

Consumers and the Changing Health Care Environment: Policy Issues for Consumer Education and Research

The health care system in the United States is changing. This session addressed issues deserving attention of consumer educators and researchers. Consumer researchers and those addressing policy issues for families and rural health providers explored these issues.

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National health care reform did not occur, but health care is evolving as managed care, state policies, and employer and health care provider resource efficiencies are being implemented. In this evolution, the role of the consumer is changing. The question is 'are consumers being prepared to understand and act upon the rights and responsibilities they have and experience in the health care market?' Such change presents new issues for consumer academicians and professionals to address.

Among the issues that require our attention are:

- 1) variety and saturation of managed care arrangements (Is it enough to educate consumers about health maintenance organizations (HMOs) and preferred provider organizations (PPOs)?),
- 2) changes in Medicare that will alter the consumer's situation (Capitated rates of reimbursement for Medicare are going into effect. Rural-urban differences in the reimbursement rates are being changed. What are the implications for consumers of health care?),
- 3) development of outcome data measures (report cards)-consumers use of information for health care choices (Norm-based measures of health care outcomes and consumer satisfaction with providers and delivered services are being developed. Are consumer researchers and educators involved?), and
- 4) increased use of telemedicine (Telemedicine is changing the availability of information for both patients and medical providers. What are the implications for consumers of health care?).

Therefore, the purpose of this session explored changes occurring in the health care market and suggested implications for consumer health policy research and education.

Lisa Swirsky

The Balanced Budget Act of 1997 (BBA) introduced Medicare+ Choice, exposing beneficiaries to new products and risks. Among the products seniors will encounter include HMOs, PPOs, Provider Service Organizations (PSOs), private fee-for-service insurance contracts, and medical savings accounts (MSAs) through the MSA Demonstration Project.

Currently, 16% of Medicare users are enrolled in HMOs. As recently as summer 1997, 12% were enrolled in HMOs. This varies by geographic area. The benefit of an HMO to the beneficiary is the freedom from supplemental insurance policies and reduction of prescription drug expenses.

PSOs feature capitated rates of reimbursement, must comply with Medicare quality standards, and are exempt state solvency laws.

Private insurance contracts range from fixed payments to fee-for-service arrangements. The BBA indicates that the package offered in these plans must be the same or better than Parts A and B of Medicare. Premiums are not capped as are deductibles and copayments.

MSAs offer high deductible, catastrophic health insurance to beneficiaries. The maximum allowable deductible is \$6000. Medicare contributions pay the premiums for such arrangements. The remaining amount paid to Medicare goes toward the MSA which will pay up to the amount of the deductible. The demonstration project

enrollment has been capped at 390,000 beneficiaries. One concern is whether consumers know that they might have to pay costs incurred which exceed the amount of the deductible.

The BBA of 1997 requires that meaningful grievance processes are put into place. In the case of emergencies, cases must be expedited. The BBA also prohibits gag rules on care of beneficiaries.

The BBA changes the nature of social insurance laying the groundwork for (1) defined contributions and (2) a tiered health care system. Questions of concern include the future of the Medicare program and security of beneficiary health in the new arrangements. Families USA will monitor and report its findings on its web site (<http://www.familiesusa.org/>).

Darin Johnson

The Balanced Budget Act of 1997 (BBA) introduced important changes in the capitated payment to providers serving Medicare beneficiaries. The BBA established a payment floor that differs by county in the United States. Over the next six years, the payment will become a blended payment, blending in a national average, accounting for 50% of the rate in 2004.

Only 1% of persons enrolled in HMOs in 1997 were rural residents. This low enrollment is due to the very low capitation payments available in HMOs, PPOs, and PSOs in rural areas. Likewise, the US government will contribute to MSA accounts on a monthly basis using the capitation formula. This will result in Medicare MSA participants in high payment areas receiving much larger deposits in their MSA accounts versus those living in low payment areas. The expectation is that consumers will gradually contribute more, thereby reducing the government's obligation.

In rural areas, provider service organizations (PSOs) are forming. Medicare allows PSOs to provide services through networks of providers. In Nebraska and Wyoming, the goal is to create statewide PSOs to serve rural beneficiaries. PSOs differ from HMOs in that providers own the organization. Two nationally-based health care organizations are exploring the possibility of creating a national PSO model or, separately, providing administrative services for PSOs.

On March 6, 1998, the negotiated rule-making committee created by the Balanced Budget Act of 1997 and charged with developing federal solvency standards for provider sponsored organizations (PSOs) came to consensus on a set of federal standards. After intense negotiations between provider and insurer groups, the committee was able to develop a set of standards that are intended to allow PSOs to form in states that have very high net worth and liquidity requirements.

The new standards only apply to PSOs who find their state standards to be prohibitive to entering the Medicare market or those whose application to the state is not acted upon within 90 days. Such a PSO can apply for a federal waiver and meet solvency standards. PSOs that receive a federal waiver are only eligible to enroll Medicare beneficiaries.

Highlights to the agreement include:

Minimum Net Worth. \$1.5 million (\$750,000 in cash or cash equivalents) would be required to start a PSO, dropping to \$1 million after it begins operations. The PSO must also have sufficient cash flow to meet its obligations as they become due.

Healthcare Delivery Assets. Allows 100 percent of book value of tangible health care delivery assets including hospitals, medical facilities, their ancillary equipment, and property required for the PSOs principal office. HCFA will allow 20 percent of all intangible assets such as the value of a physician network or a rural health clinic practice to be counted toward the minimum net worth under certain net worth stipulations.

Funding Projected Losses. The PSO must demonstrate meeting the projected losses for the entire period to break even. The guarantor must provide the PSO with cash or cash equivalents to fund the projected losses for a six month period through the first year. After the first year, the project losses can be covered by parental guarantees, letters of credit, lines of credit from regulated financial institutions, legally binding agreements for capital contributions or legally binding contracts of a similar level of reliability.

Rural PSOs. In the spring of 1998, HCFA will seek public comment on the need for downward adjustments in the net worth and liquidity requirements for rural PSOs. NRHA proposed the process noting that the new standards were actually raising the level of net worth and liquidity in many rural states.

Reimbursement for telehealth services is addressed for the first time in the BBA. But, Medicare will reimburse providers only for interactive uses where diagnosis is involved in full county health professional shortage areas. HCFA will not pay for "store and forward" information, such as sending X-rays to another site for evaluation or use. This latter format has been the main use of telemedicine in the first few years of its inception. Congress's intent may differ from HCFAs position.

The vision for the BBA reform provides a model for rural communities. Frequently, however, rural communities lack the knowledge or capital to set up rural health care models. An economic development approach is needed that assist a community in addressing its future needs and wants with regard to health care. Concerns exist for the migration of urban facilities to rural areas and whether these formats are a long term solution to providing service in rural areas. Systems will need to change to what rural residents want and receive in the future.

Carole Makela

Quality measures may focus on process, structure, and outcomes. Outcome measures address both unit costs and health quality or health results. It is the latter area in which consumers need to focus. Quality measures are intended for use by providers, purchasers, and consumers. Questions for these groups include:

What and whose quality is being measured?

What is the best practice relative to the bottom line of the health care?

Problems exist in developing standards for quality include:

- lack of agreement on criteria
- complexity of measuring, sampling, weighting
- costs of collecting data with regard to resource costs and privacy or confidentiality of data
- consumer input
- consumer awareness of quality (requires input from consumers)
- consumer needs with regard to information, understandability, and decisions making. (What decisions will consumers make? When do consumers need to make the decisions? What can they understand?)

For the development of good quality measures, consumers need to participate. The view cannot be that it is just another market survey process. Timing also becomes important if consumers who are ill may have no interest or energy to respond.

The Foundation for Accountability (FACCT) is working to encourage a health care system where consumers understand the importance of health care; make decisions based on clear, reliable quality information; provide direction to the health care system about what is important; and balance personal and societal goals in making of health care decisions. FACCT has developed a Consumer Information Framework to organize comparative information as it is developed.

The process FACCT is using to develop quality measurements for specific conditions includes:

- Foundation work
 - background paper
 - consumer focus groups input
 - consultation
- Development
 - measurement concepts identified
 - field trials
 - review by Measures Council
 - revisions
- Implementation and refinement
 - endorsement by FACCT Board
 - focus groups to:
 - (1) verify measures for consumers and
 - (2) recommend consumer information options.

Currently endorsed measures exist for adult asthma, breast cancer, diabetes, health risks, health status, and major depressive disorders. (The diabetes quality improvement project can be accessed and responded to on the web at <http://www.facct.org/DQUIP.html>). Measures that are under development address coronary artery disease (outpatient care), pediatrics, end of life, alcohol and drug dependency, and HIV/AIDS (care and culture competency issues).

Mary Gardiner Jones

Health care has shifted its focus from acute interventions in hospitals to management in the home or in neighborhood clinics, assisted living facilities, and nursing homes. Therefore, consumers' needs for information have changed and expanded substantially.

Patients are being discharged sicker and sooner or are relegated to procedures of outpatient clinics. As individual life expectancy increases, consumers are subject to increases in chronic health conditions which they are expected to manage at home. Therefore, the patients' care has evolved beyond the traditional nurse or physician. Patients increasingly are the ones who have to assume responsibility to make sure that the various members of their home care team know what each other have recommended. In addition, patients increasingly are being told they must take responsibility for their own wellness and health prevention and promotion.

Telemedicine or telehealth, the more appropriate term, makes it possible for patients and health care professionals to be in touch electronically with each other without having to see each other face to face. It has allowed physicians to connect to their patients, find resources, and receive training. This is especially important in understaffed areas. Telemedicine as team care makes communication between home and professional care providers more important.

Telemedicine provides:

- new ways to access and get information
- visual communication which assists visual learners
- links for reminders such as in patient scheduling

The policy issues relative to increased use of telemedicine include services gaps that exist for those not owning telephones (20% of the US population with incomes below \$10,000 do not have phone service); lack of advanced networks for less affluent, less densely populated areas; and special discounts (beyond rural hospitals since rural nursing homes and home health care agencies are left out of the BBA provisions) to providers as incentives for technology. The latter issue is particularly important as provisions have been made in the BBA for rural but not for inner city residents. As the use of telemedicine continues, access barriers will indicate where changes in policy need to occur.

Policy needs include:

- making sure technology is accessible,
- insuring "have nots" are NOT left out,
- guarding against moving self care from responsibility to accountability, and
- identifying consumer barriers especially for particular demographic groups.

To stimulate regulatory and private sector initiatives, two actions need to occur. (1) Grass roots advocacy efforts to ensure equitable access must be widespread. (2) A strong research base to support needs for equitable access including how consumers of various demographic characteristics seek and use health care information; how learning is facilitated through audio and visual communication in contrast to textual communications; to what extent does information result in behavioral change based on audio, visual or textual communication; and to what extent do various population groups have access to and familiarity with use of electronically generated health care information. In addition, community needs must be identified so that a comprehensive view of using the planned services will demonstrate market potential to the coming networks.

Session participants raised questions with regard to:

- quality and access of quality health care when restricted to providers in one network;
- emergency medical services; and
- the ability for a network to survive when healthy Medicare beneficiaries opt out of networks with regard to the governments long term ability to support the capitated rate.

Endnotes

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