REDESIGNING MEDICARE: CONSIDERATIONS FOR RURAL BENEFICIARIES AND HEALTH SYSTEMS

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RUPRI Rural Health Panel

Special Monograph

RUPRI Rural Health Panel:

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INTRODUCTION

As we begin a new session of Congress and a new Presidential Administration, one of the major policy debates will focus on the future of the Medicare program. The enactment of the Balanced Budget Act of 1997 (BBA) dramatically changed the context for discussions of Medicare policy. Two major pathways for discussion were identified:

- appropriate and equitable payment for services, either through traditional fee-for-service (FFS) Medicare payments or through Medicare+Choice monthly premiums; and

- appropriate and necessary changes to the program to assure long-term solvency and adequate, affordable benefits for beneficiaries.

The Rural Health Panel of the Rural Policy Research Institute (RUPRI) has been participating in the discussion along both paths, providing analyses of changes that have been enacted and of proposals for further changes. Our analyses have focused on implications of change for rural Medicare beneficiaries and health care providers in rural areas and on maintaining a rural health care delivery infrastructure. There were legislative precursors to the BBA, and the RUPRI Panel critiqued those proposals as well, including analysis of impacts on rural economies. The Appendix includes a listing of previous publications concerning the debates about Medicare along the two paths identified above.

This monograph is an extension of the previous work of the RUPRI Panel, and suggestions made by advisors to the RUPRI Center for Rural Health Policy Analysis.[1] We are detailing a framework for use by those interested in the future of health care services in rural areas in helping to shape proposals to redesign the Medicare program. As is always the modus operandi of RUPRI, *we are not building an argument for any particular change in the Medicare program; instead, we are specifying the rural interests to be considered in any proposed change*. Various advocates for rural residents and rural health care providers will want to craft more specific proposals based on the information and analysis provided to them.

With this monograph, the RUPRI Rural Health Panel is presenting a well-defined framework for what *should* be included in any discussion of Medicare policies. While we have benefitted from the counsel of many colleagues, *specific statements of policy objectives that ought to be included in any redesign of the Medicare program are those of the Panel only.*

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[1]The RUPRI Center for Rural Health Policy Analysis is one of 6 research centers supported by the Federal Office of Rural Health Policy. The advisors to the Center are: Stephen Mick, Ph.D. (Professor, Virginia Commonwealth University), Alan Morgan (Vice President, Government Affairs and Policy, National Rural Health Association), John Sheehan (Baird, Kurtz & Dobson), Kris Sparks (Director, Office of Community and Rural Health, Washington), and Stephen Wilhide, MSW, MPH (President and CEO, Soiuthern Ohio Health Services Network).

I. ORGANIZATION OF THIS CHAPTER AND MONOGRAPH

The first section of the chapter details the context within which changes in Medicare policy should be considered. There are two critical elements to that context:

- There is a *continuum of rural places*, which leads to variation in how new policies will affect the residents (including Medicare beneficiaries) of those places.

- There is a *continuum of approaches for changing the Medicare program*, which vary in their reliance on government regulation and/or activities in a competitive marketplace.

Each of these elements needs to be understood, and variation in the two continua should structure the specifics of any critiques. In brief, the effects of the Medicare program are wide-ranging, and the impact that changes in the program will have on the existing delivery system is complex.

The analysis in this monograph is structured around a set of principles that should guide any redesign effort and it establishes the rural meaning of those principles:

1. 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.

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

3. 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.

4. 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.

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

In addition, the Medicare program should be governed and administered using rules and structures that include opportunities for all important concerns to be considered, including those of rural beneficiaries and rural health care systems.

Each of the chapters in this monograph outlines the current situation for rural beneficiaries, analyzes the implications of various approaches to changing the program for rural beneficiaries,

and makes recommendations for developing a Medicare program of greatest benefit to rural residents.

The six principles may generate conflicting goals for public policy. A well-known triangle exists between access, cost, and quality. That is, overemphasis on one principle as a policy goal can easily compromise one or both of the other two. For example, if we were to say access requires a highly skilled health professional no further than 20 minutes or 20 miles from every Medicare beneficiary, the delivery system would become quite costly, and some professionals who require continued experience to maintain skills would not get that experience. Issues involved in balancing across policy goals will be considered throughout this monograph. Of note at this point in our discussion, we believe that *no principle need be sacrificed entirely in order to optimize any other principle.*

II. CONTEXT

Variation in Rural

The characteristics of what we consider to be rural places vary considerably. There are several scales for measuring rurality in use, including one that arrays rural places according to their proximity to urban areas, one that uses commuting patterns, one that uses the size of towns in rural counties, and a simple division of rural into adjacent or not adjacent to metropolitan areas. In addition to variation in place, the health care delivery systems in rural areas vary considerably, from no providers in small communities, to small hospitals and limited professionals, to large tertiary centers with multi-specialty practices. The needs of rural beneficiaries and the impacts of any changes in the Medicare program will be different in different types of rural communities.

Rural As A Place. Any simple definition of rural cannot reflect the rich variety that exists across areas that would include the Everglades of Florida, the farmlands of the Midwest and Northeast, the deserts of the Southwest, the mountains of the West, and the barren lands of the Great Plains. Nor could any single definition reflect the varying densities of population in rural America, from counties with communities as large as 35,000 to frontier counties with fewer than 7 persons per square mile. To complicate matters even more, county-based definitions of rural would classify as urban small settlements far removed from cities but still in the same county (e.g., Ajo, Arizona, across the mountains and over 100 miles from Tucson but still in Pima County). Rural places differ in geographic characteristics, climate, population density, proximity to population centers, and economic base. All of those differences could influence the effects of public policy. Where people live, *place*, can affect their opportunities to take advantage of new developments in policies, especially if policies are based on assumptions dependent on such characteristics as large population and availability of competing resources. (The argument for place-based policy is articulated in the context of welfare policy by Allen and Kirby, 2000.)

Several definitions of rural divide rural counties, or aggregations of census tracts, into different groups. Two that are used more frequently than others are based on adjacency to metropolitan areas and the size of the largest community in the county: 1) urban influence codes that include nine categories, and 2) the rural-urban continuum that includes ten categories (Ricketts, Johnson-

Webb, & Randolph, 1999). Both can be modified to incorporate certain portions of metropolitan counties in rural areas (Golsmith, Puskin, & Stiles, 1993). A different refinement that uses areas smaller than counties is the rural-urban commuting areas (RUCAs) definition, developed by researchers at the University of Washington and the U.S. Bureau of the Census. This scale uses census tracts to combine measures of commuting patterns and adjacency to establish 12 categories on an urban-rural continuum. While this monograph does not adopt a particular definition of rural, we recognize the diversity that can yield multiple categories of places within the aggregation of all rural locations. There are exceptions to any generalization about rural places and the unmet needs of the people who live there.

Health Care Services in Rural Areas. The characteristics of the health care delivery system can and do vary by location, within rural as well as between rural and urban. For example, while the vast majority of rural hospitals are small (72% of the 2,182 general hospitals are under 100 beds), there are large tertiary hospitals in rural areas (Ricketts & Heaphy, 1999). There are vast differences between the Marshfield Clinic in Wisconsin and the Garden County Hospital in Oshkosh, Nebraska. The same can be said for differences in long-term care facilities, home health agencies, pharmaceutical services, and availability of health care professionals. Rural residents living in or near communities with large medical complexes (e.g., Bend, Oregon; Danville, Pennsylvania; Marshfield, Wisconsin; or Rochester, Minnesota) enjoy access to care far superior to those who live in remote frontier counties or in health professional shortage areas.

Financing for health care services also varies tremendously. In some rural areas, where there may be domination by large employers, or a sufficient concentration of population (perhaps a retirement destination) to attract competing insurers, or a nearby metropolitan area with influence on the rural market, there may be multiple attractive insurance options. In other areas, where the dominant source of employment is small business or self-employment and the population is scattered across a large geographic area, there may be very few insurance choices, and those that are available may be cost-prohibitive.

Implications for Medicare Policy. A detailed analysis of the impact of any suggested changes in the Medicare program would need to examine the impact on each type of rural area. Some of those impacts, particularly in more densely populated areas with extensive health care systems, would mirror impacts in urban areas. Therefore, it is possible for change in the Medicare program to be quite beneficial to some rural beneficiaries but not others. For example, policies that rely on the generation and continuation of competing plans to achieve program objectives could work effectively in rural areas adjacent to metropolitan areas and perhaps in some rural areas that are retirement destinations. They might not be effective, though, in sparsely populated areas. The same logic can be applied to reliance on elaborate systems of care, which can be found in some, but far from all, rural areas. Dealing with this variation in the context of analyzing specific proposals is quite challenging. A combination of two general approaches will be used:

- identify any likelihood that a particular policy initiative could leave at least some rural beneficiaries *worse off* than they would be in the absence of the new policy; and

- assess the *net benefit* for rural beneficiaries, assuming disparate impacts across rural areas.

When referring to "rural" without any qualification, we are referring to dominant characteristics of rural areas, usually of delivery systems or of beneficiaries living in most of rural America, defined in geographic, and not population, terms. We do so recognizing that there are exceptions to those generalizations.

Variation in Approaches to Redesigning the Medicare Program

Different approaches underlie considerations to improve the Medicare program. They range across a continuum, the defining parameters being a government-run and financed system at one end and government financing (but no regulation) supporting private health plans at the other end. Either extreme—forcing all beneficiaries into a single government system at one end, or a complete absence of government-run health plans at the other—is unlikely in the current political environment. The current Medicare program is a combination of a government plan (traditional fee-for-service) and private plans (Medicare+Choice). Proposals to redesign Medicare typically build on one of those approaches.

Government-based Plans. Recommendations to alter the Medicare program can be based on using the existing program as a platform to which new benefits and/or new methods of financing the program are added. For example, a prescription drug benefit could be added to the Part B benefits, or established as a new benefit (Part D) to be made available to all beneficiaries, without changing the rest of the Medicare program. The same could be done with other benefits, as occurred for preventive benefits in the Balanced Budget Act of 1997. In its purest form, this approach would have the new benefits administered exactly as they are now, through a combination of government regulations (Health Care Financing Administration [HCFA]) and private fiscal intermediaries (folding the benefit into the current program as was proposed in S. 2758 [Graham], in the 106th Congress). A minimal departure from a government-financed, government-administered benefit would be to add new component parts to the Medicare program but contract with private entities to administer those benefits (former President Clinton's approach). To be considered a redesign of the program rather than a series of minor incremental changes, a recommendation would have to include either a major addition (e.g., prescription drugs in ambulatory settings), a restructuring in financing (e.g., share of the expense between government, individuals, and other parties), a further restructuring of payment mechanisms (e.g., capitation), or a restructuring of program design (e.g., creation of government-sponsored health plans).

Private Plans. An approach to restructuring the Medicare program that characterizes the work of the Bipartisan Commission on the Future of Medicare is to identify a "middle ground," with important administrative roles for government and private plans. In this approach, government would not use the power of financing the program to favor any particular plan, but instead, would invite all plans to compete on a "level playing field" created by government rules. In the Bipartisan Commission's proposal, subsequently drafted into legislation by Senators Breaux, Frist, Kerrey, and Hagel, this approach was labeled "premium support," with the government

contribution to the premium being a function of the bids submitted (weighted average was used). In this approach, the government would also establish an array of minimum benefits that all plans would be required to offer and perhaps a second-level minimum (for example, to include prescription drugs in a second level). The government would also subsidize the full cost of premiums for persons of low income, the amount of the subsidy determined by the market rate, not a predetermined government voucher (known as "fixed contribution"). A more limited change to provide access to prescription drugs could be to provide vouchers to Medicare beneficiaries for use in purchasing insurance coverage (this approach was proposed in H.R. 4680, 106th Congress).

Implications for Medicare Policy Affecting Rural Health Care. These different approaches to changing the Medicare program would have different impacts on health care for rural beneficiaries, as follows:

- reason for expecting success (government guarantee; competing plans offering different benefits and costs);
- payment for health care services (from government and used as a tool to control program costs; from the private sector and influenced by desire to be competitive);
- security of benefits (government-based guarantee; market entry and exit by private plans); and
- beneficiary decision-making (little or none in a government-dominated program; complete responsibility for selecting plan).

Medicare's Historical Role: Social Insurance

The Medicare program has a special role in the fabric of American society. It is a public commitment to ensure that the nation's elderly are able to afford the costs of medical care. Passed as an amendment to the Social Security Act, its purpose is related to income security in that Medicare purports to hold the elderly harmless when significant medical expenses are incurred. The social insurance role of Medicare is its value to beneficiaries, both present and future. Generations of Americans rely on Medicare to provide health insurance after age 65, whether or not there is a public understanding of the complexities of the policies established to do so. Functionally, three principles are followed which sustain Medicare's social insurance role (Moon, 1999):

1. Universality and Redistribution. All who meet the minimum qualifications for Medicare (age and contribution to the program during years of employment, either personally or someone in the household) receive the same benefits. This is the assurance that high medical expenses will be paid and that the insurance benefit will not be lost. The program redistributes wealth in that higher income households contribute more to the Medicare Trust Fund during working years, but everyone receives the same benefit in their senior years.

2. Pooling of Risks. Since everyone is in the Medicare program, risks are pooled among the healthy and the sick. This is a means of protecting the most vulnerable among the Medicare-eligible population: the very sick who would experience difficulty obtaining affordable insurance in a segmented market.

3. Role of Government. The meaning of an entitlement is that the government uses its regulatory and purchasing powers to ensure that all seniors receive the same benefits from the Medicare program. Government sanctions play a special role, for example, in overcoming any discrimination that might exist among health care providers.

Any modifications to the Medicare program should be consistent with the commitment made to continue the social insurance model, unless the debate about the program changes direction completely and challenges that commitment. The three principles, then, are important to consider when examining the effects of any redesign of the program.

The Intersection of Place and Approach

Any assessment of changes in the Medicare program should consider the impacts on rural areas. In doing so, each element of the proposed change in Medicare policy should be screened against different types of rural environments. Thus, each chapter of this monograph will incorporate descriptions of the rural context for change and of the suggestions for changes in Medicare policy. However, we cannot hope to incorporate all potential combinations, especially since both environments experience constant change. Instead, we seek to instill a frame of reference for all persons engaged in debates about reshaping Medicare policy—that the interaction of policy, people, and place has special meaning for rural beneficiaries that changes with the particulars of the policy and the local circumstances facing the beneficiaries.

REFERENCES

Allen, K. & Kirby, M. (2000). Unfinished business: Why cities matter to welfare reform. *Survey Series*, Center on Urban & Metropolitan Policy. Washington, DC: The Brookings Institution.

Goldsmith, H. F., Puskin, D. S., & Stiles, D. J. (1993). *Improving the operational definition of "rural areas" for federal programs.* Federal Office of Rural Health Policy (monograph on line). Available from URL: http://www.nal.usda.gov/ric/richs/goldsmit.htm

Moon, M. (1999). *Medicare matters: The value of social insurance*. Testimony before the committee on Finance, U.S. Senate. May 27.

Ricketts, T. C., III, & Heaphy, P. E. (1999). Hospitals in rural America. In T. C. Ricketts, III (Ed.), *Rural health in the United States* (pp. 101-112). New York: Oxford University Press.

Ricketts, T. C., III, Johnson-Webb, K. D., & Randolph, R. K. (1999). Populations in rural America. In T. C. Ricketts, III (Ed.), *Rural health in the United States* (pp. 7-24). New York: Oxford University Press.

REDESIGNING MEDICARE: EQUITY CONSIDERATIONS FOR RURAL MEDICARE BENEFICIARIES AND HEALTH SYSTEMS

A. Clinton MacKinney, M.D., M.S.

I. INTRODUCTION

Equity, a fundamental philosophical concept of social justice, serves as the rural cornerstone of the Medicare redesign dialogue. Rural health care policy discussions regarding quality, choice, access, costs, and governance demand equity consideration. Since all Medicare beneficiaries should have equal opportunity to maximize health and happiness, the goal of Medicare equity seems inarguable. Nonetheless, proposals designed to achieve Medicare equity engender great debate. Contemporary social and political perspectives influence how policymakers approach, and even define, equity. Despite shifting political climates, rural equity arguments consistently start with rural/urban differentials.

II. DEFINITIONS

Inequity drives rural advocacy concerns about rural/urban differentials such as reimbursement and access. Reducing the rural/urban differential seems appropriate, but the rural advocacy emphasis on rural/urban equity occasionally overlooks other laudable goals such as maximal quality and/or minimal cost (i.e., efficiency). The oversight is understandable; the words used in the political discourse are confusing. Differences between equity, equality (the state of being equal), and efficiency (maximum outcome at minimum cost) are subtle, but important. Therefore, the term *equity* deserves clarification. Equity does not necessarily imply equality. Simply and glibly, equity means "treating likes alike" or "equal opportunity for all." Stone (1997) cautions that these "simple prescriptions...mask the dilemmas of distributive justice." Alternately and more specific to this discussion, 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 February). No matter how specific or comprehensive, simple or complex, it is clear that health care equity definitions "contain ambiguities and problems of interpretation that make [health care equity] the object of political struggle" (Stone, 1997, p. 52).

Defining Medicare equity and the consequent "political struggle" begs several questions. How do beneficiary demographic characteristics determine rural health care utilization and reimbursement patterns? Are we unsuspectingly rationing health care by making it less accessible or less affordable to rural populations? Is the burden of payment for Medicare services appropriately distributed? Do options for more generous Medicare benefits in certain geographic areas conflict with original Medicare intent? In sum, does Medicare treat all beneficiaries with fairness and justice? These questions strike at the issue of equity. This chapter will suggest that historical and continuing Medicare equity arguments can be framed within three philosophical constructs—utilitarianism, egalitarianism, and market competition. Each has merit and should be considered when evaluating Medicare redesign solutions. Only through an acknowledgment and understanding of different equity perspectives can we develop thoughtful Medicare redesign solutions. For a more detailed discussion of equity, the reader is referred to the seminal works of Rawls (1971), Rice (1998), Nozick (1974), and other authors cited herein.

III. BACKGROUND

Medicare was originally designed as a social insurance program; that is, if an enrollee paid into the program, standard Medicare benefits with standard out-of-pocket expenses were regarded as an earned right, an entitlement. The social insurance intent is inconsistent with several current proposals that base out-of-pocket expenditures (e.g., premiums, co-pays, and deductibles) on ability to pay at time of service. Despite current policy proposals to the contrary, the public's perception that Medicare is a social insurance program remains today (National Academy, 1999, May). Evidently, the original Medicare legislation implied funding equality and standardized benefits delivered via fee-for-service. Robert Ball (1998) noted, "We proposed assuring the same level of care for the elderly as was then enjoyed by paying and insured patients…." (p. 31). Ball's comment raises profound questions. Does "same level of care" imply same access to care and same opportunity to choose? Was spatial equity (equity across geographic regions or *place of residence*) a specific Medicare goal? The long-standing rural/urban differential debate would suggest that both policymakers and the public are collectively unsure. An example is illustrative.

Capitation rate variation represents one of the most obvious geographic inequalities (not necessarily inequities) in the Medicare program. Legislation in 1972 provided a new health care delivery model—managed care delivered by health maintenance organizations. Since then, three managed care market types have emerged, each defined by health care provider supply and health care service utilization (Foote, 1997):

- Low provider supply and low service utilization (e.g., many rural areas).
- Efficient provider supply and efficient service utilization (e.g., Minneapolis, MN and Portland, OR).
- High provider supply and high service utilization (e.g., New York, NY and Miami, FL).

Medicare capitation rates are predicated on historic health care expenditures established by service utilization and provider efficiency. As a result, startling geographic capitation rate inequalities have resulted, varying from approximately $400 per beneficiary per month in low supply/utilization areas to approximately $800 per beneficiary per month in high supply/utilization areas. In turn, the capitation payment rate differential has driven significant benefit package and out-of-pocket expense variation. That is, higher capitation rates allow additions to the standard benefit package, such as eye care or prescription drugs, often at reduced out-of-pocket expense. Therefore, Medicare's social insurance intent is not preserved. The concern remains current. In June 2000, U. S. District Court Judge Donald D. Alsop called on the legislature to correct Medicare capitation inequalities. "It is hoped that those with the ultimate authority to remedy this—indeed those who created it—will promptly recognize the injustice they have created and enact legislation to correct it" (Minnesota Senior Federation, 2000).

Despite glaring capitation rate inequalities (and other inequalities such as access and health status), equity remains the final objective regardless of political perspective. The debate instead involves *distribution*—in this case, distribution of health care resources. Therefore, the Medicare redesign dialogue should not focus simply on the presence or absence of equity, but rather on *how* government regulation and/or market competition distribute health care resources.

Equity in the distribution of health care resources can be approached within three philosophical frameworks:

- The *utilitarian* model implies equity that is achieved through maximal benefit for all or the greatest good for the greatest number. Resources are distributed to those in greatest need.

- The *egalitarian* model implies equity that is achieved through maximal equality for all or equal good for all. Resources are distributed equally.

- In contrast, the *competitive* (market) model implies equity that is achieved through market-driven maximal efficiency. Resources are distributed to those who most efficiently deliver the greatest outcome at the lowest cost. Though the competitive model implicitly requires choice, it is silent about the greatest good (utilitarianism) or equal good (egalitarianism). In fact, perfect market competition precludes equality because equality precludes choice. However, competition does not preclude equity. Instead, the allocation of resources achieved by the market, or efficiency, defines equitable distribution and justice.

Both utilitarian and egalitarian approaches to equity represent distributive social justice independent of market forces. However, in 1986 Walker noted that the political discourse (the "discursive currency") used by both traditional and liberal ideologies to describe Medicare redesign has primarily involved the competitive model (Walker, 1986). That observation remains true today. Believing in the "superiority of markets over government regulation" (Rice, 1998, p. 1) to address ever-increasing health care costs, both mainstream political party health care platforms rely primarily on the competitive model. Other social justice-based solutions, e.g., utilitarianism and egalitarianism, have been more obscure. Responding to the use of the competitive model to frame Medicare redesign solutions, Rice posits that "there is, however, no *a priori* reason to believe that such a system will operate more efficiently, or provide a higher level of social welfare, than alternative systems that are based instead on government financing and regulation" (Rice, 1998, p. 3).

To build on Rice's skepticism that the market will enhance social welfare, recall that the competitive model strives for equity, but not equality. Nonetheless, the market still does not offer easy answers to equity concerns. Health care markets differ significantly from those of ideal competitive markets due to several characteristics (Folland, Goodman, & Stano, 1997):

- *Uncertainty* – Multiple unknown variables affect the health care market. These uncertainties fundamentally make health care markets unpredictable.

- *Asymmetric information* – A knowledge differential exists between beneficiaries (buyers) and health care providers (suppliers). Pure competition can only work if each party has equal access to information.

- *Externalities* – Variables external to the health care market can profoundly affect the health care market (e.g., personal health status, lifestyle choice, cultural diversity, public/workplace safety, etc.).

- *Supply-induced demand* – An increased number of health care providers tends to paradoxically increase demand for health care services. Furthermore, individual health care providers (suppliers) can induce demand for health care services.

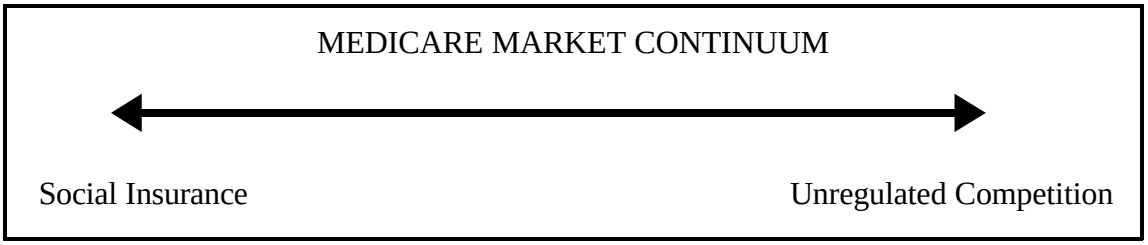
- *Moral hazard* – Insurance coverage that disconnects the beneficiary from the cost of care tends to increase health care utilization.

- *Adverse selection* – Beneficiaries choose insurance that will cover present or anticipated individual health concerns.

- *Barriers to entry* – Barriers that preclude certain health insurers or providers from entering the market tend to reduce competition and increase potential for monopolistic behavior.

Therefore, even if the competitive model (market) is the accepted vehicle to bring efficient equity to the Medicare program, health care's market characteristics are likely to encumber expected market behavior. "Every economist knows the dozens of restrictive assumptions...that are necessary to prove that a free market is the best possible economic game, but they tend to be forgotten in the play of events" (Rice, 1998, p. 3). Nobel laureate Amartya Sen (1980) notes, "In short, a society or economy can be Pareto-optimal (maximally efficient) and still be perfectly disgusting." Consequently, the market may fail those it is designed to serve—Medicare beneficiaries. Health care most certainly is an imperfect market. Therefore, it seems clear that despite the market-based solution rhetoric, regulation will be necessary to help insure competition (choice) or to help correct market failures. That is not to imply that the solution will then be complete. Government regulation is not perfect either. Examples of regulation resulting in unintended consequences are legion. Therefore, policymakers are left with an uncomfortable choice between "an imperfect market and imperfect regulation" (Pauly, 1997).

With three seemingly exclusive equity models, policymakers tend to migrate to one model or another without an acknowledgment that Medicare is, and is likely to remain, a hybrid of competing agendas. That is, Medicare redesign exists in a tension between regulation to insure utilitarian and/or egalitarian resource distribution versus competition to insure efficient resource distribution. Potential Medicare redesign options generally fall on a continuum between two extremes—from a tightly regulated social insurance program without cost or benefit variation to a market-based system in which Medicare vouchers of equal value are used in an unregulated competitive market. Of course, neither end of the spectrum is likely to prevail.



Therefore, equity discussions must consider the ongoing tension between desires for social justice and market-driven efficiency. It is a classic situation described by Okun (1975) as the Equity–Efficiency Tradeoff. Okun was almost correct. As described above, efficiency *can* lead to equity defined within a competitive market paradigm. Therefore, the tradeoff more accurately exists between equality and efficiency, not equity and efficiency.

In summary, a tension exists between the three philosophical principles outlined previously:

- Resource distribution to attain quality (utilitarianism).
- Resource distribution to attain equality (egalitarianism).
- Resource distribution to attain efficiency (competition).

The tension does not represent a flaw, but rather an understanding that competing agendas are omnipresent and require consideration during policy deliberation. Policymakers should not choose a Medicare redesign model of distributive justice *or* competition; public policy is unlikely to lead Medicare to a pure regulatory or a pure market model. Successful solutions must acknowledge the tension between different equity models and then attempt to balance different philosophical perspectives.

IV. STATUS QUO – THE RURAL CONTEXT

Several facts have fueled the Medicare equity policy debate for years. The debate surrounding rural/urban differentials questions the justice in any system that maintains (or promotes) apparent inequities. Though the use of the term *inequity* is arguable, the rural/urban differential is not and deserves review. Research has identified the following rural/urban differentials (Ricketts, 1999).

- *Health status* – Rural people experience more chronic disease and lower self-reported health status.

- *Income status* – Rural people are more impoverished.

- *Access* – Rural people access health care services less and at a greater distance.

- *Choice* – Fewer rural providers suggests fewer health care choices.

- *Costs* – Rural people pay proportionally higher out-of-pocket health care expenses due to lower incomes.

- *Benefits* – Lower rural capitation rates, with consequent fewer rural managed care options, mean fewer Medicare benefits.

It is important to note that only some rural/urban differentials are amendable by Medicare policy, but many could be made more equitable. For example, the Critical Access Hospital program is designed to preserve vulnerable rural hospitals and ensure rural access to hospital services. Nonetheless, despite good research and well-intended health care policy, Vladeck's assessment 20 years ago remains contemporary, "In our society, those most likely to encounter access difficulties in that literal, ordinary, use of the term, are the rural poor, especially the minority rural poor" (Vladeck, 1981, p. 75).

Though the rural/urban differential debate considers factors other than expenditure limits or financing, financing remains either the primary differential or the chosen vehicle to settle other differentials. Unlike variables such as access and health outcomes, financing is generally objective, definable, and understandable—a common currency. Furthermore, financing differentials may directly correlate with benefit, access, and other disparities. Finally, because health status is a paramount concern for beneficiaries and providers alike, it is reasonable to wonder whether these differentials may play a part in rural peoples' lower health status. Therefore, cost-control via efficiency deserves special comment.

Relying on competition-based Medicare redesign policies to improve outcomes and reduce costs (i.e., improve efficiency) generates broad concerns (as noted previously) and rural concerns specifically. Fewer rural providers reduces the opportunity for choice (a prerequisite for competition). Lower rural population densities provide less opportunity to spread costs, consequently reducing potential Medicare provider/health plan profit and increasing business risk. Rural people have less managed care experience, reducing the likelihood of managed care entry (as a health care option for rural). Historically low rural health care utilization has resulted in low managed care capitation rates, again reducing likelihood of managed care access or added benefits. Hence, Medicare policy, especially managed care compensation policy, has engendered inequalities in cost and benefits unintended by original policymakers.

Utilitarian and egalitarian perspectives are silent about cost-control. Yet there are opportunity costs associated with health care expenditures. That is, other societal needs compete with Medicare for taxpayer funding. Therefore, a desire for responsible resource allocation drives a desire for cost-control via efficiency. In an imperfect market, regulation is implicitly required to control cost. On the other hand, the competitive model relies on market forces to improve efficiency and consequently control cost. Though the political pendulum has swung toward the competitive model, utilizing the competitive model to reduce costs may reduce rural access and choice. Furthermore, if urban areas realize market-driven efficiencies unavailable to rural systems, the relative rural costs will increase. Therefore, rural markets are uniquely vulnerable in the competitive model.

V. ASSESSING MEDICARE REDESIGN

Medicare redesign approaches should be considered on a continuum—from regulated social insurance to unregulated market competition. Neither end of the spectrum is likely to prevail, though the political discourse invoking market arguments suggests a trend toward competition-oriented redesign solutions. To help make the philosophical debate concrete, several potential or proposed solutions are briefly described below within a rural context.

Premium Support Based on Beneficiary Income

Premium support establishes Medicare premiums based on ability to pay at time of service. This strategy conflicts with the implicit understanding, and societal view, that Medicare represents a social insurance. If one pays into the Medicare program via payroll tax, one is entitled to benefits, regardless of ability to pay at the time of receiving benefits. Therefore, premium support represents a competitive approach to equity. This approach could disproportionately and adversely affect those beneficiaries who use benefits the most unless a sophisticated risk-adjustment system considers increased costs associated with increased utilization. Moreover, those with lower income (the near poor) may expend a disproportionate share of disposable income on health care. Due to comparatively prevalent chronic disease and lower personal incomes, rural people may be adversely affected compared to urban. Both consequences suggest a movement away from egalitarianism. On the other hand, premium support does return some market strengths to Medicare. Beneficiaries may be less inclined to over-utilize services if out-of-pocket expenses are higher. In addition, premium support may infuse Medicare with new funding. A financially sustainable Medicare is certainly in the rural best interest. However, if Medicare becomes financially stable yet appears inequitable to policymakers, program modification is likely. Therefore, once implemented, policymakers may simply return some social justice equity via regulation rather than retreat from premium support.

Equalize Capitation Rates Via Regulation

“Leveling the playing field” with capitation rate equalization regardless of geographic location (egalitarianism) would generally increase rural capitation rates significantly. Increased capitation income would attract Medicare providers, thus increasing choice. Competition would be based on quality (to increase market share) and efficiency (to increase unit profit). However, government maintenance of equal capitation rates or maintenance of competition would subterfuge market forces and rapidly require regulation to improve efficiency. Shifting resources from high capitation rate areas with fewer health care needs to low capitation rate areas with greater health care needs would be a utilitarian solution. Yet despite the implicit social justice, dramatic shifting of health care resources from one group to another while maintaining budget neutrality would be politically daunting.

Prescription Drug Plan

The current Medicare system allows prescription drug benefit for some (primarily for beneficiaries in high capitation rate areas), but not for many others (most rural beneficiaries). Adding a national prescription drug plan is movement toward egalitarianism (all beneficiaries

would have some prescription drug coverage) and utilitarianism (greater prescription drug access may improve population health), yet different plans proposed do differ in expected out-of-pocket expenses. Any plan that proportionally costs more out-of-pocket is likely to adversely affect rural populations due to lower average income.

Subsidize Rural Providers and Health Plans

Approaches that subsidize rural providers and health plans to improve access are egalitarian. Since it is likely that subsidies would require a redistribution of static resources, they are unlikely to be purely utilitarian unless original resource use was inefficient. Subsidies are regulation-defined and generally noncompetitive unless they are used to maintain competition. Even so, choice maintained outside of market forces may reward inefficiencies and therefore increase global costs. Rural beneficiaries may benefit, however, with increased health care provider and/or health plan access and choice.

Reward Quality Outcomes, Not Simply Medical Services

Rewarding outcomes, rather than medical service delivery, represents a fundamental change from traditional fee-for-service Medicare and Medicare managed care payment policy. A few nonMedicare payers provide limited reimbursement for health outcome proxies (e.g., mammography rates as a proxy for breast cancer prevention or aspirin use as a proxy for heart attack survival). Nonetheless, desirable outcomes would need to be specified as public policy, and for at least some of them, favor a distinct group of providers. Recalling that efficiency equals outcomes divided by cost, quantifying outcomes is essential. Yet, outcome measures are elusive and very difficult to quantify uniformly. For example, since outcomes are predicated on health care access and quality, can outcome measurement instruments appropriately consider unique rural access needs and quality preferences and then make valid comparisons to urban areas? Moreover, how can inefficiency secondary to low rural volumes be fairly considered? The fact that we cannot accurately gauge "optimal efficiency" limits this approach despite the fact that it moves Medicare redesign in the proper direction. Though this approach is competitive, it would lead to equity that is more utilitarian as well.

Incremental Reforms

Theoretically, incremental reforms are a series of multiple steps that lead to program redesign. Incremental reform allows for varying political climates (social insurance versus market and regulation versus competition) and maintains plurality. Therefore, incremental reform is often most politically feasible. Yet, rural populations are at risk with incremental reforms because rural/urban differentials represent fundamental societal issues that often reach well beyond traditional health care to sectors such as transportation, education, and welfare. In fact, rural/urban differentials could worsen despite incremental reform. After 20 years of concerted public program efforts to improve rural health care access with the hope of improving rural population health, the relative status of rural health care access and rural health has remained unchanged (Ricketts, 2000). This tragic finding suggests that incremental reform of the rural health care system without consideration of other sectors may not be in the rural beneficiary's best interest. *Fundamental* societal inequities, even if manifested as rural/urban health care differentials, are unlikely to be solved by incremental health care reform.

VI. FINAL RECOMMENDATIONS

The political discourse surrounding health care distribution will endure. It is a worthy debate; health deserves special consideration. Rice (1998) notes that "what would appear to be truly different about health concerns opportunities and capabilities: good health provides people with the opportunity and/or capability to achieve other desired things" (p. 161). The Medicare program is a fundamental, but not exclusive, route to improved senior health. Enlightened Medicare redesign dialogue first acknowledges the market continuum of resource distribution – from regulated social insurance to unregulated market competition. Neither extreme is politically likely. The health care market, and Medicare policy, will always fall somewhere in between. Though policy proposals for the past two decades have emphasized the competitive model, the health care market differs from classic markets and will not respond with perfect market efficiency. Utilitarianism and egalitarianism may resonate with a desire for social justice, yet efficiency also deserves emphasis because other societal needs compete with Medicare for funding. Social insurance and competitive market perspectives are both valid. An understanding of each will lead the Medicare equity discussion to Medicare redesign solutions that encourage efficiency *and* provide equal opportunities for improved rural health status.

REFERENCES

Ball, R. M. (1998). Reflections on how Medicare came about. In R. D. Reischauer, S. Butler, & J. R. Lave (Eds.), *Medicare: Preparing for the Challenges of the 21st Century* (pp. 27-37). Washington, DC: National Academy of Social Insurance.

Folland, S., Goodman, A. C., & Stano, M. (1997). *The economics of health and health care.* Upper Saddle River, NJ: Prentice Hall.

Foote, S. B. (1997). The information trading process: The case of Medicare Payment Equity. In M. E. Lewin & E. Liphoff (Eds.), *Information trading: How information influences the health policy process* (pp. 120-135). Washington, DC: The National Academy Press.

Minnesota Senior Federation, PRNewswire via COMTEX, July 7, 2000.

National Academy of Social Insurance. (1999, February). *Medicare and the American Social Contact – Final Report of the Study Panel on Medicare's Larger Social Role*. Washington, DC: National Academy of Social Insurance. (www.nasi.org/medicare/largerpt.htm).

National Academy of Social Insurance. (1999, May). *Should higher income beneficiaries pay more for Medicare?* Washington, DC: National Academy of Social Insurance. (www.nasi.org/Medicare/Briefs/medbr2.htm).

Nozick, R. (1974). *Anarchy, state, and utopia.* New York: Basic Books.

Okun A. (1975). *Equality and efficiency: The big trade-off.* Washington, DC: The Brookings Institute.

Pauly, M. (1997). Who was that straw man anyway? A comment on Evans and Rice. *Journal of Health Politics, Policy and Law, 22,* 466-473.

Rawls, J. (1971). *A theory of justice.* Cambridge, MA: Harvard University Press.

Rice, T. (1998). *The economics of health reconsidered*. Chicago, IL: Health Administration Press.

Ricketts, T. (2000, August). *The future of health care research.* Speech delivered to National Rural Health Association Research Setting Agenda Conference, Washington, DC.

Ricketts, T. C., III, Johnson-Webb, K. D., & Randolph, R. K. (1999). Populations in rural America. In T. C. Ricketts, III (Ed.), *Rural health in the United States* (pp. 7-24). New York: Oxford University Press.

Sen, A. (1980). *Equality of what? Tanner Lectures on Human Values.* Cambridge, MA: Cambridge University Press.

Stone, D. (1997). *Policy paradox: The art of political decision making.* New York: W.W. Norton.

Vladeck, B. (1981). Equity, access, and the costs of health services. *Medical Care, 19* (Suppl. 12), 69-80.

Walker, G. (1986). Reforming Medicare: The limited framework of political discourse on equity and economy. *Social Science Medicine, 23,* 1237-1250.

REDESIGNING MEDICARE: QUALITY CONSIDERATIONS FOR RURAL BENEFICIARIES AND HEALTH SYSTEMS

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I. PRINCIPLE GUIDING REDESIGN

The Medicare program should promote the highest attainable quality of care that results in improved beneficiary health outcomes. Medicare reform proposals should be evaluated based on:

- the direct and indirect impact that proposals will likely have on maintaining or improving the quality of care that beneficiaries receive, and

- the likelihood that disparities in quality of care between rural and urban beneficiaries and/or communities may be created, widened, or minimized.

II. WHAT IS QUALITY OF CARE?

Quality of care has increasingly become a focus of attention for providers, consumers, policymakers, and purchasers. While quality of care commands attention in its own right, it is also closely linked to two other policy considerations: access to health care and cost of health care. In fact, for those individuals without access to adequate health care services, discussion of quality of care is virtually meaningless.

Policy initiatives designed to alter either cost, quality, or access can often influence one or both of the other two policy drivers. While in this chapter quality is discussed primarily independent of cost and access issues, the reader should be mindful that linkages and tensions exist across the cost, access, and quality triad.

Quality, defined by the Institute of Medicine, is *"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). Types of problems associated with quality of care have been categorized in four ways: overuse, underuse, variation, and misuse/error.

- *Overuse* – The provision of unnecessary health services with concomitant unnecessary costs that in some cases poses risks that may compromise a patient's health.

- *Underuse* – The failure to provide a service where the benefits of that service are known to outweigh associated risks (President's Advisory Commission, 1998). The result of not receiving necessary care can be avoidable illness. In this context, compromised quality of care can be directly affected by limited access to services.
- *Variation* – Variation in health services occurs across providers and regions of the country, including variation related to differences in health status. Some variation is expected; however, given that evidence-based guidelines do not exist for the use of many interventions, overuse and underuse cannot always be explicitly determined, only the fact that variation exists in the application of interventions. Practice patterns and availability of facilities and technology drive some of the

variation, the magnitude of which is not scientifically defensible (Chassin, 1997). The prospects for variation may be greater for the 80% of physician-patient encounters for which there are no evidence-based rules determined by the outcomes of double-blinded studies.

- *Misuse/Error* – The failure of a planned action to be completed as intended (an error of execution), or the use of the wrong plan to achieve an aim (error of planning) (Adapted from Reason, 1990).

Each of these quality-related problems can stem from a confluence of factors including characteristics of health care organizations (e.g., hospitals that have poor systems in place for preventing medication errors), reimbursement (e.g., capitation which may in some instances encourage underuse of services), and practice patterns (e.g., clinicians who rely on personal experience and preferences in choosing interventions, leading to variation in services). These quality of care problems can result in harm to beneficiaries as well as unnecessary costs to payers, including the Medicare program.

To minimize the likelihood of compromised quality care, significant efforts are underway to better understand and influence quality, through the development and application of quality of care measures. When reliable and valid measures are used, quality of care monitoring can help ensure that payment systems are designed correctly and that providers are responding appropriately to system incentives (i.e., cost and quality linkage); that trends are tracked over time, providing early warning of impending problems; and that information generated is used to educate beneficiaries and improve their care (Medicare Payment Advisory Commission, 2000b). An important measurement challenge affecting rural health care delivery is how to measure increases in the "likelihood of desired health outcomes" and consistency "with current professional knowledge" (Lohr, 1990). The stereotypical assumption that bigger and newer is somehow better cannot be confirmed or denied without such measurement and evidence gathered over time.

Donabedian (1996) describes three dimensions of quality including structure, process, and outcome. Structure includes the health care organization and the systems of care that influence quality. Process includes the interventions and activities associated with health care delivery. Outcomes are the results obtained. When evaluating quality across these three dimensions, clear links must be established. For example, an evidence base can support care processes for diabetic Medicare beneficiaries that includes a program of diet and exercise, monitoring biologic parameters, and medication management. Taken together, these processes can impact patient outcomes.

Health care quality is typically monitored and evaluated on one of two bases: either for quality assurance (QA) or for quality improvement (QI). QA "…aims to provide a means of ensuring that health care providers have the capacity to furnish safe care of good quality" (Medicare Payment Advisory Commission, 2000a, p. 82) by setting minimum standards and enforcing

compliance. In contrast, the goal of QI is to improve "the average quality of care furnished by providers…that can be attained only in a blame-free environment in which providers are encouraged and assisted to assess their performances, make changes, reassess quality, and strive for continuous improvements" (Medicare Payment Advisory Commission, 2000a, p. 85). Interest in QI, as an approach to influence health care quality, has markedly increased.

III. CURRENT APPROACHES TO ENSURING QUALITY OF CARE IN THE MEDICARE PROGRAM

This section focuses on selected aspects of the Medicare program that directly or indirectly impact quality of care. The Medicare program is responsible for providing access to quality care for Medicare beneficiaries (Medicare Payment Advisory Commission, 1999). The Health Care Financing Administration (HCFA) is responsible for quality assurance for the Medicare program and establishes minimum requirements for health care provider program participation. HCFA uses different quality standards for different types of providers and is responsible for enforcing compliance with standards through mechanisms, such as conditions of participation, to which providers must adhere. Historically, conditions of participation have emphasized structural characteristics such as conditions of the physical plant rather than outcomes of care provided to beneficiaries. More recently, HCFA has devoted increasing attention to beneficiary outcomes and has held providers accountable for implementing procedures to reduce the incidence of medical errors in their institutions.

HCFA pursues QA by focusing "on assessing providers' capacities to provide safe care of good quality, because judging the actual quality of health care…was infeasible until recently. However, new tools for measuring quality and performance are beginning to…generate information on a routine basis" (Medicare Payment Advisory Commission, June 2000, p. 87). HCFA contracts with state survey agencies to assess compliance with program standards and uses private accreditation bodies (e.g., Joint Commission on the Accreditation of Healthcare Organizations) to conduct compliance assessments. In the June 2000 report to Congress, the Medicare Payment Advisory Commission (MedPAC) noted that QA activities could be shifted to the private sector. However, MedPAC recommended that QA monitoring and enforcement continue to be within the purview of the public sector suggesting that the public sector offers more effective channels for enforcing compliance with quality standards (Medicare Payment Advisory Commission, 2000a).

HCFA has addressed QI by redirecting responsibility for conducting QI projects to peer review organizations (PROs). These projects incorporate efforts to measure quality, implement interventions, and reassess quality. PRO efforts can be specifically targeted toward quality improvement in rural delivery systems and to priority health problems of rural Medicare beneficiaries. It is important to note that providers, including hospitals and physicians, are not mandated by Medicare to participate in these activities. However, HCFA holds PROs contractually responsible for improving average statewide performance on specific quality measures (Medicare Payment Advisory Commission, 2000a).

Collecting Data on Quality of Care in the Medicare Program

Currently, Medicare has significant databases to which providers, in particular hospitals, are required to report substantial amounts of information. Some of the collected data reflect information about quality of care. Compared to inpatient settings, fewer data are systematically collected and available to use to monitor quality of care in outpatient care settings such as skilled nursing facilities and beneficiaries' homes. Adequate data collection on quality of care is particularly important in outpatient settings given recent and anticipated changes that incorporate prospective payment policy and that can potentially impact care quality.

Analysis of available data indicates that while Medicare beneficiaries generally have access to a range of health care services, their care is too often characterized by service overuse and/or underuse. For example, studies indicate that Medicare beneficiaries do not always receive appropriate treatment for heart attacks or diabetes. Also, despite benefits that cover many of these services, beneficiaries underutilize prevention-related services such as vaccinations and mammograms (Medicare Payment Advisory Commission, 1999). In terms of rural beneficiaries, data indicate that they generally underutilize health care services compared to their urban counterparts. However, a recent study indicates that rural elderly nursing home residents have higher numbers of hospitalizations than urban nursing home residents, which raises concerns about care quality (Coburn, Keith, & Bolda, 2000).

While collecting sufficient information is essential to QA and QI efforts to adequately evaluate quality of care, the related burden of data collection for rural facilities must be carefully evaluated.

Quality of Care in Medicare+Choice (M+C) Plans

The Balanced Budget Act of 1997 established minimum quality program requirements for all plans participating in the M+C program, with more extensive requirements for health maintenance organizations, provider-sponsored organizations, and preferred provider organizations (PPOs). M+C plans are generally required to have QA systems in place but they are not required to demonstrate improved patient outcomes. In the 1999 Balanced Budget Refinement Act, Congress exempted PPOs from stringent reporting requirements and applied the same quality requirements to PPOs as were applied to private fee-for-service (FFS) plans and nonnetwork Medical Savings Account plans. This action was taken in part to encourage PPOs to participate in the M+C program and also because Congress was interested in promoting PPOs as a more feasible alternative for rural areas than HMO's (Medicare Payment Advisory Commission, 2000b). The same legislation required MedPAC to study the appropriateness of various quality of care standards for different types of providers and health plans.

IV. QUALITY OF RURAL HEALTH CARE

Measuring Quality

Although there is a growing inventory of specific standards for quality of care, policymakers will need to consider further, and in more detail, what the goal should be for quality of care delivered in rural areas. Additionally, providers and other stakeholders may wish to consider setting aims for improvement of care in rural areas. In the meantime, assessing care quality to determine whether standards are met requires performance measurement, and rural areas present unique challenges to such measurement in great part because of the low volume of services provided (Moscovice & Rosenblatt, 1999). Small numbers of rural Medicare beneficiaries accessing the same provider make it difficult to detect differences in care quality, whether the number consists of beneficiaries with a particular chronic condition or the number of surgical interventions done by an individual provider. A common solution to this methodological problem is to aggregate across similar areas (Rosenblatt, 2000). However, as noted in the introduction to this monograph, there is considerable variation in the characteristics of rural areas and their health care systems, making the aggregation of data for purposes of analysis a challenge. Nevertheless, bench marking on quality of care requires comparisons across similar providers and organizations. Exacerbating the problem is the fact that national Medicare data sets do not incorporate adequate rural samples, increasing the difficulty in conducting rural-focused research on quality of care. Furthermore, researchers are generally unable to turn to rural facilities for data because the latter are often beset by limited operating margins, and are consequently hard-pressed to develop information systems from which data elements could be extracted and analyzed. In spite of the tendency to compare rural and urban quality of care (through data and anecdote), it is important to not lose sight of unique characteristics that impinge on the quality of care that rural Medicare beneficiaries receive. For example, while quality of care is viewed as an important by-product of competition among health plans, providers, and facilities, such competition is less common in rural areas, and therefore, quality of care in rural areas is often a product of other characteristics such as provider practice patterns and regulation. Furthermore, rural providers may have quality of care issues that stem from different health care structure and process characteristics. That is, quality is related to the scope and mix of services and the resources and infrastructure available to support rural providers as well as to the dissemination and adoption of evidence-based practices across rural providers.

The common types of problems associated with care quality—overuse, underuse, variation and error—may differentially impact Medicare beneficiaries in rural versus urban settings. For example, rural Medicare beneficiaries are more likely than urban beneficiaries to be hospitalized for conditions that resulted from underutilization of ambulatory care (Medicare Payment Advisory Commission, 2000a). These problems may result from provider behavior, different beneficiary characteristics and expectations, and/or from known differences in utilization patterns. These and other rural-specific concerns raise questions about whether, and to what extent, performance measurement should be the same for rural and urban providers. Ultimately, when providing the same type of services, rural and urban providers should deliver comparable quality of care. However, while standards of care should not vary, there may be adaptations of standards that accommodate rural characteristics. Acknowledging the uniqueness of one type of

rural entity, Critical Access Hospitals (CAHs), the Joint Commission on the Accreditation of Healthcare Organizations is currently developing separate CAH accreditation criteria from those applied to traditional hospitals.

Much more information is needed about the quality of health care in rural America to inform a range of decisions at the provider, consumer, purchaser, and (in terms of Medicare redesign) public policy levels. As quality-related information is obtained, it should be used to establish equity in quality of care for rural and urban beneficiaries. That is, the quality of care that health care beneficiaries receive should be comparable and not vary based on where they reside.

V. IMPLICATIONS OF MEDICARE REDESIGN ON QUALITY OF CARE FOR RURAL BENEFICIARIES

How will redesign affect the quality of health care provided to Medicare beneficiaries? Quality, as with financing and access, should be monitored closely whenever changes are planned and implemented in the Medicare program, particularly when fundamental changes in program policies are being considered. Proponents of a competitive (market) model note that competition in the Medicare program is a tool that should theoretically result in improved quality of care at plan, provider, and clinician levels. And, as noted in the chapter on costs, market-based reform can achieve cost savings that can be used to meet other rural Medicare reform goals. The latter could include quality improvement efforts. However, competitive behavior may also adversely impact quality through loss of continuity when plans enter and leave markets.

Payment Redesign Linked to Quality of Care: Plans and Providers

To ensure that Medicare beneficiaries have access to necessary care in appropriate settings, "payments need to approximate the costs that efficient providers would incur in furnishing high-quality care" (Medicare Payment Advisory Commission, 2000b, p. xvi). If this balance is not achieved, payment policy can unintentionally drive overuse or underuse of services. FFS payment reductions, as an instrument to achieve cost savings, can diminish both quality and access because of reactive provider behavior (i.e., underuse). On the other hand, providers receiving payment rates in excess of costs per unit have financial incentives to furnish more units of a product (i.e., overuse) (Medicare Payment Advisory Commission, 2000). Excess payment rates may also sustain low-quality providers. Medicare payment systems that are designed to reward efficiency associated with either managed care or FFS can cause quality problems if providers adopt cost-containment strategies that inappropriately reduce the intensity, duration, or skill level of the services that are furnished to beneficiaries. That is, payment inadequacy can contribute to underuse of services by encouraging provider behavior such as stinting on care. Given the high proportion of rural Medicare beneficiaries who rely on traditional FFS Medicare, the ability of many rural providers to deliver quality care is contingent on adequate payment through traditional FFS Medicare. Medicare payment policies designed to reward efficiency do not adequately consider the fact that rural areas typically have low-volume providers with fixed costs.

With a high proportion of Medicare beneficiaries served by rural health care systems, Medicare payment policy and adequacy can significantly impact provider ability to maintain structure and process characteristics that are important to quality care. For example, when considering structural elements of care quality, payment policy should not impede access to new technology in rural facilities. That is, policy that influences availability and utilization of technology should be based not just on cost considerations but also on the capacity to achieve quality outcomes. In addition, striking a balance among beneficiary interests, cost, access, and quality concerns merits consideration when payment-related reforms are proposed that may influence technology diffusion.

The rural Medicare population itself also prompts the need for special considerations in redesign. For example, rural Medicare beneficiaries have a higher incidence of chronic illness, the treatment of which requires special monitoring to ensure that payment to rural providers for beneficiaries who need higher levels of care is not too low. Accurate risk adjustment is particularly important for capitated rural providers.

Finally, to the extent that M+C plans do not expand to rural areas, traditional FFS Medicare will continue to dominate rural areas. Consequently, changes in FFS payment streams and reimbursement amounts can significantly impact the quality of care provided, including influencing where beneficiaries receive their care. A new consideration for payment may be a need to include, within the payment for services, sufficient revenue to compensate for investment in the technologies and personnel needed to improve quality of care and reporting systems to meet quality of care requirements. This may be especially true for under-capitalized, low-volume rural providers. Virtually all changes in payment policy need to be evaluated for their potential influence on the quality of care rural Medicare beneficiaries receive. In many cases there needs to be some sort of "catch up" where low fee-for-service payments combined with low volume has caused some small hospitals to not keep up with even minimum technology investments. Also, the restricted reimbursement from both public and private sources over long periods of time seems to have reduced relative salaries in the industry along with working conditions and respect, resulting in fewer people entering the industry.

Payment Systems Linked to Quality of Care: Financial Liability for Beneficiaries

Significant Medicare beneficiary financial liability can result in underuse of health care services. On the other hand, as noted in the chapter on equity, insurance coverage can increase healthcare utilization by disconnecting the beneficiary from the costs of care (moral hazard). In an analysis of 1998 Medicare Current Beneficiary Survey data, rural beneficiaries were found to be more likely to delay care due to cost than their urban counterparts (Medicare Payment Advisory Commission, 1999). In contrast, managed care beneficiaries, who are more likely to live in urban areas, have less financial liability and, consequently, are more likely to take advantage of additional covered benefits. Underuse of appropriate health care services can adversely impact Medicare beneficiary health status. In any policy to redesign Medicare, health plans can be compelled (or not) to defray expenses for beneficiaries through such mechanisms as waiving cost-sharing for low-income enrollees.

Monitoring Quality of Care

Redesign efforts should ensure that quality of care furnished by all types of providers is monitored through standardized, core measures that are used across both managed care and traditional FFS Medicare systems. Relevant rural circumstances associated with structure and process should be taken into consideration in monitoring for both QA and QI. Given the high reliance on traditional FFS Medicare by rural beneficiaries, FFS providers could be required to report the same quality-related data that managed care plans do under the Health Plan Employer Data & Information Set, with reporting occurring through certification (meeting Medicare conditions of participation) processes. Without such requirements, very little data are available to assess quality in FFS rural health care delivery. (Medicare Payment Advisory Commission, 2000).

Volume and Quality. Research studies have documented relationships between processes of care (such as higher volume of certain services) and better patient outcomes. That is, facilities that provide services on an infrequent basis have, in certain circumstances, poorer outcomes than facilities with higher volume. In some instances, these research findings have prompted related recommendations to patients about where to seek care. For example, after identifying a relationship between high-volume providers of complex surgical procedures needed by cancer patients and better outcomes, the National Cancer Policy Board recommended that cancer patients in need of such care seek it from those facilities providing higher volume (Donaldson, 1999).

Volume of provider services is an imprecise quality indicator as evidenced by the fact that some high-volume providers have poor outcomes while some low-volume providers have very good outcomes. While a relationship between high volume and better outcomes has not been identified in all volume-outcome studies, nevertheless, it has been documented frequently enough to raise concerns about patient outcomes associated with low-volume procedures and care processes, a characteristic of some services delivered in rural areas. While the research focus is primarily on volume, more data needs to be collected that helps to identify specific characteristics associated with high volume that influence quality outcomes. That is, high volume is a proxy for characteristics such as the application of well-established procedures, smooth interdisciplinary team functioning, and other important elements that may help to determine patient outcomes. Virtually all of this research has been done in hospitals and has focused on acute, urban-based care, while little has been conducted in rural areas (Rosenblatt, 2000). Consequently, research is needed to establish the specific encounters benefitting from higher volume and the levels of volume needed to yield more optimum quality. For the procedures and other patient encounters for which such characteristics are determinative of outcomes, maintaining minimum volumes is an important consideration for making the services available. For other services, volume will be less of a concern. Further, the importance of increased volume to improve quality (defined in terms of consistent application of knowledge and skills) may need to be balanced against the potential for underuse if an emphasis on volume results in services being concentrated only in certain geographic areas that are not easily accessible to rural beneficiaries. Clearly, much more information is needed about rural provider volume and beneficiary outcomes and consequently, Medicare payment policy should not rush to judgment by making changes in payment policy based solely on volume-outcome.

Even with data about quality of care associated with rural providers, many rural consumers lack the resources necessary to travel to high-volume facilities or, when research indicates lower quality, will still choose to receive their care locally. While good patient outcomes may be established related to some high-volume care, separation from family support and receiving care in unfamiliar surroundings may also impact beneficiaries. Furthermore, in spite of volume-outcome relationships, some rural patients in unstable condition will be unable to be transferred to more complex, higher-volume facilities. In general, where volume is related to better beneficiary outcomes, there will likely be direct implications for the organizational structure of care delivery including patient flow within and across rural-rural and rural-urban networks and increased attention to the regionalization of care. Medicare redesign efforts should be structured in ways that recognize and support the characteristics of rural networks that improve quality of care.

Outpatient Care. Currently, Medicare's ability to monitor quality of care in outpatient settings is limited, although HCFA has moved toward obtaining information on quality of post-acute provider care. Quality monitoring relevant to rural beneficiary care in outpatient settings will require data collection with associated costs that may be more onerous for rural providers with much thinner operating margins than their urban counterparts. Rural health care delivery systems, particularly those in sparsely populated areas, are often financially fragile, and Medicare redesign efforts directed toward collecting data and monitoring quality of care should adequately compensate rural providers for these efforts. Monitoring across all rural providers to assess problems associated with quality of care is also challenging because of limited local expertise and data collection infrastructure. However, given the challenges identified, collecting quality-related data across rural health care settings is especially important as the Medicare program undergoes significant redesign.

Assessing the Quality Of Care Implications of Selected Medicare Redesign Elements

Medicare Board. The creation of a Medicare Board would provide an entity to supervise all health benefits and premiums. The board could be responsible for requiring all health plans and FFS providers to report on the quality of care their enrollees receive. The availability of such information should encourage beneficiaries to seek care from high quality health care providers and encourage poorer performing providers to improve care.

Beneficiary Information. Where market competition exists in rural areas, user-friendly, appropriate information for beneficiaries about their Medicare program choices can have an impact on quality of care. For market approaches to work, strategies for disseminating information need to take into consideration communication vehicles that will be viable in rural communities. One proposal introduced during the106th Congress established Medicare Consumer Coalitions (MCC) which would provide beneficiaries with timely and accurate information at the federal, state, and local levels with respect to Medicare benefits and options. These organizations would also ensure that beneficiaries have grievance and appeals processes available for all Medicare benefits. The MCC, made up primarily of eligible Medicare beneficiaries, would be responsible for conducting beneficiary information campaigns regarding benefits under all plan types. The content of the education campaign may include comparative information on benefits, quality, and performance; beneficiary costs; and consumer satisfaction

surveys associated with the plans. Important to quality-based beneficiary decision-making the Commissioner would develop standards to ensure that information provided to beneficiaries is complete, accurate, and uniform.

Disease Management Programs. To improve quality of care and decrease Medicare program costs, attention is being given to allowing the Secretary to contract for disease management services for beneficiaries with chronic, high-cost conditions. For example, in one Medicare reform proposal, HCFA is directed to establish disease management programs. While more evaluation of outcomes related to these programs is needed, they are designed to improve care coordination by integrating care processes tailored to specific population needs, such as beneficiaries with cardiac disease. Given that rural populations have a higher incidence of chronic conditions, proposals that provide primary care case management and disease management services for care coordination of certain illnesses could be particularly beneficial. However, given the limited complement of services available in some rural communities, reimbursement may need to incorporate care provided through nontraditional mechanisms such as telehealth technology, regionalization of services, and networks. Payment policy, with appropriate risk adjustment, should encourage M+C plans as well as FFS providers to develop care management programs that provide quality care for chronic conditions.

Prescription Drugs. The use of prescription drugs is a key therapy for Medicare beneficiaries. However, with few exceptions, prescription drug coverage is not available through the rural-dominant traditional fee-for service Medicare program and is not uniformly available in Medicare+Choice plans. To the extent that rural Medicare beneficiaries are unable to afford or otherwise obtain prescription drugs, problems of underutilization of this key therapy will occur. These concerns may be especially true for rural Medicare beneficiaries who, on average, have lower incomes than their urban counterparts and can have greater difficulty accessing pharmacists locally, which could result in prescriptions remaining unfilled and less monitoring of potentially contra-indicated medication. Furthermore, as new choices and procedures are incorporated in the Medicare program, rural Medicare beneficiaries will have less experience with these processes than their M+C urban counterparts. Decreased access to local pharmacists can compromise beneficiary knowledge of both pharmaceuticals and related program procedures and requirements.

VI. RECOMMENDATIONS

- Regardless of whether regulatory or market-driven approaches are employed, responsibility and accountability for QA and QI activities should be clearly identified. Quality cannot be driven by market competition in rural areas where competition among plans and providers does not exist.

- Additional efforts to obtain and analyze data on quality of care among rural providers (both inpatient and outpatient) and beneficiary outcomes are needed. These efforts should compensate for any significant burdens of data collection borne by rural providers.

- More effort to evaluate care quality of FFS providers is especially important given the high reliance on FFS in rural areas.

- Changes in payment policy (affecting plans, providers, and/or beneficiaries) should be evaluated, particularly for the potential to drive underuse of services.

- Research should be conducted that explores volume-outcome relationships of common procedures in rural areas.

- Assist rural providers needing access to information regarding QI.

In summary, policymakers, purchasers, and payers have given inadequate attention in the past to the relationship between payment policy and QA/QI. As Medicare redesign is contemplated, consideration must be given to the impact of regulatory and market approaches on quality of care for rural Medicare beneficiaries. The locus of responsibility for QA and QI may shift depending on which approach dominates the Medicare program. Ultimately, however, while "it is customary to…hold providers, practitioners, and health plans accountable for the care they provide, it is at least as important to hold purchasers (including) Medicare…accountable for the quality of the care they purchase, because they are making continual and important decisions that potentially balance quality against expenditures" (Jencks et al., 2000, p. 1676).

Changes to the Medicare program should recognize the unique circumstances of rural health care, ensuring flexibility in structure and processes of care while requiring the achievement of quality patient outcomes. Furthermore, policy directions should be evaluated for their impact on minimizing or driving overuse, underuse, variation, and error in health care services for rural Medicare beneficiaries.

VII. TABLE: MEDICARE REDESIGN COMPONENTS AND QUALITY IMPLICATIONS FOR BENEFICIARIES AND PROVIDERS/HEALTH SYSTEMS

	Quality Implications	
Redesign Components	**Beneficiaries**	**Providers/Health Systems**
Provider Payment Redesign		
1. Provider payment redesign.	1. Should facilitate comparable quality of care for rural and urban beneficiaries.	
2. Assess for overpayment.		2. Excessive payment may encourage overuse of services or sustain low-quality providers.
3. Assess for underpayment.		3. Insufficient payment may contribute to underuse of appropriate services (i.e., stinting).
4. Payment for care of chronic conditions.	4. Especially important because of the higher proportion of rural beneficiaries with chronic illness.	4. Payment should adequately reimburse treatment of chronic conditions across care settings.
5. Payment structure that increases competition.	5. Competition may result in plans entering and exiting markets, with a potential adverse impact on continuity of care.	5. Where competition exists (plan, provider, and clinician levels), quality should improve. Apply cost savings to quality improvement efforts.
6. Payment adequacy.		6. Adequate payment to rebuild and/or maintain structure and process characteristics important to quality, including personnel and technology. Protects and encourages regionalization of care.
Beneficiary Payment Redesign		
1. Beneficiary liability.	1. Beneficiary liability should not result in underuse of health care services.	

	Quality Implications	
Redesign Components	**Beneficiaries**	**Providers/Health Systems**
Monitoring Care Quality		
1. Quality assurance (regulatory responsibility).		1. Emphasis on beneficiary outcomes, accommodating flexibility in rural structures and processes.
2. Quality improvement (regulatory and market responsibility).		2. Standardize core measures for FFS and M+C. Increase data reporting for FFS providers. Build capacity/reward for quality improvement. PROs target rural initiatives. Quality information dissemination to rural providers.
3. Increase national collection of quality data on rural beneficiaries and rural providers.		3. Offset burden of data collection on rural providers.
4. Target research to common rural interventions to ascertain volume-outcome relationships.		
5. Monitoring quality of care.	5. Information can be used by beneficiaries to improve their care.	5. Quality monitoring can help to ensure that providers are responding appropriately to payment incentives.

	Quality Implications	
Redesign Components	**Beneficiaries**	**Providers/Health Systems**
Program Characteristics		
1. Beneficiary information.	1. Used to inform choice. Vehicles for communicating quality-related information should consider rural beneficiary characteristics and available means for information dissemination. Viable approaches for rural could include the use of Medicare Consumer Coalitions.	1. Used to improve quality in order to enroll/retain beneficiaries.
2. Medicare board.		2. The Board could assume responsibility for requiring that health plans and FFS providers report on quality.
3. Disease management programs.	3. Primary care case management and disease management services could be especially helpful at improving quality of care for rural beneficiaries given the higher incidence of chronic illness.	3. Recognizes rural health care delivery characteristics compensating for elements such as travel, telemedicine, and networks.
4. Prescription drugs.	4. Affordable for low-income beneficiaries, to avoid underutilization of this therapy. Decreased access to pharmacists can compromise beneficiary knowledge of both pharmaceuticals and related Medicare program procedures and requirements.	4. Use of prescription drug utilization review and other quality improvement strategies. Availability of local pharmacists.

REFERENCES

Chassin, M. (1997). Assessing strategies for quality improvement. *Health Affairs, 16,*151-161.

Coburn, A., Keith, R., Bolda, E. (2000). *Multiple hospitalizations among elderly nursing facility residents: Is rural residence a risk factor?* (Research & Policy Brief). Portland, ME: Maine Rural Health Research Center.

Donabedian. A. (1980). *Exploration in quality assessment and monitoring* Vols. I-III. Ann Arbor, MI: Health Administration Press.

Donaldson, M. (Ed.). (1999). *Measuring the quality of health care.* Washington, DC: Institute of Medicine, National Academy Press.

Jencks, S., Cuerdon, T., Burwen, D., Fleming, B., Houck, P., Kussmaul, A., Nilasena, D., Ordin, D., & Arday, D. (2000). Quality of medical care delivered to Medicare beneficiaries. *Journal of the American Medical Association, 284,* 1670-1676.

Lohr, K. (1990). *Medicare: A strategy for quality assurance.* Washington, DC: National Academy Press.

Medicare Payment Advisory Commission (1999). *Report to the Congress: Selected Medicare Issues.* June. Washington, DC: Medicare Payment Advisory Commission.

Medicare Payment Advisory Commission (2000a). *Report to the Congress: Selected Medicare Issues.* June. Washington, DC: Medicare Payment Advisory Commission.

Medicare Payment Advisory Commission. (2000b). Report to the Congress: Medicare Payment Policy. March. Washington, DC: Medicare Payment Advisory Commission.

Moscovice, I. & Rosenblatt, R. (1999). *Quality of care challenges for rural health.* (Monograph) Minneapolis, MN: Rural Health Research Center, University of Minnesota.

President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. (1998). *Quality first: Better health care for all Americans.* Washington, DC

Reason, J. (1990). *Human error.* Cambridge: Cambridge University Press.

Rosenblatt, R. (2000, August). *Quality of care in the rural context: A proposed research agenda.* Paper prepared for the conference, Setting the Rural Health Agenda, Washington, DC.

Rosenblatt, R., Baldwin, L., Chan, L., Fordyce, M. Hirsch, I., Palmer, J. Wright. G., & Hart, G. (2000). *The quality of care received by diabetic patients in Washington State: A rural-urban comparison.* Seattle, WA: University of Washington Rural Health Research Center.

REDESIGNING MEDICARE: CHOICE CONSIDERATIONS FOR RURAL BENEFICIARIES AND HEALTH SYSTEMS

Keith J. Mueller, Ph.D.

I. INTRODUCTION

A pause to reflect is in order before rushing into a discussion of the presence or absence of choice among health plans in Medicare. Promoting *choice as a value* is much more than assuring a sufficient number of competing health plans and sufficient information to choose among them. Choice is associated with the more fundamental value of individual freedom. Without choice there is no meaningful freedom:

> The possibility of choice is center, then, to the concept of freedom of action. Unfreedom is created by the restriction of choice, by physical restraints that prevent any choice because they prevent any action whatsoever, or by the loading of choices, so that some become, for ordinary practical purpose, ineligible (Benn & Weinstein, 1973, p. 320).

In the context of health care, limited choice for beneficiaries can include restrictions on choice of providers, health insurance plans, or options for treatment. Choice can be restricted by "loading," even among multiple alternatives. For example, an insurance plan with very high premiums charged directly to the consumer is not a viable choice for low income households, nor is a plan that excludes certain types of treatment a viable choice for the chronically ill.

Since choice is a value to each individual, for choice to be effective criteria must include:

- the person making the choice has a realistic understanding of the alternatives (consumer education);
- the person making the choice has to be motivated on his/her own to make a choice;
- the person making the choice is not forced into choice because someone else says it is "good for them" (freedom to make what some observers would label a "bad" choice); and
- the person making the choice is capable of rejecting proposals offered to her/him (independent sources of information) (Benn & Weinstein, 1973, p. 321).

Thus, if choice is to be a cornerstone of Medicare policy, the focus needs to be on creating meaningful choices for beneficiaries and being certain that beneficiaries have the information and freedom to accept or reject the options available. Most Medicare beneficiaries will have no previous experience in choosing from among different health plans, and this is even more true for rural beneficiaries where even supplemental options are limited. To exercise their choices, beneficiaries will need information about each choice, presented in a manner easily understood, but accurate, and through a medium readily available to rural residents.

Fundamental Value

Is choice a fundamental value in its own right? Yes. As part of a strong belief in the value of pluralism, choice is a fundamental value (Morrison, 2000). There are obvious linkages between the value of choice and the pragmatic application of other values – competition and consumerism (Morrison, 2000). The latter is a new value, placing individual patient decision-making at the core of interactions with the professionals in the delivery system.

The precise use of choice as a general goal in Medicare policy is a function of the motive for doing so and the context within which choices are offered. Choice could be an independent goal, especially if the motive is to contribute to personal well-being and individual liberty. Choice could be an instrumental goal, contributing to achieving another goal, perhaps efficiency. The context could vary from pressure to preserve funding for Medicare (increasing emphasis on efficiency) to demand for access to a full range of providers and plans (increasing the emphasis on individual liberty).

Another chapter of this monograph discusses the importance of *equity* in any redesign of the Medicare program, arguing that rural beneficiaries should have opportunities comparable to those of urban beneficiaries. One of those opportunities should be availability of *choices*, among health care providers, health plans (combinations of premiums and benefits), and benefits (e.g., access to choices in a redesigned Medicare program). Assuring choices for rural beneficiaries takes a philosophical step beyond equity, in that choices may exceed a "basic decent minimum" (Daniels, 1985) that should be guaranteed to all beneficiaries. Rather than restricting that minimum to notions of a single level of benefits and uniform public financial contribution, an argument based on choice says that all beneficiaries, rural and urban alike, deserve to select from multiple options. However, just as *equity* does not necessarily mean *equality*, choices need not be identical, but should be comparable. *Medicare beneficiaries should have an appropriate number and variety of choices available to them – among health care plans (e.g., benefits covered and out-of-pocket expenses potentially incurred), and among health care providers*. Local community norms should drive the meaning of "appropriate" for Medicare beneficiaries as well as the general community, since the community, or at least its members, will have to share in the financing of a delivery system to provide what is determined to be the appropriate number of choices.

Providers, Benefits, and Plans

The value of choice is most obvious in matters of care, be that a choice of provider or a choice of how the care is administered (for example, choice of prescription medications). Within boundaries determined by the potential to infringe on other values (including choices others could make) and by resource constraints, persons should be free to choose their own providers of care and select among options for treatment. Specifically, the choice of physician affects the dynamics of a personal relationship, and the ability to choose treatments such as prescription drugs is central to maintaining well-being.

Is choice more than the means to an end (excellence in health care)? In a discourse on the drive for excellence as a fundamental value, Dougherty (1996) includes *choosing* as one of three important human capacities. In this context he is specifically referring to the "choice of provider" because: "The fit of personality between a doctor and a patient can be an important dimension of patient satisfaction, and thus of the quality of care" (p. 149). The "fit" between doctor and patient is important in building the trust thought to be important in quality of care (Dougherty, 1996). At a minimum, negative choice is important – the ability of a patient to choose not to see a particular provider.

Any move by government to restrict fundamental choices (which could include choosing a personal caregiver) requires strong justification (Stone, 1997). When one set of choices might interfere with another (as is the case when persons are influenced by exogenous circumstances [such as price] to choose among health plans that restrict access to providers and/or treatments), there should be a compelling argument limiting choice, based on public good. Choice among plans is important either as a means of promoting other values (pluralism, competition, consumerism) or because it creates opportunities for consumers that ought to be available to all consumers.

Medicare policies could enhance or limit choices for the beneficiaries, and some combinations of policies have both effects simultaneously. Ideally, any consumer should have choices among health care providers, health care plans, and insurance benefits they wish to purchase. However, maximizing choice of providers could restrict choice of health plans, precluding those plans that will pay the cost of care only if it is delivered by one of the providers selected by the plan. If open access to any health care provider is mandated by Medicare policies, fewer plans may want to participate in the program.

In the current debates about redesigning the Medicare program, choice has been associated with gaining efficiencies through consumer participation in choosing health plans. Beneficiaries would contribute to the long-term fiscal health of the Medicare program by choosing plans that meet their needs, which are also less costly in a competitive market. This is a somewhat different role for beneficiaries, who were previously passive participants in the financing elements of the program. To consider policy options that would have the Medicare program mirror the private insurance market (perceived to be more competitive), the Institute of Medicine (IOM) appointed a committee to:

> provide guidance to policy makers and decision makers on ensuring public accountability, promoting informed purchasing, and installing the necessary protections to help Medicare beneficiaries to operate effectively, safely, and confidently in the new environment of greater health plan choice (Jones & Lewin, 1996, p. 4).

In the Medicare program, choice has been associated specifically with the presence of managed care options.

The Rural Context

The rural context for Medicare policy means that choices cannot be the same; there is too much variation in both population density and availability of providers to expect multiple choices for all rural beneficiaries. Nevertheless, there should be choices available for critical dimensions of Medicare policy, including among health plans, if the philosophy driving Medicare is one that relies on the benefits of market competition. Rural beneficiaries should have at least some choice among providers, recognizing that not all beneficiaries may have multiple primary care providers in close proximity. There is additional discussion of the availability of providers, as well as benefits, in the *access* chapter of this monograph.

The intersection of choice as a goal in Medicare policy (e.g., choice among providers in the context of the traditional fee-for-service [FFS] program and choice among health plans in the context of redesign proposals reliant on market competition to achieve policy objectives) and rural as places in which only limited choices are available, creates a challenge for any proposal. Efforts to redesign the Medicare program should be consistent with the principle of *choice, defined as maximizing choices for beneficiaries*. There are several choices involved in the Medicare program, with the choice of provider being a top priority. After establishing the importance of choice as a goal in the Medicare program, the balance of this chapter will be organized by considering beneficiary choices of providers, benefits, plans, and costs. For each of those categories, the parameters of the goal are defined, the current choices available to rural beneficiaries are described, the possible impact of redesign on the range of choices is considered, and recommendations are made that would optimize choices for rural beneficiaries.

II. GOALS INVOLVING CHOICE

Is choice a primary goal of the Medicare program? As initially designed in 1965, the answer was clearly "yes" but only as applied to choice of provider. The purpose of Medicare was to secure financial access to the providers of choice for the elderly. This was done by removing the most onerous financial obligations—high bills for hospitals and specialty care—from the decision matrix of the elderly in ill health. The very nature of the Medicare program, reimbursing health care providers for care rendered to beneficiaries, encourages beneficiaries to seek care anywhere they wish – their financial burden does not vary as a consequence of their choice. However, the process of having consumers choose among a variety of health plans could, potentially, lower costs and improve benefits because plans would compete for enrollment (Neuman & Langwell, 1999).

The current debate adds other dimensions: that beneficiaries should have the option to secure coverage for benefits not included in the basic Medicare plan, that they should be able to select among a variety of health plans to maximize their personal preferences, and that out-of-pocket costs would vary according to the choice of plan and benefits. The IOM's Committee on Choice and Managed Care recommended that choices be available to all beneficiaries:

> All Medicare choices that meet the standard conditions of participation and that are available in a local market should be offered to Medicare beneficiaries to increase the likelihood that beneficiaries can find a plan of value. Traditional Medicare should be

> maintained as an option and as an acceptable 'safe harbor' for beneficiaries, especially those who are physically or mentally frail (Jones & Lewin, 1996, p. 80).

The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry saw choice as an essential element in sustaining health care quality:

> If the marketplace power of this $310 billion to protect and improve health care quality is to be maximized, the individuals who control the use of this money will need to be able to exercise their judgment and preferences as consumers and choose among competing providers, products, and health plans (Herman & Shalala, 1998, p. 105).

The two prestigious groups just cited support choice as a value for all Medicare beneficiaries and, in the case of the President's Commission, all U. S. residents. However, their conceptualization of choice leaves room for disparities in the sets of choices available to urban and rural residents. Indeed, that disparity is explicitly accepted by the IOM Committee when it considers choice in the context of local markets.

Since choice is an important policy objective, it should not be restricted to only those "local markets" where it is easily sustained. Harkening back to the discussion of *equity* in an earlier chapter of this monograph, some set of minimum choices must be *available to all beneficiaries, including those living in rural areas.*

As Deborah Stone (1997) argues persuasively, fundamental values are often in conflict, and enriching one may limit opportunities to enrich another (efforts to assure equality may sacrifice some degree of individual liberty). The same can be said for the various elements of choice as related to the Medicare program. For beneficiaries, the choice to remain in sparsely populated rural areas inherently limits other choices, such as among a group of providers or competing health plans. Similarly, maximizing choice of providers may result in a more costly system and limit choices among types of health plans. An important question for policymakers to resolve is: What are the most important choices that must be maintained or provided for Medicare beneficiaries, including those residing in rural areas?

Choice of Providers

As managed care organizations have learned, most people value their ability to use a health care provider of their choice. At a minimum, Medicare beneficiaries must themselves decide that the ability to choose among providers is less important than some other objective, presumably spending less of their own money. To make this decision consistent with the criteria for freedom of choice, the difference in cost cannot be so great, particularly at the high end, as to make one option unrealistic. To be consistent with the value of excellence discussed by Dougherty and others, beneficiaries must be free to choose providers in whom they can build trust and free to reject forced choices of providers in whom they have no trust (the second criteria of freedom to choose).

Rural beneficiaries, especially those not near one of the large medical plan communities that dot rural areas (e.g., Marshfield in Wisconsin, Grand Junction in Colorado, Danville in Pennsylvania), cannot hope to have the same choices as their urban counterparts. However, most can still select from a small pool of primary care providers, particularly if the beneficiary is willing to travel some distance as a means of expanding choice. Further, rural beneficiaries can choose among a wide array of specialists, since different groups of specialists may be equally distant, in different directions. Thus, even for rural beneficiaries who may already have fewer options than urban beneficiaries, there is a possibility for new Medicare plans to *restrict existing choices* of rural beneficiaries. For example, if a plan uses only those cardiologists located in city *x*, located 70 miles south of the beneficiary's home town, and not those in community *y*, located 75 miles north, choice has been restricted. Conversely, new Medicare plans may *expand existing choices* of providers if, by signing up large provider groups who agree to accept discounted fees, the plans offer more providers at costs affordable to the beneficiaries. In the previous fictitious example, perhaps the cardiologists south of the community had not been accepting new Medicare patients prior to signing on with the new health plan. If the plan allows selection of the providers north of the town (in a point-of-service option), choices would have been expanded. If both of these examples are present, beneficiaries have meaningful choice because the choice of plans is associated with a choice of providers. If one or the other dominates (that is, it has nearly all of the market, making the alternative an unstable choice) in a given local market, the choice for beneficiaries is less meaningful.

Choice of Benefits

Medicare beneficiaries in the U.S. are currently assured the basic benefits included in Part A and Part B. They may choose not to enroll in Part B, but that is a one-time choice and very few fail to exercise the option; in 1997, 33.1 million persons (nondisabled) were enrolled in Part A and 32.1 million were enrolled in Part B (Gross & Brangan, 1998). There are no other choices regarding benefits in the basic Medicare program; it is an approach of *fixed benefits* at a cost determined by use and price. The presence of an array of fixed benefits is said by some to be fundamental to the social contract that is Medicare. This contract assures access to those benefits for vulnerable populations (Moon, 1999; Davis, 1999). However, those benefits are somewhat limited, especially since they do not include prescription medications, dental services, foot care, or eye examinations.

Supplemental plans can also be used to expand the benefits covered by insurance, with a cost to the beneficiary for an additional premium (beyond their Part B monthly withdrawal from their Social Security payment). For example, 2 of the 10 generic supplemental plans, defined by the federal government for the purposes of creating consistency across plans offered, include coverage for prescription drugs. Another means of expanding benefits is through managed care plans (Medicare+Choice, Part C) that attract enrollment by offering benefits beyond those in traditional FFS Medicare (Parts A and B). Neither of these options is universally available at affordable rates for all beneficiaries (the rural disadvantage is detailed below).

The ability to choose is of course a function of the amount of resources available to pay for some choices that may be more expensive than others. When managed care plans are able to offer expanded benefits at no additional costs, for example, the beneficiaries' choices are close to optimal. That scenario, once common, is now rare. One reason for the decline has been the payment constraints built into the Balanced Budget Act of 1997 (there are other reasons, see Penrod, McBride and Mueller, forthcoming). When health plans are paid less by Medicare, they offer fewer benefits (McBride, 1998). To make a wider array of benefits available, beneficiaries would have to pay higher premiums out of their own pockets. A similar scenario holds for supplemental insurance packages.

Choice Among Health Plans

As just described, beneficiaries have some choices among supplemental health insurance plans, which means adding different benefits at varying costs to what Medicare provides. In contrast, comprehensive managed care plans include the full array of traditional FFS Medicare benefits plus additional benefits. The plans could vary in their costs to beneficiaries, provider networks used, and benefits offered. In brief, various plans could incorporate the trade-offs inherent in balancing costs, benefits, and access to providers. Were Medicare to evolve into competing plans, all beneficiaries should have comparable choices among those plans.

Choice of Costs

If choices exist among health plans, benefits, and providers, there are likely to be parallel choices to make based on the out-of-pocket costs to the beneficiary. For some beneficiaries, the very poorest who are eligible for Medicaid benefits, these choices would not be meaningful. For all others, though, differences in costs across options are likely to matter. The choices should include the monthly premium, deductibles and co-payments, and costs of services not included in the basic plan being purchased.

III. CHOICE IN CURRENT MEDICARE POLICY

Basic Choices

The traditional FFS Medicare program has maximized opportunities to choose health care providers. However, choice is only optimal if all providers are willing to accept Medicare patients and if all beneficiaries have providers to choose from in reasonable proximity to their residence. The former condition has, in nearly all instances, been met, but the latter has always been problematic in rural areas.

Continued constraints in Medicare spending have precipitated reductions in payment to providers, including professionals (especially physicians) and institutions (hospitals, home health agencies, and skilled nursing facilities have been particular targets since 1997). As of yet there is no evident crisis in access (Medicare Payment Advisory Commission, 2000b), but anecdotal evidence is showing vulnerabilities in the rural health care delivery system. Examples of the difficulties facing rural hospitals are available on the web site of the American Hospital

Association, www.aha.org, in their campaign, "Real People, Real Pain." In some instances, care for the elderly has been disrupted because of nursing homes not accepting discharges from hospitals (Hilzenrath, 1999). Anecdotes are also being reported describing instances in which providers are refusing to accept any new Medicare patients. These actions demonstrate a link between having *choices* available with considerations of *cost* in the Medicare program. In the name of having an *efficient* program, sacrifices might be made in *choices available* to beneficiaries. This is especially likely in rural areas, if policies designed to thin out "inefficient" providers in urban areas are applied to rural providers who, for reasons of running low volume businesses, cannot adapt to changes in payment policies.

Medicare payment policies are implemented in the context of a rural health care delivery system that, at least in places, is spread very thin over vast areas. As of December 31, 1998, over 22 million rural residents lived in designated health profession shortage areas (HPSAs), and 2,343 practitioners would be needed to remove those designations (Bureau of Primary Health Care, 1998). The new Medicare designation of Critical Access Hospitals applies to those institutions proving they are essential for access to services in more remote areas. As of December 1, 2000, there were 300 hospitals certified as Critical Access Hospitals (for the current number see the web site: www.rupri.org/rhfp-track).

In brief, the current Medicare program does not offer a perfect array of basic choices to rural beneficiaries. Any changes to the program should endeavor to improve on the likelihood of choices for rural beneficiaries.

Choice Beyond Traditional FFS Medicare

Options beyond the basic Medicare program are not universally available. In the case of supplemental insurance policies, most are technically available everywhere, licensed by individual states. However, the more attractive plans (especially those that include a benefit for prescription drugs) are not always affordable. They may be experience-rated, which would put the cost out of reach for most rural beneficiaries. Even when community-rated but sold on an individual basis, policies may be unaffordable. The net effects of these circumstances are that 46.1% of rural seniors lacked prescription drug coverage in 1995, compared with only 30% of urban seniors (Poisal et al., 1999).

The other more comprehensive class of plans, Medicare+Choice (M+C) plans, are not widely available. Further, those that are sold do not always include attractive benefits such as prescription drugs. Only 16% of rural Medicare beneficiaries have access to an M+C plan that includes prescription drug coverage, compared to 79% of urban beneficiaries with such access (Medicare Payment Advisory Commission, 2000a). As of October 2000 there were only 201,655 rural Medicare beneficiaries enrolled in M+C plans, accounting for 2.1% of all rural beneficiaries (data from the Rural Policy Research Institute Medicare County Capitation file).

Learning From Other Experiences. Advocates of radical redesign of the Medicare program have used other health insurance systems to illustrate the strengths of a competitive model. An often cited system is the Federal Employee Health Benefit Plan (FEHBP). During the 1990s, the

FEHBP was successful, as indicated by only moderate increases in cost and widespread availability of choices among competing plans. In the years 1983-96, premiums increased by less than 4% per year, and most participants could choose among 10-20 competing plans (Study Panel on Capitation and Choice, 1998). However, in recent years premiums have increased more sharply (8.5% in 1998), and only seven plans are national in scope, available to all federal employees (Study Panel on Capitation and Choice, 1998). Indeed, in remote rural areas choice is quite limited. In Rushville, Nebraska only one national insurer includes local providers in its panel; other choices use primary care providers located at least 35 miles away (Mueller, 2000).

Successes of the FEHBP may not translate readily into the Medicare program. Four issues were referenced by the Study Panel on Capitation and Choice (1998) that were originally presented by Robert Reischauer in testimony before the Senate Committee on Finance:

1. The FEHBP does not adjust premiums to reflect health risk, which would be a greater problem for Medicare beneficiaries than in the younger, general population of federal employees and dependents.

2. The FEHBP model does not use standardized benefits packages, making it more difficult for Medicare beneficiaries, who generally have more medical needs than the FEHBP population, to make choices.

3. The FEHBP allows plans to define their own market areas.

4. The FEHBP administrative burden is high due to negotiating rates with individual plans. At the same time, though, FEHBP staff is not responsible for information dissemination, enrollment, disenrollment, and initial handling of questions and complaints.

In brief, there may be valuable lessons to glean from the experience of the FEHBP, but the model cannot be transmitted as-is to the Medicare program. For rural beneficiaries, the most glaring deficiency of the model is that its premise, offering realistic choices among multiple plans, does not apply in all rural areas.

IV. CHOICE AS AN ELEMENT IN REDESIGN

Given the political rhetoric of the times, all proposals to strengthen and/or redesign the Medicare program will include *choice* as a core objective. An important initial decision is *which choice* should have priority – choice of provider, choice of benefits, or choice among competing plans. All too often this dilemma is ignored in an excitement to create new choices among plans that offer different benefits. Promoting choice among plans could have the trade-off of restricting choice of providers. Given the earlier discussion of the philosophical underpinnings of choice as a value, *choices involving personal health care* should have top priority. Modest incremental improvements to the current program would aspire to enhance choices among providers and regimens of care, in particular, by minimizing the financial burden of any given choice.

Plans to redesign the program would see choice as a value, but also as a means to improve the cost-effectiveness of the program through introducing more competition among health plans. However, *choice* has little meaning unless beneficiaries make informed decisions based on the choices available. Therefore, the design of the Medicare program must include efforts to ensure that beneficiaries understand the choices available to them, and that they have structured information available to enable fair comparison of alternatives. The IOM found that independent private organizations exist or would develop that could assist beneficiaries in making informed choices, and recommended that nothing in Medicare law and regulation inhibit the development of such private organizations (Jones & Lewin, 1996). Advocates of managed competition have always placed an emphasis on the importance of providing full information to consumers in a manner they can understand and use (Enthoven, 1980).

Two design issues, relevant to informed choices, arise from an array of health plans:

- Conditions of participation imposed on health plans must include uniformity of a basic benefit package (standardized benefits), availability of information about the plan (including measures of customer satisfaction), and requirements assuring beneficiaries understand the choice they make.

- The Medicare program accepts the burden of educating beneficiaries about the choices available to them.

Regardless of the specific approach used to improve the Medicare program, strengthening the ability of beneficiaries to make wise choices is essential. In the extreme example of a government-driven regulatory approach, beneficiaries would still be making choices to select certain providers. In the completely private approach, beneficiaries would need to choose among health plans, which in turn would affect their selection of providers, benefits, and out-of-pocket expenses.

The IOM's Committee on Choice and Managed Care recommended that conditions of participation for health plans include "the burden of assuring informed choice by beneficiaries" (Jones & Lewin, 1996). The Committee reported that information of most interest to beneficiaries could be grouped within three principal categories (Jones & Lewin, 1996, p. 59):

1. Structural information, including:
   - premiums and copayments;
   - ratings of hassle factor associated with paperwork;
   - description of grievance and disenrollment process; and
   - medical/loss ratio of the plan.

2. Benefit package, including:
   - description of standard benefit package; and
   - coverage of special concern such as prescriptions, foot care, home care, long-term care.

3. Quality, including:
    - accreditation status;
    - percentage of board-certified physicians;
    - patient reports and ratings of care for all members and for members over age 65;
    - appointment waiting times; visit waiting times;
    - access to and choice of primary care physicians and specialists; and
    - HEDIS and other technical measures.

Any plan that includes more than one option within a benefit category must provide all of the information just listed. This requirement includes traditional FFS Medicare.

The Medicare program itself has a major responsibility for educating beneficiaries. The IOM Committee recommended "that special and major efforts be directed to building the needed consumer-oriented information infrastructure for Medicare beneficiaries" (Jones & Lewin, 1996, p. 89). The program should provide information on 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; and
- how participating health care professionals are paid (Jones & Lewin, 1996, p. 90).

Presentation of information should meet two criteria: easy access to essential information and formatting and content that is easily understood.

Both criteria for information systems may pose special challenges in rural areas. Communication modalities, including the Internet and use of telephone consultation, can enable Medicare beneficiaries who initiate the contact to obtain the information they seek. However, a more important challenge is getting the beneficiaries to realize they need the information. In rural areas where there has been very restricted choice (traditional FFS Medicare and limited numbers of providers), there has been little or no incentive to learn about options. The Medicare program will need to identify the channels of communication used most often by elderly residents especially in less populated areas. Multi-faceted approaches are likely to be required. An important consideration is that beneficiaries need to understand differences among plans within discrete categories (e.g., benefits, premiums, copayments, deductibles, physician networks), and across those same categories (e.g., level of premiums will covary with benefits). Especially in those Medicare proposals that build upon a competitive market, beneficiaries are making the trade-offs across the elements of plans.

Another issue in choices for rural beneficiaries, is that *access* to appropriate health care services needs to be assured. This topic is taken up in a different chapter of this monograph.

V. OPTIMIZING CHOICE FOR RURAL BENEFICIARIES

The purpose of focusing on choice as a principle to follow in redesigning Medicare is to maximize welfare, both for the individual beneficiary and for the program. Doing so requires balancing appropriate choice among plans with a system that can be understood by beneficiaries and one that does not facilitate skimming and adverse risk selection (Aaron, 1999). Our purpose in incorporating this principle is focused on the beneficiaries, specifically those residing in rural areas. Their participation in the Medicare program would be enriched if they had meaningful choices among:

- providers in their local area;
- health insurance plans (including traditional FFS Medicare) that include benefits not presently in the basic Medicare program; and
- different combinations of out-of-pocket expenses and parallel benefits.

To exercise their choices, beneficiaries will need information about each choice, presented in a manner easily understood, but accurate, and through a medium readily available to rural residents.

VI. TABLE: SUMMARY COMMENTS ABOUT CHOICES AND ALTERNATIVE DESIGNS OF THE MEDICARE PROGRAM

Traditional Fee-for-Service (FFS) Medicare	Traditional Fee-for-Service (FFS) Medicare & Prescription Drugs	Medicare+ Choice (M+C)	Using Competing Health Plans	Vouchers
CHOICE OF PROVIDER				
• Any provider selected will be paid by Medicare, in accordance with the specific fee schedule or prospective payment. • Geographic distribution of providers limits choice.	• Same as traditional FFS Medicare.	• Favors the providers under contract to the M+C plan; choosing another increases direct cost to the beneficiary. • Regulations specify making care available within reasonable proximity to beneficiaries.	• There may be more variation in restrictions to choice than in M+C plans, because payment is determined by competing plans rather than by a county-specific formula.	• Same as competing health plans.
CHOICE OF BENEFITS				
• No choice within the Medicare program. • Beneficiaries can supplement Medicare with other plans that expand benefits.	• Still no choice, but a prescription drug benefit becomes part of Medicare instead of being available only through supplements. • Makes the prescription drug benefit more real for rural beneficiaries.	• Minimum Medicare benefits are available in all plans. • An array of choice sets may be available depending on what plans offer. • Less choice in rural areas because of lower payment.	• A set of minimum benefits in the authorizing legislation is likely. • An array of choice sets may be available, but they are linked to the premiums to be paid by the beneficiary. • Choices could be narrower in rural areas because of the limited number of competing plans and less applicability of economies of scale.	• A set of minimum benefits in the authorizing legislation is likely. • Choices are, in part, a function of the amount of the voucher, since pricing close to the voucher payment is a likely market response to federal funding. • Choices available in rural areas are, in part, a function of how the voucher payment is calculated. The national averaging would favor rural areas where costs are lower than average.

Traditional Fee-for-Service (FFS) Medicare	Traditional Fee-for-Service (FFS) Medicare & Prescription Drugs	Medicare+ Choice (M+C)	Using Competing Health Plans	Vouchers
CHOICE OF PLANS				
• No choice for the basic plan. • A variety of choices for supplemental insurance. • Fewer supplemental choices in rural areas.	• Same as traditional FFS Medicare, except that prescription drugs are part of the basic package.	• Creates options where M+C plans are available. • A reduction in the number of plans in recent years has lessened choices. • The availability of M+C in rural areas is much less common than urban areas.	• If the theory works, multiple choices for the most beneficiaries. • Implicit recognition of the limited choices in rural areas because proposals increase the subsidies in counties with only one or two plans. • Choice is also limited by the ability of the beneficiary to pay additional premiums.	• Same as competing health plans.
CHOICE OF COSTS				
• Same as choice of plans.	• Same as traditional FFS Medicare, except that the costs of supplementals should be lower since prescription drugs are part of the basic Medicare benefit.	• Multiple plans in the same area would present an array of options. • Beneficiaries would need to assess differences in premiums, deductibles, and copayments. • At present there is not a meaningful set of choices available for rural beneficiaries.	• Costs should vary among competing plans. • Fewer competing plans in rural areas would mean less choice of costs.	• Maximizes differences in costs among plans, since there is no defined link between costs and the amount of the voucher. • Fewer competing plans in rural areas means less choice of costs.

Traditional Fee-for-Service (FFS) Medicare	Traditional Fee-for-Service (FFS) Medicare & Prescription Drugs	Medicare+ Choice (M+C)	Using Competing Health Plans	Vouchers
CONSUMER EDUCATION				
• Important for beneficiaries to understand what is included in basic Medicare coverage. • Beneficiaries need independent, reliable information about supplemental plans.	• Important for plans to include a basic description of what is and is not included in the prescription drug benefit, including having this information at the time of filling the doctor's orders. • Beneficiaries need information about supplemental plans.	• Information is needed about plans in the area, and for rural areas, this information is needed through means other than the Internet. • Information is needed about what to do when plans are discontinued. • For rural providers in particular, information about what providers can be seen with full plan coverage.	• Greater importance for beneficiary education, since there is an expectation that traditional FFS Medicare will not be a competitive plan. • The modality used in education needs to be consistent across markets. • Specific education is needed related to any restrictions on choice of providers.	• Same as competing health plans, with a greater emphasis on understanding the out-of-pocket financial obligations associated with each choice.

REFERENCES

Aaron, H. J. (1999). Medicare choice: Good, bad, or it all depends. In A. J. Rettenmaier & T. R. Saving (Eds.), *Medicare reform: Issues and answers* (pp. 37-64). Chicago: University of Chicago Press.

Benn, S. I. & Weinstein, W. L. (1973). Being free to act and being a free man. In R. E. Flathman (Ed.), *Concepts in social & political philosophy* (pp. 309-321). New York: Macmillan Publishing Co., Inc.

Bureau of Primary Health Care, Division of Shortage Designation. (1998). *Selected Statistics on Health Professional Shortage Areas As of December 31, 1998*. Rockville, MD: Health Resources and Services Administration, U. S. Department of Health and Human Services.

Daniels, N. (1985). *Just Health Care*. Cambridge: Cambridge University Press.

Davis, K. (1999). Shaping the future of medicare. *Health Services Research, 34,* Part II, 295-306.

Dougherty, C. (1996). *Back to reform: Values, markets and the health care system*. New York: Oxford University Press.

Enthoven, A. C. (1980). *Health plan: The only practical solution to the soaring cost of medical care*. Reading, MA: Addison-Wesley Publishing Co.

Gross, D. J. & Brangan, N. (1998). The Medicare program *fact sheet*. Public Policy Institute, American Association of Retired Persons.

Herman, A. M. & Shalala, D. E. (1998). *Quality first: Better health care for all Americans*. Final Report to the President of The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Washington, DC: Government Printing Office.

Hilzenrath, D. S. (1999, June 7). Nursing homes shun some Medicare patients. *The Washington Post,* p. A01.

Jones, S. B. & Lewin, M. E. (1996). *Improving the Medicare market: Adding choice and protection*. Washington, DC: National Academy Press.

McBride, T. (1998). Disparities in access to Medicare managed care plans and their benefits. *Health Affairs, 17,* 170-80.

Medicare Payment Advisory Commission (2000a) *Report to the Congress: Selected Medicare issues*. June. Washington, DC: Medicare Payment Advisory Commission.

Medicare Payment Advisory Commission (2000b) *Report to the Congress: Medicare Payment policy*. March. Washington, DC: Medicare Payment Advisory Commission.

Moon, M. (1999). Will the care be there? Vulnerable beneficiaries and Medicare reform. *Health Affairs, 18,* 107-117.

Morrison, I. (2000). *Health care in the new millennium: Vision, values, and leadership*. San Francisco: Jossey-Bass Publishers.

Mueller, K. J. (2000). Competition in the Medicare program. Testimony before the U. S. Senate Committee on Finance. February 29.

Penrod, J., McBride, T., & Mueller, K. (forthcoming). Geographic variation in determinants of Medicare managed care enrollment. *Health Services Research.* Accepted for publication, May, 2000.

Poisal, J., Murray, L., Chulis, G., & Cooper, B. (1999). Prescription drug coverage and spending for Medicare beneficiaries. *Health Care Financing Review, 20,*(3), 15-27.

Stone, D. (1997). *Policy paradox: The art of political decision making*. New York: W.W. Norton & Company.

Study Panel on Capitation and Choice. (1998). *Structuring Medicare choices*. Washington, DC: National Academy of Social Insurance.

REDESIGNING MEDICARE: ACCESS CONSIDERATIONS FOR RURAL BENEFICIARIES AND HEALTH SYSTEMS

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I. ACCESS AS A GOAL FOR MEDICARE BENEFICIARIES

Perhaps the single most important issue in Medicare redesign is whether beneficiaries have access to health care services, without which the core Medicare benefits guaranteed by law are meaningless. In the last few decades, Medicare has been a critical factor in improving access for the elderly by providing nearly universal insurance coverage (Vladeck, 1981). However, barriers to care still exist for many rural residents who on average are older, less educated, have lower incomes, and are in poorer health than urban residents (Stearns, Slifkin, & Edin, 2000; Coburn & Bolda, 1999). Other factors contribute to access problems for rural beneficiaries, including the threat of hospital closures, fewer medical professionals, and a lack of specialty services (Knapp, Paavola, Maine, Sorofman, & Politzer, 1999; Rosenblatt & Hart, 1999; Conner, Kralewski, & Hillson, 1994).

Andersen and colleagues (1983) state that "Equity of access may be said to exist when services are distributed on the basis of people's need for them (p. 53)." Since rural residents are poorer, older, and sicker than urban residents they are likely to need more health care services (Coburn & Bolda, 1999). However, defining "need" is difficult. While assuring access to needed services is an important goal, no gold standard of access exists within the medical community. It is therefore difficult to define precisely the specific services to which rural Medicare beneficiaries should have access, and the ease with which these services should be obtainable, or to determine how much utilization represents an adequate level of service.

For populations that reside in remote locations, there is a need for certain types of services to be obtainable in a reasonable amount of time. For instance, emergency services must be accessible, because the patient might die if services are not quickly obtained. Similarly, primary care and preventive services should be accessible because these types of services might not be used if travel distances are too far. There are many types of services in-between, however, for which a definition of need is not as clear.

Complicating the lack of a gold standard with which to evaluate appropriate access is ambiguity concerning the role of the Medicare Program in assuring access to care for Medicare beneficiaries. When the Social Security Amendments of 1965 were enacted into law, Medicare was envisioned as a universal entitlement program where "despite the value of markets in other contexts, certain goods and services should be provided to everyone at some basic level" (Aaron & Reichauer, 1995, p. 9). Although the traditional fee-for-service (FFS) Medicare program provides access to the same benefits for all beneficiaries, there have historically been disparities in access to services between urban and rural beneficiaries. For universal entitlement to be meaningful there also needs to be universal access. 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 that are essential to maintaining access.

II. THE RURAL CONTEXT

Rural Medicare beneficiaries tend to be more vulnerable than those in urban areas. Differences in the social and health characteristics of rural and urban Medicare beneficiaries have potentially significant implications for health care access. On average, Medicare beneficiaries in nonmetropolitan counties are frailer and poorer than those in metropolitan counties (Coburn & Bolda, 1999). Beneficiaries in nonmetropolitan counties that are not adjacent to metro areas are even *more* likely to be disabled or report poor health status, have less education, and have lower incomes (Stearns et al., 2000), and income appears to be associated with access to care (Weinick, Zuvekas, & Drilea, 1997; Kralewski et al., 1992; Strickland & Strickland, 1996). Although rural residents, based on their characteristics, are more likely to need health care services, findings suggest that the culture and lack of education make this same population less likely to seek care, both preventive and acute (Fox, Merwin, & Blank, 1995; Strickland & Strickland, 1996). In addition, rural residents have been found to put off seeking care because of long distances to services and transportation difficulties (Blazer, Landerman, Fillenbaum, & Horner, 1995).

Primary care provider shortages are much more common in rural than in urban areas (Korczyk, 1994) and distances to hospital care are further. There are fewer pharmacists in rural areas (78.2 per 100,000 people in all of the U.S. but only 66.4 in rural ZIP codes) (Knapp et al., 1999), and financial pressures from managed care companies are causing many small independent pharmacies to close (MacPherson, 1996).

Rural elderly have fewer physician visits than their urban counterparts, and the intensity of services received is lower (Himes & Rutrough, 1994; Dor & Holahan, 1990). Utilization of inpatient services by individuals who reside in rural areas is similar to that of urban residents (Codman, 1990; Himes & Rutrough, 1994; Stearns et al., 2000). However, skilled nursing facility admission rates were 15% higher for rural Medicare beneficiaries (Dubay, 1993). While rural residents are less likely to use home health services, there is a higher average number of visits among those who do (Kenney, 1993). Despite this, rural Medicare beneficiaries were less likely to receive home health services that met condition-specific guidelines (Chen & Phillips, 1993).

III. THE EFFECTIVENESS OF THE CURRENT MEDICARE PROGRAM IN ASSURING HEALTH CARE ACCESS

One of the critical issues in evaluating the implications of proposals for Medicare restructuring is whether and how the problems of health service availability and beneficiary access in rural areas will be appropriately addressed. Changes in the health care market in the 1980s and 1990s have resulted in the inability of some providers of basic services, most notably rural hospitals, to remain financially viable without special financial support from the Medicare program. Since the early to mid 1980s, Congress and the Health Care Financing Administration have addressed the equity and appropriateness of Medicare payment policies by adopting a number of special payment provisions that support essential providers in rural areas, thereby contributing to preserving access to basic health care services for many rural beneficiaries. There have been a number of provisions aimed at keeping rural providers financially solvent, including special

payment categories for rural hospitals (Sole Community Hospitals, Medicare Dependent Hospitals, Rural Referral Centers and most recently, Critical Access Hospitals), that provide enhanced Medicare payments for hospitals meeting certain criteria. In addition, the Medicare program has provided bonus payments to physicians who practice in underserved rural areas and has provided cost-based reimbursement for Federally Qualified Health Centers and Rural Health Clinics located in underserved rural areas.

The elimination of these special payment provisions in any restructured Medicare program could have significant implications for maintaining an essential rural health service infrastructure in underserved areas. Any assessment of Medicare redesign proposals must consider the adequacy of Medicare provider payments and/or other policy provisions in assuring the availability of, and appropriate access to, health services in rural areas.

In addition to assuring the financial survival of essential rural providers, Medicare redesign proposals should be evaluated on the extent to which they address beneficiaries' financial barriers to care. Currently, the vast majority of rural Medicare beneficiaries are enrolled in the traditional FFS Medicare plan. Under this plan, the Medicare program has no explicit mechanisms for dealing with financial barriers to care. The majority (80%) of Medicare beneficiaries purchase supplemental Medigap coverage to reduce their out-of-pocket costs associated with Part B premiums, deductibles, and coinsurance. A small subset of these plans covers the cost of additional benefits such as prescription drugs. Supplemental coverage is too expensive for some Medicare beneficiaries, however. Rural Medicare beneficiaries, in particular, are less likely than their urban counterparts to have supplemental Medigap coverage or coverage for prescription drugs (Coburn & Bolda, 1999).

The lowest income Medicare beneficiaries may be eligible for Medicaid coverage. For low income beneficiaries whose income is slightly too high for Medicaid eligibility, however, there are no federal programs to help with financial barriers such as Part B premiums and copayments and/or Medigap premiums. The extent to which relief is offered by the states is dependent on state-determined Medicaid or pharmacy assistance program policies.

IV. ASSESSING THE ACCESS IMPLICATIONS OF MEDICARE REDESIGN

The access implications of Medicare redesign center on three basic questions: Do rural and urban Medicare beneficiaries have access to similar benefits? Are the out-of-pocket costs of those benefits equitable relative to beneficiaries' ability to pay? And, are comparable health care services available to rural beneficiaries?

In recent years there have been a number of proposals to reform Medicare. These proposals vary in the extent to which they rely on government regulation at one end of the continuum and on the competitive market place at the other end as a means of changing the Medicare program. A number of these legislative proposals, such as those put forth by the Bipartisan Commission on the Future of Medicare and by Senators Breaux, Frist, Kerrey, and Hagel, rely on beneficiary enrollment into competing health care plans. The work of the Commission and the subsequent legislation have been referred to as "premium support plans," a specific application of the more

general idea of encouraging competing health plans. This approach contains elements of both competition and government regulation, and provides a good example around which to build a framework for assessment of the access implications of Medicare redesign.

Redesign proposals relying on competing health plans are based on the model of the Federal Employee Health Benefit Program. They would provide Medicare beneficiaries with a pre-determined contribution toward the purchase of a competitively offered and priced health plan. In this model, plans would compete for beneficiary enrollment on a "level playing field" created by government rules. In the premium support application of the competitive model, the government's contribution to the premium would be established based on the competitively generated bids submitted by health plans. For example, legislative proposals in the 106th Congress set the contribution using the weighted average of plan premium costs. The government would also establish the minimum benefits that all plans would have to offer, with perhaps a second level minimum that might include prescription drugs or other benefits. And finally, the government would also subsidize the cost of premiums for low income persons with the amount of the subsidy determined by the market rate for available health plans and not a predetermined government voucher (known as "fixed contribution").

To assess in greater detail the access implications of proposals that rely at least in some part on a competitive market, we have chosen to focus on six specific sets of features of these proposals:

- The availability of competitively priced plans;
- The adequacy of premium contributions by the beneficiary and the government;
- The benefit structure of available plans;
- The adequacy of provider panels;
- The payment arrangements between plans and providers; and
- The beneficiary enrollment and continuity of coverage features and options.

In each of the following sections, we address two fundamental questions: (1) Are rural Medicare beneficiaries likely to be better or worse off under a competing plans approach to Medicare than under the traditional FFS Medicare program? and (2) Relative to urban beneficiaries, will rural Medicare beneficiaries be treated more or less equitably under a competing plans approach?

Availability of Competitively Priced Plans and Adequacy of Premium Contributions

The affordability of Medicare coverage for beneficiaries is the principal determinant of financial accessibility in the Medicare program. Financial accessibility for beneficiaries must be balanced, of course, with the financial solvency needs of the Medicare program as a whole. So for example, beneficiary cost-sharing features such as deductibles and coinsurance have important cost-saving value to the Medicare program but may present financial barriers to the appropriate use of health services for certain lower-income beneficiaries.

As indicated in Table 1, one of the first questions concerning financial access for beneficiaries is the out-of-pocket cost of the premium. Under the competing plans model, out-of-pocket premium costs will be determined by: (1) the competitiveness of the market for health plans, and (2) the level of governmental support provided toward the cost of the premium. In areas where plans actively compete for beneficiaries based on benefits and price, Medicare beneficiaries could have access to better benefits at a lower out-of-pocket cost than is currently available under the traditional FFS Medicare program. Conversely, in areas with limited competition among plans, the cost of purchasing a plan may exceed current out-of-pocket costs for the traditional Medicare benefit.

For Medicare beneficiaries living in rural areas the question will be whether and to what extent more competitive urban health care markets will extend to rural areas. In other words, will health plans that compete for Medicare beneficiaries in urban areas also serve adjacent or more distant rural areas? Or will plans develop in rural areas, perhaps sponsored by local providers, or partnerships of providers and insurance companies? The answer to these questions will depend largely on the specific framework for competition that is offered in each redesign proposal. Proposals that prescribe market areas that plans must serve could assure that rural beneficiaries are offered the same plans at the same rates as urban beneficiaries. On the other hand, without some definition of market areas, plans would be unlikely to serve smaller, less densely populated rural areas, thereby reducing the rural beneficiaries' choices and potentially increasing their out-of-pocket costs.

In addition to the prices that plans offer in their respective markets, the level of premium support offered by the government, the availability and level of other subsidies for lower income beneficiaries, and the cost-sharing requirements of the plans will all affect financial affordability of Medicare coverage for beneficiaries under a competing plans approach. Because rural seniors tend to have lower average incomes than urban seniors, the level of government contribution toward the premium costs of plans and the availability of subsidies for lower income seniors who do not qualify for Medicaid assistance are especially important to rural Medicare beneficiaries. Proposals which offer sliding scale premium contributions and subsidies of other out-of-pocket costs, based on the income of beneficiaries, would be essential for many rural Medicare beneficiaries.

Health plan cost-sharing requirements may vary among plans and markets in ways that could disadvantage rural beneficiaries. As indicated above, cost-sharing provisions such as deductibles and coinsurance are important benefit design options for achieving utilization and cost restraints that contribute to long-term solvency of the Medicare program. On the other hand, such features can also represent barriers to the appropriate use of health services among lower income beneficiaries. If plan features such as cost-sharing are not regulated under Medicare redesign proposals, subsidy mechanisms will be needed to balance cost-sharing requirements that some plans may impose. Such subsidies will be especially important for rural beneficiaries who are more likely than urban beneficiaries to have lower incomes and whose choices among plans may be limited to plans with higher cost-sharing requirements.

Benefit Structure of Available Plans, Adequacy of Provider Panels, and Payment Arrangements Between Plans and Providers

Under a competing plans approach to redesign, the benefits structure of plans offered to beneficiaries will vary within and potentially across market areas. This raises the question of whether rural beneficiaries would have access to the same benefits at comparable out-of-pocket costs as urban beneficiaries. The experience of the Medicare+Choice (M+C) program clearly indicates that the scope of benefits and their cost to the beneficiary are influenced by the level of competition among plans in the market area (McBride, 1998). The lack of competitiveness in rural areas, combined with lower payment rates, has meant that where M+C plans have been offered, they have tended to offer fewer additional benefits and have had higher out-of-pocket costs for beneficiaries. Although the link to county-based payment rates would be broken under a competing plans approach, it is not clear how plans might structure and price their plan offerings and whether there might be significant rural-urban differentials in either benefits or costs.

Another concern for rural beneficiaries and rural health care providers is how plans will choose to define and compensate their provider panels. For most rural Medicare beneficiaries, the inclusion of local hospitals, physicians, and other health service providers in health plans' panels is essential for maintaining reasonable access to basic health services. In communities with limited numbers of providers, however, plans may be inclined to shift care to providers in other areas where, because of greater supply, they can obtain greater discounts or other advantageous financial arrangements. For beneficiaries this could result in greater travel times, inconvenience, and other access barriers. For some rural providers and health systems, the movement of Medicare services and payments out of the community could undermine the financial stability of the local health system. The development and enforcement of reasonable access standards for health plans will likely be needed to assure a balance between the needs and demands of health plans for freedom to negotiate reasonable arrangements with providers and the needs of Medicare beneficiaries for reasonable access to a sustainable local and regional health system.

The treatment of essential community providers under the competitive managed care arrangements will be an issue of special importance to rural beneficiaries and providers. As noted above, current Medicare payment policies include a variety of special provisions designed to compensate providers for the higher cost of providing services in rural areas and/or to create incentives for practitioners and providers to locate or remain in rural, underserved areas. Allowing competing plans to negotiate separately with providers eliminates these payment provisions.

It is not clear whether the rates and payments that rural providers could negotiate with health plans would result in Medicare payments comparable to what they would be paid under current Medicare payment policies. The financial health and stability of rural providers and health systems could be threatened, and beneficiary access to health services potentially compromised, if rural providers were to experience a significant loss of Medicare revenue.

Beneficiary Enrollment and Continuity of Coverage

Under a competitive approach, beneficiary access to health services will be influenced by whether beneficiaries have access to information about choices among plans, can enroll in and voluntarily disenroll (with cause) from plans with minimal barriers, and can re-enroll in a comparable plan in the event of involuntary disenrollment from a plan. The experience of the past decade with the expansion of managed care plans to vulnerable populations under Medicare and Medicaid initiatives clearly demonstrates the importance of enrollment, outreach, and beneficiary education for assuring that beneficiaries participate in these initiatives and can exercise informed choices among alternative plans. The enrollment of rural beneficiaries in plans which are competing for their membership will be affected by how plan marketing, outreach, and beneficiary education is handled by plans or other entities. So, for example, open enrollment procedures may need to be designed to accommodate the fact that it will be more difficult and time-consuming to enroll hard-to-reach, vulnerable rural populations. Assuring that rural beneficiaries have access to comparable outreach and education services will be essential for maintaining equitable access to informed choices among rural and urban Medicare beneficiaries.

If Medicare redesign incorporates the competitive market, beneficiaries will not only have to choose a plan, but may need to switch plans, either because of a voluntary disenrollment (for cause) or because a plan leaves the market. Continuing access to health services for rural beneficiaries will depend in part on how these transitions are accommodated and also on the volatility in the market for health plans. Because rural beneficiaries may have access to fewer plan options, they may face more limited choices than beneficiaries in urban areas when choosing to switch plans or when being dropped from plans. Traditionally, these problems have been addressed through requirements that beneficiaries have access to a certain number of plan options and/or by setting specific plan solvency thresholds to protect against financially vulnerable plans entering the market.

Another issue of concern to rural beneficiaries will be whether policies and procedures for re-enrollment are designed to assure continuity of coverage in the event that beneficiaries switch or are dropped from a plan. Assuring this continuity may be more difficult in rural areas if there are fewer plan options available. For example, will beneficiaries be allowed to re-enroll in a plan outside of the normal open enrollment periods? Will rural beneficiaries have comparable access to membership services to help facilitate a transfer from one plan to another?

V. RECOMMENDATIONS

To meet the goals of ensuring equitable access to care for rural Medicare beneficiaries, any restructuring of the Medicare program should include, ideally, mechanisms for assuring access at each step of the care-seeking process. Specific mechanisms should include:

- Cultural and educational interventions to ensure that beneficiaries are able to make informed choices regarding their health plan, health care providers, and their need for and use of health services;

- A financial structure that does not impose barriers to the appropriate use of health services;

- Financial support for vulnerable health service providers that are essential to the maintenance of access for rural Medicare beneficiaries; and

- Requirements that health care systems and organizations be structured in ways that support and ensure the receipt of appropriate care.

Legislation should include, ideally, a definition of appropriate access to health care services, especially emergency and primary care, and ensure that participating plans are required to provide such access. To reach access goals, Medicare redesign should support alternative forms of service delivery (telemedicine, use of mid-levels, etc.) in places that do not have the population base to support delivery models that are found in urban areas.

Most important, new proposals should include a central authority that is responsible for monitoring the financial condition of, and supporting, essential providers. It is unlikely that reliance exclusively on the private market will ensure the survival of many institutions that are critical to maintaining appropriate access for rural beneficiaries.

VI. TABLE: COMPETING PLANS AND ACCESS IMPLICATIONS FOR BENEFICIARIES AND PROVIDERS/HEALTH SYSTEMS

	Access Implications	
Competing Plans	**Beneficiaries**	**Providers/Health Systems**
Availability of Competitively Priced Plans		
• Will market areas be defined in a manner which assures that multiple plan options with comparable benefits and prices are offered in rural markets? • What requirements/restrictions, if any, will plans have to meet in serving potentially undesirable markets (e.g. smaller, vulnerable populations/areas)? • To what extent will premium costs be allowed to vary geographically?	• Will rural beneficiaries have access to comparable plan choices (i.e., benefits, premiums, cost-sharing)? • Market segmentation by plans could lead to exclusion of rural areas or populations or reductions in benefits and/or higher out-of-pocket costs for beneficiaries.	• Expanded coverage for low income seniors who currently have more limited supplemental Medigap coverage could reduce charity care in rural areas.
Level of Premium Support		
• How much of premium will be supported? • What cost-sharing requirements will there be?	• Will there be equity in out-of-pocket costs for premiums and cost-sharing for rural beneficiaries?	• Underinsured rural seniors could place greater burden on rural providers.
Plans and Benefits		
• How will benefit package be determined – by regulation/law or market?	• Will competition among plans produce comparable choices of benefits at an affordable out-of-pocket cost for rural beneficiaries?	• Increased benefits could increase Medicare payments to providers and reduce charity care load.
Adequacy of Provider Panels		
• What requirements will plans have to meet concerning provider panels and beneficiary access to providers? –Inclusion of local providers, essential community providers • Will there be access standards?	• Reasonable access to health services for rural beneficiaries could be compromised if local providers are not included in plans' provider panels. • Loss of essential community providers not included in provider panels could threaten availability of health services in underserved rural communities.	• Inclusion of local providers could strengthen rural health systems through development of provider networks. • Loss of essential community providers not included in provider panels could threaten availability of health services in underserved rural communities.

	Access Implications	
Competing Plans	**Beneficiaries**	**Providers/Health Systems**
Payment Arrangements Between Plans and Providers		
• How will providers be paid? • Will provider revenues be sufficient in rural areas to assure appropriate availability of essential community providers who have been supported by Medicare special payment provisions? • What managed care features will plans have and how will those affect beneficiary access and provider payments?	• Depending on negotiations between plans and providers, rural providers could negotiate rates and payments that exceed current Medicare payments. This could strengthen the local health infrastructure. • The availability of and access to local health providers could be threatened if Medicare revenues are not sufficient to sustain local service providers. • Some managed care features such as plan and provider "lock-ins" tend to reduce access.	• Market-based and prospective payment schemes could reduce Medicare revenue for some rural providers. • Loss of special Medicare payment provisions could create financial problems for some essential community providers in underserved rural areas.
Enrollment and Continuity of Coverage		
• What marketing/outreach/education restrictions/requirements will plans have to meet? –Geographic coverage –Cultural, racial, ethnic differences in beneficiary population • What solvency requirements will plans have to meet? • If plan leaves market, what policies and procedures will govern re-enrollment?	• Rural enrollment, and hence access to plan benefits, will be affected by how market, outreach, and education is handled. • Access could be compromised by volatility in market. • Both beneficiaries and providers could be affected by plan failures/pull-outs. Continued accessibility dependent on re-enrollment policies and procedures.	• Both beneficiaries and providers could be affected by plan failures/pull-outs.

REFERENCES

Aaron, H. J. & Reischauer, R. D. (1995). The Medicare reform debate: What is the next step? *Health Affairs, 14*(4), 8-30.

Andersen, R. M., McCutcheon, A., Aday, L. A., Chiu, G. Y., & Bell, R. (1983). Exploring dimensions of access to medical care. *Health Services Research, 18,* 49-74.

Blazer, D. G., Landerman, L. R., Fillenbaum, G., & Horner, R. (1995). Health services access and use among older adults in North Carolina: Urban vs rural residents. *American Journal of Public Health, 85,* 1384-1390.

Cheh, V., & Phillips, B. (1993). Adequate access to posthospital home health services: Differences between urban and rural areas. *The Journal of Rural Health, 9,* 262-269.

Coburn, A. & Bolda, E. (1999). The rural elderly and long-term care. In T. C. Ricketts, III, (Ed.). *Rural health in the United States* (pp. 179-189). New York: Oxford University Press.

Codman Research Group. (1990). *The relationship between declining use of rural hospitals and access to inpatient services for Medicare beneficiaries in rural areas* (Technology Report #E-90-01). For the Prospective Payment Assessment Commission. Washington, DC.

Connor, R. A., Kralewski, J. E., & Hillson, S. D. (1994). Measuring geographic access to health care in rural areas. *Medical Care Review, 51,* 337-377.

Dor, A. & Holahan, J. (1990). Urban-rural differences in Medicare physician expenditures. *Inquiry, 27,* 307-318.

Dubay, L.C. (1993). Comparison of rural and urban skilled nursing facility benefit use. *Health Care Financing Review, 14*(4), 25-37.

Fox, J., Merwin, E., & Blank, A. (1995). De facto mental health services in the rural south. *Journal of Health Care for the Poor and Underserved, 6,* 434-468.

Himes, C. L. & Rutrough, T. S. (1994). Differences in the use of health services by metropolitan and nonmetropolitan elderly. *The Journal of Rural Health, 10,* 80-88.

Kenney, G. M. (1993). Rural and urban differentials in Medicare home health use. *Health Care Financing Review, 14*(4), 39-57.

Knapp, K. K., Paavola, F. G., Maine, L. L., Sorofman, B., & Politzer, R. M. (1999). Availability of primary care providers and pharmacists in the Unites States. *Journal of the American Pharmaceutical Association, 39,* 127-135.

Korczyk, S. M. (1994). Health care needs, resources and access in rural America, final report. National Rural Electric Cooperative Association.

Kralewski, J. E., Liu, Y., Shapiro, J. (1992). A descriptive analysis of health insurance coverage among farm families in Minnesota. *Journal of Rural Health, 8,* 178-184.

MacPherson, P. (1996). Rural drugstore's bitter pill. *Hospitals & Health Networks, 70*(9) 58.

McBride, T. (1998). Disparities in access to Medicare managed care plans and their benefits. *Health Affairs, 17,* 170-80.

Rosenblatt, R. A. & Hart, L. G.(1999). Physicians and rural America. In T. C. Ricketts, III, (Ed.). *Rural health in the United States* (pp. 38-51). New York: Oxford University Press.

Stearns, S. C., Slifkin, R. T., Edin, H. M. (2000). Access to care for rural Medicare beneficiaries. *Journal of Rural Health, 16,*(1) 62-73.

Strickland, J. & Strickland, D. L. (1996). Barriers to preventive health services for minority households in the rural south. *Journal of Rural Health, 12,* 206-217.

Vladeck, B.C. (1981). Equity, access and the costs of health services. *Medical Care,* 19(12) Supp., 69-80.

Weinick, R. M., Zuvekas, S. H. & Drilea, S. K. (1997). *Access to health care—sources and barriers. 1996.* Rockville (MD): Agency for Health Care Policy and Research. MEPS Research Findings No. 3. AHCPR Pub. No. 98-0001.

REDESIGNING MEDICARE: COST CONSIDERATIONS FOR RURAL BENEFICIARIES AND HEALTH SYSTEMS

Timothy D. McBride, Ph.D.

I. COSTS GOAL

Medicare spending has grown very rapidly in the last few decades, from $7.1 billion in 1970, to $246.3 billion in 2000. Although many factors, including general price inflation, contributed to this staggering 3500% increase over a 30-year period, the design of the Medicare program has long been cited as a major factor contributing to this incredible spending growth. Given this history, *the cost containment goal in Medicare redesign proposals should be to minimize Medicare costs, while not sacrificing the achievement of other goals (access, quality, choice, governance, equity)*. Within the objective of cost minimization, there are two separable but related cost goals that any Medicare reform policy should try to achieve. These are to: (1) minimize the budgetary costs of the Medicare program, and (2) minimize the out-of-pocket costs for Medicare and health care to the beneficiary.

The first goal relates to the 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, including rural taxpayers and elderly persons who pay federal taxes. The second goal relates to structuring 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. Therefore, to fulfill the second goal, Medicare redesign must seek to minimize costs to recipients by considering the impact on the beneficiary of both cost-sharing and additional expenses incurred due to restrictions on covered services.

Conflicts Between Goals

Outlining these two goals immediately raises the point that they often conflict. Therein lies one of the most difficult aspects of Medicare reform. Policies that lower the out-of-pocket costs for the elderly shift those costs to the taxpayer, meaning the first goal will not be enhanced while the second is, and vice versa. However, proponents of market-based approaches to Medicare reform seek policies that achieve one goal without sacrificing the other. This would be accomplished through enhanced efficiency, which would lower costs for either beneficiaries or taxpayers or, perhaps, for both. Other approaches to Medicare redesign would resolve this conflict through regulatory approaches (e.g., prospective payment) that would slow the growth in Medicare spending and thus allow for the expansion of benefits without raising Medicare spending as much.

Another fundamental issue affecting Medicare reform is that the goal of minimizing costs may conflict with other goals outlined previously, that is, access, quality, equity, and choice. Medicare reforms that expand access to Medicare covered services are likely to increase costs for

either the taxpayer or beneficiary. Reforms that expand the benefits covered under Medicare are likely to increase Medicare costs. Increased quality often comes at increased cost. Despite these conflicts, market-based reform for Medicare may increase efficiency, which could lower spending growth and create cost-savings that could be used to achieve some other goals (such as enhanced benefits or improved access).

A fundamental issue that must be addressed then is: What is the potential for market-based reform of Medicare to achieve cost-savings that can then be used to meet other Medicare reform goals?

II. THE PROBLEMS WITH THE STATUS QUO

Medicare and the Budget: The "Solvency Problem"

According to the most recent projections by the Board of Trustees for the Medicare Hospital Insurance (HI) program, the balances in the Medicare HI trust funds will be exhausted in 2025 (U. S. Social Security Administration, 2000, Figure I.F3). In previous reports the Trustees had predicted that the trust funds would be exhausted much earlier than that. This solvency problem is one of the factors that inspired the creation of the Bipartisan Commission on Medicare Reform. Over a 75-year period ending in 2073, the Trustees concluded that the Medicare HI deficit is 1.46% of taxable payroll, implying that to keep the program solvent, an increase in the payroll tax by this amount would be needed unless cost-savings can be achieved. This is the principal reason that Medicare reform proposals have moved to the top of the legislative agenda – so that future payroll tax increases can be avoided.

Of course, the focus on the solvency problem for the HI program neglects the fiscal problems facing the other portions of Medicare. Only the HI program (Part A) is financed through a Trust Fund and thus is subject to solvency constraints. But Medicare is made up of several parts: the Hospital Insurance program (Part A), the Supplemental Medical Insurance program (Part B), and the Medicare+Choice program (Part C). The combined costs of Medicare are projected to rise from 2.3% of Gross Domestic Product (GDP) to 4.36% of GDP in 2030 and 5.3% of GDP by 2073 (Trustees Report, 2000, Table III-B1). In many respects these figures are much more important than the financial solvency of the HI program because they reflect the true resource cost of Medicare. This projected rapid increase in the next 30 years is what has led policymakers to consider significant Medicare reform, as part of the Balanced Budget Act of 1997, because there is a belief that the structure of the Medicare program itself has contributed to the problem of escalating costs. In 1999, and even more so in 2000, the realization of federal budget surpluses has led to adding to the policy dialogue the prospects of enhancing the program with a prescription drug benefit.

The projected increase in total Medicare expenditures results from a number of factors, but the most important are: (1) a large projected increase in the elderly population, and (2) increases in medical spending per capita that exceed the growth in the tax base. Although Medicare costs per beneficiary have been rising and are projected to continue to rise, projections of increased Medicare spending in the future result, to a large extent, from a rapidly increasing elderly

population. The "baby boom" generation (born between about 1945 and 1963) will begin to reach age 65 after 2010, and this will result in a large increase in the elderly population eligible for Medicare. Between 2010 and 2030, the population of elderly is projected to increase by about 75%, from 39.7 million to 69.1 million, and the number of workers per beneficiary is projected to drop from 4.7 to 2.8 (U. S. Social Security Administration, 2000, Table II.H1). This inescapable situation is the biggest funding dilemma faced by Medicare.

While the large projected rise in the elderly population is a significant factor behind rising Medicare costs, proponents of Medicare redesign proposals do not explicitly argue that redesign will eliminate the budget problems resulting solely from a rise in the elderly population. However, to the extent that Medicare redesign can achieve efficiencies, this may help to make the demographic transition costs more manageable.

Given that it is inevitable that the elderly population will rise significantly in the first few decades of the 21st century, one consideration to keep in mind is that it is likely to be inevitable that the budget costs of Medicare will rise significantly, both as a share of the federal budget and as a share of our income (Gross Domestic Product). Thus, it is not realistic to conclude that policies can be found to constrain total Medicare spending to its year 2000 levels. However, a more realistic framing of the cost containment goal would be to consider policies that *constrain the growth* of Medicare spending to reasonable and affordable levels. Put another way, it might be possible to set a goal of achieving policies that constrain *the rate of growth in* Medicare spending *per beneficiary*, while it would be hard to adopt policies that could constrain total Medicare spending to current levels. Thus, finding policies that will constrain the rate of growth in per capita Medicare spending should be the focus of Medicare redesign proposals.

It seems inevitable that the rapid growth in the elderly population will mean that Medicare spending will rise as a percent of GDP, no matter what Medicare redesign proposal is adopted. For this reason, options for raising revenues into the Medicare program will need to be adopted. A recent study panel on Medicare's Long Term Financing sponsored by the National Academy of Social Insurance explored various revenue sources that could be used to meet the future needs of Medicare (Bernsten & Reischauer, 2000). Additional revenue could be obtained from sources such as increased payroll taxes, income tax surcharges, consumption taxes, additional excise taxes on products such as alcohol or cigarettes, taxation of employer-sponsored health insurance, or increased beneficiary premiums.

It is worth noting that in the future some trends may make it feasible for our country to afford an expanded set of Medicare beneficiaries. For instance, our GDP will continue to grow, providing an expanded amount of income that can be used to pay for Medicare. In addition, when the first waves of the baby boom generation begin to retire, this group of elderly will be relatively healthy as compared to their aging parents alive today. Thus, the average health needs of the elderly may fall for a few years, at least until the baby boomers advance into their twilight years. Finally, an increased emphasis in recent years on prevention and health promotion may constrain the growth of spending in the future.

Out-of-Pocket Costs Faced by Beneficiaries

The current structure of the Medicare system leaves recipients vulnerable to significant out-of-pocket costs for (1) health care services that are not covered, and (2) cost-sharing for Medicare-covered services. Regarding the first cost factor, Medicare does not cover two types of important services that can lead to significant out-of-pocket spending for the elderly: prescription drugs and long-term care. In 1996, the average total annual prescription drug cost for Medicare recipients was $593, with Medicare covering only 3% of the cost. Since Medicaid and private insurance covered 40% of the cost and other sources covered only 7%, that left recipients to pay for 49% of the cost out-of-pocket (Olin, Liu, & Merriman, 1999). Long-term care spending amounted to a much more significant burden for the small number of people exposed to these costs. In 1996, the average annual spending on long-term care by a Medicare recipient who used a long-term care facility at some point during the year was $27,643, with Medicare covering only 7% of this spending. Recipients had to cover 34% of this spending out-of-pocket (the rest was covered by Medicaid, 45%; private insurance, 2%; other sources, 12%) (Olin, Liu, & Merriman, 1999). Although there are other services that are not covered extensively by Medicare (e.g., dental services), prescription drugs and long-term care remain the uncovered services that represent the most significant burden for recipients.

In addition to the out-of-pocket costs of uncovered services, Medicare recipients are also burdened by out-of-pocket payments for coinsurance, deductibles, and premiums for Medicare-covered services. Although the burden of these costs may not be significant for Medicare recipients who did not use inpatient hospital services, for those who did, the combined costs of these payments could represent a significant portion of disposable spending. The biggest out-of-pocket payments are for premiums, both the premium for Part B coverage, which amounted to $546 per year in 2000, and the premiums recipients pay for supplemental coverage, which amounted to an average of $534 in 1996 (based on Medicare Payment Advisory Commission, 2000, data but adjusted to 1996 dollars). Also significant were copayments for physician services, primarily because Medicare beneficiaries are responsible for 20% of these costs after paying a $100 deductible. In 1996, physician and supplier expenditures amounted to an average of $1,896 for Medicare beneficiaries, who had to pay 18% of these expenditures out-of-pocket.

Total out-of-pocket spending for Medicare recipients averaged $2,605 in 1996 (Moon, Kuntz & Pounder, 1996), representing a significant 21% share of the household income of the elderly. The burden of health care costs is projected to rise significantly in the future, to perhaps 29% of household income of the elderly by 2025 (Moon, 1999). But the burden is most significant on those with lower incomes. For example, in 1997 Medicare beneficiaries below the poverty line spent 35% of their income on out-of-pocket health spending; those with incomes four times the poverty rate spent only 10% of their income out-of-pocket on health care (Bernsten & Reischauer, 2000, Exhibit 5).

Is There a "Rural Differential" on the Costs Issue?

Recent evidence shows that rural people are more likely to be burdened by higher out-of-pocket health spending.[2] For example, 38% of rural Medicare recipients faced out-of-pocket costs, in addition to premiums, of $750 or more in 1996, as compared to only 33% of urban recipients. In addition, 25% of rural persons spent more than 10% of their income on health care in 1996, as compared to 21% of urban recipients. Finally, 17% of rural Medicare recipients paid for more than 75% of their health spending out-of-pocket, compared to only 13% of urban recipients.

There are several factors that could explain why out-of-pocket health spending is a greater burden on rural Medicare recipients than on urban recipients. These include: (1) rural people have lower health status, which could lead to higher health costs; (2) rural people have less access to Medicare+Choice and supplemental insurance plans (McBride & Mueller, 1999), which have lower out-of-pocket costs; (3) rural people have lower incomes and higher poverty rates, raising their costs as a percentage of income; and (4) rural people may face higher costs for the same types of services due to problems with economies of scale and limited competition in their health markets (Mueller et al., 1999).

Some, or all, of these factors could account for the finding that rural beneficiaries tend to have higher out-of-pocket costs, though there is evidence that the finding may be driven mostly by lower incomes in rural areas and lower availability of supplemental Medigap insurance or Medicare+Choice plans (McBride & Mueller, 1999). The lower availability of plans could particularly be driving the higher out-of-pocket expenditures on prescription drugs in rural areas (Coburn & Ziller, 2000).

How the Current Medicare Structure Contributes to Escalating Costs

The projected increase in total Medicare expenditures results from a number of factors, but the most important are: (1) a large projected increase in the elderly population, and (2) increases in medical spending per capita that exceed the growth in the tax base. While the large projected rise in the elderly population is a significant factor behind rising Medicare costs, proponents of Medicare redesign proposals do not explicitly argue that redesign will eliminate the budget problems resulting solely from a rise in the elderly population. However, to the extent that Medicare redesign can achieve efficiencies, this may help to make the demographic transition costs more manageable.

Health analysts have long noted that the structure of the traditional fee-for-service (FFS) Medicare program contributes to rising costs. When it was originally designed in 1965, Medicare was structured to mimic the insurance models of the time (Phelps, 1997). Thus, the Medicare insurance structure follows the Blue Cross model that predominated in the private sector during the 1960s. Despite the recent attempts to increase options through the Medicare+Choice program (which took the place of the Medicare risk program), the traditional FFS Medicare program still

[2]The source of the data cited in this paragraph, unless otherwise indicated, is the Medical Expenditure Panel Study (MEPS), as compiled by analysts at the University of Southern Maine.

greatly influences Medicare spending growth because about 84% of Medicare recipients are enrolled in the traditional FFS portion of Medicare. Thus, Medicare has not kept pace with the rest of the private health insurance sector, because the private sector now predominantly employs managed care insurance strategies (HMOs, PPOs, and POS).

The traditional FFS structure of Medicare likely has contributed to the escalating costs over time because of a host of problems with the structure of the program but principally because traditional FFS Medicare is a blank check for beneficiaries to use in freely selecting providers and utilizing services without regard to costs. As Phelps (1997) discusses, "the economic consequences of Medicare and Medicaid were only poorly understood initially, in part because no clear picture existed about the effects of insurance on the demand for medical care at the time...almost nobody understood the effects on demand in the short run or the long-run effects on demand for technology." (p. 403). Until the introduction of prospective payment in the 1980s, providers faced few constraints on the amount they could charge for Medicare services. And, since recipients could choose any provider, they would likely choose the provider regardless of cost.

The structure of Medicare is "upside down" relative to what standard economic models would suggest as optimal forms of insurance (Phelps, 1997), and as a result has likely contributed to significant overutilization of medical care because there are no constraints on demand for care (i.e., there is a "moral hazard" problem). After an initial (and significant) deductible, there are no copayments for Medicare Part A services (unless a patient stays for more than 90 days per episode of illness). To cite another example, Medicare recipients pay a very low $100 annual deductible for Part B services (low from the insurance perspective of what would be optimal), but face a 20% copayment for these services after the deductible without any catastrophic limits. Evidence from a host of empirical studies (summarized in Newhouse, 1994) shows that the optimal structure of insurance would have a higher annual deductible and higher copayments combined with catastrophic coverage. This structure is being increasingly used in private insurance plans. Medicare's low deductible contributes to overutilization of medical care, while the lack of catastrophic coverage, in addition to the significant amount of noncovered services (described above), leads many recipients to seek supplemental Medicare coverage through Medigap or employer plans (Phelps, 1997). Empirical evidence shows that supplemental Medicare coverage also leads to increased utilization. Thus the combined effects of Medicare policy could arguably contribute to overutilization.

Although moral hazard concerns are raised by the structure of Medicare, the characteristics of the rural population make resolving these issues more complex. Evidence shows that elderly rural persons have lower incomes and lower health status than their urban counterparts (Coburn & Bolda, 1999). Higher deductibles and copayments are more likely to represent a significant hardship for low-income elderly. Thus, rural elderly persons may, in general, be disadvantaged relative to the elderly living in metropolitan areas.

III. APPROACHES TO SOLVING THE COSTS PROBLEM

As described in the introduction to this monograph, we are focusing on two broad approaches to achieve Medicare reform – reliance primarily on incremental changes to the existing Medicare program, as contrasted with an approach to redesign the Medicare program using a market-based approach. Both of these approaches are designed, to a great extent, to deal with the escalating costs problem, since it is believed that solutions tried in the private marketplace for non-Medicare recipients are likely to be successful in helping Medicare solve its financial problems. The question is, what approaches are there to solving the costs problem and how would they affect health care costs for the beneficiary and the taxpayers? As described in the introduction to this monograph, we are focusing on two broad approaches (described in detail elsewhere) to achieve Medicare reform. Here we examine the specific provisions of these proposals that are designed to achieve cost-savings.

Introduction of Private Plans as an Alternative (e.g., Premium Support)

As outlined above, traditional FFS Medicare (especially when combined with Medigap) has some problematic features that have fueled the growth in Medicare spending, at least in the earlier years of the program. Managed competition approaches would rely on supply-side incentive schemes that have shown some success in the private sector and thus would not have to rely on incentives that would curb the demand-side problems raised above (e.g., moral hazard) to slow Medicare spending (Ellis & McGuire, 1993).

Aggregate health spending has been growing more slowly in recent years, and many analysts have concluded that the private sector's initiatives, especially managed care, have slowed health care spending growth. Managed competition approaches to Medicare reform establish competition among managed care plans and other choices to improve efficiency and reduce costs. Traditional FFS Medicare relies on regulatory approaches (e.g., prospective payment) to reduce or slow the growth rate in costs and creates paperwork burdens and administrative costs for health care providers not reflected fully in Medicare expenditure data. These regulatory approaches assume that reasonable prices can be determined prospectively by agencies not involved in providing the services. This approach also leads to setting prices based on aggregated averages, a practice which has historically led to disadvantages for rural providers.

The current Medicare FFS program has a set of benefits established by Congressional legislation, with little flexibility in covered services, even though the benefits offered were set largely in the original legislation over 35 years ago. In contrast, private sector approaches allow flexibility for plans to cover services not currently covered by Medicare (e.g., prescription drugs, skilled nursing homes, catastrophic costs), which should result in lower out-of-pocket costs for many beneficiaries. In addition to possibly expanded benefits, managed competition approaches rely on competitive bidding for setting payment rates. This could be an advantage because it could lead to innovative approaches to setting reimbursement rates, in contrast to the current approach, which links payment to Medicare+Choice plans to previous Medicare expenditures.

Despite the potential benefits of the managed competition approaches, there are reasons to believe that these approaches might not lead to constraints in the growth of health spending, particularly in rural areas. In many rural areas, utilization is already low, suggesting that there is not much to gain through the increased efficiency that managed competition might bring. But even beyond that, a great deal of evidence has demonstrated that there are problems with making the competitive model work in rural areas because of low population in these areas (Mueller et al., 1999). As a result, some of the efficiency that results from a private sector approach might not translate well to rural areas and rural areas might even experience higher costs for some services without the benefits of economies of scale. In particular, rural communities with a small population base might be particularly disadvantaged. In some rural areas, networks of providers are more difficult to form (due, for example, to a lack of providers or the heavy investment needed to develop a networking infrastructure) and, even when they can be formed, the cost-savings may not be great.

In addition, it is well known that markets for health insurance are plagued with a number of problems that severely question whether competition leads to the cost efficiencies promised (Arrow, 1963; Rice, 1998). The most significant problems in the health care sector contributing to higher costs are information problems, overutilization resulting from insurance (the "moral hazard" problem), monopoly power of health providers, and adverse selection (the tendency for insured persons to self-select into health plans by their health risk).

Adverse selection problems are a particular concern for managed competition approaches. When adverse selection occurs, insured persons with higher health costs are more likely to seek health insurance that covers those costs well. Thus, generous plans will be loaded with individuals that have higher costs, while less generous plans will have more healthy individuals enrolling. This problem could become more acute in rural areas where the small population could exacerbate the adverse selection problem (in other words, one very expensive case could cause severe financial problems for a rural plan). Risk adjustment could, in theory, be used to alleviate problems caused by adverse selection, but it is well known that adequate risk adjustment procedures have eluded researchers to date, and prospects for finding improved risk adjustment mechanisms do not seem to be on the horizon. In the absence of adequate risk adjustment, the out-of-pocket costs for beneficiaries will be higher. The absence of adequate risk adjustment could be an especially difficult problem for rural areas because of evidence that shows that rural elderly persons have lower health status, and because the risk adjustor developed to date by HCFA (the PIP-DCG risk adjustor) relies on prior *inpatient hospitalization* as a measure of health status. The risk factors affecting rural populations, where there may be historical underutilization, will not be captured well by such measures.

Features of managed competition that are designed to control overutilization of medical care could also create new problems in rural areas. In particular, increased cost-sharing, while providing incentives to lower program costs, may disproportionately disadvantage rural residents given that rural persons are more likely to have lower incomes and higher poverty rates. In addition, to the extent that managed competition relies on restricting the set of providers offered to beneficiaries (as in managed care plans), beneficiaries may be forced to travel to see providers, creating additional access problems. Rural areas might find it difficult to structure competing plans because there are more limited sets of providers (among the primary care providers in

remote rural areas and the few sub-specialties found in larger rural communities). Due to the low volume of insured lives that plans might enroll in rural areas, negotiations with tertiary care providers in nearby large urban areas could prove difficult. Finally, evidence shows that rural Medicare beneficiaries are already consuming fewer health services than their urban counterparts. Therefore, policies that are designed to curb utilization may not be very effective in rural areas where utilization is already constrained by other forces. All these points suggest that features of managed competition may help foster the cost containment goal, but may also come into conflict with other goals, such as quality, access, and equity.

One test of the equity of any new reform proposal is whether out-of-pocket costs are nearly the same for urban and rural beneficiaries. One might especially argue for the achievement of this goal because urban and rural beneficiaries paid the same tax rates while they were working. However, an inherent aspect of markets is that prices will differ across space, due to regional differences, economies of scale, and a whole host of other market factors. If urban plans can offer cheaper options where they have economies of scale, the "market" may be working “better,” but this will not lead to lower costs for rural people, leading to an inherent conflict between goals. In addition, as Medicare is currently structured, options that reduce out-of-pocket costs (such as prescription drug coverage) are not likely to be available to most rural elderly because of market factors, while they are widely available to urban elderly, setting up another inequity.

Finally, the traditional FFS Medicare program has been developed over time with special programs to provide subsidies for certain providers, especially many providers in rural areas. Medicare redesign proposals that do not include these subsidies could lead to higher out-of-pocket costs for rural elders. These higher out-of-pocket costs might arise because rural beneficiaries will pay more for services now subsidized under a host of Medicare programs (e.g., to recruit and retain providers and enhance facilities). Medicare currently pays a share for our health infrastructure, although it is not clear how that would be handled under Medicare redesign proposals.

Regulatory Approaches to Cost Containment

Although managed competition approaches hold promise of cost containment, an alternative strategy would be to continue to rely on the regulatory approaches that have been used to guide Medicare policies for the last 15-20 years. These include the implementation of prospective payment, first for hospital inpatient services, then for physician services, and now for a range of the remaining Medicare-covered services. Evidence shows that the growth in Medicare spending per capita has been below the rate of growth in the private sector in most recent years (Moon, 1999; Stevens & Reischauer, 1999).

The provisions of the Balanced Budget Act of 1997 led to a dramatic drop in the rate of growth of Medicare spending in the 1997-2000 period, through provisions restraining the growth of provider payments, and provisions instituting prospective payment for a number of Medicare-covered services not now governed by prospective payment (e.g., long-term care, home health, hospital outpatient). In contrast, the approaches embodied in some of the Medicare redesign

proposals rely on market forces, even though it is not clear whether the competitive model applies well to health care markets, especially in rural areas. Thus it might be possible that further reliance on the regulatory approach may lead to more cost containment than could be achieved through market reforms.

Despite the evidence that regulation has led to a slowing of growth in Medicare spending, increased regulation has also come with additional costs, both directly to the Medicare program and indirectly because of the provider expense involved in compliance with regulations. Regulations that drive prices to levels at or below actual costs, combined with the burdens of compliance on providers, could threaten access to care for Medicare beneficiaries if providers either withdraw from the program or close their business entirely. Sorting out the net effects of these changes is difficult. Advocates of private sector approaches to Medicare redesign believe that private sector efficiency will lead to more net cost-savings than can be achieved through increased government regulation.

IV. FINAL THOUGHTS AND RECOMMENDATIONS

Achieving the goal of minimizing the costs of the Medicare program to the beneficiaries and taxpayers without sacrificing the attainment of the other goals of the Medicare program (such as access, equity, quality or choice) is a difficult task. Attaining the cost containment goal will be even more difficult in the next decade and beyond, because Medicare faces extraordinary fiscal pressures. Like health spending in general, Medicare spending per beneficiary has grown rapidly, and this growth is likely to exceed the growth in the taxes collected to support the program. But in addition, the baby boom generation will begin leaving the work force and moving on the Medicare rolls shortly after 2010, leading eventually to a 75% increase in the elderly population, exerting further pressure on the fiscal status of Medicare.

Given these constraints, and the discussion in this chapter, specific legislation to redesign Medicare should include:

- provisions that appropriately balance the goal of cost containment with the other goals for Medicare;
- provisions that reflect an understanding that market competition may not work as well in rural areas as it does in urban areas; and
- provisions that provide incentives for consumers and producers to maximize health quality and access, while passing along a fair share of the costs to the beneficiary.

Although it is usually assumed that “market forces” will lead to the lowest-cost provision of health care and other publicly-subsidized goods and services, there are reasons to suspect that market forces may not be the best route to achieve that goal, especially in rural areas. This is because of the market failures and problems outlined here and elsewhere. But these concerns may be most acute in rural areas, where it is possible that there will not be enough providers to ensure the competition that makes markets work.

There may be market-based plans that are projected to lower the overall cost of the Medicare program. However, given the market failures that are especially acute in rural areas, even these plans could lead to increases in costs (to Medicare) in rural areas. To make this situation palatable, however, an approach might be to use some of the cost-savings in urban areas to cover the cost increases in rural areas.

An alternative to market forces in Medicare is the continued reliance on incremental changes in the current Medicare program, thus achieving cost containment primarily through regulation of reimbursement rates or through increased reliance on approaches such as prospective payment. While these provisions have been shown to be effective in constraining the growth of Medicare spending, analysts have increasingly pointed to problems created by this approach, especially for providers. These problems appear to be more acute in rural areas where financial margins are lower, and where the rural infrastructure cannot adjust as rapidly to changes in Medicare policy. Thus, policymakers who seek to continue to use the regulatory approach to Medicare cost containment should be careful to pay attention to the differential effects of such policies on rural areas.

V. TABLE: MEDICARE REDESIGN APPROACHES AND COST IMPLICATIONS FOR BENEFICIARIES AND PROVIDERS/HEALTH SYSTEMS

	Cost Implications	
Medicare Redesign Approaches	**Beneficiaries**	**Medicare Program**
Current Program: Traditional Fee For Service Medicare		
1. General structure of the program (following the Blue Cross model of the 1960s).	1. Beneficiaries can choose any provider. Beneficiary access could be threatened if providers withdraw from the program or close their business entirely, due to regulations that drive prices to levels at or below actual costs and/or the burden of compliance with regulations.	1. Overutilization of medical care because there are no financial constraints. Additional costs because of the provider expense involved in compliance with regulations.
2. Limited set of benefits established by Congressional legislation.	2. Little flexibility in covered services.	
3. Medicare does not cover two important services: prescription drugs and long-term care	3. High out-of-pocket spending for rural beneficiaries.	
4. High out-of-pocket payments combined for coinsurance, deductibles, and premiums.	4. High out-of-pocket spending for rural beneficiaries.	
5. Regulatory approaches (e.g., prospective payment) to slow the growth rate in costs.		5. Maintains financial stability of program, but could create paperwork burdens and administrative costs for health care providers.
6. Setting prices based on aggregate historical spending.	6. Has led to lack of access to a full range of benefits for rural beneficiaries	6. Historically has led to disadvantages for rural providers.
7. Availability of options that reduce out-of-pocket costs.	7. Options that reduce out-of-pocket spending (i.e., prescription drug coverage) are not likely to be available to most rural elderly because of market forces. This creates inequity between rural and urban beneficiaries with regard to out-of-pocket costs.	
8. Special programs to provide subsidies for certain providers.		8. Many rural providers are eligible for special programs and/or receive special incentives from Medicare.

	Cost Implications	
Medicare Redesign Approaches	**Beneficiaries**	**Medicare Program**
Managed Competition		
1. Rely on supply-side incentives to curb utilization (e.g., competition between plans)	1. To the extent that managed competition restricts the set of providers offered to beneficiaries, rural beneficiaries may be forced to travel to see providers, potentially creating access problems.	1. May be difficult to structure competing plans because there are a more limited set of providers. Negotiations with tertiary care providers in nearby large urban areas could prove difficult. Policies designed to curb utilization may not be very effective in rural areas where utilization is already constrained by other forces.
2. Establish competition among managed care plans and other choices to improve efficiency and reduce cost growth.	2. Cost containment for some beneficiaries (particularly urban beneficiaries). Rural beneficiaries may experience higher costs for some services without the benefits of economies of scale. Rural areas with a small population base might be particularly disadvantaged. Information problems may hamper beneficiary ability to achieve costs savings.	2. In some rural areas, networks of providers are more difficult to form, and even when they can be formed, the costs-savings may not be great. Utilization is already low in rural areas, suggesting that there is not much to gain through the increased efficiency that managed competition brings. Overutilization of health care services; monopoly power of health providers.
3. Allow flexibility for plans to cover services not currently covered by Medicare.	3. Expanded choice of benefits (prescription drugs, skilled nursing homes, catastrophic costs) and lower out-of-pocket costs.	
4. Rely on competitive bidding for setting payment rates.		4. Could lead to innovative approaches to setting reimbursement rates.
5. Adverse selection.	5. Plan could lead to adverse selection (where insured persons with higher health costs are more likely to seek health insurance that covers those costs well). Out-of-pocket costs for the beneficiary will be higher without adequate risk adjustment. Government plan may be filled with "bad risks" while private plans "skim off" good risks.	5. Adverse selection: more acute in rural areas where the small population could exacerbate the adverse selection problem.
6. Increased cost sharing.	6. Could disproportionately disadvantage rural residents given that rural persons are more likely to have lower incomes and higher poverty rates, creating access problems.	6. Provides incentives to lower program costs.

REFERENCES

Arrow, K. J. (1963). Uncertainty and the welfare economics of medical care. *American Economic Review 53,* 941-973.

Bernsten, J. & Reischauer, R. D. (Eds.). (2000). *Restructuring Medicare: Next steps* (Final Report of the Medicare Steering Committee) Washington, DC: National Academy of Social Insurance.

Clewar, A. & Perking, D. (1998). *Economics for health care management.* London: Prentice Hall.

Coburn, A. & Ziller, E. (2000). *Designing a prescription drug benefit for rural Medicare beneficiaries: Principles, criteria, and assessment* (A Joint Paper of the Maine Rural Health Research Center and the RUPRI Rural Health Panel. Policy Paper P2000-14). Columbia, MO: Rural Policy Research Institute.

Coburn, A. & Bolda, E. (1999). The rural elderly and long-term care. In T. C. Ricketts, III, (Ed.). *Rural health in the United States* (pp. 179-189). New York: Oxford University Press.

Ellis, T. & McGuire, T. (1993). Supply-side and demand-side cost sharing in health care. *Journal of Economic Perspectives, 7*(4), 135-152.

Folland, S., Goodman, A., & Stano, M. (2001). *The economics of health and health care (3rd ed.).* New York: Macmillan.

Gluck, M. G. & Moon, M. (Eds.). (2000). *Financing Medicare's future* (Final Report of the Study Panel on Medicare's Long Term Financing). Washington, DC: National Academy of Social Insurance.

Medicare Payment Advisory Commission. (2000a). Report to the Congress: Selected Medicare Issues. Washington, DC: Medicare Payment Advisory Commission.

Medicare Payment Advisory Commission. (2000b). Report to the Congress: Medicare Payment Policy. Washington, DC: Medicare Payment Advisory Commission.

Moon, M. (1999). *Growth in Medicare spending: What will beneficiaries pay?* Washington, DC: Commonwealth Fund.

Moon, M., Kuntz, C., & Pounder, L. (1996). *Protecting low-income Medicare beneficiaries*. New York: Commonwealth Fund.

Mueller, K. J., & McBride, T. D. (1999). Tracking the response to the Balanced Budget Act of 1997: Impact on Medicare managed care enrollment in rural counties. *Journal of Rural Health, 15*(1) 67-77.

Mueller, K. J., Coburn, A., Cordes, S., Crittenden, R., Hart, J. P., McBride, T., & Myers, W. (1999). The changing landscape of health care financing and delivery: How are rural communities and providers responding? *The Milbank Quarterly, 77,* 485-510.

Newhouse, J. (1993). *Free for all? Lessons from the RAND health insurance experiment.* Cambridge, MA: Harvard University Press.

Olin, G., Liu, H., & Merriam, B. (1999). *Health and health care of the Medicare population: Findings from the Medicare Current Beneficiary Survery.* Rockville, MD: WESTAT.

Phelps, C. (1997). *Health economics.* New York: Harper Collins.

Rice, T. (1998). *The economics of health reconsidered.* Chicago: Health Administration Press.

Stevens, R. A. & Reischauer, R. D. (1999). *Medicare and the American social contract* (Final Report of the Study Panel on Medicare's Larger Social Role). Washington, DC: National Academy of Social Insurance.

U. S. Social Security Administration, Board of Trustees of the Social Security and Medicare Programs. (2000). *2000 Annual report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds.* Washington, DC: OASDI Board of Trustees.

APPENDIX

PREVIOUS RUPRI RURAL HEALTH PANEL PUBLICATIONS CONCERNING THE DEBATES ABOUT MEDICARE

Redesigning Medicare: Considerations for Rural Beneficiaries and Health Systems. February 2001. (PB2001-6)

Rural Implications of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000: Concerns, Legislation, and Next Steps. A Companion Brief to P2001-3. January 2001. (PB2001-4)

Rural Implications of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000: Final Bill: P.L. 106-554. A Consolidation of P2000-16 and PB2001-1. January 15, 2001. (P2001-3)

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. August 31, 2000. (P2000-14)

Redesigning the Medicare Program: An Opportunity to Improve Rural Health Care Systems? August 31, 2000. (P2000-13)

The Area Wage Index of The Medicare Inpatient Hospital Prospective Payment System: Perspectives, Policies, And Choices. August 27, 2000. (P2000-12)

Improving Prescription Drug Coverage for Rural Medicare Beneficiaries: Key Rural Considerations and Objectives For Legislative Proposals. June 30, 2000. (P2000-8)

Calculating and Using the Area Wage Index of the Medicare Inpatient Hospital Prospective Payment System. June 2000. (PB2000-5)

A Rural Assessment of Leading Proposals to Redesign the Medicare Program. May 31, 2000. (P2000-4)

Rural Implications of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999: A Rural Analysis of the Health Policy Provisions. December 8, 1999. (P99-11)

Implementation of the Provisions of the Balanced Budget Act of 1997: Critical Issues for Rural Health Care Delivery. July 29, 1999. (P99-5)

Implementation of the Provisions of the Balanced Budget Act of 1997: Critical Issues for Rural Health Care Delivery. July 1999. (P99-5)

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Taking Medicare into the 21st Century: Realities of Post BBA World and Implications for Rural Health Care. February 10, 1999. (P99-2)

Taking Medicare into the 21st Century: Realities of a Post BBA World and Implications for Rural Health Care. February 1999. (P99-2)

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The Rural Perspective on National Health Reform Legislation: What are the Critical Issues?" February 24, 1994. (P94-1)

RUPRI Rural Health Panel

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Can Payment Policies Attract M+C Plans to Rural Areas? May 2001. (PB2001-8)

An Update on Medicare+Choice: Rural Medicare Beneficiaries Enrolled in Medicare+Choice Plans through October 2000. March 2001. (PB2001-7)

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