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A Rural Assessment of Leading Proposals to Redesign the Medicare Program

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RUPRI Rural Health Panel

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EXECUTIVE SUMMARY

This *Policy Paper* provides a critique of two proposals to redesign the Medicare program: the "Medicare Preservation and Improvement Act of 1999" (*S. 1895*, introduced by Senator Breaux and others) and "The President's Plan to Modernize and Strengthen Medicare for the 21st Century." Rural implications of the proposals are discussed, specifically how they affect rural Medicare beneficiaries and rural providers of health care services.

Both plans redesign the Medicare program in a manner that expands basic benefits and provides increased economic incentives favoring health plans that are able to price their products competitively. Major elements of the two proposals include:

- prescription drug benefits available to all Medicare beneficiaries;
- current Medicare benefits included in a core package that must be offered to all Medicare beneficiaries;
- health plans encouraged to compete based on price and benefits;
- traditional Medicare treated as a competing plan;
- new authority for traditional Medicare to adopt the purchasing strategies used by managed care organizations; and
- special efforts to provide Medicare beneficiaries education about the new structure.

The proposals differ in how they would finance the prescription drug benefit: by making it a part of defined benefits in high option plans (*S. 1895*), or as a new, separately financed, part of Medicare (President's proposal). The President's proposal retains current payment systems, *S. 1895* does not.

Both plans rely on offering beneficiaries *choices among competing health plans*, to provide greater access to comprehensive benefits (including prescription drugs). The following realities of delivering and financing health care services in rural areas would need to be considered in adopting this approach:

- in remote rural areas there is unlikely to be any competition among health plans;
- in other rural areas the small number of providers and a modest number of beneficiaries will limit the number of competing plans;
- in some rural areas regional providers may be able to support a locally-based competitive health plan;
- in most rural areas the success of new plans, particularly managed care plans, will depend on the active participation of networks of health care providers; and
- national premiums will be influenced by the ability of insurers to extract savings from health care delivery predicated on a high volume of business, which would disadvantage plans operating in rural areas.

In the judgement of the RUPRI Rural Health Panel, the following implications of the two proposals warrant attention during future discussions of Medicare redesign:

- To the extent that competing plans are relied upon as the source of affordable benefits, rural areas are at a disadvantage.

- If traditional Medicare is the only option in rural areas, fiscal difficulties encountered by that plan would pose special problems for rural residents.

- All rural beneficiaries would have access to a plan that includes coverage for prescription drugs, a significant improvement for rural persons. There is no assurance that the difference in current plan offerings between urban and rural Medicare HMOs would be discontinued under these reform proposals. Rural beneficiaries may continue to experience a different, less attractive set of choices.

- Extensions of cost saving provisions in the BBA (President's proposal), while less onerous than those in effect in 2000, perpetuate the problem of imposing several reductions on the same providers in rural communities.

- Selective contracting could have serious implications for rural providers, especially essential providers.

- The HCFA-Sponsored Medicare plan (*S 1895*) could be required to continue special payment considerations for specified rural providers, but with a special subsidy so as not to affect the competitive position of that plan.

I. INTRODUCTION

This *Policy Paper* provides a rural perspective on two proposals to redesign the Medicare program: the “Medicare Preservation and Improvement Act of 1999" (*S. 1895*, introduced by Senator Breaux and others) and the “President’s Plan to Modernize and Strengthen Medicare for the 21st Century.” The paper examines the implications of these proposals for rural Medicare beneficiaries and providers and offers general considerations about how these proposals could affect the delivery of health care services in rural areas. One of the aims of this analysis is to identify features of these proposals that would strengthen rural health and those that might have adverse effects. The paper also suggests changes to these proposals that could address specific rural concerns.

II. BACKGROUND

Beginning with the Balanced Budget Act of 1997 (BBA), Congress and the President have been engaged in a far ranging debate about the future of the Medicare program. In the context of the BBA, the initial focus of the debate was among competing ideas for assuring the fiscal solvency of the program through the years in which the “baby boom” generation would retire and become beneficiaries. As Medicare spending has slowed following the implementation of the BBA (for a variety of reasons, including the impacts of the BBA itself, and general slowing of medical care expenditures) and Medicare revenues benefitted from the economy’s continuing strength, the pressure to deal with solvency has eased somewhat. During 1999, though, pressure increased to redesign the Medicare program to include additional benefits, especially for prescription drugs.

The two leading proposals discussed in this paper reflect this shifting debate. Both still include provisions to improve the fiscal health of the Medicare program, but the emphasis of each proposal extends redesign efforts beyond fiscal health to fundamental changes. Both proposals presume that adding benefits is more affordable and therefore secure if the philosophy underlying the program changes from guaranteeing benefits regardless of cost, to one of guaranteeing minimum financial support for the beneficiary to select among health plans offering different levels of benefits. This new approach for the Medicare program assumes that a competitive market can be established, with different health plans competing for Medicare enrollment.

Experience to date has shown that the Medicare+Choice program has not encouraged the spread of plan choices into rural areas. Plans have withdrawn from rural counties, and the number of rural Medicare beneficiaries enrolled in M+C plans has declined since December, 1997.

Before turning to the specifics of the two proposals, readers should be reminded that rural health care delivery systems are different from urban systems, and that rural Medicare beneficiaries face different circumstances than their urban counterparts. The important differences include:

- geographically large service areas with fewer persons residing in those areas;
- lower volume of patient business for institutional providers, e.g., hospitals;

- absence of competing providers in most communities;
- lower revenue to expenditure margins and therefore a greater likelihood that the local provider is in a financially precarious situation;
- dependence on primary care providers performing a wide range of medical tasks;
- shortages of health care professionals and services;
- interdependence of the component elements of the continuum of care; and
- reliance on innovative models in delivering services and maintaining financial subsidies to sustain services in remote areas.

The differences in the circumstances faced by rural vs. urban beneficiaries include:

- few competing supplemental Medicare plans, including limited availability of supplements with prescription drugs benefits;
- few Medicare+Choice plans;
- difficulty accessing some plans that are "available" because of underwriting practices;
- difficulty accessing services due to distance and difficulty in traveling great distances (lack of personal transportation and limited public transportation); and
- lower incomes and therefore less ability to purchase plans or specific services.

Consideration of these differences resulted in targeted changes in payment from the Medicare program. Changes in payment policy, such as prospective payment systems, affect rural providers differently than urban providers. Over the years, categories of rural hospitals have achieved special status in the Medicare program:

- Sole Community Hospitals,
- Rural Referral Centers,
- Medicare Dependent Hospitals, and
- Critical Access Hospitals.

These institutions are paid outside of the prospective payment system used for other hospitals. Another special rural consideration has been to adopt different Medicare prospective payment updates for small rural hospitals.

III. ASSESSMENT OF TWO PROPOSALS

This assessment is organized by using the principal conceptual parts of the two plans:

A. The applicability of the competitive model in rural areas
B. Beneficiary choice for rural residents
C. Effects of Medicare payment on rural providers
D. Rural representation in governance of the Medicare program

A. The Applicability of the Competitive Model in Rural Areas

The competitive model relies on health plans competing for Medicare beneficiaries by offering different benefits and by pricing their plans differently. To do so, plans would be expected to develop their service areas in accordance with the locations where they anticipate achieving maximum market share and earnings.

S. 1895 relies on a marketplace, with very few regulatory directives, to provide expanded Medicare benefits at an affordable cost. Two types of plans would be marketed: a low option plan that includes only those benefits that are part of traditional Medicare; and a high option plan that adds benefits -- at a minimum, prescription drug benefits and a stop-loss provision for spending on the core benefits. A HCFA-administered plan would replace the current traditional Medicare plan, and would compete with other plans for enrollment. Except for requiring that they offer core benefits and a minimum actuarial value for prescription drugs, plans are free to vary the amount of both benefits and premiums. Plans charging more than the weighted national average premium would, in essence, charge beneficiaries the difference, while those below the average would contribute to savings for beneficiaries and the Medicare program.

The President's Proposal is also market-based, but is more directive, and would not treat the traditional Medicare program as a HCFA-sponsored competing plan. Plans would compete based on price, presumably attracting more enrollees as the Part B premium approaches zero. The prescription drug benefit, Medicare Part D, is fully funded by the government and therefore not a basis for competition.

1. How Private Plans Would Compete

1.1 Service Areas

Currently: Medicare+Choice plans define their own service areas (subject to approval by state insurance agencies), provided that they do not discriminate based on health status, economic status, or previous utilization by Medicare beneficiaries. Plans are allowed to define distinct but adjoining service areas, creating different benefit packages and member premiums in those areas.

S. 1895: Plans define their service areas, with the only restriction being that they are not defined to discriminate "based on health status, economic status, or prior receipt of health care of Medicare beneficiaries" Sec. 2223 (b)(3)(B).	*President's Proposal:* There is no definition of, or restriction on service areas.

1.2 Benefit Packages

Currently: Medicare+Choice plans must offer the basic Medicare benefits. Other benefits are added at the discretion of the plan. If payment to the plan exceeds the allowed rate of return, the plan must use the surplus to either provide additional benefits to its enrollees and/or create a special reserve fund.

S. 1895: Competing plans must offer both basic and high option coverage. All plans must offer all of the benefits currently offered through the Medicare program. Under the high option, outpatient prescription drugs are included, with a Year 2000 minimum actuarial value of $800, and discounts for member purchases of prescriptions. High option plans would include a stop loss provision to limit cost-sharing for core benefits to a maximum of $2,000 in 2003, adjusted afterward by the Medicare Board.	*President's Proposal*: Plans must provide the defined core of Medicare benefits. Plans would be subsidized equally (with geographic adjustments) for the prescription drug benefit. They also have the option of providing additional benefits, but would not be subsidized by the government for the costs of those benefits. The prescription drug benefit is designed as follows: no deductible, discounts on purchases for the beneficiaries, 50 percent beneficiary cost sharing for each prescription, and limits on the benefit beginning with $2,000 ($1,000 for Medicare payment) in the first two years, building to $5,000 in the sixth year. Beneficiaries could choose this benefit on a one-time only basis during their enrollment in the Medicare program.

2. How Traditional Medicare Fee-for-Service Plans Would Compete

Currently: There are no special "rules of competition" for the traditional Medicare program. It is administered under the payment and coverage parameters defined by statute, such as various prospective payment systems included in the BBA. Payment to M+C plans is based on the expenditures incurred in the traditional fee-for-service system.

S. 1895: A new "Division of Sponsored Plans" would offer one standard Medicare plan throughout the United States, which would include only the core benefits. There also would be at least one high option Medicare plan in each area of the U.S., that includes the core benefits, the outpatient prescription drug benefit, and the stop-loss provision specified in this proposal. HCFA-sponsored plans (the traditional fee-for-service program) assume the same financial risk as other plans, and can assure solvency through "improvements in the efficiency and economy" of the plans (Section 2282 (b) (1)). HCFA would not be obligated to continue the current policies used to contain health care expenditures (such as prospective payment systems). In fact, given that one of the goals of the proposal is to reduce government micro-management, HCFA would most likely not continue those policies. Instead, HCFA should be expected to use the same strategies used by private health plans. HCFA would contract with private entities for the provision of the prescription drug benefit. HCFA would have to submit a business plan to Congress each year for approval. The plan would include recommendations for the coordination of, and improvement to, benefits provided.

President's Proposal: HCFA would not be a direct competitor in the sense of accepting financial risk for plans submitted in a bidding process. The following strategies would become part of the Medicare program administered by HCFA:

A. a new Medicare Preferred Provider Option (PPO);
B. Centers of Excellence consisting of providers delivering complex medical care with exceptional quality;
C. primary care case management (PCCM) through physicians receiving case management fees;
D. competitive bidding and price negotiations to set payment rates for Part B items and services including authority for selective contracting;
E. authority to pay single case payments to combinations of providers;
F. a demonstration of bonus payments for physician group practices who reduce use and demonstrate positive medical outcomes; and
G. and authority to select fiscal intermediaries and carriers through a competitive process.

3. How Premiums and the Government Payment Would be Determined

Currently: M+C plans are paid a per-member-per-month premium for each county in their service area. The amount is based on the 1997 payment, adjusted for changes in the BBA, and trended forward based on changes in national fee-for-service payment. Since 1997, with one exception, plans have received either the minimum increase specified by the BBA, or the floor payment also specified by the BBA. In traditional Medicare, providers are paid based on legislative formulas, and in most cases this is done through prospective payment.

S. 1895: The Medicare Board computes a national average premium for the core benefit plan, which is then weighted for the number of beneficiaries enrolled in the previous year. Plans are paid their full premium, including geographic and risk adjustments, as approved by the Medicare Board. Beneficiary payments, based on the difference between the plan's premium and the national weighted average, are made directly to the Medicare trust fund.

President's Proposal: A maximum government payment to health plans would be set at 96 percent of the costs incurred by the traditional Medicare program. A risk adjustment would be applied to the rate. A geographic adjustment would be included that reflects full "local" costs. Higher payments to rural plans secured in the BBA would be maintained. Beneficiaries would pay any difference between the government payment and the premium charged by the plan. If beneficiaries enroll in a plan charging less than the government payment, they would realize some of the savings through adjustment to or elimination of their Part B premiums.

B. Beneficiary Choice for Rural Residents

1. Range of Options Available to Beneficiaries

Currently: Beneficiaries can enroll in Medicare+Choice plans, but only if there are such plans serving their counties. At present 15 percent of rural counties are in the service areas of M+C plans, and M+C plans actually enroll beneficiaries in 18 percent of rural counties. Beneficiaries can also enroll in supplemental health plans which cover some benefits and costs (deductibles and copayments) not covered by basic Medicare. Rural beneficiaries are less likely to have supplemental plans that include benefits for prescription drugs (plan types H, I and J).

S. 1895: The HCFA-sponsored Medicare plan must offer a high option plan in every location in the U.S., which would make prescription drugs an available benefit for all rural beneficiaries who choose it. There are explicit provisions for HCFA to use supplemental insurers as one means of providing prescription drug benefits. There is no other mention of supplemental plans in the proposal.

President's Proposal: All beneficiaries would have the same prescription drug benefit, the new Medicare Part D. Medicare+Choice plans would receive payment to cover all costs, in an effort to encourage more widespread service areas for those plans. Supplemental plans would be encouraged to protect beneficiaries against catastrophic costs, related to all benefits. Existing supplemental plans are expected to continue. The Secretary of Health and Human Services would be directed to study policy options to improve supplemental coverage, with a special focus on limiting out-of-pocket spending for Medicare-covered services.

2. Beneficiary Ability to Choose (Education)

Currently: The BBA included provisions creating a special fund, collected from M+C plans, for educating Medicare beneficiaries about the choices they would have among competing Medicare+Choice plans. HCFA has launched special projects designed to assist beneficiaries, including mass mailings and a special web site for the Medicare program.

S. 1895: Medicare Consumer Coalitions are established to conduct information programs that: 1) prepare comprehensive, accurate, and understandable information; and 2) disseminate the information in a timely fashion. Coalitions are nonprofit organizations whose boards of directors are composed primarily of Medicare beneficiaries. Information programs would include comparisons of benefits, quality and performance, beneficiary costs, consumer satisfaction surveys, and other information. The Medicare Board would measure the impact of the Coalitions on the following: premiums of Medicare plans in the service area; quality of items and services covered; access of Medicare beneficiaries to items and services covered by plans in the area; choice of Medicare plans in the area; changes in enrollment in Medicare plans; and other factors the Board may deem appropriate.

President's Proposal: A new Citizen Advisory Panel of Medicare Education would establish a public forum for continual feedback on how to improve educational efforts. A Management Advisory Council would help HCFA "identify, adapt, and adopt innovations in customer services, purchasing, and management" (p. 18).

3. Incentives for Beneficiaries to Choose Among Plans (Cost Sharing)

Currently: Beneficiaries are presented choices that require them to pay premiums in addition to the Part B premium they already pay. The amount of additional payment varies across areas of the country, and across different types of supplemental or M+C plans. M+C plans attempt to offer special incentives by pricing their products below what supplemental plans charge for similar packages.

S. 1895: Beneficiaries would be choosing among plans whose premiums would vary around a national weighted average. When those premiums are below 85 percent of the national average, the beneficiary will pay nothing. Between 85 and 100 percent of the national average, the beneficiary pays 80 percent of the amount in excess of 85 percent of the national average. If plans are charging at or above the national average, the beneficiary will pay 12 percent of the national average and all of the amount by which the premium exceeds the average. Premiums for low-income persons above poverty are discounted on an income-based sliding scale. Persons with incomes below poverty are eligible for other programs already in existence. Special provisions are included to limit beneficiary obligations in areas where there is only one Medicare plan being offered (the HCFA-sponsored plans). In such areas the beneficiary obligation is limited to 12 percent of the national average premium for the standard plan. Low income beneficiaries (135 percent of poverty or less) shall not be liable for any of the premium of the lowest cost high option plan available in the area.

President's Proposal: Beneficiaries choosing plans with premiums below 96 percent of the traditional Medicare plan would keep 75 percent of the savings. If plans at or below 80% of traditional costs were purchased, it is unlikely that a Medicare Part B premium would be charged.

C. Effects of Medicare Payment on Rural Providers

1. Payment in Traditional Medicare

Currently: A variety of prospective payment formulas are being used, or phased in, affecting the following payment categories: inpatient hospital; outpatient hospital; skilled nursing; and home health. Fee schedules are used to pay physicians, and for certain services such as hospice, durable medical equipment, and non-PPS hospitals. Special payments are in place for the following categories of rural providers:

- sole community hospitals;
- rural referral hospitals;
- critical access hospitals;
- physicians, nurse practitioners, and physician assistants practicing in health professions shortage areas;
- disproportionate share hospitals;
- rural health clinics and federally qualified health centers; and
- Medicare dependent hospitals.

Expenses for graduate medical education, which benefit teaching hospitals and other providers involved in health professions training (as of provisions in the BBA and BBRA), are included in current Medicare payments.

1. Payment in Traditional Medicare (continued)

S. 1895: Under the high-option traditional Medicare plan HCFA would contract with private entities, including insurers, pharmaceutical benefit managers, chain pharmacies, groups of independent pharmacies, and other appropriate entities. However, HCFA would be required to include any willing provider that meets the requirements established by the Medicare Board for offering such benefits, subject to the Medicare Board's approval of the partnership. HCFA's business plan, which requires annual approval, will include "a comprehensive payment and management plan for all aspects of offering the core benefits" (Section 2284 (a) (2) (A)).	*President's Proposal:* The current payment system is retained for traditional Medicare, but changes could be made. Payments in traditional Medicare could be used to promote use of selected providers, including Medicare PPOs and Centers of Excellence. Competitive pricing would be used for Part B items and services, with protections built in for rural areas where this competition may be difficult. There would also be authority to selectively contract with providers accepting negotiated or bid prices. Medicare could negotiate alternative flexible administrative arrangements with providers and suppliers who agree to provide discounts and demonstrate better performance and higher quality. Large physician groups who reduce excessive use and demonstrate positive medical outcomes could receive bonus payments. The proposal would constrain Medicare spending growth in hospital payment to below market basket increases through fiscal 2009, and would reduce other payment updates. The new prescription drug benefit would be contracted out through private sector entities, including: pharmacy benefit managers; retail drug chains; health plans or insurers; states (Medicaid); or multiple entities in collaboration, provided that collaboration increases their scope or efficiency and is not anti-competitive. Entities could bid to manage the benefit for a particular service area, and single contracts could be awarded in areas large enough to encourage efficiency. Entities would have to meet access and quality standards established by the Secretary of HHS, including the "capacity and pharmacy availability to serve all beneficiaries in the geographic area" (p. 23). Benefit managers would be required to negotiate with pharmacies that have the information systems needed to participate in the plan. Fees for dispensing medications would be required to be sufficient to ensure participation by most pharmacies.

2. Payment in Alternative (Medicare+Choice) Plans

Currently: There are no particular requirements governing payment from M+C plans to participating providers. Payment for graduate medical education is being phased out from inclusion in M+C premium payments and is being paid separately to teaching hospitals.

S. 1895: There are no particular requirements governing payment from M+C plans to providers. The HCFA Division of Health Programs would be responsible for federal support of graduate medical education and disproportionate share hospitals, presumably removing those payments from the responsibility of M+C plans.

President's Proposal: There are no requirements governing payment from M+C plans to providers. Disproportionate share payment to hospitals would be made directly, not through M+C plans. Payments related to prescription drugs are made according to the provisions of the legislation, not by health plans.

D. Representing Rural Interests in Governing the Medicare Program

1. Oversight of the New Program

Currently: HCFA oversees the activities of Medicare+Choice plans and the fee-for-service component of the program.

S. 1895: A seven-member Medicare Board would be established. Its members are appointed by the President, with the advice and consent of the Senate, for three years (after an initial staggered appointment length) and a maximum of two terms each. The Board administers the competitive premium system, including entering into and enforcing contracts with entities offering Medicare plans (including the Division of HCFA-Sponsored Plans), disseminating information to Medicare beneficiaries, and establishing a beneficiary education program. The Board has the authority to modify regulations promulgated by the Secretary in order to carry out the requirements of Medicare Part C. The Board submits reports to Congress at least annually, and it may submit reports, legislative recommendations, testimony, or comments on legislation directly to Congress.[1] The Board is funded through levies on Medicare plans.	*President's Proposal:* The program is administered by the Department of Health and Human Services, Health Care Financing Administration.

[1] In recent weeks, the sponsors of *S. 1895* have indicated their intent to have the Board operate within the Executive Branch of government (under the President).

2. Role of the Health Care Financing Administration

Currently: HCFA oversees all parts of the Medicare program. As part of the Department of Health and Human Services, oversight is provided by the Secretary, and ultimately the President. There are no separate Boards or Commissions set up for the various parts of the Medicare program, including plans operating under Medicare Part C.

S. 1895: HCFA would be reorganized into a Division of HCFA-Sponsored Plans and a Division of Health Programs. The former would be responsible for the traditional fee-for-service Medicare program. The latter would administer the following: the Medicaid program, the State Children's Health Insurance Program, federal support of graduate medical education, and federal support of disproportionate share hospitals.

President's Proposal: HCFA management would be reconfigured in an attempt to become more competitive with other health plans. A new Management Advisory Council would help HCFA adopt innovations in customer service, purchasing, and management by providing private sector expertise. A new Medicare Coverage Advisory Committee would help guide a new process for determining whether treatments and devices should be covered by Medicare. The Committee would include experts in medicine and science, and consumer and industry representatives.

IV. RURAL IMPLICATIONS AND RECOMMENDATIONS

A. The Applicability of the Competitive Model in Rural Areas

Insufficient details are provided in the plans to permit effective analysis, including: the formula used to calculate risk adjustment; the formula used to calculate geographic adjustment; and how plans would reimburse providers. In those cases in which sufficient detail was available, analyses were conducted and are reported below.

There is little incentive for private plans to move into rural areas and compete with traditional Medicare fee-for-service plans. Since the traditional Medicare plan is likely to be adopting many of the same purchasing strategies as private plans, the latter would not have any competitive advantage. The low number of beneficiaries in rural markets render them unappealing, unless they are adjacent to existing urban markets. As a consequence, fewer additional benefits may be offered by plans operating in rural areas. ***To the extent that competing plans are relied upon as the source of affordable benefits, rural areas are at a disadvantage.***

Both proposals attempt to correct for the deficiencies of the competitive model in rural areas. S. 1895 uses refined geographic adjusters, and the President's proposal adds a guarantee of the BBA minimum payments to geographic adjusters. The President's proposal also assures full cost payment in high-cost areas, which would continue the current considerable variation in payment. ***The adjustments derived from national and area averages for rural payment could be improved through refined definitions of service areas and minimum payments in each area that account for costs associated with prescription drug benefits and plan administration.***

Under S. 1895, it is envisioned that the traditional Medicare plan would be restructured, eliminating the current set of cost containment provisions (e.g., Prospective Payment System, Resource Based Relative Value Scale, prospective payment for other services), and offering high option benefits, financed from its own revenues. It will be difficult to sustain this program with the payment provided through a national weighted average premium, especially if the plan faces adverse selection. This would lead to either failure of the plan or to some sort of fiscal bailout in order to protect access for rural beneficiaries, or the adoption of strict cost containment provisions that cannot be anticipated at this time. ***If traditional Medicare is the only option in rural areas, fiscal difficulties encountered by that plan would pose special problems for rural residents.***

Neither proposal includes any adjustment for pent-up demand, which has been experienced by at least some rural Medicare+Choice plans. ***The provisions of the Balanced Budget Refinement Act of 1999 allowing for additional payments for M+C plans entering new markets should be continued, and perhaps increased above the 5% first year and 3% second year.***

Neither proposal includes any special consideration for locally-based health plans. Some experiences in rural America, such as experienced in Bend, Oregon and Rugby, North Dakota,

indicate that in rural areas locally-based plans have a greater chance of lasting success. ***Proposals relying on cost savings from managed care to provide affordable benefits should include provisions to encourage locally-based plans in rural areas.***

B. Beneficiary Choice for Rural Residents

All rural beneficiaries will have access to a plan that includes coverage for prescription drugs, a significant improvement for rural persons. However, the richness of the prescription drug benefit may vary considerably between rural and urban areas. For example, if urban and rural plans both offer benefits valued at $800 per year, the urban plan may be able to offer better purchasing options because of the higher number of beneficiaries included in the plan. ***There is no assurance that the difference in the current plan offerings between urban and rural Medicare HMOs would not continue under these reform proposals. Rural beneficiaries may continue to experience a different, less attractive set of choices.***

Subsidies would be available for rural beneficiaries enrolling in the high option traditional Medicare program (S. 1895), but subsidies do not apply to other benefits not included in the core benefit plan, which is likely to be affordable to rural residents. A higher percentage of rural (compared to urban) beneficiaries are in households with low incomes, and therefore more likely to opt out of plans with more than modest cost-sharing provisions. ***The value of supplemental benefits for rural beneficiaries is related to the specifics of cost-sharing provisions.***

The effectiveness of new initiatives to educate rural beneficiaries about their options in the redesigned Medicare program is a function of local input into the design of those programs and the capacity of the local infrastructure. The President's proposal relies on a centralized strategy (potentially with local outreach) and S. 1895 would use a number of Councils, but with indeterminate regional responsibility. Issues of transportation and communication infrastructure are not addressed. ***These proposals should address differences between rural and urban audiences, and among rural residents with different cultural experiences.***

Limiting premium cost sharing is important to rural beneficiaries, given their comparatively lower incomes. This is especially important in considering the traditional Medicare program, where increased costs are likely to lead to higher premiums. ***Establishing maximum beneficiary premiums as a function of household income, either by limiting cost-sharing or by subsidizing the beneficiary's premium, is critically important in rural areas, and is accomplished by the specifics included in S. 1895.***

Creating a prescription drug benefit that relies on using purchasing strategies such as pharmacy benefit management and discounts available through chain stores could jeopardize the future of local rural pharmacies. This could in turn affect rural beneficiary access to drugs needed quickly, and to the advice they may be seeking from local pharmacists. Both proposals contain protections for local pharmacists, such as the any willing provider provision in S. 1895 and a provision in the President's proposal to pay adequate dispensing fees to sustain local pharmacies. ***The ultimate***

impact on local rural pharmacists of the purchasing strategies used for the new prescription drug benefit cannot be determined, but should be monitored.

In the President's proposal there is only one chance to enroll in the new Medicare Part D program. ***The implications of allowing only one opportunity to enroll in Part D may disadvantage rural beneficiaries who have only one option when they initially enroll in Medicare, but who have more attractive opportunities later due to an increased number of options where they live.***

C. Effects of Medicare Payment on Rural Providers

Under the President's proposal large physician groups who reduce excessive use and demonstrate positive medical outcomes could receive bonus payment. ***Rural health physician or physician-hospital networks that demonstrate similar performance should be eligible for bonus payments.***

In the President's proposal, ***extensions of cost saving provisions in the BBA, while less onerous than those in effect in 2000, perpetuate the problem of imposing several reductions on the same providers in rural communities.***

Selective contracting could have serious implications for rural providers, especially essential providers. The adequacy of special protections for rural providers is unknown.

Under current Medicare payment policies certain providers are provided cost-based reimbursement to assure access. In S. 1895, under the new Medicare program run by the HCFA Division of Sponsored Programs, it is uncertain that those special considerations would continue. ***The HCFA-sponsored Medicare plan could be required to continue special payment considerations for specified rural providers, but with a special subsidy so as not to affect the competitive position of that plan.***

D. Representing Rural Interests in Governing the Medicare Program

Assurances are needed that rural representation is an explicit requirement in any redesign of governance.

RUPRI Rural Health Panel

Andrew F. Coburn, Ph.D., is the Director of the Institute for Health Policy and Associate Professor of Health Policy and Management in the Edmund S. Muskie School of Public Service at the University of Southern Maine. Dr. Coburn is also Director of the Maine Rural Health Research Center, one of five national centers funded by the federal Office of Rural Health Policy. He is currently directing studies of rural health insurance coverage and rural long-term care. Dr. Coburn is an active member of the National Academy for State Health Policy.

Charles W. (Chuck) Fluharty is the Director of the Rural Policy Research Institute. He also currently serves as Interim Director of the Missouri Institute of Public Policy, and holds Adjunct Faculty Appointments in the University of Missouri Graduate School of Public Affairs and Department of Rural Sociology. He was the recipient of the 1999 Friend and Partner Award from the National Association of Counties Rural Action Caucus, the 1999 National Rural Development Partnership Recognition Award, the 1998 Distinguished Service Award from the National Association of Counties, and the 1998 Recognition Award from the National Organization of State Offices of Rural Health. He received his M.Div. from Yale University Divinity School, and has focused his career upon service to rural people, primarily within the public policy arena.

J. Patrick Hart, Ph.D., is President of Hart and Associates in Grand Forks, North Dakota. Before accepting his current responsibilities, Dr. Hart held faculty positions at the University of Minnesota-Duluth School of Medicine, Tulane University, the University of Oklahoma, the University of Texas Health Science Center and the University of North Dakota. He is past President of the Board of Directors of the National Rural Health Association and past Chair of the Rural Health Committee of the American Public Health Association.

A. Clinton MacKinney, MD, MS is a board-certified family physician. He is currently practicing with Central Minnesota Group Health in St. Cloud, Minnesota. He earned his medical degree at Medical College of Ohio and completed residency training at the Mayo-St. Francis Family Practice Residency. His MS degree is in Administrative Medicine, University of Wisconsin. He has lectured and published articles regarding rural health, and has served on committees for the American Medical Association, the American Academy of Family Physicians, the Robert Wood Johnson Foundation, and the National Rural Health Association.

Timothy D. McBride, Ph.D., is Associate Professor of Economics, Public Policy and Gerontology at the University of Missouri- St. Louis. Dr. McBride's research concerns public economics, with special emphasis on the economics of aging and health. In the health policy area, Dr. McBride's research has focused on the uninsured, long-term care, and health care reform. He is the author of over a dozen research articles and co-author of a monograph, titled The Needs of the Elderly in the 21st Century. Dr. McBride joined the Department of Economics in 1991 at the University of Missouri- St. Louis after spending four years at the Urban Institute in Washington, D.C. He received his Ph.D. from the University of Wisconsin in 1987.

Keith J. Mueller, Ph.D. is a Professor and the Director of the Nebraska Center for Rural Health Research, University of Nebraska. He was the 1996-97 President of the National Rural Health Association, and the recipient of the Association's Distinguished Rural Health Researcher Award in 1998. Dr. Mueller's Ph.D. is from the University of Arizona, in Political Science. He is the author of a University of Nebraska Press book, *Health Care Policy in the United States*, and has published articles on health planning, access to care for vulnerable populations, rural health, and access to care among the uninsured. He is the Chair of the RUPRI Rural Health Panel, and in that capacity has provided expert testimony to Committees and staff of the U.S. Congress. He recently testified on rural health issues before the Bipartisan Commission on the Future of Medicare.

Rebecca Slifkin, Ph.D., is a Senior Research Fellow and Director of the Program on Heath Care Economics and Finance at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill. She is also a Research Assistant Professor in the Department of Social Medicine in the Medical School. Since 1993, Dr. Slifkin has focused on rural health issues as a member of the North Carolina Rural Health Research Program. She is currently co-director of the North Carolina Rural Health Research and Policy Analysis Center, one of five centers funded by the Federal Office of Rural Health Policy. Dr. Slifkin's work has spanned a broad array of topics, including Medicare Graduate Medical Education payments, Medicaid managed care, Critical Access Hospitals, and access to care for rural minorities.

Mary K. Wakefield, Ph.D. is Professor and Director of the Center for Health Policy at George Mason University, Fairfax, Virginia. From January 1993 to January 1996, Dr. Wakefield was the Chief of Staff for United States Senator Kent Conrad (D-ND). Prior to that she served as Legislative Assistant and Chief of Staff to Senator Quentin Burdick (D-ND). Throughout her tenure on Capitol Hill, Dr. Wakefield advised on a range of public health policy issues, drafted legislative proposals, worked with interest groups and other Senate offices. From 1987 to 1992, she co-chaired the Senate Rural Health Caucus Staff Organization. Dr. Wakefield served on President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. She was appointed to the Institute of Medicine's Committee on Quality of Health Care in America and is a member of the Medicare Payment Advisory Commission.

Recent Health Policy Documents

A Report on Enrollment: Rural Medicare Beneficiaries in Medicare+Choice Plans. PB2000-1

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

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

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

Considerations for Federal Legislation to Improve Rural Health Care Delivery: Recommendations for the 106th Congress. A RUPRI Rural Policy Brief. **(PB99-1)**

The Economic Importance of the Health Care Sector. Operation Rural Health Works Project Briefing Report. March, 1999. **(OR99-1)**

Regulations Implementing the Balanced Budget Act of 1997: Provider Sponsored Organizations and Medicare+Choice. Primary Author: Keith Mueller. September 25, 1998. **(P98-5)**

Tracking the Response to the Balanced Budget Act if 1997: Impact on Medicare Managed Care Enrollment in Rural Counties. Primary Authors: Timothy D. McBride, Keith Mueller. August 25, 1998. **(P98-4)**

RUPRI Mission

The Rural Policy Research Institute provides objective analysis and facilitates public dialogue concerning the impacts of public policy on rural people and places.

RUPRI Vision Statement

"The Rural Policy Research Institute will be recognized as the premier source of unbiased, policy relevant analysis and information on the challenges, needs and opportunities facing rural people and places."

Additionally, RUPRI will be viewed as a national leader and model in demonstrating how an academic-based enterprise can--

- Build an effective and lasting bridge between science and policy.
- Meet diverse clientele needs in a flexible and timely fashion
- 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.

2000 Program of Work

RUPRI Panels
Rural Health
Rural Policy
Rural Welfare Reform

RUPRI Task Forces
Rural Finance
Rural Equity Markets
Rural Telecommunications

RUPRI Work Groups
Rural Baseline
Community Policy Decision Support
Regional Analysis

RUPRI Initiatives
Rural Communities Initiative
Comparative Rural Policy Initiative
The Role of Place in Public Policy
Rural Partnership Working Group

Topical Research
Rural Telecommunications
Rural Education
Rural Health