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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 RUPRI Rural Health Panel

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EXECUTIVE SUMMARY

Introduction

This paper was jointly prepared by the Maine Rural Health Research Center and the RUPRI (Rural Policy Research Institute) Rural Health Panel to offer a rural perspective on the current debate over the design and implementation of a Medicare prescription drug benefit. Background information on rural Medicare beneficiaries' need for, and access to, prescription drugs is provided, along with a set of rural-oriented principles for use in evaluating how different prescription drug proposals may meet the needs of rural beneficiaries. These principles are applied to six proposals introduced between April and August 2000.

The Importance of Prescription Drug Coverage for Rural Seniors

Older persons in rural areas have both a higher need for, and reduced access to, prescription medications when compared to those in urban areas. This is true for a number of reasons:

1. Rural seniors are less healthy than urban seniors and purchase more prescription medications than urban seniors.

The rural elderly are more than 20% more likely to be in fair or poor health compared to the urban elderly. Moreover, rural seniors are significantly more likely to suffer from chronic, life-threatening health conditions such as diabetes or hypertension for which prescription medications are critical to reducing morbidity and mortality. As a result, the mean number of prescriptions purchased by the rural elderly in 1996 was 24 compared to 21 among the urban elderly, a statistically significant difference (Agency for Healthcare Research and Quality (AHRQ), 1998 & 2000).

2. Although they have a greater need for prescription medications, the rural elderly are more likely than urban seniors to lack prescription drug coverage.

In 1995, 46% of the rural elderly lacked prescription drug coverage compared to only 31% of urban elderly (Poisal et al., 1999).

3. As a consequence of their generally poorer prescription drug coverage and higher utilization of prescription drugs, the rural elderly experience higher annual out-of-pocket costs for their medications than do the urban elderly.

One-third of rural elderly Medicare beneficiaries paid more than $500 in out-of-pocket prescription drug costs in 1996 compared to only one-fourth of beneficiaries in urban areas. In 1996, the rural elderly were more likely to cover more than 75% of their own medication costs than were the urban elderly (49.1% vs. 21.3%) (AHRQ, 1998 & 2000).

4. ***The burden of prescription drug expenditures upon the rural elderly is compounded by the generally lower personal incomes among rural elderly.***

More than half of all rural seniors have family incomes below 200 percent of the federal poverty level, compared to 37.9% of urban seniors. Twenty-nine percent of rural seniors paid more than 5% of their gross income on prescriptions compared to 22% of urban seniors (AHRQ, 1998 & 2000).

Analysis of Proposed Legislation

This document summarizes six proposals to add prescription drug benefits to Medicare that were introduced in Congress between April and August 2000. These six proposals were selected because they typify the different design options under consideration and/or because they are at the center of the current debate. We are commenting on those proposals *as they were introduced*. Our summaries are restricted by the text of the bills — we do not infer intent, or attempt to render specificity where, at this time, there is none.

The current proposals being considered in Congress that we have included in this paper are:

- S.2753—"Medicare Expansion for Needed Drugs (MEND) Act of 2000" introduced 6/19/2000 by Daschle.
- S.2342—"Medicare Modernization Act of 2000" introduced 4/4/00 by Moynihan on behalf of President Clinton, as modified by the mid-year budget review published by the Office of Management and Budget.
- S.2758—"Medicare Outpatient Drug Act of 2000" introduced 6/20/00 by Graham.
- H.R.4680—"Medicare Rx 2000 Act" introduced by Thomas and passed in the House on 6/28/00.
- S.2807—"The Medicare Prescription Drug and Modernization Act of 2000" introduced 6/28/00 by Breaux.
- S.2836—"Medicare Rx Drug Discount and Security Act of 2000" introduced 6/30/00 by Hagel.

The Panel's analysis is based on four guiding principles that we believe encompass the issues of paramount concern for rural beneficiaries. These are:

1. ***The benefit must be <u>affordable</u> for rural beneficiaries.***

Balancing the affordability of any prescription drug plan for the beneficiary with the need to assure the long term affordability of the plan for the Medicare program is critical. The Panel supports the use of beneficiary cost-sharing (i.e. premiums, deductibles, and co-insurance) as a protection against the tendency for individuals to increase utilization of services for which they do not bear full cost and to ensure the long-term affordability of the prescription drug plan. Cost-sharing should be combined, however, with income-based subsidies and stop-loss provisions that recognize the greater burden that rural beneficiaries face in paying for prescription drugs.

2. There must be no negative impact on the <u>availability</u> of services in rural areas.

Appropriate access to pharmaceutical services in their local communities is vital to rural seniors and should be assured in any 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. One plan, S.2753, takes these issues into account by allowing for possible bonus payments to rural pharmacies, and requiring impact studies of the effects of these cost containment measures on beneficiary access and pharmacy solvency.

3. Rural beneficiaries must have <u>guaranteed access</u> to a plan and <u>continuity of coverage</u> must be assured.

Several of the plans reviewed here include explicit provisions that assure that the federal government would provide or arrange for the provision of a "plan of last resort." In addition, solvency protection features are important to assure continuity of coverage for rural residents. Features that protect against variations over time in the design of such plans are also important. Ideally, the same plans would be offered continuously.

4. Safeguards to <u>ensure rural participation</u> must be included.

The definition of the enrollment period is a critical issue for all seniors, but may be particularly important in rural areas where rural Medicare beneficiaries may face limited plan choice or need tailored education approaches. Nearly all of the plans limit the enrollment period for the prescription drug benefit to a "one-time only" window that coincides with enrollment in Medicare Part B. The best assurance of rural participation is found in S.2758, which allows beneficiaries to enroll after the open enrollment period, and to re-enter following disenrollment, subject to a premium surcharge based on the length of time they were eligible but not enrolled in the benefit.

To ensure enrollment of rural seniors, mechanisms appropriate to rural communities and norms must be developed to inform rural seniors of their benefit options and to facilitate their enrollment in their plan of choice. Several plans include provisions to allow the establishment of Medicare Consumer Coalitions to organize and implement beneficiary education efforts. This option would be most beneficial if service areas for these Coalitions were relatively small, so that rural beneficiaries could be served by entities from their own or neighboring communities. Additionally, Coalitions serving rural areas should receive adequate compensation to allow for travel into the communities they service, since direct contact is the most effective tool for outreach and education.

I. INTRODUCTION

This paper was jointly prepared by the Maine Rural Health Research Center and the RUPRI (Rural Policy Research Institute) Rural Health Panel (Panel) to offer a rural perspective on the current debate over the design and implementation of a Medicare prescription drug benefit.[1] The Maine Rural Health Research Center has analyzed data from the 1996 Medical Expenditure Panel Survey (MEPS)[2] to provide background information on rural Medicare beneficiaries' need for, and access to, prescription medicine. These data identify the individual cost burdens that rural beneficiaries face, as well as the characteristics that distinguish them from urban beneficiaries, and provide a baseline from which to judge the likely impacts of various policies upon rural seniors and disabled adults.

To complement this background information, the Panel has developed a set of rural-oriented principles for use in evaluating how different prescription drug proposals may meet the needs of rural Medicare beneficiaries. These principles are included in this document, along with a summary of relevant sections of six proposals that were introduced in Congress between April and August 2000. These six proposals were selected because they typify the different design options under consideration and/or because they are at the center of current debate. Following the summaries, we present our assessment of how specific plan features may or may not support the set of rural oriented principles.

In this paper we do not provide a comprehensive analysis of each of the individual proposals under consideration, nor do we advocate adopting any specific proposal. Instead, we present different components of the competing plans and analyze their potential impact on rural Medicare beneficiaries. In conducting this analysis, we recognized the inherent conflict between providing a benefit generous enough to be meaningful to rural beneficiaries and maintaining the long-term affordability of a prescription drug plan. Where possible, we have tried to illustrate these conflicts and provide an overview of the rural issues to be considered.

II. BACKGROUND: THE IMPORTANCE OF PRESCRIPTION DRUG COVERAGE FOR RURAL SENIORS

Over the past decade, prescription drugs have become an increasingly large segment of the health care sector, both in terms of utilization and cost. Because Medicare does not pay for prescription drugs, and because many beneficiaries lack supplemental prescription drug coverage, the elderly and disabled have borne a substantial degree of this price inflation out of their own pockets. In response, Congress has introduced a number of proposals aimed at improving access to prescription drugs for Medicare beneficiaries.

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[1]This study has been funded by a grant from the Federal Office Of Rural Health Policy, Health Resources and Services Administration, DHHS (cooperative Agreement # CSUR00003-02-0).

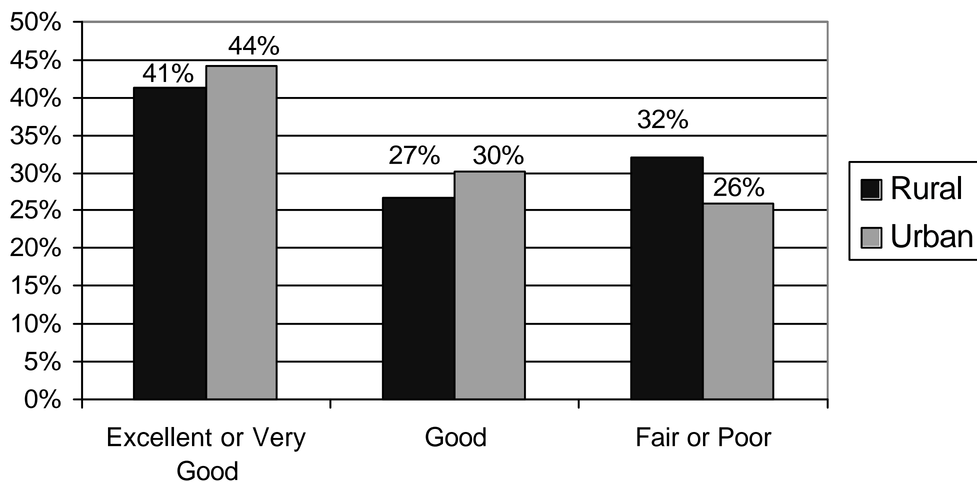
[2]The 1996 MEPS data are taken from a combination of two electronic releases by the Agency for Healthcare Research and Quality (1998 and 2000).

Improving access to prescription drugs will be a particularly important policy initiative for rural Medicare beneficiaries. Older persons in rural areas have both a higher need for, and reduced access to, prescription medications when compared to those in urban areas.[3]

Rural seniors are less healthy than urban seniors and purchase more prescription medications than urban seniors.

The rural elderly tend to be in poorer health and have higher rates of chronic health problems (Coburn & Bolda, 1999). As indicated in Figure 1, the rural elderly are more than 20% more likely to be in fair or poor health compared to the urban elderly (32% versus 26%). Moreover, rural seniors are significantly more likely to suffer from chronic, life-threatening health conditions such as diabetes or hypertension for which prescription medications are critical to reducing morbidity and mortality (Agency for Healthcare Research and Quality (AHRQ), 1998 & 2000). As a result, the mean number of prescriptions purchased by the rural elderly in 1996 was 24 compared to 21 among the urban elderly (this difference is statistically significant, P=.038) (AHRQ, 1998 & 2000).

Figure 1: Self-reported Health Status of Elderly Medicare Beneficiaries, 1996



c2, p £ .05
Source: 1996 Medical Expenditure Panel Survey

[3] The background information presented in this section focuses on elderly Medicare beneficiaries. We recognize that access to affordable prescription drugs is an important issue for rural beneficiaries who are covered by Medicare because of a disability. However, the MEPS data do not contain a large enough sample of rural persons with disabilities who are under the age of 65 to duplicate this analysis for that group.

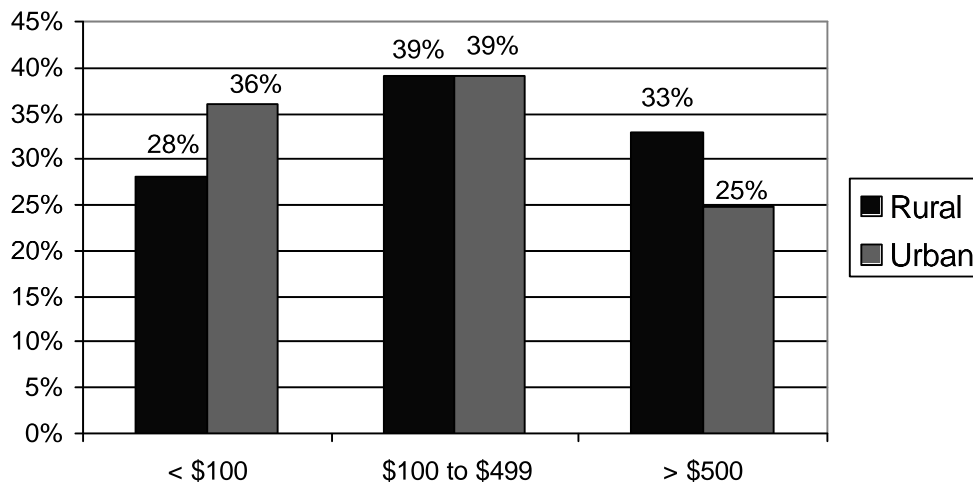
Although they have a greater need for prescription medications, the rural elderly are more likely than urban seniors to lack prescription drug coverage.

Rural seniors are 50% more likely than urban seniors to lack prescription drug coverage. In 1995, 46% of the rural elderly lacked prescription drug coverage compared to only 31% in urban areas (Poisal et al., 1999). This stems in part from the fact that rural residents have lower access to employer-sponsored retirement health plans than urban residents, and consequently are more likely to purchase individual Medigap plans or go without supplemental insurance (Coburn & Bolda, 1999). Only 36% of individually purchased Medigap policies in 1995 included a prescription drug benefit, compared to more than 86% of group plans (Poisal et al., 1999). Recent policy efforts to improve prescription drug access for the elderly, namely the Medicare+Choice program, have been much less successful in rural areas. Only 16% of rural seniors have access to a Medicare+Choice plan with drug coverage compared to 79% of urban seniors (Shay et al., 2000; MedPAC, 2000).

As a consequence of their generally poorer prescription drug coverage and higher utilization of prescription drugs, the rural elderly experience higher annual out-of-pocket costs for their medications than do the urban elderly.

In 1996, one-third of rural elderly Medicare beneficiaries paid more than $500 out-of-pocket for prescription drugs, compared to only one-fourth of beneficiaries in urban areas (Figure 2). Moreover, among older beneficiaries with one of six serious chronic health conditions, a significantly greater percentage of rural beneficiaries (40% compared to 32% for urban beneficiaries) had out-of-pocket expenses costs in excess of $500 (AHRQ, 1998 & 2000).

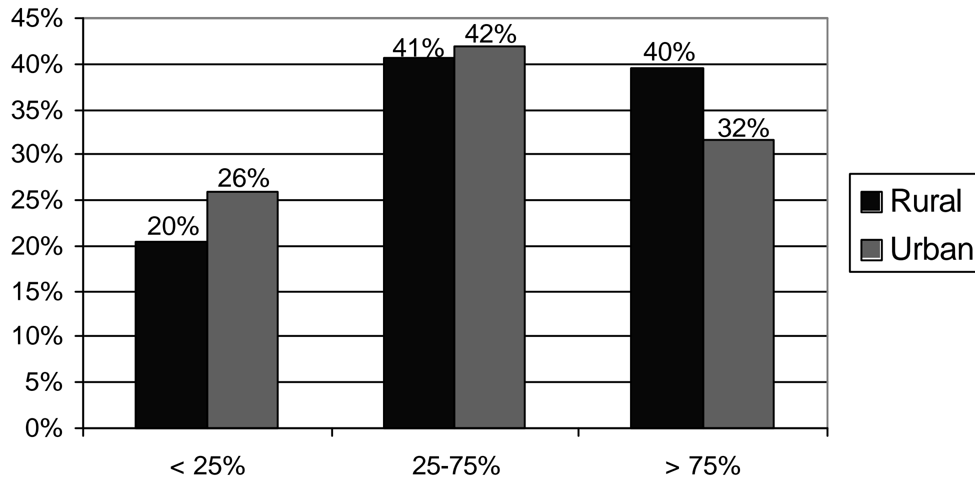
Figure 2: Out-of-Pocket Prescription Drug Expenditures Among Elderly Medicare Beneficiaries, 1996



c2, p £ .001
Source: 1996 Medical Expenditure Panel Survey

Rural seniors pay a significantly higher percentage of expenses out-of-pocket than do urban seniors. In 1996, the rural elderly were more likely to cover more than 75% of their own medication costs (49.1%) than the were urban elderly (21.3%) (Figure 3). This most likely reflects the poorer prescription drug coverage for rural seniors.

Figure 3: Portion of Prescription Drug Costs Paid Out-Of-Pocket by Elderly Medicare Beneficiaries, 1996



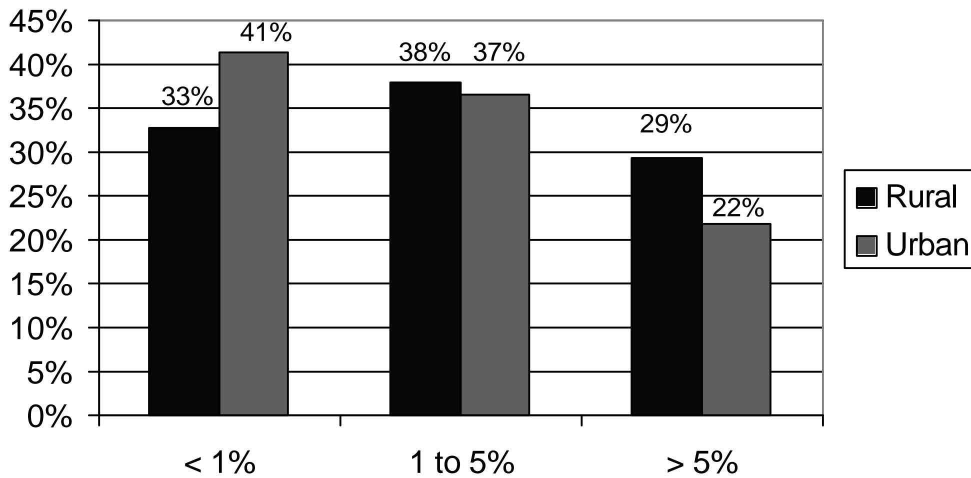
c2, p £ .001
Source: 1996 Medical Expenditure Panel Survey

The burden of prescription drug expenditures upon the rural elderly is compounded by generally lower personal incomes among rural families.

More than half of all rural seniors have family incomes below 200 percent of the federal poverty level, compared to 37.9% of urban seniors (Coburn & Bolda, 1999). As a consequence, the burden of prescription drug costs as a proportion of individual personal income is significantly higher for rural than for urban elderly Medicare beneficiaries. Twenty-nine percent of rural seniors paid more than 5% of their gross income on prescriptions compared to 22% of urban seniors (Figure 4).

The higher proportion of out-of-pocket costs among rural seniors increases the risk that they will not follow the appropriate prescription drug regimens prescribed by their physicians, by either neglecting to fill prescriptions or by taking smaller doses of their medications than prescribed. In 1997, the proportion of rural Medicare beneficiaries who reported that they did not obtain prescribed medication due to cost was more than 60% higher than among urban beneficiaries (National Economic Council/Domestic Policy Council, 2000). This difference will only be exacerbated as prescription drug costs continue to rise, absorbing increased portions of the fixed incomes of seniors, with the potential to increase morbidity and mortality among rural elderly Americans.

Figure 4: Portion of Personal Income Paid for Prescription Drugs by Elderly Medicare Beneficiaries, 1996



c2, p £ .001
Source: 1996 Medical Expenditure Panel Survey

III. ANALYSIS OF PROPOSED LEGISLATION

The six legislative proposals summarized in this document were introduced in Congress between April and August 2000. We are commenting on these proposals using the text at the time of introduction, with one exception (modifying S. 2342 to reflect changes in the mid-year review published by the Office of Management and Budget). 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 proposals we have included in this paper fall under one of three categories: plans that propose to use the Medicare program itself as the vehicle to administer the prescription drug benefit ("Full Medicare"), plans that would expand the availability of private drug coverage ("Medicare/Private"), and plans that are not comprehensive prescription drug plans per se, but offer more limited protection ("Limited Coverage").[4] The "Full Medicare" plans propose that the Medicare program administer the prescription drug benefit by contracting with private plans or entities to manage the benefit. The plans falling under this category include:

> S.2753—"Medicare Expansion for Needed Drugs (MEND) Act of 2000" introduced 6/19/2000 by Daschle.

[4]Analysts for the Kaiser Family foundation created the first two classifications and we will also use this language for consistency (Fuchs et al., 2000).

S.2342—"Medicare Modernization Act of 2000" introduced 4/4/00 by Moynihan on behalf of President Clinton, as modified by the mid-year budget review published by the Office of Management and Budget.

S.2758—"Medicare Outpatient Drug Act of 2000" introduced 6/20/00 by Graham.

The Medicare/Private proposals would expand the availability of private prescription drug coverage through a variety of incentives and subsidies. These plans are:

H.R.4680—"Medicare Rx 2000 Act" introduced by Thomas and passed in the House on 6/28/00.

S.2807—"The Medicare Prescription Drug and Modernization Act of 2000" introduced 6/28/00 by Breaux.

The "Limited Coverage" plan, that offers more limited protection from prescription drug costs for beneficiaries, has two key features, that participants would: 1) become eligible to purchase their medications at negotiated prices, and 2) have catastrophic benefits to protect them from excessive pharmaceutical costs. The single plan included under this category is:

S.2836—"Medicare Rx Drug Discount and Security Act of 2000" introduced 6/30/00 by Hagel.

In this section we analyze, from a rural perspective, the six Medicare prescription drug plans. Because of their higher need for prescription drugs, their lower access to prescription drug coverage, and their higher out-of-pocket costs, rural beneficiaries will clearly benefit from any proposal that expands prescription drug access. However, rural areas and residents have unique characteristics that can impede the equitable distribution of, and enrollment in, any new government program. To complete our analysis, we established four rural-oriented principles that we believe encompass the issues of greatest concern for rural beneficiaries. These are:

1. The benefit must be affordable for rural beneficiaries.
2. There must be no negative impact upon the availability of services in rural areas.
3. Rural beneficiaries must have guaranteed access to a plan and continuity of coverage must be assured.
4. Safeguards to ensure rural participation must be included.

For each of these principles, we present the specific criteria that we believe would need to be met in order to ensure that a prescription drug benefit would meet the needs of rural Medicare beneficiaries. Following the listing of our criteria for judging bills, we describe the provisions included in current proposals and then offer a summary of how certain bills meet or fall short of those criteria.

A. Affordability

Because rural seniors tend to have lower incomes than do urban seniors, affordability is of paramount importance to rural Medicare beneficiaries. Premium costs, together with deductibles and co-insurance features, must be structured to assure that rural beneficiaries have equitable

access to an affordable product. If out-of-pocket costs are not affordable, rural participation will be low in any voluntary plan, frustrating the policy objective of expanded use of a prescription drug benefit. Furthermore, rural seniors will not use medications optimally if their out-of-pocket costs for doing so force them to make trade-off decisions between prescriptions and other uses for their scarce dollars.

In addition to creating a benefit that is affordable for rural Medicare beneficiaries, special consideration is needed to ensure that costs are fairly distributed between rural and urban beneficiaries. Equitable access to affordable prescription drug coverage requires that premiums charged to rural beneficiaries should not vary because they live in rural areas (consistent with historical Medicare policy as evidenced by Part B premiums). Markets should be structured to assure that plans have a broad enough base of enrollees to enable the plan to spread risk using community rates rather than individual underwriting. This means that 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.

Criteria:

Rural beneficiaries will benefit most from proposals that encourage the broadest level of participation, and consequently bigger risk pools, because this will allow for lower premium pricing.

Although lower premium costs will encourage broader participation, enrollees or employers should bear a substantial portion of the premium cost, with adequate subsidization for low-income beneficiaries. This will minimize dependence on the regressive payroll tax that affects the working poor, a group that is over-represented in rural areas. This is a much bigger concern if the benefit is financed through a payroll tax rather than through general revenue funds.

In order to contain costs, limit premium increases, and ensure the long-term solvency of any Medicare prescription drug plan, it is important that some deductible be included. This is because the presence of a deductible has a significant protective effect against the tendency for individuals to increase utilization of services for which they do not bear full cost.

Although some deductible is advisable, the lower relative incomes of rural seniors means that the deductible level should be set low enough to ensure that they have adequate access to needed medications.

Because rural beneficiaries have lower incomes, they will be disproportionately affected by high coinsurance requirements. This is a particular problem given their higher need for medication. Subsidies may be needed for low-income beneficiaries enrolling in plans with high coinsurance requirements.

Stop-loss coverage is particularly important for rural beneficiaries because of their higher rates of chronic health conditions.

Provisions:

	S.2753 (Daschle)	H.R..4680 (House Bill)	S.2342 (Moynihan for Clinton)	S.2807 (Breaux/Frist)	S.2758 (Graham)	S.2836 (Hagel)
Premium	Enrollees pay 50% of the Part D premium; employers enrolling their retirees pay 2/3 of the premium	Enrollees pay Part D premium	Enrollees pay 50% of the Part D premium; employers enrolling their retirees pay 2/3 of the premium	Enrollees pay Part D premium	Enrollees pay 50% of the Part D premium; for incomes over $75,000 (individual) enrollees' share increases up to 100%; employers enrolling their retirees pay 2/3 of the premium	$35 enrollment fee, waived if income below 200% of poverty
Deductible	None	$250	None	$250	$250, waived for generic drugs, tied to performance measures & other incentives	Each plan would determine
Coinsurance	50% coinsurance up to $2,000; then coverage ceases (2002-4); likewise at $3,000 (2005-6); $4,000 (2007-8); $5,000 (2009)	50% after the deductible, on the next $2,100, then 100% up to the stop loss	50% of costs up to $2,000 in 2003-4; $3,000 in 2005-6; $4,000 in 2007-8; $5,000 in 2009	50% after the deductible, on the next $2,100, then 100% up to the stop loss	50% up to $3,500; 25% between $3,500 and $4,000; zero above $4,000	Each plan would determine
Stop Loss: Catastrophic limit	To be determined, due 6 months after enactment	$6,000	$4,000	$6,000	$4,000	Income-based Up to 200% of poverty, $1,200; 200-400%, $2,500; above 400% and less than $100,000 then $5,000
Premium subsidies for low income	Medicaid pays 100% of premium for income up to 135% poverty, then sliding scale to 150% poverty; federal government pays when person not on Medicaid	100% premium subsidy, 95% cost sharing for income below 135% poverty; declining subsidy to 150% poverty	Medicaid pays 100% of premium if income below 135% poverty, then sliding scale to 150% poverty; federal government pays when person not on Medicaid	100% subsidy for income up to 135% poverty, then sliding scale to 150% of poverty and 25% above 150%	100% premium subsidy, 95% cost sharing for income below 135% poverty; declining subsidy to 150% poverty	$35 enrollment fee waived for households below 200% of poverty
Cost provisions for non-covered drugs	Pharmacies shall not charged more than negotiated price for an individual drug	Beneficiaries have access to negotiated prices for drugs, even when benefit is not otherwise payable because of cost sharing	Enrollees who exhaust plan's benefits will have access to prescription drugs at negotiated prices equivalent to those used by the plan	Beneficiaries have access to negotiated prices even for drugs for which coverage not otherwise provided		Beneficiaries possess discount card, lowering prices, even when prescriptions not included in catastrophic coverage provisions

Assessment:

The Full Medicare proposals (S. 2753, S. 2342, and S. 2758) have the potential to encourage the broadest level of participation by targeting employers as well as individual enrollees. Enrolling employer-sponsored groups, in addition to those currently with an individually purchased plan or no coverage, will result in larger risk pools and permit more affordable plan pricing. The extent of this participation will depend heavily on the degree to which employers perceive a Medicare D prescription benefit to be more affordable and beneficial for their employees. Providing a 25% premium subsidy to employers should be adequate incentive to encourage broad participation. One recent study has estimated that, under a Full Medicare plan with this level of employer subsidy, 80% of beneficiaries covered by an employer-based plan would enroll compared to only 36% under a Medicare/Private plan (Fuchs et al., 2000). Rural beneficiaries are less likely to be enrolled in any group plan, including employer-based plans. Hence, proposals targeting employers will have much less of an impact in rural areas.

For those proposals that rely on individual enrollees purchasing coverage from private plans, such as H.R.4680 and S.2807, competition between plans is the intended mechanism for keeping premiums affordable. However, as demonstrated by the implementation of Medicare+Choice, ensuring competition in rural areas is often not an achievable goal. To limit variations in premiums and improve the risk pools, organizations could be required to offer their plans on a statewide basis using a community rating approach. This would protect rural beneficiaries from being left out of plan markets and facing higher premiums than their urban counterparts. Any increase in premiums in urban areas because of a community rating approach should be minimal given the small numbers of rural elderly.

By excluding a deductible, both S.2753 and S.2342 offer first dollar coverage, which we feel is not the most efficient use of resources. First, the risk of increased utilization and subsequent premium increases that would ensue could undermine the long-term affordability of Medicare Part D. At the same time, first dollar coverage particularly benefits enrollees whose overall prescription drug needs are not high. Since rural beneficiaries tend to be in poorer health, with more chronic conditions, including a deductible and using the cost savings to reduce coinsurance burdens would be of greater benefit. Limiting the annual out-of-pocket expenses (stop-loss coverage) could also benefit low income rural elderly.

Stop-loss coverage is a costly but important plan feature for rural Medicare beneficiaries because of their higher rates of chronic illness. However, determining the specific level of stop-loss coverage represents yet another complicated trade-off between containing program costs and providing meaningful coverage to individuals with catastrophic prescription drug costs. One analysis has estimated that in 2003 only 4% of beneficiaries will have out-of-pocket prescription drug costs in excess of $6,000, while 10% will have costs in excess of $4,000 (Fuchs et al., 2000). While the lower catastrophic ceiling would benefit a larger number of rural beneficiaries, the impact on long-term premium costs will need to be evaluated. The insurance facet of proposal S.2836 is primarily a catastrophic benefit (with discounts for non-catastrophic drug costs) and staggers the catastrophic limit based on family income. This strategy would particularly benefit rural seniors who have lower incomes, and would consequently have lower out-of-pocket limits.

Provisions to control beneficiary costs for non-covered drugs (e.g., drugs not included as a Medicare benefit, or drugs not included in a specific list (formulary) used by a particular plan)

could be of particular benefit for rural residents because they tend to have less access to large pharmacy chains that rely on volume to offer lower prices. Negotiated discounts between Medicare and prescription drug providers would be particularly helpful for rural Medicare beneficiaries whose costs fall between the benefit limit and the stop-loss ceiling of either the Full Medicare or Medicare/Private proposals. Although this would be an improvement over the status quo, it is critical that price negotiations for drugs be conducted in a way that does not undermine small, local pharmacies. S.2836 is almost solely (along with the catastrophic benefit) based upon this mechanism to reduce retail costs and increase beneficiary access. While this proposal does not provide the richest benefit, it would be an improvement over the status quo.

B. Impact on Local Services

Appropriate access to pharmaceutical services in their local communities is vital to rural seniors and should be assured in any prescription drug plan. Rural seniors are used to the service provided by local pharmacies. Logistical impediments, like having to pick up prescriptions from the post office because it is delivered to a post office box (which could be true if new plans use mail order pharmacies), can be a significant problem in rural places. Local rural pharmacists are primary care providers (Miller & Scott, 1996), serving as safety net providers in many communities (Lewin & Altman, 2000). Local pharmacists are important resources for health care information in isolated rural communities. They are also a vital resource for other health care providers. Proposals to add prescription drugs to the Medicare program should explicitly encourage the inclusion of local pharmacists as vendors.

Criteria:

The role of local pharmacies must not be undermined by the implementation of a Medicare prescription drug benefit.

Private plan or government incentives to lower costs for prescription drugs, such as mail-order or other bulk purchasing arrangements, should not be implemented without protections for low-volume, local pharmacies.

Plans must not be allowed to reimburse rural pharmacies at lower rates than urban pharmacies. In fact, given the higher marginal costs inherent in selling smaller volumes of medications, policymakers may want to consider ways to help small rural pharmacies meet these marginal costs.

Provisions:

	S.2753 (Daschle)	H.R..4680 (House Bill)	S.2342 (Moynihan for Clinton)	S.2807 (Breaux/Frist)	S.2758 (Graham)	S.2836 (Hagel)
Requirements specifying access	Evidence of contracts with local providers to ensure access, special attention to access and delivery in rural and hard-to-serve areas	Secure sufficient participation of pharmacies to ensure convenient access	Secure sufficient participation of pharmacies to ensure convenient access	No specific provisions	To the extent feasible, use retail pharmacies located throughout the service area to ensure reasonable geographic access (determined by the Secretary)	No requirements or restrictions
Use of local pharmacies	Possible bonus to retail pharmacists in rural areas	See previous statement	Permit participation of any pharmacy in the service area that meets the participation requirements	No specific provisions	See previous statement	See previous statement
Use of incentives, steering	Possible bonus to retail pharmacists in rural areas; bonus and penalty incentives to encourage administrative efficiency; plans submit proposals to increase Govt. cost-sharing for generic drugs, drugs on formulary, mail order pharmacies	Incentives for plan to expand to adjacent under-served area	Bonus and penalty incentives to encourage administrative efficiency under which benefit managers share in any benefit savings; risk sharing arrangements related to benefit payments	Plans will create programs To assure effective cost and utilization, quality assurance measures to reduce medical errors and adverse drug interactions, and to control fraud, abuse and waste	Use mechanisms to encourage beneficiaries to select cost-effective drugs or less costly means of receiving drugs	None
Special provisions	MedPAC study of the program, including impact on beneficiary access to prescriptions and rural pharmacies	None	None	None	None	None

Assessment:

Previous experience has demonstrated that changes in the Medicare program, such as the Prospective Payment System for hospital inpatient care, have the potential to undermine the health care delivery system in rural areas. Instead of attempting to fix access problems that could ensue from a prescription drug benefit, plans should proactively establish provisions to protect small rural pharmacies. The pharmacist in particular serves a crucial function by providing education and advice to rural Medicare beneficiaries who typically have reduced access to other sources of health care compared to urban beneficiaries. (Ranelli & Coward, 1997)

Of the Full Medicare plans, S.2753 provides the strongest protection for rural pharmacies by requiring that insurers who are providing or managing the benefit must contract with local providers. Another Full Medicare proposal, S.2758, requires that "where feasible" retail pharmacies should be the method for delivering medications to beneficiaries, but it is unclear how this will be assured or how feasibility will be defined. The House's Medicare/Private plan (H.R.4680) and a third Full Medicare plan, S.2342 both require that a sufficient number of pharmacies be included in plan contracts to ensure convenient access. However, as with S.2758, this language is imprecise and does not make clear how this access will be assured. S.2342 includes a provision to require that a plan managing the prescription benefit must contract with any willing, eligible pharmacy within its service area.

Nearly all of the plans contain incentives to encourage the use of lower cost prescription drugs, either at the plan or the individual patient level. At the plan level these incentives include allowing plans to share in cost savings achieved through administrative efficiency and bulk purchasing, including negotiated discounts with pharmacies. Other strategies designed to influence consumer behavior include formularies and lower coinsurance for generic medications. Because small rural pharmacies typically have lower sales volume, their marginal costs are higher and they could bear higher losses from negotiated prices than their urban counterparts. Also because of their low volume, independent rural pharmacies may have a harder time stocking a wide range of generic drugs and could consequently lose market share to chain pharmacies. While limiting prescription drug costs will help keep a prescription drug benefit affordable, the impact of these arrangements on rural pharmacies will need to be evaluated. There is already evidence that efforts to control prescription drug costs by managed care companies have forced many small independent pharmacies to close (MacPherson, 1996). Only S.2753 takes these issues into account by allowing for possible bonus payments to rural pharmacies and requiring impact studies of the effects of these cost containment measures on beneficiary access and pharmacy solvency.

C. Plan Availability and Continuity of Coverage

If a prescription drug proposal is to meet the needs of rural beneficiaries, one of the chief issues to be addressed is how plan availability will be guaranteed to eligible enrollees. Under the Full Medicare proposals, private insurers (or other eligible entities) would manage the prescription drug benefits, as defined and administered by the government, while under the Medicare/Private proposals, private health plans would actually create and administer benefit plans. In both cases, the private market alone cannot be relied upon to ensure that plans are available for rural

Medicare beneficiaries. Past experience with Medicare+Choice has demonstrated that the distribution of plans across the country is not uniform, and that rural areas in particular often have no available plan.

Continuity of coverage is a particular concern for rural Medicare beneficiaries because they are likely to have fewer options, if any, available to them if the plans in which they are enrolled become insolvent or have profit margins that are not sufficient to continue participation in the Medicare program. Changes in coverage could be greater in smaller rural states and markets which tend to be more volatile. Rural beneficiaries need assurance that they will have continuous access to an affordable plan with comparable benefits in the event that plans drop coverage. Although ideally the same plans would be offered continuously, at least there should be only minimal variation over time in the design of substitute plans.

Criteria:

Because private insurers may be reluctant to offer or manage prescription drug plans in rural areas, the federal government must provide or arrange for the provision of a "plan of last resort."

Private plans applying to provide or manage the prescription benefit should be required to provide sufficient proof of long-term solvency.

Benefit structure and management should be roughly comparable between plans so that rural seniors do not face large disruptions in coverage if forced to switch plans.

Provisions:

	S.2753 (Daschle)	H.R..4680 (House Bill)	S.2342 (Moynihan for Clinton)	S.2807 (Breaux/Frist)	S.2758 (Graham)	S.2836 (Hagel)
Defining the service area	At least 15 areas designated, done to assure reasonable level of competition and reach maximum number of areas	Not specified; but plans primarily serving rural areas must meet minimum enrollment criteria of 1,500 persons in rural areas	At least 15 areas designated, to a "maximum feasible number"		Must be at least the size of the commercial service area of the contracting entity, and not smaller than a state	
Plan solvency or related assurance	"entity shall have financial resources adequate to perform services … without risk of insolvency"	Plan is licensed by a state or meets financial solvency standards established by the Medicare Benefits Administrator	"entity shall have financial resources adequate to perform services … without risk of insolvency"	Plan is licensed by a state, or meets financial solvency and capital adequacy standards set by the commissioner	Entity must meet financial standards set by the Secretary	No specific requirement
Guaranteed availability or "Plan of last resort"		Medicare Benefits Administrator to assure at least 2 qualifying plans in every area		Commissioner makes arrangements in areas where no plan is offered	Secretary shall develop procedures for areas where there are no contracted benefit managers	No specific provision but presumption of multiple entities being available
Benefit structure	One level of defined benefits	Plans must offer the standard benefit, or a benefit of equal or higher actuarial value	One level of defined benefits	Plans must offer the standard benefit, or a benefit of equal or higher actuarial value	One level of defined benefits	No specific requirement
Formularies	Pays for any drug deemed medically necessary by medical provider, regardless of formulary	Requires formation of committees to review formularies; drugs from each therapeutic class must be included	Pays for any drug deemed medically necessary by medical provider, regardless of formulary	Drugs from each therapeutic class must be included	Formulary standards set by Secretary and Advisory Committee; drugs from each therapeutic class must be included; two drugs & one generic from each class must be in formulary if available; medically necessary drugs must be covered regardless of formulary	

Assessment:

Because the Full Medicare proposals are designed to be a single universal benefit, these plans offer the greatest guarantee of availability and continuity of coverage for rural beneficiaries. However, these plans require Medicare to enter into contracts with bidding private entities to manage the new benefit. Two of the proposals, S.2753 and S.2342 do not provide a specific procedure to follow should there be no bidders in a given service area. Some provision must be in place in the event that no private entities choose to manage the prescription drug benefit in rural areas or if there is a higher degree of volatility in the plans available to rural residents. Bill S.2758 gives the Secretary of DHHS the responsibility to develop a procedure to administer benefits in areas where there are no contracting benefit managers. To the extent that this "procedure" creates an equitable and accessible benefit when compared to private entities, it could provide the needed assurance of plan availability for rural beneficiaries.

The way that service areas are defined also affects the likelihood that a plan would choose to offer or manage a prescription drug benefit for rural Medicare beneficiaries. Allowing plans to cover very small areas, or to carve out parts of regions, could lead to service areas that exclude rural beneficiaries. Four of the six proposals are silent or vague about how they would prevent this market segmentation. The House bill does not set specific requirements for defining service areas, but does mandate that plans serving rural areas include at least 1,500 rural residents, assuring some minimum size for risk pooling. S.2758 provides the strongest protection against market segmentation by requiring that any entity seeking to manage the benefit must cover a service area at least the size of its commercial market and no smaller than a state.

Assuring the availability and continuity of coverage for rural Medicare beneficiaries will be more challenging under the Medicare/Private models, as has been demonstrated by the Medicare+Choice program's limited penetration into rural areas. These proposals are premised on the availability and competition among plans offering prescription drug coverage. H.R.4680 has a provision for offering unspecified "incentives" to encourage plans to offer policies in areas without at least two plans. There is no specific requirement that every area be served by a competing health plan. The Senate Medicare/Private proposal, S.2807, provides some protection against the failure of plan availability in rural areas by requiring the Commissioner of the Competitive Medicare Agency to "make arrangements" for areas where no plan is offered. This would qualify as a plan of "last resort" if the arrangements for plans were guaranteed to include comprehensive and accessible benefits for rural Medicare beneficiaries.

Comparability between plans is critical given the higher degree of volatility in the rural health insurance market. Two areas where plans could differ are in the benefit structure and in the use of formularies to cover only certain brands of medication for specific illnesses or chronic conditions. Because the Full Medicare proposals are designed to create one universal prescription drug benefit, the only differences between plans would be in the way the benefits are managed, not in the benefits themselves. Under the Medicare/Private proposals, plans are required to offer the "standard benefit" but can, under certain circumstances, offer a "qualified alternative benefit"—one that has an identical or higher actuarial value. If private insurers choose to create a number of different "alternative benefit" plans, then rural residents could face different benefit structures if forced to change plans.

Another source of variation in plans could be in the use of formularies to restrict the treatment of specific illnesses or chronic conditions to certain brands of medications or their generic

counterparts. Because plans could use different formularies, beneficiaries forced to change plans could also be forced to change medications to achieve maximum coverage. Safeguards will be needed to achieve comparability between formularies so that rural beneficiaries, who typically take more medications, will not suffer any negative health effects or complications from having to switch plans. The Medicare/Private plans provide only a minimal safeguard by requiring that drugs from all therapeutic classes be covered. At the other end of the spectrum, the Full Medicare bill S.2758 offers the strongest protection against involuntary medication changes by requiring two drugs and at least one generic option to be included in each class for which multiple formulas are available. This plan, as well as the other two Full Medicare proposals, also includes a provision assuring that drugs deemed to be medically necessary by a beneficiary's provider will be covered, regardless of the formulary. We believe this to be the minimal safeguard needed to ensure that rural Medicare beneficiaries do not face disruptions in their pharmaceutical therapies.

D. Ensuring Rural Participation

Providing a prescription drug benefit is a necessary but insufficient condition for assuring that rural Medicare beneficiaries actually enroll in the plan. To ensure enrollment of rural seniors, mechanisms appropriate to rural communities and norms must be developed to inform rural seniors of their benefit options and to facilitate enrollment in their plan of choice.

Rural beneficiaries tend to have lower levels of formal education than do urban beneficiaries. In 1996, nearly half (46%) of rural seniors had less than a high school education, compared to only 36% of urban seniors (Source: 1996 MEPS). At the same time, rural Medicare beneficiaries have lower rates of supplemental coverage, particularly for prescription drugs, and consequently have less experience enrolling and participating in privately owned or managed plans. For this reason, a special effort must be made to enroll rural beneficiaries and educate them about their rights and responsibilities under a Medicare prescription drug benefit.

In addition to needing specific education around benefit features, rural residents may have different enrollment needs. Proposals that limit a beneficiary's ability to enroll in a prescription drug benefit plan to one narrow window of time could disproportionately reduce rural participation. This would be particularly true in the early phases of the program if rural Medicare beneficiaries lack an attractive prescription drug plan option in their area that could later become available, especially if the Medicare/Private model were adopted. However, we recognize that unlimited opportunities to enroll could encourage beneficiaries to wait until they have expensive pharmaceutical costs to sign up for a plan. This problem of adverse selection could be minimized by imposing waiting periods or surcharges for individuals who enroll after a certain period of time.

Criteria:

Because of the unique characteristics of rural residents, safeguards to ensure rural participation in a Medicare prescription drug benefit are needed.

Educational activities should allow for the unique characteristics of rural areas and permit education by those most familiar with these characteristics.

Enrollment should not be limited to a one-time only window of eligibility, although adverse selection measures should be adopted.

Provisions:

	S.2753 (Daschle)	H.R..4680 (House Bill)	S.2342 (Moynihan for Clinton)	S.2807 (Breaux/Frist)	S.2758 (Graham)	S.2836 (Hagel)
Beneficiary Education	Disseminate materials designed to encourage effective use of drug benefits, and assure that individuals understand rights and obligations	Active dissemination of information related to price, quality, and other features; use of annual informational documents, toll-free hotlines, and non-Federal entities	Disseminate materials designed to encourage effective use of drug benefits, and assure that individuals understand rights and obligations	Commissioner conducts activities to broadly disseminate information to eligible beneficiaries; disclosure by plan of formulary, access to covered drugs, copayments, coinsurance, and deductibles Medicare Consumer Coalitions can be established and paid to execute beneficiary education programs	Medicare Consumer Coalitions can be established and paid to execute beneficiary education programs	Materials disseminated by competing entities; commissioner to provide for broad dissemination of information
Enrollment	Initial enrollment at time of eligibility for Part B	Initial enrollment at time of eligibility for Part B; annual selection of plan	Initial enrollment period same as for Part B, unless enrolling for the first time under an employer-based plan	Initial enrollment at time of eligibility for Part B; annual selection of plan	Open enrollment with 10% premium penalty for every year beneficiary is eligible but not enrolled	Open at time of eligibility for Part B, except for initial open enrollment after enactment
Ability to exit, reenter	Secretary to study feasibility and advisability of an annual open enrollment period	Enrollment for those who involuntarily lose coverage	Secretary to study feasibility and advisability of an annual open enrollment period	Enrollment for those who involuntarily lose coverage	Enrollees who exit and reenter are charged 10% premium penalty for every year between exit and re-enrollment	Special enrollment for those recently losing medical assistance

Assessment:

Two of the Full Medicare plans propose to "disseminate materials" on how to use a prescription drug benefit effectively and cost-effectively, as well as the rights and obligations of enrollees. This method of information dissemination would be inadequate for addressing the needs of rural Medicare beneficiaries whose formal education and experience with private insurance tends to be lower than those of urban beneficiaries. Prior experience has shown that outreach and enrollment for new health programs, such as the State Children's Health Insurance Program (S-CHIP), are most successful in rural areas when implemented at the community level. Local entities, such as Area Agencies on Aging, have the experience and cultural sensitivity necessary to gain rural Medicare beneficiaries' trust and effectively educate them about their benefit options.

For this reason, S.2807 and S.2758 offer the best opportunity to provide the needed education to rural Medicare beneficiaries. These plans include a provision to allow the establishment of Medicare Consumer Coalitions to organize and implement beneficiary education efforts. This option would be most beneficial if service areas for these Coalitions were relatively small, so that rural beneficiaries could be served by entities from their own or neighboring communities. Additionally, Coalitions serving rural areas should receive adequate compensation to allow for travel into the communities they service, since direct contact is the most effective tool for outreach and education.

Nearly all of the plans limit the enrollment period for the prescription drug benefit to a "one-time only" window that coincides with enrollment in Medicare Part B. As indicated in our discussion above, we believe that one-time only enrollment opportunities could be a barrier to enrolling rural Medicare beneficiaries who may face limited plan choice or need extra education about their options. Two of the Full Medicare proposals include provisions to study the impact of annual open enrollment, however, there would clearly be significant lag time between the study's inception and the implementation of annual enrollment, if it is deemed feasible. The Medicare/Private proposals address the involuntary disenrollment risk that rural beneficiaries in particular face, by permitting enrollment for involuntary disenrollees. However, a Medicare beneficiary whose cost sharing in an employer-based plan rose above the new Medicare prescription benefit would be stuck in the higher cost plan. Similarly, a beneficiary whose income dropped from 150 percent of poverty (no subsidy) to 135 percent of poverty (full subsidy) would not be able to enroll, even if that were the first time that the benefit was affordable. Consequently, the plan that offers the best assurance of rural participation is S.2758, which allows beneficiaries to enroll after the open enrollment period, and to reenter following disenrollment, subject to a premium surcharge based on the length of time they were eligible but not enrolled in the benefit.

IV. CONCLUSIONS

Rural Medicare beneficiaries would benefit from the expanded prescription drug coverage offered in all of the legislative proposals reviewed in this paper. As demonstrated by this analysis, however, the extent of the financial and other benefits will vary depending on the specific design and features of any legislative proposals. The nature and circumstances of rural communities and Medicare beneficiaries pose unique challenges to the design and

implementation of a benefit that will provide meaningful and equitable prescription drug access for rural seniors and persons with disabilities. Special consideration must be paid to these rural challenges and safeguards included to ensure widespread participation among rural seniors.

Based on the principles articulated earlier in this paper, the RUPRI Rural Health Panel considers the following to be among the chief challenges in designing a prescription drug plan that will benefit rural Medicare beneficiaries:

A. Affordability

Balancing the affordability of any prescription drug plan for the beneficiary with the need to assure the long term affordability of the plan for the Medicare program is critical. As our analysis demonstrates, affordability for both the beneficiary and the Medicare program will be influenced by a number of plan features. In addition to the obvious features such as beneficiary cost-sharing and stop-loss provisions, features such as incentives for employer participation and the extent of discounts (or other price control mechanism) will have an important impact on the costs which beneficiaries and the Medicare program will face.

> **Specific Recommendations:** The Panel supports the use of beneficiary cost-sharing (i.e., premiums, deductibles and co-insurance) as a protection against increased utilization and to ensure the long-term affordability of the prescription drug plan. These should be combined, however, with income-based subsidies and stop-loss provisions that recognize the greater burden that rural beneficiaries face in paying for prescription drugs. Plans that include more generous stop-loss provisions are particularly important for rural beneficiaries because of their higher rates of chronic illness and, hence, need for prescription medications. In addition, proposals that control beneficiary costs through negotiated discounts or price control schemes are especially important to rural beneficiaries who tend to have less access to large pharmacy chains that can use volume to offer lower prices.

B. Impact on Local Services

Appropriate access to pharmaceutical services in their local communities is vital to rural seniors and should be assured in any prescription drug plan. The Panel believes that provisions are needed to protect local, low volume pharmacies in rural areas, especially in plans that create incentives for cost-savings through mail order or bulk purchasing arrangements. A number of bills include such provisions.

In addition, plans should provide equitable payments to rural and urban pharmacies. Ideally plans should recognize the higher cost of providing local pharmacy services in rural communities. As noted, rural pharmacies typically have lower sales volume and therefore higher marginal costs. They are at greater financial risk than their urban counterparts under plans involving negotiated prices. Independent rural pharmacies may also have a harder time stocking a wide range of generic drugs and could consequently lose market share to chain pharmacies and mail-order pharmacy services.

Specific Recommendations: Legislative proposals should take these issues into account by allowing for possible bonus payments to rural pharmacies, and requiring impact studies of the effects of cost containment measures on beneficiary access and pharmacy solvency.

C. Plan Availability and Continuity of Coverage

As indicated by our analysis, the question of whether and how to use private plans and the market and/or the Medicare program to make prescription drug coverage plans available for Medicare beneficiaries has important implications for rural seniors. Continuity of coverage is also a particular concern for rural Medicare beneficiaries because they are likely to have fewer options available to them if the plan in which they are enrolled becomes insolvent or withdraws from the program due to insufficient profit margins.

Specific Recommendations: Several of the plans reviewed here include explicit provisions that assure that the federal government would provide or arrange for the provision of a "plan of last resort." In addition, solvency protection features are important to assure continuity of coverage for rural residents. Features that protect against variations over time in the design of such plans are equally critical; ideally, the same plans would be offered continuously.

D. Ensuring Rural Participation

The definition of the enrollment period is an important issue for all seniors, but especially in rural areas where rural Medicare beneficiaries may face limited plan choice or need extra education about their options. Whether and how beneficiaries who have involuntarily lost coverage because of the departure of a plan or changes in their income are able to regain coverage is also of particular concern to rural seniors.

Nearly all of the plans limit the enrollment period for the prescription drug benefit to a "one-time only" window that coincides with enrollment in Medicare Part B. Two proposals (S. 2753 and S. 2342) include provisions to study the impact of annual open enrollment.

Specific Recommendations: A provision in several plans allowing re-enrollment of beneficiaries who have involuntarily lost coverage is particularly important for rural seniors who may be at greater risk of losing access to a plan. Ideally, however, beneficiaries should be allowed to enroll after the open enrollment period, and to reenter following disenrollment, subject to a premium surcharge based on the length of time they were eligible but not enrolled in the benefit.

To ensure enrollment of rural seniors, mechanisms appropriate to rural communities and norms must be developed to inform rural seniors of their benefit options and to facilitate their enrollment in their plan of choice.

Specific Recommendations: Several plans include provisions to allow the establishment of Medicare Consumer Coalitions to organize and implement beneficiary education efforts. This option would be most beneficial if service areas

for these Coalitions were relatively small, so that rural beneficiaries could be served by entities from their own or neighboring communities. Additionally, Coalitions serving rural areas should receive adequate compensation to allow for travel into the communities they service, since direct contact is the most effective tool for outreach and education.

This analysis of legislative proposals for prescription drug coverage is consistent with one of the important lessons of the Medicare+Choice Program: program design is critical for ensuring that rural Medicare beneficiaries have equitable access to the same program benefits as urban seniors. It also demonstrates that specific plan features and how they are implemented could have significant implications–positive or negative--for the important policy goal of assuring that rural Medicare beneficiaries have a sustainable, high quality health system to meet their health care needs. All of the legislative proposals reviewed here have the potential for improving the circumstances of rural Medicare beneficiaries. It is critical that policymakers pay careful attention to the design and implementation features in these proposals that are especially important for rural seniors and the rural health system.

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RUPRI Rural Health Panel

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