MEDICARE PRESCRIPTION DRUG LEGISLATION: What It Means for Rural Beneficiaries

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EXECUTIVE SUMMARY

Congress is currently debating legislation that would not only add a prescription drug benefit to Medicare but create an unprecedented role for private health insurers in delivering all Medicare services. Such changes would have profound effects on the 41 million people covered by Medicare -- particularly the one in four who lives in rural America. Previous studies have shown that rural beneficiaries have different health care needs and delivery systems than their urban counterparts. Indeed, the bills that passed the House and Senate address payments to rural hospitals and other providers. However, less attention has been paid to the rural beneficiary implications of the prescription drug benefit and private plan reforms included in the Medicare legislation. This study does so, through new data analysis and synthesis of existing information.

The results of this study underscore the unique challenges that face Medicare's 9 million rural beneficiaries today and under the Medicare proposals under consideration. New analysis shows that rural beneficiaries are, relative to urban beneficiaries, older, sicker, and poorer and have a greater need for a Medicare drug benefit. They are nearly twice as likely to lack any type of insurance coverage for prescription drugs. However, the design of a Medicare prescription drug benefit is critical to ensuring that the unique needs of Medicare's rural beneficiaries are met. Rural beneficiaries would be disadvantaged by a Medicare prescription drug benefit that has weak protections for low-income beneficiaries – or excludes them altogether. Their higher incidence of chronic illnesses like arthritis and heart disease would leave them vulnerable to higher prescription drug cost sharing and premiums if private insurers rather than Medicare were to define the benefit. In addition, a prescription drug benefit that relies exclusively on private insurers could create serious access problems for rural beneficiaries. This study shows that private insurers have proven unreliable in rural areas: they are less likely to serve rural areas, and when they do, they are less likely to maintain service over a sustained period of time. Finally, reforms outside the addition of a prescription drug benefit could exacerbate the current inequities caused by Medicare funding of supplemental health benefits only through private plans. Not only do rural beneficiaries have less access to subsidized benefits through private plans, but they would fund these benefits through higher Medicare premiums. The report concludes by recommending that stronger protections for low-income and sicker beneficiaries, a more stable prescription drug delivery system, and a more equitable allocation of Medicare subsidies for supplemental benefits – rather than concentrating them in private plans -- would make the ultimate Medicare legislation more responsive to rural beneficiaries' circumstances.

Highlights of the study include:

Greater Need for a Medicare Drug Benefit in Rural America

- **Lower rate of prescription drug coverage:** The proportion of rural beneficiaries lacking drug coverage is nearly double that of urban beneficiaries. Nearly one in three (31%) of rural Medicare beneficiaries had no prescription drug coverage in 2000, compared to 18 percent of urban beneficiaries.

- This disparity is greater for sicker beneficiaries: among those in fair to poor health, rural beneficiaries are over 70 percent more likely to lack drug coverage than urban beneficiaries (28.8 versus 16.2%).

- The oldest rural beneficiaries are least likely to have drug coverage despite their greater need for medications. About 37 percent of rural beneficiaries age 85 and older lacked drug coverage, compared to 23 percent of the oldest urban beneficiaries.

- **Much lower Medicare managed care coverage**: Medicare implicitly subsidizes prescription drug coverage by paying Medicare managed care plans more than their costs of providing Medicare's core benefits. However, rural beneficiaries have less access to such plans. This helps explain why only 3 percent of rural beneficiaries received drug coverage through these plans compared to 18 percent of urban beneficiaries.

- **Higher out-of-pocket costs:** Rural Medicare beneficiaries' average out-of-pocket spending on prescription drugs is about 25 percent higher than that of urban beneficiaries. This difference reflects the much-lower rates of supplemental prescription drug coverage among rural beneficiaries rather than a greater use of medications.

Implications of Prescription Drug Benefit Designs on Rural Beneficiaries

- **Fewer eligible for the drug benefit**: Rather than creating a universal benefit, the Senate bill would exclude from the Medicare prescription drug benefit those beneficiaries who also are enrolled in Medicaid. Due to their lower average income, a greater proportion of rural beneficiaries would not qualify for the Medicare benefit (12.4 rural versus 10.5%). Applied to 2006 projections, this could mean 1.7 million rural beneficiaries are prohibited from accessing the Medicare benefit. This means that the lowest-income and sickest Medicare beneficiaries could get a different, and ultimately, lesser benefit as states, which share in Medicaid costs, scale back coverage due to costs. Not only do more "dual eligibles" live in rural areas, but their average drug costs are higher compared to that of urban beneficiaries. Predominantly rural states would therefore face a disproportionately larger cost burden.

- **Less relief from high out-of-pocket drug costs**: Both bills, to fit within budget constraints, would subsidize only about one-third of total prescription drug costs. Because over half of rural beneficiaries without drug coverage also have low income (below 150 percent of poverty or about $13,500 per single), extra assistance would be needed to eliminate cost as a barrier to needed medicines for rural beneficiaries.

- **Potentially higher drug cost sharing and premiums:** Neither proposal includes a defined Medicare benefit. Instead, they would allow private plans to set cost sharing for covered drugs, within bounds, and determine beneficiary premiums. Since rural beneficiaries are more likely to be in fair to poor health (32.5 versus 28.9%) and to have chronic diseases like diabetes and arthritis, they could be vulnerable to higher cost sharing and premiums as private plans try to avoid their enrollment and cover their costs.

Implications of Promotion of Private Plans on Rural Beneficiaries

- **Access uncertain:** The Senate bill would rely on, and the House bill would require, private insurers to deliver the prescription drug benefit. Yet, studies have found that, even with payment rates well above the average accosts of traditional Medicare, private plans are much less likely to serve rural seniors.

- **More unstable in rural areas:** Even in rural areas that private plans have opted to served, private plan participation has been more volatile than in urban areas. Among beneficiaries with access to private plans, rural residents were four times more likely than urban beneficiaries to lack a private plan option that was available for the past three years.

    - Loss of private health plans was a greater cause of instability in rural than urban areas, accounting for nearly half of volatility (and 33% of urban volatility).

    - In five predominantly rural states, no single private plan offered and enrolled Medicare beneficiaries for the entire 2001-03 period. These states were Alaska, Maine, Montana, South Dakota and Vermont. In addition, Delaware, New Hampshire and South Caroline lacked a stable private plan option in their rural counties during the period.

- **Exacerbates benefit inequity:** Both proposals would continue the current system that allows Medicare overpayments to private plans to be used to subsidize extra benefits for enrollees. In addition, the legislation would increase private plan payment rates, costing Medicare $6 to $8 billion over 10 years, according to the Congressional Budget Office. Under the Administration's projected enrollment, this cost could be up to 4 times higher, or $32 billion over the period. This is on top of the relief that private plans would get with the passage of a Medicare-subsidized prescription drug benefit.

    - Increased private plan funding and, thus, subsidized benefits would most likely benefit urban beneficiaries, given patterns in the past.

    - The increased private plan funding could instead be used to either improve benefits for all Medicare beneficiaries or eliminate the bills' increases in home health and lab copayments and the Part B deductible. These cost sharing increases would disproportionately affect rural beneficiaries given their lower average income and already-higher out-of-pocket cost burden. Compared to urban beneficiaries, rural beneficiaries' out-of-pocket spending on Medicare-covered provider services, outpatient hospital and inpatient hospital care is 10, 30 and 80 percent higher respectively.

- **Penalizes those staying in traditional Medicare:** As with any increase in Medicare Part B costs, the House- and Senate-proposed increases in payments to private plans would increase beneficiary premiums. This means that rural beneficiaries would pay higher premiums to subsidize private plans even if they lack access to the extra benefits offered by those plans.

- The House "premium support" provision would exacerbate this premium increase by changing the structure of Medicare financing beginning in 2010. The government would, in areas where private plans participate, cap its liability for costs, even for traditional Medicare. Although rural areas are less likely to have private plan participation and thus premium support, the premium impact would be greater if private plans emerged. The proposal could cause premiums to rise by $24 a month if fully implemented in 2010, an amount that would represent a larger percentage of rural beneficiaries' lower average Social Security checks.

As policy makers move toward final passage of this legislation, a number of changes could be made to the pending legislation to ensure that it protects and strengthens Medicare for rural beneficiaries. First, given the age, health, and income profile of rural beneficiaries, stronger protections for low-income and sicker beneficiaries should be considered. Making Medicare accessible for all beneficiaries, including the lowest-income seniors, as is done in the House bill, would help the larger proportion of rural beneficiaries who are enrolled in Medicaid and thus be disqualified under the Senate plan. However, the Senate bill's prescription drug subsidies for those above Medicaid eligibility limits are more generous than the House bill's. This assistance would be critical since near-poor rural beneficiaries are less likely to have prescription drug coverage and more likely to spend a high percentage of their income on prescriptions. In addition, since rural beneficiaries are more likely to be in poor health, defining the benefit would prevent private insurers from avoiding or cost shifting to rural seniors through high copayments on expensive drugs or high premiums.

Second, Congress should consider a more stable delivery system for the prescription drug benefit. The experience of the Medicare+Choice program promises greater private plan scarcity and volatility in rural versus urban areas. This suggests that rural beneficiaries should be given a choice of receiving the drug benefit through private insurers or a stable, non-risk bearing private plan. Short of that, defining larger service areas for prescription drug plans, ensuring that there is a "fallback" system in place if private plans do not serve rural areas, having multi-year contracts for plans, and letting fallback plans stay in areas vulnerable to under-service could lessen the volatility in prescription ding coverage that is likely to occur in rural America.

Third, Medicare subsidies for supplemental benefits should be allocated so that all beneficiaries, regardless of where they live or which delivery system they choose, receive the same level of Medicare assistance. Rather than exacerbating the benefit inequities caused by overpayments in the Medicare managed care system, the final legislation should use the proposed funding increase for this system to improve benefits for all beneficiaries or eliminate the proposed increases in cost sharing. Finally, the House bill's premium support proposal, while less likely to affect rural areas, would create a greater cost burden on rural versus urban beneficiaries given their lower income and already-high spending on Medicare cost sharing. It should be reconsidered. All together, these recommendations are intended to contribute to the goal of ensuring that the final Medicare prescription drug legislation meets the needs of this vulnerable group of Americans.

MEDICARE PRESCRIPTION DRUG LEGISLATION: WHAT IT MEANS FOR RURAL BENEFICIARIES

INTRODUCTION

After years of debate, the U.S. Congress has reached a key stage in the effort to add a prescription drug benefit to the Medicare program. Both the House and Senate passed legislation in June 2003, with the intention of enacting a Medicare prescription drug benefit this fall. Few policy makers, fewer experts, and virtually no seniors deny that this action is long overdue. The health and economic consequences of this major gap in Medicare's benefit package are well documented. However, the costs and complexities of providing a meaningful drug benefit to over 40 million people with significant medication needs have made it hard to develop consensus around proposals. In addition, the extent to which prescription drug legislation includes reform to the underlying Medicare program has been an obstacle. The House and Senate overcame these challenges to pass legislation, but they did so with different bills that may be difficult to merge. In addition, myriad other issues have surfaced in this complex legislation, ranging from the large, unintended effects that the proposals may have on retiree coverage to who defines the term "therapeutic class" for determining what drugs must be covered under the drug benefit.

A key question in the Medicare debate is the implication of the legislation on rural beneficiaries. Organization such as the National Rural Health Association[1] and the Rural Policy Research Institute (RUPRI)[2] have issued criteria to be used in developing legislation to meet rural beneficiaries' needs. In addition, a Presidential Commission presented a report to President Bush on guidance for Medicare reform in 2001.[3] Indeed, the legislation passed in both chambers of Congress has provisions aimed at addressing rural needs. Both bills include a set of policies that would increase various provider payments in rural areas. Both bills include explicit provisions to ensure that rural beneficiaries have access to pharmacies in the new prescription drug benefit. And the Senate proposal would direct various groups to monitor the impact of the legislation on rural areas.[4]

Despite this interest, little analysis to date has focused on what these House- and Senate-passed bills would mean for rural beneficiaries. This study offers such an assessment. Specifically, it provides new information on the need for a prescription drug benefit among rural beneficiaries, discusses the implications of the current proposals on rural beneficiaries, and identifies changes to the proposals that would reduce potential disparities in the treatment of rural residents. The report focuses on issues affecting beneficiaries' access to benefits and costs. As such, it does not address quality, overall drug pricing issues, and the rural health care provider payment provisions in the bills. It does assess the Medicare managed care changes, but does so from the viewpoint of its effect on access to supplemental benefits. The report is divided into five sections: the greater need for a Medicare drug benefit in rural America; the proposed Medicare legislation; the implications of the prescription drug benefit designs on rural beneficiaries; the implications of the proposed promotion of private plans on rural beneficiaries, and a discussion and recommendations section. The methodology is described in the appendix. The research aim is to provide policy makers, the public, and rural beneficiaries with information that could be used to ensure that the final Medicare prescription drug bill meets the needs of this vulnerable group of Americans.

GREATER NEED FOR A MEDICARE DRUG BENEFIT IN RURAL AMERICA

The elderly who live in rural America are often considered symbolic of the nation's past: former farmers, teachers, World War II veterans and others whose efforts paved the way for the current generation. In addition to the rural elderly, Medicare covers certain rural people with disabilities, who are a larger fraction of the rural than urban beneficiary population. Nine million Medicare beneficiaries live in rural America. Representing nearly one in four Medicare beneficiaries nationwide, rural beneficiaries comprise 60 percent or more of all beneficiaries in seven states (ID, IA, ME, MS, MT, SD, WY) (see Appendix). And, as younger people move out of rural areas and the baby boom generation begins to retire, rural beneficiaries' representation will grow.[5] In addition to their demographic importance, rural Medicare beneficiaries face special challenges to their health, access to health services, and economic well-being. Compared to urban beneficiaries, rural Medicare beneficiaries are:

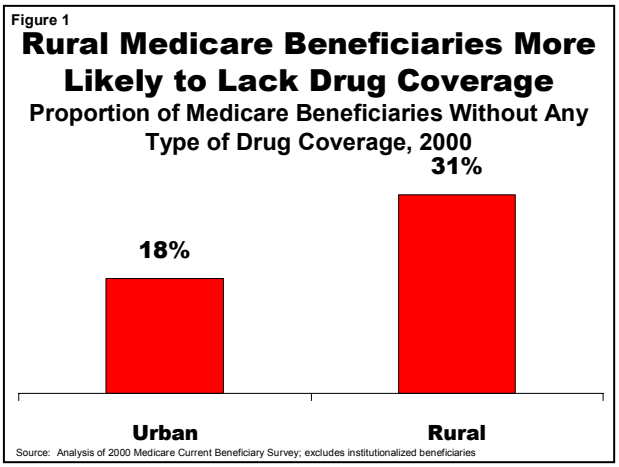
- **Older:** A larger proportion of the rural seniors are age 85 or older (7.8 versus 7.0%). In this age 85+ group, rural residents are more likely to be women (68.1 versus 64.5%) and to live alone (63.1 versus 60.5%).[6]

- **Sicker**: Rural Medicare beneficiaries are more likely to report fair to poor health than urban beneficiaries. This does not just reflect the greater proportion of rural beneficiaries with disabilities. In all age groups, rural seniors are more likely to be in worse health.[7] Rural beneficiaries, as with younger rural residents, are also more likely to have a chronic illness.[8]

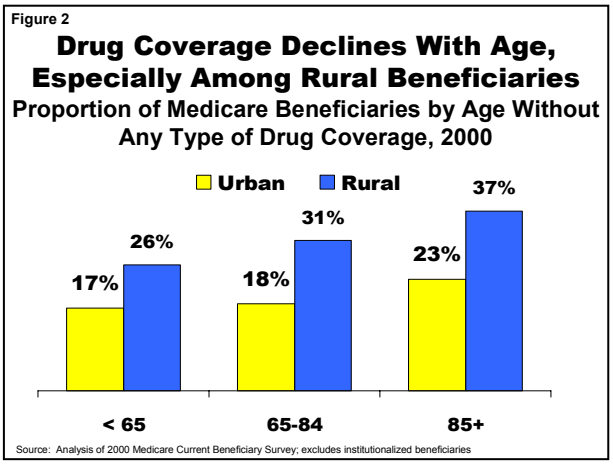
- **Poorer:** Compared to urban seniors, rural seniors have lower average income, higher poverty rates, and a greater reliance on Social Security income.[9]

Previous studies have also found that rural Medicare beneficiaries have a greater need for a prescription drug benefit.[10] This study provides new analyses from the 2000 Medicare Current Beneficiary Survey (MCBS) that compares rural and urban beneficiaries on their coverage and spending. The results are described below.

Lower rate of prescription drug coverage. The proportion of rural beneficiaries lacking any prescription drug coverage is nearly double that of urban beneficiaries. Nearly one in three (31% of) rural Medicare beneficiaries had no prescription drug coverage in 2000, compared to 18 percent of urban beneficiaries (Figure 1).

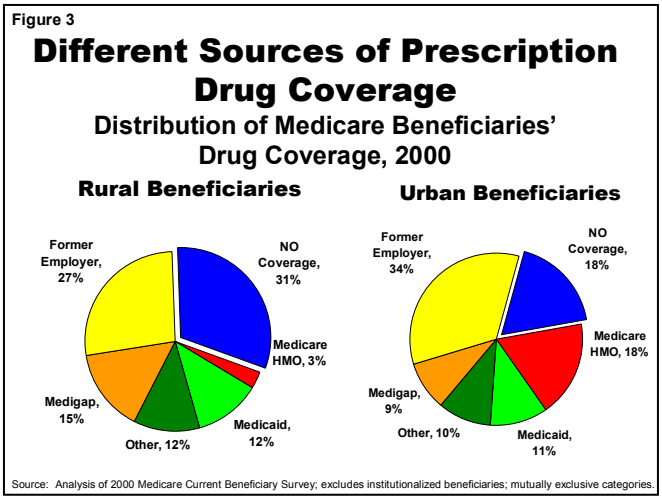


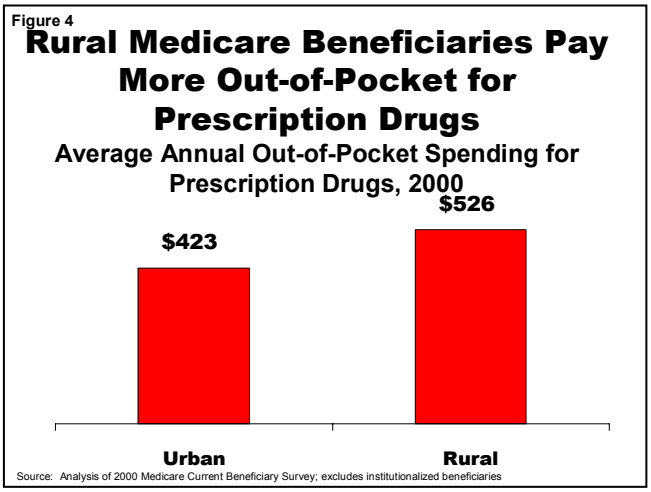
This disparity is greater for those in fair to poor health: amongst them, rural beneficiaries are over 70 percent more likely to lack drug coverage than urban beneficiaries (28 versus 16%) (Appendix).



The oldest rural beneficiaries are least likely to have drug coverage despite their greater need for it. About 37 percent of rural beneficiaries age 85 and older lacked drug coverage, compared to 23 percent of the oldest urban beneficiaries (Figure 2). This deterioration of coverage among the oldest rural residents may reflect their lack of access to sources of coverage like employer-sponsored retiree health plans and Medigap, and their lower participation in Medicare Health Maintenance Organizations (HMOs) when given the option.

Much lower Medicare managed care coverage. Historically, Medicare has subsidized prescription drug coverage by allowing private plans to use excess Medicare payments to pay for such coverage. However, rural beneficiaries have less access to such plans. This helps explain why only about 3 percent rural beneficiaries received coverage through Medicare HMOs, compared to 18 percent of urban beneficiaries (Figure 3). Rural seniors are also far less likely to have drug benefits from former employers, leaving them with few options except to buy coverage on their own through Medigap.





Higher out-of-pocket costs. Rural Medicare beneficiaries' average annual out-of-pocket spending on prescription drugs is about 25 percent higher than that of urban beneficiaries -- $526 versus $423 (Figure 4). While their out-of-pocket spending is higher, rural beneficiaries' total prescription drug spending is, actually, slightly lower than that of urban beneficiaries, despite their higher age and worse health. The most likely cause of this discrepancy is the much lower supplemental prescription drug coverage among rural beneficiaries.

Rural beneficiaries' combination of poor health, low levels of drug coverage, and low income create particular problems in gaining access to needed medications. A study of rural seniors in North Carolina found that 17 percent bought only part of the recommended prescription, and 15

percent took less medicine than prescribed.[11] Another study found that rural beneficiaries were 60 percent more likely than urban beneficiaries to forgo necessary prescriptions due to cost.[12]

PROPOSED MEDICARE LEGISLATION

Both Chambers of Congress passed legislation before the July 4th recess that would, most notably, add a prescription drug benefit to Medicare. By a one-vote margin (216 to 215), the House of Representatives passed H.R. 1, "Medicare Prescription Drug and Modernization Act of 2003." This legislation includes a standard prescription drug benefit that has a $250 deductible, 20 percent coinsurance through $2,000 in total costs, and an annual limit on out-of-pocket spending of $3,500 in 2006. The Congressional Budget Office (CBO) estimates that the benefit's average premium would be $35.50 per month.[13] Later on the same day (June 27, 2003), the Senate voted 76 to 21 in favor of S. 1, "Prescription Drug and Medicare Improvement Act of 2003." Its standard drug benefit in 2006 would have a $275 deductible, 50 percent coinsurance through $4,500 in total spending, and 10 percent coinsurance once annual out-of-pocket spending has exceeded $3,700. Its premiums are estimated to average $34 per month. The conference committee to reconcile differences in these bills was appointed on July 14, and adopted a schedule that would conclude its work in September 2003.[14]

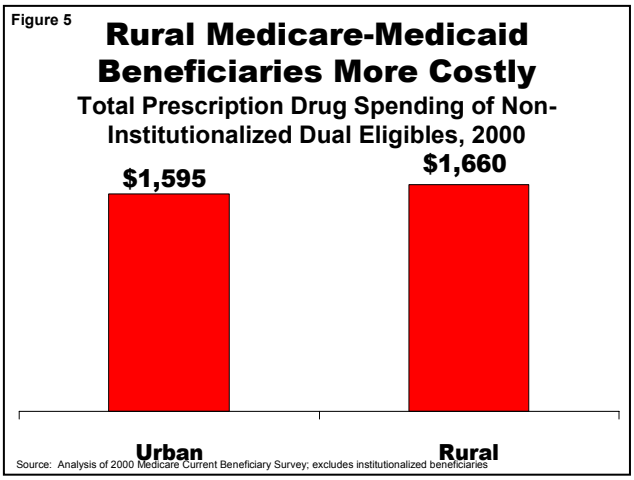
The House and Senate proposals are similar in a number of respects.[15] Both give private insurers the primary role in delivering the drug benefit. To facilitate insurer participation, the proposals would let them charge cost sharing that is different than the standard benefit, described above, within limits. Both bills would create a prescription drug discount card program aimed at reducing prices before the drug benefit is implemented in 2006. Both are estimated to cost about $400 billion over 10 years.[16] In addition to the creating a drug benefit, the bills include provisions on improving access to generic drugs, reducing payments for drugs already covered by Medicare, and re-importing drugs from other countries for sale in the U.S. They would reform Medicare's regulatory structure, create a new agency, and change numerous provider payment rates in the traditional program. Over the 2004-13 period, the bills would increase payments to rural health care providers by about $25 billion; increase Medicare cost sharing by $13 billion (House) and $29 billion (Senate), and increase payments to Medicare HMOs and preferred provider organizations (PPOs) by about $8 billion (without the Senate demonstration).[17]

Important differences exist as well. The House bill would exclusively rely on private insurers to deliver the drug benefit, not authorizing the use of non-risk bearing "fallback" plans in underserved areas, as is done in the Senate bill. In addition, the bills include very different policies regarding low-income beneficiaries. The Senate bill would prohibit low-income beneficiaries also eligible for Medicaid from enrolling in the Medicare drug benefit. The House bill would provide no financial assistance for low-income seniors above Medicaid eligibility limits for costs in the Medicare benefit "gap". Outside of the drug benefit, the House bill includes a premium support provision, called "FEHBP-style competitive reforms" that, beginning in 2010, would cap Medicare's contribution to all plans, including the traditional program in areas with two or more plans. The hundreds of pages of legislation contain numerous other differences as well.

IMPLICATIONS OF PRESCRIPTION DRUG BENEFIT DESIGNS ON RURAL BENEFICIARIES

In many respects, rural beneficiaries are no different than urban beneficiaries in their need for a universal, affordable, reliable prescription drug benefit in Medicare. Advocates and experts have examined these bills from this broader perspective.[18] This study focuses on those aspects of the proposals that would have a unique or disproportionate affect on those who live in rural America. To do so, it draws on new analysis of the current differences between rural and urban beneficiaries on a number of dimensions. Three major issues are identified, described below.

Fewer eligible for the drug benefit. Rather than creating a universal benefit, the Senate bill would exclude from the Medicare prescription drug benefit those beneficiaries who also qualify for Medicaid (called "dual eligibles"). Their lower average income means that a greater proportion of rural beneficiaries are dual eligilbes and would not qualify for the Medicare benefit (12.4 versus 10.5%).[19] Applying this relationship to the Congressional Budget Office's estimates of the number of dual eligibles in 2006, an estimated 1.7 million low-income rural beneficiaries would be prohibited from enrolling in the Medicare benefit.[20] This could result in worse prescription drug coverage for the lowest-income seniors. Since states share in Medicaid costs and have options to reduce Medicaid drug coverage, they will likely do so as the baby boom generation retires, increasing Medicaid long-term care costs as well as drug costs.



Not only do more dual eligibles live in rural areas, but their average drug costs are higher compared to their urban counterparts (Figure 5). This suggests that predominantly rural states would face a disproportionately larger cost burden if the final legislation requires states to continue providing drug coverage for poor Medicare beneficiaries through Medicaid.[21]

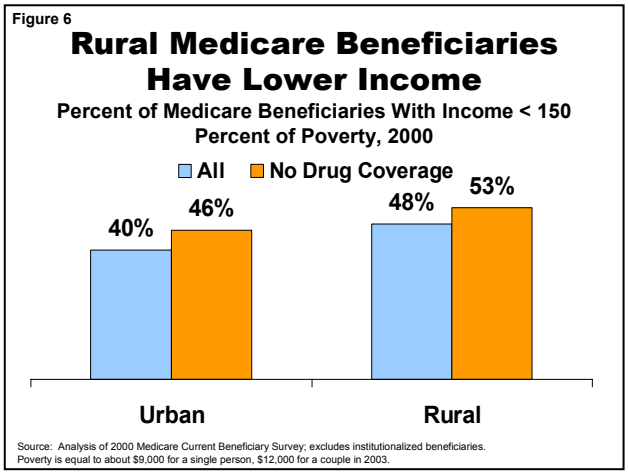
Less relief from high out-of-pocket drug costs. Both bills, to fit within budget constraints, would subsidize only a fraction of total prescription drug costs. Consequently, average beneficiaries would still pay for two-thirds of their current drug costs through premiums and cost sharing (Table 1). This level of out-of-pocket spending could prevent some seniors from purchasing needed drugs, especially if they have lower income. Both bills provide extra assistance for people with lower income. The Senate invests considerably more in this assistance, eliminating the benefit "gap" for beneficiaries with income below 160 percent of the poverty level ($19,200 per couple).

Table 1. Average Medicare Beneficiary Payments for Standard Prescription Drug Coverage in the H.R. 1 and S. 1, 2006

	House	Senate
Avg Total Costs*:	**$3,081**	**$3,127**
Annual Premiums*:	$426	$408
Deductible:	$250	$275
Coinsurance:	$350	$1,426
Gap:	$1,081	--
Total Out-of-Pocket:	**$2,107**	**$2,109**
As % of Total Costs:	***68%***	***67%***

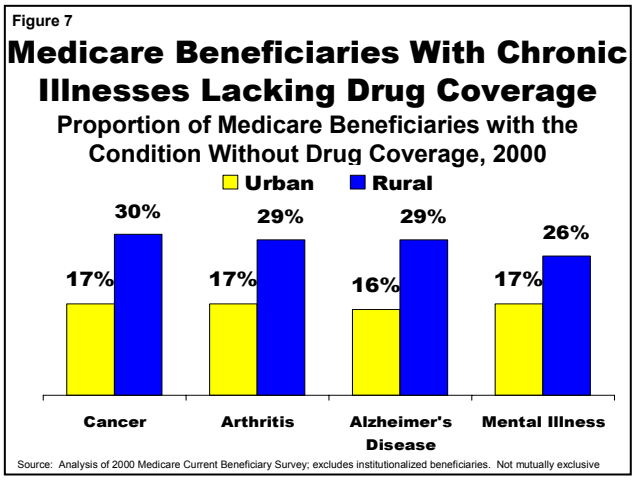
* CBO, 7/03

However, even with these protections, some low-income beneficiaries could still pay up to 15 percent of their income on out-of-pocket drugs cost sharing and premiums.[22] Adopting strong low-income protections is especially important for rural beneficiaries. Rural beneficiaries have lower income than urban beneficiaries generally, and over half of rural beneficiaries without prescription drug coverage have low income (Figure 6). While generally improving the standard benefits in both bills would assist rural beneficiaries, targeting any additional resources at strengthening the low-income provisions would probably result in a relatively greater reduction in out-of-pocket costs for rural beneficiaries.



Potentially higher drug cost sharing and premiums. The proposals do not include a defined Medicare benefit. Instead, they would create "standard benefits" that serve as yardsticks for insurers that want to change the cost sharing. For example, under the House bill, a private insurer could eliminate the gap by charging 47.8 percent coinsurance on all drug costs above the deductible but below the catastrophic limit.[23] In addition, an insurer could vary beneficiary copays across types of drugs. For instance, it could charge very high copay on an expensive but rare medication and a slightly lower copay on a less expensive but more common drug and still satisfy the bills' requirements.[24] The copayment structure could be a way for drug insurers to avoid sicker enrollees. Beyond the variable cost sharing, there would be no standard premium for drug coverage, as in the current Part B program. Medicare would adjust premium subsidies to plans for drug price (not utilization) variation and risk of enrollees and provide reinsurance. However, private plans would determine what beneficiaries pay and this could be higher for rural beneficiaries if their higher costs are not fully accounted for in the Medicare payments.

Rural beneficiaries would be particularly affected by the potential for higher cost sharing and premiums for sicker beneficiaries in the absence of a defined benefit. Rural beneficiaries are more likely to be in fair to poor health (32 versus 29%) and to have chronic diseases like cancer, diabetes and arthritis. In addition, as with all rural beneficiaries, chronically ill rural beneficiaries are more likely to lack any type of drug coverage (Appendix). For example, a rural senior with cancer is nearly twice as likely as an urban senior to lack drug coverage (30 versus 17 percent) (Figure 7). This coverage gap exists among those with Alzheimer's disease, chronic lung disease, mental disorders, and stroke.

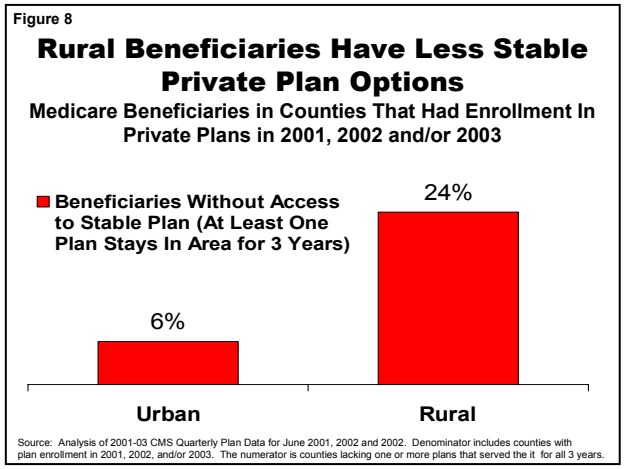


IMPLICATIONS OF PROMOTION OF PRIVATE PLANS ON RURAL BENEFICIARIES

Both Medicare proposals under consideration would, to different degrees, promote the role of private insurers in Medicare. The Senate bill would provide preferences to, and the House bill would require, that the new prescription drug benefit be delivered only through private insurers. The Senate bill, recognizing that private plans may not serve some, particularly rural areas, has a "fallback" provision that would allow Medicare to contract with organizations other than private insurers to deliver the drug benefit in rare circumstances. The House has no such provision.[25] In addition, both Medicare proposals under consideration would increase payments to and create new systems of paying Medicare HMOs and other private plans. Medicare managed care plans have typically used excess Medicare payments to subsidize supplemental benefits. This would increase under the legislation that would increase private plans rates and would require that private plans offer supplemental benefits like a limit on beneficiaries' annual out-of-pocket costs.

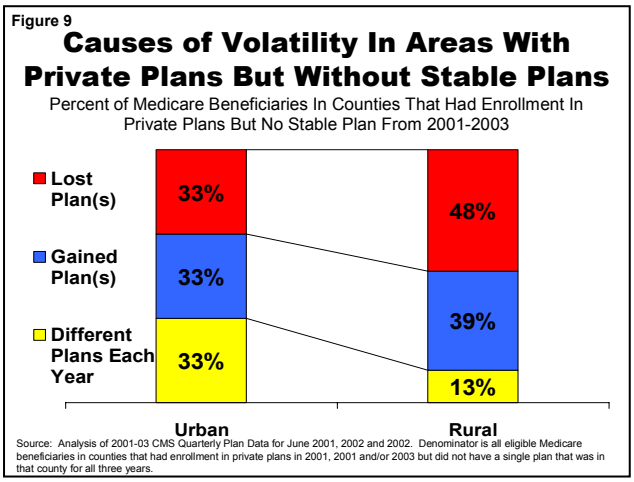
To assess the impact of these policies on rural beneficiaries, this study: (1) reviews evidence on rural beneficiaries' access to private plans; (2) provides new information on the recent stability of private plan participation in rural areas; and (3) discusses the implications of the proposed changes to Medicare's private plan system and the traditional program's premium on rural beneficiaries.

Lower access to private plans. To date, no major employer or insurer has paid for prescription drug coverage through a separate, risk-based prescription drug insurer. This raises questions about private insurers' interest in and ability to provide a prescription drug benefit to Medicare beneficiaries in general, let alone rural beneficiaries. The experience in Medicare managed care plans offers lessons for the challenges facing a system that relies on private insurers. Despite years of effort, a much lower proportion of rural Medicare beneficiaries have access to private plans for the delivery of health benefits. In 2003, 13 percent of rural beneficiaries have access to a Medicare coordinated care plan compared to 72 percent of urban beneficiaries, according to the Medicare Payment Advisory Commission (MedPAC). When talking into account other types of private plans like private fee-for-service, 61 percent of rural beneficiaries have access to a private plan compared to 85 percent of urban beneficiaries – a smaller difference, but still one that leaves nearly 30 percent fewer rural beneficiaries with a private plan option.[26] It is important to note that the additional private plan options available to rural beneficiaries rarely provide supplemental benefits like prescription drugs. This lack of managed care plans in rural areas is generally attributed to three factors: the challenges in developing provider networks, the low density of the population, and the inability to gain savings by reducing utilization, which, despite rural seniors' worse health status, is not high relative to most standards.[27]



Greater volatility of private plans. A less-studied concern about private plans is their stability in sparsely-populated areas. The recent "pull-outs" of managed care plans from Medicare have demonstrated that continuity

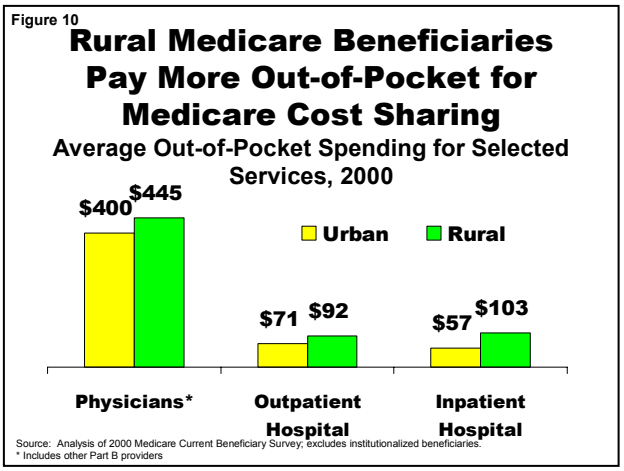
matters to beneficiaries.[28] To assess whether private plan participation is more or less volatile in Medicare, this study examined patterns of plan participation in counties with some enrollment in private plans (HMOs, private fee-for-service plans, etc.) in the years 2001, 2002 and/or 2003. It found that, even in rural areas that private plans have opted to serve, plan participation was more volatile than it was in urban areas. Rural beneficiaries who had access to a private plan during this period were four times more likely to experience plan instability, meaning that there was no private plan that stayed in their county for the entire period (24 versus 6%) (Figure 8).[29] In five predominantly rural states, not one private plan came and participated in Medicare for all of the 2001-03 period. These states are Alaska, Maine, Montana, South Dakota and Vermont. In addition, no rural areas in Delaware, New Hampshire and South Caroline had stable access to private plans. In rural areas, nearly half of those experiencing this volatility had lost access to plans, whereas in urban areas, an equal proportion of beneficiaries had gained and lost access to private health plans (Figure 9).



These findings suggest that even if private plans emerge to deliver the prescription drug benefit in rural areas, beneficiaries in those areas could be forced to change plans more often due to private plan turnover. This may cause problems beyond inconvenience. Since the proposals would provide insurers with the ability to use a formulary and vary cost sharing, the amount that a rural senior pays for the same prescription could change from year to year.

Exacerbates benefit inequity. Both proposals would continue the current system that allows Medicare overpayments to private plans that deliver the core Medicare benefits to be used to subsidize extra benefits for enrollees. In addition, the legislation would increase private plan payment rates which are currently paid about 4 percent more than it would cost to deliver the same services in the traditional program.[30] Medicare experts have suggested that private plans like PPOs would have to be paid well above the average traditional Medicare costs to participate[31] – meaning that increased use of private plans in Medicare could worsen rather than strengthen Medicare's long-run financing outlook. CBO estimates that private plan payment increases in the Medicare bills would cost from $6 to $8 billion from 2004 to 2013 (excluding the House's 2010 "premium support" policy and Senate 2009 PPO demonstration). These payment changes would increase enrollment from 8 to 11 percent, under CBO assumptions.[32] However, the other official estimator of Medicare costs, the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS), projects that, without the House premium support provision, private plan enrollment could reach 43 percent by 2010.[33] It has not released its estimates of the cost associated with this much-higher enrollment projected, but if the Medicare cost increase is commensurate with the coverage increase, costs could be up to 4 times higher, or $32 billion over the period. This is in addition to the relief that private plans would get with the passage of a Medicare-subsidized prescription drug benefit.

Since private plan rates are already higher than the cost of traditional Medicare in rural areas, it is not clear that these extra payments, and, thus, subsidized benefits, would benefit rural Medicare beneficiaries. However, the size of this investment is large enough that it could be reallocated to improve Medicare's preventive service coverage or start down a path of providing catastrophic cost protection in Medicare for all of its beneficiaries, irrespective of plan choice. Maintaining current payment levels for private plans would also allow conferees to eliminate the increases in beneficiary cost sharing proposed in both bills.[34] In each bill, the cost of the private plan payment increase is about the same as the savings achieved by these policies. These cost sharing increases would disproportionately affect rural beneficiaries given their lower average income and already-higher out-of-pocket burden. Compared to urban beneficiaries, rural beneficiaries' out-of-pocket spending on Medicare-covered provider services, outpatient hospital and inpatient hospital care is 10, 30 and 80 percent higher respectively (Figure 10).



Penalizes those staying in traditional Medicare. As with any increase in Medicare Part B costs, all beneficiaries would share in the private plan cost increases through higher premiums. This means that, under both proposals, rural beneficiaries would pay higher premiums even if they lack access to the extra benefits offered by private plans, which are subsidized, in part, through those premiums. The Senate bill, in addition to the rate increases, would authorize a $6 billion demonstration to promote participation of PPOs.[35] The cost of this, too, would be borne in part by beneficiaries in the traditional program who might lack access to this option.

The House "premium support" provision would, beginning in 2010, change the structure of Medicare premiums. The government would, in areas where private plans participate, cap its liability for costs, even for traditional Medicare. This means that if two or more private plans were to come to a rural area, then beneficiaries' premiums for staying in traditional Medicare could go up, even if they do not join a private plan.[36] The impact of this provision is quite uncertain. CBO projects that it could both increase and decrease premiums in traditional Medicare under different circumstances.[37] The CMS Actuaries put an upper bound on the potential effect, suggesting that the proposal could raise Medicare's Part B premiums by 25 percent.[38] This would translate into about a $24 per month increase in the Medicare premium if the proposal were fully implemented in 2010. One analysis found that this increase, coupled with the Part B deductible increase, would eliminate the average Social Security cost-of-living adjustment when fully effective.[39] Although private plans are less likely to go to rural areas, in 2003, about 1.4 million rural beneficiaries lived in areas with access to two or more private plans which would trigger premium support.[40] The premium impact of premium support would disproportionately affect rural seniors, given their lower average Social Security checks and higher average out-of-pocket spending on health care.[41]

DISCUSSION AND RECOMMENDATIONS

Congress is on the verge of enacting a Medicare prescription drug benefit – an historic opportunity and challenge. Both the House and Senate bills would invest about $400 billion over 10 years in a prescription drug benefit that has features that would help all beneficiaries as well as rural beneficiaries. For example, both bills provide some level of protection against excessive out-of-pocket drug costs and ensure convenient access to pharmacies. The proposals contain various provisions to improve Medicare's care coordination, preventive benefits, and payment systems for rural health care providers. And some provisions would make prescription drugs more affordable for nonelderly Americans.

That said, the Medicare proposals currently being considered include provisions that would not lessen the current disadvantages faced by rural beneficiaries and, in some cases, could exacerbate them. Rural beneficiaries have lower income and thus a greater proportion would be excluded from the Senate Medicare benefit that denies coverage to Medicare-Medicaid dual eligibles. The greater proportion of near-poor rural beneficiaries would be left unprotected from the "gap" in the House plan. In addition to the problems associated with having lower income, rural beneficiaries are more likely to have chronic illnesses like arthritis or cancer. Without a defined benefit, private insurers could vary the cost sharing to discourage enrollment of less healthy and more expensive beneficiaries who disproportionately live in rural areas. For the same reasons, the insurer-set premiums for drug coverage could be higher in rural areas.

The prescription drug benefit's delivery system in both plans would be part of a larger effort to promote the use of private health insurance in Medicare. The drug benefit would be delivered exclusively by private insurers in the House bill. If past is prologue, it would be a challenge attracting private plans to all rural areas. Even if the proposal succeeded, this study suggests that rural beneficiaries would experience less continuity and greater turnover in plans: 4 times the proportion of rural beneficiaries who had some access to private plans in Medicare did not have a single plan that stayed for three consecutive years. In addition, legislation would significantly increase payments to private plans, exacerbating the differential between urban and rural beneficiaries' access to Medicare-funded supplemental benefits. Not only would rural seniors generally have less access to private plans' extra benefits, the proposed payment rate increases would result in higher premiums for rural beneficiaries. Finally, the House plan's provision that would cap Medicare's contribution to the traditional program could result in premium increases that would be harder to afford for lower-income rural beneficiaries.

As policy makers move toward final passage of this legislation, a number of changes could be made to ensure that it protects and strengthens Medicare for rural beneficiaries. First, given the age, health, and income profile of rural beneficiaries, stronger protections for low-income and sicker beneficiaries should be considered. Making the Medicare prescription drug benefit accessible to all beneficiaries, as is done in the House bill, would help the larger proportion of rural beneficiaries who are enrolled in Medicaid and thus disqualified under the Senate plan. Indeed, this change is essential to making this drug benefit universal, meaning that all beneficiaries, irrespective of where they live or their financial circumstances, would be eligible for it.[42] While the Senate bill is weaker in its treatment of the lowest-income seniors, it would provide more generous prescription drug subsidies for those with income above Medicaid

eligibility limits. Specifically, it would eliminate both the Medicare coverage gap prior to reaching the catastrophic limit for low-income beneficiaries and the "assets test" for certain types of assistance, increasing the number of seniors who qualify for help. Yet, to truly help low-income rural beneficiaries, the final legislation would need to improve upon the Senate bill's protections as well, since its average out-of-pocket drug costs would consume 15 percent of certain low-income beneficiaries' income, according to a recent study.[43]

Along the same lines, the profile of rural beneficiaries shows that they tend to be sicker and thus would especially benefit from a defined prescription drug benefit. Both proposals would provide private insurers wide latitude in setting the cost sharing generally and across different types of drugs. This could lead to sicker beneficiaries paying higher cost sharing or being discouraged from enrolling in a plan (adverse selection). For example, a private plan's coinsurance could be set low (e.g., 10%) for initial costs but could increase as costs rise (e.g., 80% for expenditures just before the coverage gap). This could be addressed by having the standard benefits in both bills serve as the upper limit rather than the average target for cost sharing.[44] In addition, private insurers would be permitted to charge very high copays for expensive but rare medications and slightly lower than average copays on less expensive but more commonly used drug. The bills could require that the coinsurance for covered drugs be the same across all types of drugs.[45] The prescription drug premiums as well as the cost sharing would be set by private insurers under the bills. Having the government pay for full geographic cost variation (not just price differences) would help insulate rural beneficiaries from paying relatively higher premiums due to their greater need. Limits could also be placed on both the variation in drug premiums charged to beneficiaries across the nation as well as annual increases in premiums to provide greater predictability for rural seniors who typically pay Medicare premiums from lower-than-average, fixed Social Security checks.

Second, Congress should consider a more stable delivery system for the prescription drug benefit. The experience of the Medicare+Choice program promises greater private plan scarcity and volatility in rural versus urban areas. This suggests that rural beneficiaries should be given a choice of receiving the drug benefit through private insurers or a stable, non-risk bearing private plan (e.g., pharmaceutical benefit manager). This would mitigate against the access problems that could result from frequent changes in drug coverage for rural seniors, which would likely occur under both bills. Short of providing this choice, the legislation could specify the minimum size of service areas for prescription drug plans, improving the odds that private plans serve rural America.[46] For example, the legislation could require that private drug insurers serve an area with no fewer than one-tenth of the Medicare population.[47] In addition, having a "fallback" system of non-risk bearing plans in place would mitigate against possible access problems that could occur in the event that private plans do not serve rural areas. While the Senate bill contains such a fallback plan, it could be strengthened by allowing organizations that provide fallback coverage to operate under the same rules as private plans (e.g., having a multi-year contract with Medicare). The legislation could, as well, allow a fallback option to stay in areas that are susceptible to under-service, even if a private plan returns, given the greater likelihood that the return is temporary. These policy changes would lessen the volatility of prescription drug coverage that is likely to occur in rural America under these proposals.

Third, Medicare subsidies for supplemental benefits should be allocated equitably so that all beneficiaries, regardless of where they live or which delivery system they choose, receive the same level of Medicare assistance. Rather than exacerbating the benefit inequities in the current Medicare managed care system, the final legislation could use the $8 to $12 billion in funding for the PPO demonstration and private plan rate increases to improve benefits for all beneficiaries. For example, benefits recommended by the U.S. Preventive Services Task Force that are not now covered by Medicare[48] probably could be added to the program for the cost of the private plan payment increases. New payment systems for chronic disease management, care coordination for high-cost cases, and incentives for quality could be tested or funded with this investment. And, a catastrophic limit on all Medicare cost sharing, not just for prescription drugs, could be phased in for all Medicare beneficiaries, not just those in private plans. Alternatively, this funding could be used to eliminate the proposed increases in Medicare cost sharing. Rural beneficiaries would be disproportionately affect by these changes given their already-higher out-of-pocket spending for Medicare services and lower average income. For the same reasons, the House bill's premium support proposal, while less likely to be implemented in rural areas, would create a greater cost burden on rural versus urban beneficiaries and should be reconsidered.

Many of these recommendations are consistent with those suggested by rural health experts and others. A RUPRI Rural Health Panel, recognizing the special needs of rural Medicare beneficiaries, emphasized the importance of making the prescription drug benefit affordable, especially to low-income beneficiaries. It also recommended "that premiums charged to rural beneficiaries should not vary because they live in rural areas (consistent with historical Medicare policy as evidenced by the Part B premiums)."[49] The suggestions on improving the stability of the prescription drug delivery system echo those of a National Rural Health Association expert panel that recommended that the "government should also offer a base (default) plan" to ensure affordable access.[50] And, on the role of private plans, the Advisory Committee on Rural Health, chaired by former Senator Nancy Kassebaum Baker, wrote, "The real policy issue is not about getting more managed care plans into rural counties but rather about equity of benefits for rural beneficiaries."[51] These policy changes have also been considered in alternative legislation, amendments, and by broader aging advocate groups.[52] The passage of a Medicare prescription drug benefit is, perhaps, more important to rural beneficiaries, given their greater need and lower coverage today, but improvements should be made to ensure that the legislation meets its promise for these rural Americans.

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APPENDIX
Medicare's Rural Beneficiaries By State, 2003

	Rural Beneficiaries	Percent of All Beneficiaries		Rural Beneficiaries	Percent of All Beneficiaries
Alabama	229,014	32%	Montana	90,268	66%
Alaska	24,657	55%	Nebraska	142,621	56%
Arizona	107,501	14%	Nevada	38,907	14%
Arkansas	267,822	58%	New Hampshire	82,349	45%
California	184,502	4%	New Jersey		0%
Colorado	94,181	19%	New Mexico	115,753	45%
Connecticut	46,873	9%	New York	251,988	9%
Delaware	35,474	29%	North Carolina	471,135	39%
District of Columbia		0%	North Dakota	50,104	58%
Florida	239,200	8%	Ohio	348,538	20%
Georgia	343,892	36%	Oklahoma	241,663	45%
Hawaii	49,270	27%	Oregon	181,012	34%
Idaho	119,384	65%	Pennsylvania	361,974	17%
Illinois	354,033	21%	Rhode Island	14,508	8%
Indiana	275,278	31%	South Carolina	206,616	33%
Iowa	287,822	60%	South Dakota	55,258	60%
Kansas	190,077	49%	Tennessee	343,541	38%
Kentucky	369,726	56%	Texas	528,938	22%
Louisiana	172,254	27%	Utah	65,131	29%
Maine	144,268	62%	Vermont	62,287	72%
Maryland	65,730	9%	Virginia	287,453	30%
Massachusetts	14,589	1%	Washington	179,391	22%
Michigan	295,939	20%	West Virginia	212,475	59%
Minnesota	266,826	39%	Wisconsin	311,605	38%
Mississippi	307,501	68%	Wyoming	48,459	69%
Missouri	333,972	37%	**U.S.**	**9,511,759**	**23%**

Source: Calculated from data from the Centers for Medicare and Medicaid Services. Note: these data are from the eligibility files for the managed care plan penetration. The latest official state and county counts of Medicare beneficiaries are for 2001.

Note: A study from Families USA (May 2003) found a much larger number or rural beneficiaries in North Dakota (68,181) and South Dakota (85,738).

Percentage of Urban and Rural Non-Institutionalized Medicare Beneficiaries Who Lacked Prescription Drug Coverage, 2000

	Urban	Rural
Total	18%	31%
Age		
< 65	17%	26%
65-84	18%	31%
85 +	23%	37%
Health Status		
Fair / Poor	16%	28%
Self-Reported Chronic Illness		
Heart condition	16%	25%
Cancer	17%	30%
Arthritis	17%	29%
Chronic lung disease	13%	23%
Mental disorder	17%	26%
Alzheimer's disease	16%	29%
Diabetes	13%	24%
Hypertension	16%	27%
Stroke	17%	31%

Source: Authors' analysis of the Medicare Current Beneficiary Survey 2000. Does not include institutionalized persons.

METHODOLOGY

Data from the 2000 Medicare Current Beneficiary (MCBS) Cost and Use file were used to study prescription drug coverage, expenditures and use across urban and rural residence. The MCBS is a longitudinal panel survey of a representative national sample of the Medicare population conducted under the auspices of the Centers for Medicare and Medicaid Services. Begun in the fall of 1991, over 12,000 Medicare beneficiaries are interviewed three times a year using computer assisted personal interviewing. MCBS interviewers collect extensive information on individuals' use and expenditures for health services including source of payment, as well as information on health insurance, access to care, health and functional status, socioeconomic status, and demographic characteristics. Prescription drug utilization data in the MCBS are based on self-reports of each prescription filled and refilled during the year. To assure accurate recall, respondents are asked to keep bill records and prescription containers to show interviewers during the thrice-yearly interviews.

Our sample consisted of disabled and aged Medicare beneficiaries living in the community. We excluded persons who lived in institutional facilities throughout the entire year because drug use data for this population are not available. We categorized the sample as living in rural or non-rural areas as defined by the MCBS, which takes this information from the administrative records of the Centers for Medicare and Medicaid Services. The MCBS defines "rural" as counties that do not lie within a Metropolitan Statistical Area (MSA). By this definition, rural areas include counties that are contiguous to urban centers but are not part of the MSA. Our unweighted samples sizes are: 3,361 beneficiaries in rural areas and 8,616 beneficiaries in nonrural areas.

The data for the analysis of the stability of private plan participation in Medicare came from the Medicare managed care market penetration state/county/plan files from June 2001, 2002 and 2003.[53] Counties were considered rural if they were not classified as part of an MSA according to the OMB/ Census Bureau.[54] The analyses excluded the territories, a small number of counties with incomplete data, and enrollment in the United Mine Workers Association plan (due to its distinction from other types of Medicare plans). "Plan" throughout the study means one type of benefit offering offered by an organization; the same organization can offer multiple plans. Because the authors were interested in access within counties that have had active private plan participation, only those counties where there was minimum enrollment (11 enrollees) in the last three years were included.[55] Each county was placed into one of four categories: (1) stable plan(s): the county had at least one plan that has served the county for all three years; (2) changing plans: the county had enrollment in private plans in each year, but no single plan stayed for all three years; (3) gained plan(s): the county did not have an active plan in 2001 and/or 2002 and gained one or more in 2002 or 2003; and (4) lost plan(s): the county had a plan in 2001 and/or 2002 and lost it in 2002 or 2003. The number of eligible Medicare beneficiaries in each county for 2003 was summed by plan category and tabulated separately for rural and urban counties to produce the results described in this study.

The analysis was done twice, using both the broadest and narrowest types of Medicare private plans to assess whether the results differed. Typically, analysts only use the HMO, PPO and provider sponsored organizations (PSOs) (coordinated care plans) in assessing the program.

This is because these types of plans generally meet the traditional definition of managed care plans and are paid for under the rules of the Medicare+Choice program. However, recently, the emergence of private fee-for-service plans and, to a lesser extent, the PPO demonstration plans has significantly increased access to private plans in rural areas. Thus, to be conservative, the results highlighted in this paper use the broadest definition of private plans, including any type of private plan or demonstration, although the results using the narrower group of managed care plans were consistent.

NOTES AND REFERENCES

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[1] National Rural Health Association (NRHA). (2003). *Protecting Rural Beneficiaries with a Medicare Prescription Drug Benefit.* Alexandria, VA: NRHA.

[2]See A.F. Coburn and E.C. Ziller. (August 31, 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*. Omaha, NE: RUPRI P2000-14; K.J. Mueller. (October 7, 2002). *The Rural Beneficiary Need for a Medicare Drug Benefit Delivered Through the Rural Delivery System.* Presentation delivered to Congressional Staff Briefing.

[3] National Advisory Committee on Rural Health. (May 2001). *Medicare Reform: A Rural Perspective.* A Report to the Secretary, U.S. Department of Health and Human Services.

[4] The Senate bill would have the Medicare Payment Advisory Commission and the newly-created Medicare Competitive Advisory Board assess access and competition in rural areas. It would also create the Office of Rural Health Policy to monitor grants relating to rural health.

[5] See Economic Research Service (ERS). (May 28, 2002). *Briefing Room: Rural Population and Migration: Rural elderly.* Washington, D.C.: U.S. Department of Agriculture.

[6] ERS, 2002.

[7] ERS, 2002.

[8] Center on an Aging Society. (January 2003). *Rural and Urban Health: Health Care Service Use Differs.* Washington, DC: Georgetown University, Data Profile Number 7.

[9] ERS, 2002.

[10] National Economic Council / Domestic Policy Council (NEC/DPC). (June 13, 2000). *Prescription Drug Coverage & Rural Medicare Beneficiaries: A Critical Unmet Need.* Washington, DC: The White House.

[11] J. Mitchell, H.F. Mathews, L.M. Hunt et al. (June 2001). "Mismanaging prescription medications among rural elders: The effects of socioeconomic status, health status, and medication profile indicators," *The Gerontologist* 41(3): 348-356.

[12] NEC/DPC, 2000.

[13] Congressional Budget Office (CBO). (July 22, 2003). *Cost Estimate: H.R. 1, Medicare Prescription Drug and Modernization Act of 2003 and S. 1, Prescription Drug and Medicare Improvement Act of 2003.* Washington, DC: CBO.

[14] This schedule is posted on the U.S. House of Representatives, Committee on Ways and Means website: http://waysandmeans.house.gov/media/pdf/hr1/hr1calendar.pdf

[15] For a thorough comparison of the bills, see Health Policy Alternatives. (August 8, 2003). *A Side-by-Side Comparison of the Prescription Drug Coverage Provisions of S.1 and H.R. 1*. Washington, DC: The Henry J. Kaiser Family Foundation.

[16] The House bill includes a last-minute addition that would provide $174 billion over 10 years in tax breaks to non-elderly people purchasing certain types of medical savings accounts. See E. Park, J. Friedman, A. Lee. (July 8, 2003). *Health Savings Security Accounts: A Costly Tax Break that Could Weaken Employer-Based Health Insurance.* Washington, DC: The Center on Budget and Policy Priorities. Because it has a revenue rather than an outlay effect, it is considered under separate budget rules than the Medicare provisions.

[17] CBO, July 22, 2003.

[18] M. Moon. (June 6, 2003). "Getting It Right: Issues for Medicare Reform," Testimony before the Senate Finance Committee; AARP, Letter to Congress, July 14, 2003: http://www.aarp.org/press/statements/2003/st071403.html

[19] Note that these rates of Medicaid enrollment among Medicare beneficiaries excludes people in institutions who are typically covered by Medicaid. As such, other studies suggest a larger proportion of Medicare beneficiaries are dual eligibles.
[20] This was calculated by multiplying the proportion of rural Medicare-Medicaid dual eligibles by CBO's projected total number of Medicare beneficiaries fully eligible for Medicaid benefits (distributed to Congressional staff in June 2003).
[21] Governors unanimously oppose this Senate provision (see http://www.nga.org/nga/legislativeUpdate/1,1169,C_LETTER^D_5783,00.html). For a description of this policy and its potential implications, see M. Nathanson, E. Park, R. Greenstein. (July 31, 2003) *Senate Prescription Drug Bill Would Exclude Millions of Low-Income Beneficiaries.* Washington, DC: Center on Budget and Policy Priorities,
[22] D.G. Shea, B.C. Stuart, B. Briesacher. (August 2003). *Caught In Between: Prescription Drug Coverage of Medicare Beneficiaries Near Poverty*. New York: The Commonwealth Fund.
[23] American Academy of Actuaries. (July 203). Actuarial *Equivalence of Medicare Prescription Drug Benefits*. Luncheon Briefing Sponsored by the American Academy of Actuaries and the Society of Actuaries. Washington, DC.
[24] For an example of this type of practice, see R. Langreth. (March 31, 2002). "The New Drug War," *Forbes.com*
[25] Both bills would allow Medicare to reduce the amount of risk that plans bear to encourage participation in underserved areas.
[26] Medicare Payment Advisory Panel (MedPAC). (June 2003). *A Data Book: Healthcare Spending and the Medicare Program*. Washington, DC: MedPAC.
[27] Medicare Payment Advisory Commission. (MedPAC). (June 2001). *Report to the Congress: Medicare in Rural America*. Washington, DC: MedPAC.
[28] See M. Gold, N. Justh. (September 2000). *Forced Exit: Beneficiaries in Plans Terminating in 2000*. Washington, DC: Mathematica's Monitoring Medicare+Choice, Fast Facts #3. T. McBride. (July 26, 2000). "Withdrawals from Medicare Managed Care Plans will Harm Rural Residents", http://www.missouri.edu/~news/releases/junjul00/rupri.html
[29] This analysis includes all types of private plans participating in Medicare, including private fee-for-service. The authors also conducted the same analysis using only HMOs, PPOs, and PSOs. The results were similar: the proportion of rural beneficiaries experiencing plan volatility was four times higher than that of urban beneficiaries (35 versus 7%).
[30] MedPAC, 2003.
[31] P. Ginsberg. (April 10, 2003). Letter to Senator Baucus regarding the potential for private plans in the Medicare program to achieve lower spending; R. Pear. (May 6, 2003). "Plan to Overhaul Medicare by Enlarging Role of Private Plans is Criticized," *The New York Times,* P. A28.
[32] CBO, July 22, 2003.
[33] Centers for Medicare and Medicaid Services, Office of the Actuary. (June 26, 2003). Memorandum to Representative Charles B. Rangel on the Estimated Impact of H.R. 1 on Premiums for Fee-for-Service Beneficiaries in 2010 and Later. Baltimore, MD: CMS, U.S. Department of Health and Human Services.
[34] Both would increase the Part B deductible by indexing it (to general inflation in the Senate and program growth per capita in the House). The Senate bill would add a 20 percent coinsurance to lab services and the House bill would add a co-payment for home health services.
[35] It would allow PPOs to be paid purely based on their bids, ideally in competitive regions, but exceptions are allowed for underserved areas.
[36] The legislation would phase in premium increases in areas newly part of the premium support system.
[37] CBO, July 22, 2003.
[38] CMS Office of the Actuary, June 26, 2003.
[39] Joint Economic Committee Democrats. (July 2003). *House Medicare "Reform" Proposal Would Wipe Out Social Security COLAs for Many Seniors.* Washington, DC: JEC.
[40] Families USA. (May 2003). *Managed Care Plans Offer No Real Choice for Rural Medicare Beneficiaries.* Washington, DC: Families USA.
[41] This study has focused only on the differential impact of this proposal on rural beneficiaries. For a broader assessment of premium support, see for example, T. Rice and K.A. Desmond. (February 7, 2002). *An Analysis of Reforming Medicare through a "Premium Support" Program.* Menlo Park, CA: The Kaiser Family Foundation.
[42] R.D. Reischauer. (July 16, 2003). "When More Means Less," *The New York Times.*
[43] Shea, Stuart and Briesacher, 2003.

[44] Under this change, private insurers could offer lower coinsurance but all beneficiaries, especially those in rural area that are more vulnerable, would pay no more than 20 percent in the House (50 percent in the Senate) for prescriptions that are filled before the coverage gap begins.
[45] This would mean that if a plan set its coinsurance for a set of expenditures as 50 percent, the preferred drug in each therapeutic class would have a 50 percent coinsurance.
[46] One study suggests that larger services areas could improve access to Medicare+Choice plans in rural areas. See T. McBride, C. Andrews, K. Mueller and M. Shambaugh-Miller. (May 2003). *Draft: Availability and Use of Health Plan Choices in Rural America: Medicare+Choice, Commercial HMOs, and Federal Employees Health Benefit Program Plans*. Omaha, NE: RUPRI Center for Rural Health Policy Analysis.
[47] The Senate bill provides greater guidance than the House bill on defining service areas. For example, a service cannot be smaller than a state and must include at least one state.
[48] MedPAC, June 2002.
[49] Coburn and Ziller, 2001, p. 7.
[50] NRHA, 2003, p. 4.
[51] National Advisory Committee on Rural Health, May 2001, p. 36.
[52] See, for example, AARP, Letter to Congress, July 14, 2003: http://www.aarp.org/press/statements/2003/st071403.html
[53] CMS website (http://www.cms.gov/healthplans/statistics/mpscpt/)
[54] (http://www.census.gov/population/estimates/metro-city/a99mfips.txt)
[55] Note: using only counties with plan enrollment may understate access, since it may be the case in rural areas that a private plan is accessible but simply has no enrollees.