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RURAL POLICY
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MINNESOTA STATE UNIVERSITY, MANKATO

THE RURAL HEALTH CARE MARKETPLACE:

A Survey of Businesses and Health Care Providers in Southwestern and Northwestern Minnesota

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Seeking Solutions for Greater Minnesota's Future

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Executive summary

This study reports results from surveys of 160 businesses and 21 health care providers in rural Western Minnesota during the summer of 2000. Survey topics include health insurance, local access, provider payment and service trends, and collaboration between and among local businesses and local providers. The results of the business survey show that some actions by businesses have been helpful in containing costs and improving health insurance coverage: forming an insurance plan; forming a health care purchasing alliance; contracting directly with local providers; and adopting a defined contribution benefit plan. However, despite these actions, many full-time employees of smaller rural businesses and many part-time employees of all rural businesses are not offered health insurance. Also, rural businesses and their employees are facing high premium inflation, increasing co-payments, decreasing services covered, and less access to local providers.

Changes in health insurance coverage are also reported to be decreasing the ability of smaller rural businesses to recruit and retain employees. This is serious because, when asked to rate on a scale of 1 to 10 how important it is for their business that their employees have access to local health care providers, 55 percent of rural business rated this a 10.

The results of the provider survey show harsh reimbursement trends, with nearly half the providers reporting a decrease in average reimbursement since last year. The gap between premium inflation rates faced by rural businesses and reimbursement inflation rates for payment to rural providers does not necessarily mean that private health plans are reaping the difference. There may be explanations based on cost shifting or increased utilization per plan enrollee. However, this gap merits investigation and suggests that collaboration and/or contracting between businesses and providers in rural areas can be beneficial.

Specific policy initiatives that should be considered in addressing these problems include:

1) Support employer collaboration for health care benefits.
2) Support provider collaboration for local coverage options.
3) Support out-migration that will in turn support rural health.
4) Pursue equity in provider reimbursement.
5) Pursue health tax equity for rural, working Minnesotans.
6) Regulatory flexibility in rural areas.
7) Public-private bridge program for low-paid workers.

Introduction

This study reports results from surveys of businesses and health care provider organizations in rural Southwest and Northwest Minnesota concerning health insurance, access to local health care providers, provider payment and service trends, and collaboration among and between local businesses and local providers. The survey was administered during the summer of 2000 and is a collaborative effort by the University of Minnesota Carlson School of Management; Advocates for Marketplace Options for Mainstreet (AMOM); Minnesota Medical Group Managers Association; the Southwest Regional Development Commission; and the University of Minnesota Crookston Northeast Minnesota Civic Health Initiative.

Research Questions

Primary research questions for the study included:

- What are the characteristics and extent of health insurance coverage options that rural businesses offer to their employees? How are these changing? Does this coverage provide local residents with access to local providers?

- What actions have rural businesses taken during the past three years to improve the health insurance options they offer to their employees? Which involved collaboration with local providers or other businesses? What have been the results of these actions?

- What are the trends with respect to rural provider reimbursement, expense inflation and patient service volume?

- What actions have rural providers taken during the past three years to improve health care in their communities? Which involved collaboration with local businesses or other providers? What have been the results of these actions?

- Based on these survey results, what policy initiatives would likely improve insurance coverage and access to health care in rural Minnesota?

Data and methods

The business survey had three sections: employee health insurance trends and access to local providers, health insurance-related actions by local businesses, and the effects of those actions on access and cost. Surveys were distributed to approximately 600 rural businesses during the summer of 2000. Approximately 160 responses were received, for a response rate of 27 percent. Bivariate and multivariate methods were used to analyze the results.

The rural provider survey also had three sections: provider collaboration, participation in insurance plans, service volume trends, reimbursement and expense inflation, and access of local residents to local providers; actions by local providers to improve the health of their communities; and the effects of those actions. Surveys were distributed to approximately 40 rural provider organizations (hospitals and clinics), and 21 complete responses were received for a 53-percent response rate. This number does not allow tests of statistical significance, but does allow tabular analysis and qualitative comparisons of provider responses to complement the results of the business survey.

Results from the Rural Business Survey

The detailed results of the rural business survey are displayed in two-way Tables A1-A58 in Appendix A. The first numeric column in each table shows the distribution of responses from smaller rural businesses with 10 or fewer employees ("e<=10"). The second column shows responses from larger businesses ("e>10"). The last column shows the results for both sizes of businesses combined.

Tables A4 and A6 show that smaller businesses are much less likely to provide health insurance for their employees than larger businesses. Table A4 indicates that nine out of ten larger businesses provide health insurance for their full-time employees, but only around one-half of the smaller businesses do so. Table A6 shows that the least insured people are part-time employees of smaller businesses, for whom fewer than one out of twenty are offered employment-based health insurance.

Table A8 indicates that fewer than one out of twenty smaller rural businesses and one out of five larger rural businesses are self-insured for health care benefits. Table A10 shows that only around one out of ten businesses offer more than one health plan. Offering more than one health plan is particularly rare among smaller businesses.

Tables A12 and A14 show that around 60 percent of smaller rural businesses offering health insurance and around 43 percent of larger rural businesses offering health insurance pay 100 percent of the premium for full-time employee health insurance coverage. Although smaller businesses are less likely to offer health insurance, when they do so, they are more generous in terms of premium contribution.

Table A16 shows high rates of health insurance premium inflation from 1999 to 2000 reported during the summer of 2000. Over half of the businesses reported premium inflation of more than 15 percent. Interestingly, larger businesses reported higher rates of premium inflation than smaller businesses. Over half of the larger businesses reported health care premium increases over 20 percent. Some noted increases over 30 percent in comments on the survey.

Higher rates of premium inflation for larger businesses may be partly because smaller businesses were already paying higher rates the previous year and would have been more likely to drop coverage if faced with larger increases. Subsequent results also suggest that smaller businesses have accepted greater reductions in covered services to contain health premium inflation.

Tables A17 and A18 indicate trends of increased employee co-payments and decreased services covered by health insurance. Combining these results with high rates of premium inflation suggests that rural businesses and their employees may be paying more and receiving less. Almost one-third of the businesses reported higher deductibles and co-payments for health insurance since last year. Almost one-fifth of the businesses reported fewer services covered by health insurance since last year. Larger businesses were more likely to report increased co-payments and smaller businesses were more likely to report reduced services.

Table A19 documents a downward trend in health insurance coverage of local health providers. This could be eroding access to these local providers. Table A20 shows that decreasing insurance coverage is negatively affecting businesses' ability to recruit and retain employees, especially for smaller businesses.

Tables A1 through A20 combined present an overall pattern of differences between smaller and larger businesses. Smaller businesses are less likely to provide health insurance for their employees and are experiencing reductions in services covered, but when small businesses do provide health insurance, they tend to make a more generous premium contribution.

Table A21 shows estimates of the number of people whose health insurance does not cover care by local providers because these providers are not in insurance networks. Almost one-half of rural businesses estimate that more than one-fourth of people in their communities are not covered for care by local providers. Table A22 suggests that the number of people not covered for care by local providers is increasing. This is significant because, when rural businesses rated how important it is for their employees to have access to local health care providers, 55 percent rated this 10 on a scale of 1 to 10.

Tables A1-A21 has shown that rural businesses and community residents face increasing health care costs and decreasing local provider access. Tables A25-A41 show what actions have been taken by local businesses to address these problems. For each type of action, businesses were asked whether local businesses have "not done" this action, have "done a little" or have "done a lot." Tables A42-A58 report the effects of these actions collectively on various aspects of access, cost, and quality. For each effect, businesses were asked whether the prior actions have had "no effect," have "done a little" or have "done a lot."

Based on Tables A25-A41, the most common actions by rural businesses are: requesting bids for health care coverage (conducted by approximately two out of three businesses); and discussing problems with local providers (conducted by approximately one out of two businesses). Other actions that are relatively common (i.e., conducted by at least 40 percent of businesses) include: working to increase insurance options; adopting a fixed-contribution health plan; and lobbying for rural health care issues. Smaller businesses generally report less action than larger businesses, particularly concerning: working to increase insurance options and plan competition; becoming self-insured; and requesting bids for health care coverage.

Tables A42-A58 report the combined effects of these local business actions on various aspects of cost and access. These actions have been uniformly successful in influencing some of the effects, but there were some results with respect to improved access to local providers and improved quality of health for the community. We explore this further in the multivariate analysis that follows. Interestingly, one of the often-cited goals of business-provider collaboration – reducing the "middle man" cost of insurance – is least affected by business actions.

Table A59, repeated here, presents three multivariate regression models of the influence of business actions on three key effects: 1) lower health insurance premiums (see Table A54); 2) improved access to local providers (see Table A42); and 3) total health access and cost effects (sum of results from Tables A42-A58). The number of employees and the years of operation for each business are controlled for through their inclusion in each model. Due to the relatively low number of observations, only the most influential of the seventeen actions were included in each model.

Table A59: *Three models: Effects of business actions on premium inflation, access to local providers, and overall cost and access.*

Dependent Variable	Constrain Premium Inflation	Access Local Providers	Overall Cost & Access
R-Squared =	.50	.48	.30
F-Test Significance =	.000009	.000009	.002388
Variables and Coefficients:			
Constant	.576730***	.549930***	12.13***
Log of number employees	-.005413	.052662	-.001635
Years in operation	.000967	-.000555	-.025165
Form purchasing alliance	.302430*		2.93*
Help recruit local providers		.221790~	
Contract with local providers			3.57*
Form health plan or HMO	.282970**	.409530***	
Purchase reinsurance/stop-loss	-.323680~		
Adopt fixed contribution plan	.184340*	.189270~	3.44*
Drop health care coverage		-.272470**	-3.9*

Coefficient Significance:
~=p<.1
**=p<.05*
***=p<.01*
****=p<.001*

The first column of numbers shows the model of which factors contribute to "lower health insurance premiums" (lower, at least, than what they would have been without the actions). This model is significant at the p<.001 level and explains approximately 45 percent of the variation in responses to "lower health insurance premiums." The action most successful for constraining insurance premiums is "formed an insurance plan or HMO," with a significance level of p<.01. The actions "formed health care purchasing alliance" and "adopted fixed-contribution plan" also have positive effects (p<.05) on constraining insurance premiums. "Purchasing reinsurance or stop-loss coverage" has a weak (p<.10) negative association with constraining insurance premium cost.

The second column of numbers shows a model of which factors contribute to "improved access to local providers." This model is significant at the p<.001 level and explains approximately 48 percent of the variability in responses to "improved access to local providers." Once again, the action with the greatest impact is "formed an insurance plan or HMO" with a significance level of p<.001. "Worked to recruit new local providers" and "adopted employer fixed-contribution plan" also have positive, but

weak ($p<.10$), effects on access to local providers. "Dropped health care coverage for employees" has a strong ($p<.01$) negative effect.

The last column shows a model of which factors contribute to combined health access and costs effects. The model is significant at the $p<.001$ level and explains approximately 30 percent of the variation in total health access and costs. The following actions were positively and significantly ($p<.05$) associated with improvements in total health access and costs: "formed health care purchasing alliance," "contracted directly with local providers," and "adopted fixed-contribution plan." "Dropped health care coverage for employees" was negatively associated with improvements in total health access and cost.

Results from the Rural Provider Survey

The detailed results of the rural provider survey are displayed in Tables B1-B57 in Appendix B. We partitioned survey results between those providers who reported increased patient numbers over the previous year versus those providers who reported decreased or constant patient numbers over the same period of time. The first column ("PtsUp") shows responses from providers with increased patient numbers since last year. The second column ("NotUp") shows the distribution of responses from providers with decreased or constant patient numbers. Providers turned out to be split approximately evenly between those with and without patient volume increases. The last column shows the results for all providers combined.

The results of Tables B2 through B5 suggest that providers with decreasing or constant patient volume tend to contract with more health plans, belong to more provider networks, and expand their plan and network relationships. Although it is possible that participating with more plans and networks reduces patient numbers, it is more likely that providers who experienced reduced patient numbers responded by participating in more plans and networks.

In Table B6, rural provider estimates of the percentage of people in their communities who are not covered by insurance networks for care by local providers are lower than the estimates by rural businesses. No providers thought that over one-fourth of community residents were not covered – as compared to over 40 percent of businesses that thought that this is the case. It is hard to tell who is correct based on this information alone. Businesses might be more accurate because they have a wider population perspective than providers, who may focus primarily on the patients they see. Alternatively, providers may be more accurate because they are more familiar with the structure of health care networks.

The growth shown in Tables B8-B10 and B13 is noteworthy. Approximately two-thirds of providers reported increases in the number of physicians practicing at their

organization. Even among organizations with a decline in patient numbers, over half reported growth in the number of physicians. Interestingly, a different pattern is seen concerning growth in Nurse Practitioners (NPs) and Physician Assistants (PAs). Only those providers with an increase in patient numbers also reported an increase in NPs and PAs.

Table B14 is sobering. Almost one-half (45%) of the rural providers report a decrease in average reimbursement rates since last year. This is a real cut in prices that certainly does not cover inflation for provider wages and supplies. Over one-third of providers reported a drop in average reimbursement of more than 5 percent. Some of these negative trends may be due to Medicare payment cuts.

There is a large gap between the low inflation rates for rural provider reimbursement (all under 10 percent, and many negative) and the higher inflation rates for health insurance premiums reported by rural businesses (more than one-third over 20 percent, and none negative). Alternative explanations for this gap include:

1. Insurers may be paying providers less and charging businesses more to replenish depleted reserves lost during a different phase in the insurance premium cycle.

2. Insurers may be paying rural providers less and charging rural businesses more because small, rural organizations have less market clout than their larger urban counterparts.

3. Providers may be charging private insurers more than average to compensate for decreased reimbursement from government payers such as Medicare, an activity called "cost shifting."

4. Total provider reimbursement may be increasing by more than the average provider reimbursement if services per patient per month are increasing.

If explanation #2 is true, then there is considerable benefit for rural communities in collaborating and/or direct contracting between rural businesses and rural providers. If explanation #3 is true, then it means that adequate reimbursement equity between rural and urban providers is vital.

Table B15 shows a pattern of expense inflation that is roughly in line with reimbursement growth or the lack thereof. Average overall expense growth for rural health care providers is close to zero. However, over two-thirds of providers report 1- to 5-percent growth in the expenses associated with managed care contracting.

Tables B18 through B40 explore what actions local providers have taken in the past three years. One activity reported by 100 percent of rural providers is recruiting new

providers to the area. Other common provider actions are: joining a network; forming a provider network or alliance; contracting with a managed care payer; working with local businesses; working on health education; expanding NP or PA services; and lobbying for rural health issues.

Confirming the difference between providers with increasing vs. decreasing numbers of patients seen in Tables B8 through B13, providers with decreasing numbers of patients report more "joining" behavior. Again, it is possible that joining groups reduces patient numbers, but it is more likely that providers facing declining patient numbers are more motivated to join groups, form alliances, or merge with other providers to survive.

Tables B41 through B57 show the effects of provider actions. The strongest reported effects were improved access to local providers; improved quality of health for the community; new local providers; and increased flexibility in physician choice. Although the numbers are small, providers with decreasing or constant patient numbers seem to have been more likely to report that provider actions have "done a lot" with respect to increased health insurance choices and more local control of health care.

Discussion of policy implications

High premium inflation, limited insurance options, large numbers of uninsured workers, reimbursement cuts for local providers, and limited access to local providers in rural Minnesota can be missed when one looks at statistical averages for the entire state. The results of this focused survey, however, show areas of rural Minnesota with just such problems that have not been adequately addressed by current statewide policy initiatives. In fact, survey results show that some of these problems are growing worse, confirming the "rural pockets of uninsured" found by the study "Urban-Rural Differences in Minnesota's Health Care Uninsurance Rates" released by the University of Minnesota earlier this year.

Many full-time employees of smaller rural businesses and part-time employees of any size rural business do not have health insurance provided by their employer. At rural businesses with under 10 employees, only around half of full-time employees and 5 percent of part-time employees are offered health insurance. Of those employees who are offered health insurance through their employer, 90 percent do not have a choice among health plans.

TABLE A4: *Does your business provide health insurance for full-time employees?*

	e<=10	e>10	All
Yes	52%	90%	68%
No	48%	10%	32%
Total	100%	100%	100%
N=	92	63	155

TABLE A6: *Does your business provide health insurance for part-time employees?*

	e<=10	e>10	All
Yes	4%	28%	17%
No	96%	72%	83%
Total	100%	100%	100%
N=	49	58	107

Although smaller businesses are less likely to offer health insurance, those that do generally pay a greater portion of the premium than larger businesses. This is offset by trends among smaller businesses toward increasing employee co-payments, decreasing service coverage, and decreasing coverage of services by local health care providers. Changes in health insurance coverage are also reported to be decreasing the ability of smaller rural businesses to recruit and retain employees. This is serious because, when asked to rate how important it is on a scale of 1 to 10 for their business that their

employees have access to local health care providers, 55 percent of rural businesses rated this a 10.

TABLE A14: *How much does your business contribute for premiums for full-time employee and family coverage?*

	e<=10	e>10	All
100% of premium	45%	28%	36%
Amount equal to low-cost premium	8%	2%	5%
Amount less than low-cost premium	13%	13%	13%
Percent of premium for plan chosen	34%	57%	46%
Total	100%	100%	100%
N=	38	46	84

Most rural businesses are also facing very large increases in health care premiums. Over half of rural businesses reported premium inflation in excess of 15 percent. In contrast, almost half of rural providers reported a cut in their average reimbursement rates, and none reported an increase over 10 percent. The gap between what rural businesses are paying and what rural providers are receiving does not necessarily mean that large health plans are reaping the difference as "middle men." There may be explanations based on cost shifting or increased utilization per plan enrollee. However, this gap merits further investigation. It also suggests that collaboration and direct contracting between local businesses and local providers in rural areas can benefit both parties.

TABLE A16: *How much has the total premium for (low cost) plan increased since last year?*

	e<=10	e>10	All
Decreased 5% or more	0%	0%	0%
Decreased 1-4%	0%	0%	0%
No change	13%	5%	9%
Up 1-4%	9%	5%	7%
Up 5-10%	17%	12%	14%
Up 11-15%	19%	14%	16%
Up 16-20%	17%	11%	13%
Up more than 20%	26%	53%	40%
Total	100%	100%	100%
N=	47	57	104

To some extent, these problems in rural Minnesota may be addressed by local initiatives without outside support. Some rural businesses and providers are already working on initiatives to improve health care access for their employees and communities. Despite these efforts, however, there have been negative trends in health insurance coverage for employees of businesses in rural Minnesota. Many rural

businesses and providers are between a rock and a hard place, facing greater problems than their urban counterparts with fewer resources.

Problems in rural areas are often greater than those in urban areas due to the smaller size and geographic isolation of rural businesses and providers. In urban areas, competition among multiple insurers and providers creates market forces that can contain costs, ensure access, and improve quality. In rural areas with only one or two insurance products or providers, however, market forces do not work as well. Without the critical mass to form local health plans or networks, rural businesses and providers can find themselves facing a monopoly/monopsony with little negotiating leverage.

To make matters worse, rural businesses and providers often have fewer resources to address their problems. There are economies of scale in health insurance options. Larger firms can self-insure. Larger providers can form their own care system or health plan. There are also economies of scale for managerial expertise. Larger businesses and providers can more easily devote time and resources to learning about new solutions and hire consultants to guide them. These factors provide additional rationale for policy initiatives to help rural businesses and providers to achieve economies of scale, create new health coverage options, and share information on new approaches.

There are also social equity reasons for state initiatives. Currently, some of the most vulnerable and lowest-paid Minnesotans have the fewest health coverage options, but end up paying the most for coverage. As much as a third of Northwestern and Southwestern Minnesota's businesses do not offer health care coverage. For employers with 10 or fewer employees, that number jumps to half. These workers and their children, along with many farm families, are often uninsured and underinsured. For these families to receive coverage, they often must purchase individual insurance policies. However, individual policies can be the most expensive, because they are not fully tax-deductible, cover fewer services and usually require higher out-of-pocket contributions.

Finally, programs to improve rural health insurance and access can be justified by synergism between rural health care and rural economies overall. Geographic and financial access to health care is central to the economic well being of most rural communities. When businesses do not locate in rural areas because of a lack of affordable health care options, job creation is stifled and the local economy suffers. The situation is aggravated when workers move to urban areas to obtain health insurance for their families. If Minnesota is to be truly committed to strong local economies throughout the state, encouraging "out-migration," and reducing congestion in urban areas, then support of rural health care is a worthwhile investment that will yield multiple returns.

Facing skyrocketing premiums on their own without external support, rural businesses may have to significantly decrease insurance coverage offered to their employees. Also, isolated rural providers without support may have trouble continuing operations. In

addition to the human suffering that these negative results would cause, the costs of uncompensated care would show up as losses at locally owned community facilities and add expenses to other government-funded programs.

For all the above reasons, local rural efforts may have to be supplemented by external support, including state policy initiatives. State initiatives that help to expand health care options in rural areas would be particularly useful. State policy initiatives to help create more health care options in rural areas are consistent with a market approach to health care. For markets to work, there must be choices for buyers and sellers. Using public programs and funds to encourage collaboration and communication among rural businesses and providers will leverage existing private sector initiatives and jump-start new ones. The result will be more choices for buyers and sellers – more businesses finding a way to offer comprehensive health insurance and more providers finding a way to keep operating in rural settings.

Specific policy initiatives for consideration

1. Support employer collaboration for health care benefits

Many of the difficulties that rural employers face with respect to health care insurance and access come from their small size and geographic isolation. Collaborative efforts – such as the purchasing alliances organized and supported by the University of Minnesota Crookston in Northwest Minnesota and the Southwest Regional Development Commission in Southwest Minnesota – can help businesses achieve the critical mass of people, dollars, and expertise needed to overcome these difficulties. In this survey, businesses in Western Minnesota reported that purchasing alliances are promising. From separate communication, we know that purchasing alliances can help by joining businesses together to negotiate health care benefits and pricing, creating a focus on local health care services, and raising commitment to meet local health care needs.

The challenges faced by collaborative arrangements are formidable, especially the high number of working uninsured identified by the survey. The Minnesota Legislature and other policymakers should consider initiatives to support rural employer collaboration efforts. These initiatives may include: sponsoring group purchasing alliances; supporting direct contracting between rural businesses and local providers; pilot programs connecting rural businesses, residents, and providers through the internet; reducing adverse selection in group purchasing; and sponsoring conferences or publications to communicate successful methods to rural businesses across the state.

One program to reduce the effects of adverse selection is under way in New York State. The state partially guarantees stop-loss, reinsurance coverage for farm families and other uninsured working residents. This allows purchasing alliances to include farm families, other businesses of one, and many of the working uninsured – with less fear of the effects of adverse selection. Although it requires some public funds, funding is far less than is required for full subsidization of insurance coverage. Public funding provides an actuarial safety net for participating insurance companies. If this program reduces costs that would otherwise be paid by the state or a local government unit through other programs, then it can save taxpayers money on balance.

2. Support provider collaboration for local coverage options

In rural areas, health care providers are often faced with low reimbursement rates, exclusion from the networks covering some community's residents, and insufficient size to form their own care system. In this case, allowing some collaboration among providers can actually promote market competition by increasing health coverage options for rural businesses and residents. When there is a monopoly/oligopoly by a large statewide organization and a barrier to entry based on size, then allowing

collaboration by local providers to achieve entry is pro-competitive. It can provide additional choices for both rural businesses and providers.

The state of Minnesota can support constructive collaboration among rural providers through passive measures (such as reducing prohibitions and increasing regulatory flexibility) and active measures (such as promoting innovative organizational forms and communication of successful results across the state). To help ensure that collaboration serves the interests of the rural communities, information on types and effects of provider collaboration should be tracked and disseminated.

3. Support out-migration that will in turn support rural health

The Ventura administration has proposed out-migration of people and resources to rural areas to help rural economic growth and relieve urban congestion. Due to the inter-relationship between rural economies and rural health care, out-migration will also help to address health access problems.

Successful out-migration requires planning and commitment. State appropriations should be linked to the out-migration plan. Funding requests, such as those for state employee positions and program development, should include a statement of how out-migration will be improved. Policymakers may also designate and promote specific rural areas as industry or knowledge clusters. For example, a large company may locate a new plant in Crookston because of the University of Minnesota Crookston's knowledge cluster. As another example, a state worker whose spouse is an entrepreneur may move to Slayton because a state position is based there. As out-migration occurs, rural community economies will be strengthened and rural health care markets will grow stronger.

4. Pursue equity in provider reimbursement

Major government health payment systems involve higher discounts for payment to rural providers than to urban providers. When rural providers are paid less to provide the same service, they must struggle to sustain operations with lower revenues and "cost shift" (shifting their unmet expenses) to non-government payers. This is especially troublesome for rural hospitals, which rely heavily on government payers – many with more than 60 percent Medicare and 15 percent Medicaid patients. This amplifies the effect of cost shifting on the 25 percent who are private pay patients.

Cost shifting increases prices for rural residents who are insured through small employers. It also increases prices for those who pay cash, usually the uninsured and the underinsured. The negative effects of inequitable reimbursement don't stop there. Milliman and Robertson Actuarial Firm have made some national projections which,

when applied specifically to Minnesota, indicate that each 1-percent increase in premiums causes 3,000 Minnesotans to lose their health care coverage. Thus, geographic inequalities in provider payment can lead to higher numbers of uninsured people in rural areas. Rural areas are particularly vulnerable because each uninsured person has a significant effect on a fragile local economy.

Tracing the effects of cost shifting, we find that one of the root causes of uninsured and underinsured people in rural areas is inequitable provider reimbursement. Correction of these inequities is an important way to help rural business and providers provide affordable health coverage for their employees and communities.

5. Pursue health tax equity for rural, working Minnesotans

There are three health care taxes in Minnesota for which farm families and those who work for small employers pay a disproportionately high amount. Because most businesses in rural Minnesota are small, rural employees are probably paying a disproportionate share of these taxes. The State Chamber of Commerce has estimated these taxes to be more than 6 percent of the health care premium. Again, every 1 percent increase in premium probably decreases the number of Minnesotans insured by about 3,000.

The first tax, the Minnesota Comprehensive Health Association (MCHA) assessment, is levied only on the fully insured market, consisting largely of small employers and individuals, to pay for services for the uninsurable. While the program is necessary, it is inequitable to ask the generators of our economy (entrepreneurs), the lowest paid workers (who usually work for smaller employers), and farm families to shoulder this financial burden on their own for the entire state.

The second tax, the Minnesota Premium Tax, is also only levied on the fully insured market, which is made up primarily of small employers and individuals. Since small group and individual policies are 10- to 25-percent more expensive than self-insured (large company) health coverage, and since the premium tax is paid on a percent of premium, workers who work for small companies both pay more and are taxed more for their health care coverage.

Third, the provider tax is paid by all those who seek health care services – which is why some people call it the "sick tax." While originally resisted, the MinnesotaCare program is now broadly recognized as successfully filling a need, especially to assure coverage of children. However, since most small business policies do not cover as many services, and those that are covered are done so at less of a provider discount than those covered by the government or a large company, Minnesota's farm families, entrepreneurs, lowest paid workers, and uninsured residents who pay cash for health care services are paying disproportionately more of the provider tax than those working for large companies or covered by government-subsidized programs.

If state policymakers are serious about reducing the number of uninsured and of fostering business growth in rural areas, then this inequitable tax structure must be redesigned so it does not fall disproportionately on working, rural Minnesotans. Funding for these programs should come either from taxes that are borne equitably by urban and rural residents or from other dedicated funds.

6. Regulatory flexibility in rural areas

Regulations concerning the organization and payment of health care can have a different effect in a town of 1,000 people than in a metropolitan area of 4 million. Sometimes the design and implementation of regulations involves a trade-off between one social good (such as geographic access to care) versus another (such as minimum patient volume or capacity to decrease costs or increase quality). When making these trade-offs, it is important for regulators to consider the effects on small rural areas and whether benefits of regulatory flexibility outweigh the costs.

For example, some regulations concerning where certain services are eligible for Medicare and Medicaid reimbursement are generally intended to reduce costs and maintain quality. However, some regulations may have a contrary effect in rural areas, and regulatory flexibility might better serve both the payer and patient. For example, if a nursing home resident cuts her hand and needs stitches, EMS transport may be required to take the resident to a hospital in a neighboring town if the stitches are to be reimbursed by Medicare. Could the wound be sutured at a lower overall cost and with equal quality at a local clinic?

Smaller rural communities may be best served by flexible regulations that consider the following: What health care services are needed in a town of 400, 4,000 or 40,000? How can policymakers assist communities in defining their needs and adjust regulations to meet those needs? Some progress has been made in this area with the designation of Critical Access Hospitals, but much more can still be done.

7. Public-private bridge program for low-paid workers

Many of the above initiatives involve leveraging public money by helping private markets work to further public policy objectives. There may also be situations where blended public- and private-sector efforts and funding can achieve coverage goals more effectively than either sector alone. For example, there may be cases where one or both sectors may only have sufficient funds to provide "half" of the health insurance coverage needed to cover an individual or family. It may be that one sector will choose to foot the entire bill, effectively subsidizing the other sector. Alternatively, neither sector may act – letting the individual or family fall through the cracks between the public and private sectors.

For these reasons, there may be merit to a bridge program between private, employer-subsidized coverage and government programs such as MinnesotaCare. Employer contributions and government funds could be partially pooled to achieve better coverage and greater cost and coverage efficiencies than either sector could do separately. This effort would require close work between Administration officials and small employers in rural areas, where the greatest proportion of low paid workers are.

APPENDIX A: RURAL BUSINESS SURVEY RESULTS

Tables A1 - A59

TABLE A1: *In which area are you located?*

	e<=10	e>10	All	
Northwest Minnesota		38%	61%	47%
Southwest Minnesota	62%	39%	53%	
Total	100%	100%	100%	
N=		95	62	157

TABLE A2: *How many employees does your business have in this area?*

	e<=10	e>10	All	
1	16%	0%	9%	
2-5		42%	0%	25%
6-10	42%	0%	25%	
11-25	0%	51%	20%	
26-50		0%	24%	9%
51-100		0%	13%	5%
101-500		0%	10%	4%
Over 500	0%	3%	1%	
Total	100%	100%	100%	
N=		95	63	158

TABLE A3: *How many years has your business been in operation?*

	e<=10	e>10	All	
1	0%	0%	0%	
2-3	5%	2%	4%	
4-5	5%	0%	3%	
6-10	15%	5%	11%	
11-24	37%	23%	31%	
26-49	20%	34%	26%	
50-74	8%	13%	10%	
Over 75	0%	23%	15%	
Total		100%	100%	100%
N=	93	61	154	

TABLE A4: *Does your business provide health insurance for full-time employees?*

	e<=10	e>10	All
Yes	52%	90%	68%
No	48%	10%	32%
Total	100%	100%	100%
N=	92	63	155

TABLE A5: *Change since last year?*

	e<=10	e>10	All
No change	98%	98%	98%
Started	2%	2%	2%
Stopped	0%	0%	0%
Total	100%	100%	100%
N=	46	55	101

TABLE A6: *Does your business provide health insurance for part-time employees?*

	e<=10	e>10	All
Yes	4%	28%	17%
No	96%	72%	83%
Total	100%	100%	100%
N=	49	58	107

TABLE A7: *Change since last year?*

	e<=10	e>10	All
No change	100%	98%	99%
Started	0%	2%	1%
Stopped	0%	0%	0%
Total	100%	100%	100%
N=	37	52	89

TABLE A8: *Is your business self-insured?*

	e<=10	e>10	All
Yes	4%	18%	12%
No	96%	82%	88%
Total	100%	100%	100%
N=	48	56	104

TABLE A9: *Change since last year?*

	e<=10	e>10	All
No change	100%	96%	98%
Started	0%	2%	1%
Stopped	0%	2%	1%
Total	100%	100%	100%
N=	37	51	88

TABLE A10: *How many health plans do you offer full-time employees?*

	e<=10	e>10	All
1	93%	84%	88%
2	2%	7%	5%
3 or more	4%	9%	7%
Total	100%	100%	100%
N=	46	57	103

TABLE A11: *Change since last year?*

	e<=10	e>10	All
No change	100%	94%	97%
Decreased	0%	0%	0%
Increased	0%	6%	3%
Total	100%	100%	100%
N=	36	53	89

TABLE A12: *How much does your business contribute for premiums for full-time employee individual coverage?*

	e<=10	e>10	All
100% of premium	60%	43%	50%
Amount equal to low-cost premium	11%	9%	10%
Amount less than low-cost premium	4%	4%	4%
Percent of premium for plan chosen	24%	45%	36%
Total	100%	100%	100%
N=	45	56	101

TABLE A13: *Change since last year?*

	e<=10	e>10	All
No change	100%	91%	95%
Lower portion contributed	0%	6%	3%
Higher portion contributed	0%	4%	2%
Total	100%	100%	100%
N=	38	54	92

TABLE A14: *How much does your business contribute for premiums for full-time employee and family coverage?*

	e<=10	e>10	All
100% of premium	45%	28%	36%
Amount equal to low-cost premium	8%	2%	5%
Amount less than low-cost premium	13%	13%	13%
Percent of premium for plan chosen	34%	57%	46%
Total	100%	100%	100%
N=	38	46	84

TABLE A15: *Change since last year?*

	e<=10	e>10	All
No change	94%	94%	94%
Lower portion contributed	3%	4%	4%
Higher portion contributed	3%	2%	3%
Total	100%	100%	100%
N=	33	47	80

TABLE A16: *How much has the total premium for (low cost) plan increased since last year?*

	e<=10	e>10	All
Decreased 5% or mo	0%	0%	0%
Decreased 1-4%	0%	0%	0%
No change	13%	5%	9%
Up 1-4%	9%	5%	7%
Up 5-10%	17%	12%	14%
Up 11-15%	19%	14%	16%
Up 16-20%	17%	11%	13%
Up more than 20%	26%	53%	40%
Total	100%	100%	100%
N=	47	57	104

TABLE A17: *Have deductibles and co-pays for (low-cost) plan changed since last year?*

	e<=10	e>10	All
No change	72%	62%	67%
Decreased	2%	4%	3%
Increased	26%	35%	30%
Total	100%	100%	100%
N=	47	55	102

TABLE A18: *Have services provided by (low-cost) plan changed since last year?*

	e<=10	e>10	All
No change	77%	76%	76%
Fewer services cover	21%	13%	17%
More services covered	2%	11%	7%
Total	100%	100%	100%
N=	47	54	101

TABLE A19: *Has coverage for care by local providers (e.g. doctors and hospitals in your community) by your low-cost health plan changed since last year?*

	e<=10	e>10	All
No change	91%	83%	86%
Less coverage	9%	13%	11%
More coverage	0%	4%	2%
Total	100%	100%	100%
N=	44	52	96

TABLE A20: *How have changes in your health insurance coverage affected your ability to recruit and retain employees?*

	e<=10	e>10	All
Decreased coverage decreased ability	21%	15%	18%
Little or no effect	75%	72%	74%
Increased coverage improved ability	4%	13%	8%
Total	100%	100%	100%
N=	81	60	141

TABLE A21: *Approximately how many insured people in your community would you estimate are not covered for care by local provider because those providers are not in insurance plan networks?*

	e<=10	e>10	All
None	11%	4%	8%
Some, but under one-fourth	41%	58%	48%
Between one-fourth and one-half	34%	33%	34%
Over one-half	13%	4%	9%
Total	100%	100%	100%
N=	61	45	106

TABLE A22: *Change since last year?*

	e<=10	e>10	All
No change	60%	77%	68%
Decreased	13%	4%	9%
Increased	27%	19%	23%
Total	100%	100%	100%
N=	30	26	56

TABLE A23: *On a scale of 1-10 (10 = most important), rate how important it is for your employees to have access to local health care providers.*

	e<=10	e>10	All
3 or less	6%	0%	4%
4	0%	0%	0%
5	5%	0%	3%
6	0%	2%	1%
7	2%	7%	4%
8	23%	13%	19%
9	17%	13%	16%
10	46%	65%	54%
Total	100%	100%	100%
N=	81	60	141

TABLE A24: *Is there an organization or group which helps your organization to have a working relationship with the local health providers to maintain or improve local health care?*

	e<=10	e>10	All
No	92%	86%	90%
Yes	8%	14%	10%
Total	100%	100%	100%
N=	79	59	138

What have local businesses done in the past three years?

TABLE A25: *Formed health care purchasing alliance?*

	e<=10	e>10	All
Not done	85%	76%	81%
Done a little	11%	18%	14%
Done a lot	5%	6%	5%
Total	100%	100%	100%
N=	66	49	115

TABLE A26: *Worked to increase insurance options?*

	e<=10	e>10	All
Not done	75%	41%	60%
Done a little	19%	45%	31%
Done a lot	6%	14%	10%
Total	100%	100%	100%
N=	63	51	114

TABLE A27: *Worked to increase health plan competition?*

	e<=10	e>10	All
Not done	79%	53%	67%
Done a little	18%	35%	25%
Done a lot	3%	12%	7%
Total	100%	100%	100%
N=	61	49	110

TABLE A28: *Discussed problems with local providers?*

	e<=10	e>10	All
Not done	58%	40%	50%
Done a little	37%	46%	41%
Done a lot	5%	14%	9%
Total	100%	100%	100%
N=	57	50	107

TABLE A29: *Contracted directly with local providers?*

	e<=10	e>10	All
Not done	66%	76%	70%
Done a little	25%	20%	23%
Done a lot	9%	4%	7%
Total	100%	100%	100%
N=	56	49	105

TABLE A30: *Worked to recruit new local providers?*

	e<=10	e>10	All
Not done	79%	77%	78%
Done a little	12%	21%	16%
Done a lot	9%	2%	6%
Total	100%	100%	100%
N=	58	48	106

TABLE A31: *Contracted with managed care payer?*

	e<=10	e>10	All
Not done	78%	66%	73%
Done a little	19%	26%	22%
Done a lot	3%	9%	6%
Total	100%	100%	100%
N=	59	47	106

TABLE A32: *Formed an insurance plan or HMO?*

	e<=10	e>10	All
Not done	86%	82%	84%
Done a little	7%	12%	9%
Done a lot	7%	6%	7%
Total	100%	100%	100%
N=	58	49	107

TABLE A33: *Became self-insured?*

	e<=10	e>10	All
Not done	73%	59%	67%
Done a little	13%	29%	20%
Done a lot	13%	12%	13%
Total	100%	100%	100%
N=	60	49	109

TABLE A34: *Purchased reinsurance or stop-loss coverage?*

	e<=10	e>10	All
Not done	91%	73%	83%
Done a little	9%	20%	14%
Done a lot	0%	7%	3%
Total	100%	100%	100%
N=	54	45	99

TABLE A35: *Paid risk-adjusted capitation rates?*

	e<=10	e>10	All
Not done	90%	88%	89%
Done a little	10%	12%	11%
Done a lot	0%	0%	0%
Total	100%	100%	100%
N=	49	43	92

TABLE A36: *Adopted employer fixed-contribution plan?*

	e<=10	e>10	All
Not done	67%	50%	59%
Done a little	21%	31%	26%
Done a lot	12%	19%	15%
Total	100%	100%	100%
N=	52	48	100

TABLE A37: *Requested bids for health care coverage?*

	e<=10	e>10	All
Not done	44%	18%	33%
Done a little	34%	41%	37%
Done a lot	21%	41%	30%
Total	100%	100%	100%
N=	61	49	110

TABLE A38: *Worked with providers on health education?*

	e<=10	e>10	All
Not done	73%	57%	66%
Done a little	23%	39%	30%
Done a lot	4%	4%	4%
Total	100%	100%	100%
N=	56	49	105

TABLE A39: *Lobbied for rural health care issues?*

	e<=10	e>10	All
Not done	61%	60%	60%
Done a little	36%	30%	33%
Done a lot	3%	11%	7%
Total	100%	100%	100%
N=	59	47	106

TABLE A40: *Dropped health care coverage for employees?*

	e<=10	e>10	All
Not done	73%	75%	74%
Done a little	22%	19%	20%
Done a lot	5%	6%	6%
Total	100%	100%	100%
N=	55	48	103

TABLE A41: *Expanded health care coverage for employees?*

	e<=10	e>10	All
Not done	72%	66%	69%
Done a little	23%	27%	25%
Done a lot	5%	7%	6%
Total	100%	100%	100%
N=	57	44	101

What have these business actions caused?

TABLE A42: *Improved access to local providers?*

	e<=10	e>10	All
No effect	67%	47%	56%
Done a little	27%	50%	39%
Done a lot	6%	3%	4%
Total	100%	100%	100%
N=	33	38	71

TABLE A43: *Improved quality of health for community?*

	e<=10	e>10	All
No effect	64%	50%	56%
Done a little	27%	45%	37%
Done a lot	9%	5%	7%
Total	100%	100%	100%
N=	33	38	71

TABLE A44: *Improved health status of community?*

	e<=10	e>10	All
No effect	71%	53%	61%
Done a little	19%	45%	33%
Done a lot	10%	3%	6%
Total	100%	100%	100%
N=	31	38	69

TABLE A45: *Added new local providers?*

	e<=10	e>10	All
No effect	79%	63%	70%
Done a little	18%	34%	27%
Done a lot	3%	3%	3%
Total	100%	100%	100%
N=	33	38	71

TABLE A46: *Avoided loss of local medical practice?*

	e<=10	e>10	All
No effect	70%	67%	68%
Done a little	24%	25%	25%
Done a lot	6%	8%	7%
Total	100%	100%	100%
N=	33	36	69

TABLE A47: *Avoided possible loss of local hospital?*

	e<=10	e>10	All
No effect	73%	59%	66%
Done a little	21%	35%	29%
Done a lot	6%	5%	6%
Total	100%	100%	100%
N=	33	37	70

TABLE A48: *Increased health insurance choices?*

	e<=10	e>10	All
No effect	76%	61%	68%
Done a little	24%	37%	31%
Done a lot	0%	3%	1%
Total	100%	100%	100%
N=	33	38	71

TABLE A49: *Increased flexibility in physician choice?*

	e<=10	e>10	All
No effect	67%	54%	60%
Done a little	30%	46%	38%
Done a lot	3%	0%	2%
Total	100%	100%	100%
N=	30	35	65

TABLE A50: *Better coverage of preventative services?*

	e<=10	e>10	All
No effect	73%	45%	57%
Done a little	23%	53%	40%
Done a lot	3%	3%	3%
Total	100%	100%	100%
N=	30	38	68

TABLE A51: *Better coverage of prescription drugs?*

	e<=10	e>10	All
No effect	77%	55%	65%
Done a little	23%	37%	30%
Done a lot	0%	8%	4%
Total	100%	100%	100%
N=	31	38	69

TABLE A52: *Better coverage of other services?*

	e<=10	e>10	All
No effect	75%	65%	70%
Done a little	25%	32%	29%
Done a lot	0%	3%	1%
Total	100%	100%	100%
N=	32	37	69

TABLE A53: *Lower co-pays or deductibles?*

	e<=10	e>10	All
No effect	75%	82%	79%
Done a little	22%	18%	20%
Done a lot	3%	0%	1%
Total	100%	100%	100%
N=	32	38	70

TABLE A54: *Lower health insurance premiums?*

	e<=10	e>10	All
No effect	75%	82%	79%
Done a little	25%	16%	20%
Done a lot	0%	3%	1%
Total	100%	100%	100%
N=	32	38	70

TABLE A55: *Reduced middle-man cost of insurance?*

	e<=10	e>10	All
No effect	84%	85%	85%
Done a little	16%	15%	15%
Done a lot	0%	0%	0%
Total	100%	100%	100%
N=	31	34	65

TABLE A56: *Higher payment rates to local providers?*

	e<=10	e>10	All
No effect	74%	79%	77%
Done a little	19%	15%	17%
Done a lot	6%	6%	6%
Total	100%	100%	100%
N=	31	33	64

TABLE A57: *More prompt payment to local providers?*

	e<=10	e>10	All
No effect	77%	87%	82%
Done a little	16%	10%	13%
Done a lot	6%	3%	5%
Total	100%	100%	100%
N=	31	31	62

TABLE A58: *More local control of health care?*

	e<=10	e>10	All
No effect	75%	81%	78%
Done a little	19%	16%	17%
Done a lot	6%	3%	5%
Total	100%	100%	100%
N=	32	31	63

TABLE A59: *Three models: Effects of business actions on premium inflation, access to local providers, and overall cost and access*

Dependent Variable	Constrain Premium Inflation	Access Local Providers	Overall Cost & Access
R-Squared =	.50	.48	.30
F-Test Significance =	.000009	.000009	.002388
Variables and Coefficients:			
Constant	.576730***	.549930***	12.13***
Log of number employees	-.005413	.052662	-.001635
Years in operation	.000967	-.000555	-.025165
Form purchasing alliance	.302430*	___	2.93*
Help recruit local providers	___	.221790~	___
Contract with local providers	___	___	3.57*
Form health plan or HMO	.282970**	.409530***	___
Purchase reinsurance/stop-loss	-.323680~	___	___
Adopt fixed contribution plan	.184340*	.189270~	3.44*
Drop health care coverage	___	-.272470**	-3.9*

Coefficient Significance:
~=p<.1
**=p<.05*
***=p<.01*
****=p<.001*

APPENDIX B: PROVIDER SURVEY RESULTS

Tables B1 - B57

TABLE B1: *In which area are you located?*

	PtsUp	NotUp	All
Northwest Minnesota	40%	45%	43%
Southwest Minnesota	60%	55%	57%
Total	100%	100%	100%
N=	10	11	21

TABLE B2: *How many health insurance plans do you contract with?*

	PtsUp	NotUp	All
none	0%	0%	0%
1-4	56%	18%	35%
5-9	33%	27%	30%
10 or more	11%	55%	35%
total	100%	100%	100%
N=	9	11	20

TABLE B3: *Change since last year?*

	PtsUp	NotUp	All
no change	63%	18%	37%
decreased	13%	0%	5%
increased	25%	82%	58%
total	100%	100%	100%
N=	8	11	19

TABLE B4: *How many provider networks are you part of?*

	PtsUp	NotUp	All
none	0%	0%	0%
1-4	80%	70%	75%
5-9	20%	30%	25%
10 or more	0%	0%	0%
total	100%	100%	100%
N=	10	10	20

TABLE B5: *Change since last year?*

	PtsUp	NotUp	All
no change	75%	50%	61%
decreased	13%	0%	6%
increased	13%	50%	33%
total	100%	100%	100%
N=	8	10	18

TABLE B6: *Approximately how many people in your community are not covered to receive care at your organization because you are not in their plan network?*

	PtsUp	NotUp	All
none	60%	9%	33%
some, but under one-fourth	40%	91%	67%
between one-fourth and one-half	0%	0%	0%
over one-half	0%	0%	0%
total	100%	100%	100%
N=	10	11	21

TABLE B7: *Change since last year?*

	PtsUp	NotUp	All
no change	78%	50%	63%
decreased	22%	30%	26%
increased	0%	20%	11%
total	100%	100%	100%
N=	9	10	19

TABLE B8: *Has the number of physicians practicing in your organization changed since last year?*

	PtsUp	NotUp	All
no change	10%	36%	24%
decreased	10%	9%	10%
increased	80%	55%	67%
total	100%	100%	100%
N=	10	11	21

TABLE B9: *Has the number of primary care physicians in your organization changed since last year?*

	PtsUp	NotUp	All
no change	20%	45%	33%
decreased	10%	9%	10%
increased	70%	45%	57%
total	100%	100%	100%
N=	10	11	21

TABLE B10: *Has the number of nurse practitioners or physician assistants in your organization changed since last year?*

	PtsUp	NotUp	All
no change	44%	73%	60%
decreased	0%	0%	0%
increased	56%	27%	40%
total	100%	100%	100%
N=	9	11	20

TABLE B11: *What percentage of your reimbursement is based on capitation payments?*

	PtsUp	NotUp	All
none	50%	20%	35%
some, but under one-fourth	50%	70%	60%
between one-fourth and one-half	0%	0%	0%
between one-half and three-quarters	0%	10%	5%
over three-quarters, but not all	0%	0%	0%
all	0%	0%	0%
total	100%	100%	100%
N=	10	10	20

TABLE B12: *Change since last year?*

	PtsUp	NotUp	All
no change	100%	89%	94%
gone down	0%	0%	0%
gone up	0%	11%	6%
total	100%	100%	100%
N=	8	9	17

TABLE B13: *Has the number of patients served by your organization changed since last year?*

	PtsUp	NotUp	All
no change	0%	45%	24%
gone down	0%	55%	29%
gone up	100%	0%	48%
total	100%	100%	100%
N=	10	11	21

TABLE B14: *How much have your average reimbursement rates changed since last year?*

	PtsUp	NotUp	All
down more than 10%	8%	0%	5%
down 5-10%	33%	25%	30%
down 1-4%	0%	25%	10%
no change	8%	13%	10%
up 1-4%	17%	13%	15%
up 5-10%	33%	25%	30%
up more than 10%	0%	0%	0%
total	100%	100%	100%
N=	12	8	20

TABLE B15: *What is your organization's approximate expense inflation since last year?*

	PtsUp	NotUp	All
down 10%	0%	0%	0%
down 5-10%	25%	0%	11%
down 1-4%	25%	20%	22%
no change	0%	40%	22%
up 1-4%	25%	20%	22%
up 5-10%	25%	20%	22%
up more than 10%	0%	0%	0%
total	100%	100%	100%
N=	4	5	9

TABLE B8: *Has the number of physicians practicing in your organization changed since last year?*

	PtsUp	NotUp	All
no change	10%	36%	24%
decreased	10%	9%	10%
increased	80%	55%	67%
total	100%	100%	100%
N=	10	11	21

TABLE B16: *How have your organization's internal costs associated with managed care contracts changed since last year (negotiation compliance, monitoring, UR, prior authorization, claims review)?*

	PtsUp	NotUp	All
down more than 5%	0%	0%	0%
down 1 to 5%	0%	0%	0%
no change	50%	14%	33%
up 1 to 5%	50%	86%	67%
up 6 to 10%	0%	0%	0%
up more than 10%	0%	0%	0%
total	100%	100%	100%
N=	8	7	15

TABLE B17: *Is there an organization or group which helps your organization to have a working relationship with the local businesses to maintain or improve local health care?*

	PtsUp	NotUp	All
no	80%	82%	81%
yes	20%	18%	19%
total	100%	100%	100%
N=	10	11	21

What have local providers done (in the past three years)?

TABLE B18: *Local hospitals joined together in a network*

	PtsUp	NotUp	All
not done	10%	18%	14%
done a little	50%	18%	33%
done a lot	40%	64%	52%
N=	10	11	21

TABLE B19: *Hospital joined a non-local system*

	PtsUp	NotUp	All
not done	60%	64%	62%
done a little	30%	9%	19%
done a lot	10%	27%	19%
N=	10	11	21

TABLE B20: *Local medical practices joined together*

	PtsUp	NotUp	All
not done	90%	45%	67%
done a little	10%	27%	19%
done a lot	0%	27%	14%
N=	10	11	21

TABLE B21: *Medical practice joined non-local system*

	PtsUp	NotUp	All
not done	80%	45%	62%
done a little	20%	18%	19%
done a lot	0%	36%	19%
N=	10	11	21

TABLE B22: *Local nursing home joined together*

	PtsUp	NotUp	All
not done	100%	82%	90%
done a little	0%	9%	5%
done a lot	0%	9%	5%
N=	10	11	21

TABLE B23: *Nursing home joined non-local system*

	PtsUp	NotUp	All
not done	90%	82%	86%
done a little	10%	0%	5%
done a lot	0%	18%	10%
N=	10	11	21

TABLE B24: *Practice and hospital joined together*

	PtsUp	NotUp	All
not done	70%	55%	62%
done a little	30%	18%	24%
done a lot	0%	27%	14%
N=	10	11	21

TABLE B25: *Hospital and nursing home joined together*

	PtsUp	NotUp	All
not done	80%	64%	71%
done a little	10%	9%	10%
done a lot	10%	27%	19%
N=	10	11	21

TABLE B26: *Practice and nursing home joined together*

	PtsUp	NotUp	All
not done	100%	82%	90%
done a little	0%	9%	5%
done a lot	0%	9%	5%
N=	10	11	21

TABLE B27: *Formed a provider network or alliance*

	PtsUp	NotUp	All
not done	20%	18%	19%
done a little	30%	36%	33%
done a lot	50%	45%	48%
N=	10	11	21

TABLE B28: *Contracted with a managed care payer*

	PtsUp	NotUp	All
not done	10%	9%	10%
done a little	50%	36%	43%
done a lot	40%	55%	48%
N=	10	11	21

TABLE B29: *Capitation payment from Medicare*

	PtsUp	NotUp	All
not done	90%	73%	81%
done a little	10%	9%	10%
done a lot	0%	18%	10%
N=	10	11	21

TABLE B30: *Capitation payment from an HMO*

	PtsUp	NotUp	All
not done	60%	45%	52%
done a little	30%	45%	38%
done a lot	10%	9%	10%
N=	10	11	21

TABLE B31: *Capitation payment from self-insured business*

	PtsUp	NotUp	All
not done	100%	82%	90%
done a little	0%	9%	5%
done a lot	0%	9%	5%
N=	10	11	21

TABLE B32: *Formed an insurance plan or HMO*

	PtsUp	NotUp	All
not done	90%	73%	81%
done a little	0%	18%	10%
done a lot	10%	9%	10%
N=	10	11	21

TABLE B33: *Worked with local businesses*

	PtsUp	NotUp	All
not done	10%	0%	5%
done a little	70%	64%	67%
done a lot	20%	36%	29%
N=	10	11	21

TABLE B34: *Formed alliance with local businesses*

	PtsUp	NotUp	All
not done	80%	64%	71%
done a little	20%	27%	24%
done a lot	0%	9%	5%
N=	10	11	21

TABLE B35: *Worked with community on health education*

	PtsUp	NotUp	All
not done	0%	9%	5%
done a little	80%	55%	67%
done a lot	20%	36%	29%
N=	10	11	21

TABLE B36: *Expanded NP or PA practitioner services*

	PtsUp	NotUp	All
not done	20%	36%	29%
done a little	50%	36%	43%
done a lot	30%	27%	29%
N=	10	11	21

TABLE B37: *Developed a limited-service hospital*

	PtsUp	NotUp	All
not done	90%	82%	86%
done a little	10%	9%	10%
done a lot	0%	9%	5%
N=	10	11	21

TABLE B38: *Recruited new providers to the area*

	PtsUp	NotUp	All
not done	0%	0%	0%
done a little	60%	36%	48%
done a lot	40%	64%	52%
N=	10	11	21

TABLE B39: *Formed a joint purchasing group*

	PtsUp	NotUp	All
not done	50%	64%	57%
done a little	30%	27%	29%
done a lot	20%	9%	14%
N=	10	11	21

TABLE B40: *Lobbied for rural health issues*

	PtsUp	NotUp	All
not done	10%	18%	14%
done a little	60%	36%	48%
done a lot	30%	45%	38%
N=	10	11	21

What have these provider actions caused?

TABLE B41: *Improved access to local providers?*

	PtsUp	NotUp	All
no effect	10%	27%	19%
done a little	70%	36%	52%
done a lot	20%	36%	29%
total	100%	100%	100%
N=	10	11	21

TABLE B42: *Improved quality of health for community?*

	PtsUp	NotUp	All
no effect	10%	36%	24%
done a little	70%	36%	52%
done a lot	20%	27%	24%
total	100%	100%	100%
N=	10	11	21

TABLE B43: *Improved health status of community?*

	PtsUp	NotUp	All
no effect	20%	45%	33%
done a little	80%	36%	57%
done a lot	0%	18%	10%
total	100%	100%	100%
N=	10	11	21

TABLE B44: *Added new local providers?*

	PtsUp	NotUp	All
no effect	10%	9%	10%
done a little	50%	45%	48%
done a lot	40%	45%	43%
total	100%	100%	100%
N=	10	11	21

TABLE B45: *Avoided loss of local medical practice?*

	PtsUp	NotUp	All
no effect	70%	27%	48%
done a little	10%	55%	33%
done a lot	20%	18%	19%
total	100%	100%	100%
N=	10	11	21

TABLE B46: *Avoided possible loss of local hospital?*

	PtsUp	NotUp	All
no effect	60%	55%	57%
done a little	20%	36%	29%
done a lot	20%	9%	14%
total	100%	100%	100%
N=	10	11	21

TABLE B47: *Increased health insurance choices?*

	PtsUp	NotUp	All
no effect	50%	18%	33%
done a little	40%	55%	48%
done a lot	10%	27%	19%
total	100%	100%	100%
N=	10	11	21

TABLE B48: *Increased flexibility in physician choice?*

	PtsUp	NotUp	All
no effect	20%	27%	24%
done a little	60%	45%	52%
done a lot	20%	27%	24%
total	100%	100%	100%
N=	10	11	21

TABLE B49: *Better coverage of preventative services?*

	PtsUp	NotUp	All
no effect	40%	36%	38%
done a little	40%	45%	43%
done a lot	20%	18%	19%
total	100%	100%	100%
N=	10	11	21

TABLE B50: *Better coverage of prescription drugs?*

	PtsUp	NotUp	All
no effect	80%	73%	76%
done a little	10%	9%	10%
done a lot	10%	18%	14%
total	100%	100%	100%
N=	10	11	21

TABLE B51: *Better coverage of other services?*

	PtsUp	NotUp	All
no effect	60%	64%	62%
done a little	20%	18%	19%
done a lot	20%	18%	19%
total	100%	100%	100%
N=	10	11	21

TABLE B52: *Lower copays or deductibles?*

	PtsUp	NotUp	All
no effect	90%	91%	90%
done a little	0%	9%	5%
done a lot	10%	0%	5%
total	100%	100%	100%
N=	10	11	21

TABLE B53: *Lower health insurance premiums?*

	PtsUp	NotUp	All
no effect	90%	82%	86%
done a little	10%	9%	10%
done a lot	0%	9%	5%
total	100%	100%	100%
N=	10	11	21

TABLE B54: *Reduced middle man cost of insurance?*

	PtsUp	NotUp	All
no effect	90%	73%	81%
done a little	10%	27%	19%
done a lot	0%	0%	0%
total	100%	100%	100%
N=	10	11	21

TABLE B55: *Higher payment rates to local providers?*

	PtsUp	NotUp	All
no effect	80%	91%	86%
done a little	20%	9%	14%
done a lot	0%	0%	0%
total	100%	100%	100%
N=	10	11	21

TABLE B56: *More prompt payment to local providers?*

	PtsUp	NotUp	All
no effect	90%	82%	86%
done a little	10%	9%	10%
done a lot	0%	9%	5%
total	100%	100%	100%
N=	10	11	21

TABLE B57: *More local control of health care?*

	PtsUp	NotUp	All
no effect	40%	36%	38%
done a little	60%	45%	52%
done a lot	0%	18%	10%
total	100%	100%	100%
N=	10	11	21