National Health Policy Reform: The Rural Perspective

September 1992

National Rural Health Association
301 East Armour Boulevard, Suite 420
Kansas City, Missouri 64111

National Health Policy Reform: The Rural Perspective

September 1992

This project was supported by a grant from the Henry J. Kaiser Family Foundation in Menlo Park, Calif. The editorial content of this project was overseen by the NRHA National Health Reform Work Group. For additional information, contact the NRHA at (816) 756-3140, Kansas City, Mo.; or at (202) 232-3553, Washington, D.C.

National Rural Health Association
301 East Armour Boulevard, Suite 420
Kansas City, Missouri 64111

Copyright 1992
National Rural Health Association

Contents

Executive Summary 3

Part I

The National Rural Health Association's Necessary Components for National Health Reform 5

Part II

National Health Policy Reform: The Rural Perspective 7

Part III

A Discussion and Analysis of National Health Reform Proposals 12

Notes 16

References 16

Appendix

A Comparison of Select National Health Care Reform Proposals 18

National Health Reform Proposal Scorecard 24

National Rural Health Association National Health Reform Work Group

Charles Alfero
Albuquerque, New Mexico

Malcolm Findlater, M.D.
Cedar Rapids, Iowa

Paul Fitzpatrick
Albany, New York

Millicent Gorham
Washington, D.C.

J. Patrick Hart
Wausau, Wisconsin

Kate Korman
Santa Monica, California

Carol Miller
Ojo Sarco, New Mexico

Fred Moskol
Madison, Wisconsin

Bonnie Post
Manchester, Maine

David Pratt, M.D.
Cooperstown, New York

Kim Sibilsky
Kansas City, Missouri

Tim Size
Sauk City, Wisconsin

Robert T. Van Hook
Kansas City, Missouri

Acknowledgement

The National Rural Health Association would like to express special appreciation to Pamela Hanes Spohn, Ph.D., University of Wisconsin, for authoring the text and compiling and analyzing the health care reform proposals. In addition, thanks go to Doris P. Slesinger, Ph.D., University of Wisconsin, and Jim Galliher, University of Missouri—Kansas City, for reviewing portions of the text.

Executive Summary

The subject of health care reform is on everyone's lips. Escalating costs and the increasingly severe problems associated with lack of access to basic health care services for the poor and middle class alike have caused policy-makers in Washington, D.C., and the states to propose far-reaching reforms to the health care system. Many of these targeted reform strategies have been framed and articulated by powerful vested interests who stand to benefit or lose by changes that are made to the existing health care system—changes that include reform of the financing, organization and delivery of health care goods and services. The debate about health care financing and the ensuing reform proposals introduced range from ensuring access to health care as a basic entitlement of citizenship (comparable to public education) to incremental steps that are intended to improve access to health care while preserving the status quo, which is characterized by the buying and selling of health care goods and services in a private competitive marketplace.

The National Rural Health Association (NRHA) is one of many groups concerned about the implications of the various proposals for reform for its membership and primary constituency— rural Americans. Of major concern to the NRHA is that reform strategies recognize the unique access barriers that impede the delivery of health care in rural communities and that they provide the necessary system flexibility and incentives to meet the challenge of these formidable barriers. Access issues in rural America are exacerbated by geography as well as severely depressed economic conditions that have set rural economies apart from metropolitan areas in terms of levels of unemployment and loss of industry during the 1980s.

Necessary Components for National Health Reform

The objective of this paper is to establish a range of necessary components that the NRHA believes to be essential to successful national health reform. This list of components has been adopted by the governing board of the NRHA. They are based on a thoughtful and thorough analysis of the range of reform strategies that have been or are being considered by Congress. The NRHA has not taken a position on a specific proposal or type of reform, but rather has put forth what it considers to be necessary rural considerations that should be embodied in any proposal under debate.

Without consideration of these components, any national health policy reform package will come up short when attempting to ensure proper health care to rural Americans. Once these guiding principles are accepted and employed in planning national health reform, then the policies and regulations built on these principles will better be able to meet the unique health care needs of rural and other Americans.

The National Rural Health Association's Necessary Components for National Health Reform

1. **Universal Access**
   Any national health plan must ensure universal access to comprehensive health care without financial barriers.
2. **Federal Leadership**
   The federal government must assert leadership in the development and financing of a national health plan.
3. **State and Local Self-determination**
   Any national health plan should ensure that state and locally determined community needs and preferences are addressed in the design, development and maintenance of local health care systems. This decentralized approach should include local planning, collaboration, coordination and evaluation efforts.
4. **Community Development**
   National health plan proposals should encourage the development of local health care systems that are comprehensive in scope and promote the building of local economic and social infrastructures (including jobs, housing, sanitation, schools, etc.).
5. **Consumer Choice**
   National health plan reform proposals should contain assurances of consumer choice in terms of financing intermediaries and providers of care.
6. **Financing Incentives**
   The federal government should establish a range of provider payment and systems development mechanisms that is flexible so that incentives, exceptions and adjustments to provider payments reflect state and local needs and system capacity constraints.
7. **Education and Training**
   Any national health plan should provide policy direction and funding for the education and training of a sufficient number and mix of appropriate health care providers to meet the personnel needs that exist in medically underserved areas.
8. **Quality and Efficiency**
   Any national health plan should have quality assurance systems and accountability mechanisms that ensure continuous re-examination of and improvement in health care service delivery.

The Rural Perspective to National Health Policy Reform

Rural Americans are victims of one of our nation's top domestic problems—the lack of access to appropriate, affordable and quality health care services. In spite of romantic notions about rural lifestyles, the geographic and economic challenges of country living have resulted in a population that is disproportionately poor, experiences significantly higher rates of chronic illness and disability, is aging at a faster rate than the nation as a whole, and has a substantial uninsured and underinsured population because many rural workers are self-employed and therefore do not have employer paid or subsidized insurance programs available to them. Given these obstacles, obtaining good health care is a challenge for most rural residents; for others, it just is not possible.

At least 34 million Americans are uninsured and millions more are underinsured. However, even if insurance was made available to all, that would not solve the access issue for rural Americans. Compounding the insurance problem is the constant threat of closure of rural hospitals and clinics, and the shortage of health care professionals who are willing or able to locate and practice in rural areas. Unless the issues of resource development and capacity building are addressed concurrently with financing reform, the majority of rural Americans will continue to face significant barriers to accessing essential health care services.

Current and Recent National Health Reform Proposals

This study examines 16 health care reform proposals that have been introduced into Congress as well as the proposal prepared by President George Bush's administration, particularly how they address the health concerns of rural Americans. In the Appendix all 17 proposals appear in a side-by-side comparison in "A Comparison of Select National Health Care Reform Proposals." How the proposals score on addressing rural health care issues is assessed in the "National Health Reform Proposal Scorecard," also in the Appendix. Through this process, four types of proposals emerged. They are presented below.

Overall, all of the proposals dealt with some of the rural issues that need to be addressed in health care reform. However, as yet, no one proposal adequately addresses the full myriad of health care issues facing rural Americans.

A Primer on National Health Plan Proposals

When considering current and recent health reform package proposals, four basic approaches to reform have developed—a mixture of market reform combined with expansion of public benefits, pay or play, single payer, and managed competition.

1. **Mixed: Market Reform/Expansion of Public Benefits**
   First put forth by the Health Insurance Association of America (HIAA), this type of proposal is characterized by the idea that the existing model of a private health insurance market within the context of an employer-based insurance system is the most appropriate and realistic approach to health care financing.
   These proposals specifically target the small firm employment sector where the largest number of uninsured workers can be found.
   Key features of this reform strategy include: federal statutory authority to pre-empt state mandated benefits; annual limits on premium increases for small group employees; not allowing insurers to cancel high-cost policyholders solely because of their medical conditions; insurance for all employees of a group regardless of pre-existing medical conditions; and comparable rates for small groups within a given geographic area and job classification.

2. **Pay or Play**
   This approach to health care reform mandates that employers, usually with more than 25 employees, offer health insurance to their employees. To ensure coverage for those not privately insured, a surcharge would be levied against employers who do not provide health insurance to their employees. The revenues from this tax would be used to support a public insurance plan to which uninsured workers would be assigned. The public plan would be administered by a government agency.

3. **Single Payer**
   Under the single payer approach, the federal government would finance health care through a universally available plan with revenues from broad-based payroll or income taxes, or both. The single payer model assumes a much diminished role for private insurance, and in several proposals, private insurance would be eliminated completely. Most single payer plans allow individuals to chose among providers and all maintain a private delivery system.

4. **Managed Competition**
   Managed competition, also known as the Enthoven plan, is receiving increased attention from both federal and state policy-makers. The basic tenet of this plan is to establish a competitive health care system that rewards the most efficient health care agencies and providers with the most customers, thereby creating an economic incentive for effective use of health care dollars.
   Key elements of this model include: a totally private sector health care system; employer-based coverage; a capped federal tax exclusion for health benefits based on the lowest cost plan in a region; and three private sector boards that would be responsible for developing standards and an independent, quasi-governmental agency to administer the boards.

Part I

The National Rural Health Association's Necessary Components for National Health Reform

1. Universal Access

Any national health plan must ensure universal access to comprehensive health care without financial barriers.

Policy Goals/Action Strategies

- Any public, private, or mixed financing mechanism should cover all U.S. residents, and premiums, if levied, should be based on the ability to pay.
- In the event a mixed financing model is adopted, all persons not covered through a private plan would be entitled to coverage in a public plan based on their ability to pay. Persons at or below the federal poverty level would be fully subsidized.
- Federal costs associated with extending health care coverage to all U.S. residents should be financed through broad-based, progressive tax mechanisms.
- Self-employed workers should receive a federal and state tax deduction for 100 percent of premium costs associated with the purchase of private health insurance.
- In the event that private employer-based insurance is expanded and/or reformed, premium costs should be shared by employers and employees; low income workers should receive subsidies for their share of the premium; and employees with earnings at or below the federal poverty level should have their premiums fully subsidized.
- In the event that private employer-based insurance is expanded, the costs of deductibles, co-payments and other out-of-pocket costs should be based on an employee's income and family size. Low income workers should receive subsidies for their cost-sharing responsibilities, and employees with earnings at or below the federal poverty level should be exempt from these cost-sharing mechanisms.

2. Federal Leadership

The federal government must assert leadership in the development and financing of a national health plan.

Policy Goals/Action Strategies

- The federal government should set minimum eligibility and coverage standards to which states and private insurers would be required to adhere.
- The federal government should be responsible for setting annual spending limits and establishing equitable reimbursement policies for provider reimbursement under all publicly financed programs (i.e., Medicare, Medicaid, etc.).
- The federal government should be responsible for establishing uniform administrative and claims processing systems to simplify and streamline the administration of health care financing and delivery.
- The federal government should ensure the portability of public health care financing, benefits and access across state jurisdictional boundaries, as well as the portability of private coverage across employer-based plans.

3. State and Local Self-determination

Any national health plan should ensure that state and locally determined community needs and preferences are addressed in the design, development and maintenance of local health care systems. This decentralized approach should include local planning, collaboration, coordination and evaluation efforts.

Policy Goals/Action Strategies

- Any national health policy reform legislation should include state and local representatives from rural areas on program transition teams, blue ribbon commissions, policy advisory councils, etc.
- National health policy reform strategies that expand access, particularly in rural and medically undeserved areas, should require community representation and involvement in local planning and development efforts.
- Any efforts to promote managed care or case management systems should be flexible and recognize the unique barriers and system development challenges created by geography and other limitations inherent to rural areas.
- Within federal guidelines, states should ensure the equitable distribution of health care resources and equal access to care for all state residents.

4. Community Development

National health plan proposals should encourage the development of local health care systems that are comprehensive in scope and promote the building of local economic and social infrastructures (including jobs, housing, sanitation, schools, etc.).

Policy Goals/Action Strategies

- National health policy reforms should include federal fiscal incentives to states and local communities to integrate categorical programs across program jurisdictions (e.g., housing, economic development, employment and training, education, maternal and child health, and public health) to maintain and build strong rural communities.

5. Consumer Choice

National health plan reform proposals should contain assurances of consumer choice in terms of financing intermediaries and providers of care.

Policy Goals/Action Strategies

- Any national health plan should provide for multiple delivery system options (e.g., health maintenance organizations (HMOs), preferred provider organizations (PPOs), private practices, community clinics) based on unique population characteristics, geography and consumer choice. Federal guidelines should provide the necessary flexibility to ensure that consumer choice will be protected.

6. Financing Incentives

The federal government should establish a range of provider payment and systems development mechanisms that is flexible so that incentives, exceptions and adjustments to provider payments reflect state and local needs and system capacity constraints.

Implementing national health reforms and establishing health care spending limits, if necessary, must be done to protect programs that support the expansion and development of systems capacity in underserved areas and for underserved populations. Therefore, the capacity to redirect resources within the system must be included in any national health reform proposal. To achieve comprehensive, accessible rural health care delivery systems, the federal government should establish a systems capacity-building program based on the following action strategies.

Policy Goals/Action Strategies

- Federal policy should establish a range of provider payment mechanisms (e.g., capitation, negotiated fees) that would promote cost efficiency and at the same time respect local delivery system constraints (disproportionate share hospitals, sole provider status, geographic barriers, etc.), leaving the establishment of payment mechanisms to the states.
- Federal regulations governing public health care programs (e.g., Medicare, Medicaid and/or an alternative public programs) should provide incentives for the expansion of care coordination services that link and coordinate primary care, mental health and other health services (e.g., long-term care) in rural areas.
- Federal funding should be provided for the expansion of rural health outreach programs to ensure access to care for all eligible residents.
- Federal guidelines should establish standards for the direct reimbursement of nurse practitioners, certified nurse midwives, physician assistants, social workers, mental health professionals, and other licensed providers who practice in health professional shortage areas or medically underserved areas. All payers (public and private) should be required to reimburse these health care practitioners under specified protocols.
- Federal funding for community health centers, migrant health clinics, and other innovative delivery system models appropriate to rural underserved areas should be significantly increased to ensure the adequate distribution of appropriate and quality health care services.
- Federal financial incentives should be made available to states to assist in the development of comprehensive rural health care delivery systems.
- Federal funding and expansion of rural hospital stabilization programs such as rural hospital transition grants, the Essential Access Community Hospital program (with needed modifications to reimbursement, inpatient day limits and maximum acute care bed capacity), and the Rural Primary Care Hospital program should be increased.

7. Education and Training

Any national health plan should provide policy direction and funding for the education and training of a sufficient number and mix of appropriate health care providers to meet the personnel needs that exist in medically underserved areas.

Policy Goals/Action Strategies

- The federal government should significantly expand programs and increase funding for health care personnel training programs including the National Health Services Corps, area health education centers, and interdisciplinary training grants. Included in this expansion should be scholarships to support nurse practitioners, physician assistants, certified nurse midwives, social workers and mental health workers.
- The federal government should set graduate medical school education standards, which are enforced through the medical education funding pass-through in Medicare, requiring that a minimum number of family practice (primary care) residencies and fellowships be filled each year based on the calculation of need for these slots.
- The federal government should adopt financing incentives that encourage ambulatory training experiences in rural areas.

8. Quality and Efficiency

Any national health plan should have quality assurance systems and accountability mechanisms that ensure continuous reexamination of and improvement in health care service delivery.

Policy Goals/Action Strategies

- The federal government should increase its funding for research of medical and health outcome studies. Additionally, it should increase funding for rural health demonstration projects that test new and innovative models of service delivery in rural areas.
- The federal government should assume a leadership role in the establishment of goals for managed care, utilization review, pre-admission screening, and other systems accountability and quality assurance mechanisms. It should provide states flexibility in determining quality assurance and cost efficiency mechanisms based on the nature of state and local delivery systems.
- The federal government should assume a leadership role in the establishment of national policy regarding the financing and delivery of long-term care services so as to ensure that they are available and accessible to all individuals determined to be in need of such care.

Part II

National Health Policy Reform: The Rural Perspective

In 19 states across the country, more than 40 percent of the population (Note 1) lives in a non-metropolitan area (Office of Technology Assessment [OTA], 1990). In total, approximately 27 percent of the nation's population lives in rural America (Note 2). In spite of the many romantic notions about rural lifestyles, the geographic and economic challenges of country living have resulted in a population that is disproportionately poor, experiences significantly higher rates of chronic illness and disability, and is aging at a faster rate than the nation as a whole (Cordes, 1989; Norton & McManus, 1989; Rowland & Lyons, 1989). Comprising one-quarter of the country's population, rural America has one-third of the nation's poor and approximately 29 percent of the nation's elderly citizens (OTA, 1990).

There is great cultural and ethnic diversity among rural Americans, as well as a richness and resiliency of character that has enabled them to survive a severe economic downturn during the 1980s—one that significantly weakened their economic base. In spite of many formidable obstacles, rural Americans continue to make important contributions to the nation's economy, largely through extractive industries, manufacturing, agriculture, and recreational services. While doing so they share in one of the nation's top domestic problems—the lack of access to appropriate, affordable and quality health care services.

As became clear during the 1992 election, the topic of health care reform is being widely discussed and debated. With health care costs estimated to exceed $800 billion (14%) of the gross national product by the close of 1992, Congress is awash with proposals for health care financing reform. The majority of these proposals strive to preserve the status quo through a series of incremental reforms of the private insurance industry and an expansion or restructuring of public sector health programs. Additionally, they contain a few targeted strategies intended to modify the way health care services are delivered. The policy goal of these modifications is to contain rising costs through increased efficiency in the system. The implicit assumption in the current debate is that costs must be contained, quality preserved, and access to medical care increased.

The access to health care concern stems from the stark reality that at least 34 million people are currently uninsured (Friedman, 1991) and that millions more are underinsured because of benefit and coverage limitations and exclusions resulting from pre-existing medical conditions and/or disabilities. However, increasing access to health care services is much more complex than simply issuing a health insurance card to all Americans. Equally significant, and perhaps more formidable, are the access barriers that exist because of geographic and specialty maldistribution of health care professionals and, in the case of rural America, the constant threat of closure of rural hospitals, clinics and other rural health care providers. Unless the issues of resource development and capacity building are addressed concurrently with financing reform, the majority of rural Americans will continue to experience significant barriers to accessing essential health care services.

This paper discusses what is unique about rural Americans in terms of their sociodemographic characteristics as well as how the particular challenges of geography and rural economies affect their access to health care. It further discusses how the combined effect of demographics, geography and local economics have disenfranchised many rural residents from the mainstream of the health care system. The overall objective of this paper is to assess the range of current legislative proposals in Congress relative to the attention they give to the unique circumstances and needs of rural Americans.

Characteristics of the Rural Uninsured: Personal Attributes or Market Failure?

Rural Americans of all ages are less likely than urban residents to have private health insurance coverage. As Table 1 illustrates, the disparity between rural and urban policyholders grows greater with age and by source of insurance coverage. In the case of private insurance coverage (Table 2), it is instructive to note the differences between metropolitan and non-metropolitan residents relative to employer-based versus individually purchased policies (i.e., other private coverage). These figures suggest that a significantly larger percentage of rural residents who have private insurance purchase it outside of the workplace.

The insurance status of rural residents is a reflection of the economic and demographic realities of rural America—the aging of the population, the profile of local industries and rural economic development, and the incidence of poverty in the population. Rural workers are more likely to be employed in small firms, family run enterprises, or industries characterized by self-employment—each of which have significantly lower levels of private health insurance coverage. Industries such as agriculture, mining, construction, recreational services, forestry and fishing are characteristic of rural economies and, at the same time, are industries where the likelihood of being uninsured is the greatest. With the exception of mining (because of the unionization of mine workers), workers in these industries have the highest rates of uninsurance—each hovering around 30 percent. Unfortunately it is not only the worker who is left uncovered, but also the worker's dependents, leaving rural families uninsured.

These high levels of uninsurance can be partially explained by a health insurance system historically based on employer-sponsored coverage. As a result, many elderly rural residents who have retired from rural-based industries are significantly underinsured because they lack the retiree health benefits that are provided to workers in larger firms. As Table 1 illustrates, rural elders are less likely to have private supplemental insur-

Table 1
Percentage of Population with Health Insurance Coverage by Age and Residence, 1984[1]

	All Ages		0-17 Years		18-64 Years		65 Years and Older	
Type of Insurance	Metro	Nonmetro	Metro	Nonmetro	Metro	Nonmetro	Metro	Nonmetro
Private insurance	77.2	74.7	72.6	72.3	78.9	76.2	75.0	71.9
Medicare	11.1	13.7	1.1[2]	1.4[2]	1.1[2]	1.4[2]	95.3	96.1
Public assistance (Medicaid)	6.1	5.8	11.5	9.1	4.0	3.9	5.6	7.6
Military/Veteran's Administration	3.2	3.9	2.7	2.9	3.1	3.9	4.5	6.1
No insurance	12.3	14.5	13.0	16.2	13.8	16.7	0.9	0.9

1. Numbers do not add to 100 percent because individuals may be covered by more than one type of insurance, e.g., Medicare and private insurance.
2. Number applies to all persons younger than 65 years.

Source: Ries, 1987.

ance policies and are more likely to rely on Medicaid to supplement their Medicare coverage (Ries, 1987). A higher reliance on Medicaid among rural elders is also a reflection of their higher rates of poverty relative to urban elders—12.4 percent of elders living in metropolitan areas have incomes below the poverty level, whereas 20.7 percent of rural elders have incomes below the poverty level (OTA, 1990).

Higher rates of uninsurance among rural residents also can be explained by the actuarial and underwriting practices of private insurance carriers that have moved steadily away from community rating of insurance premiums toward an experience rating system based on individual or employee group risk factors. Many rural workers (farmers, field hands, heavy machine operators, foresters, etc.) are considered to be at high risk from an occupational health and safety perspective, and their health insurance premiums are priced accordingly. Because the Bureau of Labor Statistics collects information exclusively on businesses with 11 or more employees, the injury experience of most rural workers is not well documented (Pratt, 1990). Wakefield (1990) comments that despite this limitation in existing labor statistics, "the National Safety Council (1987) listed agriculturally related work as the most dangerous in the nation. While agricultural workers constitute less than 3 percent of the work force, they have more than 14 percent of work-related deaths." Additionally, it has been documented that farmers have the highest rates of hospitalization and the lowest rates of physician visits of any occupation (Ingersoll, 1989).

As a result of private insurance companies' exclusionary practices, many small firms have ceased to offer health insurance benefits to their employees. Also, increasing numbers of the self-employed are unable to purchase health insurance policies because premiums are prohibitively expensive and high deductibles and co-payments make the policies beyond the means of most lower income purchasers.

Another factor influencing the insurance status of rural residents relates to coverage under Medicaid, the publicly financed health program for low income families, persons with permanent disabilities and low income elderly persons. Until recently, Medicaid eligibility was contingent upon participation in one of two federal public assistance programs: Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). In spite of higher levels of poverty at all ages among rural Americans, Medicaid participation rates among rural children ages 0-17 years are significantly lower than those found among urban dwelling children (OTA, 1990), despite the fact that one-quarter of all rural children live in poverty (Wakefield, 1990). These lower participation rates can be explained, in large part, by the fact that poor children in rural areas are more likely than urban children to be living in two-parent families and thus, until quite recently, were ineligible for

Table 2
Private Insurance Coverage by Source of Coverage and Place of Residence, 1987

	Percent of Population with Type of Health Insurance			
Place of Residence	Employment-related Private Coverage	Other Private Coverage	Public Coverage	No Coverage
20 largest metro areas	65.0	9.7	10.2	15.1
Other metro areas	76.4	8.9	9.0	14.7
Nonmetro areas	57.4	13.4	11.8	17.4

Source: Short, Monheit, and Beauregard (1989).

AFDC and likewise for Medicaid coverage (McManus & Newacheck, 1989).

The final factor in the uninsurance equation is unemployment. To be unemployed is to be at extremely high risk of being uninsured. Changes in the rural economy during the 1980s resulted in higher than national average unemployment rates. According to *Health Care in Rural America* (OTA, 1990), "...the rural unemployment rate skyrocketed from 5.7 percent in 1979 to 10.1 percent in 1982, and by 1985 it was still considerably higher than the urban rate (8.4 versus 6.9 percent). When the unemployment rate is adjusted to account for discouraged workers (those no longer looking for jobs) and involuntary part-time workers, differences were even more extreme (13.0 percent for rural workers versus 9.9 percent for urban workers in 1985)."

In summary, the lack of health insurance coverage among rural Americans is more often related to depressed wages, high levels of unemployment, and the absence of industries that provide health benefits to their employees than to disinterest or apathy among lower income workers to purchase health insurance. In fact, the data show that rural residents are more likely to purchase individual private plans than their urban counterparts. These purchases are in spite of the fact that rural residents often have lower incomes than urban residents and thus have less disposable income with which to purchase the expensive individual or small group plans that are made available to them.

Health Status of Rural Americans: Unique Health Care Issues for Rural Communities

"Poverty, poor nutrition, unsafe or deteriorating housing, inadequate water supply, transportation difficulties, and limited medical resources combine to intensify health problems in rural areas" (Rowland & Lyons, 1989). Compared to urban residents, rural Americans have slightly lower mortality rates, comparable rates of acute illnesses and their resultant days of lost activity, but significantly higher rates of chronic disease and functional impairment or disability (Norton & McManus, 1989). According to Norton and McManus (1989), rural residents are between two and 10 times more likely than urban residents to die from accidents including accidental shootings, falls, equipment-related deaths, etc. Individuals living in rural areas are more likely than their urban counterparts to report that they are in fair or poor health and less likely to report being in excellent health (Norton & McManus, 1989) (Note 3). By looking at the health problems of certain high risk groups of rural Americans, we can gain a much more precise picture of their particular and ongoing health care needs.

Mothers, Infants and Children

In 1987, 22 percent of all babies born in the United States were born in rural areas (Department of Health and Human Services, 1989). The infant mortality rate was 2 percent higher in rural than in urban areas (American Academy of Pediatrics and American College of Obstetricias and Gynecologists, 1988). This simple statistic masks the significant variation in rural infant mortality rates between various regions of the country and between white babies and others. For example, in rural Virginia the black infant mortality was 17.6 deaths per 1,000 births compared to 8.8 per 1,000 births for white infants; likewise in rural Georgia the black infant mortality rate was 20 deaths per 1,000 births compared to 10 per 1,000 births for white infants (OTA, 1990).

Infant mortality and low birth weight are inextricably linked to the lack of early and ongoing comprehensive prenatal care. Studies have found that having a source of payment for prenatal care has a less significant impact on birth outcomes than having a source of financing coupled with comprehensive care coordination that provides nutritional and psycho-social counseling as well as a range of supports for expectant mothers including adequate housing and income (Schlesinger & Kronebusch, 1990).

Access to prenatal care is particularly problematic for pregnant women who live in rural areas. In 1988, while there were 61 obstetric care providers per 100,000 women in urban areas, there were only 25 per 100,000 in rural areas. Because of the low numbers of obstetricians who practice in rural areas, most prenatal care and delivery is provided by general and family practitioners who have been trained to provide obstetric care (OTA, 1990). As noted in *Health Care in Rural America* (OTA, 1990):

> The availability of rural physicians trained to deliver obstetric care varies by region. In rural areas of the East South Central region of the country there were 156 physicians trained to provide obstetric services per 100,000 rural women of reproductive age. In contrast, there were 242 per 100,000 in the rural areas of states in the West North Central Region.... Over half a million rural residents live in counties that are without a physician trained to deliver obstetric care, and other areas are without available obstetric services because many physicians trained to provide obstetric services do not provide them.

McManus and Newacheck (1989) have noted several major problem areas related to the health status of rural mothers, infants and children. These areas relate specifically to the lack of insurance coverage and health care resources. Once again, we are confronted with the relationship between systems capacity, user friendliness, and the ultimate health of citizens. Without access to adequate prenatal care, nutrition, immunizations, and infant and well child check-ups, there will continue to be underdeveloped rural children who fail to reach their maximum physical and mental growth potential. McManus and Newacheck argue: "An understanding of problems surrounding the financing of care for maternal, child, and adolescent health in rural areas is central to designing changes that could lead to future improvements in health services utilization and, ultimately, to health status improvements for the nonmetro population."

Persons with Chronic Disease and Disabilities

As stated previously, the incidence of chronic disease and disability is higher in rural than urban areas. In five of the six chronic condition groupings used in the National Health Interview Survey, rural dwellers had higher rates of chronic disease than urban residents (Norton & McManus, 1989). Although chronic conditions generally tend to be more prevalent among the elderly, there is a sizable group of working age persons who suffer from chronic diseases that inhibit their ability to perform routine daily activities. These conditions include arthritis, sensory impairments (vision and hearing loss), epilepsy, kidney

problems, heart disease, hypertension and emphysema. These and other conditions result in more reported activity limitations (from minor limitations to the inability to perform work) among rural residents than their urban counterparts—15.9 percent versus 13.4 percent (Norton & McManus, 1989).

Certainly rural elders constitute the largest percentage of those persons who report activity limitations and chronic disease. As is the case among other disability groups, rural elders report more chronic health impairments than urban elders—41 percent versus 36 percent (OTA, 1990). Chronic illness is particularly problematic for elders living in rural areas because of the great distances that often must be traveled by the elderly who seek rehabilitative and other forms of long-term health and supportive care. Additionally, because much long-term care is provided in the home, home care workers face the same challenges of distance, travel time and geographic isolation.

Rural elders visit physicians in every specialty category less often than urban elders, and "...evidence indicates that the range of services for elders living in small towns and rural communities is more narrow, that fewer alternatives are available within any one service area, and that fewer health care providers exist to offer particular services" (Coward & Cutler, 1989). If one considers only numbers, the 1990 Bureau of the Census report shows that 12.6 percent of the total U.S. population was older than 65 years in 1990, and 13 percent of rural Americans are older than 65 years (OTA, 1990). The implications of an aging population for rural health delivery systems are great, particularly in terms of the existing bias (in all systems) toward acute care and the shortage of long-term care services in rural areas.

Seasonal and Migrant Farm Workers

Although estimates of the seasonal and migrant farm worker population are imprecise, most data sources suggest that there are between 3 and 4 million workers in the United States and Puerto Rico. Because there have been few studies of migrant workers, our understanding of their health problems and needs is limited. A literature review of the health status of migrant farm workers revealed a "lack [of] even such basic data as crude death rates, median survival, infant and maternal mortality, and incidence of permanent disability" (Rust, 1990). Among the limited studies that have been conducted, researchers found that infant mortality among Mexican American farm workers was nearly three times greater than that of the general population (Chase et al., 1971); another study found that 44.5 percent of migrant farmworker households had one or more members who described themselves as disabled (Department of Health, Education, and Welfare, 1974). Available data suggest that the major causes of mortality among migrant workers are cardiovascular disease, hypertension and complications of diabetes (Rust, 1990).

As noted earlier, in 1987 agriculture surpassed mining as the most hazardous occupation in the United States (both as the leading cause of work-related deaths and injury). Significant agricultural hazards for migrant farmworkers include chronic exposure to toxic pesticides, a lack of safe drinking water, inadequate toilet facilities, occupational dermatoses, acute injuries from falls and farm machinery, and chronic low-grade back pain and joint trauma (Rust, 1990). Other occupational hazards are related to the mobility of migrant workers. Overcrowded vehicles, little use of car safety restraints, towing a trailer, traveling long distances at night with little sleep for the driver, and traversing country farm roads, all make for greater risks when driving from one agricultural job to the next (Slesinger, 1992).

In 1985, the average migrant farm worker earned only $3,295 from farm labor and a total income of $6,194 (Department of Agriculture, 1987). Because the link between poverty and health status has been well established, one must surmise that the health care needs of migrant and seasonal farm workers are significant and that increased attention and resources should be directed at understanding these needs and developing an array of appropriate, quality health services to meet them.

Access to health care is problematic for migrant farm workers. Their mobility, poverty, and, for many, inability to speak English create almost insurmountable obstacles. The Office of Migrant Health in the Department of Health and Human Services recently estimated that the federally funded Migrant Health Program of the Community Health Centers Act serves approximately 13 percent of its targeted population (OTA, 1990). Farm workers are not often near one of the clinics when they need medical care.

In summary, health status comparisons between rural and urban residents reveal similar mortality and morbidity rates with the exceptions noted above. Pregnant women, infants, children, elders, and persons with chronic disease and disability are the most vulnerable persons in any community—urban or rural. Unfortunately, economics explains the access problems these groups face. Women, children and elders are more likely to be poor and therefore are more likely to lack access to the health care system. In the case of prenatal care and delivery, fears of malpractice and low reimbursement rates under Medicaid have severely compromised the availability of obstetric providers in rural and underserved inner city areas. In rural areas, economic factors are confounded by geographic factors with the end result being that rural Americans have poorer outcomes than urban residents on a number of important health status indicators.

Organization and Delivery of Health Services in Rural Areas: Special Challenges, Particular Opportunities

Although health insurance coverage is a major determinant of access to care, it is not the only, nor necessarily the most important, factor. There are many non-financial barriers that are equally formidable in the access equation. Without an adequate number and range of health care providers and services, the most comprehensive health insurance coverage is extremely limited in its ability to extend access.

A recent report issued by the National Association of Community Health Centers (NACHC) (Hawkins & Rosenbaum, 1992) has determined that in 1990 there were 51 million Americans (20% of the total population) at risk for medical underservice in the United States. Of these, 42.8 million were deemed to be underserved. According to Hawkins and Rosenbaum (1992), persons at risk of medical underservice are those with low incomes (less than 200% of the poverty level) who are completely uninsured, younger than 65 years and dependent on Medicaid, or older than 65 years and covered by

Medicare. To be underserved—as opposed to being at risk—is to have an at-risk profile (i.e., low income coupled with other sociodemographic indicators such as ethnicity or unemployment); to lack health insurance or be underinsured; to live in a county with poor health status indicators; and to live in an area with an inadequate supply of primary care physicians. Using these formulas, Hawkins and Rosenbaum (1992) found that one in five Americans was at risk, while one in six was underserved.

Not surprisingly, among those found to be underserved were 14 million (33%) children under the age of 18, including 6 million (13%) under the age of 6; more than 9 million (21%) women of child bearing age; and 10.1 million (24%) elderly or disabled Medicare beneficiaries (Hawkins & Rosenbaum, 1992). In terms of absolute numbers of underserved, the majority reside in urban areas, but the proportion of persons who are medically underserved relative to the general population is comparable in urban and rural areas. For the urban underserved, poverty is a much more powerful predictor of being underserved than living in an area of medical underservice (as defined by the primary care physician-to-population ratio). In fact, most urban underserved persons live in areas that are surrounded by highly sophisticated, state of the art health care systems and a full complement of primary care, specialty and subspecialty physicians.

For rural Americans, the issue of underservice is complicated by geography and inadequate resources. Health care providers and services are simply not available in many frontier and rural areas of the country. As noted by Hawkins and Rosenbaum (1992), "...rural underserved counties outnumber urban counties (1,586 nonmetropolitan versus 561 metropolitan);...19 states had more than 75 percent of their counties underserved, while seven had more than 90 percent underserved." Further, "554 counties were identified as 'double jeopardy' counties—those showing both severely diminished health status and a shortage of physicians. Of these, 16 percent were metropolitan and 84 percent were nonmetropolitan."

These data suggest that systems capacity is a critical variable in the health care access dilemma as it pertains to rural areas. Whereas urban health care systems have the full range of services and levels of care, rural communities are considered fortunate to keep their local hospital open and fiscally viable. The typical components of a rural health system include a community hospital; solo practitioners or small group practices; a community health center or migrant health clinic; and a varying range of county health, mental health and social services. It is less common that these elements co-exist in a rural community, but rather one, two or several of them, or, in the case of a frontier area, a solo practitioner with back-up in an adjacent community.

The challenges confronting rural health care providers are formidable. Available resources are usually inadequate, and the situation is compounded by weakened local economies that make recruitment and retention of health workers particularly difficult. Additionally, biases in reimbursement policies and medical and nursing education that disproportionately favor specialty care training over primary care have impeded the flow of an adequate supply of primary care practitioners into rural areas.

The vulnerability of rural hospitals has been well documented. The consolidation and integration frenzy that occurred throughout the industry during the 1980s has had a ripple effect on rural hospitals as well. The intensity of competition that has resulted from changing reimbursement and regulatory policies for hospitals has caused many metropolitan hospitals on rural fringes to compete for and secure referrals from rural practitioners, thus putting rural hospitals in an extremely vulnerable position.

The Total Picture: Health Care Access in Rural America

This paper has discussed many of the issues involved in the current health care debate and has presented these issues from a rural perspective. It is a complex picture that cannot be completed with a single brush stroke. The message is that the subtleties and contrasts of hue and tone that exist between locality, person and system require multiple responses and multiple solutions. Many lessons have been learned during the past 20 years about the health care needs of rural Americans and the best ways to deliver health care in rural settings. Included among these innovations are:

- the focused recruitment and deployment of health care practitioners to medically underserved areas through the National Health Service Corps (NHSC) and area health education centers (AHECs);
- the establishment of community-oriented primary care practices through locally planned and managed community and migrant health clinics;
- regulatory flexibility and the provision of fiscal incentives to rural hospitals to allow them to meet the changing needs of their aging communities;
- the development of federal programs that support the integration of mental health and primary care services in rural areas; and
- the provision of federal and state categorical and block grant funds to increase the capacity of local public health, social services and other agencies to meet community determined health care needs.

As a result of an intimate understanding of the health needs of rural Americans, and experience with the successes of these targeted health system interventions, the National Rural Health Association (NRHA) strongly believes that any discussion of national health care reform must include a commitment to system-level enhancements that will mitigate the systemic access barriers that exist in rural America. In February 1991, the NRHA issued a working paper entitled *Necessary Components for Any National Health Plan.* Using these necessary components as organizing principles, the NRHA proposes the above-noted series of policy goals and action strategies, which must be included in any national health reform proposal under serious consideration.

Part III

A Discussion and Analysis of National Health Reform Proposals

What is Really Wrong With the Health Care System? That Depends on Who You Ask

A major objective of this paper is to assess and critique a range of national health reform proposals relative to the level of attention they give to the concerns of rural Americans. Examined are 17 proposals, 16 of which are currently tracking through both houses of Congress, and the other being President Bush's health reform package (see Appendix).

Each of the current health care reform proposals reviewed in this section is attempting to right a wrong in the current system. In attempting to assess the adequacy and fairness of the proposed solution, it is critical to clarify the terminology, concepts and assumptions that are contained in each proposal. The first step in this exercise is to identify the problems targeted for solution and secondarily, to ask if these problems affect all persons equally or whether there are groups within the population—for example, rural residents—that are more vulnerable to the adverse affects of the problem.

The most significant problems in the current health care system, as identified by policy analysts and other experts, are unabated cost inflation in health care goods and services and the increasing number of persons who are being denied access to appropriate and timely medical care because they lack health insurance coverage or are underinsured because of other structural barriers that exist in the health care system. These non-financial barriers include a shortage of trained health care professionals; geographic and specialty maldistribution of health care providers and services; lack of culturally sensitive health care providers; attitudes, beliefs and cultural norms that inhibit access; language barriers; and other issues that relate to the organization and delivery of health care services.

The American people, through numerous opinion polls in the past several years, have identified many serious problems they associate with the current health care system. These problems relate to the issues of escalating costs and lack of access in the system, but they are much more focused and concrete when described by the consuming public as compared to the policy analysts and systems experts. A series of critical issues identified in a Harris Poll conducted in February 1992 included:

- 61 percent "worry a great deal" about not being able to afford health insurance;
- 50 percent "worry a great deal" about having to pay very expensive bills not covered by their health insurance;
- 48 percent "worry a great deal" about not being able to get care because they can't afford it; and
- 48 percent "worry a great deal" that their benefits will be cut.

The litany goes on. The bottom line is that working Americans have lost faith in the private health insurance system they once believed was there to protect them and their families from the the high costs of illness and disability. Their loss of confidence is the result of widespread exclusionary practices of private insurers that have systematically sought out younger, healthier workers as their preferred market and likewise screened out all persons—young and old alike—who have medical conditions or chronic illnesses that require them to use the health care system. This screening process occurs through the outright denial of coverage, the imposition of excessively high premium costs, the denial of coverage for pre-existing medical conditions, and the levying of costly deductibles and equally onerous co-insurance charges.

If the issues identified above represent the real problems in the current health care system, then the proposed solutions must address these issues squarely and precisely. The Harris Poll highlights many of the bedrock concerns of the American public.

Additionally, other problems affect the health and well-being of rural Americans:

- depressed rural industries where health insurance is not offered;
- large numbers of self-employed workers;
- low wage workers who cannot afford private health insurance;
- high rates of chronic disease and disability that require the provision of community-based and institutional long-term care services; and
- inadequate systems of care that require attention be given to the barrier that geography imposes on access to care for rural residents.

Current Legislative Proposals: Targets of Health Care Reform

Each of the legislative proposals currently being debated in Congress contains a range of provisions that can be characterized as "targets of reform." With few exceptions, these reform strategies are incremental steps toward the goal of true reform—they do not propose to change the basic structure of the current health care system or how it is financed, but rather they attempt to fill the gaps in health care coverage by instituting reforms in the private health insurance market and extending publicly financed health programs to a broader population. These financing reform strategies have potentially significant and differential implications for rural Americans and deserve a thorough analysis from a uniquely rural perspective.

To summarize briefly, the most widely circulated legislative proposals currently being debated in Congress contain some or all of the elements described below.

- A strategy or combination of strategies to achieve universality of health care coverage for all Americans.

- Private insurance market reforms intended to make more affordable and available insurance products for the small employer and self-employed market (the lion's share of the currently uninsured).
- Ensurance of a basic benefit package available either through the private market or the public sector.
- Reform of the medical underwriting practices of private insurance companies, which has resulted in the exclusion from the private health insurance market of increasing numbers of individuals with pre-existing medical conditions.
- Providing subsidies, either through the tax system or through individual and family vouchers, to low income workers and the unemployed to use to purchase health insurance.
- Medicaid or Medicare expansions or some other variant of public insurance to provide coverage to those individuals who would continue to be excluded from the private health insurance market because of employment status, low income, or chronic disease or disabling conditions.
- Financial and administrative incentives intended to encourage more cost efficient modes of delivering health care services (e.g., managed care, coordinated care, second general medical audit processes, case management, etc.).

A major policy issue in the health reform debate is whether micro- or macro-level management of the health care system will produce the best results in terms of controlling the overall costs in the system and ensuring quality across the range of health care services available. Many believe the trade-off between micro-management techniques (e.g., the external imposition of second opinions for surgical procedures, utilization review, and other practice-related audit procedures) and macro-management (e.g., setting annual national health care spending limits) is at the heart of the debate.

A Primer on National Health Plan Proposals

To better understand the Comparison of Health Care Reform Proposals matrix, a primer on three basic approaches to reform—a mixtureof market reform and expansion of public benefits, pay or play, and single payer—is presented, as well as discussion of a fourth newly emerged approach—managed competiton. In many instances a legislative proposal may reflect the principles and components from more than one strategy.

The discussion and critique of these variants of health care financing reform that follows is drawn from numerous expert sources as reported in academic and professional journals. As Blendon, Edwards and Hymans (1992) note, there are politically well equipped camps of both supporters and detractors for each approach to reform and the grounds for their support or opposition have become an integral part of the debate. To more fully appreciate the political and ideological arguments put forth, the essence of the debate surrounding each approach is briefly discussed here (Note 4).

Mixed: Market Reform/Expansion of Public Benefit Proposals

In early 1991, the Health Insurance Association of America (HIAA), the primary trade association of health insurers, put forth an industry-sponsored package of reforms that has been widely incorporated into many congressional and state legislative proposals. The basic assumption undergirding the HIAA package is that the existing model of a private health insurance market within the context of an employer-based insurance system is the most appropriate and realistic approach to health care financing. "Proponents argue that eight out of 10 people under the age of 65 years now get their health insurance through their place of employment, and it is least disruptive to extend coverage to the working population through employer-based private insurance" (Blendon, Edwards, & Hymans, 1992).

While the private health insurance industry acknowledges that this prevailing model of employer-based insurance is not without problems, the HIAA position is that the provision of health insurance in the United States has historically been in the context of a private market, and public financing of health care, with the relatively recent exception of Medicare for the elderly and disabled, has been a residual function of a reluctant welfare state. The market reform proposals are basically targeted at the small firm employment sector where the largest number of uninsured workers can be found. Key features of this reform strategy include:

- developing a basic benefits package with federal statutory authority to preempt state mandated benefits;
- setting annual limits on premium increases for employees of small groups;
- requiring that insurers cannot cancel high-cost policyholders solely because of their medical conditions;
- insurers must offer a policy to all members of a group of employees (in groups with more than two employees) regardless of pre-existing medical conditions; and, finally,
- modifying the current practice of experience rating so small groups within a given geographic area and job classification are offered comparable rates (give or take 20%).

The market reform proposals do not mandate that employers offer health insurance but rather attempt to make the products offered more competitive and thus induce employers into providing and employees into sharing in the cost of health insurance coverage. These proposals acknowledge the critical role played by Medicaid in extending coverage to poor families, elders and disabled individuals who do not have the financial resources to purchase private insurance or are medically underwritten out of the private market and subsequently include an expanded role for Medicaid or a comparable publicly financed program.

Variations of the market reform approach include plans by Reps. Rostenkowski and Johnson and Sen. Bentsen that propose small group reforms without subsidies, and plans by Sen. Chafee and President Bush that propose small group reforms and premium vouchers or tax subsidies for low- to moderate-income workers to induce them to purchase health insurance through their employers, or privately in the case of the self-employed. All of these plans propose a 100 percent tax deduction for the premium costs of the self-employed. In terms of consumer choice, individuals would be able to pick and choose among private plans, although the Chafee and Bush proposals contain a strong emphasis on managed care, which could have the effect of limiting rather than expanding choice, particularly in rural areas where health care resources are limited (Wilensky & Rossiter, 1991).

Several concerns have been voiced about the efficacy of a market driven reform strategy in terms of its ability to extend coverage to the most vulnerable among the uninsured. As long as the poor and chronically ill or disabled continue to be channeled into Medicaid or a comparable public program without a significant commitment to equalizing provider payments with those paid by private payers, this approach could lead to a "larger, more formalized two-tiered health care system than exists today" (Blendon, Edwards, & Hymans, 1992). Additionally, analyses of the tax credit features of the Bush proposal suggest that the credit is an insufficient inducement for low income workers who are on the margin to pay for the additional costs of health insurance premiums, deductibles and co-payments when other more immediate and compelling fiscal responsibilities (e.g., housing, food and transportation) peel off their monthly disposable income. Although the idea of tax subsidies and vouchers is attractive on the surface, it is highly unlikely that the subsidies would keep pace with medical care inflation and thus the purchasing power gained would not be a sufficient incentive to purchase a private "bare bones" insurance policy, particularly because the costs of deductibles, co-payments and uncovered services would be substantial under this type of reform.

In terms of the adequacy of coverage, a "bare bones" basic benefit package falls short of meeting the identified needs of many rural Americans. The prevalence of chronic disease and disability among this population requires the inclusion of a range of long-term care benefits. In total, a market reform strategy may extend limited coverage to a segment of the currently uninsured but would have limited success at meeting the needs of most low income workers and particularly the rural uninsured and underinsured.

Pay or Play Proposals

This approach to health care reform mandates that employers, usually with more than 25 employees, offer health insurance to their employees. Again, the implicit assumption is that the competitive marketplace is the most appropriate vehicle for extending health care coverage, but in the pay or play model, there is a much larger role for a publicly sponsored plan because in pay or play universal coverage is the goal. In this strategy, universal coverage is achieved through a public-private partnership. The public piece of this proposal can be conceptualized as a competitive force in the marketplace because it would be offered as an alternative product to the private insurance plans available. Some analysts have argued that the pay or play approach is a measured first step toward a unified national health insurance system.

The *pay* in pay or play refers to the surcharge that would be levied against employers who chose not to provide health insurance to their employees. The revenues that are generated from this tax would be used to support the public plan to which uninsured workers would be assigned. In most pay or play proposals, the costs of health care would be controlled in the same way as a single payer plan. The federal government, or a quasi-governmental entity, would be responsible for setting spending targets for health care expenditures and for negotiating fee schedules with doctors and hospitals. All of the pay or play plans currently in Congress strongly emphasize managed care models of delivery as an integral feature necessary to control the costs in the currently unmanaged system.

After full implementation, a pay or play plan would result in universal coverage for all Americans. This goal would be achieved over five to eight years, depending on the proposal discussed. This model has been described as being more politically palatable than a single payer model because it does not eliminate, but rather reforms, the existing private insurance industry. It has also been argued that it is less disruptive because it retains the post-World War II employer-based insurance model.

It has been argued that establishing national spending limits, a feature of most pay or play proposals, will significantly slow the overall rate of inflation in health care costs. On the negative side, this approach places a significant financial burden on small businesses, which will ultimately have an adverse effect on low wage earners and the businesses that employ them—many of whom now operate on the margin from a profit perspective. This is especially true in rural areas where there is a significant percentage of small to midsize businesses.

Single Payer Proposals

Under the single payer approach, the federal government would finance health care through a universally available plan with revenues from broad-based payroll or income taxes, or both. In only one proposal, sponsored by Rep. Dingell, the system would be financed by a value-added tax on all produced goods and services. The single payer model assumes a much diminished role for private insurance, and in several proposals, private insurance would be eliminated completely. Most single payer plans allow individuals to chose among providers and all maintain a private delivery system. In all the single payer plans government (either federal or state) assumes a leadership role in setting national spending limits, defining a comprehensive range of covered services (usually including long-term care), ensuring portability between states, and ensuring quality and cost-efficiency.

It has been argued by proponents that a single payer approach most effectively and expeditiously guarantees universal coverage. Additionally, this approach to universal access has the greatest potential for increasing efficiency and reducing the excessive administrative costs associated with a multipayer system. This approach would eliminate the cost-shifting that currently occurs between public and private payers. Because it is based on the principle of progressive financing, the costs of health care services would be equitably distributed throughout the population based on the ability to pay. Additionally, universal coverage through a broad-based progressive tax would achieve the policy goal of spreading the risk of higher cost users across the whole population, equalizing the cost among all users.

Opponents of a single payer plan cite disincentives to innovation resulting from artificial restraints on the proliferation and diffusion of medical technology and the possibility for health care rationing as chief among the reasons that a single payer plan would not be palatable to the American people. These arguments have particular relevance to rural areas where the cost effectiveness of rural hospitals purchasing highly technical diagnostic equipment has long been debated.

Managed Competition

Newly introduced as a specific legislative proposal, managed competition, also known as the Enthoven plan, is receiving

increased attention from both federal and state policy-makers. The philosophy of reform embodied in the managed competition model is described as "a competitive health system where health insurance and health care competition is motivated, structured and regulated to reward with the most customers those health care organizations that get the best results at the lowest costs. By inference, those customers who choose a healthy lifestyle and the most cost-effective health organizations are rewarded with the best health care at lower expense. Coverage is universal. Quality is uniformly and objectively measured on the basis of health outcomes" (Jackson Hole Group, 1992).

The managed competition model was developed principally by Alan Enthoven, an economist from Stanford University. The guiding principles of this model are solidly based in economic theory, a feature that makes this approach highly compatible with much of the current policy thinking surrounding health care reform. Specific features of the model include:

- a totally private sector health care system;
- employer-based coverage (employers would be mandated to provide full-time workers with coverage through a pooled prudent purchaser, i.e., a sponsoring organization that functions as a broker between private insurers, providers and purchasers);
- a capped federal tax exclusion for health benefits based on the lowest cost plan in a region; and
- three private sector boards that would be responsible for developing standards and a Security and Exchange Commission-like independent, quasi-governmental agency to administer the boards; a range of uniform health care benefits; and standards for the prohibition of medical underwriting, waiting periods, and exclusions for pre-existing medical conditions.

Although not explicitly addressed in the managed competition model, it is assumed that the current Medicaid and unemployed and underemployed uninsured population also would be covered through a sponsoring organization under other than an employer auspice. Inherent in this approach is the idea of "informed customers" and "customers who choose healthy lifestyles and cost-effective health organizations [being] rewarded with the best health care at lower expense" (Jackson Hole Group, 1992). From a medically underserved rural perspective, this approach to health care reform and system re-structuring warrants close and careful scrutiny because of the limited available resources in rural areas.

As was discussed in Part II of this paper, persons living in rural areas are more likely to live on the margin economically; are less likely to visit physicians and other health care providers; and most importantly, are less likely to have a range of health care providers and services to choose from. If the underlying principle of managed competition is a "market" in equilibrium—that is, informed consumers and a balance between supply and demand, then much needs to be done to shore up the supply of quality health care alternatives in rural areas as well as educating consumers in how to wisely use these newly acquired choices. Any serious proposal based on market competition must first and foremost deal with the issue of resource availability including providing the necessary fiscal inducements to ensure that sufficient providers exist to compete for the available "customers" of care in rural areas.

Notes

1. The 19 states are as follows: Alaska (57.6%), Arkansas (60.5%), Idaho (80.4%), Iowa (56.9%), Kansas (47.2%), Kentucky (54.2%), Maine (63.9%), Mississippi (69.7%), Montana (75.8%), Nebraska (52.8%), New Hampshire (43.7%), New Mexico (51.6%), North Carolina (44.7%), North Dakota (62%), Oklahoma (41.2%), South Dakota (71.3%), Vermont (76.9%), West Virginia (63.7%), and Wyoming (71%).
2. As noted in *Health Care in Rural America* (OTA, 1990) and elsewhere (Cordes, 1989), "rural" is variously defined by, among others, the U.S. Bureau of the Census and the federal Office of Management and Budget. For the purposes of this paper, data on rural residents are actually data on non-metropolitan residents unless otherwise noted.
3. Self-reported health status has been well documented to be a highly reliable predictor of actual health status when validated by medical charts and physician assessment.
4. Readers wanting a more in-depth discussion of the pros and cons of these various reform strategies should see the *Journal of the American Medical Association* theme issue published on May 15, 1991, and Blendon, Edwards, and Hymans (1992).

References

American Academy of Pediatrics and American College of Obstetricians and Gynecologists. (1988). Standard terminology for reporting of reproductive health statistics in the United States. *Guidelines for Perinatal Care* (2nd Ed.), 308-324. Evanston, IL: Author.

Blendon, R.J., Edwards, J.N., & Hymans, A.L. (1992). Making the critical choices. *Journal of the American Medical Association*, 267(18), 2509-2524.

Chase, H.P., Kumar,V., Dodds, J.M., Sauberlich, H.E., Hunter, R.M., Burton R.S., & Spalding, V. (1971). Nutritional status of preschool Mexican American farm children. *American Journal of the Disabled Child*, 122, 316-324.

Cordes, S.M. (1989). The changing rural environment and the relationship between health services and rural development. *Health Services Research*, 23(6), 757-784.

Coward, R.T., & Cutler, S. (1989). Informal and formal health care systems for the rural elderly. *Health Services Research*, 23(6), 785-806.

Department of Agriculture. (1987). Table 553, Migratory farmworkers: Number and sex of workers and earnings received. *Agricultural Statistics, 1987*, p. 386. Washington, DC: Author.

Department of Health, Education and Welfare. (1974). *Handicapped migrant farmworkers* (DHEW Publication No. OHD 75-25084). Washington, DC: InterAmerica Research Association.

Friedman, E. (1991). The uninsured: From dilemma to crisis. *Journal of the American Medical Association*, 265(9), 2491-2495.

Hawkins, D., & Rosenbaum, S. (1992). *Lives in the balance: A national, state and county profile of America's medically underserved.* Washington, DC: National Association of Community Health Centers.

Ingersoll, B. (1989, July 20). Farming is dangerous, but fatalistic farmers oppose safety laws. *The Wall Street Journal*, p. 1.

Jackson Hole Group. (1992). *A proposal for reform from the Jackson Hole Group.* Unpublished manuscript.

McManus, M., & Newacheck, P. (1989). Rural maternal, child and adolescent health. *Health Services Research*, 23(6), 807-848.

National Safety Council. (1987). *Accident facts.* Chicago, IL: Author.

Norton, C., & McManus, M. (1989). Background tables on demographic characteristics, health status, and health services utilization. *Health Services Research*, 23(6), 725-755.

Office of Technology Assessment. (1990). *Health care in rural America* (OTA Publication No. OTA-H-434). Washington, DC: Government Printing Office.

Pratt, D.S. (1990). Occupational health and the rural worker: Agriculture, mining and logging. *Journal of Rural Health*, 6(4), 399-417.

Ries, P. (1987). *Health care coverage by sociodemographic and health characteristics, United States, 1984* (Vital and Health Statistics Series 10, No. 162, DHHS Publication No. [PHS] 87-1590). Washington, DC: Government Printing Office.

Rowland, D., & Lyons, B. (1989). Triple jeopardy: Rural, poor, and uninsured. *Health Services Research*, 23(6), 975-1004.

Rust, G.S. (1990). Health status of migrant workers: A literature review and commentary. *American Journal of Public Health*, 80(10), 1212-1217.

Schlesinger, M.,& Kronebusch, K. (1990). The failure of prenatal care policy for the poor. *Health Affairs*, 9(4), 91-111.

Short, P.F., Monheit, A., & Beauregard, K. (1989). *A profile of uninsured Americans* (DHHS Publication No. [PHS] 89-3443). Rockville, MD: Department of Health and Human Services.

Slesinger, D. (1992). Health status and needs of migrant farm workers in the United States: A literature review. *Journal of Rural Health*, 8(3), 227-234.

Wakefield, M.K. (1990). Health care in rural America: A view from the nation's capital. *Nursing Economics*, 8(2), 83-89.

Wilensky, G., and L. Rossiter. (1991). Coordinated care and public programs. *Health Affairs*, 10(4), 62-77.

Appendix

A Comparison of Select National Health Care Reform Proposals

National Health Reform Proposal Scorecard

A Comparison of Select National Health Care Reform Proposals

Proposal	Type of Reform	Delivery System Enhancements	Eligibility
Pay or Play Proposals			
Pepper Commission Health Access Reform Act of 1991 H.R. 2535 Waxman	A "pay or play" plan, universal coverage after full implementation through employer-based plans and expanded Medicare Program for all others (Medicaid phased out).	0.5 to 1 percent set-aside in public plan (estimated $1 billion over 5 years) for development of primary care centers and public health clinics in medically underserved areas; reimbursement for nurse practitioners, physician assistants and social workers.	In general, all persons not covered by Medicare or through an employer would be included in a federally administered public plan.
Affordable Health Care for all Americans—HEALTHAMERICA S. 1227 Mitchell	A "pay or play" plan, workers in firms with more than 25 employees covered; unemployed and workers in small firms covered under new public plan—AmeriCare (replaces Medicaid).	$1.3 billion over 5 years for expansion of primary care clinics (community and migrant health clinics) in medically underserved areas; incentives for managed care; practice guidelines developed.	Phased-in coverage for all workers (5 year plan), all others covered under AmeriCare (replaces Medicaid).
S. 1177 Rockefeller	A "pay or play" plan mixed with a newly created federally administered public plan.	0.5 to 1 percent set-aside (estimated to be $1 billion over 5 years) for development of primary care centers and public health clinics serving medically underserved areas.	All U.S. citizens (except Medicare beneficiaries) would be enrolled in either an employer-based plan or the public plan.
Mixed: Market Reform/Public Benefit Expansion Proposals			
Health Insurance Coverage and Cost Containment Act of 1991 H.R. 3205 Rostenkowski	Private insurance reforms.	Not applicable.	Employees in firms with 2 to 50 employees who work at least 17.5 hours per week.
Health Equity and Improvement Act of 1991 S. 1936 Chafee	Private insurance reforms; encourages the development of state plans for the remaining uninsured.	Expanded funding for community health centers ($2.9 billion over 5 years) and the National Health Service Corps (to provide access to 7.5 million people over the next 5 years); increase funds for childhood immunizations ($50 million per year); fund a new program to help develop cost-effective health delivery systems in MUAs; increased funding for AHECs, Medicare Rural Health Outreach Grants and EACH; encourage the development of private sector managed care delivery systems.	To the extent individuals and employers purchase insurance and states establish new public programs, coverage is expanded.

May 1992

Benefits	Financing	Consumer Costs/ Credits	Administration
Minimum benefit package (physician, hospital, clinic services, prenatal and well child care, pap smears, mammograms and limited mental health).	Premiums paid by employer; public plan premiums based on income; additional funding for public program from a surtax on personal and corporate income.	No premium costs for persons below poverty level; based on income for persons between 100 and 200 percent of poverty; no cost sharing on preventive services; $250 deductible for individuals, $500 for families, $3,000 per year stoploss; 100 percent tax credit for self-employed who purchase basic plan.	Public plan administered by federal government; regulation of private plans.
Minimum benefit package (physician, hospital, prenatal and well child care, pap smears, mammograms and limited mental health), long-term care only for low-income beneficiaries.	Employer/employee share 80/20 based on annual premium of $1,717; raises SSHI taxable wage to $200,000; public plan premiums based on income; other payroll taxes and surtax on personal and corporate income.	No premiums for persons below poverty level in public plan; $250 per year deductible for individuals; $500 per year for families; 20 percent co-insurance; $3,000 per year stoploss for employer-based insurance.	Public program administered by states under federal guidelines; federal rules govern private insurance reforms.
Both employer-based and public plans would cover inpatient hospital care; outpatient services; clinic services; physician services; rural health clinics and preventive care (home visits, well child care, mammography, pap smears).	Employer/employee premiums, general revenues and individual payments.	Low-income unemployed waived from premiums, co-payments and deductibles; unemployed persons with incomes below 200 percent of poverty will have subsidized premiums, deductibles and co-payments; in general, 80/20 premium roles would apply to employed persons; $250 per individual and $500 per family yearly deductible (no deductible for preventive care); 20 percent co-insurance and $3,000 per year stoploss.	Public plan federally administered by HCFA.
Minimum benefit package based on Medicare with added preventive services.	Self-funded by policy holders and employer contributions.	100 percent tax credit for self-employed who purchase the basic plan.	Standards established by DHHS secretary; states may administer standards under federal guidelines.
For small businesses, DHHS would define a basic benefit package; in new public program no federal support for long-term care.	Financing of expanded coverage by private insurance premiums shared by employers and employees; shared federal-state funding for new public program (new program would eventually replace Medicaid).	Tax credits for individuals ($600) and families ($1,200)—the credit is phased out at $32,000 for a family and $16,000 for an individual; tax credits for small businesses; persons without employer-based insurance and the self-employed would receive 100 percent tax deduction for the premiums they pay; tax credit up to $250 for preventive care.	Federal standards for health insurance reforms established by the secretary of DHHS; states responsible for the administration of the new public plan.

Proposal	Type of Reform	Delivery System Enhancements	Eligibility
Mixed: Market Reform/Public Benefit Expansion Proposals (continued)			
Health Insurance Reform and Cost Control Act S. 1872 Bentsen	Private insurance reforms.	Increases authorization for outcomes research from $110 million to $175 million in FY 1992; $225 million in FY 1993; and $275 million in FY 1994.	Employees in small firms with 2 to 50 employees.
Health Equity and Access Reform Today (HEART) H.R. 1565 Johnson	Private insurance reforms.	$4.5 billion in grants over 5 years to community health centers to expand services and improve birth outcomes.	Employees in small firms with 3 to 25 employees.
Universal Coverage, Single Payer Proposals			
Universal Health Care Act of 1992 H.R. 1300 Russo S. 2320 Wellstone	A national health insurance plan, single payer, universal coverage, private insurance eliminated.	Outcome research and practice guidelines; preventive services covered; national plan for training health personnel.	All legal U.S. residents.
MediPlan Health Care Act of 1991 H.R. 650 Stark	A national health insurance plan, universal coverage through an expansion of Medicare.	Not applicable.	All legal U.S. residents.
Comprehensive Health Care for All Americans H.R. 8 Oakar	A national health plan administered by the states, universal coverage for all but Medicare beneficiaries, private insurance eliminated.	$1 billion for systems development in medically underserved areas; reimbursement for PAs, NPs, CNMs, and social workers.	All legal U.S. residents, except Medicare beneficiaries.
American Health Security Plan S. 2513 Daschle	A national health insurance plan, universal coverage, and publicly financed.	Home and community-based long-term care services are covered; Federal Health Board will sponsor efforts by states and providers to create innovative approaches to health care delivery; health training budgets with institutions must include at least 50 percent to primary care practitioners, must fund non-hospital-based residency programs, must take into account the higher costs of placing students in rural areas, and must fund the training of non-physician practitioners.	All legal U.S. residents.
National Health Care and Cost Containment Act "Vermont Plan" H.R. 2530 Sanders	Universal coverage through state administered single payer system.	Encourages states to develop their own universal health insurance systems, potential for state innovations.	All legal U.S. residents.

Benefits	Financing	Consumer Costs/ Credits	Administration
Two required packages: a minimum package based on Medicare benefits plus preventive care; and a "stripped down" plan.	Financing of expanded coverage shared by employers and employees.	100 percent tax deduction for health insurance premiums paid by the self-employed.	National Association of Insurance Commissioners defines standards for health insurance reforms. If NAIC fails to do so, the DHHS secretary will set and enforce them.
Minimum benefit package with basic hospital, medical, surgical and some preventive care.	Financing of expanded coverage shared by employers and employees.	100 percent tax deduction for health insurance premiums paid by the self-employed in managed care plans or plans with a 30 percent co-payment provision.	Same as Bentsen's provisions.
Physician and hospital care, home health care, prescription drugs, long-term care, dental, preventive, vision and limited mental health.	Six percent payroll tax on employers, 4 percent corporate tax on firms with profits of more than $75,000; increase top income bracket to 38 percent (persons with incomes of more than $200,000).	No premiums, co-payments or deductibles.	State administered under federal rules and guidelines.
Medicare benefits plus well baby and child care, preventive dental, prescription drugs, glasses, hearing aids, prenatal care and family planning.	Employer/employee share 80/20; 2 percent tax on gross income of single taxpayers with income more than $16,000 and for couples with income more than $32,000; 2 percent corporate income tax and state contributions.	No premiums; $500 per year deductible except for low-income pregnant women and children below 200 percent of poverty level; deductibles income related; Medicare co-insurance rules apply; $2,500 per year stoploss.	Administered by DHHS secretary through fiscal intermediaries (same as Medicare).
Dependent on state plans. Minimum benefit package would include physician, hospital, prenatal and well child care, limited mental health and substance abuse, and hospice.	Federal revenues and state matching funds.	Income-related cost-sharing; states can impose deductibles and co-insurance; no deductibles for pregnant women or families below 150 percent of poverty; $1,000 per year stoploss for individuals and $2,500 for couples.	National Health Board established, jointly administered between federal and state government.
Physician and hospital care; all medically necessary care; preventive care; prescription drugs; outpatient mental health; substance abuse; home health and rehabilitation; and long-term care.	80 percent federally funded through Federal Health Trust Fund—sources of revenue include individual premiums based on progressive tax; employer tax; and funds currently in Medicare, Medicaid and CHAMPUS; states fund additional 20 percent (replaces Medicaid).	The Federal Health Board will determine co-payments and out-of-pocket limits based on principles of fairness and appropriate utilization of services.	A Federal Health Board (appointed by the president and confirmed by the Senate) will specify services and budgets; the program will be state administered; and the plan will be portable among the states.
Would vary by state, but would include hospitalization, physician, dental and long-term care.	Presumed to be budget neutral because states would be allowed to pool Medicare, Medicaid and other federal and state health funds to finance state health plans.	Not applicable.	States.

Proposal	Type of Reform	Delivery System Enhancements	Eligibility
Universal Coverage, Single Payer Proposals (continued)			
Health U.S.A. Act of 1991 S. 1466 Kerrey	A national plan administered by the states, universal coverage.	An estimated $5 billion over five years to support development of health clinics in medically underserved areas.	All legal U.S. residents.
National Health Insurance Act of 1991 H.R. 16 Dingell	A national health plan targeted at working Americans and their dependents; administered by state and local entities.	Grants-in-aid for training and education.	Employees and their dependents; Social Security and civil service retirees; dependents of above groups; non-workers are optional.
Other Proposals			
BasicCare Health Access and Cost Control Act Glickman S. 2346 Kassebaum	Establishes a single, nationally defined core benefits package and leaves its administration and financing in the private sector.	Significantly expands funding for National Health Service Corps ($120 million for each of five years); physicians allowed a $1,000 per month tax credit for practicing in a health professional shortage area (NPs and PAs would receive a $500 per month credit); new funding for community health centers and other state and local public health clinics ($600 million annually).	At the end of three years all citizens would be enrolled in BasicCare.
Health Empowerment and Access Legislation (HEAL) H.R. 1230 Grandy	A mandate on employers to provide *access* to group coverage (not that they provide coverage).	Encourages managed care.	Employed persons.
President Bush's Comprehensive Health Care Reform	Market-based reforms including tax credits, development of basic benefit plan for small employers and HIAA market reforms.	Encourages the development of Health Insurance Networks (HINs) for the purpose of pooling small businesses to purchase insurance products; encourages the use of coordinated care including HMOs, PPOs, and other forms of managed care; expands funding for community and migrant health centers and the National Health Service Corps.	Potential expanded coverage for the uninsured who purchase insurance in the private market.

Benefits	Financing	Consumer Costs/ Credits	Administration
Physician and hospital care; preventive services; limited mental health and substance abuse; nursing home and home health care; prescription drugs, lab and diagnostic services.	Consolidates funds currently spent in Medicare, Medicaid and other health programs and state funds committed to health programs; 5 percent payroll tax; alcohol and cigarette taxes; 2 percent tax on non-wage income; new 33 percent top federal tax bracket; increase in corporate income tax; raises OASDHI taxable wage to $125,000.	Annual deductible of $100 per individual and $300 per family; 20 percent co-insurance; $5 for first physician visit; $1,000 individual cap for out-of-pocket expenses ($1,500 for family of two); no cost sharing for preventive care, hospital care or first three months of nursing home care; low-income persons protected.	Federal administration at DHHS (guidelines to states). Program administered by states or regions through public planning process.
All medical (hospital and physicians) and dental care; preventive, therapeutic and periodic exams; podiatry; home nursing; and eye glasses.	A 5 percent national value-added tax on all products and services.	No cost-sharing required in statute; left to the discretion of national board.	Administered by local agencies designated by state health department. Administered nationally by a five-member National Health Insurance Board.
The BasicCare plan would cover basic hospitalizations, basic outpatient services, catastrophic coverage, extraordinary long-term care costs, prescriptions drugs, periodic health exams, and preventive care.	Existing Medicaid appropriation; would limit current 100 percent tax deduction for employer health benefit contribution to the cost of the BasicCare plan; a limited draw from the Social Security payroll tax (not to exceed 1 percent).	100 percent tax deduction for all covered individuals (either employer or self-employed eligible for deduction); vouchers for low-income persons to purchase BasicCare coverage.	Independent expert commission that will contract with regional and local entities for the collection and dissemination of quality and cost data.
Basic acute care benefits.	Employer and employee premiums.	100 percent tax deduction for self-employed; existing deductibles and co-payments assumed in force.	Private market.
States would be required to develop a basic benefit package equal to the value of the health insurance credit.	Employer and employee premiums.	Health insurance tax credit: $1,250 per individual, $2,500 per couple, and $3,750 per family for persons with incomes up to $50,000, $65,000 and $80,000, respectively.	Private market.

National Health Reform Proposal Scorecard

National Rural Health Association's Necessary Components for National Health Reform

Necessary Component	H.R. 1300 Russo/ S. 2320 Wellstone	S. 1227 Mitchell	H.R. 3205 Rostenkowski	H.R. 2535 Waxman	H.R. 650 Stark	H.R. 8 Oaker	S. 2513 Chafee	S. 2513 Daschle
Universal Access								
All U.S. residents covered	+++	+++ (phased in)	—	+++	+++	+++	—	+++
Premiums based on ability to pay	N/A	++	++	+++	N/A	+++	—	++
Deductibles, co-payments based on ability to pay	N/A	++	++	++	+++	+++	—	Most likely
Federal costs to expand access funded through progressive taxes	+++	+++	N/A	+++	+++	+++	N/A	+++
Self-employed receive 100% tax deduction for premiums	N/A	Unknown	+++	+++	N/A	N/A	+++	N/A
Comprehensive benefits	+++	++	++	++	+++	+++	++	+++
Federal Leadership								
Federal government establishes eligibility standards and benefits coverage	+++	+++	+++	+++	+++	+++	—	+++
Federal government establishes spending limits	+++	+++	+++	+++	Unknown	+++	—	Unknown
Federal government establishes equitable reimbursement policies for providers under public programs	+++	+++	+++	+++	++	Most likely	—	+++
Federal government responsible for streamlining claims processing procedures	+++	+++	+++	+++	++	Most likely	—	+++
Federal government assures portability of plans	+++	++	++	++	++	++	—	+++
State and Local Self-Determination								
Rural representation on transition terms and policy boards	—	—	—	—	—	—	—	—
Local planning and evaluation efforts	—	—	—	—	—	—	—	—
Flexibility in managed care other utilization control and mechanisms	—	—	—	—	—	—	—	—
States assure equitable health care resource distribution	—	—	—	—	—	—	—	—

Legend:

+++ Highly consistent with NRHA principles
++ Moderately consistent with NRHA principles
\+ Minimally consistent with NRHA principles
— Not consistent with NRHA principles or not addressed

S. 1872 Bentsen	H.R. 1565 Johnson	S. 1466 Kerrey	H.R. 16 Dingell	S. 2346 Kassebaum	S. 1177 Rockefeller	President Bush	H.R. 1230 Grandy	H.R. 2530 Sanders
—	—	+++	+++	+++ (phased in)	+++	—	—	++
—	—	+++	Unknown	Unknown	+++	—	—	+++
—	—	+++	Unknown	Unknown	++	—	—	N/A
N/A	N/A	+++	++	++	+++	—	—	++
+++	+++	Unknown	N/A	+++	+++	+++	+++	N/A
++	+	+++	Unknown	++	++	++	—	Unclear
++	—	+++	Unknown	—	+++	—	—	++
—	—	+++	Unknown	—	+++	—	—	Unknown
—	—	+++	+++	—	+++	—	—	++
—	—	+++	Unknown	—	+++	—	—	Unknown
—	—	+++	++	—	++	—	—	++
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—
++	++	—	Unknown	+++	—	—	—	—
—	—	—	—	—	—	—	—	—

Necessary Component	H.R. 1300 Russo/ S. 2320 Wellstone	S. 1227 Mitchell	H.R. 3205 Rostenkowski	H.R. 2535 Waxman	H.R. 650 Stark	H.R. 8 Oakar	S. 2513 Chafee	S. 2513 Daschle
Community Development								
Federal fiscal incentives for rural community-building activities	—	—	—	—	—	—	—	—
Consumer Choice								
Multiple delivery system options	+++	+++	+++	+++	++	++	+++	+++
Financing Incentives								
Flexibility in provider payment mechanisms	+++	++	++	++	++	++	+++	++
Incentive for care coordination services	—	—	—	—	—	—	—	—
Expansion of rural health outreach grants	—	—	—	—	—	—	++	Most likely
Guidelines for direct reimbursement of nurse practitioners, certified nurse midwives, physician assistants and other allied health professionals	—	—	—	+++	—	+++	++	—
Increased funding for migrant and community health centers as well as other innovative delivery models in rural areas	+++	+++	—	+++ (not for operations)	—	—	+++	Most likely
Federal financial incentives for development of comprehensive rural delivery systems	—	—	—	—	—	++	+++	Most likely
Federal funding for rural hospitals	—	—	—	—	—	—	++	Most likely
Education and Training of Health Personnel								
Expansion of the National Health Service Corps, area health education centers, and interdisciplinary training grants	Most likely	—	—	—	—	—	+++	Most likely
Medical education standards for training of primary care physicians	Most likely	—	—	—	—	—	—	+++
Ambulatory training experiences in rural areas	—	—	—	—	—	—	—	—
Quality and Efficiency								
Increased funding for outcomes research	Most likely	Most likely	—	—	—	—	—	—
National standards established for systems accountability and quality assurances	Most likely	+++	++	—	—	—	—	—

S. 1872 Bentsen	H.R. 1565 Johnson	S. 1466 Kerrey	H.R. 16 Dingel	S. 2346 Kassebaum	S. 1177 Rockefeller	President Bush	H.R. 1230 Grandy	H.R. 2530 Sanders
—	—	—	—	—	—	—	—	—
++	++	+++	Unknown	—	+++	++	++	+++
+++	+++	++	+++	+++	++	+++	+++	++
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—
—	+++	—	—	++	+++ (not for operations)	+++	—	—
—	—	+++	—	++	—	—	—	—
—	—	—	—	—	—	—	—	—
—	—	—	Most likely	+++	—	++	—	—
—	—	—	—	++	—	—	—	—
—	—	—	—	—	—	—	—	—
+++	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—