Stark Regulations and Health Care in Rural America

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Over the past twenty years, Congressman Fortney "Pete" Stark (D-CA) has taken a special interest in, and substantially impacted regulations regarding, self-interest referrals within the health professions. It may be true that some unscrupulous physicians in the past took advantage of a system which allowed them to refer patients to entities in which they had ownership, but the overall effect of "Stark laws" has been to chill a large source of investment in our US healthcare system. This has made us less and less competitive over time. This is especially true since corporate entities control a larger and larger portion of new investment (with attendant merger/acquisition activity and consolidation/concentration of market forces). "Stark laws," although publicly lauded, have had adverse effects on physicians and hospitals. Rural providers are more able than most to understand the needs in their local markets. They react by investing in ventures that, for the most part, would not be set up for individual benefit, but rather to serve and unmet need. Porter and Teisberg, in their recent *Harvard Business Review* article (June 2004) are quite blunt in their assessment of US healthcare as having problems – mostly that we "compete on the wrong things." In short, healthcare is not a competitive market at all as we know it, and some of the regulatory initiatives (Stark I, II, and "R"), put in place with good intentions, have created more dysfunctional and less competitive markets within US healthcare. Prevention of investment in new facilities causes our healthcare system to function less and less like a free market, with attendant increased costs, but without quality gains Porter and Teisberg, 68).

Regulation has had its most destructive effect, and concurrently had the least effect on combating fraud, in our rural health care system. Here a limited pool of investors for new health market initiatives is further restricted by the exclusion of physicians as major investors. Porter and Teisberg (67) direct most of their focus onto "wrongly focused efforts at cost reduction, when value improvements should be the primary goal." Rural healthcare already suffers from poor reimbursement (relative to overhead costs) and poor overall utilization, but for many small towns in America, the hospital is a major employer. The hospital is often a major reason for industry (if it is considering rural relocation) to consider a particular community. Barr, in *Introduction to US Health Policy* lists rural "access to care" as a significant barrier for individuals (216), all the more reason for small rural communities to desire to hold onto their facilities. Employers want healthcare available for their employees, and they are unlikely to relocate to communities without a hospital – no matter its size.

Organizations representing the medical community, such as the American Medical Association, tend to be dominated by members in large population centers. Indeed, about 90% of physicians

are located in non-rural areas (National Rural Health Association fact sheet, 2004). Their interests in regard to rural health initiatives are minimal as would be expected, especially if contemplated reforms tend to favor rural members at the expense of urban and suburban members. Freeing up regulatory oversight initiatives by allowing market division and greater physician investment in hospital market ventures is unlikely to make it to the top of the AMA advocacy agenda. Such would defeat public and governmental intent at control with "Stark" and "DHS" regulations. AMA would be unlikely to support initiatives benefiting only rural members, even though overall US health improvement could be a potential net result. Why should they support sweeping regulatory change at all? The AMA's direction has been to push for exemptions to the "Stark" and "DHS" regulations, since that has been the politically expedient approach. Piecemeal exemptions will not benefit the rural healthcare system to any great extent.

Perhaps a basic review of our current rural healthcare system is in order. Rural hospitals have low bed capacity, and a much greater percentage of their costs go to overhead (certain minimum staffing levels are imperative even at low census). Rural hospitals exist for some of the same reasons that most hospitals do, but rural facilities are vastly different in terms of the choices provided and the distances involved for US citizens in receiving care. According to the NHRA, 25% of the US population, but only 10% of the physicians, are rural (NHRA documents, 2004). Reimbursements from Medicare in the rural setting cover only 90% when looking at payment-to-cost ratio (NHRA). Glover, Moore, et al, note significantly decreased access to care among the working-age adults in rural settings when compared to urban settings. As our population ages and shifts to rural settings, there will be an even greater demand for healthcare in small town America. A certain number of rural facilities must exist, or we place large numbers of our population (both now and in the future) beyond the reach of adequate emergency, urgent care, and basic healthcare services.

Government reimbursements do not address the competitive market nature, only the "survival issue" for rural healthcare. More needs to be done to help (Anderson, 507). Rural markets could benefit from selected aspects of competition such as being distinctive in one market segment. Markets that are truly competitive however, would result in most of our rural hospitals being unable to survive. Although the authors of this paper favor competition, closings of rural facilities would be a healthcare disaster for rural communities, and overall levels of rural health would fall, not to mention the economic fallout on communities that would certainly follow. There are better alternatives for rural and underserved areas, while still allowing some forms of competition. Continued existence for these facilities may mean changes in the nature of their mission. Certainly basic emergency services are a given, but if these small hospitals could somehow "divide their markets" by agreeing not to compete in all areas without coming under antitrust or regulatory restriction, they could remain viable, profitable businesses within rural America. Take for example a market segment which requires a certain volume both to be profitable and achieve quality outcomes. Cardiac rehabilitation comes to mind. In a rural market, very few hospitals could achieve the volumes required for successful cardiac rehabilitation services – but one small hospital in a region could effectively specialize in that arena. Porter and Teisberg (73) suggest that providers "not try to match competitors every move." A group of four or five hospitals could each specialize in a "niche," not choosing competition but rather complementary specialization. All would benefit, and so would overall health for this population. Meanwhile, there would be no need for funds to leave the communities. In this manner, a larger portion of overall healthcare dollars would remain local and fewer would be spent in larger facilities. This would mean benefits in quality, as well. Greater numbers of cases in healthcare mean greater experience gains, and almost always quality improvements measured in outcomes for patients (Porter and Teisberg, 73).

Currently, both antitrust and Stark provisions would be violated in such a plan. Only the largest rural facilities would survive, resulting in the slow withering of the smaller facilities as the big get bigger, stronger, and more profitable. These larger facilities might be tempted to acquire smaller facilities rather than aligning with them or changing their basic mission. Dyer (109) makes a strong point that acquisitions are not always the best. Alliances that benefit both parties are often better than acquisitions in which both parties end up financially damaged. Regulations should be changed to allow for this. Outside of the rural setting, this would enable greater competition. In the rural setting, facilities can continue to exist, and market division allowing for specialization might mean greater profitability. Part of the difficulty in relaxing regulations will be ensuring that patients are not harmed. This was the rationale for many of the regulations in the first place. Many rural markets are not large enough to support more than a single entity in each arena (hospital, nursing home, home health agency), so preventing the opening of an entity means that no service will be available at all.

Restricting physicians from partnering with each other and with hospitals in the rural setting means that many will not explore options, even within the current framework. No chances taken mean no violations. Rural physicians, even with lower incomes than those in urban and suburban settings, are often the individuals in a small community with disposable income that would be available for investment in new rural health ventures. Examples would be buying a new piece of equipment, or in partnering with other providers for a service line. Restricting those investments through regulations meant to accomplish other goals only damages these facilities, communities, and those they aim to serve. Hospitals and providers should not be discouraged from alliances. Government should actually find ways to help. Stark “R” would simplify some aspects, but would impose contractual and written requirements on these arrangements in rural settings (Pontius). This would seem to be regulatory overkill in a setting where there is only one facility offering a particular service. What would the regulation accomplish except to discourage new entities from being formed?

There are components of the new “Stark R” regulation which could help rural providers. Easing “direct supervision” requirements would help benefit small towns that have been encouraged to utilize physician-extenders to reach further into rural areas (Barr, 216). Allowing those with the most market knowledge and capital (rural physicians and rural hospitals) to explore these scenarios without fear of governmental violation might encourage investment and a healthier marketplace. Also, there is a financial side benefit of no small measure to the individual patient and the community. Government should not ignore of belittle rural healthcare. It is fundamentally different than its urban/suburban cousin. Less regulation in the rural setting would not be likely to increase fraud, but it would help those Americans most by allowing investment and varied competition. The authors of this paper encourage legislators to carefully consider the unique nature of rural healthcare as they plan and consider upcoming legislation in this field. We also encourage healthcare administrators in all fields to be vocal in their support of less regulation, and wiser regulation, of the healthcare marketplace. That government is best which governs least? Yes, when it comes to rural healthcare, we believe that John Locke was exactly right.

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