

**RURAL INTEGRATED SERVICE NETWORKS:
THE IMPACT OF CURRENT HEALTH REFORM PROPOSALS**

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EXECUTIVE SUMMARY

This paper examines how key provisions in current legislative proposals may affect the development of rural integrated service networks (ISNs). The current legislative environment in Congress is dominated by concerns over universal coverage and how to finance insurance for the currently uninsured. Congressional consideration of provisions beneficial to rural areas remains a second order priority pending resolution of these fundamental financing questions. Nevertheless, there is a widespread belief that the development of ISNs, which is emphasized in most health reform legislation, will help rural and underserved communities develop a more stable and comprehensive health care infrastructure through consolidation and rationalization of existing services and by linking these communities to larger service systems. The frameworks of the early health reform bills, as well as more recent bills and Committee marks emerging from the House and the Senate committees of jurisdiction, each contain features which will influence, positively or negatively, the development of rural ISNs.

Our analysis of current legislation focuses on three essential preconditions for the development of ISNs that may pose significant challenges for many rural communities and provider systems and lend themselves to policy intervention: (1) the stability of the financial base for the network, (2) the capacity of the provider and network infrastructure, and (3) the establishment of appropriate market or service areas for networks.

Stable Financial Base: The extent of insurance coverage, as it affects the ability of the population to be served by an ISN to pay for services, and the method used to pay network providers will be critical in determining the financial viability and stability of rural ISNs. The extent of, and timetable for, universal coverage, an important ingredient for the financial security of rural providers and networks, varies across proposals. There is little consensus over how to achieve this goal or the appropriate timetable for doing so. In general, longer phase-ins for universal or near-universal coverage will create more problems for rural network providers, particularly those in areas with high percentages of small businesses and would contribute to a further erosion of the financial base for rural providers and inhibit the development of rural ISNs. Current legislative proposals contain a variety of provider payment provisions, principally targeted to public programs (ie. Medicare and Medicaid) designed to improve and stabilize the financial well-being of rural providers. Several bills contain payment provisions potentially disadvantageous to rural providers, however, which would perpetuate current inequities in payment, including payment reductions for certain providers, particularly disproportionate share hospitals and Medicare-dependent hospitals. Many of the current proposals also rely on a variety of reimbursement and other provisions designed to achieve "savings" in Medicare and Medicaid spending to finance expanded subsidies for insurance coverage. The impact of these provisions on rural providers and, in turn, on their ability to form new network arrangements, is likely to be significant if, in the short run, cuts in Medicare and Medicaid payments are not accompanied by increased payments on behalf of previously uninsured or underinsured patients.

Provider and Network Capacity: Underserved rural communities and areas face numerous capacity-related barriers to network development which will have to be overcome if they are to successfully adopt these new service structures. Legislative proposals contain a wide variety of grant programs to develop networks and health plans in underserved and other rural areas. Proposals also contain provisions providing regulatory flexibility in the area of antitrust

policy and enforcement, to enable rural physicians, hospitals and other service organizations, many of whom may be sole community providers, to enter into network arrangements. And finally, current proposals contain a variety of provisions to enhance the supply of primary care providers which will be vital to the development and long-term success of rural networks.

Appropriate Market/Service Area: Voluntary purchasing cooperatives or alliances are central features of many health reform bills. Both the population size included in a market area and the area's overlap with natural markets are important to the success of rural networks. The size of the population base to be served by the ISN will shape the organizational, service, and financial structure of the network. The congruence with market areas will influence the ability for natural collaboration across providers. In general, proposals that allow purchasing areas to correspond to natural market areas, many of which cross geopolitical boundaries, will favor rural network development. A concern in rural areas with voluntary alliances for small employers and individuals is that this approach could perpetuate the highly segmented market system currently in place in most areas. The degree of market segmentation will depend not only on the size of the firms targeted for participation in voluntary purchasing alliances but also the authority, if any, that the alliances may have for selectively contracting with rural ISNs. The inclusion of Medicare and Medicaid beneficiaries in health plans serving rural areas provides a means for assuring an adequate population base for plan and network development. Provisions contained in several bills that at least permit Medicare and Medicaid recipients to participate in regional purchasing programs are likely to increase enrollment in health plans that work with rural ISNs. The issue of whether and how health plans will provide services in underserved rural areas is handled differently in the various plans. The most certain means of ensuring services for those areas is to require that health plans must make their services accessible to residents throughout the purchasing area.

Current uncertainties over the prospects for comprehensive, national reform, make it critically important that we not overlook the potential contributions of incremental strategies, whether federal or state, for advancing the development of rural networks. In the longer term, however, the sustainability of rural networks is likely to depend on finding national solutions to the fundamental financial and structural weaknesses in current rural health systems.

BACKGROUND AND POLICY CONTEXT

Notwithstanding the debate over the relevance of the concept of "managed competition" to rural America (Kronick et. al., 1993), there is a widespread belief that the development of integrated service networks (ISNs) offers substantial potential for helping rural communities overcome longstanding problems in the availability and accessibility of essential health services (Christianson and Moscovice, 1993; Korczyk and Witte, 1991; Fuchs, 1994). The development of integrated delivery networks, which is emphasized in most health reform legislation, is seen as helping rural and underserved communities develop a more stable and comprehensive health care infrastructure through consolidation and rationalization of existing services and by linking these communities to larger service systems. Health provider recruitment and retention, arguably the most intractable problems in most underserved rural communities, could, be dramatically improved with the stronger financial and service base that ISNs offer (Christianson and Moscovice, 1993).

This paper examines the potential impact on rural integrated service networks (ISNs) of key provisions of current legislative health reform proposals. The paper begins with a discussion of rural networks, the preconditions for building effective networks, and the role that policy may play in supporting or inhibiting network development. We follow this discussion with an analysis of current legislative proposals. The major reform bills that have been introduced represent our frame of reference for this analysis. We have not attempted to provide a bill-by-bill analysis, but rather reference and compare key features of these bills. Our discussion focuses on the likely impact of these features on rural network development and the options for improving current policy proposals.

The final section summarizes the key policy choices that lawmakers face in their efforts to support the development of rural networks. This section includes a discussion of incremental strategies that might be considered in the event that policymakers are unable to achieve consensus on comprehensive reform.

THE POTENTIAL CONTRIBUTIONS OF POLICY TO THE DEVELOPMENT OF RURAL INTEGRATED NETWORK DEVELOPMENT

How could federal and state policy contribute to the development of integrated service networks in underserved rural areas? The answer to this question depends, in part, on what we mean by "integrated service networks." In his paper for this forum, Ira Moscovice provides a definition from one of his colleagues: "an integrated rural health network is a formal organizational arrangement between and among rural health care providers, social service providers, and insurers that uses the resources of more than one existing organization and specifies the objectives and methods by which various collaborative functions will be achieved." (Moscovice, 1994)

The models for rural networks vary considerably along several important dimensions including: (1) the range of service providers they include, (2) the nature of their governance structure, and (3) the extent to which they are locally-based and/or linked to larger organizational and financial entities. Services may vary from combining primary care and preventive services to including a complete array of services, cradle-to-grave. The latter are not likely to be found in rural areas unless they are integrated into urban-based systems.

Governance can range from simply sharing goals and common interests, to sharing services and administrative tasks, to corporate integration (Rural Health Consultants, Inc., 1994). Rural networks also exhibit different approaches for linking locally-based providers to other, usually larger, provider and/or insurance system. Many rural providers and networks are, or will be, partners with larger, urban-based networks and/or managed care systems. However, there is growing interest in locally-based, rural ISNs. All types of networks are included in this discussion of what could be done legislatively to foster the development of rural ISNs.

As many observers have noted, rural networks are not new. So-called horizontal hospital networks have been developing and expanding in rural areas for the past decade (Campion et al., 1993; Kovner and Kiel, 1992; Seavey, et al., 1992). Interest in rural service networks has increased in recent years, however, due to the emergence and seeming rapid development of new, vertically integrated network structures which go beyond hospital to hospital linkage strategies to include other service providers (Moscovice, et. al., 1994; Rosenberg, 1994). This interest is clearly evident in the principal health reform bills which include a variety of features intended to support the expansion of ISNs in rural, underserved areas. But what do we know about what it will take to develop these systems and how federal and state policy might contribute to overcoming the barriers that rural communities and providers may face?

There are at least three essential preconditions for the development of ISNs that may pose significant challenges for many rural communities and provider systems and lend themselves to policy intervention:

- **Stable financial base:** The ability of the population to be served by an ISN to pay for services and the method used to pay network providers will be critical in determining the financial viability and stability of rural ISNs.
- **Provider and network capacity:** underserved rural communities and areas face numerous capacity-related barriers to network development which will have to be overcome if they are to adopt these new service structures successfully.
- **Appropriate market/service area:** The organization of insurance and health care markets through voluntary purchasing cooperatives, alliances or other similar structural mechanisms is a central feature of many health reform bills. Both the population size included in a market area and the area's overlap with natural markets are important to the success of networks. The size of the population base to be served by the ISN will shape the organizational, service, and financial structure of the network. The congruence with market areas will influence the ability for natural collaboration across providers.

Stable Financial Base

1. Adequate insurance coverage and benefits

Rural health care providers are especially susceptible to the financial woes accompanying unpaid patient bills, due to smaller patient bases and proportionately higher shares of Medicare and Medicaid patients. Although rates of uninsurance in most rural areas

may be comparable to those of urban areas, underinsurance rates tend to be higher. Addressing the problem of providing all persons with adequate insurance coverage is very important to the financial success of rural networks.

The extent of universal coverage in any new system will be important in determining the level of uncompensated care that is likely to continue in rural areas and, in turn, the subsidies needed to ensure the financial viability of rural providers. In addition, the scope and level of benefits provided under health reform will be important in shaping the configuration of services in rural networks. Given the high percentage of elderly in rural communities, for example, including long-term care in any standard benefits package would be helpful to rural networks. Similarly, the inclusion of mental health benefits in any reform package may be critical in addressing the shortage of rural mental health services. In both cases, the scope and nature of the benefits provided are likely to influence the configuration of service providers included in the network.

2. Adequate provider reimbursement

Provider payment methodologies and rates will play an important role in shaping the development of networks. Rural areas historically have had lower health care costs due primarily to lower payment levels and use rates. Some of the difference in costs is attributable to lower wages and input costs in rural areas. However, a portion of the difference is also associated with longstanding rural access and capacity problems. Lower capitation or fee-for-service payments to rural providers under health reform could serve to perpetuate historical rural-urban payment inequities and further contribute to problems in building and retaining provider capacity and developing stable provider systems.

Capacity Building

Rural areas face numerous other barriers to developing ISNs, including money, technical capacity and provider and service capacity.

1. Financial support

Rural providers who have struggled to make capital investments in aging equipment and facilities will be unable to invest in network development. Financial assistance will be needed to cover the costs of initial network formation, such as information system design and implementation, and initial organizational infrastructure needs. Capital assistance is also needed to assure appropriate facilities and services.

2. Technical assistance

Rural providers are likely to need technical support and assistance to establish ISNs. Legal and actuarial assistance, help with organizational development and strategic planning, and assistance in developing marketing strategies will be especially important.

3. Regulatory flexibility

Substantial regulatory flexibility, particularly in the area of antitrust, will be needed to allow rural providers, many of whom represent sole community providers, to pursue collaborative network development.

4. Expansion of provider supply

The availability of an adequate supply of providers is critical to rural ISN development. Policies enacted in a more general context to increase the supply of primary care providers and encourage them to practice in rural areas would be helpful. In addition, rural networks could be involved in special programs to train health care professionals.

Appropriate Market/Service Area

In the context of the policy debate over "managed competition," some have argued that most rural areas do not provide sufficient population base for the development of competitive health plans (Kronick et al., 1993). The question of the optimal or necessary population base for ISN development is more ambiguous, however, as it depends largely on the service capacity that ISNs are expected to have and whether and how ISNs accept financial risk as health plans. If an ISN is to become a locally-based managed care organization, accepting financial risk through capitation payments, the required population base will be larger to ensure an adequate risk-spreading capacity.¹ Other types of ISNs, which do not involve financial risk-taking by providers or the network, can be developed with much smaller populations.

Rural networks will need to include at least an appropriate mix of primary care providers, hospital services, and the most frequently utilized subspecialists (such as general surgeons, orthopedic surgeons) to care for patients using network services. The providers need to be able to service a natural medical market, regardless of geo-political boundaries crossed in doing so.

In the context of current health reform legislation, the structure and requirements for health plans and whatever form of purchasing groups emerges (e.g., Health Alliances, Health Insurance Purchasing Cooperatives) will be critical in determining how rural communities and providers will fare in the development of ISNs. There are at least five major policy issues, which will either promote or inhibit the formation of rural networks, depending how they are treated in health reform legislation.

¹ Although there is no absolute criterion for defining the minimum population base needed to support a risk-bearing managed care system, the smaller the base, the more vulnerable providers and the network will be under a capitated arrangement. There are a variety of means to overcome this problem including the development of financial and other linkages with larger, health systems and/or creative uses of re-insurance.

1. *The definition of boundaries for voluntary, regional purchasing groups*

The boundaries specified for purchasing areas could create two critical problems, inhibiting network development: (1) segmentation of traditional health care market areas and (2) redistribution of health costs among areas and populations in a manner that could hurt rural providers and communities (GAO, 1994; Haugh et al. 1993; Fuchs, 1994).

Many rural areas of this country, particularly in the Midwest and West, are served by health care providers spanning multiple states. Different requirements for regional purchasing cooperatives that divide natural service areas may make service coordination and the development of rural ISNs more difficult. From a consumer and provider perspective, there are concerns that the configuration of providers and plans that emerge from these boundary questions may not include the providers and populations that have traditionally relied on each other.

2. *Participation in plans purchased through purchasing groups*

Networks will need a critical mass of enrollees to sustain their activities. Presumably, both self-insured firms and individuals who insure through a regional purchasing groups could choose to participate in the network. However, ISNs may be slower to develop in rural areas if legislation provides broad opportunities for rural employers to offer their own plans outside the structure of the purchasing groups.

3. *The inclusion of Medicare and Medicaid beneficiaries in purchasing groups*

Many rural areas have a high proportion of Medicare and Medicaid beneficiaries. The inclusion or exclusion of these populations from participation in voluntary regional purchasing groups will have important implications for the formation of ISNs. Rural providers could be denied a substantial base of patients with which to support the development of networks if, for example, Medicare and Medicaid patients could continue to purchase care from any provider they wish.

4. *Requirements that health plans serve underserved, rural areas*

Requirements that health plans service entire geographic areas, including underserved urban and rural areas, may be critical in ensuring that these areas are not isolated and thereby disadvantaged in efforts to build solid service infrastructures. The effects of such requirements on network development will vary. On the one hand, there may be greater financial risk to the network in serving underserved areas, unless doing so increases public payments to the networks. Including larger areas in order to reach the underserved, however, may enhance the patient base and revenue for networks, provided all patients are paying patients.

5. *Risk adjustments to premiums for underserved rural areas and populations*

How premium and capitation rates are calculated will have important financial implications for rural ISN development. Rural ISNs may be underpaid if premium and provider capitation rates are based solely on historical prices paid to rural providers. While there are

legitimate urban-rural cost differences based on lower input prices in some rural areas, some of the price or expenditure differential is attributable to rural service availability and access problems. Appropriate premium and/or capitation adjustment factors may be needed to correct for such historical payment inequities.

There are also a variety of reasons to believe that serving rural populations and communities may be more costly for health plans than other populations and areas. In some cases these costs may be associated with population-based health risks. The higher costs of serving a lower income and older population with transportation and other enabling services are also a factor. Whether and how premiums are risk adjusted for plans serving higher cost rural and underserved populations and areas may be critical in determining the financial viability of these plans and provider networks.

THE IMPACT OF PENDING LEGISLATION ON RURAL ISN DEVELOPMENT

The current legislative environment in Congress is dominated by concerns over universal coverage and how to finance insurance for the currently uninsured. Congressional consideration of provisions beneficial to rural areas remains a second order priority pending resolution of these fundamental financing questions. Between the introduction of President Clinton's bill (HR 3600) in November, 1993 and action in congressional committees in June, 1994, many of the central features of health reform, such as mandatory Health Alliances, have changed significantly. As of late June, 1994, another linchpin of the original plan, employer mandates, is similarly being challenged. It is very difficult to predict, therefore, whether the Congress will enact a comprehensive reform bill or what form such a bill will take.

Nevertheless, as committees search for consensus on key features of a bill, they are relying on the frameworks and provisions provided in the President's bill, HR 3600 and alternative plans introduced over the past two years, including, S 491, "American Health Security Act of 1993," (Wellstone), S 1770, "Health Equity Access and Reform Act Today of 1993," (Chafee), and HR 3222, "Managed Competition Act of 1993," (Cooper). In addition, as of this writing, the Committee on Ways and Means, the Committee on Education and Labor in the House of Representatives, and the Committee on Finance and the Committee on Labor and Human Resources in the Senate have either completed work on bills or have draft legislative proposals.

Each of these legislative documents contains features which will influence, positively or negatively, the development of rural ISNs. The purpose of this section is to examine some of these features using the framework of essential preconditions for ISN development introduced earlier. For each of the three preconditions - stable financial base, provider and network capacity and appropriate service areas - we examine both the positive and negative features of the six major bills without identifying particular legislation.

Stable Financial Base

Insurance Coverage and Benefits: The extent of, and timetable for, universal coverage, an important ingredient for the financial security of rural providers and networks, varies across proposals. Current legislative debate indicates that there is little consensus over how to achieve this goal or the appropriate timetable for doing so. Only one proposal begins universal coverage immediately after enactment; others phase it in over a 3 to 7 year period. Longer phase-ins create more problems for rural network providers, particularly those in areas with high percentages of small businesses and/or elderly. One current proposal, as well as suggestions being made in committees of jurisdiction, would stop short of universal coverage. This would contribute to a further erosion of the financial base for rural providers and inhibit the development of rural ISNs.

The scope of benefits in most proposals includes all acute care services and preventive care services with proven efficacy. Only one proposal covers all aspects of long term care, a critical element in most rural areas with a high proportion of elderly residents. The scope of benefits for mental health services, another critical service need in most rural areas, also varies considerably across proposals. No proposal fully covers the complete array of support services (eg. transportation) likely needed to make rural networks fully effective.

Provider Reimbursement: The legislative proposals introduced to date contain a variety of measures designed to improve and stabilize the financial well-being of rural providers. Most of these provisions are targeted to public programs, principally Medicare and Medicaid. They include:

- adjustments to payments for providers serving rural and underserved areas
- special payments to providers in rural and underserved areas during periods of transition to universal coverage
- payment adjustments for serving uncompensated persons (illegal aliens) even after universal coverage is achieved
- payment adjustments for facilities providing outreach services
- risk adjustment methodologies that favor plans offering services in underserved areas
- inclusion of factors other than historical expenditures in calculating any regional expenditure or premium limits/targets

These provisions, together with proposals for bonus payments, tax credits and/or loan repayment assistance for physicians and other health professionals serving rural and underserved areas, would respond to longstanding recruitment and retention problems, and contribute indirectly to the financial base of rural networks.

Although most of the legislative proposals are sensitive to the financial problems of rural providers, several bills contain payment provisions potentially disadvantageous to rural providers which would perpetuate current inequities in payment, including:

- payment reductions for certain providers, particularly disproportionate share hospitals and Medicare-dependent hospitals, which, if implemented before achieving universal coverage, would adversely affect rural network revenues.
- at least one plan would continue Medicaid and cap Medicaid payments.
- payment or premium limits/targets based on historical data which would institutionalize payment inequities between urban and rural providers, disadvantaging rural networks.

Provider payment methodologies are critically important for rural providers. Many of the current proposals rely on a variety of reimbursement and other provisions designed to achieve "savings" in Medicare and Medicaid spending to finance expanded subsidies for insurance coverage. The impact of these provisions on rural providers and, in turn, on their ability to form new network arrangements, is likely to be significant if, in the short run, cuts in Medicare and Medicaid payments are not accompanied by increased payments on behalf of previously uninsured or underinsured patients.

Capacity Building

Financial and Technical Assistant: A number of the legislative proposals recognize the need for financial and technical support for infrastructure and network development in rural areas with special grant programs. The bills contain a wide variety of grant programs to:

- develop consortia to deliver services to low-income or medically underserved areas
- develop and implement coordinated, multi-disciplinary and comprehensive health and social service programs intended to improve maternal and child health
- develop health plans in underserved and other rural areas, including assistance in network development and expansions of a federally qualified health centers and rural health clinics
- expand service-linked educational networks that train primary care providers in community settings

Some of these grant programs include requirements for local participation, which would strengthen rural-based ISNs.

Several proposals include provisions that would provide technical assistance to rural networks, and/or create a more positive environment in which they could flourish:

- requiring coordination of services for persons who qualify for long-term and chronic care services
- establishing health care data systems
- allowing for a single health plan in underserved areas
- technical assistance from the U.S. Department of Justice in underserved areas seeking exemption from anti-trust regulations

Some proposals call for state governments to provide additional technical assistance to rural networks, with grants to the states for that purpose.

The need for technical assistance and financial support will vary depending on whether rural providers, and particularly those in underserved areas, have access to administrative and financial resources of larger provider or insurance partners. For locally-based networks in underserved areas with minimal populations, substantial assistance may be needed either permanently or on a cyclical basis. Very little technical assistance is provided in the reform proposals targeted to developing rural ISNs. Presumably, grants for development and implementation could be used to purchase such assistance, but a separate program is warranted.

Regulatory Flexibility: Some regulatory flexibility will be needed, particularly in the area of antitrust policy and enforcement, to enable rural physicians, hospitals and other service organizations, many of whom may be sole community providers, to enter into network arrangements. Some of the provisions in bills submitted to date include:

- joint ventures for using advanced technology and costly equipment could be considered safe harbors under anti-trust regulations
- hospital mergers would be considered safe harbors if one hospital has 150 or fewer beds and an average daily census of less than 50%
- safe harbors could be granted on a proposal-by-proposal basis

Additional flexibility would be the responsibility of state governments as they certify health plans.

In addition to the need for greater flexibility in antitrust matters, some rural facilities, notably small rural hospitals, need assistance in making the transition to new service systems in which their current inpatient capacity will not be needed. A number of bills contain provisions modelled after the Essential Access Community Hospital/Primary Care Hospital (EACH/PCH) Demonstration Program to provide smaller hospitals to adopt new "limited service" models with corresponding changes in Medicare reimbursement policy.

Provider Supply: Enhancing the supply of providers and, in particular, primary care practitioners, will be vital to the development and long-term success of rural networks. All of the proposals address the issue of increasing provider supply using some combination of the following provisions:

- setting a national goal or quota for the proportion of graduate medical residencies in primary care
- including community-based primary care provider organizations in medical education consortia
- increasing funding for the National Health Service Corps
- funding hospital residencies in ambulatory settings
- providing financial incentives to practice in rural and underserved areas
- retraining subspecialists in primary care
- increasing funding to train non-physician providers
- giving priority for residency allocation to programs with demonstrated success in training professionals who practice in rural areas

Appropriate Service Area

Boundaries for Voluntary Regional Purchasing Groups: Several bills allow alliance, or purchasing area, boundaries to vary according to local health markets, including markets that encompass multiple states. The most straightforward means of doing so applies to metropolitan areas, which in all bills that use purchasing groups (the single payer option does not), cannot be divided into multiple regions. While no such mandates have been written for rural areas, there are legislative provisions that permit two or more states to agree to establish a single region that includes territory in multiple states. Other proposals permit states to enter into agreements that would have bordering alliances use the same rules, which would facilitate cross-state networks.

Some proposals, especially those offered early in the debate, restrict the boundaries of purchasing regions to state borders, except for metropolitan areas. Several proposals require that each purchasing area include at least 250,000 persons, thought to be the minimum necessary to foster managed competition. However, as we stated earlier, the minimum for meaningful networks is far fewer. Requiring large service areas could actually work against the development of rural networks if they are required, as part of health plans, to serve areas that exceed their capacities.

Requirements to Participate in Purchasing Groups: Based on recent Congressional discussions and committee actions, there is little likelihood that any bill emerging from this Congress will include the requirements for employer participation in purchasing alliances originally contained in the President's bill, HR 3600. Requirements to participate in regional cooperatives or

alliances varied across the original plans, from requiring all employers under 5000 employees to enroll their workers through alliances to allowing voluntary participation for employers with fewer than 100 employees. Congress appears most interested in this latter approach of allowing smaller firms and individuals to participate in voluntary group purchasing arrangements.

As noted earlier, the concern in rural areas with voluntary alliances for small employers and individuals is that this approach could perpetuate the highly segmented market system currently in place in most areas. Given the cost efficiencies of purchasing through an alliance, however, the market may not be as segmented as it is today. The degree of market segmentation will depend not only on the size of the firms targeted for participation in voluntary purchasing alliances but also the authority, if any, that the alliances may have for selectively contracting with rural ISNs. Some recent legislative proposals give states the authority to grant alliances latitude for negotiating with health plans that may include selective contracting with rural ISNs. The effects of these various approaches to regional alliances and purchasing groups on ISNs is unclear at the end of the spectrum in which ISNs are not themselves health plans. When they are health plans, the more segmented the market, the more uncertain their financial security. No proposals restrict arrangements between either alliances or self-insured employers and health plans.

Medicare and Medicaid: The inclusion of Medicare and Medicaid beneficiaries in health plans serving rural areas provides a means for assuring an adequate population base for plan and network development. Some legislative proposals eliminate Medicaid and provide subsidies to all low-income persons to use in purchasing their insurance from among the menu of health plans available in their region. Medicare is generally left as a separate program, although Medicare beneficiaries are given the option in some plans of purchasing insurance through the regional cooperative, thereby selecting among competing plans. Provisions contained in several bills that at least permit Medicare and Medicaid recipients to participate in regional purchasing programs are likely to increase enrollment in health plans that work with rural ISNs.

Requirements to Serve Rural Areas: The issue of having health plans provide services in underserved rural areas is handled differently in the various plans. The most certain means of ensuring services for those areas is to require that health plans must make their services accessible to residents throughout the purchasing area, and available on a first-come, first-served basis to prevent potential "redlining" of underserved areas. Another approach, and one gaining in legislative popularity, is to require that health plans include in their panel of providers, "essential community providers" such as migrant and community health centers, which have traditionally served underserved areas. Either approach would facilitate extending health networks into underserved areas. For those plans that provide services to populations for whom services are expensive, such as establishing provider networks accessible to underserved areas, two proposals explicitly include geographic area as one basis for risk adjustment across plans.

INCREMENTAL POLICY STRATEGIES

As efforts to pass a comprehensive reform bill become bogged down over the critical issue of the financing of universal coverage, policymakers and others representing rural interests and areas are increasingly looking for incremental policy solutions that might improve rural health system development in the near term and contribute to longer-term health reform efforts. In addition, states, some of which have passed and are attempting to implement, comprehensive reform legislation, are addressing rural health needs through a variety of initiatives designed to foster the development of rural ISNs. Drawing on federal legislation which has been recently introduced by members of the Rural Health Care Coalition in the House, and the experience of states like Minnesota, Washington and New York, we outline in this final section some of the critical elements of this incremental strategy.

Federal Legislation

Policymakers representing rural states and areas have been concerned with defining the "rural primacy issues and strategies" that could either be introduced as amendments to comprehensive reform bills emerging through these committees or as separate legislation. A recent bill, the "Rural Health Delivery System Development Act of 1994 (HR 4555), introduced as a bipartisan bill by Representatives Stenholm and Roberts, (Co-Chairs of the Rural Health Care Coalition in the House), contains many of these critical elements. These include:

- grant and other financial support to foster the development of rural networks (including support for technical assistance)
- an expansion of incentives for health professionals to practice in rural areas, (e.g. expansion of the National Health Services Corps, student loan deferments, model scope of practice laws, and refinement of geographic adjustment factor for Medicare physician services)
- expanded assistance to rural institutional providers, including community and migrant health centers, rural hospitals and rural emergency medical systems
- demonstrations to support rural, community-based Graduate Medical Education
- broader anti-trust exceptions for rural hospital mergers and/or affiliations

Although the provisions in this bill would not solve many of the fundamental problems in insurance coverage which undermine rural health care delivery systems, they represent one of the first attempts to develop a coordinated strategy for rural health systems development. Many of these provisions are not new and represent approaches to rural health systems development contained in current legislation, including the EACH/PCH, Rural Outreach and Hospital Transition programs. Nevertheless, the bill is important for at least two reasons. First, it specifically targets the development of rural health networks. Second, it consolidates and, in some cases, expands current funding programs in order to achieve a critical mass of financial and technical support needed to achieve this end.

Whether or not this bill is enacted in its current form, it is likely that some of its key provisions will find their way as amendments into whatever bills emerge from current committee deliberations or in floor debate.

State Policy

Although current policy and media attention is focused on the Congress and federal reform efforts, a handful of states, including Washington, Minnesota, Florida and Vermont, have enacted reform legislation through which a variety of policy initiatives to support rural network development are emerging. Other states, such as New York and West Virginia, have developed policies and programs outside of major health reform initiatives. State efforts to support the development of rural networks include everything from the direct provision of technical and financial assistance in network development to establishing regulatory flexibility to facilitate network development.

Current uncertainties over the prospects for comprehensive, national reform, make it critically important that we not overlook the potential contributions of incremental strategies, whether federal or state, for advancing the development of rural networks. In the longer term, however, the sustainability of rural networks is likely to depend on finding national solutions to the fundamental financial and structural weaknesses in current rural health systems.

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