

Review & Commentary on Health Policy Issues for a Rural Perspective – December 1st, 2003

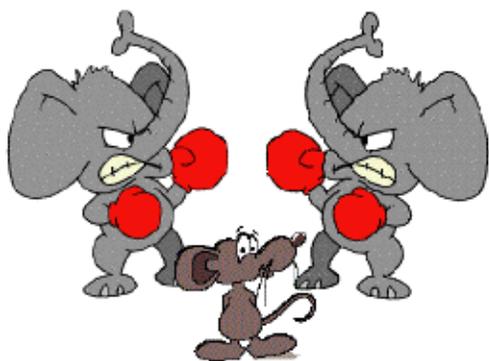
Why Medicare Bill Should Pass

Apart from the major improvement in rural provider payment equity there is a separate case for this bill passing; from “The Moment for Medicare Reform,” a Commentary in *The Christian Science Monitor*, 11/19/03:

“Congress should embrace the opportunity to pass the compromise measure that would both reform Medicare and add a prescription-drug benefit for the nation’s seniors.”

“The group of Republicans and Democrats who crafted the compromise from different Senate and House bills found the right balance between competing visions for improving this federal program from the 1960s. Most Republicans and some Democrats believe that to remain fiscally viable, Medicare must be open to market forces and more private insurers.

RWHC Eye On Health



Holiday Tip: Avoid Dancing Elephants.

Rurals’ Greater Need for Medicare Drug Benefit

From a study by the Center for American Progress, 9/3/03:

- **Lower rate of prescription drug coverage:** The proportion of rural beneficiaries lacking drug coverage is nearly double that of urban beneficiaries. Nearly one in three (31%) of rural Medicare beneficiaries had no prescription drug coverage in 2000, compared to 18 percent of urban beneficiaries.
 - ☞ This disparity is greater for sicker beneficiaries: among those in fair to poor health, rural beneficiaries are over 70 percent more likely to lack drug coverage than urban beneficiaries (28.8 versus 16.2%).
 - ☞ The oldest rural beneficiaries are least likely to have drug coverage despite their greater need for medications. About 37 percent of rural beneficiaries age 85 and older lacked drug coverage, compared to 23 percent of the oldest urban beneficiaries.
- **Much lower Medicare managed care coverage:** Medicare implicitly subsidizes prescription drug coverage by paying Medicare managed care plans more than their costs of providing Medicare’s core benefits. However, rural beneficiaries have less access to such plans. This helps explain why only 3 percent of rural beneficiaries received drug coverage through these plans compared to 18 percent of urban beneficiaries.
- **Higher out-of-pocket costs:** Rural Medicare beneficiaries’ average out-of-pocket spending on prescription drugs is about 25 percent higher than that of urban beneficiaries. This difference reflects the much-lower rates of supplemental prescription drug coverage among rural beneficiaries rather than a greater use of medications.

“We make our decisions, and then our decisions turn around and make us.” F.W. Borum (a nineteenth-century writer) quoted by David Maraniss in *They Marched Into Sunlight: War And Peace, Vietnam And America, October 1967.*

Liberal Democrats, and a few Republicans, want it to remain strictly a government program.”

“The temptation to play politics rather than pass a compromise bill is tremendous. Seniors are a powerful voting bloc, and each political party may prefer to make the other seem responsible for any failure to pass a bill.”

“With the GOP dominating both chambers, and a Republican in the White House, prospects for passage of this bipartisan bill look good. But that assumes that House GOP leaders can keep their horses in the corral, and that at least 10 Senate Democrats resist any effort to block the bill.”

“In many respects, the bill’s introduction of market competition into Medicare is but baby steps. It would only allow private health plans to compete with traditional Medicare in a six-year pilot program beginning in 2010 in six metropolitan areas.”

“That’s six areas too many for opponents, who believe that market competition will destroy the program and drive up premiums for unhealthy seniors. These opponents say the healthiest seniors would move into health-maintenance organizations or preferred-provider organizations where they would, in theory, receive less expensive treatment, leaving a less-healthy pool of seniors in the traditional program. The higher costs the program would thus incur would

cause standard Medicare premiums to skyrocket, these opponents predict.”

“That’s possible. But the current bill does not introduce competition in one fell swoop. It calls for a limited experiment that could be expanded if successful or altered if not.”

“Proponents hope competition will help drive down the growth in Medicare’s costs. The already financially shaky program will need such savings to help pay for the \$400 billion the prescription-drug program will cost over 10 years.”

“As it is with most compromises, there’s plenty in the bill to dislike. But lawmakers who want a prescription-drug benefit and those who want more competition in Medicare should consider that this may be their best opportunity in the next several years to achieve those goals.”

Consumer Driven & Employers Cutting Losses

From “Health Costs Prompt ‘Consumer-Driven’ Plans” by Roger Yu. in *Knight Ridder Tribune News Service*, 11/10/03:”

“There is a new form of health insurance known as the ‘consumer-driven’ plan, the creation of an industry scrambling to reduce demand for health care as a way to hold back skyrocketing expenses.”

“At its core, the ‘defined contribution plan,’ as it’s also known, is managed care with a high deductible.”

“But, conceptually, it is a dramatic departure from the recent past in that it forces members to pay attention to the costs of their health care services.”

“While many Americans are savvy shoppers for products and services they pay for out of their own pockets, they are docile and almost willfully ignorant when it comes to health care.”

“That’s because most health services in this country are paid for by a third party, such as an employer, a health insurer or the government. The arrangement

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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leaves little financial incentive for patients to be more active consumers.”

“With consumer-driven plans, members are given a health spending account from which they pay for the entire cost of their medical care. Regular coverage kicks in only after the account and a deductible are fully exhausted.”

“ ‘As soon as you bring consumers to become more engaged, they begin to manage it like any of the other accounts they have, like other purchases they make,’ said Doug Kronenberg, chief strategy officer of Lumenos. ‘The overall awareness has changed.’ “

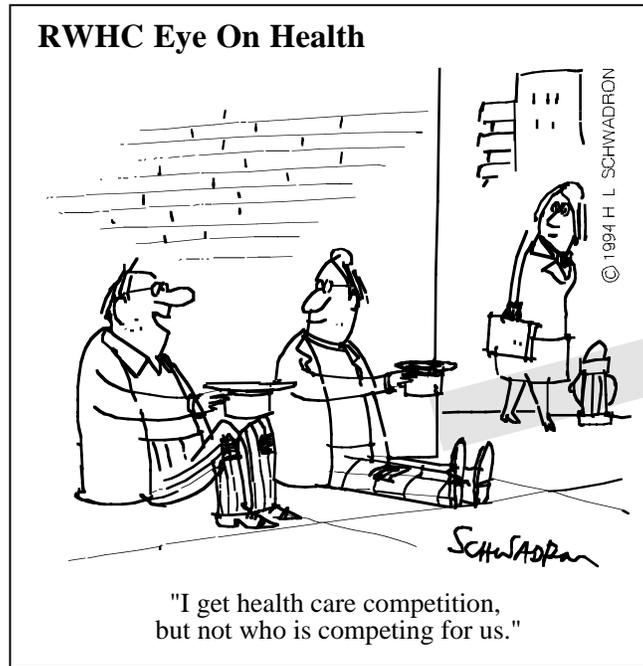
“Employers like the plans because they can prompt behavior changes among their staffers in how they use health care, said Beth Bierbower, Humana’s vice president of product innovation.”

“Consumer-driven plans have their share of critics, who say they’re merely a clever means to pass on more costs to employees. They say the plans do little to reduce the cost burden for members who may need extensive health care in a given year.”

“Some hospital officials and doctors also worry that consumer-driven plans could encourage hoarding of account savings and deter people from seeking out care that they need.”

“ ‘Typically, these plans are created to reduce cost by passing on more cost to consumers,’ said Lisa McGiffert, a policy analyst for Consumers Union’s Southwest regional office. ‘People who will come out worst are people with low to moderate income who don’t have a lot of cash around, and people who need a lot of medical services, with chronic conditions, since their out-of-pocket cost will be higher.’ “

“Consumer-driven plans can be tricky to understand. Here’s how they typically work: An employer con-



tributes a fixed amount; say, \$900 for an individual and \$1,900 for a family, to an employee’s health savings account. Anything left over at the end of the year rolls over to the following year.”

“A member who spends all the health savings account before the end of the year has to pay for all of the medical bills in the form of a deductible. This deductible, known as a ‘bridge,’ could typically range from \$500 to \$1,000 for an individual and \$1,200 to \$2,000 for a couple.”

“After the saving account and deductible have been spent, regular health coverage kicks in, resembling a plan from a typical preferred provider organization.”

“Consumer-driven plans also differ from traditional forms of insurance in that they come with ‘co-insurance’ requirements, in which members pay a fixed percentage, typically 10 percent to 20 percent, of the cost of services. All these plans cap out-of-pocket spending at certain amounts, thus limiting financial liability.”

The Employee Benefits Research Institute has published a comprehensive analysis of the potential costs and benefits of “consumer directed health plans.” Available at <www.ebri.org/books/conshlthbk.htm>.

Defined Contribution Plan Explosion Predicted

From “Consumer-Driven Health Plans; Skyrocketing Healthcare Costs Prompt Change In Insurance Options” in *Health & Medicine Week*, 10/20/03:

“Employers’ healthcare costs are expected to rise another 12% in 2004. That’s 5 consecutive years of double-digit increases in costs. What’s more, costs have doubled in less than 4 years.”

“This is why economists and healthcare experts predict that consumer-directed health plans will account for as much as half the health insurance market within the next 3 to 5 years, even though fewer than 1.5 million U.S. workers are now enrolled in them.”

“According to the National Association of Business Economists (NABE):

1. Two-thirds of NABE members said in a recent poll that consumer-directed health insurance is either very important or extremely important in controlling costs, improving access, and increasing healthcare quality.
2. Health Affairs’ Market Watch projects that consumer-directed health plans will account for 20% of the health insurance market by 2005 and as much as 50% within the next 4 years.
3. BNA reports that consumer-directed health plans will account for at least 24% of the health insurance market by 2010.”

“These are amazing results, considering less than 1% of employees currently are enrolled in consumer-driven health plans,” said John C. Goodman, founder and vice-chairman of NABE’s Health Care Roundtable.”

Paying For Quality—Policy Elite Speaks Up

From an “Open Letter, Paying For Performance: Medicare Should Lead” in *Health Affairs*, 11/03; signatures include: Donald M. Berwick, Nancy-Ann DeParle, David M. Eddy, Paul M. Ellwood, Alain C. Enthoven, George C. Halvorson, Kenneth W. Kizer, Elizabeth A. McGlynn, Uwe E. Reinhardt, Robert D. Reischauer, William L. Roper, John W. Rowe, Leonard D. Schaeffer (**CEO, WellPoint Health Network, new owner of Wisconsin’s old BlueCross plan, now Cobalt**), John E. Wennberg and Gail R. Wilensky.

“We the undersigned are united in our belief that a unique opportunity now exists to address the crisis of quality facing the nation’s health system. The human and financial costs of medical error and substandard

care have been exhaustively documented. A robust inventory of measures and standards for quality improvement has been developed and continues to grow. The strategic concept of paying for performance—a bedrock principle in most industries—has begun to emerge in health care in a variety of experiments in both the private and public sectors. But further progress is by no means assured.”

“Despite a few initial successes, the inertia of the health system could easily overwhelm nascent efforts to raise average performance levels out of mediocrity. At issue is not the dedication of health professionals but the lack of systems—including information systems—that reduce error and reinforce best practices, as such systems do in other industries such as aviation and nuclear power. We have concluded that such systematic changes will not come forth quickly enough unless strong financial incentives are offered to get the attention of managers and governing boards. As the biggest purchaser in the system, the Medicare program should take the lead in this regard. Decisive change will occur only when Medicare, with the full support of the administration and Congress, creates financial incentives that promote pursuit of improved quality.”

“Quality is not an issue for partisanship. Nor, in urging that Medicare take a leading role, are we suggesting that such an initiative be dominated by government. Indeed, both private payers and public agencies have made important strides in recent years in tackling the quality challenge. The National Committee for Quality Assurance has promulgated widely used performance indicators for health plans. The National Quality Forum has brought public and private payers together with consumers, researchers, and clinicians to broaden consensus on performance measures and best practices for a growing portfolio of health care settings, conditions, and treatments. The Agency for Healthcare Research and Quality (AHRQ) has established itself as an honest broker of evidence-based treatment standards. The self-insured employers in the Leapfrog Group have moved boldly to tie provider payment to selected performance indicators; and many insurers, health plans, and provider systems are testing new disease management models and other approaches that tie payment to performance.”

“The Centers for Medicare and Medicaid Services (CMS) has taken significant steps toward a quality strategy based on quality measurement and incentives. The agency’s publication of performance data on nursing homes and home health agencies has heightened public awareness of the value of information on quality and has alerted the provider community that it has a critically important role to play in adopting best practices and improving patient safety. While information on hospital and physician performance is much more difficult to collect and organize, the CMS plans to extend the consumer information campaign to hospitals and in the meantime has launched a breakthrough demonstration project with Premier Inc., a national alliance of nonprofit hospitals, to pay quality-improvement incentive bonuses for Medicare patients at participating institutions. Three other large hospital groups—American Hospital Association, Federation of American Hospitals, and Association of American Medical Colleges—are collaborating with the National Quality Forum, the CMS, AHRQ, and the Joint Commission on Accreditation of Healthcare Organizations in a voluntary quality-reporting initiative announced late in 2002.”

“Measured against the magnitude of the problem, however, these efforts have barely begun to achieve critical mass and momentum. The Institute of Medicine noted a ‘cycle of inaction’ in its landmark 1999 report on medical error. Just as sobering are the results of a large national study published recently in the *New England Journal of Medicine*, which found that patients were receiving an average of only 55 percent of recommended care across a variety of conditions and treatments. The complexity and sensitivity of measures, standards, and quality-reporting regimes often discourage providers from embracing voluntary quality initiatives and fuel resentment of the costly data-gathering burden that quality improvement may entail. The uneven deployment of nonstandardized information technology in the health sector has frustrated the development of promising opportunities to gather comparative performance information efficiently and to promulgate sophisticated decision-support and error-prevention systems.”

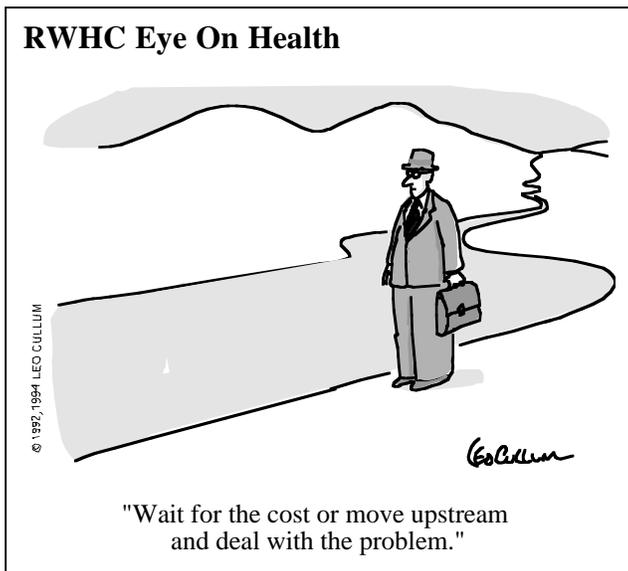
“The available measures are less than perfect, but the CMS–Premier demonstration and the National Quality Forum’s hospital initiative show that we have

adequate tools to accelerate the pace of change. Standardized, interoperable electronic data formats mandated by the Health Insurance Portability and Accountability Act (HIPAA) are now making their way forward. The CMS’s demonstration authority gives the agency the power to continue to expand experimentation and testing of models. Congress has an opportunity to advance quality of care nationally by endorsing the goal of differential quality payments and supporting Medicare’s initiatives toward that goal.”

“Our recommendation—to the executive branch; to Congress; to employers and health plans; and to hospitals, physicians, nurses, and other health professionals—is that payment for performance should become a top national priority and that Medicare payments should lead in this effort, with an immediate priority for hospital care. Sustained leadership within Medicare will be a crucial ingredient. The current CMS administrator has shown aggressiveness and commitment. His successors must follow suit to assure that quality improvement becomes a priority throughout the agency, year in and year out. A major initiative by Medicare to pay for performance can be expected to stimulate similar efforts by private payers, just as Medicare’s adoption of prospective payment for hospitals did two decades ago. We call on the administration and congressional leaders of both parties to act in a bipartisan spirit on health care quality and to join the campaign to rally our underperforming health care system by empowering Medicare to take the further necessary and decisive steps to make pay-for-performance a national strategy for better quality. We should settle for nothing less.”

Balancing Individual & Community Health

RWHC has just been awarded a grant to address the question “How Can Rural Balanced Scorecards Best Incorporate Population Health Measures?” Funding for this project was provided by the UW-Madison Health & Society Research Competition, sponsored by the RWJ Health & Society Scholars Program at the University of Wisconsin-Madison. Stroudwater & Associates, a national consulting firm specializing in performance improvement initiatives and financial/operational analysis for rural hospitals, and



faculty from the Dept. of Population Health Science are partners in this study. A focus group of rural hospital CEOs and CFOs will provide reality testing.

This study is intended to partially address how rural hospitals at the grassroots can contribute to the design and implementation of a new health care system. "The health care system of the 21st century should maximize the health and functioning of both individual patients and communities. To accomplish this goal, the system should balance and integrate needs for personal health care with broader community-wide initiatives that target the entire population. The health care system must have well-defined processes for making the best use of limited resources." *Fostering Rapid Advances In Health Care: Learning From System Demonstrations*, Institute of Medicine of the National Academies, 11/02.

Population health as a concept of health can be defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group." These populations are often geographic regions, such as nations or communities, but they can also be other groups, such as employees, ethnic groups, disabled persons, or prisoners. Such populations are of relevance to policymakers. In addition, many determinants of health, such as medical care systems, the social environment, and the physical environment, have their biological impact on individuals in part at a population level." ("What Is Population Health?" by David Kindig and Greg Stoddart, published in the March, 2003 edition of the *American Journal of Public Health*.)

Robert Kaplan and David Norton at the Harvard Business School developed the Balanced Scorecard. This management approach to performance improvement has received significant positive attention in recent years and is starting to reach the health care sector. The Balanced Scorecard focuses on specific, measurable objectives in four areas of improvement for the purpose of aligning employees, organizational and departmental goals:

- Financial Performance (e.g., cash flow, cost reduction)
- Customer Knowledge (e.g., use, improvements in customer service)
- Internal Business Processes (e.g., actual productivity as compared to what was planned)
- Innovation, Learning And Growth (e.g., the time it takes to develop new services)

The Balanced Scorecard approach is about looking at long term strategies; investing in clients, customers and staff; new service development; and in systems. It goes beyond only looking at financials. The alignment is among people and services with the mission and system. Then monitoring this alignment toward achievements, keeping the long-term strategy in focus. This approach does require some intensive measuring and reporting; however, this is what makes the scorecard successful and useful.

The following questions will be addressed:

1. How can RWHC most effectively evolve/bundle its current performance measurement data sets to mirror those available through the current Balanced Score Card approach?
2. How can rural networks like RWHC most effectively promote individual member's linking of these performance measurement sets to their ongoing strategic planning processes?
3. What population-based measures are available which can most readily, appropriately be added to the Balanced Score Cards for rural hospitals?
4. What arguments for the inclusion of population-based measures are most relevant or effective with the administration and boards of directors of rural hospitals/networks?

Rural Life Stile

From *American Country Life: A Legacy* By Gene Wunderlich, available through University Press of America at <www.univpress.com> for \$36.00 + p&h.

“*American Country Life* chronicles both rural living in the 20th century and an organization, the American Country Life Association (ACLA), which championed the interests of rural people. Though the ACLA did not survive the 20th century, it left a rich legacy of successors and inspirations. This book contains important lessons about organizational success and failure, the relation of land to people, and America’s changing perspectives of space.”

“From outdoor privies, one room schools, and Model Ts to satellite assisted farming, distance learning, and superhighways, rural America absorbed enormous technical and social change in the swirling 20th century. Most country folk streamed to the cities and assumed urban ways. Barnyards and dusty fields gave way to factories and gleaming offices. Within a few generations country life devolved from an unhurried life in open spaces to one beset with traffic gridlock and suburban sprawl. Then the old agonies of isolation, poor health services, limited education, and exploitive markets became veiled with fantasies about rural people’s romance with nature.”

“*When you visit a primeval forest you are impressed, not only with the magnificent trees, but with the forest floor which has been made gradually as the result of the continuous contributions, generation after generation, by trees which no longer stand.* (H.C. Taylor, *National Policies Affecting Country Life*, 1933).”

“The passing of ACLA, into the forest floor, did sustain and support the magnificent trees arising as third generation of country life awareness. In the last quarter century, a green generation has awakened to the downside of agricultural and industrial development. The information age has formed new communities and provided new opportunities, but not without some hazards.”

“Like people, organizations impart lessons and ACLA’s are both instructive and cautionary. For ex-

ample, its initial leadership was heavily dependent on a single person, Kenyon Butterfield, and so the advantages of continuity and consistency may have precluded the rise of other persons or ideas. In the years following Butterfield, the ACLA presidency only once exceeded three years.”

“A firmly held principle of ACLA was non-advocacy of positions, policies, or politics. This probably reinforced the Association’s integrity and objectivity in discourse and promoted divergent opinions. The downside of their non-advocacy, however, was a distaste for controversial issues, a lack of zeal, a lack of focus, and, critically, a lack of financial support.”

“Diversity of interests was reflected in the agenda of ACLA. The topics of health, recreation, communication, organization, home, government, and education elicited a broad array of concerns in the conferences and committees. The Association, as an umbrella organization, encompassed the interests and occupations of tens of thousands of members, again, both a strength and a weakness. Had ACLA been abundantly endowed financially, it might have become a powerful integrating force. Given its meager funding, however, diversity only meant that it lacked a singularity of purpose, zealous membership with organizational savvy, and efficiency in fulfilling a specific mission.”

“Of the many lessons of country life taught by ACLA, four stand out:

- Not all rural life is farming
- Rural life is multidimensional
- Community extends beyond place or people
- Space matters”

“The founders of ACLA were prescient in directing their concerns toward the conditions of rural living, and toward rural development, regarding farm production as only piece of the picture. As such, the ACLA mission included the home, the community, local government, and the health, education, and social well-being of citizens.”

“The magnetic attraction for rural areas is hastening the destruction of the very qualities so eagerly sought by the millions migrating from cities. The classic problems of rural areas have evolved accordingly:

Education once compromised by isolation, poor facilities, and undertrained teachers; is now beset by drugs, handguns and crime. Rural health problems used to be contaminated water and food, unsanitary waste disposal, and lack of medical or hospital facilities; now health problems include drugs, fouled air, junk food, and sexually transmitted diseases. Transportation problems have gone from an absence of roads to roads clogged with traffic.”

“The categories of concern for both generations of ACLA are just as relevant today. Education remains critical with some anomalies in rural areas but with many problems similar to those in urban areas. The other categories of concern—health, home, government, organization, planning, income and well-being, recreation and social life, morals and religion, and international affairs—are still critically important, and are being attended by countless organizations and agencies. The categories remain, but the problems within the categories take new forms.”

“From Midas Dekker’s *Way of All Flesh* we learn the importance of transience, the role of transience, the universality and inevitability of transience. In the

large picture, the ends of organizations are as essential as, perhaps more essential than, beginnings. An organization at its end gives up its history, its lessons, its meaning. A new organization offers little except a promise for the future. As Dekkers observes, ‘The only interesting thing about a baby is its future.’ “

“Here a slight extension of, perhaps departure from, Dekkers may be helpful. Instead of stairway, think of a stile. A stile, you will recall, is a special stairs to surmount a fence or barricade. Unlike the stairway, a stile goes up, then down, all in the same direction, that is, with no turnaround. Climbing the stile at once elevates over, and liberates from, a confinement. An organism or organization grows, then crosses over to a decline that leads to death and a merger with the outside—a new, larger universe. The process is Taylor’s forest rising from the forest floor.”

“The shape, strength, height, and durability of the life ‘stile’ depends upon the elements of the organization, the leadership, staff, members, structure, resources, and the climate within which it functions. These elements are examined in the ACLA story.”

Space Intentionally Left Blank For Mailing