

Review & Commentary on Health Policy Issues from a Rural Perspective - June 1st, 1999

Uninsured & Small Employers Closely Linked

From *Health Benefits of Small Employers in 1998, Report Prepared for The Henry J. Kaiser Family Foundation* <www.kff.org/homepage/> by Jon Gabel, Kimberly Hurst, Heidi Whitmore and Samantha Hawkins of KPMG Peat Marwick, 2/99:

Introduction

“Small employers are often seen as living proof that America is an authentic meritocracy. Small firms are the key to the ‘great American job machine,’ accounting for more than three-quarters of job expansion in most years. Yet, this source of economic opportunity and growth is also the Achilles heel of America’s employer-based health insurance system. Health insurance costs more for small employers than for large employers in the sense that they pay higher premiums for the benefits they receive. Administrative costs may consume as much as 40% of every premium dollar. Less than half of firms with fewer than ten workers offered health benefits in 1998. The problems of the uninsured are closely tied to the availability and cost of health insurance in the small employer sector.”

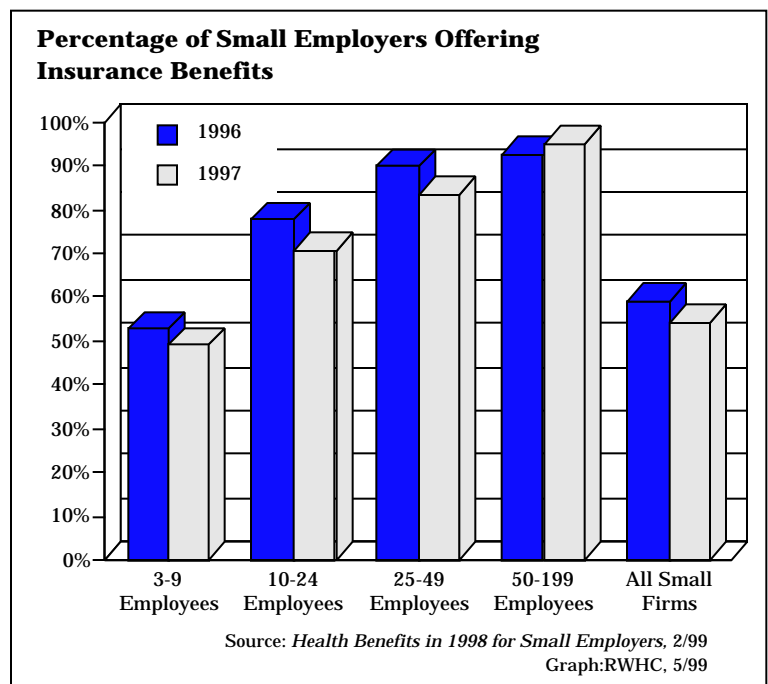
“This report examines trends among small employers from 1996 to 1998. It compares the state of health insurance among firms with fewer than 200 workers, our definition of small employers, with firms with 200 or more workers. We present data on coverage, premium trends, employee cost sharing, plan offerings and enrollments, and other aspects of job-based health insurance. The paper also reports on employers’ attitudes towards specific consumer protection provisions similar to those that have been proposed in the Clinton Administration’s ‘Patient Bill of Rights’.”

“Findings are based on a telephone survey of employee benefit managers at 1,581 randomly selected firms with 199 or fewer workers. As a basis of comparison, we use data from KPMG’s annual survey of 1,583 randomly selected firms with 200 or more workers. KPMG conducted the survey of large employers from January to March of 1998, and the survey of small employers from June to August of 1998. As a basis of historical comparison, we compare 1998 data

on health benefits with data from the 1996 KPMG survey of 1,965 firms, 854 of which employed fewer than 200 workers.”

Major Findings Include

- “Premiums for small employers increased by 5.2% from the summer of 1997 to the summer of 1998. Although substantially less than anecdotal reports in the nation’s leading newspapers, premiums increased only 1.7% in 1996, with the expectation of higher premium increases to come.”
- “Among all small firms in 1998, less than half of employees (47%) are covered by their employers’ health plans, a decline of five percentage in two years.”
- “From 1996 to 1998, in the midst of the best economy in thirty years, the percentage of small firms offering health coverage to their workforce declined from 59 to 54.”
- “Enrollments in HMOs and conventional plans fell sharply between 1996 and 1998. For small employers, HMO market share declined from 29% to 17%



and conventional plans' market share decreased from 27% to 13%. Many small firms switched to POS coverage, as its market share grew from 7% to 30%."

- "Compared to firms with 200 or more workers, the smallest firms (three to nine workers) receive far less value for their premium dollars. Average premiums among the smallest firms are about ten percent higher, fewer benefits are covered, and deductibles are commonly over double those of larger firms."
- "Smaller firms provide fewer consumer protections than large firms, yet are more supportive of legislation mandating patient bill of rights-type protections; 45% of small firms would support legislation allowing patients to sue their health plan for malpractice, as opposed to 28% of large employers."
- "Since the passage of the Health Insurance Portability and Accountability Act (HIPAA) in 1996, small and large employers' use of pre-existing condition clauses has fallen substantially. For example, the use of pre-existing clauses in conventional plans fell from 59% to 40% among small employers and 62% to 38% for large employers."
- "The use of self-insurance has fallen considerably over the past two years among small firms. The decline may be linked to new regulatory requirements which HIPAA imposes on self-insured firms."
- "Roughly one in ten small firms is familiar with NCQA accreditation. In selecting health plans, small employers consider NCQA accreditation and HEDIS minor factors relative to traditional determinants such as price and the quality and quantity of physicians in the network."

The **Rural Wisconsin Health Cooperative**, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural health care which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

Eye On Health Editor: Tim Size, RWHC
880 Independence Lane, PO Box 490
Sauk City, WI 53583
(T) 608-643-2343 (F) 608-643-4936
Email: timsiz@rwhc.com
Home page: www.rwhc.com

For a free email subscription of *Eye On Health*, write office@rwhc.com with "subscribe" on subject line.

Conclusion

"The 1998 KPMG survey of small employers discloses reversals of many favorable trends of the 1990s. In the midst of the best economy in three decades, many indicators of coverage have deteriorated. Fewer small firms are offering coverage, fewer employees in small firms are covered by their employer's health plan, and employers have made eligibility requirements more restrictive. More stringent eligibility requirements include longer waiting periods for new hires, and a slight decrease in the percentage of firms covering part-time and temporary workers."

"During the 1990s health care inflation has declined to levels unimaginable at the turn of the decade. Although nowhere near the anecdote-based double-digit inflation reported in the media, the 5.2% increase in premiums from 1997 to 1998 indicates a heating-up of inflation for the future. Higher inflation would be consistent with the historic underwriting cycle, where insurer underwriting losses are followed two years later by increased inflation. About two-thirds of insurers and managed care organizations suffered underwriting losses in 1996 and 1997, prompting an exit from the market for many insurers and MCOs, and a need to raise premiums in 1998."

"Following years of strong growth in enrollment, HMO market share declined from 29% to 17% in the small employer market. Conventional plans' long-term decline accelerated so that now only 13% of the employees in small firms are enrolled in a conventional plan. POS plans, and to a lesser extent PPO plans, have been the big gainers. The decline in HMO enrollment reflects a desire on the part of employers to expand employees' opportunity to select non-network providers."

"There are some positive trends worth noting. Employees' contributions for single coverage have ebbed in small firms, although contributions for family coverage increased. Following the passage of HIPAA in 1996, the use of pre-existing condition clauses has declined substantially. More employees are enrolled in fully-insured plans than two years ago, so that more employees have the consumer protections afforded by state regulation of the health insurance industry."

"The most alarming trend uncovered by the survey is the decline in the percentage of employees in small firms covered by their employer's health plan. Offer rates are declining and eligibility requirements are tightening even in these economic 'good times.' This trend is consistent with data from household surveys, such as the Census Bureau's Current Population Survey, which found the number of uninsured Americans from 1996 to 1997 increased from 41 to 43 million. Should health premium inflation heat up and the economy cools down, the willingness of small employers to offer health benefits is likely to suffer further and even more workers may lose their health insurance."

Politicians Fiddle as Number Uninsured Grow

From "Medical Outcasts: Does Anyone Care?" by David Broder in *The Washington Post*, 5/12/99:

"It is quite a trick for something to grow larger and at the same time become more invisible. But that is what's happening to the health care problem in the United States. The greater the number of people without medical insurance, the less the politicians want to talk about it -- let alone deal with it."

"In 1992, when the plight of the uninsured became a major issue in the presidential campaign, there were 38 million non-covered Americans below Medicare age. Five years later, according to a report released last week, the number had grown by 5 million. And the rate of increase is accelerating, from an average of half a million annually in the first two years to an average of 1.2 million annually in the three most recent years."

"But last week, when the National Coalition on Health Care, a bipartisan group headed by former presidents Bush, Carter and Ford, put out its latest report on *The Erosion of Health Insurance Coverage in the United States*, it barely made a ripple." (The complete study is at www.nchc.org/releases/erosion.html.)

"Why is this happening? The report's authors, Steven Findlay and Joel Miller say the legions of the uninsured are rising because of fundamental economic and demographic forces, which, by themselves, are certain to make the problem worse. The authors say that 'even if the rosy economic conditions prevalent since 1992 prevail for another decade, a projected 52 million to 54 million non-elderly Americans -- one in five -- will be uninsured in 2009.' If a recession occurs, that number likely will jump to 61 million -- one in four."

"Most of the uninsured have jobs, but increasingly, they work in small businesses or in service sectors that either do not cover employees or require them to pay so much for health insurance that they cannot afford it. The growing numbers of self-employed, part-timers and contract workers swell the totals."

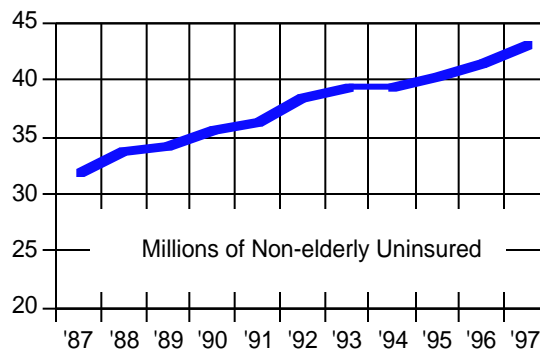
"It is a double whammy. Between 1996 and 1998, the percentage of small firms (with fewer than 200 employees) offering health insurance dropped from 59 percent to 54 percent. On average, their employees were required to pay almost half (44 percent) of the policy

premiums for themselves and their families. Faced with those costs, more workers are declining health insurance."

"The study also notes that it is increasingly difficult for the uninsured to get health care. In one survey of more than 10,000 doctors, those receiving no income from managed care companies reported spending about 10 hours a month treating indigents. But those who get the bulk of their income from these companies gave up only half as much of their time to charity. As cost-containment pressures increase, the uninsured face ever greater medical risks."

"In language that is remarkably calm, given the contents of their report, the authors conclude, 'The accelerating decline in health insurance coverage in the United States is a serious problem, affecting the financial security and health of millions of Americans every day. Despite strong economic growth and low unemployment, employer sponsored health insurance coverage has continued to erode throughout the past decade.'"

Number of Uninsured Americans



Data: Employee Benefits Research Institute, 12/98

Graph: RWHC, 5/99

Rural Sympathy Scarce for Teaching Hospitals

From "Teaching Hospitals Bemoan Lower Margins" by Kristen Hallam in *Modern Healthcare*, 5/3/99:

"Teaching hospitals, which have enjoyed beefy Medicare profit margins for years, are now seeking sympathy from Congress and the public because those margins are shrinking. The question is: Who'll listen?"

"In addition to cuts in inpatient Medicare payments, which affected all hospitals, the balanced-budget law also trimmed teaching hospitals' Medicare reimbursement for the 'indirect' costs of medical education, or the costs related to providing care to a sicker patient population using inexperienced residents."

"What made teaching hospitals an easy target in the budget law was nearly a decade of prospective payment system profit margins that consistently expected those of all hospitals, especially rural facilities."

"According to data from the Medicare Payment Advisory Committee, major teaching hospitals enjoyed a whopping 28.4% PPS margin in 1997, compared with 16.1% for all hospitals and 9.4% for rural hospitals." (Editor's note: These are margins for Medicare inpatient services only--much higher than other Medicare or all payer margins.)

“Last month, about 100 teaching hospital executives from across the nation met in New York to discuss the recent Medicare reimbursement changes and how they’re going to fight them. But don’t expect any rural hospital executives to hold out a handkerchief.”

“The National Rural Health Association, which represents 393 rural hospitals, said its members have been ‘most definitely’ more devastated by the cuts than their teaching counterparts.”

“‘All of us have community clinics, home health agencies and other services that are subject to their own cuts under the 1997 law,’ said Darin Johnson, the NRHA’s director of government affairs. ‘Rural hospitals are taking a significant hit.’”

Angry Seniors Preparing Medicare Equity Suit

From “Seniors Group to Unveil ‘Fairness’ Class Action Suit Against Medicare,” *Inside Washington Publishers’ Inside HCFA*, 4/15/99:

“A group of seniors in Minnesota is seriously considering launching a class action suit against the Medicare program arguing that Medicare reimbursement rates discriminate against beneficiaries based on geographic location, according to informed sources, who say that the suit could blossom into a hundred billion dollar national challenge to the calculation of both fee-for-service and managed care payments. These sources say that a law firm in Minneapolis has been working on the case pro bono and that early indications are that the lawyers are cautiously optimistic.”

Moreover, these sources say, the case is being studied by Minnesota Attorney General Mike Hatch, who has been a strong supporter of the strategy and is looking for a way to join into the suit. They say that lawyers in Fresno, California have also begun to study the strategy and that attorneys general in more than 30 states may have a stake in the suit. If the case spreads to a national class action suit, hundreds of billions of dollars in Medicare payments could be affected.”

“The case, which would be brought by members of the Minnesota Seniors Federation (MSF), is based on the concept that the Medicare program disadvantages beneficiaries who live in so-called ‘low-cost’ Medicare reimbursement areas, i.e., areas where medical spending is more frugal on a national average when compared to so-called ‘high-cost’ areas like the metropolitan centers of New York, Miami and Los Angeles. Early indications of the disparity are stark, according to sources, who say that HCFA’s own documents assert that there is a 15 percent variation in medical costs around the country but a whopping 241 percent disparity in reimbursement rates when you measure community by community.”

“The issue of equity in Medicare reimbursement has already gained national attention through a group called the Fairness Coalition, which has pressed Congress for relief on the community by community disparity with respect to calculating capitated rates for Medicare managed care. MSF is one of the few senior groups that is a member of the Fairness Coalition, which mostly represents small health plans, hospitals and other providers who argue for more equity in capitated payments for beneficiaries in low cost areas.”

“Sources say that lawyers working the case have found the same disparity in fee for service reimbursement rates in some cases, which means that hundreds of billions of dollars in Medicare reimbursement rates could be affected.”

“The suit is focused on challenging how HCFA comes up with reimbursement rates as fundamentally skewed against low-cost areas. Winning the suit would likely result in a total reallocation of Medicare reimbursement rates.”

Health Care Quality Demands Improvement

From “How Good Is the Quality of Health Care in the United States?” by Mark A Schuster, et al in *The Milbank Quarterly*, Vol. 76, No. 4, 1998:

“Much of the interest in quality of care has developed in response to the dramatic transformation of the health care system in recent years. New organizational structures and reimbursement strategies have created incentives that may affect quality of care. Although some of the systems are likely to improve quality, concerns about potentially negative consequences have prompted a movement to assure that quality will not be sacrificed to control costs.”

“The concern about quality arises more from fear and anecdote than from facts; there is little systematic evidence about quality of care in the United States. We have no mandatory national system and few local systems to track the quality of care delivered to the American people. More information is available on the quality of airlines, restaurants, cars, and VCRs than on the quality of health care.”

“We have conducted a review of the academic literature for articles on quality of care in the United States, and we summarize our findings in this article. Perhaps the most striking revelation to emerge from this review is the small amount of systematic knowledge available on the quality of health care delivered in the United States. Even though health care is a huge industry that affects the lives of most Americans, we have only snapshots of information about particular conditions, types of surgery, and locations of care.”

“The dominant finding of our review is that there are large gaps between the care people should receive and the care they do receive. This is true for all three types of care—preventive, acute, and chronic—whether one goes for a check-up, a sore throat, or diabetic care. It is true whether one looks at overuse or underuse. It is true in different types of health care facilities and for different types of health insurance. It is true for all age groups, from children to the elderly. It is true whether one is looking at the whole country or a single city.”

“A simple average of the findings of the preventive care studies shows that about 50 percent of people received recommended care. An average of 70 percent of patients received recommended acute care, and 30 percent received contraindicated acute care. For chronic conditions, 60 percent received recommended care and 20 percent received contraindicated care. These values do not indicate exact levels of quality in the United States, but they do provide a quantitative sense of how much could be done in all areas to identify and eliminate overuse and underuse of care.”

“A few examples emphasize this point. An annual influenza vaccine is recommended as a preventive measure for all adults 65 years or older, a group at especially high risk for complications and death from influenza; in 1993, 52 percent of people in this age group in the United States received the vaccine; among people who had been to the doctor at least once that year, the percentage was slightly higher at 56 percent.”

“A major issue in acute care is the overuse of antibiotics, which has led to the development of strains of bacteria that are resistant to available antibiotics. Antibiotics are almost never an appropriate treatment for people with a common cold because almost all colds are caused by a virus, for which antibiotics are not effective. However, in a study of Medicaid beneficiaries diagnosed with a cold in Kentucky from 1993 to 1994, 60 percent filled a prescription for an antibiotic.”

“Whether the care is preventive, acute, or chronic, it frequently does not meet professional standards. We can do much better. The solution is not simply a matter of spending more money on health care. A large part of our quality problem is the amount of inappropriate care provided in this country. Elimination of such non-beneficial and potentially harmful care would lead to a large savings in human and financial costs. However, there are also many examples of people who receive either too little or technically poor care; fixing these problems may increase expenditures.”

“For those who want to improve our health care system, techniques exist to measure and change the delivery of care. Clinicians and health plans can use information on quality to determine where to focus their efforts to provide better care. If this information is made available regularly and in an interpretable form, consumers and large purchasers can also use it to make informed decisions when choosing among clinicians and

plans, which will, in turn, give providers an added incentive to improve quality.”

“The United States cannot afford to let this situation continue. A systematic strategy for routine monitoring and reporting on quality, as well as the information systems needed to support such activities, will be essential if we are to preserve the best of the American health care system while striving to improve the efficiency with which high-quality services are provided.”

“This strategy could be organized by the federal government, the private sector, or a public-private partnership. It could involve coordination among all three. Regardless, the strategy will need to cover the aspects of quality that patients, purchasers, and providers care about; it will need to collect data in a way that is manageable, reasonable, and affordable; and it will need to produce information in a format that is useful for making a variety of decisions.”

“The United States is capable of setting up a quality measurement system that can provide the multiple participants in the health care system with the information they need to ensure delivery of high-quality care. In light of the changes that the health care system has been experiencing, a strategy to measure and consequently to improve quality is needed now.”

Are We More than Our Repairable Parts?

From a letter by Bernard Lown, M.D. and Thomas Graboys, M.D. in *The New Yorker*, 5/17/99:

“As cardiologists who are involved with research and the clinical care of patients with heart disease, we were extremely disquieted to read Joseph Epstein’s poignant account of his bypass surgery (Personal History, April 12th). On the advice of several doctors, Epstein underwent a strenuous operation whose risks may well have exceeded those presented by his ‘silent’ ischemia. Without having examined him, we cannot say whether his surgery was necessary or not, but our experience and research, and those of others, demonstrate that a very significant percentage of patients undergoing bypass surgery and angioplasty—perhaps as many as two-thirds—can safely defer or altogether forgo these procedures by managing their heart problems with medication. Regrettably, much of the rush to invasive procedures is driven by nonmedical factors—principally economic ones. We believe that the modern medical model has become increasingly reductionist: human beings are seen as repositories of malfunctioning organs that need repair. This view results in an onslaught of tests and assaultive procedures that purport to give definitive answers in a field fraught with uncertainty. Doctors often take refuge behind technology because it is easier and less time-consuming than talking with a complex human being who is their patient.

Leadership Training Available By Satellite

From promotional materials for "The Excellence in Nonprofit Leadership and Management," produced by: The Learning Institute for Nonprofit Organizations, Madison, Wisconsin and presented by the PBS Adult Learning Service:

"Last year, this satellite-delivered series was a major success in towns throughout North America. This year, be the one to bring it to your community. Nonprofit organizations across North America have already discovered what a powerful, community-building force this series can be."

"The series not only provides critical training. Organizers found that by forming partnerships with other nonprofits to offer the series, they strengthened relationships among the people and organizations that serve their communities. The experience became richer--and more useful--for everyone."

"Starting in September, you can bring this educational initiative to nonprofit staff, volunteers and board members in your area."

September 16, 1999	Strategic Planning
October 21, 1999	Resource Development
November 18, 1999	Board Governance
January 20, 2000	Marketing
February 17, 2000	Mission-Based Management
March 16, 2000	Social Entrepreneurship
April 20, 2000	Volunteer Management
May 18, 2000	Strategic Alliances

How is the instruction delivered?

"To put it simply: We give you the components, and you put them to use!"

"The core curriculum is delivered via eight live satellite broadcasts, bringing nationally known leaders of the nonprofit sector right to your community. Phone and fax allow learners to ask questions during the broadcast. Further follow-up and Q & A take place on the Internet."

"Your own on-site facilitator leads learning exercises that are designed by our faculty. During these activities, learners begin to apply the principles presented in the programs to their own real-life situations. You can focus the discussions at your site on local issues and truly bring the content home."

What do we need in order to participate?

- "Access to a satellite downlink facility
- A viewing room with phone, fax, TV monitor, and desks or tables
- A facilitator to lead activities each session"

License Fee:

"For the right to downlink and offer the series, you'll pay a license fee. You can choose either a flat fee or a per-person fee."

"Flat Fee--Serve as many learners as you like at your site for a single fee. We recommend that you not exceed 50 learners per facilitator. \$4400 flat fee."

"Per Person Fee--Under this plan, you pay based on enrollment. \$45 per learner per program, minimum 6 learners per program. Thus, at minimum you will be charged \$2,160 for the series (\$45 x 6 learners x 8 programs)."

**For more information, contact:
PBS Adult Learning Service
1-800-257-2578
www.pbs.org/als/nonprofit**

Institute of Medicine Backs Collaboration

From "IOM: Collaboration Rather than Competition Would Improve Care Offered by Health Plans" by: Peggy Eastman in *Oncology Times*, 4/99:

"Collaboration: Is the very word an impossibility for managed care plans competing for the same patients? The answer is a qualified no, according to a new report released by the National Roundtable on Health Care Quality, a project of the Institute of Medicine (IOM)."

"The report concludes that despite antitrust laws governing competition, a number of imperfections in the health care market could be addressed by collaborative action. Specifically, the authors found that suitable collaboration among competing managed care health plans could improve the quality of medical care when competitors want to use scientific methods to help guide improvement."

"The group went further, stating that health care is a service industry and that 'the social purpose of the health care may justify special treatment under anti-trust laws.' Thus, it should be possible for competing organizations to cooperate when the common good justifies it - as, for example, in implementing collaboratively developed mandatory standards for infection control."

Why Collaborate?

"Why should managed care organizations collaborate? Primarily, to improve their perceived and actual quality standards. The report notes that collaboration among competitors is not exactly new, and states that successful collaboration have improved entire industries, not-

ing such examples are the automotive and electronics industry.”

“What is new, however, is the extent of competition at the managed care organization level in individual regional markets, according to George J. Isham, MD, Medical Director and Chief Health Officer of HealthPartners, a large health care plan that enrolls about 800,000 members in Minnesota. Dr. Isham was a speaker at the conference that led to the IOM report.”

Examples of Real-Life Collaborations

“Today, real-life collaborations among competing health care organizations are already operating. Among the collaborations the IOM’s National Roundtable identified are the following:”

“The Health Care Education Research Foundation (HERF), a nonprofit Minnesota organization that comprises a high proportion of the state’s health plans, hospital systems, provider organizations, business coalitions, and the health department.”

“The Employer’s Managed Health Care Association (MHCA), which comprises Fortune 250 companies and their personnel benefits staffs.”

“The Pacific Business Group on Health (PBGH), a collaboration among health maintenance organizations.”

“The Foundations for Healthy Communities (FHC), founded by the New Hampshire Hospital Association in 1996.”

“The Rural Wisconsin Health Cooperative (RWHC), an effort for HMOs to share a vision of cooperation that would reduce duplicative and fragmented interventions within and among rural communities... Collaboration avoids the chaos and disruption that would be caused by having multiple reviewers for multiple health plans descending on multiple medical practices at about the same time.”

Health & Safety Needs Real Communities

From “The Littleton I Know Isn’t Anytown. It’s Notown,” By Lakis Polycarpou in *The Washington Post*, 5/2/99:”

“In the hours after the killings, the cable television networks, fueled by the need for constant commentary, began rounding up the usual suspected causes of mass murder by teens--media violence, dysfunctional families, easy access to guns, lack of adequate moral fiber in our youth--while at the same time acknowledging that such explanations were not quite satisfactory. In the end, the moral handed up to the nation was as

simple as it was pessimistic: Violence in this country is random, no one is completely safe, and Columbine High School proves it.”

“After my initial shock, it occurred to me that the attack--in its suddenness, its scale, its manner and its lack of understandable motive--in a strange way suited the suburbs southwest of Denver. Those suburbs include Littleton, the town nearest the high school, which is located in an unincorporated part of Jefferson County. That particular kind of insanity didn’t occur in the Bronx, where schools were fought over as turf or students were shot in drug disputes. I don’t pretend to know what motivated Eric Harris and Dylan Klebold, but murder as reenactment of action movies or video games . . . that was something that fit Littleton.”

“The area where Columbine is located was empty prairie before 1970. When I graduated in 1990, much of it was still prairie, but the unrelenting growth of the metro Denver area has rapidly eaten away at that. Every time I return to visit my parents, it seems that there is another new strip mall or clump of tract housing going up. Wadsworth Boulevard, the major street near the high school, has become an endless series of chain stores that extends all the way to north Denver, some 30 miles away. Driving the whole road is unremitting *deja vu*; every so often the stores repeat themselves, and one discovers yet another Office Max, Best Buy or Red Lobster.”

“When I first went to Columbine, I knew a fellow student whom I used to talk to every day during my free period. A couple of months after I met him, he disappeared for 10 days. I didn’t know if he had changed his schedule, moved away or died. I didn’t know his last name, so I couldn’t call him. Finally, he reappeared. He had been sick with pneumonia. Despite our previous daily contact, we had failed to build a close enough connection for me to know even the most basic facts about his life.”

“In the aftermath of last month’s shooting, there has been much talk of how it has devastated ‘the community’ and how ‘the community’ would pull together. While true, it also sounds strange to me, as I always pictured community as something that happened anywhere but in a place like the Littleton area. We never knew our neighbors, except in passing; we certainly never had a social connection to them. Children rarely played outside on the street, as I had in elementary school in Lakewood. As far as I know, no one in my family ever joined a ‘neighborhood community’ anything in the area. There was no pool, no ice rink, no town square in the area around Columbine. Neighbors moved into homes and then moved out, and it was often some time before you realized the people next door were new.”

“The media describe Littleton as ‘anytown’ but it could just as easily be called ‘notown.’ The Columbine area is technically not a part of any city: Littleton, which is in

the next county, is just a mailing address for the vast area that includes the school. Several years ago, there was a ballot initiative to collect several of the neighborhoods into a township; because it would have raised property taxes, it went nowhere. My neighborhood was the apotheosis of a bedroom community, where shiny new automobiles slipped quietly in and out of their automatic-door garages and there was never any need to step past your mailbox.”

“Against the backdrop of this interchangeable world, with minimal connections to others, it’s not difficult to imagine a student so dissociated from his environment and himself that prefabricated, reductive fantasy replaces reality. Many of my high school classmates--particularly those who had few social connections--devoted enormous amounts of time to video games. Suburban alienation breeds a kind of solipsism that is reinforced by the intense solitude of games such as Doom or Quake, which have as their singular goal blowing away as many bad guys as possible.”

“Since the Columbine tragedy, commentators have also pointed generally to the role of Hollywood violence, but haven’t yet looked deeply at the specific kinds of media violence favored by the two student killers, whose favorite film, Oliver Stone’s ‘Natural Born Killers’ (1994), depicts an extreme, semiconscious reaction against suburban conformity, hypocrisy and alienation. We should be asking not just if media violence has an effect on kids, but why Harris and Klebold related particularly to a film like that.”

“We are unlikely to hear much of that kind of analysis, because it would indict something much deeper than action movies or the gun culture. It would blame suburban society and the inherent alienation in places like Littleton, where culture and community are either a function of monotonous consumption or dispensable altogether. Without a more nuanced critique of the kinds

of choices people make about communities in late 20th-century America--where we live and how those places develop--we are unlikely to accurately account for the behavior of individuals whose actions are, after all, perhaps an extreme manifestation of something that’s widely felt but rarely acted upon.”

“For the victims of horrific violence, understanding the perpetrators’ motives provides little comfort. But if, as a society, we succumb to the temptation to believe that the specific causes that produce tragedies like the one at Columbine are either indecipherable or random, we risk missing the opportunity to diagnose a deeper malaise.”

Internet Now the Gardener’s Best Friend

From “On The Web,” *Brill’s Content*, 5/99:

Garden Solutions, www.gardensolutions.com.

“A plethora of information on bulbs, roses, fruit trees, shrubs and exotic plants.”

American Rose Society, www.ars.org

“Although not particularly fancy, this site provides information on exhibiting, pruning, spraying, and growing roses.”

Garden Escape, www.garden.com

“ ‘This is the six-hundred-pound gorilla in the field,’ says Horticulture’s Cooper of this commercial site, which features tips on garden design and a weekly almanac.”

National Gardening Association, www.garden.org

“This official NGA website provides gardening tips and a broad selection of guide books and catalogs for sale.”

Virtual Garden, www.vg.com

“This site, sponsored by Time-Life, offers links to other web gardening sites, such as the American Orchid Society.”

The Garden Village, garden.vbutler.com

“This easy-to-navigate page offers links to more than 150 sites devoted to such subjects as agriculture, organic gardens, pest control, and small-space gardening.”

Garden Town, www.gardentown.com

“Plant yourself in this virtual town to enjoy the ‘Library,’ chock full of helpful info on seeds, roses, herbs, and more, or browse through the ‘Mall,’ which offers a listing of books, magazines, and gardening apparel available for purchase.”

The Butterfly Website, www.mgfx.com/butterfly

“Luring butterflies to your garden may be easier than you think.”

