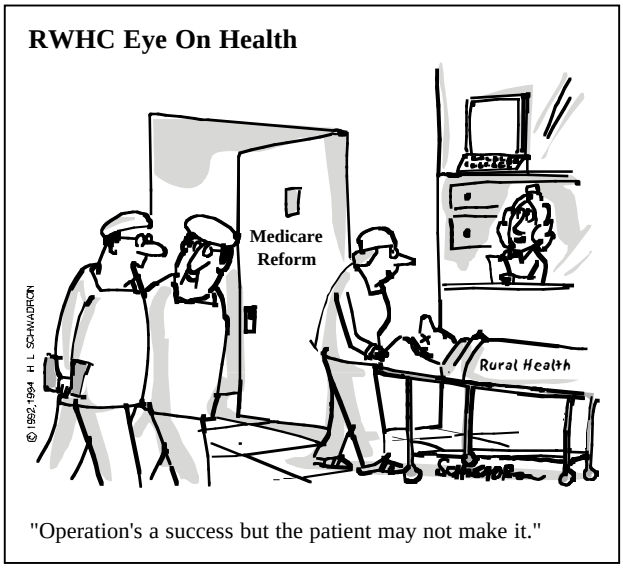
Rural Wisconsin
Health Cooperative

Eye On Health

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

Mega-HMOs Set To Invade Rural America?

President Bush is expected to unveil during his January 28th State of the Union Address a major proposal to fundamentally restructure or "modernize" Medicare. It is widely assumed that the President's plan will be based in large part on the *Medicare Preservation and Improvement Act (S.1895)* first proposal in the 106th Congress by now Senate Majority Leader Bill Frist. The Rural Policy Research Institute (RUPRI) has published an assessment of that bill, *A Rural Assessment of Leading Proposals to Redesign the Medicare Program* remains available at <www.rupri.org>. The following is from RUPRI's statement of "Rural Implications and Recommendations":



"Operation's a success but the patient may not make it."

<u>The Competitive Model Works In Rural Areas?</u>

"Insufficient details are provided in the proposal to permit effective analysis, including: the formula used to calculate risk adjustment; the formula used to calculate geographic adjustment; and how health plans would reimburse providers. In those cases in which sufficient detail was available, analyses were conducted and are reported."

"There is little incentive for private plans to move into rural areas and compete with traditional Medicare fee-for-service plans. Since the traditional Medicare plan is likely to be adopting many of the same purchasing strategies as private plans, the latter would not have any competitive advantage. The low number of beneficiaries in rural markets render them unappealing, unless they are adjacent to existing urban markets. As a consequence, fewer additional benefits may be offered by plans operating in rural areas. ***To the extent that competing plans are relied upon as the source of affordable benefits, rural areas are at a disadvantage."***

"This proposal uses refined geographic adjusters to correct for the deficiencies of the competitive model in rural areas. ***The adjustments derived from national and area averages for rural payment could be improved through refined definitions of service areas and minimum payments in each area that account for costs associated with prescription drug benefits and plan administration."***

"Under S. 1895, it is envisioned that the traditional Medicare plan would be restructured, eliminating the current set of cost containment provisions (e.g., Prospective Payment System, Resource Based Relative Value Scale, prospective payment for other services), and offering high option benefits, financed from its

"I have always thought that the far left and far right need each other, desperately, for if either one were to vanish the other would lose its reason to exist…" *The Emperor Of Ocean Park* by Stephen Carter

own revenues. It will be difficult to sustain this program with the payment provided through a national weighted average premium, especially if the plan faces adverse selection. This would lead to either failure of the plan or to some sort of fiscal bail-out in order to protect access for rural beneficiaries, or the adoption of strict cost containment provisions that cannot be anticipated at this time. ***If traditional Medicare is the only option in rural areas, fiscal difficulties encountered by that plan would pose special problems for rural residents."***

NRHA Annual Rural Health Policy Institute, March 3-5, 2003
Grand Hyatt Hotel, Washington, D.C.
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"The proposal does not include any adjustment for pent-up demand, which has been experienced by at least some rural Medicare+Choice plans. ***The provisions of the Balanced Budget Refinement Act of 1999 allowing for additional payments for M+C plans entering new markets should be continued, and perhaps increased."***

Beneficiary Choice for Rural Residents

"*All rural beneficiaries will have access to a plan that includes coverage for prescription drugs, a significant improvement for rural persons.* However, the richness of the prescription drug benefit may vary considerably between rural and urban areas. For example, if urban and rural plans both offer benefits valued at $800 per year, the urban plan may be able to offer better purchasing options because of the higher number of beneficiaries included in the plan. ***There is no assurance that the difference in the current plan offerings between urban and rural Medicare HMOs would not continue under these reform proposals. Rural beneficiaries may continue to experience a less attractive set of choices."***

"Limiting premium cost sharing is important to rural beneficiaries, given their comparatively lower incomes. This is especially important in considering the traditional Medicare program, where increased costs are likely to lead to higher premiums. ***Establishing maximum beneficiary premiums as a function of household income, either by limiting cost-sharing or by subsidizing the beneficiary's premium, is critically important in rural areas, and is accomplished by the specifics included in S. 1895."***

"Creating a prescription drug benefit that relies on using purchasing strategies such as pharmacy benefit management and discounts available through chain stores could jeopardize the future of local rural pharmacies. This could in turn affect rural beneficiary access to drugs needed quickly, and to the advice they may be seeking from local pharmacists. The proposal contains an any willing provider provision for local pharmacists. ***The ultimate impact on local rural pharmacists of the purchasing strategies used for the new prescription drug benefit cannot be determined, but should be monitored."***

Effects of Medicare Payment on Rural Providers

"Selective contracting could have serious implications for rural providers, especially essential providers. The adequacy of special protections for rural providers is unknown. Under current Medicare payment policies certain providers are provided cost-based reimbursement to assure access. Under the new Medicare program run by the HCFA Division of Sponsored Programs, it is uncertain that those special considerations would continue. ***The HCFA-sponsored Medicare plan could be required to continue special payment considerations for specified rural providers, but with a special subsidy so as not to affect the competitive position of that plan.***"

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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Affordable Insurance For Small Employers

The following is from "The Potential for a Small-Employer Purchasing Pool in Wisconsin: Issues and Options for Overcoming Barriers to the Development of the Private Employer Health Care Coverage Program (PEHCCP)" prepared for the Wisconsin Department of Employee Trust Funds and presented to the Private Employer Health Care Coverage Board on January 12th by Rick Curtis, Rafe Forland and Ed Neuschler, Institute from Health Policy Solutions, Washington, D.C.

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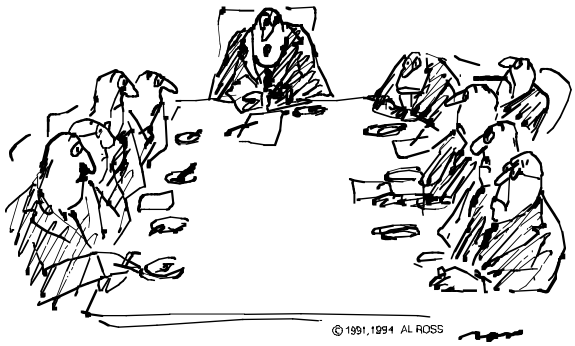

"The world's not over just because we can't compete any longer on how well we avoid sick people."

The next day, Rick Curtis participated in a seminar held for the legislature and invited guests. The seminar along with the preparation of additional background papers was organized by The Policy Institute for Family Impact Seminars in collaboration with the Wisconsin Public Health and Health Policy Institute. The complete set of briefing reports are available at:

www.uwex.edu/ces/familyimpact/fis18.htm

"Although Wisconsin has one of the highest rates of employer-sponsored coverage in the country, small employers have been increasingly concerned about often unprecedented escalation in their health care premiums. Given these escalating costs and the inherent fragmentation among small employers, **the small group market in Wisconsin and other states is increasingly characterized by administrative inefficiencies, wide variation in premium costs, and wildly-fluctuating premium increases."**

"Policymakers often are drawn to purchasing pools as a potential means to stabilize small employer premiums through increased administrative economies of scale and purchasing clout with health plans. In addition, by aggregating a large number of small firm employees, purchasing pools can offer those employees something not normally available in the small employer market—specifically, choice of competing health plans."

"But to date, voluntary, unsubsidized consumer choice pools have not gained enough market share to realize lower costs for small employers. And, health plans would generally not be serving their own interests if they were to offer lower rates that would allow a start-up or small pool to become a larger purchaser. However, the potential for large pools could likely be realized if subsidies or other policies are structured so that health plans could reach an attractive group of enrollees only through such a pool, or if reforms less attractive to health plans are the likely alternative."

"To pursue their goals, such purchasing pools have several common characteristics. Particularly to maximize administrative efficiency, pools centralize the administrative functions of enrollment, premium collection, and customer service. Also, to minimize adverse selection (i.e., disproportionate enrollment of high-cost individuals for the pool overall or for individual plans participating in a pool), pools create participation rules, benefit plans, and premium rating methodologies that are relatively uniform across all participating plans. In addition, pools often consolidate and perform communication activities on behalf of the participating health plans."

"The passage of 1999 Wisconsin Act 9 charged the Department of Employee Trust Funds to develop the Private Employer Health Care Coverage Program (PEHCCP) and to have this program operational by January 1, 2001. Unfortunately, several aspects of this authorizing legislation inhibited the development of the program. Many of these issues were addressed in subsequent legislation (2001 Wisconsin Act 16), but health plans are highly unlikely to participate in the program unless it is significantly restructured."

"*Below are three alternative scenarios; a carefully crafted combination of some of these concepts would have substantial potential to meet the above goals.*"

Small Group Market Rating Reforms

"If the state were to adopt rating rules that did not allow rates to vary based on the health status or claims experience of a given employer group (but still allowed some adjustment for 'case characteristics' such as age and geography), then the pool would be much less likely to experience adverse selection at the hands of the open market. This change would also substantially reduce the maximum premium costs or the volatility in rates a given small employer might experience in the open market. It would also increase rates for those employers who currently present the lowest risks."

"Such rating reforms could greatly diminish the degree of exposure to adverse selection for a pool. But it is still unlikely that more than a few (if any) Wisconsin health plans would be willing to participate on a voluntary basis in a pool that largely competes against the plan's own direct contracting with small employers. Some plans with small market shares or with limited numbers of participating physicians or hospitals (who might be more attractive as an individual employee choice) might be willing to participate. But even with such state market rules, if federal legislation is enacted allowing 'Association Plans' to operate outside of state market rules, the pool as well as traditional health plans would be disadvantaged."

Subsidies for low income employees of small firms exclusively through the pool.

"If significant subsidies for uninsured small firm workers were made available exclusively through the pool, a sizable and attractive pool of people could be uniquely reached through the pool. In effect, the subsidies would play the role that large employer contributions play for their employee plans. They would create cohesion similar to that which a 'natural' group enjoys and presents to a health plan. (If health plans nevertheless refused to participate, in an effort to avoid 'building' a sizable pool, the state could establish linkages to participation in other state programs without significant risk of cross-subsidies.)"

"Such 'premium assistance' subsidies for populations otherwise eligible for public programs like BadgerCare could reduce rather than increase state outlays. Employer coverage with premium assistance for the employee share, combined with employer contributions and federal tax subsidies, would cost the state less than enrolling those families in the public BadgerCare program. But such savings would likely be realized only if those eligible for such employer coverage were required to take it as a condition of receiving subsidies, i.e., in lieu of direct BadgerCare enrollment."

"It should be noted that when BadgerCare was designed, the state's intent was that low-income working families should rely on employer coverage whenever possible. This advances two goals: To encourage career development and increase low-income workers' attachment to work (rather than welfare), and to strengthen, rather than undermine, employment-based coverage generally. But this intent has not been realized due to other BadgerCare policies. Information about employer coverage is not obtained for almost half of employed BadgerCare applicants. For applicants for whom the necessary information is obtained, about half are found to have employer coverage available; however, only a tiny fraction ever become enrolled in that coverage and receive premium assistance."

"Under a revised policy context, premium assistance could do a much better job of accessing employer coverage that is available, or could be available to people who are otherwise eligible for BadgerCare. One way to simplify and encourage this would be to make the pool the sole venue through which low-income small-firm workers and their families can receive premium assistance."

"Using the pool to manage the flow of subsidy dollars on behalf of small-firm workers and their families would be administratively efficient. And working with such a pool rather than with myriad individual small employers and associated health benefit plans could make it much easier to meet federal and state requirements regarding premium assistance (e.g., verification of enrollment and use of funds, reviewing and approving benefit structures, etc.)."

"Making premium assistance available to low-income, small-firm workers through the pool could also encourage more uninsured small employers to begin offering coverage— by allowing them to make a smaller employer contribution than would usually

be required. This could be a very cost-effective way of expanding coverage to the low-income working population. But, since most small firms have childless workers as well as parents in their employ, arranging subsidies for low-wage childless workers would need to be addressed."

"The potential new enrollment represented by people receiving public subsidies should help to overcome the chief obstacle to the growth of consumer-choice pools in the current marketplace—the reluctance of health plans to participate in them."

Pool IS the Small Employer Health Insurance Market

"Some have suggested a more sweeping option: that the 'pool' be constituted as the exclusive small employer coverage venue in Wisconsin. While quite controversial, some have observed that this approach would be more effective than rating reforms in protecting the pool, its health plans, and its enrollees from a systemic adverse selection spiral. And this approach could almost certainly achieve economies associated with large scale purchasing, with more stable coverage, and with substantial administrative economies of scale."

"But unless such an approach were tied to broader health insurance financing and coverage policies, it should be recognized that some lower risk small employers might choose the option to 'self-insure' under either existing federal law (i.e., Employee Retirement Income Security Act preemption of state regulation of employee benefit plans) or pending federal proposals (i.e., Association Plan proposals)."

RWHC WAN To Receive Telecom Subsidy

Last November RWHC submitted an appeal to the Federal Communications Commission to over-ride a decision by the Rural Health Care Division (RHCD) of the Universal Service Administrative Company (USAC) that RWHC's Wide Area Network (WAN) was not eligible for federal telecommunication subsidies (available to rural hospitals and consortia of rural hospitals.) **The law allows for consortia of rural hospitals to receive USAC funding but RWHC (one of the country's oldest consortia of rural hospitals) was deemed not eligible because it is incorporated (as long encouraged by Federal policy).** This month, RWHC received an offer of an administrative resolution which it has accepted.

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"It seems that sometimes a consortia is just a consortia."

RHCD decided that they did not need to determine if RWHC was an eligible entity as each of the eligible rural Health Care Providers (HCPs) using RWHC's T-1 lines could be a part applicant for those lines. "There is no problem with who actually pays for the line; under this 'third party payer' scenario the eligible rural HCP can designate any payer to receive the discounted bill for the line, as long as the benefit of the discount accrues to the eligible entity."

This approach is acceptable to RWHC as an interim solution and we appreciate the willingness of the RHCD to work with us to make the process as efficient as possible. However, the policy constraint of not recognizing "consortia" as "entities" under any scenario clearly conflicts with espoused regulatory simplification goals. We continue to strongly believe in the correctness of the policy issue raised in our appeal and we hope that it will receive the serious attention it merits as part of the FCC's upcoming review of the Rural Health Care Support Mechanism.

On May 15th, 2002, the FCC published a Notice of Proposed Rulemaking (NPRM) for the Rural Health Care Support Mechanism seeking comments from

any interested parties for making new rules for the program. Our comments submitted to you on May 23rd requested that the FCC include otherwise eligible "entities" such as RWHC in its definition of "consortia." As we said then, "while we understand the FCC's need to guard against fraud and abuse it is obvious that RWHC meets the published eligibility criteria as well as the spirit of the program." RWHC continues to respectfully request that the FCC clarify this issue as it considers new rules for the Rural Health Care Support Mechanism.

End Of The Drug Company Kick-Back?

From "Drug Makers Battle Plan to Curb Rewards for Doctors" by Robert Pear in *The New York Times*, 12/25/02:

"Drug companies and doctors are fighting a Bush administration plan to restrict gifts and other rewards that manufacturers give doctors and insurers to encourage the prescribing of particular drugs."

"In October, the Department of Health and Human Services said many gifts and gratuities were suspect because they looked like illegal kickbacks. Since then, a few consumer groups, including AARP, have voiced support for the restrictions. But they are outnumbered by the drug makers, doctors and health maintenance organizations that have flooded the government with letters criticizing the proposal."

"In contending that the proposed federal code of conduct would require radical changes, those opposing the change discuss their tactics with unusual candor and describe marketing practices that have long been shrouded in secrecy."

"Drug makers acknowledged, for example, that they routinely made payments to insurance plans to increase the use of their products, to expand their market share, to be added to lists of recommended drugs or to reward doctors and pharmacists for switching patients from one brand of drug to another."

"Insurers, doctors and drug makers said such payments were so embedded in the structure of the health care industry that the Bush administration plan would be profoundly disruptive. Moreover, doctors said that drug companies were a major source of money for their professional education programs, and that the administration proposal could drastically reduce such subsidies."

" 'Without financial support from industry, medical societies would most likely be forced to curtail or stop offering these important educational activities,' said Dr. Michael D. Maves, executive vice president of the American Medical Association."

"In its guidance to the industry, the government warned drug makers not to offer financial incentives to doctors, pharmacists or other health care professionals to prescribe or recommend particular drugs. The government said the industry's aggressive marketing practices could improperly drive up costs for Medicare and Medicaid."

"But a coalition of 19 pharmaceutical companies, including Pfizer, Eli Lilly and Schering-Plough, said the Bush administration proposal was 'not grounded in an understanding of industry practices.' The payments and incentives to which the government objects are standard in the drug industry, they said."

"Merck & Company said it routinely gave discounts and payments to health plans to reward 'shifts in market share' favoring its products. Merck complained that the administration proposal would 'criminalize a wide range of commercial conduct' that the industry regards as normal."

"The Pharmaceutical Research and Manufacturers of America, the chief lobby for brand-name drug com-

panies, acknowledged that these payments created a strong incentive to prescribe certain drugs, or to shift patients from one drug to another. But, it said, that did not make the payments 'illegal kickbacks.' "

"Drug manufacturers said they often encouraged the use of their products by making payments or giving discounts to H.M.O.'s and to the specialized companies that manage drug benefits for millions of Americans. Such companies, known as pharmacy benefit managers, can exert immense influence over what drugs are prescribed and dispensed."

"H.M.O.'s and pharmacy benefit managers said they typically received money from the manufacturer of a drug if sales of that drug reached a certain level — say 40 percent of all the prescriptions for cholesterol-lowering agents. The manufacturer may agree to a higher payment if the drug achieves a larger share of the market."

"While describing such arrangements, the drug companies, doctors and insurers did not divulge who received how much for promoting a specific drug, nor details about individual marketing campaigns."

"Kaiser Permanente, a nonprofit H.M.O. based in Oakland, Calif., said the administration plan would impair its ability to negotiate lower drug prices for its 8.5 million members because it suggested that discounts and rebate payments create 'a prosecutorial risk' under the kickback law."

"The Blue Cross and Blue Shield Association said the proposal would impede what it described as legitimate cost-control measures. 'Pharmaceutical companies may be less willing to offer large discounts if those discounts cannot be tied to movements in market share,' said Alissa Fox, policy director for the association, whose members insure more than 84 million people."

"But the Food Marketing Institute, whose members operate 12,000 supermarket pharmacies, applauded the proposal. 'Pharmacy benefit managers routinely refuse to disclose their financial arrangements with drug companies,' said Tim Hammonds, president of the institute, 'and they do not wish to be subjected to any kind of accountability, such as an annual audit.' "

"As a result, Mr. Hammonds said, 'it is not possible to know with any certainty whether P.B.M.'s are helping to control drug costs for the federal government or if these middlemen are contributing to skyrocketing drug costs.' "

Rural Dentists Don't Grow In the Fields

From "Dentist Shortage Haunts Rural America" in the *NRHA Rural Clinician Quarterly*, Fall 2002:

"In rural America, 11 percent of residents have never seen a dentist, and according to the Department of Health and Human Services' Health Resources and Service Administration (HRSA); 2,029 areas in the country have been designated dental health professional shortage areas. The scarcity of dentists continues to be one of the largest barriers to improving oral health in rural areas and the problem is growing."

"In an effort to get practitioners to underserved areas, HRSA's National Health Service Corp offers incentives such as scholarships and loan repayment programs for providers willing to work in these areas, said Laura Griffin, spokeswoman for HRSA."

"As of September 2001, 259 dentists were participating in the program and more than 750 have been involved over the past decade. 'This is one mechanism that HRSA has to address the needs of rural areas, as 60 percent of National Health Service Corps placements are in rural areas,' she said."

"**In the next year, more dentists will leave the profession due to retirement and death than will graduate from dental school, a trend that will continue as the workforce age increases.**"

"Monetary benefits, such as the National Service Corps program, are often successful in attracting younger dentists to rural areas. One factor is that younger dentists have high debt problems, averaging about six figures. Programs that provide loan forgiveness have been used successfully by state and local governments. Others have tax incentive programs and financial or lifestyle incentives."

"NRHA member John Knapp, DDS, MPH, said he looks at both ends of the spectrum and targets enthusiastic younger practitioners as well as middle-aged dentists. 'If they're married and have kids they're going to think this is a great place to raise a family,' he said. 'If they're single, though, they might not be able to find a social circle and that gets in the way of keeping them in the community.' "

"Knapp, executive director of the Alliance for Rural Community Health in California and former associate dean at the School of Dentistry at the University of California, said he tries to recruit dentists who grew up in rural areas or who have a strong desire to live there, because 'city people just don't stay.' "

"Knapp said another factor in the workforce shortage is that many older dentists are retiring because they no longer want to have to run a private practice. One way to keep these dentists practicing, he said, is through dental clinics set up as sections of community health clinics."

" 'Some of the dentists are looking to wind down their practices and they are looking for ways where they can just treat patients – not have to run a practice and worry about the business aspect,' he said. Adding dental clinics to clinics in California communities has helped cover the dental needs of community members, especially those on Medicaid, Knapp said."

Oral Health Resources On The Web

www.kidsoralhealth.org	tools for kids oral health awareness campaigns
www.nohic.nidcr.nih.gov	oral health data base, publications, resources
www.oralhealthamerica.org	increasing awareness re link of oral health to total health
www.adha.org	valuable tips from American Dental Hygienists Association
www.NRHArural.org	white paper examines rural provider and consumer issues
www.detalcare.com	wide variety of oral health information

Info: NRHA *Rural Clinician Quarterly*, Fall 2002

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