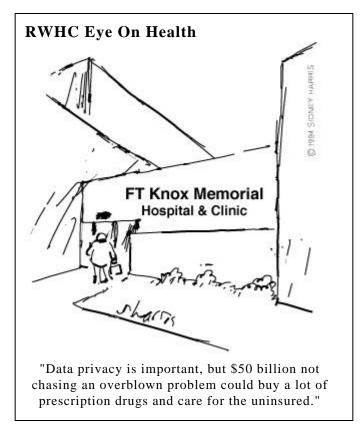Review & Commentary on Health Policy Issues from a Rural Perspective - December 1st, 2000

HIPAA = Y2K x 100

From "Old Before Its Time: HIPAA And E-Health Policy" by Rob Cunningham in *Health Affairs*, 11/00:

"The cornerstone of federal policy on information technology (IT) in health care is an ambitious law that by a twist of fate was conceived just before network computing and the World Wide Web revealed themselves as the building blocks of a new electronic marketplace. As a result, federal policy making remains locked in a frame-work that does not properly fit the realities of current IT and the challenges that the emerging electronic marketplace pose for the health system. At the same time, the slow pace and crowded agenda of the health policy process have been aggra-

vated by delays in the rule-making process and jurisdictional fragmentation in Congress that is even more acute than usual because of the high stakes and keen interest that e-commerce arouses. Despite the extravagant claims that are now routinely made about the potential impact of the Internet on health care, only a minimum of effective focus on these issues has been discernible on Capitol Hill in the year 2000."

"Final rules on HIPAA's Administrative Simplification provisions were not expected to appear until the end of summer 2000. One such rule was issued in August that defines standards for financial and administrative transactions, including required data elements and their code sets; these rules, effective after a twenty-four-month period for industry to gear up, are an important step toward achieving 'interoperability' of health system information platforms. But many stakeholders and policy experts have already declared inadequate the crucial privacy rule also published in late summer 2000 and called for Congress to remodel the privacy legislation."

"Rule-making is in progress to implement further provisions of HIPAA on security and additional standardization measures for electronic health information. However, the technical obstacles to meeting the act's security standards in a network computing environment are formidable, and the challenges to achieving some of the law's standardization requirements may be even more difficult."

"Notwithstanding the general debate about whether more or less regulation is best for the future of e-commerce, or corollary differences of opinion about whether HHS exceeded its authority with the HIPAA privacy regulation or did not go far enough, the 600-plus pages of the rule suffer unmistakably from the antediluvian origins of the underlying statute. HIPAA's IT provisions are 'based on the wrong technology model,' says one HHS official--an early-1990s world in which electronic health information was stored in large, centralized payer and provider legacy systems, before network service providers and

RWHC Eye On Health

"Data privacy is important, but $50 billion not chasing an overblown problem could buy a lot of prescription drugs and care for the uninsured."

"We'll either reach across lines and become problem-solvers or dissolve into intransigence." Gov. Mike Leavitt

browser technology achieved the capability of marshalling huge fields of data in a common cyberspace accessible to anyone with a telephone line."

"The HIPAA privacy regulation reflects many tough decisions and controversial choices, but none better illustrates the difficulties created by this essential anachronism than the law's definition of 'covered entities,' including plans, providers, and data clearinghouses. The Internet service providers (ISPs) and application service providers (ASPs) that came to dominate the electronic landscape in the late 1990s—and whose central role in managing the flow of networked information must be addressed to create meaningful privacy protection or broader IT policies—are not contemplated by the 1996 law. Regulation writers get credit for creativity for inventing the concept of 'business partners' to extend the reach of the privacy regulation beyond the covered entities defined in statute. However **this artifice—which makes the covered entities responsible for the conduct of ASPs, ISPs, and others with whom they contract—is 'a Rube Goldberg kind of response' that may create as many problems as it solves."**

"The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), for example, estimated that it would take about 20,000 separate contracts for it to conduct the business of accrediting providers under the regulation. The Health Insurance Association of America (HIAA) said that the rules 'would force insurers to renegotiate hundreds of thousands of contracts.' "

"Opposition came from across stakeholder groups, with health plans and employer and physician groups among those urging HHS to drop the business partner approach. Nor did the 52,000 comment letters seem to represent a mere knee-jerk reaction to regulation per se by entrenched interests: The Workgroup for Electronic Data Interchange, a large constellation of insurers, providers, government agencies, and vendors established during the Bush administration, was among those arguing for the scope of the rule to be expanded, suggesting that 'all entities involved in electronic exchange of individually identifiable health information should be included in the rule as health care clearinghouses.' "

"Some established stakeholder groups that are usually the most vigorous upholders of the status quo have been surprisingly supportive in their responses to the proposed HIPAA privacy rule. The regulation is 'better than we expected,' said an employer representative."

" 'Insurers got what they wanted,' she said, because the 'standing authorization' provision allows covered entities to share individually identifiable information for routine treatment and payment purposes without obtaining explicit patient consent—a formulation decried by patient advocates as overly broad."

"Some of the more powerful stakeholder groups, though, especially large businesses with regional or national operations (health plans, employers, and health information clearinghouses), called for a stronger federal privacy law that would preempt more-stringent state regulations. The HIPAA statute expressly stops short of preemption. 'Many commentators cited the need for Congress to act' on various shortcomings of the underlying legislation, said a U.S. General Accounting Office (GAO) official summarizing responses to the proposed rule for the Senate Health, Education, Labor, and Pensions (HELP) Committee in April 2000."

As You Respond To HIPAA: An Important Resource

The Computer-based Patient Record Institute Toolkit on Managing Information Security in Health Care , Version 2
can be downloaded at no cost from:
www.3com.com/healthcare/securitynet/hipaa/document_center.html

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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.

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"The National Committee on Vital and Health Statistics (NCVHS), a broad-based expert panel charged by HIPAA with advising Congress on information policy, concurred: 'There is a need for comprehensive federal legislation…The proposed rule is limited in scope and does not cover all records or all entities…The definition of protected health information raises serious problems.' "

"The closely related HIPAA regulation detailing security standards for electronic patient information, also expected to appear in final form this year, are similarly problematic for stake-holders and seen by some as likely to create additional pressure for congressional intervention. Both the American Hospital Association and the American Medical Association called for immediate withdrawal of the rule when it was first proposed in 1998, and in this case the HIAA joined with the provider lobbies to protest the rule, claiming that the insurance industry was already held to rigorous computer security standards under state law."

" 'Even the most sophisticated medical centers are unlikely to come close to meeting HIPAA's security standards,' the chairman of the American Bar Association's computer law division wrote recently. 'HIPAA requires the health care industry to begin treating medical records in the same way that the federal government treats national defense secrets—as a form of classified information.' The security standards will in many cases require health care institutions still reeling from the disruptions of the Y2K transition to overhaul data systems yet again, if not replace them—at enormous expense, of course. 'HHS's proposed privacy and security standards will impose burdens so substantial that new efforts to convince Congress to amend HIPAA are inevitable,' wrote the official. **'In 2001…expect an intense political debate about the nature and extent of security regulation needed to achieve an adequate, cost-effective, sensible level of privacy for medical records.' "**

"Although they constituted a very forward-looking piece of legislation, HIPAA's IT provisions are now cast in a doubly problematic light, simultaneously behind the times and crowding the road ahead with mandates. Stakeholders from across the spectrum, as well as disinter-

ested parties such as the NCVHS—with its statutory authority to advise Congress and the HHS secretary on HIPAA—have called on Congress to revisit the issues, and the Senate HELP Committee will likely do its best to reassert leadership next year."

"Senator Jeffords has 'made it clear that confidentiality standards will be a high priority for the Committee during the 107th Congress,' said a HELP staff member in July 2000, noting also that the HIPAA regulations do not become effective until twenty-four months after final rules are issued and that the statute allows for the updating of regulations as often as every twelve months. Final rules on transaction standards and code sets were published in August, clearing the way for covered entities and vendors to begin with the costly process of gearing up for implementation. Even in the absence of a viable rule for the unique patient identifier, these rules will help to create a foundation for increased electronic data exchange."

Drug Spending Driving Insurance Increases

From "Rise in Health Care Costs Rests Largely on Drug Prices" by Robert Pear in *The New York Times*, 11/13/00:

"**Prescription drugs accounted for 44 percent of the increase in health costs last year**."

"In a report published in the journal *Health Affairs*, the researchers said overall health costs for services covered by private insurance rose by 6.6 percent last year, while drug spending increased by 18.4 percent."

"Paul B. Ginsburg, an author of the report, said prescription drugs accounted for more of the 6.6 percent increase in health costs than either hospital care or doctors' services. 'Drug spending is growing much faster than other components of health care,' said Mr. Ginsburg, an economist who is president of the Center for Studying Health System Change, a private research institute. 'Drug costs are having a bigger and bigger effect on overall health costs.' "

National Campaign For Rural Hospitals

At the invitation of the Texas Organization of Rural and Community Hospitals, individuals from around the country met in Kansas City on November 11th to address the critical need to find a permanent solution for equitable Medicare reimbursement for rural hospitals. Leadership from the American Hospital Association and the National Rural Health Association were well represented. Plans for a national multi-association campaign were sketched out with a February meeting planned to confirm a details for this collaborative initiative. Email timsize@rwhc.com if you would like to receive information about participating as it becomes available.

"Inflation is back after several years of low growth in health insurance premiums, said Mr. Ginsburg, a former director of health care studies at the Congressional Budget Office. The higher premiums mean higher costs for employers and, in many cases, for employees, he said."

"The rise in prescription drug costs has stimulated interest in proposals to rein in drug prices or add drug benefits to Medicare, the federal health insurance program for the elderly and disabled. Representative Tom Allen, Democrat of Maine, has introduced a bill that he said would make prescription drugs available to Medicare beneficiaries at the prices negotiated by large government purchasers."

"Mr. Allen and other Democrats complain that elderly people often must pay far more for prescription drugs than do the drug companies' most favored customers, like health maintenance organizations."

"The report in *Health Affairs* said that about one-third of the increase in drug spending last year was attributable to higher prices. The remainder, it said, was attributable to a higher volume of sales, reflecting the advent of new medicines and the increased use of existing drugs."

"While prescription **drugs accounted for 44 percent** of the increase in health costs last year, **doctors' services accounted for 32 percent**, and **outpatient hospital care accounted for 21 percent**, **while inpatient hospital care was responsible for only 3 percent**."

"The period from 1994 to 1998 was a time of record-low rates of growth in health insurance premiums and in the underlying medical expenses that are covered."

" 'The premium for a typical private health insurance plan grew an average of 2 percent a year from 1994 to 1998 less than the increase in per capita gross domestic product, the output of goods and services,' the authors said. 'Premiums this year rose an average of 8.3 percent for all businesses and 7.5 percent for companies with 200 or more workers.' "

Editor's note: renewal rates for small businesses in Wisconsin are running substantially higher than these national, one year old, aggregated figures.

Whether or not the underlying factors in Wisconsin are in the same proportion as the country as a whole, is being studied by several groups in Wisconsin and will hopefully be reported later this winter.
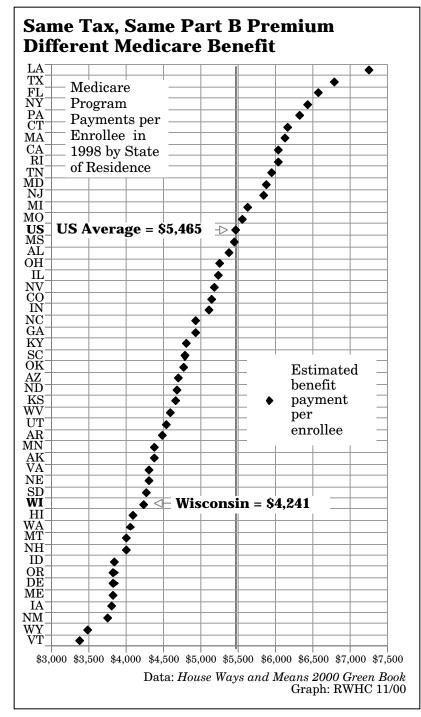
HMOs Out Of Steam Or Just Getting Ready?

From "Do Recent Enrollment Trends Indicate The HMO Concept Is Running Out Of Steam?" by John Harkey, Ph.D., in the *The Harkey Report*, 11/00:

"Enrollment changes at key managed care firms offering the full product spectrum indicate a shift in emphasis towards more loosely managed PPO, but current trends in a four-state area may reverse as price increases force the industry to rethink its direction."

"For the first time in at least a decade, HMO and POS managed care plans in Florida, Georgia, North Carolina and Tennessee lost market share during the past year. All of the slack and more was taken up by PPO plans, which showed strong growth."

"The overall loss of market share by the HMO product lines is not surprising. Managed care has suffered from an almost universally bad press, taking its place in the lineup beside big tobacco, big oil, and big tire manufacturers as one of the industries Americans love to hate. Combined with the bad press, HMOs have been going through a period of financial difficulty. Most have lost money during the past few years, and few have been very profitable."

RWHC Eye On Health

"Just like you said, with or without managed care, there is no free lunch."

Same Tax, Same Part B Premium Different Medicare Benefit

Medicare Program Payments per Enrollee in 1998 by State of Residence

US Average = $5,465

Wisconsin = $4,241

Estimated benefit payment per enrollee

States (top to bottom): LA, TX, FL, NY, PA, CT, MA, CA, RI, TN, MD, NJ, MI, MO, US, MS, AL, OH, IL, NV, CO, IN, NC, GA, KY, SC, OK, AZ, ND, KS, WV, UT, AR, MN, AK, VA, NE, SD, WI, HI, WA, MT, NH, ID, OR, DE, ME, IA, NM, WY, VT

X-axis: $3,000 $3,500 $4,000 $4,500 $5,000 $5,500 $6,000 $6,500 $7,000 $7,500

Data: *House Ways and Means 2000 Green Book*
Graph: RWHC 11/00

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cline into 2000. Average HMO/POS enrollment in these four states stood at 40% of the commercial market as of July 2000. All four of the major players claim a roughly equivalent percentage of the HMO/POS market, and together account for more than two thirds (68%) of the HMO/POS market in these states."

"The large players are clearly gaining enrollment, probably at the expense of smaller life and health players in the indemnity and PPO market. The big enrollment loser, among the different network options, is POS plans, the very kind of plan that has been emphasized by legislative mandates in several states to provide more choice for enrollees. Several managed care executives have pointed out that the POS is being adversely selected by sicker employees, making it less financially viable."

"HMO, the strongest form of managed care, has lost ground relative to its weaker cousin, PPO, despite an overall increase in HMO lives in these four states with these four plans. The PPO is just growing more rapidly. This pattern seems to be one that is happening in other states covered by *The Harkey Report*, and is likely the pattern in most states across the nation."

"At the same time the PPO is showing relative strength, the HMO product is changing its 'look and feel' and its relative cost effectiveness as open-access products are introduced, as all-product provider contracts are negotiated with similar or the same reimbursement rates, as capitation arrangements become fee-for-service in some markets, and as HMO provider networks get larger to the point of looking like PPO networks. As a result, the HMO and PPO product lines aren't as sharply distinguished as they once were, and the HMO does not bring as much additional cost savings to the table."

"Will this trend continue? The consumer seems to be saying yes, but without having yet felt much of a pinch from higher premiums. Anyone would want more provider choice and fewer utilization restrictions, if it didn't cost any more. However, as employers face stiff premium increases, and as employees and dependents face more cost sharing, the current trend towards PPO-style plans may not continue. Premium and cost sharing increases may make employers and employees look for better solutions, in some cases back to tighter, capitated networks and in others to some form of defined employer contribution with the employee taking on more costs."

"*The Harkey Report* tracks HMO, POS and PPO enrollment by state and metropolitan area on a quarterly basis, and enrollment information is now available through July 2000. To assess underlying trends, we decided to look at the four biggest players: the Blues, Aetna/Prudential, CIGNA, and UnitedHealthCare in the four southeastern states and explore the enrollment pattern during the 18-month period from January 1999 through July 2000."

"For each of these states, 1999 represented peak HMO/POS enrollment, and there has been a slight de-

Helping Uninsured Helps Bottom Line

From *Putting the Patient First* by Bob Richards & Jeanan Yasiri:

"Dean Medical Center's Community Care Program works very closely with ABC for Health in making sure staff have appropriate information and patients are getting that information. The program was established in 1992 and serves hundreds of patients annually. On average, the program is responsible for bringing in approximately $600,000 annually in public assistance monies that would have certainly otherwise never been received."

"Patients who are uninsured, underinsured or facing a medical need that goes beyond their means are encouraged to complete a Community Care application. The information in the application provides Dean Community Care staff with a picture of the entire household–the number of family members, ages, income, current medical and other debt. A history of the family's insurance status and experience with the public assistance system is also requested."

"Based on this information, a Community Care specialist is able to determine whether anyone in the household is likely eligible for public assistance monies. In turn, the specialist can work with the family in helping them understand their rights and responsibilities within that public assistance program. Patients are then directed to the appropriate agency to apply for benefits or, when necessary, clinic staff assist patients in applying."

"In the event of an inappropriate denial, Community Care staff will work directly with the granting agency to reevaluate a patient's eligibility. In this way, Community Care staff serve as the patient's advocate in helping patients make appropriate inquiries of the agency and making sure they get a fair hearing if necessary."

"The end result is often patients who are afforded benefits through a program that can help them in settling their medical expenses. Importantly, they have also received a meaningful service from the clinic in the form of education and information about a system they most likely would have found difficulty accessing without that service."

"**Q. Isn't it the county's job to help indigent patients access public assistance resources? Why should we take responsibility for doing their job?** A. It is true that most counties have caseworkers assigned to the task of out-reaching to populations in need of benefits. However, the reality is that most county social service agencies have little incentive to actually perform such outreach."

"**Q. Why don't patients simply go down to the local social service office and apply on their own? Everyone knows that these programs exist.** A. Perhaps this is the area that surprised us the most. Many of the patients we serve through our health benefits counseling area have no knowledge of the public assistance programs for which they are eligible."

"**Q. I can't afford to hire a fleet of social workers to help every uninsured patient who walks through our door. It would bust our human resources budget.** A. While health benefits counseling is a service that comes at a cost to a clinic, it is not without its financial rewards. Recognize that the majority of these patients would be presenting for service anyway. The question is how would your clinic be reimbursed in the end? If they are uninsured, the likelihood is that the patient will end up in collection or falling in a bad debt category on your ledger sheets."

Editor's note: Both the Dean Medical Center and ABC for Health have offered to share their experience with this model; ABC for Health has received grant funds to train other Wisconsin providers; contact information is as follows:

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Wild Rose Cited As National CAH Model

From "Wisconsin: Strategies for Hospital Communication With The Community" in *FINDINGS FROM THE FIELD* by the CAH/FLEX National Tracking Project (www.rupri.org/srhf-eval/), 10/2/00:

"Critical Access Hospitals (CAHs) are dependent on their communities for long-term survival. First and foremost, community residents are the primary consumers of hospital services. They are also the most likely source of charitable contributions and support

for any tax-based funding initiatives supporting the hospital."

"The potential exists for the public to … view the newly designated CAH as a lesser institution. However, conversion also presents an opportunity to engage the community in a discussion regarding the hospital's future and to take charge of the message that the hospital wishes to communicate."

"A hospital considering conversion must clearly think through its communication strategy and prepare a clear and consistent message. Wild Rose Community Memorial Hospital in Wild Rose, Wisconsin, has developed a model communication strategy for other rural hospitals considering conversion."

"Early in their consideration of the CAH program, the Board of Directors of Wild Rose Community Memorial Hospital recognized that many of the operational changes resulting from CAH conversion would be relatively small, occur 'behind the scenes,' and be difficult to communicate clearly through brief, written press releases. The Board also acknowledged that the culture of the Wild Rose community necessitated that key constituencies be given opportunities to ask questions and voice their concerns regarding CAH conversion. Finally, the hospital realized that its communication needed to be consistent and targeted to the unique concerns of each constituency."

"The board and the hospital administration took several key steps that would guide and define the hospital's communication with the community:
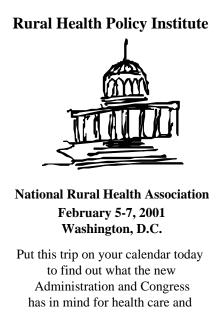
• Designate two senior administrators as the primary individuals responsible for communicating with key constituencies.

• Identify the key constituencies within the community.

• Use group and personal meetings to communicate the hospital's message, supplemented by press releases and other written materials.

• Develop a consistent core message for all communications. The message is that the hospital has been identified as 'critical' to the local health system and that CAH conversion is an opportunity to ensure that the area's health care needs are met."

"Key points in the development of an effective communication strategy:

• Designate primary individuals to manage the communication process.

• Identify key constituencies within the community and listen to their concerns.

• Develop the core message tailored to those concerns.

• Recognize the role of the hospital's employees as a link to the community.

• Identify the primary modes of communication."

"The Board was aided in the development and implementation of its communication strategy by the Community Relations Department of the Community Health Network, a health care system based in Berlin, Wisconsin, with which the hospital is affiliated."

Read Fine Print Before Going Whole Hog

From "Clues In The News: Read Past The Headline Before Changing Your Life" in *U.S. News & World Report*, 11/13/00:

"You knew if you waited long enough, you'd come across headlines like one that recently exhorted: 'Time to Put Lard Back in the Larder.' But before going whole hog on the rendered pig fat or doing some other 180-degree turn in your diet, you need to know how seriously to take a new study."

"Here are clues to look for when you read health news stories:

- Does the study corroborate earlier research?

- How big is the claimed benefit or harm, and can reasonable amounts of the food produce it?

- Does the news story give numbers or just anecdotes?

- Does the story offer a biological explanation for the effect?

- Were the tests conducted on humans?

- Was the study published in an established journal and not just delivered at a conference?

- Who sponsored it? If industry or an advocacy group funded the research, a little extra skepticism is in order.

"Most important 'read past the headline,' says Diane Quagliani of the American Dietetic Association. 'The breakthroughs are in the first paragraph,' agrees Marcia Angell, former editor-in-chief of the *New England Journal of Medicine*, 'and the caveats are in the fifth.' "

RWHC Eye On Health

The Information Age: An expert for every opinion.

Space Intentionally Left Blank For Mailing