Cite this article as:
J Christianson and I Moscovice
Health care reform and rural health networks
*Health Affairs* 12, no.3 (1993):58-75
doi: 10.1377/hlthaff.12.3.58

The online version of this article, along with updated information and services, is available at:
http://content.healthaffairs.org/content/12/3/58

For Reprints, Links & Permissions:
http://content.healthaffairs.org/1340_reprints.php

Email Alertings:
http://content.healthaffairs.org/subscriptions/etoc.dtl

Not for commercial use or unauthorized distribution
To Subscribe:  https://fulfillment.healthaffairs.org
Prologue: Rural areas pose a unique challenge to health care reform. Rural populations require more medical attention since they are older, poorer, and more hazardous employed than their urban/suburban counterparts. Yet rural areas contain only half as many primary care physicians per capita, and specialized facilities are scarce. Does managed competition adequately address rural concerns? Some believe that meaningful competition among providers cannot occur in areas that often contain only one provider; that state-specific global budgets may lock in historical inequities, thus punishing poorer rural states; and that managed competition's cost containment focus does not address the greater rural problem of improving delivery systems. Rep. Fortney (Pete) Stark (D-CA), chair of the House Ways and Means Subcommittee on Health, said in a 24 June 1993 hearing that “the managed competition approach ... could exacerbate the problems of under-served inner-city and rural areas.” Authors Jon Christianson and Ira Moscovice take a different view. Moscovice has described managed competition as “a real opportunity to help improve rural health care,” primarily through encouragement of network building and an emphasis on bolstering primary care. In this paper the authors neither champion nor criticize managed competition but take a systematic look at the shape managed competition will likely assume in rural areas. Christianson is a professor at the Institute for Health Services Research at the University of Minnesota’s School of Public Health; he directs the university's Health Care Financing Administration Research Center. He holds a doctorate in economics from the University of Wisconsin. Moscovice is a professor and associate director of the Institute for Health Services Research at the University of Minnesota and directs the university's federally funded Rural Health Research Center. He earned his doctorate in operations research at Yale University.
Abstract: Health care reform is likely to raise unique issues for rural communities and providers. This paper identifies and discusses several of these issues, with a particular focus on the potential relationship between health care reform and rural health networks. Topics addressed include the likely impact of health reform on the organization and development of rural health networks, the reimbursement of rural providers, rural medical practice, and state roles in the organization, delivery, and oversight of rural health care.

The gathering momentum for health care reform at the federal and state levels has been accompanied by concerns about the unique issues that reform initiatives are likely to raise for rural communities and providers. We identify and discuss a variety of these issues in this paper, with a particular focus on the potential relationship between health care reform and rural health networks. To structure our discussion, we assume that health care reform will combine both managed competition and global budgeting initiatives. In particular, we assume that (1) a mandated set of benefits is defined at the federal level and that long-term care is a part of this benefit package initially; (2) all individuals and employers share the cost of health insurance, with subsidies provided for the poor; (3) everyone, except employees of very large firms and Medicare beneficiaries, obtains coverage through health insurance purchasing cooperatives (HIPCs) that serve defined geographical areas; (4) HIPCs contract with private health plans, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), and one free-choice-of-provider option, and manage the enrollment process; (5) the plans are paid by risk-adjusted capitation, although providers within the plans could be paid using a variety of different methods; (6) HIPCs pay an amount equal to the lowest-cost plan, and a consumer choosing a higher-cost plan must pay the difference between this amount and the plan’s premium; (7) enrollees are charged community-rated premiums, and no medical underwriting by health plans is allowed; (8) states have authority to supervise HIPCs and license health plans, and also have the ability, with federal approval, to experiment with different administrative approaches in order to adapt to local needs; (9) the federal government employs “benchmark budgeting” by annually determining a maximum allowable rate of increase in the premiums of the “benchmark” (lowest-cost) health plan option and a target for capping overall spending; (10) in areas where managed competition does not result in increases consistent with these goals, HIPCs have discretionary authority to set rates; and (11) Medicaid is eliminated, but the elderly continue to receive coverage under Medicare, at least in the initial stages of reform.

Under health care reform, we expect that a large percentage of rural providers will be organized into networks for the purpose of contracting with health plans or HIPCs to serve rural areas. Therefore, an important objective of this paper is to identify issues relating primarily to rural
provider networks that will merit attention under a reformed health care system.

**Organization Of Rural Health Networks**

**Definition.** Networks of organizations have been defined at a general level as “organizational arrangements that use resources and/or governance structures from more than one existing organization.” The organization and structure of existing rural health networks vary according to the goals of participants, the availability of providers, and the characteristics of rural communities. Network development has received support from several foundations over the past decade, most notably from The Robert Wood Johnson Foundation, which recently funded a demonstration to provide support to thirteen rural hospital networks. At the federal level, the Essential Access Community Hospital Program, initiated in 1991, was designed to link smaller to larger rural health care facilities. At the state level, Minnesota has introduced the concept of “integrated service networks” in the implementation of its reform legislation, while New York State is sponsoring a demonstration in the development of rural health networks.

Despite this encouragement, examples of rural-based networks that provide the full range of acute inpatient and outpatient services are relatively rare and are confined primarily to a small number of successful rural-based HMOs. Instead, existing rural networks tend to comprise groups of similar primary care, and sometimes secondary care, providers that form to address common problems or to respond to reimbursement opportunities. While the experience of these more limited networks has demonstrated that rural providers can work together cooperatively, it has provided little evidence regarding the ability of rural networks to effectively assume responsibility for all of the medical care of entire communities, to operate within a constrained budget, to guarantee access to needed services, or to provide substantial benefits to participating providers.

**Possible relationships between networks, health plans, and HIPCs.** Health plans seeking to serve rural communities will attempt to contract with networks of rural providers to provide access to care for their enrollees. Where existing networks are not available, health plans will create networks by aggregating rural providers into risk pools for reimbursement purposes. In rural areas that health plans decline to serve, HIPCs will need to, in effect, assemble rural networks to serve as free-choice-of-provider or preferred provider plans.

The ways in which rural networks develop and the responsibilities they assume are likely to depend in part on geographic considerations and in part
on prior collaborative relationships among rural providers, both of which vary considerably across states and regions. For example, in rural areas that are relatively close to urban areas and relatively densely populated, rural networks likely will form primarily through contracts with urban-based health plans that may already serve their rural neighbors. In other rural areas, where network arrangements among rural providers already exist (although they may not be structured as vertically integrated delivery systems), health plans seeking to serve these areas likely will attempt to take advantage of existing networks in establishing their delivery systems. This could, in turn, cause existing rural networks to organize more formally to function as contracting entities for negotiating with health plans. Existing networks also might broaden the composition of their membership to offer a full range of health services when contracting with health plans. Once organized in this manner, rural networks conceivably could contract with multiple health plans.

In more remote, sparsely populated rural areas, examples of provider networks contracting with prepaid health plans are relatively rare. This reflects in part the fact that prepaid health plans have not found these areas attractive. For example, where rural providers have a “captive market,” there is little incentive for them to contract with a health plan to attract new patients or to retain existing ones. In these cases HICPs may choose to require that health plans contracting to serve more densely populated areas also demonstrate an ability to serve less populated areas. In addition, HICPs may need to set reimbursement rates for rural providers so that health plans are not forced to pay abnormally high prices to induce rural providers to contract with them.

Alternatively, HICPs may choose to offer residents of these areas a choice between a statewide PPO or a free-choice-of-physician plan, with regulated fee schedules for rural providers. The HIPC could sponsor and manage the free-choice plan itself or, as envisioned under some reform proposals, contract with an insurer for this purpose. In either case networks of rural providers likely would be created to facilitate negotiation over reimbursement and the carrying out of quality assurance and utilization management activities.

**Shape of managed competition in rural areas.** In a recent paper Richard Kronick and colleagues argue that meaningful managed competition can occur only when providers have exclusive affiliations with health plans. Then, when individuals change their health plans, they also must change their providers, presumably creating a strong incentive for providers under contract to health plans to compete for patients. Rural provider networks would contract with only one health plan or would form their own health plan and not subcontract with existing health plans. “In a
geographically isolated area with a population base large enough to support only one hospital and one group of physicians, it is difficult to envision how competition would work,” Kronick and colleagues contend. To address this issue, they suggest a possible role for “alternative models of reform (based on planning and the promotion of cooperation as the basis for achieving the efficiencies that the population-based perspective of the classic HMO brings to the health care economy).”

Rural health networks seem well suited for alternative models of reform that rely on some version of “sole-source” contracting in rural areas. In regions where competition was thought to be infeasible, franchises could be granted by HIPCs to rural health networks to serve specific geographic areas in return for capitated payments. After granting a franchise, the HIPC would play an essentially regulatory role to ensure that future premium increases fell within permissible boundaries and that the network was carrying out its other contractual responsibilities related to the delivery of services.

The limitations that Kronick and colleagues see for the viability of managed competition in rural areas are not universally acknowledged. For instance, in designing its health care reform initiative, the Minnesota Health Care Commission focused on competition among “integrated service networks” (ISNs) for enrollees, suggesting that the state should “promote and facilitate competition between ISNs even in rural areas of the state where only one provider system exists. Just as multiple health insurance plans are available now, ISNs will compete in terms of the coverage they offer, their costs and efficiency, and the extent to which their contractual relationships with local providers are more efficient or offer better quality or service.” Under this scenario rural networks could contract with more than one health plan but generally would not risk the loss of patients when rural residents switched health plans.

Some analysts view this type of competition, where all health plans employ the same provider network, as potentially inefficient because of the administrative burdens it would impose on participating providers, who would need to comply with the administrative and reimbursement practices of multiple plans. Under managed competition, however, there presumably would be a standardized benefit plan, common administrative and data collection procedures, and control exercised by HIPCs over the number of plans offered in a given region. It seems unlikely, particularly in rural areas, that providers would participate simultaneously in large numbers of plans. A related concern, however, is even more significant. If rural networks serve enrollees from multiple plans, it may be difficult for a single plan to exercise sufficient leverage on network providers to ensure meaningful participation in the plan’s cost containment efforts.
Summary of organizational issues. Local health care delivery systems in rural areas exhibit considerable diversity. Some rural areas are served by technologically sophisticated acute care facilities and large multispecialty group practices, while others struggle with financially marginal, understaffed hospitals and a shortage of primary care physicians and mid-level health practitioners. Rural areas contiguous to urban centers often have relatively high population densities, especially in comparison to sparsely populated frontier areas in many western states. These differences suggest that health care reforms are likely to unfold in different ways across rural communities. We offer here a summary of some of the issues raised thus far, with the understanding that these issues will vary in their importance across rural areas.

First, the number of rural health networks will need to be expanded, and existing networks will need to be modified if they are to play significant roles under health care reform. There may be limited potential for rapid network formation under the leadership of rural providers; initially, some rural networks may consist of providers who happen to contract with the same urban-based health plan, with network leadership provided by health plan staff.

Second, if rural health networks are seen as a desirable means to facilitate health reform in rural areas, then government may need to allocate funds for investment in network building. Also, to protect fledgling networks that assume risk under capitated contracts, it may be necessary for government to provide reinsurance in the initial stages of network development. As one of their functions, HIPCs could facilitate the pooling of risks across rural networks for reinsurance purposes.

Third, most reform proposals suggest that areas where rural providers decline to participate be subject to regulatory oversight, including government administration of fee schedules coupled with stringent utilization management. Providers in remote rural areas may respond to these initiatives by moving their practices to more populous areas, creating access problems for some rural communities. HIPCs will need to balance their efforts to ensure that services are provided within a fixed budget with the need to maintain access to care for rural residents.

Reimbursement Of Rural Providers

Provider reimbursement in prepaid health plans. We consider it very likely that most rural providers will continue to be reimbursed under some form of fee-for-service payment, whether they participate in health plans or their rates are regulated under a global budget approach. There are innumerable variations in the way that payment schedules and risk-sharing
arrangements for rural providers could be structured. Under one arrange-
ment rural providers would participate in an urban-based, individual prac-
tice association (IPA)–model plan. The plan would group primary care
providers, specialists, and hospitals within a designated rural area into
separate risk pools for reimbursement purposes. Primary care providers
would be reimbursed according to a fee schedule established by the plan,
with a percentage of each payment withheld and placed in a “withhold”
fund. This money would be returned to the primary care provider after one
year (or some other designated time period) if expenditures for primary care
did not exceed a prespecified amount. If expenditures were greater than
budgeted, only a portion (or none) of the withhold-pool dollars would be
returned. If the funds allocated to hospital and specialist risk pools were not
sufficient to cover all expenditures, shortfalls would be covered through a
transfer of funds from the primary care providers’ withhold pool. Usually, a
referral from a primary care provider would be required for enrollees to see
a specialist, and preadmission certification would be required for all non-
emergency hospital admissions.

Under this scheme rural providers would be at limited financial risk,
since the most they could lose in a given year would be their contribution
to the withhold pool. The strength of their incentive to contain costs
would be related to the number of providers participating in the risk pool.
Of course, if projected expenditures for any provider group (or the health
plan as a whole) were exceeded in a given year, the health plan would be
likely to propose lower payment schedules, more substantial withholds (or
more substantial risk sharing through other mechanisms, such as paying
primary care physicians on a capitated basis), and/or more aggressive utiliza-
tion review policies in subsequent years. Ultimately, health plans that did
not break even in a particular rural area would terminate their contracts
with providers, leaving it to the HIPC to determine provider reimburse-
ment and utilization review policies for that area.

A second type of arrangement would require rural providers to assume a
greater degree of direct financial risk for the delivery of services. To illus-
trate this alternative, assume that a HIPC contracts with a rural health
network to act as the health plan for a designated geographic area. The
network is “owned” and administered by the rural providers and receives a
capitated payment for each enrollee to provide all covered medical services.
The same options are available to structure provider reimbursement and
risk sharing as are used by prepaid health plans in general. However,
providers participating in the capitated rural network may feel stronger
incentives to contain costs, by virtue of their “ownership” of the network.
As HMOs currently do, rural networks could protect themselves against
substantial losses, incurred on an aggregate or a per patient basis, through
the purchase of reinsurance.

**Provider reimbursement in PPOs or free-choice plans.** Providers participating in these plans would be reimbursed on the basis of fee schedules established through negotiation with the plans. PPOs by their nature create financial incentives for patients to seek care from "preferred" providers. PPOs usually employ the same types of utilization controls as prepaid plans, but providers are not at direct financial risk for the performance of the PPO. However, if the PPO’s premiums increased more rapidly than the targets established by HIPC, then rural providers likely would face reductions in fee schedules and more aggressive application of utilization management techniques. Providers who were not responsive to efforts to change their practice patterns would be dropped from the PPO panel.

The free-choice-of-physician plan has somewhat less flexibility in the options it has available to control costs. As in PPOs, providers would be reimbursed using a fee schedule established by the plan. However, if all providers were allowed to participate in the plan, the managers of the plan (or the government agency charged with enforcing budget limits) could not drop providers who were unresponsive to utilization control efforts. Therefore, the only direct way to control expenditures would be through adjustment of provider fee schedules so that expenditures fell within established targets.

In some cases it may not be possible for any privately administered health plan (prepaid, PPO, or free-choice-of-physician) to serve a given geographic area and maintain premium increases within the range targeted by the HIPC. The HIPC then would establish reimbursement rates and attempt to control use of services (or contract with a private firm to undertake utilization management activities). Presumably, as in the free-choice-of-physician plan, the primary mechanism for restricting spending growth would be the regulation of fees and charges. Providers could “quit the plan” only by refusing to see plan patients (in which case their incomes would depend solely on revenues from patients excluded from health care reform initiatives, such as Medicare beneficiaries), by moving to another location (an option that presumably would be available to noninstitutional providers), or by retiring (for individual providers) or ceasing operations (for institutional providers). To discourage rural providers from quitting the plan, benefits or sanctions relating to professional licensure or Medicare certification could be implemented if necessary.

**Summary of reimbursement issues.** There are likely to be limits to the ways in which reimbursement can be used to alter provider behavior in rural, as opposed to urban, areas and to the degree of risk sharing that can be expected of rural providers. These constraints probably will be most apparent with respect to providers located in more remote rural areas. This
raises several important issues that must be considered in designing health care reform initiatives.  

First, in rural areas it may be appropriate to consider grouping different provider types into the same risk pool to encourage providers to work cooperatively to manage care more effectively. If only similar providers are grouped together, the geographic area covered by the providers might need to be quite large in order to accomplish risk pooling among an appropriate number of providers, and distances among providers participating in the risk pool might be too great for cooperative activity.  

Second, as described earlier, primary care providers in many prepaid plans play a “gatekeeper” role, with financial incentives to control referrals to specialists. However, one commonly expressed concern is that rural residents do not always have appropriate access to specialty care. Providing primary care providers with financial incentives to control access to specialists could heighten this concern.  

Third, rural providers fear that new fee schedules, whether implemented by health plans or by HIPCs, will “lock in” perceived inequities in the present relationships between fees received by urban and rural providers and between primary care and specialist providers. In addition, there is the question of whether fee schedules can be used in rural areas as instruments to reduce costs without causing providers to leave their rural practices, thereby jeopardizing access to care for rural residents in underserved areas.  

---

Impact Of Reform On Rural Medical Practice  

Rural primary care physicians and other rural providers have been characterized as overworked, inadequately reimbursed, and lacking sufficient professional support. If this characterization is accurate, rural providers may welcome organization and delivery system changes that improve the circumstances of their practices. Alain Enthoven has described one scenario that may be attractive to some rural providers:  

HIPCs might request proposals from established urban comprehensive care organizations to establish and operate a network of primary care outposts, paying doctors and nurse practitioners what is needed to attract them to provide high-quality ambulatory care in rural locations, while giving them professional support in the form of telephone consultations, temporary replacements, continuing education, and transportation and referral arrangements.  

Either “horizontal,” or “top-down” approaches to rural network development could occur under health care reform, depending on the supply of and organizational relationships among existing health professionals in a rural community and the geographic proximity of that community to an urban center or a large rural referral institution. Locally developed horizontal
networks could be effective if they had the necessary leadership and resources to expand the scope of activities of existing providers to meet new responsibilities. Top-down networks, initiated by urban health care organizations, could be effective if they were sensitive to local issues and concerns and were able to identify and support the positive attributes of rural medical practice. If one of the results of health reform is to stimulate the widespread development of rural provider networks, rural medical practice is likely to be transformed in a variety of ways.

**Provider response to increased management and oversight.** Most rural providers now have little, if any, experience with managed care arrangements. Under the proposed health reform initiatives, including global budgeting, it is likely that rural providers will be required to participate in utilization management techniques such as preadmission certification for inpatient care, preauthorization review for surgery, physician profiling, and practice guidelines. The level of oversight imposed by government or health plans on rural providers’ individual clinical decisions (and providers’ corresponding response to this oversight) is likely to define rural providers’ view of health care reform. Under managed competition, health plans and networks may be under strong pressure to micromanage providers to maintain their competitive position. Regional governments may feel the same pressure in order to stay within budget caps. Yet the goal of these techniques has been described as not to remove the decision-making power of individual providers, but rather to improve their ability to make better decisions.

The degree to which rural providers accept or rebel against the imposition of new utilization management techniques on their practices clearly will be related to the manner in which these techniques are implemented and their perceived value to patients. If utilization management consists primarily of complex information compiled and interpreted by distant urban-based institutions or government agencies, rural physicians will greatly resist it. On the other hand, where a rural-based provider network has organized as a health plan, developed a mechanism for integrating local providers’ input into practice guidelines, and carried out utilization management efforts with a sensitivity to local conditions, rural providers are likely to be more tolerant of oversight activities. Certainly, top-down networks also can operate in ways that are sensitive to rural providers’ concerns, but rural-based, horizontal networks may find it easier to develop the trust of rural providers.

Another factor that will influence rural providers’ receptivity to increased management and oversight is the responsibility given to primary care providers in networks. Primary care providers often serve as case managers in managed care networks, regulating the flow of referrals and specialty services throughout the network. Depending on the financial
relationships that are established, this role may place the rural primary care provider (or provider group) in a position of financial risk for the services provided to their patients. Although the gatekeeper role can increase the status of rural primary care providers vis-à-vis specialists, it may be an uncomfortable role for rural providers who view themselves primarily as advocates for their patients.

**Specialist services and technology.** An important issue related to health care reform is its potential impact on the location and availability of specialist services and technology in rural communities. Some subspecialty services clearly will not be available in most rural communities, and health plans will need to contract for these services with providers from outside the area. However, it may be financially feasible and medically appropriate for other specialty services to be provided locally. If urban-based plans encourage referral of the full range of specialty care to urban specialists and hospitals under contract to the plans, they may be perceived by rural communities and providers as contributing to the decay of rural health care delivery systems. On the other hand, if rural-based plans attempt to limit referrals to urban-based specialists to assure that more care is provided locally, they may be criticized for inhibiting access to specialty care. How HIPCs and health plans resolve this issue will affect the magnitude of cost savings attributed to reform initiatives, the public’s perception of rural providers, the economic base for health care institutions in rural communities, medical outcomes for rural residents, and the acceptability of health care reform efforts to rural providers.

**Differences in urban and rural practice styles.** Differences are likely to exist in the practice styles of urban and rural providers who are members of the same network or health plan. How these differences are accommodated will encourage or discourage rural providers’ participation in and commitment to a network or health plan. Under one proposal a federal board would be responsible for setting standards to eliminate unnecessary care and to assure the use of the most cost-effective technology. Its work would be facilitated by national data systems that would track utilization, expenditure, and outcomes information. Thus, under this approach the responsibility for technology assessment and the development of practice parameters and guidelines would rest at the federal level. The reaction of rural providers to this approach will depend largely on whether rural providers’ input is incorporated into guidelines development and whether there is some flexibility in the application of the guidelines in rural medical practice. In general, the impact of managed care arrangements on quality improvement and patient outcomes is not yet well understood. However, the pooling of data and the use of large-scale management information systems by health plans should facilitate comparisons of patient outcomes
across rural providers to a degree that is not now possible; this has the potential to improve the quality of care.

**Provider recruitment and retention.** A final issue relating to rural medical practice is the impact of network development under health reform on the willingness of providers to move to rural areas and to remain there over time. The central health care issue for many rural communities is not cost, but rather an inadequate and unstable supply of physicians and other providers. For instance, it has been reported that almost 50 percent of rural primary care physicians in North Carolina left their rural practice setting within three years.\(^\text{19}\) Physician turnover, as well as inadequate numbers of physicians and other health providers, could hinder the implementation of new health care initiatives in rural communities and the development of integrated service networks. Isolated rural areas in particular will continue to be difficult to serve under any health care reform initiative, and it is not clear what incentives can be created by networks to attract physicians or other health professionals to practice in these areas. Many providers who practice in frontier areas are extremely independent and may wish to avoid practicing as part of an organized medical system. Health plans will be faced with the dilemma of balancing their desire to alter provider practice patterns with the impact those alterations might have on providers’ remaining in underserved rural areas.

**Summary of rural medical practice issues.** We have raised a variety of issues related to the potential impact of health reform initiatives on rural medical practice; the following are the most significant.

First, health care reform could affect whether specialty services and technology are provided in rural communities or whether rural residents must travel to urban areas for this care. Achieving the appropriate balance is complex and will depend on the nature of the service, the present availability of specialists already in the rural area, the willingness of urban specialists to conduct outreach clinics, the outcomes of care under different approaches, and relative costs, including costs imposed on patients.

Second, practice standards differ significantly between urban and rural areas and among rural areas. Attempts to implement practice standards on a broad scale are likely to meet resistance in rural areas, unless rural providers participate in their development and the standards are flexible enough to accommodate the unique characteristics of some rural practices.

Third, efforts to control fee increases, implement utilization management techniques, and institute practice standards could discourage providers from locating or remaining in some rural areas, if these efforts are not sensitive to rural needs. On the other hand, if health reform stimulates the formation of rural health networks that support rural practices, the ability of rural areas to recruit and retain providers would be enhanced.
Roles For State Governments

In the debate over health care reform, various roles have been proposed for federal and state governments.²⁰ Most analysts agree, however, that implementation of managed competition and global budgeting in many rural areas will be difficult and that states should be provided with as much flexibility as possible to develop solutions appropriate to local circumstances. We see four roles for state government in administering health reform initiatives.

**Purchasing health care.** States are experienced in the purchasing of health care for public employees and for low-income populations eligible for Medicaid and general assistance. While many health reform initiatives would eliminate Medicaid, they would give states authority to supervise and charter or license HIPCS.²¹ States would support HIPC efforts in contracting with health plans, developing risk adjustments across plans, enrolling eligible groups, and collecting premiums.²² An alternative to this purely administrative role would have states serve as HIPCs. As Paul Starr and Walter Zelman have pointed out, HIPCs are very similar to existing state health benefit programs. Several states have taken aggressive positions in trying to contain health care costs for their employees. In Minnesota state employees comprise the largest employer-based health insurance group in the state, serving almost 120,000 employees, dependents, and retirees.²³ Minnesota has employees in all of its eighty-seven counties, many of which include rural areas not served by managed care plans. In 1989 the state replaced its statewide fee-for-service plan with a PPO, resulting in changes in physicians or higher out-of-network costs for state employees in some rural areas. In response to the threat of losing patients, physicians in eleven rural counties joined an HMO plan that had not served their counties previously.²⁴ In this instance the state, functioning like a HIPC for the pool of state employees, served as a catalyst for rural managed care development. The California Public Employees Retirement System (CalPERS) also includes smaller county and local governments. It may be possible in some states to add small employers in rural areas to the existing public employee insurance plan.

The desirability of placing state or local governments in the dual role of both HIPC and risk-bearing entity for cost overruns under health reform has been questioned. Some analysts believe that this would simply result in a shift of health costs from one government budget to another. Enthoven suggests that no organization functioning as a HIPC should bear financial risk; instead, HIPCs should serve only as brokers among risk-bearing health plans.²⁵ In contrast, other analysts believe that state or local governments may be able to assume risk for the delivery of services provided by rural
networks and point to the current efforts of New York State in that regard.\textsuperscript{26} Policymakers need to examine the feasibility of expanding the state role in health care reform beyond an administrative function for rural areas.

**Building network capacity and infrastructure.** An important role for states might be to support the development and maintenance of rural provider networks as building blocks for managed care systems or accountable units for global budgeting. States could support network formation in several ways, including (1) the use of loans and/or grants to support the capital investment necessary for networking building; (2) the provision of reinsurance to networks in their early stages of development; (3) the protection of existing capacity building programs such as community health centers, rural health clinics, federally qualified health centers, and migrant health centers; (4) the provision of necessary technical assistance to support local network development; and (5) the creation of financial, education, and licensure incentives that support the training of health professionals likely to participate in rural health networks.

For example, New York State has established a framework for rural network development based on the publication of proposed network guidelines and requirements and proposed criteria and standards for network delivery models. Under one legislative proposal, network development in New York would be promoted through planning grants, start-up grants, and administrative grants.\textsuperscript{27} The state also has proposed to enact permanent fiscal incentives to support networks through adjustments to existing payment methods and categorical grant programs. The New York State initiatives highlight how a state that believes there is a pressing need to develop new delivery systems in rural areas can take an active role in rural network development.

**Balancing antitrust enforcement and network establishment.** While the formation of rural provider networks may facilitate the implementation of health reform initiatives in rural areas, it also raises antitrust questions. The major goal of antitrust law is to preserve and enhance competition by making it illegal to enter into contracts or arrangements that restrain trade or that create a monopoly. Antitrust laws attempt to assure that private arrangements do not reduce public access to services through price increases or output limitations.\textsuperscript{28}

How then should the formation of rural health networks be viewed vis-à-vis antitrust considerations? It has been suggested that federal and state enforcement of antitrust laws be adjusted as necessary to permit the undertaking of HIPC-approved joint endeavors, such as rural network development.\textsuperscript{29} Underlying this suggestion is the possibility that the literal application of existing antitrust laws to the delivery of medical care in rural areas may not yield net benefits for consumers. Rather than promoting
access to care and containing costs, it could pose a threat to the availability of health care services in some rural communities.30

The Supreme Court has recognized that states can insulate certain activities by private parties that otherwise would be viewed as illegal under antitrust law. The state action exemption applies to arrangements that are conducted pursuant to a clear state policy to supplant competition and actively supervised by the state.31 For the state action exemption to hold, a state must provide prior approval to an arrangement and supervision after it begins. State action immunity could be used to address antitrust issues regarding rural network development in isolated rural areas that are not likely to be attractive to health plans or networks. For these areas it may be desirable to award exclusive franchises or monopolies that will need to be closely monitored to ensure that they operate in the public’s interest. The monitoring or regulating function could be the responsibility of the HIPC, the state, or the federal government.

Allocating and enforcing budgets. If global budgeting is included as part of health reform, a key issue is how a federally set global budget will be allocated to the states and the role that states will play in managing its implementation. Kronick has suggested that if states are accountable for their level of health expenditures, they should have the freedom to experiment with different approaches for setting and meeting a budget.32 Others have suggested that the federal government may need to set state expenditure targets and create disincentives for exceeding those targets.33 In either case there are political and technical trade-offs in using different strategies for implementing a global budgeting approach.

Assuming that states are given some flexibility with respect to meeting expenditure limits allocated to them, several issues are particularly relevant for rural constituencies. The first is whether allocation procedures will treat urban and rural providers and consumers equitably. If initial expenditure targets and payment rates are based primarily on historical expenditure and/or payment data, the controversies surrounding the early implementation of the diagnosis-related group (DRG) system are likely to be repeated. Rural areas typically have had lower per capita health expenditures than urban areas. As David Helms, Anne Gauthier, and Daniel Campion suggest, expenditure limits need to account for “the difficult problem of not unduly penalizing states which have already achieved efficiencies in their delivery systems and states which have not made adequate investments to assure adequate health services for all residents.”34

A second issue involves clearly defining which items would be included in a state budget constrained by expenditure limits. Items of special interest to rural areas include public dollars that currently flow to categorical programs, income subsidies to attract providers to underserved areas, and
the costs associated with building rural network capacity and infrastructure.

A final issue relates to mechanisms for containing costs for providers not participating in health plans. This is particularly relevant for underserved rural areas where competitive markets will be difficult to establish. In these cases exclusive franchises or monopolies may be established and paid on a regulated fee-for-service basis. The response of providers to this type of payment mechanism and controls on technology and specialized services will need to be monitored by states.

Summary of state issues. Important issues raised in the previous discussion include the following: First, it may be relatively straightforward for some states to add all of the small employers in rural areas or entire rural portions of the state not served by health plans to their existing public employee insurance plan. States also may consider granting exclusive franchise agreements as an incentive for plans and providers to meet the needs of isolated rural populations. However, budget concerns will limit the ability of states to assume direct financial risk for service provision within predetermined budgets.

Second, many states have only a minimal infrastructure available to support managed care systems in rural areas. However, some rural areas have existing cost-based programs (such as community, rural, and migrant health centers) directed at meeting the health care needs of vulnerable rural populations. States may be able to assist in the incorporation of these programs into managed care systems.

Third, enforcement of antitrust laws in recent years has reduced joint-venture opportunities among providers. Currently, however, several states are planning to use state action immunity to provide relief from antitrust laws for appropriate joint ventures. States will need to closely examine the antitrust implications of their policies in rural areas, particularly as they relate to the awarding of exclusive franchises to health plans.

Fourth, any approach for allocating budgets that depends solely on historical expenditure or payment data is likely to raise concerns in rural areas. When allocating budgets to rural providers and areas, we need to consider whether budgets should include public dollars that flow to categorical programs, subsidies to attract providers to underserved areas, and costs associated with capacity building and infrastructure improvements.

Further Comments

One-quarter of the U.S. population lives in rural areas. One measure of success of the Clinton administration’s health reform package will be how it addresses the unique needs of these citizens. Health care reform is likely to stimulate the development of rural provider networks. These networks in
turn can play an important role in implementing reform initiatives in rural areas.

An earlier version of this paper was prepared under contract from the Federal Office of Rural Health Policy for the invitational meeting on Health Care Reform in Rural Areas in Little Rock, Arkansas, 10-12 March 1993, under the sponsorship of The Robert Wood Johnson Foundation and the Arkansas Department of Health. We gratefully acknowledge the comments and suggestions of reviewers of earlier drafts.

NOTES


18. Zelman and Garamendi, “Universal Access through Managed Competition and Budgetary Restraint.”

19. R. Homer, G. Samsa, and T. Ricketts, “Preliminary Evidence on Retention Rates of Primary Care Physicians in Rural and Urban Areas” (submitted for publication).


24. Ibid.

25. Enthoven, “The History and Principles of Managed Competition.”


29. Zelman and Garamendi, “Universal Access through Managed Competition and Budgetary Restraint.”


32. Kronick, “Where Should the Buck Stop.”

33. Zelman and Garamendi, “Universal Access through Managed Competition and Budgetary Restraint.”

34. Helms et al., *State Roles in Administering Health Care Reform*.