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Redesigning the Medicare Program:
An Opportunity to Improve Rural Health Care Systems?

August 31, 2000

P2000-13

RUPRI Rural Health Panel:

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The Rural Policy Research Institute provides objective analyses and facilitates dialogue concerning public policy impacts on rural people and places. The Rural Health Panel receives continuing support from RUPRI, the result of a Congressional Special Grant, administered through the Cooperative State Research, Education, and Extension Service, U.S. Department of Agriculture.

This document is the result of special project funding received from the Federal Office of Rural Health Policy.

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INTRODUCTION

As we prepare for a new session of Congress and a new 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) changed dramatically the context for discussions of Medicare policy. Policy discussions since the BBA have sharpened two major pathways for dialogue/debate:

- appropriate and equitable payment for services, either through traditional Medicare fee-for-service 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 both paths, providing analysis of changes that have been enacted, and of proposals for further changes. Our analysis has focused on implications of the BBA and subsequent policies for rural Medicare beneficiaries, rural health care providers, and the 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. Appendix A includes a list of previous publications and presentations concerning the two debates about Medicare.

This *Policy Paper* incorporates input from The National Advisory Committee on Rural Health (NAC), and is published by the RUPRI Center for Rural Health Policy Analysis. We are detailing a framework for use by those interested in the future of health care services in rural areas, to help 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 included 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 paper, 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, including the NAC, ***specific statements of policy objectives that ought to be included in any redesign of the Medicare program are those of the Panel only.***

ORGANIZATION OF THIS PAPER

The first section of the paper 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 rural residents (including Medicare beneficiaries).

- There is an **array of approaches for changing the Medicare program**, which variably rely on government regulation and/or activities in a competitive marketplace.

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Each of these elements needs to be understood and the variation in them should structure the specifics any critiques. In brief, the effects of the Medicare program are extensive, especially in rural areas, and the interplay of changing that program and characteristics of the health care delivery system creates a complex mosaic of impacts.

The analysis in this paper is structured around a set of rural principles that should guide any Medicare redesign effort:

1. The Medicare program should maintain **equity** among its beneficiaries, who should be neither disadvantaged nor advantaged vis-à-vis benefits and costs 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. Medicare beneficiaries should 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. Medicare beneficiaries should have reasonable **access** to all medical services, including having essential services within a reasonable distance/time of their residence, and having access to affordable medically-necessary services.

5. The Medicare program should include mechanisms to make the **costs** affordable, both to beneficiaries and to public resources used in the program.

6. 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 sections develops 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. While each section is treated independently, we recognize there will be some duplication. Therefore, the early sentences of each section will identify overlap with other sections, referencing material and page numbers.

The six principles may generate conflicting goals for public policy. A well known triangle exists between access, cost, and quality. That is, over-emphasis on one of those three as a policy goal

can easily compromise one of the other of those three. Issues involved in balancing across policy goals will be considered throughout this document, and there will be a special section devoted to this topic at the end of the paper. Of note at this point in our discussion, ***no principle need be sacrificed entirely in order to optimize any other principle.***

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CONTEXT

Variation in Rural Places

The characteristics of what we consider to be rural places vary considerably. There are several scales of 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 division of rural areas 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 care 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 can not 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 vast 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 small settlements far removed from cities but still in the same counties as urban (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, i.e., *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 & Kirby, 2000).

There are several definitions of rural that 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: urban influence codes that include nine categories, and the rural-urban continuum which 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 10 basic codes, with up to 5 sub-codes each, on an urban-rural continuum. While this paper 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 that live there.

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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 care hospitals in rural areas (Ricketts and 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, with large employers, or a sufficient concentration of population to attract competing insurers (perhaps a retirement destination), 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 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 would 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 so recognizing that there are exceptions to those generalizations.

Variation in Approaches to Redesigning the Medicare Program

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Two fundamental approaches have been used by policy makers trying to improve the Medicare program. One approach calls for government intervention through a combination of regulation and financial action (paying for new benefits, or changing its payment to providers and/or health plans). The other approach relies on actions of privately-based health plans and providers to extend cost-effective services to beneficiaries (for example by allowing private plans to bid for Medicare business).

These approaches are not mutually exclusive. Other approaches have been offered which incorporate elements of each. During the height of debate about a national system in the early 1990s, a popular approach to expanding access to health insurance was applying *managed competition*, whereby government regulation would set the parameters within which private plans could compete.

Government-based Plans. Some recommendations to alter the Medicare program are 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 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 done now, through a combination of government regulations (Health Care Financing Administration) and private fiscal intermediaries, for example folding the benefit into the current program as is done by S. 2758 (Graham). Another recommendation represents a minimal departure from a government-financed, government-administered benefit by adding new component parts to the Medicare program, but contract with private entities to administer those benefits (President Clinton's approach). For a recommendation to be considered as a redesign of the program rather than minor incremental changes, one of the following characteristics must be present: 1) a major benefit addition (e.g., prescription drugs in ambulatory settings); 2) financial restructuring (e.g., share of the expense among government, individuals, and other parties); or 3) restructuring of program design (e.g., creation of government-sponsored health plans).

Private Plans. The polar extreme to extending the government's role is, of course, to have government involved only in financing the program. We will not consider the complete absence of government, recognizing that complete withdrawal of government financing will not occur. However, the federal government could provide vouchers to Medicare beneficiaries with instructions to purchase health insurance in the private marketplace (the approach used in H.R. 4680 for a drug benefit). A variation of this approach is to entitle all beneficiaries to a new benefit but offer it through both private and public plans, and subsidize the premium (as written into the Breaux/Frist 2000 prescription drug proposal).

Managed Competition. A class of plans would be included within the general description of *managed competition*, a concept that combines reliance of private initiative with government regulations to assure a "level playing field." One approach, drawn from 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 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, the 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 all plans must 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 to be determined by the market rate, not a predetermined government voucher (known as "fixed contribution").

Implications for Medicare Policy Affecting Rural Health Care. The two fundamental approaches to changing the Medicare program would have different impacts on health care for rural beneficiaries (with the *managed competition* compromise being a blend). The two differ in the following dimensions:

- fundamental philosophy (government guarantee, private-based with a government-based minimum);
- payment for health care services (by government and used as a tool to control program costs; by 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).

The Intersection of Rural Place and Medicare Policy

Any assessment of Medicare program changes should consider rural impacts. In doing so, each element of the Medicare policy should be evaluated within different types of rural environments. Thus, each section of this paper incorporates descriptions of rural areas as well as different Medicare policies. However, we cannot hope to incorporate all potential combinations of these two variables, especially since both environments experience constant change. Instead, we seek to create a frame of reference for all persons engaged in debates about reshaping Medicare policy – the interaction of policy, people, and place has special meaning for rural beneficiaries, and that meaning changes with the particulars of the policy and the local circumstances facing the beneficiaries.

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RUPRI Rural Health Panel

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Recent Health Policy Documents

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- Foster and reward scientists who wish to contribute to the interplay between science and policy.
- Overcome institutional and geographic barriers.
- Make adjustments in the academic "product mix" to enhance relevancy and societal contributions.

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