounts); all beneficiaries treated alike for catastrophic benefit

Access

The Medicare program should ensure that beneficiaries have reasonable access to all medical services, including having essential services within a reasonable distance/time of their residence and being able to afford medically necessary services.

Although the traditional fee-for-service Medicare program provides access to the same benefits for all beneficiaries, historically there have been disparities in access to services between urban and rural beneficiaries. Although there is a distinction between equality of access and the assurance of access to minimally "needed" services (Vladeck, 1981), to fulfill the promise of universal entitlement, Medicare must not only pay claims, but proactively share in the support of providers who are essential to maintaining access (for example, in hospital payment, Medicare payment is based on costs for Critical Access Hospitals as compared to hospitals paid through a prospective payment system based on rates determined by diagnosis-related group).

The access implications of significant changes in Medicare design center on three basic questions:

- Will rural and urban Medicare beneficiaries have access to the same benefits?
- Will rural and urban beneficiaries have comparable financial access to the services included in the outpatient prescription drug benefit proposals?
- Will rural and urban beneficiaries have comparable geographic access to essential health care services under the proposed plans?

Appropriate access to pharmaceutical services in their local communities is vital to rural seniors and should be assured in any outpatient prescription drug plan. Because rural pharmacies typically have lower sales volume and therefore higher marginal costs, and may also have a harder time stocking a wide range of generic drugs, they could consequently lose market share to chain pharmacies.

Preserving access to local pharmacy services is critically important in many rural communities and should be an important policy objective in the design of a Medicare outpatient prescription drug benefit. The role of the local, rural pharmacy often goes well beyond the filling of prescriptions. In many rural communities, the local pharmacy is the closest source of health care advice and assistance. In addition, the local pharmacy and pharmacist often provide vital support services for other rural health care providers, including physicians, home health agencies, nursing homes, and hospitals.

Access Criteria Applied to an Outpatient Prescription Drug Benefit

1. Rural beneficiaries must have access to at least one Medicare outpatient prescription drug plan and preferably a choice of plans that offer actuarially comparable benefits as those offered by plans in urban areas. Outpatient prescription drug proposals can address this criterion in a variety of ways:

1.a. Proposals may specify the definition of service areas so that plans would be required to offer their products in areas that encompass both rural and urban markets.

1.b. Proposals can offer incentives for plans to market their products in smaller rural areas that might not be seen as "primary" market areas. To assure comparability of benefits, proposals can require plans to offer actuarially equivalent plans in rural and urban markets.

1.c. Because incentives may not be sufficient to attract private plans to all rural areas, proposals can provide for a "plan of last resort" that assures availability of outpatient prescription drug coverage with comparable benefits for all beneficiaries.

2. The Medicare outpatient prescription drug benefit should not undermine rural Medicare beneficiaries' access to local pharmacy services.

2.a. Plans should ensure that local, rural pharmacies have a reasonable opportunity to participate as providers.

2.b. Plans should reimburse providers in a manner that makes it possible for rural providers to participate and that is different than reimbursing for an efficient provider's costs of providing care.

Rural Considerations: Access

Outpatient prescription drug proposals vary in how beneficiaries would access benefits. In some proposals, the outpatient prescription drug benefit would be added to the existing benefits offered in the Medicare program. Other proposals would provide vouchers to beneficiaries for the purchase of an outpatient prescription drug plan offered by private insurers that would compete to offer plans in defined markets. The implications of this design feature maybe significant to beneficiaries' access to plans, benefits, and services. For example, rural beneficiaries' access may be compromised if private insurers choose not to offer outpatient prescription drug plans in rural areas. Access may also be affected if the plans that are offered in rural markets do not offer rural beneficiaries actuarially comparable benefits.

Medicare outpatient prescription drug proposals can be structured in several ways to preserve access to pharmacy services within a reasonable distance and/or travel time of beneficiaries' residence. For example, proposals that rely on beneficiaries accessing plans through private insurers can require that insurers provide a reasonable opportunity for local, rural pharmacies to participate as plan providers. Proposals can also prohibit plans from paying rural pharmacies less than urban pharmacies for comparable services. In fact, because rural pharmacies typically have lower sales volume and therefore higher marginal costs, proposals can require or encourage plans to pay rural pharmacies at higher rates than urban pharmacies.

Table 3. Access: An Assessment of Provisions

***Principle*: The Medicare program should ensure that beneficiaries have reasonable access to all medical services, including having essential services within a reasonable distance/time of their residence and being able to afford medically necessary services.**

Access Criteria	Provisions in H.R. 4954 (House R)	Provisions in H.R. 5019 (House D)	Provisions in S. 2625 (Graham)	Provisions in S. 2729 (Grassley)	Provisions in Amendment to S. 812 (Hagel)
1.a. Definition of service areas	No provision	Section 1859B (a) (6): Secretary sets accounting for number of individuals enrolled in an area to encourage participation by pharmacy contractors; create at least 10 regions, none smaller than a state; (7): one bid can cover multiple areas	Section 1860G (b): Secretary determines regions in which contractors will market the new benefit; subareas can be designated if they are at least a state; at least 10 different regions; consideration for number of eligible beneficiaries to encourage participation by eligible entities	Section 1860D (b): Administrator establishes service areas that maximize availability to eligible beneficiaries, minimize favorable selection, and are not smaller than a state	No provision
1.b. Incentives	Section 1860D (d) (1): Administrator of program can provide incentives to entice plan sponsors to expand service area	No provision	No provision	Section 1860D-13: Secretary can provide financial incentives for entity to offer a plan in an area	No provision
1.c. Plan of last resort	Section 1860E (d): Administrator shall "assure" each individual entitled to benefit has at least two plans available in her or his area; incentives provided for plan to expand area or establish plan	Section 1859B (a): Secretary shall develop procedures for provision of coverage to beneficiaries that reside in areas not covered by any contracts	1860G (d): Secretary shall develop procedures to cover beneficiaries in areas not covered by any contract	Section 1860D (d): Administrator shall approve at least two contracts in an area	Section 1860F (4) (D): Secretary shall develop procedures for provision of catastrophic benefit in areas where there are no prescription drug discount card plans offered

Access Criteria (continued)	Provisions in H.R. 4954 (House R)	Provisions in H.R. 5019 (House D)	Provisions in S. 2625 (Graham)	Provisions in S. 2729 (Grassley)	Provisions in Amendment to S. 812 (Hagel)
2.a. Rural pharmacy participation	Section 1860C (c): Plans shall secure participation of sufficient number of pharmacies that dispense drugs directly to beneficiaries to ensure convenient access as determined by Administrator	Section 1859B (a): Pharmacy contractor shall ensure that covered medicines are accessible and convenient to beneficiaries and, if a network is used, it must meet minimum access standards for reasonable distance	Section 1860H (e): If eligible entity uses a preferred pharmacy network, it must meet minimum access standards established by Secretary that take into account reasonable distance to pharmacy services	Section 1860D-5: Eligible entity shall secure participation in network of sufficient number of pharmacies that dispense drugs directly to beneficiaries to ensure convenient access as determined by Administrator in accordance with standards that take into account reasonable distance	Section 1860D (b): Eligible entity shall secure participation in network of sufficient number of pharmacies that dispense drugs directly to beneficiaries to ensure convenient access as determined by Administrator in accordance with standards
2.b. Reimbursement of rural pharmacies	Section 1860C (d): Plans must take into account resources and time used in implementing program when establishing fees for pharmacies	Section 1859B (a): Secretary shall give special attention to access, pharmacy counseling services, and delivery in rural and hard to serve areas through use of incentives to pharmacists	Section 1860H (a): Eligible entity shall enter into participation agreement with any pharmacy that meets requirements, including payment of a reasonable dispensing fee	Section 1860D-5: Eligible entity must take into account resources and time used in implementing program when establishing fees for pharmacies	Section 1860D(b): Eligible entity must take into account resources and time used in implementing program when establishing fees for pharmacies

Costs

The Medicare program should include mechanisms to make the costs affordable, both to beneficiaries and to the taxpayers financing the program.

Any Medicare outpatient drug program should address two related cost goals: (1) minimize reasonable out-of-pocket costs to the beneficiary, and (2) minimize the budgetary costs of the Medicare program. The first goal structures the program to achieve cost-savings so that beneficiary out-of-pocket costs for recipients do not rise too rapidly relative to the status quo. In addition to cost-sharing (premiums, deductibles, and copayments), out-of-pocket costs for Medicare beneficiaries include expenditures on services not covered by Medicare and costs incurred for supplemental coverage, if it is purchased. The second goal attempts to ensure that the Medicare program is solvent in the long run, however that is defined, and that the costs of the program do not grow rapidly as a share of the federal budget. Minimizing the costs of the program benefits taxpayers who pay for the program, especially non-elderly taxpayers who pay for most of the program's costs through federal payroll and income taxes.

Applying the principle of containing costs and protecting beneficiaries from undue personal burdens to a new outpatient prescription drug benefit requires balancing specific beneficiary cost-sharing strategies (premiums, deductibles, coinsurance) with designing a benefit that will be used when needed. As appropriate for any insurance plan, the costs of the new benefit would be shared by those being insured (Medicare beneficiaries) and those securing the benefit on their behalf (the federal government). Any proposal, including an entirely government-funded program, would incorporate this principle (above certain income levels, Medicare beneficiaries pay income taxes, which would be a presumed source of support for a new Part D in the Medicare program). Proposals that use direct out-of-pocket contributions to the costs of the program are incorporating an additional tool intended to control the growth in spending, especially when the additional spending yields few medical benefits (e.g., brand name medication when a generic medication will meet the same clinical need or a prescribed medication when other remedies will serve the same purpose).

Costs can inhibit appropriate use of outpatient prescription drugs. The problem of costs as a barrier is particularly insidious because it affects both *whether* the benefit is used and *the extent of use* when a prescription is filled. That is, the presence of a coinsurance payment may lead to trying to stretch the use of a prescription by taking medication less frequently or in lower than prescribed doses. Given the lower average income of rural beneficiaries, and the lower likelihood that they carry coverage provided by previous employers, this problem is especially relevant in rural areas. Avoiding this problem while still using beneficiary cost-sharing as a means of making the program affordable requires subsidies for low-income beneficiaries, either in dollars or in waivers of cost-sharing requirements.

Special consideration is needed to ensure that premium costs are fairly distributed between rural and urban beneficiaries. Consistent with historical Medicare policy in the setting of Part B premiums, premiums (for any out-of-pocket costs) charged to rural

beneficiaries should not vary because they live in rural areas. Markets should be structured to assure that plans have a broad enough base of enrollees to spread risk using community rates rather than individual underwriting; service or market area definitions should prohibit plans from segmenting markets in ways that could carve out rural and other underserved areas as separate markets, or charge higher premiums in rural areas.

Costs Criteria Applied to an Outpatient Prescription Drug Benefit

1. The benefit structure of the outpatient prescription drug program should simultaneously balance the goals of cost containment and affordability for the rural Medicare beneficiary. The goal of cost containment can be achieved by the judicious use of (a) deductibles, (b) coinsurance or copayment rates, and (c) premiums. However, the goal of affordability needs to be achieved by making these deductibles, coinsurance rates, and premiums reasonable for low-income persons. In addition, proposals should (d) enact reasonable out-of-pocket limits and (e) subsidize the premiums. These provisions are especially important to rural residents because a greater proportion of rural beneficiaries are low income and have lower health status as compared to urban beneficiaries.

2. Proposals should be structured to provide protection against rapid growth in prescription drug prices, necessary to meet the goals of cost containment for the program and affordability to the taxpayer. Without protection from the rapid growth in prices, the benefits of a Medicare outpatient prescription drug program could be rapidly eroded by inflation.

Rural Considerations: Costs

All of the prescription drug proposals will lead to a net improvement in the financial status of most Medicare beneficiaries by lowering their out-of-pocket costs for prescription drugs. The proposals vary by the extent of the benefit that recipients will receive.

Prescription drug proposals that leave recipients with significant amounts of out-of-pocket costs—plans with relatively high coinsurance rates, catastrophic-only coverage, high stop-loss amounts, or gaps in coverage (e.g., large spans of spending when coverage is not available—the "doughnut")—will disproportionately impact rural recipients because of their lower incomes and lower health status as compared to urban beneficiaries. Plans should focus on protecting the needs of lower- and moderate-income beneficiaries.

Plans without deductibles, or with low deductibles, or other moderate cost-sharing required of the beneficiary run the risk of creating a program that grows significantly in budgetary costs over time. Without due attention to budgetary control, the goal of making the Medicare program affordable to the rural taxpayer will be jeopardized. Prescription drug proposals should consider effective cost-containment proposals, including provisions allowing for plan administrators to be effective price negotiators.

In order to keep the prescription drug plans affordable to low- and moderate-income rural beneficiaries, proposals need to keep a proper balance between out-of-pocket costs and

subsidies. For example, the proposals with the highest deductibles ($250) should have the most generous lower income subsidies, ideally waiving the deductibles for the lower-income levels (up to 150% of poverty) and reducing the subsidies after that (up to 175% of poverty). Similar design principles should be applied to the balance between premium levels (as set by the plan sponsor) and coinsurance and copayment (e.g., 50% of $1,000 to $2,000). Consideration should be given to providing subsidies up to 200% of the poverty line (not just 175% of the poverty line as in most of the proposals), especially in rural areas, where beneficiaries may face prescription drug program options that have higher premiums (because of a lack of competition).

Considerable attention should be paid to the setting of premium prices in rural areas because of the lack of competition in rural areas and the likelihood that risk pools will be small, leading to insurance market problems. This could lead to a lack of comparability of plans in terms of benefits and premiums. The legislation should specifically indicate that plans be comparable in terms of affordability to the beneficiary, without regard for location of the beneficiary.

Retaining a modest difference in reduced copayments (e.g., $2 for generic prescriptions and $5 for nongenerics) protects the steering influence of copayments without imposing prohibitive costs. Incorporating copayments above these levels could result in medications not being affordable for low-income elderly. If higher copayments are needed to create disincentives, those copayments should be waived if, in the judgment of the health professional, the more expensive medication is required.

Table 4. Costs: An Assessment of Provisions

***Principle*: The Medicare program should include mechanisms to make the costs affordable, both to beneficiaries and to the taxpayers financing the program.**

Costs Criteria	Provisions in H.R. 4954 (House R)	Provisions in H.R. 5019 (House D)	Provisions in S. 2625 (Graham)	Provisions in S. 2729 (Grassley)	Provisions in Amendment to S. 812 (Hagel)
1a. Deductible	Section 1860B: $250 in 2005 under standard benefit, indexed	Section 1859D (c): $100 in 2005, indexed	None	Section 1860D-6: $250 in 2005, indexed	None; catastrophic coverage only
1b. Co-insurance or copayments	Section 1860B: 20% between $251-$1,000; 50% between $1,001-$2,000; no coverage between $2,001-$3,799; full coverage after $3,800 out-of-pocket	Section 1859D (c): 20% for preferred drugs until $2,000; full coverage after $2,000 stop-loss limit is hit; for nonpreferred drugs, 20% plus difference between lowest-price preferred drug and nonpreferred drug	Section 1860F: Tiered: $10 for generics; $40 for preferred; $60 for non-preferred; more than $60 for nonformulary drugs; $4,000 stop-loss	Section 1860D-6: 50% between $251 and $3,450; no coverage between $3,451-$3,699; 10% after $3,700 out-of-pocket costs reached	Section 1860F: Enrollees pay negotiated price until catastrophic limit is reached, then pay 10% coinsurance
1c. Out-of-pocket limits (stop-loss)	Section 1860B: $3,800, indexed	Section 1859D (c): $2,000, indexed	Section 1860F: $4,000, indexed	Section 1860D-6: None; coinsurance still exists after $3,700	Section 1860F: Income-related: Up to 200% of poverty, $1,500; 200-400% of poverty, $3,500; 400-600% of poverty, $5,500; >600% of poverty, drug spending that exceeds 20% of income
1d. Premium	Section 1860H: Set by plan sponsor; federal payment to plan set at 65% of value of standard coverage; based on enrollee choice; estimated to be $33 in 2005	Section 1859D (d): $25 in 2005 (in law), indexed	Section 1860E: $25 in 2005 (in law), indexed	Section 1860D-14,15: Based on enrollee choice; Beneficiary pays difference between plan premium and 57% of weighted average of national premiums; federal payment equal to 30% of value of standard coverage; estimated to be $24 in 2005	Section 1860E: $25 annual enrollment fee in 2004, indexed

Costs Criteria (continued)	Provisions in H.R. 4954 (House R)	Provisions in H.R. 5019 (House D)	Provisions in S. 2625 (Graham)	Provisions in S. 2729 (Grassley)	Provisions in Amendment to S. 812 (Hagel)
1e. Subsidies for low-income beneficiaries	Section 1860G: Up to 150% of poverty: full premium subsidy and reduced coinsurance ($5 brand, $2 generic) 150-175% of poverty: sliding-scale premium subsidy and reduced coinsurance ($5 brand, $2 generic)	Section 104: Up to 150% of poverty: full premium and cost-sharing subsidies 150-175% of poverty: sliding-scale premium subsidies and full cost-sharing subsidies	Section 1860D-19: Up to 135% of poverty: full premium and cost-sharing subsidies 135-150% of poverty: sliding-scale premium subsidies	Section 1860D-19: Up to 135% of poverty: full premium subsidy and reduced cost-sharing (5% of deductible, 2.5% coinsurance in "gap," no coinsurance above stop-loss) 135-150% of poverty: sliding-scale premium subsidy and reduced cost-sharing (50% in "gap")	Section 1860D, F: Up to 200% of poverty: enrollment fee is waived; catastrophic threshold is income-related
2. Price growth	Section 1860C: Plans use formularies; formularies must include standards with each therapeutic category and class; plans encouraged to have effective cost and drug utilization management program; Medicare administrator may not institute a price structure or interfere in price negotiations in any way	Section 1859A: Pharmacies must develop lists of preferred medications; price negotiations must be conducted so there is a contract for at least one preferred medicine in each class; use of reduced coinsurance on preferred medications; incentives to pharmacists to make cost-saving decisions	Section 1860H: Entities must establish formularies; formularies must establish generics and at least one but no more than two drugs in each class; payment to administrative entities tied to their effectiveness at cost control; entities encouraged to provide incentives to consumers to lower consumption (e.g., lower coinsurance for preferred drugs)	Section 1860D-5: Each plan must establish formulary; formularies must include drugs within each category and each class; entities must have an effective cost-management program and include incentives for consumers to control costs (e.g., tiered coinsurance, mail-order pharmacies)	Section 1860D: Each plan must establish formulary; formularies must include drugs within each category and class; plan sponsors must have in place an effective cost-containment mechanism and drug utilization program

Quality

The Medicare program should promote the highest attainable quality of care for all beneficiaries, defined in terms of health outcomes for beneficiaries.

Quality is defined by the Institute of Medicine as "the degree to which health services for individuals and populations increase the likelihood of desired health care outcomes and are consistent with current professional knowledge" (Lohr, 1990).

A Medicare outpatient prescription drug benefit program is predicated on several steps in which quality processes must be addressed to ensure that beneficiaries obtain appropriate prescribed drugs to achieve desired health outcomes:

- Drug manufacture
- Drug distribution to pharmacies
- Formulary design and drug choice
- Education of health professionals and patients
- Interactions among health professionals, pharmacists, and patients
- Infrastructure (including information systems) to support above interactions
- Quality improvement processes

The steps have complex features embedded within each of them, and inadequate implementation of quality processes in any of the steps supporting the Medicare outpatient prescription drug benefit program has the potential to compromise quality. Those steps involving health professionals and information systems that occur at the local level are central to an outpatient prescription drug program. They are complex and, given current circumstances, will be difficult for many rural providers to fully implement. A Medicare outpatient prescription drug benefit program must require quality standards and ensure appropriate resources for meeting those standards. In rural areas, the greatest risk in meeting the goal of ensuring that Medicare beneficiaries obtain appropriate prescribed drugs to achieve desired health outcomes lies in the potential inadequacy of the human resources, information technology, and financial infrastructure in rural provider organizations to support necessary quality processes and systems.

Quality Criteria Applied to an Outpatient Prescription Drug Benefit

1. The outpatient prescription drug benefit shall include quality standards and programs to improve rural health outcomes.

2. Rural provider organizations should have access to resources and mechanisms for training personnel and implementing rural-appropriate quality assurance and improvement systems.

3. Rural provider organizations should have access to resources and mechanisms to acquire and develop information systems. Associated computer and telecommunications infrastructure requirements shall be appropriate for rural

provider system size and scope.

4. Advisory committees considering infrastructure issues shall include members sensitive to the rural challenges of implementing and operating a rural Medicare outpatient prescription drug benefit.

Rural Considerations: Quality

Prerequisites to achieving many of the legislative provisions designed to promote safe and effective drug therapy include (1) provider and beneficiary knowledge and (2) access to computer and information technology. Quality improvement efforts require personnel equipped with knowledge about quality improvement and quality assurance approaches to ensure safe and effective drug therapy utilization. This is particularly important for clinicians caring for Medicare beneficiaries with chronic health problems requiring ongoing prescription drug management or with conditions requiring multiple prescriptions. Yet current and complete quality improvement information is often inadequately disseminated and consequently unavailable in many rural health care settings. For example, while some legislative provisions address education of beneficiaries, materials developed to assist consumers in enhancing the likelihood that they receive safe medication therapy are not always available nor do rural providers and consumers always recognize their value. In addition, some provisions include provider and pharmacist education targeted at efficiency and effectiveness of formulary or knowledge concerning unnecessary or inappropriate prescribing or adverse reactions. However, there are no provisions that cover knowledge and skills required to implement quality assurance and improvement systems that are an essential foundation for these more targeted quality-related activities.

Furthermore, with limited provider availability in many rural communities, rural providers are constrained in their ability to leave their practices to obtain quality improvement information off site. Therefore, knowledge and resource expectations related to legislative provisions, such as compliance with established quality standards or implementing programs to reduce medication errors, may occur only with distance-sensitive information dissemination. These efforts are necessary to assist rural providers in meeting stated requirements.

In addition to information gaps in rural settings, electronic information systems that help ensure appropriate drug therapy do not exist in many rural delivery systems. Basic computing and telecommunications infrastructure to support quality improvement systems is often lacking. Financial constraints may serve as barriers to developing both basic infrastructure and systems. Information systems and computer technology in rural settings should be appropriate to the size and scope of rural health care systems yet avoid incentives that encourage implementation of overly complex processes and information technology more appropriate to urban settings. While technology-intensive advances in quality improvement, such as computerized prescription order entry systems, may not be immediately available, transmittable, or affordable to rural areas, other alternative and better-aligned quality improvement efforts may be. Legislation should support efforts to develop an evidence base for quality improvement efforts that consider size, scope, and processes in rural health care environments. Achieving similar outcomes related to safe

and effective drug therapy utilization may not require complex and expensive infrastructure.

With some exceptions, the technological environment of rural health provider organizations and networks differs substantially from urban providers, thus calling for a rural perspective in guiding the selection and development of information technology in rural areas. Rural health organizations tend to lack internal computing capacity and external telecommunications infrastructure, have few options for ongoing technical support, and lack affordable access to information technology developers. Furthermore, technology developers are often unaware of or insensitive to the technical environment, user characteristics, geographic factors, and financial limitations of rural providers. Urban health care settings are more likely to have greater computer workstation sophistication, availability of continuous connectivity via broadband, and access to a wide array of technical support and system development resources. With such differences at play in choosing appropriate technology with which to implement and administer electronically supported quality assurance and improvement efforts, it is essential that advisory task forces or committees charged with recommending software, hardware, networking, transmission, security, and user training elements include representation that is knowledgeable of rural settings and implementation issues.

While there are differences in rural and urban health care infrastructure available to implement prescription drug benefit programs, there are also important differences in the characteristics of rural and urban beneficiaries. For example, rural Medicare beneficiaries are more likely than urban beneficiaries to be hospitalized for conditions that result from underutilization of ambulatory care (Medicare Payment Advisory Commission, 2000), which could include underutilization of prescription drugs. Finally, pharmaceutical quality improvement resources (financial, technical, and human), as previously indicated, may be less available to rural providers who often have a high proportion of Medicare beneficiaries within their practices.

Table 5. Quality: An Assessment of Provisions

***Principle*: The Medicare program should promote the highest attainable quality of care for all beneficiaries, defined in terms of health outcomes for beneficiaries.**					
Quality Criteria	**Provisions in H.R. 4954 (House R)**	**Provisions in H.R. 5019 (House D)**	**Provisions in S. 2625 (Graham)**	**Provisions in S. 2729 (Grassley)**	**Provisions in Amendment to S. 812 (Hagel)**
1. Standards and programs to achieve health outcome improvement	Section 1860C (d): Directs the prescription drug plan sponsor to have in place quality assurance measures and systems including a medication therapy management program	Section 1859 B (b): The Secretary shall establish standards and programs to avoid adverse medicine reactions and to continually reduce errors	Section 1860H (a): The Secretary shall specify quality standards for eligible entities including drug utilization review procedures to ensure appropriate utilization of drugs, deter medical errors, and avoid adverse drug reactions	Section 1860D-5 (c): Entities eligible to provide benefits under a Medicare Prescription Drug plan shall have in place quality assurance measures, including a medication therapy management program, to reduce medical errors and adverse drug interactions	Section 1860D (a): Eligible entities offering a prescription drug discount card plan may have in place quality assurance measures and systems to reduce medical errors and adverse drug interactions including a medication therapy management program and an electronic prescription program
2. Resources and mechanisms to ensure human resources and processes to support quality improvement	Section 1860C (c): Provides for educating and informing health care providers concerning the formulary	Section 1859B (b): Includes education of providers, pharmacists, and enrollees on matters such as unnecessary or inappropriate prescribing, adverse reactions, and use of generic products	No provision	Section 1860D-5 (a): Provides for educating and informing health care providers concerning the formulary	Section 1860D (b): Provides for educating and informing health care providers concerning the formulary
3. Resources and mechanisms to ensure information technology to support quality improvement processes	Section 1860C (d): Beginning with 2006, include an electronic prescription drug program and grant funds are to be authorized under section 399(O) of the Public Health Service to provide assistance in implementing an electronic prescription drug program	Section 1869B (b): Ensures that pharmacy contractors provide on-line review to evaluate for medicine therapy problems	No provision	No provision	No provision

Quality Criteria (continued)	Provisions in H.R. 4954 (House R)	Provisions in H.R. 5019 (House D)	Provisions in S. 2625 (Graham)	Provisions in S. 2729 (Grassley)	Provisions in Amendment to S. 812 (Hagel)
4. Advisory committee rural membership	Section 1860C (d) (3) (B) (11): The Administrator of the MBA shall establish an Advisory Task Force to provide recommendations on standards for the Electronic Prescription Program	Section 1859H: A Medicare Prescription Medicine Advisory Committee shall be established to advise the Secretary on policies related to implementation of guidelines for the implementation and administration of the outpatient prescription medicine benefit program	Section 1860L: A Medicare Prescription Drug Advisory Committee shall be established to advise the Secretary on the development of guidelines for the implementation and administration of the outpatient prescription drug benefit program	Section 1860D-25: Medicare Competitive Policy Advisory Board shall be established within the Medicare Competitive Agency to advise, consult with, and make recommendations to the Administrator with respect to the administration of program including ways to improve the quality of benefits provided under Parts C and D	Section 1860K: A Medicare Advisory Board shall submit to Congress and the Secretary reports concerning legislative or administrative changes to improve the administration of the program

Choices

The Medicare program should ensure that all beneficiaries have comparable choices available to them—among health care plans (e.g., benefits covered and out-of-pocket expenses potentially incurred) and among health care providers.

Promoting choice as a criterion for assessing Medicare reform proposals assumes that choice is a value associated with individual freedom and that to restrict choices is to limit freedom. In Medicare policy, limited choices for beneficiaries can include restrictions on the choice of providers, health insurance plans, or options for treatment. Choice can be restricted by "loading" (Benn & Weinstein, 1973) among alternatives, for example by charging high premiums or imposing high deductibles. Choices should not be unduly restricted based on where beneficiaries live. While the range of choices supported by a large, concentrated population may be greater than that available in sparsely populated areas, having choices between at least two distinctly different health plans and among different providers should be protected.

Choice of providers and courses of treatment are personal decisions over which beneficiaries should have control, not directed by the design of the Medicare program. In the case of an outpatient prescription drug benefit, this would mean having the ability to select a pharmacist and the ability to select the desired medication. This need not mean that every pharmacist would receive the same copayment from the beneficiary or that all medications with equivalent clinical effects would be available at the same price. The criterion does mean, however, that choice has to be within the means of the beneficiary, meaning that pharmacy services have to be accessible and that the costs, while different for different providers and drugs, would have to be affordable to the beneficiary.

When choice among health care plans becomes a cornerstone of Medicare policy, policy makers must focus on creating meaningful choices for beneficiaries and ensuring that beneficiaries have the information and ability to accept or reject options. Most beneficiaries will have no previous experience in choosing from among different health plans, and this is especially true for beneficiaries in rural areas, where even supplemental options are limited. To exercise choices, beneficiaries will need accurate information about each choice, presented in a manner easily understood and through a medium readily available to rural residents. Beneficiaries need full information regarding the choices available to them, including the following:

- How different choices actually work
- Out-of-pocket costs of plans
- Experiences of people in comparable groups (age, health, sex, ethnicity)
- Access to, and treatment by, providers
- Accessibility of services, especially services used most frequently
- Accuracy of information presented by health plans
- How participating health care professionals are paid (Jones & Lewin, 1996, p. 90)

Choices Criteria Applied to an Outpatient Prescription Drug Benefit

1. If the outpatient prescription drug benefit proposal is predicated upon offering beneficiaries a choice of privately sponsored plans as a central principle of the proposal, then rural beneficiaries should have a choice of these plans available to them.

2. Choice of pharmacists should be assured. This will require offering at least one option in reasonable proximity to the beneficiary (in the closest town of 2,000 people) and at least one option that is the low-cost choice available through the plan, which may include mail-order.

3. Private plans applying to provide or manage the outpatient prescription drug benefit should be required to provide proof of long-term solvency, so that rural beneficiaries have consistent choices available to them.

4. Enrollment periods need to be of sufficient length to allow beneficiaries unfamiliar with choosing among alternative plans (disproportionately rural beneficiaries) to make informed decisions. Based on experiences with Medicare+Choice, rural beneficiaries are more likely to need to enroll in a new plan after an existing plan withdraws from their area. Therefore, provisions for guaranteed re-enrollment without penalty and with adequate time are important to rural beneficiaries.

5. Educational activities should allow for the unique characteristics of rural areas and permit education by those most familiar with these characteristics. Local civic groups and area agencies on aging are likely candidates to provide education to rural beneficiaries.

Rural Considerations: Choices

The process for enrolling beneficiaries into new plans offering outpatient prescription drug benefits, including enrollment into a single plan as Part D of Medicare, has been standardized in all proposals to be comparable to enrolling into Part B, which allows for sufficient time to learn of the new benefit and choices available.

The strongest assurance of choice among pharmacists is that there are no exclusionary practices; that is, the exchange is directly between the beneficiary and provider he or she chooses, as it is in traditional Medicare. However, only proposals that add an outpatient prescription drug benefit as a fee-for-service benefit without competing plans could offer that possibility. For proposals that rely on some form of competing plans for delivery of the new benefit, the strongest provision assuring choice of pharmacies is to require that plans accept any pharmacy willing to meet their conditions for participation, ***and*** that there be a point-of-service option available for beneficiaries to obtain drugs from pharmacies that do not participate in a plan's preferred network. Adopting one or the other of the provisions is not providing all possible opportunities for local pharmacies to participate.

The strongest provisions for educating beneficiaries are those that include specific

information that must be provided, including consumer satisfaction surveys. Such information may help inform beneficiaries as to the plan's satisfaction of rural beneficiary needs for access to outpatient pharmaceutical counseling. Complete information about any preferred provider networks and the costs incurred in exercising the option of point-of-service will be important to rural beneficiaries. Involving consumer coalitions would be a means of helping beneficiaries interpret and understand the information made available by plans. Education is weakest when it is no more than sending information to beneficiaries and providing a phone line for further contact.

Proposals are requiring that plans not licensed by state governments meet solvency standards as determined by the Administrator of the new program, or by the Secretary of Health and Human Services. The specifics of federal solvency requirements would be determined through the regulatory process.

Table 6: Choices: An Assessment of Provisions

***Principle*: The Medicare program should ensure that beneficiaries have comparable choices available to them—among health care plans (e.g., benefits covered and out-of-pocket expenses potentially incurred) and among health care providers.**

Choices Criteria	Provisions in H.R. 4954 (House R)	Provisions in H.R. 5019 (House D)	Provisions in S. 2625 (Graham)	Provisions in S. 2729 (Grassley)	Provisions in Amendment to S. 812 Hagel
1. Choice of plans	Section 1860E: Administrator would "assure" all beneficiaries have choice of at least two qualifying plan options and would provide financial incentives if necessary to do so, including partial underwriting of risk	Use of traditional Medicare program, so options are to enroll in government plan, Medicare+Choice plan, other plan, or no plan	Section 1860G: Secretary to contract with at least two entities in all areas, unless only one plan meets standards	Section 1860D-13: Administrator must approve at least two plans in each service area	Section 1860G: Secretary shall award two contracts in each area, unless only one bidding entity meets terms and conditions specified by Secretary
2. Choice of pharmacists	Section 1860C: Plan sponsors must have a point-of-service option allowing beneficiaries to use pharmacies not in their networks	No restrictions	Section 1860H: Plans must accept any pharmacy that meets Medicare's and their standards for participation; payment of reasonable dispensing fee	Section 1860D-5: Plan sponsors must have a point-of-service option for pharmacies not in their network	Section 1860D: Eligible entities shall establish point-of-service method of operation for pharmacies not in their network

Choices Criteria (continued)	Provisions in H.R. 4954 (House R)	Provisions in H.R. 5019 (House D)	Provisions in S. 2625 (Graham)	Provisions in S. 2729 (Grassley)	Provisions in Amendment to S. 812 Hagel
3. Long-term solvency	Section 1860D: Plans required to be licensed under state law as risk bearing entity, or meet solvency standards established by the Administrator; plans required to assume full financial risk except as covered by federal reinsurance payments for high-cost enrollees or as covered by federal incentive payments to encourage expanded service areas	Benefit is added to traditional Medicare program, so solvency is of the program	No specific requirements	Section 1860D-7: State licensure required, or financial solvency and capital adequacy standards established by Administrator in consultation with the National Association of Insurance Commissioners	Section 1860G: Entity meets state licensing requirements or, if a national plan, the requirements of the Employee Retirement Income Security Act of 1974
4. Enrollment/re-enrollment periods	Section 1860A: Same enrollment period as Part B; special election period if involuntarily lost coverage, enrollment delays, or non-enrollment attributable to government action	Section 1859C: 90-day enrollment period from time of eligibility; special l6-month period following ending participation in another plan; other late enrollment subject to premium penalty	Section 1860B: Similar to process for part B; 10% penalty for each 12 months late enrolling Section 1860C: default enrollment of beneficiary into plan when beneficiary fails to make a choice	Section 1860D-2: Initial enrollment same as Part B; if beneficiary does not involuntarily lose coverage, penalty for late enrollment	Section 1860B: Same as Part B; special period if lost eligibility for prescription benefit for reasons beyond beneficiary's control

Choices Criteria (continued)	Provisions in H.R. 4954 (House R)	Provisions in H.R. 5019 (House D)	Provisions in S. 2625 (Graham)	Provisions in S. 2729 (Grassley)	Provisions in Amendment to S. 812 Hagel
5. Educational activities	Section 1860C: Plan must disclose information on access to covered drugs including use of pharmacy networks; functions of any formulary, co-payment and deductible requirements; grievance and appeals procedures; requirements for internet access to information; and monthly detailed explanation of benefits when drug benefits provided	Section 1859C: Secretary distributes information to individuals; 800 line open for inquiries	Section 1860D: Provide information at least 30 days prior to open enrollment period; information compares benefits, quality and performance of plans, cost-sharing, and consumer satisfaction surveys; Secretary may contract with Medicare Consumer Coalitions, selected with a preference for broad participation by organizations with experience providing information to beneficiaries	Section 1860D-4: Administrator shall conduct activities to broadly disseminate information to beneficiaries; beneficiaries shall have such information at least 30 days prior to first enrollment period; information shall include comparison of benefits, quality and performance, cost-sharing, consumer satisfaction surveys, and additional information the Administrator specifies; disclosure requirements for plans; marketing materials subject to approval	Section 1860c: Secretary shall provide broad dissemination of information regarding enrollment and drug card plans offered; each entity under contract shall disclose information about how enrollees have access to covered outpatient drugs, including access through pharmacy networks, how any formulary is used, grievance and appeals procedures, enrollment fees and prices; each entity shall have mechanism for providing specific information upon request

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RUPRI Rural Health Panel

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Recent Health Policy Documents

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