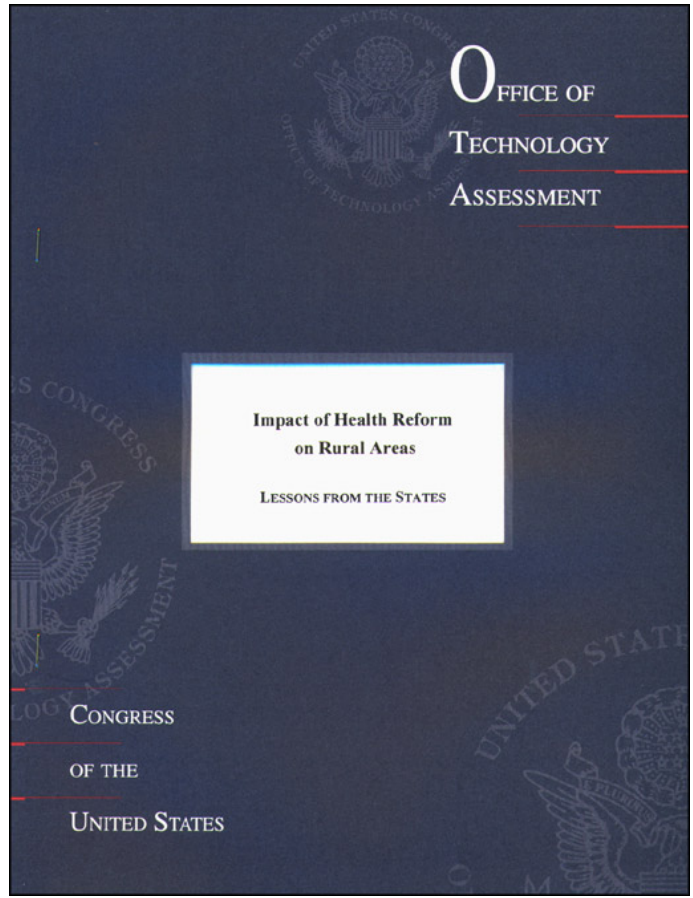
Impact of Health Reform on Rural Areas: Lessons From the States

September 1995





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Summary

Basic rural issues remain constant. For all the national reform discussion, the predominant issues in rural health care are the same as they have been for many years. Mainly, these issues involve how to get health care providers and services into rural areas and keep them there.

Broad-based reforms can have special rural impacts. Most general health system reforms affect both rural and urban areas alike. Nonetheless, some reforms are likely to have somewhat different impacts or raise additional concerns in the context of rural care.

Likely impacts are related to rural characteristics. Rural areas have several characteristics that influence the effects of reforms. These include lower incomes, poorer health, higher percentages of elderly people, fewer local providers, and lower rates of insurance--especially insurance obtained through large employers with ERISA-exempt health plans--than urban residents. Rural areas vary among themselves in these characteristics as well.

Many incremental reforms could benefit rural areas. All else equal, incremental insurance reforms aimed at easing insurance access for harder-to-insure people (e. g., guaranteed issue) should tend to benefit rural residents. Community rating has more complex potential effects because of rural health care fees are often lower than urban fees (which affects insurance premium prices) and because of the use of geographic adjustments in many rating schemes.

ERISA complicates the equation, however, because rural areas are at a relative disadvantage under ERISA. If reforms cause more employers who currently offer insurance to self-fund to obtain ERISA exemptions, or more small businesses to gain ERISA privilege, rural residents will probably see the costs of their insurance rise disproportionately. The reason for this is that rural residents are more likely than urban people to purchase insurance individually, and because the rural population is disproportionately composed of high-risk people.

The likely advantages of MSAs **in rural areas depend on their design.** Reforms that permit medical savings accounts to be established by individuals are reportedly attractive to some rural residents who prefer self-sufficiency to insurance and are currently uninsured

for this reason. However, proposals that permit only employers to establish MSAs are not likely to benefit rural residents much.

Managed care has the potential to improve rural access to affordable, good-quality care. When it's good, managed care supports local providers (e. g., by providing modem information technologies) and enhances rural residents' access to coordinated care, linking local and distant care resources. At present, however, neither managed care plans nor providers are usually enthusiastic about rural managed care. Some states are using their leverage as purchasers to encourage managed care plans to "pool" urban enrollees with rural enrollees (who are generally less profitable to serve), through participation requirements for HMOs serving Medicaid beneficiaries and state employees, and through state purchasing alliance requirements.

Managed care also raises special risks of provider abandonment in rural areas. The primary concerns about managed care and large multiprovider delivery systems are that they may take over providers in a rural areas, then abandon the area if it is not profitable; that they may direct patients away from local providers, exacerbating problems of long patient travel times and local hospital closure; and that they threaten the autonomy that is highly valued by many rural physicians.

Most of the rural-specific impacts predicted above are highly speculative. Good evidence and solid experience on the effects of these reforms--most of them only recently implemented by states--generally don't exist yet, and states' experiences are likely to differ (especially in the area of managed care). Evaluation is important to understanding effects, and would aid the federal debate on reform impacts, but little evaluation is occurring.

Introduction

In 1995, the focus of the national health reform debate has shifted to incremental reforms in the health care marketplace. Many of these reforms are being tried in some form by individual states, bringing a renewed federal interest in states' experiences.

At the same time, the health care system has been undergoing enormous changes of its own. Yesterday's system--independent health care providers being reimbursed by patients and indemnity insurers on a fee-for-service basis--has been uprooted by a turbulent mix of new forms of payment, multiprovider delivery networks, and novel ways of managing the care that enrollees are eligible to receive.

Amid these changes, rural areas are trying to address the same underlying problem that they have always faced in health care: How can they keep local, financially accessible, good-quality care available to rural populations that are less able to pay and less efficient for providers to serve (because of low population density) than their urban counterparts? States continue to implement new programs aimed at continuing to improve ways to address the fundamental problem of rural health care directly, through such mechanisms as special educational and incentive programs for health professionals willing to locate in rural areas.

Systemwide health delivery changes raise special issues in rural areas. [1] By definition, broad-based health reforms and marketplace changes affect both urban and rural areas. However, they will not necessarily have the same impacts in the two places. As states have been instituting broad health care reforms over the past several years, they have had to confront the special barriers, concerns, and opportunities that arise in planning and implementing these reforms in rural areas.

This paper examines the issues that arise in the context of two different categories of reforms:

1. The effects of insurance market reforms--measures intended to make the market more equitable, or to make health care more affordable to those without insurance. These reforms may sometimes have different impacts in rural than in urban areas.

[1] "Rural" has two different formal definitions for federal statistical purposes (34). In this paper, the term is used loosely to refer to areas of relatively sparse population. It is not linked specifically to either formal definition.

2. **The** effects of reforms aimed at the health care delivery system. Many delivery system reforms are intended either to encourage or restrain the managed care market and the way the delivery system is responding to this market. Many of the issues in this category are secondary effects of managed care (e. g., effects on provider viability).

There is very little literature on the impact of the specific types of health changes and reforms in rural areas that are currently being debated by Congress. Most of the information in this paper is drown from conversations with researchers, policymakers, and other experts; and from a small workshop at which several state legislators and other policymakers shared and contrasted their states' experiences with the impact of broad reforms on rural areas (see appendix A).2 These experts and policymakers were not randomly selected, and they do not necessarily represent all experiences and opinions. Nonetheless, the issues they raised, and the diversity of experiences they presented, imply that systemwide reforms can have different impacts on rural than on urban areas, and that these differences merit attention.

Rural Characteristics

Rural America has unique characteristics that have long-recognized effects on the accessibility and availability of health care (33). For example:

. Rural residents are poorer, more likely to be elderly or children, and more likely to be disabled--i. e., have higher health risks--than urban residents.

. Rural individuals are more likely than urban persons to be uninsured for their health care. When they are insured, rural residents are more likely than urban dwellers to be covered through public or individually purchased insurance rather than through an employer.

. Employed rural residents are more likely than urban ones to work for small firms, which in turn are less likely than large firms to offer health insurance benefits (8;10). Furthermore, among small firms, rural firms are less likely than urban ones

[2]The workshop, held at the Office of Technology Assessment (OTA) on May 5, 1995, was sponsored jointly by OTA and the Milbank Memorial Fund.

to offer benefits (13; 17). This factor is a major contributor to the lower rates of rural health insurance coverage.

. Fewer health professionals are willing to establish practices in rural than in urban areas. Specialty health services are often not available locally, and primary care services are often provided by nonphysician practitioners (e. g., nurse practitioners, physician assistants). In 1992, 106 U.S. counties, with a combined population of 300,000 people, had no physicians at all (35).

. Hospitals in rural areas tend to be small and have higher proportions of uninsured or publicly insured patients than urban hospitals (33). Some are the sole providers within large geographic areas. Rural hospitals and other health providers are often valued by residents as much for their importance as a source of jobs and a community focal point as for their medical contributions.

These generalities aside, rural (nonmetropolitan) areas vary enormously in the characteristics of their specific populations. The rural Midwest, for example, has a much higher prevalence of elderly residents than does the rural West. Conversely, a very high proportion of rural western residents are children (33). Persistently poor rural counties tend to be clustered in the South, and "frontier" counties with extremely sparse populations are located mostly in the West.

Although many of the kinds of reforms currently being debated nationally have been implemented by some states, implementation is generally too recent to yield solid evidence of their rural-specific impacts. Thus, predicting potential impacts depends on states' more general experiences and impressions of their reforms so far, and an analysis of how the characteristics of rural areas are likely to affect impacts on rural residents.

Incremental Insurance Reforms

Reforming the health insurance market is an important state strategy for making health care more accessible to people. A few states (e.g., Hawaii, Washington) have previously been very ambitious in this area, passing legislation that requires either individuals or employers to purchase insurance. In 1995, however, this trend has reversed. With changes in the political environment and legal barriers to implementation of such

global reforms, most states passing such legislation have repealed it or delayed implementation. Instead, states have tended to pursue more incremental strategies.

These incremental reforms aim at making the health insurance market more efficient and equitable. Among the most commonly discussed reforms in this category are:

1. those that restrict insurers' ability to avoid insuring people who are at high risk of getting sick, and

2. those aimed at changing the tax system so that people who save for their medical expenses, or who purchase their insurance themselves, can reap the same tax benefits as people whose employers have purchased insurance on their behalf.

INSURANCE MARKET RESTRICTIONS

By early 1995, most states (45 of 50) had enacted some kind of incremental insurance market reforms aimed at restricting adverse selection in the market (16). These reforms generally apply to insurance policies written to cover small groups; in many cases, they also apply to policies sold to individuals. Types of reforms include:

- "guaranteed issue" and "guaranteed renewal"--requirements that insurers must issue policies to all applicants, and must renew those policies even if the enrollee gets seriously ill;

- "portability' '--laws that allow people to keep their insurance coverage when they change to a different job (or, more rarely, when they leave their job and seek coverage under an individual policy);

. limits on insurers' ability to exclude persons from coverage for a period of time due to their pre-existing health care conditions, and

- rating restrictions, which limit the differences in premiums that insurance companies can charge to people solely because of their different risk of needing health care. (Pure "community rating, " for example, requires that all subscribers be charged the same price for the same benefit package, regardless of their age, gender, or other factors associated with health care use and costs.)

These reforms have been popular among states, and they continue to find considerable support among state policymakers (26).

One early concern was that passing these reforms could lead insurers to stop selling policies in a state, a particular concern for small or rural states in which there are already only a few insurers and relatively limited consumer choice. This concern has been alleviated somewhat by experience. For example, when Vermont implemented community rating, the number of insurers willing to offer policies in the state was only reduced by one (from 9 to 8 insurers), despite dire predictions of insurers fleeing the market (37). Furthermore, additional insurers--e. g., CIGNA--are currently trying to move into the market.

A more lasting concern is the effect of insurance reforms on rural consumers' insurance premium costs. The purpose of most reforms is to make insurance more accessible to people who are at high risk of getting sick (or who are already ill) by making insurance prices low enough to be affordable to them. In turn, on average one would expect the costs of insurance premiums for lower risk people to go up. In theory, if costs are being spread over a large insured group, the costs of the large group of relatively healthy people will go up only a little, while the much smaller group of people at high risk of illness will see the costs of their (previously very high) premiums go down considerably. The impact of these reforms is likely to be different for rural than for urban residents for two reasons: their different demographic and health characteristics, and their different sources of health insurance.

As previously mentioned, rural residents are more likely to be elderly or in poor health than the population as a whole. They are also more likely to purchase their insurance through individual policies, the portion of the market in which access to insurance is the most difficult for disabled or high-risk people (since insurers can refuse to insure them, or offer insurance only at extremely high prices). Thus, insurance market reforms such as guaranteed issue and renewal should disproportionately benefit rura1 residents if there is a statewide pool.

The potential effect of community rating is slightly more complex. Like the other incremental insurance reforms, it benefits persons of higher health risk. However, insurance premium prices also vary according to health care costs. Rural areas have lower health care utilization and (often) lower prices. Statewide pure community rating thus could, on balance, result in disproportionately high premium increases in rural (vs. urban)

areas. Many rural advocates thus have supported different community rating pools for different geographic areas, and a number of states (e.g., Kentucky and Maryland) permit rates to be modified based on geographic region. Some policymakers, however, believe that geographic differentials are of dubious ultimate benefit to rural residents, since they may tend to keep health care prices in rural areas depressed and dissuade providers from serving rural regions (36).

State insurance reforms only affect part of the market. Insurance provided by employers who self-fund the employee benefits they provide is exempt from state regulation under ERISA,[3] the federal law governing the administration of employer-funded pension and welfare plans. Nearly half of people who are employed by mid- to large-sized firms and are insured through their employers are in self-funded plans (8) and thus are unaffected by state insurance reform.

Most people covered by ERISA-governed plans are currently employed and thus are probably, on average, less disabled than the remaining pool of people seeking insurance in the general market. Reforms such as community rating can only affect the average premium of this higher-risk group, since the lower-risk, lower cost ERISA group is excluded from the community pool. The consequence is that high-risk individuals still face relatively high premiums, and low-risk people in the community group may see their premiums increase substantially.

Rural residents are likely to be disproportionately affected by ERISA's impact on state health reforms. People who live in rural areas are less likely than urban residents to work in large businesses, which offer most of the self-funded plans. Furthermore, two separate studies have found that even among small businesses, rural businesses are less likely than urban ones to offer health care coverage (13;17). The net result is that far fewer rural residents than urban residents are probably covered by ERISA-exempt plans, and rural residents--with their higher rates of disability--are disproportionately represented in the non-ERISA "community" pool affected by state reforms.

Thus, in the absence of ERISA, many incremental insurance market reforms would probably benefit rural residents more heavily than urban residents. ERISA, however, counters this effect. The net likely effect of incremental reforms on rural areas (relative to their effects on urban areas), therefore, is unclear.

[3] ERISA is the acronym for the Employee Retirement Income Security Act of 1974.

At a broader level, the impact of incremental insurance reforms in rural areas is limited by the willingness of people to buy insurance. Insurance reforms **make the most** difference to people who want to buy insurance but are unable to buy it at any but extreme prices--if at all--because their pre-existing disabilities or chronic illnesses make them very high risks. These reforms don't necessarily make insurance all that much more appealing to people who already have access to moderately priced insurance but feel they still can't afford it, or those whose sense of "rugged individualism" makes them simply prefer to depend on themselves.

TAX INCENTIVES FOR MEDICAL SAVINGS AND INSURANCE

There has been considerable discussion and enthusiasm in 1995 for tax incentives as an approach to addressing problems of insurance access and equity. These incentives take two general forms: medical savings accounts MSAs and tax deductions for the payment of health insurance premiums.

MSAs are savings accounts in which the deposits and interest in the account are untaxed (or qualify for tax credits) as long as the purpose of the deposits is to save for medical expenses. As of May 1995, eleven states had enacted MSA legislation (most of them very recently) (7). The specifics vary considerably among states. For example, some states permit money in the account to be spent on nonmedical expenses at the end of the year, while others do not without substantial penalty. In 6 states, MSA exemptions are coupled with a requirement that the account holder also purchase back-up catastrophic insurance (with a high deductible) for major medical expenses; in the other 5, they are not.

Because state MSAs have been implemented so recently, there is no experience yet with which to evaluate their use and effect. Although MSAs are a popular legislative measure in the states, the strength of the incentive to use them is limited by the fact that to date, only state taxes are affected.

There are some reasons to believe that urban and rural people may take advantage of the option to invest in MSAs at different rates. In theory, at least, MSAs should be attractive to people who place a heavy value on self-reliance and are consequently unenthusiastic consumers of health insurance, even relatively inexpensive insurance. As one state policymaker pointed out: "Those individuals who would potentially use the [MSAs] may well be without insurance right now and are simply paying out of pocket for

the care that they get" (28). Anecdotal evidence suggests that many rural residents may fall into this category.

The potential attractiveness of MSAs as a way to increase health care "coverage" for at least a small segment of the rural population, however, applies only to MSAs that can be established by individuals. Most state MSAs permit individually sponsored accounts (7). Many national proposals, however, envision MSAs more as an alternative method of employer-sponsored coverage. If the design of an MSA law is such that only employers can establish them, they are likely to have little impact on rural residents, who are far less likely to have any employer-sponsored coverage in the first place.

Direct tax incentives to purchase health insurance are an alternative tax-based approach aimed at improving insurance market equity. At present, employers' contributions to their employees' insurance premiums are exempt from federal taxes. Only 25 percent of the cost of insurance premiums purchased by self-employed and other individuals, however, are currently federally tax-exempt (Public Law 104-7).

Clearly, changing the tax treatment of either way of purchasing insurance would have broad effects, both for individuals whose level of taxation changed (for better or for worse), and for those who benefit from public spending (financed by taxes). Changing the tax rules regarding income spent on health insurance would probably have slightly different average effects in rural than in urban areas. Because rural residents are more likely than urban ones to purchase insurance individually, rather than receive it as an employee benefit, they would benefit disproportionately from a policy that increased the deductibility of individually purchased insurance. They would also, in general, be less harmed by an increase in the tax liability for dollars spent on employer-sponsored insurance.

Despite these urban/rural differences in relative effect, it is worth remembering that more people in both regions receive their health insurance through employers than purchase it as individuals. Thus, many of the effects of a change in tax policy would probably be similar for both populations. Those broad effects include not only the effects on individuals whose taxes change, but the effects on those who benefit from public spending.[4]

[4] Despite the impact on state revenues of greater tax exemptions for individually purchased insurance, the policy makers at the OTA workshop clearly believed this approach could improve the level of insuredness of the population. Interestingly, these policymakers tended to support the principle of tax equity even over

Managed Care and Delivery System Consolidation

Irrespective of public policy changes, the health care system is undergoing a radical transformation. Managed care has become not only common but the dominant form of health care plan in many areas. The crucial characteristics of "managed care, " as the term is used in this paper, are that:

1. providers have a close (sometimes exclusive) contractual relationship with the insurer,
2. the insurer exerts some control over the care that is provided, and
3. patients face financial penalties for using providers not associated with the insurance plan.

Approximately one-fourth of the insured population is enrolled in HMOs the most stringent form of managed care (12). HMO plans not only constrain the providers their enrollees can use without incurring severe financial penalties; they also generally operate on a per-capita payment basis, with a strong incentive to keep costs and service use low. Many additional people are enrolled in "preferred provider organization" (PPO) managed care plans, in which patients' copayments are lower if they use providers in the plan's network. According to one estimate, as many as 90 million people were enrolled in either HMOs or PPOs in 1992, an almost 4-fold increase from 1985 (38).

At the same time that consumers have been increasingly turning to managed care plans (often as a result of the insurance their employer or government sponsor has chosen), the health care insurance and delivery systems have been consolidating. HMOs are larger and fewer in number than a few years ago (12). Multihospital systems are proliferating. Most recently, physicians and hospitals, and sometimes other care providers (e.g., nursing homes) are associating to form large "integrated delivery systems" in the interests of efficiency and bargaining power when negotiating with managed care plans and other payers.

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universal tax-deductibility --i.e., if necessary, increasing taxes paid on employer-provided insurance benefits in order to pay for an equivalent level of tax deductibility for insurance purchased by individuals.

States' policies and experiences regarding these delivery system changes are very diverse. In many ways, states have actively encouraged changes--especially the expansion of managed care--by encouraging or even requiring many covered populations, like state employees and Medicaid beneficiaries, to enroll in managed care plans. On the other hand, many states also express a wariness with some of the implications of these changes in rural areas, where managed care and multiprovider networks raise some unique issues.

Managed care organizations (such as HMOs are underrepresented in rural areas. In 1992 there were HMOs present in only 36 percent of 2,361 rural (non-metropolitan) counties (31). Only about half of urban-based HMOs include rural areas in their market areas, and as of 1993 only 10 HMOs were primarily rural plans (22;29). Urban physicians are much more likely to participate in managed care plans than rural physicians (11 ;25).

There are at least four likely reasons for HMOs rural underrepresentation:

1. Rural providers are often scarce. If a managed care plan cannot convince the few rural hospitals or physicians in a particular area to contract with the plan, the plan cannot serve patients in that area.

2. Many rural providers value autonomy more highly than they do managed care contracts. As one Minnesota health care professional put it: "The reasons people go out to practice in rural areas are somewhat counter to reform. They're out there because they want to get *out* of the bureaucracy" (9).

3. Serving rural residents is often considered less profitable for managed care plans than serving higher-density urban and suburban areas, whose greater number of providers allow plans to take advantage of provider competition for patients.

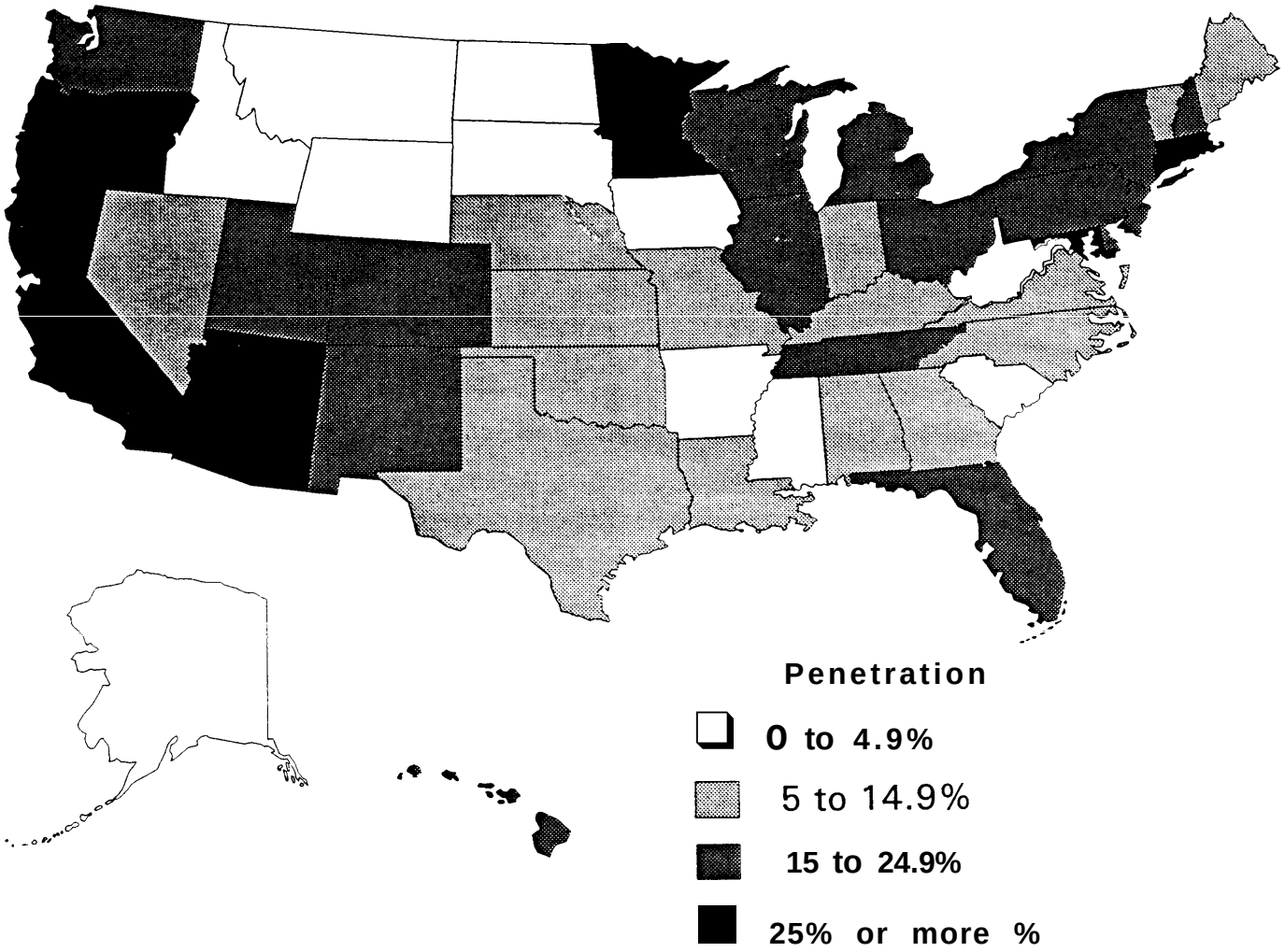
4. Rural residents often aren't covered by employer-based group insurance, so there is no pre-specified covered group for HMOs to serve in many rural areas.

Thus, managed care penetration in rural areas is generally much less than in urban areas of a given state. But because states themselves differ so dramatically in the extent to which managed care dominates the health market (figure 1), the experiences of rural areas of different states are themselves very diverse.

In states such as Oregon and Minnesota, which have a long history of managed care, for example, managed care has a substantial presence even in many rural areas. In

Figure 1

Percentage of Insured Population in HMOs 1994



SOURCE: Based on data from Group Health Association of America, *Patterns in HMO Enrollment* (Washington, DC: GHAA, June 1995).

contrast, Idaho's rural areas have virtually no managed care; in fact, managed care's share of the overall state market is only 1 % (12). An Idaho policymaker dryly describes the growth of managed care elsewhere in the Northwest as a remarkably effective solution to that state's physician supply problem. A significant number of physicians have reportedly moved their practices to Idaho in an attempt to avoid managed care elsewhere (28).

Issues surrounding managed care delivery systems and rural areas fall into two categories: those that relate to encouraging the current trends toward managed care and delivery system consolidation, and those that relate to controlling managed care's ability to have harmful effects.

ENCOURAGING MANAGED CARE

Many states are interested in promoting managed care systems and rural health networks. They do so for two reasons: in order to control their own health-related state expenditures, and to enable rural residents access to more sustainable, better-coordinated care. To encourage managed care, states are pulling hard on one of the few levers they control directly: payment for services provided to state employees and Medicaid beneficiaries.

Pulling Managed Care into Rural Areas Through Medicaid

When the Medicaid program was established in 1965, it included a "freedom of choice" provision. States receiving Federal Medicaid matching finds were required to permit beneficiaries to receive services from any provider they chose who would serve them. Over time, a number of states have sought and received permission to waive this provision so they could test managed care delivery systems for certain Medicaid beneficiaries, usually in a few selected urban areas. Recently, however, an increasing number of states--l3 as of July 1995--have received statewide "Section 1115" Medicaid waivers that, among other things, permit them to vastly increase the number of beneficiaries enrolled in managed care. (In addition, a number of states have more limited waivers that also permit them to enroll many Medicaid beneficiaries in managed care.)

Arizona has the longest experience in using Medicaid to draw managed care into rural areas. Arizona was the first--and for many years the only--state to operate its Medicaid program under a statewide 1115 waiver. Approximately one-third of its Medicaid population lives in rural communities (22). When the state's waiver program began in 1982, it operated through managed care plans in its urban areas but paid many rural providers on a fee-for-service basis (22). Now, however, all rural areas are also served by managed care plans, and all plans receive per capita payments from the state's Medicaid program (23;27).

Of all the states, Tennessee has been the most ambitious in its use of Medicaid as a lever for bringing sweeping changes to its health care delivery system. Until the approval of its statewide Medicaid waiver in 1993, Tennessee had a very low level of managed care. In January 1994, with only a few months' warning, Tennessee greatly expanded its Medicaid program to include tens of thousands of new low-income uninsured persons. At the same time, the state required all Medicaid beneficiaries to enroll in prepaid managed care in order to receive acute care services (30). Although the road to managed care has been very bumpy, with major protests from many provider groups over issues such as coercion and payment levels, it has been undeniably effective in encouraging the expansion of managed care. Tennessee changed its HMO penetration from 5.7 percent to 16.2 percent in the course of a single year (2).

Oregon likewise recently received a statewide Medicaid waiver that enables it to expand Medicaid coverage to many previously uninsured people, and require most beneficiaries to receive their care through prepaid managed care programs. Unlike Tennessee, however, Oregon had an extensive history of managed care in the urban areas of the state at the time it implemented its new program. To encourage providers--and managed care plans--to want to participate in Medicaid, and to stimulate the formation of rural plans, the state did three things:

1. Increased the buying power of the Medicaid program by extending coverage to a large number of low-income people who were previously uninsured (and may previously often have relied on charity care) (32).

2. Recalculated the Medicaid reimbursement rates to make them more representative of actual costs. The rates were per-capita rather than per service, and included some assumptions of lower costs through efficiencies, so these new rates may not

have reflected actual costs (32). The effect, though, was to further encourage participation of both providers and plans in managed care.[5]

3. Designed a continuum of managed care possibilities for providers in rural areas with little experience in managed care. Rural providers were allowed to test the waters of managed care with risk-sharing arrangements in which the physicians would at first receive partial fee-for-service, or be capitated only for some services, but share in any savings from efficiencies and reduced service use. Once the providers had some experience, they could move gradually to a full-risk-bearing per-capita payment system (32).

Supporting Multiprovider Networks

Dragging an entire state delivery system into the era of managed care, as Tennessee's Medicaid program did, or encouraging managed care organizations to expand from urban to rural communities, as Oregon's Medicaid program did, are two ways in which states have encouraged coordination *among rural* and urban health providers. Another mechanism has been to encourage affiliations among providers in rural areas more directly. The public policy goals of this approach are to improve care coordination for patients, and to help rural providers survive in an era of managed care.

Hospitals clearly see multiprovider networks as crucial to their long-term survival, because it improves their ability to negotiate managed care contracts (14;22). Additional perceived benefits to rural hospitals include a chance to hire the medical residents that urban hospitals decline; access to specialized treatments (without ceding all control over patient revenues); and broadening the combined patient base, thus decreasing the financial risk that rural hospitals tend to face (15). Currently, nearly half of rural hospitals have established contracts with other hospitals, most of them in urban areas.

Rural provider networks have most commonly linked "similar types of providers that have joined together to address common problems or to respond to capitated or other payment opportunities" **(22). The** number of formal networks that integrate across provider types--e.g., linking hospitals, nursing homes, and physicians' offices together--is

[5] Those areas without managed care plans continued to be paid as traditional fee-for-service with primary care case managers; these fees did not increase, except for the primary care managers.

still small (22). Nonetheless, integrating across provider types is an active area in not only urban but rural areas, as providers struggle to position themselves to survive in a managed-care-dominated environment.

In some cases, states have actively encouraged providers to link together, both within and across provider types. Minnesota has been especially active in promoting provider networks (box A).

CONTROLLING RURAL MANAGED CARE

Competition and Access

Although most states are interested in encouraging at least some level of provider networking and managed care in rural areas, rural managed care presents a dilemma. The scarcity of providers and population that characterizes rura1 health care means that if local providers join a managed care network, what results may be a monopoly (20). Left to itself, the market may not sustain competing plans, leaving consumers with only a single choice (31).

In the most visible example of this dilemma to date, Blue Cross Blue Shield (BC/BS) of Wisconsin sued the physician-led rural health network Marshfield Clinic, long considered a model rural integrated delivery system. BC/BS claimed that Marshfield has required that its affiliated rural physicians contract exclusively with it, and, in doing so, that the network suppressed competition and locked the insurer's HMO plan out of Marshfield-dominated counties, thus violating antitrust law (18). BC/BS prevailed in court, and the Federal District judge ordered the Marshfield network not to prohibit its physicians from affiliating with non-Marshfield HMOs

Even where a second managed care plan exists, requiring enrollees to use a particular plan's providers can exacerbate the long distances rural consumers must often travel for care. One rural health researcher relates an anecdote involving a chicken processor who decided to provide managed care insurance for his workers (24). The processor could not strike an acceptable deal with the managed care plan nearest to the plant and opted to purchase health insurance through another plan, whose closest participating hospital was 70 miles away.

Box A: Integrated Service Networks in Minnesota

In 1993, Minnesota passed landmark health reform legislation that included an important role for newly defined entities called "Integrated Service Networks" (ISNs). Legislation the following year extended this concept to similar but smaller entities, "Community Integrated Service Networks" (CISNs), which were to be particularly appropriate for rural areas.

CISNs are similar in concept to HMOs in that they coordinate service delivery and offer managed care health plans to enrollees for a per-capita fee (6). However, they have a 50,000 enrollee limit and have a unique organization and administration.[6] Specifically, the cost control and delivery systems of CISNs are governed by those who provide the care themselves: hospitals, physicians, other providers, and involved health plans. Over half of a CISN's governing board members must reside in the immediate service area, to keep community ties strong and keep the service delivery and insurance functions of the plan coordinated at the local level (6).

Three CISNs have been legally operational since January 1995. Minnesota health officials predict that there will be two additional CISNs licensed by the end of 1995, bringing the total to five (5).

Membership in a provider cooperative is another option for rural providers (6). Provider co-ops, as defined by state legislation, are groups of independent providers (rural and urban) who band together to market their services as a group to licensed health plans (e.g., HMOs CISNs They may be especially attractive for rural providers, since this option permits them to be linked with managed care organizations (thus allowing their patients the security of managed care membership) while still permitting providers the flexibility of continuing fee-for-service care for some patients.

States have begun to grapple with these issues. In North Carolina, for instance, the state's Health Planning Commission recommended (unsuccessfully) that managed care plans be required to issue coverage to entire geographic regions, not just the most profitable urban areas (3). Similarly, Vermont is currently negotiating for a statewide waiver to enroll most Medicaid beneficiaries in managed care. Under the new program, the state is planning to require that any managed care plan wishing to contract with the state to serve Medicaid patients in a particular region must serve the rural areas of that region, too (37).

[6] In contrast, ISNs are expected to be largely urban entities and are allowed a greater number of enrollees.

In its newly revamped Medicaid program, Oregon requires every rural managed care plan to demonstrate the capacity to serve its enrollees adequately. The state does so by calculating the physician-to-population ratios in each rural county, and requiring each plan to show that it has contracts with a sufficient number of providers in the relevant county to cover its enrollee population (l). As of March 1995, all but 8 of Oregon's rural counties (which contain only 5 % of the population) were served by managed care plans that accepted per capita payment for Medicaid beneficiaries (l).

"Any Willing Provider"

"Any willing provider" laws are an increasingly common form of legislation in the states. These laws require managed care plans to contract with any provider who is willing to meet the plan's contract terms; they prevent plans from limiting the number of providers (e.g., certain specialists) in their network.

These laws may have somewhat different impacts in rural than in urban areas. It is not clear, however, exactly how the impacts will play out.

For example, the relative scarcity of providers in rural areas means that managed care plans that want to move into an area must court those providers, putting the providers in a position to negotiate fairly favorable terms. In Vermont, for example, CIGNA is actively pursuing contracts with several rural health clinics in an area into which it wants to expand (37). In such cases, "any willing provider" laws would have little, if any, positive effect.[7]

Also, many rural providers reportedly have rather skeptical attitudes towards managed care and may not want to participate. Again, in such cases, "any willing provider" laws would be irrelevant.

On the other hand, managed care plans may be equally skeptical about serving rural patients. Where they are unwilling to contract voluntarily with local providers--e. g.,

[7] Managed care organizationa argue that "any willing provider" laws can have a negative effect on health care costs, because these laws require the plans to accept any provider meeting the terms of the plan's contract, they prohibit the plans from using their buying power effectively. For example, plans cannot guarantee a certain volume of patients to any one provider in return for a lower negotiated payment rate to that provider, because the total volume of patients per provider is diluted each time another provider contracts with the plan.

because they consider it unprofitable--"any willing provider" laws allow local providers to take the initiative on behalf of their patients and contract with plans. Related laws, such as laws requiring "point-of-service" plans, may allow patients to participate in managed care plans but still choose to go to closer, more convenient nonparticipating local providers (if the patients are willing to pay higher costs).

Maintaining Local Control

State legislators express some concern about the potential effects of large (usually for-profit) delivery systems and managed care organizations when they take over local rural facilities. On the one hand, these moves can infuse needed capital to update rural hospitals (e.g., to invest in telecommunications technologies and information networks), and they can link local facilities to other sources of expertise and tertiary care. On the other hand, large managed care organizations and delivery systems may ignore local community investment issues, and they take control of local facilities out of the hands of local residents.

As one Vermont legislator observed about the proposed purchase of his local rural hospital by a larger multiprovider system: "It's not a question of having a monopoly on services. The hospital always has had a monopoly on serving the local area, but right now it's a monopoly with local people on the board. Once it's purchased by a large distant body, we no longer have any control over what happens to it--we're not even in the information loop" (37).

Other state policymakers are worried that because larger delivery systems must be concerned frost with the distant company's bottom line, they may make decisions that ultimately further damage local communities, and critical providers in those communities, instead of supporting them.

Because they restrict the providers that their enrollees may consult and still be covered, managed care plans control where patients go. If a managed care plan should require rural enrollees to use an urban hospital rather than the local one, it would exacerbate the general problem of rural residents bypassing their local hospital and could speed its downfall, without regard to any other non-health benefits of the hospital (e.g., as an employment center, a community core, and an attraction to draw other businesses).

The issue of bypassing local providers has been particularly acute for publicly funded health centers. Community health centers in some states have argued that they are the "safety net" provider for low-income uninsured people, and that if managed care plans control access to Medicaid beneficiaries but do not include the local publicly funded health center, the centers will lose their primary source of service-related payment and be forced to close (box B).

Despite the legitimate concerns of many "critical" local providers, their expectations in the current environment may be unrealistic. Not all may be able to survive, and those that do are likely to need to adapt to managed care and become part of more formal networks and alliances (3).

One final concern is that ambitious managed care plans wishing to expand may move into rural areas and take over or force out all the providers, then pull out and abandon those providers when the local hospital still doesn't make a profit, or the plan itself loses money or declares bankruptcy. Given the boom-and-bust experiences of many managed care plans in states such as California and Florida over the past two decades, the concern is not easily dismissed and may require policymakers' close attention over the coming few years.

Box B: Publicly Funded Rural Health Centers in the Managed Care Era

Nearly every state contemplating putting its Medicaid population statewide in managed care has had to consider how to integrate the existing publicly funded primary care clinics (e.g., community health centers and local public health clinics) into the managed care system. These clinics serve a high proportion of Medicaid and low-income uninsured patients, many of them in rural areas, and they often act as last-line safety net providers. Community health centers and public health clinics are subsidized through federal funds. In addition, to protect community health centers financially, federal Medicaid rules require that states reimburse them at cost for any Medicaid services they provide (Public Law 101-239).

Under managed care, however, these clinics have three choices, all of them risky:

1. They can elect not to serve Medicaid patients. If they do not, however, they may not be able to survive financially (since most of the rest of their patients are uninsured and often charity care patients).

2. They can choose to establish managed care plans themselves and contract with states to serve Medicaid patients, accepting per capita payment and the attendant financial risks. This road can be difficult, since most such clinics have little experience managing risk and may lack the financial and personnel resources to establish self-sufficient plans.

3. They can contract with an approved managed care plan to serve that plan's Medicaid enrollees. In this case as well, however, they forego cost-based reimbursement and must accept whatever rates they can negotiate with the plan.

States' experiences have varied. In Vermont, clinics have actually been actively courted by managed care plans wishing to meet the state's requirements for Medicaid participation (37). In Rhode Island, the community health centers successfully joined together to form their own plan (19). In Oregon and Tennessee, on the other hand, clinics have fought bitterly the loss of their right to cost-based reimbursement (4;33).

Appendix A

Workshop on:

The Impact of Health Care Reform on Rural Health Care Delivery

A Meeting with State Officials Sponsored by the Office of Technology Assessment and the Milbank Memorial Fund

OTA, Washington, DC
May 4-5, 1995

AGENDA AND PARTICIPANTS

9:00 a.m. - 9:15 a.m.	Welcome and Purpose of the Meeting *Sean Tunis, Director, Health Program, OTA* *Daniel M. Fox, President, Milbank Memorial Fund*
9:15 a.m. - 9:30 a.m.	OTA's Interest in Reform at the State Level *Sean Tunis*
9:30 a.m. - 9:45 a.m.	*The* Rationale for the Workshop *Elaine Power, Project Director, OTA*
9:45 a.m. - 12:00 a.m.	Salient Developments in Seven States: Presentations and Questions *Senator John Moyer, Ranking Member* *Committee on Health and Welfare* *Washington State Senate* *Senator Sandra Praeger, Chair* *Public Health and Welfare Committee* *Kansas State Senate* *Representative Gene Davis, Member* *Appropriations Subcommittee on Health and Human Services* *Utah House of Representatives*

Richard Schultz, Administrator
Division of Health
Idaho Department of Health and Welfare

Senator Peggy Rosenzweig, Chair
Insurance Committee
Wisconsin State Senate

Representative Richard Westman, Minority Leader
Vermont House of Representatives

Richard Grant, Deputy Director
Area Health Education Centers Program
Oregon Health Sciences University

12:00 p.m. -1245 p.m.	**Lunch:** Informal Discussion
12:45 p.m. - 2:00 p.m.	What Have States Learned About Health Reform and Rural Health Care?
2:00 p.m. - 3:00 p.m.	Federalism in Health Reform for Rural Areas: Potential for Collaboration
3:00 p.m. - 3:30 p.m.	Summary and Concluding Remarks *Daniel M. Fox* *Sean Tunis*

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