Rural Wisconsin
Health Cooperative

Eye On Health

Review & Commentary on Health Policy Issues from a Rural Perspective - December 1st, 1998

Rural Health's Future Keeps Changing

From *U.S. Hospitals and the Future of Health Care, A Continuing Opinion Survey* by Deloitte & Touche, 1998:

"Consolidation in the industry continues but is beginning to show some differences based on the region of the country and type of hospital. Integrated delivery systems have continued to grow but are evidently not the universal model that hospitals and other providers will form."

"Much of what is happening is being fueled, if not driven, by the continued growth in managed care. Its growth, however, is steady and not at the rapid rate predicted by hospital executives in 1996. That fact is actually good news since the knowledge physicians, hospital workers and patients have about managed care and hospital management's comfort with it, is far from what that knowledge needs to be. Capitation, at least on the hospital portion of the managed care business, is still fairly limited as to its existence and the revenues involved."

"Efforts to improve efficiency continue with many hospitals focusing on more specific areas for reengineering. Investment in capital expenditures as well as information technology is evidence of the attempt to adapt to future needs and facilitate implementation of clinical pathways, disease management techniques, outcome research findings, and true patient care management."

- "Fifty-eight percent of CEOs say their hospitals are stand-alone institutions, and 34 percent believe their hospitals will continue to be stand-alone facilities in five years. In 1996, 21 percent of respondents believed their hospitals would be stand-alones in five years, and in 1994 the figure was 19 percent."

- "The vast majority of inner city (83 percent), other urban (79 percent) and suburban (74 percent) hospitals expect to join larger organizations in five years, in contrast to only 59 percent of rural hospitals."

- "More than 50 percent of all hospitals that are part of larger organizations report they have not eliminated or reduced any patient services. Half of responding hospitals have not combined any services, and among those that have, most have focused more on combining financial or administrative rather than clinical or ancillary services."

- "While the number of hospitals belonging to integrated delivery systems (IDSs) continues to grow, IDSs in the development stage have dropped significantly, continuing a trend reported in 1996. More inner city hospitals (79 percent) report belonging to IDSs, while rural hospitals report the least IDS membership (30 percent)."

"Rural in-your-face advocacy is saying it early, saying it often and keep saying it." Anonymous.

EOH Editors note: Of particular interest this year was that the overwhelming majority of quotes in the report were from rural administrators-but then we've always known we were more quotable; a good cross section of opinion about the future of rural health is shown in the comments from these rural administrators:

"We are witnessing a convergence of marketplace pressures. Managed care penetration and government payment cutbacks mean declining net revenue per patient...(yet) costs increase as we compete with nearby urban areas to attract and retain good employees and capital investment becomes increasingly vital. Meanwhile, large organizations lurk nearby, waiting for a misstep."

"Medicare and Medicaid are 75 percent of our business. They are still huge wild cards in predicting what will happen in the future...we can expect lower payments, increasing costs, and no indications that HCFA cares or understands the operational implications of their frequently misguided decisions."

"Hospitals and physicians are being squeezed and are working harder. The problem is over-capacity, and mergers and acquisitions are not solving it."

"My fear is that coping with declining Medicare reimbursement will require us to reduce the level of services our patients and physicians are accustomed to. I'm not sure they are prepared to accept that."

"The Balance Budget Act portends drastic consequences for small, primary care-oriented providers, except for those that may qualify for Critical Access Hospital designation."

"We are not heavily penetrated by managed care...but we have to be ready because it's coming, and with our present information systems, we're just not in a position to deal with it effectively."

"While we are not formally affiliated or contractually connected to other organizations, we nevertheless have a virtual network based on our historic referral patterns."

"Compliance is of great concern, requiring significant resources and priority in view of other necessary objectives to overcome reimbursement shortfalls and competitive forces. Overzealousness by government regulators could cripple (our) institution."

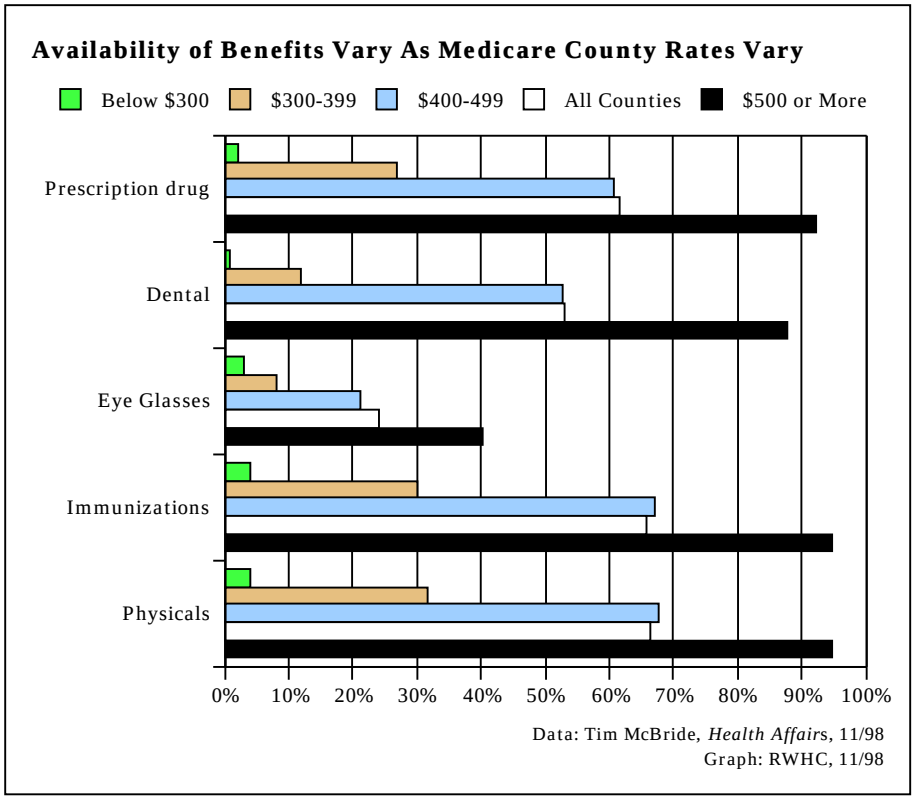
"It is now time for physicians to step up to the plate and show leadership in shaping the new health care delivery system. Physicians have been too passive and have allowed outsiders to control their relationships with patients. We need to help physicians in assuming/accepting their responsibility."

Rural Seniors, Get Mad--Location Matters

From "Disparities in Access to Medicare Managed Care Plans and Their Benefits," by Tim McBride in *Health Affairs*, 11/98:

"Concern about the variation in rates paid to Medicare managed care plans across the United States led to the passage of major reforms of formulas for setting these rates as part of the Balanced Budget Act of 1997. However, observers have focused much more on the variation in the rates per se than on the disparity in benefits offered by these plans and in the premiums they charge."

"This analysis shows that there is considerable variation in the range of risk plans available to Medicare beneficiaries, the premiums charged, and the benefits offered and that the variation is strongly related to the payment made by the Health Care Financing Administration (HCFA) on behalf of the beneficiary and to the beneficiaries residence."



$2 Billion State Shortfall

From *Medicare: a $2 Billion State Biennial Shortfall*, RWHC's testimony before the Wisconsin legislature's Special Committee on Capture of Federal Resources, 11/18/98 (full text at www.rwhc.com):

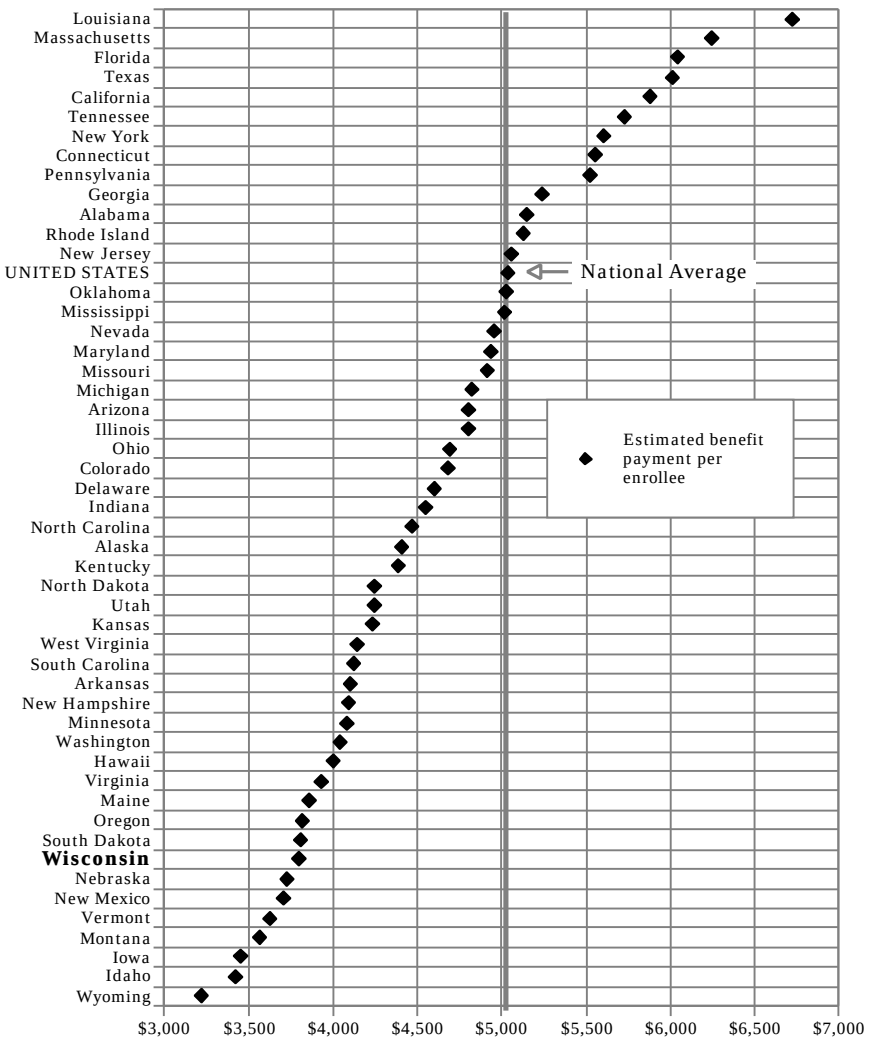
Medicare spending per enrollee in Wisconsin is eighth from the bottom and 25% below the national average--$3,795 estimated annual benefit payments per Medicare enrollee compared to a national average of $5,034. (*House Ways and Means 1997 Green Book*).

If Wisconsin's average payment had been at the national rate, the state would have received almost another billion dollars per year--$1,239 in benefits lost for each of 766,000 Wisconsin Medicare enrollees or $950 million lost each year.

Part of the lower Medicare spending in Wisconsin may be due to area differences in the average need for health care, is due to our more efficient delivery systems and most certainly is due to ongoing inequitable federal payment policies, particularly the application of very flawed adjustments for regional wage differences. (Several years ago, we were able to win a phase out of such an adjustment for physician payments.)

Our failure to obtain equitable Medicare benefits and payments effects all Wisconsin sectors; for example, compared to private payers in other states, those in Wisconsin pay a higher share of total costs to make up for Wisconsin's Medicare shortfall.

Medicare Program Payments per Enrollee in 1996 By State of Residence



Data: *House Ways and Means 1997 Green Book, 1997*
Graph: RWHC 1/98

Wage Adjustments: a Root Cause of the Problem

Medicare has a complex formula to determine what it pays any hospital for providing a particular service to a Medicare beneficiary. In brief, about three-quarters of that payment is increased or decreased by applying a "hospital wage index." The index is intended to adjust for the fact that market wage rates for nurses and other hospital employees vary somewhat across the country.

The index actually goes well beyond the original intent, adjusting not only for differences in local wage rates but also rewarding hospitals in areas where a greater than average number of high salary employees are hired (even after adjusting for hospitals with sicker patients). This hurts Wisconsin's more efficient health care system in general and rural counties in particular.

The problem is about to get significantly worse. Medicare is expanding the use of the hospital wage index to be used to adjust payments for hospital outpatient, Medicare Choice health plans, home health and nursing home services--the wage index isn't just for hospitals any more.

Wisconsin must implement a coordinated Medicare strategy among Wisconsin's state government, congressional delegation and other key allies.

Your County's Medicare Options on Internet

From www.medicare.gov, the new Medicare Consumer site; visit it to make your own local comparisons of the increasing differences in Medicare benefits:

"Welcome to the Health Care Financing Administration's (HCFA) Medicare Compare Database. Medicare Compare is an interactive database which includes detailed information on Medicare's health plan options."

"Medicare beneficiaries need thorough and timely information about the variety of managed care plans available to them. The facts presented allow you to 'comparison shop' and find the plans that work best for you. You can gather data in a number of different areas. For example, you will be able to look at all the plans in your zip code. You can also compare costs for premiums and types of services offered, but this is just a starting point. You are advised to call any plans you are considering before making a decision about which one to select to ensure that you have up-to-the-minute information about that plan."

"If you are not sure about how to choose the best plan, you can go to our 'Choosing a Plan' section. Once you enter, you will be taken on a step-by-step tour designed to help you select the plan that best fits your needs. If you know what you're looking for in a plan, you can use the quick search methods below. Each search leads you to a wealth of information about the plans offered in your area."

Small Firms Hard Hit by Premium Increases

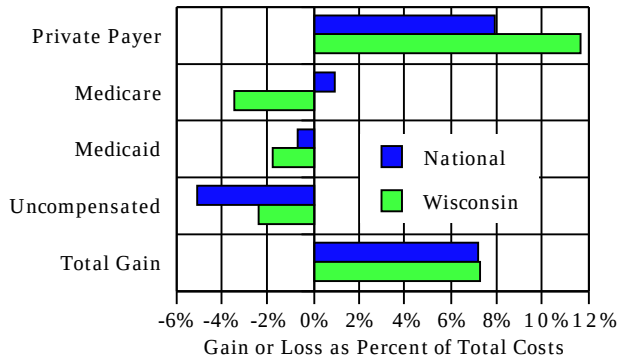
From "Businesses' Health Premiums Are Rising" by Dale Buss, *The Wall Street Journal*, 11/17/98:

"After several years of relatively flat health insurance costs, U.S. businesses are starting to be hit with a startling increase in premiums--and small businesses are being wacked the hardest."

"Renewal increases in renewal notices are running as high as 50% for some small companies, according to benefits consultants. Even medium and large companies are seeing increases about 5%, after flat or even declining increases in the past few years."

"Small companies have always been hit harder than large companies by healthcare inflation, largely because their tiny employment base pose much greater actuarial risks to insurers. In large companies, the costs of sudden medical events is spread over hundreds or thousands of workers. But in a small company, if just a few employees bear children at the same time, the increased cost to the insurer in percentage terms could be

WI Private Payers Pay for Government Shortfalls



Data: Medicare Payment Advisory Commission, 7/98
Graph: RWHC, 9/98

enormous and insurers try to recover these costs through large premium increases."

"What's more, HMOs have eased their price-slashing battles for market share and have made it clear that they are now focusing on restoring their tattered profitability by raising premiums."

"At the same time, some experts argue that managed care has done little to change fundamental high-cost patterns in American health care. 'They got the easy piece under control by getting (hospital) bed days cut in half," says Dr. Charles Peck, director of physician and managed care services for Arthur Anderson & Company in Atlanta. 'Now comes the really hard work: redesigning the way we delivery health care, preventing illness, changing bad habits.' "

Purchasing Pools Can Make a Difference

From "Voluntary Purchasing Pools: A Market Model for Improving Access, Quality, and Cost in Health Care," a position paper of the American College of Physicians published in *Ann Intern Med*. 1996;124:845-853:

"Voluntary purchasing pools-groups of businesses, governments, and sometimes individual persons formed to purchase health coverage-hold many potential advantages for the practice of medicine in the emerging marketplace. Purchasing pools can decrease costs, provide access for some otherwise uncovered populations, increase choice and continuity of care, and provide competitive opportunities for a wider variety of health plan types, including community-based, physician-run networks."

"Of special concern to both physicians and their patients is the potential of purchasing pools to protect continuity of care. In a purchasing group, employers and individual persons continue to finance care, but

buying is done through a central pool that offers an array of plans from which individual employees can choose. Consolidation of buyers creates a mechanism-the pool-for aggregating and expanding health plan choices beyond those offered by individual employers. One survey of employers, done by the Kaiser Family Foundation and KPMG Peat Marwick, found that 84% of firms that offered health insurance made only one plan available. Another Kaiser survey found that 45% of nonfederal workers had only one health plan available to them. (The percentage of employees without choice is lower than the percentage of firms offering choice because more employees work for larger firms, which are more likely than small firms to offer choice.)"

"By breaking the employment-insurance link and offering a wider choice of health plans, pools increase the likelihood that patients who change jobs can keep their personal physicians. Although we are not aware of any data that measure job-related disruptions in patient care, many physicians and their patients are acutely aware of the problems such disruptions cause. Without a mechanism to break the link between employment and health coverage as more persons move into network managed care plans, these disruptions will only worsen."

"In addition to providing continuity, the expanded consumer choice enabled by purchasing pools increases the competitiveness of types of health plans other than those offered by the large proprietary managed care companies. In the current environment, in which employers rather than individual persons do most of the choosing of health plans, large employers control huge segments of the consumer market and tend to deliver them to large corporate plans. **However, if individual employees choose from a menu available to an entire region, then smaller health plans, such as physician-directed networks or physician-hospital organizations, might enjoy greater access to patients.** Both continuity and a broader diversity of available health plans can play an important role in the overall quality of care in a community."

"Purchasing cooperatives are attractive to the general public because they can decrease costs through administrative savings and group leverage, making health coverage more affordable and therefore more accessible to cooperative members. More broadly, purchasing cooperatives consolidate what has become an extremely fragmented marketplace structured on risk-selection practices. Combined with insurance reforms, consolidation of the buyers' side of the health insurance marketplace can reduce risk-selection opportunities, forcing health plans to compete by delivering high-quality, cost-effective health care. The American College of Physicians has supported all three of these principles-expanded access and market-induced quality improvement and cost containment."

WI Coalition for Health Insurance Reform

An update from Kelly Haverkampf, Executive Director of Wisconsin Rural Partners, Inc.:

A forum sponsored by Wisconsin Rural Partners, Inc. in February, 1997 on the topic of health insurance revealed widespread interest in increasing the options for individuals and small businesses to have access to affordable health insurance. Since then, nineteen organizations representing farmers, small businesses, health care providers, associations and cooperatives have joined together to work through the complexities of the health insurance market toward developing feasible and acceptable reforms.

The Coalition first developed an issue paper which explores the problems encountered by farmers, small businesspeople, retirees and small municipalities, in securing health insurance at comparable prices and coverage to larger groups throughout Wisconsin. Coalition members participated in a collaborative learning workshop where they identified issues of importance to all the groups, and assessed the environment of the health insurance market and regulatory structures to identify feasible solutions. With the assistance of an expert consultant from the Institute for Health Policy Solutions, in Washington, D.C., the group studied and debated alternative solutions to different aspects of the current health insurance market, most of which have been implemented to some degree in other states. After developing a common vision and goals, the group built a comprehensive strategy whose solutions provide an opportunity for all parties to participate in reforming the system.

The Coalition's plans for the coming year include hosting workshops to work through the strategy with insurers and legislators. The Coalition is open to any organization or agency interested in health insurance reform. Anyone interested in participating should contact Jane Thomas at (608) 267-3837.

(Editor's note: Special thanks to the Wisconsin Health & Hospital Association for a generous donation to help underwrite the next phase of this initiative.)

1st Stark Opinion Focuses on Rural Exception

From *HFMA Express News*, 11/6/98:

"HCFA has issued its first advisory opinion addressing questions about the physician referral prohibition law. The law, familiarly known as the Stark law, prohibits physicians from referring Medicare and Medicaid patients to certain health services in which the physician or an immediate family member has a financial rela-

tionship. Because the many exceptions to the prohibition make it very complex, Congress mandated in the Balanced Budget Act that HCFA furnish advisory opinions on the law."

"The advisory opinion focuses on the rural provider exception under Stark. According to the opinion, a limited liability company proposed to build and operate an ambulatory surgical treatment center in a rural area. There will be physician investors who will also make patient referrals to the center, and some of the physicians will also treat patients at the center. HCFA determined that the proposed arrangement met the exception because the designated health services would be furnished in a rural area and substantially all (at least 75 percent) of the services would be furnished to individuals living in the rural area. The full opinion can be viewed on HCFA's web site at::

www.hcfa.gov/regs/aop/ao98001.htm

Crashes - #1 Killer of America's Kids

From a flyer distributed by the National Highway Traffic Safety Administration, 10/26/98:

- "Traffic crashes are the leading cause of death and injury to children ages 0-15."
- "There are one-third fewer fatalities to children who ride properly restrained in the back seat."
- "Seat belts increase the chance of surviving a crash by nearly 45 percent. Child safety seats, properly installed, reduce the risk of death by 69 percent for infants and 47 percent for toddlers."
- "Studies consistently show that the best way to get children buckled up is to get adults buckled up."

1st Rural Medicare HMO, Leader or Anomaly?

From "Stage Set For Premiere: Medicare+Choice Plan To Debut In '99 In Rural Oregon," by Eric Weissenstein in *Modern Healthcare*, 11/16/98:

"HCFA has signed off on its first Medicare+Choice plan: a state-licensed provider-sponsored organization in rural Oregon that's jointly owned by a hospital system and an independent practice association. The seven-hospital Central Oregon Hospital Network owns 38% of the PSO, called Central Oregon Independent Health-Services (COIHS). The 287-physician Central Oregon IPA owns the remaining 62%."

"The PSO is headquartered in Bend, Ore., and will service a seven-county region that has no other Medicare managed-care option for the elderly. It plans to begin signing up Medicare enrollees Jan. 1. Patricia Gibford, COIHS chief executive officer, said the PSO was notified last week that it was the first Medicare+Choice plan and first PSO to be certified by HCFA."

"COIHS was created more than three years ago to contract with the Oregon Health Plan, the state's Medicaid managed-care program, Gibford said. It has about 21,000 Medicaid enrollees in a 10-county area. It has no commercial insurance product. The PSO's service area is rural. Bend, with a population of about 50,000, is the largest city and home to 181-bed St. Charles Medical Center, the flagship of the Central Oregon Hospital Network."

"HCFA estimated that about 30,000 Medicare enrollees reside in the COIHS service area. Medicare pays HMOs in all seven counties its minimum reimbursement rate, projected to be $378 per enrollee per month in 1999. Medicare payment rates go up to a high of $800 a month in places like New York City and Dade County, Fla."

Rural HMOs Spreading-the Implications?

The following is from "Implications of HMOs for Rural Providers and Consumers," by Tony Wellever in a special issue of *The Journal Of Rural Health* on "The Growing Presence of Managed Care in Rural Areas." This is a must read issue of the Journal published by the National Rural Health Association:

The "six health maintenance organizations (HMOs) considered in this study vary in their ownership, organization, management, tax status, size, age, products, and marketing strategies. Despite these differences, the effects of these HMOs on rural providers and consumers and the possible consequences of these HMOs for the rural areas in which they operated were similar in many respects."

"To compete with traditional indemnity health insurance plans in rural areas, these HMOs needed to differentiate themselves by pricing their products below those of other health plans. Typically, HMOs are able to reduce costs--and thus premium prices--by the management of utilization, which implies a partial shift of clinical decision making from the provider to the plan. To date, however, these six HMOs have competed successfully with other health plans in rural insurance markets largely without introducing either stringent utilization management or aggressive quality improvement programs targeted at rural providers."

"The impact of the six HMOs studied on rural providers has, to this point been relatively small. However, at some sites, changes in HMO and provider relations appear to be on the horizon. These changes include the acceptance of greater financial risk by rural providers and the more aggressive management of costs by the HMOs. As with their urban counterparts, rural employees are concerned about restrictions in access to providers of their choice and financial incentives in physician payment arrangements that may discourage the provision of services or the arrangement of referrals."

Physicians "The rural physician assumed little or no financial risk under their managed care organization (MCO) contracts. Typically, payments to physicians were based on fee-for-service rates, although most of the HMOs used fee schedules (rather than billed charges) to limit payment for specific services. (Whether or not the use of a fee schedule constituted a discount depended on the generosity of the fee schedule and the pricing policies of a particular practice.) Additionally, four of the six HMOs withheld a portion of the fee-for-service payment pending the year-end financial performance of the HMO. The amounts withheld varied from 5 percent to 20 percent of payments. Providers usually received substantial portions of these monies at the end of the year... Rural physicians seem willing to participate in withhold payment systems only if there is a reasonably high probability that a substantial portion of the funds withheld will be returned to them."

"Three of the six HMOs contract with intermediate organizations, including independent practice associations (IPAs) and physician-hospital organizations (PHOs), on the basis of an established price per member month. These middle-tier organizations, in turn, pay physicians on a fee-for-service basis for services provided to patients enrolled in the HMO."

"Intermediate organizations buffer the relationship between rural physicians and HMOs; rather than contracting with HMOs directly, local physicians contract with their own provider organization. Although they stop short of (plan) ownership, these organizations enhance the control that rural physicians exercise over managed care by increasing their bargaining power with HMOs and by transferring the management of payments and care from the HMO to an organization with local provider representation. They are protected from catastrophic losses by reinsurance that they purchase or that is provided under their contract with the HMO."

Hospitals "Rural hospitals play multiple roles in their relationships with HMOs. They provide acute and ambulatory care services to HMO enrollees under contract; they may purchase HMO coverage for their own employees; and occasionally they own HMOs. Rural hospitals can also encourage local physicians to contract with HMOs independently or collectively through PHOs."

"The rural hospitals in this study were paid primarily on a fee-for-service basis by HMOs. Discounts of about 5 percent from charges were common across the sites, but only one-half of the HMOs asked rural hospitals to share risk in the form of withhold."

"Five of the six HMOs studied either had obtained National Committee on Quality Assurance (NCQA) accreditation or were preparing to enter the accreditation process. **As the number of people in rural areas served by HMOs increases, it will be important to monitor the effect that the demands associated with NCQA accreditation have on rural providers**. For example, NCQA requires that MCOs develop their own standards of participation and conduct their own on-site quality assessments of hospitals if the hospitals are not accredited by the Joint Commission for Healthcare Organizations." (*Editors Note*: RWHC is working with HMOs in Wisconsin through the Wisconsin Zones of Collaboration Initiative (funded by the federal Office of Rural Health) to mediate the potential duplication and contradictions of this phenomena.)

Employers "With one exception, the rural employers studied said that a low premium was the primary criterion in the selection of health insurance for their employees. Another key factor in selecting health plans, but clearly of secondary importance to price, was the extent to which plans restricted the provider panel available to employees. All other things being equal, employers desired a plan whose provider network was sufficiently broad so that most employees were able to keep their current doctors, including specialists."

"Rural employers typically lack resources to systematically obtain and compare competitive bids for health insurance coverage. Accordingly, many rural employers in this study sought the services of local insurance agents, who not only acted as brokers in selling HMO plans but also served as *de facto* benefits consultants."

Employees "The HMO enrollees interviewed as part of this study spoke favorably of the larger scope of benefits available under HMO plans. Most also thought that participation in HMOs had lowered their out-of-pocket expenses compared with previous indemnity plans, while maintaining or increasing the range of health services they received."

"These favorable reactions to HMOs were offset most often by complaints regarding restrictions related to providers... Restriction on the freedom to choose any physician is the most obvious difference between managed care plans and the indemnity or other plans that are familiar to most rural residents."

"The stories reported in the national media (e.g., huge salaries for HMO executives and 'unreasonable' restrictions on care for enrollees) tend to cast HMOs in a negative light and make rural employees apprehensive of HMO coverage."

HMOs--Problem or Symptom?

From a Letter by Robert Kaiser, Philadelphia, *The New York Times*, 11/22/98:

"H.M.O.s are probably just the villains of the moment. The real villain is the clash between expectations and reality. The public has every right to expect excellent medical care, but as a society we have not decided how much care is needed and who should provide it. Clinton's health care plan went down to defeat because the public did not trust or want government to be in charge of medical care. Yet they resent the profiteers who restrict care and gladly look to government to wield its regulatory power to protect them."

Editor's Note: Every once in a while some hype is really justified; Gillette's new razor, the MACH3, is worthy of its name. A closer shave than your last negotiation with an HMO.

"This conflict will not be resolved until the public's underlying ambivalence is addressed. This much is clear: they would like their physicians to be effective advocates for them in a system that is benevolent, economical and accessible."

Rural Population Surging

The following is from the *Population Profile of the Nation*--"A report that brings together under one cover a wide range of sample survey and census data on demographic, social and economic trends for the nation" has been released by the U.S. Commerce Department's Census Bureau and is available at:

www.census.gov/prod/3/98pubs/p23-194.pdf

"Nonmetropolitan growth surged between 1990 and 1996-- Nonmetropolitan population increased 5.8 percent to 53.5 million, adding nearly 3 million residents and more than doubling the 1980s gain (1.3 million). The average annual nonmetropolitan population growth rate was 1.0 percent, more than tripling that of the previous decade (0.3 percent) and nearly matching the metropolitan annual growth rate (1.1 percent)."

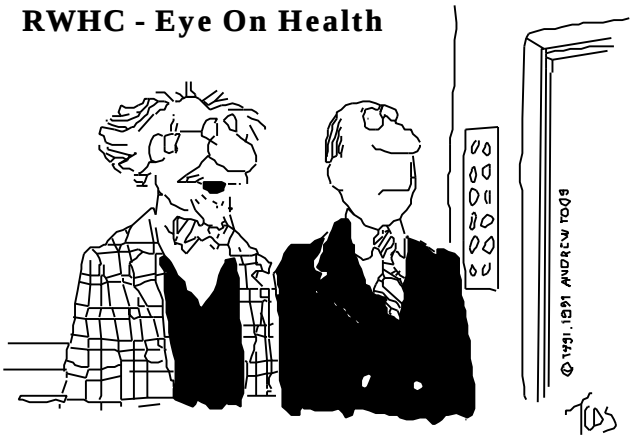
"Nonmetropolitan population growth was strong in the South and West between 1990 and 1996--The South and West accounted for more than 75 percent of all nonmetropolitan growth. The nonmetropolitan West grew at a faster rate than the nonmetropolitan South (13.5 percent compared with 5.9 percent) but the South added more nonmetropolitan residents than any other region (1.3 million)... Growth in the nonmetropolitan Midwest (3.4 percent) and Northeast (2.5 percent) was less than the national nonmetropolitan average."

All Things Bright, Beautiful, Great & Small

Yea, the Rose Bowl is important but how'bout those Breweries? With sincerest apologies to the state-boundary-impaired, two of southern Wisconsin's breweries just showed up in the list of the world's top ten breweries, two of the three U.S. awardees!

From *the Wisconsin State Journa*l, 11/26: "After tasting 999 beers from 25 countries, the Beverage Tasting Institute in Chicago has released its Top 10 Breweries of 1998." The two master firms are firmly situated in the small employer category, Capital Brewery Co. in Middleton was the top U.S. brewery with 9 employees and New Glarus Brewing shared world top ten honors with 10 full-time and three part time workers.

RWHC - Eye On Health



"Given how well our Monica strategy worked on Newt, what scandal can we engineer to get health care reform?"