rupri

rural policy research institute

IOWA STATE UNIVERSITY • UNIVERSITY OF MISSOURI • UNIVERSITY OF NEBRASKA

Improving Prescription Drug Coverage for Rural Medicare Beneficiaries:

Key Rural Considerations and Objectives For Legislative Proposals

June 30, 2000

P2000-8

A Joint Policy Paper of the

Maine Rural Health Research Center
and the
RUPRI Rural Health Panel

Principal Authors:

Andrew F. Coburn, Ph.D. and Erika C. Ziller, M.S.
Maine Rural Health Research Center

Other Panelists:

Chuck Fluharty
J. Patrick Hart, Ph.D.
A. Clinton MacKinney, M.D., M.S.
Timothy McBride, Ph.D.
Keith Mueller, Ph.D., Chair
Rebecca Slifkin, Ph.D.
Mary Wakefield, Ph.D., M.S.N.

The Rural Health Panel of the Rural Policy Research Institute (RUPRI) receives continuing support from RUPRI, the result of a Congressional Special Grant, administered through the Cooperative State Research, Education, and Extension Service, U.S. Department of Agriculture. The Federal Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services, also provides support for this Panel's work.

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

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This *Policy Paper* combines the work from current projects of the Maine Rural Health Research Center (MRHRC) and the Rural Health Panel of the Rural Policy Research Institute (RUPRI) to provide a statement of specific rural considerations and objectives for any proposal that would add a prescription drug benefit to the Medicare program. Our intent is to establish a framework for assessing the effects of proposals on rural beneficiaries. The framework is applied to three proposals currently being considered by the 106th Congress.

The Rural Differential Challenge in Prescription Drug Coverage

- The percent of all elderly who live below 200 percent of the federal poverty level: rural: 52.3%, urban: 41.2%. (AHRQ 2000; AHRQ 1998)
- The percent of seniors without prescription drug coverage, 1995 (Poisal et al. 1999): rural: 46.1%, urban: 30.1%, *a 50% difference*
- The percent of seniors with private Medicare supplemental insurance covered by a group plan (AHRQ 2000; AHRQ 1998): rural: 65%, urban 75.2%
- The percent of plans covering prescription drugs (Poisal et al. 1999): individually purchased: 35.9%, group plans: 86.3%
- The percent of seniors with access to Medicare+Choice plan with drug coverage (MedPAC 2000): rural: 16.0%, urban: 79.0%
- The percent of seniors with prescription drug purchase in 1996 spending more than $500 out of pocket (AHRQ 2000; AHRQ 1998): rural: 32.0%, urban: 24.0%

Rural Considerations and Objectives:

Affordability is of paramount importance to rural Medicare beneficiaries, given their lower average incomes. Premium costs, together with deductibles and co-insurance features, need to be structured to assure that rural beneficiaries have equitable access to an affordable product. If out-of-pocket costs are not affordable, rural participation will be low in any voluntary plan. Furthermore, rural seniors will not optimally use medications if their out-of-pocket costs for doing so forces them to make trade-off decisions vis-à-vis other uses of scarce dollars.

Equitable access to affordable prescription drug coverage requires that premiums charged to rural beneficiaries should vary only because of the region of the country in which they live, not because they live in rural areas. Markets should be structured to assure that plans have sufficient enrollees to enable the plan to spread risk using community rates rather than individual underwriting. This means that service or market area definitions should prohibit plans from

segmenting markets in ways that could carve out rural and other underserved areas as separate markets.

Rural beneficiaries should have access to the same plan choices with the same benefits as their urban counterparts. To the extent that competitive models are used as a means to achieve affordable plans, these proposals need to provide assurance that at least one affordable plan with comparable benefits would be available to all beneficiaries. Ideally, rural seniors should have access to more than more plan, achieved by defining service areas so that rural beneficiaries are included in the areas of several plans.

Once a plan is offered in a competitive market, there is no guarantee of continuity. This problem could be greater in smaller rural states and markets which tend to be more volatile. Rural beneficiaries need assurance that they will have continuous access to an affordable plan with comparable benefits in the event that plans drop coverage. Further, there should be only minimal variation over time in the design of such plans. Ideally, the same plans would be offered continuously.

Appropriate access to pharmaceutical services in their local communities is vital to rural seniors and should be assured in any prescription drug plan. Rural seniors are used to the services provided by local pharmacies, like home delivery. Logistical impediments, like having to pick up prescriptions from the post office because the package couldn't be delivered (which could be true if new plans use mail order pharmacies), can be a significant problem in rural places. Local pharmacists are important resources for health care information in isolated rural communities. They are also a vital resource for other health care providers. Proposals to add prescription drugs to the Medicare program should explicitly encourage the inclusion of local pharmacists as vendors.

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

I. INTRODUCTION

Two current projects provide the knowledge base and analytical input for this *Policy Paper*. The Maine Rural Health Research Center is analyzing the current status of prescription drug coverage among rural Medicare beneficiaries and is partnering with RUPRI's Rural Health Panel to develop policy recommendations based on that analysis.[1] This *Policy Paper* includes data analyzed by the MRHRC concerning the current status of prescription drug coverage for rural Medicare beneficiaries. These data provide a baseline from which to judge the likely impacts of various policies. The data also demonstrate those characteristics that distinguish rural from urban beneficiaries. The RUPRI Rural Health Panel is developing a more comprehensive set of rural-oriented principles to use in assessing proposals to redesign the Medicare program.[2] Both projects are scheduled for completion in the Fall of 2000.

This *Policy Paper* presents six objectives for improving rural Medicare Beneficiary access to prescription drugs. After each objective, relevant sections of three legislative proposals are summarized. By direct comparison of the objective and legislative summary, ***readers can develop their own judgement of the merits of the proposals***. Both the MRHRC and RUPRI will continue analysis of potential improvements in prescription drug benefits, and present further analysis and policy recommendations in a Fall, 2000 *Policy Paper*. In the interim, members of this analytical team are available to offer current thinking about such recommendations, by calling any of the following:

RUPRI Office (Chuck Fluharty):	573-882-5000
MRHRC (Andy Coburn):	207-780-4435
RUPRI/Nebraska (Keith Mueller):	402-559-4318

II. BACKGROUND

A. How are rural Medicare beneficiaries different?

Improving access to prescription drugs will be a particularly important policy initiative for rural Medicare beneficiaries. Elderly residents in rural areas have both a higher need for, and reduced access to, prescription medications when compared to those in urban areas. This higher need stems from the general tendency for the rural elderly to be in poorer health and to have higher rates of chronic health problems. According to data from the 1996 Medical Expenditure Panel Survey (MEPS) sponsored by the Agency for Healthcare Research and Quality (AHRQ 2000; AHRQ 1998):

- The percent of seniors reporting themselves to be in "Fair" or "Poor" health: rural:32.2% , urban: 25.7%.

---

[1]Support for this project is from the Federal Office of Rural Health Policy, in their cooperative agreement with the MRHRC # CSUR00003-04.

[2]Support for this effort is from the Federal Office of Rural Health Policy, as a special project award.

- The percent of seniors having a serious, potentially life-threatening, chronic condition, including heart disease, stroke, cancer, diabetes, and emphysema: rural: 38.7%, urban: 33.6%.
- The percent of seniors with high blood pressure: rural: 39.7%, urban: 34.8%.

As a result of this poorer health, rural elderly are more dependent upon prescription medication. In 1996, the mean number of prescriptions filled was 24 among the rural elderly, compared to 21 for the urban elderly (AHRQ 2000; AHRQ 1998).

Despite this demonstrated higher need for prescription drugs, rural seniors are also at a higher risk of being unable to afford the medications that they need. Compared to the elderly in urban areas, the rural elderly are significantly less likely to have supplemental insurance coverage that pays for prescriptions:

- The percent of seniors without prescription drug coverage, 1995 (Poisal et al. 1999): rural: 46.1%, urban: 30.1%. *(A 50% difference)*
- The percent of seniors with private Medicare supplemental insurance covered by a group plan (AHRQ 2000; AHRQ 1998): rural: 65%, urban 75.2%.
- The percent of plans covering prescription drugs (Poisal et al. 1999): individually purchased: 35.9%, group plans: 86.3%.
- The percent of seniors with access to Medicare+Choice plan with drug coverage (MedPAC 2000): rural: 16.0%, urban: 79.0%.

As a consequence of this reduced access to prescription drug coverage, rural seniors face higher out-of-pocket costs for their medications. Because of this, and because rural seniors typically have lower incomes than urban seniors, the rural elderly must spend a higher proportion of personal income on prescription drug coverage than the urban elderly do:

- The percent of seniors with prescription drug purchases in 1996, spending more than $500 out of pocket (AHRQ 2000; AHRQ 1998): rural: 32.0%, urban: 24.0%.
- The percent of seniors paying more than 75% of the costs of their medication themselves (AHRQ 2000; AHRQ 1998): rural: 49.1%, urban: 39.6%.
- The percent of seniors spending more than 5% of their gross annual income on prescription drug expenses (AHRQ 2000; AHRQ 1998): rural: 28.5%, urban: 21.3%.

The higher proportion of out-of-pocket costs among rural seniors increases the risk that they will not follow the appropriate prescription drug regimens prescribed by their physicians, by either neglecting to fill prescriptions or taking smaller doses of their medications than prescribed. This will be particularly true as prescription drug costs continue to rise vis-à-vis the fixed incomes of seniors, with the potential for dramatic increases in morbidity and mortality among rural elderly Americans.

B. The three proposals

The three proposals summarized in this document were introduced between May 9, 2000 and June 23, 2000. We are commenting on those proposals *written, on the date of introduction.* Our

summaries are restricted by the text of the bills — we do not infer intent, or attempt to render specificity where, at this time, there is none. All three proposals would likely become more specific before final enactment.

H.R. 4680, "Medicare Rx 2000 Act"
This bill was reported out of the House Ways and Means Committee on June 21, 2000. It would create a voluntary program in Medicare, administered by a new Medicare Benefits Administration. All beneficiaries would have an opportunity to enroll in a plan that would have an actuarial value of at least $740. Beneficiaries would pay a deductible of $250. Subsidies would be available for low income beneficiaries. There would be an out-of-pocket limit of $6,000 annually. The bill creates a new Part D for the Medicare program and invites private plans to enter the market as prescription drug plans. It also invites Medicare+Choice plans to include prescription drug benefits.

S. 2541 ("Medicare Expansion for Needed Drugs (MEND) Act of 2000")
This bill was introduced on May 10, 2000 by Senator Daschle and others. A new Part D would be added to the Medicare program, and be available for enrollment at the same time beneficiaries decide to enroll into Part B. The Secretary would contract with private entities to administer the plan, in at least 15 regions of the country. Beneficiaries would pay 50% of the premium and share in costs up to $2000 in the first year (2002), increased to $5000 in 2009.

Amendment 3598 ("Medicare Outpatient Drug Act of 2000")
This amendment to the appropriations for Health, Education and Labor was introduced on June 22, 2000 by Senator Robb and others. It was not adopted. A new Part D would be added to the Medicare program and made available to all beneficiaries for enrollment at the time they enroll into Part B. Beneficiaries would pay 50% of the premium associated with Part D, employers who sponsor their former employees would pay 2/3 of the premium. Beneficiaries would pay a $250 deductible, and a coinsurance of 50%, up to an initial ceiling of $3,500 in the first year, increased to $4,000 in the third year. The Secretary would contract with private entities to administer this benefit. Where there are no private entities the Secretary would "develop procedures" to cover beneficiaries.

III. RURAL CONSIDERATIONS APPLIED

A. Beneficiary cost sharing: Implications for affordability for rural beneficiaries

Rural Considerations and Objectives

Affordability is of paramount importance to rural Medicare beneficiaries given their lower average incomes. Premium costs, together with deductibles and co-insurance features, need to be structured to assure that rural beneficiaries have equitable access to an affordable product. If out-of-pocket costs are not affordable, rural participation will be low in any voluntary plan. Furthermore, rural seniors will not optimally use medications if their out-of-pocket costs for doing so forces them to make trade-off decisions vis-à-vis other uses of scarce dollars.

The Three Plans: Table 1 summarizes the deductible, co-insurance, and catastrophic coverage limits of the three proposals under consideration.

Table 1 Cost Sharing and Subsidy Features of Legislative Proposals for Prescription Drug Coverage

	H.R. 4680	**S.2541**	**Amend. 3598**
Deductible Amount	$250	None	$250
Coinsurance	50% coinsurance between $250-$2,100	50% coinsurance up to $2,000, then coverage ceases; (2002-4); likewise at $3,000 (2005-6), $4,000 (2007-8) and $5,000 (2009).	50% coinsurance between $250-$3,500; 25% $3,500-$4,000/
Catastrophic Limit	$6,000	Catastrophic benefit to be determined, after recommendations from the Secretary, due six months after enactment.	$4,000
Beneficiary Premium/ Government Subsidies	Enrollees pay Part D premium; government subsidies of beneficiary premiums limited to qualified low income persons (see below).	Enrollees pay Part D premium; government subsidizes premiums at 50% of cost.	Enrollees pay Part D premium; government subsidizes premiums at 50% of cost.
Government Subsidies/Low-income Beneficiaries	For incomes to 135% of poverty, government pays 100% of premium and 95% of cost sharing cost. Sliding premium subsidies for incomes between 135% (100% subsidy) and 150% of poverty (0% subsidy).	For incomes to 135% of poverty, government pays 100% of premium and cost sharing cost. Sliding premium subsidies for incomes between 135% (100% subsidy) and 150% of poverty (0% subsidy).	No specific provision.

B. Premium costs: Implications of price variations across plans

Rural Considerations and Objectives

Equitable access to affordable prescription drug coverage requires that premiums charged to rural beneficiaries should vary only because of the region of the country in which they live, not because they live in rural areas. Markets should be structured to assure that plans have sufficient enrollees to enable the plan to spread risk using community rates rather than individual underwriting. This means that service or market area definitions should prohibit plans from segmenting markets in ways that could carve out rural and other underserved areas as separate markets.

HR 4680: This plan presumes competition among plans offering prescription drug coverage. It is not clear whether or how premium costs would be affordable in markets or states with limited competition among plans. In areas with few offerings, however, there are likely to be higher premiums.

S. 2541: In this proposal, premiums could not vary within or across market or geographic areas. The bill requires the Secretary to set premiums using a method set forth in the bill. The Secretary would also be responsible for defining market areas in which competing plans would be offered. There would be a minimum of 15 areas designated. Areas would be designated "to assure reasonable competition among provider entities."

Amendment 3598: In this proposal, premiums could not vary across market or geographic areas. The bill requires the Secretary to set premiums using a method set forth in the bill. The Secretary would also be responsible for defining market areas in which competing plans would be offered. There would be a minimum of 10 areas designated. The bill specifies that no area could be smaller than a state.

C. Availability of plans in rural areas

Rural Considerations and Objectives

Rural beneficiaries should have access to the same plan choices with the same benefits as their urban counterparts. To the extent that competitive models are used as a means to achieve affordable plans, these proposals need to provide assurance that at least one affordable plan with comparable benefits would be available to all beneficiaries. Ideally, rural seniors should have access to more than one plan by defining service areas so that rural beneficiaries are included in the areas of several plans.

HR 4680: This proposal is premised on the availability of and competition among plans offering prescription drug coverage. The bill has a provision for offering "incentives" (unspecified) to encourage plans to offer policies in areas without at least two plans, but no specific requirement that every area be served by a competing health plan.

Plans are required to offer the "standard benefit" but can, under certain circumstances, offer a "qualified alternative benefit." Plans would be able to use formularies, and would be required to

have committees to review those formularies. The formularies would be required to include drugs from each therapeutic class.

S 2541: The plan requires that the Secretary enter into contracts with bidding private entities to administer the new benefit in every area of the country. However, the plan does not provide a procedure to follow should there be no bidders in a given service area. Plans would be required to provide any drug that is prescribed by a qualified health professional regardless of whether it is included in a formulary. Different plans could use different formularies and other strategies to contain the costs of prescription drugs.

Amendment 3598: Beneficiaries would be guaranteed access to at least one plan under this bill. If in any area there are no bids from private entities the Secretary is required to offer a plan. Benefits under this plan could not vary. Provider entities could use formularies, but those would be regulated to assure comparability of benefits.

D. Continuity of coverage for rural beneficiaries

Rural Considerations and Objectives

Once a plan is offered in a competitive market, there is no guarantee of continuity. This problem could be greater in smaller rural states and markets which tend to be more volatile. Rural beneficiaries need assurance that they will have continuous access to an affordable plan with comparable benefits in the event that plans drop coverage. Further, there should be only minimal variation over time in the design of such plans. Ideally, the same plans would be offered continuously.

HR 4680: This bill is silent on the question of how continuity of coverage would be maintained in the event that a plan discontinued providing coverage. The plan gives the Administrator the authority to waive licensing and other requirements of provider entities to "assure choice and access." The plan offers significant re-insurance protections to plans to discourage plan exits from markets due to adverse selection problems. Even though the re-insurance provisions in the plan would likely help address the adverse selection problem that is likely to occur in any voluntary program, experience with the Medigap market suggests that plans enter and exit frequently. This risk of discontinuity in coverage could be a significant deterrent to enrollment, and will have a greater effect in rural areas.

S 2541: This bill is silent on the question of how continuity of coverage would be maintained in the event that an eligible beneficiary loses coverage as a result of a plan termination. The plan requires that the Secretary take steps to assure the viability of competing bidders in each service area.

Amendment 3598: This proposal contains explicit provisions governing enrollment periods that require eligible provider entities to guarantee that eligible beneficiaries who lose coverage "under circumstances that would permit a special election period… the entity will continue to provide coverage under this part…" It is not clear from this language, nor the bill, whether these provisions would ensure continuity of coverage in the event of loss of coverage due to plan

termination.

E. Beneficiary access to pharmacy providers: Implications for rural pharmacies

Rural Considerations and Objective

Appropriate access to pharmaceutical services in their local communities is vital to rural seniors and should be assured in any prescription drug plan. Rural seniors are used to the services provided by local pharmacies, like home delivery. Logistical impediments, like having to pick up prescriptions from the post office because the package couldn't be delivered (which could be true if new plans use mail order pharmacies), can be a significant problem in rural places. Local pharmacists are important resources for health care information in isolated communities. They are also a vital resource for other health care providers. Proposals to add prescription drugs to the Medicare program should explicitly encourage the inclusion of local pharmacists as vendors.

HR 4680: Provider entities are required to develop an affiliated network of providers sufficient "to make access to covered benefits convenient for enrolled beneficiaries." Convenient access is not defined. The plan is silent with regard to assurances that local pharmacies would be included in any provider networks. This plan assumes cost savings from competition among plans. To achieve those savings, plans will likely seek volume discounts in the purchasing of prescription medications.

S 2541: Plans would be required to specify how they would contract with local pharmacy providers "to ensure access, including compensation for pharmacists' services." The bill requires that provider entities permit the participation of any pharmacy in the service area that meets the participation requirements. Further, the plan requires that the Secretary give "special attention" through "bonus" or "extra payments" to pharmacists and/or to provider entities to ensure access in rural and hard-to-serve areas. The General Accounting Office is required to report no later than 2 years after implementation on access to pharmaceuticals and pharmacists' services in rural and hard-to-serve areas. This proposal assumes competing bids for the contracts to administer the new benefit. To be competitive and profitable plans would adopt strategies to achieve cost savings, within the restrictions specified in the legislation.

Amendment 3598: This plan requires provider entities to maintain contacts with a sufficient number of retail pharmacies necessary to assure "reasonable geographic access." This proposal assumes competing bids for the contracts to administer the new benefit. To be competitive and profitable plans would adopt strategies to achieve cost savings, within the restrictions specified in the legislation.

F. Implications of education, marketing, and enrollment procedures for rural beneficiaries

Rural Considerations and Objectives

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

seniors of their benefit options and to facilitate their enrolment in their plan of choice.

HR 4680: Part D benefits would be administered through a Medicare Benefits Administration that would conduct open enrollment periods and would actively disseminate comparative plan information to beneficiaries. State Medicaid programs would be responsible for determining eligibility for qualified low-income beneficiaries for premium and cost-sharing subsidies.

S 2541: Each provider entity would be responsible under this plan for furnishing enrolled individuals an explanation of their benefits and regular notices of their balance of benefits. In addition, they will be responsible for conducting education and information activities designed to encourage cost-effective use of the drug benefits and to ensure that enrollees understand their rights and obligations under the program.

Amendment 3598: This plan calls for the Secretary to establish a process through which eligible beneficiaries may elect to enroll in Part D coverage.

References

Agency for Healthcare Research and Quality. (1998). *Medical Expenditure Panel Survey: MEPS HC-003, 1996 Panel Population Characteristics and Utilization Data for 1996*. [Electronic data file]. AHRQ Pub. No. 98-DP12.

Agency for Healthcare Research and Quality. (2000). *Medical Expenditure Panel Survey: MEPS HC-011, 1996 Preliminary Person Level Expenditure File*. [Electronic data file].

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

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

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, M.D., M.S., 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 T. 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 RUPRI Rural Health Policy Documents

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

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

RUPRI Initiatives
Community Policy Analysis Network
Comparative Rural Policy Initiative
The Role of Place in Public Policy
Rural Partnership Working Group

Topical Research
Rural Telecommunications
Rural Education
Rural Health

Medicare prescription drug, improvement, and modernization act. Of 2003. VerDate 11-MAY-2000 15:01 Jan 08, 2004 Jkt 029139 PO 00173 Frm 00001 Fmt 6579 Sfmt 6579 E:\PUBLAW\PUBL173.108 APPS10 PsN: PUBL173. 117 STAT. 2066.Â 614. Improved payment for certain mammography services. Subtitle Câ€"Other Provisions. Sec.Â (3) BASIC PRESCRIPTION DRUG COVERAGE.â€"For purposes of this part and part C, the term â€˜basic prescription drug coverageâ€™ means either of the following: â€˜â€˜(A) Coverage that meets the requirements of para-graph (1)(A). â€˜â€˜(B) Coverage that meets the requirements of para-graph (1)(B) but does not have any supplemental prescrip-tion drug coverage described in paragraph. 15 Medicare Prescription Drug and Modernization Act of 2000 [S. 2807 (Breaux and Frist et al.) labeled â€œBreaux-Frist 2000"] . . . .Â Even though 65% of beneficiaries have some private or public coverage for these costs, they state that many persons do not have adequate supplemental coverage for drug costs and note that, on average, beneficiaries themselves pay for half of their drug costs out-of-pocket.1 The absence of a significant drug benefit is not a new concern.Â Other proposals 1 For background information about Medicare beneficiariesâ€™ total and out of pocket prescription drug expenditures see CRS Report RS20612, Medicare: Prescription Drug Expenditures, 1996, by Paulette Como. CRS-2 would establish a separate drug benefit for the Medicare population.