Managed Care and Rural America

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Rural America has not been neglected in the national move toward managed health care. Some people may find this surprising since health care in rural America is generally characterized by limited resources spread over sparsely populated areas—regions in which managed care organizations might be less inclined to invest. These regions, however, seem especially vulnerable to economic pressures in today's health care arena, as evidenced by the large number of recent rural hospital closings.[1] Since 1980, 20% of all rural hospitals have closed,[2] and two thirds of the 45 hospitals that closed in 1991 were rural.[3]

Managed care is not new to rural America. More than 150 years ago, miners paid a fixed fee to secure medical care from salaried physicians.[4] Care provided by "camp doctors" was not uniform in quality, and some states later passed laws restricting physician employment to practice medicine on a salaried basis. In a review of early models of managed care in rural America, Christianson[5] outlined some of the difficulties in establishing health maintenance organizations (HMOs) in these areas. The Health Maintenance Act of 1973 led to the development of a few rural HMOs, but funds set aside for rural HMO development were never fully spent. About one half of the federally funded projects never progressed past the feasibility stage.

Measuring the Growth of Managed Care in Rural America

Trends and issues related to the growth of managed care in rural America were presented at a recent conference sponsored by the Agency for Health Care Policy and Research (AHCPR).[6] Participants agreed that it is complicated to determine the extent to which communities in the United States, including those in rural areas, are now being served by managed care organizations (MCOs). Estimates depend on the definition of MCO being used. If, for example, health insurance plans are divided into either traditional indemnity plans or managed care plans, two thirds of US employees with private health insurance would be considered part of a managed care plan.[7] However, if managed care is defined as involving significant risk-sharing by its health care providers, the calculation becomes less clear-cut. The organizational model of some plans reveals little about the extent of provider risk-sharing. For example, many people do not recognize first-generation preferred provider organizations (PPOs) as "true" managed care, because they simply offer discounts to group purchasers, whereas the managed care label certainly would be considered applicable to third-generation PPOs, which place the participating physician at financial risk for the care provided.[8] What classification, then, would be given to second-generation PPOs, which restrict physician participation and often include primary care gatekeeper functions?

HMOs, on the other hand, are universally accepted as a form of managed care. For this reason, HMOs, while acknowledged as representing only a portion of managed care, are often used as an indicator of growth in managed care.

Trends in Rural HMO Growth

HMOs play a significant role in the US health care delivery system, with 23% of employees with private health insurance enrolled in HMOs in 1994.[7] Nationally, however, the total number of separate HMOs decreased 17% (from 594 to 492) between 1988 and 1993. In examining such trends in rural communities, Christianson[8] noted that the number of HMOs headquartered in rural areas decreased to an even greater extent, by 39% (from 31 to 19), over approximately the same period. However, the percentage of rural counties (defined as those that are less urbanized, nonmetropolitan, and not adjacent to metro-

Submitted, revised, May 1, 1995.

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ISSN 0094-3509

politan areas) in which an HMO is available increased from 14% to 28% during this time. These data suggest that, across the country, small HMOs are being merged into larger HMOs, a trend that appears to be even more pronounced among rural HMOs. At the same time, more rural counties than ever are now being served by HMOs. Christianson also found that HMO-served rural counties tend to have more physicians per capita, fewer hospital beds, and higher per capita income than other rural counties.

Forces Stimulating the Growth of Rural Managed Care

There are at least three forces influencing the growth of rural managed care organizations. In the locally driven force, rural communities may organize an MCO to preserve or increase availability of health care services. For example, many rural-based clinics are developing managed care arrangements in addition to fee-for-service options. Most of these arrangements were made subsequent to the Health Maintenance Act of 1973.

A second force occurs when an urban MCO develops adjacent rural services. To acquire a contract with the urban corporation, for example, an MCO often must be able to serve employees in all locations where the company operates; thus, the appearance of MCOs serving predominantly urban corporations with rural offices or suboperations.

The third force stimulating rural MCO development is pressure on state governments to control Medicaid costs. Currently, about one fourth of all Medicaid beneficiaries are enrolled in MCOs, and most states are trying to increase that number.[9] In a related effort, state public employee health benefit plans, through their purchases of services, are encouraging MCOs to provide service in rural areas. California's plan, for example, led Blue Cross of California's HMO to expand to a state-wide HMO that serves all rural counties.[10]

Physician Participation in Rural Managed Care

For physicians, participation in rural managed care offers both advantages and disadvantages. An expected advantage is the development or preservation of market share, ie, maintenance of the number of patients in the practice. Other advantages might include data collection, and assistance from the MCO corporation in complying with nonclinical requirements, such as Occupational Safety and Health Administration (OSHA) and disability access regulations.

Although some reports indicate that physicians with HMO patients net more income,[11] physicians participating in rural or urban MCOs may at the same time lose control of certain aspects of their practice. A feeling of cultural distance or lack of understanding by the corporation may be accentuated if the MCO headquarters are in an urban location miles away from the practice.

Legal Issues

A growing number of physicians are organizing into networks to contract with health plans.[12] Although the legal issues involved in joining or establishing a managed care network are essentially the same for urban and rural physicians, some issues may arise more frequently in rural areas.

Certain activities potentially involved in business agreements within a rural provider network are forbidden by regulations related to antitrust legislation. For example, physician activities such as price-fixing, market-splitting (assignment of patients by physician agreement), and group boycott (agreement to boycott a new or potential arrangement) will clearly lead to enforcement actions. Other activities such as an exclusive arrangement between community physicians and an MCO, while seemingly in the community's interest, may be classified as anticompetitive. In enforcing these regulations, the US Department of Justice and the Federal Trade Commission (FTC) try to balance the goal of enhancing health care services through cooperation among rural providers with the goal of promoting competition.

An issue that frequently arises is the number of physicians who can enter an exclusive agreement before it becomes anticompetitive. An exclusive agreement means the physician will not affiliate with any other plan. The Department of Justice and the and FTC have published an "antitrust safety zone" rule-of-thumb that they will not challenge any exclusive physician network consisting of 20% or fewer of physicians in a geographic market, provided certain other qualifications are met by the network. The "safety zone" for nonexclusive networks is 30% or fewer of physicians in each physician specialty, provided other conditions are also met. A list of management consulting firms available to assist with these and other issues related to the development of rural managed care networks has been published by the American Hospital Association.[14]

Unanswered Questions

Even as managed care is growing in rural areas, certain questions remain unanswered: Do managed care net-

works improve the health status of rural residents? Which types of networks result in the most improvement at the least cost? There is a clear need for research that addresses these issues.[15]

The ultimate effect of managed care on the rural community is unknown. Will the competitive market in which managed care networks operate require cutbacks in high-cost community services? While managed care organizations in general may be forced to reduce or eliminate their "social output,"[16] such reductions may be greater in rural communities. Lower population density in rural areas may force centralization of many services to nearby or distant urban locations, and may even result in discontinuation of some services. Given such pressures, will rural managed care networks be able to survive in today's competitive market while remaining responsive to the needs of rural residents, especially those least able to help themselves—children, the elderly, persons with disabilities, and the economically disadvantaged?

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