

Medicare Equity Emerges As Crucial Issue
for Rural Americans

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Introduction

I'm Steve Brenton, President of the Association of Iowa Hospitals and Health Systems. The organization is a trade association representing all of Iowa's 120 community hospitals and emerging regional and statewide health systems.

Message: New Opportunities/New Choices

The message I'd like to leave with you today is a simple onereform of Medicare health plan payment will provide new *opportunities* for Iowa hospitals and physicians and new *choices* for Iowa Medicare beneficiaries and the impact of those positive developments *will enhance the delivery of health care in much of rural America*. Achieving equity and fairness in Medicare payments should be viewed as the primary vehicle to bring Medicare choices to all regions of the nation, a goal my organization shares with other health reform advocates including the American Hospital Association and the Medicare Fairness Coalition.

Fairness and Equity: A Rural Health Issue

Fair and equitable payment is a rural health issue because most of rural America is plagued with a payment formula which is the product of low Medicare fee-for-service spending and conservative medical practice patterns. That payment formula is predicated on historic spending, not on historic or current costs of doing business and is now penalizing numerous, largely rural regions of the country in which reside millions of seniors who have *no Medicare choices*, beyond fee-for-service.

Since I'm assuming that Congress, in debating major Medicare initiatives in 1997 will place heavy emphasis on market oriented solutions and on structurally reforming the program to achieve long term, systemic savings and encouraging managed care choices for seniors the issue of adequate payment rates is huge, especially for health providers and seniors living in Iowa and other upper Midwestern states.

The opportunity for Medicare managed care to successfully emerge as an option in Iowa, Nebraska, the Dakotas, Wisconsin and much of rural America is negligible *today* and will be minimal *tomorrow* unless the current payment formula for Medicare health plans is significantly changed by Congress this year.

Provider Opportunities

Many of the folks I represent hospitals and emerging health systems want the opportunity to participate

in direct contracting with the Medicare population or partner in risk sharing opportunities with existing insurance companies like Iowa's Blue Cross plan. But that just won't happen unless the flawed payment system is fixed.

Discussions that I've had with these folks, as recently as last week, consistently point to the fact that current payment rates, which in Iowa average about \$350 per month in urban areas and less than \$300 per month in rural areas, are inadequate to develop "at risk" business, let alone finance new benefits, like pharmacy, which are necessary to encourage seniors to enroll in Medicare HMOs.

Assumptions

In looking at this issue, I'm making five assumptions:

Choices of health plans (running from the traditional fee-for-service program to a variety of HMO opportunities) is good for all Medicare seniors.

The opportunity to be owners of new health plans or partners with traditional insurance companies in Medicare risk products is a good thing for existing and emerging community-based provider organizations.

The absence of Medicare health plan activity in much of rural America directly relates to the low payment rates existing today in those counties. And, in fact, even in those areas of the country like Omaha, NE that have a couple of health plans open for business, those plans are only being marketed in adjacent counties with monthly rates in excess of \$400 and the benefit packages available in those markets do not begin to compare to the generous "add-ons" found in markets with \$500-700 monthly premiums.

Most of the payment differential between "high" payment areas of the country like Dade County, FL and "low" payment areas of the country like Winneshiek County, Iowa and Vernon County, Wisconsin relate more to medical practice and utilization issues than input price issues. Hence, we have beneficiaries in certain parts of the country who through an accident of history are rewarded or penalized by a system which is not aligned to rationally move folks into a reformed Medicare environment.

Medicare health plans *will emerge* in Iowa and much of rural America as early as 1998 if Congress acts in 1997.

Guidelines for a Solution

Here are the parameters of an equity solution:

Establish a payment floor of at least 85 percent of 1998 USPPCC effective January 1, 1998. This would provide a \$425 payment floor in every county in the nation.

Further payment variations should be reduced through a blending formula which would reach 50/50 (county/national) after three years.

Ultimately, risk contracting should be de-linked from fee-for-service spending and moved to competitive bidding after geographic equity has been achieved.

"Hold harmless" proposals should be opposed as an impediment to achieving equity in a timely manner.

Reform of Graduate Medical Education is a fairness issue and a defined funding mechanism must be identified to ensure the appropriate education and training of future medical professionals.

Conclusion

I'm appreciative of having the opportunity to speak to this important topic. Seldom does an issue emerge which presents such an outstanding opportunity to improve the delivery of health care to rural seniors and I encourage your diligence in fashioning a solution that is fair and equitable to all stakeholders.